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AUTH.NAME AUTHOR AFFILIATION
MORGAN,H.E Southern California Edison Co.
RECIP.NAME RECIPIENT AFFILIATION

SUBJECT: LER 88-027-01:on 871130,Tech Spec fire door surveillance discrepancies.

DISTRIBUTION CODE: IE22D COPIES RECEIVED:LTR 1 ENCL 1 W/8 ltr. SIZE: 6
TITLE: 50.73 Licensee Event Report (LER), Incident Rpt, etc.

NOTES:

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	NRR/DLPQ/QAB 10	1	1	NRR/DOEA/EAB 11	1	1
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EXTERNAL:	EG&G GROH,M	4	4	FORD BLDG HOY,A	1	1
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LICENSEE EVENT REPORT (LER)

Facility Name (1)	Docket Number (2)	Page (3)
SAN ONOFRE NUCLEAR GENERATING STATION, UNIT 2	0 5 0 0 0 3 6 1	1 of 0 5

Title (4)

TECHNICAL SPECIFICATION FIRE DOOR SURVEILLANCE DISCREPANCIES

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	3 0	8 7	8 7	0 2 7	0 1	0 4	1 4	8 8	SONGS, UNIT 3	0 5 0 0 0 3 6 2
										0 5 0 0 0

OPERATING MODE (9): 5

POWER LEVEL (10): 0 0 0

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10CFR (Check one or more of the following) (11)

___ 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)
___ 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
H. E. Morgan, Station Manager	AREA CODE 7 1 4 3 6 8 - 6 2 4 1

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

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

SUPPLEMENTAL REPORT EXPECTED (14)

___ Yes (If yes, complete EXPECTED SUBMISSION DATE) X NO

Expected Submission Date (15): Month ___ Day ___ Year ___

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

On 11/30/87, with Unit 2 in Mode 5 and Unit 3 at 100% power, a Quality Assurance audit determined that Technical Specification (TS) 4.7.9.1 surveillance requirements had not been fulfilled for 11 fire doors. Specifically, the 6-month visual inspection of the closing mechanism and latches on 7 of the 11 doors had not been adequately performed and the 18-month functional testing had not been performed on any of the 11 doors. In addition, it was identified that the 6-month and 18-month surveillances on fire doors containing two leaves (double doors) were in some cases not performed correctly. There is no safety significance to this event since subsequent surveillances of the fire doors involved demonstrated them to be operable.

The causes of these surveillance discrepancies were procedural deficiencies and inadequate training. The fire door surveillance procedure did not require adequate visual inspection and functional testing of various doors when ALARA considerations were involved. The procedure also did not require cycling of water-tight doors to satisfy functional testing requirements. Incorrect interpretation of TS surveillance requirements lead to the procedural deficiencies. Additionally, the training program for fire door inspectors was not sufficiently prescriptive to ensure complete surveillance of both leaves on double doors.

To ensure all TS fire door surveillance requirements are adequately performed, 1) enhancements to the training program for fire door inspectors have been implemented, 2) personnel involved in the preparation of the fire door surveillance procedure have been reinstructed on the importance of verbatim compliance with TS, and 3) the fire door surveillance procedure has been revised to clarify program requirements.

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Plant: San Onofre Nuclear Generating Station (SONGS)
Units: 2 and 3
Reactor Vendor: Combustion Engineering
Event Date: 11-30-87

A. PLANT CONDITIONS AT THE TIME OF THE EVENT:

The discrepancies identified herein occurred at various times during various plant operating conditions.

B. BACKGROUND INFORMATION:

San Onofre Units 2 and 3 Technical Specification (TS) section 3.7.9 requires that all fire rated assembly penetrations (fire doors) be OPERABLE at all times. OPERABILITY of fire doors is confirmed by performing the surveillance specified in TS 4.7.9.1. The following surveillances are found in TS 4.7.9.1 and are applicable to the fire doors in question:

" a. Verify at least once per 24 hours the position of each closed fire door and that doors with automatic hold-open and release mechanisms are free of obstructions.

b. Inspect at least once per 6 months the automatic hold-open, release and closing mechanisms and latches.

c. Perform a functional test at least once per 18 months of automatic hold-open, release, closing mechanisms and latches. "

C. DESCRIPTION OF THE EVENT:

1. Event:

On 11/30/87, with Unit 2 in Mode 5 and Unit 3 at 100% power, a Quality Assurance (QA) audit determined that TS 4.7.9.1 surveillance requirements had not been fulfilled for 11 fire doors. Specifically, the 6-month visual inspection of the closing mechanism and latches on 7 of the 11 doors had not been correctly performed and the 18-month functional test had not been performed on any of the 11 doors. In addition, investigation into the performance of fire door surveillances has determined that there were some instances in which the required 6 and 18-month TS surveillances had not been performed on the secondary leaf (inactive door) of each double fire door.

