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 DIETZ,C.R. Carolina Power & Light Co.  
 RECIP.NAME RECIPIENT AFFILIATION  
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SUBJECT: Responds to NRC ltr re violations noted in isp rept  
 50-261/93-18.C/A:valves in Post Accident Venting Sys  
 were properly locked.

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**Carolina Power & Light Company**

Company Correspondence

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OCT 11 1993

Robinson File No: 13510E

Serial: RNP/93-2535

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. 50-261/93-18 REPLY TO A NOTICE OF VIOLATION

Gentlemen:

Carolina Power and Light Company hereby provides this reply to the Notice of Violation identified in NRC Inspection Report 50-261/93-18.

Enclosure 1 provides a description of the occurrence, the causal factors and root causes identified for the violation, and a discussion of the corrective actions taken and planned for the occurrence.

Should you have any questions regarding this matter, please contact Mr. D. B. Waters at (803) 383-1802.

Very truly yours,

Charles R. Dietz  
Vice President  
Robinson Nuclear Plant

RES:dwm

Enclosure

cc: Mr. S. D. Ebnetter  
Mr. W. T. Orders  
INPO

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REPLY TO A NOTICE OF VIOLATION

RII-93-18-01-SL4:

Technical Specification 6.5.1.1 Procedures, Tests and Experiments require in part that written procedures be established, implemented and maintained, covering the activities recommended in Appendix A of Regulatory Guide 1.33, Rev 2. 1978, including the operation of the auxiliary feedwater system, combatting emergencies/significant events, procedures for log entries, and procedures for the operation of the emergency diesel generators.

Operations Procedure OP-402, Auxiliary Feedwater System, requires in Section 6.0, Normal Operations, Step 6.1.1 that valves FCV-1424 and FCV-1425 be aligned in the closed position with the manual actuators disengaged and locked when placing the system in standby alignment.

Operations Management Manual OMM-009, Locked Valve List, which delineates those valves within the plant which are required to be locked, lists valves FCV-1424, FCV-1425, and PAV-35 as valves which are to be locked.

Operations Management Manual Procedure, OMM-023, Operator Logs and Rounds, requires that an operator perform a thorough general inspection of his assigned area and be knowledgeable of equipment parameters that are to be monitored.

Operating Procedure, OP-604, Diesel Generators "A" and "B", requires in part that the engine speed be raised to 900 RPM prior to flashing the field and contains a prohibition against operating an EDG at less than 900 RPM with field excitation in service.

Contrary to the above;

- a. On July 26 and July 30, 1993, respectively, resident inspectors found valves FCV-1424, FCV-1425 and PA-35 un-secured.
- b. On July 27, 1993, an on-duty reactor operator failed to detect ERFIS computer alarms associated with a deviation between the indicated position for control rod B-10 and its average bank position for a period of approximately 9.5 hours.
- c. On August 2, 1993, a reactor operator flashed the field of the A EDG at an indicated engine speed of approximately 750 RPM.

Reply

CP&L acknowledges the violation.

1. The Reason for the Violation

Although the examples provided involve separate and independent occurrences, certain important aspects of human performance, procedure adherence, and personal accountability are common to all. Therefore, although the circumstances of each occurrence have been and are being addressed independently, those issues which appear to be common to all will provide the substance of this report.

Based upon review of these occurrences, the issues which are common to all and the reasons for this violation, are personnel errors and a failure to comply with procedures. A further contributing factor is procedural inadequacy in that Operations shift personnel have exhibited weaknesses in the understanding and implementation of operational expectations set by management.

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

The following corrective actions were taken to address the individual examples:

- (1) The locked valves identified were properly locked. A check of other locked valves which were accessible during plant operation without entering containment or High Radiation areas was completed using OMM-009 as a guide. During this checking process, three additional valves in the Post-Accident Venting System were found improperly locked and were properly locked.
- (2) The operator who failed to properly review the ERFIS log printout has been counselled relative to management expectations for proper watchstanding. This event has been discussed with other licensed and non-licensed operators to emphasize the need for diligence and attention to detail in conduct of licensed activities.
- (3) The operator who inappropriately flashed the field on the diesel generator has been counselled relative to management expectations of procedures in use and the expectation for procedure compliance. This event has been discussed with other licensed and non-licensed operators to emphasize the need for procedure compliance.

To address the problem of procedure compliance on a broader basis, Operations management is pursuing the corrective action plan submitted in response to violation 93-11-02. Discussion sessions have been held with each operating shift to review procedure compliance and human performance issues and to solicit input into the process for affecting the needed improvement. Draft guidance has been issued for comment as a result of input received at these sessions.

