CATEGORY

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FACIL:50-261 H.B. Robinson Plant, Unit 2, Carolina Power & Light C 05000261
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MOYER,J.W. Carolina Power & Light Co.
RECIP.NAME RECIPIENT AFFILIATION

SUBJECT: LER 97-010-00:on 970820,discovered EDG was inoperable due to mispositioned output breaker control switch.Restored switch to correct position.W/970915 ltr.

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10 CFR 50.73

CP&L

Carolina Power & Light Company
Robinson Nuclear Plant
3581 West Entrance Road
Hartsville SC 29550

Robinson File No: 13510C
Serial: RNP-RA/97-0196

SEP 15 1997

United States Nuclear Regulatory Commission
Attn: Document Control Desk
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H. B. ROBINSON STEAM ELECTRIC PLANT, UNIT NO. 2
DOCKET NO. 50-261/LICENSE NO. DPR-23
LICENSEE EVENT REPORT NO. 97-10-00

Gentlemen:

The attached Licensee Event Report is submitted in accordance with 10 CFR 50.73. Should you have any questions regarding this matter, please contact Mr. H. K. Chernoff at (803) 857-1437.

Very truly yours,

J. W. Moyer
Plant General Manager

IE22

Attachment
c: Mr. L. A. Reyes, Regional Administrator, USNRC, Region II
Ms. B. L. Mozafari, USNRC Project Manager, HBRSEP
Mr. B. B. Desai, USNRC Senior Resident Inspector, HBRSEP

190054

NRC FORM 366 (4-95) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB NO. 3150-0104
EXPIRES 04/30/98

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS MANDATORY INFORMATION COLLECTION REQUEST: 50.0 HRS. REPORTED LESSONS LEARNED ARE INCORPORATED INTO THE LICENSING PROCESS AND FED BACK TO INDUSTRY. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (T-6 F33), 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 9

TITLE (4)
EMERGENCY DIESEL GENERATOR INOPERABILITY DUE TO MISPOSITIONED OUTPUT BREAKER CONTROL SWITCH

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
08	20	97	97	010	00	09	15	97		
									FACILITY NAME	DOCKET NUMBER

OPERATING MODE (9)	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)					
N	20.2201(b)	20.2203(a)(2)(v)	X	50.73(a)(2)(i)		50.73(a)(2)(viii)
POWER LEVEL (10)	20.2203(a)(1)	20.2203(a)(3)(i)	X	50.73(a)(2)(ii)		50.73(a)(2)(x)
100	20.2203(a)(2)(i)	20.2203(a)(3)(ii)		50.73(a)(2)(iii)		73.71
	20.2203(a)(2)(ii)	20.2203(a)(4)		50.73(a)(2)(iv)		OTHER
	20.2203(a)(2)(iii)	50.36(c)(1)		50.73(a)(2)(v)		Specify in Abstract below or in NRC Form
	20.2203(a)(2)(iv)	50.36(c)(2)		50.73(a)(2)(vii)		

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER (Include Area Code)
H. K. Chernoff, Supervisor, Licensing-Regulatory Programs	(803) 857-1437

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)

On August 20, 1997, at approximately 1544 hours, plant operations personnel determined that the output breaker control switch for the "B" Emergency Diesel Generator (EDG-B) was in the tripped position. In the tripped position, the breaker would not be able to supply power to the associated emergency bus. The switch was immediately returned to the neutral position. During the time the EDG-B was considered inoperable, certain equipment in its redundant train did not meet the TS definition of OPERABILITY, a condition prohibited by TS. Operations personnel applied Technical Specifications (TS) Section 3.0 to this condition, which requires the plant to be placed in hot shutdown within eight hours and in cold shutdown within the next 30 hours. This condition also represents a condition that was outside the design basis of the plant. The NRC Operations Center was notified of this condition on August 20, 1997, at 1634 hours. Investigation of this event could not determine the specific cause of the switch mispositioning. A check of other selected switches in the plant was performed to verify they were in the correct position and to detect other evidence of tampering. A review of other switches outside the control room that could disable safety significant equipment without giving indication or annunciation in the control room will be completed, and a method will be provided for protecting and periodically checking the positions of these switches. Training will be provided to plant personnel on the switches outside the control room that could disable safety significant equipment without giving indication or annunciation in the control room.

