PRIORITY 1
(ACCELERATED RIDS PROCESSING)

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR:9407220083 DOC.DATE: 94/07/15 NOTARIZED: NO DOCKET #
FACIL:50-261 H.B. Robinson Plant, Unit 2, Carolina Power & Light C 05000261
AUTH.NAME AUTHOR AFFILIATION
HINNANT,C.S. Carolina Power & Light Co.
RECIP.NAME RECIPIENT AFFILIATION
Document Control Branch (Document Control Desk)

SUBJECT: Responds to NRC 940615 ltr re violations noted in insp rept 50-261/94-15.Corrective actions:CR differential pressure instrument DPI-6520 scale adjusted for proper indication & new EDG lube oil strainer pressure plate washer installed.

DISTRIBUTION CODE: IE01D COPIES RECEIVED:LTR 1 ENCL 1 SIZE: 7
TITLE: General (50 Dkt)-Insp Rept/Notice of Violation Response

NOTES:

	RECIPIENT ID CODE/NAME	COPIES LTTR	COPIES ENCL	RECIPIENT ID CODE/NAME	COPIES LTTR	COPIES ENCL
	PD2-1 PD	1	1	MOZAFARI,B	1	1
INTERNAL:	AEOD/DEIB	1	1	AEOD/DSP/ROAB	1	1
	AEOD/DSP/TPAB	1	1	AEOD/TTC	1	1
	DEDRO	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/HDS3	1	1	REG FILE 02	1	1
	RES/HFB	1	1	RGN2 FILE 01	1	1
EXTERNAL:	EG&G/BRYCE,J.H.	1	1	NRC PDR	1	1
	NSIC	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 19 ENCL 19

PRIORITY 1 DOCUMENT

CP&L

10 CFR 2.201

Carolina Power & Light Company
Robinson Nuclear Plant
PO Box 790
Hartsville SC 29551

Robinson File No.: 13510E
Serial: RNP/94-1372

JUL 15 1994

United States Nuclear Regulatory Commission
Attn: Document Control Desk
Washington, DC 20555

H. B. ROBINSON STEAM ELECTRIC PLANT, UNIT NO. 2
DOCKET NO. 50-261/LICENSE NO. DPR-23
NRC INSPECTION REPORT NO. 50-261/94-15
REPLY TO A NOTICE OF VIOLATION

Gentlemen:

This provides the Carolina Power & Light Company reply to the Notice of Violation identified in NRC Inspection Report No. 50-261/94-15, which was transmitted by letter dated June 15, 1994. The violations involve: the failure to properly establish, implement, and maintain maintenance procedures; the inadvertent level reduction of a safety injection accumulator; and, the failure to take adequate corrective action for excessive boric acid concentration in the "A" boric acid storage tank.

As requested in the letter transmitting the Notice of Violation, the enclosure restates each violation, followed by our reply.

Should you have any questions regarding this matter, please contact Mr. R. M. Krich at (803) 383-1802.

Very truly yours,

C S Hinnant

C. S. Hinnant
Vice President

DTG:dwn
Enclosure
c: Mr. S. D. Ebneter, Administrator, USNRC, Region II
Ms. B. L. Mozafari, USNRC Project Manager, HBRSEP
Mr. W. T. Orders, USNRC Senior Resident Inspector, HBRSEP

JE01

REPLY TO A NOTICE OF VIOLATION

Violation A

TS 6.5.1.1, Procedures, Tests, and Experiments, requires 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 procedures for the control of measuring and test equipment and maintenance of safety-related equipment.

Work Request/Job Order, WR/JO 94-AEBT1 was provided to troubleshoot and repair the control room differential pressure instrument DPI-6520. This instrument is used to verify that control room ventilation equipment performance complies with Technical Specification requirements.

Work Request/Job Order, WR/JO 94-ACYRI was provided to calibrate the boric acid storage tank A temperature controller and alarm.

Corrective maintenance procedure, CM-507, Emergency Diesel Generator Lube Oil Strainers, provides instructions for the disassembly, inspection and reassembly of the emergency diesel generator lube oil strainers.

