REGULATORY [redacted]ORMATION DISTRIBUTION SYS[redacted]M (RIDS)

ACCESSION NBR: 8710230004 DOC. DATE: 87/10/16 NOTARIZED: YES DOCKET #
FACIL: 50-261 H. B. Robinson Plant, Unit 2, Carolina Power & Light C 05000261
AUTH. NAME AUTHOR AFFILIATION
MCDUFFIE, M. A. Carolina Power & Light Co.
RECIP. NAME RECIPIENT AFFILIATION
LIEBERMAN, J. Office of Enforcement (Post 870413)

SUBJECT: Responds to violations noted in notice of violation dtd 870918. Corrective actions: operations personnel responsible for valve misalignment disciplined & briefing conducted for each operating shift re misalignment event. Fee paid.

DISTRIBUTION CODE: IE14D COPIES RECEIVED: LTR 1 ENCL 0 SIZE: 6
TITLE: Enforcement Action Non-2.790-Licensee Response

NOTES:

	RECIPIENT ID CODE/NAME	COPIES LTTR	COPIES ENCL	RECIPIENT ID CODE/NAME	COPIES LTTR	COPIES ENCL
	PD2-1 LA	1	1	PD2-1 PD	1	1
	ECCLESTON, K	1	1			
INTERNAL:	AEOD/DOA	1	1	AEOD/DSP/TPAB	1	1
	DEDRO	1	1	NRR/DOEA/EAB	1	1
	NRR/DREP/EPB	1	1	NRR/PMAS/ILRB	1	1
	OE FILE 01	1	1	OE LIEBERMAN, J	1	1
	REG FILE 02	1	1	RGN2 FILE 03	1	1
	RGN2/DRSS/EPRPB	1	1			
EXTERNAL:	LPDR	1	1	NRC PDR	1	1
	NSIC	1	1			

REC'D w/CHECK $50,000

TOTAL NUMBER OF COPIES REQUIRED: LTTR 17 ENCL ~~17~~ 0

CP&L
Carolina Power & Light Company

OCT 16 1987

SERIAL: NLS-87-229
10CFR2.201

Mr. James Lieberman
Director, Office of Enforcement
United States Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, DC 20555

H. B. ROBINSON STEAM ELECTRIC PLANT, UNIT NO. 2
DOCKET NO. 50-261/LICENSE NO. DPR-23
REPLY TO NOTICE OF VIOLATION, EA 87-112

Dear Mr. Lieberman:

In accordance with 10CFR2.201, Carolina Power & Light Company (CP&L) provides the following reply to the Notice of Violation (EA 87-112) issued by Dr. J. Nelson Grace on September 18, 1987. As recognized in Dr. Grace's letter on page 2, CP&L identified and reported this violation. As also noted, CP&L has a good performance history in the area of concern and has taken extensive long-term corrective actions following the events. Carolina Power & Light Company agrees, however, that the violation occurred as stated and thus encloses a check for $50,000.

STATEMENT OF VIOLATION

The NRC's Notice of Violation states as follows:

"I. Inoperable Low Pressure Safety Injection System - Valve RHR-764

"A. Technical Specification (TS) 3.3.1.3 requires, in part, that when the unit is in the hot shutdown condition, the requirements of 3.3.1.1 shall be met.

"Technical Specification Limiting Condition for Operation (LCO) 3.3.1.1 requires two residual heat removal (RHR) pumps and all essential features including valves, interlocks, and piping associated with the pumps to be operable.

"Technical Specification 3.0 states that, except as provided for in each specification, if an LCO cannot be satisfied because of circumstances in excess of those addressed in the specification, the unit shall be placed in hot shutdown within eight hours and in cold shutdown within the next thirty hours unless corrective measures are taken under the permissible LCO statements or until the unit is placed in a condition in which the specification is not applicable.

411 Fayetteville Street • P. O. Box 1551 • Raleigh, N. C. 27602

IE14
1/0

Rec'd w/check $50,000

"Contrary to the above, on June 5, 1987, the essential features associated with both RHR pumps were not operable in that the discharge flow paths for low pressure safety injection were isolated with the unit in hot shutdown due to valve RHR-764 being shut, and the unit was not placed in cold shutdown within 38 hours.

