CONNECTICUT YANKEE ATOMIC POWER COMPANY
HADDAM NECK PLANT
RR#1 • BOX 127E • EAST HAMPTON, CT 06424-9341

September 14, 1990
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 50-213/90-015-00

Gentlemen:

This letter forwards the Licensee Event Report 90-015-00, required to be submitted, pursuant to the requirements of Connecticut Yankee Technical Specifications.

Very truly yours,

John P. Stetz
Station Director

JPS/dl

Attachment: LER 50-213/90-015-00

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

J. T. Shedlosky
Sr. Resident Inspector
Haddam Neck

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 3

TITLE (4)

Failure to Add New Fire Door to Surveillance Procedure

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
0 8	1 7	9 0	9 0	–	0 1 5	–	0 0	0 9	1 4	9 0		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)	0 0 8		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
T. B. Kazukynas, Fire Protection Engineer	2 0 3 2 6 7 1 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 August 17,1990, at 0815 hours, with the plant in Mode 1 at 8 percent power, the operations shift supervisor determined that a fire door in a newly designated fire barrier was not being inspected on a weekly basis as required by the plant's technical specifications. The fire door is in a wall separating a portion of the primary auxiliary building main corridor from the primary side auxiliary operators' office. The fire door was added to the list of technical specification barriers on July 30, 1990 but was not inspected until August 17, 1990. The root cause of this event was the failure to initiate all procedure revisions required as a result of adding new fire doors to the list of technical specification barriers. Immediate corrective action included a verification that the door was in its proper position and adding the fire door to the surveillance procedure. The procedure which implements the fire protection program was revised to prevent recurrence. This event is reportable under 10CFR50.73(a)(2)(i)(B) since it resulted in a condition prohibited by the plant's technical specifications.

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

BACKGROUND INFORMATION

On July 30, 1990, the station administrative control procedure which implements the fire protection program was revised to add four new fire door (EIIS Code: DR) assemblies. These were included as a result of the penetration fire seal upgrade project which added two new fire barriers. Three of the four fire doors were already being administratively controlled as non-Technical Specification fire doors and were being inspected daily. The fire door in the barrier separating the primary auxiliary building (PAB) main corridor (El. 21' 6") and the primary side auxiliary operators' office was the only door not included in the daily inspection. This door is kept locked by the operations department to control access to the office.

EVENT DESCRIPTION

On August 17, 1990, at 0815 hours, with the plant in Mode 1 at 8 percent power, the operations shift supervisor determined that a fire door in a newly designated fire barrier was not included in the operations surveillance procedure that is used for conducting operator rounds each shift. Technical Specification 4.7.7.3.a requires that each locked closed fire door be verified closed at least once per 7 days. This constituted a missed surveillance from July 30, 1990 to August 17, 1990. During this period two weekly inspections were not performed.

CAUSE OF THE EVENT

The root cause of this event was the failure to initiate all procedure revisions required as a result of adding new fire doors to the list of technical specification barriers.

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 basis for requiring the inspection of fire doors is to assure that the doors are kept in the closed position. The door in question is kept locked by the operations department to control access into the room. As such, with the exception of times when personnel passage was occurring during the two week period in question, the door was in the closed position and there was no safety significance to the missed inspections.

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

CORRECTIVE ACTION

The immediate corrective action was to inspect the door to determine that it was not blocked open. In addition, a procedure change was processed to add the door to the auxiliary operators shift surveillance procedure. These actions ensured that the door was operable and that the door will be inspected on a daily basis in the future. Corrective action taken to prevent recurrence was to revise the station administrative control procedure which implements the requirements for the fire protection program. A note was added to this procedure to point out that any additions to the list of technical specification fire doors must be added to the auxiliary operators shift surveillance procedure.

ADDITIONAL INFORMATION

None

PREVIOUS SIMILAR EVENTS

None