

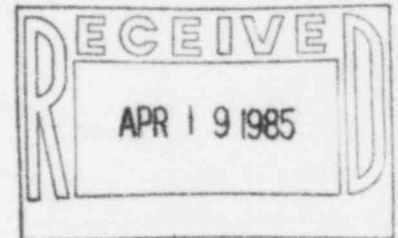


GULF STATES UTILITIES COMPANY

RIVER BEND STATION POST OFFICE BOX 220 ST. FRANCISVILLE, LOUISIANA 70775
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April 11, 1985
BG- 20698
ile Nos. G9.5, G9.25.1.1

Mr. Robert D. Martin, Regional Administrator
U. S. Nuclear Regulatory Commission
Region IV
611 Ryan Plaza Drive, Suite 1000
Arlington, Texas 76011



Dear Mr. Martin:

River Bend Station - Unit 1
Docket No. 50-458
Final Report/DR-182

On January 18, 1985, GSU provided Region IV with a 30-day written report on DR-182 concerning a Limitorque motor operator failure on a feedwater isolation valve. The attachment to this letter is GSU's revised final written report with regard to this deficiency.

Sincerely,

J. E. Booker
Manager-Engineering,
Nuclear Fuels & Licensing
River Bend Nuclear Group

PJD
JEB/PJD/trp

Attachment

cc: Director of Inspection & Enforcement
U. S. Nuclear Regulatory Commission
Washington, D. C. 20555

NRC Resident Inspector-Site

INPO

85-213

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ATTACHMENT

April 11, 1985

RBG- 20698

DR-182/Limitorque Motor Operator Failure on Feedwater Isolation Valve

Background and Description of the Problem

This deficiency concerns a Limitorque motor operator failure on a feedwater isolation valve as identified in Nonconformance and Disposition Report (N&D) No. 5458.

During testing at the River Bend jobsite of feedwater system valve 1FWS*MOV7B, the drive sleeve for the valve operator failed. The failure of the drive sleeve prevented any subsequent operation of the valve prior to repair. Failures of this type have been limited to one valve based on the review of test data of other valves with the same style operators. Valves 1FWS*MOV7A, 1B21*MOVFO65A and B, and 1B21*MOVFO98A through D are equipped with the same style operators. The operators for 1FWS*MOV7A and B are equipped with smaller motors than the other valves. No other problems have been noted with the other valves.

Response to the N&D required the return of the valve operator to Limitorque Corporation for determination of the cause of failure, replacement of damaged parts, specified testing, and inspection prior to return to the jobsite. In addition, a meeting was held at the jobsite between the responsible piping engineers and test engineers in an attempt to uncover the cause of failure. This meeting failed to identify the cause of failure.

A review of the condition of the operator by the Seller as documented in Limitorque Inter-Office Correspondence dated September 25, 1984, did not show the cause of failure. However, the Stone and Webster Engineering Corporation (SWEC) shop inspector reported that the Seller suspects one of the following:

1. The torque switch was wired incorrectly.
2. The motor was misphased and produced stall torque a number of times.

Safety Implication

Valve 1FWS*MOV7B does not affect short-term containment isolation. However, this valve is required for long-term containment isolation following a loss of coolant design basis accident.

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Corrective Action

In accordance with N&D No. 5458, the operator was returned to the vendor shop and all damaged parts were replaced. The vendor tested the operator to insure proper operation, proper torque, proper motor current, and proper limit and torque switch setting and operation.