

ACCELERATED DISTRIBUTION DEMONSTRATION SYSTEM

ACCESSION NBR:8808160353 DOC.DATE: 88/08/05 NOTARIZED: NO DOCKET #
 FACIL:50-316 Donald C. Cook Nuclear Power Plant, Unit 2, Indiana & 05000316
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SUBJECT: LER 88-008-00:on 880719,fire door was made inoperable due to
 placement of hose for a hydrostatic test.W/880805 ltr.

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

NOTES:

RECIPIENT ID CODE/NAME	COPIES LTTR ENCL	RECIPIENT ID CODE/NAME	COPIES LTTR ENCL
PD3-1 LA	1 1	PD3-1 PD	1 1
STANG,J	1 1		
INTERNAL: ACRS MICHELSON	1 1	ACRS MOELLER	2 2
AEOD/DOA	1 1	AEOD/DSP/NAS	1 1
AEOD/DSP/ROAB	2 2	AEOD/DSP/TPAB	1 1
ARM/DCTS/DAB	1 1	DEDRO	1 1
NRR/DEST/ADS 7E	1 0	NRR/DEST/CEB 8H	1 1
NRR/DEST/ESB 8D	1 1	NRR/DEST/ICSB 7	1 1
NRR/DEST/MEB 9H	1 1	NRR/DEST/MTB 9H	1 1
NRR/DEST/PSB 8D	1 1	NRR/DEST/RSB 8E	1 1
NRR/DEST/SGB 8D	1 1	NRR/DLPQ/HFB 10	1 1
NRR/DLPQ/QAB 10.	1 1	NRR/DOEA/EAB 11	1 1
NRR/DREP/RAB 10	1 1	NRR/DREP/RPB 10	2 2
NRR/DRIS/SIB 9A	1 1	NUDOCS-ABSTRACT	1 1
<u>REG FILE</u> 02	1 1	RES TELFORD,J	1 1
RES/DSIR DEPY	1 1	RES/DSIR/EIB	1 1
RES/DSR DEPY	1 1	RGN3 FILE 01	1 1
EXTERNAL: EG&G WILLIAMS,S	4 4	FORD BLDG HOY,A	1 1
H ST LOBBY WARD	1 1	LPDR	1 1
NRC PDR	1 1	NSIC HARRIS,J	1 1
NSIC MAYS,G	1 1		

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) D. C. Cook Nuclear Plant, Unit 2										DOCKET NUMBER (2) 0 5 0 0 0 3 1 6					PAGE (3) 1 OF 0 5	
TITLE (4) Fire Door Inoperable Without Required Continuous Fire Watch Due to Labeling Problem and 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)			
0	7	1	9	8	8	0	0	8	D. C. Cook, Unit 1				0 5 0 0 0 3 1 5			
0	7	1	9	8	8	0	0	8					0 5 0 0 0 3 1 5			
OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)														
6		20.402(b)				20.405(c)				50.73(a)(2)(iv)				73.71(b)		
POWER LEVEL (10)		20.405(a)(1)(i)				50.36(c)(1)				50.73(a)(2)(v)				73.71(c)		
0 1 0 1 0		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)(ix)						
LICENSEE CONTACT FOR THIS LER (12)																
NAME K. R. Baker, Operations Superintendent										TELEPHONE NUMBER						
										AREA CODE						
										6 1 6		4 6 5 - 1 5 9 0 1				
COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)																
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPDs		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPDs						
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 07/19/88 at approximately 1500, the roll up fire door to the West Motor Driven Auxiliary Feedwater Pump (WMDAFP) room was made inoperable when a hose was placed through the doorway for a hydrostatic test. The door was then closed down on the hose and the sliding missile door (uninhibited by the hose) was closed over the hose. Due to inadequate labeling of the fire door and the fact that the missile door was previously the fire door until a design change installed the roll up door; the involved persons did not recognize the inoperability and no fire watch was posted.

At 1715 on 07/19/88, a routine fire protection tour identified the hose through the doorway of the WMDAFP roll up fire door and a roving fire watch was subsequently established. The fire door was restored to an operable status at 1206 on 07/21/88 when the hose was removed. It was subsequently identified that a continuous fire watch should have been posted. The failure to post a continuous fire watch was caused by personnel error.

The door labeling problem has been corrected. A guidance letter was issued to persons involved with fire watch postings to stress the importance of positively identifying whether a roving or continuous fire watch is required whenever they are involved with an inoperable fire door.

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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)

Conditions Prior to Occurrence

Unit 1 was in Mode 1 (Power Operation) at 90 percent.

Unit 2 was in Mode 6 (Refueling) with the fuel off loaded.

Description of Event

At approximately 1500 on 07/19/88, a jumper hose was placed through the doorway to the West Motor Driven Auxiliary Feedwater Pump (WMDAFP) (EIIS/BA-MDP) in preparation for a hydrostatic test. The Contractor pipe fitter who placed the hose then closed the Technical Specification roll up fire door (EIIS/DR) down on the hose and then closed the sliding missile protection door over the hose. The closing of the sliding door was not inhibited by the hose due to the gap beneath the door.

