

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR:8011030423 DOC.DATE: 80/10/28 NOTARIZED: NO DOCKET #
 FACIL:50-261 H. B. Robinson Plant, Unit 2, Carolina Power and Ligh 05000261
 AUTH.NAME AUTHOR AFFILIATION
 STARKEY,R.B. Carolina Power & Light Co.
 RECIP.NAME RECIPIENT AFFILIATION
 Region 2, Atlanta, Office of the Director

SUBJECT: LER 80-024/01T-0:on 801014,small fire was reported inside
 containment & airlock door interlocks failed to function.
 Caused by personnel error.Airlock door & interlock were
 repaired & placed in satisfactory sealed condition.

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	A/D SFTY ASSE12		1	1	A/D TECHNOLOG13	1	1
	ACC EVAL BR 14		1	1	AEOD	2	2
	ASLBP/J.HARD		1	1	AUX SYS BR 15	1	1
	CHEM ENG BR 16		1	1	CONT SYS BR 17	1	1
	CORE PERF BR 18		1	1	D/DIR,HUM FAC19	1	1
	DIR,ENGINEERI20		1	1	DIR,HUM FAC S21	1	1
	DIR,SYS INTEG22		1	1	EFF TR SYS BR23	1	1
	EQUIP QUAL BR25		1	1	GEOSCIENCES 26	1	1
	I&C SYS BR 29		1	1	I&E 05	2	2
	JORDAN,E./IE		1	1	LIC GUID BR 30	1	1
	LIC QUAL BR 31		1	1	MATL ENG BR 32	1	1
	MECH ENG BR 33		1	1	MPA	3	3
	NRC PDR 02		1	1	OP EX EVAL BR34	3	3
	OR ASSESS BR 35		1	1	POWER SYS BR 36	1	1
	RAD ASSESS BR39		1	1	REACT SYS BR 40	1	1
	<u>REG FILE</u> 01		1	1	REL & RISK A 41	1	1
	SFTY PROG EVA42		1	1	STRUCT ENG BR44	1	1
	SYS INTERAC B45		1	1			
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	NSIC	05	1	1	TERA:DOUG MAY	1	1

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S.L

LICENSEE EVENT REPORT

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7 8 9 14 15 25 26 30 57 CAT 58
LICENSEE CODE LICENSE NUMBER LICENSE TYPE

CON'T
01 | L | 0 | 5 | 0 | 0 | 0 | 2 | 6 | 1 | 7 | 1 | 0 | 1 | 4 | 8 | 0 | 8 | 1 | 0 | 2 | 8 | 8 | 0 | 9
7 8 60 61 68 69 74 75 80
REPORT SOURCE DOCKET NUMBER EVENT DATE REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 | On two occasions, at 0910 and 1600 hours on October 14, 1980, while in a hot shutdown
03 | subcritical condition, the containment personnel airlocks were opened simultaneously.
04 | During the first event, maintenance was being performed on the airlock door interlocks
05 | when a small fire was reported inside containment. During an attempt to enter
06 | containment, operations personnel opened the exterior door while the inner door was
07 | not sealed. During the second event, the interlock failed to function properly,
08 | allowing both doors to be opened. These events are contrary to Technical
09 | Specification 3.6.1.a and is reportable pursuant to paragraph 6.9.2.a.2 of Technical
10 | Specifications.

09 | S | A | 11 | A | 12 | A | 13 | P | E | N | E | T | R | 14 | A | 15 | Z | 16
7 8 9 10 11 12 13 14 15 16 17 18 19 20
SYSTEM CODE CAUSE CODE CAUSE SUBCODE COMPONENT CODE COMP. SUBCODE VALVE SUBCODE
17 | LER/RO | 8 | 0 | 2 | 4 | 0 | 1 | T | 0
7 8 21 22 23 24 25 26 27 28 29 30 31 32
REPORT NUMBER EVENT YEAR SEQUENTIAL REPORT NO. OCCURRENCE CODE REPORT TYPE REVISION NO.
18 | B | 19 | A | 20 | Z | 21 | Z | 22 | 0 | 0 | 0 | 0 | Y | 23 | Y | 24 | A | 25 | C | 3 | 1 | 0 | 26
33 34 35 36 37 38 39 40 41 42 43 44 45 46 47
ACTION TAKEN FUTURE ACTION EFFECT ON PLANT SHUTDOWN METHOD HOURS ATTACHMENT SUBMITTED NPD-4 FORM SUB. PRIME COMP. SUPPLIER COMPONENT MANUFACTURER

