



UNITED STATES
 NUCLEAR REGULATORY COMMISSION
 REGION II
 101 MARIETTA STREET, N.W.
 ATLANTA, GEORGIA 30323

Report No.: 50-261/90-05

Licensee: Carolina Power and Light Company
 P. O. Box 1551
 Raleigh, NC 27602

Docket No.: 50-261

License No.: DPR-23

Facility Name: H. B. Robinson

Inspection Conducted: March 11 - April 10, 1990

Inspectors: R.E. Carroll for
 L. W. Garner, Senior Resident Inspector

4/24/90
 Date Signed

R.E. Carroll for
 K. R. Jury, Resident Inspector

4/24/90
 Date Signed

Approved by: Wm. C. Dance
 Wm. C. Dance, Chief
 Reactor Projects Branch 1
 Division of Reactor Projects

4/24/90
 Date Signed

SUMMARY

Scope:

This routine, announced inspection was conducted in the areas of operational safety verification, monthly surveillance observation, maintenance observation, inspection of quality verification functions, onsite followup of written reports of nonroutine events, and followup on previous inspection findings.

Results:

Within the areas inspected, no violations or deviations were identified.

The practice of verifying the latest revision of a procedure other than immediately prior to its use was identified as a weakness (paragraph 2).

Housekeeping inside the containment vessel continued to warrant management attention (paragraph 2).

Accelerated microbiologically induced corrosion attack on service water piping inside the auxiliary building has been detected (paragraph 2).

Lack of initial work request reviews was indentified as a weakness in the quality assurance program (paragraph 5).

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REPORT DETAILS

1. Persons Contacted

C. Baucom, Senior Specialist, Regulatory Compliance
C. Bethea, Manager, Training
*F. Bishop, Project Engineer, Onsite Nuclear Safety
R. Chambers, Engineering Supervisor, Technical Support
D. Crook, Senior Specialist, Regulatory Compliance
C. Dietz, Manager, Robinson Nuclear Project
R. Femal, Shift Foreman, Operations
*S. Griggs, Technical Aide, Regulatory Compliance
*E. Harris, Manager, Onsite Nuclear Safety
*L. Lynch, Supervisor, Quality Assurance/Quality Control
*T. Kinnaman, Engineering Supervisor, Technical Support
D. Knight, Shift Foreman, Operations
*J. Kloosterman, Director, Regulatory Compliance
R. Moore, Shift Foreman, Operations
*R. Morgan, Plant General Manager
M. Page, Manager, Technical Support
F. Roy, Engineer, Technical Support
D. Seagle, Shift Foreman, Operations
J. Sheppard, Manager, Operations
*E. Shoemaker, Project Engineer, Operations
*R. Smith, Manager, Maintenance
*D. Stadler, Onsite Licensing Engineer
R. Steele, Shift Foreman, Operations
*K. Williams, Senior Engineer, Technical Support
H. Young, Director, Quality Assurance/Quality Control

Other licensee employees contacted included technicians, operators, mechanics, security force members, and office personnel.

*Attended exit interview on April 16, 1990.

Acronyms and initialisms used throughout this report are listed in the last paragraph.

2. Operational Safety Verification (71707)

The inspectors evaluated licensee activities to confirm that the facility was being operated safely and in conformance with regulatory requirements. These activities were confirmed by direct observation, facility tours, interviews and discussions with licensee personnel and management, verification of safety system status, and review of facility records.

To verify equipment operability and compliance with TS, the inspectors reviewed shift logs, operation's records, data sheets, instrument traces, and records of equipment malfunctions. Through work observations and

discussions with operations staff members, the inspectors verified the staff was knowledgeable of plant conditions, responded properly to alarms, adhered to procedures and applicable administrative controls, cognizant of in-process surveillance and maintenance activities, and aware of inoperable equipment status. The inspectors performed channel verifications and reviewed component status and safety-related parameters to verify conformance with TS. Shift changes were routinely observed, verifying that system status continuity was maintained and that proper control room staffing existed. Access to the control room was controlled and operations personnel carried out their assigned duties in an effective manner. Control room demeanor and communications continued to be informal yet effective.

Plant tours and perimeter walkdowns were conducted to verify equipment operability, assess the general condition of plant equipment, and to verify that radiological controls, fire protection controls, physical protection controls, and equipment tagging procedures were properly implemented.

