NORTHEAST UTILITIES
The Connecticut Light And Power Company
Western Massachusetts Electric Company
Holyoke Water Power Company
Northeast Utilities Service Company
Northeast Nuclear Energy Company

General Offices: Selden Street, Berlin Connecticut

P.O. BOX 270
HARTFORD, CONNECTICUT 06141-0270
(203)665-5000

April 6, 1992
MP-92-361

Re: 10CFR50.73

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

Reference: Facility Operating License No. NPF-49
Docket No. 50-423
Licensee Event Report 92-007

Gentlemen:

This letter forwards Licensee Event Report 92-007 required to be submitted within thirty (30) days pursuant to 10CFR50.73(a)(2)(i), any operation or condition prohibited by the plant's Technical Specifications.

Very truly yours,

NORTHEAST NUCLEAR ENERGY COMPANY

FOR: Stephen E. Scace
Director, Millstone Station

BY: Carl H. Clement
Millstone Unit 3 Director

SES/PAF:dlr

Attachment: LER 92-007

cc: T. T. Martin, Region I Administrator
W. J. Raymond, Senior Resident Inspector, Millstone Unit Nos. 1, 2 and 3
V. L. Rooney, NRC Project Manager, Millstone Unit No. 3

Cert # P888736187

140019

IE22

NRC Form 366 (6-89) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104
EXPIRES: 4/30/92

Estimated burden per response to comply with this information collection request: 50.0 hrs. Forward comments regarding burden estimate to the Records and Reports Management Branch (p-530), U.S. Nuclear Regulatory Commission, Washington, DC 20555, and to the Paperwork Reduction Project (3150-0104), Office of Management and Budget, Washington, DC 20503.

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Millstone Nuclear Power Station Unit 3	0 5 0 0 0 4 2 3	1 OF 0 3

TITLE (4)
Missed Firewatch Patrol During CO_2 Testing

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
0 3	0 5	9 2	9 2	0 0 7	0 0	0 4	0 6	9 2		0 5 0 0 0
										0 5 0 0 0

OPERATING MODE (9)		THIS REPORT IS BEING 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
Peter A. Freeman, Engineer, Ext. 5322	AREA CODE 2 0 3 — 4 4 7 - 1 7 9 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)

		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)

On March 5, 1992 with the plant at 100% power (Mode 1), a non-licensed operator (PEO) failed to perform an firewatch tour of the 45 ft. 6 in. elevation of the West Motor Control Center (MCC) area prior to the commencement of a Fire Protection CO_2 system surveillance test. The incomplete firewatch tour was discovered on March 7, 1992 during the surveillance testing of the East MCC areas CO_2 fire protection system. The duration of the event was approximately 1 hour 15 minutes.

Root cause of the event was miscommunication between shift personnel. The surveillance Test Director and the PEO did not successfully communicate resulting in the missed firewatch tour.

Immediate corrective action was not required. Previously established hourly firewatch patrols had been reinstated upon completion of surveillance testing. The Test Director has been and the non-licensed plant equipment operator will be counseled concerning the importance of ensuring all required information has been transmitted and understood prior to performing an evolution.

I. Description of Event

On March 5, 1992 with the plant at 100% power (Mode 1), a non-licensed operator (PEO) failed to perform a complete firewatch tour of the West Motor Control Center (MCC) zone of the Auxiliary Building prior to the commencement of the "Functional Check of the Carbon Dioxide (CO2) Fire Protection System" Operations Department surveillance. The West MCC zone consists of areas located on two elevations, the 24 ft. 6 in. and 45 ft. 6 in. elevations of the Auxiliary building. A partially visible communicable fire path exists between the two elevations. The PEO performed a firewatch tour of the 25 ft. 6 in. elevation but did not enter the 45 ft. 6 in. elevation prior to the commencement of surveillance testing. The incomplete firewatch tour was discovered on March 7, 1992 during the functional check of the CO2 fire protection system for the East MCC area. The East and West MCC's are similar in their physical configurations. The PEO that had performed the pre-surveillance firewatch tour of the West MCC on March 5, 1992 was also a participant in the functional check of the East MCC. The subject PEO recognized that he had performed a incomplete firewatch in the West MCC area after the Test Director for the East MCC functional test surveillance directed a firewatch tour for both the 24 ft. 6 in. and 45 ft. 6 in. elevations of the East MCC elevations prior to commencing surveillance testing.