Contrary to the above;

1. WR/JO 94-AEBT1 was inadequate in that, it did not provide adequate instructions for ensuring that control room differential pressure instrument DPI-6520 was properly initialized following maintenance. As a result, the instrument was returned to service following maintenance on April 27, 1994, with an erroneous indication of control room pressure.

2. On April 12, 1994, WR/JO 94-ACRY1 was implemented incorrectly in that the maintenance technician assigned to perform the calibration of the A boric acid storage tank temperature controller and alarm, erroneously commenced work on the B boric acid storage tank temperature controller.

3. On April 25, 1994, CM-507 was not properly implemented in that the lube oil strainer on the B emergency diesel generator was improperly re-assembled. This occurred when the maintenance technicians failed to install the pressure plate washer as required by Step 7.3.10 of the procedure.

Reply

Carolina Power & Light (CP&L) agrees that the violation occurred as described.

1. The Reason for the Violation

This violation was due to insufficient attention to detail and inadequate self-checking on the part of the individuals involved in each of the cited examples. The following causal factors address each of the individual examples in the Notice of Violation.

a. The instructions provided by the system engineer to the Work Control group maintenance planner were vague and did not completely address the scope of the repair activity on the control room differential pressure instrument DPI-6520. Subsequently, the instructions provided to the maintenance technician by the Work Control planner did not address instrument scale adjustment after it was leveled and secured in its mounting. Additionally, the technician failed to question whether the scale required adjustment after the work was completed.

b. While initiating calibration activities for the each Boric Acid Storage Tank (BAST), the Instrumentation & Control (I&C) technician was given clearance to perform work on the "A" BAST temperature controller, TIC-107. However, the technician mistakenly proceeded to work on the temperature controller for "B" BAST. Both tanks and the respective controllers were properly labeled and there was sufficient lighting in the area to allow for proper tank identification. The technician failed to apply adequate self-checking practices prior to commencing work.

c. During quarterly preventive maintenance on the "B" Emergency Diesel Generator (EDG), Corrective Maintenance Procedure CM-507, "Emergency Diesel Generator Lube Oil Strainer," was being performed. The lead mechanic performing CM-507 failed to properly follow procedure steps during the strainer disassembly, inspection, and subsequent reinstallation; therefore, the mechanic did not identify that the strainer's pressure plate washer was missing. As a result, the washer was not reinstalled as required. A causal factor to this failure to follow procedure is that this procedure was classified as a "reference use" level procedure (i.e., required to be at the work location to be referenced during the activity). The mechanic failed to pay sufficient attention to detail to the requirements of the procedure, since he perceived the task to be routine.

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

   a. The control room differential pressure instrument DPI-6520 scale was adjusted for proper indication.

      The Work Control planner, I&C technician, and system engineer were counselled on lessons learned from this event.

   b. Appropriate disciplinary action was taken with the I&C technician involved in working on the incorrect BAST temperature controller.

   c. A new EDG lube oil strainer pressure plate washer was requisitioned and installed.

      Appropriate disciplinary action was taken with the mechanic involved with the EDG lube oil strainer pressure plate washer issue.

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

   Because the examples cited in the violation represent an adverse trend with respect to human performance concerns, site management has initiated a series of "Stand-Down" meetings for all plant personnel. During these meetings, management will discuss the consequences relating to recent examples of poor work practices resulting from inattention to detail and inadequate self-checking practices. The meetings will also convey a consistent message regarding management expectations in this area.

   Additionally, all maintenance procedures being used for safety-related work activities will be designated as "Continuous Usage" documents (i.e., the user is required to read each step of the procedure prior to performing that step). This designation will remain in effect until the Manager - Maintenance determines that "continuous usage" is no longer necessary to ensure the proper level of procedure adherence.

4. The Date When Full Compliance Will Be Achieved

   Full compliance will be achieved by August 5, 1994.

Violation B

TS 6.5.1.1, Procedures, Tests, and Experiments, requires 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 procedures for operating emergency core cooling system components.

Operating Procedure OP-202, Safety Injection and Containment Vessel Spray System, provides instructions for draining the Safety Injection Accumulators.

