



UNITED STATES
NUCLEAR REGULATORY COMMISSION

REGION II
101 MARIETTA STREET, N.W.
ATLANTA, GEORGIA 30303

Report No.: 50-261/83-33

Licensee: Carolina Power and Light Company
411 Fayetteville Street
Raleigh, NC 27602

Docket No.: 50-261

License No.: DPR-23

Facility Name: H. B. Robinson

Inspection at H. B. Robinson site near Hartsville, South Carolina

Inspector: A. K. Hardin for
S. Weise

12/16/83
Date Signed

Approved by: Paul R. Bemis
for Paul R. Bemis, Section Chief
Division of Project and Resident Programs

12/19/83
Date Signed

SUMMARY

Inspection on November 11 - December 10, 1983

Areas Inspected

This routine, unannounced inspection involved 125 inspector-hours on site in the areas of technical specification compliance, plant tour, operations performance, reportable occurrences, housekeeping, site security, surveillance activities, maintenance activities, quality assurance practices, radiation control activities, outstanding items review, IE Bulletin, Circular, Notice Followup, TMI Action Item Review, steam generator repair preparations, modification activities, independent inspection, and previous enforcement action followup.

Results

Of the 17 areas inspected, no violations or deviations were identified in 14 areas; three violations were found in three areas (failure to implement procedures, paragraph 5.c; failure to report, paragraph 6.b; and failure to establish adequate controls, paragraph 9).

No apparent deviation was found in any areas.

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REPORT DETAILS

1. Persons Contacted

Licensee Employees

- *+G. P. Beatty, Jr., Manager, Robinson Nuclear Project Dept.
- +R. E. Morgan, General Manager
- * J. Curley, Manager, Technical Support
- * F. Gilman, Project Specialist, Regulatory Compliance
- F. Lowery, Unit 2 Operations Supervisor
- * W. Crawford, Manager, Operations and Maintenance
- R. Chambers, Unit 2 Maintenance Supervisor
- *+C. Wright, Specialist, Regulatory Compliance
- S. Crocker, Manager, Environmental and Radiation Control
- *+M. Reid, Construction Project Manager
- * J. Benjamin, Project Engineer - Operations
- * H. J. Young, Director, Onsite QA/QC
- * J. Huntley, Senior Specialist - Electrical
- * L. Waring, Project Engineer - Construction
- * R. Barnett, Principal Specialist - Maintenance

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

Other Organizations

R. Muth, Westinghouse

+Attended exit interview November 30

*Attended exit interview December 7

2. Exit Interview

The inspection scope and findings were summarized on November 30 and December 7, 1983, with those persons indicated in paragraph 1 above. The potential violations were discussed with and acknowledged by the licensee. The licensee committed to correct the post-accident sampling system design deficiency discussed in paragraph 12.b. during the next refueling outage, assuming the modification under development is found acceptable. At no time during this inspection was written material provided to the licensee by the inspector.

3. Licensee Action on Previous Enforcement Matters

(Closed) Infraction 261/82-03-01. The inspector reviewed CP&L response letter dated July 24, 1982. Licensee management controls appear adequate to prevent recurrence. The licensee has also submitted letters LAP-83-301 dated August 19, 1983, and LAP-83-471 dated October 14, 1983, which, respectively, provide surveillance capsule analysis results and a request for license amendment. Licensee corrective actions appear complete.

(Closed) Unresolved Item 261/83-30-03. The inspector reviewed CP&L letter to ONRR NO-80-1759 dated December 1, 1980. Page 7-1 of the criticality control analysis indicates that poison plates are not necessary on one side of adjacent faces between modules since the criticality calculation model assumes infinite racks, which are more reactive than the installed finite racks. Additionally, the modules in question have a five to six inch water gap between them. Criticality calculations support the existing module configuration.

(Open) Deviation 261/82-37-07. The inspector reviewed Modification 696 for installation of a low pressure alarm on the nitrogen supply to the low temperature overpressure protection system (LTOP). The alarm was installed, calibrated to alarm at 1000 psig decreasing, and tested. The alarm causes reflash of an existing LTOP annunciator window in the control room. The inspector reviewed the hardware changes in the field and the turnover and acceptance test documentation. The alarm feature appeared operable based on control board indication. The modification required changes to drawings, annunciator procedures, operating procedures, and maintenance procedures. At the completion of the inspection period, drawing and maintenance procedure changes had not been issued. The review of past CP&L/NRC commitment correspondence has been completed, but not all of the information has been evaluated to determine regulatory impact. This item will remain open until the review is complete and controlled documents are updated.

