

EXPIRES 4-30-82

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

PHONE: 704-373-2844

**DUKE POWER COMPANY**

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

HAL B. TUCKER  
VICE PRESIDENT  
NUCLEAR PRODUCTION

December 22, 1983

TELEPHONE  
(704) 373-4531

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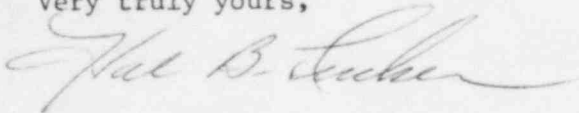
✓ Mr. James P. O'Reilly, Regional Administrator  
U. S. Nuclear Regulatory Commission  
Region II  
101 Marietta Street, NW, Suite 2900  
Atlanta, Georgia 30303

Re: Oconee Nuclear Station  
Docket No. 50-287

Dear Mr. O'Reilly:

Please find attached Reportable Occurrence Report RO-287/83-13. This report is submitted pursuant to Oconee Nuclear Station Technical Specification 6.6.2.1.a(9), which concerns the discovery of conditions not specifically considered in the safety analysis report or Technical Specifications that require corrective measures to prevent the existence or development of an unsafe condition, 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. The investigation into the cause of this occurrence, however, is continuing and a supplement to this report will be submitted to you when the information is available.

Very truly yours,



Hal B. Tucker

PFG:scs

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. J. 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-287/83-13

Report Date: December 22, 1983

Occurrence Date: November 24, 1983

Facility: Oconee Unit 3, Seneca, South Carolina

Identification of Occurrence:

Containment Isolation Valve 3CS-5 was declared inoperable due to leakage past the seat.

Conditions Prior to Occurrence: Oconee 3 100% Full Power

Description of Occurrence:

At 0230 hours on November 24, 1983 an Engineered Safeguards (ES) valve 3CS-5 was discovered to be leaking past the seat while attempting to isolate and drain the portion of the line between 3CS-5 and 3CS-6 to repair 3CS-25. Therefore, valve 3CS-5 was declared inoperable. The valve was cycled to see if it would properly reseal. After several attempts, the valve reseated and no leakage was observed. For several days the valve was observed for leakage. On December 2, 1983, it was hypothesized that the cycling had corrected the problem, thus the valve was declared operable. However, on December 3, 1983, the valve was again discovered to be leaking past the seat, therefore, the valve was declared inoperable.

Apparent Cause of Occurrence:

The cause of this occurrence was determined to be a component failure. Initially, it was hypothesized that foreign material was lodged in the valve seat and was subsequently flushed away when the valve was being cycled. The December 3, 1983, failure of the valve to properly reseal cannot be determined at this time. A supplemental report on the apparent cause of the valve failure to properly reseal will be submitted when information is available.

Analysis of Occurrence:

The inoperability of valve 3CS-5 meant that one of the two containment isolation valves for penetration number 29 was not performing its intended function. The redundant valve in the quench tank drain line, (valve 3CS-6), was fully operable during unit operation. By deactivating and administratively locking it closed within four hours of declaring 3CS-5 inoperable, continued containment isolation was assured and the limits of 10 CFR 100 would not have been exceeded should the maximum hypothetical accident occurred. Therefore, the health and safety of the public was not endangered.

DUKE POWER COMPANY  
OCONEE NUCLEAR STATION

Corrective Action:

Within four hours of declaring 3CS-5 inoperable, the redundant valve 3CS-6 was deactivated and administratively locked. This action was performed both times 3CS-5 was declared inoperable, November 24 and December 3, 1983. The failure and eventual repair of valve 3CS-5 will be completed at the next available outage. The results of this investigation will be submitted as a supplemental report.