

Indian Point 3
Nuclear Power Plant
P.O. Box 215
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L. M. Hill
Resident Manager

January 28, 1995
IPN-95-010

U.S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Mail Stop P1-37
Washington, D.C. 20555

SUBJECT: Indian Point 3 Nuclear Power Plant
Docket No. 50-286
License No. DPR-64
Licensee Event Report # 95-001-00
**"Interruption of Continuous Fire Watch Duties
in the Switchgear Room Placed the Plant in a
Condition Prohibited by the Technical Specifications"**

Dear Sir:

The attached Licensee Event Report (LER) 95-001-00 is hereby submitted as required by 10CFR50.73. This event is the type defined in 10CFR50.73 (a)(2)(i)(B). Also attached are the commitments made by the Authority in this LER.

Very truly yours,

A handwritten signature in black ink, appearing to read 'L. M. Hill'.

L. M. Hill
Resident Manager
Indian Point 3 Nuclear Power Plant

Attachment

LMH/vjw

cc: See next page

9502030326 950128
PDR ADDCK 05000286
S PDR

IF22
1/1

cc: Thomas T. Martin
Regional Administrator
Region I
U.S. Nuclear Regulatory Commission
475 Allendale Road
King of Prussia, Pennsylvania 19406-1415

U.S. Nuclear Regulatory Commission
Resident Inspectors' Office
Indian Point 3 Nuclear Power Plant

INPO Records Center
700 Galleria Parkway
Atlanta, Georgia 30339-5957

List of Commitments

Number	Commitment	Due
IPN-95-010-01	AP-21, "Conduct of Operations," will be revised to require operators to adhere to the Technical Specification Interpretations. This will be completed by March 1, 1995.	March 1, 1995
IPN-95-010-02	Administrative controls will be instituted to ensure that before a continuous fire watch is manned, the initial fire watch will be briefed by the Shift Supervisor or designee on the specific responsibilities of the fire watch. Thereafter, it will be the responsibility of each fire watch to brief the succeeding fire watch on the specific responsibilities of the fire watch. This will be implemented by February 15, 1995.	February 15, 1995
IPN-95-010-03	Operator training will include the expectation for Senior Reactor Operator usage of the Technical Specification Interpretations. This will be completed by February 24, 1995.	February 24, 1995
IPN-95-010-04	Training for qualified fire watch personnel will include the specific requirements of a continuous fire watch. This will be completed by March 31, 1995.	March 31, 1995

LICENSEE EVENT REPORT (LER)

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

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 (MNB 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.

FACILITY NAME (1) Indian Point Unit 3	DOCKET NUMBER (2) 05000286	PAGE (3) 1 OF 7
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TITLE (4) Interruption of Continuous Fire Watch Duties in the Switchgear Room Placed the Plant in a Condition Prohibited by the Technical Specifications

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
01	01	95	95	-- 001 --	00	01	28	95		05000
									FACILITY NAME	DOCKET NUMBER
										05000

OPERATING MODE (9) N	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)										
POWER LEVEL (10) 000	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	
	20.405(a)(1)(iii)			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 Alfred R. Froebrich, Watch Engineer	TELEPHONE NUMBER (Include Area Code) (914) 736-8836
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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)				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 1, 1995, between 0720 hours and 0744 hours, and on January 4, 1995, between 1102 hours and 1125 hours, with the plant in the cold shutdown condition, the reactor coolant system depressurized, and the carbon dioxide (CO₂) fire protection system out of service, a fire watch was not maintained in the switchgear room as required. During these events, the plant was in a Limiting Condition for Operation required by Technical Specifications section 3.14.G.3.a, "CO₂ Fire Protection System," which requires a continuous fire watch in the switchgear room when this CO₂ fire protection system is not in service. This event occurred when the fire watch left the room to assist in ventilating the Control Room. The cause of the event was that Operations and Security personnel were not aware that the interpretation of the continuous fire watch requirement was to mean that the fire watch person was to be within the unprotected area, with no other concurrent responsibilities. Corrective actions include enhanced training for Senior Reactor Operators and fire watch personnel, mandatory fire watch briefings, and a procedure revision.

**LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION**

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

DESCRIPTION OF THE EVENT

On January 4, 1995, the plant was in the cold shutdown condition with reactor power at 3 counts per second, and reactor coolant system (AB) temperature at 98 degrees Fahrenheit and vented at atmospheric pressure. At 1117 hours, the on-watch Shift Supervisor (SS) discovered that there was no fire watch in the switchgear room (Control Building: 15 foot elevation) as required by Technical Specifications section 3.14.G.3.a, "CO₂ Fire Protection System," when equipment in that area is required to be operable. The carbon dioxide (CO₂) fire protection system (KQ) was in a degraded condition and had been taken out of service, and a continuous fire watch had been established in the switchgear room in accordance with the Technical Specification. The assigned fire watch had left the switchgear room in order to open a nearby door that was part of a coordinated action to ventilate the Control Room (CR).

The CR ventilation system (VI) was taken out of service on December 29, 1994, for maintenance. At the beginning of the day shift, on January 4, 1995, the CR Operators decided that the air in the CR had become stale, and the CR should be ventilated. The Reactor Operator (RO) coordinated the CR ventilation process with the Security Supervisor as security access doors would be required to be opened for the duration of the ventilation process. The ventilation process would draw fresh air from the main transformer yard through a door adjacent to the CR ventilation intake into the control building's 15 foot elevation, through a hallway and up a stairway, through the CR rear door into the CR, through the CR, and through CR front door into the turbine building. The turbine building fans were utilized to assure that ventilation flow was established. Security personnel were to be stationed at three doors while the doors were opened because this action would breach a security barrier, and the security personnel would also provide access control to the vital areas.

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The switchgear room is on the Control Building's 15 foot elevation. This room has a door that exits into the hallway that was part of the proposed CR ventilation path, and this door is approximately 15 feet from the door that was to be opened in order to draw fresh air from the transformer yard into the hallway. Because of the close proximity of the two doors the Security Supervisor asked the RO if the security officer providing the continuous fire watch in the switchgear room could also provide the security for the breached door to the transformer yard. It was thought that with the door opened, between the switchgear room and the hallway, a security person stationed at this door could satisfy the requirement for a continuous fire watch of the switchgear room and the requirement for monitoring the door to the transformer yard. The RO agreed with this arrangement since a similar method for venting the CR was performed on January 1, 1995. The shift Senior Reactor Operator (SRO) was aware that the RO was coordinating the CR ventilation process, but the SRO was not aware that the security officer would be performing concurrent responsibilities, a situation contrary to the Technical Specification for a continuous fire watch.

On January 4, 1995, at approximately 1102 hours, a door was opened to provide air flow from the transformer yard into the Control Building hallway, and the ventilation of the CR commenced. During the venting process the on-watch SS, performing a routine plant tour, entered the switchgear room at approximately 1117 hours and found no security officer on fire watch. The door between the switchgear room and the hallway was closed. The security person who was responsible for providing the fire watch was in the hallway holding open the door to the transformer yard. The SS remained in the switchgear room to provide a fire watch. The SS was not credited as a fire watch because he had concurrent duties. The SS utilized the communications in the room to notify the CR, and the CR operators immediately acted to secure the CR ventilation process. At 1125 hours, the transformer yard door was closed, and the required fire watch was restored. The switchgear room was without a qualified fire watch from 1102 hours to 1125 hours for a duration of 23 minutes. Deviation Event Report 95-0010 was initiated to document that there was no fire watch in the switchgear room.

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This event was categorized as a human performance problem, and a Performance Enhancement Review Committee (PERC) was convened on January 12, 1995, to review the event. This is required by Administrative Procedure AP-37.5, "IP3 Performance Enhancement Program," to provide management support and involvement in the systematic identification, analysis, and correction of the underlying causes of human performance problems. At that meeting, it became known that a Technical Specification Interpretation, number IP3-TSI-017, was issued on Technical Specification section 3.14.G, "CO₂ Fire Protection System," and that the operators were not aware of this interpretation. PERC decided that the event should be re-evaluated relative to the interpretation. The interpretation states "The use of a roving fire watch does not satisfy the requirement because the fire watch must continuously be in the protected area described above. The use of an individual with other, concurrent responsibilities does not satisfy this requirement." Technical Specification Interpretations are developed, approved and issued in accordance with Administrative Procedure AP-18.7, "Control of Technical and Operational Specifications."

