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

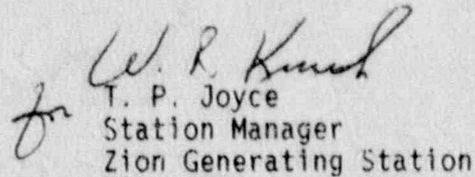
November 27, 1989

U.S. Nuclear Regulatory Commission
Document Control Clerk
Washington, D.C. 20555

Dear Sir:

The enclosed Licensee Event Report number 89-019-00, 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/PG/or

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 Firewatch Surveillance on Unit 1 Volume Control Tank Room 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)
1 0	2 6	8 9	8 9	0 1 9	0 0	1 1	2 7	8 9	N/A	

OPERATING MODE (9): ___

POWER LEVEL (10): 0

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)
___	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)
___	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)

___ Yes (If yes, complete EXPECTED SUBMISSION DATE) X NO

Expected Submission Date (15): Month ___ Day ___ Year ___

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

Unit 1 was defueled. An hourly firewatch was in effect for the Unit 1 Volume Control Tank (VCT) room because of a degraded fire barrier. The 0800 surveillance was missed because of the failure of the responsible security guard to obtain a R-key. A R-key is required to obtain entry into this room to perform the surveillance.

The cause of the event is personnel error in that the security guard did not aggressively pursue obtaining the required R-key.

The safety significance was minimal in that the Unit was defueled, and thus the Charging System is not required for any safeguards function. The area outside the VCT Room is monitored by fire detectors, and very well travelled. Thus a fire in this area going undetected is very unlikely.

A memo was issued on 10-27-89 to the security force requiring that the firewatch security guard report via radio that the firewatch has been performed. Also, the offgoing firewatch guard will not turn in the R-key until relieved by another firewatch guard with an R-key.

A. CONDITION PRIOR TO EVENT

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

B. DESCRIPTION OF EVENT

Unit 1 was defueled. An hourly firewatch was in progress for the Unit 1 VCT Room because of a degraded fire barrier. The firewatch requirement is documented in Performance Test (PT)-14 #89-1-415. 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. As the VCT Room is a high radiation area and thus a locked space, the hourly firewatch must have a R-key to perform the required surveillance. The Security Department provides individuals for the firewatches. Typically, this individual will check out a R-key from the Health Physics (HP) Office at the beginning of the watch, and turn it in at the end of the watch. On 10-26-89, the responsible security guard turned in the R-key at 0715 after performing the 0700 surveillance, in anticipation of being relieved prior to the 0800 surveillance. When a relief did not arrive, the guard returned to the HP Office at about 0800 to obtain the R-key again. The HP Office was very busy at this time of day, and when the guard was not waited on immediately, the guard left the office. A few minutes later, the HP Office received a call from another security guard who had been informed of the situation, and said that it was imperative that the first guard be issued an R-key. The first guard returned to the HP Office, and the key was issued at 0815. As a result of this delay, the 0800 firewatch surveillance was missed.

C. APPARENT CAUSE OF EVENT

The cause of the event is personnel error in that the responsible security guard did not aggressively pursue obtaining the required R-key for the surveillance. A contributing condition was the unexpected late relief. This caused the guard to be distracted from his duties as firewatch.

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 0700 and 0900 firewatches were performed as required. The area outside the VCT Room on the 617' level of the Auxiliary Building is monitored by fire detectors. This particular area is also very well travelled. 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.

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)					Page (3)		
		Year	///	Sequential Number	///	Revision Number			
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TEXT Energy Industry Identification System (EIIS) codes are identified in the text as [XX]

E. CORRECTIVE ACTIONS

The security guard involved in the event resigned shortly after the incident. This precluded taking any corrective action with the individual.

The fire barrier was repaired on 10/31/89, ending the need for the firewatch.

To prevent future occurrences, a memo was issued on 10-27-89 to the guard force emphasizing the importance of performing required firewatches. This memo also requires that:

1. The security supervisor will have a copy of the PT-14 that requires the firewatch, and the security guard must inform the supervisor via radio at the start and end of each hourly firewatch.

2. The offgoing security guard will not turn in the R-key to the HP Office until after being relieved by a security guard with another R-key.

This memo has been added to the instruction book at each guard post. Each guard is required to review this book at the start of the watch.

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.