P.O. Box 399 Hwy. 75 - North of Pt. Calhoun Fort Calhoun. NE 68023-0399 402/636-2000

July 13, 1992 LIC-92-142L

U. S. Nuclear Regulatory Commission Attn: Document Control Desk Mail Station P1-137 Washington, DC 20555

Reference: Docket No. 50-285

Gentlemen:

Subject: Licensee Event Report 92-021 for the Fort Calhoun Station

Please find attached Licensee Event Report 92-021 dated July 13, 1992. This report is being submitted pursuant to 10 CFR 50.73(a)(2)(i)(B) and pursuant to Fort Calhoun Station Technical Specification 5.9.3. If you should have any questions, please contact me.

Sincerely,

W. Z. Hate

W. G. Gates Division Manager Nuclear Operations

WGG/lah

Attachment

c: J. L. Milhoan, NRC Regional Administrator, Region IV S. D. Bloom, Acting NRC Project Manager R. P. Mullikin, NRC Senior Resident Inspector INPO Records Center

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On June 11, 1992, during the OP-ST-FP-0001, 'Fire Protect Charging Pumr Valve Room (Ro closing mechanism for the do plate was missing. The oper that the latch was broken, b	on System Inspection om 7) was found to have ber was operating pro- ator who made the di	n and Test ave a broke perly; howe scovery not	', Fi en la ever, ted o	re D tch. the	Door 98 The latel	89-4 hyd h or vei	4 to draul n the llanc	ic stri e ter	: 1	v	

OP-ST-FP-0001 or initiate a Maintenance Work Request (MWR). A note at the beginning of a fire door checklist in procedure OI-FP-6, 'Fire Protection System Inspection and Test', stated, in part, that "All doors shall be closed unless in use or a Fire Watch is posted." (Note: Procedure OP-ST-FP-0001 requires the fire protection test and inspection be performed in accordance with OI-FP-6.) It was the opinion of the operator that since the door was closed, the criterion was met.

On June 13, 1992, following completion of OP-ST-FP-0001, the Shift Supervisor reviewing the completed surveillance test noted that the latch on the door had been found to be broken, and initiated an MWR to repair it. He did not consider a fire watch to be required based on the note at the beginning of the OI-FP-6 checklist. The actual time when the fire door latch broke could not be determined.

On June 17, 1992, at approximately 0755, a General Maintenance craft sperson, experienced in lock repair and fire door requirements, contacted System Enginee ing to generate a fire barrier impairment and initiate an appropriate fire watch. The door was repaired and the impairment cleared on June 23, 1992.

NECTORN MMA (6-50)	U.B. NUCLEAR REQULATORY COMMISSION	APPROVED OMB NO. 5160-0164 EXPIRES: 4/30/92							
LICENSEE EVENT REPORT TEXT CONTINUATION		ESTIMATED BURDEN PER RESPONSE TO INFORMATION COLLECTION REQUEST: COMMENTE REGARDING BURDEN ESTIM AND REPORTS MANAGEMENT BRANCH REGULATORY COMMISSION, WASHINGT THE PAPERWORK REDUCTION PROJECT OF MANAGEMENT AND BUDGET, WASHINGT	50.0 HPB. FORWARD ATE TO THE RECORDS P-530, U.S. NUCLEAR IN, DC 20555, AND TO						
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Also on June 23, 1992, the System Engineer, while in the process of reviewing the completed OP-ST-FP-0001, realized that the fire barrier impairment and associated fire watch had not been generated at the time the door latch was discovered by Operations to be inoperable. Incident Report (IR) 920451 was generated to document the fact that the fire barrier impairment and associated fire watch were not implemented within one hour of discovery as required by TS 2.19(7).

This report is being submitted pursuant to 10 CFR 50.73(a)(2)(i)(B). This report is also being submitted pursuant to TS 5.9.3 (as referenced in TS 2.19(7)) because Fire Door 989-4 was inoperable for more than seven days.

A review of OP-ST-FP-0001 and OI-FP-6 found that a note at the beginning of OI-FP-6, Checklist H, which is utilized for fire door checks, stated, in part, that "All doors shall be closed unless in use or a Fire Watch is posted." The operator who discovered the broken latch and the Shift Supervisor who reviewed the completed surveillance test both interpreted the note as an indication that as long as the door was shut, the requirements of TS 2.19(7) were met. A review of other operating instructions, standing orders, surveillance tests and maintenance procedures related to fire doors was also conducted. As a result, it has been determined that fire door/latching mechanism operability was not adequately addressed in the following procedures: SO-G-58, 'Control of Fire Protection System Impairments' and GM-PM-MX-0501, 'Inspection and Repetitive Maintenance for Alarmed RCA Doors.'

The significance of this event with respect to nuclear, equipment and personnel safety was negligible because Room 7 does not contain significant amounts of combustible material and the fire detectors in the area were operable to alert the Control Room in the event of a fire.

The root cause of this event was determined to be ambiguous instructions contained in the note at the beginning of procedure OI-FP-6, Checklist H, 'Fire Protection Door Check.' A contributing cause identified with respect to this event was that upon discovery of the discrepancy, the operator did not report his finding to the Shift Supervisor as required by the procedure.

The following corrective actions have been completed:

1.

2.

Procedure OI-FP-6 has been revised to clearly define that the latching mechanism on a fire door must be operable in order for the fire door to be considered operable.

A memorandum has been issued to plant personnel to inform them of the event, requirements for maintaining fire door qualification and the importance of notifying the Shift Supervisor immediately upon discovery of a discrepancy with a fire door.

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The fol	lowing corrective actions will	l be completed:									
1.	that the latching mechan	Procedure SO-G-58 will be revised by September 30, 1992 to clearly define that the latching mechanism on a fire door must be operable in order for the fire door to be considered operable.									
2.	Procedure GM-PM-MX-0501 define that a fire impair inspection of alarmed do mechanism on a Technical inoperable.	rment is required with ors in the Radiation C	in one ontro	e hi 11ei	our if, d Area,	du th	iring le lat		,		
3.	Shift Supervisors will d immediately notifying the identified while perform completed by July 31, 19	e Shift Supervisor of ing a surveillance tes	any ar	nom	alies o	r d	lefici	encie ill t	es De		
	-003, 91-006 and 90-001 docume tches. None of these previous								ire		