4. Unresolved Items

Unresolved items are matters about which more information is required to determine whether they are acceptable or may involve violations or deviations. New unresolved items identified during this inspection are discussed in paragraph 5.d.

5. Plant Tour (71707/71710)

- a. The inspector conducted plant tours periodically during the inspection interval to verify that monitoring equipment was recording as required, equipment was properly tagged, operations personnel were aware of plant conditions, and plant housekeeping efforts were adequate. The inspector determined that appropriate radiation controls were properly established, excess equipment or material was stored properly, and combustible material was disposed of expeditiously. During tours, the inspector looked for the existence of unusual fluid leaks, piping vibrations, pipe hanger and seismic restraint abnormal settings,

various valve and breaker positions, equipment clearance tags and component status, adequacy of firefighting equipment, and instrument calibration dates. Some tours were conducted on backshifts. The inspector performed major flowpath valve lineup verifications and system status checks on the following systems:

1. Safety Injection Accumulator System
 2. Selected Containment Isolation Valves
 3. DC Power Supply
 4. Engineered Safety Features Instrument Valves
 5. Boration Flowpaths
- b. On November 14 and 15, 1983, the inspector conducted a walkdown of the Safety Injection Accumulators and associated piping and valves. The inspector reviewed the following:
- Operating Procedure-1203 Revision 0, Safety Injection System Checkoff
 - Drawing 5379-1082 Sheet 4 Revision 15 and DRN 83-240.
 - Drawing 5379-1082 Sheet 5 Revision 15 and DRN 83-241.

The inspection was conducted to confirm that valve lineups and drawings matched as-built configurations, to identify potential system degradation, to verify that valves were in proper positions and locked if appropriate, and to verify that instrumentation was calibrated, valved-in, and functioning. No deficiencies were noted, and no violations or deviations identified.

- c. During a tour of the DC Power supply panels on November 21, 1983, the inspector determined that the DC control power fuses for the three Main Steam Isolation Valves (MSIV) were removed. Further investigation revealed that these fuses were pulled as part of Master Secondary Clearance 83-1613 on November 6, 1983, and the fuses were placed under the control of the Control Operator. Clearance tag numbers 22, 23, and 24 were indicated on the clearance as covering the fuse removal for each of the three MSIVs. The inspector identified the following deficiencies:
1. No clearance tags were hung at any of the empty fuseholders for the MSIVs.
 2. Each MSIV has two fuses on each of two auxiliary DC supply panels (i.e., four fuses per valve). Therefore, one clearance tag could not be used for fuse removal on an MSIV.

Licensee Administrative Procedure -027 Section 11.6 requires that each component requiring clearance be individually identified in the clearance and that such component be tagged using a tag or cap with the appropriate component clearance information annotated on it. Failure to implement these equipment control requirements is a violation. (261/83-33-01). Operations personnel took prompt corrective action to identify each circuit whose fuses were pulled and to hang the required clearance tags. The inspector noted that the control board switches for the MSIVs were properly tagged and the plant was in cold shutdown during the period of the violation, which mitigates the safety significance of the event.

- d. On December 5, 1983, during a tour of the Containment Spray/Safety Injection Pump Room, the inspector determined that valve SI-892J, Test Isolation Valve, was shut vice open. The plant was in the cold shutdown condition with preparations for startup in progress. Operations personnel promptly restored the valve to its proper position. The inspector reviewed the completed system valve lineup dated December 2, 1983. This valve lineup, Operating Procedure-1203 Revision 0, documented that the valve was checked open and received independent verification. The valve position, as found, did not affect system operability since the test flowpath is used only during refueling surveillance test OST-351 and is normally isolated by upstream valves. The inspector further reviewed the event and determined that the valve was tagged shut for clearance 83-1719, but was restored to the open position and independently verified on November 27th. The inspector also noted that the valve had a prominent and legible valve identification tag. The licensee is continuing to investigate the valve problem, and the inspector will review investigation results as an unresolved item (261/83-33-02).

