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NRC INSPECTION REPORT NO. 50-261/88-30

Gentlemen:

Carolina Power and Light Company (CP&L) submits this response to the request for information by NRC Inspection Report No. 50-261/88-30. At issue is a concern over an apparent weakness shown by CP&L in identifying the applicability of containment isolation valve Technical Specification 3.6.3 when Motor Control Center MCC-6 was declared inoperable. This submittal discusses CP&L actions related to the event as well as actions CP&L has taken and planned in order to improve the Unit 2 Operators' review for applicable Technical Specification statements upon determination of inoperable equipment.

The NRC Inspection Report describes the event in Paragraph 7a and states in part:

"On October 14, 1988, a review by a licensed operator on rotation into the regulatory compliance group identified that on October 13, at 9:00 p.m., the plant should have declared a phase B containment isolation valve inoperable when MCC-6 was declared inoperable. This automatic isolation valve, CC-735, is associated with the reactor coolant pumps' component cooling water return line from containment. Consequently, it can not be shut when the reactor coolant pumps are running. PEP-101, Initial Emergency Actions, item 6, Loss of CV Integrity, requires an unusual event be declared if one or more automatic isolation valves are inoperable for greater than 4 hours and are not isolated or repaired. Thus in accordance with PEP-101, an unusual event was declared at 11:06 a.m., on October 14, 1988. The plant remained in an unusual event status until 9:45 p.m. on October 15, 1988, when the unit was placed in cold shutdown. The failure to identify that a containment isolation valve was effected resulted in the unusual event being declared approximately 11 hours late. Additionally, TS 3.6.3 LCO was unknowingly entered when the MCC was declared inoperable, but was not violated in that the plant was in cold

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shutdown within 40 hours of the initial inoperability determination. As stated above, after the fact, it was proven that MCC-6 had been operable and declaration of an unusual event had not been required. Nevertheless, it is of significant concern that all the relevant TS Action Statements and regulatory requirements were not properly assessed by the operations department personnel. This is of significant concern because of the long period of time that was available for review prior to declaring MCC-6 inoperable (e.g. from October 5, 1988, when the operability of MCC-6 came into question, to October 13, 1988, when MCC-6 was declared inoperable)."

In discussing the incident, it should be noted that an Unusual Event was declared in a timely manner as soon as it was recognized that MCC-6 inoperability affected a containment isolation valve. Of significant concern, however, is the adequacy of original reviews to determine the impact of MCC-6 being inoperable.

Two issues need to be addressed in explaining the circumstances surrounding the event and the cause of the delayed identification of the 4-hour LCO. These issues do not excuse the incident but do shed light on the reasons for the actions taken. First, the uniqueness of declaring an energized, functioning safety-related MCC inoperable made the situation extraordinary. Second, the communications between Operations management and onshift personnel were less than successful in providing the right direction for the review of the most limiting component affected by MCC-6 when declared inoperable.

Regarding the first issue, the declaring of an entire motor control center inoperable while it is still energized and with all of its safety-related loads remaining in service (operating or capable of operating) is a very unusual occasion. There is no clear cut LCO associated with either the emergency buses or Motor Control Centers 5, 6, 9, and 10 because it has never been envisioned that these components could be energized but inoperable. In fact, the Technical Specifications have no operability statement associated with the buses or the MCCs. Technical Specification 3.7.1.b simply requires that both of the emergency buses be energized for critical operations.

In the case of MCC-6, the operability concerns changed often during the week preceding October 13, from questions over the individual loads, to breaker settings, to the feeder supply cable to the MCC. Even on October 13, the feeder cable ampacity issue shifted rapidly, resulting finally in declaring the entire MCC inoperable.

The Operations unit has detailed procedures, Operations Work Procedures (OWPs), for removing specific safety-related components from service. These OWPs contain requirements such as LCOs and Technical Specification references. But no OWP exists for the safety-related MCCs since it was never envisioned that they would be removed from service during critical operations. This should illustrate that this incident was indeed unique and should also support CP&L's belief that no generic weakness is indicated in the Unit 2 operations procedures and methods.

Of greater significance, though, is the issue of the adequacy of the interface and communications between Operations supervision and the Shift Foreman on duty October 13. At the time, when the Operations Supervisor was notified that MCC-6 was to be declared inoperable because of ampacity concerns under accident conditions, the Supervisor informed the Shift Foreman of the situation and directed him to determine which LCOs applied. Based on their discussion, however, the Shift Foreman interpreted that his management had determined that the "B" Service Water Booster Pump was the most limiting component on the MCC and therefore Technical Specification 3.3.4.2.b applied, with its 24-hours/hot shutdown LCO. The Shift Foreman therefore relied upon his interpretation of management's determination and no further investigation into the most limiting component was pursued. Although Operations management never intended to influence the decision making of the Shift Foreman, apparently the message received was unclear.

To correct this problem, the Shift Foreman is now required to document his determination associated with any LCO in the Shift Foreman's Log. Should management counter the original determination, this fact will also be logged. These actions will require the operating shift personnel to research LCO issues and to reach a conclusion independent of discussions with management.

As recognized in the NRC Inspection Report, MCC-6 was later determined to have been operable throughout the event and no Unusual Event was required. The event did, however, provide an opportunity to emphasize and strengthen the responsibility of onshift licensed personnel to determine LCOs.

Should you have any question with regard to this response, please contact Mr. J. M. Curley, telephone (803) 383-1367.

Very truly yours,



R. E. Morgan  
General Manager

H. B. Robinson S. E. Plant

DAS:jch

cc: Mr. M. L. Ernst  
Mr. L. W. Garner  
INPO