

A 6/12/78

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)
DISTRIBUTION FOR INCOMING MATERIAL

50-261

REC: OREILLY J P
NRC

ORG: BANKS H R
CAROLINA PWR & LIGHT

DOCDATE: 06/06/78
DATE RCVD: 06/09/78

DOCTYPE: LETTER NOTARIZED: NO

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SUBJECT:

LTR 1 ENCL 1

FORWARDING LICENSEE EVENT REPT (RO 50-261/78-013) ON 05/11/78 CONCERNING
CONTROL OPERATOR OBSERVED NO REMOTE INDICATION ON THE RTGB FOR SVC WATER
VALVE V6-12D... PROBLEM FOUND TO BE BLOWN CONTROL PWR FUSE FOR THE VALVE MOTOR
OPERATOR... W/ATT.

PLANT NAME: H B ROBINSON - UNIT 2

REVIEWER INITIAL: XJM
DISTRIBUTOR INITIAL: DL

***** DISTRIBUTION OF THIS MATERIAL IS AS FOLLOWS *****

INCIDENT REPORTS
(DISTRIBUTION CODE A002)

FOR ACTION: BR CHIEF ORB#1 BC**W/4 ENCL

INTERNAL:

REG FILE**W/ENCL
I & E**W/2 ENCL
I & C SYSTEMS BR**W/ENCL
NOVAK/CHECK**W/ENCL
AD FOR ENG**W/ENCL
HANAUER**W/ENCL
AD FOR OPER TECH**W/ENCL
ENGINEERING BR**W/ENCL
KREGER/J. COLLINS**W/ENCL
K SEYFRIT/IE**W/ENCL

NRC PDR**W/ENCL
MIPC**W/3 ENCL
EMERGENCY PLAN BR**W/ENCL
EEB**W/ENCL
PLANT SYSTEMS BR**W/ENCL
AD FOR PLANT SYSTEMS**W/ENCL
REACTOR SAFETY BR**W/ENCL
VOLLMER/BUNCH**W/ENCL
POWER SYS BR**W/ENCL

EXTERNAL:

LPDR'S
HARTSVILLE, SC**W/ENCL
TIC**W/ENCL
NSIC**W/ENCL
ACRS CAT B**W/16 ENCL

COPIES NOT SUBMITTED PER
REGULATORY GUIDE 10.1

DISTRIBUTION: LTR 45 ENCL 45
SIZE: 1P+1P+1P

CONTROL NBR: 781600343

***** THE END *****

June 6, 1978

FILE: NG-3516 (R)

SERIAL: GD-78-1486

Mr. James P. O'Reilly, Director
U. S. Nuclear Regulatory Commission
Region II, Suite 1217
230 Peachtree Street, N.W.
Atlanta, Georgia 30303

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JUN 6 1978
SERVICES

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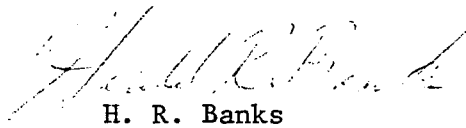
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H. B. ROBINSON STEAM ELECTRIC PLANT, UNIT NO. 2
DOCKET 50-261
LICENSE NO. DPR-23
LICENSEE EVENT REPORT 78-013

Dear Mr. O'Reilly:

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 NUREG-0161, July, 1977.

Yours very truly,



H. R. Banks
Manager
Nuclear Generation

DCS:men

Attachment

cc: Messrs. R. A. Hartfield
E. Volgenau

781600343

A002
5/1

$$(7.77)$$

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

CON'T

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

08 | _____ 80

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

7 8 9 80

7	8	9	10	12	13	44	45	46	80
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7	8	9	10	11	44	45	80
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7	8	9	11	12	13	80
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7	8	9	11	12	80
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7	8	9	10	80
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[illegible]

PHONE: (803) 332-1351

Supplemental Information For
Reportable Occurrence 78-13

1. Report No.: 50-261/78-13
- 2a. Report Date:
- 2b. Occurrence Date: May 11, 1978
3. Facility: H. B. Robinson Unit No. 2, Hartsville, South Carolina 29550
4. Identification of Occurrence: Failure of the control power fuse for the motor operator of Service Water System Valve V6-12D, thus rendering the motor inoperable, constitutes a Reportable Occurrence in accordance with Technical Specification 6.9.2.b.2.
5. Conditions Prior to Occurrence: The plant was operating at 100% of rated power.
6. Description of Occurrence: At approximately 0945 hours on May 11, 1978, the control operator observed that there was no position indication on the RTGB for Service Water Valve V6-12D. Visual inspection of the valve showed that the valve operator failed to cycle upon signal from the RTGB.
7. Designation of Apparent Cause of Occurrence: Investigation of the valve motor control showed that the control power fuse had blown. The fuse was replaced and the valve was cycled repeatedly. The circuitry for the motor operator was tested in an attempt to identify the cause of the blown fuse. No electrical anomalies were discovered, and the failure was attributed to a faulty fuse.
8. Analysis of Occurrence: Due to the redundant flow path of the Service Water System and the failed-open position of the Valve V6-12D, there was no functional degradation of the Service Water System due to the failure of the valve motor operator control power. In the event of a pipe rupture downstream of V6-12D, the valve could have been closed manually to isolate the leak. Therefore, plant safety was not jeopardized nor were any limiting conditions of operation exceeded. No personnel injuries, undue exposures, release of radioactive materials or threat to the public health and safety resulted from this event.
9. Corrective Action: Following discovery of the blown control power fuse, the fuse was replaced and the valve was cycled repeatedly to verify operability. Investigation of the valve operator circuitry revealed no apparent cause for the failure. Failure was therefore attributed to a faulty fuse. Valve V6-12D was returned to service at 1457 hours on May 11, 1978.
10. Failure Data: No failures of this type have previously occurred.