

DUKE POWER COMPANY

POWER BUILDING

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

WILLIAM O. PARKER, JR.  
VICE PRESIDENT  
STEAM PRODUCTION

August 17, 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. 50-287



Dear Mr. O'Reilly:

Please find attached Reportable Occurrence Report RO-287/81-15. This report is submitted pursuant to Oconee Nuclear Station Technical Specification 6.6.2.1.a(3) which concerns operation less conservative than the least conservative aspect of a LCO and to Technical Specification 6.6.2.1.b(3) which concerns a shutdown required by 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. My letter of August 3, 1981 addressed the delay in the preparation of the report.

Very truly yours,

A handwritten signature in cursive script, appearing to read "William O. Parker, Jr.".

William O. Parker, Jr.

JLJ:ls  
Attachment

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

Mr. Bill Lavalley  
Nuclear Safety Analysis Center  
P. O. Box 10412  
Palo Alto, California 94303

Mr. Frank Jape  
NRC Resident Inspector  
Oconee Nuclear Station

IF22  
5/11

8108240117 810817  
PDR ADOCK 05000287  
S PDR

DUKE POWER COMPANY  
OCONEE UNIT 3

Report Number: RO-287/81-15

Report Date: August 17, 1981

Occurrence Date: July 18, 1981, and July 20, 1981

Facility: Oconee Nuclear Station, Seneca, South Carolina

Identification of Occurrence: "B" LPI Pump Out Of Service Past 24 Hour Limit

Conditions Prior to Occurrence: 100% FP

Description of Occurrence: At 0620 hours on July 17, 1981 the 3-B Low Pressure Injection (LPI) Pump was removed from service to correct a high vibration problem on the motor. At 0838 hours on July 18, 1981 the 3-B LPI pump was returned to service after the replacement of both motor bearings and satisfactory completion of post surveillance testing. At 1155 hours on July 20, 1981 while attempting to perform an Engineered Safeguard (ES) periodic test, the 3-B LPI pump failed to start. The cause of this failure was determined to be the incorrect positioning of the spring charging motor switch for the 4160V LPI pump supply breaker, thus resulting in personnel error. This switch was correctly positioned and the pump restored to operable status. The problem with the pump motor bearings involved a "...shutdown required by a limiting condition for operation" and is reportable pursuant to Technical Specification 6.6.2.1.b(3). The problem with the spring charging motor switch constituted operation less conservative than the least conservative aspect of an LCO in that the 24 hour time limit specified in the Technical Specifications for LPI train inoperability was exceeded and is reportable pursuant to Technical Specification 6.6.2.1.a(3).

Apparent Cause of Occurrence: The Unit had to begin reducing power 10% per hour because the 24 hour limit permitted by Technical Specification 3.3.2.b expired. The cause of the failure of the pump to start was determined to be personnel error concerning the incorrect positioning of the spring charging motor switch for the 4160V LPI pump supply breaker.

Analysis of Occurrence: During the period of time that the 3-B LPI train was inoperable, both during the motor repair work and the time that the switch was mispositioned, the "A" LPI train was operable. Although the 3-B LPI pump was inoperable for a period longer than that permitted by the Technical Specifications it is considered that this did not represent a significant increase in risk to the health and safety of the public.

Corrective Action: The pump motor bearings were replaced, the motor and pump were aligned and recoupled and a post maintenance verification test successfully completed.

The person involved has been counselled concerning his actions in this event. He has been instructed not to operate plant equipment without procedural guidance and Operation's knowledge and permission.

The procedure utilized to return these type breakers to service will be revised to include verifying the position of the spring charging motor switch.