REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR: 8706260288 DOC. DATE: 87/06/23 NOTARIZED: NO DOCKET #
FACIL: 50-323 Diablo Canyon Nuclear Power Plant, Unit 2, Pacific Ga 05000323
AUTH. NAME AUTHOR AFFILIATION
NELSON, T. A. Pacific Gas & Electric Co.
SHIFFER, J. D. Pacific Gas & Electric Co.
RECIP. NAME RECIPIENT AFFILIATION

SUBJECT: LER 87-012-00: on 870524, w/cardox fire protection sys out of svc, continuous fire watch for cable spreading room left station to work on another job in violation of Tech Spec 3.7.9.3. Personnel counseled. W/870623 ltr.

DISTRIBUTION CODE: IE22D COPIES RECEIVED: LTR 1 ENCL 1 SIZE: 5
TITLE: 50.73 Licensee Event Report (LER), Incident Rpt, etc.

NOTES:

	RECIPIENT ID CODE/NAME	COPIES LTTR	COPIES ENCL	RECIPIENT ID CODE/NAME	COPIES LTTR	COPIES ENCL
	PD5 LA	1	1	PD5 PD	1	1
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	AEOD/DOA	1	1	AEOD/DSP/ROAB	2	2
	AEOD/DSP/TPAB	1	1	DEDRO	1	1
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	NRR/DEST/ICSB	1	1	NRR/DEST/MEB	1	1
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	NRR/DOEA/EAB	1	1	NRR/DREP/RAB	1	1
	NRR/DREP/RPB	2	2	NRR/PMAS/ILRB	1	1
	NRR/PMAS/PTSB	1	1	REG FILE 02	1	1
	RES DEPY GI	1	1	RGN5 FILE 01	1	1
EXTERNAL:	EG&G GROH, M	5	5	H ST LOBBY WARD	1	1
	LPDR	2	2	NRC PDR	1	1
	NSIC HARRIS, J	1	1	NSIC MAYS, G	1	1

TOTAL NUMBER OF COPIES REQUIRED: LTTR 44 ENCL 42

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
DIABLO CANYON UNIT 2	0 5 0 0 0 3 2 3	1 OF 0 4

TITLE (4) PERSONNEL ERROR RESULTS IN FAILURE TO MEET TECHNICAL SPECIFICATION 3.7.9.3 LIMITING CONDITION FOR OPERATION FOR THE CABLE SPREADING ROOM CARDOX SYSTEM

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	DOCKET NUMBER(S)
0 5	2 4	8 7	8 7	0 1 2	0 0	0 6	2 3	8 7		0 5 0 0 0
										0 5 0 0 0

OPERATING MODE (9)	5
POWER LEVEL (10)	0 0 0

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (11)

[X] 10 CFR 50.73(a)(2)(i)(B)

[ ] OTHER (Specify in Abstract below and in Text, NRC Form 366A)

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER AREA CODE
THOMAS A. NELSON, REGULATORY COMPLIANCE ENGINEER	8 0 5 5 9 5 - 7 3 5 1

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

ABSTRACT (16)

On May 24, 1987, at 0850 PDT, with the Cardox fire protection system out of service, the continuous fire watch for the cable spreading room left his station to work another job, in violation of the limiting condition for operation (LCO) of Technical Specification (TS) 3.7.9.3.

The event was discovered by a senior control operator who went to return the Cardox system to service approximately 15 minutes later.

The cause of this event was personnel error in that the fire watch did not comply with the instructions on the fire watch log and misunderstood his duty to remain on station until the Cardox system was returned to service.

To prevent recurrence, a tailboard session was held with personnel from General Construction qualified as fire watches which emphasized the importance of remaining on station until the Cardox system is returned to service. Additionally, the Emergency and Safety department sent a memo to all plant personnel informing them of this incident and its causes.

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FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
DIABLO CANYON UNIT 2	0 5 0 0 0 3 2 3	8 7	0 1 2	0 0	0 2 OF 0 4

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

I. Initial Conditions

The unit was in Mode 5 (Cold Shutdown).

