NRC Form 366
(9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/88

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Millstone Nuclear Power Station Unit 3	0 5 0 0 0 4 2 3	1 OF 0 3

TITLE (4)
Failure to Monitor an Inoperable Fire Boundary Door

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 3	1 8	8 8	8 8	— 0 1 2	— 0 0	0 4	1 8	8 8		0 5 0 0 0
										0 5 0 0 0

OPERATING MODE (9)	1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)			
POWER LEVEL (10)	0 9 9	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)	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
Frances M. Marshall, Engineer - Extension 5400	2 0 3 4 4 7 - 1 7 9 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)	X NO				

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

On March 18, 1988, at 1900 hours, while operating in Mode 1 at 99% power, 2250 psia and 586 degrees Fahrenheit, a fire boundary door was found blocked open by a temporary air hose without an hourly fire watch patrol being established as required by the Plant's Technical Specifications. The door separates the Auxiliary Building general area from the Motor Control Center/Rod Control Air Conditioner area. The discovery was made by an unlicensed operator (PEO) during routine rounds. After the PEO determined that the hose was no longer necessary, he removed the hose and closed the door.

Root cause of the event was procedural deficiency. There was no means for personnel involved to readily determine that the door was a fire rated assembly. As action to prevent recurrence, the administrative procedure on work practices has been revised to include a listing of the attributes of doors. A memo has been distributed to unit personnel discussing the incident and the guidelines which have been established to prevent recurrence of this event. As discussed in LER 87-048-00, Failure to Monitor Inoperable Fire Assemblies, a program has been instituted to mark all plant doors with their attributes by December 31, 1988.

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

I. Description of Event

On March 18, 1988, at 1900 hours, while operating in Mode 1 at 99% power, 2250 psia and 586 degrees Fahrenheit, a fire boundary door was found blocked open by a temporary air hose without an hourly fire watch patrol being established as required by the Plant's Technical Specifications. The door separates the Auxiliary Building general area from the Motor Control Center/Rod Control Air Conditioner area.

The discovery was made by an unlicensed operator (PEO) during his routine rounds. After the PEO determined that the hose was no longer necessary, he removed the hose and closed the door.

Maintenance work, requiring a dedicated air supply, was being performed on an air conditioner in the Motor Control Center/Rod Control Air Conditioner area, in accordance with an approved Work Order. Since no permanent air supply existed in the area, a hose was run from an air supply line in the adjacent Auxiliary Building general area. The hose was left in place after work was completed during the day shift on March 18, 1988, for continuation of work on the following day.

II. Cause of Event

The root cause of the event was procedural deficiency in that the Administrative Control Procedure on work practices was deficient in identifying fire and other barrier doors. There was no means for personnel involved to readily determine that the door, which was being blocked open, was a fire boundary door.

III. Analysis of Event

This incident is reportable under 10CFR50.73(a)(2)(i), any condition prohibited by the Plant's Technical Specifications. Technical Specification 3.7.13 requires that all fire sealing devices, including doors, are operable at all times. An hourly fire watch patrol is required to be posted if a door is blocked open for more than one hour.

This event posed no danger to the health and safety of the public due to the continued operability of the fire detection system and the availability of the fire protection and suppression system. Redundant equipment was not affected since the boundary did not connect areas containing redundant safety related equipment.

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

IV. Corrective Action

Immediate corrective action was to remove the hose and close the door to reestablish the fire barrier. The Administrative Control Procedure on work practices has been revised to incorporate a listing of the attributes of plant doors. This procedure also requires the work supervisor to notify the Control Room so that appropriate action can be taken when a Technical Specifications related barrier door is breached. A memo has been distributed to unit personnel discussing the incident and guidelines established to prevent recurrence of this event.

As discussed in LER 87-048-00, Failure to Monitor Inoperable Fire Assemblies, a program has been instituted to mark all doors with their attributes (i.e., fire, supplementary leak collection and Control Room habitability) by December 31, 1988. This will serve as an added preventive measure against recurrence of a similar event.

V. Additional Information

Although there have been no previous events with the same root cause and sequence of events, the events described in LER 87-048-00, Failure to Monitor Inoperable Fire Assemblies, are similar in that fire doors were blocked open without the proper actions being taken.

EIIS Codes

System	Component
Auxiliary Building - NF	Door - DR

NORTHEAST UTILITIES
THE CONNECTICUT LIGHT AND POWER COMPANY
WESTERN MASSACHUSETTS ELECTRIC COMPANY
HOLYOKE WATER POWER COMPANY
NORTHEAST UTILITIES SERVICE COMPANY
NORTHEAST NUCLEAR ENERGY COMPANY

General Offices • Selden Street, Berlin, Connecticut

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HARTFORD, CONNECTICUT 06141-0270
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April 18, 1988
MP-11730

Re: 10CFR50.73(a)(2)(i)

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

Reference: Facility Operating License No. NPF-49
Docket No. 50-423
Licensee Event Report 88-012-00

Gentlemen:

This letter forwards the Licensee Event Report 88-012-00 required to be submitted within thirty days pursuant to 10CFR50.73(a)(2)(i), any operation or condition prohibited by the Plant's Technical Specifications.

Very truly yours,

NORTHEAST NUCLEAR ENERGY COMPANY

For: Stephen E. Scace
Station Superintendent
Millstone Nuclear Power Station

By: John P. Stetz
Unit 1 Superintendent
Millstone Nuclear Power Station

SES/FMM:cjh

Attachment: LER 88-012-00

cc: W. T. Russell, Region I
W. J. Raymond, Senior Resident Inspector

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