Prior to completing the connection of hydrostatic test hoses to the East Motor Driven Auxiliary Feedwater pump (EMDAFP) and the Turbine Driven Auxiliary Feedwater pump (TDAFP) (EIIS/BA-TRBP) the pipefitter was preparing to call for a fire watch for the EMDAFP and TDAFP room fire doors when the contractor hydrostatic test supervisor arrived in the area. The supervisor and the pipefitter discussed the WMDAFP room door and it was agreed that since the hose did not obstruct the closing of the missile door, which they thought was the fire door, then no fire watch was required. The supervisor then proceeded to call for fire watches for the EMDAFP and TDAFP rooms.

At 1715 on 07/19/88, a routine fire protection tour identified the hose in the doorway of the WMDAFP. The fire watch supervisor was called and he came to the door. A discussion was held between the fire watch supervisor and a Quality Control technician who happened to be passing by the area. From this discussion it was concluded that the door should be considered inoperable and added to the roving fire watch patrol.

It was identified during the investigation of this event that a continuous fire watch should have been posted in accordance with T.S. 3.7.10 which requires a continuous fire watch when there are no operable fire detectors (EIIS/IC-DET) on either side of the door.

The WMDAFP fire door was restored to operable status at 1206 on 07/21/88 when the hose was removed from the doorway. The total time of non-compliance to the action statement of T.S. 3.7.10 was approximately forty-four hours.

Other than the WMDAFP fire door, there were no inoperable structures, components or systems which contributed to this event.

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

Cause of Event

There are two areas of concern in this event. The first being the failure to initially identify that a T.S. fire door was made inoperable and the second being the posting of a roving fire watch instead of the required continuous fire watch.

A. Failure to initially identify the inoperability of the WMDAFP fire door.

1. The roll up door for the WMDAFP was installed in late 1984 when it was determined that the sliding missile door could not meet the requirements for a fire door. Both the pipefitter and the supervisor were unaware that the sliding missile door was no longer the fire door. The pipefitter thought the roll up door had been installed for noise reduction.
2. The supervisor did not know that the roll up fire door existed. When he arrived in the area, the missile door had already been closed and the roll up door was hidden from view.
3. The T.S. fire door designation for the roll up door is on the door hood which is above eye level. When wearing a hard hat, the sign is not visible unless a person looks up. With the sliding missile door closed, the T.S. fire door designation cannot be seen.

The human factors problems with the identification of the T.S. fire door coupled with the mind set caused by the sliding missile door previously being the fire door; is considered to be the root cause for the failure to initially identify the inoperability of the WMDAFP fire door.

B. Posting of a roving fire watch instead of the required continuous fire watch.

1. The Quality Control technician who assisted the fire watch supervisor, although qualified to do so, does not normally work with the establishment of fire watches and did not realize that the fire watch supervisor was relying on his determination of actions needed. The fire watch supervisor on the other hand, believed that the technician had made the final determination on actions required.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104

EXPIRES: 8/31/88

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

2. In order to positively determine which fire rated assemblies have associated fire detectors, drawings must be used. For doors which are frequently made inoperable, a decision on the type of fire watch required is sometimes made based on previous experience with the door rather than sorting through the drawings. In this event the technician made the decision based on his previous experience with other auxiliary feedwater (AFW) pump room doors instead of positively identifying the type of fire watch required.
3. There are fire detectors in the corridor for the EMDAFP and TDAFP rooms. Therefore a roving fire watch is satisfactory for those rooms. The majority of the AFW pump room fire watch postings in the recent past have been for the EMDAFP and TDAFP rooms. This contributed to a mind set that an inoperable AFW pump room door only requires a roving fire watch.

The misunderstanding between the fire watch supervisor and the Quality Control technician as to who was making the final determination on fire watch requirements coupled with the mind set concerning AFW pump room fire doors, contributed to the personnel error which resulted in the posting of a roving fire watch instead of the required continuous fire watch.

Analysis of Event

This event is considered reportable pursuant to 10 CFR 50.73 (a)(2)(iB).

At the time of this event the WMDAFP was not required to be operable. Since the WMDAFP was not required, any damage to the pump which could have been caused by a fire would not have posed a significant safety problem as defined in 10 CFR 50.59.

Corrective Actions

1. Signs have been placed at the entrance to the Unit 1 and Unit 2 WMDAFP rooms to identify the Technical Specification roll up fire door which is behind the sliding missile door.
2. A memorandum was issued to affected Quality Control personnel to stress the importance of positively identifying whether a roving or continuous fire watch is needed whenever they are involved with an inoperable fire door.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104

EXPIRES: 8/31/88

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Failed Component Identification

None

Previous Similar Events

LER 50-315/82-026
LER 50-316/82-049
LER 50-316/82-052
LER 50-315/82-064
LER 50-315/83-012
LER 50-315/84-003
LER 50-315/84-006
LER 50-315/85-009
LER 50-315/85-051

These previous events basically involved persons blocking open doors and failing to establish a fire watch due to unfamiliarity with the requirements for a blocked door. This event is different in that the persons were knowledgeable of the requirements, but did not know that a T.S. fire door was being blocked. No previous events of posting a roving fire watch instead of a continuous fire watch were identified.

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616 465 5901



August 5, 1988

United States Nuclear Regulatory Commission
Document Control Desk
Washington, D.C. 20555


Operating License DPR-58
Docket No. 50-316

Document Control Manager:

In accordance with the criteria established by 10 CFR 50.73
entitled Licensee Event Reporting System, the following
report is being submitted:

88-008-00

Sincerely,


W. G. Smith, Jr.
Plant Manager

WGS:clw

Attachment

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