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SUBJECT: Responds to NRC 940711 ltr re violation noted in Insp Rept 50-261/94-16.Corrective actions:LI-802 toggle switch returned to required (on) position & applicable steps of Operating Procedure OP-308 performed.

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Carolina Power & Light Company
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Robinson File No.: 13510E
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AUG 05 1994

United States Nuclear Regulatory Commission
Attention: 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. 50-261/94-16
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 50-261/94-16, that was transmitted by letter dated July 11, 1994. The violation involves the failure of control room operators to detect that a containment water level instrument was de-energized.

As requested in the letter transmitting the Notice of Violation, the enclosure restates the 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

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

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REPLY TO A NOTICE OF VIOLATION

Violation 94-16-01

Technical Specification 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, Revision 2, 1978, including procedures for safe operation of the facility.

Operations Management Manual Procedure, OMM-038, Operations Organizational Responsibilities is provided to define and delineate the duties and responsibilities of Unit 2 Operations personnel. OMM-038 requires that the Shift Supervisor, Senior Control Operator, and Control Operators be aware of the status of plant equipment.

Contrary to the above, on May 26, 1994, control room operators failed to detect that Level Instrument, LI-802, Channel II, Containment Vessel Water Level, a Technical Specification required instrument was deenergized for approximately an hour, until a related display of CV water level was questioned by the resident inspectors.

Reply

1. The Reasons for the Violation

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

   This event was caused by personnel error. While conducting pre-shift turnover Post Accident Monitor instrument checks, the Senior Control Operator and a Control Operator failed to adequately conduct self-checking activities to ensure that the three position toggle switch for the Channel II, Containment Vessel (CV) Water Level indication instrument (i.e., LI-802) was returned to the "on" position following completion of the checks. The process for conducting these checks requires that the toggle switch for LI-802 be placed in the "Reference" position in order to verify instrument operability. When released from this position, the switch automatically returns to the "Off" position. The operator is then required to manually place the switch in the "On" position to re-energize the instrument. However, following completion of the instrument checks, the Control Operator failed to properly return the switch to the "On" position, and the Senior Control Operator did not verify that the position of the toggle switch had been properly restored prior to completing the shift turnover checklist. This action would have verified that the CV Water Level indication instrument LI-802 was properly re-energized. Consequently, the operating crew was not aware of the de-energized status of LI-802 for approximately one hour.

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

Upon discovery of the error, the LI-802 toggle switch was returned to the required (i.e., "On") position. The applicable steps of Operating Procedure OP-308, "Post Accident Monitoring System," were performed to ensure the proper system line-up existed.

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

Appropriate personnel action has been taken with the individuals involved.

This event has been reviewed with operating crews as an example of how self-checking can prevent errors from occurring.

4. The Date When Full Compliance Will Be Achieved

Full compliance has been achieved.