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SUBJECT: Responds to NRC 940520 ltr re violation noted in Insp Rept 50-261/94-12.Corrective actions:instructions for not placing matl in travel path of fire doors communicated to site employees via site info sys.

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10 CFR 2.201

Carolina Power & Light Company
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Robinson File No.: 13510E
Serial: RNP/94-1214

JUN 17 1994

United States Nuclear Regulatory Commission
Attention: Document Control Desk
Washington, DC 20555

H. B. ROBINSON STEAM ELECTRIC PLANT, UNIT NO. 2
DOCKET NO. 50-261/LICENSE NO. DPR-23
NRC INSPECTION REPORT NO. 50-261/94-12 REPLY TO A NOTICE OF VIOLATION

Gentlemen:

This provides the Carolina Power & Light Company (CP&L) reply to the Notice of Violation identified in NRC Inspection Report 50-261/94-12, which was transmitted by letter dated May 20, 1994. The Violation involves the failure to preclude recurrence of rendering a fire door inoperable.

As requested in the letter transmitting the Notice of Violation, the enclosure restates the violation, followed by our reply.

Should you have any questions regarding this matter, please contact Mr. R. M. Krich at (803) 383-1802.

Very truly yours,

C S Hinnant

C. S. Hinnant
Vice President

RDC:rdc
Enclosures
c: Mr. S. D. Ebneter, Regional Administrator, USNRC, Region II
Ms. B. L. Mozafari, USNRC Project Manager, HBRSEP
Mr. W. T. Orders, USNRC Senior Resident Inspector, HBRSEP

IE01

REPLY TO A NOTICE OF VIOLATION

Violation 94-12-01

10 CFR 50, Appendix B, Criterion XVI, requires in part that corrective actions be taken to preclude repetition of conditions adverse to quality.

Contrary to the above, the licensee failed to take adequate corrective actions on December 23, 1992, in which an automatic door which serves as a fire barrier, was erroneously blocked open, in that the same door was again erroneously blocked open on April 14, 1994.

Reply

CP&L acknowledges the violation.

1. The Reasons for the Violation

This violation was caused by failure of the Corrective Action Program (CAP) to identify the existence of an adverse trend. During the time that the violation occurred, the CAP process did not provide an adequate method for performing an analysis of all adverse conditions for identification of adverse trends. As a result, the corrective actions taken for previous events were not identified as inadequate in preventing fire door obstruction recurrence. Inattention to detail has been identified as an apparent primary contributing factor for the April 14, 1994, event when a stanchion was moved into the pathway of a fire door. Interviews with work group leaders that routinely enter the area of concern could not identify any specific group or individuals entering the area during the time frame of this incident, and attempts to identify the individual(s) responsible for moving the stanchion were unsuccessful.

Our investigation of this occurrence identified that an unacceptable history exists with respect to obstructing or otherwise opening fire doors without notifying fire protection. Since 1992, six previous occurrences were identified. Each occurrence was evaluated separately, without consideration of a similar event(s). Previous corrective actions focused primarily on counselling an individual(s) involved with each respective incident and retraining personnel on the fire door procedure. Therefore, the resultant corrective actions for each event were not effective to prevent recurrence.

The six previous occurrences were also reviewed collectively to determine if similarities existed. A common factor was that each resulted from a conscious decision to block open a fire door for the purpose of accomplishing a particular activity. In each case, adequate attention to detail was not provided with regard to the consequences of the action.

However, with respect to the occurrence on April 14, 1994, the fire door was inadvertently obstructed. The stanchion was not specifically placed in the discovered location to aid in completing a particular work activity, but apparently was inadvertently and carelessly placed in the fire door pathway due to inattention to detail by a worker or workers.

2. The Corrective Steps That Have Been Taken and the Results Achieved

As an interim, immediate action, instructions for not placing material in the travel path of fire doors were communicated to site employees via site information systems.

An investigation was conducted of the occurrence on April 14, 1994, and a review was performed to identify similar occurrences. The results of the investigation were presented to the Plant Nuclear Safety Committee on June 3, 1994.

3. The Corrective Steps That Will Be Taken to Avoid Further Violations

The Corrective Action Program has been revised, and a common database is now being used which will aid in more effectively identifying adverse trends across all site organizations. This database, now available for use by each line organization, provides methods where potential problems can be identified and corrected before they occur.

Robinson management continues to utilize a broad variety of methods to address "attention to detail" issues. One of these methods will be to conduct "Stand-down" meetings for RNP personnel. In these meetings, each Unit Manager will present a consistent message regarding recent poor work practices resulting from inattention to detail. We anticipate that these meetings will result in fewer adverse conditions related to poor human performance.

4. The Date When Full Compliance Will Be Achieved

Full compliance has been achieved with the revision to the Corrective Action Program, which now provides a means for performing more effective trending. Implementation of these human performance improvements will be an on-going process.