



UNITED STATES
 NUCLEAR REGULATORY COMMISSION
 REGION II
 101 MARIETTA STREET, N.W., SUITE 2900
 ATLANTA, GEORGIA 30323-0199

Report No.: 50-261/93-19

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 Unit 2

Inspection Conducted: August 15 - September 11, 1993

Lead Inspector: *W. T. Orders* 9/29/93
 W. T. Orders, Senior Resident Inspector Date Signed

Other Inspectors: C. R. Ogle, Resident Inspector
 J. E. Tedrow, Senior Resident Inspector - Shearon Harris

Approved by: *H. O. Christensen* 12/4/93
 H. O. Christensen, Chief Date Signed
 Reactor Projects Section 1A
 Division of Reactor Projects

SUMMARY

Scope:

This routine, unannounced inspection was conducted in the areas of operational safety verification, surveillance observation, maintenance observation, engineered safety feature system walkdown, and followup of previously identified items.

Results:

One violation was identified involving an operator failing to follow the applicable procedure during the performance of a surveillance test (paragraph 3).

Another violation, with two examples, was identified concerning an inadequate calibration program procedure (paragraph 6).

A non-cited violation was identified involving an area firewatch leaving his post (paragraph 3).

A second non-cited violation was identified involving a degraded diesel generator ventilation system (paragraph 8).

An unresolved item was identified concerning the testing adequacy of component cooling water pump start circuitry (paragraph 5).

A second unresolved item was identified concerning the manipulation of control room ventilation dampers during performance of testing (paragraph 6).

A third unresolved item was identified pertaining to the adequacy of control room ventilation system testing (paragraph 6).

The licensee's response to an ethylene glycol spill was poor; however, the licensee met the reporting requirements of 50.72 (paragraph 3).

REPORT DETAILS

1. Persons Contacted

- *R. Barnett, Manager, Project Management
- C. Baucom, Senior Specialist, Regulatory Compliance
- S. Billings, Technical Aide, Regulatory Compliance
- *B. Clark, Manager, Maintenance
- *T. Cleary, Manager, Technical Support
- *D. Crook, Senior Specialist, Regulatory Compliance
- C. Dietz, Vice President, Robinson Nuclear Project
- R. Downey, Shift Supervisor, Operations
- J. Eaddy, Manager, Environmental and Radiation Support
- S. Farmer, Manager Engineering Programs, Technical Support
- R. Femal, Shift Supervisor, Operations
- *W. Flanagan Jr., Acting Plant General Manager
- W. Gainey, Manager, Plant Support
- P. Jenny, Manager, Emergency Preparedness
- D. Knight, Shift Supervisor, Operations
- J. Kozyra, Project Specialist, Licensing/Regulatory Programs
- A. McCauley, Manager, Electrical Systems, Technical Support
- R. Moore, Shift Supervisor, Operations
- D. Morrison, Shift Supervisor, Operations
- D. Nelson, Manager, Outage Management
- *A. Padgett, Manager, Environmental and Radiation Control
- D. Seagle, Shift Supervisor, Operations
- M. Scott, Manager, NSSS Technical Support
- E. Shoemaker, Manager, Mechanical Systems, Technical Support
- W. Stover, Shift Supervisor, Operations
- *A. Wallace, Acting Operations Manager
- D. Waters, Manager Regulatory Affairs
- D. Winters, Shift Supervisor, Operations

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

*Attended exit interview on September 15, 1993.

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

2. Plant Status

Except for power reductions to perform required testing, the unit operated at full power until initiating a shutdown at approximately 10:30 p.m., on September 10, 1993, to begin refueling outage 15. The unit completed 351 days of continuous operation prior to the shutdown. This was a record run for both Robinson and CP&L.

3. 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, Operations 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-progress 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 were appropriate.

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.

Boraflex Neutron Absorber

The resident inspectors performed a review of the licensee's use of Boraflex in the spent fuel pool. The inspectors determined that the plant uses Boraflex as a neutron absorber in the high density fuel racks. The licensee is aware of documented industry problems with Boraflex and has evaluated IEN 87-43. At the close of this report period, the licensee had not received IEN 93-70: Degradation Of Boraflex Neutron Absorber Coupons. The licensee's operating staff is cognizant of potential problems pertaining to spent fuel pool dilution and there are procedural controls in place intended to prevent spent fuel pool dilution.

