

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

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FACIL:50-287 OCONEE #3, DUKE POWER CO.

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SUBJECT: LER 78-019/03L-0 on 781207:both trains of PR ventilation sys
were inoperable due to excess water in filters caused by
leakage from 3FDW-25.

DISTRIBUTION CODE: A002S COPIES RECEIVED:LTR 1 ENCL 2 SIZE: 2+1
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DUKE POWER COMPANY
OCONEE UNIT 3

Report Number: RO-287/78-19

Report Date: January 9, 1979

Occurrence Date: December 7, 1978

Facility: Oconee Unit 3, Seneca, South Carolina

Identification of Occurrence: Both Purge Room Ventilation System Trains
Inoperable

Conditions Prior to Occurrence: 98% Full Power

Description of Occurrence:

At 0618 on December 7, 1978, it was determined by observation of flow indications, that both trains of the Reactor Building (RB) Ventilation System were inoperable. The trains registered flow indications of 0 and 150 cfm as compared to a nominal flow rate of 1000 cfm. The inoperability was apparently due to saturation of the filters with water from one or more valve leaks in the penetration room. The filters were replaced and a reactor shutdown was initiated at 1500 in order to meet the requirements of Oconee Nuclear Station Technical Specification 3.15. The operability of the A train was verified by 2300.

Apparent Cause of Occurrence:

The filters apparently failed due to moisture saturation caused by steam leakage from 3FDW-251. The valve leaked steam into the penetration room for approximately 3 days prior to being temporarily repaired during a unit outage on November 3, 1978. Both fans were run on November 1, 1978 for approximately 2.61 hours during which time the filters were apparently saturated with moisture.

Analysis of Occurrence:

For the period of time the penetration room ventilation system was inoperable, the filters could not have performed their required safety function.

In the event of a postulated loss of coolant accident, and without this system operable, however the offsite doses would be considerably less than 10CFR100.

It is considered that this incident did not adversely affect the safety of the public.

Corrective Action:

The filters were replaced and verified to be operable as required by Technical Specifications. The periodic test has been revised to assure greater reliability of the system by including verification of adequate flow (1000 cfm \pm 10%). An investigation into the humidity levels which could cause such failure(s) has been initiated.

LICENSEE EVENT REPORT

EXHIBIT A

CONTROL BLOCK: 1										(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)									
01		S C N E E 3 2 0 0 - 0 0 0 0 0 - 0 0 3 4 1 1 1 1 4										5							
7 8		9 14 15 25 26 30 57 CAT 58																	
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7 8		60 61 68 69 74 75 80																	
EVENT DESCRIPTION AND PROBABLE CONSEQUENCES 10																			
02		At 0618 on December 7, 1978 it was observed that both trains of the PR																	
03		ventilation system were inoperable due to excess water in the filters. The																	
04		filters were replaced and a unit shutdown was initiated at 1500. Train A																	
05		was verified to be operable at 2300. With the PR Vent System inoperable																	
06		10CFR 100 limits would not be approached even during LOCA conditions. Thus																	
07		it is considered that public safety was not adversely affected.																	
08																			
7 8 9												80							
09		SYSTEM CCDE 11 CAUSE CODE 12 CAUSE SUBCODE 13 COMPONENT CODE 14 COMP. SUBCODE 15 VALVE SUBCODE 16																	
7 8		9 10 11 12 13 18 19 20																	
17		LER/RO REPORT NUMBER 21 EVENT YEAR 22 7 8 23 0 1 9 24 26 27 0 3 28 29 30 L 31 32 0 33																	
7 8		33 34 35 36 37 40 41 42 43 44 47																	
10		ACTION TAKEN 18 FUTURE ACTION 19 EFFECT ON PLANT 20 SHUTDOWN METHOD 21 HOURS 22 ATTACHMENT SUBMITTED 23 NPRO-4 FORM SUB. 24 PRIME COMP. SUPPLIER 25 COMPONENT MANUFACTURER 26																	
7 8		33 34 35 36 37 40 41 42 43 44 47																	
CAUSE DESCRIPTION AND CORRECTIVE ACTIONS 27																			
10		The excess water in the filters was apparently caused by leakage from 3FDW-251.																	
11		The leak was repaired on November 3, 1978. The filters have been replaced																	
12		and procedures have been revised in order to assure greater reliability of																	
13		the system.																	
14																			
7 8 9												80							
15		FACILITY STATUS 28 0 9 8 29 OTHER STATUS 30 METHOD OF DISCOVERY 31 Operator Observation 32																	
7 8 9		10 12 13 44 45 46 48 80																	
16		ACTIVITY CONTENT 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50																	
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