

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) BROWNS FERRY UNIT 1	DOCKET NUMBER (2) 0 5 0 0 0 2 5 9	PAGE (3) 1 OF 0 3
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TITLE (4)
VIOLATION OF FIRE PROTECTION TECHNICAL SPECIFICATIONS DUE TO 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)
08	30	88	88	026	00	09	29	88	BROWNS FERRY UNIT 2		0 5 0 0 0 2 6 0
									BROWNS FERRY UNIT 3		0 5 0 0 0 2 9 6

OPERATING MODE (9) N

POWER LEVEL (10) 6010

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

<input type="checkbox"/> 20.402(b)	<input type="checkbox"/> 20.405(a)	<input type="checkbox"/> 50.73(a)(2)(iv)	<input type="checkbox"/> 73.71(b)
<input type="checkbox"/> 20.405(a)(1)(i)	<input type="checkbox"/> 50.36(a)(1)	<input type="checkbox"/> 50.73(a)(2)(v)	<input type="checkbox"/> 73.71(l)
<input type="checkbox"/> 20.405(a)(1)(ii)	<input type="checkbox"/> 50.36(a)(2)	<input type="checkbox"/> 50.73(a)(2)(vi)	<input type="checkbox"/> OTHER (Specify in Abstract below and in Text, NRC Form 306A)
<input type="checkbox"/> 20.405(a)(1)(iii)	<input checked="" type="checkbox"/> 50.73(a)(2)(i)	<input type="checkbox"/> 50.73(a)(2)(vii)(A)	
<input type="checkbox"/> 20.405(a)(1)(iv)	<input type="checkbox"/> 50.73(a)(2)(ii)	<input type="checkbox"/> 50.73(a)(2)(vii)(B)	
<input type="checkbox"/> 20.405(a)(1)(v)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(ix)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
Richard L. Baker, Engineer, Plant Operations Review Staff	2 1 0 5 7 1 2 1 9 - 1 2 5 1 3 8

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 fifteen single-space typewritten lines) (16)

On August 30, 1988, at 0830 hours, with all three Browns Ferry units defueled, a condition adverse to quality report (CAQR), which identified a condition outside the requirements of the plant's technical specifications (TS), was delivered to the shift operations supervisor (SOS). This CAQR stated that fire doors 643, 644, 659 and 660 were blocked open without proper compensatory measures. TS 3.11.E requires a continuous fire watch be posted on nonfunctional fire barrier penetrations unless a fire detection system on either side of the penetration is operable and a roving fire watch is established. Doors 643, 644, 659 and 660 were blocked open using an existing roving fire watch without a fire detection system on either side of the doors. A decision was made following a general disqualification of all BFN fire barriers in November 1985 to establish roving fire watch patrols throughout the plant. At the time of this decision the Fire Hazard Analysis was inadequate and no well defined fire barrier compartmentation existed. These factors contributed to the inappropriate decision and subsequent compensatory measures. The immediate corrective action was to close these doors and complete the appropriate administrative controls. The plant's fire protection TSs have been reviewed for similar conditions in other fire protection areas and no additional violations were found. All fire protection technical and engineering staff will review the CAQR on this event. The fire protection procedure will be revised to correctly identify the TS requirements for fire barrier penetrations. A new Fire Hazards Analysis which includes defined fire barrier compartmentation has been completed and previously submitted for NRC review.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
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TEXT IF more space is required, use additional NRC Form 3654 (17)

Description of Event

On August 30, 1988, at 0830 hours, with all three Browns Ferry units defueled a condition adverse to quality report (CAQR) was delivered to the shift operations supervisor (SOS). This CAQR identified a condition outside the requirements of the fire protection plan (FPP) 2 attachment M, Fire Watch Requirements and Responsibilities, and the plant's technical specifications (TS) 3.11.E. The CAQR (BFQ 880533) states that fire doors 643, 644, 659 and 660 were blocked open without proper compensatory measures. The deficiency was discovered during quality surveillance monitoring. TS 3.11.E requires a continuous fire watch be posted unless a fire detection system on either side of the door is operable and a roving fire watch is established. However, these doors were blocked open under an existing roving fire watch without a fire detection system on either side of the doors. These doors are 480 volt shutdown board room 2B and 2A and 4KV shutdown board room C and D respectively. These doors have been blocked open several times since November, 1985 for cooling of these rooms during work on the ventilation system (EISS code VI). These doors were immediately closed and the appropriate FPP forms that allow fire protection equipment and barrier penetration removal from service were closed.