II. Description of Event

A. Event:

On May 24, 1987, with the unit in Mode 5, work was being performed in the cable spreading room which required the Cardox fire protection system (KQ) to be removed from service. When the work was completed, the fire watch supplied by General Construction (GC) turned his duties over to one of the individuals in the cable spreading room and then left to inform the senior control operator that the Cardox system was ready to be placed back in service. The senior control operator informed the fire watch that it would be placed back in service immediately. The fire watch returned to the cable spreading room and told the individuals present that the job was done and they could leave for other jobs. Without checking for Cardox system operability or checking with the senior control operator, the fire watch signed out on the log sheet and left the area to work another job.

B. Inoperable structures, components or systems that contributed to the event:

None

C. Dates and approximate times for major occurrences:

1. May 24, 1987, 0850 PDT: Event Date - Fire watch exited the cable spreading room and left it without the continuous fire watch required by TS 3.7.9.3.

2. May 24, 1987, 0905 PDT: Discovery Date - Control operator found the cable spreading room without a fire watch and returned the Cardox system to service.

D. Other systems or secondary functions affected:

None

E. Method of discovery:

The event was discovered when the senior control operator went to the cable spreading room to restore the Cardox system to operation.

F. Operator actions:

The senior control operator returned the Cardox system to service.

G. Safety system responses:

None

III. Cause of Event

A. Immediate cause:

The fire watch left the cable spreading room before the Cardox system had been returned to service.

B. Root cause:

Personnel Error: The fire watch did not comply with the instructions on the fire watch log sheet that required the fire watch not to leave the area while the Cardox system was out of service. The fire watch also misunderstood his duty to remain on station until the Cardox system was returned to service.

IV. Analysis of Event

The Cardox system is required to be operable whenever equipment protected by it is required to be operable. During this event, fire detection instruments required by Technical Specification 3.3.3.8 were operable and capable of alarming in the control room in case of a fire in the cable spreading room. The alarm would have allowed the site fire brigade, required by Technical Specification 6.2.2, to respond in an expeditious manner. Although the cable spreading room Cardox system was out of service, it could have been restored quickly to provide either a manual or an automatic discharge in the case of a fire.

Thus, no safety consequences or implications would have resulted from this event.

V. Corrective Actions

1. A tailboard was conducted for all GC personnel qualified as fire watches which emphasized the importance of not leaving the fire watch station until the Cardox system is returned to service.

2. A memo was sent to all plant personnel informing them of the incident and its causes, specifically referencing following the instructions on the fire watch log sheet.

VI. Additional Information

A. Failed components:

None

B. Previous LERs on similar events:

LER 2-86-003: Personnel Error Results in Failure to Meet Limiting Condition for Operation of Technical Specification 3.7.9.3 for the Cable Spreading Room.

Corrective actions for this event included covering fire system impairment requirements in general employee training and specific training for fire watches. Since the fire watch failed to follow procedures and misunderstood his duties, the corrective actions for this event would not have prevented the current event from happening.

PACIFIC GAS AND ELECTRIC COMPANY

PG&E

77 BEALE STREET • SAN FRANCISCO, CALIFORNIA 94106 • (415) 781-4211 • TWX 910-372-6587

JAMES D. SHIFFER
VICE PRESIDENT
NUCLEAR POWER GENERATION

June 23, 1987

PGandE Letter No.: DCL-87-144

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

Re: Docket No. 50-323, OL-DPR-82
Diablo Canyon Unit 2
Licensee Event Report 2-87-012-00
Personnel Error Results in Failure to Meet Technical Specification 3.7.9.3 Limiting Condition for Operation for the Cable Spreading Room Cardox System

Gentlemen:

Pursuant to 10 CFR 50.73(a)(2)(i)(B), PGandE is submitting the enclosed Licensee Event Report concerning a personnel error which resulted in a failure to meet the Technical Specification 3.7.9.3 limiting condition for operation for the cable spreading room Cardox system.

This event has in no way affected the public's health and safety.

Kindly acknowledge receipt of this material on the enclosed copy of this letter and return it in the enclosed addressed envelope.

Sincerely,

J. D. Shiffer

Enclosure

cc: L. J. Chandler
J. B. Martin
M. M. Mendonca
P. P. Narbut
B. Norton
CPUC
Diablo Distribution
INPO

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DC2-87-ST-N067

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