This report is submitted in accordance with 10 CFR 50.73(a)(2)(ii)(B) as a condition that was outside the design basis of the plant, and 10 CFR 50.73(a)(2)(i)(B) as a condition prohibited by the plant's TS.

I. DESCRIPTION OF EVENT

On August 20, 1997, at approximately 1115 hours, plant operations personnel were notified by the NRC Resident Inspector that the output breaker (EIIS Component function: BKR) control switch (EIIS Component function: 33) for the "B" Emergency Diesel Generator (EDG-B) (EIIS System Code: EK) was potentially in the tripped position. In the tripped position, the breaker would not be able to supply power to the associated emergency bus (i.e., E-2) (EIIS Component function: BU). The output breaker control switch is a three-position, spring-return to neutral, "T-handle" switch with a "pull-to-lock" feature for the TRIP position. The "pull-to-lock" feature allows the switch to be used during EDG maintenance as a method to ensure the breaker will not be able to supply power to emergency bus E2 by maintaining the control circuit trip contacts closed. In addition to the TRIP position, the switch also has a CLOSE and neutral (i.e., normal) position. During normal operation of the switch, the switch is turned to the CLOSE position to close the EDG output breaker and the TRIP position to open the breaker. In either case, the switch is released following operation and allowed to return to the center or neutral position, where it remains.

On August 20, 1997, the switch position was evaluated by Operations and Engineering personnel, as well as plant management, and at 1544 hours the switch was confirmed to be in the tripped position. The switch was immediately returned to the neutral position. Operations personnel applied Technical Specifications (TS) Section 3.0, which requires the plant to be placed in hot shutdown within eight hours and in cold shutdown within the next 30 hours, for the period of time from 1115 hours to 1544 hours on August 20, 1997.

At the time this condition was discovered evidence existed that the EDG-B may have been inoperable since its last scheduled surveillance test on July 28, 1997. Technical Specifications (TS) Section 3.7.2 provides an Allowed Outage Time (AOT) of seven days for one EDG. Accordingly, plant personnel notified the NRC Operations Center on August 20, 1997, at 1634 hours Eastern Daylight Time via the Federal Telephone System (FTS), that the potential existed for the EDG-B to have been inoperable for a period of approximately three weeks. Since the EDG-B may have been inoperable for a significant period of time beyond its AOT, a condition outside the design basis of the plant, and a condition prohibited by the plant's Technical Specifications (TS), would have existed. H. B. Robinson Steam Electric Plant (HBRSEP), Unit No. 2 was operating at 100 percent power at the time this condition was discovered.

Investigation of this event concluded that the following equipment in the "A" train did not meet the TS definition of OPERABILITY during the time the "B" EDG was inoperable: The "A" train of the Engineered Safeguards System (ESF) (EIIS System Code: JM) for the Containment Automatic Isolation Trip Valves (EIIS Component: ISV); the A-1 Battery Charger (EIIS System Code: EI; Component: BYC); the Steam Driven Auxiliary Feedwater (SDAFW) Pump (EIIS System Code: BA; Component: P) Flow Control Valve (FCV)-6416 (EIIS Component: FCV); the "A" train of the Heating, Ventilation, and Air Handling system (EIIS Component Code: AHU) that supports the Safety Injection (SI) (EIIS System Code: BQ; Component: P) and Containment Spray (CS) (EIIS System Code: BE) pumps.

II. CAUSE OF EVENT

Investigation of this event could not determine the specific cause of the EDG-B output breaker control switch mispositioning. Following discovery of the switch mispositioning and restoration of the switch to its correct position, plant management formed an Event Review Team to investigate the cause of this condition, along with any generic implications, and to identify appropriate corrective actions. The team inspected the switch while the control circuit was deenergized on August 24, 1997, and found no signs of malfunction that would have contributed to mispositioning; however, the switch handle or shaft was noted to have some movement in the TRIP, "pull-to-lock," and the neutral positions. When the switch was allowed to spring return to the neutral position, it did not always return exactly to the vertical position, but a few degrees from vertical.

Three scenarios were proposed that could have resulted in the switch mispositioning:

1) The switch was inadvertently left in the TRIP position during the last known operation;
2) The switch was deliberately placed in the incorrect position; and
3) The switch was inadvertently manipulated.

The conclusions reached for each of these scenarios are discussed below.

