PSEG

Public Service Electric and Gas Company P.O. Box 236 Hancocks Bridge, New Jersey 08038

Salem Generating Station

July 30, 1992

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

Dear Sir:

SALEM GENERATING STATION
LICENSE NO. DPR-70
DOCKET NO. 50-272
UNIT NO. 1

LICENSEE EVENT REPORT 92-016-00

This Licensee Event Report is being submitted pursuant to the requirements of the Code of Federal Regulations 10CFR 50.73(a)(2)(i)(B). This report is required to be issued within thirty (30) days of event discovery.

Sincerely yours,

C. A Vondra
General Manager -
Salem Operations

MJP:pc

Distribution

400092

IE22
1/1

NRC FORM 366 (6-89)

U.S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT (LER)

APPROVED OMB NO. 3150-0104
EXPIRES: 4/30/92
ESTIMATED BURDEN PER RESPONSE TO COMPLY WTH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Salem Generating Station - Unit 1	0 5 0 0 0 2 7 2	1 OF 0 5

TITLE (4)

Noncompliance with Tech. Spec. 3.7.11 Action "a" 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)
									Salem Unit 2	0 5 0 0 0 3 1 1
0 7	0 1	9 2	9 2	0 1 6	0 0	0 7	3 0	9 2	HCGS	0 5 0 0 0 3 5 4

OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)			
5		20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)
POWER LEVEL (10)	0 0 0	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)	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
	AREA CODE
M.J. Pollack - LER Coordinator	6 0 9 3 3 9 - 2 0 2 2

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

CAUSE	SYSTEM	COMPONENT	MANUFAC-TURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFAC-TURER	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 July 1, 1992, firewatch supervision discovered that firewatch rove personnel at the Hope Creek Generating Station (HCGS) were apparently not performing rounds. Further investigation revealed that this problem also existed with Salem Generating Station (both Hope Creek and Salem are located on the same site). Investigation revealed that seventeen of the 35 firewatch personnel were involved in this event. The uncompleted firewatch roves is contrary to the requirements of Salem Station Technical Specification 3.7.11 Action "a". The cause of the occurrences was failure to comply with specific instructions and inappropriate work practices by personnel performing the roves. Lack of adequate supervision and contractor oversight were also contributing factors. Investigation is continuing to understand and address all contributing root causal factors. Corrective action taken included: suspension of the firewatch personnel involved; instructing firewatch supervisors on their responsibilities for ensuring firewatch roves are correctly completed; review of this event with current firewatch employees; copies of recent NRC notices on falsification of records were posted and distributed to current firewatch employees; and supervisors will be retrained in supervisory techniques relating to people skills. A review of current practices for control of contractors will be conducted and corrective action will be taken as appropriate.

PLANT AND SYSTEM IDENTIFICATION:

Westinghouse - Pressurized Water Reactor

Energy Industry Identification System (EIIS) codes are identified in the text as {xx}

IDENTIFICATION OF OCCURRENCE:

Noncompliance with Technical Specification 3.7.11 Action "a" due to personnel error.

Discovery Date: 07/01/92

Report Date: 07/30/92

This report was initiated by Incident Report No. 92-417.

CONDITIONS PRIOR TO OCCURRENCE:

Salem Unit 1: Mode 5 (Cold Shutdown)
Salem Unit 2: Mode 5
Hope Creek: Mode 1 Rx. Power 100% 1100 MWe

DESCRIPTION OF OCCURRENCE:

On July 1, 1992, at 1705 hours, an Assistant Firewatch Supervisor noticed a firewatch, assigned to a roving patrol, was off his assigned round location. After performing the firewatch patrol herself, the Assistant Supervisor notified the on duty Senior Firewatch Supervisor that the firewatch assigned to the Hope Creek Generating Station (HCGS) Service Water structure was apparently not performing his rounds. When the firewatch assigned to the HCGS Service Water structure called his rove into the firewatch office, he was questioned and admitted that he had not checked the structure. He further admitted he did not check any areas on the Hope Creek site except the 163' elevation in the Radwaste building.

As a result of this initial finding, the firewatch contractor and PSE&G began in depth investigations to determine if additional areas were missed and/or other firewatch personnel were not performing their assigned roves. Preliminary findings indicated several of the firewatch personnel were negligent in completing their rounds at both the Hope Creek and Salem Stations. It was reported to Salem Operations that the 84' to 64' elevation switchgear room roves were missed on 07/01/92 at 0740 hours. A review of the card reader access system revealed 17 firewatch personnel had not entered areas which they logged as checking on their rove logs. PSE&G immediately suspended site access to those employees who had missed any locations of their assigned rove.

