

# ACCELERATED DISTRIBUTION DEMONSTRATION SYSTEM

## REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

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SUBJECT: Responds to NRC ltr re violations noted in insp rept  
50-261/91-17. Corrective actions: Personnel involved w/events  
that lead to violation understand significance of their  
actions & need for procedural compliance.

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H. B. ROBINSON STEAM ELECTRIC PLANT  
UNIT NO. 2  
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NRC INSPECTION REPORT NO. 50-261/91-17: REPLY TO A NOTICE OF VIOLATION

Gentlemen:

Carolina Power and Light Company hereby provides this reply to the Notice of Violations identified in Inspection Report 50-261/91-17.

Severity Level IV Violation (RII-91-17-01)

Technical Specification (TS) 6.5.1.1.1 requires written procedures be established for test activities of safety-related equipment and activities recommended in Appendix A of Regulatory Guide 1.33, Revision 2. Item 6.a of Appendix A requires procedures for combating a loss of coolant event.

Contrary to the above, written procedures were not adequately established in that:

- a. Special test procedure, SP-1023, IVSW Leak Test of Penetration 6, Revision 0, was approved on July 10, 1991, with a limitation that would allow the plant to enter a less restrictive TS limiting condition for operation (TS 3.3.6.2) than the applicable limiting condition for operation (TS 3.0).
- b. Loss of coolant emergency operating procedure EPP-010, Transfer to Hot Leg Recirculation, Revision 4, was not subsequently revised as required when EPP-009, Transfer to Cold Leg Recirculation, was revised on March 1, 1991. This resulted in EPP-010 not providing adequate instructions for the establishment of an alternate hot leg injection flow path.

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REPLY

1. The Reason for the Violation

CP&L acknowledges that the violation occurred as described. The circumstances surrounding each of the two examples cited are discussed in the following paragraphs.

- a. The cause of this concern is attributed to an inadequate review of the Technical Specifications during the development of the Special Procedure for IVSW leak testing. Contributing to this is the fact that Technical Specification 3.3.6.2 is unclear in describing the LCO for IVSW. This specification reads.. "If the system does not meet the requirements of 3.3.6.1 within 24 hours, the reactor shall be placed in hot shutdown condition utilizing normal operating procedures." This was misinterpreted to mean that a 24 hour LCO could apply to "all essential features" when in fact it means only the redundant actuation valves. In order to accurately understand the intent of this specification, it would be necessary for the user to compare it to other similar specification restrictions on essential features of the system. This was not done prior to approval of the initial testing procedure.
- b. This concern is attributed to an inadequacy in the Verification and Validation (V&V) process, which caused an inadequate technical review of the procedure change to occur. The procedure inadequacy was discovered during a review of EPP-9 and EPP-10 to address several items that were brought up during discussions of the Large and Small Break LOCA analysis. In reviewing the procedures, it was discovered that the alternate flow path in EPP-10 would not work due to a change made in February, 1989 to EPP-9. The EPP-9 change addressed the isolation of the charging pump and reactor coolant pump seal injection lines, and the initiation of Isolation Valve Seal Water to containment penetrations 24, 25, 26, and 27. The EPP-10 steps depended upon the charging line to provide the alternate flow path. During the February 1989 revision to EPP-9, the EOP V&V process contained weaknesses, as were identified in NRC Inspection Report 89-16. The EOP Background Document, which is necessary for the V&V process to adequately function, was not up to date and was not included as an official part of the V&V program. Further, the WOG Emergency Response Guidelines (ERGs) provide minimum guidance as to the development of EPP-9 and EPP-10. These procedures are plant specific and the interrelationship between them are not part of the WOG ERG information. Had the EOP Background Document been adequately complete, the V&V process would have identified the error as it would have contained a description of the relationship between EPP-9 and EPP-10.

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

- a. Prior to performance of the Special Procedure, the incorrect LCO reference was discovered. An Adverse Condition Report was generated to document the discrepancy, and the procedure was revised to identify the correct LCO as an 8 hour to hot shutdown condition.
- b. Plant Operations Directors in the Emergency Response Organization, Operations management, and the Shift Supervisors, were alerted of the inadequate procedure on the day that the deficiency was identified, and an Adverse Condition Report was initiated for a root cause analysis. Operations personnel were advised that, until a revision to EPP-010 could be prepared and validated, the procedure would not properly respond to a loss of hot leg recirculation. It was noted at the time that the procedure still correctly aligned hot leg recirculation, but the response to a loss of hot leg recirculation would have to be made in the case that these procedures were implemented. As such, the Emergency Response Plan would have been implemented, and the Technical Support Center would be manned with necessary expertise to respond to such an event.