"B. Technical Specification 6.5.1.1.1 requires that written procedures be implemented covering the procedures recommended in Appendix A of Regulatory Guide 1.33. Appendix A of Regulatory Guide 1.33 requires procedures for the operation of safety-related systems and for procedural adherence.

"Contrary to the above, on June 5, 1987, procedures were not properly implemented for the operation of the Residual Heat Removal (RHR) System (low pressure safety injection) and resulted in the incorrect configuration of the RHR System causing its isolation for approximately 42 hours.

"Specifically:

"1. While the valve lineup in ATTACHMENT 9.1 to Operation Procedure OP-201 (Revision 6), Residual Heat Removal System, required Valve RHR-764 (HCV-758 Bypass) to be placed in the locked open position, the valve remained shut.

"2. Although Section 6.2.3 of Plant Program PLP-030 (Revision 0), Independent Verification, requires that both the initial positioner and the second individual conducting independent verification perform the evolution independently, the individuals conducted the RHR Heat Exchanger room valve lineup together, eliminating the opportunity to correctly position RHR-764.

"3. While Section 6.2.3 of Plant Program PLP-030 also requires that the results of a valve lineup be documented on the valve lineup sheet by the individuals conducting the lineup and independent verification, the documentation was not completed. Furthermore, a Senior Reactor Operator documented the independent verification as complete via communication on the plant phone system, removing the last opportunity to recognize that Valve RHR-764 was still shut causing the isolation of the low pressure safety injection system."

Response

1. Admission of the Violation

Carolina Power & Light Company admits the violation as stated.

2. Reason for the Violation

The cause of this violation is attributed to personnel error resulting from a failure to follow procedures during performance of system valve lineup. Some personnel followed inappropriate work practices by using personal notes in contaminated areas versus the actual checklist required by administrative

procedures. In addition, poor judgement on the part of an operator, in that he relied on an inadequate communication, resulted in his signing off a specific checklist item in response to a general question rather than performing an independent, hands-on check of the valve position prior to sign-off.

A contributing factor was that the definition, provided by the Operations administrative procedures, of the method for use of specific procedure types may not have been sufficiently clear. This led to the misapplication of the guidance that was provided for other procedures.

3. Corrective Steps Which Have Been Taken and Results Achieved

a. Operations personnel responsible for the valve misalignment were disciplined, and for the foreseeable future only licensed operators will sign for the independent verification requirements of operating procedures.

b. A briefing was conducted for each operating shift, by the Operating Supervisor, prior to each shift's next watch period. This briefing covered the RHR-764 misalignment event and how it was discovered. It also included a review of the administrative requirements for conduct and documentation of valve lineups, procedure performance, and independent verification of actions.

c. In addition to the above, the following actions were taken to ensure the scope of the valve misalignment concern was not pervasive but was limited to a specific shift and specific procedure. Also, these actions were taken to assess the possible contribution of human factors concerns and hardware configurations.

1) The operability of certain critical systems was ensured by an independent verification of major flowpaths by QA personnel and functional testing and injection flowpath verification by Operations.

2) Interviews were conducted with on-shift operators by the On-site Nuclear Safety Organization (ONS) in order to independently assess the scope of operators' improper use of the administrative procedure's guidance regarding valve lineups and sign-offs, to assure the operators understood the administrative requirements for performing valve lineups, and to correct any misunderstanding they may have had.

3) Certain completed valve lineups were reviewed by ONS to determine to what extent human factors deficiencies associated with the valves might contribute to valve misalignment or operator sign-off concerns. Although some human factor inadequacies were noted, no conclusions could be reached regarding sign-off of lineups by persons other than who performed the actual position check.

4) Feedback from the on-shift briefings was evaluated by Operations management.

5) In addition to the results of the above four items, management also reviewed the administrative guidance for valve lineups and verifications, past valve misposition nonconformance reports (NCR), and Plant Nuclear Safety Committee (PNSC) Meeting Minutes and actions regarding valve misalignment concerns, to determine if changes to any management practices were necessary.

d. As of this date, no subsequent valve mispositionings have occurred, and plans for modification of procedural guidance are in progress.