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

The following corrective actions will be taken to address the individual examples:

- (1) All locked valves will be verified to be properly locked during completion of valve line-ups as a part of the return to service of systems at the end of the ongoing refueling outage. In addition, an alternate method of securing valves will be evaluated to determine if changes are warranted on the basis of improved position control and/or exposure reduction. This will be completed prior to December 31, 1993.
- (2) Administrative controls to ensure increased observation and awareness of Control Room indications will be implemented prior to return to power operation following the ongoing refueling outage.
- (3) No additional corrective actions specific to this example are planned.

To address the problem of procedure compliance on a broader basis, Operations management will complete the implementation of the corrective action plan provided in the response to violation 93-11-02.

4. The Date When Full Compliance Will Be Achieved

As was previously committed to the NRC, the corrective action provided in the response to violation 93-11-02 has been scheduled for completion by April 6, 1994, based on the current training schedule and the impact of the current refueling outage.

RII-93-18-03-SL4:

10 CFR 50 Appendix B, Criterion III, Design Control, as implemented by the CP&L Corporate Quality Assurance Program requires in part that measures be established to assure that applicable regulatory requirements and the design basis, as specified in the license application, are correctly translated into specifications, drawings, procedures, and instructions of the type to ensure the design integrity of the structure, system or component; that measures be established to verify the adequacy of the design such as by suitable testing; and that design changes be subject to the design control measures commensurate with those applied to the original design.

Contrary to the above;

The licensee failed to implement adequate measures to maintain the integrity of the Reactor Auxiliary Building Ventilation System design in that modifications and design altering maintenance were implemented which ultimately resulted in the system being inoperable from January 1992 until July 1993.

REPLY

CP&L acknowledges the violation.

1. The Reason for the Violation

Inadequate design control in concert with a weakness in the monitoring of the design requirement to maintain a negative building pressure.

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

On July 29, 1993, at approximately 1800 hours, a walkdown of the RAB was conducted to evaluate the effect of the change of airflow in the second floor hallway. Actions were initiated to restore the Reactor Auxiliary Building Ventilation System to a negative pressure environment. This was accomplished by partially opening the prefilter room door upstream of the room containing exhaust fans HVE-2A&B. This allowed the operating unit to induce a negative pressure, as observed by the direction of movement of the tarp erected by the modification.

As a result of the walkdown, Caution Tags were established to control the opening of the door to the room containing HVE-2A&B. Signs were hung on the open door and on both sides of the tarp at the north end of the hallway to control the existing configuration. Additionally, on July 30, 1993, Caution Tags were hung to control the opening of the access doors associated with HVS-1 that was opened during further balancing activities. These actions restored the Reactor Auxiliary Building Ventilation System to operable status.

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

The following steps will be taken to alleviate future violation:

1. Perform an RAB air balance in the near-term in accordance with Modification 934.
2. Evaluate the adequacy of the existing gauges to monitor RAB air pressure and install additional gauges as required.
3. Formalize periodic monitoring of the RAB air pressure to assure compliance with design requirements.
4. Identification and trending of RAB Ventilation System equipment operating or building conditions that could singularly or in combination cause significant change in building air pressure.
5. Review other plant ventilation systems (e.g., Control Room Ventilation) that provide contamination control for conditions similar to this incident and implement, as appropriate, similar corrective actions.

6. Conduct continuing training of design engineers concerning the potential for modifications to affect building ventilation system capability to maintain design requirements both during and after installation.

4. The Date When Full Compliance Will Be Achieved

Completion of the above tasks is anticipated by May 20, 1994.

RII-93-18-04-SL4:

Technical Specification 6.5.1.1 Procedures, Tests and Experiments require in part that written procedures be established, implemented and maintained, covering the activities recommended in Appendix A of Regulatory Guide 1.33, Rev 2. 1978, including general procedures for the control of maintenance work.

Plant Program, PLP-013, Maintenance Program, requires in part that Shift Supervisor permission be obtained before maintenance is performed on any safety-related equipment.

Contrary to the above, on August 2, 1993, personnel initiated maintenance on the south Control Room door without obtaining the Shift Supervisor's permission. This resulted in the door, as well as the Control Room Ventilation System, being declared inoperable.

REPLY

CP&L acknowledges the violation.

1. The Reason for the Violation

As stated above, personnel performed maintenance on the south Control Room door without obtaining the Shift Supervisor's permission. The cause of this violation was personnel performing work outside the scope of the work order.

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

The Control Room Ventilation was placed back in service in accordance with OST-750. ACR-93-131 was initiated to document this concern and to initiate a root cause evaluation. Based on the findings of the evaluation, Operations and Maintenance personnel reviewed this event to ensure their understanding of the door's function and the importance of accurate and timely communication of potential operability concerns. Review also included discussion of performing work outside the scope of the work order.

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

Facilities personnel and supervision have been informed that they will be held accountable for working within the scope of the Work Request and will not proceed further without proper authority.

4. The Date When Full Compliance Will Be Achieved

Full compliance has been achieved.