**Tennessee Valley Authority**, Post Office Box 2000, Soddy-Daisy, Tennessee 37379-2000

R.J. Adney
Site Vice President
Sequoyah Nuclear Plant

February 20, 1996

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

Gentlemen:

TENNESSEE VALLEY AUTHORITY - SEQUOYAH NUCLEAR PLANT (SQN) UNITS 1 AND 2 - DOCKET NOS. 50-327 AND 50-328 - FACILITY OPERATING LICENSES DPR-77 AND DPR-79 - LICENSEE EVENT REPORT (LER) 50-327/96001

The enclosed report provides details concerning the failure to perform an hourly fire watch as required by technical specifications (TSs). This report is being reported in accordance with 10 CFR 50.73(a)(2)(i)(B) as an operation prohibited by technical specifications.

Sincerely,

R. J. Adney

Enclosure
cc: See page 2

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1/1

Enclosure
cc (Enclosure):

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NRC FORM 366 (5-92)

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB NO. 3150-0104
EXPIRES 5/31/95

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (MNBB 7714), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

# LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

| FACILITY NAME (1) | DOCKET NUMBER (2) | PAGE (3) |
|---|---|---|
| Sequoyah Nuclear Plant (SQN), Unit 1 | 05000327 | 1 of 5 |

TITLE (4) Missed 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 NAME | DOCKET NUMBER |
| | | | | | | | | | SQN, Unit 2 | 50-328 |
| 01 | 21 | 96 | 96 | 001 | 00 | 02 | 20 | 96 | FACILITY NAME | DOCKET NUMBER |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| OPERATING MODE (9) | 1 | THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11) | | | | | |
| | | 20.402(b) | | 20.405(c) | | 50.73(a)(2)(iv) | 73.71(b) |
| POWER LEVEL (10) | 100 | 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 |
| | | 20.405(a)(1)(iii) | X | 50.73(a)(2)(i) | | 50.73(a)(2)(viii)(A | (Specify in Abstract below and in Text, NRC Form 366A) |
| | | 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 (Include Area Code) |
|---|---|
| S. D. Gilley, Compliance Licensing Engineer | (423) 843-7427 |

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 15 single-spaced typewritten lines) (16)

On January 26, 1996, with Units 1 and 2 operating in Mode 1 at 100 percent power, it was discovered that a fire watch patrol was not performed within the timeframe required by technical specifications. During a routine review of the access control system computer printouts, it was discovered that the assigned fire watch did not patrol some of the assigned areas in the control building on January 21, 1996, during the 0400 Eastern standard time (EST) fire watch. The route check sheets and fire watch journal logs were completed as if the assigned fire watch had completed the route as required by the procedure. The 0300 EST fire watch was properly conducted as required by the procedure, as was the subsequent fire watch at 0500 EST. Following the discovery of this event, access control system records were reviewed for personnel assigned to fire watch duty from January 3 through January 30, 1996. One additional individual was identified that failed to perform a fire watch patrol in all of the assigned areas. No other instances were identified where a fire watch failed to enter an assigned area. The appropriate disciplinary action was taken with the involved individuals. Management expectations for the proper performance of firewatch duties was emphasized with firewatch personnel. Random reviews of access control system computer records at SQN continue to be performed.

## I. PLANT CONDITIONS

Units 1 and 2 were in power operation at approximately 100 percent.

## II. DESCRIPTION OF EVENT

### A. Event

On January 26, 1996, with Units 1 and 2 operating in Mode 1 at 100 percent power, it was discovered that a fire watch patrol was not performed within the timeframe required by technical specifications. During a routine review of the access control system computer printouts, it was discovered that the assigned fire watch did not patrol some of the assigned areas in the control building (EIIS Code NA) on January 21, 1996, during the 0400 Eastern standard time (EST) fire watch. The access control system computer records the entry and exit times for those areas of the plant where access is controlled by card key. A review of these records indicated that the fire watch did not enter the control building (EIIS Code NA) computer room on Elevation 685 or the assigned areas on Elevation 669 during the 0400 EST fire watch, but the route check sheets and fire watch journal logs were completed as if the assigned fire watch had completed the route as required by the procedure. The 0300 EST fire watch was properly conducted as required by the procedure, as was the subsequent fire watch at 0500 EST. Fire watches are routinely conducted by one individual the first hour and by a second individual the following hour; these individuals then continue to alternate throughout the shift. Records indicate that the involved individual did patrol the assigned areas as required during the 0200 EST patrol and the 0600 EST patrol.

