

NRC DISTRIBUTION FOR PART 50 DOCKET MATERIAL

FILE NUMBER
INCIDENT REPORT

TO: N.C. MOSELEY

FROM: CAROLINA PWR & LIGHT CO.
RALEIGH, N.C.
H.R. BANKS

DATE OF DOCUMENT

4/15/77

DATE RECEIVED

4/20/77

☐ LETTER
☐ ORIGINAL
☒ COPY☐ NOTORIZED
☒ UNCLASSIFIED

PROP

INPUT FORM

NUMBER OF COPIES RECEIVED

1 CC

DESCRIPTION

LTR. TRANS THE FOLLOWING.....

(1P) (3P)

PLANT NAME: H.B. ROBINSON # 2
SAB

ENCLOSURE

LICENSEE EVENT REPORT FOR RO# 77-4 ON 3/17/77
CONCERNING AXIAL FLUX DIFFERENCES BEING LOGGED
AS REQUIRED PER PLANT OPERATING PROCEDURES.....

ACKNOWLEDGED

DO NOT REMOVE

NOTE: IF PERSONNEL EXPOSURE IS INVOLVED
SEND DIRECTLY TO KREGER/J. COLLINS

FOR ACTION/INFORMATION

BRANCH CHIEF:

W/3 CYS FOR ACTION

LIC. ASST.:

W/ CYS

ACRS 16 CYS HOLDING/SENT

K&D

INGRAM

CAT B

INTERNAL DISTRIBUTION

REG FILE

NRC PDR

I & E (2)

MIPC

SCHROEDER/IPPOLITO

HOUSTON

NOVAK/CHECK

GRIMES

CASE

BUTLER

HANAUER

TEDESCO/MACCARY

EISENHUT

BAER

SHAO

VOLLMER/BUNCH

KREGER/J. COLLINS

EXTERNAL DISTRIBUTION

LPDR: Hartsville, SC

TIC:

NSIC:

CONTROL NUMBER

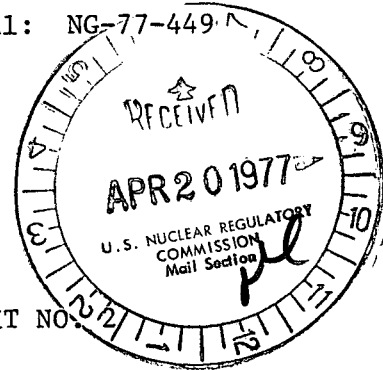
771120123

April 15, 1977

FILE: NG-3516 (R)

Serial: NG-77-449

Mr. Norman C. Moseley, Director
U. S. Nuclear Regulatory Commission
Region II, Suite 818
230 Peachtree Street, N.W.
Atlanta, Georgia 30303



H. B. ROBINSON STEAM ELECTRIC PLANT, UNIT NO.
DOCKET 50-261
LICENSE NO. DPR-23
LICENSEE EVENT REPORT 2-77-4

Regulatory

File Cy

Dear Mr. Moseley:

In accordance with Section 6.9.2.b of the Technical Specifications for the H. B. Robinson Steam Electric Plant, Unit 2, the attached Licensee Event Report is submitted. This report fulfills the requirement for a written report within thirty (30) days of a reportable occurrence and is in accordance with the format set forth in Regulatory Guide 1.16, Revision 4.

Yours very truly,

H. R. Banks
Manager
Nuclear Generation

WH:pap

Attachment

cc: Mr. W. G. McDonald
Mr. E. Volgenau

771180123

CONTROL BLOCK:

1

E

LICENSEE

LICENSE NUMBER

LICENSE

EVENT

0	1	S	C	H	B	R	2	0	0	-	0	0	0	0	-	0	0	4	1	1	1	0	0	3	
7	8	9					14	15									25	26					30	31	32

CATEGORY		REPORT TYPE	REPORT SOURCE	DOCKET NUMBER				EVENT DATE				REPORT DATE											
01	CON'T	L	L	0	5	0	-	0	2	6	1	0	3	1	7	7	7	0	4	1	5	7	7
7	8	57	58	59	60	61					68	69					74	75					80

