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SUBJECT: Forwards response to NRC 950810 ltr re violations noted in
insp rept 50-261/95-21. Corrective actions: matl blocking fire
door swing path was removed & door was returned to svc.

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Robinson File No.: 13510E
Serial: RNP-RA/95-0167

SEP 11 1995

United States Nuclear Regulatory Commission
Attn: Document Control Desk
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H. B. ROBINSON STEAM ELECTRIC PLANT, UNIT NO. 2
DOCKET NO. 50-261/LICENSE NO. DPR-23
NRC INSPECTION REPORT NO. 50-261/95-21
REPLY TO A NOTICE OF VIOLATION

Gentlemen:

This provides the Carolina Power & Light (CP&L) Company reply to the Notice of Violation identified in NRC Inspection Report No. 50-261/95-21 for the H. B. Robinson Steam Electric Plant (HBRSEP), Unit No. 2, which was transmitted by letter dated August 10, 1995. Violation A involves a failure to preclude rendering a fire door inoperable. Violation B involves failure of the operating crew to monitor plant status. As requested in the letter transmitting the Notice of Violation, the enclosure restates each violation, followed by our reply. This reply is required to be submitted to the NRC by September 11, 1995.

Should you have any questions regarding this matter, please contact Mr. R. M. Krich at (803) 857-1802.

Very truly yours,

C. S. Hinnant
C. S. Hinnant
Vice President

DTG:dtg
Enclosure

c: Mr. S. D. Ebnetter, Regional Administrator, USNRC, Region II
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REPLY TO A NOTICE OF VIOLATION

Violation A

Technical Specification 6.5.1.1.1, Procedures, Tests, and Experiments, states that written procedures shall be established, implemented, and maintained, covering the activities recommended in Appendix "A" of Regulatory Guide 1.33, Rev. 2, February 1978, including administrative procedures related to fire protection program implementation.

Fire Protection Procedure, FP-014, Control Of Fire Barrier Penetrations, provides administrative procedures to implement the plant fire protection program. This procedure requires that Operations personnel be notified prior to blocking a fire door so as to perform verification of the operability of the fire detection systems on either side of the door.

Contrary to the above, on May 26, 1995, the fire door to pipe alley was blocked open for approximately 30 minutes without notification of Operations personnel.

Reply

Carolina Power & Light (CP&L) agrees that the violation occurred as described.

1. The Reason for the Violation

The principal cause of this violation was inattention to detail by the involved individual. The individual, a contractor, responsible for impeding the fire door, failed to read the posting on the Reactor Auxiliary Building (RAB) Pipe Alley room main entry door that identified the door as an automatic closure fire door, and that included instructions not to block the doorway. This individual also failed to observe the painted area on the floor in front of the door that indicated the door swing path and included a caution message; however, this painted area was partially obscured as discussed below.

In March 1995, the area of the floor at the door entrance to the RAB Pipe Alley was painted with yellow and red stripes with the words, "DO NOT BLOCK, AUTOMATIC CLOSURE." However, this caution message was not readily visible to personnel in the area because a contamination control step-off-pad was placed partially over the caution message. Partial covering of the caution message is considered a contributing cause. Our investigation also determined that the individual did not display a questioning attitude nor was the individual aware of the specific fire door configuration or its surroundings.

As a result of a previously identified trend regarding blocked RAB Pipe Alley fire doors in 1994, site-wide "Stand Down" meetings were held during the second quarter of 1994. The meeting presentations focused on personnel work practice problems resulting from inattention to detail. The "Stand Down" meetings were effective in preventing repeat events for approximately eleven months. Since March 1995, three events, including this one, have occurred in which automatic closure fire doors were potentially obstructed from closing properly. Two of the three events were due to actions performed by contractors. These contractors were not present for the previous "Stand Down" meeting presentations. Accordingly, the "Stand Down" meetings that were held in the past appear to be an effective corrective action for plant staff. However, as discussed below, this action to heighten the awareness of all personnel working in the plant was not institutionalized.

A contributing cause of this event is inadequate Plant Access Training (PAT) and Plant Specific General Employee Training at H. B. Robinson Steam Electric Plant (HBRSEP), Unit No. 2. that is provided to all personnel who obtain unescorted access to the plant Protected Area. Our review of the PAT indicated that the automatic closure fire doors are not adequately addressed. Four (4) fire doors located in the RAB that remain in the open position under normal conditions, including the door involved in this event, are not addressed in the PAT or Plant Specific General Employee Training at HBRSEP, Unit No. 2.

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

The material blocking the fire door swing path was removed, and the door was returned to service.

The individual responsible for blocking the fire door was removed from the site.

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

The Training staff will incorporate information regarding automatic closure fire doors into Plant Specific General Employee Training since the HBRSEP, Unit No. 2 is the only CP&L nuclear plant that utilizes automatic closure fire doors.

Additional training will be provided to Radiation Control technicians, stressing the importance of not placing radiological signs over other plant signs. Additionally, formal management expectations will be published regarding placement of radiological postings or step-off-pads over plant signs.

4. The Date When Full Compliance Will Be Achieved

Full compliance will be achieved by October 6, 1995.

