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May 14, 1996

U.S. Nuclear Regulatory Commission
Washington, DC 20555

ATTENTION: Document Control Desk

SUBJECT: Calvert Cliffs Nuclear Power Plant
Unit No. 1; Docket No. 50-317; License No. DPR 53
Licensee Event Report 96-002
Missed Fire Watch Due to Lack of Ownership

The attached report is being sent to you as required under 10 CFR 50.73 guidelines. Should you have questions regarding this report, we will be pleased to discuss them with you.

Very truly yours,

A handwritten signature in cursive script, reading "Peter E. Katz", is positioned above the distribution list.

PEK/DWM/dlm

Attachment

cc: D. A. Brune, Esquire
J. E. Silberg, Esquire
Director, Project Directorate I-1, NRC
A. W. Dromerick, NRC

T. T. Martin, NRC
Resident Inspector, NRC
R. I. McLean, DNR
J. H. Walter, PSC

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LICENSEE EVENT REPORT (LER)

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

FACILITY NAME (1) Calvert Cliffs, Unit 1	DOCKET NUMBER (2) 05000 317	PAGE (3) 1 OF 05
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TITLE (4)

Missed Fire Watch Due to Lack of Ownership

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
04	10	96	96	-- 002	-- 00	05	14	96	FACILITY NAME	DOCKET NUMBER
										05000
									FACILITY NAME	DOCKET NUMBER
										05000
OPERATING MODE (9)		5	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR (Check one or more) (11)							
			20.2201(b)		20.2203(a)(2)(v)		X		50.73(a)(2)(i)	50.73(a)(2)(viii)
POWER LEVEL (10)		0	20.2203(a)(1)		20.2203(a)(3)(i)				50.73(a)(2)(ii)	50.73(a)(2)(x)
			20.2203(a)(2)(i)		20.2203(a)(3)(ii)				50.73(a)(2)(iii)	73.71
			20.2203(a)(2)(ii)		20.2203(a)(4)				50.73(a)(2)(iv)	OTHER
			20.2203(a)(2)(iii)		50.36(c)(1)				50.73(a)(2)(v)	Specify in Abstract below
			20.2203(a)(2)(iv)		50.36(c)(2)				50.73(a)(2)(vii)	

LICENSEE CONTACT FOR THIS LER (12)

NAME D. W. Muth, Engineer	TELEPHONE NUMBER (include Area Code) 410-495-3592
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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)

YES (If yes, complete EXPECTED SUBMISSION DATE).	X	NO	EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
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ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-space typewritten lines) (16)

On April 10, 1996 at 0900 hours, a required hourly fire watch was missed. The fire watch had been previously combined with a required continuous fire watch. When the continuous fire watch was no longer needed, it was discontinued but the hourly fire watch was not resumed. The problem was found on April 15, 1996 and the hourly fire watch was immediately reinstituted.

The root cause of this event was lack of fire watch ownership. The immediate cause was a miscommunication between Safety and Fire Protection Unit (SFPU) and the security contractor responsible for posting the fire watch.

The Supervisor, SFPU has temporarily directed that fire watches may not be combined and reiterated his expectation that the security contractor will not revise or discontinue fire watches without formally documented authorization. We will revise the procedure governing compensatory fire watches to clarify ownership of fire watch responsibility and provide improved SFPU oversight. The circumstances of this event will be reviewed with the appropriate groups.

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

I. DESCRIPTION OF EVENT

On Wednesday, April 10, 1996 at 0900 hours, a required hourly fire watch was missed. The fire watch had been previously combined with a required continuous fire watch. When the continuous fire watch was no longer needed, it was discontinued but the hourly fire watch was not resumed. Unit 1 was in MODE 6 (refueling) at 100 degrees F and atmospheric pressure at the time of the event. Unit 2 was not affected since the missed fire watch occurred only in the Unit 1 Service Water Room.

On March 26, 1996 a temporary alteration was put in place to disable the fire detection system in the Unit 1 Service Water Room in order for welders to remove and replace Service Water System pipe. The temporary alteration was made to prevent nuisance alarms resulting from the large amount of hot work going on in the room. Technical Specification 3.3.3.7 requires that an hourly fire watch patrol be established whenever fire detection equipment in the Service Water Room is inoperable.

The job supervisor, responsible for posting the fire watch per interdepartmental procedure SA-1-100, "Fire Prevention," requested assistance from the Safety and Fire Protection Unit (SFPU) in posting the fire watch. Safety and Fire Protection Unit contacted the site security contractor, who frequently performs compensatory fire watches, to have the Service Water Room added to the designated hourly fire watch log sheet.

