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SUBJECT: LER 90-002-00:on 900226,fire watch patrol hourly patrol performed in wrong areas due to personnel error.
W/9 ltr.

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March 23, 1990

U. S. Nuclear Regulatory Commission
Document Control Desk
Washington, DC 20555

Subject: LER 90-002, Fire Watch Patrol Performed Technical Specification Hourly Patrol in the Wrong Areas Due to Personnel Error.
R. E. Ginna Nuclear Power Plant
Docket No. 50-244

In accordance with 10CFR50.73, Licensee Event Report System, Item (a)(2)(i)(B), which requires reporting of "Any Operation Or Condition Prohibited by the Plant's Technical Specifications", the attached Licensee Event Report LER 90-002 is being submitted.

This LER is being submitted because an Hourly Fire Watch Patrol patrolled the wrong area and did not meet the Ginna Technical Specification 3.14 requirements for hourly patrol for two (2) Technical Specifications systems.

This event in no way affected the public health and safety.

Very truly yours,

Robert C. Mecredy
Division Manager
Nuclear Production

xc: U. S. Nuclear Regulatory Commission
Region I
475 Allendale Road
King of Prussia, PA 19406

Ginna USNRC Senior Resident Inspector

IE22 Cert No. P340957205
1/1

NRC Form 366 (9-83)

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/85

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
R. E. Ginna Nuclear Power Plant	0 5 0 0 0 2 4 4	1 OF 0 5

TITLE (4) Fire Watch Patrol Performed Technical Specification Hourly Patrol in the Wrong Areas Due to Personnel Error.

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES	DOCKET NUMBER(S)
										0 5 0 0 0
0 2	2 6	9 0	9 0	0 0 2	0 0	0 3	2 8	9 0		0 5 0 0 0

OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)			
POWER LEVEL (10)	98	20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)
		20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)
		20.405(a)(1)(ii)	50.36(c)(2)	50.73(a)(2)(vii)	X OTHER (Specify in Abstract below and in Text, NRC Form 366A)
		20.405(a)(1)(iii)	X 50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	
		20.405(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(viii)(B)	
		20.405(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
Mark E. Cavanaugh Fire Protection Engineer	AREA CODE 3 1 5 5 2 4 - 4 4 4 6

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS

SUPPLEMENTAL REPORT EXPECTED (14)		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE)	X NO				

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

On February 26, 1990, at approximately 1544 EST with the Reactor at approximately 98%, it was determined that the roving Fire Watch that was assigned to perform the hourly tours of the "A" and "B" Battery Rooms mistakenly performed the tours of the "A" and "B" Diesel Generator Rooms. The error was identified by the responsible Fire Watch during an afternoon pre-turnover meeting.

Immediate action was to ensure an hourly patrol covered the "A" and "B" Battery Rooms.

The cause of the event was determined to be personnel error by the assigned Fire Watch.

Corrective action has been taken by the Fire Protection section by issuing a card to each individual performing a Technical Specification Fire Watch commitment, which identifies the area of their responsibility.

NRC Form 366 (9-83)

I. INITIAL PLANT CONDITION

The plant was at approximately 98% steady state full power with no major activities in progress.

II. DESCRIPTION OF EVENT

A. DATES AND APPROXIMATE TIMES FOR MAJOR OCCURRENCES:

. February 26, 1990, 1544 EST: Discovery date and time.

. February 26, 1990, 1551 EST: Fire Watch correctly performed hourly patrol of "A" and "B" Battery Rooms, in compliance with Technical Specifications.

. February 26, 1990, 1744 EST: Fire Detection System which was inoperable due to construction activities was restored to service.

B. EVENT:

. On February 26, 1990, at approximately 1544 EST with the Reactor at approximately 98% full power, it was determined by the Fire Watch Patrol that she was touring the "A" and "B" Diesel Generator Rooms instead of the "A" and "B" Battery Rooms.

. On February 26, 1990, at approximately 1551 EST, a Fire Watch was sent to the "A" and "B" Battery Rooms to perform the hourly tour.

