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SUBJECT: Responds to violations noted in Insp Rept 50-261/90-22 re failure to adequately implement procedures.

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H. B. ROBINSON STEAM ELECTRIC PLANT  
DOCKET NO. 50-261  
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NRC INSPECTION REPORT NO. 50-261/90-22 REPLY TO A NOTICE OF VIOLATION

Gentlemen:

Carolina Power and Light Company (CP&L) provides this reply to the Notice of Violation identified by NRC Inspection Report No. 50-261/90-22.

Severity Level IV Violation (RII-90-22-02)

Technical Specification Section 6.5.1.1.1.b. requires that written procedures shall be established, implemented, and maintained covering refueling operations.

Contrary to the above, two examples of failure to adequately implement procedures occurred, in that:

1. During performance of General Procedure GP-009, Filling, Purification, and Draining of the Refueling Cavity, revision 9, on September 22, 1990, valve WD-1757C, the drain valve from the lower cavity to the containment sump, was opened rather than closed as required by step 5.1.2.6. This resulted in the discharge of approximately 8,000 gallons of spent fuel pool water into the containment sump.
2. On October 8, 1990, it was discovered that the instrument air and nitrogen supply valves to the refueling cavity pneumaseal were not wired open as required by procedure MRP-001, Pneumaseal Installation and Removal, revision 3, step 7.2.9. As a result of these valves not being open, both the primary and backup air supplies were isolated from the pneumaseal.

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REPLY

Example 1

(1) The Reason For The Violation

As part of the Plant's Corrective Action Program, a Significant Condition Report (SCR) 90-071 was initiated to investigate the mispositioning of Waste Disposal (WD) valve WD-1757C. The SCR determined that this event is a Human Performance problem caused by a combination of procedural deficiencies, labeling deficiencies, poor training, and inadequate self-checking. Valve WD-1757C is located in a locked high radiation area, and is covered with lead blanketing for shielding purposes. Valve operation is by means of a reach rod through the room's door and the valve is reverse acting (i.e., clockwise to open), which is a different operation than almost all valves at Robinson Plant. Valve WD-1757C is a ball valve with movement limited by mechanical stops.

(2) The Corrective Steps That Have Been Taken and The Results Achieved

Valve WD-1757C was promptly repositioned following the identification that the valve was open in lieu of closed as required. SCR 90-071 was initiated to identify the root cause and appropriate further corrective actions.

(3) The Corrective Steps That Will Be Taken To Avoid Further Violations

- a) General Procedures GP-009, GP-010, and Operating Procedure OP-701 will be revised to conspicuously identify this valve as a reverse acting valve.
- b) Permanent labels will be installed on the valve position indication plate to clearly identify the valve stops as "OPEN" and "CLOSED".
- c) Licensed Operators will review this event as a part of Real-Time Training. Training lesson plans will be reviewed for needed revisions and revised as necessary.

(4) The Date When Full Compliance Will Be Achieved

Full compliance will be achieved by May 31, 1991.

Example 2

(1) The Reason For The Violation

SCR-077 was initiated to investigate the mispositioning of the pneumaseal valves. The SCR was unable to identify the root cause of this event due to the inability to reconstruct the events related to this event between October 2 and 8, 1990. However, the investigation did yield "lessons to be learned" and recommended corrective action as follows:

- a) The regulator on the nitrogen bottle at the time the isolation was detected was not the same one installed prior to fuel movement.

Recommendation: Specify required regulator types in Maintenance Refueling Procedure, MRP-001.

- b) MRP-001 did not contain sign-offs or acceptance criteria which made verification of proper installation difficult.

Recommendation: Add sign-offs and acceptance criteria to procedure MRP-001.

- c) The sign required by the original procedure was inadequate to maintain the supply valves in the required position.

Recommendation: Use Caution Tags on supply line valves.

(2) The Corrective Steps That Have Been Taken and The Results Achieved

The pneumaseal air and nitrogen supply valves were promptly opened, wired, and tagged. SCR-077 was initiated to identify the root cause and appropriate further corrective action.

Additionally, Maintenance Refueling Procedure MRP-001 has been revised to:

- a) specify the type of regulators to be used in the air and nitrogen supply lines,
- b) identify acceptance criteria,
- c) require the placement of caution tags on the supply line valves as a part of the pneumaseal installation, and
- d) provide for sign-off steps in the procedure.

(3) The Corrective Steps That Will Be Taken To Avoid Further Violations

The revision made to procedure MRP-001 identified above have been completed. Additionally, procedure GP-010 will be revised to provide for shift checks of pneumaseal pressure, and proper positioning of the valves in the air and nitrogen supply lines while the pneumaseal is in service.

(4) The Date When Full Compliance Will Be Achieved

Full compliance will be achieved by December 31, 1990.

The corrective actions identified above are specific to the examples given as "Failure To Adequately Implement Procedures As Required By The Technical Specifications". In addition to those specific corrective actions herein, the Plant General Manager has started, and will continue, to emphasize the importance of procedural compliance to, and through management, to plant personnel using whatever means of communication available and appropriate. This is not intended to be a structured program with start and completion dates and periodic measurement of progress. It is however, continual reinforcement of acceptable behavioral traits that cannot have an end or completion date.

