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)
Missed Hourly Fire Watches Because of Inaccessibility

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 3	1 8	8 6	8 6	0 0 6	0 0	0 4	1 5	8 6		0 5 0 0 0
										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
Glenn E. 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	
E	X X	D R	0 1 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)

A roving fire watch person was unable to comply with the action statement of Technical Specification (TS) 3.7.12. The action statement requires an hourly roving fire watch 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 March 18, 1986, the fire watch could not enter two rooms to check for fires because of an inoperable fire door. The fire watch was able to resume his patrol as soon as the door could be opened. This door has been inoperable on four previous occasions in 1986. All previous occasions were caused by either the screw backing out of the pull handle or the screw breaking into inside the pull handle. These screws are brass and are being replaced with steel screws. Also, locktite will be used to hold the screws in place, and a lubrication program will be initiated by May 1, 1986, to help maintain the door in an operable status. Only one other door of this type has had this problem and then only on one occasion.

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.

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

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

DESCRIPTION OF EVENT

During this occurrence, unit 1 was in mode 5 (0 percent power, 280 psig, 131 degrees F) and unit 2 was in mode 5 (0 percent power, 275 psig, 119 degrees F). This occurrence was discovered and reported by the fire watch in the process of performing his normal duties.

At 0810 CST on March 18, 1986, a roving fire watch was unable to complete his route for the 0800 CST hour because door A123 would not open. A work request was prepared, and the door was opened as soon as possible. The fire watch was able to resume his route through this door at the 1400 CST hour. The rooms affected were the unit 1 Auxiliary Building (AB) supply air fan room and the unit 1 AB supply air intake filter room. The AB is a common area for units 1 and 2.

CAUSE OF EVENT

The fire watch was unable to complete his route because of an inoperable door. Door A123 had a screw backed out of the pull handle making the handle useless and preventing the door from being pulled open. This door is manufactured by Overly Manufacturing Company (0105). 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 EVENT

This occurrence is reportable as an operation prohibited by the plant's technical specification (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 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. The fire door was returned to service within 24 hours even though 7 days are allowed in accordance with TS 3.7.12.

CORRECTIVE ACTION

This door has been inoperable on four previous occasions in 1986. All previous occasions were caused by either the screw backing out of the pull handle or the screw breaking into inside the pull handle. These screws are brass and are being replaced with longer steel screws, and locktite will be used on the screw threads to help hold them in place. Additionally, the screws will be staked with a punch to keep them from backing out. A lubrication program will be initiated by May 1, 1986, to help maintain the door in an operable status. Only one other door has had this problem and then only on one occasion. All fire doors with the same type handle and latching mechanism will have their brass screws replaced with steel screws by July 31, 1986.

Previous occurrences - 14 - SQRO-50-327/84075, 85008, 85011, 85012, 85013, 85015, 85022, 85024, 85028, 85036, 85051, 86001, 86005, and SQRO-50-328/85008. This is the third 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-50-327/86006

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 the special report requirements of Technical Specification 3.7.12.

Very truly yours,

TENNESSEE VALLEY AUTHORITY

P.R. Wallace

P. R. Wallace
Plant Manager

Enclosure
cc (Enclosure):

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