PRIORITY 1
(ACCELERATED RIDS PROCESSING)

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR:9411020260 DOC.DATE: 94/10/27 NOTARIZED: NO DOCKET #
FACIL:50-387 Susquehanna Steam Electric Station, Unit 1, Pennsylva 05000387
50-388 Susquehanna Steam Electric Station, Unit 2, Pennsylva 05000388
AUTH.NAME AUTHOR AFFILIATION
BYRAM,R.G. Pennsylvania Power & Light Co.
RECIP.NAME RECIPIENT AFFILIATION
Document Control Branch (Document Control Desk)

SUBJECT: Responds to NRC 940917 ltr re violations noted in Insp Repts 50-387/94-16 & 50-388/94-16.Corrective actions:stand used to block Fire Door 44 removed & fusible link assembly verified to hold door open.

DISTRIBUTION CODE: IE01D COPIES RECEIVED:LTR 1 ENCL 1 SIZE: 6
TITLE: General (50 Dkt)-Insp Rept/Notice of Violation Response

NOTES: 05000387

	RECIPIENT ID CODE/NAME	COPIES LTTR	COPIES ENCL	RECIPIENT ID CODE/NAME	COPIES LTTR	COPIES ENCL
	PD1-2 PD	1	1	POSLUSNY,C	1	1
INTERNAL:	ACRS	2	2	AEOD/DEIB	1	1
	AEOD/SPD/RAB	1	1	AEOD/SPD/RRAB	1	1
	AEOD/TTC	1	1	DEDRO	1	1
	FILE CENTER 02	1	1	NRR/DORS/OEAB	1	1
	NRR/DRCH/HHFB	1	1	NRR/PMAS/IRCB-E	1	1
	NUDOCS-ABSTRACT	1	1	OE DIR	1	1
	OGC/HDS2	1	1	RES/HFB	1	1
	RGN1 FILE 01	1	1			
EXTERNAL:	LITCO BRYCE,J H	1	1	NOAC	1	1
	NRC PDR	1	1			
NOTES:		1	1			

NOTE TO ALL "RIDS" RECIPIENTS:
PLEASE HELP US TO REDUCE WASTE! CONTACT THE DOCUMENT CONTROL DESK, ROOM P1-37 (EXT. 504-2083) TO ELIMINATE YOUR NAME FROM DISTRIBUTION LISTS FOR DOCUMENTS YOU DON'T NEED!

TOTAL NUMBER OF COPIES REQUIRED: LTTR 22 ENCL 22

PRIORITY 1 DOCUMENT

Pennsylvania Power & Light Company
Two North Ninth Street • Allentown, PA 18101-1179 • 610/774-5151

Robert G. Byram
Senior Vice President—Nuclear
610/774-7502
Fax: 610/774-5019

OCT 27 1994

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

SUSQUEHANNA STEAM ELECTRIC STATION
REPLY TO NOTICE OF VIOLATION
(387/94-16-01 AND 387/94-16-03) **Docket Nos. 50-387**
PLA-4211 FILE R41-2 **50-388**

Dear Sir:

This letter provides Pennsylvania Power & Light Company's response to the Notice of Violation for NRC Combined Inspection Report 50-387/94-16 and 50-388/94-17 dated September 27, 1994.

The notice required submittal of a written reply within thirty (30) days of the date of the letter transmitting the Notice of Violation. We trust that the commission will find the attached response acceptable.

Very truly yours,

R. G. Byram

Attachment

cc: Regional Administrator - Region I
Ms. M. Banerjee, NRC Sr. Resident Inspector
Mr. C. Poslusny, Jr., NRC Sr. Project Manager

IE01
1/1

REPLY TO A NOTICE OF VIOLATION

A. Violation (387/94-16-03)

10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Actions," requires, in part, that in cases of significant conditions adverse to quality, measures shall assure that the cause of the condition is determined and corrective action taken to preclude repetition.

Contrary to the above, on March 4 and March 7, 1994, the licensee discovered that fire door 44 was blocked open and the required form NDAP-QA-0441 which authorizes and recognizes the condition was not completed contributing a significant condition adverse to quality. Additionally, prior to these occurrences, the licensee identified several instances where fire doors were blocked open without form NDAP-QA-0441 being completed. On July 20, 1994, the inspector discovered fire door 44 blocked open without the required approval. Corrective actions for these previous events did not preclude repetition in that the inspector identified, again, on August 23, 1994 that fire door 44 was blocked open without approval.

Response

1. Reason for the Violation

The identification of station doors as also being fire doors is inadequate, and combined with other labeling on the door, makes the determination as a fire door difficult. The only way to identify a fire door is by the red door label which is located in the upper corner of the door or by utilizing NDAP-QA-0441, "Fire Protection System Status Control."

Fire Door #44 also had a label affixed to it which states "this door to remain open" (for ventilation purposes). The intent was that fire door #44 only be held open by its fusible link. However, no notification was available at the door which specifies that the door may not be held open by any method other than a fusible link.

2. **Corrective Steps Which Have Been Taken and the Results Achieved**

   a. The stand used to block open Fire Door #44 was removed and the fusible link assembly was verified to hold the door open.

   b. The label on Fire Door #44, that stated "this door to remain open" was removed to assist in eliminating labeling confusion.

