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DUKE POWER COMPANY

POWER BUILDING

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

81-023-03L

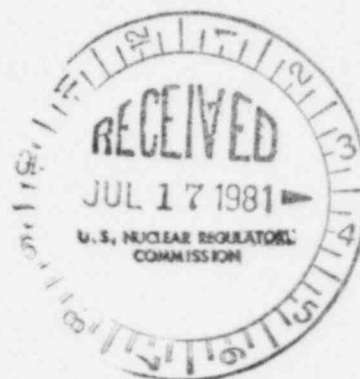
WILLIAM O. PARKER, JR.
VICE PRESIDENT
STEAM PRODUCTION

May 15, 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. 50-270



Dear Mr. O'Reilly:

Please find attached Reportable Occurrence Report RO-270/81-09. 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,

A handwritten signature in dark ink, appearing to read "William O. Parker, Jr.".

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, California 94303

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DUKE POWER COMPANY
OCONEE UNIT 2

Report Number: RO-270/81-09

Report Date: May 15, 1981

Occurrence Date: April 15, 1981

Facility: Oconee Unit 2, Seneca, South Carolina

Identification of Occurrence: '2B' RBCU Inlet Valve Inoperable

Conditions Prior to Occurrence: 97% F.P.

Description of Occurrence: At approximately 0930 on April 15, 1981, the monthly Low Pressure Service Water (LPSW) pump periodic test was being conducted. Upon completion of the Unit 2 test, valves 2LPSW-19 ('2B' RBCU inlet valve) and 2LPSW-21 ('2B' RBCU outlet valve) were closed, thus resulting in '2B' RBCU being out of service. At 1600 on April 15, 1981, at the completion of shift turnover, personnel were requested to provide flow through '2B' RBCU. At this time 2LPSW-21 was positioned to provide flow through the '2B' RBCU, and it was noted that 2LPSW-19 was shut. Valve 2LPSW-19 was opened at this time. This incident constitutes operation in a degraded mode per Technical Specification 3.3.5.c and is thus reportable pursuant to Technical Specification 6.6.2.1.b(2).

Apparent Cause of Occurrence: This incident was the result of personnel error. During test performance, personnel failed to properly note the initial valve position and thus returned valve 2LPSW-19 to the improper position.

Analysis of Occurrence: By having 2LPSW-19 shut, the '2B' RBCU was inoperable, since 2LPSW-19 is not activated to open under E.S. signal. Since the other two RBCU's and both building spray trains were operable, the health and safety of general public were not affected.

Corrective Action: The immediate corrective action was to open valve 2LPSW-19. The appropriate personnel involved have been counseled.