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 6 2 4 8 1 (8) | 0 7 2 4 8 1 (9)
DOCKET NUMBER — EVENT DATE — REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 On June 25, 1981, valve 3PR-8 failed in the closed position thus isolating
0 3 radiation monitors 3 RIA-47, -48, and -49. While the radiation monitors
0 4 were out of service, the requirements of Technical Specification 3.1.6.8
0 5 were met. Thus, the health and safety of the public were not affected.
0 6
0 7
0 8

0 9	SYSTEM CODE: B B (11)	CAUSE CODE: E (12)	CAUSE SUBCODE: B (13)	COMPONENT CODE: V A L V 0 P (14)	COMP. SUBCODE: J (15)	VALVE SUBCODE: Z (16)

(17) LER/RO REPORT NUMBER: EVENT YEAR 8 1 — SEQUENTIAL REPORT NO. 0 1 2 / OCCURRENCE CODE 0 3 — REPORT TYPE L — REVISION NO. 0

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS (22)	ATTACHMENT SUBMITTED	NPRD-4 FORM SUB.	PRIME COMP. SUPPLIER	COMPONENT MANUFACTURER
B (18)	Z (19)	Z (20)	Z (21)	0 0 0 0	Y (23)	Y (24)	L (25)	G 2 5 5 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 Valve 3 PR-8 failed to open due to a ruptured diaphragm in the air operator
1 1 on the valve. The air operator diaphragm was replaced, and the valve PR-8
1 2 diaphragm replacement frequency has been increased to every refueling outage.
1 3
1 4

	FACILITY STATUS	% POWER	OTHER STATUS (30)	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION (32)
1 5	E (28)	1 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

DUKE POWER COMPANY
OCONEE UNIT 3

Report Number: RO-287/81-12

Report Date: July 24, 1981

Occurrence Date: June 25, 1981

Facility: Oconee Unit 3 Seneca, South Carolina

Identification of Occurrence:

Conditions Prior to Occurrence: 100% FP

Description of Occurrence: At 0421 hours on June 25, 1981, valve 3PR-8 failed in the closed position, thus isolating radiation monitors 3RIA-42, -48, and -49 causing them to be inoperable. Subsequent investigation revealed that the diaphragm in the air operator on the valve had ruptured. This constitutes operation in a degraded mode per Technical Specification 3.1.6.8 and is thus reportable pursuant to Technical Specification 6.6.2.1.b(2).

Apparent Cause of Occurrence: The reason for the inoperability was a ruptured diaphragm in the air operator on the valve.

Analysis of Occurrence: Technical Specification 3.1.6.8. requires that two means of different operating principles shall be operable for detecting reactor coolant leakage when the reactor is critical and above 2% power with one of the systems sensitive to radioactivity. The system sensitive to radioactivity may be out of service for 48 hours if there are two other means to detect leakage operable.

While RIA's 47, 48, and 49 were out of service, the above requirement was met by operability of the normal RB sump level indicator and the means described in Technical Specification 3.1.6 Bases Section d. Since 3PR-8 failed closed and 3PR-7 was locked closed, the R.B. isolation was not degraded by this incident. Therefore, the health and safety of the public were not endangered.

Corrective Action: The air operator diaphragm was replaced, and the valve PR-8 diaphragm replacement frequency has been increased to every refueling outage.