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DOCKET NUMBER: 50-270

FILE NUMBER: INCIDENT REPORT

TO:
Mr. Norman C. Moseley

FROM:
Duke Power Company
Charlotte, North Carolina
William O. Parker, Jr.

DATE OF DOCUMENT: 5/5/77

DATE RECEIVED: 5/23/77

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PLANT NAME:

Oconee Unit No. 2

RJL

ACKNOWLEDGED

ENCLOSURE

Licensee Event Report (RO 50-270/77-6) on 4/5/77 concerning low pressure injection valve 2LP-21 failing to open.....

(1-P)

NOTE: IF PERSONNEL EXPOSURE IS INVOLVED SEND DIRECTLY TO KREGER/J. COLLINS

FOR ACTION/INFORMATION

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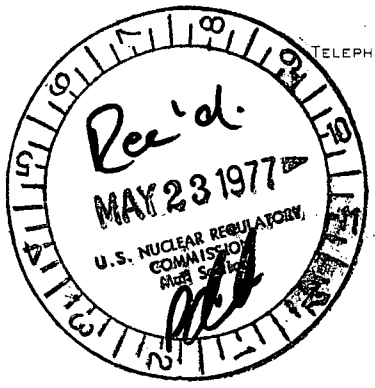
DUKE POWER COMPANY
POWER BUILDING
422 SOUTH CHURCH STREET, CHARLOTTE, N. C. 28242

WILLIAM O. PARKER, JR.
VICE PRESIDENT
STEAM PRODUCTION

TELEPHONE: AREA 704
373-4083

May 5, 1977



Mr. Norman C. Moseley, Director
U. S. Nuclear Regulatory Commission
Suite 818
230 Peachtree Street, Northwest
Atlanta, Georgia 30303

Re: Oconee Unit 2
Docket No. 50-270

Dear Mr. Moseley:

Pursuant to Sections 6.2 and 6.6.2 of the Oconee Nuclear Station Technical Specifications, please find attached Reportable Occurrence Report RO-270/77-6.

Very truly yours,

William O Parker Jr

William O. Parker, Jr.

LJB:ge
Attachment

cc: Director, Office of Management Information
and Program Control

DUKE POWER COMPANY
OCONEE UNIT 2

Report No.: RO-270/77-6

Report Date: May 4, 1977

Occurrence Date: April 5, 1977

Facility: Oconee Unit 2, Seneca, South Carolina

Identification of Occurrence: Low pressure injection valve, 2LP-21 failed to open

Conditions Prior to Occurrence: 100 percent full power

Description of Occurrence:

On April 5, 1977, while performing a Reactor Building Spray (RBS) system on-line test, valve 2LP-21 failed to open. The valve, which is located in the "A" train of the RBS system, controls one train of the borated water supply from the borated water storage tank to the RBS system and the Low Pressure Injection (LPI) system. The redundant valve 2LP-22 was verified operable thus verifying the operability of the redundant trains of RBS and LPI. Valve 2LP-21 was returned to service within eight hours.

Apparent Cause of Occurrence:

Valve 2LP-21 failed due to a loose set screw on the pinion gear of the motor shaft of the valve.

Analysis of Occurrence:

This occurrence resulted in the loss of one train of the LPI system and one train of the Reactor Building Spray system for approximately eight hours. During this period the redundant trains were operable and had full capability to perform the ES functions of the systems. It is therefore concluded that this occurrence did not adversely affect the health and safety of the public.

Corrective Action:

Valve 2LP-21 was repaired and its operability verified. This occurrence was a random equipment failure and therefore it is felt that no further corrective action is necessary.