

ACCELERATED DISTRIBUTION DEMONSTRATION SYSTEM

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR: 9405270124 DOC. DATE: 94/05/23 NOTARIZED: NO DOCKET #
 FACIL: 50-261 H.B. Robinson Plant, Unit 2, Carolina Power & Light C 05000261
 AUTH. NAME AUTHOR AFFILIATION
 HINNANT, C.S. Carolina Power & Light Co.
 RECIP. NAME RECIPIENT AFFILIATION
 Document Control Branch (Document Control Desk)

SUBJECT: Responds to NRC 940415 ltr re violations noted in insp rept
 50-261/94-08. Corrective actions: restored setpoints to proper
 respective values & issued RNP Operations Night Order.

DISTRIBUTION CODE: IE01D COPIES RECEIVED: LTR 1 ENCL 1 SIZE: 6
 TITLE: General (50 Dkt)-Insp Rept/Notice of Violation Response

NOTES:

	RECIPIENT		COPIES		RECIPIENT		COPIES	
	ID	CODE/NAME	LTTR	ENCL	ID	CODE/NAME	LTTR	ENCL
	PD2-1	PD	1	1	MOZAFARI, B		1	1
INTERNAL:	AEOD/DEIB		1	1	AEOD/DSP/ROAB		1	1
	AEOD/DSP/TPAB		1	1	AEOD/TTC		1	1
	DEDRO		1	1	NRR/DORS/OEAB		1	1
	NRR/DRCH/HHFB		1	1	NRR/DRIL/RPEB		1	1
	NRR/DRSS/PEPB		1	1	NRR/PMAS/ILPB1		1	1
	NUDOCS-ABSTRACT		1	1	OE-DIR		1	1
	OGC/HDS2		1	1	<u>REG FILE</u> 02		1	1
	RES/HFB		1	1	RGN2 FILE 01		1	1
EXTERNAL:	EG&G/BRYCE, J.H.		1	1	NRC PDR		1	1
	NSIC		1	1				

NOTE TO ALL "RIDS" RECIPIENTS:

PLEASE HELP US TO REDUCE WASTE! CONTACT THE DOCUMENT CONTROL DESK,
 ROOM P1-37 (EXT. 20079) TO ELIMINATE YOUR NAME FROM DISTRIBUTION
 LISTS FOR DOCUMENTS YOU DON'T NEED!

TOTAL NUMBER OF COPIES REQUIRED: LTTR 21 ENCL 21

R
I
D
S
/
A
D
D
S
/
A
D
D
S
/
A
D
D
S



10CFR2.201

Carolina Power & Light Company
Robinson Nuclear Plant
PO Box 790
Hartsville SC 29550

Robinson File No.: 13510E
Serial: RNP/94-0888

MAY 23 1994

United States Nuclear Regulatory Commission
Attn: Document Control Desk
Washington, DC 20555

H. B. ROBINSON STEAM ELECTRIC PLANT, UNIT NO. 2
DOCKET NO. 50-261/LICENSE NO. DPR-23
NRC INSPECTION REPORT NO. 50-261/94-08 REPLY TO A NOTICE OF VIOLATION

Gentlemen:

This provides the Carolina Power & Light Company (CP&L) reply to the Notice of Violation identified in NRC Inspection Report 50-261/94-08, which was transmitted by letter dated April 15, 1994. Violation A involves the failure to follow procedure when terminating a containment purge; Violation B involves two examples of inadequate corrective actions.

As requested in the letter transmitting the Notice of Violation, the enclosure restates each violation, followed by our reply. As agreed during a telephone discussion between Mr. H. O. Christensen (NRC) and Mr. R. M. Krich (CP&L) on May 12, 1994, this reply is being submitted one week later than the requested due date in order to ensure that the proper causes and corrective actions have been identified.

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

Very truly yours,

C. S. Hinnant
Vice President

RDC:

Enclosure

c: Mr. S. D. Ebnetter, Regional Administrator, USNRC, Region II
Ms. B. L. Mozafari, USNRC Project Manager, HBRSEP
Mr. W. T. Orders, USNRC Senior Resident Inspector, HBRSEP

9405270124 940523
PDR ADOCK 05000261
PDR

Highway 151 and SC 23 Hartsville SC

REPLY TO A NOTICE OF VIOLATION

Violation A

Technical Specification 6.5.1.1, Procedures, Tests, and Experiments, requires, in part, that written procedures be established, implemented, and maintained, covering activities recommended in Appendix A of Regulatory Guide 1.33, Rev. 2, 1978, including procedures for operation of the reactor building ventilation and gaseous effluent monitoring systems.

Operating Procedure, OP-921, Containment Air Handling, requires that radiation monitor setpoints be properly established following the termination of a continuous containment vessel purge.

Contrary to the above, three radiation monitor setpoints were improperly established following the termination of a continuous containment vessel purge on March 14, 1994. As a result, a non-conservative setpoint existed for approximately two hours on radiation monitor R-14C, Plant Stack, Noble Gas Radiation Monitor.

Reply

Carolina Power & Light (CP&L) agrees that the violation occurred as described. Although the R-14C setpoint was set non-conservatively relative to the procedurally required setpoint for a period of two hours, the Radiation Monitoring System would have alarmed at all times prior to 10 CFR 20 release limits being exceeded.

1. The Reason for the Violation

This violation was caused by inattention to detail and failure to use self checking practices. On March 5, 1994, the operator terminating the release did not realize he had to close out both a Batch and a Continuous Release permit, and mistakenly only closed out the Batch permit. This situation caused another operator, on March 14, 1994, to improperly utilize the Continuous Release permit that was used for the March 5 release.

