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SUBJECT: Responds to NRC 941229 ltr re violations noted in insp rept
50-261/94-27. Corrective actions: checklist to verify RTGB
switch positions will be incorporated as plant procedure by
950407.

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10 CFR 2.201

Carolina Power & Light Company
Robinson Nuclear Plant
3581 West Entrance Road
Hartsville SC 29550

Robinson File No.: 13510E
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JAN 30 1995

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. 50-261/94-27
REPLY TO A NOTICE OF VIOLATION

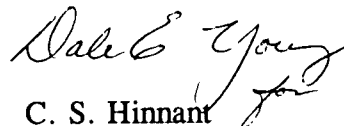
Gentlemen:

This provides the Carolina Power & Light (CP&L) Company reply to the Notice of Violation identified in NRC Inspection Report 50-261/94-27, which was transmitted by letter dated December 29, 1994. Violation A involves the mispositioning of the control switch for one of the control room ventilation fans. Violation B involves inadequacies associated with the power range calorimetric program.

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) 857-1802.

Very truly yours,


C. S. Hinnant
Vice President

070033

RDC:rdc
Enclosure

c: Mr. S. D. Ebnetter, 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 A

Technical Specification 3.15.1 requires the control room air conditioning system be operable during all modes of plant operation, including two trains of active safety-related components and shared safety-related passive components.

Technical Specification 6.5.1.1.1 requires, in part, that procedures be established, implemented, and maintained covering the operation of the control room heating and ventilation system.

Operations surveillance test procedure OST-750, Control Room Emergency Ventilation System, requires in Step 7.2.1 that HVA-1B be verified to be OFF but does not require the operator to take the switch to the STOP position.

Contrary to the above, on November 11, 1994, an operator failed to follow the requisites of operations surveillance test OST-750, Control Room Emergency Ventilation System, when he placed the control switch of idle control room air conditioning system fan HVA-1B in STOP when the procedure required that he verify that the fan was OFF. This misconfiguration resulted in the B train of the system being inoperable for four days, and rendered the system incapable of performing its intended safety function, assuming an active single failure.

Reply

Carolina Power & Light (CP&L) agrees that the violation occurred as described. While the switch misposition was self-identified, this occurrence is significant, in that, the circumstances are representative of inattention to detail, including the failure to demonstrate a critical, questioning attitude and effective self-checking. However, we consider the safety significance of the inoperability of the Control Room Emergency Ventilation System (CREVS) minimal. With the Heating and Ventilation System Unitary Air Container (HVA)-1B control switch in the "stop" position, and an assumed single failure rendering the train "A" fan inoperable, the CREVS would have been incapable of automatically functioning to pressurize the Control Room. The HVA-1B fan was, however, available for manual actuation by operator action. In addition, steps within Emergency Operating Procedures verify proper operation of the CREVS and would have prompted the required manual actions had the automatic actuation not occurred.

1. The Reason for the Violation

This violation was the result of inattention to detail, including the failure to demonstrate a critical, questioning attitude and effective self-checking during the performance of Operations Surveillance Test (OST) procedure OST-750, "Control Room Emergency Ventilation System." The operator performing the test procedure utilized Operating Procedure (OP)-906, "Heating, Ventilation, and Air Conditioning," to place the "B" CREVS train in standby in order to perform OST-750 on this train. OP-906 requires that the HVA-1B control switch be placed in the "auto" position. OST-750, which refers to indication positions "On" and "Off," and not the switch positions, "Stop," "Auto," and "Start," was then performed. Because the operator failed to understand and question the difference between indication lights and switch positions, the control switch for HVA-1B was incorrectly left in the "stop" position. The operator failed to maintain the overall cognizance of the evolution by not assuring the as-left switch positions for both HVA-1A and 1B were consistent with their safety-functions and the operability requirements of the applicable Technical Specifications (TS). This problem was further compounded by the failure of subsequent shifts to effectively use self-checking practices, which would have identified and corrected this situation during subsequent shift turnover checks.

A contributing factor to this violation is that procedure OST-750 does not provide clear instructions regarding the operation or as-left positions of these switches and controls. The train "A" testing instructions provided in this procedure state that HVA-1B should be "off." There are no specific instructions regarding the position of the HVA-1B control switch, and the system restoration instructions provided in procedure OST-750 provide no specific guidance or instructions regarding the as-left system alignment or switch positions.

