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EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

7 80

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

7 80

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SUPPLEMENTAL INFORMATION
FOR
LICENSEE EVENT REPORT 81-022

1. Cause Description and Analysis:

On October 15, 1981, at approximately 1315 hours, with the unit at 50% power, an auxiliary operator noted a lower than normal temperature (138°-150°F) indication on the strip chart recorder for the motor operated valves and associated piping on the discharge line of the boron injection tank. Investigation revealed that the secondary channel of heat tracing circuit #70 had failed and the circuit was declared inoperable at 1410 hours. The cause of failure was determined to be a broken wire splice at the circuit fuse holder which was probably the result of wire movement during the course of daily amperage readings taken using a clamp-on type ammeter.

The inoperability of this heat tracing circuit resulted in a degraded mode of operation permitted by Technical Specification 3.3.1.2.h which is reportable pursuant to 6.9.2.b.2. The redundant channel was operable so there was no threat to the public health and safety.

2. Corrective Action:

The secondary channel of heat trace circuit #70 was repaired, tested, and declared operable at 1530 hours on October 15, 1981.

3. Corrective Action to Prevent Recurrence:

As previously stated, this failure is believed the result of wire movement during daily testing. The potential for future failures of this type will be essentially eliminated by a plant modification which will eliminate the need for use of clamp-on type ammeters for daily amperage readings and thereby reduce wire movement to a minimum. The modification is currently in progress and will be completed by January 1, 1982. Future failures from previous amperage readings, although not expected, would be identified by indication and/or alarm. No further action is considered necessary.