A revision to EPP-10 has been prepared that identifies an alternate hot leg recirculation flowpath.

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

- a. This violation and response will be reviewed in Licensed Operator Retraining in order to clearly delineate expectations of Operations management with regard to literal interpretation of Technical Specifications.
- b. NRC Inspection 89-16, conducted during September, 1989, evaluated the adequacy of the EOPs and conformance of those procedures to the WOG ERGs and writer's guide. In response to that Inspection, CP&L made certain commitments regarding the V&V Program. The V&V program has since been upgraded. However, the enhanced V&V process has not been performed because the EOP Background Document has not been completely upgraded. The revised process will be fully utilized when the EOP's are upgraded to address the specific recommendations in the EOP Inspection Report.

4. The Date When Full Compliance Will Be Achieved

- a. Full compliance will be achieved with the completion of Licensed Operator Retraining in December, 1991.
- b. As committed in CP&L's response to Inspection Report 89-16, development of Plant Specific EOP's is scheduled to be completed by December 31, 1991.

Severity Level IV Violation (91-17-02)

10 CFR 50 Appendix B Criterion V requires that activities affecting quality shall be prescribed by documented instructions, procedures, or drawings, of a type appropriate to the circumstances and shall be accomplished in accordance with these instructions, procedures, or drawings. Maintenance Management Manual Procedure MMM-001, Maintenance Administration Program, Revision 12, section 5.3.2, requires that all maintenance activities and labor performed by maintenance craft personnel shall be initiated using proper maintenance work requests.

Contrary to the above, on July 29, 1991, maintenance was performed on safety-related equipment of the Safety Injection system without a proper maintenance work request. The maintenance activity resulted in valve SI-867A, Boron Injection Tank inlet bypass valve, as well as its associated injection flow path, being declared inoperable.

REPLY

1. The Reason for the Violation

CP&L acknowledges that the violation occurred as described. The cause of this violation is attributed to miscommunication on the part of the Traveling Maintenance Instrumentation and Control Technician performing the work and the System Engineer responsible for the project. Although the technician was aware of the MMM-001 requirements for having proper work instructions on the maintenance work request, an assumption was made that because the System Engineer in charge of the project had requested that voltage readings be taken on MOV SI-867A, he could proceed with the data collection without properly revised work instructions. Operations personnel were not aware that voltage readings were to be taken simultaneously with the current traces. The technician's use of an underrated voltmeter, which caused the SI-867A breaker trip was caused by inattention to detail. The voltmeter was clearly marked "maximum of 300VAC usage".

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

The immediate corrective action taken was to investigate the breaker trip and effect repairs necessary to return valve SI-867A to service. This action was completed, and the system declared operational. An Adverse Condition Report was initiated for an independent root cause analysis investigation.

Concurrent with the above, the Traveling Maintenance technician involved was counselled on the necessity and importance of procedural compliance and attention to detail. The event has been discussed with his work group and within the Nuclear Craft Resources Unit, which includes all seven traveling maintenance crews. In addition, Plant I&C/Electrical maintenance personnel have reviewed this inspection report and have been reminded of the necessity of proper documentation of work activities. The System Engineer in charge of the project has attended additional training with the Technical Support staff on work management processes to emphasize importance of proper communication and documentation of work activities.

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

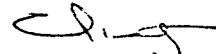
The personnel involved with the events that lead to this violation understand the significance of their actions and the need for procedural compliance and proper work practices. Therefore, sufficient corrective actions have been taken to avoid further violations.

4. The Date When Full Compliance Will Be Achieved

Full compliance was achieved with the completion of the activities above on September 13, 1991.

Should you have any questions regarding this matter, please contact Mr. J. D. Kloosterman at (803) 383-1491.

Very truly yours,



Charles R. Dietz  
Vice President

Robinson Nuclear Project Department

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