



ROCHESTER GAS AND ELECTRIC CORPORATION • 89 EAST AVENUE, ROCHESTER, N.Y. 14649

GRANGER E. GREEN  
VICE PRESIDENT

TELEPHONE  
AREA CODE 716 546-2700

August 23, 1974

Mr. James P. O'Reilly, Director  
Directorate of Regulatory Operations  
Region I  
U. S. Atomic Energy Commission  
631 Park Avenue  
King of Prussia, Pennsylvania 19406



Subject: Abnormal Occurrence 74-15: Malfunction of the  
"A" Steam Generator Blowdown Isolation Valve  
R. E. Ginna Nuclear Power Plant, Unit No. 1  
Docket No. 50-244

Dear Mr. O'Reilly:

In accordance with Technical Specifications, Article 6.6.2a, the  
attached report of Abnormal Occurrence 74-15 is hereby submitted.

Very truly yours,

Granger E. Green

Attachment

*50-244  
inquiry*

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1. Report Number: 50-244/74-15
- 2a. Report Date: August 23, 1974
- 2b. Occurrence Date: August 15, 1974
3. Facility: R. E. Ginna Nuclear Power Plant, Unit No. 1
4. Identification of Occurrence:

This abnormal occurrence is defined by Technical Specifications Article 1.9a, violation of a limiting condition for operation, and Article 1.9d, failure of one or more components in an engineered safety feature or plant protection system that causes the feature or system to be incapable of performing its intended function.

5. Conditions Prior to Occurrence:

The plant was operating at approximately 91% power.

6. Description of Occurrence:

On August 15, 1974 instrument and control personnel checked out a trouble report of improper status light indication for the 1A Steam Generator blowdown isolation valve CV70, noted during performance of periodic test PT-16, Auxiliary Feedwater System Flow. Investigation revealed that the position switch for the status light was working properly and the valve was only closing 80%. Upon observing the malfunction of valve CV-70, the manual valve upstream of valve CV-70 was not closed. At 1000 hours on August 16, 1974 the manual valve was closed to establish containment integrity. Further testing was then conducted in accordance with Plant Operations Review Committee recommendations. The valve operator was observed to stroke properly and the valve was observed to close satisfactorily when isolated. With the manual valve open, the valve was observed, at times, to stroke smoothly 100% closed.

7. Designation of Apparent Cause of Occurrence:

On August 17, 1974 the valve was disassembled. The cause of the valve malfunction was found to be a piece of carbon steel resting on top of the valve seat ring. It was approximately 5/8" x 5/8" x 1/2" in dimensions and too large to pass through the valve port. Whenever flow was established through the valve, the piece would roll into contact with the valve plug and intermittently prevent valve closure.

8. Analysis of Occurrence:

The failure of this valve to close completely did not affect normal operations since the valve is normally open and blowdown is throttled at a downstream needle-valve at a rate of 5 gallons per minute. Isolation of the blowdown line outside of containment was still available at the manual isolation valve upstream of CV-70. Since there are no steam generator tube leaks, the valve malfunction did not result in release of fission products to the environment; therefore there was no hazard to the public health and safety.

9. Corrective Action:

After removal of the foreign object, the valve internals were inspected for possible damage. Although no apparent damage was done to the valve seat or plug, the valve stem and plug assembly was replaced and the plug lapped into the seat.

10. Failure Data:

This was a Masoneilan 2" - 600 psi globe diaphragm valve Model 38-20521 AB. This is the first instance of malfunction of this type blowdown valve in the Ginna plant.