C. INOPERABLE STRUCTURES, COMPONENTS OR SYSTEM THAT CONTRIBUTED TO THE EVENT:

. Inoperable Fire Detection System - Pyrotronics

D. OTHER SYSTEMS OR SECONDARY FUNCTIONS AFFECTED:

None

E. METHOD OF DISCOVERY:

This event was discovered by the responsible Fire Watch during an afternoon turn-over meeting.

F. OPERATOR ACTION:

The control room operators were notified by the Safety Coordinator at which time they performed the following:

- Initiated an A-25.1 Ginna Station Event Report
- Notified Duty Engineer
- Notified Shift Technical Advisor (STA)
- Notified Plant Superintendent
- Notified Nuclear Regulatory Commission Resident Inspector

G. SAFETY SYSTEM RESPONSES:

- None

III. CAUSE OF EVENT

A. IMMEDIATE CAUSE:

Technical Specifications fire detection system was not Fire Watch toured hourly.

B. ROOT CAUSE:

The root cause was determined to be unintentional human error.

IV. ANALYSIS OF EVENT

Hourly Fire Watch tours of two (2) Technical Specifications areas with inoperable fire detection systems were not conducted so Technical Specifications 3.14.1 and 3.14.1.1 were not met. This event is reportable in accordance with 10CFR50.73, Licensee Event Report System, Item (a)(2)(i)(B), which requires reporting of, "Any Operation Or Condition Prohibited by the Plant's Technical Specifications".

An assessment was performed considering the safety of this event with the following results and conclusions:

There were no operational or safety consequences or implications attributed to the inoperable fire detection system because:

Inoperable Fire Detection System "A" Battery Room:

- The fire area for the "A" Battery Room has a maximum permissible fire load of 160,000 BTU's/Sq. Ft. with an actual fire load of 44,021 BTU's/Sq.Ft. The actual fire load of 44,021 BTU's/Sq.Ft. is considered low (<80,000 BTU's/Sq.Ft.). The wall separating the "A" Battery Room from the Turbine Building is a 2 hour rated wall. The wall separating the "A" Battery Room from the "B" Battery Room is a 2 hour rated wall. The wall separating the "A" Battery Room from the Air Handling Room is a 2 hour rated wall.

Inoperable Fire Detection System "B" Battery Room:

- The fire area for the "B" Battery Room has a maximum permissible fire load of 160,000 BTU's/Sq.Ft. with an actual fire load of 52,656 BTU's/Sq.Ft. The actual fire load of 52,656 BTU's/Sq.Ft. is considered low(<80,000 BTU's/Sq.Ft.). The wall separating the "B" Battery Room from the Turbine Building is a 2 hour rated wall. The wall separating the "B" Battery Room from the "A" Battery Room is a 2 hour rated wall.

- These two fire areas/zones (BR1A-1 and BR1B-1) have fire extinguishing equipment within the area and there are hose stations adjacent to them.

- The fire detection system for the area adjacent to the "A" and "B" Battery Room in the Turbine Building basement was operable.

- The fire suppression system for the area adjacent to the "A" Battery Room in the Air Handling Room was operable.

- No work was performed in either of the "A" or "B" Battery Rooms.

Based on the above, it can be concluded that the public's health and safety was assured at all times.

V. CORRECTIVE ACTION

A. ACTION TAKEN TO RETURN INOPERABLE FIRE DETECTION SYSTEM TO OPERABLE STATUS:

- Fire System reconnect was performed under plant procedure SC-3.16.2.4 Fire Signaling System/Component Disconnection - Reconnection

- System declared operable on February 26, 1990 at 1744 EST.

B. ACTION TAKEN OR PLANNED TO PREVENT RECURRENCE:

- As the root cause was determined to be a personnel error, the Fire Watch Supervisor has been instructed to follow-up the assignments given to fire watches to ensure they are going to the right area. Index cards have also been issued to the Fire Watch to ensure they have written instructions on where their patrols are to be conducted.

VI. ADDITIONAL INFORMATION

A. FAILED COMPONENTS:

None

B. PREVIOUS LER'S ON SIMILAR EVENTS:

A similar LER event historical search was conducted with the following results: No documentation of similar LER events with the same root cause at Ginna Station could be identified.

C. SPECIAL COMMENTS:

During the five (5) hours in which the assigned Fire Watch inspected the incorrect area, Security entered the area of concern ten (10) times.