The pool is maintained at a boron concentration of greater than 1950 ppm. The licensee has a chemistry sampling program in place to routinely evaluate the boron concentration of the spent fuel pool. The results of the last three samples indicate a concentration in excess of 2100 ppm.

The licensee evaluates the integrity of the Boraflex absorber by periodically analyzing coupon samples for signs of degradation.

According to the licensee's engineering staff, there has been no evidence of the current, industry reported degradation in samples from the Robinson SFP.

Turbine Runback During OST-005

At 11:28 a.m., on August 14, 1993, the unit experienced a runback during the performance of OST-005, Nuclear Instrumentation Power Range (Bi-Weekly). The runback occurred when the SRO performing the OST inadvertently mispositioned the dropped rod mode switch on power range nuclear instrument N-41.

Following the SRO's recognition that a turbine runback was in progress, the switch was restored to the correct position and the shift responded to the transient. Following recovery from the transient, the unit was restored to 100 percent power.

The inspectors interviewed the operator conducting OST-005; reviewed the ACR and shift supervisor logs associated with the transient; and analyzed the ERFIS printout for the runback. Additionally, the inspectors reviewed the transient with the system engineer. Based on this inspection effort, the inspectors determined that the operator mispositioned the dropped rod mode switch when the OST was recommenced following a brief interruption in the procedure. This interruption occurred when the operator stopped the OST to obtain assistance in monitoring an adjacent panel for an expected alarm. When the OST was restarted, the operator manipulated the dropped rod mode switch instead of the required operation selector switch.

Technical Specification 6.5.1.1, Procedures, Tests, and Experiments requires, in part, that written procedures be established, implemented and maintained, covering the activities recommended in Appendix A of Regulatory Guide 1.33, Rev 2, 1978. Regulatory Guide 1.33 Paragraph 8.b. requires that procedures be written for technical specification surveillances. Implicit in this is the requirement that these procedures be followed while performing technical specification required surveillances. Operations Surveillance Test Procedure, OST-005, Nuclear Instrumentation Power Range (Bi-Weekly) is provided to satisfy a Technical Specification required surveillance for the power range nuclear instruments.

Contrary to the above, on August 14, 1993, an on-duty operator deviated from OST-005 and repositioned the dropped rod mode switch to normal position from the specified bypass position. This action resulted in a turbine runback. This is identified as a potential violation, VIO 93-19-01: Operator Deviation From OST-005 Results in Turbine Runback.

From the review of the ERFIS printout, the inspectors noted anomalies associated with the runback. These observations included an unexpected 1.5 second interruption in the turbine load limit runback. Additionally, the time delay relay actuation did not occur concurrently with the turbine load limit runback as expected. These observations

were provided to the system engineer. Following his review of the transient, and confirmation of these observations, the system engineer indicated that the performance of the system would be examined during the upcoming outage. This commitment was also reaffirmed by the cognizant engineering supervisor.

As turbine power was decreased by the runback, an expected deviation in the reactor coolant reference temperature (Tref) and the average reactor coolant temperature (Tave) developed. In response to this deviation, an automatic insertion of control rods occurred. This insertion eventually resulted in control rod bank D being inserted below the rod insertion limit. This condition was cleared after a boric acid addition and restoration of control rods to normal position in the subsequent recovery. The control rod bank D rods were below the insertion limit for approximately 5 minutes. During a subsequent review of the transient the licensee recognized that the insertion limit had been exceeded and generated an ACR and LER to address this situation.

TS 3.10.1.3 requires that the control rod insertion limits be satisfied. However, no action statements or LCOs are provided for inability to maintain the rod insertion limits.

During their review, the licensee concluded that the rod insertion limits may be violated during transients. The licensee has indicated their intention to revise TS 3.10.1.3 to incorporate this conclusion and provide an action statement for restoring rod positions. The inspectors have no further question on this item.

Area Fire Watch Vacates Post

On August 31, 1993, the licensee determined that an area fire watch had vacated his assigned post prematurely. The watch had been stationed in the Unit 2 cable spread room as required by Fire Protection Procedure FP-012, Fire Protection Systems Minimum Equipment and Compensatory Actions, when the halon suppression system for that area (zone 19) was disabled. The system was disabled at 9:29 a.m., on August 31, 1993, to support work on penetrations associated with an ongoing plant modification. At 5:36 p.m. that same day, while restoring the zone 19 system to service, the on-shift fire technician determined that the area fire watch had left the cable spread room prior to the restoration of the system.

