

# DUKE POWER COMPANY

POWER BUILDING

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

WILLIAM O. PARKER, JR.  
VICE PRESIDENT  
STEAM PRODUCTION

April 9, 1982

TELEPHONE AREA 704  
373-4083

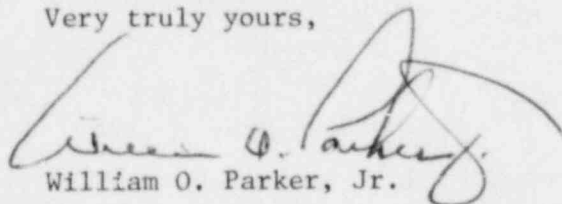
Mr. James P. O'Reilly, Regional Administrator  
U. S. Nuclear Regulatory Commission  
Region II  
101 Marietta Street, Suite 3100  
Atlanta, Georgia 30303

Re: Oconee Nuclear Station  
Docket No. 50-269

Dear Mr. O'Reilly:

Please find attached Reportable Occurrence Report RO-269/82-09. This report is submitted pursuant to Oconee Nuclear Station Technical Specification 6.6.2.1.a(9), which concerns the discovery of conditions not specifically considered in the safety analysis report or Technical Specifications that require corrective measures to prevent the existence or development of an unsafe condition, 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,



William O. Parker, Jr.

JFK/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

Records Center  
Institute of Nuclear Power Operations  
1820 Water Place  
Atlanta, Georgia 30339



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DUKE POWER COMPANY  
OCONEE NUCLEAR STATION UNITS 1 AND 2

Report Number: RO-269/82-09

Report Date: April 9, 1982

Occurrence Date: March 29, 1982

Facility: Oconee Units 1 and 2, Seneca, South Carolina

Identification of Occurrence: Reactor Building Hydrogen Analyzer System  
Differential Pressure Regulators had ruptured diaphragms.

Conditions Prior to Occurrence: Oconee 1 100% FP  
Oconee 2 Cold Shutdown

Description of Occurrence: While troubleshooting a low sample flow alarm on the Unit 1 Channel B hydrogen analyzer, the differential pressure regulator for the oxygen supply was found with the diaphragm ruptured. Subsequent investigation found 5 of 12 regulators with ruptured diaphragms.

Apparent Cause of Occurrence: The apparent cause of this occurrence is a manufacturing deficiency in that in three cases, the panels with defective regulators had not been used prior to this incident. The regulators would have to have been exposed to a backpressure substantially higher than the normal operating pressure to cause the ruptured diaphragm.

Analysis of Occurrence: The Reactor Building Hydrogen Analyzer System is normally secured, and is operated only under accident conditions. This problem was found during functional testing prior to system turnover to Operations. The defective regulator caused a low sample flow alarm and common alarm, preventing proper operation of the analyzer. This led to the identification of several ruptured diaphragms in the Reactor Building Hydrogen Analyzer System pressure regulators. Since this system was undergoing functional testing prior to operation it is felt that the health and safety of the public were not affected by this incident.

Corrective Action: The defective diaphragms will be replaced prior to completion of system function testing and turnover to Operations.