

# WOLF CREEK

NUCLEAR OPERATING CORPORATION

John A. Bailey  
Vice President  
Operations

October 18, 1991

NO 91-0288

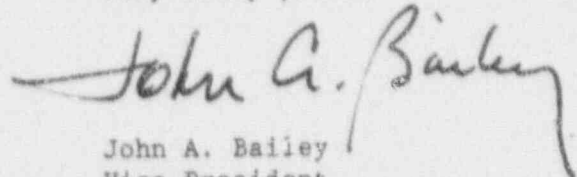
U. S. Nuclear Regulatory Commission  
ATTN: Document Control Desk  
Mail Station P1-137  
Washington, D. C. 20555

Subject: Document No. 50-482: Licensee Event Report 91-017-00

Gentlemen:

The attached Licensee Event Report (LER) is being submitted pursuant to 10 CFR 50.73 (a) (2) (i) and 50.73(a)(vii) concerning a Technical Specification violation that could have caused the inoperability of a system designed to control the release of radiation.

Very truly yours,



John A. Bailey  
Vice President  
Operations

JAB/aem

Attachment

cc: L. L. Gundrum (NRC), w/a  
A. T. Howell (NRC), w/a  
E. D. Martin (NRC), w/a  
W. D. Reckley (NRC), w/a

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# LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Wolf Creek Generating Station	DOCKET NUMBER (2) 0 5 0 0 0 4 8 2 1	PAGE (3) 1 of 0 5
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TITLE (4) Failure to Follow Procedure By Propping Door Open Results in Potential Inoperability of Fuel Building and Auxiliary Building Emergency Exhaust Systems

EVENT DATE (5)			LER NUMBER (6)		REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)		
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	DOCKET NUMBER (9)	
0 9	2 0	9 1	9 1	- 0 1 7	0 0	1 0	1 8	9 1	0 5 0 0 0 0	

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR : (Check one or more of the following) (11)											
OPERATING MODE (9) 3	20.402(b)			20.405(v)			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)			<input checked="" type="checkbox"/> 50.73(a)(2)(vii)			OTHER (Specify in Abstract below and in Text, NRC Form 385A)	
	20.405(a)(1)(iii)			<input checked="" type="checkbox"/> 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 Merlin G. Williams - Manager Plant Support										TELEPHONE NUMBER 3 1 6 3 6 4 - 6 8 3 1	

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)											
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPHOS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPHOS		

SUPPLEMENTAL REPORT EXPECTED (14)										EXPECTED SUBMISSION DATE (15)		MONTH	DAY	YEAR
<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE) <input checked="" type="checkbox"/> NO														

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

On September 21, 1991, at 0748 CDT, Security personnel notified Control Room operators that a Fuel Building/Auxiliary Building pressure boundary door was found propped open without a continuous watch having been established. Subsequent evaluation concluded that with this door open, the Fuel Building and Auxiliary Building Emergency Exhaust Systems (EES) may not have been able to maintain a negative pressure greater than or equal to .25 inch Water Gauge independently as required by Technical Specification 3.7.7 and 3.9.13 for Fuel Building and Auxiliary Building EES operability.

The root cause of this event is failure to follow procedures by the craftsmen who propped the door open to move scaffolding through the door. To prevent recurrence of this event, the Manager Modifications has discussed this event and its ramifications with his craftsmen's supervision. Additionally, a Security Special Order has been issued to enhance the administrative controls for maintaining pressure boundary doors closed.

**LICENSEE EVENT REPORT (LER)  
TEXT CONTINUATION**

FACILITY NAME (1)	DOCKET NUMBER (2)	YEAR	LER NUMBER (3) SEQUENTIAL NUMBER	REVISION NUMBER	PAGE (5)
Wolf Creek Generating Station	0500048291	-	017	-00	02 of 05

TEXT (If more space is required, use additional NRC Form 386A's) (17)

**INTRODUCTION**

On September 21, 1991, at approximately 0748 CDT, Security personnel notified Control Room operators that a Fuel Building[ND]/Auxiliary Building [NF] pressure boundary door [ND/NF-DR] was found propped open without a continuous watch having been established. Subsequent evaluation concluded that with this door open, the Fuel Building and Auxiliary Building Emergency Exhaust Systems (EES) may not have been able to maintain a negative pressure greater than or equal to .25 inch Water Gauge independently as required by Technical Specification (T/S) 3.7.7 and 3.9.13 for Fuel Building and Auxiliary Building EES operability. Therefore, this event is being reported pursuant to 10 CFR 50.73(a)(2)(i)(B) and 10 CFR 50.73(a)(2)(vii).

**DESCRIPTION OF EVENTS**

On September 20, 1991, at 1842 CDT, Security personnel took Door 15071 [ND/NF-DR] off-line to facilitate the movement of scaffolding through Door 15071 into Door 1507A by Modifications craftsmen. Door 15071 is located between the Fuel Building and Auxiliary Building. Door 15071 is a fire door and also serves as part of the EES pressure boundary. A Security Officer, who was posted at nearby Door 1507A, was informed to provide alarm assessment and monitor access for the door during the transfer of equipment through Door 15071. The craftsmen entered the area and were informed by the Security Officer that someone would need to hold the door open and be responsible for closing the door when they were finished since it was a pressure boundary door. Subsequently, the craftsmen propped Door 15071 open with a spool of rope and commenced the transfer of equipment through the door.

On September 21, 1991, at approximately 0330 CDT, the craftsmen, whose shift was to be ending soon, stopped the transfer of equipment. The Security Officer then returned to monitoring only Door 1507A as originally posted. Following the Security Shift turnover at approximately 0700 CDT, the on-coming Security Officer posted at Door 1507A recognized that Door 15071 required a continuous watch while propped open. On September 21, 1991, at 0748 CDT, Security personnel notified Control Room operators that Door 15071 was found propped open without a continuous watch having been established and the door was immediately secured.

