Alabama Power Company 40 Inverness Center Parkway Post Office Box 1295 Birmingham, Alabama 35201 Telephone 205 868-5581

W. G. Hairston, III Senior Vice President Nuclear Operations

February 15, 1991



10CFR50.73

Docket No. 50-348

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

Gentlemen:

Joseph M. Farley Nuclear Plant - Unit 1 Licensee Event Report No. LER 91-001-00

Joseph M. Farley Nuclear Plant, Unit 1 Licensee Event Report No. LER 91-001-00 is being submitted in accordance with 10CFR50.73. If you have any questions, please advise.

Respectfully submitted,

G. Hairston, III

WGH, III/BHW: maf8.24

Enclosure

cc: Mr. S. D. Ebneter Mr. G. F. Maxwell

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Plant and System Identification:

Westinghouse - Pressurized Water Reactor Energy Industry Identification System codes are identified in the text as [XX].

Summary of Event

At 1440 on 01-23-91, it was recognized that an hourly fire watch patrol required by Technical Specification 3.3.3.9 was not being performed.

Description of Event

At 0805 on 01-23-91 the control room fire alarm for the "Aux. Bldg 121' East Side" Fire Alarm Zone (FAZ) was disabled due to recurring spurious alarms. The Shift Foreman Operating (SFO) immediately initiated a Limiting Condition for Operation (LCO) and referred to FNP-0-SOP-0.4 (Fire Protection Program Administration Procedure) to determine the fire watch requirements for this FAZ. It was necessary to establish a fire watch in the area covered by fire detection system (FDS) 1A-103. However, the SFO mistakenly established a fire watch in the area covered by FDS 1A-102 rather than 1A-103. Thus, a fire watch patrol required by Technical Specifications was not performed. Contributing to this oversight was the failure of the SFO to specify on the LCO status sheet the required actions including a list of zones or rooms affected.

The failure to establish a fire watch was promptly identified by the SFO on the next shift. The required firewatch was established at 1445 on 01-23-91.

Cause of Event

This event was caused by cognitive personnel error.

Reportability Analysis and Safety Assessment

This event is reportable because the hourly fire watch required by Technical Specification 3.3.3.9 was not performed.

This area is normally inspected at least once per shift by the system operator.

This event had no effect on plant operation. No fire occurred during the time that the fire watch was not performed. The health and safety of the public were not affected by this event.

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Corrective Action

The fire watch patrol was established immediately.

The SFO involved has been counseled.

Additional Information

This event would not have been more severe if it had occurred under different operating conditions.

The Unit was operating at approximately 100% power at the time of this event.

No components failed during this event.

The following LERs involved personnel errors by the Shift Foreman in establishing and maintaining fire watches:

Unit 1 (Docket Number 050000348): LERs 84-013-00, 84-015-00, 84-022-00, 86-013-00, 87-006-00, 88-004-00, 90-001-00

Unit 2: LERs 84-007-00, 85-007-00, 85-013-00, 88-004-00, 88-005-00, 90-002-00