

DUKE POWER COMPANY

P.O. BOX 33189
CHARLOTTE, N.C. 28242

HAL B. TUCKER
VICE PRESIDENT
NUCLEAR PRODUCTION

TELEPHONE
(704) 373-4531

November 3, 1982

92 NOV 8 P 3:00

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. 50-287

Dear Mr. O'Reilly:

Please find attached Reportable Occurrence Report RO-287/82-11. 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,

H.B. Tucker

Hal B. Tucker

JCP/php
Attachment

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

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

INPO Records Center
Suite 1500
1100 Circle 75 Parkway
Atlanta, Georgia 30339

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

OFFICIAL COPY
IE 22

DUKE POWER COMPANY
OCONEE NUCLEAR STATION

Report Number: RO-287/82-11

Report Date: November 3, 1982

Occurrence Date: October 4, 1982

Facility: Oconee Unit 3, Seneca, South Carolina

Identification of Occurrence: Snubber was found to be inoperable.

Conditions Prior to Occurrence: 40% FP

Description of Occurrence: On October 4, 1982, at 1525, a mechanic reinspected a Unit 3 mechanical snubber that was located on the main steam supply to the emergency feedwater pump turbine line that was installed October 2, 1982, and found it to be bottomed out, thus inoperable. At this time Unit 3 was at 40 percent full power conducting Power Escalation Testing.

Apparent Cause of Occurrence: The cause of this occurrence was attributed to installation deficiency. During installation, the mechanic misread the snubber setting on the hanger sketch, and adjusted the snubber to a lower than required setting.

Analysis of Occurrence: The installation deficiency would have been noticed when Quality Assurance inspected the job. The probability of an earthquake was very low, and the removal of this snubber did not cause the Turbine Driven Emergency Feedwater Pump Turbine to be inoperable. Also, the Motor Driven Emergency Feedwater Pumps were operable during this time. The snubber was reinstalled within 72 hours as allowed by Technical Specification 3.14.2, and no radiation was released as a result of this incident. The health and safety of the general public were not endangered as a result of this incident.

Corrective Action: The immediate corrective action was to remove the snubber and manually cycle the snubber to ensure it was not frozen or jammed. Then the hanger was modified to get the proper settings, and the snubber was then reinstalled. This work was completed within 45 hours. The man who made the error and his supervisor were counseled concerning the error. Further, a letter has been written to all people involved in hanger fabrication concerning checking all dimensions provided on a hanger sketch.