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)
Wolf Creek Generating Station	0 5 0 0 0 4 8 2	1 OF 0 3

TITLE (4) Failure To Effectively Communicate Allows An Open Door Creating A Control Room Pressure Boundary Breach

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 5 0 0 0
0 8	2 0	8 7	8 7	— 0 3 4	— 0 0	0 9	2 1	8 7		0 5 0 0 0

OPERATING MODE (9)	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)			
1	20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)
POWER LEVEL (10) 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)	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
Merlin G. Williams - Superintendent of Regulatory, Quality and Administrative Services	AREA CODE 3 1 6 — 3 6 4 - 8 8 3 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 August 20, 1987, at approximately 1330 CDT, an NRC Resident Inspector found Door 36171, which separates the Control Room from an electrical chase area, propped open for rework of penetrations by Facilities and Modification (F&M) personnel. The Shift Supervisor was aware of the rework activity, but was unaware that it required the door to be propped open. The Shift Supervisor promptly took compensatory measures upon notification that the door was propped open. With this door open, it was concluded that positive pressure could not be maintained in the Control Room which is contrary to Technical Specifications (T/S) and should have resulted in T/S 3.0.3 entry.

This event has been attributed to a failure to effectively communicate between the Shift Supervisors involved and the F&M personnel performing the work activity. A permanent sign has been posted on this door to clearly identify its Control Room pressure boundary function. F&M Engineers have been instructed to add precautionary statements into their work packages to emphasize pressure boundary considerations. In addition, a change has been made to the Control Room Ventilation Isolation Signal alarm response procedure to close the doors if they are open.

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

INTRODUCTION

On August 20, 1987, at approximately 1330 CDT, an NRC Resident Inspector found Door 36171 [NA-DR] propped open. With this door open, it was concluded that positive pressure could not be maintained in the Control Room [NA]. The inability to maintain positive pressure in the Control Room is equivalent to both trains of the Control Room Emergency Ventilation System (CREVS)[VI] being inoperable. Because the plant's Technical Specifications do not provide an action for this condition, the plant should have entered Technical Specification 3.0.3. This event is being reported pursuant to 10CFR 50.73(a)(2)(i)(B) as an operation prohibited by the plant's Technical Specifications.

DESCRIPTION OF EVENT

On August 20, 1987, at approximately 1330 CDT, an NRC Resident Inspector discovered that Door 36171 was propped open by Facilities and Modification (F&M) personnel. This door was opened by F&M to facilitate the rework of fire barrier penetrations inside Room 3716. Upon notification by the NRC Resident Inspector that the door was propped open, Control Room personnel promptly took compensatory measures.

Door 36171 is located on the 2047 foot level of the Control Building, separating the Control Room from an electrical chase area.

Review of this event concluded that having this door open did create a breach of the Control Room pressure boundary. It was determined that the Control Room pressurization fans [VI-FAN] would not have been able to maintain the Control Room at a positive pressure of greater than or equal to 1/4 inch water gauge relative to the outside atmosphere during system operation as required by Technical Specification 3.7.6 because of a floor drain located inside the electrical chase area. Therefore with the door open, the requirements of Technical Specification 3.7.6 could not be satisfied, and entry should have been made into Technical Specification 3.0.3.

The rework on the penetrations was subsequently completed on August 27, 1987.

ROOT CAUSE AND CORRECTIVE ACTIONS:

This event has been attributed to a failure to effectively communicate between the Shift Supervisors involved and the F&M personnel performing the rework activity on the penetrations. Although it was known that the penetration seals were not part of the pressure boundary, F&M personnel were unaware that the door was the pressure boundary. As a result, the F&M personnel performing the rework activity did not recognize the consequences of propping open the door. On August 20, 1987, the on-duty Shift Supervisor was not aware that the ongoing rework activity required the door to be propped open, thus allowing a breach of the Control Room pressure boundary.

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

In order to prevent the recurrence of this event, the following corrective actions have been/will be implemented:

(1) Permanent signs have been posted on Door 36171 and two other similar doors informing personnel that the doors are part of the Control Room pressure boundary and the Control Room must be contacted prior to initiating any work that would require propping the doors open.

(2) F&M Engineers have been instructed to include precautionary statements into their work packages to emphasize pressure boundary considerations prior to starting work.

(3) F&M personnel, including Contractors, have been instructed to contact Control Room personnel when work could affect a pressure boundary.

(4) A change has been made to the Control Room Ventilation Isolation Signal alarm response procedure to close the doors if open.

(5) This report will be added to Operations' Required Reading to remind licensed personnel of the importance of considering potential effects on pressure boundaries when authorizing work activities.

ADDITIONAL INFORMATION:

The unit was in Mode 1, Power Operation, at approximately 100 percent power at the time of the event.

During this event all other equipment required for Control Room pressurization was capable of fulfilling its intended function. There was no damage to plant equipment or release of radioactivity as a result of this event. At no time did conditions develop that may have posed a threat to the health or safety of the public.

Licensee Event Report 87-009 discusses a previous occurrence of both trains of the CREVS being declared inoperable. The corrective actions discussed in that report were appropriate to that event and had no relationship to the event discussed in this report.

WOLF CREEK
NUCLEAR OPERATING CORPORATION

Bart D. Withers
President and
Chief Executive Officer

September 21, 1987

WM 87-0240

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

Subject: Docket No. 50-482: Licensee Event Report 87-034-00

Gentlemen:

The attached Licensee Event Report (LER) is submitted pursuant to 10 CFR 50.73 (a) (2) (i) concerning a Technical Specification violation.

Very truly yours,

B D Withers

Bart D. Withers
President and
Chief Executive Officer

BDW/jad

Attachment

cc: P. O'Connor (2)
R. Martin
J. Cummins

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