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RECIP.NAME RECIPIENT AFFILIATION

SUBJECT: LER 89-019-00:on 891218,failure to reestablish roving fire watch in auxiliary bldg,per Tech Spec 3.14.5.
W/8 ltr.

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L-90-15
10 CFR 50.73

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

Gentlemen:

Re: Turkey Point Units 3 and 4
Docket No. 50-250/251
Reportable Event: 89-19
Date of Event: December 18, 1989
Failure to Re-establish a Roving Fire Watch in the Auxiliary Building per Technical Specification 3.14.5
Due to Personnel Error

The attached Licensee Event Report is being submitted pursuant to the requirements of 10 CFR 50.73 to provide notification of the subject event.

Very truly yours,

K. N. Harris

K. N. Harris
Vice President
Turkey Point Plant Nuclear

KNH/DRP/DWH/rat

cc: Stewart D. Ebneter, Regional Administrator, Region II, USNRC
Senior Resident Inspector, USNRC, Turkey Point Plant

IE22
1/1

NRC Form 366
(9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO 3150-0104
EXPIRES 8/31/88

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Turkey Point Units 3 and 4	0 5 0 0 0 2 5 0	1 OF 0 4

TITLE (4) Failure to Re-establish A Roving Fire Watch In The Auxiliary Building Per Technical Specification 3.14.5 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)
1 2	1 8	8 9	8 9	0 1 9	0 0	0 1	1 2	9 0	Turkey Point Unit 4	0 5 0 0 0 2 5 1
										0 5 0 0 0

OPERATING MODE (9)	1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more of the following) (11)					
POWER LEVEL (10)	1 0 0	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)	X 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
David R. Powell, Regulation and Compliance Supervisor	AREA CODE 3 0 5 2 4 6 - 6 5 5 9

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)	X NO				

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

At 1640, on December 18, 1989, with Units 3 and 4 in Mode 1 at 100 percent power, it was determined that Technical Specification (TS) 3.14.5 Limiting Condition for Operation (LCO) Action Statement requirements were not met on December 1, 1989. A precautionary evacuation of the common Auxiliary Building (Aux. Bldg.) required suspension of a roving fire watch and an existing continuous fire watch. To meet the requirements of TS 3.14.5, these fire watches had to be re-established within one hour of suspension. The evacuation of the Aux. Bldg., except for the chemistry lab, lasted fifteen minutes. Due to a cognitive error by licensed and non-licensed utility personnel, the roving fire watch was not re-established in the Aux. Bldg. until two hours after the evacuation. The regulatory impact of the condition was not determined until December 18, 1989. The Plant Supervisor-Nuclear (PSN)/Assistant Plant Supervisor-Nuclear (APSN) did not verify that the Aux. Bldg. fire watches had been re-established within one hour of the evacuation. The Fire Protection Shift Supervisor did not re-establish the Aux. Bldg. fire watches within one hour of the evacuation. No fires occurred in the Aux. Bldg. during the time fire watches were suspended. The PSNs/APSNs and FPSSs have received instruction on TS 3.14.5 LCO Action Statement requirement compliance.

*U.S.GPO:1984-0-464-481/18750

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
Turkey Point Unit 3 and 4	0 5 0 0 0 2 5 0	8 9	— 0 1 9	— 0 0	0 2 OF 0 4

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

DESCRIPTION OF THE EVENT

At 1640, on December 18, 1989, with Units 3 and 4 in Mode 1 at 100 percent power, it was determined that Technical Specification (TS) 3.14.5 Limiting Condition for Operation (LCO) Action Statement requirements were not met on December 1, 1989.

At 1420, on December 1, 1989, Process Radiation Monitor (PRM) Channel 14 (Plant Vent Gas Monitor) alarmed in the Control Room. Operations personnel attributed the alarm to sampling the Unit 3 Volume Control Tank (VCT). Health Physics (HP) personnel were dispatched to verify the source and level of airborne activity in the Auxiliary Building. HP personnel verified the source of airborne activity to be the sample rig being used by Chemistry Department personnel to sample the Unit 3 VCT. An air sample taken in the Auxiliary Building hallway registered 2.0 E-6 uci/cc. At 1430, HP personnel evacuated the Auxiliary Building as a precautionary measure and notified the Assistant Plant Supervisor-Nuclear (APSN).

Prior to the evacuation, a roving (hourly) fire watch had been established to cover approximately thirty-one fire protection impairments in the Auxiliary Building. The 1500 hour tour (1400 to 1500) of the Auxiliary Building had been completed before the evacuation. Additionally, a continuous fire watch had been established in Fire Zones 14, 15 and 16. An open piping penetration through a fire barrier wall had previously been identified in this area which required an hourly fire watch patrol per Technical Specification 3.14.5. Contract painters entered the area to work and bagged the four smoke detectors to prevent intrusion of paint or dust which could cause a spurious alarm in the Control Room. With the smoke detectors within these fire zones inoperable, a continuous fire watch was required by Technical Specification 3.14.5.

At 1438, The Fire Protection Shift Supervisor (FPSS) notified the APSN that fire watches had been evacuated from the Auxiliary Building. The APSN acknowledged the notification and stated that he would look into the condition.