Switch Left in the TRIP Position

The EDG output breaker control switch was last operated on July 28, 1997, during scheduled surveillance testing on the EDG-B. This was a routine test using procedure Operations Surveillance Test (OST)-401-2, "EDG "B" Slow Speed Start." A pre-job briefing was conducted prior to the test, with personnel involved in the testing present. Procedure OST-401-2 was performed by a trainee under the direction of an Auxiliary Operator (AO). A licensed Senior Reactor Operator (SRO) also observed the actions of the trainee.

The investigation found that, with the exception of delays due to Emergency Response Facility Information System (ERFIS) voltage indications, there were no significant problems with the EDG testing. After the EDG run was completed, the EDG load was reduced in accordance with the test procedure, and the output breaker was opened by taking the output breaker control switch to the TRIP position. This was performed by the trainee, with both the AO and the SRO observing. The AO and the SRO stated that the trainee had his hand on the correct switch, operated it at the correct time, and that the breaker opened as expected. However, they did not specifically look at the control switch following operation. The trainee stated that he knew the switch was "pull-to-lock" and spring-return to neutral prior to operating the switch, and that he would have known if the switch had not returned to the neutral position. After the output breaker was opened, the remainder of procedure OST-401-2 was satisfactorily completed by the trainee, with the AO and SRO observing.

II. CAUSE OF EVENT (Continued)

Statements from other operators who stood watch during the 23 day time period between the performance of procedure OST-401-2 on July 28, 1997, and the discovery of the switch being in the trip position on August 20, 1997, indicate that the switch was not likely left in the incorrect position following testing. An AO standing watch on July 29, 1997, stated that he looked at the panel twice during his tour of the room and that, based on his knowledge of the normal switch position, he would have noticed an out of position switch. This is further substantiated by the day shift Superintendent - Shift Operations (SSO) during the period of August 16-18, 1997, who specifically examined this switch during a plant tour and determined that it was in the correct position.

Figure 1 illustrates the switch in the normal, and the as-found position on August 16, 1997. Detail "A" illustrates the switch position as found on August 20, 1997, and detail "B" illustrates the position as found on August 16, 1997. Based on a comparison of the switch position as described by the SSO and the position as found on August 20, 1997, along with observation of actual switch operation, the investigation concluded that the switch position when observed by the SSO between August 16-18, was not the same as that observed by the NRC Resident Inspector on August 20, 1997. Additionally, two individuals who stood watch subsequent to the SSO's observation (i.e., during day shift on August 18, and night shift on August 19, 1997) also stated that they were certain that the switch was in the normal position.

Based on these observations, the investigation concluded that the switch was not left in the incorrect position following the performance of OST-401-2 on July 28, 1997, but rather became mispositioned in the days immediately preceding discovery on August 20, 1997. The direct examination of the switch by the SSO during the period of August 16 through 18, 1997, demonstrates that the earliest the switch could have been mispositioned was sometime after August 16, 1997.

Deliberate Placement of the Switch in the Incorrect Position

The investigation included an evaluation of the potential for the EDG-B output breaker control switch to have been intentionally placed in the incorrect position, and concluded that, while possible, this was unlikely. Following discovery of this switch mispositioning, other switches in the plant that could potentially disable safety-related equipment without giving indication in the control room were checked, and none were found out of their required positions. Also, normal operation of the switch when opening the EDG output breaker may cause an alarm in the Control Room. Since the switch was only partially pulled out (i.e., it was not fully in the "pull-to-lock" position), it is unlikely that the switch would have been in this position if someone had intended to place it in the "pull-to-lock" position.

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

II. CAUSE OF EVENT (Continued)

Although there have been equipment mispositionings over the last 24 months for which a cause was not found, only two of these occurred within the last 12 months. There is no recent trend of "unknown" equipment mispositioning. The expectation that Operations personnel control operation of plant equipment has been clearly communicated and is reinforced annually through Plant Access Training.

Based on the above facts, the investigation concluded that, while possible, it is unlikely that the switch was intentionally placed in the incorrect position.

Inadvertent Operation of the Switch

The investigation considered that the EDG output breaker control switch could have been "bumped" out of position as a result of:

1) work being performed in the EDG-B room;
2) removal/restoration of a ladder or other equipment from the EDG-B room to support other work; or
3) an individual coming in contact with the panel.