Severity Level IV Violation RII 90-22-03

10 CFR 50, Appendix E, Section IV.F.5, requires that exercises provide for formal critiques in order to identify weak or deficient areas that need correction and provides that any weaknesses or deficiencies that are identified be corrected. Critique of the 1989 Emergency Exercise identified the failure of the Shift Foreman to recognize the occurrence of an initiating condition for an Emergency Action Level as an exercise weakness.

Contrary to the above, an exercise weakness identified during the 1989 Emergency Exercise was not corrected, in that, during a release of Freon gas on September 11, 1990, the Shift Foreman failed to recognize the occurrence as an initiating condition for an Alert. Specifically, the HVAC equipment room was initially identified as only being within the protected area; whereas, it was later determined to be a vital area. This resulted in the condition being initially classified as an Unusual Event and subsequently reclassified as an Alert.

REPLY

(1) The Reason For The Violation

The Shift Foreman, Site Emergency Coordinator (SEC) during the event, made an incorrect Emergency Action Level (EAL) classification of Unusual Event (UE) based on information that was available in the Control Room. An Alert should have been declared at the initial classification considering the room in which the Freon gas leak occurred was a Vital Area as defined in the Site Security Plan (SSP), a copy of which was located in the Shift Foreman's office.

Factors which significantly diminished the Shift Foreman's capability to make the correct decision were identified as follows:

- a) The SSP did not provide a clear and ready reference that the room in question was classified as a Vital Area. Drawing 5.4 in Chapter 5, Vital Area Portals, did define both security doors to the room in question as Vital Area Portals. However, the listing of vital areas/rooms under section 5.2.1.1 did not list the room in question. The listing in the back of the SSP manual also did not list the room in question. The Shift Foreman read the listings but did not know the drawing was there that defined the room to be a Vital Area. Thus, he made the initial EAL classification of Unusual Event based on his reasoning that the room in question was in the Protected Area. If he had recognized the room to be in the Vital Area, he would have declared the event an Alert in the initial classification.
- b) The Plant Emergency Procedures (PEPs) did not identify Vital and Protected Areas for use in making Emergency Response Organization (ERO) decisions. The PEPs and associated Emergency Action Level decision flowpath charts did not provide clear definitions for the words "toxic", "vital", and "protected" used in the decision blocks of the EAL-2 path chart. With no clear definition of these terms, the Shift Foreman's decision process was impaired when he reached the EAL-2 decision block containing the words "toxic" and "vital". He made a conservative decision in assuming the released gas to be toxic but then was faced with a decision based on "vital" or "protected". These two words were the keys to deciding whether the event was to be classified as an Unusual Event or an Alert. When the SSP did not readily provide clarification, the Shift Foreman decided the room was not a Vital Area and declared the Unusual Event. Shortly thereafter, Security personnel recommended the room be classified as a Vital area whereupon the Shift Foreman promptly reclassified the event as an Alert.

- c) PEP procedures did not identify gases used at Robinson Plant as to their toxicity or life-threatening properties (e.g., Freon gas). It was noted that other gases, such as nitrogen, halon, argon, carbon dioxide and oxygen are similarly not effectively identified in the procedures. Absence of this information contributed to a delay in classification of the event.

(2) The Corrective Steps That Have Been Taken and The Results Achieved

The initial incorrect Emergency Action Level (EAL) classification was corrected at the time the available information was clarified. The event was reclassified from an Unusual Event to an Alert. Significant Condition Report (SCR) 90-069 was initiated to determine the root cause of the event and ensure proper followup of the implementation of the identified corrective actions. The SCR was completed and received management review and concurrence for corrective action implementation on November 11, 1990.

(3) The Corrective Steps That Will Be Taken To Avoid Further Violation

The SCR contains several corrective actions associated with other aspects of the event which occurred on September 11, 1990. The corrective actions associated with the specifics of this Violation are addressed as follows:

- a) The information provided to identify plant Vital areas will be clarified and specific references provided in the Plant Emergency Procedures to ensure Emergency Response Organization personnel, and especially the Control Room Staff, are provided specific identification to be used during emergency classification activities.
- b) The specific PEPs for event classification (PEP-102, 103, 104, and 105) and the EAL flowcharts will be evaluated and reviewed to identify key words (such as Vital Area, Protected Area, toxic gas, etc.) and definitions will be developed and made available for use during decision making activities.
- c) The information available on the toxicity and other life threatening properties of the various gases used on plant site will be provided for use during emergency response activities.
- d) Considering the repeat aspect of this event, the above mentioned corrective actions will not be limited to those aspects specific to this event, but will identify other needed clarifications and provide the necessary definitions, interpretations, etc. in a form readily available for use during emergency classification activities.

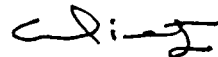
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(4) The Date When Full Compliance Will Be Achieved

Full compliance will be achieved by September 30, 1991.

Should you have any questions regarding this submittal, please contact  
Mr. J. D. Kloosterman at (803) 383-1491.

Very truly yours,



Charles R. Dietz  
Manager

Robinson Nuclear Project Department

RDC:dwm

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INPO