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SUBJECT: Responds to NRC ltr re violations noted in insp rept 50-261/93-03.Corrective actions:Maint personnel will be counselled to ensure that personnel understand that deviations from matl specified in WR will be discussed.

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United States Nuclear Regulatory Commission
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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. 50-261/93-03 REPLY TO A NOTICE OF VIOLATION

Gentlemen:

Carolina Power and Light Company hereby provides this reply to the Notice of Violation identified in NRC Inspection Report 50-261/93-03.

Enclosure 1 provides a description of the occurrence, the causal factors and root causes identified for the violation, and a discussion of the corrective actions taken and planned for the occurrence.

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

Very truly yours,

Ray H. Chamlee for CRD

Charles R. Dietz
Vice President
Robinson Nuclear Plant

DHB:lst

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

IE01
1/1

REPLY TO A NOTICE OF VIOLATION

RII-93-03-03

10 CFR 50, Appendix B, Criterion V, requires activities affecting quality to be prescribed by documented instructions and be accomplished in accordance with these instructions. Documented instruction WR/JO 93-AARG1 was written to provide instructions for the repair of Heat Trace Circuit 25S. The WR/JO identified the Heat Trace Cable Type for Circuit 25S as 2B10. Circuit 25S is a part of one of two channels of heat tracing whose operability is required per Technical Specification 3.2.2.e for the flow path from the boric acid tanks.

Contrary to the above, WR/JO 93-AARG1 was not implemented in that on January 11, 1993, Heat Trace Cable Type SF2A40 was installed in Circuit 25S whereas WR/JO 93-AARG1 had specified that 2B10 be installed.

REPLY

1. The Reason for the Violation

During the performance of Heat Trace Maintenance Surveillance Tests (MST), Circuit 25 secondary was observed to be open. A Work Request (WR) was written to repair the circuit. The technician assigned to troubleshoot and repair the circuit was the same person that had performed the MST earlier that day. Troubleshooting was conducted and a portion of Circuit 25 secondary was identified as requiring replacement. The WR specified a part number that identified an unsheathed Heat Trace Cable Type 2B10. The technician substituted a cable that he believed to be sheathed 2B10 when in fact the cable selected was SF2A40 which has different electrical resistance characteristics than 2B10 cable. The SF2A40 cable was installed and the post maintenance test revealed that the existing current in the repaired circuit was at the minimum allowable value. After a few days of operation at minimum allowable current, the same technician requested that he be allowed to rework the circuit to eliminate the possibility of the current going below the minimum value and creating an additional Limiting Condition of Operation (LCO). Following the second repair, the current readings returned to the middle of the expected range.

The reason for the violation is the failure of the technician to install the specified material, failure of Stores personnel to maintain control of the Warehouse, failure of the technician to document actual material used, and failure of the technician to inform management that the specified cable was not installed during the first repair.

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

Carolina Power and Light (CP&L) conducted an investigation to determine the cause of the lower than expected current on the Heat Trace Circuit. This team involved the Manager - Maintenance, I&C Supervisors, technicians, System Engineer, and others. After some period of time, and following the suggestion of the Senior Resident Inspector to examine a bag of radioactive trash, the cause was determined to be that SF2A40 cable had been installed in lieu of the specified 2B10 cable on January 11, 1993. However, the investigation team had been led to believe (by the technician) that he had installed the cable that had been issued on January 11, 1993, and that if an error had been made, it had been made by the Stores personnel. The Senior Resident Inspector had also made statements to the Manager - Maintenance, I&C Supervisor, System Engineer, and a Technical Support supervisor that he had looked at the cable that was removed from the piping on Friday, January 15, 1993, and indicated that this cable appeared to be the correct cable and that he had observed red markings on it that were characteristic of the cable specified for use. This statement by the Senior Resident Inspector contributed to Management's perception that the correct cable had in fact been installed on January 11, 1993, and resulted in Management's attention being focused on other possibilities.

The NRC Inspection Report also expressed a concern for certain aspects of this event which are repeated and responded to below:

1. Unauthorized substitution of materials on a safety-related maintenance activity.

   This action was taken by the technician performing the maintenance and is not condoned by CP&L. The individual involved has received disciplinary action deemed to be appropriate by Management. The implementation of Corrective Actions 1, 2, 3, and 4 below will prevent recurrence of this event.

2. Failure of the electrician to correct erroneous information that was provided by Management to the inspectors.

   The individual involved apparently provided erroneous information to CP&L and has received appropriate disciplinary action. CP&L is not aware of any actions that can be taken to ensure that everyone is always 100% truthful. Individuals who are found to not be truthful will continue to be dealt with on a case-by-case basis.

