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DUKE POWER COMPANY
POWER BUILDING
422 SOUTH CHURCH STREET, CHARLOTTE, N. C. 28242

WILLIAM O. PARKER, JR.
VICE PRESIDENT
STEAM PRODUCTION

TELEPHONE: AREA 704
373-4083

May 18, 1981

81-011-03L ✓

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. 50-287

Dear Mr. O'Reilly:

Please find attached Reportable Occurrence Report RO-287/81-03, Revision 1. This revision to the original report, submitted to your office on March 12, 1981, revises the corrective action section of the subject report. This report is submitted pursuant to Oconee Nuclear Station Technical Specification 6.6.2.1(2), which concerns operation in a mode less conservative than the least conservative aspect of a LCO, 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.

Very truly yours,

William O. Parker, Jr.

William O. Parker, Jr.

JLJ:scs
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, California 94303

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DUKE POWER COMPANY
OCONEE NUCLEAR STATION
UNIT 3

Report Number: RO-287/81-03, Revision 1

Report Date: May 18, 1981

Occurrence Date: February 26, 1981

Facility: Oconee Unit 3, Seneca, South Carolina

Identification of Occurrence: Over-Pressurization of "B" OTSG Secondary Side

Conditions Prior to Occurrence: Cold Shutdown

Description of Occurrence:

At apprixomately 1600 hours on February 26, 1981, the Unit 3 "B" Steam Generator was pressurized to 550 psig. The Steam Generator was overfilled, and water got in the main steam line. This was a violation of Technical Specification 3.1.2.6 and is thus reportable pursuant to Technical Specification 6.6.2.1.a(2).

Apparent Cause of Occurrence:

This incident was apparently caused by the startup control valve leaking through and filling the "B" OTSG and main steam line. Since nothing could be found wrong with the control valve either electrically or mechanically, the reason for the excess valve leakage is unknown. However, the leakage through the control valve is not inconsistent with the design of the valve (i.e. the valve is not designed to shut off flow completely). Thus the major cause of the incident was the result of a procedural deficiency in that the block valves are not specified as shut in that particular mode of operation.

Analysis of Occurrence:

No systems or piping were damaged by this incident. The integrity of the main steam lines, hangers, inspection and the OTSG itself were verified by inspection and analyses. Thus, this incident was of no significance with respect to safe operation, and the health and safety of the public were not affected.

Corrective Action:

The immediate corrective action was to open valves 3SD-5 and 3SD-290 in order to lower the OTSG pressure. The Condensate and Feedwater Procedure will be revised to lower OTSG level to between 60% and 80% on the operating range prior to initiating FDW recirculation. A note will also be added to close the start-up block valves if the control valves leak.

NRC FORM 366 (7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

EXHIBIT A

CONTROL BLOCK: | | | | | | | (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0 1 | S C N E E 3 (2) | 0 0 - 0 0 0 0 0 - 0 0 (3) | 4 1 1 1 1 (4) | | (5)
LICENSEE CODE | LICENSE NUMBER | LICENSE TYPE | CAT

CON'T 0 1 | REPORT SOURCE L (6) | 0 5 0 0 0 2 8 7 (7) | 0 2 2 6 8 1 (8) | 0 5 1 8 8 1 (9)
DOCKET NUMBER | EVENT DATE | REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 On February 26, 1981, the "B" Steam Generator was pressurized to 550 psig.

0 3 No systems or piping were damaged by this incident. The integrity of the

0 4 main steam lines, hangers, and the OTSG itself were verified. Thus, this

0 5 incident was of no significance with respect to safe operation, and the

0 6 health and safety of the public were not affected.

0 7

0 8

	SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
0 9	C B (11)	D (12)	Z (13)	V A L V E X (14)	E (15)	G (16)

(17) LER/RO REPORT NUMBER	EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
	8 1	—	0 0 3	/	0 1	X	—	1

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS (22)	ATTACHMENT SUBMITTED	NPRD-4 FORM SUB.	PRIME COMP. SUPPLIER	COMPONENT MANUFACTURER
X (18)	G (19)	Z (20)	Z (21)	0 0 0 0	Y (23)	Y (24)	L (25)	X 9 9 9 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The major cause of the incident was the result of a procedural deficiency.

1 1 Valves 3SD-5 and 3SD-290 were opened in order to lower the OTSG pressure.

1 2 The procedure will be revised to lower OTSG level to between 60% and 80% on

1 3 the operating range prior to initiating FDW recirculation. A note will also

1 4 be added to close the start-up block valves if the control valves leak.

	FACILITY STATUS	% POWER	OTHER STATUS (30)	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION (32)
1 5	H (28)	0 0 0 (29)	NA	A (31)	Operator Observation

	ACTIVITY RELEASED	CONTENT OF RELEASE	AMOUNT OF ACTIVITY (35)	LOCATION OF RELEASE (36)
1 6	Z (33)	Z (34)	NA	NA

PERSONNEL EXPOSURES

	NUMBER	TYPE	DESCRIPTION (39)
1 7	0 0 0 (37)	Z (38)	NA

PERSONNEL INJURIES

	NUMBER	DESCRIPTION (41)
1 8	0 0 0 (40)	NA

LOSS OF OR DAMAGE TO FACILITY (43)

	TYPE	DESCRIPTION
1 9	Z (42)	NA

PUBLICITY

	ISSUED	DESCRIPTION (45)	NRC USE ONLY
2 0	N (44)	NA	

NAME OF PREPARER J. L. Jones PHONE: (704) 373-8197

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