Prior to November 1985, whenever fire barrier penetrations were nonfunctional, proper compensatory measures were established. In November 1985, a spare sleeve in a fire barrier was found to be unsealed. A subsequent investigation discovered that piping penetrations were not being inspected as required by the plant's TSs due to a procedural deficiency. At that time the piping penetrations were declared nonfunctional. During this time not all piping penetrations were considered fire barriers according to plant fire protection personnel. A decision was made to establish roving fire watch patrols throughout the plant following a general disqualification of all BFN fire barriers. At the time of this decision the Fire Hazard Analysis was inadequate and no well defined fire barrier compartmentation existed. These factors contributed to the inappropriate decision and subsequent compensatory measures.

Cause of Event

This condition was caused by an incorrect management decision made by the fire protection supervisor allowing credit for the roving fire watch which had been established since 1985, to satisfy the compensatory requirements when a fire door or penetration was removed from service. This decision resulted in a continuous fire watch not being established within one hour as required by the plant's technical specifications for nonfunctional fire barrier penetrations without operable fire detectors on either side of the affected penetration.

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

Analysis of Event

The blocked open fire doors were to the 480 volt shutdown board room 2A and 2B and the 4KV shutdown board room C and D. The small fire load in these rooms made the probability of a fire spreading through the fire barrier doors remote. With a roving fire watch passing through the area once every hour it would be highly improbable that a fire could cross one of these barriers before it was detected. The plant has been shutdown for the event duration. The only design basis event requiring mitigation in that plant condition is the fuel handling accident. The systems which are required for this type of event are fully redundant. If a fire had spread between the separate fire compartments it would not have resulted in a loss of these redundant systems.

Corrective Action

The immediate corrective action was to close the fire doors and the appropriate FPP forms that allow fire protection equipment and barrier penetration removal from service were closed. Additional corrective action was to correct the management directive such that it does not violate the plant's technical specifications. This management decision and subsequent TS violation has existed since November, 1985. However, this condition was corrected within 15 minutes from the time it was identified to the SOS as a condition adverse to quality. All fire protection technical and engineering staff will review the CAQR on this event. The fire protection procedure will be revised to correctly identify fire barrier penetrations without a fire detection system or an operable fire detection system on either side of the penetration as requiring a continuous fire watch when removed from service. The plant's fire protection technical specifications have been reviewed by the fire protection section for similar conditions in other fire protection areas. No violations of the plant's TSs were found in other fire protection areas. The fire protection supervisor that made this incorrect management decision is no longer employed at Browns Ferry Nuclear Plant and the present fire protection supervisor is aware of the technical specification requirement for establishing continuous fire watches. A new Fire Hazards Analysis which includes defined fire compartmentation has been completed and previously submitted for NRC review.

Previous Similar Events - None

Commitments

All fire protection technical and engineering staff will review the CAQR on this event.

The fire protection procedure will be revised to correctly identify fire barrier penetrations without a fire detection system or an operable fire detection system on either side of the penetration as requiring a continuous fire watch when removed from service.

TENNESSEE VALLEY AUTHORITY

Browns Ferry Nuclear Plant
Post Office Box 2000
Decatur, Alabama 35602

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

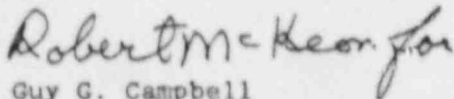
Dear Sir:

TENNESSEE VALLEY AUTHORITY - BROWNS FERRY NUCLEAR PLANT UNIT 1 - DOCKET
NO. 50-259 - FACILITY OPERATING LICENSE DPR-33 - REPORTABLE OCCURRENCE REPORT
BFRO-50-259/88026

The enclosed report provides details concerning the violation of fire protection
technical specifications due to personnel error. This report is submitted in
accordance with 10 CFR 50.73 (a)(2)(i).

Very truly yours,

TENNESSEE VALLEY AUTHORITY



Guy G. Campbell
Plant Manager
Browns Ferry Nuclear Plant

Enclosures

cc (Enclosures):

Regional Administration
U.S. Nuclear Regulatory Commission
Office of Inspection and Enforcement
Region II
101 Marietta Street, Suite 2900
Atlanta, Georgia 30303

INPO Records Center
Suite 1500
1100 Circle 75 Parkway
Atlanta, Georgia 30339

NRC Resident Inspector, Browns Ferry Nuclear Plant

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