3. **Corrective Steps Which Will Be Taken to Avoid Further Violations**

   a. Station fire doors will be labeled in large letters at eye level as follows:

      "FIRE DOOR - DO NOT BLOCK OPEN WITHOUT AUTHORIZATION"

   b. Site personnel will be trained on the status control requirements for station fire doors. Training of site personnel will be conducted through GET Training/Retraining and Pre-outage briefings.

4. **Date of Full Compliance**

   Based on (2) above PP&L is in full compliance. Labeling of station fire doors, as identified in (3.a) above will be completed by December 31, 1994. Training of station personnel as identified in (3.b) above will be completed by April 10, 1995.

B. *Violation* *(387/94-16-01)*

Technical Specifications 3.3.7.9, 3.7.6.2 and 3.7.7 requires that continuous fire watches be established within one hour when fire detection and suppression systems are inoperable.

Contrary to the above, on August 2, 1994, at 9:31 p.m., continuous fire watches were not established within the required one hour following the determination that the Simplex Fire Protection System (fire detection and suppression system) was inoperable. Specifically, for at least 10 hours following the event, continuous fire watches were not implemented.

Response

Reference LER 50-387/94-012-00 for more details concerning this event

1. **Reason for the Violation**

On August 2, 1994, at 2131 hours a lightning strike caused a complete failure of the Simplex Fire Protection System. Available personnel were assigned roving fire watch duties in the affected areas. Continuous fire watches could not be established due to manpower limitations and the extensive number of areas requiring coverage.

Additionally, miscommunication between the Site Fire Protection Engineer and Shift Supervision, and inadequate communication between Shift Supervision and Station Management contributed to the failure to establish continuous fire watches within one hour. Shift Supervision asked if hourly fire watches were acceptable given the situation and the Fire Protection Engineer responded that it was. However, Shift Supervision interpreted this to mean acceptable for the duration of the LCO, and what the Fire Protection Engineer actually meant by his response was that this was acceptable in the interim until additional personnel were called in to man the continuous fire watches.

Inadequate communication then occurred during a telephone conversation when Shift Supervision notified Station Management of the event. Assumptions were made by Station Management as to the action plan and recovery efforts for the remainder of the evening. Additional questioning and/or conversation would have led to a more appropriate response, specifically related to continuing efforts to staff continuous firewatch as soon as possible.

2. Management Expectations

a. Station Management's expectations regarding fire protection was communicated to station personnel via a letter from the Vice President - Nuclear Operations. This letter was also published in the departmental newsletter which is distributed to the Nuclear Department. This letter stated expectations with respect to fire protection program compliance, procedure implementation, and system/component operability. It also identified programmatic shortcomings, stated actions that must be achieved, and actions being taken to achieve stated objectives. The letter concluded by stating that Susquehanna cannot tolerate less than excellent performance regarding fire protection.

b. Additionally, Operation's Management issued a memorandum to Shift Supervision identifying the failure to meet the continuous fire watch LCO requirement of the technical specifications, and their expectations that requirements of the technical specifications are to be achieved.

3. Corrective Steps Which Have Been Taken and the Results Achieved

a. At 0730 hours on August 3, 1994, it was determined that continuous fire watches were required and efforts were started to support continuous fire watches. Between 0800 and 1210 hours on August 3, 1994, identification of all fire zones requiring continuous fire watches was completed and staffing of these zones began. At 1145 hours on August 3, 1994, the Simplex System was restored, and at 1250 hours the fire watches established for this event were removed.

b. Operating Instruction (OI-AD-013) was issued to provide shift supervision guidance in the event of Simplex failures and to assist the operator through assessment and compensatory measures deemed appropriate.

c. Requirements for continuous fire watches have been reevaluated and updated consistent with Technical Specifications. This resulted in a reduction in the number of continuous fire watches required.

d. A memorandum has been issued to Operations shift supervision emphasizing expectations regarding Technical Specification compliance. (item 2.b)

e. A memorandum has been issued to site personnel (letter) and departmental personnel (newsletter) clarifying expectations regarding fire protection. (item 2.a)

4. **Corrective Steps Which Will Be Taken to Avoid Further Violations**

a. Train additional on-shift personnel to be able to perform fire watch duties.

b. Provide Operations control room personnel training on Simplex system operation, messages and failure modes

c. Review this event with appropriate work groups stressing the importance of clear communications.

d. Evaluate Technical Specification requirements for posting fire watches within one hour and process appropriate changes.

e. An Event Review Team (ERT) was established and performed a root cause analysis. The ERT identified several other contributing factors in addition to the primary causes for the failure to establish the required fire watches and Simplex failure (manpower limitations, extensive fire watch areas requiring coverage and communications). These items will be dispositioned as determined by the ERT.

5. **Date of Full Compliance**

Based on (3.a) above PP&L is in full compliance. Training of additional fire watches identified in (4.a) above will be completed by 12/31/94. Other training/reviewing action identified in (4.b and c) above will be completed by 3/31/95. Evaluation/submittal of Technical Specification revisions, if necessary, will be completed by June 30, 1995.