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WILLARD,S.C. Tennessee Valley Authority
CAMPBELL,G.G. Tennessee Valley Authority
RECIP.NAME RECIPIENT AFFILIATION

SUBJECT: LER 89-001-00:on 890209,failure to provide required continuous fire watch on inoperable fire doors.
W/8 ltr.

DISTRIBUTION CODE: IE22D COPIES RECEIVED:LTR 1 ENCL 1 SIZE: 4
TITLE: 50.73 Licensee Event Report (LER), Incident Rpt, etc.

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	NRR/DEST/CEB 8H	1	1	NRR/DEST/ESB 8D	1	1
	NRR/DEST/ICSB 7	1	1	NRR/DEST/MEB 9H	1	1
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	NRR/DLPQ/HFB 10	1	1	NRR/DLPQ/QAB 10	1	1
	NRR/DOEA/EAB 11	1	1	NRR/DREP/RAB 10	1	1
	NRR/DREP/RPB 10	2	2	~~NRR/DRIS/SIB~~ 9A	1	1
	NUDOCS-ABSTRACT	1	1	REG FILE 02	1	1
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EXTERNAL:	EG&G WILLIAMS,S	4	4	FORD BLDG HOY,A	1	1
	H ST LOBBY WARD	1	1	LPDR	1	1
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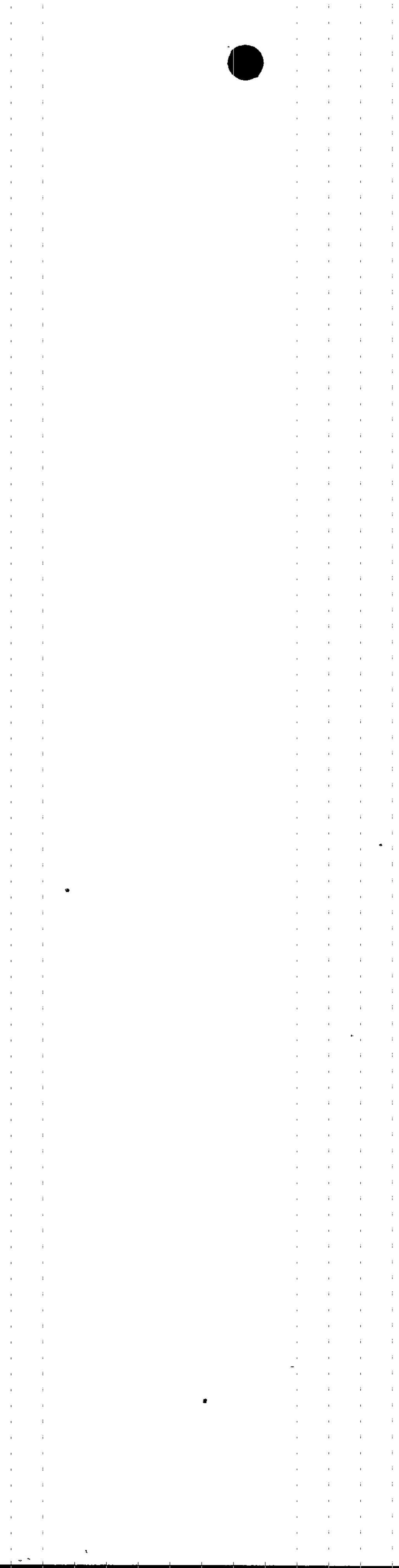

NRC Form 366
(9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/88

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
BROWNS FERRY UNIT 3	0 5 0 0 0 2 9 6	1 OF 0 3

TITLE (4) FAILURE TO PROVIDE REQUIRED CONTINUOUS FIRE WATCH ON INOPERABLE FIRE DOORS CAUSED BY PERSONNEL ERROR DUE TO INSUFFICIENT TRAINING

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES	DOCKET NUMBER(S)
										0 5 0 0 0
0 2	0 9	8 9	8 9	— 0 0 1 —	0 0	0 3	1 0	8 9		0 5 0 0 0

OPERATING MODE (9): N

POWER LEVEL (10): 0 0 0

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)

