

**LICENSEE EVENT REPORT (LER)**

FACILITY NAME (1) Catawba Nuclear Station, Unit 1										DOCKET NUMBER (2) 0   5   0   0   0   4   1   3   1   OF   0   3										PAGE (3) 1							
TITLE (4) Fire Watches Not Established 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 N/A					DOCKET NUMBER(S) 0   5   0   0   0				
0   2		1   7		8   7		8   7		0   0   9		0   1   0		4   0   9		8   7							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) 1   0   0		20.402(b)				20.406(a)(1)(i)				20.406(c)				50.73(a)(2)(iv)				73.71(b)									
		20.406(a)(1)(ii)				50.36(c)(1)				50.73(a)(2)(v)				73.71(c)													
		20.406(a)(1)(iii)				50.36(c)(2)				50.73(a)(2)(vi)				OTHER (Specify in Abstract below and in Text, NRC Form 365A)													
		20.406(a)(1)(iv)				50.73(a)(2)(i)				50.73(a)(2)(viii)(A)																	
		20.406(a)(1)(v)				50.73(a)(2)(ii)				50.73(a)(2)(viii)(B)																	
		20.406(a)(1)(vi)				50.73(a)(2)(iii)				50.73(a)(2)(ix)																	
LICENSEE CONTACT FOR THIS LER (12)																											
NAME Julio G. Torre, Assistant Engineer - Licensing															TELEPHONE NUMBER 7   0   4   3   7   3   -   8   0   2   9												
COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)																											
CAUSE		SYSTEM		COMPONENT		MANUFACTURER		REPORTABLE TO NRC				CAUSE		SYSTEM		COMPONENT		MANUFACTURER		REPORTABLE TO NRC							
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 February 17, 1987, at 0138 hours, personnel discovered two fire doors propped open near the Diesel Generator 1A room. No hourly fire watch had been established as required per Technical Specifications. The doors were closed at 0200 hours, which returned them to an operable status. Unit 1 was at approximately 100% power at the time these doors were found open.

On March 10, 1987, at 1920 hours, personnel found fire door AX353C, near Diesel Generator 1B room, propped open. No hourly fire watch had been established as required per Technical Specifications. At this time, the fire door was closed and returned to its operable status. Unit 1 was in Mode 4, Hot Shutdown, at the time this door was found open.

This incident is assigned Cause Code A, Personnel Error, because the doors were propped open by personnel. The responsible personnel could not be determined.

During the time that the fire doors were inoperable, the fire detectors in the area were operable and would have notified personnel if a fire had occurred. The health and safety of the public were unaffected by this incident.

This incident is reportable pursuant to 10CFR 50.73, Section (a)(2)(i)(B).

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PDR ADCK 05000413  
S PDR

## LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104

EXPIRES: 8/31/85

FACILITY NAME (1)  Catawba Nuclear Station, Unit 1	DOCKET NUMBER (2)  0 5 0 0 0 4 1 3 8 7 - 0 0 9 - 0 1 0 2 OF 0 3	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			

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

BACKGROUND

Technical Specification (Tech Spec) 3.7.11 states that all fire barrier penetrations (EIIS:PEN) and all sealing devices in fire rated assembly penetrations shall be operable at all times. The action statement for this Tech Spec states: With one or more of the above fire barrier penetrations and/or sealing devices inoperable, within 1 hour either establish a continuous fire watch on at least one side of the affected penetration, or verify the operability of fire detectors on at least one side of the inoperable penetration and establish an hourly fire watch patrol.

DESCRIPTION OF INCIDENT

On February 16, 1987, at 1917 hours, Security Officer A patrolled through the Switchgear Room adjacent to the Unit 1 Diesel Generator (D/G) (EIIS:DG) rooms. Security Officer A noticed that fire door (EIIS:DR) AX353B, leading into the D/G 1A room, was closed. Security Officer A exited the area at 1922 hours, and Security Officer B entered the area at 1923 hours. Security Officer B also noticed that fire door AX353B was closed. At 1925 hours, Security Officer B exited the area. At 2147 hours, a Nuclear Equipment Operator (NEO) entered the D/G room while performing his rounds. The NEO noticed that fire doors AX353B and AX302, leading into the D/G 1A room, were opened. The NEO exited the area at 2155 hours. The NEO re-entered the area at 2203 hours and exited at 2208 hours. Quality Assurance (QA) surveillance personnel entered the Switchgear Room at 0138 hours on February 17, 1987. The QA personnel noticed that each of the two doors leading into the D/G 1A room were propped open by a waste receptacle. QA personnel notified the Fire Protection Console Operator (FPCO) of the open fire doors. The need to establish an hourly fire watch had not been identified to the FPCO. The FPCO dispatched a Security Officer to close the doors. At 0200 hours, the doors were closed. Unit 1 was operating at 100% power at the time these doors were found open.

On March 10, 1987, at approximately 0730 hours, a Security Officer performed the Fire Door Inspection Procedure, Daily Enclosure, which is a daily check to ensure fire doors are closed and latched. Fire door AX353C, leading into D/G 1B room was closed and latched. Throughout the day, personnel were working in the area of the switchgear and D/G rooms. Personnel noticed that door AX353C was propped open; however, no one was seen or could recall opening the door. At 1920 hours, QA Surveillance personnel discovered fire door AX353C propped open and notified the FPCO. The need to establish an hourly fire watch had not been identified to the FPCO. The QA personnel closed the fire door, at the instruction of the FPCI, returning it to an operable status. Unit 1 was in Mode 4, Hot Shutdown, at the time this door was found open.

CONCLUSION

During the time of this incident, personnel in the area of the Unit 1 Switchgear and D/G 1A rooms noticed that the rooms were warm. The doors were probably opened to allow air circulation and cool down the area. A violation of Tech Spec 3.7.11 resulted when the fire doors were opened and a fire watch was not established.

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

Both incidents have been assigned Cause Code A, Personnel Error, because the doors were propped open by personnel. The responsible personnel could not be determined. During the time of the incident on March 10, 1987, the Security computer was experiencing problems. Log sheets were being utilized to record access into vital areas.

There have been two previous incidents in which fire watches were not established for impaired fire barriers due to a lack of follow-up activity (see LERs 413/84-32 and 413/85-46).

CORRECTIVE ACTION

## IMMEDIATE

- (1) Security Officer closed doors AX302 and AX353B.
- (2) QA surveillance personnel closed door AX353C.

## PLANNED

- (1) All appropriate Station personnel will be reminded, in the monthly safety meeting, to keep fire doors closed.

SAFETY ANALYSIS

During the time that the fire doors were inoperable, the fire detectors in the area were operable and would have notified personnel if a fire had occurred.

The health and safety of the public were not affected by this incident.



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April 9, 1987

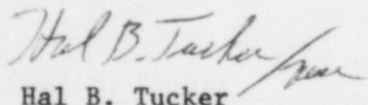
Document Control Desk  
U. S. Nuclear Regulatory Commission  
Washington, D. C. 20555

Subject: Catawba Nuclear Station, Unit 1  
Docket No. 50-413  
LER 413/87-09 Revision 1

Gentlemen:

Pursuant to 10 CFR 50.73 Section (a) (1) and (d), attached is Licensee Event Report 413/87-09 Revision 1 concerning fire watches not being established due to a personnel error. This event was considered to be of no significance with respect to the health and safety of the public.

Very truly yours,

  
Hal B. Tucker

JGT/17/sbn

Attachment

xc: Dr. J. Nelson Grace, Regional Administrator  
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Mr. P. K. Van Doorn  
NRC Resident Inspector  
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