

NRC DISTRIBUTION FOR PART 50 DOCKET MATERIAL
(TEMPORARY FORM)

2484

CONTROL NO: _____

FILE: INCIDENT REPORT

FROM: Duke Power Co. Charlotte, N.C. A.C. Thies			DATE OF DOC 2-19-75	DATE REC'D 3-5-75	LTR XXXX	TWX	RPT	OTHER
TO: Mr. Norman C. Moseley			ORIG 1-signed	CC	OTHER	SENT AEC PDR <u>xxx</u> SENT LOCAL PDR <u>xxx</u>		
CLASS	UNCLASS xxxxxx	PROP INFO	INPUT	NO CYS REC'D 1		DOCKET NO: 50-287		

DESCRIPTION:

Ltr trans the following;

*ACKNOWLEDGMENT
DO NOT WRITE*

ENCLOSURES:

Abnormal Occurrence #75-2 on 2-5-75 concerning valve 3LP-18 control power fuse failure

PLANT NAME: Oconee #3

FOR ACTION/INFORMATION 3-7-75 JGB

BUTLER (S) W/ Copies	SCHWENCER (S) W/ Copies	ZIEMANN (S) W/ Copies	REGAN (E) W/ Copies
CLARK (S) W/ Copies	STOLZ (S) W/ Copies	DICKER (E) W/ Copies	LEAR (S) W/ Copies
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KNIEL (S) W/ Copies	PURPLE (S) W/4 Copies	YOUNGBLOOD (E) W/ Copies	

INTERNAL DISTRIBUTION

<u>REC FILE</u>	<u>TECH REVIEW</u>	<u>DENTON</u>	<u>LIC. ASST.</u>	<u>A/T IND</u>
✓NRC PDR	✓SCHROEDER	GRIMES	DIGGS (S)	BRAITMAN
✓OCC. ROOM P-506-A	✓MACCARRY	GAMMILL	GEARIN (S)	SALTZMAN
✓BOSSICK /STAFF	✓KNIGHT	LASTNER	GOULBOURNE (S)	B. HURT
✓CASE	✓PAWLICKI	BALLARD	KREUTZER (E)	
GIAMBUSSO	✓SHAO	SPANGLER	LEE (S)	<u>PLANS</u>
BOYD	✓STELLO		MAIGRET (S)	MCDONALD
MOORE (S) (BWR)	✓HOUSTON	<u>ENVIRO</u>	REED (E)	CHAPMAN
DEYOUNG (S) (PWR)	✓NOVAK	MULLER	SERVICE (S)	DUBE w/input
SKOVHOLT (S)	✓ROSS	DICKER	✓SHEPPARD (S)	E. COUPE
GOLLER (S)	✓IPPOLITO	KNIGHTON	SLATER (E)	✓R. Hartfield (2)
P. COLLINS	✓TEDESCO	YOUNGBLOOD	SMITH (S)	✓KLEGGER
DENISE	✓LONG	REGAN	TEETS (S)	✓F. WILLIAMS
REG OPR	✓LAINAS	PROJECT LDR	WILLIAMS (E)	
✓FILE & REGION	✓BENAROYA		WILSON (S)	
✓T.R. WILSON	✓STEELE	<u>HARLESS</u>	INGRAM (S)	
	✓VOLIMER			

EXTERNAL DISTRIBUTION

1-LOCAL PDR <u>Walhalla, S.C.</u>	(1)(2)(10)-NATIONAL LABS	1-PDR SAN/LA/NY
1-TIC (ABERNATHY)	1-W. PENNINGTON, RM E-201 G.T.	1-BROOKHAVEN NAT LAB
1-NSIC (BUCHANAN)	1-CONSULTANTS	1-G. ULRIKSON, ORNL
1-ASLB	NEWMARK/BLUME/ACBABIAN	1-AGMED (RUTH GUSSMAN)
1-NEWTON ANDERSON		RM B-127 G.T.
5-ACRS SENT TO LIC. ASST.		1-J. RUNKLES, RM E-201
		G.T.

Sheppard

70-4

DUKE POWER COMPANY

POWER BUILDING

422 SOUTH CHURCH STREET, CHARLOTTE, N. C. 28201

A. C. THIES
SENIOR VICE PRESIDENT
PRODUCTION AND TRANSMISSION

P. O. Box 2178

February 19, 1975

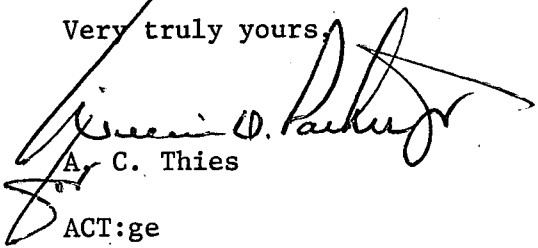
Mr. Norman C. Moseley, Director
U. S. Nuclear Regulatory Commission
Suite 818
230 Peachtree Street, Northwest
Atlanta, Georgia 30303

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 Abnormal Occurrence
Report AO-287/75-2.

Very truly yours,


A. C. Thies

ACT:ge
Attachment

cc: Mr. Angelo Giambusso



2484

Duke Power Company
Oconee Unit 3

Report No.: AO-287/75-2

Report Date: February 19, 1975

Occurrence Date: February 5, 1975

Facility: Oconee Unit 3, Seneca, South Carolina

Identification of Occurrence: Valve 3LP-18 Control Power Fuse Failure

Conditions Prior to Occurrence: Shutdown in progress; T_{ave} ~300°F

Description of Occurrence:

On February 5, 1975 a reactor shutdown for scheduled maintenance was in progress on Oconee Unit 3. Attempts to remotely open valve 3LP-18 to establish decay heat flow with the Low Pressure Injection System were unsuccessful. Investigation showed that a fuse in the control power transformer had failed. The fuse was replaced and proper valve operation was verified.

Designation of Apparent Cause:

The occurrence resulted from the failure of a fuse in the control power transformer of valve 3LP-18. A check of the control circuitry associated with this valve found no loose, burned or shorted wires. The fuse was not loose in its holder. After the blown fuse had been replaced, the current on the secondary of the transformer was measured during operation of the valve. The maximum current recorded, 2.5 amperes, was well below the 6 ampere rating of the fuse. It was concluded that the fuse failed because of either voltage surge or a defective fuse.

Analysis of Occurrence:

This occurrence rendered one train of the Low Pressure Injection System inoperable for Engineered Safeguards actuation or decay heat removal cooling. The second redundant train of Low Pressure Injection train was operable; however, and would have provided the necessary LPI flow as described in the Oconee FSAR, Table 6-2. It is therefore concluded the occurrence did not effect the safe operation of the unit nor the health and safety of the public.

Corrective Action:

The blown fuse was replaced and the valve operability was verified.

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U.S.A.E.C.
REGULATORY OPERATIONS
REGION II
ATLANTA, GA.
FEB 24 10 18 AM '75