	20.402(b)		20.405(c)		50.73(a)(2)(iv)		73.71(b)
	20.405(a)(1)(i)		50.36(c)(1)		50.73(a)(2)(v)		73.71(c)
	20.405(a)(1)(ii)		50.36(c)(2)		50.73(a)(2)(vii)		OTHER (Specify in Abstract below and in Text, NRC Form 366A)
	20.405(a)(1)(iii)	X	50.73(a)(2)(i)		50.73(a)(2)(viii)(A)		
	20.405(a)(1)(iv)		50.73(a)(2)(ii)		50.73(a)(2)(viii)(B)		
	20.405(a)(1)(v)		50.73(a)(2)(iii)		50.73(a)(2)(x)		

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER	
	AREA CODE	
Stephen C. Willard, Engineer, Plant Reporting Section	2 0 5	7 2 9 - 2 5 3 6

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFAC-TURER	REPORTABLE TO NPRDS	CAUSE	SYSTEM	COMPONENT	MANUFAC-TURER	REPORTABLE TO NPRDS

SUPPLEMENTAL REPORT EXPECTED (14)

[ ] YES (If yes, complete EXPECTED SUBMISSION DATE) [X] NO

EXPECTED SUBMISSION DATE (15): MONTH | DAY | YEAR

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

On February 9, 1989, a fire protection engineer discovered that a roving fire watch had been covering two inoperable fire barriers rather than a continuous watch as required by Technical Specification (TS) 3.11.E. A continuous fire watch was established in the area on February 5, 1989 because of another deficiency which had been identified on one of the fire doors.

Upon discovery of the inoperable fire barriers, on January 29 and January 31, 1989, respectively, the fire protection crew performing the daily inspection of fire barriers did not properly inplement the TS required compensatory measures. The cause of this error has been attributed to insufficient training of fire protection personnel with regard to TS required compensatory measures.

A fire watch will remain in the area until the doors are adjusted. Corrective maintenance has been initiated for the inoperable fire doors. Personnel performing the fire barrier inspections (Emergency Service Technicians (ESTs)) will receive training on the fire protection program section 2, and TS requirements for fire watches. This training will be required for current and future ESTs.

All three units were shutdown during this condition. Licensed operators were not involved in this condition and were not required to respond.

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PDR ADOCK 05000296
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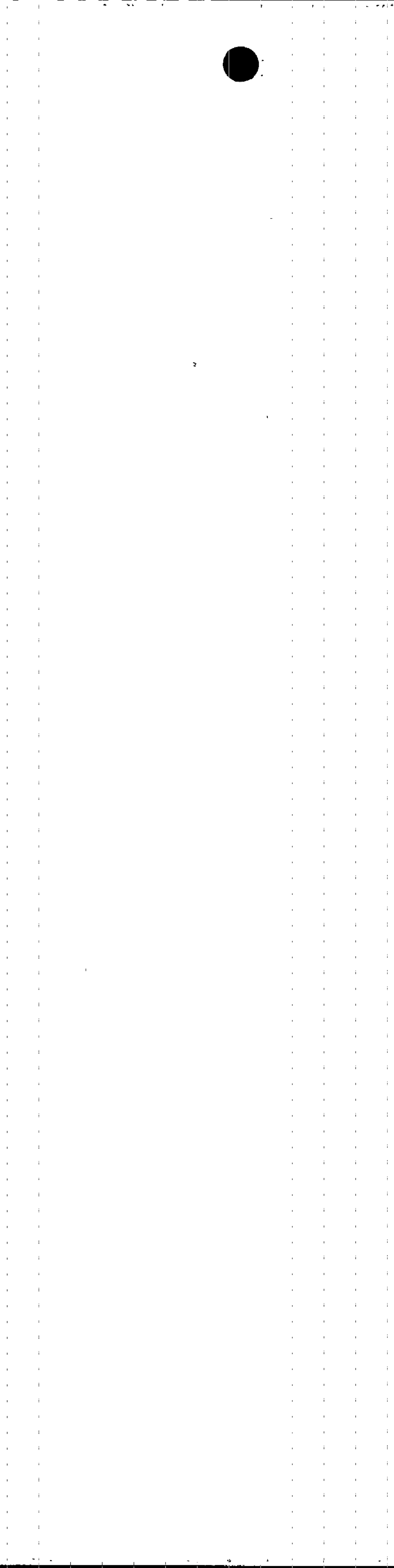


FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6) YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	PAGE (3)
BROWNS FERRY UNIT 3	0 5 0 0 0 2 9 6	8 9	— 0 0 1	— 0 0	0 2 OF 0 3

TEXT (If more space is required, use additional NRC Form 366A's) (17)

Description of Event

On February 9, 1989, a fire protection engineer (utility, non-licensed) discovered that a roving fire watch had been covering two inoperable fire barriers rather than a continous watch as required by Technical Specification (TS) 3.11.E. A continuous fire watch was established in the area on February 5, 1989 because of another deficiency which had been identified on one of the fire doors.

