CONNECTICUT YANKEE ATOMIC POWER COMPANY

HADDAM NECK PLANT
362 INJUN HOLLOW ROAD • EAST HAMPTON, CT 06424-3099

January 14, 1994
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 50-213/93-019-00

Gentlemen:

This letter forwards the Licensee Event Report 93-019-00, 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/mlg

Attachment: LER 50-213/93-019-00

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

William Raymond
Sr. Resident Inspector
Haddam Neck

210091

1028-3 REV. 2-91

IE22 1/1

NRC Form 366
(9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/88

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Haddam Neck	0 5 0 0 0 2 1 3	1 OF 0 4

TITLE (4)

Incorrect Action Statement Applied to Inoperable Fire Door

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 0 0 0
1 2	1 7	9 3	9 3	-	0 1 9	- 0 0	0 1	1 4	9 4		0 5 0 0 0

OPERATING MODE (9)	1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)			
POWER LEVEL (10)	1 0 0	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 (Specify in Abstract below and in Text, NRC Form 366A)
		20.405(a)(1)(iii)	X 50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	
		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	TELEPHONE NUMBER
	AREA CODE
J. Beaupre, Engineer	2 0 3 2 6 7 - 2 5 5 6

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 fifteen single-space typewritten lines) (16)

ABSTRACT

On December 17, 1993, at 1000 hours, with the plant in Mode 1 at 100 percent power, plant personnel determined that an inappropriate ACTION statement had been used while attempting to comply with the requirements of Technical Specification 3.7.7, "Fire Rated Assemblies". On December 13, 1993, at 1857 hours a fire door (T594) which separates the turbine building upper level from the service building access hallway was declared inoperable due to damage to the door. An hourly fire watch patrol was established in accordance with ACTION statement a.1. On December 17, 1993, it was determined that the conditions allowing the use of ACTION statement a.1 did not exist and that a continuous fire watch was required in accordance with ACTION statement a.2. The cause was misinterpretation of the Technical Specification ACTION statement. This interpretation had been used in the past for similar occurrences and was determined to be appropriate at the time. Immediate corrective action was to establish a continuous fire watch at 1000 hours on December 17, 1993. Additional corrective action will consist of issuing a clarification of Technical Specification 3.7.7 ACTION statements to plant operators. This event is reportable under 10CFR50.73 (a)(2)(i)(B) since it resulted in a condition prohibited by the plant's Technical Specifications.

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
Haddam Neck	0 5 0 0 0 2 1 3	9 3	— 0 1 9	— 0 0	0 2 OF 0 4

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

BACKGROUND INFORMATION

Fire door T594 is located on the upper level of the turbine building (EIIS Code:NM) and is a passive element of the plant Fire Protection Program. The door (EIIS Code:DR) is designed to prevent a fire from spreading into or out of the turbine building via an adjacent hallway. The ACTION statements of Technical Specification 3.7.7 provide requirements for establishing fire watches for inoperable fire doors. If an inoperable fire door is located between areas that each contain an OPERABLE fire detection system (EIIS Code:IC) or automatic fire suppression system (EIIS Code:KP) at the fire barrier then ACTION statement a.1 requires that a fire watch patrol inspect both sides of the door once per hour. Otherwise, a continuous fire watch must be established on either side of the door per ACTION statement a.2. The corridor outside of fire door T594 contains neither a fire detection system nor an automatic fire suppression system. In addition, the upper level of the turbine building contains no general area fire detection or suppression systems, although there are local and general area fire detection and suppression systems in other areas of the turbine building.

EVENT DESCRIPTION

On December 17, 1993, at 1000 hours, with the plant in Mode 1 at 100 percent power, plant personnel determined that an inappropriate ACTION statement had been used while attempting to comply with the requirements of Technical Specification 3.7.7, "Fire Rated Assemblies". On December 13, 1993, at 1857 hours fire door T594 was declared inoperable because of damage to a molding strip which created three 1/4 inch holes in one face of the door. Plant personnel misinterpreted ACTION statement a.1 and established an hourly fire watch patrol reasoning that since all of the fire detection and suppression systems in the turbine building were OPERABLE then this ACTION statement was appropriate. This interpretation had been used in the past for similar occurrences and, at that time, was determined by plant management to be appropriate. Plant personnel failed to consider that the lack of fire detection and suppression systems in the areas adjacent to the inoperable fire door prohibited the use of ACTION statement a.1. On December 17, 1993 it was determined that the appropriate ACTION statement was ACTION a.2 and a continuous fire watch was immediately established at 1000 hours.

CAUSE OF THE EVENT

The cause of the event was the misinterpretation of Technical Specification 3.7.7, ACTION statement a.1. The conditions under which ACTION a.1 applied were not clearly understood by plant personnel and led to the decision to perform an hourly fire watch patrol rather than the required continuous fire watch at the inoperable fire door.

SAFETY ASSESSMENT

This event is reportable under 10CFR50.73(a)(2)(i)(B) since it resulted in a condition prohibited by the plant's Technical Specifications. The damage to the fire door was of such a minor nature that the door would have been capable of withstanding any fire exposure from the in-situ combustible loading of the fire areas. The three small holes in the turbine building side of the door did not create any through openings in the door and did not degrade the door to a point where fire could have breached the barrier. Existing local fire detection systems and local and area fire suppression systems in the turbine building were operable during this period and there was no fire loading in the general proximity of the door which could have exposed the door. In addition, the hourly fire watch patrol which was established from the onset of the event was monitoring the areas for any transient combustible loading and would have taken corrective action to prevent any build-up of transient combustibles.

As part of this event it was determined that this same misinterpretation has been applied on various fire doors in the past. A total of nine fire doors were noted to require a continuous fire watch when declared inoperable due to the lack of fire detection and/or automatic suppression systems at both sides of the barrier. Three of these doors are located on the turbine building upper level and lead into the service building (control room and service building hallway on the 59' 6" elevation), two doors lead from the control room enclosure to the service building hallway, two doors lead from the "B" Switchgear Room to a stairwell and a walkway, one door from the turbine building mid-level to the "A" Switchgear Room personnel entry vestibule and one door from the service building cable spreading area walkway to the Health Physics/Chemistry office building hallway.

In all of these cases the safety significance of not posting a continuous fire watch was negligible due to a combination of the following factors:

- Smoke detection and/or automatic suppression systems are installed in any area where an appreciable fire load existed which might expose the degraded fire doors.
- No fire exposure to the doors due to an absence of combustible loading in hallway, walkway, or stairwell areas.
- The hourly fire watch patrol established in each case monitoring the area for accumulations of transient combustibles in the vicinity of the doors.

As such there were no safety consequences as a result of this or the previous events.

CORRECTIVE ACTION

A continuous fire watch was immediately established at the inoperable fire door and repair of the door was expedited. Repairs were completed on December 17, 1993 at 1115 hours and the door was declared operable. Additional corrective action will consist of issuing a clarification of Technical Specification 3.7.7 ACTION statements to plant operators.

ADDITIONAL INFORMATION

None

PREVIOUS SIMILAR EVENTS

Refer to Safety Assessment.