

Commonwealth Edison Zion Generating Station 101 Shiloh Blvd. Zion, Illinois 60099 Telephone 312/746-2084

October 12, 1989

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

Dear Sir:

The enclosed Licensee Event Report number 89-014-00, Docket No. 50-295/DPR-39 from Zion Generating Station is being transmitted to you in accordance with the requirements of 10CFR50.73(a)(2)(i)(B), which requires a 30 day written report when any operation or condition is prohibited by the plant's Technical Specifications.

Very truly yours,

W.R. Kuch

2 T. P. Joyce Station Manager Zion Generating Station

GJP/sdd

Enclosure: Licensee Event Report

cc: NRC Region 111 Administrator NRC Resident Inspector INFO Record Center CECo Distribution List

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On 9-12-89 at 1115 hours, an operator found the Unit 1 inner cable spreading room fire door propped open and the U-1 outer cable spreading room fire door ajar without a fire watch present. The doors were closed and focked upon discovery.

It was determined that contractors working in the eres had opened the doors to facilitate installation of tables the unit was in midn 6. Cole Shutmown, at the start of a refueling outage.

The safety significance was minimal because the unit was in cold shutdown and the fire detectors in both nable spreading rooms were operable. The Halon and Cardox Systems were also operable throughout the event.

Contracto: personnel at the foreman and creft latel are instructed on the requiransots and actions necessary to block open a fire door in a new program called Non-Station Sersonnel orientation. Engineering and Construction Department provides the training.

	LICENSEE EVENT REPORT (LER)	TEXT CONTI	NUAT	ON			For	m Rey	1 2.		
FACILITY NAME (1)	DOCKET NUMBER (2)	LER N	LER NUMBER (6)						Page (3)		
		Year	11/1	Sequential Number	11/1	Revision Number					
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A. CONDITION PRIOR TO EVENT

B. DESCRIPTION OF EVENT

On 9-12-89 at 1115 hours, a "B" Operator found the U-1 inner cable spreading room fire door propped open during routine rounds. The U-1 outer cable spreading room door was found unlocked and ajar. No firewatch was present and no workers could be found in the area. The "B" Operator notified his supervisor and was instructed to close and lock both doors.

C. APPARENT CAUSE OF EVENT

Contractor personnel were pulling cable in the cable spreading rooms. The doors were apparently opened for their convenience. The contractors were not aware of the significance of blocking open a fire door and ignored a warning posted on each door.

D. ANALYSIS OF THE EVENT

Zion Station had begun a refueling outage on Unit 1. The unit was in Mode 5, cold shutdown, preparing for Mode 6, refueling. The stairwell, from which the doors lead to the cable spreading rooms, is frequented by the operators during their shift rounds and activities. This would indicate with some certainty that the doors were opened on the same shift that they were discovered. In addition all fire detectors in both cable spreading rooms remained operable. Both cable spreading rooms are protected by an automatic halon suppression system and a manual Cardox suppression system. Upon actuation of the halon system, an alarm in the control room will alert Operating personnel. Upon receiving the alarm, the Shift Supervisor will dispatch an operator to the area. The operator would discover and close the doors. If the halon system was not capable of extinguishing a fire because of the open doors, then the manual Cardox system could be actuated by the operator.

Based on the above conditions, the health and safety of the general public was not compromised.

E. CORRECTIVE ACTIONS

The fire doors for both cable spreading rooms were closed and looked upon discovery of the event.

Regulatory Assurance venified that contractor personnel and trained via the Nuclear General Employee Training (N-GET) program to properly operato firm sours.

Contractor personnel are now bying instructed on the requirements and actions necessary to block open a fire door. The Non-Station Personnel crientation program commenced in early September, 1989. The program provides adequate instructions and information und augments the N-GET program.

F. PREVIOUS EVENTS

There have been several occurrences since 1985 of fire doors being opened without the proper fire watch posted. The corrective actions taken for those events would not have prevented this personnel error event.

G. COMPONENT FAILURE DATA

None