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HARRIS,K.N. Florida Power & Light Co.
RECIP.NAME RECIPIENT AFFILIATION

SUBJECT: LER 90-015-00:on 900720,roving fire watch failed to complete TS required rounds due to cognitive personnel error.
W/9 ltr.

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AUG 14 1990

L-90-289
10 CFR 50.73

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

Gentlemen:

Re: Turkey Point Unit 3
Docket No. 50-250
Reportable Event: 90-15-00
Date of Event: July 20, 1990
Roving Fire Watch Failed to Complete Technical Specification Required Rounds Due to a Cognitive 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
Plant Vice President
Turkey Point Plant Nuclear

KNH/DPS/ds

attachment

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

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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 UNIT 3	0 5 0 0 0 2 5 0	1 OF 0 3

TITLE (4) ROVING FIRE WATCH FAILED TO COMPLETE TECHNICAL SPECIFICATION REQUIRED ROUNDS DUE TO A COGNITIVE 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)
										0 5 0 0 0
0 7	2 0	9 0	9 0	0 1 5	0 0	0 8	1 4	9 0		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
D. R. POWELL, SUPERINTENDENT OF LICENSING	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)

On July 20, 1990, at 2400 EDT, the limiting condition for operation of Technical Specification (TS) 3.14.1 was not met when the roving fire watch, established in accordance with this TS did not perform the watch during the 2300 to 2400 rotation. A different person, who had the route for the following hour, did complete the route and found no indication of any fire protection related problems. The cause of the event was cognitive personnel error by a contract non-licensed worker. The contract worker claimed to have made the required rotation. When presented with conclusive evidence that the controlled access part of the route had not been entered during the required time frame, the individual confessed that the watch rotation was not performed. The individual was then escorted from the site and access authorization to the site was terminated.

I. EVENT DESCRIPTION

On July 20, 1990, at 2400 EDT, the limiting condition for operation of Technical Specification (TS) 3.14.1 was not met when the roving fire watch, established in accordance with this TS, did not perform the watch during the 2300 to 2400 rotation. The roving fire watch for Firewatch Route 2 called the Fire Watch Shift Supervisor stating that he had forgotten to sign the log and that he would sign the log at his next opportunity. The Fire Watch Shift Supervisor agreed to this. However, one of the continuous fire watches reporting to the Fire Watch Shift Supervisor after being relieved said that the roving fire watch never came to relieve him for his break and was not seen in the required watch area. The shift supervisor expressed a concern that the watch may have been missed. On Monday morning, July 23, 1990, a review of a printout from the access computer confirmed that at least part of the roving fire watch had been missed between 2300 and 2400 EDT on July 20, 1990.

On Monday, July 24, 1990, at 1000 EDT, applicable FPL and contract personnel met to evaluate a potential missed roving fire watch tour and possible falsification of the Fire Watch Log by a contract individual on Friday night, July 20, 1990. Conclusive evidence that the individual performing the fire watch in question had not entered the controlled access part of the roving fire watch route during the required time frame was available from the access computer and witnesses.

II. EVENT CAUSE

The cause of the event was cognitive personnel error by a contract non-licensed worker. The contract worker claimed to have made the required rotation but later confessed when presented with conclusive evidence that the controlled access part of the route had not been performed during the required time frame.

III. EVENT SAFETY ANALYSIS

A complete tour of the missed route was completed by different personnel the hour before and the hour after the missed tour. No fire protection problems were noted during either of these tours. During the period the fire watch was absent, no fires occurred. Had a fire occurred in one of the areas covered by the missed fire watch tour, other personnel working in the area or operable fire detection instrumentation could have detected the fire and brought prompt response. In addition, FPL policy on maintaining flammable material at a minimum has helped limit the potential for a fire in these areas.

IV. CORRECTIVE ACTIONS

A. The fire watch was escorted from the controlled area.

B. Unescorted access authorization for the individual was terminated.

C. In addition, the fire watch was discharged by the contractor as a result of this incident.

D. Contract firewatch management has held training sessions with contract firewatch personnel to discuss this occurrence.

V. ADDITIONAL INFORMATION

A. Similar Events

LER 250/89-019, issued January 12, 1990 reported a missed roving fire watch due to personnel error. In this case, a fire watch was removed from the space due to a precautionary area evacuation ordered by health physics technicians. However, the fire watch was not re-established immediately after the evacuation was canceled.

B. Equipment Failures

None