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AUTH.NAME AUTHOR AFFILIATION
DORMAN,W.J. Carolina Power & Light Co.
PEARSON,M.P. Carolina Power & Light Co.
RECIP.NAME RECIPIENT AFFILIATION

SUBJECT: LER 94-001-01:on 940204,failure to test instrumentation channels per TS due to procedural deficiencies.Procedure MST-007 Reactor Coolant Low Temp Over Pressure Protection Sys Test revised to include untested circuit.W/940415 ltr.

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10 CFR50.73

Carolina Power & Light Company
Robinson Nuclear Plant
PO Box 790
Hartsville SC 29550

APR 15 1994

Robinson File No: 13510C
Serial: RNP/94-0815

United States Nuclear Regulatory Commission
Attn: Document Control Desk
Washington, DC 20555

H. B. ROBINSON STEAM ELECTRIC PLANT, UNIT NO. 2
DOCKET NO. 50-261/LICENSE NO. DPR-23
LICENSEE EVENT REPORT NO. 94-001-01

Gentlemen:

The enclosed supplemental Licensee Event Report (LER), is submitted in accordance with 10 CFR 50.73.

Very truly yours,

Marc P. Pearson
Plant General Manager

WJD:lst
Enclosure
c: Mr. S. D. Ebneter, Administrator, US NRC, Region II
Mr. W. T. Orders, Senior Resident Inspector, HBRSEP
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Enclosure to Serial: RNP/94-0815

NRC FORM 366 (5-92) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB NO. 3150-0104
EXPIRES 5/31/95

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.

LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
H.B. ROBINSON STEAM ELECTRIC PLANT, UNIT NO.2	50-261	1 OF 7

TITLE (4)
FAILURE TO TEST INSTRUMENTATION CHANNELS PER TECHNICAL SPECIFICATIONS

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
02	04	94	94	-- 001 --	01			94		05000
									FACILITY NAME	DOCKET NUMBER 05000

OPERATING MODE (9)	N
POWER LEVEL (10)	0

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)
	20.405(a)(1)(i)		50.36(c)(1)		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)	X	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	TELEPHONE NUMBER (Include Area Code)
W. J. DORMAN, REGULATORY AFFAIRS	(803) 383-1186

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).	No				

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

On January 31, 1994, H. B. Robinson Steam Electric Plant (HBRSEP), Unit 2 was in the cold shutdown condition. A 1992 internal assessment questioned the previously accepted interpretation of testing methodology for Technical Specifications (TS) Table 4.1-1, Items 8 and 31, required surveillance test. These interpretations have been effective since the issuance of the plant's full power license. Therefore, the associated tests had not been adequately implemented to address all of the pertinent features of the equipment being tested. This event had no actual impact on plant safety. The tests for the applicable TS Surveillance Requirements (SRs) were revised to include the untested portion of the equipment in question and were performed with satisfactory results. Therefore, there is reasonable assurance that the equipment has always been capable of performing its intended safety function.

The failure to promptly disposition the findings from the 1992 internal assessment and to correctly apply NRC reporting criteria are the result of: 1) an overall focus on completing the assessment without proper plans for addressing the findings, 2) failure to adhere to the formalized corrective action process, and 3) differing and evolving conclusions regarding the technical adequacy and correctness of the internal assessment findings.

This condition was determined to be reportable on February 4, 1994. This report is submitted pursuant to 10 CFR 50.73(a)(2)(i)(B) as a condition prohibited by TS, since the SRs were not fully complied with and the associated TS actions were not taken within the allowed time interval.

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APPROVED BY OMB NO. 3150-0104
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TEXT (If more space is required, use additional copies of NRC Form 366A)

I. DESCRIPTION OF EVENT

On January 31, 1994, H. B. Robinson Steam Electric Plant (HBRSEP), Unit 2 was in the cold shutdown condition and preparing for startup from a forced outage. As part of our startup plan, a readiness review determined, based on an internal assessment completed in June, 1992, that a previously accepted interpretation of testing methodology for certain Technical Specifications (TS) Table 4.1-1 required surveillance tests was incorrect, and therefore, the tests had not been adequately implemented. The specific items of concern were as follows.

