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Writer's Direct Dial Number:

October 24, 1990

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

Dear Sir:

Subject: Oyster Creek Nuclear Generating Station
Docket No. 50-219
Licensee Event Report

This letter forwards one (1) copy of Licensee Event Report (LER) No. 90-013.

Very truly yours,

E. E. Fitzpatrick
Vice President & Director
Oyster Creek

9011020031 901024
PDR ADOCK 05000219
S PNU

Enclosure
cc: Mr. Thomas Martin, Administrator
Region I
U.S. Nuclear Regulatory Commission
475 Allendale Road
King of Prussia, PA 19406

Mr. Alexander W. Dromerick
U.S. Nuclear Regulatory Commission
Mail Station P1-137
Washington, DC 20555

NRC Resident Inspector
Oyster Creek Nuclear Generating Station
Forked River, NJ 08731

(docs/ler/covltrs)

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NRC Form 366 (9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/88

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Oyster Creek, Unit 1	0 5 0 0 0 2 1 9	1 OF 0 3

TITLE (4)
Technical Specification Violation due to Missed Fire Watch Caused by 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 9	2 6	9 0	9 0	– 0 1 3	– 0 0	1 0	2 4	9 0		0 5 0 0 0
										0 5 0 0 0

OPERATING MODE (9): N
POWER LEVEL (10): 1 0 0

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (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, 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	
Paul Cervenka	6 0 9	9 7 1 - 4 8 9 4

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)

[ ] 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)

On September 26, 1990 at approximately 1500 hours, a preventive maintenance activity associated with the C Battery Room ventilation was completed and the hourly fire watch for the C Battery Room was secured by the on duty Group Shift Supervisor. At 1700 hours, after shift turnover, the new on duty Group Shift Supervisor reviewed the fire watch patrol list and realized that there was still a requirement for the C Battery Room fire watch, due to a malfunctioning door. The fire watch was immediately reinstated, however one of the hourly fire watches was missed. The cause of this occurrence is attributed to personnel error. A contributing factor to this occurrence is the priority assigned to the maintenance activity associated with repairing the malfunctioning door. The safety significance of this event is minimal because all fire detectors in the C Battery Room, as well as adjacent areas were operable. The missed fire watch was quickly recognized and corrected. For corrective action, management will ensure appropriate personnel are aware of the need to give a high priority to activities associated with the restoration of fire protection equipment. Also, this Licensee Event Report will be assigned as required reading for all licensed personnel in the Operations Department.

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DATE OF OCCURRENCE

The date of occurrence was September 26, 1990, at approximately 1600 hours.

IDENTIFICATION OF OCCURRENCE

On September 26, 1990 at approximately 1600 hours, the hourly fire watch for the C Battery Room was missed. This condition is considered reportable in accordance with 10CFR50.73(a)(2)(i)(B).

CONDITION PRIOR TO OCCURRENCE

The reactor was in the run mode operating near one hundred percent power. An hourly fire watch was in effect for the C Battery Room for two separate reasons. The first reason was due to a door closure mechanism malfunctioning. This condition was reported on September 14, 1990. The second reason was due to a preventive maintenance activity associated with the ventilation system, which occurred on September 23, 1990.

DESCRIPTION OF OCCURRENCE

On September 26, 1990 at approximately 1500 hours, the preventive maintenance activity associated with the C Battery Room ventilation was completed and the hourly fire watch for the C Battery Room was secured by the on duty Group Shift Supervisor. At 1700 hours after shift turnover, the new on duty Group Shift Supervisor reviewed the fire watch patrol list and realized that there was still a requirement for the C Battery Room fire watch due to a malfunctioning door. The fire watch was immediately reinstated.

APPARENT CAUSE FOR OCCURRENCE

The cause of this occurrence is attributed to personnel error in that the on duty Group Shift Supervisor secured the fire watch on the C Battery Room when the fire patrol list still required a fire watch due to a malfunctioning door.

A contributing factor to this occurrence was the priority assigned to the maintenance activity associated with repairing the malfunctioning door. This condition was reported on September 14, 1990 and work was not completed until October 2, 1990.

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6) YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	PAGE (3)
Oyster Creek, Unit 1	0 5 0 0 0 2 1 9	9 0	— 0 1 3	— 0 0	0 3 OF 0 3

TEXT (If more space is required, use additional NRC Form 366A's) (17)

ANALYSIS OF OCCURRENCE AND SAFETY ASSESSMENT

Fire protection systems and instrumentation provide for early detection and rapid extinguishment of fires in safety related areas thus minimizing fire damage. The technical specifications assure that in the event of inoperable fire protection equipment, corrective action will be initiated in order to maintain fire protection capabilities during all modes of reactor operation.

In the case of this occurrence the technical specification requirement for an hourly fire watch was missed for only a one hour period. All of the technical specification required fire detectors for the C Battery Room as well as adjacent areas were operable and would have provided an alarm in the Control Room upon a fire condition. Based upon the above, the safety significance of this event is considered minimal.

CORRECTIVE ACTION

Immediate corrective action was taken to reinstate the fire watch for the C Battery Room. Management will ensure appropriate personnel are aware of the need to give a high priority to activities associated with the restoration of fire protection equipment. This Licensee Event Report will be assigned as required reading for all Licen[illegible] Personnel in the Operations Department.

SIMILAR EVENTS

LER 88-035 "Fire Watch Required by Technical Specifications Missed Due to Failure of Communications During Shift Change".

LER 87-024 "Failure to Post Fire Watch For a Non-Functional Fire Barrier Due to Personnel Error in Failing to Follow Procedure".