

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR: 8707200605 DOC. DATE: 87/07/13 NOTARIZED: NO DOCKET #
 FACIL: 50-410 Nine Mile Point Nuclear Station, Unit 2, Niagara Moho 05000410
 AUTH. NAME AUTHOR AFFILIATION
 RANDALL, R. G. Niagara Mohawk Power Corp.
 LEMPGES, T. E. Niagara Mohawk Power Corp.
 RECIP. NAME RECIPIENT AFFILIATION

SUBJECT: LER 87035-00 : on 870618, fire watch inappropriately terminated while detection inoperable. Log requirement revised for fire chief log book & lesson learned program will be implemented for plant fire dept. W/870713 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 ENCL		RECIPIENT ID CODE/NAME	COPIES LTTR ENCL	
	PD1-1 LA	1	1	PD1-1 PD	1	1
	NEIGHBORS, D	1	1	MINER, S	1	1
INTERNAL:	ACRS MICHELSON	1	1	ACRS MOELLER	2	2
	AEOD/DOA -	1	1	AEOD/DSP/ROAB	2	2
	AEOD/DSP/TPAB	1	1	DEDRO	1	1
	NRR/DEST/ADE	1	0	NRR/DEST/ADS	1	0
	NRR/DEST/CEB	1	1	NRR/DEST/ELB	1	1
	NRR/DEST/ICSB	1	1	NRR/DEST/MEB	1	1
	NRR/DEST/MTB	1	1	NRR/DEST/PSB	1	1
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	NRR/DLPQ/HFB	1	1	NRR/DLPQ/QAB	1	1
	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	RES TELFORD, J	1	1
	RES/DE/EIB	1	1	RGN1 FILE 01	1	1
EXTERNAL:	EG&G GROH, M	5	5	H ST LOBBY WARD	1	1
	LPDR	1	1	NRC PDR	1	1
	NSIC HARRIS, J	1	1	NSIC MAYS, G	1	1

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LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Nine Mile Point Unit 2	DOCKET NUMBER (2) 0 5 0 0 0 4 1 0	PAGE (3) 1 OF 04
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TITLE (4) Fire Watch Inappropriately Suspended Which Results in a Technical Specification Violation - Personnel Error

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)																																													
06	18	87	87	035	00	07	13	87	N/A		0 5 0 0 0																																													
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td colspan="2">OPERATING MODE (9)</td> <td colspan="10">THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)</td> </tr> <tr> <td colspan="2">4</td> <td>20.402(b)</td> <td>20.406(c)</td> <td>50.73(a)(2)(iv)</td> <td>73.71(b)</td> </tr> <tr> <td colspan="2">POWER LEVEL (10)</td> <td>20.406(a)(1)(i)</td> <td>50.36(c)(1)</td> <td>50.73(a)(2)(v)</td> <td>73.71(c)</td> </tr> <tr> <td colspan="2">0 0 10</td> <td>20.406(a)(1)(ii)</td> <td>50.36(c)(2)</td> <td>50.73(a)(2)(vi)</td> <td rowspan="4">OTHER (Specify in Abstract below and in Text, NRC Form 366A)</td> </tr> <tr> <td colspan="2"></td> <td>20.406(a)(1)(iii)</td> <td>X 50.73(a)(2)(i)</td> <td>50.73(a)(2)(viii)(A)</td> </tr> <tr> <td colspan="2"></td> <td>20.406(a)(1)(iv)</td> <td>50.73(a)(2)(ii)</td> <td>50.73(a)(2)(viii)(B)</td> </tr> <tr> <td colspan="2"></td> <td>20.406(a)(1)(v)</td> <td>50.73(a)(2)(iii)</td> <td>50.73(a)(2)(x)</td> </tr> </table>												OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)										4		20.402(b)	20.406(c)	50.73(a)(2)(iv)	73.71(b)	POWER LEVEL (10)		20.406(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)	0 0 10		20.406(a)(1)(ii)	50.36(c)(2)	50.73(a)(2)(vi)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)			20.406(a)(1)(iii)	X 50.73(a)(2)(i)	50.73(a)(2)(viii)(A)			20.406(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(viii)(B)			20.406(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)
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OPERATING MODE (9) 4

POWER LEVEL (10) 0 0 10

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)

20.402(b) 20.406(c) 50.73(a)(2)(iv) 73.71(b)

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20.406(a)(1)(v) 50.73(a)(2)(iii) 50.73(a)(2)(x)

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
Robert G. Randall, Supervisor Technical Support	3 1 5 3 4 9 1 - 2 4 4 5

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRRDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRRDS

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE) NO X

EXPECTED SUBMISSION DATE (15)

MONTH	DAY	YEAR

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

On June 18, 1987 at 1150 with the reactor in cold shutdown (operational condition 4), a fire watch was inappropriately terminated while the detection in two fire zones was inoperable. This action resulted in a violation of the Nine Mile Point Unit 2 (NMP2) Technical Specification Sections 3.3.7.8 and 3.7.7.2. The fire detection in these fire zones was restored to an operable status at 1345 which ended this event.

The root cause for this event is personnel error.

The corrective actions taken subsequent to this event are:

1. Log entry requirements have been revised for the fire chiefs' log book.
2. An improved status board will be procured and shall be located in the fire department office. The anticipated implementation date is September 15, 1987.
3. A lessons learned program, being prepared by the fire department supervision, will be implemented for the NMP2 fire department. The anticipated implementation date is August 1, 1987.
4. Meetings discussing fireman responsibility and conduct have been held with the fire department personnel involved in this event.
5. This report will be discussed in fire department training.

