Commonwealth Edison
Zion Generating Station
101 Shiloh Blvd.
Zion, Illinois 60099
Telephone 312/746-2084

November 22, 1989

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

Dear Sir:

The enclosed Licensee Event Report number 89-020-00, Docket No. 50-295/DPR-39 from Zion Generating Station is being transmitted to you in accordance with the requirements of 10CFR50.73(a)(2)(i)(B), which requires a 30 day written report when any operation or condition occurs that is prohibited by the plant's Technical Specifications.

Very truly yours,

T. P. Joyce
Station Manager
Zion Generating Station

TPJ/mg

Enclosure: Licensee Event Report

cc: NRC Region III Administrator
NRC Resident Inspector
INPO Record Center
CECo Distribution List

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LICENSEE EVENT REPORT (LER)

Form Rev 2.0

Facility Name (1)	Docket Number (2)	Page (3)
Zion Unit 1	0 5 0 0 0 2 9 5	1 of 0 3

Title (4)

Missed Hourly Fire Watches on Unit 1 Volume Control Tank Room Fire Barrier 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)
											N/A	
1 0	2 3	8 9	8 9	---	0 2 0	---	0 0	1 1	2 2	8 9		

OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10CFR (Check one or more of the following) (11)			
	--	___ 20.402(b)	___ 20.405(c)	___ 50.73(a)(2)(iv)	___ 73.71(b)
POWER LEVEL (10)		___ 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)
	0	___ 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
Paul Geddes LER Coordinator ext. 201	7 0 8 7 4 6 - 2 0 8 4

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	///
				N							

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 7/21/89, Performance Test (PT)-207B, which is the 18 month surveillance of various fire barriers in the Auxiliary Building, was not accomplished in the Unit 1 Volume Control Tank(VCT) room because of high radiation levels. PT-14 # 89-1-285 was instituted to track this fact. This surveillance (PT-207B) was performed on 10/15/89, and PT-14 #89-1-285 was closed out on 10/19/89. An entry was made to this effect at 1300 in the Shift Engineers' Log Book. During the performance of PT-207B on 10/16/89, a degraded fire barrier was found in the VCT room. This degraded condition requires an hourly fire watch, which was instituted immediately. This firewatch requirement was documented in PT-14 # 89-1-415. On 10/21/89, at 0615, the Shift Control Room Engineer(SCRE) mistakenly secured the firewatch for the VCT room, due to the fact that PT-14 # 89-1-285 had been closed, not realizing that PT-14 # 89-1-415 was the actual mechanism being used to track the firewatch. The same SCRE discovered the mistake on 10/23/89 at 0300. The firewatch was restarted immediately.

The cause of the event is personnel error in that the SCRE did not adequately review the PT-14 log prior to securing the firewatch.

The Unit was defueled, and thus the charging system was not required for any Safeguards function. The area outside the VCT room on the 617' level of the Auxiliary Building is monitored by fire detectors which were operable. Due to these considerations, the safety impact of this event is minimal.

A. CONDITION PRIOR TO EVENT

MODE -- - Defueled RX Power 0 RCS [AB] Temperature/ Pressure -- °F/ -- psig

B. DESCRIPTION OF EVENT

On 7/21/89, PT-207B, which is the 18 month surveillance of various fire barriers in the Auxiliary Building, was unable to be accomplished in the Unit 1 VCT room because of the high radiation levels. PT-14 # 89-1-285 was instituted to track this fact. This surveillance (PT-207B) was performed on 10/16/89, PT-14 # 89-1-285 was closed out on 10/19/89, and an entry was made to that effect at 1300 in the Shift Engineers' Log Book. During the performance of PT-207B, a degraded fire barrier was found in the VCT room. The fire barrier of concern consists of fire retardant material around piping which penetrates the North wall of the VCT room to the pipe chase area. Some of the fire retardant material had been removed. This degraded condition requires an hourly fire watch, which was instituted immediately. This firewatch requirement was documented in PT-14 # 89-1-415. On 10/21/89, at 0615, the Shift Control Room Engineer (SCRE) mistakenly secured the firewatch for the VCT room. The SCRE assumed that PT-14 # 89-1-285 was the mechanism being used to track the firewatch in the VCT room. When the SCRE read the Shift Engineers' Log Book entry closing PT-14 # 89-1-285, the SCRE concluded that the firewatch was no longer required, and thus secured the watch. He had forgotten about PT-14 #89-415, which was the actual mechanism being used to track the firewatch. The firewatch was immediately restarted. The surveillance was missed for the period 0615 on 10/21/89 to 0300 on 10/23/89.

C. APPARENT CAUSE OF EVENT

The cause of the event is personnel error in that the SCRE did not adequately review the PT-14 log prior to securing the firewatch. A contributing cause is the confusion caused by use of the PT-14 system to track both surveillance and non-surveillance items.

D. SAFETY ANALYSIS OF EVENT

The Unit was defueled, and thus the charging system was not required for any Safeguards function. In addition, during this situation, the VCT had no hydrogen gas in it (the Reactor Coolant System had been degassed), and the VCT had been inerted with nitrogen.

The area outside the VCT room on the 617' level of the Auxiliary Building is monitored by fire detectors which were operable. This particular area of the Auxiliary Building is also very well traveled. Thus the possibility of a fire going undetected in this area of the plant is very small.

Due to the above considerations, the safety impact of this event is minimal.

E. CORRECTIVE ACTIONS

The firewatch was immediately restarted. The PT-14 system is being changed to include a Degraded Equipment Log Status Sheet. Degraded Equipment Log Status Sheets shall be used to track component or system failures which do not require surveillance testing to be performed and do not place the Unit on a time clock for Unit shutdown. This will reduce the number of PT-14s that the SCRE has to track. This new system would have prevented the confusion that led to this event. The new system will be in place by 12/31/89.

F. PREVIOUS EVENTS

There have been several missed firewatch surveillance events, but the corrective actions taken would not have prevented this event.

G. COMPONENT FAILURE DATA

None