

RIVER BEND STATION

POST OFFICE BOX 220 ST FRANCISVILLE LOUISIANA 70276

AREA CODE 504 635-5094 346-8651

October 16, 1990 RBG- 33790 File Nos. G9.5, G9.25.1.3

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

Gentlemen:

River Bend Station - Unit 1 Docket No. 50-458

Please find enclosed Licensee Event Report No. 90-027 for River Bend Station - Unit 1. This report is submitted pursuant to 10CFR50.73.

W. H. Odell

Manager-Oversight

River Bend Nuclear Group

PDG/GAB/DCH/RLR/pg

cc: U.S. Nuclear Regulatory Commission 611 Ryan Plaza Drive, Suite 1000 Arlington, TX 76011

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Mr. C. R. Oberg Public Utility Commission of Texas 7800 Shoal Creek Blvd., Suite 400 North Austin, TX 78757

Technician proceeded to get the control building keys and started the fire watch run at 0850, but did not complete the fire watch in time. In addition, the Level I Technician failed to immediately inform the Foreman after the fire watch was missed.

To prevent recurrence, each person assigned to a fire watch on shift and the Level I Technician will be required to carry a complete set of keys to make all rounds. Retraining of all fire protection personnel will be conducted due to this incident.

NRC FORM 366A

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104 EXPIRES 4/30/92

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

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 20565. AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503

FACILITY NAME (1)	DOCKET NUMBER (2)		 	L	ER NUMBER (6	PAGE (3)				
			YEAR		SEQUENTIAL NUMBER	I	REVISION			
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TEXT (If more space is required, use additional NRC Form 366A's) (17)

REPORTED CONDITION

At approximately 1540 hours on 9/16/90, the Electrical Maintenance Foreman discovered that the hourly fire watch inspection for the control building (*NA*), radwaste building (*NE*), turbine building (*NM*), normal switchgear, and services buildings (*MF*) had not been signed for as being completed at 0900. Further investigation revealed the inspection had not been completed as required by River Bend Station Technical Specification 3.7.7. Therefore, this report is submitted pursuant to $10\text{CFR}_{5}0.73(a)(2)(i)(b)$ as operation prohibited by the Technical Specifications.

INVESTIGATION

On 9/16/90, the person assigned to the firewatch consisting of the control building (*NA*), radwaste building (*NE*) arbine building (*NM*), normal switchgear, and the services bu . ngs (*MF*) became ill. She had started her fire watch runs just an er 0600 that morning and had completed the 0700 and the 0800 runs. Between these 2 runs, she became very ill and had control room personnel page a first Note that first responders are emergency medical responder. personnel. The first responder took her temperature and advised her to go home. She notified her Foreman at 0830 and went home at 0845. The Electrical Foreman contacted the on shift Level I Technician to replace her. There was some confusion concerning the required keys; however, this was resolved and the Level I Technician entered the control room and started the fire watch at 0850. After completing this fire watch he signed the log for the 1000 fire watch. He failed to immediately notify the Foreman when it became clear that he cruld not complete the 0900 fire watch on time. Later that day, the Foreman was reviewing the log as required by plant procedure and noticed no one had signed for the 0900 fire watch. After questioning the personnel involved, he determined that the 0900 firewatch had not been performed, and therefore initiated a condition report.

A review of previously submitted reports has revealed four similar events. As reported in LERs 86-012 and 86-031, fire watch patrols were missed because they were mistakenly cancelled. In LER 88-017, fire watch personnel were denied access to the containment due to high airborne radiation levels and failed to take the appropriate steps to gain access and complete the fire watch patrols. This event resulted in the fire watch program being placed under the supervision of Electrical Maintenance. Finally, in LER 90-024, a fire watch was missed due to a combination of miscommunication and inadequate verification of the fire watch log.

NRC FORM 366A

U.S. NUCLEAR REGULATORY COMMISSION

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CORRECTIVE ACTION

Corrective action will consist of retraining fire watch personnel on procedure FPP-0070 and this specific event. Additionally, all fire watch personnel on shift and the Level I Technician will carry keys to allow quicker response should someone get sick during a shift.

SAFETY ASSESSMENT

The fire detection and suppression systems in the affected areas were operational during the period of noncompliance. There were no fires in the affected areas during this event. Therefore, the health and safety of the public were not adversely affected by this event.

NOTE: Energy Industry Identification System Codes are identified in the text as (*XX*).