NRC FORM 366 (6-1998) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB NO. 3150-0104
EXPIRES 06/30/2001
ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS MANDATORY INFORMATION COLLECTION REQUEST: 50.0 HRS. REPORTED LESSONS LEARNED ARE INCORPORATED INTO THE LICENSING PROCESS AND FED BACK TO INDUSTRY. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (T-6 F33), 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.

# LICENSEE EVENT REPORT (LER)

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

| FACILITY NAME (1) | DOCKET NUMBER (2) | PAGE (3) |
|---|---|---|
| Susquehanna Steam Electric Station - Unit 1 | 05000387 | 1 OF 3 |

TITLE (4)
Continuous Fire Watch Not Established Within Technical Specification Time Limit

| 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 |
| | | | | | | | | | | 05000 |
| 7 | 1 | 98 | 98 | -- 013 -- | 00 | 7 | 31 | 98 | FACILITY NAME | DOCKET NUMBER 05000 |

| | | | | | |
|---|---|---|---|---|---|
| OPERATING MODE (9) | 1 | THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11) | | | |
| POWER LEVEL (10) | 100 | 20.2201(b) | 20.2203(a)(2)(v) | X 50.73(a)(2)(i) | 50.73(a)(2)(viii) |
| | | 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 or in NRC Form 366A |
| | | 20.2203(a)(2)(iv) | 50.36(c)(2) | 50.73(a)(2)(vii) | |

LICENSEE CONTACT FOR THIS LER (12)

| NAME | TELEPHONE NUMBER (Include Area Code) |
|---|---|
| Cornelius T. Coddington - Senior Engineer, Licensing | 717 / 542-3294 |

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

| CAUSE | SYSTEM | COMPONENT | MANUFACTURER | REPORTABLE TO EPIX | | CAUSE | SYSTEM | COMPONENT | MANUFACTURER | REPORTABLE TO EPIX |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | |
| | | | | | | | | | | |

| 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 July 1, 1998, at 1030 hours, with Unit 1 in Condition 1 (Power Operation) at 100 % power, a Fire Protection System Engineer (Utility; non-licensed) determined that a continuous fire watch should have been established on the previous day when a door on a panel protected by a halon system was removed (resulting in halon system inoperability) for more than one hour in order to cool components in the panel. Technical Specification 3.7.6.4 requires that within one hour of a halon system becoming inoperable, a continuous fire watch must be established. Therefore, this event has been determined to be reportable per 10CFR50.73(a)(2)(i)(B). Upon discovery that a continuous fire watch had not been established, it was confirmed that the panel door had been replaced and closed. The root cause of this event was determined to be human performance in that the System Engineer did not verify, via use of the governing procedure, that opening the panel door did not result in the halon system becoming inoperable. Corrective actions that were completed were (1) replacement and closure of panel door, (2) generation of a new Fire Protection System Status Change form to state that a continuous fire watch is needed when the panel door is open/removed, and (3) coaching and counseling of involved personnel on the importance of following and checking procedures, and the importance of being exact when supplying information to other groups. There were no safety consequences or compromises to the health and safety of the public as a result of having the panel door removed since the halon system remained functional and all the detection for the halon system was operable during the event.

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

## EVENT DESCRIPTION

On July 1, 1998, at 1030 hours, with Unit 1 in Condition 1 (Power Operation) at 100 % power, a Fire Protection System Engineer (Utility; non-licensed) determined that a continuous fire watch should have been established on the previous day when a door on a panel protected by a halon system (EIIS Code: KQ) was removed (resulting in halon system inoperability) for more than one hour in order to cool components in the panel. Technical Specification 3.7.6.4 requires that within one hour of a halon system becoming inoperable, a continuous fire watch must be established. On June 30, 1998, the Fire Protection System Engineer was requested to determine if a continuous fire watch was required when a door in a panel protected by a halon system was opened. The engineer recalled a previous instance where a panel door was removed and the halon system was still considered to be operable; therefore, the system engineer stated that no fire watch was required. However, in the previous instance the design of the particular panel was such that the door could be removed and the halon system still remain operable. For the panel door removed on June 30, 1998, the design of the panel was such that removal of the door resulted in the halon system becoming inoperable. Upon discovery that a continuous fire watch had not been established, it was confirmed that the panel door had already been replaced and closed.

## CAUSE OF EVENT

The root cause of this event was determined to be human performance in that the System Engineer did not verify, via use of the governing procedure, that opening the relay room panel door did not cause the halon system to become inoperable.

## REPORTABILITY/ANALYSIS

Technical Specification 3.7.6.4 states that with one or more halon systems inoperable, within one hour establish a continuous fire watch. During work on a panel that was protected by a halon system, the door was removed. Removing the panel door made the halon system inoperable. A continuous fire watch was not established in accordance with Technical Specification 3.7.6.4 ACTION a. Therefore, this event has been determined to be reportable per 10CFR50.73(a)(2)(i)(B).

During the time the door of the panel was removed, the halon system was still functional and the detection for the halon system was operable. If a fire were to have occurred in the panel, the halon system would have been activated and most likely would have put the fire out, since halon is heavier than air and the nozzles blow down on the components. In addition, the relay room's Carbon Dioxide System and associated detection remained operable. There were no safety consequences or compromises to the health and safety of the public as a result of having the panel door removed.

In accordance with the guidelines provided in NUREG-1022, Revision 1, Section 5.1.1, the required submission date for this report was determined to be July 31, 1998.

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

## CORRECTIVE ACTIONS

Corrective actions that have been completed include:

- Replacement and closure of the panel door.
- Generation of a new Fire Protection System Status Change form to state that a continuous fire watch is needed when the panel door is open/removed. This action is a contingency in case the panel door has to be left open and unattended or removed again.
- Coaching and counseling of the system engineer on the importance of following and checking procedures, and the importance of being exact when supplying information to other groups.

## ADDITIONAL INFORMATION

Past Similar Events: None

Failed Component: None