



Commonwealth Edison

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

December 8, 1989

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

Dear Sir:

The enclosed Licensee Event Report number 89-023-00, 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,

for 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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11

8912120019 891208
PDR ADOCK 05000295
S FDC

LICENSEE EVENT REPORT (LER)

Form Rev 2.0

Facility Name (1) Zion Unit 1	Docket Number (2) 0 15 10 10 10 12 19 15	Page (3) 1 of 0 3
Title (4) Missed Firewatch Surveillance 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	1	0 8	8 19	0 2 3	0 1 0	1	2	0 8	N/A	

OPERATING MODE (9) 6

POWER LEVEL (10) 0 0 0

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10CFR (Check one or more of the following) (11)

<input type="checkbox"/> 20.402(b)	<input type="checkbox"/> 20.405(c)	<input type="checkbox"/> 50.73(a)(2)(iv)	<input type="checkbox"/> 73.71(b)
<input type="checkbox"/> 20.405(a)(1)(i)	<input type="checkbox"/> 50.36(c)(1)	<input type="checkbox"/> 50.73(a)(2)(v)	<input type="checkbox"/> 73.71(c)
<input type="checkbox"/> 20.405(a)(1)(ii)	<input type="checkbox"/> 50.36(c)(2)	<input type="checkbox"/> 50.73(a)(2)(vii)	<input type="checkbox"/> Other (Specify in Abstract below and in Text)
<input type="checkbox"/> 20.405(a)(1)(iii)	<input checked="" type="checkbox"/> 50.73(a)(2)(i)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)	
<input type="checkbox"/> 20.405(a)(1)(iv)	<input type="checkbox"/> 50.73(a)(2)(ii)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)	
<input type="checkbox"/> 20.405(a)(1)(v)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

Name Paul Geddes LER Coordinator	ext. 201	TELEPHONE NUMBER AREA CODE 7 0 8 7 4 6 - 12 10 8 14
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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
				N					

SUPPLEMENTAL REPORT EXPECTED (14)

Yes (If yes, complete EXPECTED SUBMISSION DATE) NO

Expected Submission Date (15) _____

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

Unit 1 was in Mode 6 for refueling. On 11/8/89, at approximately 1500, it was discovered that the door from the Control Room to the Unit 1 process computer room had been blocked open, and no hourly firewatch had been established. Prior to noon on the 0700 to 1500 shift, a member of the Management Information System (MIS) group had requested permission from the Shift Control Room Engineer (SCRE) to block open the process computer room door. The MIS individual talked to the Shift Engineer, who said he would take care of it, and the Shift Engineer called Security immediately. The MIS individual blocked open the door, assuming that the firewatch would be established. At this point, communication broke down between the Shift Engineer and Security, and no firewatch was started. When the deficiency was discovered at approximately 1500 on 11/8/89, the firewatch was immediately started.

The cause of the event is personnel error in the apparent misunderstanding between the Shift Engineer and the Security Department.

This particular area is very well traveled by both the MIS group and control room personnel; thus the possibility of a fire going undetected in this area of the plant is very small. There was no safety impact as a result of this event.

The immediate corrective action was to start the firewatch. The long term corrective actions is the establishment of a supplemental guard force that will be dedicated for firewatches.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

Form Rev 2.0

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)						Page (3)		
		Year	Sequential Number	Revision Number						
Zion Unit 1	0 5 0 0 0 2 9 15	8 9	- 0 2 3	-	0 0	0 2	OF	0 13		

TEXT Energy Industry Identification System (EIS) codes are identified in the text as [XX]

A. CONDITION PRIOR TO EVENT

MODE 6 - Refueling RX Power 0 RCS [AB] Temperature/ Pressure -- °F/ -- psig

B. DESCRIPTION OF EVENT

Unit 1 was in Mode 6 for refueling. On 11/8/89, at approximately 1500, it was discovered that the door from the Control Room to the Unit 1 process computer room had been blocked open, and no hourly firewatch had been established as required by Technical Specification 3.21-6. Prior to noon on the 0700 to 1500 shift, a member of the Management Information System (MIS) group had requested permission from the Shift Control Room Engineer (SCRE) to block open the process computer room door due to the failure of the air conditioning units for the room. Opening the door provides ventilation for the room in this circumstance. Since the SCRE was very busy at the time, the SCRE referred the individual to the Shift Engineer. The MIS individual talked to the Shift Engineer, who said he would take care of the firewatch. The Shift Engineer called Security immediately to set the firewatch. At this point communication broke down between the Shift Engineer and Security, and no firewatch was started. The Shift Engineer also did not initiate a Performance Test (PT)-14 because he assumed the SCRE would write it. The SCRE assumed the Shift Engineer would write the PT-14 since he had made the phone call to security. Thus the PT-14 was not initiated to track the firewatch requirement. The MIS individual blocked open the door, assuming that the firewatch would be established. When the deficiency was discovered at approximately 1500 on 11/8/89, the firewatch was immediately started. The surveillance was missed for approximately 4 to 6 hours on 11/8/89.

C. APPARENT CAUSE OF EVENT

The cause of the event is personnel error in the apparent misunderstanding between the Shift Engineer and the Security Department. Additionally, the Shift Engineer did not initiate a PT-14, which is the mechanism used to track firewatches. The investigation could not determine exactly where the communication breakdown between the Shift Engineer and security occurred. A causal factor to this event is the frequent process computer room air conditioning system breakdown which makes the firewatch necessary.

D. SAFETY ANALYSIS OF EVENT

This particular area is very well traveled by both MIS group and control room personnel. Thus the possibility of a fire going undetected in this area of the plant is very small. There was therefore no safety impact as a result of this event.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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E. CORRECTIVE ACTIONS

The immediate corrective action was to start the firewatch. Regulatory Assurance has discussed this event with Security, the MIS individual, the SCRE and the Shift Engineer. Recently the Shift Engineer involved went on vacation, on his return, the Assistant Superintendent of Operations will provide additional counseling concerning the failure to initiate the PT-14 and proper communications. The long term corrective action is the establishment of a supplemental guard force that will be dedicated for firewatches; this will help remove the problems associated with the current firewatch system by centralizing control. These corrective actions will be in place by 2/90 and are already being tracked by other commitments. A problem analysis of the air conditioning system for the Unit 1 and Unit 2 process computer rooms is being performed by the Maintenance Staff. This analysis will provide recommended solutions for the air conditioning system problems.

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