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SUBJECT: Forwards response to NRC 950918 ltr re violations noted in  
insp rept 50-261/95-23. Corrective actions: review of plant  
operations using excess letdown was conducted. I

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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. 50-261/95-23  
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. 50-261/95-23 for the H. B. Robinson Steam Electric Plant (HBRSEP), Unit No. 2, which was transmitted by letter dated September 18, 1995. The Violation involves an inadequate operating procedure, and an operator's failure to communicate intended plant configuration changes. As requested in the letter transmitting the Notice of Violation, the enclosure restates the violation, followed by our reply. This reply is required to be submitted to the NRC by October 18, 1995.

Should you have any questions regarding this matter, please contact Mr. R. M. Krich at (803) 857-1802.

Very truly yours,

C. S. Hinnant  
 Vice President

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

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## REPLY TO A NOTICE OF VIOLATION

### Violation

Technical Specification 6.5.1.1.1, Procedures, Tests, and Experiments, states that written procedures be established, implemented, and maintained, covering the activities recommended in Appendix "A" of Regulatory Guide 1.33, Rev. 2, February 1978, including procedures related to the operation of the Chemical And Volume Control System and the Authorities and Responsibilities For Safe Operation And Shutdown.

Operations Management Procedure OMM-001, Operations - Conduct of Operations, Revision 44, requires that "Three-way communications should be used for all communications dealing with the plant..." including the alteration of plant configuration.

Operating Procedure OP-301, Chemical and Volume Control System provides the instructions for the normal and infrequent operation of the Chemical and Volume Control System, including placing excess letdown in service.

Contrary to the above;

- A. On July 24, 1995, Operation Procedure OP-301, Chemical And Volume Control System, was inadequate in that it contained no specific guidance concerning the manipulation of the charging and seal injection valves while the system was being operated with excess letdown in service. This resulted in system over-pressurization and damage.
- B. On July 24, 1995, a reactor operator failed to follow procedure OMM-001, in that he did not communicate his intended actions to the Senior Control Operator before ordering an Auxiliary Operator to throttle reactor coolant pump seal injection flow. The Reactor Operator's actions resulted in the Chemical and Volume Control System being over-pressurized and damaged.

## Reply

Carolina Power & Light (CP&L) agrees that the violation occurred as described. As a clarification, we note that the Chemical and Volume Control System (CVCS) was not over-pressurized with respect to the piping material mechanical limits in that stresses imposed on the piping during the event did not exceed allowable values since pressure was relieved by the operation of the relief valves.

### 1. The Reason for the Violation

This violation was caused by our failure to take adequate corrective actions for previous similar events. Our investigation found that procedure changes implemented for the previous events were too limited in that they did not consider the operating evolutions covered by Operating Procedure (OP)-301, "Chemical and Volume Control System," and did not identify improvements needed in Operator training for charging system operation. Additionally, incomplete communication occurred during the pre-job briefing and during this evolution, resulting in damage to the charging pump relief valves.

On July 24, 1995, the normal letdown line was removed from service for planned maintenance, and excess letdown was placed in service. As a result of this configuration, the pressurizer level was slowly increasing. The Shift Supervisor (SS) and Senior Reactor Operator (SRO) discussed the increase in pressurizer level, and determined that the rate of increase was not a concern sufficient to require decreasing seal injection flow. This discussion between the SS and the SRO was not communicated to the Reactor Operator (RO) or operators in the plant. The Control Room operators (i.e., the SS, SRO, and RO), acting upon a report from the Auxiliary Operator (AO) that seal injection was low, discussed and decided to increase seal injection flow through reduction of normal charging flow. Charging flow was decreased until seal injection flow increased to within the nominal flow range, but was higher than normal. The RO, without supervisory knowledge or approval, instructed the AO to locally decrease the seal injection flow, resulting in CVCS pressure increase, which resulted in actuation of the "A" and "C" charging pumps' discharge relief valves and subsequent damage to the relief valve weld. The action taken by the RO to adjust seal injection flow without prior approval by his supervisor, in conjunction with the failure by supervision to communicate their discussion pertaining to maintaining seal injection at current flows to the RO, resulted in damage to the CVCS.

Our review of the circumstances surrounding this violation found that corrective actions taken for previous events that occurred on November 9, 1993, and November 11, 1993, were too limited. Although the reasons were different for reducing the charging flow in the November 9, 1993, and November 11, 1993, events, the operating evolutions were very similar to this event.

Our evaluation of the previous events identified the need to add procedure caution statements to avoid lifting the charging pumps' discharge relief valves when performing procedure Operations Surveillance Test (OST)-160, "Pressure Isolation Check Valve Back Leakage Test," and to enhance operator training. These measures were too limited because they did not consider other operating evolutions that could challenge the charging pump relief valves. Had the corrective actions to the previously identified events been adequate, procedures such as OP-301, as well as Operator training, would have precluded this event.

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

A review of plant operations using excess letdown was conducted, and comparisons were made with the conditions of the July 24, 1995, event. Based on this review, initial recommendations were made to ensure that proper control is provided for charging and seal injection flows to preclude challenges to the charging pump discharge relief valves. These recommendations were implemented in procedure OP-301. However, these procedure changes were somewhat limited in scope based on the consideration of the heightened sensitivity that this event and the lessons learned had engendered within the plant operators. After further consideration prompted by the NRC Senior Resident Inspector, additional changes were made to procedure OP-301 with respect to operation of the system while excess letdown was in service.

A review of procedures for operating the charging pumps, as well as other positive displacement pumps, was completed. As a result of this review, improvements in affected Operating Procedures, Abnormal Operating Procedures, and Emergency Operating Procedures were implemented to minimize the potential for challenging the charging pump relief valves.

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

During 1993, due to programmatic inadequacies in the Corrective Action Program (CAP), the CAP process did not ensure a thorough analysis of adverse conditions. Since that time, the CAP process was revised to include increased management involvement in and oversight of the CAP implementation. We described these changes to the NRC during a meeting on May 13, 1994, at the Region II offices.

Improvements in the RO/SRO initial training program have been initiated. Improvements in classroom training involve reviews of the theoretical concepts of positive displacement pump operation, with emphasis on practical applications of system interrelationships, interactions of system malfunctions, and off-normal operations. This will include pressurizer level control without normal letdown and involve establishing excess letdown, manipulation of seal injection, and reducing charging flow with valve HCV-121. Secondly, this training will include positive displacement pump operation with one or more pumps in operation. Finally, this training will include reviews of previous similar events as operating experience information.

Simulator training exercises will be implemented to complement the Licensed Operator Requalification (LOR) classroom training, allowing the operator to develop and improve skills associated with operation of the CVCS and the charging system under off-normal conditions. These improvements will also be implemented during the next (i.e., Cycle 15) LOR training cycle.

4. The Date When Full Compliance Will Be Achieved

Full compliance will be achieved by December 31, 1995, with the completion of Cycle 15 LOR.