NON-PUBLIC?: N
ACCESSION #: 9304200086
LICENSEE EVENT REPORT (LER)

FACILITY NAME: TURKEY POINT UNIT 3 PAGE: 1 OF 4

DOCKET NUMBER: 05000250

TITLE: FAILURE TO MAINTAIN AN HOURLY FIRE WATCH PATROL;
TECHNICAL SPECIFICATION VIOLATION
EVENT DATE: 03/24/93 LER #: 93-004-00 REPORT DATE: 04/14/93

OTHER FACILITIES INVOLVED: DOCKET NO: 05000

OPERATING MODE: 1 POWER LEVEL: 100

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR SECTION:
50.73(a)(2)(i)(B)

LICENSEE CONTACT FOR THIS LER:
NAME: C. L. Mowrey, Licensing OEF TELEPHONE: (305) 246-6204
Engineer/Analyst

COMPONENT FAILURE DESCRIPTION:
CAUSE: SYSTEM: COMPONENT: MANUFACTURER:
REPORTABLE NPRDS:

SUPPLEMENTAL REPORT EXPECTED: NO

ABSTRACT:

Turkey Point Unit 3 was in Mode 1 at 100% power. An hourly Fire Watch patrol had been established (required by Technical Specification 3.7.9) whose rounds included the Unit 3 west penetration room. The Fire Watch had entered the room at 1630. Entries required at 1730, 1830, and 1930 were not made because the door could not be opened. The Nuclear Plant Supervisor was notified of the missed entries at 1920; at about 2000 the door was forced open, and the hourly Fire Watch patrol was resumed.

The root cause was inadequate control of painting of the door. The door was allowed to close before the paint was sufficiently cured; the uncured paint created seals which required substantial effort to break. A contributing cause was inadequate training of Fire Watch personnel to ensure timely notification of conditions preventing completion of assigned duties.

All Fire Watch personnel have been briefed on the event, and the need for timely notification of problems. All Fire Watch personnel will be retrained using a newly completed Fire Watch Training Manual. Utility Fire Protection staff personnel have been assigned to specific shifts for three months, to oversee the operations of Fire Watch personnel. Directions have been given to ensure that adequate steps are taken to prevent newly painted doors from sticking.

END OF ABSTRACT

I. DESCRIPTION OF THE EVENT

On March 24, 1993, Florida Power and Light Company's (FPL) Turkey Point Unit 3 was in Mode 1 at 100% power. Because the Thermo-Lag 330 used as a fire barrier material has been determined to be inoperable (Ref: NRC Information Notice 92-82), an hourly Fire Watch patrol has been established, in accordance with Technical Specification Action Statement 3.7.9.a, in those areas where Thermo-Lag 330 is used. The Unit 3 west electrical penetration room is one of these areas. It is one of two rooms where electrical cables penetrate into the Reactor Containment Building.

At approximately 1720 on March 24, the Fire Watch was unable to enter the Unit 3 west electrical penetration room. He had last checked that room at about 1630. He called the Fire Watch Shift Supervisor's (FWSS) office and left a message, then continued his patrol to ensure compliance with the hourly requirement in the remaining areas. The FWSS was not in the office at the time since he was processing other fire impairment tags in the Control Room. The FWSS learned of the problem when he returned to his office at about 1750.

The access problem was first thought to be caused by the anti-pick device on the door lock, so the FWSS contacted Security at about 1815 to try to get the door open. The Nuclear Plant Supervisor in the Control Room was notified at about 1920, after repeated attempts to open the door failed.

It was then determined that the door had been freshly painted, and the paint bonded the door to the door seal. Operations, Maintenance, and Security personnel broke the paint bond and opened the door at about 2000. The Fire Watch verified that there was no evidence of fire, thereby reinstating compliance with the Technical Specification Action Statement.

The failure to maintain an hourly Fire Watch in the Unit 3 west electrical penetration room is a condition prohibited by the plant's Technical Specifications, and is being reported in accordance with 10 CFR 50.73 (a)(2)(i)(B).

II. CAUSE OF THE EVENT

The immediate cause of the event was personnel error in that the Fire Watch (non-licensed contractor personnel) failed to ensure that the required hourly Fire Watch patrol was performed; he did not ensure that the Unit 3 west electrical penetration room was checked within one hour.

A contributing cause was inadequate training of Fire Watches and FWSSs. Procedure 0-ADM-016.4, Fire Watch Program, states that, "The Fire Watch Shift Supervisor is responsible for notifying the Nuclear Plant Supervisor if ... conditions occur which may prevent Technical Specification Compliance (e.g., a plant condition which would not allow required Fire Watch duties to be performed)." Procedure O-ADM-016.4 further states that, "Fire Watch Patrols are responsible for notifying their supervisor of any condition that would prevent the completion of their assigned duties (i.e., plant conditions etc)."

