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LaSalle Generating Station
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ComEd

November 6, 1995
United States Nuclear Regulatory Commission
Attention: Document Control Desk
Washington, D.C. 20555

Licensee Event Report #95-010-00, Docket #050-374 is being submitted to your office in accordance with 10CFR50.73 (a) (2) (i) (B).

Sincerely,

D. J. Ray
Station Manager
LaSalle County Station

DJR/JEA/lja

Enclosure

cc: H. J. Miller, NRC Region III Administrator
P. G. Brochman, NRC Senior Resident Inspector
R. J. Zuffa, IDNS Resident Inspector
F. Niziolek, IDNS Senior Reactor Analyst
INPO - Records Center
D. L. Farrar, Nuclear Regulatory Services Manager

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NRC FORM 366 (5-92) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB NO. 3150-0104
EXPIRES 5/31/95

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.

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
LaSalle County Station Unit Two	05000374	1 of 4

TITLE (4)
Unit Two Fire Door 615 Left Open due to 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 NAME	DOCKET NUMBER
									None	
10	07	95	95	010	00	11	06	95	FACILITY NAME	DOCKET NUMBER

		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)					
OPERATING	N	20.2201(b)		20.2203(a)(3)(i)		50.73(a)(2)(viii)	73.71(b)
POWER	000	20.2203(a)(1)		20.2203(a)(3)(ii)		50.73(a)(2)(x)	73.71(c)
		20.2203(a)(2)(i)		20.2203(a)(4)		50.73(a)(2)(v)	OTHER
		20.2203(a)(2)(ii)		50.36(c)(1)		50.73(a)(2)(vii)	(Specify in
		20.2203(a)(2)(iii)		50.36(c)(2)		50.73(a)(2)(viii)(A)	
		20.2203(a)(2)(iv)	X	50.73(a)(2)(i)		50.73(a)(2)(viii)(B)	
		20.2203(a)(2)(v)		50.73(a)(2)(ii)		50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER (Include Area Code)
James Arnould, Operations	(815) 357-6761 x 2771

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	MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE).	X	NO				

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

At 0630 hours on October 7, 1995, a security officer, while performing routine security rounds, found fire door 615 open. Security notified the shift engineer that door 615 was open and the shift engineer verified that there was not an active fire impairment in the fire impairment log. Fire door 615 is a roll-up door, in the Unit 2 Auxiliary Electric Equipment Room (AEER), and requires a fire impairment be issued and an hourly fire watch be implemented whenever the door is opened. Tech Spec 3.7.6.a, "Fire Rated Assemblies", requires that when a fire door is left open, within one (1) hour either establish a continuous fire watch or verify the operability of the fire detectors and establish an hourly fire watch patrol on at least one side of the door. These actions had not been taken. Operating personnel inspected the door for obstructions and it was closed at approximately 0700 hours.

The root cause of this event was due to personnel error. An equipment operator had opened the door while performing panel readings and did not close fire door 615 before leaving the area.

PLANT AND SYSTEM IDENTIFICATION

General Electric - Boiling Water Reactor

Energy Industry Identification System (EIIS) codes are identified in the text as [XX].

A. CONDITION PRIOR TO EVENT

Unit(s): 2 Event Date: 10/07/95 Event Time: 0630 Hours

Reactor Mode(s): 1 Modes(s) Name: Run Power Level(s): 99%

B. DESCRIPTION OF EVENT

On October 7, 1995 between 0200 and 0230 hours, the Unit 2 equipment operator (EO) was performing rounds in the Unit 2 Auxiliary Electric Equipment Room (AEER). In order to access the Jet Pump Instrumentation Panel on 2H13-P619 and take readings, the equipment operator opened the roll-up door 615. This door separates Division One equipment from Division Two equipment. After taking the readings, the equipment operator continued on with his rounds.

