

DUKE POWER COMPANY

POWER BUILDING

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

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81-022-01P✓

WILLIAM O. PARKER, JR.
VICE PRESIDENT
STEAM PRODUCTION

June 10, 1981

TELEPHONE: AREA 704
373-4083

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

Re: Oconee Nuclear Station
Docket No. 50-269



Dear Mr. O'Reilly:

Please find attached Reportable Occurrence Report RO-269/81-08. This report is submitted pursuant to Oconee Nuclear Station Technical Specification 6.6.2.1.a(9), which concerns operation in a manner less conservative than assumed in the accident analyses, and describes an incident which is considered to be of no significance with respect to its effect on the health and safety of the public. My letter of May 27, 1981 addressed the delay in the preparation of this report.

Very truly yours,

William O. Parker Jr. by WAH
William O. Parker, Jr.

JLJ:pw
Attachment

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

Mr. Bill Lavallee
Nuclear Safety Analysis Center
P. O. Box 10412
Palo Alto, CA 94303

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DUKE POWER COMPANY
OCONEE NUCLEAR STATION

Report Number: RO-269/81-08

Report Date: June 10, 1981

Occurrence Date: May 13, 1981

Facility: Oconee Nuclear Station, Seneca, South Carolina

Identification of Occurrence: Loss of Automatic Operability for CCW-8 valve position

Conditions Prior to Occurrence: Oconee 1 - 100% FP
Oconee 2 - 100% FP
Oconee 3 - 100% FP

Description of Occurrence: At 1535 hours on May 13, 1981, a loss of valve position indication for CCW-8 was noticed. The valve was determined to be electrically inoperable. This is in violation of Technical Specification 3.4.4 and is thus reportable pursuant to Technical Specification 6.6.2.1.a(9).

Apparent Cause of Occurrence: The loss of CCW-8 valve automatic operability was caused by an open circuit in several conductors in the control cable. The bad cable section was between the T-100 trench and the valve. Some construction activity is being conducted in the area of this cable, and the cable could have been damaged.

Analysis of Occurrence: With the turbine driven emergency feedwater pump, but without either electrical power or the presence of Lake Keowee, 20 hours are available before exhausting the supply of stored condensate pumped into the steam generators and the steam vented to the atmosphere.

The health and safety of the public were not affected by this incident. Placing an operator at the valve to manually open it if required was adequate protection.

Corrective Action: Immediate corrective action was to send an operator to the valve to verify operability. Operability was verified by manually cracking CCW-8 open and verifying flow through the valve. The valve was then closed and an operator stationed at the valve until electrical control was re-established. The control cable was replaced and the valve electrically cycled.