At 1445, HP personnel deposted the Auxiliary Building, with exception of the chemistry lab, based on an air sample reading of 3.0 E-9 uci/cc in the Auxiliary Building hallway. The APSN was notified of the deposting at approximately 1500. Contract painters for Fire Zones 14, 15 and 16 were standing-by and re-entered their work area upon deposting of the Auxiliary Building to clean up the area following work completion. At approximately 1530, the contract painters removed the bags from the four smoke detectors in Fire Zones 14, 15 and 16 after cleaning the area. Removing the bags placed the four smoke detectors in an operable status and reduced the fire watch requirements in Fire Zones 14, 15 and 16 from continuous to hourly.

At 1700, the oncoming roving fire watch questioned HP personnel on the status of the Auxiliary Building evacuation. Upon receiving word that the Auxiliary Building had been deposted, the roving fire watch re-entered the Auxiliary Building and performed the 1800 hour tour (1700 to 1800) in its entirety.

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
Turkey Point Units 3 and 4	0 5 0 0 0 2 5 0	8 9	— 0 1 9	— 0 0	0 3 OF 0 4

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

On December 4, 1989, an individual in the Fire Protection Department notified the Regulation and Compliance (RCG) Supervisor of the December 1, 1989 event. An investigation was initiated to establish the regulatory impact of the event.

Technical Specification 3.14.5 requires that a continuous fire watch be established on at least one side of a non-functional fire barrier penetration within one hour. If fire detectors on at least one side of the non-functional fire barrier can be demonstrated to be operable, a roving (hourly) fire watch may be posted within one hour.

On December 14, 1989, it was determined that the LCO Action Statement requirements of Technical Specification 3.14.5 had been met on December 1, 1989. The smoke detectors in Fire Zones 14, 15, and 16 were restored to an operable status within approximately one hour of the Auxiliary Building evacuation which reduced the fire watch requirement from a continuous fire watch to a roving fire watch. The contract painters re-entered the Auxiliary Building at 1445 and were capable of making proper notification in the event of a fire. Additionally, written statements from roving fire watch personnel indicated that only the 1600 hour tour (1500 to 1600) of the Auxiliary Building was not performed.

On December 18, 1989, during final review of the available information, an inconsistency between the fire protection log sheets and the written statements from the roving fire watch personnel was discovered. Upon further investigation, it was determined that the 1600 hour tour (1500 to 1600) and 1700 hour tour (1600 to 1700) of the Auxiliary Building had not been performed on December 1, 1989. Written statements made by a roving watch were in error due to confusion in converting 12 hour clock time to 24 hour clock time (ie., 1500 versus 5:00 PM). Failure to re-establish a roving fire watch in the Auxiliary Building within one hour of the evacuation is a violation of TS 3.14.5 LCO Action Statement requirements.

Upon determining that the event was reportable, an Unusual Event was declared and closed per Emergency Plan Implementing Procedure (EPIP) 20101, "Duties of Emergency Coordinator," for the December 1, 1989 event to place the event condition on record. NRC notification was made at approximately 1705 on December 18, 1989.

CAUSE OF THE EVENT

The cause of the failure to re-establish fire watches in the Auxiliary Building within one hour of suspension was cognitive errors by licensed and non-licensed utility personnel. The Plant Supervisor-Nuclear (PSN)/Assistant Plant Supervisor-Nuclear (APSN) is responsible for compliance with the Technical Specifications but did not verify that the fire watches were re-established within one hour of evacuating the Auxiliary Building. The FPSS is responsible for ensuring that continuous and roving fire watches are established and manned by qualified personnel. Although the FPSS notified the APSN that fire watches had been evacuated from the Auxiliary Building, the FPSS did not ensure that the required continuous and roving fire watches were re-established within one hour of being suspended.

The cause for the delay in recognizing that Technical Specification 3.14.5 LCO Action Statement requirements were not met was cognitive error by licensed utility personnel. Failure of the PSN/APSN to verify that the Auxiliary Building fire watches were re-established within one hour of the evacuation led to the failure to recognize that the LCO Action Statement requirements of TS 3.14.5 had been violated. Additionally, the evaluation performed to determine the regulatory impact of the event was not pursued in a timely manner by non-licensed utility personnel.

ANALYSIS OF THE EVENT

To meet Technical Specification 3.14.5 LCO Action Statement requirements, the continuous and roving fire watch in the Auxiliary Building had to be re-established within one hour of suspending the watches. The roving fire watch in the Auxiliary Building was re-established within two hours of suspension. Plant personnel were in and out of the Auxiliary Building during this time and could have notified Control Room personnel of any detected smoke or fire. During the period roving fire watches were absent from the Auxiliary Building, no fires occurred. The health and safety of the public were not affected by this event.

CORRECTIVE ACTIONS

1. An entry has been made in the Operations Department Night Order Book which discusses the event of December 1, 1989 and re-emphasizes the role of the PSN/APSN whenever a fire protection compensatory measure is suspended. The Night Order also requires that administrative LCOs be treated the same as equipment LCOs (ie., logged and tracked).

2. Strict compliance to TS 3.14.5 LCO Action Statement requirements and the responsibility for notifying to the PSN/APSN when these requirements will be or have been violated, were conveyed to Fire Protection Shift Supervisors during a FPSS training meeting.

3. A checklist has been attached to fire watch post instructions that provides guidance in the event the roving/continuous fire watch cannot fulfill their assigned duties.

4. This Licensee Event Report (LER) will be reviewed by the Turkey Point Nuclear Plant Human Performance Evaluation System (HPES) Coordinator. If the event cause changes or significant changes are made to the identified corrective actions, a supplemental LER will be submitted. The HPES review will be completed by February 16, 1990.

ADDITIONAL INFORMATION

No similar Licensee Event Reports have been issued for Turkey Point Units 3 or 4.