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SUBJECT: Responds to NRC ltr re violations noted in insp rept 50-261/92-28.Corrective actions:abnormal operating procedures will be requested to train on classification of unusual events & significant events during scenarios.

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Carolina Power & Light Company

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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. 50-261/92-28 REPLY TO A NOTICE OF VIOLATION

Gentlemen:

Carolina Power and Light Company hereby provides this reply to the Notice of Violations identified in NRC Inspection Report 50-261/92-28.

The enclosure to this letter provides a description of each occurrence, the causal factors and root causes identified for the violations, and a discussion of the corrective actions taken and planned.

Should you have any questions regarding this matter, please contact J. L. Harrison at (803) 383-1433.

Very truly yours,

Charles R. Dietz
Vice President
Robinson Nuclear Project Department

RDC:lst

Enclosure

cc: S. D. Ebneter
L. W. Garner
INPO



IE01

# REPLY TO A NOTICE OF VIOLATION

RII-92-28-01:

Technical Specification 6.5.1.1.1.e requires that written procedures be established and implemented for the Emergency Plan. Emergency Plan implementing procedure, PEP-101 step 5.1.4, requires that if an Emergency Action Level (EAL) for an Unusual Event is exceeded, implement PEP-102, Emergency Control-Unusual Event. Unusual Event Matrix Item D.1 of the EAL-2 Flowpath provides that the failure of any pressurizer relief valve to close following reduction of pressure constitutes a condition for an Unusual Event.

Operating Procedure OMM-001, step 5.14.1 requires that shift operating personnel must consider control indications to be true unless they are proven to be incorrect.

Contrary to the above, on October 31, 1992, PEP-101 was not implemented in that an Unusual Event was not declared and therefore, PEP-102 was not implemented as required when Operations personnel observed indication that PCV-456, a pressurizer relief valve, did not fully close after reduction of pressure. Subsequently, PCV-456 was determined to have closed; however, at the time of the event and for a period of time afterwards, Operations personnel did not verify that the observed PCV-456 position indications were incorrect. Thus, based on the requirements of OMM-001 to consider control indications true, the actions to be taken when a pressurizer relief valve failed to close were required to be implemented.

REPLY

1. The Reason for the Violation

CP&L acknowledges that the violation occurred as described.

Following termination of the load reduction transient due to partial loss of feedwater, the Operating Crew failed to classify the opening of a Pressurizer Power Operated Relief Valve (PORV) and the subsequent dual indication as an Unusual Event in accordance with the Emergency Plan. This omission was identified by the relieving crew twelve hours later. The following sequence of events is provided in order to adequately describe the causal factors surrounding this issue:

At 1914 hours on October 31, 1992, a partial loss of feedwater flow at one hundred percent power occurred due to a sudden drop in Heater Drain Pump flow. This sudden drop was caused by blockage of the air regulator for FCV-1530A due to trash in the air line. The Feedwater System was being monitored due to large flow oscillations. These oscillations have been found to be caused by failed gaskets on the Main Steam Reheaters.

During the loss of feedwater flow, the Main Turbine was manually runback to decrease load to match existing feedwater requirements. Following this load decrease, the Steam Dump system became erratic in that the valves oscillated between full open and full shut. A sluggish response of "A" Feedwater Regulating Valve caused Steam Generator levels to increase and approach to the High Level trip setpoint. Prompt action by the Operators prevented a trip on high Steam Generator level. During this transient, Pressurizer Pressure controller PCM-444J saturated low, causing the Pressurizer PORV to open when the Steam Dumps oscillated closed since no Pressurizer Spray Valves were open. PORV indication remained dual during this time indicating a stuck open PORV. Operations stabilized the plant and initiated an investigation of the cause of the transient. By this time personnel investigating the feedwater oscillations had arrived and begun gathering data on the operation of FCV-1530A. The Balance Of Plant (BOP) Operator and the Shift Supervisor, following the transient, began updating their logs in accordance with the formal logging practices. This consumed approximately two hours of their time while they also continued with their normal duties.

On November 1, 1992, while reviewing the previous shifts logs and event, the day shift crew realized that an Unusual Event should have been declared based on indications of a failure of the Pressurizer PORV to close. This was immediately communicated to Plant Management, the NRC Resident, and the NRC Operations Center.

