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 4

TITLE (4)

Missed Hourly Fire Watch Due To Inaccessibility And A Personnel Error

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)
										Sequoyah, Unit 2	0 5 0 0 0 3 2 8
0 2	1 8	8 6	8 6	–	0 0 5	– 0 1	0 4	1 5	8 6		0 5 0 0 0

OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)			
5		20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)
POWER LEVEL (10)		20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)
0 0 0		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
Glenn E. Duggin, Compliance Section Engineer	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	
E	X X	D R	0 1 0 5	NO							

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)

Fire watch personnel were unable to comply with the action statement of Technical Specification (TS) 3.7.12 on three separate occasions, and a fire watch was not initiated on one occasion. The action statement requires an hourly fire watch patrol when a fire barrier, in a fire zone boundary protecting safety-related areas, is nonfunctional. A special report is also required in accordance with TS 3.7.12, and it is considered to be part of this report.

On February 18, March 1, and March 5, the fire watch could not enter applicable rooms to check for fires because of inoperable fire doors. On March 3, the fire watch was not initiated as required because of a personnel error. A breaching permit was issued, but the shift technical advisor did not realize that the Diesel Generator Building was not in the normal fire watch patrol area, and the craft foreman on the work order did not know that a fire watch had not been initiated. The breaching permit was closed on the third day of the allowed seven days.

There were no events in the subject rooms or surrounding areas which would have required a fire barrier or a fire watch; therefore, there was no effect on public health or safety. In cases where the doors were inoperable, the fire watch could feel of a door or look for smoke if he could not enter the room to determine if a fire was in progress. Also, the fire detector on one side of the fire barrier was operable as required by TS.

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This revision is to correct an administrative error on a due date for corrective action.

DESCRIPTION OF EVENTS

During all of these occurrences, unit 1 was in mode 5 (0 percent power, 20 psig, 130 degrees F) and unit 2 was in mode 5 (0 percent power, 250 psig, 125 degrees F).

Occurrence Number One:

The roving fire watch was unable to complete his rounds for the 0900 CST hour on February 18, 1986, through door A132. This door is to the unit 2 Auxiliary Building (AB) supply air fan room. The assistant shift engineer (ASE) was notified immediately when the door was found to be jammed. The ASE verified the door was jammed and initiated a work request (WR). The door was opened, and the fire watch was able to resume his rounds at the 1400 CST hour.

The following also applies to occurrences two and four. A breaching permit (BP) was issued at this time to allow the door to be opened (breached) for repair. The BP is good for seven days in accordance with Technical Specification (TS) 3.7.12. The fire watch felt of the door each hour to see if it was hot and looked for smoke to determine if a fire was in progress. The fire detector on one side of the fire barrier was operable as required by TS. This occurrence was found and reported by the fire watch in the process of performing his normal duties.

Occurrence Number Two:

The roving fire watch was unable to complete his rounds for the 2000 CST hour on March 1, 1986, through door A123. This door is to the unit 1 AB supply air fan room and the unit 1 AB supply air intake filter room. The ASE was notified immediately when the door could not be opened. A WR was initiated, and the door was opened in time for the 0008 CST fire watch, on March 2, 1986.

Occurrence Number Three:

At 0920 CST on March 3, 1986, a fire watch was not established on door D-13 in the Diesel Generator (D/G) Building. A fire door breaching permit was issued as required, but the shift technical advisor (STA) did not realize that the D/G Building was not in the normal fire watch patrol area. Also, the craft foreman on the workplan (WP) (to work on the door) did not realize that a fire watch had not been initiated. Normally, the fire watch will get a copy of the breaching permit and include the new area in their roving patrols. In this case, since the D/G Building is outside their regular patrol area, a special fire watch should have been initiated using different people than on the regular patrol. The door was closed and returned to operable status on March 5, 1986, at 0845 CST. The BP was also closed at that time.

Occurrence Number Four:

The roving fire watch was unable to complete his rounds for the 2200 CST hour on March 5, 1986, through door A123. These are the same rooms as specified in occurrence number two. The ASE was notified immediately, and a WR was initiated. The door was opened and repaired in time for the 0100 CST fire watch.

CAUSE OF EVENTS

Occurrence Number One and Two:

The fire watch was unable to complete his route because of an inoperable door. Doors A123 and A132 respectively were jammed shut because of a screw backing out of the pull handle, making the handle useless and preventing the door from being pulled open. These doors are manufactured by Overly Manufacturing Company (0105). The doors were repaired and returned to service. The fire watch was able to resume his route as soon as the doors were opened to start repairs.

Occurrence Number Three:

The fire watch was not established because of a personnel error on the part of the STA and the craft foreman. The STA normally gives a copy of the breaching permit to the fire watch, and that is all that is needed to add an area to the route. However, the D/Gs are outside the normal route area, and a special fire watch should have been initiated. The foreman knew that a fire watch was required, but he did not verify that a fire watch was actually in place while the door was breached. By procedure, the STA (or shift engineer) has the responsibility for arranging fire watch coverage. There were no unusual characteristics of the work area that contributed to this personnel error.

Occurrence Number Four:

The fire watch was unable to complete his route because of an inoperable door. The handle to door A123 came loose, and the door could not be opened. The screw that connects the release mechanism to the pull handle broke. This particular screw in this type of door was made of brass. The screw that broke was replaced with a steel screw. The door was repaired and returned to service. The fire watch was able to resume his route as soon as the door was opened to start repairs.

ANALYSIS OF EVENTS

All of the occurrences were reportable as an operation prohibited by the plant's TS because the action of limiting condition for operation (LCO) 3.7.12 was not met. The action statement requires an hourly fire watch patrol when a fire

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

barrier, in a fire zone boundary protecting safety-related areas, is nonfunctional. A fire detector is required, and it was operable on one side of the fire barrier. A special report is also required in accordance with TS 3.7.12, and it is considered to be part of this report.

There were no events in the subject rooms or surrounding areas which would have required a fire barrier or a fire watch; therefore, there was no effect on public health or safety.

The fire watch is unaffected by the plant operating mode or power level. If a fire had occurred in a room that was not accessible by the fire watch and the unit was at power, equipment damage may have resulted in shutdown for repairs in accordance with a LCO.

Since the fire watch makes hourly rounds, the maximum amount of time that a fire door was unknowingly inoperable was one hour. All of the inoperable fire doors were returned to service within 24 hours even though 7 days are allowed in accordance with TS 3.7.12.

CORRECTIVE ACTIONS

Corrective actions for occurrences one and two were detailed in SQRO-50-327/86001. A quarterly preventative maintenance program will be initiated by May 1, 1986. Steel screws are now in stock to replace the brass screw that broke in occurrence four. All fire doors with the same type handle and latching mechanism will have their brass screws replaced with steel screws by July 31, 1986. This should help solve the problems experienced in occurrences one, two, and four.

For occurrence number three, the craftsman involved and the Modifications Section foreman were informed that the D/G Building and other outside buildings are outside of the plant's roving fire watch. When doors in those buildings are breached, a special fire watch must be initiated. The foremen were advised that they should ensure that the fire watch is established before beginning work. The STA was reminded that he is responsible for ensuring that provisions for a fire watch are made when the breaching permit is written.

Previous occurrences - 13 - SQRO-50-327/84075, 85008, 85011, 85012, 85013, 85015, 85022, 85024, 85028, 85036, 85051, 86001, and SQRO-50-328/85008. This is the second report of missed fire watches for 1986.

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

April 17, 1986

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-50-327/86005 REVISION 1

The enclosed revised 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 the 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, Sequoyah Nuclear Plant

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