Contrary to the above, on April 30, 1994, OP-202 was improperly implemented during efforts to drain Safety Injection Accumulator B in that the drain valve for accumulator A was opened. As a result, safety injection accumulator A was inadvertently drained below the minimum technical specification level.

Reply

CP&L agrees that the violation occurred as described.

1. The Reason for the Violation

This event was caused by a personnel error; the Reactor Operator (RO) failed to apply self-checking and the proper level of attention to detail, as work practices. The level of the "B" Safety Injection (SI) accumulator had gradually increased due to a leaking check valve. As a result, the accumulator was being periodically drained to maintain the level within the required range. This evolution is performed in accordance with Operating Procedure, OP-202, "Safety Injection and Containment Vessel Spray System," and was considered to be a routine task by the RO. The RO inadvertently selected and opened the drain valve for "A" SI accumulator while monitoring the "B" SI accumulator level indication. The low level annunciator for "A" SI accumulator was subsequently received which alerted the RO to the mistake.

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

The RO was relieved of the watch and counselled on communication and self-checking expectations.

The "A" SI accumulator was filled to a level above the minimum required by Technical Specifications (TS), and the "B" SI accumulator was drained to its desired level.

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

Partly as a result of an adverse trend with respect to inattention to detail and failure to self-check, Operations shift crew members have been reassigned to different crews to reduce complacency and to improve the collective knowledge and abilities of the operating crews.

Additionally, as stated in the response to the first violation, Operations management is conducting "Stand-Down" meetings with Operations personnel. During these meetings, management will discuss the consequences relating to recent examples of poor work practices resulting from inattention to detail and inadequate self-checking practices. The meetings will also convey a consistent message regarding management expectations in this area.

4. The Date When Full Compliance Will Be Achieved

Full compliance will be achieved by July 29, 1994.

Violation C

10 CFR 50 Appendix B, Criterion XVI requires in part that measures be established such that conditions adverse to quality, such as failures, malfunctions, deficiencies, deviations, defective material and non-conformance are promptly identified and corrected.

Contrary to the above, on May 4, 1994, control room operators failed to take prompt corrective actions after being provided with chemistry sample results which indicated that the boric acid concentration in the A BAST was in excess of the concentration allowed by Technical Specification 3.2.2.c. The fact that the boric acid concentration was in excess of the maximum allowable concentration went unrecognized for almost seven hours.

Reply

CP&L agrees that the violation occurred as described.

1. The Reason for the Violation

This violation was caused by personnel error. The Environmental & Chemistry (E&C) technician identified that the "A" BAST boron concentration was above the administrative limit as specified in Chemistry Procedure CP-001, "Chemistry Monitoring Program," but failed to recognize potential impact on the TS requirements for BAST boron concentration. This condition did not exceed TS requirements however, since 3,080 gallons of borated water in proper concentration was available in the "B" BAST. The E&C technician did not report that "A" BAST exceeded the TS collective boron concentration limit of the tanks to his supervision, nor did the E&C Supervisor recognize or respond to the abnormal boron concentration as procedurally required. The RO was informed by the E&C technician that "A" BAST was above its administrative limit when the sample results were being reported to Operations. However, the RO also failed to recognize the reported sample result from the E&C technician could have potentially impacted TS requirements. The Operations Shift Supervisor subsequently recognized that the "A" BAST exceeded the TS collective boron concentration limit of the tanks when preparing to update the Control Room Status Board.

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

"A" BAST was re-sampled and it was verified that the tank's boron concentration was accurate. As a result, a dilution was initiated and the boron concentration was returned to the proper concentration.

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

E&C supervision and technicians have been counselled on the importance of procedure adherence and the need to re-sample/report of out-of-specification parameters.

Operations will establish a procedurally documented management expectation that plant parameters are to be within their respective administrative limits, and that if parameters are not within these limits, appropriate corrective actions will be promptly initiated (i.e., shift management will be immediately notified).

Additionally, procedure and process enhancements to more readily identify trends in Chemistry parameters will be implemented.

4. The Date When Full Compliance Will Be Achieved

Full compliance will be achieved by September 1, 1994.