6. Plant Operations Review (71707)

- a. The inspector periodically during the inspection interval reviewed shift logs and operations records, including data sheets, instrument traces, and records of equipment malfunctions. This review included control room logs, auxiliary logs, operating orders, standing orders, jumper logs and equipment tagout records. The inspector routinely observed operator alertness and demeanor during plant tours. During abnormal events, operator performance and response actions were observed and evaluated. The inspector conducted random off-hours inspections during the reporting interval to assure that operations and security remained at an acceptable level. Shift turnovers were observed to verify that they were conducted in accordance with approved licensee procedures.

- b. During a review of the Control Operator's Log and Operating Procedure-1008 for November 4, 1983, the inspector determined that one train of low temperature overpressure protection (LTOP) was inoperable due to its power operated relief valve (PORV) not meeting the cycle time of two seconds. The PORV had about a six second cycle time, and this condition was not repaired before the system was placed in operation thirty minutes after cycle-time testing. Technical Specifications allow operation with one inoperable LTOP train for seven days, but entrance into the limiting condition requires a thirty day report to the NRC. As of December 5, 1983, licensee personnel had not identified this reportable occurrence. Failure to submit the required licensee event report is a violation. (261/83-33-03). In light of the new reportable occurrence regulations which take effect January 1, 1984, the inspector requested that licensee corrective actions to prevent recurrence address management controls and sensitivity with respect to 10 CFR 50.73 implementation.

7. Technical Specification Compliance (71707/61726/62703)

During this report interval, the inspector verified compliance with selected limiting conditions for operation (LCOs) and reviewed results of selected surveillance tests. These verifications were accomplished by direct observation of monitoring instrumentation, valve positions, switch positions, and review of completed logs and records. The licensee's compliance with selected LCO action statements were reviewed as they happened. No violations or deviations were identified.

8. Physical Protection (71707/62703)

The inspector verified by observation and interview during the reporting interval that measures taken to assure the physical protection of the facility met current requirements. Areas inspected included the organization of the security force, the establishment and maintenance of gates, doors and isolation zones in the proper condition, that access control and badging was proper, that search practices were appropriate, and that escorting and communications procedures were followed. No violations or deviations were identified.

9. Service Water Cable Damage (71707/6270?)

- a. On November 5, 1983, during power excavation associated with the construction of a new radioactive waste facility, backhoe operators damaged two safety-related cable runs in the Unit 2 protected area. The plant was in cold shutdown at the time. The inspector conducted interviews with selected CP&L and contractor construction personnel and determined the following sequence of events. The area in question had been scanned with detecting instrumentation to identify underground obstructions, and these obstructions were marked/staked out on the existing asphalt. The marked asphalt was subsequently removed, and no stakes or markings were replaced to identify obstruction location. Dayshift contractor supervision indicated that obstruction location was

known, however. A Power Equipment Excavation Authorization was obtained for the work which required that land excavation be used within two feet of known obstructions. A drawing of some of the underground obstructions was attached to the authorization, however, the cable runs were not indicated on the drawing. Through the use of the incomplete drawing and poor communication between crews, the nightshift excavation crew was unaware of the cable run obstructions and associated power excavation restrictions. Initial use of the backhoe in the area damaged one cable run, and excavation was stopped and the construction foreman and shift foreman informed. Subsequently, excavation activities were moved about eighteen feet away, resulting in backhoe damage to the second cable run. All excavation activity was then stopped. The following equipment was damaged:

1. 'B' Service Water Pump main power cable insulation cut to bare metal
2. 'B' and 'D' Service Water Pump motor heater cables severed
3. Service Water discharge valves motor cables and valve position power cables outer insulation cut
4. Several unused cables damaged or severed.

The licensee took action to either temporarily or permanently repair the affected cables and stopped power excavation activities.

b. The inspector had the following findings:

1. The Authorization Form for Power Equipment Excavation was not described or controlled by any Construction Department procedure and did not require documentation of all known obstructions.
2. Inadequate management control was exhibited when excavation was not halted after damage to the first cable run.
3. The two cable runs involved carry all service water pump and discharge valve power to the intake structure.

Failure to adequately control excavation activities affecting safety-related service water equipment is a violation (261/83-33-04).

c. The inspector reviewed planned licensee corrective actions and determined that no power excavation will be performed until excavating equipment operators and the responsible construction foreman receive training on a revised form for authorizing power equipment excavation. The form is being revised to require attachment of an obstruction drawing and validation of the drawing by the detector operator who scanned the excavation area for obstructions. Additional notes and signatures will be added to ensure better communications. A procedure

will be written to address use of the form. Repairs to damaged safety-related equipment were made and reviewed prior to plant startup. Implementation of licensee corrective actions will be reviewed by the inspector.

