# NRC DISTRIBUTION FOR PART 50 DOCKET MATERIAL (TEMPORARY FORM)

CONTROL NO: 5387

FILE: INCIDENT REPORT FILE

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FROM:	arolina Powe	er & Light Co.	DATE OF DOC	DATE REC'D	LTR	TWX	RPT	OTHER
Raleigh, N.C.			5-9-75	5-15-75	XX			
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Norman C. Moseley			1 Signed		SE	SENT LOCAL PDR XXX		
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		(1 Encl. Rec'd)						
PLANT	NAME: H.B.	. Robinson # 2		(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			·J	•
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CP&L

Carolina Power & Light Company

May 9, 1975

50 - 261File: NG-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 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 fulfills the requirement for a written report within ten days of our Abnormal Occurrence and is in accordance with the format set forth in Regulatory Guideline 1.16, Revision 1.

Yours very truly,

E. E. Utley Vice-President

Bulk Power Supply

DBW:mc Attachment

cc: Messrs. N. B. Bessac

P. W. Howe

R. E. Jones

Donald Knuth

J. B. McGirt

D. B. Waters

#### Abnormal Occurrence Report

1. Report No. 50-261/75-8

2a. Report Date May 7, 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 Specification.

## 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 419  $^{\circ}$ F, 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 SMB-O 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 SMB-O motor operator was out of adjustment. This caused the valve to be wedged onto the seat. When the valve was moved off its seat with the manual operator, movement of the valve was free.

## 8. Analysis of Occurrence

Upon determination that valve RHR-862A would not meet its design function, a plant cooldown was commenced. 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 was adjusted to prevent the valve from being forced on the seat. Also, at 1011 hours, April 30, 1975, a complete inspection of the operator was performed, and excessive grease was found in the Belleville spring chamber at the end of the worm gear shaft. This could potentially create a hydraulic lock effect around the spring and not permit it to function properly. The excess grease was removed as a precaution, and the operator was returned to service at 1418 hours. The valve operation was tested at this time with satisfactory results.

#### 10. Failure Data

None.

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