

# DUKE POWER COMPANY

POWER BUILDING

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

WILLIAM O. PARKER, JR.  
VICE PRESIDENT  
STEAM PRODUCTION

July 21, 1982

TELEPHONE: AREA 704  
373-4083

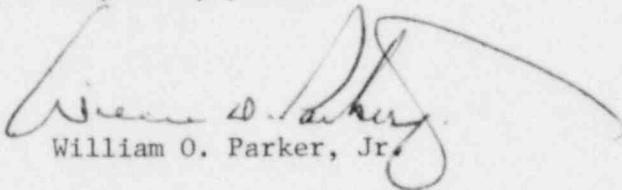
Mr. James P. O'Reilly, Regional Administrator  
U. S. Nuclear Regulatory Commission  
Region II  
101 Marietta Street, Suite 3100  
Atlanta, Georgia 30303

Re: Oconee Nuclear Station  
Docket No. 50-269

Dear Mr. O'Reilly:

Please find attached Reportable Occurrence Report RO-269/82-12. This report is submitted pursuant to Oconee Nuclear Station Technical Specification 6.6.2.1.a(2) which concerns an operation subject to a limiting condition for operation which was less conservative than the least conservative aspect of the limiting condition for operation established in the Technical Specifications, 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 July 7, 1982 addressed the delay in preparation of this report.

Very truly yours,



William O. Parker, Jr.

JFK/php  
Attachment

cc: Document Control Desk  
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

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

Duke Power Company  
Oconee Nuclear Station Unit 1

Report Number: RO-269/82-12

Report Date: July 21, 1982

Occurrence Date: June 23, 1982

Facility: Oconee Unit 1, Seneca, South Carolina

Identification of Occurrence: Both trains of the Reactor Building Spray System inoperable.

Conditions Prior to Occurrence: 100% FP

Description of Occurrence: On June 23, 1982, the A Reactor Building Spray (RBS) Pump discharge valve failed to indicate OPEN during surveillance testing of the valve. The A train of RBS was lined up with both the pump suction and discharge valves open to make the A train operable, while the redundant discharge valve on the B train was tested prior to initiating maintenance on the A train discharge valve indication. To perform the RBS pump discharge valve surveillance test the appropriate RBS train is taken out of service by racking out the RBS pump breaker for the train being tested. While the B train of RBS was out of service for the discharge valve test, the Control Room Operator shut the A train RBS suction valve due to gravity flow from the Borated Water Storage Tank into the Reactor Building. This placed both trains of RBS out of service.

Apparent Cause of Occurrence: The apparent cause of this occurrence is personnel error. Testing the redundant component was not required in this situation; thus, performing the test on the B train with the A train in an abnormal line-up (pump suction and discharge valves open) led to the condition of having both RBS trains out of service.

Analysis of Occurrence: The Reactor Building Cooling System was operable during this incident. The Reactor Building Cooling System, acting independently from the Reactor Building Spray System, is capable of limiting containment pressure below the design pressure in the event of a loss-of-coolant accident. Additionally, the Reactor Building Spray System could have been returned to an operable status within a short period of time. Thus, it is considered that this incident had no significant effect on the health and safety of the public.

Corrective Action: Upon discovery that both trains of RBS were out of service, the B RBS pump breaker was racked in, returning the B train to service. The A RBS pump discharge valve indication failure was corrected.

The Assistant Shift Supervisor has been counseled regarding his error, and this incident will be reviewed by all operators and included in the license requalification program.