1) The implementation of TS Table 4.1-1, Item 31, to calibrate the Overpressure Protection System (EIIS Code: JC) at a refueling frequency was not adequate. Time testing of the actuation of the Power Operated Relief Valve solenoids from the test switch was being conducted in accordance with Procedure OST-703, "ISI Primary Side Valve Test," and calibration of the logic was being performed in accordance with Procedure LP-039, "Over Pressure Protection System." The portion of the circuit between the bi-stable output and the portion tested by Procedure OST-703 was not included.

2) The implementation of TS Table 4.1-1, Item 8, to perform monthly functional testing of Reactor Protection System (RPS) 4KV undervoltage relay (EIIS Code: JC) was not adequate. Monthly functional testing of RPS logic was being conducted in accordance with Procedure MST-020, "Reactor Protection Logic Train 'A' At Power (Monthly)," and Procedure MST-021, "Reactor Protection Logic Train 'B' Logic At Power (Monthly)," respectively. These tests included the inputs to the RPS Logic circuits; however, they did not include the 4KV undervoltage trip. Calibration of the 4KV undervoltage relays was being conducted at a refueling interval in accordance with Procedure PIC-805, "Westinghouse Type CV-7 Undervoltage Relays."

The self initiated action to thoroughly evaluate the quality of the surveillance testing program relative to TS Table 4.1-1 was completed in June, 1992, and resulted in the identification of eighteen (18) items for which corrective actions may potentially need to be taken. An assessment conducted at that time, as well as a more recent assessment by the Plant Nuclear Safety Committee (PNSC), concluded that these findings did not indicate generic weaknesses in the surveillance testing program. Of these eighteen (18) items, the above two items were determined to be reportable on February 4, 1994.

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

II. CAUSE OF EVENT

The cause of these specific events is procedural deficiencies in that the surveillance tests in question did not address all of the pertinent features of the equipment being tested.

1) The development of the testing process for TS Table 4.1-1, Item 31, did not encompass that portion of the circuit between the bi-stable output (i.e, PC-502/PC-503) and the Test Switch (i.e, TC-456/TC-455C). The design of the originally installed tested hardware contributed to the presumption that the portion of the circuit in question was not required to be tested.

2) Because the TS Surveillance Requirements are not explicit, the interpretation of the information contained in the "Remarks" section of the TS Table 4.1-1, Item 8, had been that only the logic portion of the circuit was required to be tested on a monthly basis. Upon further review, we have determined that the interpretation was incorrect.

Our preliminary assessment is that these reportable conditions are individual oversights or misinterpretations and support the recent conclusion by the PNSC that the assessment findings do not indicate generic weaknesses in the surveillance testing program. Our final determination of the causes of these reportable conditions and any resultant changes to our conclusion regarding the adequacy of the surveillance testing program will be included in a supplement to this LER.

Although the planning for the conduct of the 1992 internal assessment was detailed, planned, and scheduled, the failure to promptly disposition the findings is the result of the lack of management oversight for the overall project. Specifically, plans and schedules were not established to provide for dispositioning the assessment results, the corrective action process was not implemented, and methods to resolve the differing opinions of the validity of the assessment results were not established.

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

II. CAUSE OF EVENT (CONTINUED)

As the internal assessment progressed through the end of 1991 and into 1992, the initial approach for dispositioning of significant findings was to utilize the plant's Corrective Action Program through the initiation of Adverse Condition Reports (ACRs). This process requires documented operability and reportability evaluations. However, instances occurred where plant technical experts took exception to certain findings from the assessment. These instances were primarily the result of differing understandings regarding the intent of Robinson's custom TS, or an understanding by plant personnel that certain testing requirements were being met without a sufficient level of programmatic documentation to validate these understandings. The lack of consensus regarding certain assessment findings resulted in the following adverse consequences.

1) Adverse Condition Reports (ACRs) were not consistently generated as findings were identified. Absent the use of the formal Corrective Action Program, no alternate methods were developed or employed to document operability or reportability reviews by plant personnel. Therefore, many of the assessment findings were informally reviewed outside of the plant's Corrective Action Program with no documentation regarding the conclusions of these reviews.

