

DUKE POWER COMPANY

POWER BUILDING

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

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WILLIAM O. PARKER, JR.
VICE PRESIDENT
STEAM PRODUCTION

February 11, 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-269/81-25. 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. My letter of January 28, 1982 addressed the delay in the preparation of this report.

Very truly yours,

William O. Parker, Jr.

JFK/php
Attachment

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

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

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

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DUKE POWER COMPANY
OCONEE NUCLEAR STATION UNIT 1

Report Number: RO-269/81-25

Report Date: February 11, 1982

Occurrence Date: December 29, 1981

Facility: Oconee Unit 1, Seneca, South Carolina

Identification of Occurrence: Reactor Building Cooling Unit Inoperable

Conditions Prior to Occurrence: Hot Standby, performing Zero Power Physics Tests

Description of Occurrence: On December 29, 1981, Valve 1LPSW-24 was cycled and shut to stop leakage through the valve, and could not be reopened. Valve 1LPSW-24 is the discharge valve for the 'C' Reactor Building Cooling Unit. The inability to open this valve rendered the cooling unit inoperable.

Apparent Cause of Occurrence: The apparent cause of this incident was excessive valve vibration causing the operator torque limit switches to vibrate loose, thus allowing the valve to shut with excessive torque.

Analysis of Occurrence: The two redundant Reactor Building Cooling Units were operable during this incident as required by the Technical Specifications. Additionally, the Reactor Building Spray Pumps were operable; thus, the health and safety of the public were not affected by this incident.

Corrective Action: The valve operator was loosened and the valve cycled manually. The limit switches were tightened and reset, and the valve was satisfactorily cycled electrically; the Reactor Building Cooling Unit was declared operable. This valve application will be analyzed to determine if the use of the valve as a throttle valve is a correct application of this valve design.