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New York Power Authority

Radford J. Converse
Resident Manager

October 25, 1991
JAFP-91-0691

United States Nuclear Regulatory Commission
Document Control Desk
Mail Station P1-137
Washington, D.C. 20555

SUBJECT: DOCKET NO. 50-333
LICENSEE EVENT REPORT: 91-020-00

Dear Sir:

This report is submitted in accordance with 10 CFR 50.73(a)(2)(i)(B).

Questions concerning this report may be addressed to
Mr. R. Alan Heath at (315) 349-6349.

Very truly yours,

RADFORD J. CONVERSE

RJC:RAH:lar

Enclosure

cc: USNRC, Region I
USNRC Resident Inspector
INPO Records Center

IE22
1/1

NRC Form 366
(9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES 8/31/88

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
JAMES A. FITZPATRICK NUCLEAR POWER PLANT	0 5 0 0 0 3 3 3	1 OF 0 3

TITLE (4) Fire Door 76FDR-RW-272-16 Inoperable Due to Tape on Latch Bolt as a Result of Human 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 NAME	DOCKET NUMBER(S)
0 9	2 5	9 1	9 1	--- 0 2 0	--- 0 0		1 0	2 5	9 1		0 5 0 0 0
											0 5 0 0 0

OPERATING MODE (9)	N	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)	20.405(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, 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
R. Alan Heath	AREA CODE 3 1 5 — 3 4 9 — 6 3 4 9

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)

EIIS Codes are in []

On 09/25/91 at 0100 hours fire door 76FDR-RW-272-16 in the Appendix R barrier between the turbine building [NM] and radwaste building [NE] was found with the latch mechanism taped thus preventing latching of the door. A firewatch was posted. The latch was taped as a personnel safety concern when it was found that the latch was inoperative. A firewatch was posted and the door was repaired and tested. The cause of this event was human error.

NRC Form 366
(9-83)

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Description

The plant was operating at 100% power on September 25, 1991. At 0100 hours fire door 76FDR-RW-272-16 in the Appendix R barrier between the turbine building [NM] and the radwaste building [NE] was found with the latch taped over making the fire door inoperative. The door latching mechanism was restricted such that, if closed, the latch bolt would not release to secure the door. A firewatch was established at 0120 hours on September 25, 1991. Door repair was undertaken and completed by 1600 hours on September 25, 1991.

Cause

On August 19, 1991 a work request was written indicating that the door latch mechanism on fire door 76FDR-RW-272-16 was hard to operate. The review of the work request did not include a review of operability since the latch stuck when the door closed, an acceptable position to maintain the fire barrier. On September 24, 1991 a new work request was written stating the latch mechanism was broken and the door could not be opened. The originator of the work request of September 24, 1991 was able to release the latch with a pocket knife. An operator released the latch and taped the latch mechanism. He did not inform anyone of his actions assuming that for personnel safety concerns personnel should be able to move through this opening. Personnel exiting the radwaste building [NE] must pass through this door to access the turbine building [NM]. Exits from the restricted area are from the turbine building to the administration building or the turbine building to the screenwell.

The cause of this event is human error, Cause Code [A].

Analysis

This event is reportable per the provisions of 10 CFR 50.73(a)(2)(i)(B), Technical Specifications, Section 3.12.F.1.b, requires that if a fire barrier is found inoperable, a continuous fire watch be established on one side of the barrier. The tape over the latch bolt mechanism caused fire door 76FDR-RW-272-16 to be inoperative. The door was held in a closed position by the closure mechanism, the opening was closed but not fully operational. There are limited combustibles on either side of this opening.

Corrective Actions

Immediate corrective action: A fire watch was established on one side of fire door 76FDR-RW-272-16 and maintained until the door was repaired by the installation of a temporary modification and operability of the door was verified.

Long-term corrective action: More emphasis will be placed on stressing the importance of functional fire barriers in General Employee Training. A new replacement door has been ordered and is expected within two (2) months.

In addition, a memorandum to plant staff was issued informing them of the issue and the importance of maintaining fire doors in an operable condition.

Additional Information

There have not been any other LERs at this facility in which personnel intentionally disabled (made inoperable) a fire door latch in the belief that disabling the latch was necessary for personnel safety (emergency egress) purposes.

The following LERs deal with fire doors disabled in the open position: 91-002, 91-003, 91-008, 91-012, and 91-017.