

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1): Vermont Yankee Nuclear Power Station
DOCKET NUMBER (2): 0 5 0 0 0 2 7 1 1 OF 0 3

1.1: Failure to Identify Fire Protection System Inoperable and Establish Required Fire Watch

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 (8)
08	02	88	88	010	00	09	01	88	N/A		0 5 0 0 0
08	02	88	88	010	00	09	01	88	N/A		0 5 0 0 0

OPERATING MODE (9): N
POWER LEVEL (10): 1 0 1 0

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

<input type="checkbox"/> 20.402(b)	<input type="checkbox"/> 20.406(e)	<input type="checkbox"/> 20.736(a)(2)(iv)	<input type="checkbox"/> 73.71(b)
<input type="checkbox"/> 20.406(a)(1)(i)	<input type="checkbox"/> 20.50(a)(1)	<input type="checkbox"/> 20.736(a)(2)(v)	<input type="checkbox"/> 73.71(a)
<input type="checkbox"/> 20.406(a)(1)(ii)	<input type="checkbox"/> 20.50(a)(2)	<input type="checkbox"/> 20.736(a)(2)(vi)	<input type="checkbox"/> OTHER (Specify in Abstract below and in Text, NRC Form 205A)
<input type="checkbox"/> 20.406(a)(1)(iii)	<input checked="" type="checkbox"/> 20.736(a)(2)(i)	<input type="checkbox"/> 20.736(a)(2)(vii)(A)	
<input type="checkbox"/> 20.406(a)(1)(iv)	<input type="checkbox"/> 20.736(a)(2)(ii)	<input type="checkbox"/> 20.736(a)(2)(vii)(B)	
<input type="checkbox"/> 20.406(a)(1)(v)	<input type="checkbox"/> 20.736(a)(2)(iii)	<input type="checkbox"/> 20.736(a)(2)(viii)	
<input type="checkbox"/> 20.406(a)(1)(vi)	<input type="checkbox"/> 20.736(a)(2)(iv)	<input type="checkbox"/> 20.736(a)(2)(ix)	

LICENSEE CONTACT FOR THIS LER (12): James Pelletier, Plant Manager
TELEPHONE NUMBER: 8 1 0 2 2 5 7 1 - 7 1 7 1 1

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC

SUPPLEMENTAL REPORT EXPECTED (14): YES (1) or NO (2)
YES (1) NO (2)

EXPECTED SUBMISSION DATE (15): MONTH DAY YEAR

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

ABSTRACT:

On July 28, 1988, during annual surveillance testing, the Cable Penetration Area Sprinkler system control valve (EIS Identifier = XCV) failed to automatically open upon receipt of a detector trip signal. A plant maintenance request (MR) was immediately initiated to correct the problem. The shift supervisor and operations supervisor review of this MR failed to recognize that the sprinkler system was out of service. Consequently, the Tech. Spec. Limiting condition for Operation associated with this out of service component was not recognized and therefore no fire watch was established.

This discrepancy was identified on August 2, 1988 during managements review of these surveillance results. Upon discovery, a fire watch was immediately established.

Two independent personnel errors (assessments) allowed Tech. Spec. equipment to be out of service without establishing the necessary Tech. Spec. fire watch.

This event was reviewed with all operating shifts with emphasis on responsibilities for determining equipment operability and equipment control.

This event occurred while the plant was operating under normal conditions at 100% power.

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NRC Form 2064
(4-83)

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104
EXPIRES 03-85

PLANT NAME (1) Vermont Yankee Nuclear Power Station	DOCKET NUMBER (2) 0 5 0 0 0 2 7 1	LER NUMBER (4)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		8 8	0 1 0	0 0	0 2	OF	0 3

TEXT IF MORE SPACE IS REQUIRED, use additional NRC Form 2064 (1/77)

DESCRIPTION OF EVENT:

On July 28, 1988 with the plant at 100% power, Vermont Yankee was performing annual surveillance testing of the plant fire protection sprinkler systems. The Cable Penetration Area system control valve failed to automatically operate upon receipt of a trip signal from the fire detection system. A Maintenance Request (MR) was generated to initiate repair. (The valve failure was evaluated separate from this LER and determined not reportable.)

Technical Specification 3.13.F.1 requires that this sprinkler system be operable. If this specification cannot be satisfied then Technical Specification 3.13.F.2 requires that an hourly fire watch shall be established within one hour.

The shift supervisor and the operations supervisor review of the MR failed to determine that the system was out of service. Consequently the Tech. Spec. LCO requirement was not identified and therefore the required fire watch was not established.

On August 2, 1988 at 1000 hours, managements review of these surveillance results revealed that a Tech. Spec. required fire watch had not been posted.

Upon this discovery, the required fire watch was immediately established in accordance with Tech. Spec. 3.13.F.2. During the period of time that the valve was inoperable in the automatic mode the fire detection system remained fully operable providing local and remote (control room) alarm capability.

CAUSE OF EVENT:

The root cause of this event was that, during the review of the MR, the shift supervisor and operations supervisor failed to determine that the sprinkler system was out of service as a result of the loss of the automatic trip function.

ANALYSIS OF EVENT:

Tech. Spec. section 3.13.F.2 states that from and after the date that one of the sprinkler systems specified in Table 3.13.F.1 is inoperable, a fire watch shall be established within one hour to inspect the location with the inoperable sprinkler system at least once every hour. This alternate action was not performed from July 28 to August 2, 1988.

During this period of time the fire detection system was operable. In the event of a fire, an alarm would be received in the control room and the fire brigade dispatched. The subject deluge valve, if needed, would have been manually operated and the sprinkler system initiated. Although this response would be delayed, relative to the automatic actuation of the system, an effective response to a fire in the affected areas was available.

This occurrence is determined to be an isolated incident.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

PLANT NAME (1) Vermont Yankee Nuclear Power Station	DOCKET NUMBER (2) 0 5 0 0 0 2 7 1	LER NUMBER (3)			PAGE (3)	
		YEAR 88	SEQUENTIAL NUMBER - 0 1 0	REVISION NUMBER - 0 0	OF	0 3

TEXT IF MORE THAN 2 PAGES, use additional NRC Form 2054 (11/77)

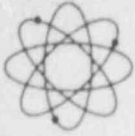
Based on the above information and since there was no need for a fire suppression response, it is determined that there was no potential adverse effects on the public health and safety as a result of this event.

CORRECTIVE ACTIONS:

This event was reviewed with all operating shifts emphasizing responsibilities of operations personnel in determining equipment operability and control.

ADDITIONAL INFORMATION:

No similar events have been reported to the commission in the last five years.



VERMONT YANKEE NUCLEAR POWER CORPORATION

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VERNON, VERMONT 05354

September 1, 1988
VYV 88-190

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

REFERENCE: Operating License DPR-28
Docket No. 50-271
Reportable Occurrence No. 88-10

Dear Sirs:

As defined by 10CFR50.73, we are reporting the attached Reportable Occurrence as LER 88-10.

Very truly yours,

VERMONT YANKEE NUCLEAR POWER CORPORATION

James P. Pelletier
Plant Manager

cc: Regional Administrator
USNRC Office of Inspection and Enforcement
Region I
475 Allendale Road
King of Prussia, PA 19406

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