

ACCELERATED DOCUMENT DISTRIBUTION SYSTEM

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR:9212160026 DOC.DATE: 92/12/11 NOTARIZED: NO DOCKET #
 FACIL:50-261 H.B. Robinson Plant, Unit 2, Carolina Power & Light C 05000261
 AUTH.NAME AUTHOR AFFILIATION
 CROOK,D. Carolina Power & Light Co.
 CHAMBERS,R.H. Carolina Power & Light Co.
 RECIP.NAME RECIPIENT AFFILIATION

SUBJECT: LER 92-022-00:on 921113,potential for safety injection sys
 to become inoperable identified.Caused by procedure defect.
 Procedure OP-202 revised under temporary change.Changes made
 permanent under Rev 29 to procedure.W/921211 ltr.

DISTRIBUTION CODE: IE22T COPIES RECEIVED:LTR 1 ENCL 1 SIZE: 4
 TITLE: 50.73/50.9 Licensee Event Report (LER), Incident Rpt, etc.

NOTES:

	RECIPIENT ID CODE/NAME	COPIES LTTR ENCL	RECIPIENT ID CODE/NAME	COPIES LTTR ENCL
	PD2-1 LA	1 1	PD2-1 PD	1 1
	MOZAFARI,B	1 1		
INTERNAL:	ACNW	2 2	AEOD/DOA	1 1
	AEOD/DSP/TPAB	1 1	AEOD/ROAB/DSP	2 2
	NRR/DET/EMEB 7E	1 1	NRR/DLPQ/LHFB10	1 1
	NRR/DLPQ/LPEB10	1 1	NRR/DOEA/OEAB	1 1
	NRR/DREP/PRPB11	2 2	NRR/DST/SELB 8D	1 1
	NRR/DST/SICB8H3	1 1	NRR/DST/SPLB8D1	1 1
	NRR/DST/SRXB 8E	1 1	<u>REG FILE</u> 02	1 1
	RES/DSIR/EIB	1 1	RGN2 FILE 01	1 1
EXTERNAL:	EG&G BRYCE,J.H	2 2	L ST LOBBY WARD	1 1
	NRC PDR	1 1	NSIC MURPHY,G.A	1 1
	NSIC POORE,W.	1 1	NUDOCS FULL TXT	1 1

NOTE TO ALL "RIDS" RECIPIENTS:

PLEASE HELP US TO REDUCE WASTE! CONTACT THE DOCUMENT CONTROL DESK.
 ROOM P1-37 (EXT. 504-2065) TO ELIMINATE YOUR NAME FROM DISTRIBUTION
 LISTS FOR DOCUMENTS YOU DON'T NEED!

FULL TEXT CONVERSION REQUIRED
 TOTAL NUMBER OF COPIES REQUIRED: LTTR 29 ENCL 29

Handwritten signature/initials



Carolina Power & Light Company

ROBINSON NUCLEAR PROJECT DEPARTMENT
POST OFFICE BOX 790
HARTSVILLE, SOUTH CAROLINA 29550
DEC 11 1992

Robinson File No: 13510C

RNPD/92-3100
(10CFR50.73)

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
LICENSEE EVENT REPORT NO. 92-022-00

Gentlemen:

The enclosed Licensee Event Report (LER), is submitted in accordance with
10 CFR 50.73 and NUREG 1022, Supplements No. 1 and 2.

Very truly yours,

R. H. Chambers
General Manager

H. B. Robinson S. E. Plant

RDC:sgk

Enclosure

cc: Mr. S. D. Ebnetter
Mr. L. W. Garner
INPO

150084

9212160026 921211
PDR ADOCK 05000261
S PDR

IF22
111

NRC FORM 366 (5-92)			U.S. NUCLEAR REGULATORY COMMISSION			APPROVED BY OMB NO. 3150-0104 EXPIRES 5/31/95				
LICENSEE EVENT REPORT (LER) (See reverse for required number of digits/characters for each block)										
FACILITY NAME (1) H. B. ROBINSON, UNIT NO. 2						DOCKET NUMBER (2) 05000 261		PAGE (3) 1 OF 3		
TITLE (4) POTENTIAL FOR ESF INOPERABILITY DUE TO PROCEDURE DEFECT										
EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
11	13	92	92	-022	00	12	11	92	FACILITY NAME	DOCKET NUMBER
										05000
										05000
OPERATING MODE (9)		N	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)							
			20.402(b)		20.405(c)		50.73(a)(2)(iv)		73.71(b)	
POWER LEVEL (10)		100	20.405(a)(1)(i)		50.36(c)(1)		<input checked="" type="checkbox"/> 50.73(a)(2)(v)		73.71(c)	
			20.405(a)(1)(ii)		50.36(c)(2)		50.73(a)(2)(vii)		OTHER	
			20.405(a)(1)(iii)		50.73(a)(2)(i)		50.73(a)(2)(viii)(A)		(Specify in Abstract below and in Text, NRC Form 366A)	
			20.405(a)(1)(iv)		50.73(a)(2)(ii)		50.73(a)(2)(viii)(B)			
			20.405(a)(1)(v)		50.73(a)(2)(iii)		50.73(a)(2)(x)			
LICENSEE CONTACT FOR THIS LER (12)										
NAME David Crook, Senior Specialist-Compliance								TELEPHONE NUMBER (Include Area Code) (803) -383-1179		
COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)										
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS
SUPPLEMENTAL REPORT EXPECTED (14)						EXPECTED SUBMISSION DATE (15)		MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE).					X	NO				
ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)										
<p>On November 13, 1992, with H. B. Robinson operating at one hundred percent power, the results of an evaluation of a previously identified procedural error indicated that, if used, the error could have caused the Safety Injection System to become inoperative. The error involved procedurally changing the position of a valve in a Safety Injection System test line from "closed" to "open". A physical check of the valve found it to be in the correct (closed) position required for system operability.</p> <p>The error was caused by an inadequate review of a revision to an operating procedure for placing the Safety Injection and Containment Spray System in service. Upon discovery of the error, the procedure was corrected. The error had no impact on plant safety because the procedure, although approved, had never been implemented in the field.</p> <p>This report is submitted pursuant to 10 CFR 50.73(a)(2)(v) as a condition that could have prevented the fulfillment of a safety function.</p>										

