

EXPIRES 4-30-82

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

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EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

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ACTION TAKEN		FUTURE ACTION		EFFECT ON PLANT		SHUTDOWN METHOD		HOURS		ATTACHMENT SUBMITTED		NPRD-4 FORM SUB.		PRIME COMP. SUPPLIER		COMPONENT MANUFACTURER						20	
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ISSUED PUBLICITY  
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NRC USE ONLY

PHONE: (704) 373-2844

USNRC REGION II  
ATLANTA, GEORGIA  
**DUKE POWER COMPANY**  
P.O. BOX 33189  
CHARLOTTE, N.C. 28242

HAL B. TUCKER  
VICE PRESIDENT  
NUCLEAR PRODUCTION

83 JUL 15 P 1:53  
July 8, 1983

TELEPHONE  
(704) 373-4531

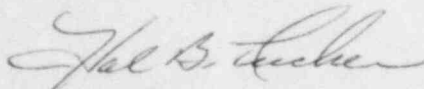
Mr. James P. O'Reilly, Regional Administrator  
U. S. Nuclear Regulatory Commission  
Region II  
101 Marietta Street, NW, Suite 2900  
Atlanta, Georgia 30303

Re: Oconee Nuclear Station  
Docket No. 50-287

Dear Mr. O'Reilly:

Please find attached Reportable Occurrence Report RO-287/83-07. The incident described in this LER is still under investigation. However, 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, a partial report is being submitted which describes the incident which was considered to be of no significance with respect to its effect on the health and safety of the public. It is expected that the investigation and supplement to this report will be completed, reviewed and submitted to you no later than August 15, 1983.

Very truly yours,



Hal B. Tucker

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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. John F. Suermann  
Office of Nuclear Reactor Regulation  
U. S. Nuclear Regulatory Commission  
Washington, D. C. 20555

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Duke Power Company  
Oconee Nuclear Station

Report Number: RO-287/83-07

Report Date: July 8, 1983

Occurrence Date: May 25, 1983

Facility: Oconee Nuclear Station, Unit 3, Seneca, South Carolina

Identification of Occurrence: Four Engineered Safeguard (ES) containment isolation valves failed in their non-ES position while inoperable due to breaker 3DIB-25 being opened to repair a cable that was damaged in fire.

Conditions Prior to Occurrence: Oconee 3 100% Full Power

Description of Occurrence: On May 25, 1983, while welding on a hanger, a fire started in a nearby flex conduit surrounding a cable. The fire had burned through the cable before it could be extinguished. This cable provides control power to control valve 3SV-90 which in turn controls valve 3HP-5 which failed in its closed position. There was an urgent need to reopen 3HP-5 in order to reestablish letdown flow. 3DIB-25 was opened to repair the cable that was damaged by the fire. Four Engineered Safeguard (ES) containment isolation valves (3HP-21, 3PR-8, 3PR-10, and 3CC-8) failed in their non-ES position when breaker 3DIB-25 was opened, and constituted a degraded mode per Technical Specification 3.6.3.b.1.

Apparent Cause of Occurrence: A fire in the power control cable to the control valve 3SV-90, which controls valve 3HP-5, caused valve 3HP-5 to fail in its ES closed position. In order to open this valve in a timely manner, breaker 3DIB-25 was opened. This caused a loss of power to the four ES containment isolation valves. These valves fail open on loss of power as required, per Table 6.2.3 of the Final Safety Analysis Report. The apparent cause of this incident is still under investigation.

Analysis of Occurrence: If 3HP-5 could not have been opened, pressurizer level would have continued increasing. At 396" in the pressurizer, the Rx would have been manually tripped. The resulting decrease in  $T_{ave}$  should have allowed additional time to repair 3HP-5. However, if 3HP-5 had remained failed shut and the pressurizer had gone solid, the resulting pressure would have been relieved to the Quench Tank via the Code Relief Valves and/or the Power Operated Relief Valve. The safety limit for Reactor Coolant System pressure would not have been exceeded.

Any contaminants released would have been contained in the reactor building because the redundant containment isolation valves, for 3HP-5, 3HP-21, 3PR-8, 3PR-10 and 3CC-8 for the affected penetrations were operable. Also, the probability of an event taking place during the time (13 minutes) 3DIB-25 was open was extremely small. Therefore, the health and safety of the public were not endangered.

Corrective Action: The immediate corrective action was to stop all welding and extinguish the fire. In order to open 3HP-5 it was necessary to open breaker 3DIB-25 to repair the fire damaged cable. When the cable was repaired the breaker was closed. The reactor coolant letdown flow was reestablished with the reopening of 3HP-5. Further corrective action is contingent upon the results of the ongoing investigation into the apparent cause of this incident.