To further evaluate these possibilities, the investigation included a review of the weekly schedule, the emergent work list, health physics records, etc. to determine what work, if any, was performed in the EDG-B room from 1600 hours on August 16, through 1115 hours on August 20, 1997. The investigation also included a review of these items to identify the potential for personnel performing work elsewhere to have removed a ladder or other equipment from the EDG-B room to support their work. Personnel who were in areas near the EDG-B room between August 16-20, 1997, were interviewed. The investigation concluded that no specific activities took place that may have resulted in the EDG output breaker control switch being inadvertently placed in the TRIP position.

Given the small likelihood of the other scenarios under which this switch could have been mispositioned, the investigation concluded the most probable cause was inadvertent operation, sometime on or after 1612 hours on August 16, 1997.

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

III. ANALYSIS OF EVENT

This event is significant in that, with the switch in the TRIP position, the EDG-B output breaker would not stay closed if required to do so to energize emergency bus E-2. Therefore, this rendered the EDG-B inoperable for a potentially extended time period. Based on the results of the investigation, the maximum time the EDG-B could have been inoperable was from approximately 1612 hours on August 16, 1997, to 1544 hours on August 20, 1997. In the TS Section 1.3 definition of "OPERABLE/OPERABILITY," when a system, subsystem, train, component or device is determined to be inoperable solely because its emergency power source is inoperable, or solely because its normal power source is inoperable, it may be considered OPERABLE for the purpose of satisfying the requirements of its Limiting Condition for Operation, provided (1) its corresponding normal or emergency power source is OPERABLE; and (2) all of its redundant system(s), subsystem(s), train(s), component(s) and device(s) are OPERABLE, or likewise satisfy the requirements of the TS. However, during the time the EDG-B was considered inoperable, although the normal power source to the "B" train was OPERABLE, the following equipment in the "A" train did not meet the TS definition of OPERABILITY during the time period specified.

On August 17, 1997, at 1951 hours, the "A" train of the Engineered Safeguards System (ESF) for the Containment Automatic Isolation Trip Valves was taken out of service for scheduled testing. TS Section 3.6.3.a states, with one or more automatic containment isolation trip valves inoperable, restore the inoperable valve(s) to operable status within four hours. The testing was satisfactorily completed, and system was returned to service at 2117 hours. Since the emergency power source for the "B" train was inoperable, both trains of Containment Automatic isolation Trip Valves were inoperable for approximately 2 hours and forty-six minutes.

On August 18, 1997, at 0928 hours, the A-1 Battery Charger was removed from service, and the A Battery Charger was placed in service at 0934 hours. TS Section 3.7.2.g allows one battery charger to be inoperable provided the batteries' backup charger is placed in service within 2 hours. During the time the EDG-B was inoperable, the train "A" battery charger was not lined up to the battery for approximately 6 minutes. Therefore, since the emergency power source for the "B" train was inoperable, both trains of batteries were inoperable for approximately six minutes.

On August 20, 1997, at 0344 hours, the Steam Driven Auxiliary Feedwater (SDAFW) Pump Flow Control Valve (FCV)-6416 was switched from the automatic operating mode to the manual operating mode to support scheduled surveillance testing. In this condition, the SDAFW pump cannot satisfy the TS definition of OPERABILITY. TS Section 3.4.1 requires three auxiliary feedwater pumps to be OPERABLE, and provides an Allowed Outage Time of 72 hours, or a Special Report be submitted within 30 days and a seven day Limiting Condition for Operation, for inoperability of one auxiliary feedwater pump and/or essential features. At this time, the normal power supply for the "B" Motor Driven Auxiliary Feedwater Pump was OPERABLE, but the emergency power supply was inoperable. However, the "A" Motor Driven Auxiliary Feedwater Pump was OPERABLE the basis of TS Section 3.4 states that one motor driven auxiliary feedwater pump can supply sufficient feedwater for removal of decay heat from the plant. Therefore, this condition had no contributing safety significance on inoperability of the EDG-B.

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

III. ANALYSIS OF EVENT (Continued)

On August 20, 1997, at 0523 hours, the "A" train of the Heating, Ventilation, and Air Handling system that supports the Safety Injection (SI) and Containment Spray (CS) pumps (i.e., HVH-6A) was placed under clearance for scheduled maintenance. Analysis results have shown that one HVH unit can perform the required cooling function for the SI and CS pumps. HVH-6A was returned to service at 1839 hours on August 20, 1997. Since the emergency power source for the "B" train was inoperable, both trains of HVH units were inoperable during the time HVH-6A was out of service, rendering both trains of SI and CS inoperable during this time period.

