

50-287

NRC DISTRIBUTION FOR PART 50 DOCKET MATERIAL

FILE NUMBER
INCIDENT REPORT

TO: Mr Moseley

FROM: Duke Power Company
Charlotte, NC
W O ParkerDATE OF DOCUMENT
11-15-76

DATE RECEIVED 12-3-76

☒ LETTER ☐ NOTORIZED
☒ ORIGINAL ☒ UNCLASSIFIED
☒ COPY

PROP

INPUT FORM

NUMBER OF COPIES RECEIVED
one signed

DESCRIPTION

Ltr trans the following:

ENCLOSURE

Licensee Event Report (RO#76-19) on 11-1-76
concerning high pressure injection stop-check
valves closed while reactor was above 350°F..
.....ACKNOWLEDGED
DO NOT REMOVE

PLANT NAME: Oconee #3

NOTE: IF PERSONNEL EXPOSURE IS INVOLVED
SEND DIRECTLY TO KREGER/J. COLLINS

FOR ACTION/INFORMATION

12-8-76 ehf

BRANCH CHIEF:
W/3 CYS FOR ACTION
LIC. ASST.:
W/1 CYS

Schwensen

Sheppard

ACRS 16 CYS HOLDING/SENT As CAT B 12-6-76

INTERNAL DISTRIBUTION

REG FILE
NRC PDR
I & E (2)
MIPC
SCHROEDER/IPPOLITO
HOUSTON
NOVAK/CHECK
GRIMES
CASE
BUTLER
HANAUER
TEDESCO/MACCARY
EISENHUT
BAER
SHAO
VOLLMER/BUNCH
KREGER/J. COLLINS

EXTERNAL DISTRIBUTION

LPDR: Wa/halla SC
TIC:
NSIC:

CONTROL NUMBER

204
12236

DUKE POWER COMPANY

POWER BUILDING

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

WILLIAM O. PARKER, JR.
VICE PRESIDENT
STEAM PRODUCTION

November 15, 1976

TELEPHONE: AREA 704
373-4083

Mr. Norman C. Moseley, Director
U. S. Nuclear Regulatory Commission
Suite 818
230 Peachtree Street, Northwest
Atlanta, Georgia 30303

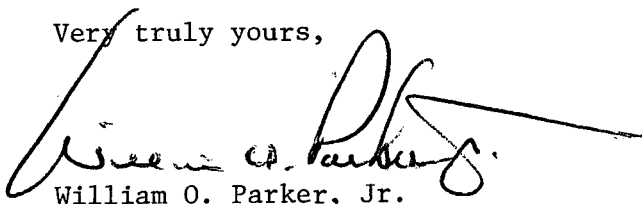


Re: Oconee Unit 3
Docket No. 50-287

Dear Mr. Moseley:

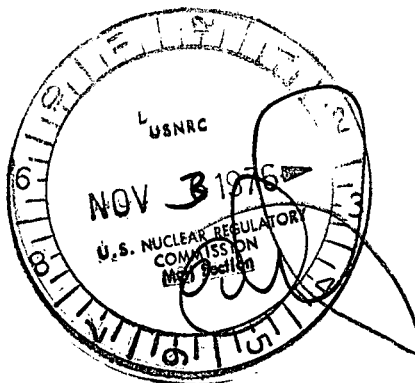
Pursuant to Sections 6.2 and 6.6.2 of the Oconee Nuclear Station Technical Specifications, please find attached Reportable Occurrence Report RO-287/76-19.

Very truly yours,


William O. Parker, Jr.

LJB:ge
Attachment

cc: Director, Office of Management Information
and Program Control



12236

DUKE POWER COMPANY
OCONEE UNIT 3

Report No.: RO-287/76-19

Report Date: November 15, 1976

Occurrence Date: November 1, 1976

Facility: Oconee Unit 3, Seneca, South Carolina

Identification of Occurrence: High pressure injection stop-check valves closed while reactor above 350°F

Conditions Prior to Occurrence: Unit in heatup

Description of Occurrence:

On November 1, 1976, during cooldown of the reactor coolant system for repair of valve 3RC-1, the high pressure injection system stop-check valves in the "B" train, 3HP-152 and 3HP-153, were discovered closed. This condition had existed for a period of eleven and one-half hours during which the "B" HPI train was required to be operable by Oconee Technical Specification 3.3.2. Upon discovery valves 3HP-152 and 153 were promptly opened.

Designation of Apparent Cause of Occurrence:

Following any major shutdown and prior to establishing seal flow to the HPI pumps and reactor heatup, an examination of the valves associated with the HPI system is made. Utilizing a checklist, this procedure verifies that the components of each train are in correct position. On October 27, 1976, prior to heatup following the Unit 3 refueling outage, valves 3HP-152 and 153 were inspected pursuant to this procedure and initialed as being open. There is no evidence that indicates that these valves were repositioned after this inspection. Therefore this incident has been attributed to a personnel error in ascertaining the proper valve position during this initial inspection.

Analysis of Occurrence:

The mispositioned valves were discovered prior to criticality and returned to the correct position. It is considered that since the reactor was sub-critical during this period, the reactor coolant temperature and pressure conditions were below the normal operating conditions, and due to the short period of time this condition existed, the probability of an incident requiring the HPI system was exceedingly remote. However, if the HPI system had been required, the redundant HPI train was operable and has full capability of performing the ES function of the system. It is, therefore, concluded that the health and safety of the public was not adversely affected by this incident.

Corrective Action:

Upon discovery, the valves in question were promptly placed in the correct ES position, and the HPI checklist was completely rerun to assure that no further discrepancies existed. This incident and methods for determining valve positions were also reviewed with all personnel. It is felt that no further corrective action is necessary.

U.S.A.E.C.
REGULATORY OPERATIONS
REGION II
ATLANTA, GA.

Nov 18 10 15 AM '76