Subsequent review by the System Engineer of the transient addressed the dual indication of the Pressurizer PORV. Conclusions from a review of the PRT temperature and pressure data indicates that the valve in fact did not actually remain open. The condition cleared later during the transient without any other action. If a mechanical problem had existed, the condition would not have cleared by itself since this is a spring shut valve.

This violation was caused by personnel error. The root cause evaluation for this violation has been completed, and has identified several causal factors. The primary factor relates to the large amount of information to be processed due to a transient of this nature, combined with requests for information from the event investigating team as well as answering incoming telephone calls for information pertaining to the event. During the event recovery and investigation process, the crew did not maintain adequate focus on the aspects of the event that required Emergency Plan classification, and therefore did not evaluate the EAL's.

A secondary causal factor relates to the adequacy of operating procedures to reference Emergency Plan entrance. All of the Abnormal Operating Procedures (AOP's) do not refer to the actions required by the Emergency Plan.

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

Adverse Condition Report ACR-92-390 was initiated to develop the root cause of this event, and to formulate corrective actions. The evaluation has been completed, and corrective actions formulated.

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

A memorandum will be issued to site management to emphasize the importance of minimizing telephone calls and visits to the Control Room during and immediately following plant transients. Needed personnel will be specifically requested for by Operations.

Abnormal Operating Procedures will be revised to refer the operator to the EAL's to determine any actions required by the Emergency Plan.

The Operations Manager will review with the Shift Supervisor his duties and responsibilities with respect the Emergency Plan and population control in the Control Room.

Simulator instructors will be requested to train on classification of Unusual Events as well as other more significant events during simulator scenarios.

4. The Date When Full Compliance Will Be Achieved

Full compliance will be achieved by June 30, 1993.

RII-92-28-02:

Technical Specification 6.5.1.1.1 requires that procedures be established for activities referenced in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978. Appendix A Item 3.d requires procedures for operation of the Emergency Core Cooling System (ECCS). OP-202 was established for operation of the Safety Injection (SI) portion of the ECCS.

Contrary to the above, on September 5, 1992, OP-202, Revision 26, was not adequately established in that Attachment 9.1 to OP-202 specified that valve SI-895K be open when the SI system is in the standby mode. Positioning this valve in a normally open position would degrade the SI system's ability to mitigate the consequences of certain accidents and could potentially render the SI system incapable of performing its safety function.

REPLY

1. The Reason for the Violation

CP&L acknowledges that the violation occurred as described.

The cause of this event is attributed to an inadequate review of a revision to Operating Procedure OP-202. Revisions 25 and 26 to this procedure were initiated to incorporate several changes resulting from Plant modifications M-1128 and M-1134, implemented during the last refueling outage. During this process, Revision 26 inadvertently changed the position of valve SI-895K from "closed" to "open". The following causal factors contributed to this error:

The administrative processes for changing procedures allows a procedure revision number to be "reserved" by a procedure change preparer. As such, during Refueling Outage 14, revision 25 to OP-202 was reserved, and a mark-up of the current revision 24 was sent to Word Processing. Later, another change to OP-202 was initiated to incorporate changes required by Modification M-1128, and a second mark-up of revision 24 was sent to Word Processing. Because the changes for M-1128 were needed as soon as possible to support plant restart, the first changes were bypassed, and revision 25 was approved. Later, another revision was initiated to support M-1134. The new preparer used the original change to the procedure, which had been superseded by the revision to support M-1128. Due to extensive changes made to the procedure, a typographical error occurred which incorrectly revised the required position for valve SI-895K. This error was not detected during the review process, and was approved as revision 26. It should be noted that this condition had no impact on plant safety because the procedure that contained the error was never used, and the valve was maintained in its correct (safe) position.

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

Upon discovery of this condition, OP-202 was immediately revised under a Temporary Change to correct the error. This change was made permanent under revision 29 to the procedure.

The procedure writer involved with this change has been counselled by his management. Additionally, Operations procedure writers have been reminded of the importance of conducting proper reviews of procedure revisions.

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

The corrective actions stated above are considered satisfactory to address the causes of this violation.

4. The Date When Full Compliance Will Be Achieved

Full compliance was achieved on September 18, 1992, by discussion of this issue with Operations procedure writers and their management.