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

SUBJECT: LER 80-020/03L-0:on 800916,refueling periodic test PT-2.1 revealed that failure of A safety injection pump breaker to close during power operation would result in operation in degraded mode.Caused by switch contact.

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TITLE: Incident Reports

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	I&C SYS BR 29	1	1	I&E 05	2	2
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	LIC QUAL BR 31	1	1	MATL ENG BR 32	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	
01 CON'T	Report Source ⑥	L
01 CON'T	Docket Number ⑦	0 5 0 0 0 2 6 1
01 CON'T	Event Date ⑧	0 9 1 6 8 0
01 CON'T	Report Date ⑨	1 0 1 5 8 0

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES ⑩

02 On September 16, 1980, further review of an event concerning the failure of "A"
03 Safety Injection (SI) Pump Breaker to close on August 11, 1980, during the performance
04 of a refueling periodic test (PT-2.1) revealed that the failure during power operation
05 would have resulted in operation in a degraded mode permitted by Technical Specifica-
06 tion 3.3.1.2.b. This constitutes a reportable occurrence per Technical Specification
07 paragraph 6.9.2.b.2.
08

Line	Field	Value
09	System Code ⑪	E B
09	Cause Code ⑫	E
09	Cause Subcode ⑬	A
09	Component Code ⑭	C K T B R K
09	Comp. Subcode ⑮	E
09	Valve Subcode ⑯	Z
⑰ LER/RO Report Number	Event Year	8 0
		—
	Sequential Report No.	0 2 0
		/
	Occurrence Code	0 3
	Report Type	L
		—
	Revision No.	0
	Action Taken ⑱	B
	Future Action ⑲	Z
	Effect on Plant ⑳	Z
	Shutdown Method ㉑	Z
	Hours ㉒	0 0 0 0
	Attachment Submitted ㉓	Y
	NPRD-4 Form Sub. ㉔	Y
	Prime Comp. Supplier ㉕	N
	Component Manufacturer ㉖	W 1 2 0

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS ㉗

10 The cause of the failure of the breaker to close was found to be a high resistance
11 breaker alarm switch contact in the closing control circuit. The switch contact was
12 cleaned and the breaker closing control circuit was tested successfully several
13 times.
14

Line	Field	Value
15	Facility Status ㉘	H
15	% Power ㉙	0 0 0
15	Other Status ㉚	NA
15	Method of Discovery ㉛	B
15	Discovery Description ㉜	Conducting Refueling Periodic Test
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
	NRC USE ONLY	

8010200581

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

GPO 917-926

SUPPLEMENTAL INFORMATION

FOR

LICENSEE EVENT REPORT 80-020

1. Cause Description and Analysis: On August 11, 1980, during the performance of Periodic Test PT-2.1 and the initiation of a start signal from the control board, "A" Safety Injection (SI) pump breaker failed to close. On September 16, 1980, further review of this event revealed that, during power operation, the failure would have resulted in operation in a degraded mode permitted by Technical Specification 3.3.1.2.b. This constitutes a reportable occurrence per Technical Specification 6.9.2.b.2. The cause of the failure was originally diagnosed as a loose control power fuse. Following the failure, the control fuses were pulled, tested, and when reinserted, the breaker operated successfully. However, later testing of the breaker revealed the cause of failure to be an intermittent high resistance breaker alarm switch contact in the breaker closing control circuit. The high resistance contact condition could be induced or cleared by jarring the breaker, which probably accounts for the breaker operating normally after the jar of removing and inserting the control fuses. This breaker had been tested successfully on August 9, 1980, during a monthly periodic test.

   The two other SI pumps were operating properly during this period so there was no threat to the health and safety of the public.

2. Corrective Action: The breaker alarm switch contact was cleaned and the breaker tested several times successfully.

3. Corrective Action to Prevent Further Occurrence: The inspection of the breaker alarm switch contacts will be added to the Maintenance Instruction MI-19 data sheet which covers the inspection and calibration of 480 volt circuit breaker overcurrent tripping devices. This Maintenance Instruction will be revised prior to January 15, 1981.

   A failure similar to this event occurred on April 14, 1979. (Reference: LER 79-08)