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AUTH. NAME AUTHOR AFFILIATION
STARKEY, R.B. CAROLINA POWER & LIGHT
RECIP. NAME RECIPIENT AFFILIATION

DOCKET #
05000261

SUBJECT: LER#78-027/03L-0 on 781109:w/reactor at full pwr, instr air
supplies to RHR flow controls valves RHR-605 & RHE-758 were
not to be isolated as req, due to deficiency in procedure
OP-38-C & misunderstanding by operator signing off procedure

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0 1 7 8 REPORT SOURCE 60 61 L 6 0 5 0 0 0 2 6 1 68 69 7 1 1 0 9 7 8 74 8 1 2 1 1 7 8 80
 DOCKET NUMBER EVENT DATE REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 | At 1940 hours on November 9, 1978, with the reactor at full power, the instrument air
0 3 | supplies to RHR flow control valves RHR-605 and RHR-758 were found not to be isolated
0 4 | as required by Technical Specification 3.3.1.1.i. Immediately upon determination that
0 5 | the air supplies were not isolated both valves were checked closed and air supplies
0 6 | were isolated. No consequences resulted from this event. Had there been an SI signal
0 7 | while the air supplies were activated, the safeguards panel would indicate valve
0 8 | status. This event constitutes a reportable occurrence pursuant to Tech. Spec. 6.9.2.b.

09		SYSTEM CODE S F		11	CAUSE CODE D		12	CAUSE SUBCODE Z Z Z Z Z					14	COMP. SUBCODE Z		15	VALVE SUBCODE Z		16			
7	8	9	10		11		12		13			18		19			20					
17		LER/RO REPORT NUMBER		EVENT YEAR 7 8		21	22	SEQUENTIAL REPORT NO. 0 2 7		24	26	OCCURRENCE CODE 0 3		28	29	REPORT TYPE L		30	31	REVISION NO. 0		32
ACTION TAKEN		FUTURE ACTION		EFFECT ON PLANT		SHUTDOWN METHOD		HOURS		22	ATTACHMENT SUBMITTED		23	NPRD-4 FORM SUB.		24	PRIME COMP. SUPPLIER		25	COMPONENT MANUFACTURER		26
X	18	G	19	Z	20	Z	21	0	0	0	0	Y	23	N	24	Z	25	Z	9	9	9	9
33		34		35		36		37		40		41		42		43		44		47		

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The event was caused by the failure of the air supply to RHR-605 and RHR-758 to be
1 1 isolated during heatup after the most recent outage on 9/29/78. This was due to an
1 2 apparent deficiency in operating procedure OP-38-C and a misunderstanding on the part
1 3 of the operator signing off the overall plant operating procedure GP-1A. When found
1 4 open on 11/9/78, valve RHR-605 was immediately closed. Both RHR valves (cont.)

FACILITY STATUS				% POWER			OTHER STATUS		METHOD OF DISCOVERY		DISCOVERY DESCRIPTION			
1	5	E	(28)	1	0	0	(29)	NA	B	(31)	Operator Observation			

ACTIVITY CONTENT-
RELEASED OF RELEASE AMOUNT OF ACTIVITY (35)

1 6 9 33 10 34 NA

7 8 9 10 11 44

LOCATION OF RELEASE (36)

NA 45 80

PERSONNEL EXPOSURES									
NUMBER			TYPE	DESCRIPTION					
1	7	0	0	0	(37) Z	(38) NA	(39)		

PERSONNEL INJURIES		DESCRIPTION	
NUMBER			
1	8	000	NA

LOSS OF OR DAMAGE TO FACILITY (43)
TYPE DESCRIPTION
1 9 Z (42) NA

PUBLICITY
 ISSUED DESCRIPTION (45) 7812140165 NRC USE ONLY
 2 0 N (44) NA

NAME OF PREPARER R. B. Starkey, Jr.

PHONE: (803) 332-1351

SUPPLEMENTARY INFORMATION FOR REPORTABLE OCCURRENCE 78-27

1. Cause Description and Analysis:

At 1940 hours on November 9, 1978, with the reactor at full power, the control operator noticed the controller for RHR flow control valve RHR-605 was indicating approximately 20% open. The operator moved the controller to the fully closed position at which time the safeguards position status light for the valve changed from blue to pink, indicating the valve had not been fully closed. Immediate investigations revealed that the instrument air supplies to RHR-605 and RHR-758 were not isolated as is required by Technical Specification 3.3.1.1.1. Both valves were then checked closed and the instrument air supply valves to these valves were closed, thus meeting Technical Specification requirements.

Investigation revealed that instrument air to RHR-605 and RHR-758 had not been isolated as required by Technical Specifications and overall plant operating procedure GP-1A during heatup on September 28, 1978. Further investigation revealed the following apparent sequence of events which led to this event. During reactor heat-up, the auxiliary operator completed the RHR system valve lineup, OP-38-C. The control operator assumed that OP-38-C, which required RHR-758 and RHR-605 to be closed, included the isolation of instrument air to these valves and signed off those steps on GP-1A. OP-38-C, however, did not include isolation of the air supply to these valves and as such the valves were not deactivated as per Technical Specification requirements. At some time prior to the identification of this event, the valve controller apparently had drifted from the fully closed condition to approximately 20%. It was the controller indication that alerted the operator to the condition.

It was determined that although the operator made a false assumption in signing off the valves in the general procedure, the misunderstanding was due to a deficiency in the operating procedure OP-38-C. This procedure provides the valve lineup for the RHR system for normal stand-by low-head safety injection and as such should have had the complete valve lineup, including isolating the instrument air to valves RHR-758 and RHR-605. Based on this review, the cause of this event is attributed to an inadequate procedure.

Had there been an SI signal while the air supplies were activated, the safeguards panel would indicate the valve status.

2. Corrective Action:

The valves were closed and the instrument air supply valves to each operator were closed.

3. Corrective Action to Prevent Further Occurrences:

The operating procedures involved will be revised to include the valve lineups the requirement to isolate the air supply to valves RHR-605 and RHR-758. This coupled with the requirements and check offs presently in the procedures should prevent any recurrence.

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (CONT.)

605 and 758 were then checked closed, and the instrument air supplies to the valves were isolated. To prevent future occurrences, OP-38-C is being revised to require isolation of the instrument air supply to RHR-605 and RHR-758. This will be consistent with Technical Specifications and overall operating procedure GP-1A and will reduce the potential for any future misunderstandings which might result in such an event.