II Cause of Event

The root cause of this event was miscommunications between shift and test personnel. The surveillance Test Director and the PEO did not successfully communicate. It was the Test Directors intent to perform a firewatch tour of the 45 ft. 6 in. elevation prior to testing. While instructions pertaining to the required firewatch tour were not complex in nature, this evolution is normally performed by dedicated firewatch personnel. Plant personnel were assigned the responsibility of performing the firewatch tour since the surveillance test group had direct control over access. Plant Technical Specifications require that a firewatch tour be performed within one hour after commencing a CO2 functional surveillance test for the affected area. By utilizing plant personnel the time period between required firewatch tours is minimized. A contributing cause was inattention to detail. Upon completing the firewatch tour of the 24 ft. 6 in. elevation the PEO signed an hourly firewatch patrol verification sheet located on the 24 ft. 6 in. elevation but failed to read the instructions section of the document. The instructions section of the document specified that both elevations of the West MCC area required an hourly firewatch patrol be performed.

III. Analysis of Event

This event is reportable pursuant to 10CFR50.73 (a)(2)(i), as an event prohibited by the plant Technical Specifications. Technical Specification 3.7.12.3 requires than an hourly firewatch patrol be established within one hour when CO2 is declared not operable with the adjacent fire barrier operable.

A computer key card transactions history confirms that on March 5, 1992 the 45 ft. 6 in. elevation of the Auxiliary building was not entered from 1552 hours to 1807 hours. This represents a time period of approximately 2 hours 15 minutes that an hourly firewatch patrol was not performed for the subject area. Fire detection for the affected area was fully operable with adjacent fire barriers intact during the event. Additionally, qualified fire brigade members were established at the associated fire detection and suppression panels throughout the event. Extinguishing agent to the affected areas was isolated during the event for the surveillance testing but remained available for a manual discharge. The 24 ft 6 in. elevation of the West MCC was patrolled on 4 separate occasions during the time frame of the event with a partially visible communicatuons path available to the 45 ft. 6 in. elevation. Therefore, this event posed no significant safety consequence.

IV. Corrective Action

Immediate corrective action was not required for this event. Previously established hourly firewatch tours had been reinstated upon the completion of CO_2 system testing for West MCC area on March 5, 1992.

The action to prevent recurrence is two part. First, the Test Director has been and the Plant Equipment Operator will be counseled concerning the importance of ensuring all required information and expectations are clearly presented and understood by the applicable personnel prior to performing an evolution.

Because of the East and West MCC areas unique configuration, an assigned firewatch patrol is required to exit the specified fire area on the 24 ft. 6 in. elevation and re-enter the fire area on the 45 ft. 6 in. elevation. The applicable procedure shall be revised requiring that firewatch patrol verification sheets be positioned for both elevations of the East and West MCC areas. The procedure revision shall be implemented by June 26, 1992. All procedures removing CO_2 from service will also be revised by June 26, 1992 to clearly delineate the multi-level inspection requirements.

V. Additional Information

There have been 4 similar events to date. Licensee Event Report (LER) 87-29 reported a fire watch was missed after removing the CO_2 system from service in the MCC area and the multi-level requirements were not effectively communicated to the fire watch. The corrective actions was to change the normal procedure for removing CO_2 from service to clearly state the need to check both levels. The corrective action for LER 87-29 was not effective in preventing this event since the normal fire watch was replaced by Operations personal under a test procedure which did not clearly delineate the multi-level requirement.

LER 88-27 reported a missed fire watch due to a misinterpretation of fire detector location between shift personal. The corrective action included a memo to shift personal on communications as well as clarifying the procedure on fire detector locations. This event and corrective action differed in that the miscommunications involved nomenclature which was clarified in the fire detector procedures.

LER 89-004 documented a fire watch which was not established for an inoperable fire detector due to a lack of communication. An I&C Technician had been investigating a fire detector panel problem an had completed his investigation when operations received alarms on the panel. The control operator who had not been informed that the investigation was complete, incorrectly assumed that the subsequent alarms were the result of the I&C checks. The alarm indications were not communicated to shift supervision. The incident and corrective action differ for this event since LER 89-004 was a failure to communicate required information to all affected individuals.

LER 90-018 reported that a firewatch patrol verification sheet had been positioned by firewatch personnel (contractor personnel) under the cognizance of shift personnel. The shift supervisor had intended that an assigned non-licensed operator (PEO) position the sheet to avoid possible confusion. The PEO correctly understood the required location but was misinterpreted by firewatch personnel. Corrective action was to council the shift supervisor and a procedural revision to verify firewatch patrol sheets within one hour.

EIIS Codes

System: Fire Protection System (CO_2) - KQ

Components: None