NRC Form 366
(9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/85

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
McGuire Nuclear Station - Unit 1	0 5 0 0 0 3 6 9	1 OF 0 4

TITLE (4)
TWO FIRE DOORS WERE BLOCKED OPEN AND A FIRE WATCH WAS MISSED 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 NAMES	DOCKET NUMBER(S)
1 1	0 9	8 7	8 7	— 0 3 4	— 0 1	0 1	2 6	8 8	Unit 2	0 5 0 0 0 3 7 0
										0 5 0 0 0

OPERATING MODE (9)	3	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)			
POWER LEVEL (10)	0 0	20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)
		20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)
		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)	XX 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
STEVEN E. LeROY - LICENSING	AREA CODE 7 0 4 3 7 3 - 6 2 3 3

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 11/09/87 at about 1010, while performing routine plant surveillance, Quality Assurance (QA) noticed that Technical Specifications (TS) required Fire Door 819A was blocked open, and the "Fire Barrier Watch" tag indicated that an hourly fire watch had been performed. QA continued surveillance and noticed that Fire Door 621A was also blocked open, and discovered the required fire watch had not been performed on an hourly basis. QA notified the Control Room about the opened fire door. The Control Room notified Mechanical Maintenance (MNT) responsible for the fire watch. MNT closed TS Fire Doors 819A and 621A and had the doors cleared from the Unit 2 Technical Specification Action Item Logbook at 1200. This event is assigned a cause of Personnel Error because the MNT Supervisors involved did not adequately communicate pertinent information about the TS fire doors to appropriate MNT personnel during shift turnover. A contributory cause of management deficiency is also assigned because MNT Shift does not maintain a logbook or turnover sheet. MNT will establish a logbook for TS items they are responsible for and will review this report with MNT shift personnel.

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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
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TEXT (If more space is required, use additional NRC Form 366A's) (17)

INTRODUCTION:

On November 9, 1987 at about 1010, while performing a routine plant surveillance, a Quality Assurance (QA) person noticed that Technical Specifications (TS) required Fire Door 819A was blocked open, and the "Fire Barrier Watch" tag indicated that an hourly fire watch had been performed. The QA person proceeded down the stairwell and noticed that TS required Fire Door 621A was also blocked open, and discovered that the required fire watch had not been performed on an hourly basis. The door had a "Fire Barrier Watch" tag attached and the last entry on this tag was at 0700 on November 9, 1987. The QA person notified the Control Room Senior Reactor Operator (SRO) about the opened TS required fire door. The Control Room SRO notified Mechanical Maintenance (MNT) personnel who were responsible for the fire watch. On November 9, 1987, MNT closed TS required Fire Doors 819A and 621A and these doors were cleared from the Unit 2 Technical Specification Action Item Logbook (TSAIL) at 1200.

Unit 1 was in Mode 3, Hot Standby, and Unit 2 was in Mode 1, Power Operation, at 100% power at the time this event was discovered.

This event has been assigned a cause of Personnel Error because the MNT Supervisors involved did not adequately communicate pertinent information about the TS required fire doors to the appropriate MNT personnel during shift turnover; therefore, two TS required fire doors were violated. A contributory cause of Management Deficiency has also been assigned because MNT Shift Supervisors do not maintain a logbook or turnover sheet in their area.

EVALUATION:

Background

Station Directive 2.11.5, McGuire TS Fire Penetrations, states that a fire door is operable and in compliance with McGuire TS 3.7.11, Fire Barrier Penetrations, if it is closed and the fire door is latched so that a draft cannot force the door open. The fire door's structural integrity is maintained as a physical barrier. The door cannot have any openings which penetrate both sides of the door. If a fire door does not meet the conditions stated above, it shall be considered inoperable and in violation of McGuire TS. Technical Specification 3.7.11 requires that all fire barriers separating portions of redundant systems important to safe shutdown within a fire area be operable at all times. When a fire barrier is determined to be inoperable, the action statement requires that a continuous fire watch be established or verify the operability of the area fire detectors and establish an hourly fire watch patrol within one hour.

When a fire door is found inoperable, immediate notification of the Control Room SRO is required for TS logging and determination of fire watch requirements.

Operations (OPS) personnel are required to notify the responsible group and assure that a documented continuous fire watch or hourly patrol is established.

Description of Event

The last documented entries by MNT on the "Fire Barrier Watch" tags for TS required Fire Doors 819A and 621A were made on November 9, 1987 at 0700. Between 0715 and 0730, MNT was involved in shift turnover.

