

NON-PUBLIC?: N
ACCESSION #: 9304070032
LICENSEE EVENT REPORT (LER)

FACILITY NAME: Haddam Neck PAGE: 1 OF 05

DOCKET NUMBER: 05000213

TITLE: Fire Door Opened Without Entering LCO and Establishing
Fire Watch
EVENT DATE: 01/07/93 LER #: 93-001-01 REPORT DATE: 04/01/93

OTHER FACILITIES INVOLVED: DOCKET NO: 05000

OPERATING MODE: 1 POWER LEVEL: 100

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR
SECTION:
50.73(a)(2)(i)

LICENSEE CONTACT FOR THIS LER:
NAME: Thomas Kazukynas, Senior Engineering TELEPHONE: (203) 267-2556
Technologist

COMPONENT FAILURE DESCRIPTION:
CAUSE: SYSTEM: COMPONENT: MANUFACTURER:
REPORTABLE NPRDS:

SUPPLEMENTAL REPORT EXPECTED: NO

ABSTRACT:

On January 7, 1993, at 1039 hours, with the plant operating in Mode 1 at 100% power, a door in a Technical Specification fire barrier protecting the "A" Switchgear Room from the Turbine Building was found open for other than routine access without establishing the appropriate fire watch. This door, which was opened so it could be painted by plant personnel, is covered by Haddam Neck Technical Specification 3.7.7, Fire Rated Assemblies. The cause of the event was personnel error since the required administrative controls were not adhered to. Since the door was opened without first implementing the required LCO Action, this event is conservatively judged to be reportable per the requirements of 10CFR50 50.73 (a)(2)(i)(B) as a condition prohibited by Technical Specifications. This Supplemental Report is being submitted to provide the results of a review of past corrective actions for previous fire door related events and to describe corrective action plans for this event.

END OF ABSTRACT

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BACKGROUND INFORMATION

The "A" Switchgear Room is one of the two switchgear rooms utilized at Haddam Neck. This room, located in the mid-level of the Service Building directly below the Control Room, provides power to "A" train safe shutdown equipment. The "B" Switchgear Room, located in a separate building, provides power to the "B" train of safe shutdown equipment. In the event of a fire in either switchgear room, there is equipment and/or methods available in the other switchgear room or in the plant areas outside the affected switchgear room to safely shut the plant down and maintain the plant in a shutdown condition.

Haddam Neck Technical Specification 3.7.7, Fire Rated Assemblies states that fire barriers which separate safety related areas shall be operable when required by the mode of operation. The "A" Switchgear Room is a safety related area which provides power to "A" train equipment needed for safe shutdown of the plant when the plant is operating in Modes 1 through 4. The fire barrier in question separates the "A" Switchgear Room from the Turbine Building.

As specified in the action statement of Technical Specification 3.7.7, when the fire rated assembly is inoperable, an hourly fire watch patrol that inspects both areas at least once per hour is required. The action statement specifies that this fire watch patrol must be established within one hour. Haddam Neck Administrative Control Procedure ACP 1.2-2.32, Implementation and Control of Fire Protection Program Requirements, also provides this guidance.

EVENT DESCRIPTION

On January 7, 1993, at 1039 hours, with the plant in Mode 1 at 100% power, an employee in the Building Maintenance group opened an equipment access door (Fire Door T412) in the barrier which separates the "A" Switchgear Room from the Turbine Building at the 37' 6' elevation, so that this door could be painted. This is a Technical Specification fire barrier, a gaseous suppression system barrier and a vital area barrier and is posted with signs which indicate all three requirements. The worker contacted Security and requested a guard respond to monitor the vital barrier door. At this point, several inappropriate actions occurred which were contrary to Technical Specifications and Admi

istrative Control Procedures. The worker misinterpreted the requirements for the Technical Specification fire door and felt that the door could be opened for one hour before the fire watch would be needed. The Security Guard failed to follow security procedure SEC 1.3-41, Application of Compensatory Safeguards Measures. This procedure

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requires that the Security Shift Supervisor contact the Operations Shift Supervisor for concurrence prior to opening any doors designated as Technical Specification doors, or doors associated with gaseous suppression systems for other than normal access. The instructions on the sign for the Halon System boundary indicated that the Control Room had to be contacted before opening the door. The worker failed to follow this guidance and did not contact the Control Room. The door was opened and painting was ongoing when a plant employee passed by and questioned having the door opened. At that time, it was determined that the appropriate administrative controls were not being adhered to. The door was closed at 1050 hours, after being open for a total of 11 minutes. The worker was instructed to contact the Control Room to explain what had occurred. The Building Maintenance employee failed to report the event to the Control Room. It wasn't until later that day at 1550 hours that the barrier breach was reported after a Security Department shift turnover occurred and the Shift Lieutenant notified the Security Shift Supervisor that the door had been opened earlier. The Security Shift Supervisor advised the Control Room of what had occurred and a determination was made that the Technical Specification LCO Action Statement had been violated.

