



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

Robert A. Fenech
Vice President, Sequoyah Nuclear Plant

December 18, 1992

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

Gentlemen:

TENNESSEE VALLEY AUTHORITY - SEQUOYAH NUCLEAR PLANT UNITS 1 AND 2 - DOCKET
NOS. 50-327 AND 50-328 - FACILITY OPERATING LICENSES DPR-77 AND DPR-79 -
LICENSEE EVENT REPORT (LER) 50-327/92020

The enclosed LER provides details concerning a failure to perform a fire
watch within the timeframe required by technical specifications.

This event is being reported in accordance with 10 CFR 50.73(a)(2)(i)(B)
as an operation prohibited by technical specifications.

Sincerely,

Robert A. Fenech

Enclosure
cc: See page 2

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U.S. Nuclear Regulatory Commission
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cc (Enclosure):

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LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Sequoyah Nuclear Plant, Unit 1 DOCKET NUMBER (2) 051010131217110F PAGE (3) 05
TITLE (4) Failure to Perform a Fire Watch Within the Timeframe Required by Technical Specifications

EVENT DAY (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)		
MONTH	DAY	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES	DOCKET NUMBER(S)		
11	11	92	02	0	11	11	92	Sequoyah, Unit 2	051010131218		

OPERATING MODE (9) 1 THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following)(11)

<u>1</u>	<u>20.402(b)</u>	<u>0</u>	<u>20.405(c)</u>	<u>0</u>	<u>50.73(z)(2)(iv)</u>	<u>0</u>	<u>73.71(b)</u>
<u>0</u>	<u>20.405(a)(1)(i)</u>	<u>0</u>	<u>50.36(c)(1)</u>	<u>0</u>	<u>50.73(a)(2)(v)</u>	<u>0</u>	<u>73.71(c)</u>
<u>0</u>	<u>20.405(a)(1)(ii)</u>	<u>0</u>	<u>50.36(c)(2)</u>	<u>0</u>	<u>50.73(a)(2)(vii)</u>	<u>0</u>	<u>OTHER (Specify in</u>
<u>0</u>	<u>20.405(a)(1)(iii)</u>	<u>XX</u>	<u>50.73(a)(2)(i)</u>	<u>0</u>	<u>50.73(a)(2)(viii)(A)</u>	<u>0</u>	<u>Abstract below and in</u>
<u>0</u>	<u>20.405(a)(1)(iv)</u>	<u>0</u>	<u>50.73(a)(2)(ii)</u>	<u>0</u>	<u>50.73(a)(2)(viii)(B)</u>	<u>0</u>	<u>Text, NRC Form 366A)</u>
<u>0</u>	<u>20.405(a)(1)(v)</u>	<u>0</u>	<u>50.73(a)(2)(iii)</u>	<u>0</u>	<u>50.73(a)(2)(x)</u>	<u>0</u>	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
<u>Jan Bajraszewski, Compliance Licensing</u>	<u>615843-7749</u>

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)

<u>0</u>	EXPECTED SUBMISSION DATE (15)	<u>0</u>	<u>0</u>	<u>0</u>
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YES (If yes, complete EXPECTED SUBMISSION DATE) X NO

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

On November 19, 1992, at approximately 1000 Eastern standard time (EST), with Units 1 and 2 in power operation at approximately 100 percent power, it was discovered that a fire watch patrol was not performed within the timeframe required. It was determined by use of vital area access control system card key entry and exit times that the assigned fire watch individual did not patrol some areas during performance of the November 5, 1992, 1500 EST fire watch. Further investigation revealed that two fire watch personnel had split one fire watch route and performed the fire watch patrol simultaneously. However, documents completed by the two individuals did not reflect a change in route. This improper performance caused the 1600 EST fire watch patrol to arrive late to some areas of the route by as much as 28 minutes. The cause of the late performance of the fire watch patrol was the result of two fire watch personnel failing to follow procedures. Additional fire protection related records were reviewed, and no additional discrepancies were found. Appropriate disciplinary action was taken with the involved individuals. Management expectations for procedure adherence and the importance of fire watch patrol duty was emphasized with fire watch personnel.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)				PAGE (3)			
		YEAR	NUMBER	REVISION	NUMBER				
Sequoyah Nuclear Plant, Unit 1		1992	020	020	00	01	01	01	05

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

I. PLANT CONDITIONS

Units 1 and 2 were in power operation at approximately 100 percent power.

II. DESCRIPTION OF EVENT

A. Event

On November 19, 1992, at approximately 1000 Eastern standard time (EST), it was discovered that a fire watch patrol in a portion of the radiological control area of the auxiliary building (EIIIS Code NF) was not performed within the timeframe required by technical specifications. On November 5, 1992, at 1500 EST, two fire watch personnel split one fire watch route into two separate routes. The fire watch patrol was then performed on both routes simultaneously without informing fire watch supervision. Route check sheets, administrative control documents, and fire watch journal logs were completed as if the assigned fire watch individual performed the route as required by procedure. The 1600 EST fire watch patrol was performed without deviation as required by procedure, resulting in the fire watch patrol arriving late to some areas of the route by as much as 28 minutes.

