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SUBJECT: Responds to NRC 961025 ltr re violations noted in insp rept 50-261/96-11.Corrective actions:returned SFP FMEA boundary to proper location,reviewed other work to verify clearance status & revised Procedure EPRAD-03, "Dose Projections."

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10 CFR 2.201

CP&L

Carolina Power & Light Company
Robinson Nuclear Plant
3581 West Entrance Road
Hartsville SC 29550

Robinson File No: 13510E
Serial: RNP-RA/96-0201

NOV 22 1996

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. 50-261/96-11
REPLY TO A NOTICE OF VIOLATION

Gentlemen:

This provides the Carolina Power & Light (CP&L) Company reply to the Notice of Violation identified in NRC Inspection Report No. 50-261/96-11 for the H. B. Robinson Steam Electric Plant (HBRSEP), Unit No. 2, which was transmitted by NRC letter dated October 25, 1996. Violation A involves three examples of personnel failure to follow procedures or inadequate procedures involving foreign material control deficiencies, outage contractor work errors, and offsite dose projection procedure deficiencies. Violation B involves a failure to implement adequate corrective actions to prevent operations personnel from being assigned duties with expired medical examinations. As requested in the letter transmitting the Notice of Violation, the enclosure restates each violation, followed by our reply.

Should you have any questions regarding this matter, please contact Mr. H. K. Chernoff at (803) 857-1437.

Very truly yours,

Dale E Young for CSH

C. S. Hinnant
Vice President

Enclosure

c: Mr. S. D. Ebneter, Regional Administrator, USNRC, Region II
Ms. B. L. Mozafari, USNRC Project Manager, HBRSEP
Mr. J. Zeiler, USNRC Resident Inspector, HBRSEP

REPLY TO A NOTICE OF VIOLATION

Violation A

Technical Specification 6.5.1.1.1, Procedures, Tests, and Experiments, states that written procedures shall be established, implemented and maintained covering the activities recommended in Appendix A of Regulatory Guide 1.33, Rev. 2, February 1978, including procedures for performing and controlling maintenance on safety related equipment and emergency procedures.

Plant Procedure, PLP-047, Foreign Material Exclusion Area Program, rev. 8, provides administrative instructions for ensuring the exclusion of foreign material from plant systems and equipment. The procedure requires that supervisors for work involving foreign material exclusion area (FMEA) be responsible for ensuring that FMEA controls are maintained.

Engineering Service Request modification, ESR 95-00764, provided installation instructions for replacing the power cable to valve SI-866A, the Safety Injection (SI) Pump Discharge Hot Leg Injection to Loop 3. Step 16.1 through 16.4 of the instructions require authorization from operations personnel to start work and implementation of clearances (i.e., tagout) prior to performing step 16.5 for determinating the power cable to valve SI-866A.

Emergency Procedure, EPRAD-03, Dose Projections, rev. 0, provides instructions for the Control Room operators to perform off-site dose projection calculations in case of possible emergencies from a release of radioactive material. Step 1.1.8 of the procedure provides instructions for assessing the computer program for calculating off-site dose projections via backup methods in case the primary access method, through the Emergency Response Facility Information System (ERFIS) computer system, was not available.

Contrary to the above:

1. Between September 17-19, 1996, the operations Shift Supervisors assigned to the shifts failed to effectively ensure that FMEA controls were maintained in the Spent Fuel Pool Building while fuel off-load was ongoing. On September 17, fuel handling personnel moved the FMEA boundary without installing boundary tape to delineate the new FMEA or updating the material log for items no longer in the FMEA area. This resulted in a loss of FMEA controls until corrected on September 19, 1996.

2. On September 16, 1996, contracted electrical technicians failed to follow ESR 95-00764, in that they cut the power cable to valve SI-866A, which was still energized at the time, prior to obtaining operations permission to start work or obtaining clearances for de-energizing the valve.

3. On August 19, 1996, EPRAD-03, was inadequate, in that the off-site dose projection computer program could not be readily assessed from the Control Room using the instructions contained in step 1.1.8 for backup access should ERFIS be unavailable.

Reply

Carolina Power & Light (CP&L) agrees that the violation occurred as described. Concerns in the Operations Unit with procedural adherence, technical adequacy, and administrative practices were also identified by the Nuclear Assessment Section. Corrective actions for these concerns include utilization of the self-assessment process to identify opportunities to improve procedure adherence, attention to detail, and conformance with management standards.

1. The Reason for the Violation

   1) This example of the violation was caused by plant personnel failing to adequately implement the requirements of procedure Plant Programs (PLP)-047, "Foreign Material Exclusion Area Program." Causal factors include failure to adequately implement previous corrective actions related to the Foreign Material Exclusion Area (FMEA) procedure, a weakness in content and structure of PLP-047, and inadequate Supervisory methods during the decision to relocate the Spent Fuel Pool (SFP) FMEA boundary.