A primary contributing factor was the complexity of the procedures for conducting off-site releases of radioactive effluents, combined with the adequacy of training provided to the specific operator involved. Review of the procedures and operator lesson plans that prescribe activities for conducting off-site releases of radioactive effluents, identified ambiguities and inconsistent wording in the sections providing instructions for changing Radiation Monitor System (RMS) setpoints and completing release permits.

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

Upon discovery that incorrect setpoints had been entered for Radiation Monitors R-11, R-12, and R-14C, the setpoints were restored to their proper respective values.

In order to increase operator awareness of this event, the Operations Manager issued an "RNP Operations Night Order," to ensure the condition would not recur prior to final corrective action implementation. This Night Order, which described the previous problems encountered and reinforced the actions to be taken, was reviewed by all on-coming Shift Supervisors and their crews.

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

Procedures that provide instructions for changing RMS setpoints and completing offsite radioactive effluent releases will be revised to remove the identified ambiguities and inconsistencies. To simplify the release permit process, Continuous Release Permits will be maintained by Environmental and Radiation Control personnel, thus eliminating the need for plant operators to document permit closure.

A Training Needs Analysis will be performed on the procedures utilized for conducting offsite radioactive effluent releases; training lesson plans will be updated as necessary.

4. The Date When Full Compliance Will Be Achieved

Full compliance will be achieved by August 10, 1994.

Violation B

10 CFR 50 Appendix B, Criterion XVI, Corrective Action, requires in part that measures be established to assure that conditions adverse to quality, such as failures, malfunctions, defective material and equipment, are promptly identified and corrected including measures to assure that the cause of the condition is determined and corrective action taken to preclude repetition.

Contrary to the above;

- 1) On February 17, 1994, the licensee's corrective actions to repair the B emergency diesel generator air flapper valve were inadequate to assure that the cause of the condition was confirmed and to preclude recurrence. The air flapper valve attachment pin which had fallen out, was improperly re-secured. This led to extensive engine damage when the pin fell out again after only three starts and was ingested by the engine's blower.
- 2) The licensee failed to take adequate corrective action to a November 1, 1993, entry into a high radiation area by two maintenance technicians without a survey meter in that a similar event occurred on March 17, 1994.

Reply

Carolina Power & Light (CP&L) agrees that the violation occurred as described, and provides the following response. Each of the specific examples cited is also addressed.

1. The Reason for the Violation

- 1) The first example of this violation was caused by failure of management to properly define and oversee the scope of the responsibility and the decision making processes of the team established to determine the February 17, 1994, "B" Emergency Diesel Generator (EDG) failure. Additionally, the initial repair activities for that failure were inadequate, in that, a thorough inspection of the air flapper valve was not performed to correctly identify the original failure mechanism. A Human Performance Enhancement System (HPES) review was conducted of this event to evaluate the decision-making process which led to the inadequate original repair. The HPES evaluation identified the following contributing factors to this event.

Time pressure resulting from the fact that the limited time remaining in the Technical Specifications (TS) Allowed Outage Time (AOT) before a plant shutdown would be required became the driving factor in the decision making process. All efforts were aimed at replacing the pin and sufficient consideration was not given to the cause of the air flapper valve pin falling out. The team's decision making process was informal; all decisions did not receive proper reviews that would have caused the reason for the pin falling out to be completely questioned. The role of team leader was not adequately defined, and decisions were made in his absence.

- 2) The second example of this violation was caused by failure of a CP&L engineer and three contract employees to pay adequate attention to their responsibilities as radiation workers. Specifically, the workers failed to follow the instructions specified on the applicable Radiation Work Permit (RWP). These instructions required the workers to read the radiological postings located at the entrance to the Non-Regenerative Heat Exchanger room, which is a HRA prior to entering the room. This posting contained the requirements for entry, including use of a survey meter. Even though the standards for HRA posting have been elevated as a result of the previous occurrence of this event in November, 1993, the workers still failed to adequately read and implement the RWP instructions and the room postings, resulting in a survey meter not being taken into the room.

The root cause investigation evaluation for the entry into the high radiation area (HRA) without a survey meter included a review of previous occurrences. Previous corrective actions have included elevated standards in HRA posting, and augmentation of employee training to emphasize the previous incidents; however, based on the cited recurrence of this type of event we have concluded that these corrective actions have not been fully effective.

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

- 1) A evaluation of this event was performed and documented by the plant HPES Coordinator. The individuals involved reviewed and understood the resultant findings.
- 2) The workers that entered the HRA without a survey meter were temporarily restricted from the Radiation Control Area (RCA) and were counselled by their management.

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

- 1) The procedural guidance for management, covering the establishment, responsibility, and function of event investigation teams, has been revised and now requires that objectives and limitations be clearly delineated in the team charter prior to the initiation of an investigation.

- 2) Although this specific event was due to personnel error, the means by which the effectiveness of previous corrective actions are evaluated is being strengthened as a result of the changes to the Corrective Action Program. These changes, described to the NRC during a meeting on May 13, 1994, at the Region II offices, are currently being implemented. Additionally, all HRAs accessible by normally closed doors have been locked. Individuals requiring access to these areas must now obtain entry authorization from a Health Physics (HP) Technician who will assure access requirements are met prior to entry.

HRAs not capable of being closed and locked, have been posted with additional signs prompting workers to verify that a survey meter is present when the room is occupied. These controls will provide additional assurance that RWP requirements are understood prior to HRA entry. Furthermore, utilization of alarming dosimeters is currently being implemented at the plant. While we anticipate that the use of alarming dosimeters will negate the necessity to use survey meters, the above corrective actions will remain in effect until management determines that they are no longer necessary to preclude recurrence of this violation.

4. The Date When Full Compliance Will Be Achieved

Full compliance has been achieved with the issuance of the event investigation team procedure and the implementation of changes to the Corrective Action Program.