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

The fire watch patrols were in place as a result of fire barrier impairments with penetration seals and Thermo Science, Incorporated (TSI) thermolag installations. Various penetration seals are considered impaired while documentation is being developed to support the design basis of the penetration seals. TSI thermolag installations are considered impaired as a result of information provided by NRC Inspection and Enforcement (IE) Bulletin 92-01. Also, in one instance, the fire watch patrol is being used to supplement a fire hazard analysis that is being reviewed by NRC for approval of an Appendix R deviation.

C. Dates and Approximate Times of Major Occurrences

November 5, 1992
at 1500 EST

Two fire watch personnel split one fire watch route into two separate routes and performed the fire watch patrol on both routes simultaneously. Fire watch route check sheets and fire watch journal logs were completed by the two individuals to indicate proper performance of the fire watch patrol.

November 5, 1992
at 1600 EST

The fire watch patrol was performed in accordance with procedure requirements without deviation.

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FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)		
		YEAR	NUMBER	REVISION	NUMBER	OF	TOTAL
Sequoyah Nuclear Plant, Unit 1	0500032792	0	2	0	0	0	3 OF 5

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

November 6, 1992 The fire watch foreman identified discrepancies with fire watch check sheets that are used for administrative control. Fire Operations management was informed of the discrepancies. Involved individuals were interviewed in an attempt to resolve the discrepancies.

November 18, 1992
at 1000 EST Additional interviews were conducted with the two fire watch personnel. A review of vital area access control system card key computer printout was completed. Improper fire watch patrol performance and log falsification were confirmed.

D. Other Systems or Secondary Functions Affected

None.

D. Method of Discovery

It was determined by use of vital area access control system computer printouts that the assigned fire watch individual was not at some of the areas identified on the route check sheets for the November 25, 1992, 1500 EST fire watch patrol. The fire watch journal logs completed by the two individuals did not reflect a change in the fire watch patrol route. Further investigation revealed that two fire watch personnel had split one fire watch route, contrary to procedure, and performed the fire watch patrol on both routes simultaneously.

F. Operator Actions

No operator actions were required.

G. Safety System Responses

Not applicable - no safety system responses were required.

III. CAUSE OF EVENT

A. Immediate Cause

The immediate cause of the event was a result of two fire watch personnel splitting one fire watch route and performing the fire watch patrol on both routes simultaneously, contrary to procedure requirements. This was compounded by the individuals not reflecting the route change on the related fire protection documents. The subsequent fire watch patrol was performed in its normal sequence, without deviation, resulting in the fire watch patrol arriving late to some areas of the route.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)	
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
Sequoyah Nuclear Plant, Unit 1		1992	020	00	4	5

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

B. Root Cause

The root cause of this event is attributed to two fire watch personnel failing to follow procedures. Procedures require fire watch personnel to perform the fire watch route without deviation. Additionally, fire watch route splitting is strictly prohibited.

C. Contributing Factors

None.

IV. ANALYSIS OF EVENT

Fire watch patrols are established to mitigate the consequences of fire protection system impairments. In this event, the areas within the fire watch route were either continuously occupied or contained limited combustible loadings. Areas within the fire watch route contained fire detection and suppression equipment that was operable and in service. Additionally, the fire watch patrols were being used to provide increased levels of assurance for potential deficiencies that could jeopardize the overall fire protection plan for Sequoyah Nuclear Plant (SQN). Therefore, 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

Appropriate disciplinary action was taken with the involved individuals. Management expectations for procedure adherence and the importance of fire watch patrol duty was emphasized with fire watch personnel. Additional fire protection related records were reviewed, and no additional discrepancies were found.

B. Corrective Action to Prevent Recurrence

The Site Quality organization will perform random assessment of fire watch patrol performance for a one month period. The assessment report of fire watch performance will be provided to Fire Operations management for review.

VI. ADDITIONAL INFORMATION

A. Failed Components

None.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)	
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
Sequoyah Nuclear Plant, Unit 1	050003 2 7 9 2	--	0 2 0	--	0 0 0	5 OF 0 5

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

B. Previous Similar Events

A review of previous events did not identify an LER associated with a late fire watch performance as a result of intentional procedure noncompliance. LER (327/88-043) identified an event where a fire watch was not properly performed. Lack of adequate management oversight of the fire watch personnel was determined to be the root cause. As a result of that LER, actions were taken to strengthen the fire watch program through formal training, procedure enhancements, and management controls. An NRC inspection report (50-327/328-92-27) addressed industry information about falsification of plant logs and operator log discrepancies at SQN. Actions resulting from this report included disciplinary action with the involved operators and management discussions and training on NRC IE Notice 92-30 with site assistant unit operators. These actions did not prevent the willful failure to follow procedure event described in this LER.

III. COMMITMENTS

None.