On April 3, 1996 the doors to the Service Water Room were opened to allow pipe to be moved in and out of the room. This resulted in a breach of the fire barrier. Per Technical Specification 3.7.12, a continuous fire watch was posted. On April 4, 1996 an SFPU specialist and a security contractor representative discussed combining the hourly and continuous fire watch. Following this discussion, at 1110 hours on Thursday, April 4, 1996 the security contractor ceased the hourly fire watch patrol, meeting both technical specification requirements via the continuous fire watch.

At approximately 0835 hours on Wednesday, April 10, 1996 the Service Water Room door was closed, the fire barrier permit was canceled, and the continuous fire watch for the fire barrier breach was terminated. The fire detection in the room was still disabled, however, requiring an hourly fire watch. This fire watch was not reinstituted and was first missed at 0900 hours that same morning. At approximately 0630 hours on Monday, April 15, 1996 the SFPU specialist was reviewing fire watch logs as part of the SFPU self-assessment program and found this problem. He immediately reinstituted the fire watch and documented his discovery in an Issue Report to ensure that the problem was

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addressed by the plant corrective action system. The total duration of the missed fire watch was four days, 20 1/2 hours.

II. CAUSE OF EVENT

The immediate cause of this event was a miscommunication between the SFPU specialist and the security contractor representative. The SFPU specialist believed that he had only been asked if it was permissible to combine the fire watches. He informed the security contractor representative that it is permissible to do so per procedure SA-1-100. He took no further action, believing that the security contractor would be in contact with SFPU if they intended to pursue combining fire watches. The security contractor representative believed that the SFPU specialist had given permission for the fire watch to be combined and did so without further discussion, believing that SFPU was aware that this was being done and would track the fire watch's status. The security contractor generally functions in a reactive mode, responding to requests from SFPU and is not expected to keep track of what technical specification fire watch requirements need to be met at any given time. Safety and Fire Protection Unit tracks fire watch requirements but in this case, since the SFPU specialist did not know that the fire watches had been combined, no action was taken to track the status of the fire watch in the Service Water Room.

Procedure SA-1-100 assigns ownership of fire watch responsibility to the group that disabled the fire protection equipment, in this case, Mechanical Maintenance. As noted above, Mechanical Maintenance had requested assistance from SFPU, who in effect accepted responsibility for the fire watch and then passed it on to the security contractor, who accepted responsibility, but didn't understand the technical specification requirements being met and felt no responsibility for tracking the status of the combined fire watch. Safety and Fire Protection Unit understood the requirements but did not pass this knowledge on to the security contractor and did not take sufficient action either to ensure that the security contractor kept track of the requirements or to verify themselves that the hourly fire watch was reinstituted when the permit door was closed. Thus, the root cause of this event was lack of fire watch ownership.

A contributing factor to this event is that, while procedure SA-1-100 does not prohibit combining fire watches as was done in this case, neither does it contain guidance for doing so. Procedural guidance might have helped focus the interaction between SFPU and the security contractor and provided barriers to prevent miscommunication from resulting in a missed fire watch.

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III. ANALYSIS OF EVENT

There were minimal safety consequences associated with this event. Although fire detection was disabled, fire suppression (a wet pipe automatic sprinkler system with fusible links that essentially function as heat detection) capability was not affected. Technical Specification 3.3.3.7 allows daily verification of the availability of the fire suppression system as an alternative to conducting the hourly fire watch patrol. Although the daily check was not made, the sprinkler system was available throughout this event. During the nearly five days that the fire watch was not performed, no hot work was performed in the room without a fire watch.

This item is reportable under the provisions of 10 CFR 50.73(a)(2)(i) as a condition prohibited by plant Technical Specifications.

IV. CORRECTIVE ACTIONS

- A. The Supervisor, SFPU has reiterated his expectation that the security contractor will not revise or discontinue fire watches without his formally documented authorization.
- B. We will revise procedure SA-1-100 to clarify the assignment of ownership for compensatory fire watch responsibility and ensure that responsible supervisors are aware of all applicable fire watch requirements. The procedure will also be revised to add a requirement that SFPU verify that all fire-related technical specifications are being met both on a periodic basis and prior to closing out fire barrier permits.
- C. Until such time as the procedure changes are implemented, the Supervisor, SFPU has directed that fire watches may not be combined.
- D. The circumstances of this event will be reviewed with the appropriate groups.

V. ADDITIONAL INFORMATION

A. Component Identification

Component or System	IEEE 803 EIIIS Funct	IEEE 805 System ID
Fire Detection System	28	KQ
Service Water System Pipe	PSP	BI
Fire Suppression System	SRNK	KP

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B. Previous Similar Events

There has been one event reported via Licensee Event Report involving a missed fire watch. Licensee Event Report 89-25 reported that a single hourly tour had been missed due to personnel error. The corrective action was to have a single individual assigned each shift to perform hourly fire tours.