2. Inoperable Structures, Systems or Components that Contributed to the Event:

None.

3. Sequence of Events:

Not applicable.

4. Method of Discovery:

During performance of a QA audit of the fire door surveillance program, the discrepancies described herein were identified.

5. Personnel Actions and Analysis of Actions:

Not applicable.

6. Safety System Responses:

Not applicable.

D. CAUSES OF THE EVENT:

Doors AR-105, 106, 107, 112, 113, 114, and 203

1. Immediate Cause:

The fire door surveillance procedure was deficient. In June 1985, the fire door surveillance procedure was improperly revised and resulted in the removal of the requirement for opening the above doors to perform the 6-month closing mechanism inspection and 18-month functional test.

2. Root Cause:

The revision to the fire door surveillance procedure took place because of a misunderstanding of TS surveillance requirements by the Fire Protection group. At the time, the above doors provided access to rooms containing radioactive materials and it was erroneously believed that ALARA concerns associated with the performance of the TS surveillance tests on these doors were valid reasons for not performing the required surveillances.

Doors S2-017, 018 and S3-017, 018

1. Immediate Cause:

The above doors, located in the Safety Equipment Buildings for Units 2 and 3, respectively, are water-tight doors. The testing method used to perform the 18-month TS surveillance on these doors (pushing and pulling on the door from one side) is now judged deficient since it did not adequately demonstrate that the above doors were properly inspected and therefore, did not satisfy the TS 18-month surveillance requirement. The method employed did not ensure that the handwheel, linkages, and latches (dogs) were adequately inspected. This method had been used since 1984.

2. Root Cause:

Water-tight doors possess unique operational characteristics (e.g., they are equipped with actuating handwheels, linkages, and latches [dogs]). Personnel responsible for developing the testing method did not fully consider the unique properties of water-tight doors and therefore failed to prescribe steps which would adequately test each of these components.

Double Door Surveillances

1. Immediate Cause:

In some cases, certain fire door inspectors did not include the inactive leaf of double doors within the scope of the inspection which accomplished the functional 18-month TS surveillance.

2. Root Cause:

It was believed that fire door inspectors possessed the skills necessary to understand that all door components, including inactive leaves, are subject to the TS surveillance requirements. This incident has indicated the contrary. Consequently, inspectors were not adequately trained in this area.

E. CORRECTIVE ACTIONS:

1. Corrective Actions Taken:

a. All required fire door TS surveillances have been successfully performed.

b. Retraining on fire door TS surveillance requirements (including secondary leaves of double doors) and proper implementation of the surveillance procedure has been provided to all fire door inspectors. Additionally, this incident has been reviewed by all fire door inspectors.

c. All personnel involved in the preparation of the fire door surveillance procedure which erroneously removed the requirement for opening doors due to ALARA considerations have been reinstructed on the importance of verbatim compliance with TS.

d. The fire door surveillance procedure has been revised to clarify the requirements and acceptance criteria for the 6 and 18-month inspections and tests.

2. Planned Corrective Actions:

a. None.

F. SAFETY SIGNIFICANCE OF THE EVENT:

The health and safety of the public and plant personnel were not affected by these occurrences because all the fire doors in question were found to be operable.

G. ADDITIONAL INFORMATION:

1. Component Failure Information:

Not applicable.

2. Previous LERs on Similar Events:

None.

Southern California Edison Company

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April 14, 1988

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

Subject: Docket No. 50-361
30-Day Report
Licensee Event Report No. 87-027, Revision 1
San Onofre Nuclear Generating Station, Unit 2

Reference: Letter, Mr. H. E. Morgan (SCE) to USNRC, dated December 30, 1987

The referenced letter provided the required 30-day written Licensee Event Report (LER) for an occurrence involving an operation or condition prohibited by the plant's Technical Specifications. This submittal provides additional information regarding this event.

If you require any additional information, please so advise.

Sincerely,

H E Morgan

Enclosure: LER No. 87-027, Rev. 1

cc: F. R. Huey (USNRC Senior Resident Inspector, Units 1, 2 and 3)

J. B. Martin (Regional Administrator, USNRC Region V)

Institute of Nuclear Power Operations (INPO)

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