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Southern Nuclear Operating Company
the southern electric system

J. D. Woodard
Vice President
Farley Project

10 CFR 50.73

November 10, 1992

Docket No. 50-348

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

Joseph M. Farley Nuclear Plant - Unit 1
Licensee Event Report No. LER 92-004-00

Gentlemen:

Joseph M. Farley Nuclear Plant, Unit 1, Licensee Event Report No. 92-004-00 is being submitted in accordance with 10 CFR 50.36. If you have any questions, please advise.

Respectfully submitted,

J. D. Woodard

JDW/EFB:map 2582

Enclosure

cc: Mr. S. D. Ebneter
Mr. G. F. Maxwell

IE22
1/1

NRC Form 366 (6-89) | U.S. NUCLEAR REGULATORY COMMISSION | APPROVED OMB NO. 3150-0104 EXPIRES: 4/30/92

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Joseph M. Farley Nuclear Plant - Unit 1	0 5 0 0 0 3 4 8	1 OF 3

TITLE (4)
Fire Door Blocked Open Without Fire Watch

EVENT DATE (5)			LER NUMBER (6)					REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR		SEQ NUM		REV	MONTH	DAY	YEAR	FACILITY NAMES	DOCKET NUMBER(S)
												0 5 0 0 0
0 8	3 1	9 2	9 2		0 0 4		0 0	1 1	1 0	9 2		0 5 0 0 0

OPERATING MODE (9)	1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR (11)			
		20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)
POWER LEVEL	1 0 0	20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)
		20.405(a)(1)(ii)	X 50.36(c)(2)	50.73(a)(2)(vii)	OTHER (Specify in Abstract below)
		20.405(a)(1)(iii)	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	
R. D. Hill, General Manager - Nuclear Plant	205	899-5156

COMPLETE ONE LINE FOR EACH FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFAC-TURER	REPORT TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFAC-TURER	REPORT TO NPRDS	

SUPPLEMENTAL REPORT EXPECTED (14)

		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES(If yes, complete EXPECTED SUBMISSION DATE)	X NO				

ABSTRACT (16)

On 8-26-92, during the performance of FNP-1-SOP-49.1, "Dewatering of a Storage Cask to the Secondary SRST" (Spent Resin Storage Tank), Operations personnel routed a drain hose under a closed fire door to facilitate the dewatering evolution. At 2015 on 8-31-92, an Operations Shift Foreman (SFO) discovered the fire door ajar and blocked open by the drain hose. No fire watch had been established. Apparently, an individual used the door and did not ensure that it reclosed over the hose. The Operations Systems Operator (SO) responsible for the area had noted the door open 4 hours earlier but assumed a fire watch had been established.

Upon recognition of this condition, the actions of Technical Specification 3.7.12 were performed. Fire detector operability on at least one side of the door was verified throughout the event, and an hourly fire watch patrol was immediately established.

The Operations SO responsible for the area has been reinstructed to question and verify rather than assume that blocked or propped open fire doors have fire watches established as required. SOP-49.1 has been changed to provide instruction on ensuring the establishment of a fire watch before routing a drain hose under or through a fire door. The fire protection program administrative procedure will be changed to include instructions regarding routing hoses through fire doors. Operations personnel will be trained on lessons to be learned from this event. The fire door was closed and returned to operable status on September 3, 1992 at 1935 hen dewatering was completed.

Plant and System Identification

Westinghouse - Pressurized Water Reactor
Energy Industry Identification System codes are identified in the text as [XX].

Summary of Event

At 2015 on 8-31-92, a Technical Specification fire door was discovered blocked open by a drain hose with no fire watch established.

Description of Event

On 8-26-92, during the performance of FNP-1-SOP-40.1, Operations personnel routed a drain hose under a closed fire door [NF] to facilitate dewatering a storage cask to the secondary SRST. On 8-31-92 at 2015, an Operations SFO discovered the fire door ajar and blocked open by the drain hose. The SFO was performing a plant tour with the SO responsible for the area at the time of the discovery. The SFO checked on the status of the door and found that a fire watch had not been established. The SO informed the SFO that the door was ajar on his 1600 rounds (4 hours earlier) but he had assumed that a fire watch had been established.

The actions required by Technical Specification 3.7.12 were immediately performed. Fire detector operability on at least one side of the door was verified throughout the event, and an hourly fire watch was immediately established.

The fire door was returned to operable status on September 3, 1992 at 1935 when dewatering was completed allowing the door to be closed.

Cause of Event

The primary cause of this event is procedural inadequacy in that no fire watch was required for the situation in which a hose was routed under a closed fire door. This led to the subsequent assumption by the SO responsible for the area that fire protection controls had been established. A contributing cause is personnel error. Apparently, an individual used the door during the time the drain hose was routed under it and did not ensure that it reclosed over the hose. The SO, who is responsible for the area, did not ensure that the appropriate fire watches had been established when he first noticed the door blocked open by the drain hose.

Reportability Analysis and Safety Assessment

This event is reportable due to the failure to meet the Limiting Condition for Operation of Technical Specification 3.7.12 for a blocked open fire door.

The fire barrier functions of the inoperable fire door were not challenged during the timeframe of the door's inoperability.

The health and safety of the public was not affected.

Corrective Action

The Operations SO responsible for the area has been reinstructed to question and verify rather than assume that blocked or propped open fire doors have fire watches established as required.

FNP-1-SOP-49.1, "Dewatering of a Storage Cask to the Secondary SRST" has been changed to provide instruction on ensuring the establishment of a fire watch before routing a drain hose under or through a fire door.

The fire protection program administrative procedure will be revised to include appropriate instructions to ensure the establishment of a fire watch prior to routing hoses regardless of whether or not the door must be propped open. Operations personnel will be trained on the lessons to be learned from this event. These corrective actions to prevent recurrence will be completed by December 31, 1992.

Additional Information

This event would not have been more severe if it had occurred under different operating conditions.

LER 86-008-00 (Unit 2) and LER 87-008-00 (Unit 1) were previously submitted by Farley Nuclear plant for failure to post fire watches on propped open fire doors.

This LER is being submitted beyond 30 days following the event date due to an error made in the research of this incident's reportability. The individual researching reportability confused the door number with a room of the same number. This room was located in a different area of the Auxiliary Building in which no additional fire watch would have been required.

The error was discovered on 10-16-92 during a review conducted subsequent to the reportability determination.