The inspectors interviewed the area fire watch and on-shift fire technician. Additionally, the inspectors reviewed the security log printout for the area; reviewed the shift supervisor and on-shift fire technician logs; and discussed the event with the cognizant supervisors. Based on this effort, the inspectors determined that the area fire watch was unaware of his responsibility to remain at his assigned station until the fire suppression system was restored to service. Instead, the area fire watch had left when the modification work being performed that day had been completed.

The licensee has documented the event on a Condition Evaluation Report and covered the event with a portion of the Craft Resources Unit. The licensee also committed to reviewing this event with all members of the Project Management Section who perform area fire watch duties.

The failure of the area fire watch to remain in the cable Spread Room with the fire suppression system disabled is a violation of FP-012. However, this violation will not be subject to enforcement action because the licensee's efforts in identifying and correcting the violation meet the criteria specified in Section VII.B of the Enforcement Policy. This item is identified as a non-cited violation, NCV 93-19-02: Area Fire Watch Vacates Post.

Ethylene Glycol Spill

On Monday, August 30, 1993, the licensee management was informed by a chemistry technician of a spill of approximately one gallon of ethylene glycol (antifreeze) which occurred on Saturday, August 28, 1993. Since this spill exceeded the reportable quantity specified in the licensee's Best Management Plan, a notification was made to the South Carolina Department of Health and Environmental Control at 9:50 a.m., on August 30. Additionally, a notification to the National Response Center was made at 9:55 a.m. that same day. As a result of these notifications, the licensee made a 4-hour non-emergency notification to the NRC in accordance with the requirement of 10 CFR 50.72(b)(2)(VI), Offsite Notification, at 11:05 a.m., on August 30, 1993.

Based on interviews of individuals involved, the inspectors determined that the spill occurred when a 55-gallon drum of antifreeze was accidentally dropped and punctured during a routine movement. The spill occurred at a site storage area and was limited to the ground in the immediate vicinity of the drum. Immediately following the spill, the on-shift chemistry technician was notified. Based upon his review of the spill, the small quantity involved, and information provided on the Material Safety Data Sheet, he concluded that the hazard presented by the spill was minimal. As a result, no further action was taken until he notified his supervisor of the spill on Monday, August 30. Following this, the dirt in the vicinity of the spill was removed and the notifications discussed above were made. Based on their review of this event, the inspectors concluded that while the licensee's initial response to the spill was poor, the licensee met the requirements for NRC notification specified in 10 CFR 50.72. The inspectors have no further questions on this event.

4. 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, testing was accomplished by qualified personnel in accordance with an approved test procedure, test

instrumentation was properly calibrated, 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 documented and rectified; and that the systems were properly returned to service. Specifically, the inspectors witnessed/reviewed portions of the following test activities:

- OST-352 Containment Spray System Component Test
- OST-401 Emergency Diesels (Slow Speed Start - EDG A Only)

No violations or deviations were identified. Based on the information obtained during the inspection, the area/program was adequately implemented.

5. Maintenance Observation (62703)

The inspectors observed safety-related maintenance activities on systems and components to ascertain that these activities were conducted in accordance with TS, approved procedures, and appropriate industry codes and standards. The inspectors determined that these activities did not violate LCOs and that required redundant components were operable. The inspectors verified that required administrative, material, testing, radiological, and fire prevention controls were adhered to. In particular, the inspectors observed/reviewed the following maintenance activities:

- WR/JO 93BTQ371 Calibrate CS Pump Discharge Pressure Gauges In Accordance With Procedure PIC-302, Process Instrument Calibration Procedure Pressure and Vacuum Gauges.
- WR/JO 93BVY371 Calibrate The CCW Pumps Pressure Instrumentation (PC-611 Only)
- WR/JO 93AIGX1 Replace Misaligned Gasket On EDG A
- WR/JO AILN2 Solenoid Valve EV 1727 Venting Continuously

Adequacy of Testing For CCW Pump Autostart Feature

During followup on the calibration of the CCW pump discharge pressure switch PC-611, the inspectors noted that the calibration procedure did not fully verify the logic associated with the switch. The switch actuates on a low pressure condition in the CCW discharge header to provide an automatic start of idle CCW pumps. The pressure switch (PC-611) operates to energize a relay, the contacts of which operate to start the standby pumps. The calibration procedure only checked the actuation of the contacts in PC-611. No check was made of the associated relay or its contacts.

