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ACCESSION NBR: 9503010249 DOC. DATE: 95/02/21 NOTARIZED: NO DOCKET #
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SUBJECT: Forwards response to NRC 950120 ltr re violations noted in
 insp rept 50-261/94-28. Corrective actions: engineering
 personnel reviewed configuration of SW sys during time
 valves opened & left unattended.

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10 CFR 2.201

Carolina Power & Light Company

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Robinson File No.: 13510E
Serial: RNP-RA/95-0028

FEB 21 1995

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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. 50-261/94-28
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 50-261/94-28, which was transmitted by letter dated January 20, 1995. This Notice of Violation involved the mispositioning of two Service Water system valves.

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

DTG:dtg
Enclosure

c: Mr. S. D. Ebnetter, Regional Administrator, USNRC, Region II
Ms. B. L. Mozafari, USNRC Project Manager, HBRSEP
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Highway 151 and SC 23 Hartsville SC

REPLY TO A NOTICE OF VIOLATION

Violation

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 equipment control.

Operations Management Procedure, OMM-005, Clearance and Test Request is provided to specify the procedures for equipment control.

Contrary to the above, on December 15, 1994, operations personnel incorrectly implemented OMM-005, in that a clearance for service water valves SW-260 and SW-271 specified an incorrect restoration position. As a result, the valves were placed in the open position instead of the required closed position.

Reply

Carolina Power & Light Company agrees that the violation occurred as described.

1. The Reason for the Violation

This event was caused by failure of Operations personnel to use proper work practices (i.e., self-checking and attention to detail) during the performance of activities associated with the calibration of Service Water (SW) system Pressure Indicators (PI)-1619A and 1619B. The Senior Reactor Operator (SRO) who prepared the Local Clearance and Test Request (LCTR) for this calibration, incorrectly assumed that the normal position of the respective root isolation valves (i.e., SW-260 and SW-271) for PI-1619A and 1619B is open, since he observed pressure indication on each gauge during the pre-LCTR walkdown. Based on this incorrect assumption, the SRO changed the restored position for SW-260 and SW-271 on the LCTR from "Closed," which is specified in the LCTR database, to "Open," without properly resolving the position discrepancy using an approved plant procedure and/or system drawing. This improper work practice resulted in these valves being inappropriately opened during the LCTR restoration alignment.

Additionally, a different SRO and Auxiliary Operator (AO) failed to recognize that the specified position of the valves was incorrect while performing the LCTR restoration alignment. Specifically, when this SRO referenced Operating Procedure, (OP)-903, "Service Water System," to determine whether the valves required independent verification, he failed to recognize that the valve position specified in OP-903 was different than that required by the LCTR. The AO that removed the LCTR tags and re-positioned the valves also failed to recognize that the valves were being improperly positioned. Both the AO and the SRO failed to recognize that the valves were labeled with instructions to not leave the valves open and unattended.

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

Engineering personnel have reviewed the configuration of the SW system during the time the valves were opened and left unattended, and determined that there were no adverse effects on the safety-related function of the system. Additionally, an engineering evaluation is being performed to determine whether or not these valves need to be closed during SW system operation.

Upon identification of the misaligned valves, the valves were restored to the correct (i.e., "Closed") position. Additionally, all valves inside the LCTR boundary were verified to be correctly positioned in accordance with plant procedures.

The individuals involved were counselled by Operations Management.

Operators were provided with "real-time" training on this occurrence to ensure they are aware that valves SW-260 and SW-271 are to be maintained in the closed position unless the valves are attended. This training was completed by February 8, 1995.

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

A comprehensive review of equipment mispositioning events and human performance problems has been conducted. This review included an analysis of equipment mispositioning events, and concluded that previous corrective actions taken in response to these types of events have not been effective. Interim actions which have been taken to achieve improvement include: performing independent verification of system line-ups for all equipment clearances (i.e., LCTRs) and system lineups within the clearance boundary unless waived at the discretion of Operations Management, self-checking evaluations by shift operating crews, and increased observations by Nuclear Assessment Department personnel.

Longer term corrective actions include using three-way communications, and reviewing Operations Surveillance Test procedures to ensure proper equipment configurations are returned at the end of testing.

4. The Date When Full Compliance Will Be Achieved

Full compliance with respect to the mispositioning of the SW system valves has been achieved.