REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

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FACIL:50-261 H. B. Robinson Plant, Unit 2, Carolina Power and Ligh 05000261
AUTH.NAME AUTHOR AFFILIATION
STARKEY,R.B. Carolina Power & Light Co.
RECIP.NAME RECIPIENT AFFILIATION
Region 2, Atlanta, Office of the Director

SUBJECT: LER 80-029/01T-0:on 801212,leak calculated to be between 8 to 16 gpm developed in RHR pump suction isolation valve RHR-750.Caused by normal wear.Leak stopped & repair made.

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TITLE: Incident Reports

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	REACT SYS BR 40	1	1	REG FILE 01	1	1
	REL & RISK A 41	1	1	SFTY PROG EVA42	1	1
	STRUCT ENG BR44	1	1	SYS INTERAC B45	1	1
EXTERNAL:	ACRS 46	16	16	LPDR 03	1	1
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NRC FORM 366 (7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

CONTROL BLOCK: (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

Line	Field	Value
01	LICENSEE CODE (2)	S C H B R 2
01	LICENSE NUMBER (3)	0 0 - 0 0 0 0 0 - 0 0
01	LICENSE TYPE (4)	4 1 1 1 1
01	CAT (5)	
CON'T 01	REPORT SOURCE (6)	L
01	DOCKET NUMBER (7)	0 5 0 0 0 2 6 1
01	EVENT DATE (8)	1 2 1 2 8 0
01	REPORT DATE (9)	1 2 2 4 8 0

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 At approximately 2002 hours on December 12, 1980, with the unit at 86% power, a leak
03 which was calculated to be between 8 gpm and 16 gpm developed in the RHR pump suction
04 isolation valve RHR-750. A unit shutdown was immediately commenced and the unit
05 reached hot shutdown at 2100. The leakage was handled by normal plant systems and no
06 off-site release occurred. This size leak is contrary to Technical Specification
07 3.1.5.2 which is reportable pursuant to 6.9.2.a.3.
08

09	Field	Value
	SYSTEM CODE (11)	C F
	CAUSE CODE (12)	E
	CAUSE SUBCODE (13)	B
	COMPONENT CODE (14)	V A L V E X
	COMP. SUBCODE (15)	E
	VALVE SUBCODE (16)	D

(17) LER RO REPORT NUMBER	Value
EVENT YEAR	8 0
(23)	—
SEQUENTIAL REPORT NO.	0 2 9
(27)	/
OCCURRENCE CODE	0 1
REPORT TYPE	T
(31)	—
REVISION NO.	0

Field	Value
ACTION TAKEN (18)	A
FUTURE ACTION (19)	Z
EFFECT ON PLANT (20)	A
SHUTDOWN METHOD (21)	A
HOURS (22)	0 0 4 0
ATTACHMENT SUBMITTED (23)	Y
NPRD-4 FORM SUB. (24)	Y
PRIME COMP. SUPPLIER (25)	N
COMPONENT MANUFACTURER (26)	0 6 3 5

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 During normal plant operation, packing on valve RHR-750 began to leak at approximately
11 10 gpm. The unit was immediately shutdown. Cooldown proceeded to approximately 350°F
12 and 400 psig at which point the leak was stopped and repair was made. This failure
13 was due to normal wear and no further actions are deemed necessary.
14

Line	Field	Value
15	FACILITY STATUS (28)	E
15	% POWER (29)	0 8 6
15	OTHER STATUS (30)	NA
15	METHOD OF DISCOVERY (31)	A
15	DISCOVERY DESCRIPTION (32)	Operator Observation
16	ACTIVITY RELEASED (33)	Z
16	CONTENT OF RELEASE (34)	Z
16	AMOUNT OF ACTIVITY (35)	NA
16	LOCATION OF RELEASE (36)	NA
17	PERSONNEL EXPOSURES NUMBER (37)	0 0 0
17	TYPE (38)	Z
17	DESCRIPTION (39)	NA
18	PERSONNEL INJURIES NUMBER (40)	0 0 0
18	DESCRIPTION (41)	NA
19	LOSS OF OR DAMAGE TO FACILITY TYPE (42)	Z
19	DESCRIPTION (43)	NA
20	PUBLICITY ISSUED (44)	N
20	DESCRIPTION (45)	NA

8012230415

NRC USE ONLY

NAME OF PREPARER R. B. Starkey, Jr.   PHONE: (803) 383-4524

GPO 917-926

Supplemental Information

for

Licensee Event Report 80-029

1. Cause Description and Analysis: On December 12, 1980, at 2002 hours, a Reactor Coolant System primary leak developed. The unit was operating at 86% power. The leak was calculated at between 8 gpm and 16 gpm. This leak rate exceeds Technical Specification 3.1.5.2 and so a unit shutdown was immediately started. The unit was in the hot shutdown condition at 2100.

   At approximately 2046 hours, the leak had been identified as a packing leak on valve RHR-750 which is a residual heat removal pump suction isolation valve from the Reactor Coolant System. The unit was cooled down to approximately 350°F and 400 psig at which time the leak was stopped and repair was made. The cause for the packing failure was determined to be normal wearout.

   The leakage was contained within the plant's containment vessel and was disposed of normally using the plant's radioactive waste water processing systems. No off-site release occurred.

2. Corrective Action: The leakage on valve RHR-750 was stopped by opening the valve and placing it on its backseat while the unit was at 350°F and 400 psig. The valve was repacked using Q-list packing material and placed back in service following testing per PT-42.0.

3. Corrective Action to Prevent Recurrence: The valve failure was due to normal wear on the the valve packing and so repacking of the valve is deemed sufficient to correct the problem.