02 On March 17, 1977, when the CAOC monitoring program was out of service, axial flux
7 8 9 80
03 differences were not logged as required per plant operating procedures. This was a
7 8 9 80
04 violation of Paragraph 3.10.2.10 of the Technical Specifications. Review of delta flux
7 8 9 80
05 chart recorders revealed no significant axial flux differences and normal control
7 8 9 80
06 operator surveillance was performed during the period in question. (R0-77-4)
7 8 9 80

SYSTEM CODE		CAUSE CODE	COMPONENT CODE					COMPONENT SUPPLIER	COMPONENT MANUFACTURER				VIOLATION			
0	7	I D	A	N	N	U	N	C	N	W	1	2	0	N		
7	8	9	10	11	12	13	14	15	16	17	43	44	45	46	47	48

08 The cause of the occurrence was operator error in following plant operating procedures
7 8 9 80
09 concerning the CAOC monitoring program out of service log. (See attached supplement)
7 8 9 80
10
7 8 9 80

FACILITY STATUS		% POWER		OTHER STATUS		METHOD OF DISCOVERY		DISCOVERY DESCRIPTION		
11	E	1	0	0	NA	A	OPERATOR SURVEILLANCE			
7	8	9	10	11	12	13	44	45	46	80

FORM OF ACTIVITY RELEASED		CONTENT OF RELEASE		AMOUNT OF ACTIVITY		LOCATION OF RELEASE	
12	Z	Z	NA		NA		
7	8	9	10	11	44	45	80

NUMBER			TYPE	DESCRIPTION
13	0	0	0	Z NA

NUMBER			DESCRIPTION
1	4	000	NA

1	5	NA
---	---	----

TYPE			DESCRIPTION
16	Z		NA

17	NA
----	----

[illegible]

19 89 80

PHONE: 803-332-1351

Supplementary Information for

Reportable Occurrence 77-4

1. Report No.: 50-261/77-4

2a. Report Date: April 12, 1977

2b. Occurrence Date: March 17, 1977

3. Facility: H. B. Robinson Unit No. 2
Hartsville, South Carolina 29550

4. Identification of Occurrence:

On March 17, 1977, during steady state operation at 100% power, the Prodac-250 process computer was taken out of service, disabling the delta flux monitoring program and associated alarms. As per plant operating procedures and Technical Specifications, axial flux differences shall be logged and conformance with limits assessed hourly. The log was not recorded and assessed which is a violation of Technical Specification, Paragraph 3.10.2.10 and constitutes a reportable occurrence in accordance with Technical Specification Paragraph 6.9.2.b.

5. Conditions Prior to Occurrence:

No unusual conditions prevailed prior to the occurrence. The plant was operating at steady state conditions and 100% power level.

6. Description of Occurrence:

On March 17, 1977, the Prodac-250 process computer was taken out of service from 1005 to 1150 and from 1306 to 1547. This disabled the delta flux monitoring program and associated alarms. The evening shift personnel discovered that axial flux differences were not logged for the intervals in question. Delta flux chart recorders were reviewed and no significant changes had occurred. Control rod positions had remained unchanged, and power level and unit load were constant. Therefore, with normal control operator surveillance of plant conditions, no parameters were exceeded during the interval.

7. Designation of Apparent Cause of Occurrence:

The cause of the occurrence was operator error in failing to follow plant operating procedures.

8. Analysis of Occurrence:

During the period of the disabled delta flux program, the plant was operating at steady state conditions with no control rod movement or load changes. Although an hourly log of axial flux differences was

8. Analysis of Occurrence (Continued)

not kept, normal control operator surveillance of plant parameters and conditions was performed, and no abnormal axial flux differences occurred. A review of delta flux chart recorders showed no significant changes during the period that a log was required, therefore, no parameters were exceeded.

9. Corrective Action:

The control operators were instructed to be more vigilant in keeping proper logs and the (CAOC monitoring) Program Out of Service logs were combined with other related out-of-service logs to prevent future violations. Corrective action was considered adequate to prevent subsequent occurrences.