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 RECIP. NAME RECIPIENT AFFILIATION
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SUBJECT: Responds to violations noted in insp rept 50-261/93-33 re
 pressurized trasmitters PT-455 & Pt-457 drifted out of
 tolerance. Corrective actions: Presurizer Pressure Transmitter
 replaced, calabrated & transmitters declared operable.

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Robinson File No.: 13510E
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United States Nuclear Regulatory Commission
Attn: Document Control Desk
Washington, D. C. 20555

**H. B. ROBINSON STEAM ELECTRIC PLANT, UNIT NO. 2
DOCKET NO. 50-261/LICENSE NO. DPR-23
NRC INSPECTION REPORT NO. 50-261/93-33 REPLY TO A NOTICE OF VIOLATION
AND A NOTICE OF DEVIATION**

Gentlemen:

Carolina Power and Light Company hereby provides this reply to the Notice of Violation and the Notice of Deviation identified in NRC Inspection Report 50-261/93-33.

The enclosure provides a description of the occurrence, the causal factors and root causes identified for the violation and the deviation, and a discussion of the corrective actions taken and planned for these occurrences.

Should you have any questions regarding this matter, please contact Mr. R. M. Krich at (803) 383-1802.

Very truly yours,

Charles R. Dietz
Vice President
Robinson Nuclear Plant

RES:lst
Enclosure
c: Mr. S. D. Ebnetter
Mr. W. T. Orders

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PDR

REPLY TO A NOTICE OF VIOLATION AND A NOTICE OF DEVIATION

Violation RII-93-33-04-SL4:

10 CFR 50, Appendix B, Criterion XVI, Corrective Action, requires that measures be established to assure that the cause of conditions adverse to quality be determined and corrective action taken to preclude repetition.

Contrary to the above, on November 30, 1993, the licensee determined that pressurizer pressure transmitters PT-455 and PT-457 had drifted out of calibration tolerance. The licensee's corrective action to a similar occurrence of these instruments drifting out of tolerance between October 13 and October 15, 1993, failed to prevent this event.

REPLY

Carolina Power & Light Company (CP&L) acknowledges that the violation occurred as described.

1. The Reason for the Violation

The cause of this violation is attributable to not recognizing that the conditions surrounding the drift of the Pressurizer Pressure Transmitters should have resulted in a more thorough investigation of the root causes of the instrument drift.

On September 16, 1993, through September 17, 1993, the Pressurizer Pressure Transmitters were found to be out of tolerance during a routine refueling interval calibration check of the instruments. During this calibration check, the technicians did not check or calibrate the transmitters properly due to improper use of the calibration pressure source. This error was discovered during the post calibration data review required for all instruments found out of calibration. A Work Request was written to perform the calibration correctly. An Adverse Condition Report, the corrective action program mechanism for initiating an evaluation, was appropriately generated to investigate the cause of the improper calibration but not the cause of the out-of-calibration condition.

We concluded that these transmitters had been out-of-calibration for the entire cycle due to the fact that the as found data was lost from the September 16, 1993, through September 17, 1993, calibration. Accordingly, a Licensee Event Report (LER) Number 93-015 was generated to report that the three Pressurizer Pressure Transmitters were assumed out of calibration during this interval and in violation of the Technical Specifications. A Corrective Action specified within this LER committed us to performing a calibration check of the transmitters if there was a mid-cycle outage of sufficient duration.

To remedy the incorrect calibration of September 16, 1993, through September 17, 1993, the Pressurizer Transmitters were recalibrated on October 13, 1993. To provide assurance that this last calibration was done properly, a calibration check was performed on October 15, 1993. During this calibration check, we found that all three transmitters were found slightly out of tolerance. Based on standard practice, the transmitters were recalibrated and left within the tolerance band. As a result of the conditions described above, a more thorough investigation of the root cause was not performed. Instead, the review of this latest out-of-tolerance incident concluded that the slight out-of-tolerance condition was due to the use of a different Dead Weight Tester, the calibration being performed by a different technician, and the inherent calibration inaccuracies of the instruments and calibration process. The calibration problems related to the pressurizer pressure transmitters were discussed in the Plant Nuclear Safety Committee (PNSC). The Committee concluded that there was no safety significance with the issue since there was no indication that the transmitters were not operable and therefore no PNSC action was warranted.

When the plant experienced a forced outage in November of 1993, Maintenance decided to perform the LER corrective action on November 30, 1993. Although the calibration did not need to be performed at that time, management concluded that performing the calibration early would be a prudent course of action. Results were that two of the transmitters were found to be out-of-tolerance. Upon reviewing the history surrounding these transmitters, Maintenance management decided to take a conservative course of action and replace the transmitters. At this point the appropriate action was taken - generation of an Adverse Condition Report to investigate the problems experienced with the calibration of the Pressurizer Pressure Transmitters during the refueling outage.

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

The Corrective Steps taken were to replace the Pressurizer Pressure Transmitters. As part of the replacement, the Pressurizer Pressure Transmitters were calibrated. The calibration was performed without any problems. The new instruments performed as expected and the transmitters were declared operable.

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

Instruments found out-of-tolerance will be evaluated to determine if an additional root cause evaluation is needed based on circumstances surrounding the out-of-tolerance condition.

4. The Date When Full Compliance Will Be Achieved

Guidance for determining if a more thorough root cause analysis is required for out-of-tolerance instruments will be provided by June 30, 1994. This will achieve full compliance.

Deviation RII-93-33-02-DEV

Licensee letter dated February 1, 1989, RESPONSE TO GENERIC LETTER 88-17, LOSS OF DECAY HEAT REMOVAL, committed to installation of a suction pressure indicator and associated low pressure alarm for each RHR pump.

The licensee deviated from the above commitment in that, this instrumentation was not installed. Alternate indications were installed, however, no documentation to revise the original commitment was made.

REPLY

CP&L acknowledges that the deviation occurred as described.

1. The Reason for the Deviation

CP&L's letter to the NRC dated February 1, 1989, RESPONSE TO GENERIC LETTER 88-17, LOSS OF DECAY HEAT REMOVAL, committed to installation of a suction pressure indicator and associated low pressure alarm for each Residual Heat Removal (RHR) Pump as a means of monitoring the Decay Heat Removal (DHR) System performance during Mid-Loop Operation. Modification Number 1011 was initiated to install the committed instrumentation. Later, an evaluation performed for Modification 1011, "Instrumentation for Mid-Loop Operation," determined that monitoring of the RHR pump discharge would be more appropriate. The modification was implemented with this change to the original design and commitment during Refueling Outage 13 (Spring, 1991), but the change to the commitment was not properly evaluated.

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

A letter was written dated January 19, 1994, to inform the NRC of the deviation to the commitment contained in our February 1, 1989, letter.

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

Based on a review of the commitment tracking process, this oversight was an isolated occurrence and therefore no further action is planned.

4. The Date When The Corrective Action Will Be Complete

The corrective action with regards to this deviation has already been achieved.