10. Steam Generator (SG) Repair Preparations (37701)

- a. The inspector held discussions with CP&L's Quality Control (QC) Supervisor for contractors. This individual's responsibilities will deal solely with the S/G replacement activities. The contractor Supervisor has arrived onsite to commence forming the contractor organization and has experience from the Florida Power and Light replacement outage. CP&L will review each contract technician's resume and require them to complete the CP&L qualification program. Welding and nondestructive evaluation (NDE) inspectors will be certified by qualified CP&L personnel. The licensee has built an NDE test lab in preparation for the outage, and is planning to build a radiographic testing bunker. QC surveillance activities will be conducted by a dedicated group of personnel not associated with the QC contractor. The inspector will monitor licensee formation and use of the contractor organizations.
- b. The inspector conducted a tour of the secondary security access facility with the Senior Specialist - Security. Personnel access and egress controls were reviewed in addition to the physical barriers and monitoring systems. The licensee intends to use this access during the next refueling outage to expedite access and gain experience prior to the replacement outage. Security controls associated with this new facility will be inspected prior to and during usage, as part of the routine inspection program.
- c. Modification 694 for uprating of the polar crane to 210 tons was conducted during the maintenance outage, with assistance from a representative of the crane vendor. Structural changes were made and a new microdrive motor unit was installed. The uprated crane was then tested, using the microdrive unit, with calculated billet weights of 194 tons and 210 tons. These test lifts were successfully conducted. To restore the crane for use on safety-related component lifts, the crane was tested using the original crane motor with a lift weight of 174 tons or about 1.25 times the weight of the reactor vessel head. A keyswitch has been installed to prevent use of both drive systems simultaneously. This feature was tested satisfactory. The licensee did experience problems with the polar crane original motor control which was corrected through replacement of a thyristor card.

- d. The inspector reviewed procedure MOD-015, Revision 0, Construction Modification Package, for acceptable controls on modification activities associated with the steam generator repair. The procedure appears to provide the basic outline necessary to delineate appropriate modification controls, however, review of actual Construction Authorization Packages (CAP) will be necessary to determine the depth of plant reviews. These reviews will be conducted as CAPs are approved.

11. Refueling Frequency Surveillance (61726/62703)

The inspector reviewed the procedures and observed licensee surveillance activities associated with Special Procedure 528, Safety Injection Test, and Special Procedure (SP) 529, Loss of Offsite Power and Safety Injection Test. The inspection included review of procedures for approval and technical adequacy, witnessing of selected portions of the testing from the control room and auxiliary building, and review of test results for acceptability.

- a. SP-528 was conducted on November 30, 1983. All appropriate equipment was tested, and the safeguards sequence timing requirements were met. Two containment isolation valves (FP-258 and WD-1728) failed to close as required, and several valve position limit switches needed adjustment/repair. The licensee investigated the valve failures and determined that the FP-258 failure was due to a bad electrical contact in the respective safeguards relay and the WD-1728 failure was due to a leaking air solenoid diaphragm. The inspector witnessed portions of the post-maintenance testing of the valves. Both valves were returned to operability.
- b. SP-529 was conducted on November 30, 1983. This test verified that the activation of safety injection coincident with a loss of vital bus power autostarted the emergency diesel generators, caused load shedding to occur, and automatically load sequenced safeguards equipment onto the emergency buses. Additionally, the test verified that nonessential diesel trips were defeated and that pressurizer heater emergency power was operable. The test was performed satisfactorily except two containment isolation valves (FP-258 and WD-1728) failed to close as required and several valve position limit switches needed adjustment/repair. The valve problem resolutions are discussed in a. above.
- c. The Special Procedures used were developed from the existing approved surveillance tests EST-003 Revision 1 and EST-014 Revision 0 due to differences in plant conditions during the tests. The inspector determined that the following procedural discrepancies existed in EST-003 and EST-014:
 1. EST-003 Steps 5.26.4 and 5.27.5 do not specify lifted leads by terminal identification and Steps 5.26.11 and 5.27.8 do not require independent verification of restored leads. Independent verification was conducted during the special procedure test.

