

## LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Sequoyah, Unit 1										DOCKET NUMBER (2) 0 5 0 0 0 3 2 7					PAGE (3) 1 OF 0 3										
TITLE (4) Failure to Comply with One-hour Fire Watch																									
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 Sequoyah, Unit 2					DOCKET NUMBER(S) 0 5 0 0 0 3 2 8											
0	2	0	6	8	5	8	5	0	1	1	0	0	0	3	0	7	8	5	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)				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)(ix)															
LICENSEE CONTACT FOR THIS LER (12)																									
NAME Glenn E. Duggin, Compliance Section Engineer										TELEPHONE NUMBER 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 NRC		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC															
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)

On seven separate occasions, an hourly fire watch was not performed within one hour. All fire watches were completed within three hours after the last watch. All of the missed fire watches were caused by equipment failures. This condition is reportable per 10 CFR 50.73(a)(2)(i) and the special report requirements of technical specification 3.7.12. There was no effect upon public health or safety.

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## LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

APPROVED OMB NO. 3150-0104  
EXPIRES: 8/31/85

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
Sequoyah, Unit 1	05000327	85	011	00	02	OF	03

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

All seven events described in this report occurred while unit 1 was in mode 1 (100 percent power, 2235 psig, 578 degrees F), and unit 2 was in mode 1 (100 percent power, 2235 psig, 578 degrees F). All of the missed fire watches were caused by equipment failures.

The first event occurred at 2200 CST on February 6, 1985. The hourly fire watch was not performed for the 2200C hour at the essential raw cooling water (ERCW) pumping station. The keycard controls for an outside access door (PS-4) were not functioning and would not allow personnel to enter the building. Maintenance personnel opened the door and propped it open while a Public Safety officer controlled access through the door. Maintenance personnel determined that the keycard was probably frozen since the keycard was working by the time they investigated the problem. The fire watch was able to gain access through the door for the 2300C fire watch.

The second event occurred at 0400C on February 8, 1985. The hourly fire watch was not performed for the 0400C hour at the ERCW pumping station. The keycard controls for an outside access door (PS-6) were frozen and would not allow personnel to enter the building. The controls were thawed out by maintenance, and the fire watch gained access through the door at 0500C.

The third event was discovered at 0215C on February 12, 1985. The hourly fire watch was not performed for the 0200C and 0300C hour at the ERCW pumping station. The inclement weather (ice and snow storm) caused an outside door (PS-5) to be frozen shut. Maintenance personnel were notified, and the door was opened in time for the 0400C fire watch.

The fourth event was discovered at 1016C on February 12, 1985. The hourly fire watch was not performed for the 1000C hour at the ERCW pumping station. The new security gate across the road to the ERCW station was not secured in the open position which resulted in the gate being blown shut by the wind. This security gate was installed for the expected change in the vital area security plan (power block), and it is not in use at this time. When the gate shut, it locked itself, and the fire watch could not gain entry to the ERCW building until a key was located and the gate unlocked. After the gate was unlocked and opened, the gate was secured in the open position, and the fire watch resumed his hourly watch.

The fifth event was discovered at 1200C on February 13, 1985. The hourly fire watch was not performed for the 1100C hour at the ERCW pumping station. An outside access door (PS-5) was jammed and could not be opened by the fire watch. Maintenance was notified, and the door was repaired in time for the 1200C fire watch.

The sixth event was discovered at 0832C on February 15, 1985. The hourly fire watch was performed late for the 0800C hour. The fire door (A183) had experienced some jamming problems due to the contacts on the relay that unlocks the door being burned and stuck. The contacts were cleaned to make the door operable again. The capacitor across the contacts had failed and had not protected the contacts from electrical arcing. The card reader on the fire door was also found to have a one-second time delay. The time delay allows the door to be opened when exiting without alarming after a keycard is approved by the access control computer. There was not enough time allowed on this door for a person to open the door before it automatically reset. A green light should be lit before the door can be opened. Maintenance personnel set the time delay to six seconds. The fire watch resumed his normal watch at the 0900C hour.

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

The seventh event occurred at 1427C on February 28, 1985. The hourly fire watch was not performed for the 1400C hour at the Technical Support Center (TSC).

The door to the TSC has been modified with a security keycard reader in preparation for changes to Sequoyah's Physical Security Plan. At this time, the door is not required to be keycard controlled, and the computer software which controls security doors has been modified to maintain this card reader in the unlocked position. The door is a required fire door and must remain closed. The computer memory had been cleared during a power supply switch earlier in the day, and when the software was reloaded, this card reader was apparently not placed automatically back in the unlocked position. Being normally unlocked, the software was not programmed to unlock this door on keycard demand, and several attempts to open the door were unsuccessful. In order to open the door, power was removed from the computer in order to allow the card reader to act independently of computer control. Once the door was opened, the latch was temporarily taped open until the computer operated the door properly. The software was reloaded, and the computer functioned correctly at 1515C. The fire watch was able to enter the TSC each hour thereafter.

Chattanooga and surrounding areas, including Sequoyah Nuclear Plant, experienced severe winter weather between February 4 and 13, 1985, with temperatures plunging to zero degrees F. These low temperatures were coupled with winds blowing snow into door jambs. The keycard controls have heaters in them, but they are not designed to ensure operability in prolonged very cold weather as was experienced. The ERCW doors discussed in this report are located on the north side of the building, therefore thawing more slowly than otherwise. We believe adequate corrective action was taken on the equipment failures as they arose.

All fire watches were reestablished as soon as possible after a problem was found and repaired. These events are reportable per 10 CFR 50.73 (a)(2)(i) and the special report requirements of technical specification 3.7.12. There was no effect on public health or safety.

Previous occurrences - three (SQRO-50-327/84075, SQRO-50-327/85003, and SQRO-50-327/85008).

TENNESSEE VALLEY AUTHORITY

Sequoyah Nuclear Plant  
Post Office Box 2000  
Soddy Daisy, Tennessee 37379

March 8, 1985

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

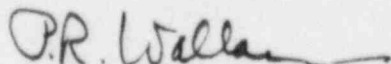
Gentlemen:

TENNESSEE VALLEY AUTHORITY - SEQUOYAH NUCLEAR PLANT UNIT 1 - DOCKET NO.  
50-327 - FACILITY OPERATING LICENSE DPR-77 - REPORTABLE OCCURRENCE REPORT  
SQRO-50-327/85011

The enclosed licensee event report provides 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 special report requirements of technical specification 3.7.12.

Very truly yours,

TENNESSEE VALLEY AUTHORITY



P. R. Wallace  
Plant Manager

Enclosure  
cc (Enclosure):

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