Following the discovery of this event, access control system records were reviewed for personnel assigned to fire watch duty from January 3 through January 30, 1996. Based on the 8,064 fire watches performed between January 3 and January 30 and the identification of three problems, this time period represented a reasonable statistical sample. One additional individual was identified that failed to perform a fire watch patrol in all of the assigned areas. This individual failed to enter the control building computer room on two separate occasions. The first occurrence was on January 8, 1996, during the 0100 EST patrol. The second occasion was on January 17, 1996, during the 0100 EST patrol. No other instances were identified where a fire watch failed to enter an assigned area. Organizational changes resulted in the fire watch personnel being transferred to a different organization in November 1995. As a result of the transfer, the responsibilities of fire watch duty were reviewed with each individual, including a review of the routes and the documentation requirements.

### B. Inoperable Structures, Components, or Systems that Contributed to the Event

None.

## C. Dates and Approximate Times of Major Occurrences

| | |
|---|---|
| January 8, 1996 at 0105 EST | The fire watch began the assigned patrol route. The fire watch patrol check sheets and fire watch journal logs were subsequently completed by the individual, indicating proper performance of the fire watch patrol. |
| January 17, 1996 at 0105 EST | The fire watch began the assigned patrol route. The fire watch patrol check sheets and fire watch journal logs were subsequently completed by the individual, indicating proper performance of the fire watch patrol. |
| January 21, 1996 at 0405 EST | The fire watch began the assigned patrol route. The fire watch patrol check sheets and fire watch journal logs were subsequently completed by the individual, indicating proper performance of the fire watch patrol. |
| January 26, 1996 | A routine check of the access control system printouts revealed a missed fire watch on January 21, 1996. An additional investigation revealed a second individual that failed to complete the assigned fire watch route on January 8 and 17 and completed the documentation as if all areas had been inspected. |

## D. Other Systems or Secondary Functions Affected

None.

## E. Method of Discovery

During a routine review of the access control system computer printouts, it was determined that the assigned fire watch individual did not patrol some of the assigned areas in the control building. The log sheet completed by the individual indicated that the areas in question had been patrolled on January 21, 1996, during the 0410 EST patrol. Further investigation revealed one additional case of a fire watch not patrolling the assigned areas. This individual failed to enter the computer room in the control building on two separate occasions.

## F. Operator Actions

No operator actions were required.

## G. Safety System Responses

No safety system response was required.

## III. CAUSE OF EVENT

### A. Immediate Cause

The immediate cause was the failure to properly perform the fire watch route as assigned.

### B. Root Cause

The root cause of the first event was that the individual involved did not perform portions of the route as assigned. An investigation concluded that the second individual walked the assigned route but failed to enter the computer room on Elevation 685. Interviews with the individuals involved did not provide any information as to why the fire watches were not successfully accomplished.

### C. Contributing Factors

None.

## IV. ANALYSIS OF EVENT

Fire watch patrols are established to mitigate the consequences of fire protection system impairments. With the exception of the computer room, the areas that were not patrolled contained fire detection and suppression equipment that was operable and in service. The carbon dioxide suppression system in the computer rooom was inoperable, but the fire detection equipment was in service. Additionally, detection and suppression equipment outside the computer room was in service and operable. In two of the three cases, the fire watch passed the doorway to the computer room in the performance of the fire watch. Therefore, it can be concluded that there were no adverse consequences to plant personnel or to the general public as a result of these events.

## V. CORRECTIVE ACTIONS

### A. Immediate Corrective Action

The appropriate disciplinary action was taken with the involved individuals. After the first occurrence was identified, additional records were reviewed for the period of January 3 through January 30, 1996. This resulted in a total of 8,064 fire watch performances being reviewed and revealed one additional individual that failed to conduct the fire watch properly.

### B. Corrective Action to Prevent Recurrence

Management expectations for proper procedure adherence, proper completion of documentation, the importance of properly conducting the assigned fire watch route, and the disciplinary actions taken for this event were reviewed with firewatch personnel. Random reviews of access control

system computer records at SQN continue to be performed. An alternative methodology to assist in the prompt identification of missed fire watches is being considered for use at SQN.

## VI. ADDITIONAL INFORMATION

### A. Failed Components

None.

### B. Previous Similar Events

A review of previous reportable events identified two LERs associated with the failure of fire watch personnel to follow the procedure. LER 327/92020 identified an event where a fire watch patrol was not performed within the required timeframe. The root cause was that two fire watch personnel failed to follow the procedure. The appropriate disciplinary actions were taken with the involved individuals, and management expectations regarding procedural adherence were emphasized. LER 328/90015 involved a fire watch employee that signed the logsheet but did not inspect one of the required rooms. The root cause for that event was that the fire watch failed to follow the procedure. Corrective actions included disciplinary actions, reinforcement of the need to follow assigned patrol routes, and monitoring fire watch rounds on a random basis.

## VII. COMMITMENTS

None.