2. EST-014 does not require pressurizer heater controller PC-444J to be at maximum for the pressurizer heater power portion of the test, does not specify testing the right-most safety injection pushbutton, and does not require closing fire detection alarm system breakers on MCC-9 and 10 within one hour. The Special Procedure covered these items.
3. EST-014 does not test the manual safety injection block/unblock features. The Special Procedure covered this testing.
4. EST-014 Step 5.24 jumper removal is not independently verified and Steps 5.26.10 and 5.26.11 do not specify lifted leads or require independent verification on restoration.
5. EST-014 does not require closing breakers 52/13 and 52/15 for supplying 4160 volt power to station service transformer 2A and 2C, respectively, and does not require closing breaker 52/32A for the dedicated shutdown bus during offsite power restoration. This was performed during the Special Procedure.

Until the above procedural deficiencies are corrected, this is an inspector followup item (261/83-33-05).

12 TMI Action Item Review (25542/25559/25560)

- a. TAP No. I.C.1.2B and I.C.1.3B, Accident Procedures Review and Revision, NUREG 0737. The licensee has developed a training program for licensed operators on the under-development, systematic, emergency operating procedures. The training concept consists of seven modules which include background information, owner's group guidelines, a detailed description of the new procedures, classroom procedure exercises, and simulator exercises. The licensee previously conducted simulator validation of the draft procedures. The inspector held discussions with operations personnel and attended training sessions on the first two modules. These sessions appeared adequate. Current licensee schedules call for completion of the emergency procedure training and implementation about mid-1984. The inspector will inspect procedures and training sessions during future inspections. This item remains open.
- b. TAP No. II.B.3, Post Accident Sampling System (PASS), NUREG 0737. On November 30, 1983, the licensee informed the inspector that a design deficiency had been identified in the PASS. Due to the location of the Residual Heat Removal (RHR) System sampling point downstream of a throttled flow control valve, sample inlet pressure is insufficient to provide PASS flow when reactor coolant system (RCS) pressure is less than about 100 psig. This is due to both flow losses in the PASS and the fact that discharge flow from the PASS goes to the pressurizer relief tank, which could be at containment pressure. The licensee is developing a modification to move the RHR sample point to the discharge of the RHR pumps to take advantage of pump discharge pressure. The

licensee committed to inform ONRR of this problem by letter and committed to modify the PASS to rectify the design deficiency during the next refueling outage, assuming the new design is verified acceptable. Until this deficiency is corrected, this is an inspector followup item (261/83-33-06).

Based on the above review and 10 CFR 2 Appendix C.IV.A., this item constitutes a licensee identified violation of NRC Order dated March 14, 1983. The backup sampling capability provided prior to PASS operability was verified available should post accident sampling be necessary with RCS pressure less than 100 psig.

- c. TAP No. II.B.1.2, NUREG 0737, Install Reactor Coolant System (RCS) Vents. During the November maintenance outage, the licensee conducted RCS vent installation activities in accordance with Modification 520. As discussed in IE Reports 251/82-04 and 83-32, these modifications were to correct design problems, restore system continuity and test system integrity. The inspector observed modification field activities, held discussions with appropriate CP&L operations and engineering personnel, and reviewed implementing and test procedures. The following modification activities were completed:
1. The previously disconnected and capped pressurizer vent line was reinstalled.
 2. Valve RC-572, Containment Atmosphere Solenoid Isolation, was reinstalled with its actuator down to provide proper pilot valve operation and prevent pressure surges from opening the main valve.
 3. the original one inch standpipe was replaced with a three inch standpipe.

Additionally, those new welds associated with the reactor coolant pressure boundary portion of the system were hydrostatically tested to 2335 psig during the plant startup. The system has been lined up available for use, with a clearance on the valves actuated from the control board.

13. Containment Fan Cooler Replacement (37700/82700)

The inspector reviewed Modification Package 769 for the replacement of the existing copper tubed heat exchangers with stainless steel heat exchangers. These coolers were replaced due to frequent tube leaks in the copper tubes as reported in Licensee Event Reports (LER) 82-16, 83-03, 83-14, 83-22, 83-25, 83-26, and 83-27. These leaks were caused by a combination of erosion and corrosion from the low pH service water cooling medium. The replacement coolers were obtained to provide a heat exchanger material more resistant to corrosion and a waterbox design to reduce flow erosion susceptible areas. The inspector reviewed the safety evaluation, including Westinghouse letter CPL-83-675 dated November 15, 1983. The new coolers are designed to remove about five percent more heat during an accident, have a

larger air flow area, and were qualified to higher earthquake forces than the previous coolers. The inspector observed replacement activities and held discussions with licensee construction and engineering personnel. Installation and testing controls reviewed appeared adequate. The licensee intends to provide a supplemental report to LER 83-14 discussing corrective actions taken. Based on the review above, the remaining cooler leakage LERs are closed as documented in paragraph 14. No violations or deviations were identified.

