

FILE: _____

FROM: Northern States Power Company Minneapolis, Minnesota 55401 L. O. Mayer		DATE OF DOC 2-12-74	DATE REC'D 2-19-74	LTR X	MEMO	RPT	OTHER
TO: J. F. O'Leary		ORIG No Orig	CC	OTHER	SENT AEC PDR X SENT LOCAL PDR X		
CLASS	UNCLASS XXXX	PROP INFO	INPUT	NO CYS REC'D 40	DOCKET NO: 50-263		

DESCRIPTION:
Ltr reporting abnormal occurrence on 2-3-74,
regarding the failure of Torus Cooling Injection
valve MO-2008.....

DO NOT REMOVE

ACKNOWLEDGED

PLANT NAME: Monticello

FOR ACTION/INFORMATION 2-19-74 GC

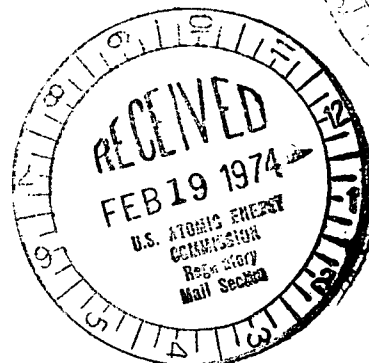
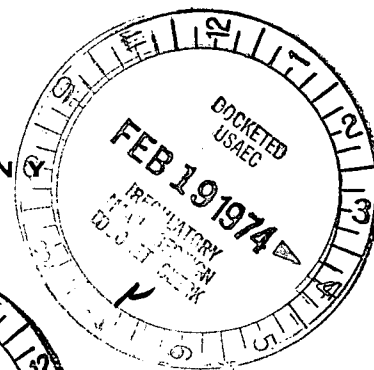
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| 2-19-74 <i>Disff</i> | 1-GERALD ULRIKSON...ORNL | 1-RD..MULLER..F-309 GT |



February 12, 1974

Mr. J. F. O'Leary, Director
Directorate of Licensing
Office of Regulation
United States Atomic Energy Commission
Washington, D. C. 20545

Dear Mr. O'Leary:

MONTICELLO NUCLEAR GENERATING PLANT
Docket No. 50-263 License No. DPR-22

Failure of Torus Cooling Injection Valve, MO-2008

A condition occurred at the Monticello Nuclear Generating Plant which we are reporting to your office in accordance with Section 6.7.B.1, Abnormal Occurrence Reports, of Appendix A, Technical Specifications of Provisional Operating License DPR-22.

On February 3, 1973, during routine transfer of torus water to radwaste, the 'A' Residual Heat Removal (RHR) torus cooling injection valve operator (MO-2008) motor failed due to stalled rotor current overheating the windings.

Investigation revealed that the set screws which fasten the stem clamp to the valve stem had loosened. This allowed the valve stem to rotate. The stem rotation misaligned the valve limit switches such that open position indication was not received and the opening control signal was not interrupted when the valve was in the full open position. This condition permitted the control room operator to stall the motor in attempts to fully open the valve. The resultant locked rotor current and subsequent insulation failure led to the motor failure. Since this valve performs a safety function, the redundant electrical protection features, such as thermal overloads and fuses, are deliberately sized so as to allow motor failure in efforts to operate the valve. The motor was replaced, the limit switches were reset, the stem clamp was repositioned and the set screw threads were staked. The valve was tested and found to operate satisfactorily.

A similar failure of this valve motor occurred on October 28, 1973, during a routine surveillance test. The cause of that failure also involved improper limit switch alignment. Neither occurrence affected safe operation, since MO-2006, which is located upstream of MO-2008, was operable and provides automatic isolation capability. It is noted that MO-2006 is a gate valve whose design does not incorporate a stem clamp. Following this occurrence, all accessible motor operated valves on ECCS subsystems were inspected to determine if any other stem

clamps had come loose. All stem clamps were found to be properly positioned and firmly seated. Other motor operated valves on ECCS subsystems which were inaccessible will be inspected at the first opportunity. The stem clamp set screw threads for similar ECCS motor operated valves will be staked. Maintenance procedures for these valves will include a verification of proper stem clamp position and proper set screw tightness.

Very truly yours,

M. H. Nath (for)

L. O. Mayer, PE
Director of Nuclear Support Services

LOM/mmm

cc: JG Keppler
G Charnoff
Minnesota Pollution Control Agency
Attn: E A Pryzina