On April 4, 1990, the inspectors observed performance of PLP-006, Containment Vessel Inspection/Closeout. When the auxiliary operator contacted the control room for permission to enter the pump bays, he was informed that entry was no longer procedurally required. The AO was performing revision 12 of the procedure; however, revision 13, approved March 29, 1990, had become effective on April 4, 1990. The inspectors were informed that on April 3, 1990, the CV entry had been pre-planned to ensure that the entry would be well coordinated and effectively conducted. One of the preplanning activities included verification, as documented by an operator's signature, that "this revision (of PLP-006) is the latest revision available and has been verified against the Revision Status List." By performing this procedural step on the day prior to the actual performance of the procedure, an outdated revision was utilized. Verification of the latest procedure revision other than immediately prior to its use was considered a weakness. This weakness was discussed with Operations supervision. Operations management subsequently issued instructions to all shifts to clarify when the latest revision verification is to be performed.

On April 9, 1990, the inspectors reviewed the completed PLP-006 procedure. The completed procedure was revision 13, not revision 12 which had been utilized in the field. The inspectors were informed that revisions 12 and 13 had been compared, and that the appropriate information had been transferred from the field copy to the new revision. Transfer of information between a field copy (especially one used in a contaminated area) and a clean copy is normal. However, no notation had been made to indicate that different revisions were involved. Transferring information between revisions without appropriate documentation is considered a poor practice. This poor practice was also discussed with Operations supervision.

During the CV inspection, the inspectors observed some debris. Specific items noted included three balls of tape, a plastic glove, a small plastic bag (approximately 10 X 15 inches), a cloth hand towel (probably used for decontamination), and several broken valve tags. A temporary sign (adjacent to valve RHR-751) warning of a radiological hazard had been secured with duct tape that had become partially unstuck. Additionally, a rectangular section of flashing covering the CV liner (behind the PRT) had become unsecured on one side and approximately two thirds around on the adjacent sides. These conditions were discussed with plant management.

SW Pipe MIC Attack

Previous inspection reports numbered 84-45, 84-48, 85-12, 85-22, 86-12, 87-03, 87-16, 87-35, 88-03, and 88-12 contain background information on MIC in SW piping. In accordance with commitments to the NRC, a sample of SW pipe welds are periodically radiographed to ensure that the amount of MIC damage will not exceed structural limitations prior to scheduled piping replacement. An administrative limit with a safety factor of two has been established as a sleeving criteria. Since all but one short section of SW piping inside the CV had been replaced with a material not susceptible to MIC, the piping of concern is the auxiliary building SW piping. Approximately one third of the 35 welds in the March 1990 sample showed an accelerated (more than the anticipated) amount of MIC increase. Consequently, all accessible welds were then radiographed (approximately 70 additional welds). Preliminary analysis of this later sample indicated an increased MIC rate on some weld affected areas, but not on as many welds as would be expected from the first sample results. No weld has exceeded the administrative sleeving limit. However, at the end of the report period, analysis was in progress to determine how the monitoring program needs to be modified to account for the accelerated MIC growth on certain welds. This is an IFI: Review SW MIC Monitoring Program Changes Required by Accelerated MIC Growth Rates, 90-05-01.

No violations or deviations were identified.

3. Monthly Surveillance Observation (61726)

The inspectors observed certain safety-related surveillance activities on systems and components to ascertain that these activities were conducted in accordance with license requirements. For the surveillance test procedures listed below, the inspectors determined that precautions and LCOs were adhered to, the required administrative approvals and tagouts were obtained prior to test initiation, testing was accomplished by qualified personnel in accordance with an approved test procedure, test instrumentation was properly calibrated, the tests were completed at the required frequency, and that the tests conformed to TS requirements. Upon test completion, the inspectors verified the recorded test data was complete, accurate, and met TS requirements; test discrepancies were

properly returned portions

properly documented and rectified; and that returned to service. Specifically, the ins portions of the following test activities:

- MST-012 (revision 9) Inspection And T Bypass Breakers
- OST-401 (revision 25) Emergency Diesel
- OST-610 (revision 17) Unit No. 2 Porta Fire Hose Static

No viola

No violations or deviations were identified.

4. Monthly

4. Monthly Maintenance Observation (62703)

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The inspectors observed safety-related mainte and components to ascertain that these acti accordance with TS, approved procedures, and and standards. The inspectors determined tha violate LCOs and that required redundant com inspectors verified that required administrat controls were adhered to. In particular, the the following maintenance activities:

- CM-305 (revision 3) Westinghouse DB Maintenance
- WR/JD 90-AEBH1 Replacement of L Contacts on B Re

No viola

No violations or deviations were identified.