The inspectors noted from a review of the "Preliminary Revision" of the CCW Design Basis Document that the low pressure autostart capability was a design feature of the system. Based on this, the inspectors requested that the license address the adequacy of the existing calibration procedure to verify this potential design feature. The licensee had not completed this evaluation prior to the end of the inspection period. Pending the resolution of this issue, this item will be tracked as an unresolved item, URI 93-19-03: Adequacy Of Testing For CCW Pump Autostart Feature.

No violations or deviations were identified. Except as noted above, the area/program was adequately implemented.

6. ESF System Walkdown (71710)

Control Room Ventilation System Walkdown

The inspectors reviewed the control room habitability system with primary emphasis on the ventilation portion of the system. This effort included a walkdown of the ventilation equipment; a review of the calibration of installed instrumentation; a review of testing accomplished to satisfy TS requirements; and a verification of selected portions of the control room envelope. The inspectors also witnessed the operation of the system in the emergency pressurization mode. Based on this review, the inspectors concluded that the system was properly aligned and capable of performing its intended safety function. However, deficiencies were identified in material storage, completeness of testing, instrument calibration, and design control.

During a physical inspection of the interior of the Main Control Room HVAC System Instrument Panel Safety Train A on August 25, 1993, the inspectors noted foreign material stored in the panel. This panel houses differential pressure instrumentation associated with the operation of the control room ventilation system. The material identified included 2 bottles of gas leak detector, 1 bottle of soap solution for leak checks, and 1 bottle of refrigerant oil. This information was conveyed to the shift supervisor for resolution. The storage of these items in a panel for Technical Specification required equipment is considered a weakness. During a subsequent inspection of the panel, the inspectors noted that the material had been removed.

During a review of instrument calibration, the inspectors noted that temperature controllers TC-6559 A and TC-6559 B, used to verify control room temperature within the limits of TS 4.15.a, were not included in the plant instrument calibration program. These instruments not only provide a display of the control room temperature, but are also used for WCCU operation. Following the identification of this item, the licensee began monitoring control room temperature using alternate calibrated temperature instruments. The licensee also performed calibrations of TC-6559 A and B. The inspectors reviewed the results of these calibrations and noted that both instruments were found in calibration. The licensee also indicated that the instruments would be added to the

calibration program. The inspectors reviewed documentation provided by the licensee which demonstrated that TC-6559 A and TC-6559 B were calibrated in December 1990 when installed as part of a modification to upgrade the control room ventilation system.

Technical Specification 6.5.1.1, Procedures, Tests, and Experiments requires, in part, that written procedures be established, implemented, and maintained, covering the activities recommended in Appendix A of Regulatory Guide 1.33, Rev. 2 1978, including procedures for ensuring calibration of instruments. Maintenance Management Manual Procedure, MMM-006, Calibration Program, is provided to ensure calibration of installed plant instrumentation.

Contrary to the above, on August 31, 1993, MMM-006 was found to be inadequate, in that, TC-6559 A and TC-6559 B (the instruments used to verify compliance with Technical Specification limits on control room temperature) were not included. This is one of two examples which in the aggregate comprise a violation, VIO 93-19-04: Failure To Properly Maintain Instrument Calibration Program, Two Examples.

Based on the as-found data for the instrument being within tolerance and observations of control room temperatures over the last operating cycle, the inspectors concluded that this finding had minimal safety significance.

The second item observed by the inspectors involved calibration of DPI-6520, Control Room Differential Pressure. The inspectors noted that this instrument, which is used in surveillance testing to verify control room pressurization capability, had not been calibrated within the frequency specified in MMM-006. When queried by the inspectors on this observation, the licensee stated that the instrument currently installed as DPI-6520 is a manometer, which does not require calibration. The calibration program had not been revised to reflect this change.

Technical Specification 6.5.1.1., Procedures, Tests, and Experiments requires, in part, that written procedures be established, implemented, and maintained, covering the activities recommended in Appendix A of Regulatory Guide 1.33, Rev. 2, 1978, including procedures for ensuring calibration of instruments. Maintenance Management Manual Procedure MMM-006, Calibration Program, is provided to ensure calibration of installed plant instrumentation.

