

DUKE POWER COMPANY

POWER BUILDING

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

OFFICIAL COPY

WILLIAM O. PARKER, JR.

VICE PRESIDENT
STEAM PRODUCTION

June 8, 1981

TELEPHONE: AREA 704
373-4083

81-026-03L

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. 50-270



Dear Mr. O'Reilly:

Please find attached Reportable Occurrence Report RO-270/31-08. This report is submitted pursuant to Oconee Nuclear Station Technical Specification 6.6.2.1.b(2), which concerns operation in a degraded mode permitted by a limiting condition for operation, 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. *By [Signature]*

JLS: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 UNIT 2

Report Number: RO-270/81-08

Report Date: June 8, 1981

Occurrence Date: May 8, 1981

Facility: Oconee Unit 2, Seneca, South Carolina

Identification of Occurrence: Solenoid Valve 2FDW-316 Inoperable

Conditions Prior to Occurrence: 100% FP

Description of Occurrence: At approximately 0830 hours on May 8, 1981 the "Auto, Manual Select" solenoid valve for 2FDW-316 was discovered stuck in the manual position, thus disabling automatic level control of the B "OTSG" from the Emergency Feedwater (EFW) system. This constitutes operation in a degraded mode per Technical Specification 3.4.1.c, and is thus reportable pursuant to Technical Specification 6.6.2.1.b(2).

Apparent Cause of Occurrence: The cause of this incident was the stuck Valcor solenoid valve.

Valcor solenoid valves have exhibited a generic design flaw which causes coil overheating and/or valve failure. Until a suitable replacement is found continued weekly testing will be required to identify failures as they occur.

Analysis of Occurrence: Only one steam generator is required for a safe cool down of the RC System. This requirement was met by the operability of 2FDW-315 to "OTSG A". Additionally, manual operation of 2FDW-316 was not affected and operator control of EFW to Steam Generator was available. 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 solenoid valve was replaced and functionally verified per procedure. All functions were normal.