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		87	035	00	02	OF	04

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

I. DESCRIPTION OF EVENT

On June 18, 1987 at 1150 with the reactor: in cold shutdown (operational condition 4), at ambient pressure, and a temperature of 101 degrees Fahrenheit, a fire watch was inappropriately terminated while the fire detection in two fire zones was inoperable. This action resulted in a violation of the Nine Mile Point Unit 2 (MNP2) Technical Specification (TS) Sections 3.3.7.8 and 3.7.7.2.

The sequence of events is as follows:

1120: A fireman is sent to the Reactor Building Track Bay to stand watch while the fire detection for fire zones 242NW and 243SW are placed to "disconnect" to allow a vehicle entry. (The detection for these zones is made inoperable (placed to "disconnect") because exhaust from an entering or exiting vehicle can cause an inadvertent fire detection actuation.)

Fire Zone 243SW consists of the North General area (azimuth 0 to 180 degrees) of the Reactor Building 261 foot elevation. Fire Zone 242NW consists of the Reactor Building Track Bay elevation 261. (An alphanumeric designation is used for fire zones at NMP2. The letter S denotes an automatic actuation of a fire suppression system. The letter N denotes no automatic actuation of a fire suppression system. The letter W denotes water fire suppression.)

1135: The fireman assigned to stand watch in the track bay is sent to another area to assist in an emergency medical call. Another fireman is sent as a replacement to stand watch in the track bay.

1150: The vehicle arrives and parks in the track bay. After the truck arrives, the fireman standing watch leaves the area.

1250: The Technical Specification Limiting Condition for Operation (LCO) pertaining to fire watch patrol requirements is exceeded. (The event starts)

1345: While investigating a trouble alarm at a local fire panel, a fireman finds the detection for fire zones 242NW and 243SW to be in "disconnect". The detection for these zones is immediately placed back into an operable status. (End of event)

1431: Control Room supervision is notified of this event. A 10CFR50.72 notification is made within the next hour.

There were no other inoperable systems which contributed to this event.



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

II. CAUSE OF EVENT

The root cause of this event is personnel error.

The second fireman on duty failed to contact his supervision prior to leaving his post. He assumed after the vehicle had entered the Reactor Building Track Bay his fire watch responsibility had ended. But, he did not verify this with his supervisor. In addition, the fire chief failed to provide the relief fireman with the adequate information as to the nature and duration of the watch.

Another contributing factor to this event, is the fire chief's failure to adequately track the status of the involved detection systems. Proper tracking of temporary system configurations and special work would have provided positive supervisory control and could have prevented this incident.

III. ANALYSIS OF EVENT

Although an LCO as defined by Technical Specifications was violated, no adverse safety consequences resulted from the event. Had a fire occurred in this area which resulted in a loss of all equipment in the area, this event would not affect the operators' ability to safely shutdown the plant under any operating condition or power level. This is due to the existence of redundant safe shutdown systems and the separation of these redundant systems by fire barriers to support the Nine Mile Point Unit 2 Safe Shutdown Analysis. This event lasted from 1250 hours on June 18, 1987, when the one hour Technical Specification time limit expired, to 1345 hours when the mistake was discovered, for a total of 55 minutes.

IV. CORRECTIVE ACTIONS

1. Log entry requirements have been revised for the fire chiefs' log book. The fire chief is now required to log all short term fire detector system disconnects in his log book. This will enable the fire chief to accurately track and assess fire zone status and determine fire watch coverage. Additionally, the relief fire chief shall be required to read and be familiar with the log entries of the previous shifts as applicable.
2. An improved fire zone status board will be procured for use as an additional tracking device for fire zone detection and suppression system status. This board will clearly show the current fire equipment status for each zone. This board, which shall be located in the fire department office, will be used as a supplement to the revised log book described above. The status board should be in place by September 15, 1987.



LICENSE EVENT REPORT (LER) TEXT CONTINUATION

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

3. A lessons learned book will be implemented for the NMP2 fire department. This book will discuss various fire department experiences and the lessons learned. This book will be required reading for all fire department personnel. The anticipated implementation date for this book is August 1, 1987.
4. Meetings discussing fireman responsibility and conduct have been held with the fire department personnel involved in this event. These meetings have dealt specifically with this event and its implications.
5. This report will be discussed in the next cycle of fire department training.

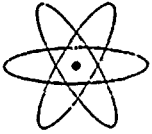
V. ADDITIONAL INFORMATION

Two previous similar events have occurred at NMP2. Details of these events may be found in LER's 86-06 and 87-15.

Identification of Components Referred to in this LER

Component	IEEE 803 EIIS Funct	IEEE 805 System ID
Fire Detection System	DET	IC





NIAGARA MOHAWK POWER CORPORATION

NIAGARA  MOHAWK

301 PLAINFIELD ROAD
SYRACUSE, NY 13212

THOMAS E. LEMPGES
VICE PRESIDENT—NUCLEAR GENERATION

July 13, 1987

United States Nuclear Regulatory Commission
Document Control Desk
Washington, DC 20555

RE: Docket No. 50-410
LER 87-35

Gentlemen:

In accordance with 10 CFR 50.73, we hereby submit the following Licensee Event Report:

LER 87-35 Which is being submitted in accordance with 10 CFR 50.73 (a) (2) (i) (B), "Any operation or condition prohibited by the plant's Technical Specifications;"

A 10 CFR 50.72 event notification was made at 1518 hours on June 18, 1987.

This report was completed in the format designated in NUREG-1022, Supplement No. 2, dated September 1985.

Very truly yours,

Thomas E. Lempges
Vice President
Nuclear Generation

TEL/POB/mjd

Attachments

cc: Regional Administrator, Region 1
Sr. Resident Inspector, W. A. Cook

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