Northern States Power Company

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February 13, 1992

10 CFR Part 50
Section 50.73

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

PRAIRIE ISLAND NUCLEAR GENERATING PLANT
Docket Nos. 50-282 License Nos. DPR-42
50-306 DPR-60

Fire Door Left Open As Result Of Personnel Error

The Licensee Event Report for this occurrence is attached.

Please contact us if you require adultional information related to this event.

for Thomas M Parker
Manager - Nuclear Support Services

c: Regional Administrator - Region III, NRC
NRR Project Manager, NRC
Senior Resident Inspector, NRC
MPCA
Attn: Dr Raymond Thron

Attachment

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NRC FORM 366 (6.89) U.S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT (LER)

APPROVED OMB NO. 3150-0104
EXPIRES: 4/30/92
ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
PRAIRIE ISLAND NUCLEAR GENERATING PLANT UNIT 1	0 5 0 0 0 2 8 2	1 OF 0 4

TITLE (4)

Fire Door Left Open As Result of Personnel Error

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 NUMBER(S)
0 1	1 7	9 2	9 2	—	0 0 1	—	0 0	0 2	1 3	9 2	Prairie Island Unit 2	0 5 0 0 0 3 0 6
												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)			
N		20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)
POWER LEVEL (10)		20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)
1 1 0	1 0	20.405(a)(1)(ii)	50.36(c)(2)	50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
		20.405(a)(1)(iii)	X 50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	
		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
Arne Hunstad	6 1 2 3 8 8 - 1 1 2 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)	XX NO				

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

On January 17, 1992, both units were at full power. At about 1520 the NRC Resident Inspector called the Control Room to report that Door No. 169 between Bus Rooms 25 and 16 was open and no fire watch was present. An operator was dispatched to investigate; the operator closed the door. The door had not been blocked open, nor was any obstruction present to hold the door open. The door had been held in the open position by a detent which was integral with the door closer. Since construction personnel had been working in the area, the project engineer was informed of the incident.

The door closer is equipped with a fusible link intended to provide automatic closure in the event of a fire. Testing showed that with the fusible link removed, the door would not close, but was still held open by its detent. Door No. 169 was determined to be inoperable when held in the open position by the detent. There was a person performing quality inspections in the room, at the time the door was found open, but he had not been designated as a fire watch. Since no fire watch was present, Technical Specification 3.14.G was violated.

EVENT DESCRIPTION

On January 17, 1992, both units were at full power. At approximately 1520 the NRC Resident Inspector for Prairie Island called the Control Room to report that Door No. 169, between safeguards 4160 V Bus Rooms 25 and 16, was open and no fire watch was present. An operator was dispatched to investigate; the operator closed the door. The door had not been blocked open, nor was there any obstruction present that would have prevented full closure. The door had been held in the open position by a detent which was integral with the door closer. Since construction personnel had been working in the area, the project engineer was informed of the incident.

At the time of the event, no compliance issues were thought to be involved since the door separates rooms of the same safeguards train. Liabilities associated with the open door were subsequently reviewed by the Site Safety Administrator. The review of the Fire Hazards Analysis showed that the door separates two fire zones. Therefore, Door No. 169 is considered a penetration fire barrier and is required to be operable per the requirements of Technical Specification 3.14.G. Since the door was found open without obstruction in the door sealing area, the operability of the door depended upon whether the door would have closed if an actual fire were to have occurred.

The Door No. 169 closer is equipped with a fusible link intended to provide automatic closure of the door in the event of a fire. Reviews showed that the fusible link was not tested or inspected. Inspection and testing were not required since administrative controls require the door to be closed or to have a fire watch assigned as compensatory measures. Because the fusible link was not tested or inspected, no credit could be taken for its function. Subsequent testing also showed that with the fusible link removed, the door would not close, but was still held open by its detent. Therefore, since it was shown that Door No. 169 would not have closed automatically in the event of a fire, it was determined that Door No. 169 was inoperable while held in the open position by the detent.

Technical Specification 3.14.G requires that fire barriers be operable or under administrative controls if made inoperable. There was a person performing quality inspections in the room, at the time the door was found open, but he had not been designated as a fire watch. Since no fire watch was present, Technical Specification 3.14.G was violated.

CAUSE OF THE EVENT

The apparent cause of the event is personnel error. Door No. 169 was inadvertently left in the held open position by someone working in the area or passing through the door. Door position information for this door is not available in the Control Room. It has not been determined when or why the door was left open.

ANALYSIS OF THE EVENT

The fire door, which separates Bus Rooms 16 and 25, is considered a 3 hour fire barrier in the Fire Hazards Analysis. Technical Specification 3.14.G requires the door to be operable, or compensatory measures taken. While standing open, the door was inoperable and no compensatory measures were in place. Therefore, this event is a violation of the Prairie Island Technical Specifications and is reportable pursuant to 10 CFR Part 50, Section 50.73(a)(2)(i)(B).

Since fire detection systems in both of the affected fire zones were operable while Door No. 169 was open, and since there was a person in the area, it is considered unlikely that a fire could have burned long enough to affect both fire zones prior to response by the fire brigade. Therefore, this event had no effect on public health and safety.

CORRECTIVE ACTION

Upon discovery, the fire door was closed. The construction project engineer was notified of the event. The impact of leaving fire doors open was discussed with construction personnel.

The door's fusible link was tested and determined to be ineffective in closing the door when held open by the detent in its closer. All unalarmed fire doors were inspected for the presence of detents in their door closers. Three similar closers were found; their detents were removed.

General employee training is being improved to increase alertness to use of fire doors.

Improvements in remote monitoring of fire door position are being investigated.

FAILED COMPONENT IDENTIFICATION

None.

PREVIOUS SIMILAR EVENTS

There have been no similar events reported at Prairie Island.