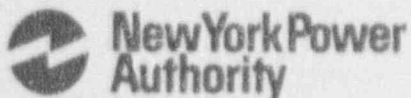


James A. FitzPatrick  
Nuclear Power Plant  
P.O. Box 41  
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315 342-3840



Radford J. Converse  
Resident Manager

February 3, 1992  
JAFF-92-0106

United States Nuclear Regulatory Commission  
Document Control Desk  
Mail Station P1-137  
Washington, D.C. 20555

SUBJECT: DOCKET NO. 50-333  
LICENSEE EVENT REPORT: 92-001-00 - Missed Fire Watches  
Due to Inadequate Training/  
Supervision

Dear Sir:

This report is submitted in accordance with 10 CFR 50.73(a)(2)(i)(B).

Questions concerning this report may be addressed to  
Mr. W. Verne Childs at (315) 349-6071.

Very truly yours,

RADFORD J. CONVERSE

RJC:WVC:lar

Enclosure

cc: USNRC, Region I  
USNRC Resident Inspector  
INPO Records Center

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LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) **JAMES A. FITZPATRICK NUCLEAR POWER PLANT** DOCKET NUMBER (2) **0 5 0 0 0 3 3 3** PAGE (3) **1 OF 0 0**

TITLE (4) **Fire Watches Missed Due to Inadequate Training and Supervision**

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 NAME	DOCKET NUMBER (8)	
0 1	0 3	9 2	9 2	0 0 1	0 0	0 2	0 3	9 2		0 5 0 0 0	
										0 5 0 0 0	

OPERATING MODE (9) **N** THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 50.71 (Check one or more of the following) (11)

25.405b(1)	20.405a(1)	50.73a(2)(iv)	73.71b(1)
20.405a(1)(ii)	50.30(a)(1)	50.73a(2)(v)	73.71b(2)
20.405a(1)(iii)	50.30(a)(2)	50.73a(2)(vi)	OTHER (Specify in Address Section and in Part 3, NRC Form 205A)
20.405a(1)(iv)	<input checked="" type="checkbox"/> 50.73a(2)(i)	50.73a(2)(vii)(A)	
20.405a(1)(v)	50.73a(2)(ii)	50.73a(2)(vii)(B)	
20.405a(1)(vi)	50.73a(2)(iii)	50.73a(2)(vii)(C)	

LICENSEE CONTACT FOR THIS LER (12)

NAME **W. VERNE CHILDS, SENIOR LICENSING ENGINEER** TELEPHONE NUMBER **3 1 5 3 4 9 - 6 0 7 1**

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC

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

ABSTRACT (Limit to 1400 spaces, i.e., approximately 10 lines single-space typewritten text) (16)

While the plant was shutdown and in a cold condition for maintenance and refueling, three separate fire watches were not completed as required by Technical Specification 3.12.F on January 3, and 11, 1992. Fire watches were missed for a maximum of 1 hour and were reestablished within the following hour. The events were caused by inadequate training and supervision of temporary personnel. Corrective actions include the hiring of supervisors to provide 24-hour-a-day supervision. No previous LERs which involve inadequate training and supervision resulting in a failure to meet Technical Specification fire watch requirements have been submitted by this facility.

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TEXT (If more space is required, use additional NRC Form 386A's) (17)

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Description

With the plant in the cold condition and undergoing routine maintenance and/or preparation for refueling, fire watch requirements of Technical Specification 3.12.F were not met on three occasions.

A number of fire watches are required to satisfy Technical Specification 3.12.F due to a variety of fire barrier penetration seal deficiencies, fire damper installation deficiencies, or the discovery of deficiencies with respect to 10 CFR 50, Appendix R, requirements. (See LER-91-010, 91-023, and 91-024). The number of fire watches required has varied, on a daily basis, from approximately 25 to 75. Some of the fire watches are continuous watches within a particular area while others perform hourly roving fire watch duties in several areas. The number of fire watches and nature of the watch duties (continuous or roving) varies somewhat from day to day depending on factors such as the presence of (or lack of) automatic fire detection, type of fire suppression equipment in the area of concern, and rate at which deficiencies are found and corrected. On three occasions on January 3, and January 11, 1992 fire watch personnel failed to complete the required duties as described below.

