VIRGINIA ELECTRIC AND POWER COMPANY
RICHMOND, VIRGINIA 23261

June 24, 1996

United States Nuclear Regulatory Commission
Attention: Document Control Desk
Washington, D. C. 20555

Serial No.	96-298
SPS	R4'
Docket Nos.	50-281
License Nos.	DPR-37

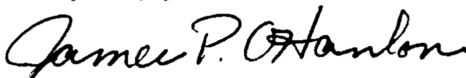
Gentlemen:

VIRGINIA ELECTRIC AND POWER COMPANY
SURRY POWER STATION UNIT 2
REPLY TO A NOTICE OF VIOLATION
NRC INSPECTION REPORT NOS. 50-280/96-03 AND 50-281/96-03

We have reviewed Inspection Report Nos. 50-280/96-03 and 50-281/96-03 dated May 31, 1996 and the enclosed Notice of Violation for Surry Unit 2. We share your concern regarding the open fire boundary door and have reviewed the circumstances of this event with respect to a similar event in 1991. The 1991 event involved a lack of understanding and sensitivity to the requirements and safety significance of fire boundary doors. Although both events were caused by personnel error, the corrective actions from the previous event were effective because the individual recently involved was fully aware of the requirements to maintain the door in a closed position. However, upon his departure through the rear exit door, it is believed that welding leads inadvertently fell between the door and doorjamb causing the door to remain ajar. The additional corrective actions discussed in this response will prevent further incidents involving these boundary doors.

We have no objection to this letter being made part of the public record. Please contact us if you have any questions or require additional information.

Very truly yours,



James P. O'Hanlon
Senior Vice President - Nuclear

Attachment

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cc: U.S. Nuclear Regulatory Commission
Region II
101 Marietta Street, N.W.
Atlanta, Georgia 30323

Mr. M. W. Branch
NRC Senior Resident Inspector
Surry Power Station

REPLY TO A NOTICE OF VIOLATION
NRC INSPECTION CONDUCTED MARCH 24 - MAY 4, 1996
SURRY POWER STATION UNITS 1 AND 2
INSPECTION REPORT NOS. 50-280/96-03 AND 50-281/96-03

NRC COMMENT:

"During an NRC inspection conducted on March 24 through May 4, 1996, a violation of NRC requirements was identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," NUREG-1600, the violation is listed below:

> Technical Specification (TS) 3.21.A.5 requires that the low pressure carbon dioxide system be operable to the extent that when equipment in the emergency diesel generator (EDG) rooms is required to be operable, fire suppression can be provided upon demand. TS 3.21.B.4 requires that with the required system in TS 3.21.A.5 inoperable, a continuous fire watch be established within one hour.
>
> Contrary to the above, on April 8, 1996, the low pressure carbon dioxide system for number 2 EDG room was inoperable when the EDG was required to be operable and a continuous fire watch was not established within one hour.

This is a Severity Level IV violation (Supplement I)."

REPLY TO A NOTICE OF VIOLATION
NRC INSPECTION CONDUCTED MARCH 24 - MAY 4, 1996
SURRY POWER STATION UNIT 2
INSPECTION REPORT NOS. 50-280/96-03 AND 50-281/96-03

1. Reason for the Violation, or, if Contested, the Basis for Disputing the Violation

The violation is correct as stated.

The Emergency Diesel Generator (EDG) No. 2 room doors are posted as Carbon Dioxide Boundary Fire Doors. Blocking or holding the doors open is not permitted, and putting the door on its automatic blow off device requires prior permission of an operations shift supervisor. Access into EDG No. 2 room is provided from the Unit 2 turbine building hallway and is restricted by the use of a keycard. The EDG No. 2 room rear door exits to the Unit 2 alleyway, but cannot be entered from the alleyway.

To support the tie-in of the new EDG fuel oil supply lines, welding leads were supplied from the Unit 2 alleyway, supported along the outside wall above the rear exit door to EDG No. 2 room and routed through the doorway into the EDG No. 2 room. While the door was open, a fire watch was posted as a compensatory measure to comply with Technical Specification (TS) 3.21.B.4. On April 8, 1996, following the completion of construction work, the welding leads were removed from the doorway and coiled outside the rear door for temporary storage. The door was closed and the operations shift supervisor was notified. The fire watch was released at approximately 0850 hours.

At approximately 1130 hours, the rear door to the EDG No. 2 room was verified as closed by Safety and Loss Prevention personnel. Another entry was made into the EDG No. 2 room at 1135 hours, and the individual exited the rear exit door at approximately 1145 hours. When interviewed, the individual indicated he saw the door closing but did not verify that it fully shut. The welding leads supported above the rear exit door had loosened and, upon the individual's exit, fell between the door and the doorjamb.

The cause of this event is attributed to cognitive personnel error on the part of 1) the personnel who secured the welding leads above the EDG No. 2 room rear exit door, and 2) the individual who exited the door without ensuring that the door was fully closed. The rear exit doors are labeled as carbon dioxide boundary fire doors and instructions on the door plainly state that the door is not to be blocked or held open. Personnel responsible for planning and implementing the EDG No. 2 room construction work recognized that the doors could not be blocked open without compensatory actions, and the individuals interviewed concerning this event were aware of the requirements.

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

Upon discovery that the rear exit door was not closed, the control room was notified. An operator removed the welding leads from the doorway and closed the rear exit door to the EDG No. 2 room. A station Deviation Report was submitted.

Construction management reviewed the event with personnel involved with the EDG fuel oil line replacement construction work, the pipe fitter craft, and the construction foreman. The requirements to maintain the carbon dioxide boundary fire door closed was re-emphasized.

Prior to the fuel oil line construction work, personnel passage through the EDG room rear exit doors was prohibited. To expedite the fuel oil line replacement work, these restrictions had been relaxed. Upon completion of the construction work, personnel passage through the EDG room rear exit doors was again prohibited. To reduce the risk of recurrence, the rear exit doors have been posted as an Emergency Exit Only. In addition, alarms on all of the EDG rooms rear exit doors have been activated.

Furthermore, the carbon dioxide boundary doors in other areas, which provide a boundary function similar to the EDG No. 2 rear exit door, have also been evaluated to determine if further corrective actions were required to ensure that the doors do not inadvertently remain open. The evaluation concluded that sufficient controls are in place to preclude a similar incident.

3. Corrective Steps Which Will be Taken to Avoid Further Violations

The corrective actions taken above are appropriate to prevent a recurrence of the inoperability of the EDG fire suppression system due to an inadvertent opening of the rear exit doors, as well as to prevent an inadvertent opening of carbon dioxide boundary doors in other areas.

4. The Date When Full Compliance Will be Achieved

Full compliance was achieved when the EDG No. 2 room rear exit doors were closed and the EDG No. 2 room Fire Suppression System was returned to operable status.