2) The inability to establish an agreement regarding the technical adequacy of assessment findings precluded a determination regarding reportability. As evidenced by this LER, the applicable reporting criteria would have been 10 CFR 50.73(a)(2)(i)(B). However, a determination of reportability under this criteria is dependent upon a technical determination regarding the adequacy of surveillance testing practices to satisfy TS requirements. The lack of agreement regarding the technical adequacy of assessment findings precluded a determination regarding reportability.

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

III. ANALYSIS OF EVENT

This event had no actual impact on plant safety. Procedure MST-007, "Reactor Coolant Low Temperature Over Pressure Protection System Test," was revised to include the untested portion of the circuit. When this test was performed on January 23, 1994, continuity was verified. Special Procedure 1294, "Testing of 4KV Undervoltage Trip Only for the Input to the Reactor Protection Circuitry," was developed and completed on January 30, 1994, with satisfactory results. Therefore, with regard to each concern, there is reasonable assurance that the affected circuitry has always been capable of providing the necessary trip signal.

The above two events are the result of a self initiated action to thoroughly evaluate the quality of the surveillance testing program relative to TS Table 4.1-1. This review was completed in June, 1992, and resulted in eighteen (18) potential action items; however, the determination of reportability made on February 4, 1994, was not completed in a timely manner.

Accordingly, the next section discusses additional evaluations that are being performed.

This report is submitted pursuant to 10 CFR 50.73(a)(2)(i)(B) as an operation prohibited by the TS due to failure to adequately implement TS surveillance requirements and not taking the associated TS actions within the required time intervals.

IV. CORRECTIVE ACTIONS

1) Procedure MST-007, "Reactor Coolant Low Temperature Over Pressure Protection System Test," was revised to include the untested portion of the circuit. This test was conducted on January 23, 1994, and continuity was verified.

2) Special Procedure 1294, "Testing of 4KV Undervoltage Trip Only for the Input to the Reactor Protection Circuitry," was written and approved on January 28, 1994. It was completed on January 30, 1994, with satisfactory results. Until such time as the Special Procedure can be incorporated into the appropriate Maintenance Surveillance Test process, it will continue to be performed on a monthly basis.

With respect to the cause of the untimely dispositioning of the results, the following changes have already occurred or are planned:

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IV. CORRECTIVE ACTIONS (Continued)

1) A new emphasis has been placed on the requirement to properly identify and correct adverse conditions.

2) Additional management monitoring of the status of evaluations and corrective actions has also started.

3) The quality of evaluations will be verified by additional oversight of performance of independent reviews targeted to begin in May, 1994.

The final causes and associated corrective actions for the reportable conditions, and any resultant changes to the PNSC conclusion that there are no generic weaknesses in the surveillance test program, will be provided in a supplement to this LER.

As a result of our review of the previous similar LERs identified below, we conclude that the causes and corrective actions stated in this LER are accurate and the PNSC decision remains unchanged. The basis for this conclusion is that the corrective actions taken for previous LERs were focused on resolving the individual cases; however, as a result of LER 90-005, an independent assessment was found to be warranted and was in fact conducted. This assessment resulted in the additional two examples of deficiencies in implementing Technical Specification surveillance requirements reported in this LER.

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

V. ADDITIONAL INFORMATION

A. Previous Similar Events

LER 84-005	High Steam Line Flow Coincident with Low Steam line Pressure or Low T_{avg}
LER 86-008	AFW Initiation on Station Blackout
LER 88-011	Automatic Trip Due to Turbine Trip From Turbine Overspeed Protection
LER 90-005	Failure to Test RPS Logic Channels
LER 91-012	Entry into Tech Spec 3.0 Due to Inadequate Undervoltage Surveillance procedure
LER 92-002	Method of Testing of the 4KV Main FW Breakers

A review of the above events will be included in the determination of the causes and corrective actions for the conditions reported in this LER, including an evaluation of the corrective actions taken for the above events and the reason these actions did not prevent recurrence. The results of this review will be included in the supplement to this LER.