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RECIP.NAME RECIPIENT AFFILIATION

SUBJECT: LER 87-022-00:on 871112,latches on two fire doors made inoperable due to inadequacies in procedure & training.

DISTRIBUTION CODE: IE22D COPIES RECEIVED:LTR 1 ENCL 1 SIZE: 4
TITLE: 50.73 Licensee Event Report (LER), Incident Rpt, etc.

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NRC Form 366
(9-83)

U.S. NUCLEAR REGULATORY COMMISSION
Approved OMB NO. 3150-0104
Expires 8/31/85

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Monticello	0 5 0 0 0 2 6 3	1 OF 0 3

TITLE (4)
Latches on Two Fire Doors Made Inoperable Due to Inadequacies in a Procedure and Training

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 NUMBERS
										0 5 0 0 0
1 1	1 2	8 7	8 7	- 0 2 2	- 0 0	1 2	1 4	8 7		0 5 0 0 0

OPERATING MODE (9)	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	N 20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)
	20.405(a)(1)(i)	50.38(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
	20.405(a)(1)(iii)	X 50.73(a)(2)(i)	50.73(a)(2)(viii)(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)(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
Oliver N. Iverson, Sr. Production Engineer	6 1 2 2 9 5 - 5 1 5 1

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 typwritten lines) (16)

During plant inspections, two fire doors located in Appendix R fire barriers were found inoperable due to latches held open with tape. These fire doors are required to be operable per Tech. Spec. 3.13.G.1. Upon discovery, the tape was removed and the doors made operable.

The root cause of these two events was determined to be inadequacies in a procedure and training. One of the latches was taped open to prevent the door from locking, while performing a radiation protection procedure which required this door to be unlocked in preparation for the refueling outage. The other door is believed to have been taped by construction personnel who were not aware that taping the latch open makes the fire door inoperable.

The radiation protection procedure will be revised to instruct personnel not to tape open the door latches. The training program will be upgraded to provide training on what will make a fire door inoperable. Also, the Daily Fire Door Inspection procedure will be revised to provide a more thorough daily inspection.

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

DESCRIPTION

While making a plant inspection on November 12, 1987, during a refueling outage, the Plant Manager found a latch taped open on fire door #18 (DR) providing access to the condenser room. This taping allowed the door to close, but prevented the latch from engaging the strike plate. This door is located in an Appendix R fire barrier which is required to be operable per Tech. Spec. 3.13.G.1. Another fire door with a taped latch was discovered on December 1, 1987, during a refueling outage by the NRC Senior Resident Inspector. This door (#42) provides access to the Torus Area and is also located in an Appendix R barrier. Upon discovery of these taped latches, the tape was removed and the doors were returned to operable status.

CAUSE

An investigation was conducted to determine the cause of the latch taping. In the case of door #18, it was determined that a Radiation Protection Specialist had taped the latch at the beginning of the refueling outage when performing Procedure R.1.4, "Outage Temporary Extended RWP Revisions". As part of this procedure, various doors are unlocked which are normally locked during power operation. The door was unlocked by taping the latch open. Door #42 is believed to have been taped by construction personnel who were not aware that taping the latch open makes the door inoperable. The root causes of these two events was determined to be inadequacies in a procedure and training.

ANALYSIS

The two door latches are believed to have been taped open during the current refueling outage and were discovered during the outage. Door latch #18 was taped on Oct. 22, 1987, the first day of the outage, and existed until Nov. 12, 1987, when discovered. Door latch #42 taping cannot be determined but is believed to have been done during the outage when there was extensive construction activities.

The period while the fire doors were inoperable did not have any effect on safety because the shutdown equipment these doors protect was not required to be operable. This event could have occurred under worse conditions such as power operation. However, it is unlikely this would happen because the activities that lead to the latch taping do not normally occur during power operation. Also, the fire loading in the area of the doors is minimal and the doors do close with the latches taped open. Therefore, there was no effect on public health and safety during this event.

CORRECTIVE ACTIONS

Procedure R.1.4 will be revised to require that any fire doors that are unlocked be left in a closed and latched condition. The training program will be upgraded to provide training on what will make a fire door inoperable. The fact that taping the latch open disables the fire door is a subtle point that is not recognized by most

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

people (NFPA 80-1983 Chapter 14 - 1.2 requires that fire doors "be kept closed and latched or arranged for automatic closing"). Also, the Fire Door Daily Inspection procedure will be revised to require that the operator check the latch on each fire door by attempting to pull the door open in addition to the present visual inspection which verifies the door is closed.

A Tech. Spec. amendment has been submitted to the NRC on March 31, 1986 which proposes that "All penetration fire barriers in fire area boundaries shall be operable whenever safe shutdown equipment in that fire area is required to be operable." These two events would not be reportable under the proposed amendment.

ADDITIONAL INFORMATION

No previous similar reportable events have occurred.

Northern States Power Company

414 Nicollet Mall
Minneapolis, Minnesota 55401
Telephone (612) 330-5500

December 14, 1987

Report Required by
10 CFR Part 50, Section 50.73

US Nuclear Regulatory Commission
Attn: Document Control Desk
Washington DC 20555

MONTICELLO NUCLEAR GENERATING PLANT
Docket No. 50-263 License No. DPR-22

Latches on Two Fire Doors Made Inoperable Due to Inadequacies in a Procedure and Training

The Licensee Event Report for this occurence is attached.

Monica Vick
for David Musolf
Manager - Nuclear Support Services

c: Regional Administrator-III, NRC
NRR Project Manager, NRC
Resident Inspector, NRC
MPCA
Attn: J W Ferman

Attachment

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