CAUSE OF THE EVENT

The root cause of the event was the failure of the Building Maintenance and Security Department employees to take actions as noted on the door signs and in plant procedures. The Building Maintenance employee failed to recognize that this door was covered by Technical Specifications and failed to initiate a fire watch. The Security Guard failed to follow a Security Department procedure which controls the opening of vital barrier doors. This procedure instructs the Security Department to contact the Control Room prior to opening any doors which are Technical Specification fire doors or doors in gaseous suppression system barriers. Had the Control Room been contacted, the work activity would have been evaluated by Control Room operators and the fire barrier inoperability potential would have been noted.

SAFETY ASSESSMENT

This event is considered reportable under 10CFR50.73 (a)(2)(i)(B) since it involved a condition prohibited by the Plant's Technical Specifications.

With the fire door open and the "A" Switchgear Room fire barrier breached, it could be postulated that a fire in the Turbine Building could have extended into the "A" Switchgear Room. The

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Security Guard and Building Maintenance employees were in attendance for the entire 11 minutes that the door was open, and it is reasonable to expect that they would have closed the door upon noting a fire in the turbine building. With this action, the equipment in the "A" Switchgear room would not have been damaged. Assuming the worst case, if the door was not closed by the Security Guard or employee painting the door, a fire in the Turbine Building might extend into the "A" Switchgear Room through the open door. With the Halon barrier breached by this open door, the halon system might not be effective in extinguishing a fire within the "A" Switchgear Room. If this occurred, damage could have occurred to "A" train safety related and safe shutdown equipment. However, this fire would not affect the ability of the plant to be safely shutdown. The "B" train of equipment, including the "B" Switchgear Room, which is located remote from the "A" Switchgear Room, would be unaffected by this fire and would be available to provide safe shutdown of the plant in accordance with 10CFR50, Appendix R requirements.

Since it is likely that the door would have been closed upon noticing a fire in the Turbine Building, and any fire in the "A" Switchgear Room would be within the bounds of the Appendix R analysis for Haddam Neck, there is no safety significance to this event.

CORRECTIVE ACTION

The initial condition was corrected by the closing of the "A" Switchgear Room door. Security and Building Maintenance personnel were counseled on the procedural requirements which govern Technical Specification fire doors and doors in gaseous suppression system barriers.

An evaluation of corrective actions on previous similar LERs is ongoing to determine if the corrective actions were appropriate for these events. The results of this evaluation will be provided in a Supplemental Report to be issued by April 1, 1993.

A review of corrective actions performed in response to previous similar events has been completed. In general, the corrective actions have fallen

into one of three categories: 1) placement of signs that note restrictions, 2) additional procedural guidelines and restrictions, and 3) additional training. This review concluded that individual actions taken in each event were appropriate for the particular event cause.

A Human Performance Enhancement System (HPES) evaluation of this event was performed. The primary cause of this event was failure to adhere to good work practices. The corrective actions provided

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for previous fire door events resulted in the establishment of a number of procedural guidelines as well as the placement of signs on the doors to provide a final level of control for personnel in the field. In this event, the program requirements were not followed.

The HPES evaluation also recommended two improvements in the program. The first recommendation was to provide additional clarity in the wording of the fire door signs. A human factors review of the signs is being performed with the goal of developing a sign message that clearly communicates the requirements. The signs will be modified when this review is completed.

The second recommendation was to expand the general employee training program to provide additional emphasis on the control of fire doors to help ensure that all personnel are fully aware of the requirements. The Nuclear Training Department has been requested to modify the Unescorted Access training program to expand the discussions on Technical Specification fire door controls and to add a discussion section on the control of gaseous suppression system barrier controls.

ADDITIONAL INFORMATION

This Supplemental Report is being submitted to provide the results of a review of past corrective actions for previous fire door related LERs and to describe corrective action plans for this event.

PREVIOUS SIMILAR EVENTS

LER 92-19, 90-30, 89-15

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CONNECTICUT YANKEE ATOMIC POWER COMPANY

HADDAM NECK PLANT

362 INJUN HOLLOW ROAD o EAST HAMPTON, CT 06424-3099

April 1, 1993

Re: 10CFR50.73(a)(2)(i)(B)

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

Reference: Facility Operating License No. DPR-61
Docket No. 50-213
Reportable Occurrence LER 50-213/93-001-01

Gentlemen:

This letter forwards the Licensee Event Report 93-001-01, required to be submitted, pursuant to the requirements of the Haddam Neck Plant's Technical Specifications.

Very truly yours,

John P. Stetz
Vice President

JPS/dl

Attachment: LER 50-213/93-001-00

cc: Mr. Thomas T. Martin
Regional Administrator, Region I
475 Allendale Road
King of Prussia, PA 19406

William Raymond
Sr. Resident Inspector
Haddam Neck

1028-3 REV. 2-91

*** END OF DOCUMENT ***
