

Serial: RNP-RA/12-0053

MAY 0 7 2012

Attn: Document Control Desk

United States Nuclear Regulatory Commission

Washington, DC 20555-0001

H. B. ROBINSON STEAM ELECTRIC PLANT, UNIT NO. 2 DOCKET NO. 50-261/RENEWED LICENSE NO. DPR-23

LICENSEE EVENT REPORT NO. 2012-003-00

PLANT MODIFICATION INTERFERED WITH THE OPERATION OF CONTAINMENT
WIDE RANGE LEVEL INDICATOR

Ladies and Gentlemen:

The attached Licensee Event Report is submitted in accordance with the requirements of 10 CFR 50.73. Should you have any questions regarding this matter, please contact William R. Hightower, Supervisor – Licensing/Regulatory Programs at (843) 857-1329.

This document contains no new Regulatory Commitments.

Sineerely,

Plant General Manager

H. B. Robinson Steam Electric Plant, Unit No. 2

TSC/rjr

Attachment

c: Mr. Victor McCree, NRC, Region II

A. Billoch-Colon, NRC, NRR

NRC Resident Inspector

Progress Energy Carolinas, Inc. Robinson Nuclear Plant 3581 West Entrance Road Hartsville, SC 29550

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NRC FORM 366 U.S. NUCLEAR REGULATORY COMMISSION (10-2010)					APPROVED BY OMB: NO. 3150-0104 EXPIRES 10/31/2013								
LICENSEE EVENT REPORT (LER) (See reverse for required number of digits/characters for each block)						Estimated burden per response to comply with this mandatory collection request: 80 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the FOIA/Privacy Service Branch (T-5 F53), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to infocollects.resource@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202, (3150-0104), Office of Management and Budget, Washington, DC 20503. If a means used to impose an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.							
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_	FACILITY NAME M. S. Connelly TELEPHONE NUMBER (Include Area Code) 843-857-1569												
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				XPECTED SUBMISSION				NO	MISSION DATE				
ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) On January 19, 2012, at approximately 0557 hours EST, while the H.B. Robinson Unit 2 was shutdown in MODE 5, Condition Report (CR) 510240 was initiated documenting that an NRC inspector identified a chain interfering with the float for the Post Accident Containment Vessel (CV) Water Level Transmitter (LT) for Channel-B. The chain prevented the LT from working correctly. The CV LT was inoperable because it could not indicate a flooded containment level of 375 inches required by the Critical Safety Function Status Trees. On March 7, 2012, work was completed which removed the obstruction. This condition existed since October 15, 2005 when the chain had been installed to restrain a folding gate that is used as a radiation dose barrier during outages. This chain was intended to prevent the folding gate from interacting with safety related equipment during normal operation. LCO 3.3.3 Condition A requires an inoperable channel to be restored in 30 days and if not restored in 30 days, Condition B requires immediate action in accordance with Technical Specification (TS) 5.6.6, PAM Instrumentation Report. TS 5.6.6 is an administrative TS with a 14 day reporting requirement. Since the LT was not returned to an OPERABLE status in 30 days and the required report was not filed in 14 days, this event is reportable under 10 CFR 50.73 (a)(2)(i)(B), operation or condition which was prohibited by the plant's TS.													

LICENSEE EVENT REPORT (LER) CONTINUATION SHEET

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H. B. Robinson Steam Electric Plant, Unit No. 2	05000261	YEAR	SEQUENTIAL NUMBER	REV. NO.	2 OF 3	
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NARRATIVE

DESCRIPTION OF EVENT

On January 19, 2012, at approximately 0557 hours EST, while H. B. Robinson Unit 2 was shutdown in MODE 5, Condition Report (CR) 510240 was initiated documenting that an NRC inspector identified that the installation of the chain for the west half of the wall on the south side of the reactor [RCT] shield area was found to interfere with the path of the float for the Post Accident Containment Vessel [VSL] (CV) Water Level Transmitter (LT), LT-802E [LT]. The CV LT was inoperable because it could not indicate a flooded containment level of 375 inches required by the Critical Safety Function Status Trees. On March 7, 2012, work was completed which removed the obstruction.

CR 510240 also determined that LT-802E had been inoperable since October 15, 2005. Although LT-802E would not have been able to provide an indicated flooded containment level of 375 inches, it would have been able to provide the indication of 354 inches required for placing the Reactor Coolant System (RCS) and Residual Heat Removal (RHR) on recirculation.

II. CAUSE OF EVENT

During the refueling outage of 2005, Engineering Change (EC) 58222 installed folding gate [GATE] walls to be used as radiation barriers in three locations of containment. The gates were designed to be chained to the wall when retracted to prevent interaction with safety related components. The apparent cause of this event is EC 58222 gave no consideration to the potential interference between the chain for the gate and LT-802E. EC 58222 was reviewed and no references or cautions regarding interference were found. CR 530799 is investigating the failure to detect the impairment created by the installation of EC 58222. A follow-up report will be submitted when CR 530799 is complete, if the apparent cause changes.

III. ANALYSIS OF EVENT

TS Table 3.3.3-1 requires two channels of Containment Sump Water Level (Wide range). Condition A of Limiting Condition for Operation (LCO) 3.3.3 requires the inoperable channel to be restored in 30 days. If not restored in 30 days, Condition B of the LCO requires immediate action in accordance with TS 5.6.6.

TS 5.6.6, Post Accident Monitoring (PAM) Instrumentation Report, states that a report shall be submitted within the following 14 days which outlines the preplanned alternate method of monitoring, cause of inoperability, and the plans and schedule for restoration of the channel.

The PAM Channel in question was determined to be inoperable for greater than 30 days and the required report was not made in 14 days; therefore this event is reportable pursuant to 10 CFR 50.73 (a)(2)(i)(B). The report due date is May 7, 2012, which is based on the date of the reportability determination date, March 8, 2012.

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NARRATIVE

IV. SAFETY SIGNIFICANCE

This condition described above did not constitute an unanalyzed condition as LT-802E was available to provide the level indication of 354 inches used by the operators to determine switchover from injection to recirculation mode of operation. Therefore, the safety function of providing level indication for switchover was available even though the alarm function was not available. The containment flooding alarm is a secondary indication of containment flooding. The sources of water causing containment flooding and reaching the alarm setpoint of 375 inches are Fire Water, Service Water, Component Cooling Water, Primary Water, and Steam Generators. The associated alarms and actions are shown below:

Cause	Alarm	Response				
Fire Water	Pump start	Investigate cause of start/isolate if required				
Service Water	Low flow alarms due to loss of water	Determine cause of low flow and isolate as required				
Component Cooling Water	Surge tank low level	Determine cause of low surge tank level				
Primary Water	Low primary water tank level	Determine cause of low tank level				
Steam Generators [SG]	Decreasing SG level	Determine path out of SG and isolate				

If any of the above conditions would have continued to exist, then LT-802E would have provided indication up to approximately 370 inches while Channel A, LT-801E (the redundant channel), would have continued to increase and alarm.

V. CORRECTIVE ACTIONS

Completed Corrective Actions:

 EC 84548 was approved, and on March 7, 2012, the chain was relocated using Work Order 2035875 so that no interaction exists between the chain and level instrumentation float for LT-802E.

Planned Corrective Actions:

 CR 530799 is investigating the failure to detect the impairment created by the installation of EC 58222. A follow-up report will be submitted when CR 530799 is complete, if any additional significant completed or planned corrective actions are identified.

VI. PREVIOUS SIMILAR EVENTS:

Licensee Event Reports (LERs) for HBRSEP, Unit No. 2, were reviewed from the past 5 years. There were no similar events found.