Tennessee Valley Authority, Post Office Box 2000, Soddy-Daisy, Tennessee 37379

January 9, 1995

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

Gentlemen:

TENNESSEE VALLEY AUTHORITY - SEQUOYAH NUCLEAR PLANT UNIT 1 - DOCKET NO. 50-327 - FACILITY OPERATING LICENSE DPR-77 - LICENSEE EVENT REPORT (LER) 50-327/94015

The enclosed LER provides details concerning the failure to perform an hourly fire watch as required by technical specifications (TSs).

This event is being reported in accordance with 10 CFR 50.73(a)(2)(i) as a condition prohibited by TSs.

Sincerely,

P. J. Adney
Site Vice President

Enclosure
cc: See page 2

IE22
1/1

cc (Enclosure):

INPO Records Center
Institute of Nuclear Power Operations
700 Galleria Parkway
Atlanta, Georgia 30339-5957

Mr. D. E. LaBarge, Project Manager
U.S. Nuclear Regulatory Commission
One White Flint, North
11555 Rockville Pike
Rockville, Maryland 20852-2739

NRC Resident Inspector
Sequoyah Nuclear Plant
2600 Igou Ferry Road
Soddy-Daisy, Tennessee 37379-3624

Regional Administrator
U.S. Nuclear Regulatory Commission
Region II
101 Marietta Street, NW, Suite 2900
Atlanta, Georgia 30323-2711

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NRC Form 366 (5-92) | U.S. NUCLEAR REGULATORY COMMISSION | Approved OMB No. 3150-0104 Expires 5/31/95

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Sequoyah Nuclear Plant (SQN), Unit 1	0 5 0 0 0 3 2 7	1 OF 0 5

TITLE (4)

Failure to Perform an Hourly Fire Watch as Required by Technical Specifications

EVENT DAY (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)
1 2	0 8	9 4	9 4	0 1 5	0 0	0 1	0 9	9 5	SQN, Unit 2	0 5 0 0 0 3 2 8
										0 5 0 0 0

OPERATING MODE (9)	1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following)(11)			
POWER LEVEL (10)	0 6 0	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)	XX 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)
S. D. Gilley, Compliance Licensing	6 1 5 8 4 3 - 7 4 2 7

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
X	YES (If yes, complete EXPECTED SUBMISSION DATE)	NO	0 1	3 1	9 5

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

On December 8, 1994, with Unit 1 in Mode 1 at 60 percent power and Unit 2 in Mode 1 at 100 percent power, a person conducting a fire watch reached the doors that were normally used for access between the control building and Elevation 734 of the auxiliary building. These doors were found to be chained and locked. The fire watch then attempted to access the area from the auxiliary building but found that access was blocked by a radiological control rope and signs which indicated that changes to radiological conditions could occur. While the fire watch was attempting to locate a Radiological Control technician, the fire watch foreman arrived. Because of the time which had elapsed, the decision was made for the fire watch to continue on the prescribed route to avoid missing additional fire watches in the auxiliary building. The doors leading from the control building to the refuel floor were chained and locked by Security personnel.

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

I. PLANT CONDITIONS

Unit 1 was in Mode 1 at 60 percent power. Unit 2 was in Mode 1 at 100 percent power.

II. DESCRIPTION OF EVENT

A. Event

On December 8, 1994, with Unit 1 in Mode 1 at 60 percent power and Unit 2 in Mode 1 at 100 percent power, a person conducting a fire watch reached a door that provides access from the control building to the auxiliary building refuel floor on Elevation 734 and found it chained and locked. The fire watch then tried to enter through a second door that provides access to the refuel floor, but this door was also locked. The fire watch then attempted to access the area through the auxiliary building but found that access was blocked by a radiological control rope and signs that indicated that changes to radiological conditions could occur. While the fire watch was attempting to locate a Radiological Control technician, the fire watch foreman arrived. Because of the time that had elapsed, the decision was made for the fire watch to continue on the prescribed route to avoid missing additional fire watches in the auxiliary building. This resulted in the failure to perform the required fire watch for two rooms on Elevation 759 of the auxiliary building within one hour as required by technical specifications (TSs). The fire watch was required for these rooms because one room contained Thermo-Lag on a section of conduit and there was an inoperable fire damper between the two rooms.

B. Inoperable Structures, Components, or Systems That Contributed to the Event

None.

