

DUKE POWER COMPANY

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HAL B. TUCKER  
VICE PRESIDENT  
NUCLEAR PRODUCTION

March 23, 1983

TELEPHONE  
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Mr. James P. O'Reilly, Regional Administrator  
U. S. Nuclear Regulatory Commission  
Region II  
101 Marietta Street, NW, Suite 2900  
Atlanta, Georgia 30303

Subject: Oconee Nuclear Station  
Docket No. 50-270

Dear Mr. O'Reilly:

Please find attached Reportable Occurrence Report RO-270/83-04. 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.

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. E. L. Conner, Jr.  
Office of Nuclear Reactor Regulation  
U. S. Nuclear Regulatory Commission  
Washington, D. C. 20555

Mr. J. C. Bryant  
NRC Resident Inspector  
Oconee Nuclear Station

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

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Duke Power Company  
Oconee Nuclear Station

Report Number: RO-270/83-04

Report Date: March 23, 1983

Occurrence Date: March 9, 1983

Facility: Oconee Unit 2, Seneca, South Carolina

Identification of Occurrence: Valve 2HP-24 declared inoperable, thus making one independent train of HPI inoperable.

Conditions Prior to Occurrence: 100% FP

Description of Occurrence: On March 9, 1983 at 0854, valve 2HP-24 failed to open during its quarterly Operational Valve Functional Test. It was manually cracked open and was unsuccessfully stroke tested. After it failed to open, 2HP-24 and one independent HPI train were both considered inoperable. 2HP-24 is a high pressure injection suction valve that uses water from the Borated Water Storage Tank (BWST).

Apparent Cause of Occurrence: The incident occurred due to component failure. The cause was lack of lubrication (oil) of the valve stem.

Analysis of Occurrence: 2HP-24 or 2HP-25 provides the HPI pumps with suction from the Borated Water Storage Tank. During the time 2HP-24 failed to remotely open, 2HP-25, the redundant valve, was operable. Had an Engineered Safeguards (ES) event occurred, 2HP-25 would have opened to provide the HPI pumps with suction from the Borated Water Storage Tank. The health and safety of the public were not endangered by this occurrence.

Corrective Action: Valve 2HP-24 was manually opened, which is its ES position, and the HPI train was returned to service. Another stroke test was attempted but was again unsuccessful. The packing on the valve was loosened, the stem of the valve was lubricated, and the packing was readjusted. The valve was then successfully cycled many times and stroke tested. HP-24 and HP-25 on all units will be included in a preventive maintenance program, which would include repacking these valves every five years.