

# REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR:8102030488 DOC.DATE: 81/01/28 NOTARIZED: NO DOCKET #  
 FACIL:50-261 H. B. Robinson Plant, Unit 2, Carolina Power and Light 05000261  
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 Region 2, Atlanta, Office of the Director

SUBJECT: LER 81-003/01T-0: on 810114, both channels of heat tracing for both boric acid transfer pumps determined to be inoperable. Caused by misleading procedural step to take pump out of svc. Procedure revised.

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 TITLE: Incident Reports

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	CORE PERF BR 18		1	1	DIR, DIV OF LIC	1	1
	DIR, ENGINEER120		1	1	DIR, HUM FAC S21	1	1
	DIR, SYS INTEG22		1	1	EFF TR SYS BR23	1	1
	EQUIP QUAL BR25		1	1	GEOSCIENCES 26	1	1
	I&C SYS BR 29		1	1	I&E 05	2	2
	JORDAN, E./IE		1	1	LIC GUID BR 30	1	1
	MATL ENG BR 32		1	1	MECH ENG BR 33	1	1
	MPA		3	3	NRC PDR 02	1	1
	OP EX EVAL BR34		3	3	OR ASSESS BR 35	1	1
	POWER SYS BR 36		1	1	RAD ASSESS BR39	1	1
	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
	NSIC	05	1	1	TERA:DOUG MAY	1	1

FEB 04 1981

LJ

## LICENSEE EVENT REPORT

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7 8 60 61 68 69 74 75 80

## EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 | On January 14, 1981, it was determined that both channels of heat tracing for both  
03 | boric acid transfer pumps were inoperable contrary to Technical Specification 3.2.3.b.  
04 | A reduction of reactor power was immediately commenced. The situation was corrected  
05 | approximately five minutes after its discovery and the unit was returned to full  
06 | power. No adverse consequences resulted from this condition. This constitutes a  
07 | reportable occurrence as per Technical Specification 3.2.3.a.2.

08 |  
09 |  
17 | LER/RO REPORT NUMBER | 8 | 1 |  
21 22 23 24 26 27 28 29 30 31 32  
SYSTEM CODE | P | C | 11 | CAUSE CODE | D | 12 | CAUSE SUBCODE | Z | 13 | COMPONENT CODE | C | K | T | B | R | K | 14 | COMP. SUBCODE | Z | 15 | VALVE SUBCODE | Z | 16 |  
9 10 11 12 13 18 19 20  
EVENT YEAR | 8 | 1 | SEQUENTIAL REPORT NO. | 0 | 0 | 3 | OCCURRENCE CODE | 0 | 1 | REPORT TYPE | T |  
21 22 23 24 26 27 28 29 30 31 32  
ACTION TAKEN | G | 18 | FUTURE ACTION | H | 19 | EFFECT ON PLANT | B | 20 | SHUTDOWN METHOD | Z | 21 | HOURS | 0 | 0 | 0 | 0 | ATTACHMENT SUBMITTED | Y | 23 | NPRD-4 FORM SUB. | N | 24 | PRIME COMP. SUPPLIER | N | 25 | COMPONENT MANUFACTURER | W | 1 | 2 | 0 | 26 |  
33 34 35 36 37 40 41 42 43 44 47

## CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 | The condition identified on January 14, 1981, was primarily caused by a misleading  
11 | step in the procedure used to take "A" boric acid transfer pump out of service,  
12 | which resulted in the de-energizing of heat tracing to both boric acid transfer pumps.  
13 | Contributing to the cause was the fact that the operator failed to verify that only  
14 | the desired circuit would be de-energized prior to opening the breakers. The  
15 | situation was corrected by closing the breakers for boric acid transfer pump heat  
16 | tracing and by revising the procedure to clarify the misleading step. A copy of  
17 | this report will be reviewed by the operating staff.

15 | FACILITY STATUS | E | 28 | % POWER | 1 | 0 | 0 | 29 | OTHER STATUS | NA | 30 | METHOD OF DISCOVERY | A | 31 | DISCOVERY DESCRIPTION | Technician Inspection | 32 |  
7 8 9 10 12 13 44 45 46 80  
16 | ACTIVITY CONTENT | Z | 33 | RELEASED OF RELEASE | Z | 34 | AMOUNT OF ACTIVITY | NA | 35 | LOCATION OF RELEASE | NA | 36 |  
7 8 9 10 11 44 45 80  
17 | PERSONNEL EXPOSURES | 0 | 0 | 0 | 37 | TYPE | Z | 38 | DESCRIPTION | NA | 39 |  
7 8 9 11 12 13 80  
18 | PERSONNEL INJURIES | 0 | 0 | 0 | 40 | TYPE | Z | 41 | DESCRIPTION | NA | 42 |  
7 8 9 11 12 80  
19 | LOSS OF OR DAMAGE TO FACILITY | Z | 42 | TYPE | Z | 43 | DESCRIPTION | NA | 44 |  
7 8 9 10 80  
20 | PUBLICITY | N | 44 | DESCRIPTION | NA | 45 |  
7 8 9 10 80

NRC USE ONLY

20 | ISSUED | N | 44 | DESCRIPTION | NA | 45 |  
7 8 9 10 80

8102030488

NAME OF PREPARER R. B. Starkey, Jr.

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## SUPPLEMENTAL INFORMATION

FOR

LICENSEE EVENT REPORT 81-003

1. Cause Description and Analysis: At 0935 hours on January 14, 1981, boric acid transfer pump "A" had its heat tracing circuit E-1 de-energized in accordance with OWP-CVC-6. This was done to perform maintenance on the pump as permitted by Technical Specifications. At 1130 hours, it was determined that heat tracing on both boric acid transfer pumps had been inadvertently de-energized, contrary to Technical Specification 3.2.3.b. A unit load reduction was immediately commenced. At 1135 hours, heat tracing was re-established to boric acid transfer pump "B" and the unit was returned to full power. At no time did boric acid transfer pump "B" temperature drop below 175 degrees fahrenheit. This event was primarily caused by a misleading step in the procedure used to take boric acid transfer pump "A" out of service. The procedure which was used could be interpreted to require that the heat tracing circuit for "A" boric acid transfer pump (Circuit E-1) be de-energized by opening the supply breakers. However, heat tracing circuits E-2 and E-5 are also supplied through the same breakers. Therefore, complete loss of heat tracing for both boric acid transfer pumps resulted when circuits E-1, E-2, and E-5 were de-energized. Contributing to the cause was the fact that the operator failed to verify that only the desired circuit would be de-energized prior to opening the breakers. The correct method of de-energizing individual heat tracing circuits is to remove the fuses from the individual circuit.
2. Corrective Action: Upon discovery of the deviation, the breakers to heat tracing circuits E-1, E-2, and E-5 were closed. With heat tracing restored to boric acid transfer pump "B", the deviation was eliminated and a return to full reactor power was commenced.
3. Corrective Action to Prevent Recurrence: A revision to the procedure used to take boric acid transfer pump "A" out of service was written. The new procedure specifies "fuses removed" vice the word "open" to de-energize circuit E-1. As further action, a copy of this report will be reviewed by the operating staff as a reminder of the need to fully understand the effects of each step of a procedure as it is being performed. This review should be completed by March 2, 1981.