NRC FORM 366
(7-77)

U.S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

CONTROL BLOCK: | | | | | | | (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0 1 | F L T P S 3 (2) LICENSEE CODE | 0 0 - 0 0 0 0 0 - 0 0 (3) LICENSE NUMBER | 4 1 1 1 1 (4) LICENSE TYPE | (5) CAT

CON'T 0 1 | REPORT SOURCE L (6) | 0 5 0 0 0 2 5 0 (7) DOCKET NUMBER | 0 2 2 9 8 0 (8) EVENT DATE | 0 3 3 1 8 0 (9) REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 A review of Maintenance Procedure 15537.2 by QC personnel to verify

0 3 TS 4.15.3.a compliance revealed that a fire hose station was not fully

0 4 operable as required by TS 3.14.3.a, in that the installed fire hose

0 5 was 25 ft. too short. Due to a misunderstanding of what constituted

0 6 operability, the hose station remained inoperable for 4 months. During

0 7 the period that hose station HS-AB-02 was inoperable, backup equipment

0 8 was available at nearby stations for emergency response.

0 9 | SYSTEM CODE: A B (11) | CAUSE CODE: A (12) | CAUSE SUBCODE: C (13) | COMPONENT CODE: X X X X X X (14) | COMP. SUBCODE: Z (15) | VALVE SUBCODE: Z (16)

(17) LER/RO REPORT NUMBER | EVENT YEAR: 8 0 | — | SEQUENTIAL REPORT NO.: 0 0 5 | / | OCCURRENCE CODE: 0 3 | REPORT TYPE: L | — | REVISION NO.: 0

ACTION TAKEN: C (18) | FUTURE ACTION: H (19) | EFFECT ON PLANT: Z (20) | SHUTDOWN METHOD: Z (21) | HOURS (22): 0 0 0 0 | ATTACHMENT SUBMITTED: Y (23) | NPRD-4 FORM SUB.: N (24) | PRIME COMP. SUPPLIER: L (25) | COMPONENT MANUFACTURER: X 9 9 9 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The fire hose station inoperability was due to (1) a misunderstanding of

1 1 what constitutes operability, (2) lack of understanding of the action

1 2 required if a Limiting Condition of Operation is not met, and (3)

1 3 failure of administrative controls which require both strict compliance

1 4 to procedures and independent review of surveillance results.

1 5 | FACILITY STATUS: E (28) | % POWER: 1 0 0 (29) | OTHER STATUS (30): NA | METHOD OF DISCOVERY: B (31) | DISCOVERY DESCRIPTION (32): Quality Control Surveillance

1 6 | ACTIVITY RELEASED: Z (33) | CONTENT OF RELEASE: Z (34) | AMOUNT OF ACTIVITY (35): NA | LOCATION OF RELEASE (36): NA

PERSONNEL EXPOSURES

1 7 | NUMBER: 0 0 0 (37) | TYPE: Z (38) | DESCRIPTION (39): NA

PERSONNEL INJURIES

1 8 | NUMBER: 0 0 0 (40) | DESCRIPTION (41): NA

LOSS OF OR DAMAGE TO FACILITY (43)

1 9 | TYPE: Z (42) | DESCRIPTION: NA

PUBLICITY

2 0 | ISSUED: N (44) | DESCRIPTION (45): NA | NRC USE ONLY

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Additional Cause Description and Corrective Actions:

The fire hose station inoperability was due to (1) a misunderstanding of what constitutes Operability, (2) lack of understanding of the action required if a Limiting Condition of Operation is not met, and (3) failure of administrative controls which require both strict compliance to procedures and independent review of surveillance results.

Maintenance Procedure 15537.2 incorporates the requirements of TS 4.15.3.a, the property insurance underwriter, and the preventive maintenance program. Hose station HS-AB-02 is atypical in that it should have been fitted with an extra length of hose to reach remote areas of the Auxiliary Building. The need for the additional hose length to reach safety related equipment was identified by the licensee in our report, "Fire Protection - A Re-evaluation of Existing Design Features and Administrative Controls," which was transmitted by letter dated February 25, 1977 (L-77-57). Through an oversight, the additional length of hose and a new hose reel were not installed. However, MP 15537.2 was revised to require the proper length of fire hose at this location.

The Fire Marshall had noted the deviation on the surveillance procedure, and had ordered the equipment necessary to properly equip the fire hose station. He, however, was not aware of the timely response required by the "Action Statement" in the event a Limiting Condition of Operation associated with the fire hose stations could not be met.

The deviation noted in the completed copy of the procedure was overlooked during review of surveillance results by the On-Site Fire Protection Coordinator. However, a third review (required in the procedure) by QC personnel detected the deviation, and corrective action was initiated.

A review of previously completed copies of the procedure disclosed similar instances of deviations that had not been corrected.

The corrective action will include revision of MP 15537.2 to require notification of the on-shift Nuclear Plant Supervisor should any fire protection system/component (required by Technical Specifications) be found in a condition other than specified by the procedure.