Contrary to the above, on August 30, 1993, MMM-006 was found to be inadequate, in that, DPI-6520, Control Room Differential Pressure Instrument, was inappropriately included. This is the second of two examples which in the aggregate comprise a violation, VIO 93-19-04: Failure To Properly Maintain Instrument Calibration Program, Two Examples.

The inspectors reviewed surveillance testing conducted on the control room ventilation system and the surveillance requirements for the system in Technical Specifications. Specifically, the following surveillances

were reviewed: EST-023, Control Room Ventilation System; OST-163, Safety Injection Test and Emergency Diesel Generator Auto Start On Loss of Power and Safety Injection and Emergency Diesels Trips Defeat; OST-924, Radiation Monitoring System; and OST-750, Control Room Emergency Ventilation System.

The inspectors noted that EST-023 performed on May 1, 1992, made reference to backflow through the air cleaning unit while it was idle. The EST noted that this was corrected by operating the dampers associated with the unit several times. When questioned by the inspectors on this issue, the system engineer indicated he was aware of intermittent problems associated with the dampers on the ACU fans in the past. However, he stated that counterweights had been added to the dampers to alleviate the problem. He was unsure if these additional weights were added before or after the conduct of the EST. The inspectors requested additional information on the sequence of these events. Pending resolution of this item it will be tracked as an unresolved item, URI 93-19-05: Manipulation Of Air Cleaning Unit Dampers During Performance Of Testing.

The inspectors also noted that the testing accomplished by OST-163 and OST-924 does not fully comply with the requirements of TS 4.15.3. TS 4.15.3 requires verification that on an SI test signal or high radiation test signal the system switches into the emergency pressurization mode with flow through the air cleaning unit (ACU). Neither OST verifies flow through the ACU. Instead, both merely check for proper alignment of dampers and starting of fans. The inspectors requested clarification from the licensee on the methodology used to satisfy the TS surveillance. Pending the resolution of this issue, it will be tracked as an unresolved item, URI 93-19-06: Adequacy Of Control Room Ventilation System Surveillance Testing.

TMI Action Plan Requirement Item III.D.3.4, Control Room Habitability Requirements, is considered closed. Closing this item is based on reviews and evaluations provided in NRC letters to CP&L dated May 17, 1991, and October 26, 1990, as well as the walkdown described above.

7. Employee Concerns Program

The inspector reviewed the licensee's employee concern Quality Check program which was created to provide employees an alternate path from their supervisor and normal line management to express safety concerns or allegations. As part of this inspection, the inspector reviewed the program implementing procedure and discussed the program/process with the site Quality Check Representative. Survey reports of Quality Check activities were also reviewed. See attachment for questions addressed during this inspection.

The licensee had established several methods for submission of employee concerns which included employee interviews, telephone, or by submission of Quality Check Report (QCR) forms in one of several Quality Check Station lockboxes. The inspector was informed that confidentiality of

the submitter was maintained. The Manager - Quality Check was responsible for reviewing the QCRs and identifying nuclear safety issues or other matters requiring management attention. Employee concerns were classified in one of three categories. Nuclear safety issues or technical/quality issues received the classification of a "Case" which required an investigation and some form of action. Other concerns, such as personnel issues, resulted in classification of Management Information Items (MIIs) or Notices of Information. Only Cases and MIIs required a formal response from line management. After review by the Manager - Quality Check, the concern was then transferred to Quality Check forms and routed to assigned evaluators/investigators. The inspector found that consideration was provided for reportability determination by reference in the Quality Check forms to the licensee's Corrective Action Program. The surveys of Quality Check activities for 1991, 1992, and through July 1993, indicated that 111 employee concerns had been expressed. Of these, only 1 remained open.

8. Followup (92700, 92701, 92702)

(Closed) Unresolved Item 93-11-04, Degraded Diesel Generator Ventilation System.