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 | The airlock interlocks were not in service at the time of the first event due to work
11 | being performed on the doors. The interlocks require periodic maintenance in order to
12 | maintain routine operation of the doors. In the haste to access containment to
13 | extinguish the fire and assess damage caused by the fire, the operator opened the door
14 | without first checking with the maintenance personnel working on the doors. The air-
15 | lock interlocks failed to function properly during the second event while personnel
16 | were exiting the containment. These events indicate the need to have the vendor
17 | inspect and recommend improvements to the airlock interlocks as necessary. This
18 | inspection and further evaluations will be performed in the near future.

15 | G | 28 | 0 | 0 | 0 | 29 | NA | A | 31 | Operator Observation
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32
FACILITY STATUS % POWER OTHER STATUS METHOD OF DISCOVERY DISCOVERY DESCRIPTION
16 | Z | 33 | Z | 34 | NA | 35 | NA | 36 | NA
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32
ACTIVITY CONTENT RELEASED OF RELEASE AMOUNT OF ACTIVITY LOCATION OF RELEASE
17 | 0 | 0 | 0 | 37 | Z | 38 | NA | 39 | NA
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32
PERSONNEL EXPOSURES NUMBER TYPE DESCRIPTION
18 | 0 | 0 | 0 | 40 | NA | 41 | NA
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32
PERSONNEL INJURIES NUMBER DESCRIPTION
19 | Z | 42 | NA | 43 | NA
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32
LOSS OF OR DAMAGE TO FACILITY TYPE DESCRIPTION
20 | N | 44 | NA | 45 | NA
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32
PUBLICITY ISSUED DESCRIPTION
21 | 2 | 0 | N | 44 | NA | 45 | NA
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32

NAME OF PREPARER

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8011030423

NRC USE ONLY

SUPPLEMENTAL INFORMATION

FOR

LICENSEE EVENT REPORT 80-24

1. Cause Description and Analysis: At 0910 hours on October 14, 1980, with the plant in a hot shutdown subcritical condition, a small fire was reported inside the containment by a construction worker. At the time of this occurrence, maintenance was being performed on the personnel airlock doors and interlocks. The interlocks were out of service. Operations personnel in their haste to enter containment to inspect for possible fire damage and verify the fire was extinguished, did not check to verify the inner door was properly sealed. Both containment personnel airlock doors were opened momentarily when the operator entered containment. At 1600 hours on the same day while personnel were exiting containment, the airlock door interlocks failed to function properly. This also resulted in a momentary opening of both airlock doors. Both doors being open, even momentarily, is contrary to the requirements of section 3.6.1.a. No adverse conditions resulted from these occurrences.
2. Corrective Action: In both occurrences, one airlock door was immediately placed in a satisfactory sealed condition. After the first event, the mechanic continued performing his work on the repair of the airlock interlock. After the second event, the interlock was repaired and placed in a satisfactory condition and door operating personnel were assigned to operate the airlock for the duration of the outage to prevent recurrence.
3. Corrective Action to Prevent Further Occurrence: Due to an unusually high level of job activities inside containment during the refueling outage, in addition to routine refueling activities, the airlock doors including the interlock mechanism was subjected to an unusually high amount of use by a significant number of personnel. As a result of this type of use, the airlock doors' operating mechanism required an excessive amount of maintenance to keep the doors operating as required. Due to this excessive amount of maintenance required, and as followup to this event, a specialist will be contracted to inspect and recommend improvements. This inspection and evaluation will be conducted in the near future. When this action is complete, a supplemental report to this LER will be submitted.