NRC Form 366
(9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/85

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
DIABLO CANYON UNIT 2	0 5 0 0 0 3 2 3	1 OF 0 1 4

TITLE (4): PERSONNEL ERROR RESULTS IN FAILURE TO MEET THE LIMITING CONDITION FOR OPERATION OF TECHNICAL SPECIFICATION 3.7.9.3 FOR THE CABLE SPREADING ROOM CO2 SYSTEM

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 1	3 1	8 6	8 6	0 0 3	0 0	0 3	0 3	8 6		0 5 0 0 0
										0 5 0 0 0

OPERATING MODE (9)	5
POWER LEVEL (10)	0 0 0

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

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
RICHARD M. LUCKETT, REGULATORY COMPLIANCE ENGINEER	AREA CODE 8 0 5 5 9 5 - 7 3 5 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 January 31, 1986 and again on February 9, 1986, with Unit 2 in Mode 5 (Cold Shutdown), a roving fire watch discovered that the cable spreading room CO2 system had been taken out of service for maintenance activities without the posting of a continuous fire watch as required by Technical Specification 3.7.9.3.

The cause of the event was personnel error in that a construction worker and a maintenance worker on two separate occasions failed to comply with the administrative procedure for fire system impairment.

To prevent recurrence of this event, special training was conducted for construction personnel to reemphasize the importance of complying with the administrative procedure for fire system impairment and clearance requirements. A maintenance tailboard will be held with all applicable personnel. Procedures relating to the removal of the cable spreading room CO2 system from service will be reviewed and revised to include additional emphasis on the need to provide a continuous fire watch when the cable spreading room CO2 system is out of service.

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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
DIABLO CANYON UNIT 2	0 5 0 0 0 3 2 3	8 6	— 0 0 3	— 0 0	0 2 OF 0 4

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

I. Initial Conditions

The unit was in Mode 5 (Cold Shutdown), with the reactor coolant average temperature at approximately 133 degrees Fahrenheit and a pressure of approximately 18 psig.

II. Description of Event

A. Event

On January 31, 1986 and again on February 9, 1986, with Unit 2 in Mode 5, a roving fire watch discovered that the cable spreading room CO2 system (KQ) had been taken out of service for maintenance activities without the posting of a continuous fire watch as required by Technical Specification 3.7.9.3.

The cause of the event was personnel error. During maintenance activities, a construction worker and a maintenance worker on two separate occasions failed to comply with the administrative procedure for fire system impairment, NPAP C-113, "Fire System Impairment." This procedure requires that a continuous fire watch be posted while the CO2 system is out of service. In both cases, the workers, who also fulfilled the requirements for fire watch, left the cable spreading room without restoring the CO2 system to service or establishing a replacement continuous fire watch.

B. Inoperable structures, components, or systems that contributed to the event:

None

C. Dates and approximate times for major occurrences:

1. January 31, 1986 at 0830 PST: Event Date - Date and time cable spreading room CO2 system was out of service without a continuous fire watch.

2. January 31, 1986 at 1100 PST: Discovery Date - Date and time continuous fire watch was reestablished in cable spreading room.

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3. February 9, 1986 at 1058 PST: Second Event Date - Date and time cable spreading room CO2 system was out of service without a continuous fire watch.

4. February 9, 1986 at 1415 PST: Discovery Date of Second Event - Date and time continuous fire watch was reestablished in cable spreading room.

D. Other systems or secondary functions affected:

None

E. Method of discovery:

Both the January 31, 1986 and February 9, 1986 events were discovered by a roving fire watch during normal patrol.

F. Operator actions:

None

G. Safety systems responses:

None

III. Cause of Event

A. Immediate cause:

Failure to post a continuous fire watch while the cable spreading room CO2 system was out of service.

B. Root cause:

Inadequate information was provided to personnel regarding recent changes to fire watch practices. During construction phase activities, continuous fire watch teams were utilized in certain areas of the plant. However, this practice was discontinued following the completion of the construction phase activities. Presently, personnel involved with maintenance activities are required to provide their own continuous fire watches.

IV. Analysis of Event

The CO2 system is required to be operable whenever equipment protected by it is required to be operable. During this event, fire detection instruments required by Technical Specification 3.3.3.8 were operable and capable of alarming in the control room in case of a fire in the cable spreading room. The alarm would have allowed the site fire brigade, required by Technical Specification 6.2.2, to respond in an expeditious manner. Although the cable spreading room CO2 system was out of service, it could have been restored quickly to provide either a manual or an automatic discharge in the case of a fire. Thus, no safety consequences or implications would have resulted from this event.

V. Corrective Actions

A. Special training was conducted for construction personnel to reemphasize the importance of complying with administrative procedure NPAP C-113, "Fire System Impairment," and clearance requirements.

B. A maintenance tailboard will be held to emphasize to appropriate personnel the need to provide continuous fire watches when the cable spreading room CO2, "Fire System Impairment," system is removed from service.

C. Information on the fire system impairment requirements will be included in general employee training for new personnel.

D. Procedures relating to the removal of the cable spreading room CO2 system from service will be reviewed and revised to include additional emphasis on the need to provide a continuous fire watch when the cable spreading room CO2 system is out of service.

VI. Additional Information

A. Failed components:

None

B. Previous LERs on similar events:

None

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PACIFIC GAS AND ELECTRIC COMPANY

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JAMES D. SHIFFER
VICE PRESIDENT
NUCLEAR POWER GENERATION

March 3, 1986

PGandE Letter No.: DCL-86-053

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

Re: Docket No. 50-323, OL-DPR-82
Diablo Canyon Unit 2
Licensee Event Report 2-86-003-00
Personnel Error Resulted in Failure to Meet Limiting Condition for Operation of Technical Specification 3.7.9.3 for Cable Spreading Room CO_2 System

Gentlemen:

Pursuant to 10 CFR 50.73(a)(2)(i), PGandE is submitting the enclosed Licensee Event Report concerning a personnel error that resulted in a failure to meet the Limiting Condition for Operation of Technical Specification 3.7.9.3 for the cable spreading room CO_2 system.

This event has in no way affected the public's health and safety.

Kindly acknowledge receipt of this material on the enclosed copy of this letter and return it in the enclosed addressed envelope.

Sincerely,

Enclosure

cc: L. J. Chandler
R. T. Dodds
J. B. Martin
B. Norton
H. E. Schierling
CPUC
Diablo Distribution
INPO

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