The uncompleted firewatch roves are contrary to the requirements of

DESCRIPTION OF OCCURRENCE: (cont'd)

Salem Station Technical Specification 3.7.11 Action "a" which states:

> "With one (1) or more of the above required fire barrier penetrations inoperable, within one hour either establish a continuous fire watch on at least one side of the affected penetration, or verify the OPERABILITY of fire detectors on at least one side of the inoperable fire barrier and establish an hourly fire watch patrol. Restore the inoperable fire barrier penetration(s) to OPERABLE status within 7 days or, in lieu of any other report required by Specification 6.9.1, prepare and submit a Special Report to the Commission pursuant to Specification 6.9.2 within the next 30 days outlining the action taken, the cause of the inoperable penetration and plans and schedule for restoring the fire barrier penetration(s) to OPERABLE status."

The above Technical Specification Action is from Unit 2's Technical Specifications. Salem Unit 1's differs only in that its Technical Specification uses the term "functional" instead of "OPERABLE".

APPARENT CAUSE OF OCCURRENCE:

The cause of the occurrences was failure to comply with specific instructions and inappropriate work practices by personnel performing the roves. All firewatch personnel are instructed on the methods of performing roves and actions to be taken if an area was missed or inaccessible. Lack of adequate supervision and contractor oversight were also contributing factors. Investigation is continuing to understand and address all contributing root causal factors.

ANALYSIS OF OCCURRENCE:

A review of firewatch roves for the month of June indicated 17 of the 35 firewatch personnel had not fully completed their assigned rounds as indicated on their rove log. Each of the firewatch personnel were initially interviewed by contractor management to determine why the roves were not completed. Results indicated personnel did not perform rounds for reasons such as inclement weather, low esteem associated with the type of work and mechanical failures which inhibited entry into some of the areas. A review of the time and frequency of the missed rounds indicated that 72% of the misses occurred during day shift, while second shift accounted for 15%, and 13% missed on the midnight shift.

Roving firewatches are required for: Appendix R issues; combustible loading; impaired penetrations; impaired fire dampers; or impaired fire detection systems.

A review of prior LERs was completed. Those involving overdue firewatch roves were identified and were due to isolated cases of

ANALYSIS OF OCCURRENCE: (cont'd)

personnel error.

The incident posed minimal safety significance. The Salem Station detection systems were operable in the areas to alert fire protection department personnel if a fire would have occurred. If a detector became inoperable at Salem Station, a continuous fire watch would have been established. The HCGS detection systems were operable except for one area. This area does not contain equipment necessary to achieve cold shutdown. Additionally, as most missed roves occurred on day shift, additional plant personnel presence would have reduced the risk of a fire going undetected in the affected areas.

As discussed above, the health and safety of the public was not affected by this event. However, since Technical Specification 3.7.11 Action "a" (both Salem Units) was not fully complied with, it is reportable to the Nuclear Regulatory Commission per Code of Federal Regulations 10CFR 50.73(a)(2)(i)(B).

CORRECTIVE ACTION:

PSE&G immediately suspended site access to those firewatch personnel involved.

Firewatch supervisors were instructed to: 1) intensify field checks; 2) brief firewatch personnel on the significance of non conformance; and 3) brief firewatch personnel that false representation may be considered a criminal act. All firewatch personnel were also instructed to call-in to the firewatch office from the 64' elevation switchgear room and the 130' elevation Fuel Handling Building as these calls will display the firewatch phoning location on the phone confirming the firewatch location.

Random checks of card reader entries to areas requiring firewatch roves will be performed.

Current firewatch employees have been instructed on the company ethics policy. New hires will be instructed on the company ethics policy as part of their indoctrination.

An aggressive rove challenge program has been instituted to reinforce positive behavior.

Copies of recent NRC notices on falsification of records have been posted and distributed to current firewatch employees. New employees will receive copies on NRC notices as part of their indoctrination process.

The presence of the PTI Ombudsman Line (internal reporting system) has been reemphasized to encourage employees to communicate directly to the corporate office on any and all nonconformance or misconduct

CORRECTIVE ACTION: (cont'd)

issues.

PTI supervisors will be retrained in supervisory techniques relating to people skills.

A review of current practices for control of contractors, per administrative procedure NC.NA-AP.ZZ-0068 ("Control of On-Site Contractor Personnel"), will be conducted and corrective action will be taken as appropriate.

Upon completion of root cause investigations, additional corrective actions will be implemented as appropriate.

General Manager -
Salem Operations

MJP:pc

SORC Mtg. 92-087