

Commonwealth Edison Company  
LaSalle Generating Station  
2601 North 21st Road  
Marseilles, IL 61341-9757  
Tel 815-357-6761



April 22, 1996

**United States Nuclear Regulatory Commission**  
**Attention: Document Control Desk**  
**Washington, D.C. 20555**

Licensee Event Report #96-002-00, Docket #050-373 is being submitted to your office in accordance with 10CFR50.73 (a) (2) (i).

Respectfully,

A handwritten signature in black ink, appearing to read "D. J. Ray", is written above the typed name.

D. J. Ray  
Station Manager  
LaSalle County Station

Enclosure

cc: H. J. Miller, NRC Region III Administrator  
P. G. Brochman, NRC Senior Resident Inspector - LaSalle  
C. H. Mathews, IDNS Resident Inspector - LaSalle  
F. Niziolek, IDNS Senior Reactor Analyst  
INPO - Records Center  
D. L. Farrar, Nuclear Regulatory Services Manager

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PDR ADOCK 05000373  
S PDR

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Handwritten initials "IFR" in black ink, with a vertical line drawn through the letters.

**LICENSEE EVENT REPORT (LER)**

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (MNBB 7714), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

<b>FACILITY NAME (1)</b> LaSalle County Station Unit One	<b>DOCKET NUMBER (2)</b> 05000373	<b>PAGE (3)</b> 1 of 5
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**TITLE (4)**  
Missed Unit One Technical Specification Fire Watch Due To Personnel Error

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL	REVISION	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
03	23	96	96	002	00	04	22	96	NONE	
									FACILITY NAME	DOCKET NUMBER

<b>OPERATING MODE (9)</b> 5	<b>THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)</b>									
	20.2201(b)		20.2203(a)(3)(i)		50.73(a)(2)(iii)					73.71(b)
<b>POWER LEVEL (10)</b> 0	20.2203(a)(1)		20.2203(a)(3)(ii)		50.73(a)(2)(iv)					73.71(c)
	20.2203(a)(2)(i)		20.2203(a)(4)		50.73(a)(2)(v)					OTHER
	20.2203(a)(2)(ii)		50.36(c)(1)		50.73(a)(2)(vii)					(Specify in Abstract below and in Text, NRC Form 366A)
	20.2203(a)(2)(iii)		50.36(c)(2)		50.73(a)(2)(viii)(A)					
	20.2203(a)(2)(iv)	X	50.73(a)(2)(i)		50.73(a)(2)(viii)(B)					
	20.2203(a)(2)(v)		50.73(a)(2)(ii)		50.73(a)(2)(x)					

**LICENSEE CONTACT FOR THIS LER (12)**

<b>NAME</b> Carlos Diaz, System Engineering	<b>TELEPHONE NUMBER (Include Area Code)</b> (815) 357-6761 x 2507
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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

<b>SUPPLEMENTAL REPORT EXPECTED (14)</b>				<b>EXPECTED SUBMISSION DATE (15)</b>		
<b>YES</b> (if yes, complete EXPECTED SUBMISSION DATE)	X	<b>NO</b>		MONTH	DAY	YEAR

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

On March 24, 1996 at 1400 hours, it was discovered that an hourly Technical Specification required fire watch was not performed on door 406 between the hours of 2300, March 23, 1996 and 0100 hours, March 24, 1996. Door 406 separates the Unit 1 Fire Zone 2F (elevation 740' of the Reactor Building) from Unit 2 Fire Zone 3F (elevation 740' of the Reactor Building). As required by the action statement for Technical Specification 3/4.7.6 "Fire Rated Assemblies", a hourly fire watch was posted on this door. The fire watch inspector attempted to enter the Reactor Building at approximately 2335 on March 23, and was informed he could not enter the building because a secondary containment leak rate test was in progress. The fire watch inspector failed to follow the post orders that direct him to contact the Shift Engineer whenever a fire watch cannot be performed.

The cause of the missed fire watch was a failure of the fire watch inspector to comply with post orders. Contributing to the event was a breakdown in communications between the system engineers involved in the test and the fire watch group.

(5-92)

## LICENSEE EVENT REPORT (LER)

## TEXT CONTINUATION

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If more space is required, use additional copies of NRC Form 366A (17)

## PLANT AND SYSTEM IDENTIFICATION

General Electric - Boiling Water Reactor

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

## A. CONDITION PRIOR TO EVENT

Unit(s): 1                                      Event Date: 03/23/96                                      Event Time: 2300 Hours  
 Reactor Mode(s): 5                                      Mode(s) Name: Refuel                                      Power Level(s): 0%

## B. DESCRIPTION OF EVENT

On March 24, 1996 at 1400 hours, it was discovered that an hourly Technical Specification required fire watch was not performed on door 406 between the hours of 2300, March 23, 1996 and 0200 hours, March 24, 1996. Door 406, which separates the Unit 1 Fire Zone 2F (elevation 740' of the Reactor Building) from Unit 2 Fire Zone 3F (elevation 740' of the Reactor Building) was impaired on January 6, 1996 in support of the Unit 1 outage (LIR07). As required by the action statement for Technical Specification 3/4.7.6 "Fire Rated Assemblies", a hourly fire watch was posted on this door. The dedicated fire watch group was assigned the responsibility of performing this watch.

The fire watch inspector attempted to enter the Reactor Building at approximately 2335 on March 23, and was informed he could not enter the building because a secondary containment leak rate test was in progress. The fire watch inspector failed to follow the post orders that direct him to contact the Shift Engineer whenever a fire watch cannot be performed. The inspector continued to perform his normal fire watch route, with the exception of door 406, until 0235 when the test was terminated and he was able to gain access into the Reactor Building.