1. On January 3, 1992 an hourly roving fire watch did not complete the prescribed hourly patrol of a portion of the reactor building [NG] (secondary containment) and the adjacent reactor water recirculation system [AD] motor generator room between 1800 and 1900 hours. During the same time period operating personnel were preparing to conduct surveillance to demonstrate the leak tightness of the reactor building as required by Technical Specification 4.1.C.1.c prior to the start of refueling.

The fire watch was assigned to perform hourly roving patrols of 12 interconnected or adjacent areas within the reactor building and adjacent (connected) structures. The hourly patrol of the 12 areas normally requires approximately 25 minutes and required the fire watch to enter and subsequently exit the reactor building on each patrol.

At approximately 1730 hours operating personnel began preparations for conducting the reactor building leak rate test. This included announcements on the plant public address system that reactor building access was limited to the 272 foot elevation airlock. The access limitations are intended to establish conditions which do not result in an aborted test.

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TEXT IF MORE SPACE IS REQUIRED, use additional NRC Form 366A's (11)

At approximately 1800 hours the assigned fire watch approached the access door to the reactor water recirculation motor generator room on the 300 foot elevation with the intention for performing the fire watch duties in that area and then entering the reactor building via the airlock on the 300 foot elevation to continue the patrol for the four additional assigned areas within the reactor building.

As the fire watch approached the reactor water recirculation system motor generator room access door, he encountered an operator stationed at that point. The operator informed the fire watch that reactor building access was limited to the 272 foot elevation access airlock. At approximately the same time a public address system announcement concerning access to the reactor building was repeated. Based on interviews (with the fire watch and operator that was stationed at the access door to the reactor water recirculation system motor generator room) after the event, it is apparent that the fire watch misunderstood the public address announcements and statements made by the operator to mean that access to the reactor building was denied.

Reactor building leak rate testing was terminated at 1830 for an upcoming shift change by operators conducting the test. Fire watch personnel also changed shift at approximately 1900. At approximately the same time the Shift Supervisor became aware that the hourly roving fire watch of the areas within the reactor water recirculation system motor generator room and reactor building had not been completed for the time period between 1800 and 1900. The Shift Supervisor provided instructions to the fire watch individual that had just come on duty to perform the patrol of the areas that had been missed during the previous hour. These instructions included a discussion which made it clear that completion of the hourly patrol was also required for all of the assigned areas during the reactor building leak rate testing. Testing of the reactor building leak rate was resumed at approximately 2035 hours and completed without further problems with completing the required fire watch activities.

2. On January 3, 1992 a continuous fire watch stationed in the condensate system demineralizer [SF] room left his assigned post prior to proper rel...

The condensate demineralizer room is an area in which loose surface contamination (loose radioactive material) is present on the floor surfaces to an extent that the wearing of protective clothing is required. The area at which

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TEXT (if more space is required, use additional NRC Form 306A's) (17)

access to the room is controlled (the "step-off pad" area) to prevent the spread of the loose surface contamination is outside the demineralizer room in the turbine building [F4] near the entrance to the room. When an individual is at the step-off pad, the area which the fire watch is required to observe cannot be viewed due to the presence of radiation shield walls and other equipment and structural components.

At approximately 2245 on January 3, 1993 the continuous fire watch left the condensate demineralizer room and went to the step-off pad area to change from protective clothing to "street" clothing in order to leave the area and visit the rest room. The fire watch's relief was in the process of dressing in protective clothing at the same time. However, no fire watch was present in the condensate demineralizer room for a period of five minutes or less when a continuous fire watch was required by Technical Specification 3.12.F.

