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)
Inoperable Fire Suppression System Due to Personnel Error

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	0 5	8 7	8 7	—	0 1 3	— 0 1	0 6	3 0	8 8		0 5 0 0 0

OPERATING MODE (9)	6	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)			
POWER LEVEL (10)	0 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
Bruce R. Danielson, Instrumentation and Controls Supervisor	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)

On August 5, 1987, at approximately 1600, with the plant shutdown in mode 6, an Instrument and Control (I&C) Specialist entered the containment penetration cable vault. Upon entering, the I&C Specialist called the control room to request the disabling of the cable vault fire suppression system, and then assumed the fire watch in accordance with the applicable procedure. Upon completion of his work, the I&C Specialist left the cable vault but failed to notify the control room so that the fire suppression system could be reactivated as required by the procedure. At 1915 it was noted by plant operators that the cable vault was not attended by a fire watch. The fire suppression system was immediately reenabled.

The cause of the event was personnel error. The individual involved knew the requirements, but failed to meet them.

Corrective action involved couseling of the individual, review of the incident with department personnel, and new signs posted at the cable vault door to remind personnel of the Technical Specification fire protection requirements in the area.

This event is reportable per 10CFR50.73(a)(2)(i) since it involved a deviation from Technical Specifications. This supplemental report has been issued to revise the safety assessment section so that it is consistent with the Appendix R safe shutdown analysis.

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

BACKGROUND INFORMATION

The containment penetration cable vault fire suppression system is a CO2 system that is automatically discharged when triggered by any one of four smoke detectors.

The system is required to be operable by Technical Specification 3.22.B.

EVENT DESCRIPTION

On August 5, 1987, at approximately 1600, an Instrument and Control (I&C) Specialist entered the containment penetration cable vault area to work on a plant modification.

At this time the plant was shut down for refueling in mode six.

The plant procedure for cable vault entry requires, for industrial safety reasons, that the fire suppression system be disabled and a fire watch set when personnel are working in the cable vault.

Upon entering the cable vault, the I&C Specialist called the control room to have the system disabled. The control room dispatched an operator to the cable vault where he disabled the fire suppression system. The I&C Specialist was a qualified fire watch, and therefore assumed the responsibility of the fire watch per procedure.

At approximately 1700, the I&C Specialist left the cable vault but failed to call the control room to have the fire suppression system activated. At approximately 1915, the operator who originally disabled the system went to check on the cable vault. He recognized that the fire watch was not stationed and immediately reenabled the fire suppression system. He then notified the control room.

This event left the cable vault without automatic fire suppression or a fire watch for approximately 2-1/2 hours in violation of Technical Specification 3.22.B.

CAUSE OF THE EVENT

The cause of this event was human error. The I&C Specialist knew by procedure that he was supposed to call the control room when his work was complete so that the automatic fire suppression system could be reenabled, but failed to do so.

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

CORRECTIVE ACTION

The I&C Specialist involved in this event has been counseled on his responsibilities concerning fire protection.

Additionally, in order to increase personnel awareness of fire protection requirements, this event has been discussed at I&C Department meetings. All I&C Specialists have been reminded of their responsibilities to adhere to station procedures.

Finally, since this event involved human factors considerations, an additional corrective measure was taken to address this problem. Signs were posted at the Cable Vault access to remind personnel of the Technical Specification fire protection requirements.

SAFETY ASSESSMENT

Technical Specification 3.22.B requires that the containment cable vault CO2 system be operable or a continuous fire watch with backup protection be established. Since the CO2 system was found inoperable without an established fire watch, this event is reportable per 10CFR50.73(a)(2)(i).

This event occurred while the plant was in mode 6 (refueling). No fire events occurred in this area during the time the condition existed. As such, there was no safety significance to this event.

If a fire occurred at power while the CO2 system was not in the automatic mode, the potential existed for damage to safety related cabling in this area. Depending on the extent of fire damage, there could have been a significant impact on the ability to bring the plant to a shutdown condition. The current Appendix R shutdown scenario for this area relies on the automatic operating CO2 system to minimize fire damage to instrumentation cables.

During the period the CO2 system was in the manual mode, the area detection system was operable. The detection system would have provided early warning of any fire condition to the control room and prompted the rapid response of the plant fire brigade to any fire occurring in this area. The combustible loading in this area consists of electrical cable insulation which typically presents only a slow developing or smouldering type fire potential. As such, the fire brigade response or manual operator action to initiate the discharge of the CO2 system would have reduced the damage potential significantly.

During this event, the interim compensatory fire watch was conducting 20 minute fire watch patrols of this area. This action served to further reduce the probability of a damaging fire occurring in this area.

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This assessment concludes that there was an increased risk to public safety as a result of this event based on the fire protection system operating requirements for satisfying Appendix R. However, the compensating features of the operable detection system, slow developing fire potential, manual operating status of the area suppression system and the fire watch patrol combine to produce a low probability that a damaging fire could have occurred as a result of this event. 1

ADDITIONAL INFORMATION

None.

PREVIOUS SIMILAR EVENTS

None.

REASON FOR REVISION

To revise the safety assessment section so that it is consistent with Connecticut Yankee's Appendix R safe shutdown analysis. 1

CONNECTICUT YANKEE ATOMIC POWER COMPANY

HADDAM NECK PLANT

RR#1 • BOX 127E • EAST HAMPTON, CT 06424-9341

June 30, 1988
Re: 10CFR50.73(a)(2)(i)

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 50-213/87-013-01

Gentlemen:

This letter forwards the Licensee Event Report 87-013-01, required to be submitted, pursuant to the requirements of Connecticut Yankee Technical Specifications.

Very truly yours,

Donald B. Miller, Jr.
Station Superintendent

DBM:REB/dlf

Attachment: LER 87-013-01

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

J. T. Shedlosky
Sr. Resident Inspector
Haddam Neck

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