NRC Form 366
(9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/85

LICENSEE EVENT REPORT (LER)

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

TITLE (4)

Failure to Comply With One-hour Fire Watch

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 1 2	0	8 5	8 5	—	0 0 8	— 0 0	0 2	1 5	8 5	Sequoyah, Unit 2	0 5 0 0 0 3 2 8
											0 5 0 0 0

OPERATING MODE (9)	1
POWER LEVEL (10)	1 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)	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
Glenn Duggin, Compliance Section Engineer	AREA CODE 6 1 5 8 7 0 - 6 5 4 8

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)*	XX NO				

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

On five separate occasions, an hourly fire watch was not performed within one hour. All fire watches were immediately reestablished or completed upon detection of the missed fire watch. This condition is reportable per 10 CFR 50.73 (a)(2)(i) and the special report requirements of technical specification 3.7.12. There was no effect upon public health or safety.

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FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
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Sequoyah, Unit 1	0 5 0 0 0 3 2 7	8 5	— 0 0 8	— 0 0	0 2 OF 0 3

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

All five events described in this report occurred while unit 1 was in mode 1 (100 percent power, 2235 psig, 579 degrees F), and unit 2 was in mode 1 (100 percent power, 2240 psig, 578 degrees F).

The first event occurred at 0700C on January 20, 1985. The fire watch assigned to Route C for the 1100 to 0700 (EST) shift mistakenly thought that he was being relieved by an auxiliary unit operator and left the plant at 0700 EST (0600 CST). The fire watch assigned to Route C for the 0700 to 1500 EST shift (the 1100 to 0700 relief) arrived at the plant late (approximately 30 minutes) due to inclement weather and discovered that Route C had not been run for the 0600 CST hour. The 0700 to 1500 shift fire watch began his rounds at 0700 CST, thus causing a two-hour delay between fire watches when one hour is required. A verbal warning was given to the 1100 to 0700 fire watch to make direct contact with his relief on shift turnover.

The second and third events occurred on January 20, 1985, at 1845 CST and 2150 CST, respectively. Both events involved key lock doors that were frozen shut due to subzero temperatures that prevented the fire watch from inspecting the affected rooms. The fire watch continued his rounds while the doors were being unfrozen. He performed the fire watch surveillance approximately thirty (30) and fifty (50) minutes late, respectively, on the affected rooms. The heaters in the outer door card key units were not large enough to keep these doors warm and operable.

The fourth event occurred at 0815 CST on January 21, 1985. The fire watch assigned to Route C on the 1100 to 0700 EST shift doubled over to the 0700 to 1500 EST shift. He was scheduled to work the Route A fire watch on the 0700 to 1500 shift, but he did not know the route well enough to perform the fire watch. Shift manning had to be swapped with someone else who knew the route, therefore delaying the performance of both Routes A and C. The 0600 CST fire watch on Routes A and C was delayed twenty (20) minutes and thirty (30) minutes, respectively. The proper hourly fire watch sequence was restored at the 0700 CST hour. The person who was not familiar with the Route A fire watch was trained on Route A. All fire watch personnel are trained in all routes initially. They are then assigned regularly to one route and are not refamiliarized with the other routes periodically. Personnel do not normally swap routes on a regular basis.

The fifth event occurred at 1230 CST on January 23, 1985. The fire watch was unable to complete a portion (10 rooms) of his route on time (approximately twenty five (25) minutes late) due to limited access to the auxiliary building. The fire watch was only late one time in his hourly fire watch route. The auxiliary building ventilation system only had one general exhaust fan available to maintain adequate pressure control. Operations personnel limited the access to the auxiliary building until another exhaust fan became operable. The fire watch could have taken an alternate route, but the extra time needed for this alternate route would probably have also resulted in exceeding the hourly limit.

All fire watches were immediately reestablished or completed upon detection of the missed fire watch. These events are reportable per 10 CFR 50.73 (a)(2)(i) and the special report requirements of technical specification 3.7.12. There was no effect on public health or safety.

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

An Operations "night order" was issued on January 29, 1985, to all Operations and fire watch personnel explaining this event. The order provided instructions to clearly and promptly explain any problems associated with the successful completion of a fire watch to the shift engineer (SE) or assistant shift engineer (ASE). The order also instructed the ASE or SE to promptly initiate investigation and corrective actions of these problems in order to allow proper completion of the inspection within the one-hour time requirement (if possible). This "night order" is required to be read and initialed by all Operations fire watch personnel before assuming their next shift. Following this January 29, 1985, "night order", any future similar failures to successfully complete fire watches will result in disciplinary action if the event could have been prevented by prompt personnel action.

Additionally, the Plant Quality Assurance Staff has initiated a periodic surveillance program to check Public Safety computer key card printouts against fire watch route logs. This will provide confidence that all areas are checked and identify any problem areas within the fire watch route.

Previous occurrences - one (SQRO-50-327/84075).

TENNESSEE VALLEY AUTHORITY
Sequoyah Nuclear Plant
Post Office Box 2000
Soddy Daisy, Tennessee 37379

February 15, 1985

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

Gentlemen:

TENNESSEE VALLEY AUTHORITY - SEQUOYAH NUCLEAR PLANT UNIT 1 - DOCKET NO. 50-327 - FACILITY OPERATING LICENSE DPR-77 - REPORTABLE OCCURRENCE REPORT SQRO-50-327/85008

The enclosed licensee event report and special report provide details concerning the failure to comply with the one-hour fire watch requirement of technical specification 3.7.12. This event is reported in accordance with 10 CFR 50.73, paragraph a.2.i and special report requirements of technical specification 3.7.12.

Very truly yours,

TENNESSEE VALLEY AUTHORITY

O.R. Wallace

P. R. Wallace
Plant Manager

Enclosure
cc (Enclosure):

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NRC Inspector, NUC PR, Sequoyah

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