PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE PNO-I-99-004

This preliminary notification constitutes EARLY notice of events of POSSIBLE safety or public interest significance. The information is as initially received without verification or evaluation, and is basically all that is known by Region I staff in King of Prussia, Pennsylvania on this date.

Facility
Northeast Utilities
Millstone 3
Waterford, Connecticut
Dockets: 50-423

Licensee Emergency Classification
Notification of Unusual Event
Alert
Site Area Emergency
General Emergency
X Not Applicable

Subject: CARBON DIOXIDE DISCHARGE INTO CABLE SPREADING ROOM

At about 6:00 p.m. on January 15, 1999, carbon dioxide (CO_2) was inadvertently discharged into the Unit 3 cable spreading room, which is a large room that contains electrical wiring. CO_2 is a gas used to suppress electrical fires in nuclear power plants. A plant equipment operator (PEO) who was doing on-the-job training preparations opened the control panel for this system. While inspecting the panel, the PEO blew on a circuit board to remove some dust, which activated the CO_2 system. The PEO immediately notified the control room, and an operator was dispatched to isolate the system. Before the system could be isolated, CO_2 was discharged into the cable spreading room for about 2 - 3 minutes.

At about 7:00 p.m., CO_2 was detected in several adjacent spaces inside the plant (northwest stairwell, and east and west switchgear rooms). General plant personnel access to these areas was restricted, and only personnel wearing self-contained breathing apparatus (SCBA) were allowed in these areas when necessary. Over the next 2 hours, operators began to ventilate these areas of the plant to remove the CO_2. However, at about 9:30 p.m., CO_2 was detected in the control room. By procedure, control room personnel donned SCBAs until 4:30 a.m. on January 16, when CO_2 levels dropped to an acceptable level. By about 5 p.m. that day normal access was restored to these areas in the plant. The plant operated at full power during the entire period. The offsite fire department was notified of this occurrence and was in a standby mode. An ambulance reported to the site as a precautionary measure.

Subsequent testing of the CO_2 system circuit board found it to be faulty; blowing on the circuit board should not have activated the CO_2 system. The circuit board was replaced and the CO_2 tank was refilled. Region 1 received initial notification of this occurrence by a telephone call from Unit 3 operations personnel at 7:05 p.m. on January 15, 1999. The information presented herein has been discussed with the licensee and is current as of 10:00 a.m. on January 20, 1999.

The licensee has assembled an event review team to investigate this occurrence. The State of Connecticut was informed of this event. The licensee is not planning to issue a press release. The resident inspectors are following licensee actions.

Contact: DURR, JACQUE (610)337-5224
LANNING, WAYNE (610)337-5126

IE34
011