

**DUKE POWER COMPANY**

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

HAL B. TUCKER  
VICE PRESIDENT  
NUCLEAR PRODUCTION

April 19, 1983

TELEPHONE  
(704) 373-4531

83 APR 25 AID: 17

INPRO REGION 2  
ATLANTA, GEORGIA

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

Re: Oconee Nuclear Station  
Docket No. 50-269

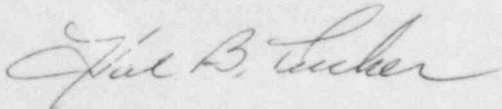
Dear Sir:

A March 22, 1983 letter submitted Reportable Occurrence Report RO-269/83-07. The report was found to have contained information errors. In the Description of Occurrence, the first sentence should read:

"On March 3, 1983 at about 1300, as a result of a follow-up investigation performed due to the recent concern of the status of valves classified as manual containment isolation valves, it was discovered that valve CF-19 was required to be closed by Oconee Technical Specifications, but was open, by procedure, on all three units.

A copy of the corrected page is attached.

Very truly yours,



Hal B. Tucker

JCP/php  
Attachment

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

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

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

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

OFFICIAL COPY

8304280069 830419  
PDR ADOCK 05000269  
S PDR

IC 22

Duke Power Company  
Oconee Nuclear Station

Report Number: RO-269/83-07

Report Date: March 22, 1983

Occurrence Date: March 3, 1983

Facility: Oconee Units 1, 2, and 3, Seneca, South Carolina

Identification of Occurrence: Manual containment isolation valve CF-19 (Core Flood) was found open on all three units.

Conditions Prior to Occurrence:

Oconee 1:	100% Full Power
Oconee 2:	100% Full Power
Oconee 3:	100% Full Power

Description of Occurrence: On March 3, 1983 at about 1300, as a result of a follow-up investigation performed due to the recent concern of the status of valves classified as manual containment isolation valves, it was discovered that valve CF-19 was required to be closed by Oconee Technical Specifications, but was open, by procedure, on all three units. CF-19 is a manual containment isolation valve on the sample line from the Core Flood Tanks. All manual containment isolation valves are required by Technical Specifications to be closed for containment integrity. Therefore, containment integrity was technically violated.

Apparent Cause of Occurrence: Previously, a procedure change was approved to allow CF-19 to remain open. The reason for the change was to provide for easier sampling of the Core Flood Tanks. The cause of this incident is classified as personnel error since the Technical Specifications applications of opening the valve were overlooked during the usual review process for procedure approval.

Analysis of Occurrence: Valve CF-19 is a 1" manual containment isolation valve. The redundant isolation valves, CF-3 and CF-4, are normally closed electric operator valves. During the time CF-3 and CF-4 were open for sampling, positive control was maintained on these valves from the Control Room. If an accident were to occur while these valves were open, the operator would have closed these valves from the Control Room. Additionally, the valves and the piping between the Reactor Building isolation valves are both safety related and seismic. Had an accident occurred, the integrity of the piping would not have been jeopardized and the containment would not have been breached at this penetration. The health and safety of the public were not endangered.

Corrective Action: Valve CF-19 was closed on all three units. All designated manual containment isolation valves were verified as being closed. The Core Flood procedure and the Reactor Building manual check list have both been changed to include CF-19 as a closed valve. Additionally, when it is required to open CF-19 above 200°F and 300 psig in the RCS, a man will be stationed at that valve. He will be in direct communication with the Control Room and will be directed to close the valve should an accident occur. A task force has been formed to review all recent containment integrity incidents and to identify additional corrective actions. All qualified reviewers and superintendents will review this report.