C. Dates and Approximate Times of Major Occurrences

December 8, 1994 0830 Eastern standard time (EST)	The Modifications (MODS) engineer contacted the Security Shift Supervisor (SSS) that a fuel handling area isolation (FHAI) would be needed to support the rerack work, and Security's responsibilities were discussed. The SSS asked about access control and was advised by the MODS engineer to contact the Shift Operations Supervisor (SOS).
December 8, 1994 at approximately 0900 EST	After discussions with an individual supporting the rerack work, the SSS decided that both doors leading from the control building to the refuel floor would be locked and briefed the shift security officers to that effect.

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
Sequoyah Nuclear Plant (SQN), Unit 1	0 5 0 0 0 3 2 7	9 4	-- 0 1 5	-- 0 0	0 3 OF 0 5

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

December 8, 1994 at approximately 1117 EST	The fire watch successfully passed through the door from the control building to the refuel floor.
December 8, 1994 1130 EST	The SSS was notified that they were ready to pull the first rack and initiate the FHAI. The SSS instructed the shift lieutenant to have both doors locked.
December 8, 1994 1135 EST	The doors between the control building and the refuel floor were chained and locked by Security personnel.
December 8, 1994 at approximately 1217 EST	The fire watch reached a door providing access from the control building to the auxiliary building refuel floor and found it chained and locked. The fire watch proceeded to a second door which accesses the refuel floor and it was also found to be locked.
December 8, 1994 at approximately 1222 EST	The fire watch called the Fire Operations foreman who instructed the watch to access the refuel floor by going back through the control building and entering the auxiliary building. The fire watch reached the refuel floor at approximately 1230 EST and found that access to the Unit 2 emergency gas treatment room was blocked by a radiological control rope and signs, which indicated that changes to radiological conditions could occur. While the fire watch was attempting to find a Radiological Control technician, the fire foremen arrived and based on the time (approximately 1234 EST), decided to have the fire watch continue the route in the auxiliary building to avoid missing the fire watch in those areas.
December 8, 1994 at approximately 1300 EST	The fire watches were told to alter their routes to avoid the locked doors. The missed area was successfully inspected at 1320 EST.

D. Other Systems or Secondary Functions Affected

None.

E. Method of Discovery

Fire Operations personnel discovered conditions that precluded the completion of the fire watch surveys required by TSs.

F. Operator Actions

None.

G. Safety System Responses

None.

III. CAUSE OF EVENT

A. Immediate Cause

The immediate cause of this event was the failure to comply with TSs and complete the required fire watch.

B. Root Cause

The root cause of this event is still under investigation. A supplemental report will be submitted following completion of this investigation.

IV. ANALYSIS OF EVENT

The hourly fire watch required by TS LCO 3.7.12 was not performed for rooms A03 and A04 on Unit 2. The fire watch was required because of conduit in the area that is covered with Thermo-Lag and because of an inoperable fire damper. Fire detection in these rooms was operable during this event. Any fire in this area would have been detected and a prompt fire brigade response initiated. Additionally, even though the Thermo-Lag and the fire damper may not be capable of meeting their design function, they would provide some protection in the event of a fire. Based on the above information, the potential safety implication does not create a significant safety concern. Therefore, it can be concluded that there were no adverse consequences to plant personnel or to the public as a result of this event.

V. CORRECTIVE ACTIONS

A. Immediate Corrective Actions

Fire watch personnel were briefed on the locked doors and adjusted their routes accordingly to cover all required areas. The SOS notified the SSS to immediately unlock one of the doors between the control building and the auxiliary building refuel floor.

B. Corrective Action to Prevent Recurrence

The Security Manager issued a Security Supervisor's Brief counseling the SSSs on proper logkeeping and turnover and on obtaining authorization from the SOS on duty before locking any doors in plant operating areas. The brief also emphasized that although other similar designations exist in the Operations section (ASOS, SRO, etc.), the SOS must be contacted in order to lock doors in plant operating areas.

MODS counseled the involved personnel on management expectations for communication between MODS and support groups.

Any additional corrective actions will be submitted in a supplemental report following completion of the investigation.

VI. ADDITIONAL INFORMATION

A. Failed Components

None.

B. Previous Similar Events

A review of previous similar events will be conducted following completion of the investigation.

VII. COMMITMENTS

Commitments identified as a result of the investigation will be established in the supplemental report. TVA expects to provide this report to NRC by January 31, 1995.