14. Licensee Event Report (LER) Followup (92700)

- a. The inspector reviewed the following LER's to verify that the report details met license requirements, identified the cause of the event, described appropriate corrective actions, adequately assessed the event, and addressed any generic implications. Corrective action and appropriate licensee review of the below events was verified. When licensee identified violations were noted, they were reviewed in accordance with the enforcement policy. The inspector had no further comments.

<u>LER</u>	<u>EVENT</u>
83-13	RC-536 Packing Leak
83-03, 22, 25, 26, 27	Containment Recirculation Unit Coolant Leaks

- b. (Closed) LER 81-33 and Revision 1. This LER resulted in citing the licensee as described in IE Inspection Report 261/82-03. As discussed in paragraph 3, the inspector has reviewed CP&L corrective actions and correspondence. This LER is closed.
- c. (Open) LER 81-31 and Revision 1. The licensee's corrective actions have included vendor representative training of maintenance personnel and replacement of the packing material with a packing less susceptible to harsh environment degradation. The preventive maintenance program is still under development as part of the larger program for motor-operated valves. The inspector reviewed 1983 maintenance on the block valves and held discussions with the Maintenance Supervisor. The packing leakage reported in LER 83-13 appears to have been solved through use of the new packing material. Valves are being checked regularly, and the licensee is procuring a higher temperature lubricant for use in the motor operator. The LER will remain open until the formal program is approved and implemented.

15. Corporate Nuclear Safety (CNS) System Assessment Review (92706)

The inspector held discussions with Corporate and Onsite Nuclear Safety Department management to assess the quality of CNS system assessments and to determine the status of system upgrade recommendations. The inspector reviewed the following CNS system assessments and their status:

- a. Reactor Protection System (RPS)
- b. Service Water System
- c. Instrument Air System
- d. Emergency Diesel Generator System

The recommendations from the RPS assessment have been evaluated and acted upon, and all original issues have been satisfactorily resolved. Significant evaluation activities have been conducted on the service water system and modifications are in progress. Additional testing and evaluation is being scheduled. The remaining two assessments require formal responses from site management and development of appropriate upgrading task schedules. The inspector observed that the assessments were valuable tools to improve safety and reliability of systems important to safety, and that responsible CNS management were knowledgeable on the progress of the recommendation followup. No violations or deviations were identified.

16. IE Bulletin 83-06 Followup (92703)

The inspector reviewed CP&L response letter dated November 18, 1983. The licensee has reviewed the Bulletin lists of purchasing and receiving companies of potentially fraudulent material and procurement documents for pipe and pipe fittings since initial commercial operation. Two purchase orders were identified involving potentially fraudulent material in the form of pipe caps and pipe elbow and U-bend fittings. Of this material, one elbow fitting and one U-bend fitting are installed in the auxiliary feedwater (AFW) system. The remaining material was not installed, and was either removed from the site or destructively tested to confirm adequacy of the material installed in AFW system. Based on a combination of destructive testing and a design loading evaluation, the licensee determined that the installed fittings meet the design loading requirements and will not be replaced. Additionally, the licensee is investigating the use of more inspection/testing during receipt inspection to improve detection of fraudulently supplied material. CP&L will submit a report of the investigation results and implementation plans by June 1, 1984. This Bulletin will remain open until the report is received and reviewed.

17. IE Bulletin 83-01 Followup (92703)

The inspector reviewed the status of licensee corrective actions to date, including followup items 261/83-09-05, 83-09-08, and 83-15-07. Previous reviews of this Bulletin are documented in IE Reports 261/83-05, 09, 15, 21. NRC Generic Letter 83-28 has been issued to licensees, which expands the scope of actions beyond those of this Bulletin. The actions taken or planned as discussed in CP&L's response letter dated March 4, 1983, are complete. The licensee is also pursuing further actions as required by the Generic Letter and documented in CP&L response letter dated November 7, 1983. Actions required by Bulletin 83-01 have been verified as complete, and the Bulletin is closed.

