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SUBJECT: Forwards response to NRC 950417 ltr re violations re insp
rept 50-261/95-06. Corrective actions: SWBP suction pressure
gauge instrument stop was opened & independently verified to
be in open position.

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MAY 17 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. 50-261/95-06
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 50-261/95-06, which was transmitted by letter dated April 17, 1994. The Notice of Violation involves five examples of failure to follow procedures, inadequate procedures, and process informality. This reply to the Notice of Violation is required to be submitted to the NRC by May 17, 1995. The enclosure restates the violation, followed by our reply.

The letter transmitting the Notice of Violation stated that the Violation was of concern because it consolidates numerous examples of failure to follow procedures, inadequate procedures, and process informality, which "...collectively symbolize management's failure to execute the fundamentals of an agenda designed to enhance the quality of their organization's performance." In response to this concern, we are taking this opportunity to point out that we have aggressively implemented management actions to improve the quality of the plant staff's performance by 1) upgrading the Corrective Action Program to clearly identify and correct trends in personnel error occurrences and procedure inadequacies and non-adherence, 2) instituting and enhancing self assessment practices to identify errors and near misses at the earliest stages in order to prevent more serious events, and 3) strengthening the independent nuclear assessment function. These steps have been recognized as being effective both internally and by NRC management on April 25, 1995, when CP&L managers met with representatives of the NRC in the NRC Region II office to discuss the CP&L's Performance Evaluation Section. During this meeting, we demonstrated a declining trend in the number of deficiencies due to personnel error and inadequate procedures.

9505240349 950517
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We consider that this positive trend is an indication that the implementation of our Near-Term Improvement Plan initiatives regarding building a capable management team, establishment and reinforcement of high organizational and performance standards and expectations, and implementation of critical self-assessment, are yielding the intended results.

We consider each of the examples cited in the Notice of Violation seriously, and are implementing corrective actions. We recognize that the common elements of the causal factors associated with each individual example are potentially more significant. Accordingly, we agree that human performance and procedure adequacy concerns are areas requiring continuing focus.

Should you have any questions regarding this matter, please contact Mr. R. M. Krich at (803) 857-1802.

Very truly yours,


C. S. Hinnant

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

REPLY TO A NOTICE OF VIOLATION

Violation

Technical Specification 6.5.1.1.1, Procedures, Tests, and Experiments, states that written procedures shall be established, implemented, and maintained covering the activities recommended in Appendix "A" of Regulatory Guide 1.33, Rev. 2, February 1978, including the operation of the service water system, administrative procedures for procedure review and approval, operation of the auxiliary building ventilation system, conduct of shift relief and turnover, and the control of Q category material.

Operating Procedure, OP-903, Service Water System specifies the valve lineup required for operation of the service water system.

Administrative Procedure, AP-004, Procedure Control provides procedure review and approval requirements and specifies that changes to plant operating procedures be accomplished by procedure revisions or temporary changes.

Operating Procedure, OP-906, Heating, Ventilation, and Air Conditioning requires, in part, that if operators stop the operating reactor auxiliary building exhaust fan, they then notify E&RC that the auxiliary building is no longer at a negative pressure.

Operations Management Manual-008, Minimum Equipment List and Shift Relief Procedure, Rev. 82, requires that the oncoming or offgoing shift supervisor conduct a pre-shift briefing to ensure that the oncoming crew is aware of required information, including procedure changes.

Maintenance Management Procedure MMM-028, Control of Field Issued Material, delineates the requirements for controlling Q category material including lubricants, oils, hydraulic fluid, and greases, including storage and marking.

Contrary to the above:

On February 14, 1995, OP-903 was improperly implemented in that, the Service Water Booster Pump suction pressure gauge instrument stop valve was shut instead of being open as required. As a result, the suction pressure gauge for the operating Service Water Booster Pump was isolated.

On January 31, 1995, the licensee implemented a procedure change for charging pump packing break-in via Night Order 95-008 instead of a procedure revision or temporary change. This consisted of a detailed step-by-step procedure for operation of the pumps following maintenance or extended idle periods. In addition, on February 7, 1995, the licensee reduced the minimum allowed CCW [Component Cooling Water] heat exchanger outlet temperature from 55°F to 45°F via Night Order 95-012 instead of a procedure revision or temporary change.

On February 24, 1995, Procedure OP-906, Heating, Ventilation, and Air Conditioning was inadequate for the intended operation in that using this inadequate procedure resulted in the Auxiliary Building Ventilation System being removed from service prior to establishing the intended compensatory measures. The desired evolution was to notify E&RC before the Auxiliary Building Ventilation System was removed from service such that compensatory measures could be put in place.

On March 7, 1995, the shift supervisor failed to notify the crew of a procedure change that had reduced the Penetration Pressurization System (PPS) leakage limit. This resulted in a Reactor Operator failing to recognize that the leakage limit had been reached at 8:00 p.m. on March 8, 1995, and take appropriate action to avoid exceeding the limit. As a result, on March 9, 1995, at 5:00 a.m., PPS leakage exceeded the TS limit which placed the unit in an 8-hour shutdown action statement.

