

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR: 7901230289 DOC. DATE: 79/01/15 NOTARIZED: NO
FACIL: 50-261 H B ROBINSON #2, CAROLINA POWER & LIGHT CO.
AUTH. NAME AUTHOR AFFILIATION
STARKEY, R.B. CAROLINA POWER & LIGHT
RECIP. NAME RECIPIENT AFFILIATION
**REG. 2, ATLANTA, OFF. OF THE DIRECTOR

DOCKET #
05000261

SUBJECT: LER 78-030/03L-0 on 781217: during test of "C" MSIV, valve
stem would not travel full test distance. Caused by
misadjusted stem packing gland.

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TITLE: INCIDENT REPORTS

NOTES: _____

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INTERNAL:	01 REG FILE	1 1	02 NRC PDR	1 1
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	16 EEB	1 1	17 AD FOR ENGR	1 1
	18 PLANT SYS BR	1 1	19 I&C SYS BR	1 1
	20 AD PLANT SYS	1 1	21 AD SYS/PROJ	1 1
	22 REAC SAFT BR	1 1	23 ENGR BR	1 1
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7 8 9 14 15 25 26 30 57 CAT 58

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0	1	REPORT SOURCE																								
7	8	L	6	0	5	0	0	0	2	6	1	7	1	2	1	7	7	8	8	0	1	1	5	7	9	9
		60	61	DOCKET NUMBER								68	69	EVENT DATE					74	75	REPORT DATE					80

0 2 | During normal operations, while conducting the weekly periodic test of "C"MSIV
0 3 | (PT-15.2), the valve stem would not travel the full test distance (5/8-inch.)
0 4 | Although closing air is not applied during the test, under these conditions, there
0 5 | remains a possibility that the valve would not have met the five second closure time
0 6 | as required by Technical Specifications 3.4.1.e.
0 7 |
0 8 |

SYSTEM CODE C D 11		CAUSE CODE A 12		CAUSE SUBCODE C 13		COMPONENT CODE V A L V E X 14				COMP. SUBCODE X 15		VALVE SUBCODE D 16	
LER/RO REPORT NUMBER 7 8 17		EVENT YEAR 7 8 21 22		SEQUENTIAL REPORT NO. 0 3 0 24 26		OCCURRENCE CODE 0 3 28 29		REPORT TYPE L 30		REVISION NO. 0 32			
ACTION TAKEN E 18		FUTURE ACTION Z 19		EFFECT ON PLANT Z 20		SHUTDOWN METHOD Z 21		HOURS 0 0 0 0 22		ATTACHMENT SUBMITTED Y 23		NPRD-4 FORM SUB. Y 24	
PRIME COMP. SUPPLIER A 25		COMPONENT MANUFACTURER S 0 7 5 26											

1 0 The cause of the problem was found to be a misadjusted stem packing gland. The
1 1 gland was adjusted and the valve then operated properly. Personnel involved with
1 2 these adjustments will be made aware of this event to caution them of the potential
1 3 impact of this relatively insignificant operation.
1 4

FACILITY STATUS		% POWER			OTHER STATUS		METHOD OF DISCOVERY	DISCOVERY DESCRIPTION	
1	5	E	1	0	0	N/A	B	Operator Observation	

ACTIVITY CONTENT:
RELEASED OF RELEASE AMOUNT OF ACTIVITY (35) LOCATION OF RELEASE (36)

1 6 Z (33) Z (34) N/A N/A

PERSONNEL EXPOSURES									
NUMBER			TYPE	DESCRIPTION					
1	7	0	0	0	(37) Z	(38) N/A	(39)		

PERSONNEL INJURIES		NUMBER		DESCRIPTION	
1	8	0	0	0	(40) N/A

		LOSS OF OR DAMAGE TO FACILITY		(43)
		TYPE	DESCRIPTION	
7	8	9	10	
1	9	Z	(42) N/A	

PUBLICITY
ISSUED (2) (0) (44) DESCRIPTION (45) N/A

NAME OF PREPARER R. B. Starkey, Jr.

PHONE: (803) 332-1351

SUPPLEMENTAL INFORMATION
FOR
LICENSEE EVENT REPORT 78-30

1. Cause Description and Analysis:

On December 17, 1978, during full power operation, the weekly test of the MSIV's (P.T.-15.2) was being conducted. It was observed that the "C" valve stem would not travel the full test distance. The test mode on these valves involves the equalizing of operating air on the opening and closing sides of the valve operator. Compressed spring force then slowly moves the valve in the closed direction until the stem travels approximately 5/8-inch and engages a test limit switch. Opening air is then re-applied, which completes the test cycle. Failure to complete this cycle was found to be caused by a misadjusted stem packing gland; a result of improper routine maintenance. Under these conditions, there remained the possibility that the valve would not have met the five second closure time as required by Technical Specification 3.4.1.e.

It should be noted that a close operation is significantly different from a test operation. As a result of a close signal 100 psi air is applied to the closing side of the operator and the opening side is vented to atmosphere. Therefore, a combination of closing air and compressed spring forces jointly close the valve against the vented opening air side of the operator. It is believed that these forces would have been sufficient to overcome the friction of the packing gland since some stem travel was noticed even with the packing gland misadjusted. However, due to plant conditions, this could not be verified. Therefore, unable to verify the requirements of Technical Specification 3.4.1.e, this report was deemed necessary.

2. Corrective Action:

The packing gland was adjusted and the valve then tested satisfactorily.

3. Corrective Action To Prevent Further Occurrence:

The event was caused by the packing gland on "C" MSIV being misadjusted during previous routine maintenance. Personnel whose responsibilities include making these packing gland adjustments will review this event to caution them of the potential impact of this seemingly insignificant operation.