18. Special Report Followup (92700)

The inspector reviewed CP&L Special Report dated June 24, 1983, pursuant to 10 CFR 20.405. This issue was previously investigated as reported in IE Inspection Report 261/83-16. The inspector reviewed these documents and the contractor's investigation report dated June 7, 1983. There are no outstanding issues associated with this event, and the Special Report is closed.

19. Outstanding Item Review (92701)

(Closed) Open Item 261/82-04-13. The licensee has assigned a refueling calibration periodicity to the hydrogen monitors, and the inspector verified that the calibration was current. Calibration Procedure LP-304, Revision 1, was reviewed and found to control the setting of the high and malfunction alarms. The licensee has instituted an auxiliary operator weekly check of the hydrogen monitors to ensure operability. The inspector reviewed the plant Q-List, TMM-003, Revision 3, and verified that the hydrogen monitor equipment is listed.

(Closed) Inspector followup item 261/82-22-02. The inspector reviewed CP&L letter LAP-83-289 dated June 30, 1983, describing the licensee's 10 CFR 50 Appendix J Test Program and including exemption requests. This letter was provided to ONRR for review and approval. This submittal provides a basis and scope for the Type C testing program.

(Closed) Inspector followup item 261/82-37-11. This item was incorporated into the Robinson Operations Improvement Program and is being tracked under Item III, Task 5 of that commitment. The procedure rewrite will be completed in December 1984.

(Open) Inspector followup item 261/83-09-05. The inspector reviewed Westinghouse E-Specification G676586, which specified a maximum interrupting time of 167 milliseconds for the reactor trip and bypass circuit breakers. The inspector reviewed work request FV3-01 conducted April 29, 1983, for measurement of trip and bypass breaker trip time. Breaker trip times ranged from 52.5 to 82.5 milliseconds. Licensee maintenance personnel indicated that a procedure was being developed for periodic measurement of breaker trip time. Until the procedure is established, this item will remain open.

(Closed) Inspector followup item 261/83-09-08. The inspector reviewed procedure OMM-010, Revision 0, Post Trip/Safeguards Review. This procedure requires that all unplanned reactor trips/safeguards actuations be reviewed by the Plant Nuclear Safety Committee at either its next monthly meeting or prior to plant startup if the cause is not clearly identified or proper performance of safety related equipment/systems is questioned.

(Closed) Inspector followup item 261/83-15-07. The inspector reviewed spare parts procedures for DB-50 breakers with licensee personnel. All parts, including the undervoltage trip attachment, are now ordered as "Q" category.

(Open) Inspector followup item 261/82-37-10. The inspector reviewed Memo/83-1249 dated November 30, 1983, delineating qualified safety reviewers; training sheets documenting individuals who have received safety reviewer training; the lesson plan used to conduct the training; and the individual safety reviewer qualification justification sheets. The inspector also verified that qualification justifications were consistent with Technical Specification 6.5.1.5.1 for sample of reviewers. Documentation was available for all reviewers to provide justification of safety review expertise and show attendance at a required training session. Additionally, Onsite Nuclear Safety personnel review all approved procedures and modifications for adequate safety reviews and return inadequate reviews to the manager that granted approval for correction. Based on the observed compliance with Technical Specification requirements, this item is closed.

(Closed) Inspector followup item 261/82-37-09. The inspector reviewed monthly corrective action program reports for July and August 1983, and held discussions with cognizant licensee management. In addition to the report, corrective action data is reported on by Corporate Nuclear Safety and by plant staff to senior corporate management at monthly management meetings. Specifically, senior management meetings routinely cover subjects such as modification status, drawing control, Robinson Improvement Program, consultant recommendations, violations, nonconformance reports, reportable occurrences, contamination incidents, and radioactive waste shipping. While the program described in Administrative Instruction-15 is not all inclusive, as noted previously, the inspector's review found that corrective action evaluation is accomplished through several communication channels. Also, due to management structure changes and a need to reduce administrative burdens, the licensee is developing changes to the program. Based on the above implementation, the overall program appears adequate.

20. Review of IE Circulars and Notices (IECs and IENs) (92717)

The inspector verified that IECs and IENs had been received onsite and reviewed by cognizant licensee personnel. Selected applicable IE Circulars and Notices were discussed with licensee personnel to ascertain the licensee's actions on these items. Licensee action on the following IECs and IENs were reviewed by the inspector and are closed.

IE Circulars

81-14

IE Notices

83-68

82-53

82-56