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 HINNANT, C.S. Carolina Power & Light Co.
 RECIP. NAME RECIPIENT AFFILIATION
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SUBJECT: Provides response to violations noted in Insp Rept
 50-261/94-23. Corrective actions: review performed to
 determine adverse trend exists of failures to properly
 adhere to escort procedures.

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

Robinson File No.: 13510E
Serial: RNP/94-1837

OCT 31 1994

United States Nuclear Regulatory Commission
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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. 50-261/94-23
REPLY TO A NOTICE OF VIOLATION

Gentlemen:

This provides the Carolina Power & Light (CP&L) Company reply to the Notice of Violation identified in NRC Inspection Report 50-261/94-23, which was transmitted by letter dated October 5, 1994. The Violation involves the failure to follow the physical security plan.

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
Vice President

RDC:rdc
Enclosure

c: Mr. S. D. Ebnetter, Regional Administrator, USNRC, Region II
Ms. B. L. Mozafari, USNRC Project Manager, HBRSEP
Mr. W. T. O'Brien, USNRC Senior Resident Inspector, HBRSEP

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Highway 151 and SC 23 Hartsville SC

REPLY TO A NOTICE OF VIOLATION

Violation 94-23-03

Licensee Physical Security Plan, paragraph 4.5, Escorts, requires that "Personnel authorized entry to the protected area as Escorted Personnel shall be escorted." Additionally, paragraph 3.2.1.6, Picture Badge System, requires that, "While in the protected area, badges will be displayed in a conspicuous manner on the upper front torso, preferably in the vicinity of the collar at shoulder height."

Contrary to the above, on September 15;

- 1) An assigned escort left two visitors unattended in the turbine building while he used an adjacent restroom.
- 2) One of the two visitors failed to display his security badge on his upper front torso while in the protected area. The badge was in the visitor's pocket.

Reply

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

1. The Reason for the Violation

This violation was caused by a personnel error on the part of the CP&L employee (i.e., a Painter/Pipe Coverer), who was escorting three contract painters in the turbine building. This escort stated that, while he understood what his responsibilities relative to escorting individuals were, he made an error in judgement when he allowed two of the three visitors he was escorting to leave the restroom without his presence, and was unaware that one of the visitors placed his security badge in his pocket contrary to badge placement requirements. The visitor who failed to display his security badge on his upper torso stated that he had placed his badge in his pocket to prevent paint from getting on it.

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

Immediately following identification of this concern, the escort established control of the visitors; the visitor with the badge in his pocket removed the badge from his pocket and displayed it properly. The CP&L employee involved was disciplined, and this incident was reviewed with other CP&L and contract painters and pipe coverers to reinforce escort requirements and responsibilities. Additionally, the Manager-Mechanical Maintenance reviewed this event with the Mechanical craftsmen on September 19, 1994, and the Maintenance Unit Manager issued a memorandum to all plant maintenance personnel, describing this incident and restating escort responsibilities. Similar information has also been provided to site personnel via the Operating Experience information process.

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

A review was performed to determine if an adverse trend exists of failures to properly adhere to escort procedures. The results of this review indicate that, based on the root cause identified, this was an isolated incident. No additional corrective actions have been identified.

4. The Date When Full Compliance Will Be Achieved

Full compliance has been achieved with the actions described above.