MNT Supervisor "A" updated MNT Supervisor "B" about the progress of jobs during shift turnover. MNT Supervisor "A" believes that he told MNT Supervisor "B" about the TS required fire doors during shift turnover. MNT Supervisor "B" believes that at approximately 0910, MNT Supervisor "A" notified him by phone about the TS required fire doors that were inoperable and that they required a fire watch. MNT Supervisor "B" notified MNT personnel who were working on the 750' EL of the Auxiliary Building about the TS required fire doors requiring a fire watch at around 0935. A MNT person located TS required Fire Door 819A and updated the entry for 0800, 0900 and 1000 on the "Fire Barrier Watch" tag. Updating the "Fire Barrier Watch" tag in this manner is contrary to approved practice. Since MNT Supervisor "B" did not tell the MNT person exactly which TS required fire doors required a fire watch, the MNT person did not look further for any open TS required fire doors.

At approximately 1040 on November 9, 1987 a QA person was performing a routine plant surveillance and discovered that the last entry on the "Fire Barrier Watch" tag for TS required Fire Door 621A was made at 0700. The QA person notified the Control Room SRO about the fire watch not being performed on an hourly basis. The Control Room SRO checked the Unit 2 TSAIL and found that MNT personnel were responsible for the TS required fire doors being open. The Control Room SRO contacted the responsible MNT personnel. MNT removed the air hoses from the TS required Fire Doors 819A and 621A and closed the doors. OPS cleared the TS required fire doors from the Unit 2 TSAIL on November 9, 1987 at 1200.

Conclusion

This event has been assigned a cause of Personnel Error because the MNT Supervisors did not adequately communicate pertinent information about the TS required fire doors to the appropriate MNT personnel during shift turnover; therefore, two TS required fire doors were violated. A contributory cause of Management Deficiency has also been assigned because MNT Shift Supervisors do not maintain a logbook or turnover sheet in their area. Information that is communicated during shift turnover is strictly based on personnel recollection so there is always the possibility that a person will forget to communicate some information.

A review of McGuire Licensee Event Reports (LER) for the past three years revealed eleven LERs that involved breached fire barriers. The corrective actions that were listed in those reports have been effective in preventing this type of event from occurring. One of the previous events was due to personnel error; therefore, this event is considered to be recurring.

This event is not reportable to the Nuclear Plant Reliability Data System (NPRDS).

CORRECTIVE ACTIONS:

Immediate: MNT closed TS required Fire Doors 819A and 621A.

Subsequent: 1) OPS cleared TS required Fire Doors 819A and 621A from the Unit 2 TSAIL.

Planned: 1) MNT will establish a logbook in their area for TS items for which MNT personnel are held responsible.

2) MNT will review this report with their Shift personnel to emphasize the importance of adequate communication during shift turnover.

SAFETY ANALYSIS:

A fire door is operable and is in compliance with McGuire TS 3.7.11 if it is closed and the fire door is latched so that a draft cannot force the door open. TS required Fire Doors 819A and 621A were known to be inoperable, but a fire watch had not been performed on an hourly basis on fire door 819A between the hours of 0700 and 0955 and on fire door 621A between the hours of 0700 and 1040.

Should a fire have occurred on 750' EL or 716' EL, it is very unlikely that the fire would have spread to another elevation via the stairwell due to a lack of combustible material in the stairwell area. Also, area fire detectors [EIIS:DET] were operable and in the event of a fire would have given an alarm in the Control Room. Control Room personnel would have notified the Fire Brigade Captain and the Fire Brigade Captain along with two Fire Brigade members would have reported to the scene of the fire within three minutes.

There were no personnel injuries, personnel overexposures, or releases of radioactive material as a result of this event.

This event is considered to be of no significance with respect to the health and safety of the public.

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VICE PRESIDENT
NUCLEAR PRODUCTION

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January 26, 1988

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

Subject: McGuire Nuclear Station, Unit 1
Docket No. 50-369
Licensee Event Report 369/87-34-01

Gentlemen:

Pursuant to 10CFR 50.73 Sections (a)(1) and (d), attached is revised Licensee Event Report 369/87-34-01 concerning Fire Doors being blocked open and a missed fire watch on November 9, 1987. This revised report is being submitted due to an error in the report, and in accordance with 10CFR 50.73(a)(2)(i)(B). This event is considered to be of no significance with respect to the health and safety of the public.

Very truly yours,

Hal B. Tucker/ja

Hal B. Tucker

SEL/214/jgc

Attachment

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