The discovery of the inoperable fire doors (EIIS system/component code NG/DR) occurred while fire protection personnel (utility, non-licensed) were performing the daily inspection of fire doors. On January 29, 1989, door 655 was determined to be inoperable because the door would stick on the floor when opened to the full open position. On January 31, 1989, door 656 was determined to be inoperable because the door would not latch properly. Corrective maintenance was initiated in both cases to repair the doors but a continuous fire watch was not posted in either case at the time of discovery. On February 9, 1989, a fire protection engineer determined that the area had not been properly monitored during the period between January 29, 1989 and February 5, 1989. A continuous fire watch had been posted in the area on February 5, 1989 because of another deficiency which had been identified on door 656. Doors 655 and 656 are adjacent to one another and lead to the unit 3, 480 volt shutdown board rooms. The plant was not in compliance with TSs for seven days and five days for the respective cases.

All three units were shutdown during this condition. Licensed operators were not involved in this condition and were not required to respond.

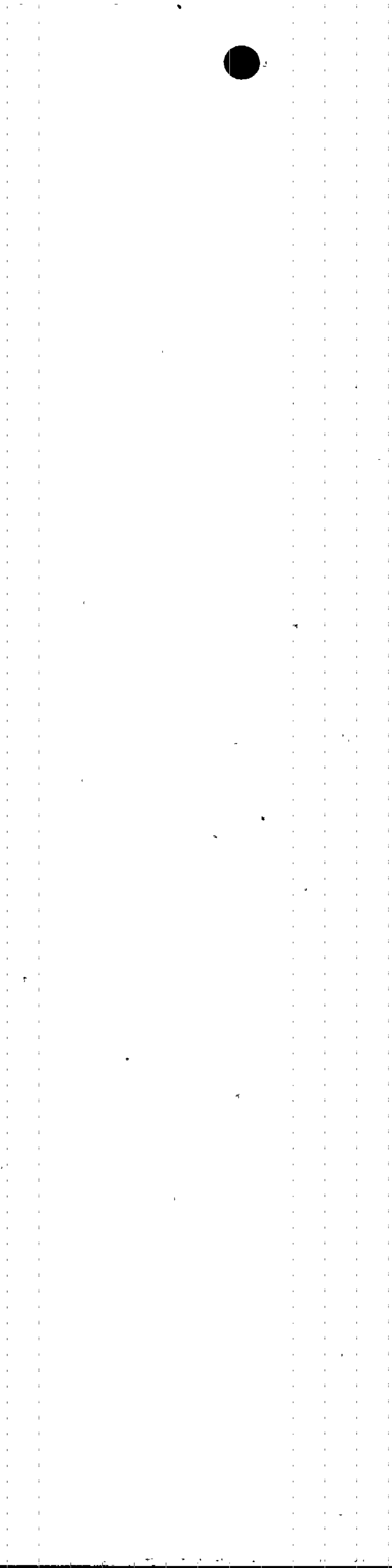
Cause of Event

The cause of this event is personnel error due to insufficient training with regard to TS required compensatory measures and section 2 of the fire protection program.

The fire protection foreman involved recognized and acknowledged that the fire doors were inoperable. He verified that the area was covered by a roving fire watch believing this to be the required compensation for the inoperable fire barriers. However, he was not adequately familiar with the TS or Fire Protection program requirements which specify a continuous fire watch when fire detection equipment is not available on either side of the barrier, as was this case.

Corrective Action

A continuous fire watch was placed in the area on February 5, 1989. A fire watch will remain in the area until the doors are adjusted. Corrective maintenance has been initiated for the inoperable fire doors.



FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6) YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	PAGE (3)
BROWNS FERRY UNIT 3	0 5 0 0 0 2 9 6	8 9	— 0 0 1	— 0 0	0 3 OF 0 3

TEXT (If more space is required, use additional NRC Form 366A's) (17)

Corrective Action (continued)

Fire protection personnel (Emergency Services Technicians (ESTs)) will receive training on the fire protection program section 2, and TS requirements for fire watches. This training will be required for current and future ESTs.