## C. CAUSE OF EVENT

The fire watch group failed to follow their training and post orders. Because plant conditions can and very often do change, each inspector is trained on contacting the Shift Engineer (SE) whenever a fire watch cannot be performed. Each inspector also carries a copy of the post orders outlining the actions to take whenever a fire watch cannot be performed. In this case, the senior fire watch inspector should have contacted the SE and informed him of the situation. The SE could have made arrangements to perform the fire watch on door 406 using personal already inside the Reactor Building.

The cause of the missed fire watch was a failure of the fire watch inspector to comply with post orders. Contributing to the event was a breakdown in communications between the system engineers involved in the test and the fire watch group.

(5-92)

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On Saturday March 23rd, a preplanning session was held to coordinate the fire watch activities during the scheduled secondary containment leak rate test. The Fire Marshal and the system engineers involved in the test established a plan to ensure the fire watch required inside the Reactor Building would be performed during the test. The plan called for one of the engineers involved in the test to contact the fire watch group 1/2 hour before the Reactor Building was to be isolated and a fire watch inspector was to assume a position inside the Reactor Building for the entire duration of the test. To ensure the fire watch group could be contacted prior to the test, the Fire Marshal's pager was given to the fire watch group. This was in addition to the dedicated fire watch group pager, which is required to be carried at all times by an inspector, and the dedicated fire watch group phone line (FIRE). These various means of contacting the fire watch group were also discussed with the system engineers in the preplanning session.

A total of 2 tests were performed on March 23rd and 24th. The first test, which began at approximately 2100 on March 23rd was successfully coordinated and the fire watch on door 406 was performed as required. The fire watch group was contacted by a test engineer prior to the Reactor Building being closed off and the fire watch inspector was dispatched to the Reactor Building where he remained until the test was completed.

The fire watch group confirmed with the test engineer that they would again be contacted approximately 1/2 hour before the beginning of the second test. While waiting to be notified of the second test, the fire watch group continued to perform their normal fire watch route. As the fire watch inspector performed his route for the 2300 time period, he was prohibited from entering the Reactor Building because the test had begun. The fire watch inspector informed the senior fire watch inspector on shift of the situation. The senior inspector assumed but did not confirm that since they were not contacted prior to the test other arrangements must have been made to perform the fire watch on door 406. The fire watch group continued to perform all fire watch duties outside of the Reactor Building until approximately 0235 when they again gained access into the Reactor Building.

#### D. ASSESSMENT OF SAFETY CONSEQUENCES

The impact of this event on nuclear and personnel safety was minimal. The impact of this event is mitigated by the fact that a member of the security force was in the area for 2 of the 3 missed hours in question and operable area wide smoke detection existed on both sides of the door (per T.S. 3/4.7.6 an hourly fire watch is required if detection is available on one side of the inoperable barrier).

Although, door 406 was not checked by the fire watch inspector from 2235 until 0235, a member of the Burns security force did tour the areas separated by door 406 at approximately 2340, and 0030. All security force members are trained on identifying signs of a fire such as smoke and on reporting such conditions. The LaSalle Station Security Post Orders clearly delineated the expectation that any signs of fire or smoke be immediately reported.



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During the time period when a fire watch could not be performed, the Reactor Building continued to be inhabited by contractors, security force members and ComEd employees who could have detected a fire and reported it, as well as operable area wide smoke detection on both sides of door 406.

#### E. CORRECTIVE ACTIONS

All the fire watch individuals involved in this event were counseled by their supervisor, as well as by the Fire Protection Group (FPG) Supervisor. In addition, the senior watch inspector was subsequently disciplined. The entire fire watch group has also been re-trained on their post orders. Emphases has been placed on their roles as fire watch inspectors and on the importance of performing their duties, not only from a regulatory standpoint, but also from a life safety standpoint. Each inspector has been given specific guidance on carrying out their duties by using all the available station resources including contacting the SE, contacting the Radiation Protection Department when a radiation concern arises, etc.

LaSalle Station management has also met with company representatives from Richardson and Estes management (dedicated fire watch group) and reinforced LaSalle's expectations for the fire watch program. Included in this discussion was the expectation that each fire watch inspector's initial qualifications be reviewed and enhanced where necessary, and that the final approval for a fire watch inspector be given only after a member of LaSalle's FPG interviews the individual and accompanies the individual on a trial fire watch tour.

The engineers involved in the test and the FW inspectors have also been counseled on the importance of communication. Proper communication, as originally planned, would have prevented the fire watch inspector from being challenged. In the future emphases will be placed on communication prior to a special plant evolution and a FW supervisor will be on-site to ensure communications are maintained and fire watch duties are not overlooked as the evolution progresses.

NRC FORM 366A (5-92)		U.S. NUCLEAR REGULATORY COMMISSION		APPROVED BY OMB NO. 3150-0104 EXPIRES 5/31/95	
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**F. PREVIOUS OCCURRENCES**

LER	TITLE
374/96-001	Missed Technical Specification Fire Watch Due to Personnel Error
374/95-010	Missed Technical Specification Fire Watch Due to Personnel Error
373-95-011	Missed Technical Specification Fire Watch
374/95-004	Fire Watch Not Established Within Hourly Limit
374/95-002	Fire Watch Not Started Per Technical Specifications

**G. COMPONENT FAILURE DATA**

Since no component failure occurred, this section is not applicable