At 0630 hours a security officer, while performing routine security rounds, found door 615 open with no fire impairment issued. Security notified the shift engineer that door 615 was open and that Security did not have an active fire impairment or fire watch in progress on the door. The shift engineer confirmed that there was not an active fire impairment in the fire impairment log. Tech Spec 3.7.6.a, "Fire Rated Assemblies", requires that when a fire door is left open, that within one (1) hour either establish a continuous fire watch or verify the operability of the fire detectors and establish an hourly fire watch patrol on at least one side of the door. This was not done. Operating personnel inspected the door for obstructions and closed it at approximately 0700 hours. At that time, there was no information regarding when or why the door was opened.

An investigation was initiated to determine the root cause of this event. On the midnight shift of October 12, 1995, as equipment operator returning to the plant after four days off read a station newspaper article (published October 11, 1995) describing the open fire door event. He immediately notified his supervisor that he must have left the roll up door open on his October 7, 1995, midnight shift. He knew that he was required to close the door after he took his readings but mistakenly failed to do this.

This event is reportable pursuant to 10 CFR 50.73(a)(2)(i)(B).

C. CAUSE OF EVENT

A fire door was mistakenly left open due to personnel error. The equipment operator knew that he was required to close the door after he took his readings, but did not.

D. ASSESSMENT OF SAFETY CONSEQUENCES

Door 615 is located in Fire Zone 4E2. This door serves to divide this zone into two sub zones (4E2-1 and 4E2-2)and provides a 3 hour rated fire barrier. The purpose of the 3 hour rated barrier is to provide adequate fire protection and limit the spread of fire and damage to only one division of safe shutdown required equipment. LaSalle Station's Safe Shutdown Analysis (SSA) describes a design base fire in sub zone 4E2-1 as effecting the Reactor Core Isolation Cooling (RCIC)(BN) system, Residual Heat Removal (RHR)(BO) loop A, and Automatic De-Pressurization (ADS) Division 1. A design base fire in sub zone 4E2-2 would effect the RCIC system, ADS Division 2, Safety Relief Valve (SRV) Division 1, Shutdown Cooling loops A & B, and RHR loop B. Since this door was found in the open position, a single fire could have potentially affected 2 divisions of equipment. This occurrence would be mitigated by the following:

Door 615 is a roll-up fire door installed with fusible links on both sides of the door. These links are designed to melt under a fire condition, thereby allowing the door to close automatically. Door 615 is designed to provide protection in both the open and closed positions, therefore placing equipment in the opening (i.e., path of closure) for door 615 is a concern. As indicated by Technical Specification Surveillance Requirement 4.7.6.2.b, "Fire Rated Assemblies", doors with automatic hold-open and release mechanisms may remain open as long as the opening is verified to be free of obstructions once per 24 hours. Since door 615 did not have a fire impairment issued, the opening was not verified to be free of obstructions until the operators visually inspected the door. At this time, the doors opening was verified to be free of obstructions and in the event of a fire would have been able to close.

Both sub zones are protected by an automatic fire detection system. The system is designed to detect a fire during its incipient stages. In the event of a fire, the detection system sounds an alarm locally and in the Control Room.

Based on the above information, the level of fire protection afforded to these areas was not decreased. Door 615 would have performed as required had a fire occurred. Therefore, the impact on nuclear and personnel safety would have been minimal.

E. CORRECTIVE ACTIONS

Security immediately notified the Shift Engineer that door 615 was open. The Fire Impairment Log was reviewed and it was determined that there wasn't an active fire impairment for fire door 615. Door 615 was inspected and no equipment was found going through the door. Door 615 was closed.

The equipment operator was counseled by supervision about having a proper questioning attitude and to re-affirm expectations regarding use of "self-check" principles.

F. PREVIOUS OCCURRENCES

LER Number	Title
373-95-011	Missed Technical Specification Fire Watch
374/95-004	Fire Watch Not Established Within Hourly Limit
374/95-002	Fire Watch Not Started Per Technical Specifications
373/92-012	Missed Fire Watch Due to Personnel Error

G. COMPONENT FAILURE DATA

Since no component failure occurred, this section is not applicable.