

NRC DISTRIBUTION FOR PART 50 DOCKET MATERIAL
(TEMPORARY FORM)

CONTROL NO: 7824

FILE: INCIDENT REPORT FILE

FROM: Carolina Power & Light Co. Raleigh, N.C. 27602 E.E. Utley			DATE OF DOC 7-11-75	DATE REC'D 7-23-75	LTR XX	TWX	RPT	OTHER
TO: Mr. Norman C. Moseley			ORIG 1 signed	CC 39	OTHER	SENT AEC PDR <u>XX</u> SENT LOCAL PDR <u>XX</u>		
CLASS	UNCLASS XXX	PROP INFO	INPUT	NO CYS REC'D 40	DOCKET NO: 50-261			

DESCRIPTION: Ltr trans the following:

ENCLOSURES: Abnormal Occurrence AO-50-261/
75-8(Revised) on 4-29-75 re failure of RHR
xmp pump suction valve RHR-862A failure...

(40 cys encl rec'd)

~~Do Not Remove~~

PLANT NAME: H.B. Robinson Unit 2

ACKNOWLEDGED

FOR ACTION/INFORMATION **DHL** **7-23-75**

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1 - NSIC (BUCHANAN)	1 - CONSULTANTS	1 - G. ULRIKSON, ORNL
1 - ASLB	NEWMARK/BLUME/AGBABIAN	1 - AGMED (RUTH GUSSMAN) Rm B-127 GT
1 - Newton Anderson		1 - J. D. RUNKLES, Rm E-201 GT
1 - ACRS SENT TO LIC ASST S. Teets 7-23-75		
** SEND ONLY TEN DAY REPORTS		

BN



Carolina Power & Light Company

Regulatory Docket File

July 11, 1975

File: 3513 (R)

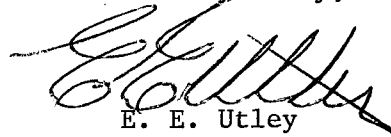
Mr. Norman C. Moseley, Director
U. S. Nuclear Regulatory Commission
Region II, Suite 818
230 Peachtree Street, N.W.
Atlanta, Georgia 30303

Dear Mr. Moseley:

H. B. ROBINSON UNIT NO. 2
LICENSE NO. DPR-23
FAILURE OF RHR VALVE 862A TO OPERATE

In accordance with Section 6.6.2.a of the Technical Specifications for H. B. Robinson Unit No. 2, the attached Abnormal Occurrence Report is submitted for your information. This report has been revised as requested to further define the analysis of the occurrence and corrective action taken, and supercedes our report of May 7, 1975.

Yours very truly,


E. E. Utley
Vice President
Bulk Power Supply

DBW:pdd
Attachment

cc: Messrs. N. B. Bessac
P. W. Howe
J. A. Jones
R. E. Jones
W. B. Kincaid
J. B. McGirt
D. B. Waters

7824

Abnormal Occurrence Report

1. Report No. 50-261/75-8 (Revised)
- 2a. Report Date July 3, 1975
- 2b. Occurrence Date April 29, 1975
3. Facility H. B. Robinson Unit No. 2
Hartsville, South Carolina 29550

4. Identification of Occurrence

Failure of RHR pump suction valve RHR-862A, which constitutes an Abnormal Occurrence, as defined in Section 1.8.d. of the Technical Specifications.

5. Conditions Prior to Occurrence

A plant heatup was in progress after a scheduled two week maintenance shutdown. The Reactor Coolant System was at 950 psi and 419⁰F, and the RHR System was being aligned for power operation.

6. Description of Occurrence

At 1123 hours while aligning the RHR System for normal power operation, valve RHR-862A failed to open when operated from the RTGB. At 1138 hours a reactor cooldown was commenced. At 1155 hours the valve was started open using the manual operator. At 1250 hours the valve was completely open and capable of performing its intended function, and the reactor heatup was recommenced. An investigation revealed that the operator torque switch was out of adjustment causing the valve to be jammed on the seat. The torque switch was adjusted and the valve returned to service at 1338 hours. The valve was cycled at this time with satisfactory results. Later, at 1757 hours, the valve was test operated on two successive cycles, and operation was satisfactory.

7. Designation of Apparent Cause of Occurrence

As previously stated the torque switch on the motor operator was out of adjustment. This caused the valve to be wedged onto the seat and prevented the motor from opening the valve. When the valve was moved off its seat with the manual operator, movement of the valve was free and subsequent motor operation of the valve with the reduced torque switch setting was satisfactory.

8. Analysis of Occurrence

Upon determination that valve RHR-862A would not meet its intended function, a plant cooldown was commenced. The valve was opened manually and the plant heatup commenced after the valve was fully open and would meet its intended function. The torque switch setting was then lowered and the valve test operated satisfactorily. The valve was again tested twice while checking the motor current temperature, and visual observations of operation were made. The motor current, temperature, and valve operation time were normal and no unusual noises were detected. At 1011 hours, April 30, 1975, the motor operator was disassembled and completely inspected. No abnormal conditions or defective parts were found during this inspection, however, an excessive amount of grease was found in the Belleville Spring pack area. An initial determination was that this grease could have created a hydraulic lock effect around the spring and not permit it to function properly. This grease was removed when the operator was re-assembled. The operator was tested and returned to service at 1418 hours. Further discussions with the vendor have been made regarding this failure. The initial determinations of the grease being a possible problem is not valid since this type operator has a slot cut in the housing that relieves any excessive grease to the main body of the operator.

This occurrence has been thoroughly investigated to determine all possible reasons for the torque switch adjustment to cause the valve jamming. No evident reason has been determined. The operator has functioned properly every time since the occurrence of April 29, 1975.

During the time of this occurrence, plant safety was not jeopardized, and no personnel injuries, undue exposures, releases of radioactive materials, or threat to the public health and safety resulted from this occurrence.

9. Corrective Action

The torque switch on this operator was adjusted to prevent the valve from being forced on the seat. No further corrective action is planned at this time but we will continue to observe this valve as part of our normal routine operations.

10. Failure Data

No failure of this nature has occurred on this type operator.