



Northeast
Nuclear Energy

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Millstone Nuclear Power Station
Northeast Nuclear Energy Company
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The Northeast Utilities System
Donald B. Miller Jr.,
Senior Vice President - Millstone

Re: 10CFR50.73(a)(2)(i)

November 16, 1994
MP-94-638

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

Reference: Facility Operating License No. DPR-65
Docket No. 50-336
Licensee Event Report 94-031-00

This letter forwards Licensee Event Report 94-031-00 required to be submitted within thirty (30) days for a condition prohibited by the Plant's Technical Specifications.

Very truly yours,

NORTHEAST NUCLEAR ENERGY COMPANY

Donald B. Miller, Jr.
Senior Vice President - Millstone Station

DBM/RAG:lfg

Attachment: LER 94-031-00

cc: T. T. Martin, Region I Administrator
P. D. Swetland, Senior Resident Inspector, Millstone Unit Nos. 1, 2, and 3
G. S. Vissing, NRC Project Manager, Millstone Unit No. 2

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LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (MNBB 7714), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1)

Millstone Nuclear Power Station Unit 2

DOCKET NUMBER (2)

05000336

PAGE (3)

1 OF 2

TITLE (4)

Fire Watch Not Established

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 NAME	DOCKET NUMBER
10	18	94	94	031	00	11	16	94		05000
										05000

OPERATING
MODE (9)

6

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

POWER
LEVEL (10)

000

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)(vi)

OTHER

20.405(a)(1)(iii)

X

50.73(a)(2)(i)

50.73(a)(2)(vii)(A)

(Specify in Abstract
below and in Text, NRC
Form 366A)

20.405(a)(1)(iv)

50.73(a)(2)(ii)

50.73(a)(2)(vii)(B)

20.405(a)(1)(v)

50.73(a)(2)(iii)

50.73(a)(2)(ix)

LICENSEE CONTACT FOR THIS LER (12)

NAME

Philip J. Lutzi, Nuclear Licensing

TELEPHONE NUMBER (Include Area Code)

(203) 440-2072

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPDOS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPDOS

SUPPLEMENTAL REPORT EXPECTED (14)

YES

(If yes, complete EXPECTED SUBMISSION DATE)

X

NO

EXPECTED
SUBMISSION
DATE (15)

MONTH

DAY

YEAR

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

On October 18, 1994, at 2100 hours, with the plant in mode 6, a fire watch was not established within the A Diesel Generator room for a period of five hours. The fire watch was required to compensate for two fire doors blocked open to facilitate exhaust ventilation for welding. Upon discovery by Operations, Technical Specification Action Statement 3.7.10.a.2 was entered and a fire watch was established in the A Diesel Generator room.

Welding in the adjacent Enclosure Building Filtration System (EBFS) area was then secured, the ventilation removed, the doors shut and the Technical Specification Action Statement was exited.

EXPIRES: 5/31/95

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (MNEB 7714), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1)

DOCKET NUMBER (2)

LER NUMBER (6)

PAGE (3)

Millstone Nuclear Power Station
Unit 2

05000336

YEAR

SEQUENTIAL
NUMBERREVISION
NUMBER

94

— 031 —

00

02 OF 02

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

I. Description of Event

While in Mode 6 on October 18, 1994, at 2100 hours, Fire/Security door providing access to A Emergency Diesel Generator Room and Fire/Security door between the A and B Emergency Diesel Generator Rooms were found blocked open to facilitate exhaust ventilation for welding in the adjacent Enclosure Building Filtration System (EBFS) Equipment room area. Security personnel had devitalized the doors and remained posted at each door but had not informed the Control Room Shift Supervisor.

Immediately upon discovery, Technical Specification Action Statement (TSAS) 3.7.10.a.2 was entered and a fire watch was established. Welding activity was then secured, the ventilation through each door was removed, the doors were closed and areas revitalized. The Technical Specification Action Statement was then exited. There were no automatic or manually initiated safety systems actuated as a result of this event.

II. Cause of Event

The root cause of the event is personnel error. The Security officers did not comply with Security Procedure to notify Control Room personnel whenever a fire door is put in an access mode.

III. Analysis of Event

This event is being reported pursuant to the requirements of 50.73(a)(2)(i)(B) "any operation or condition prohibited by the plants Technical Specifications." The A Diesel Generator room fire doors were inoperable and fire watch personnel had not been stationed for a period of approximately 5 hours. During this period of time, there were no challenges to the A Diesel Generator enclosure.

The safety significance of this event was minimal. Security personnel were posted at the blocked doors for the purpose of security during this time period and would have been available to initiate action in the event of a fire.

IV. Corrective Action

Immediate corrective action was to establish a continuous fire watch at the blocked open doors. Following this action, the welding was stopped, the exhaust ventilation was removed from the doorway and the doors were closed and vitalized.

The Security Supervisor who failed to contact Control Room personnel was disciplined. All other Security Supervisors were briefed on this event and the impact of such events on Station Operation.

V. Additional Information

There were no failed components as a result of this event.

Similar LERS: None