On March 6, 1995, Maintenance Management Procedure MMM-028, Control Of Field Issued Material, was found to be inadequate in that, the procedure does not control the shelf life of issued lubricants. This resulted in maintenance personnel using grease with an expired shelf life to lubricate the actuator MOV-350, Boric Acid to Charging Pump Suction Valve. In addition, on March 13 and 14, 1995, the inspectors determined that Maintenance Management Procedure MMM-028, Control Of Field Issued Material had not been followed in that, during an inspection conducted on those days the inspectors detected several examples of improperly stored Q category material and Q category material which was missing required markings/labeling.

Reply

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

1. The Reason for the Violation

An investigation was conducted for each of the individual examples identified in the Notice of Violation. However, in order to establish common elements or causes, and to determine the need for new, different, or more comprehensive corrective actions, a collective evaluation of the examples identified was also conducted. This evaluation was performed by examining each individual event or occurrence, by identifying the root cause or causal factors for each, and then by performing a "common cause" analysis to establish similarities or common elements shared by these examples. Viewed collectively, the examples demonstrate inadequate implementation of administrative procedure requirements and poor communications. Inadequate communications occurred within the operating shifts, within turnover of information from one shift to the next, within communications between the Operations Procedures group and the operating shifts, and within communications between Operations and other site work groups.

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

The following specific corrective actions have been taken for each of the examples cited.

- Service Water Booster Pump (SWBP) "B" Suction Pressure Gauge

The SWBP Suction Pressure Gauge Instrument Stop (i.e., PI-1602B) was opened and independently verified to be in the open position. Operating Procedure (OP)-903, "Service Water System," Attachment 9.1, "Service Water System Valve Checklist," was performed for all service water valves from the suction of the SWBPs to the discharge valves of both pumps to assure instrument isolation valves were in their proper position, and their associated indications were reading as expected for plant conditions.

- Night Order Used Instead of Procedure Revision

Procedure OP-301, "Chemical and Volume Control System (CVCS)," was revised to incorporate instructions for Charging Pump packing break-in.

Procedure OP-101, "Reactor Coolant System and Reactor Coolant Pump Startup and Operation," was performed to address the change to the Component Cooling Water low temperature limit for Reactor Coolant Pump operation.

The Manager - Shift Operations was counselled by the Manager - Operations regarding the administrative requirements governing changes to plant operating procedures that must be accomplished by the procedure revision or temporary change process.

- Auxiliary Building Ventilation Secured

The Auxiliary Building Ventilation System was restarted while the building was still at a negative pressure, and appropriate compensatory measures were formulated to support system maintenance with the ventilation secured. With these measures in place, system maintenance activities were subsequently completed on April 12, 1995.

Operations and Environmental and Radiation Control (E&RC) personnel have reviewed this incident as internal operating experience. This review emphasized the importance of effective communications during individual organization shift turnovers and during the collective shift turnover meetings.

Operations Procedure (OP)-906, "Heating, Ventilation, and Air Conditioning," was revised to ensure that E&RC personnel are notified and local monitoring initiated prior to securing Auxiliary Building Ventilation.

- Penetration Pressurization System (PPS) Leakage Limit Exceeded

An Operations Night Order was issued on March 9, 1995, to emphasize the expectation that "all indications are evaluated for adverse trends on every watch station."

Operator Logs have been revised to include the PPS leakage limit on the log sheet. Through this approach, the operator taking the logs will have the leakage limit directly available for comparison against the actual reading.

The Operations Procedures group has completed a review of this event, and the applicable sections of Operations Management Manual (OMM) procedure OMM-036, "Operations Real Time Training," to reinforce the criteria for determining when training on procedure revisions is necessary.

- Maintenance Management Manual (MMM)-028 Deficient/Not Properly Implemented

A multi-disciplined team with representatives from the Materials, Maintenance, and Procurement organizations was assembled on March 20, 1995, to review this issue and to formulate process enhancements. As a result of this review, initiatives have been established to inspect satellite staging areas for shelf life and storage of material covered by the quality assurance program, and to emphasize on a site-wide basis that material covered by the quality assurance program must be handled in accordance with MMM-028, "Control of Field Issued Material."

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

Corrective action initiatives have been taken which are designed to improve performance in the areas of procedure adherence, procedure adequacy, and communications. This includes the use of improved Corrective Action Program (CAP) trending capabilities, which incorporates improved capability for adverse condition trending and subsequent data analysis. As low-level events are captured, evaluated, and collectively analyzed, issues such as communications and procedural adequacy are being identified. Using this tool, corrective actions can be pre-emptively taken to resolve adverse trends before the occurrence of more significant deficiencies.

The Plant staff is using self-assessment findings, in conjunction with enhanced CAP tools, to ensure corrective actions are timely, adequate, and properly prioritized. These self-assessment practices will result in performance improvements within all plant organizations.

The following additional corrective actions are being taken to address procedure adherence issues, procedural inadequacies, and inadequate communications within the Operations organization.

1. Operations Unit management will discuss procedure adherence issues, procedural inadequacies, and inadequate communications during the next cycle of Licensed Operator Retraining, currently scheduled to begin in June 1995. This discussion will include the examples associated with the Notice of Violation.
 2. Improved criteria and methods for communicating procedure changes to the operating shifts will be implemented by June 30, 1995.
4. The Date When Full Compliance Will Be Achieved

Full compliance will be achieved by August 31, 1995.