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Abstract: 86-019

On April 5, 1986 at 0046 hours the fire watch inspection interval for an ineffective penetration seal (PSA-110-Z043) located between the RHR pump room and the service water pipe tunnel exceeded the one-hour limit of Technical Specification 3.7.7. The cause of this event was personnel error. The Fire Watch Coordinator failed to list the penetration seal on the fire watch patrol rounds sheet and the fire watch person failed to notice the discrepancy between the fire watch log and the rounds sheet. Consequently, the first fire watch patrol failed to inspect the affected fire area. The area was inspected during the second round of the fire watch patrol when the fire watch inspection sheet, which was posted in the area, was noticed by the fire watch person. The fire watch patrol rounds sheet was then compared to the fire watch log to ensure that all other fire areas listed in the log were listed on the rounds sheet. The Fire Protection Advisor, Fire Watch Coordinator, and fire watch person involved in this event were counseled on the importance of proper communication and performing each inspection.

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NAC fern 3664 1943)	LICENSEE EVENT R	APPROVED D	NUCLEAR RESULATORY COMMUSEION APPROVED OMB NO. 3150-0104 EXPJREE 8/31/85				
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Unit Conditions Prior to the Event:

Operating Mode 1 (Power Operation) Reactor Power 100%

Description of the Event:

On April 5, 1986 at 0046 hours, the hourly fire watch inspection for an ineffective penetration seal (PSA-110-Z043) located between the RPR pump room and the service water pipe tunnel was not performed within one hour of the previous inspection. Technical Specification 3.7.7.a states, "With one or more of the above fire rated assemblies and/or sealing devices inoperable...establish an hourly fire watch patrol."

The actual inspection interval was one hour and thirty-four minutes which exceeds the one-hour limit of Technical Specification 3.7.7.

The EIIS code for the affected system, Fire Protection, is KP.

Consequences of the Event:

The possible consequences of this event were minimal. The pipe tunnel side of the penetration contains no combustible materials. The RHR side of the penetration has a low combustible loading (weight of combustible material/floor area) and operable fire detectors which would have provided early detection of a fire. If a fire was to occur in this area, the fire brigade would be dispatched to extinguish the fire using hose stations in the affected area and surrounding areas.

NAC Form 366A (943)	ICENSEE EVENT R	EPORT (LER) TEXT CONT	NUATION			ULATORY COMMISSIO M8 NO. 3150-0104 1/85
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Cause of the Event:

The cause of this event was a cognitive personnel error. The contract Fire Watch Coordinator failed to list penetration seal PSA-110-Z043 on the fire watch patrol rounds sheet when the rounds sheet was prepared during shift change. Additionally, the oncoming contract fire watch person failed to notice the discrepancy between the fire watch log and fire watch patrol rounds sheet. Consequently, the first fire watch patrol on the shift failed to inspect the affected fire area.

Corrective Actions:

The affected fire area was inspected during the second round of the fire watch patrol when the posted fire watch inspection sheet was noticed by the fire watch person. The fire area was then added to the fire watch patrol rounds sheet. The Fire Watch Coordinator and responsible fire watch person compared the fire watch patrol rounds sheet to the fire watch log to ensure that all other fire areas listed in the log were listed on the rounds sheet.

Action Taken to Prevent Recurrence:

A mechanism exists to ensure that ineffective fire barriers or seals are properly inspected. The Fire Protection Advisor enters the ineffective barriers in the Fire Watch log which is utilized by the Fire Watch Coordinator to generate the fire watch rounds sheet. When the fire watch person picks up the rounds sheet, he signs off each barrier in the log recognizing the need for each inspection and checks the rounds sheet for agreement with the log.

nRC Farm Jack (5-83)	LICENSEE EVENT REPORT (LER) TEXT CONTINUETION										-	GULATORY COMMISSION DWB NO 3150-0104 3185									
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The Fire Protection Advisor, Fire Watch Coordinator, and fire watch person involved in this event were counseled on the importance of proper communication and performing each required inspection within the designated time period.

Previous Similar Occurrences:

Limerick LERs 85-043 and 85-033 reported failures to meet hourly fire watch requirements of the Technical Specifications which resulted from personnel errors of different root causes.

PHILADELPHIA ELECTRIC COMPANY

2301 MARKET STREET

P.O. BOX 8699

PHILADELPHIA, PA. 19101

(215) 841-4000

May 5, 1986

Docket No. 50-352

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

> SUBJECT: Licensee Event Report Limerick Generating Station - Unit 1

This LER concerns a failure to meet an hourly fire watch requirement of the Technical Specifications.

Reference:	Docket No. 50-352
Report Number:	86-019
Revision Number:	00
Event Date:	April 5, 1986
Report Date:	May 5, 1986
Facility:	Limerick Generating Station
	P.O. Box A, Sanatoga, PA 19464

This LER is being submitted pursuant to the requirements of 10 CFR 50.73(a)(2)(i)(B).

Very truly yours,

G. M. Leitch

G. M. Lerton * Superintendent Nuclear Generation Division

cc: Dr. Thomas E. Murley, Administrator, Region I, USNRC E. M. Kelly, Senior Site Inspector See Service List