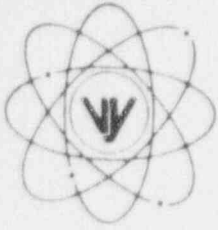


VERMONT YANKEE NUCLEAR POWER CORPORATION



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Vernon, Vermont 05354-0157
(802) 257-7711

December 18, 1996
BVY 96-164

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

Reference: (a) License No. DPR-28 (Docket No. 50-271)

Subject: Reportable Occurrence No. LER 96-007, Supplement 1

As defined by 10CFR50.73, we are reporting the attached Reportable Occurrence as LER 96-007, Supplement 1.

Sincerely,

VERMONT YANKEE NUCLEAR POWER CORPORATION

Robert J. Wanczyk
Plant Manager

c: USNRC Region 1 Administrator
USNRC Resident Inspector - VYNPS
USNRC Project Manager - VYNPS

Handwritten: 12/22

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NRC Form 366 (4-95) U.S. NUCLEAR REGULATORY COMMISSION LICENSEE EVENT REPORT (LER)				APPROVED BY OMB NO. 3150-0104 EXPIRES 04/30/98 ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS MANDATORY INFORMATION COLLECTION REQUEST: 50.0 HRS. REPORTED LESSONS LEARNED ARE INCORPORATED INTO THE LICENSING PROCESS AND FED BACK TO INDUSTRY. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (T-6 F33), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20566-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.							
FACILITY NAME (1) VERMONT YANKEE NUCLEAR POWER STATION						DOCKET NUMBER () 05000271		PAGE (3) 01 OF 03			
TITLE (4) Vital Fire Dampers not Installed In Accordance with Manufacturers Instructions											
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 NO. (5)	
03	04	96	96	-- 007 --	01	12	18	96	N/A	05000	
OPERATING MODE (9)		N		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: CHECK ONE OR MORE (11)							
				20.2201(b)		20.2203(a)(2)(v)		50.73(a)(2)(i)		50.73(a)(2)(viii)	
POWER LEVEL (10)		100		20.2203(a)(1)		20.2203(a)(3)(i)		X 50.73(a)(2)(ii)		50.73(a)(2)(x)	
				20.2203(a)(2)(i)		20.2203(a)(3)(ii)		50.73(a)(2)(iii)		73.71	
				20.2203(a)(2)(ii)		20.2203(a)(4)		50.73(a)(2)(iv)		OTHER	
				20.2203(a)(2)(iii)		50.36(c)(1)		50.73(a)(2)(v)		(Specify in Abstract below or in NRC Form 366A)	
				20.2203(a)(2)(iv)		50.36(c)(2)		50.73(a)(2)(vii)			
LICENSEE CONTACT FOR THIS LER (12)											
NAME ROBERT J. WANCZYK, PLANT MANAGER								TELEPHONE NO. (Include Area Code) 802-257-7711			
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
NA					.....	NA				
NA					.....	NA				
SUPPLEMENTAL REPORT EXPECTED (14)						EXPECTED SUBMISSION DATE (15)		MO	DAY	YEAR	
YES (If yes, complete EXPECTED SUBMISSION DATE)				X	NO						

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

On 3/4/96, with the plant at 100% power, upon completion of a self-assessment of all vital fire dampers, it was determined that eleven vital fire dampers were potentially inoperable as they were not installed in accordance with the manufacturers instructions.

These dampers, installed as a requirement of either Vermont Yankee (VY) Technical Specifications (TS), Appendix R to 10CFR50, or other license requirements, function to limit the spread of fire and hot gases through various plant fire barriers. Although inoperable per the TS definition, the installation variances were minor and the dampers most probably would have closed and restricted the spread of any fires or hot gasses.

Immediate corrective actions placed qualified fire watches in the areas with the inoperable dampers or required hourly fire watch rounds in the affected areas. Long term corrective action repaired or replaced seven of the dampers and four dampers were evaluated as acceptable as-is. All dampers were returned to an operable status. This was completed by 10/18/96.

The root cause of this event is a personnel error in that there was a failure to follow the installation procedure and install the dampers in accordance with the manufacturers instructions.

During the time period that the dampers were inoperable, no fires or conditions occurred that required the dampers to function and therefore there was no danger to the health and safety of the public.

