

DUKE POWER COMPANY

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September 21, 1982

Mr. James P. O'Reilly, Regional Administrator
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-270/82-11. This report is submitted pursuant to Oconee Nuclear Station Technical Specification 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,

Hal B. Tucker

Hal B. Tucker

JCP/php
Attachment

cc: Document Control Desk
U. S. Nuclear Regulatory Commission
Washington, D. C. 20555

Mr. Philip C. Wagner
Office of Nuclear Reactor Regulation
U. S. Nuclear Regulatory Commission
Washington, D. C. 20555

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Mr. W. T. Orders
NRC Resident Inspector
Oconee Nuclear Station

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ATLANTA, GEORGIA

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Duke Power Company
Oconee Nuclear Station

Report Number: RO-270/82-14

Report Date: September 21, 1982

Occurrence Date: August 22, 1982

Facility: Oconee Unit 2, Seneca, South Carolina

Identification of Occurrence: Boiling Water Storage Tank (BWST) level instrument Channel "A" was declared inoperable due to erratic readings.

Conditions Prior to Occurrence: 100% Full Power

Description of Occurrence:

At 1500 on August 22, 1982, Control Room personnel on Unit 2 received a high level statalarm on Unit 2's BWST. The level instrumentation was checked and Channel "A" was found to be operating erratically. At that time the level indication for Channel "A" was declared inoperable and a 24-hour Technical Specification time limit was imposed (Technical Specification 3.3.4). A work report was written to investigate the problem. The cause was found, and the corrective action was performed to have the system working properly within 24 hours.

Apparent Cause of Occurrence:

The investigation revealed boiling water in the input line to the level transmitter, 2LT-6. This resulted in steam in 2LT-6 which caused the erratic operation. Further investigation revealed a broken thermostat which was causing the heat tracing to be on continuously, thus overheating the input line water.

Analysis of Occurrence:

BWST Channel "B" was operable while BWST Channel "A" was out of service. The water level in the BWST was maintained within Technical Specification limits at all times, thus ensuring an adequate supply for emergency injection. Therefore, the health and safety of the public were not endangered.

Corrective Action:

The immediate corrective action was to secure the heat tracing and refill the transmitter lines with water. Level indication was restored. Heat tracing was not necessary at that time due to the ambient temperature being much greater than the temperature required for freezing the water or crystallization of the Boron in the water (Both $\sim 32^{\circ}\text{F}$). The thermostat was found broken and was replaced, and the heat tracing is now operating properly. After the heat tracing was secured and after it was later replaced, the level reading for Channel "A" corresponded to the level reading for Channel "B".

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After reviewing previous incident reports, it was found that this is the first occurrence of a broken thermostat causing erratic BWST level indication. Therefore, since this is apparently a random failure, no further corrective action is required.