Analysis of Event

This event is reportable under 10 CFR 50.73 (a)(2)(i)(B) as a violation of Technical Specification 3.11.E because a continuous fire watch was not established within one hour of discovery. A roving fire watch was patrolling the area at one hour intervals.

Fire barriers are utilized in the plant to provide separation and compartmentation of safety related areas and to contain postulated fires so that a minimum of plant equipment would be affected. The problems identified could have reduced the ability or prevented the doors from containing a fire had one occurred while the condition existed. Fire watches provide early detection in case of fire. Should a fire develop without a fire watch present the potential damage could be greater because of longer response to the fire.

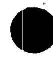
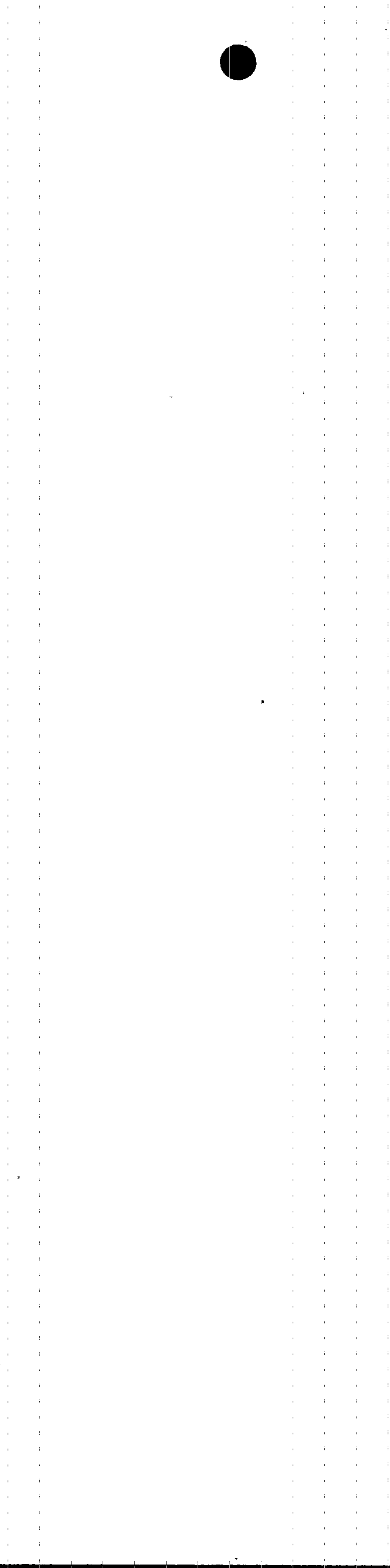
Previous Similar Events - BFRO-50-259/81052
BFRO-50-259/86025
BFRO-50-259/87001
BFRO-50-259/87010
BFRO-50-259/87016
BFRO-50-259/88026
BFRO-50-260/87006

These LERs discuss various problems in prompt and proper placement of fire watches; however, previous events did not result from the same root cause.

Commitments - A fire watch will remain in the area until the doors are adjusted. Corrective maintenance has been initiated for the inoperable fire doors.

The ESTs will receive training on the fire protection program section 2, and TS requirements for fire watches. The training will be conducted by the fire protection section and initial training completed by May 1, 1989. This training will be required for current and future ESTs.

A continuous fire watch was established in the area on February 5, 1989 because of another deficiency which had been identified on one of the fire doors.

TENNESSEE VALLEY AUTHORITY
Browns Ferry Nuclear Plant
Post Office Box 2000
Decatur, Alabama 35609-2000

MAR 10 1989

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

Dear Sir:

TVA - BROWNS FERRY NUCLEAR PLANT (BFN) UNIT 1 - DOCKET NO. 50-296 - FACILITY OPERATING LICENSE DPR-33 - REPORTABLE OCCURRENCE REPORT BFRO-50-296/89001

The enclosed report provides details concerning the failure to provide required continuous fire watch on inoperable fire doors caused by personnel error due to inadequate training and inexperience. This report is submitted in accordance with 10 CFR 50.73 (a)(2)(i).

Very truly yours,

TENNESSEE VALLEY AUTHORITY

JE Swindell

for Guy G. Campbell
Plant Manager

Enclosures
cc (Enclosures):

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Suite 1500
1100 Circle 75 Parkway
Atlanta, Georgia 30339

NRC Resident Inspector, BFN

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