Training on these responsibilities was inadequate in that the timeliness of the notification was not addressed for either the Fire Watch or the FWSS. The Fire Watch assumed that he was in full compliance with his responsibilities when he left the message for the FWSS. But the one hour time limit within which the patrol was required had expired by the time the FWSS became aware of the problem. He took immediate action to try to resolve the problem, but did not notify the Control Room for nearly two more hours. As a result of the combined failures to ensure timely notification of the problem, three consecutive hourly patrols of the Unit 3 west electrical penetration room were missed.

The root cause was inadequate control of painting, in that the fire door was allowed to close before the paint was sufficiently cured; it appears that the uncured epoxy paint may have reacted with rubber door stops along the edge of the doorjamb, bonding the door shut. There is also evidence that sufficient paint had overlapped the door edge that the paint itself formed a seal, about 18 inches in length, between the door edge and the door jamb. These epoxy paint bonds required substantial effort to break. Painting at Turkey Point is performed by non-licensed contractor personnel under the direction of the FPL Maintenance department.

III. ANALYSIS OF THE EVENT

The hourly Fire Watc
patrol required by Technical Specifications has
been touring the Unit 3 west electrical penetration room for several months, and had verified that there was no evidence of fire or smoke as of about 1630 on March 24, 1993. After the door into the room was opened, the Fire Watch again verified that there was no evidence of fire as of about 2000 on March 24. During the period of about three and one half hours in which the room was not inspected, the fire detection system in the room was operable. In addition, no welding, grinding, or other work creating a fire hazard took place in the room. Therefore, the likelihood of an undetected fire was not significantly increased by the absence of the Fire Watch, and the health and safety of the public were not materially affected.

IV. CORRECTIVE ACTIONS

1. Operators were dispatched to check all recently painted doors for similar problems. No additional problems were identified.

2. Direction has been given requiring the Fire Watch Shift Supervisors to carry whatever communications systems are available (portable radio, beeper) whenever they are out of the office.

3. All Fire Watch personnel working on shift during the event were briefed on the incident and on the need to immediately contact the Control Room if they could not notify their supervisor of any condition that would prevent them from performing their assigned duties.

4. A briefing of all Fire Watch personnel was conducted on March 26, 1993, by the Fire Protection and Safety Supervisor, emphasizing Fire Watch duties and responsibilities, expectations, and the impact of this event.

5. The Fire Watch training program was being processed into a formal Fire Watch Training manual at the time of the event. The Training Manual has been completed.

6. All Fire Watch personnel have been retrained using the Fire Watch Training Manual. New Fire Watch personnel will be fully trained with the new manual prior to being assigned and put on post.

7. All Fire Protection personnel have been briefed by the Services Manager on the impact of the event, and his expectations.

8. FPL Fire Protection staff personnel have been assigned to specific shifts for a three month period to oversee the operations of Fire Watch personnel.

9. Maintenance management issued letter PTN-MS-93-052 to require that whenever fire doors or other vital doors are painted, adequate steps and precautions are taken to prevent doors from sticking, and to ensure that access can be obtained.

10. Specification SPEC-C-004, Furnishing & Application of Service Level II & Balance-of-Plant Maintenance Coatings Turkey Point Units 3 & 4, has been revised to require that newly painted doors, windows, and their seats shall be properly cured before closing them (curing time as required by the approved Coating Data Sheet or Manufacturer Data Sheet).

V. ADDITIONAL INFORMATION

A. Failure to post a continuous Fire Watch within one hour was reported in LER 251-93-001. Failure to maintain a continuous Fire Watch was reported in LER 251-92-005. In that event the watch was posted, but left his post periodically. Additional details of the effects of hurricane Andrew on Fire Watches were reported in LER 250-92-009.

B. No other recent events have been reported involving inadequate control of contracted services.

C. System and component identification described in this report:

SYSTEM OR COMPONENT EIIS CODE IEEE 803a/83

Reactor Containment Building NH n/a
Fire Detection System IC n/a
Control Room NA n/a

ATTACHMENT 1 TO 9304200086 PAGE 1 OF 1

P.O. Box 029100, Miami, FL, 33102-9100

FPL APR 14 1993
L-93-097
10 CFR 50.73

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

Gentlemen:

Re: Turkey Point Unit 3
Docket No. 50-250
Reportable Event: 93-004-00
Failure to Maintain an Hourly Fire Watch; Technical Specification Violation

The attached Licensee Event Report 250/93-004-00 is being provided in accordance with 10 CFR 50 .73 (a) (2) (i) (B).

If there are any questions, please contact us.

Very truly yours,

T. F. Plunkett
Vice President
Turkey Point Nuclear

TFP/CLM/cm

enclosure

cc: Stewart D. Ebneter, Regional Administrator, Region II, USNRC

Ross C. Butcher, Senior Resident Inspector, USNRC, Turkey Point Plant

an FPL Group company

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