As detailed in Inspection Report 93-11, during the June 10, 1993 performance of bi-weekly surveillance test OST-401 on the A EDG, licensee personnel observed that the room ventilation air return damper was partially open when it was to have been closed. The damper is designed to automatically close when the ambient air temperature is above 55 degrees F. With the damper partially open, the efficiency of the ventilation system was degraded. The licensee found that the damper had been manually blocked open by a wooden wedge which had apparently been manufactured for that purpose. At the close of that report period, the licensee was evaluating the impact of this unauthorized modification on the system's ability to perform its intended safety function and in turn, the operability of the EDG. Pending the completion of that evaluation, the issue remained unresolved.

The resident inspectors reviewed the licensee's safety analysis of the event which indicated that the event had minimal impact on plant safety, in that, the operability of the diesel was not jeopardized. Specifically, the analysis indicated that under accident conditions, operators would investigate the source of an abnormal temperature in the room, and would have been able to take corrective actions (i.e., remove the block of wood) prior to conditions causing a threat to the diesel.

Although the unauthorized modification of the ventilation system did not result in a significant diesel generator operability challenge, it represents a failure to maintain system design integrity.

10 CFR 50 Appendix B, Criterion III Design Control, requires in part, that measures be established to ensure that the design basis for structures systems and components be maintained. Contrary to these requirements, the design integrity of the A Emergency Diesel Generator

Ventilation System was not maintained in that the system underwent an unauthorized modification which decreased its ability to perform its intended function. However, this violation will not be subject to enforcement action because the licensee's efforts in identifying and correcting the violation meet the criteria specified in Section VII.B of the Enforcement Policy. This item is identified as a non-cited violation, NCV 93-19-07: Degraded Diesel Generator Ventilation System.

9. Exit Interview (71701)

The inspection scope and findings were summarized on September 15, 1993, 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. The licensee did not identify as proprietary any of the materials provided to or reviewed by the inspectors during this inspection.

During the exit meeting, the licensee stated that the runback on August 14, 1993, was the result of operator error. The licensee questioned the appropriateness of a potential violation for a failure to follow the applicable procedure in that the SRO did not willfully fail to follow the procedural guidance. The inspectors acknowledged that the violation did not appear to be willful, but informed the licensee that the net result of the operator's error was a departure from the sequence specified in the procedure, which in this case resulted in a turbine runback. It was this deviation from the procedure which served as the basis of the violation.

The licensee also questioned the characterization of the violation for failing to calibrate TC-6559 A and B and maintaining DPI -6520 in the calibration program as a failure to properly maintain MMM-006. The licensee stated that these instruments had not been included in the calibration program as a result of a failure in the modification process (that being the failure of the modification which installed the instrumentation) to provide appropriate documentation to revise MMM-006. The licensee also stated that the inspectors had been informed of this during the inspection period.

The inspectors acknowledged that they had been advised of this potential inadequacy in the modification process during the inspection period. However, the inspectors detected this problem during an ESF walkdown while comparing the instruments installed in the control room ventilation system against instruments listed in MMM-006. Since the identification of the violation occurred while reviewing the completeness of MMM-006, the inspectors concluded that it would be appropriate to cite the violation against the inadequate procedure.

The following items were identified and reviewed during this inspection period:

<u>Item Number</u>	<u>Description/Reference Paragraph</u>
93-19-01	VIO: Operator Deviation From OST-005 Results In Turbine Runback (paragraph 3).
93-19-02	NCV: Area Firewatch Vacates Post (paragraph 3).
93-19-03	URI: Adequacy Of Testing For CW Pump Autostart Feature (paragraph 5).
93-19-04	VIO: Failure To Properly Maintain Instrument Calibration Program, Two Examples (paragraph 6).
93-19-05	URI: Manipulation Of Air Cleaning Unit Dampers During Performance Of Testing (paragraph 6).
93-19-06	URI: Adequacy Of Control Room Ventilation System Surveillance Testing (paragraph 6).
93-19-07	NCV: Degraded Diesel Generator Ventilation System (paragraph 8).