3. On January 10, 1992 an hourly roving fire watch patrol was not conducted between 2300 and 2400 in twelve (12) interconnected or adjacent areas in the electric bay cable tunnels, electric bays, emergency diesel generator (EDG) switchgear rooms, EDG rooms, and diesel engine driven fire pump rooms. These areas contain portions of non-safety-related and safety-related Class IE medium and low voltage switchgear, load centers, motor control centers and cables [EA, EB, EC, ED], as well as all four EDGs [EK] and two fire pumps [KP].

The roving fire watch personnel for the above areas normally change shifts at 0700, 1500, and 2300 hours. At 2300 hours the fire watch for the areas discussed above had completed the shift, left the post, and left the plant site. Earlier in the shift the fire watch had reviewed the work schedule and determined that he was not scheduled to work overtime (from 2300 on January 10, 1992 to 0300 on January 11, 1992). The fire watch did not determine that a relief was present prior to leaving the plant site.

Shortly after 0000 hours on January 11, 1992 other fire watch personnel noted that no one had logged completion of a patrol of the areas discussed for the one-hour time period between 2300 and 2400 on January 10, 1992. Another individual was immediately assigned to perform the required fire watch patrol and subsequent patrols were completed as required.

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TEXT (If more space is required, use additional NRC Form 366A's) (1)

Cause

In each case, the cause was a failure of plant management and supervisory personnel to provide adequate training and supervision of the fire watch personnel.

Most of the fire watch personnel are temporary employees hired specifically to perform fire watch duties. Most of the individuals have limited experience or knowledge of the day-to-day activities involved with operating and maintaining a power plant. In addition, most of the fire watch personnel have never previously worked in situations where the concepts of "watchstanding", obtaining proper relief prior to leaving a watch post, or conducting watch turnover (shift relief) could be expected to be well understood. While all of the fire watch personnel received training for the specific fire watch duties to which they are assigned, in addition to radiation protection and general employee training, no training in watch relief or watchstanding in general was provided.

In addition to the training deficiencies, supervision of the fire watches was inadequate. Only general supervision was provided by the Shift Supervisor, Assistant Shift Supervisor, the Fire Protection Supervisor, and/or a Contract Services Supervisor. No specific direction was given to this group of supervisors to provide assurance that some consistent, minimum level of supervision existed. Most of the supervisors assumed the supervision of the fire watches in addition to numerous other responsibilities.

Analysis

These events require reporting under 10 CFR 50.73(a)(2)(i)(B) as operations prohibited by the plant Technical Specifications. Specifically, the fire watch requirements of 3.12.F were not met for the short time periods noted.

None of the three (3) failures resulted in significant safety concerns by themselves due to the short time intervals, the existence of operable automatic fire detection and suppression equipment, and/or a low combustible loading in the area of concern.

The potential for other more serious lapses in providing the required fire watches as a result of the inadequate training and supervision was potentially the most significant aspect of these events. The corrective actions noted below have corrected this deficiency.

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TEXT (If more space is required, use additional NRC Form 386A's.) (17)

Corrective Actions

1. In each case the required fire watches were reestablished (for the continuous fire watch) or performed during the next one-hour period (for the hourly roving fire watch).
2. The individual continuous fire watch tours are limited to a maximum of 60 minutes to reduce the probability that a fire watch will require unscheduled relief for personal reasons. Completed on January 17, 1992.
3. Fire watches were counseled concerning the duties of fire watches and the requirements for assuring that proper relief takes place. Completed on January 17, 1992.
4. Fire watch supervisors were hired and received appropriate training to provide 24-hour-a-day direct supervision. The supervisors also provide a specific individual to which fire watch personnel may bring questions, concerns, or schedule difficulties for prompt resolution. Completed on January 31, 1992.

Additional Information

Failed Components: None

Similar Events: No previous LERs which involve inadequate training and supervision resulting in a failure to meet Technical Specification fire watch requirements have been submitted by this facility.