Collectively, these conditions represent a condition that was outside the design basis of the plant. In addition, during the time the EDG-B was considered inoperable, although the normal power source to the "B" train was operable, certain equipment in its redundant (i.e., the "A" train components discussed above) did not meet the TS definition of OPERABILITY during the time period specified. Accordingly, this event also constitutes a condition prohibited by TS.

The safety significance of this event is considered minimal. An analysis of the impact of the EDG-B inoperability on instantaneous risk was performed by Probabilistic Safety Analysis (PSA) personnel. The results of this analysis showed that the instantaneous risk of core damage did not exceed 1E-3.

This report is submitted in accordance with 10 CFR 50.73(a)(2)(ii)(B) as a condition that was outside the design basis of the plant, and 10 CFR 50.73(a)(2)(i)(B) as a condition prohibited by the plant's TS.

IV. CORRECTIVE ACTIONS

Following discovery and restoration of the switch to its correct position, plant management formed an Event Review Team to investigate the cause of the switch mispositioning, along with any generic implications, and to identify appropriate corrective actions.

On August 20, 1997, the switch was examined and returned to the normal (i.e., neutral) position. The NRC Operations Center was notified via the Federal Telephone System (FTS) that the potential existed for this condition to be outside the design basis of the plant.

A check of other selected switches in the plant was performed to verify they were in the correct position and to detect other evidence of tampering.

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

IV. CORRECTIVE ACTIONS (Continued)

By November 30, 1997, a protective cover will be designed and installed over the exposed controls of the Generator Control Panels for EDG-A and EDG-B.

By November 30, 1997, a review of other switches outside the control room that could disable safety significant equipment without giving indication/annunciation in the control room will be completed, and a method will be provided for periodically checking the positions of these switches.

By November 30, 1997, EDG Operating and Test Procedures will be revised, as appropriate, to ensure that controls manipulated during the procedure are verified to be in the correct position following operation or maintenance.

By November 30,1997, the results of this evaluation will be shared with site personnel. The focus of this communication will be on reinforcing the expectation to contact Operations personnel in the event of inadvertently contacting plant equipment, regardless of whether or not any components were visibly mispositioned.

By January 30, 1998, the need for protective covers for other switches or panels outside the control room that could disable safety significant equipment without giving indication/annunciation in the control room will be evaluated, and protective covers will be installed accordingly.

In addition to the above, by February 28, 1998, training will be provided to Operations, Maintenance, and Engineering personnel on the switches outside the control room that could disable safety significant equipment without giving indication or annunciation in the control room.

V. ADDITIONAL INFORMATION

A. Failed Component Information

None

B. Previous Similar Events

LER 93-019

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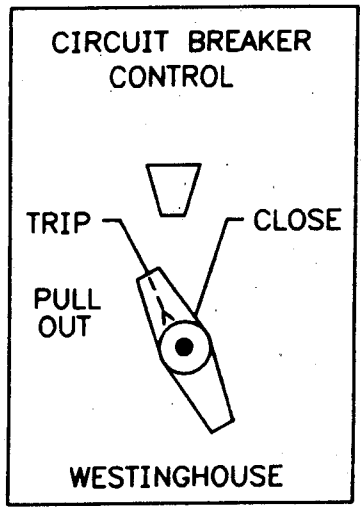
TEXT *(If more space is required, use additional copies of NRC Form 366A)* **(17)**

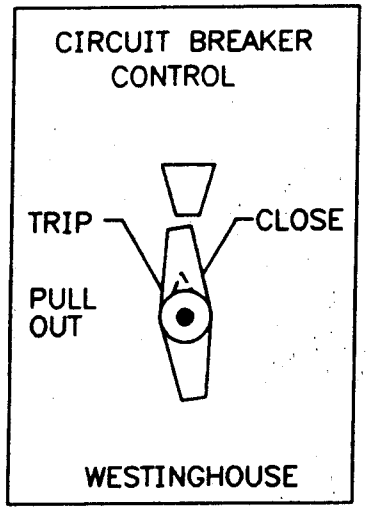
Figure 1

DETAIL A



POSITION AS FOUND
ON AUGUST 20th.

DETAIL B



POSITION AS FOUND
ON AUGUST 16th.

HANDLE SIZE IS SHOWN AT 50% OF ACTUAL SIZE TO ILLUSTRATE HANDLE POSITION.