10. List of Acronyms and Initialisms

ACU	Air Cleaning Unit
CCW	Component Cooling Water
CFR	Code of Federal Regulations
CS	Containment Spray
DPI	Differential Pressure Instrument
EDG	Emergency Diesel Generator
ERFIS	Emergency Response Facility Information System
HVAC	Heating Ventilation Air Conditioning
IEN	Inspection Enforcement Notice
LCO	Limiting Condition for Operation
LER	Licensee Event Report
LOCA	Loss of Coolant Accident
MII	Management Information Items
MMM	Maintenance Management Manual
NRC	Nuclear Regulatory Commission
OST	Operations Surveillance Test
PIC	Process Instrument Calibration
PPM	Parts Per Million
QCR	Quality Check Report
SI	Safety Injection
SFP	Spent Fuel Pool
SRO	Senior Reactor Operator
TAVE	Average Temperature of the Reactor Coolant
TI	Temporary Instruction
TMI	Three Mile Island
TREF	Reference Temperature of the Reactor Coolant

TS
URI
VIO
WCCU

Technical Specification
Unresolved Item
Violation
Water Cooled Condensing Unit

ATTACHMENT

EMPLOYEE CONCERNS PROGRAMS

PLANT NAME: Robinson LICENSEE: CP&L DOCKET #: 50-261

NOTE: Please indicate yes or no as applicable and add comments in the space provided.

A. PROGRAM:

1. Does the licensee have an employee concerns program? Yes
2. Has NRC inspected the program? No. Quality Check site representative discusses current issues with the Senior Resident Inspector on a routine basis.

B. SCOPE: (Indicate all that apply.)

1. Is it for:
 - a. Technical? Yes
 - b. Administrative? Yes
 - c. Personnel issues? Yes
2. Does it cover safety as well as non-safety issues? Yes
3. Is it designed for:
 - a. Nuclear safety? Yes
 - b. Personal safety? Yes
 - c. Personnel issues - including union grievances? Yes
4. Does the program apply to all licensee employees? Yes
5. Contractors? Yes
6. Does the licensee require its contractors and their subs to have a similar program? No
7. Does the licensee conduct an exit interview upon terminating employees asking if they have any safety concerns? Yes.

C. INDEPENDENCE:

1. What is the title of the person in charge? Manager, Quality Check
2. To whom do they report? Manager, Nuclear Assessment Department
3. Are they independent of line management? Yes
4. Does the ECP use third party consultants? The licensee does not normally use outside consultants as part of the program.
5. How is a concern about a manager or vice president followed up? A review of the concern is conducted by the next level of management. Concerns directed against the Manager, Nuclear Assessment Department are immediately forwarded to the [Executive] Vice President, Nuclear Generation Group

D. RESOURCES:

1. What is the size of the staff devoted to this program? Four. One manager and three site representatives.
2. What are ECP staff qualifications (technical training, interviewing training, investigator training, other)? Minimal. "Interviewing" training including OJT. Experienced QA/QC personnel in this position.

E. REFERRALS:

1. Who has followup on concerns (ECP staff, line management, other)? Concern is identified, reviewed and classified by ECP staff members and then forwarded to line management personnel for investigation and resolution.

F. CONFIDENTIALITY:

1. Are the reports confidential? Yes
2. To whom is the identity of the alleged made known (senior management, ECP staff, line management, other)? Senior management and ECP staff
3. Can employees:
 - a. be anonymous? Yes
 - b. report by phone? Yes

G. FEEDBACK:

1. Is feedback given to the alleged upon completion of the followup? Yes. Verbal communication of results/resolution.
2. Does program reward good ideas? Yes. Good ideas are rewarded with a letter of appreciation from the President or Chief Operating Officer.
3. Who, or at what level, makes the final decision of resolution? Manager, Quality Check
4. Are the resolutions of anonymous concerns disseminated? No, only to submitter.

H. EFFECTIVENESS:

1. How does the licensee measure the effectiveness of the program? The licensee has no formal measure of program effectiveness.
2. Are concerns:
 - a. Trended? Yes. Monthly status of number received and total YTD; semi-annual report to senior management.
 - b. Used? Yes
3. In the last three years how many concerns were raised? 111
Of the concerns raised, how many were closed? 110
What percentage were substantiated? The licensee does not substantiate concerns.
4. How are followup techniques used to measure effectiveness (random survey, interviews, other)? A random survey conducted by senior management.

5. How frequently are internal audits of the ECP conducted and by whom?
Infrequent. Only one internal audit of the program has been performed since 1990, that one being conducted in August 1993.

I. ADMINISTRATION/TRAINING:

1. Is ECP prescribed by a procedure? Yes
2. How are employees, as well as contractors, made aware of this program (training, newsletter, bulletin board, other)? Initial GET training, bulletin boards, ECP boxes located throughout the plant, posters, and brochures.