The Authority concluded on January 13, 1995 that the actions carried out by the security officer were in violation of the Technical Specification because the continuous fire watch was not in the switchgear room, and because the security officer had been assigned a concurrent responsibility, monitoring the door between the hallway and the transformer yard. The Authority also concluded that when the CR was ventilated in a similar way on January 1, 1995, the Technical Specification was violated for the same reasons. Previously, it was thought that the ventilation process on January 1, 1995, was not in violation because the door between the switchgear room and the hallway was opened, and the security person was viewing both the switchgear room and the opened door to the transformer yard. On that date, the door was opened to the transformer yard at 0720 hours and closed at 0744, and the fire watch was in violation of the Technical Specification for a duration of 24 minutes. Based on interviews with Operations staff and the department's Assistant Operations Manager, these are the only known occasions when a fire watch was used to help ventilate the CR.

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CAUSE OF THE EVENT

The cause of the event was personnel error in that Operations personnel and Security personnel were not aware that the continuous fire watch is interpreted to require the fire watch to be within the unprotected area, with no other concurrent responsibility.

Contributing to this event were the following:

- Procedural inadequacies and weaknesses. Administrative Procedure AP-21, "Conduct of Operations," stipulates that operators have the responsibility to adhere to the plant's Technical Specifications, but it does not explicitly identify Technical Specification Interpretations.
- The operators did not maintain a questioning attitude when asked by the Security Supervisor if one security officer could be utilized for fire watch and door monitor.
- Fire watch personnel are not always aware of the basis for their assigned responsibilities.

CORRECTIVE ACTIONS

IMMEDIATE CORRECTIVE ACTIONS

The following corrective actions have been performed to prevent recurrence of this event:

- Assignment of a continuous fire watch has been limited to fire watch qualified Operations and Security personnel who have been briefed on the continuous fire watch requirements.
- The operators were counseled by the PERC, in support of their training, on how an aggressive questioning attitude would have resulted in review of the Technical Specification and the Technical Specification Interpretations, and that would have prevented using the switchgear room fire watch for concurrent responsibilities.

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SUBSEQUENT CORRECTIVE ACTIONS

The following corrective actions will be performed to prevent reoccurrence of this event:

- AP-21, "Conduct of Operations," will be revised to require operators to adhere to the Technical Specification Interpretations. This will be completed by March 1, 1995.
- Administrative controls will be instituted to ensure that before a continuous fire watch is manned, the initial fire watch will be briefed by the Shift Supervisor or designee on the specific responsibilities of the fire watch. Thereafter, it will be the responsibility of each fire watch to brief the succeeding fire watch on the specific responsibilities of the fire watch. This will be implemented by February 15, 1995.
- Operator training will include the expectation for Senior Reactor Operator usage of the Technical Specification Interpretations. This will be completed by February 24, 1995.
- Training for qualified fire watch personnel will include the specific requirements of a continuous fire watch. This will be completed by March 31, 1995.

ANALYSIS OF THE EVENT

This event is reportable under 10 CFR 50.73(a)(2)(i)(B). The licensee shall report any operation or condition prohibited by the plant's Technical Specifications. Between 0720 hours and 0744 hours on January 1, 1995, and between 1102 hours and 1125 hours on January 4, 1995, a continuous fire watch was not provided in the switchgear room as required by Technical Specifications section 3.14.G.3.a, and Technical Specification Interpretation IP3-TSI-017.

Similar LER's related to personnel error resulting in failure to provide compensatory action that placed the plant in a condition prohibited by the Technical Specifications include LER's 93-019, 93-015, 93-014, 93-011, and 93-003.

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SAFETY SIGNIFICANCE

This event had no significant effect on the health and safety of the public. The combined period of time for the two occasions when a continuous fire watch, as required by the Technical Specification interpretation, was not being provided was 47 minutes. The continuous fire watch was required in the switchgear room because the CO₂ fire protection system was out of service and equipment in that area is required to be operable. The smoke detectors in the switchgear room were operable during this period providing continuous monitoring and detection with alarm capability in the CR. Had one of the switchgear room's smoke detectors alarmed during this period, the CR operators would have summoned personnel to investigate the cause. Upon indication of an apparent fire, the fire brigade would have responded accordingly.