4. Corrective Steps Taken to Avoid Further Violations

Input was solicited from each operating shift and from the PNSC membership specifically to address what procedural requirements should be used to control procedure usage and valve alignment. This input sought was intended to enhance the operators' feeling of ownership of the administrative requirements and to further ensure their procedure compliance.

Based on this input, changes to the administrative guidance of various operating procedures, primarily to Operations Management Manual Procedure OMM-001, "Operations - Conduct of Operations," are being prepared to consolidate and more clearly define the requirements of conduct of procedure performance and valve lineups. In addition, specific guidance is being provided for each procedure type, i.e., Operating Procedure (OP), General Procedure (GP), Operations Surveillance Test (OST). This guidance will address how each procedure is used, how completion of its parts are documented, and address any differences in individual requirements. Following completion of these changes, the operator training program will be reviewed and updated as required to ensure it is consistent with the latest guidance.

5. Date Full Compliance Will Be Achieved

Carolina Power & Light Company is now in compliance with the technical specifications. The corrective actions to ensure continued compliance have been and are being implemented. Specifically, the disciplinary actions, shift crew briefings, and actions noted are complete. Revisions to applicable procedures noted above will be completed by December 18, 1987. Necessary changes to the operator training program and training of all on-shift operations personnel, will be completed by April 30, 1988.

STATEMENT OF VIOLATION

The NRC's Notice of Violation states as follows:

"II. Isolation of High Pressure Safety Injection Pumps

"Technical Specification 6.5.1.1.1a requires that written procedures be implemented covering the procedures recommended in Appendix A of Regulatory Guide 1.33. Appendix A of Regulatory Guide 1.33 requires procedures for the operation of safety systems and for procedural adherence.

"Contrary to the above, on June 11, 1987, procedures were not properly implemented for the operation of safety systems in that during the performance of General Procedure GP-007 (Revision 9), Plant Cooldown from Hot Shutdown, valves not required by the procedure were shut. With the unit in hot shutdown and the reactor coolant temperature above 350°F, the Safety Injection Pumps Discharge Header Cross-Connect Valves were shut isolating two of the three pumps. The paths remained isolated for a period of approximately 14 hours."

Response

1. Admission of the Violation

   Carolina Power & Light Company admits the violation as stated.

2. Reason for the Violation

   The cause of this violation was a failure to follow procedure due to inattention to detail.

3. Corrective Steps Which Have Been Taken and Results Achieved

   The operator responsible for this evolution has been counseled regarding the importance of strict compliance with procedures and attention to detail, and he has been appropriately disciplined.

4. Corrective Steps Taken to Avoid Further Violations

   The heatup and cooldown procedures which involve manipulation of the subject valves, SI-878 A&B, have undergone a review, including human factors considerations and will be modified to more clearly define the manipulation and position verification of these valves.

5. Date Full Compliance Will Be Achieved

   Carolina Power & Light Company is now in compliance with the technical specifications. The corrective actions to ensure continued compliance have been and are being implemented. Specifically, the actions noted under Item 3 above are complete. The necessary revision of the affected procedures will be completed by December 18, 1987.

We trust the information provided above addresses your concerns regarding this subject. Should you have further questions regarding our response to the issue, please contact Mr. G. P. Beatty, Vice President - Robinson Nuclear Project Department.

Please find enclosed, in accordance with 10CFR2.205(i), a check in the amount of fifty thousand dollars ($50,000) in full payment of the civil penalty assessed.

Yours very truly,

M. A. McDuffie
Senior Vice President
Nuclear Generation

JSK/pp (5315JSK)

Enclosure

cc: Dr. J. Nelson Grace
Mr. K. Eccleston
Mr. H. Krug

M. A. McDuffie, having been first duly sworn, did depose and say that the information contained herein is true and correct to the best of his information, knowledge and belief; and the sources of his information are officers, employees, contractors, and agents of Carolina Power & Light Company.

Debra C. Johnson
Notary (Seal)

My commission expires: June 26, 1989