

DUKE POWER COMPANY

POWER BUILDING

422 SOUTH CHURCH STREET, CHARLOTTE, N. C. 28242

WILLIAM O. PARKER, JR.  
VICE PRESIDENT  
STEAM PRODUCTION

October 2, 1981

TELEPHONE: AREA 704  
373-4083

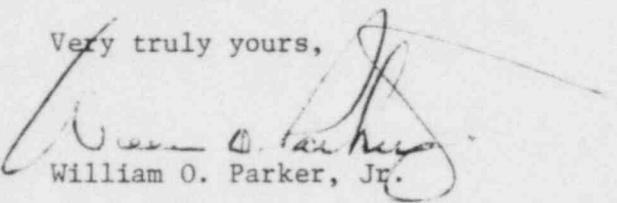
Mr. J. P. O'Reilly, Director  
U. S. Nuclear Regulatory Commission  
Region II  
101 Marietta Street, Suite 3100  
Atlanta, Georgia 30303

Re: McGuire Nuclear Station Unit 1  
Docket No. 50-369



Dear Mr. O'Reilly:

Please find attached Reportable Occurrence Report RO-369/81-152. This report concerns T.S.3.6.3, "The Containment Isolation Valves Specified in Table 3.6-2 Shall be Operable With Isolation Times as Shown in Table 3.6-2." This incident was considered to be of no significance with respect to the health and safety of the public.

Very truly yours,  
  
William O. Parker, Jr.

PBN/smh  
Attachment

cc: Director  
Office of Management and Program Analysis  
U. S. Nuclear Regulatory Commission  
Washington, D. C. 20555

Records Center  
Institute of Nuclear Power Operations  
1820 Water Place  
Atlanta, Georgia 30339

Ms. M. J. Graham  
Resident Inspector-NRC  
McGuire Nuclear Station

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McGUIRE NUCLEAR STATION

REPORTABLE OCCURRENCE

REPORT NUMBER: 81-152

REPORT DATE: October 2, 1981

OCCURRENCE DATE: August 31, 1981

FACILITY: McGuire Unit 1; Cornelius, N.C.

IDENTIFICATION OF OCCURRENCE: A containment isolation valve was declared inoperable. The valve would not close.

CONDITION PRIOR TO OCCURRENCE: Mode 3, Hot Standby.

DESCRIPTION OF OCCURRENCE: On August 31, 1981 an attempt was made to operate the Steam Generator 1C Main Feed to Auxiliary Feedwater Nozzle Isolation Valve electrically from the control room, but the valve would not function correctly. Therefore, the valve was closed manually and declared inoperable. The valve was declared operable the same day; after the valve was put in its safety position by locking it closed. Examination of the actuator determined that the motor and the flasher overload heater were burned out. The motor was replaced and functional verification performed. After completion of the valve timing test, an overload heater alarm was received. Investigation covered that the yoke on the actuator broke into two pieces, causing the part of the actuator which was not connected to the valve to fall, pulling several cables loose. These cables were repulled, and a new actuator installed. The valve timing test was performed again and the valve passed its acceptance criteria.

APPARENT CAUSE OF OCCURRENCE: The valve failed to operate correctly the first time due to the burned out motor and flasher overload heater. The second time the valve failed, a mechanical latch in the actuator malfunctioned causing other internal components to fail, and the actuator hammered until it broke.

ANALYSIS OF OCCURRENCE: It is unknown as to why the motor and flasher overload heater burned out.

The actuator (Rotork, model #30NAX1) was examined by Rotork personnel and it was determined that a mechanical latch in the actuator malfunctioned. The Rotork representative for McGuire said this was the first such failure they have seen, and it is the first such failure at McGuire. Therefore, it appears to be an isolated incident.

SAFETY ANALYSIS: Within four hours after the valve failed, it was locked in its closed position as required by Technical Specifications. Since there was nothing wrong with the valve internals and the valve could be manually locked closed, the health and safety of the public were not affected by this incident.

CORRECTIVE ACTION: The first time the valve failed to operate correctly, the motor was replaced and the valve tested per procedure "CF Valve Stroke Timing Shut-down Procedure." After the valve was repaired the second time, it was retested using the same procedure.