3. Removal from the Warehouse of material with part numbers other than that specified on a WR/JO.

   The implementation of Corrective Actions 2 and 3 below will prevent recurrence of this event.

4. Failure to document on the WR/JO the materials issued for the job.

   The implementation of Corrective Actions 1 and 4 below will prevent recurrence of this event.

5. The WR/JO specified a non-Q classification for the Heat Trace Cable whereas the Q-List identified it as Q.

   The cause of TMM-003, Q-List Control Procedure, being in error is indeterminate. The planner identified the heat trace cable as non-Q because he knew that was the correct classification and did not consult TMM-003. TMM-003 will be revised as stated below.

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

The Corrective Actions that will be completed to avoid further violations are as follows:

1. Maintenance personnel will be counseled to ensure that they understand that deviations from material specified in a WR will be discussed with their Supervisor or Maintenance Planner to obtain the specification for alternate material.

2. Instruct Stores personnel to ensure that non-Warehouse personnel are not to be allowed in the Warehouse Control Area unescorted.

3. Instruct Stores personnel to ensure that any material or equipment leaving the Warehouse be electronically recorded.

4. Instruct Maintenance personnel that material and equipment used while performing maintenance shall be recorded on the WR.

5. Revise procedure TMM-003 to reflect the non-Q status of Heat Trace Cable.

4. The Date When Full Compliance Will Be Achieved

Full compliance with the above listed Corrective Actions will be achieved by July 2, 1993.

RII-93-03-04

Technical Specification 6.5.1.1.1.a requires that procedures be implemented for activities referenced in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978. Appendix A, Item 9.c requires written procedures for repairs of safety-related equipment. The Corporate Welding Manual was established to specify welding procedures and requirements. Step 4.1.3 of Section NW-03 to the Corporate Welding Manual specifies that the welder's foreman/supervisor will verify the welder's certification prior to the assigned welding task by referring to a current copy of the Welder Qualification Status Report.

Contrary to the above, on January 28, 1993, the Corporate Welding Manual, Section NW-03, Step 4.1.3 was not implemented, in that, a welder's supervisor failed to verify the status of a welder on the Welders Qualification Status Report. As a result, the welder performed a series of welds on a piping size below that authorized for him in the Welding Qualification Status Report. Subsequent review of other records revealed that the welder was qualified for the piping size per the ASME code.

REPLY

1. The Reason for the Violation

The reason for the violation was the failure of the Maintenance Supervisor to verify the welder's qualification. The body of the Inspection Report included an additional material type control problem that was identified as a weakness. For clarity, both problems will be discussed in this response; however, the Corrective Actions for the material type control problems will not be identified or committed to in this response because it is not required by the Notice of Violation.

A Work Request was initiated to replace an elbow on one of the Hypochlorite Injection Lines to the South Service Water Header. During the cleaning and preparation of the piping prior to the repairs, two additional elbows were identified that also needed replacement. It was decided to re-plan the Work Request to include the additional elbows and piping needed to properly repair the system. During the planning process, the planner contacted a member of the Modification Implementation Unit to obtain a part number for the piping required in this repair. However, the part number obtained was for 304SS pipe in lieu of the 316SS piping required for the system. The Work Request planning was completed, including, material part numbers, Weld Data Reports (WDRs) for the required welding, and repair instructions. Personnel were assigned to perform the required repairs, and prefabrication of the replacement piping section was started. With the replacement piping assembled and tack welded, the Quality Control (QC) Inspector was contacted to perform his inspections and enter required information on the WDRs. At this time it was identified by the QC Inspector that 304SS piping was being used while the WDR required 316SS piping material. It was also noted by the Resident NRC Inspector that the welder was not identified in the Welder Qualification Status Report as being qualified for the piping diameter being welded.

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

The repair efforts were stopped until the material and welder qualification questions could be resolved. Subsequent review revealed that the welder was qualified under the requirements of the ASME Code for the size piping in question. However, because CP&L is allowed to be more restrictive than the Code, the Project Welding Engineer had opted not to include the welder's qualification for this pipe diameter in the Welder Qualification Status Report. Additionally, it was identified that 316SS material was correct for this application and that the Work Request part number for the piping material was in error.

Subsequent to resolving the material and welder problems associated with this repair, the South Header Hypochlorite Injection Line was satisfactorily replaced.

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

Training related to the requirements of the Corporate Welding Manual has been developed and presented to the Maintenance Supervisors that will ensure that the Welder Qualification Status Report will be consulted prior to the assignment of welders.

4. The Date When Full Compliance Will Be Achieved

Full compliance has been achieved.