5. Inspect

5. Inspection of Quality Verification Functions (

During the ident license review These p 25 spec Q/QC Man conduct

During a review of the WR system, the inspecto the site's policy of independent WR review. identified in work control and WR planning licensee. In attempting to ascertain the mec to identify where improvement was needed, the initial QA review of WRs is specified per Corp review procedures, OQA-202, revision 1 and OQ/ These procedures detail that QA's initial rev as specified by the Director (Manager) QA/QC. QA/QC Manager, the inspectors were informed th conducted due to a conscious management decis QA's involvement in line functions. Part o eliminating a formal QA initial review of WRs.

There is no formalized site QC inspection program (including assignment of hold points in WRs). This fact, coupled with the recent problems identified in the WR and work control processes, led the inspectors to question the prudence of QA/QC not performing initial WR reviews. Subsequently, the QA/QC management implemented a WR initial review program during the week of March 26, 1990. The non-review of initiated WRs was considered to be a QA program weakness. Completed WR have been randomly reviewed through surveillance activities as evidenced by Surveillance Reports 89-032 and 89-054.

No violations or deviations were identified.

6. Onsite Followup of Written Reports of Nonroutine Events (92700)

(Closed) P2188-03, Gamma-metrics Cable Assemblies Installed As Part of the Neutron Monitoring System May Possibly Leak, and LER 88-12, Potential For Post-Accident Neutron Flux Signal Interference Due to Manufacturing Defect. The inspectors reviewed M-977, Repairs to Protect Penetration F01. The Inspectors verified that QC had verified proper installation of the vendor recommended repair procedures and that the acceptance testing had been successfully performed.

(Closed) LER 88-23, Potential for Overcurrent Conditions on Two Motor Control Centers. Inspection of this item is contained in inspection reports 88-30 and 89-36. On April 6, 1989, EA 89-02 identified this issue as a severity level III violation. This LER is being closed since the closeout inspection is being tracked by violation number 88-36-01.

(Closed) LER 88-24, Inoperable Containment Fan Coolers Due To Lack of Environmentally Qualified Splices on Motor Leads. This issue was addressed in EA 89-02, dated April 6, 1989, as an additional example of a previously cited violation in the NOV and Proposed Imposition of Civil Penalty dated June 16, 1988. Hence, no additional enforcement action was taken concerning this matter. See inspection report 89-26 for followup inspection activities associated with the June 16, 1988, enforcement letter. The inspector witnessed installation of environmentally qualified splices on selected motor leads. The installations were performed in accordance with approved procedures.

(Closed) LER 89-12, Diesel Generator Inoperability Due To Inadequate Exhaust Line Seismic Analysis. This item was addressed by inspection report 89-32. The exhaust line was upgraded to seismic Class I criteria.

7. Action on Previous Inspection Findings (92701)

(Closed) UNR 88-28-03, Failure to Have Vent Valves Environmentally Qualified, and LER 88-20, Reactor Vessel Head Vent System Not Environmentally Qualified. Inspection report 88-36 identified this issue as a violation,

designated as 88-36-03. Subsequently, EA 89-02 was issued on April 6, 1989. The EA classified this issue as an additional example of a previously cited violation contained in the NOV and Proposed Imposition of Civil Penalty, dated June 16, 1988. Thus, no additional enforcement action was taken relative to the vent system. See Inspection Report 89-26 for followup inspection activities associated with the June 16, 1988, enforcement letter.

No violations or deviations were identified.

8. Exit Interview (30703)

The inspection scope and findings were summarized on April 16, 1990, with those persons indicated in paragraph 1. The inspectors described the areas inspected and discussed in detail the inspection findings listed below and in the summary. Dissenting comments were not received from the licensee. Proprietary information is not contained in this report.

<u>Item Number</u>	<u>Description/Reference Paragraph</u>
90-05-01	IFI - Review SW MIC Monitoring Program Changes Required by Accelerated MIC Growth Rates

9. List of Acronyms and Initialisms

AO	Auxiliary Operator
CM	Corrective Maintenance
CV	Containment Vessel
EA	Enforcement Action
IFI	Inspector Followup Item
LCO	Limiting Conditions for Operation
LER	Licensee Event Report
M	Modification
MIC	Microbiologically Induced Corrosion
MST	Maintenance Surveillance Test
NOV	Notice of Violation
NRC	Nuclear Regulatory Commission
OQA	Operational Quality Assurance
OST	Operations Surveillance Test
PLP	Plant Program
PRT	Pressurizer Relief Tank
QA	Quality Assurance
QC	Quality Control
RHR	Residual Heat Removal
SW	Service Water
TS	Technical Specification

UNR	Unresolved Item*
WR	Work Request
WR/JO	Work Request/Job Order

*Unresolved items are matters about which more information is required to determine whether they are acceptable or may involve violations or deviations.