NRC FORM 366A (5-92)		U.S. NUCLEAR REGULATORY COMMISSION		APPROVED BY OMB NO. 3150-0104 EXPIRES 5/31/95							
LICENSEE EVENT REPORT (LER) TEXT CONTINUATION				ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (MNBB 7714), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.							
FACILITY NAME (1)		DOCKET NUMBER (2)		LER NUMBER (6)							
H. B. ROBINSON, UNIT NO. 2		05000261		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; text-align: center; font-weight: bold;">YEAR</td> <td style="width: 33%; text-align: center; font-weight: bold;">SEQUENTIAL NUMBER</td> <td style="width: 33%; text-align: center; font-weight: bold;">REVISION NUMBER</td> </tr> <tr> <td style="text-align: center;">92</td> <td style="text-align: center;">-- 022 --</td> <td style="text-align: center;">00</td> </tr> </table>		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	92	-- 022 --	00
YEAR	SEQUENTIAL NUMBER	REVISION NUMBER									
92	-- 022 --	00									
				PAGE (3)							
				2 OF 3							

TEXT (If more space is required, use additional copies of NRC Form 366A) (17)

I. DESCRIPTION OF EVENT

On November 3, 1992, H. B. Robinson Unit No. 2 was operating at one hundred percent power. During an Engineering Safety Feature walkdown the site NRC Resident Inspector noted that the procedural position for valve SI-895K, as required by Operating Procedure OP-202, "Safety Injection and Containment Vessel Spray System", had been changed from "closed" to "open". A physical check of the valve revealed it to be in the closed position. Evaluation of this condition was completed on November 13, 1992. The results of the evaluation indicated that, had the valve been in the "open" position as procedurally required, a significant portion of the Safety Injection (SI) flow would have been diverted to the Refueling Water Storage Tank (RWST) if a Safety Injection actuation had occurred.

II. CAUSE OF EVENT

The cause of this event is attributed to an inadequate review of a revision to Operating Procedure OP-202. This procedure is used for placing in service or removing from service the Safety Injection and Containment Spray System. Revisions 25 and 26 to this procedure were initiated to incorporate changes resulting from Plant modifications M-1128 and M-1134, implemented during the last refueling outage. During this process, Revision 26 inadvertently changed the position of valve SI-895K from "closed" to "open".

III. ANALYSIS OF EVENT

This condition had no impact on plant safety because the procedure that contained the error was never used, and the valve was maintained in its correct (safe) position.

Valve SI-895K, located in a three quarter inch test line, is a manually operated globe valve that is in the "closed" position by system design. If this valve had been lined up in the "open" position, it would create a flow path from the High Head SI Pump discharge to the RWST. As such, in the event of Safety Injection actuation, it would be a parallel flowpath that detracts from delivery of emergency core cooling water to the Reactor Coolant System.

NRC FORM 366A
(5-92)

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB NO. 3150-0104
EXPIRES 5/31/95LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (MNBB 7714), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
H. B. ROBINSON, UNIT NO. 2	05000261	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	3 OF 3
		92	-- 022 --	00	

TEXT (If more space is required, use additional copies of NRC Form 366A) (17)

Previous evaluations of High Head Safety Injection performance have identified Small Break LOCA as the limiting FSAR Chapter 15 accident. Evaluation of the effects of the loss of flow that could have resulted from Valve SI-895K in the "open" position indicate that the accident analysis could not accommodate a further decrease in flow.

NUREG 1022, Supplement 1, provides guidance for assessing reportability of procedural errors. This guidance states that if a procedure was approved for use contains a defect that, if used, could have caused a safety system to become inoperative, the error is reportable. Therefore, this report is being submitted pursuant to 10 CFR 50.73(a)(2)(v) as a condition that could have prevented the fulfillment of a safety function.

IV. CORRECTIVE ACTIONS

Upon discovery of this condition, OP-202 was immediately revised under a Temporary Change to correct the errors. These changes were made permanent under Revision 29 to the procedure.

In order to prevent recurrence, Operations procedure writers have been reminded of the importance of conducting proper reviews for procedure revisions. Also, personnel responsible for word processing procedure changes have been reminded of the importance of ensuring that no unintended changes are made.

V. ADDITIONAL INFORMATION

A. Component Failures

None

B. Previous Similar Events

None