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

On November 15, 1994, following discovery of the HVA-1B control switch in the "stop" position, rather than the required "auto" position, the switch was immediately placed in "auto" which restored train "B" of the CREVS to an operable status. All switches on the Reactor Turbine Generator Board (RTGB) were subsequently verified to be in the correct position. The Operator involved was removed from licensed duties, and disciplinary action was taken.

To address the concern that the incorrect position of the HVA-1B control switch was undetected for four days by other operating shifts, a checklist to verify RTGB switch positions was developed and implemented under an Operations Night Order on December 22, 1994. This checklist is now performed once per shift by a licensed operator other than the RTGB operator.

A comprehensive review of mispositioning events and human performance problems has been conducted. This review included an analysis of twenty-five equipment mispositioning events, and concluded that previous corrective actions taken in response to these types of events have been ineffective. Immediate interim actions taken to achieve rapid improvement include performing independent verification of system line-ups for all equipment clearances, use of three-way communications, self-checking evaluations by shift operating crews, and increased observations by Nuclear Assessment Department personnel.

Procedure OST-750 was revised to ensure components are properly restored to service or to a standby configuration. A specific reference to switch positions is included in this procedure to avoid confusion between component status light indication and the associated component's control switch position.

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

The checklist to verify RTGB switch positions will be incorporated as a plant procedure by April 7, 1995. Operations personnel will review pertinent OST procedures to assure that the as-left positions of switches and components are consistent with pre-test positions and overall equipment operability requirements by March 1, 1995. Additional longer term actions are being taken to improve operator attention to detail and self-checking practices.

4. The Date When Full Compliance Will Be Achieved

Full compliance with respect to the mispositioning of CREVS fan HVA-1B has been achieved.

Violation B

10 CFR 50, Appendix B, Criterion II, Quality Assurance Program, requires in part that the licensee's quality assurance program provide control over activities affecting the quality of structures, systems, and components, to an extent commensurate with their importance to safety, including the use of appropriate equipment and the assurance that all prerequisites have been identified and satisfied. Further, the program is required to take into account the need for special controls, test equipment, and the need for verification of quality by inspection or test.

Contrary to the above, on November 28, 1994, the controls established by the licensee to manage the power range calorimetric program were found to be inadequate in that the program included the use of uncalibrated instrumentation, failed to control the plant condition prerequisites under which the calorimetric program results were valid, failed to specify a method or timing for acquiring manually input data, lacked verification of automatically input data, and did not consistently control the instruments used in the calorimetric.

Reply

CP&L agrees that the violation occurred as described.

1. The Reason for the Violation

This violation was caused by lack of proper management oversight of the control of the calorimetric process. The absence of a single governing document which defines and controls all aspects of the calorimetric process resulted in inadequate application of changes to the calorimetric. Our evaluation of the power range calorimetric process has concluded that, based on the conservatism present in the calorimetric analysis, the licensed thermal power level was not exceeded. The identified weaknesses predominately involve the inputs and factors which have a minor impact on the calorimetric analysis result.

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

Inputs to the calorimetric analysis have been verified to now be using calibrated instrumentation. This was accomplished through review of the existing calibration records and by replacing certain instrumentation with new, calibrated instruments where necessary. Maintenance Management Manual (MMM) procedure MMM-002, "Maintenance Procedure Preparation," now requires a review of plant instrumentation found out of calibration. For instrumentation used in the calorimetric process, this review will assess the impact of any out of calibration condition on the calorimetric analysis.

Operations Surveillance Test (OST) procedure OST-010, "Power Range Calorimetric During Power Operation (ERFIS) Daily," has been revised to ensure proper controls are in place for the power range calorimetric process.

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

Higher level controls governing management oversight of the calorimetric process will be established with the implementation of a document which will specify the controls and technical requirements for all aspects of calorimetric process. Ties between this governing document and other site programs and procedures that affect the calorimetric process will be established to ensure the controls remain consistent. This program will be in place by June 15, 1995.

4. The Date When Full Compliance Will Be Achieved

Full compliance with respect to controls over the power range calorimetric process has been achieved.