**LICENSEE EVENT REPORT (LER)  
TEXT CONTINUATION**

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
Wolf Creek Generating Station	0 5 0 0 0 4 8 2 9 1	0	1	7	0 0 0 3 of 0 5

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

The Auxiliary Building EES ensures that any radioactive materials leaking from the Emergency Core Cooling System [JE] equipment within the Auxiliary Building following a loss of coolant accident are filtered prior to reaching the environment. Technical Specification 3.7.7 requires two operable independent Auxiliary Building EES while in Mode 1, Power Operation, through Mode 4, Hot Shutdown. With one Auxiliary Building EES inoperable, T/S 3.7.7 requires restoration of the inoperable system to operable status within 7 days or to be in at least Hot Standby within the next 6 hours and in Cold Shutdown within the following 30 hours. Technical Specification 3.7.7 does not provide an action in the event both Auxiliary Building EES are inoperable. Consequently, entry into T/S 3.0.3 is required if both Auxiliary Building EES are inoperable. In part, operability of the Auxiliary Building EES must be demonstrated by verifying that the system maintains the Auxiliary Building at a negative pressure of greater than or equal to .25 inch Water Gauge relative to the outside atmosphere during system operation.

Additionally, Technical Specification 3.9.13 for the Fuel Building EES requires two operable independent Fuel Building EES whenever irradiated fuel is in the spent fuel pool. The Fuel Building EES ensures that all radioactive material released from an irradiated fuel assembly will be filtered through the HEPA filters and charcoal adsorber prior to discharge to the atmosphere. With one Fuel Building EES inoperable, T/S 3.9.13 allows fuel movement within the fuel storage areas or crane operation with loads over the fuel storage areas to proceed provided the operable Fuel Building EES is in operation and discharging through at least one train of HEPA filters and charcoal adsorbers. With two Fuel Building EES inoperable, T/S 3.9.13 requires suspending all operations involving movement of fuel within the fuel storage areas or crane operation with loads over the fuel storage area until at least one Fuel Building EES is restored to operable status. In part, operability of the Fuel Building EES must be demonstrated by verifying a negative pressure of greater than or equal to .25 inch Water Gauge relative to the outside atmosphere during system operation.

Subsequent evaluation concluded that with Door 15071 propped open, the Auxiliary Building and Fuel Building EES may not have been able to maintain negative pressures greater than or equal to .25 inch Water Gauge independently as required by T/S 3.7.7 and 3.9.13 for Fuel Building and Auxiliary Building EES operability. Although this evaluation concluded that both EES were inoperable, the action statement for T/S 3.9.13 for both Fuel Building EES being operable was met during the time Door 15071 was propped open. Because T/S 3.7.7 does not provide an action for both Auxiliary Building EES being inoperable, T/S 3.0.3 should have been entered. Additionally, this evaluation



**LICENSEE EVENT REPORT (LER)  
TEXT CONTINUATION**

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
Wolf Creek Generating Station	0500048291	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	04 of 05
			017	0	

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

determined that a pressure test would have to be performed with Door 15071 open to conclusively prove or disprove Fuel Building and Auxiliary Building EES operability in this configuration. It was determined that it was not feasible to perform this pressure test at the present time.

**ROOT CAUSE AND CORRECTIVE ACTION**

The root cause of this event is failure to follow procedures by the craftsmen who propped open Door 15071 to move scaffolding through the door. Procedure ADM 13-103, "Fire Protection: Impairment Control" instructs personnel on station policy that inanimate objects are not to be used to prop open a door since the station has committed to maintaining doors capable of closing and latching automatically at all times. The procedure also states that use of inanimate objects is allowed to prop open a door only when the door is controlled by a permit in accordance with the procedure. Additionally, this procedure states that prior to issuing a permit for any door listed in an Operations Special Order concerning pressure doors, the Shift Supervisor shall be consulted for heating, ventilation and air conditioning systems operability requirements. The craftsmen who propped open Door 15071 did not comply with procedure ADM 13-103 requirements.

Because the investigation into this event has been unsuccessful at identifying the craftsmen involved, to prevent recurrence of this event, the Manager Modifications has discussed this event and its ramifications with his craftsmen's supervision. Additionally, to enhance the administrative controls for maintaining pressure boundary doors closed, Security has issued a Special Order to Security personnel requiring notification to the Shift Supervisor when taking any normally on-line pressure boundary door off-line. The Security Special Order also instructs Security personnel to notify the Shift Supervisor any time a door is found propped open without the proper permit. Additional long-term programmatic enhancements are being evaluated and will be implemented by March 31, 1992.

**ADDITIONAL INFORMATION**

Throughout this event, the unit was in Mode 3, Hot Standby, cooling down for refueling. 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 and safety of the public. Although it has been concluded that the Fuel Building and Auxiliary Building EES may not have been

LICENSEE EVENT REPORT (LER)  
TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
Wolf Creek Generating Station	0500048291	-	017	-00	05 of 05

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

able to maintain the technical specification pressurization requirements independently, it is believed that had actuation of the Fuel Building or Auxiliary Building EES occurred all equipment in these systems was available to respond thereby providing the capability to maintain pressurization of the Fuel Building and Auxiliary Building as required.

Licensee Event Report (LER) 90-005-00 discusses an event in which inadequate procedures resulted in improper control of pressure boundary doors which adversely effected the Control Room Emergency Ventilation System operability. In response to LER 90-005-00, procedure ADM 13-103 was revised to provide administrative controls for propping open pressure boundary doors. Because the craftsmen failed to follow this procedure, this procedure revision had no effect in preventing this event's occurrence.