NRC FORM 366 (5-92) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB NO. 3150-0104
EXPIRES 5/31/95

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.

LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Fort Calhoun Station Unit No. 1	05000285	1 OF 3

TITLE (4)
Failure to Maintain Continuous Fire Watch for Impaired Halon System

EVENT DATE (5)			LER NUMBER (6)			REPORT NUMBER (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
										05000
04	27	93	93	-- 006 --	00	05	26	93	FACILITY NAME	DOCKET NUMBER 05000

OPERATING MODE (9)	3	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)					
		20.402(b)		20.405(c)		50.73(a)(2)(iv)	73.71(b)
POWER LEVEL (10)	0	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
		20.405(a)(1)(iii)	X	50.73(a)(2)(i)		50.73(a)(2)(viii)(A)	(Specify in Abstract below and in Text, NRC Form 366A)
		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 (Include Area Code)
William J. Blessie, Shift Technical Advisor	(402) 533-6896

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

SUPPLEMENTAL REPORT EXPECTED (14)			EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE)	X	NO				

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

On January 18, 1993, the Halon fire suppression system for the Switchgear Rooms was disabled to allow repair/replacement of Halon system piping. A continuous fire watch with back-up fire suppression equipment was established. On April 27, 1993 at 1941 CDT, a security officer on an hourly fire door check entered the Switchgear Rooms and noticed that the individual responsible for the continuous fire watch was not present. Computer records revealed that the individual had exited the Switchgear Rooms at 1930 CDT. Consequently, the Switchgear Rooms were without a continuous fire watch for eleven minutes, resulting in a violation of Technical Specification 2.19(8).

It has been concluded that the root cause of this event was personnel neglect and that the problem was isolated to this individual. The individual responsible for the fire watch at the time of the incident was a temporary contract employee.

The corrective action taken as a result of this event was to relieve the individual of his responsibilities, block his access to the Protected Area and terminate his services.

BACKGROUND

Fort Calhoun Station (FCS) Technical Specification (TS) 2.19(8) requires that the Halon fire suppression systems protecting the Control Room, the Switchgear Rooms and the Cable Spreading Room be operable. With a Halon system inoperable, a continuous fire watch with back-up fire suppression equipment is to be established.

On January 18, 1993, the Halon system for the Switchgear Rooms was disabled to allow repair/replacement of Halon system piping under Modification MR-FC-86-093, "Switchgear Room Halon System Improvements." A continuous fire watch with back-up fire suppression equipment was established. An outside contract agency was utilized to supply individuals to stand the continuous fire watches due to the length of time (several months) that the Switchgear Room Halon System was to be disabled. These individuals were trained by OPPD on the requirements for standing a fire watch and were under the supervision of OPPD personnel. OPPD security officers were designated to provide relief and periodic monitoring of the fire watch personnel.

EVENT DESCRIPTION

On April 27, 1993, FCS was in Hot Shutdown (Mode 3) for scheduled maintenance. At 1941 CDT, a security officer on an hourly fire door check entered the Switchgear Rooms and noticed that the individual responsible for the continuous fire watch was not present. The security officer immediately contacted the Security Shift Supervisor (SSS) and assumed the continuous fire watch duties.

The SSS traced the location of the individual through the plant security computer. The computer records revealed that the individual had exited the Switchgear Rooms at 1930 CDT. Consequently, the Switchgear Rooms were without a continuous fire watch for eleven minutes, resulting in a violation of TS 2.19(8). This report is being submitted pursuant to 10 CFR 50.73(a)(2)(i)(B).

Plant management and the responsible OPPD supervisor were notified of the event, and a decision was made to relieve the individual of his responsibilities, escort him from the site, block his access to the Protected Area and terminate his services.

SAFETY ASSESSMENT

The effect of this event on nuclear safety was negligible due to the short amount of time the continuous fire watch was not in place. During this event, eleven minutes elapsed in which no continuous fire watch was in place. The modification which disabled the Halon fire suppression system for the Switchgear Rooms did not affect the fire detection system in the rooms. In the event of a fire, the Control Room would have been alerted to the situation and the fire brigade could have been dispatched.

CONCLUSIONS

It has been concluded that the root cause of this event was personnel neglect and that the problem was isolated to this individual. A review of the fire watch program and interviews with other individuals associated with the job have concluded that the responsibilities associated with standing a continuous fire watch were clearly stated and understood by the agency personnel. The periodic monitoring by OPPD security officers was effective in limiting the significance of the event.

CORRECTIVE ACTIONS

As previously noted, the corrective action taken as a result of this event was to relieve the individual of his responsibilities, block his access to the Protected Area and terminate his services.

PREVIOUS SIMILAR EVENTS

LERs 90-001, 90-024, 90-027, 91-006, 92-003, 92-021, 92-030, 92-031 and 92-032 discuss other recent events involving Technical Specification 2.19 fire watch requirements. None of these events involved a failure to maintain an established continuous fire watch.