Violation B

Technical Specification 6.5.1.1.1, Procedures, Tests, and Experiments, states that written procedures shall be established, implemented, and maintained, covering the activities recommended in Appendix "A" of Regulatory Guide 1.33, Rev. 2, February 1978, including procedures related to plant operations.

Operations Management Manual Procedure, OMM-001, Operations - Conduct Of Operations, provides administrative process guidelines to ensure that plant operations are conducted in an effective, consistent manner in accordance with the operating license, plant procedures, and applicable regulatory requirements. The procedure requires, in part, that the operations personnel assigned to shift, continuously monitor the plant and its associated equipment during all phases of operation and take corrective actions during abnormal or emergency conditions.

Contrary to the above, on June 30, 1995, at 6:37 p.m., the operating personnel assigned to the shift failed to effectively monitor the plant and its associated equipment and take corrective actions during abnormal conditions in that, over a 45 minute period, the water levels in all three steam generators increased, unbeknownst to the operators, until a high level condition in the A steam generator resulted in a trip of the running main feedwater pump, an automatic start of the motor driven auxiliary feedwater pumps, and an automatic isolation of the steam generator blowdown isolation valves.

Reply

CP&L agrees that the violation occurred as described with the clarifications discussed below.

1. The Reason for the Violation

The violation was caused by misjudgement on the part of the operating crew and a contributing cause was equipment deficiency. On June 30, 1995, the plant was in hot shutdown for approximately four (4) hours following a reactor trip, during which time the water level in the secondary side of the three Steam Generators (SGs) continued to increase even though the main Feedwater Regulating Valves (FRVs) and FRV bypass valves were closed. The Main Feedwater (MFW) header section isolation valves were open, one MFW pump was running, and SG Blowdown was in operation. Initially, the operating crew was controlling decreasing Reactor Coolant System (RCS) temperature, in response to a decrease in decay heat from the reactor. The crew elected to isolate SG Blowdown to reduce RCS heat removal in order to stabilize RCS temperature. The Balance Of Plant (BOP) licensed control room operator was dispatched from the control room to isolate SG Blowdown. Subsequently, a high SG water level alarm in the secondary side of the "A" SG was annunciated in the control room.

The observed increase in the SG secondary side water level was not considered abnormal because the operators had previously experienced leakage through the seats of the FRV and FRV bypass valves, and an increase in SG secondary side water level was further expected as a result of isolation of SG Blowdown. The SG secondary side water level increase was expected to continue until the delayed response from an increase in RCS temperature and SG steaming rate would stabilize and subsequently reduce the high SG secondary side water levels. The Notice of Violation stated that, "water levels in all three steam generators increased, unbeknownst to the operators"; however, our evaluation found that the control room operators were attentive to increasing secondary side water levels in the three SGs. After monitoring the plant response from the isolation of SG Blowdown, the operating crew realized that the increasing SG secondary side water level trend was not stabilized. At this point, operators decided to isolate the leaking FRV bypass valves. The BOP licensed control room operator was dispatched from the control room to isolate the FRV bypass valves locally but was unable to complete manual isolation of the valves before the increasing SG secondary side water level reached the high level trip setpoint for the "A" SG.

The actions undertaken to reduce RCS heat removal for RCS temperature control (i.e., closure of the SG Blowdown valves), in conjunction with leakage past the FRVs and FRV bypass valves, resulted in the rapid increase in SG secondary side water level. The data collected from the event indicated that SG "A" secondary side water level increased from 60% to 75% in approximately 15 minutes.

The ineffective corrective actions taken by the control room operators resulted from an error in judgement in that the selected course of action could not be accomplished in time to stabilize SG secondary side water level to avoid reaching the "A" SG high level trip setpoint. The operators could have avoided this event by earlier initiation of the actions that were taken, or by isolating the MFW section header since the FRVs are not intended nor designed to be leak-tight. A contributing cause to this event was a lack of training experience utilizing scenarios that include RCS temperature and SG level control concurrent with FRV and FRV bypass valves seat leakage, as part of routine recovery from a reactor trip from full power.

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

The MFW header section valves were closed, and SG secondary side water levels were returned to normal.

Operations management discussed this event with the responsible operating crew.

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

Operations Management is reviewing this event with all operating crews to emphasize the importance of identifying and responding to adverse trends to preclude any unplanned actuation. In addition, other corrective steps described in our letter dated August 23, 1995, that are being taken include the following.

- Shift Supervisors are performing self-assessments of their shift activities and are developing action plans to reduce personnel errors.
- On-going initiatives in the area of self-assessment are being emphasized and enhanced within the Operations Unit.
- A directive and a night order requiring routine pre-job and post-job briefings for infrequently performed tests or evolutions has been issued. The intent of these briefings is to improve communications and coordination within the operations crews.

The design of the FRV bypass valves will be evaluated to either eliminate valve leakage or determine the appropriate allowable seat leakage and take actions to reduce actual leakage if necessary.

Consideration for RCS temperature response and SG secondary side water level control during hot shutdown conditions, concurrent with FRV and FRV bypass valves seat leakage, will be included in licensed operator initial and requalification simulator training. The initial training will be completed by the end of the year.

4. The Date When Full Compliance Will Be Achieved

Full compliance will be achieved by December 31, 1995.