NRC Form 366 U.S. NUCLEAR REGULATORY COMMISSION (4-95)		APPROVED BY OMB NO. 3150-0104 EXPIRES 04/30/98 ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS MANDATORY INFORMATION COLLECTION REQUEST: 50.0 HRS. REPORTED LESSONS LEARNED ARE INCORPORATED INTO THE LICENSING PROCESS AND FED BACK TO INDUSTRY. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (T-6 F33), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20566-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.			
LICENSEE EVENT REPORT (LER)					
FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
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TEXT (If more space is required, use additional copies of NRC Form 366A) (17)

DESCRIPTION OF EVENT

On 3/4/96, with the plant at 100% power, it was determined that eleven vital fire dampers (EIS = BDMP) were not installed in accordance with the manufacturers instructions and were therefore considered inoperable. The installation instructions, which are supported by a fire test, must be followed to provide the required fire barrier. This determination was made following the completion of a self-assessment to determine compliance to the installation requirements. Subsequent to this determination, qualified fire watches were established in the affected areas.

Of the eleven inoperable fire dampers, six of these are installed as a requirement of Technical Specifications (TS), one is installed as a requirement of 10CFR50 Appendix R, and four are installed as a requirement of upgrades performed to meet the requirements of Branch Technical Position 9.5-1. These fire dampers are designed to function automatically and limit the spread of fire and hot gases through various plant fire barriers.

CAUSE OF EVENT

The root cause of this event is a personnel error. Personnel installing the dampers failed to follow the installation procedure to install the dampers in accordance with the manufacturers instructions. Due to the age of this event (Approximately 17 years), it was not possible to determine why the manufacturer instructions were not followed.

Contributing causes included a lack of programmatic oversight, a lack of an independent review of the installation and the culture during the time of the installation that assumed that fire protection features were "field oriented" and as-built to suit the field conditions.

ANALYSIS OF EVENT

The automatic fire area dampers are provided as a means to isolate areas so that fires are prevented from propagating from one area to another.

The degraded fire dampers are located in the fire barriers for the Main Control Room, the West Switchgear Room, the East Switchgear Room, the Turbine Lube Oil Room and the High Pressure Coolant Injection System Room.

Each area that has inoperative fire dampers has a fire detection system and three of the five areas are protected by fire suppression systems. The Control Room has a fire detection system and is manned twenty-four hours a day. The East and West Switchgear Rooms have fire detectors and a CO2 System which when actuated would electrically actuate the fire dampers. The Turbine Lube Oil room has a detection system and is protected by an automatic pre-action sprinkler system. The HPCI room has a fire detection system and limited combustible material. Additionally the plant has a trained fire brigade on staff twenty-four hours a day which responds as required to alarms. Compensatory fire watches, required by this event, also enhance the ability for early fire detection and suppression.

If a fire had or were to occur with the fire dampers inoperable, the detection systems would actuate and activate alarms in the Control Room and alert the operators to initiate a fire brigade response to suppress the fire. Additionally, if required, the installed fire suppression systems would actuate automatically to suppress the fire. Plant procedures also direct the operators to review the Safe Shutdown Analysis for any area affected by the fire to evaluate the potential impact on safe shutdown equipment and take appropriate actions which could include plant shutdown. Operations Standing Order #17 also provides guidance for the operators when dealing with fires in areas of concern to Appendix R.

Although potentially inoperable per the TS definition, the dampers most probably would have closed and restricted the spread of any fires or hot gasses.

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

With early detection of a fire by the detection systems, a rapid response by the fire brigade, the installed suppression systems, and procedural requirements to review the Safe Shutdown Analysis and with Operations Standing Order # 17, there would be minimum impact on the facility with no safety consequences resulting from this event.

At no time was there any danger to the health and safety of the public .

CORRECTIVE ACTIONS

Immediate Corrective Actions

- 1) Fire Control Permits were written or upgraded for the areas affected by the inoperable dampers.
- 2) Compensatory fire protection actions were taken that stationed qualified fire watches in the affected areas or required hourly rounds by fire watches.
- 3) The Plant Fire Protection Coordinator completed a walkdown to ensure that the compensatory fire watches were implemented effectively.

Long Term Corrective Actions

- 1) Of the eleven dampers in question, seven were repaired or replaced and four were evaluated in accordance with Generic Letter 86-10 and deemed to be acceptable as-is. All dampers were returned to operable status. This work was completed by 10/18/96.
- 2) Corrective Actions for the contributing causes were previously identified through VY's corrective action process and addressed as part of that process.

ADDITIONAL INFORMATION

During the past five years similar events involving unqualified fire barrier components have been reported as LER's 93-01, 94-18, and 95-04.