   2) This example of the violation was caused by personnel error. During shift turnover, personnel failed to properly review and communicate the equipment clearance status to the on-coming shift. Prior to performing work, personnel failed to verify or institute appropriate clearances for the work activity.

   3) This example of the violation was caused by weaknesses in configuration control. As changes to computer software and hardware were made, neither procedures nor software were adequately revised to provide instructions with an appropriate level of detail for using the computer program for calculating off-site dose projections when the primary access method, through the Emergency Response Facility Information System (ERFIS) computer system, was not available. As a result, misleading and insufficient detail existed in Emergency Preparedness procedure EPRAD-03, "Dose Projections," resulting in the inability of operators to readily assess the off-site dose projection computer program from the Control Room.

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

1) Upon identification of the loss of FMEA controls, the SFP FMEA boundary was returned to the proper location as specified within procedure PLP-047, and actions were initiated to properly organize the personnel and material logs. An inventory was completed to verify items within the SFP FMEA were accounted for. A visual inspection of the SFP was completed to assure none of the unaccounted for items had been introduced into the pool.

2) Upon discovery that the cable to valve SI-866A that had been cut was energized, the workers notified their supervision. Associated modification work activities were suspended, and a stand-down meeting was conducted with both CP&L and contract workers. During this meeting, expectations for procedure compliance and verification of the status of equipment prior to starting work were stressed. A review of other work being performed was conducted to verify the clearance status of associated equipment.

3) Procedure EPRAD-03, "Dose Projections," has been revised to remove misleading statements and to provide adequate instructions for assessing the computer program for calculating off-site dose projections. Additionally, the software has been revised to simplify the steps needed to run the program when the computer is operating in a stand alone mode. The new revision was reviewed and validated by Control Room operators under actual failure modes to ensure procedure steps and intent are more evident to the end user. End users were notified of these changes.

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

1) Plant management will review FEMA areas defined in procedure PLP-047 and specify an individual or position to be accountable for each FMEA. Following identification of individuals or positions, this procedure will be revised to reflect these accountabilities. In addition, procedure PLP-047 will be revised by December 20, 1996, to simplify methods for documenting access and egress of personnel and material through the FMEA boundary.

During the current cycle of Licensed Operator Continuing Training (LOCT), Operations management is discussing the need for and expectation of verbatim procedure compliance.

2) The current methodology utilized during modification activities for assessing equipment status prior to commencing work will be reviewed. Expectations for procedure compliance and verification of the status of equipment prior to starting work will be incorporated into contractor training program prior to Refueling Outage 18.

3) ERFIS Training will be upgraded by March 14, 1997, to reflect the current system and dose projection configuration for use in Emergency Preparedness and Licensed Operator Training.

4. The Date When Full Compliance Will Be Achieved

1) Full compliance was achieved on September 19, 1996.

2) The expectation for verification of the status of equipment prior to starting work will be incorporated into the Contractor Training program, and will be implemented prior to the start of Refueling Outage 18, currently scheduled for March 1998.

3) Full compliance was be achieved on August 26, 1996, with the revisions to procedure EPRAD-03.

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 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, the licensee's corrective actions to ensure that operator medical examination requirements were maintained current were inadequate to assure recurrence of individuals standing various watch functions with expired examinations. Between August 1-6, 1996, an Auxiliary Operator stood five watches as a Fire Brigade member with an expired examination. Previous to this, between March 2-12, 1996, a licensed senior reactor operator stood seven control room shift supervisor watches with an expired NRC required medical examination and, between January-February, 1996, two Auxiliary Operators stood 11 watches as Fire Brigade members with expired examinations.

Reply

CP&L agrees that the violation occurred as described.

1. The Reason for the Violation

   This violation was caused by personnel error. The individual with the expired Fire Brigade physical failed to meet specific expectations for maintaining his medical status current, and supervisory oversight methods were not utilized to detect the required medical examination due date. Additionally, medical examination tracking and scheduling processes established as a result of previous occurrences were not adequately implemented to prevent recurrence.

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

   The Fire Brigade member satisfactorily completed his medical examination on August 20, 1996. The Fire Brigade member and his supervisor were counseled regarding management expectations for maintaining the medical examination conditions current.

   As an interim measure, plant procedures were implemented on August 16, 1996, to provide specific assignments for Operations personnel to review, for each on-coming shift, the qualification status for oncoming shift members to verify that shift Fire Brigade, license holders, and respirator qualifications are current to allow standing watch.

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

   Processes utilized at the Corporate level for tracking medical examinations are being revised to ensure health screening expiration information is available to personnel that are required to have medical examinations prior to performing their respective duties. These processes will be implemented at the site by March 3, 1997.

4. The Date When Full Compliance Will Be Achieved

   Full compliance was achieved on August 16, 1996.