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DUKE POWER COMPANY

POWER BUILDING

Regulatory Docket File Church Street, Charlotte, N. C. 28242

WILLIAM O. PARKER, JR. VICE PRESIDENT STEAM PRODUCTION

January 20, 1977

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

Re: Oconee Unit 1 Docket No. 50-269

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-269/ 77-1.

Very truly yours,

W. O. Parker, fr William O. Parker, Jr. By MC

LJB:ge Attachment

cc: Director, Office of Management Information and Program Control

1217

Report No.: RO-269/77-1

Report Date: January 20, 1977

Occurrence Date: January 4, 1977

Facility: Oconee Unit 1, Seneca, South Carolina

Identification of Occurrence: Exhaust fan discharge valve inoperable

Conditions Prior to Occurrence: Unit at 100 percent full power

Description of Occurrence:

On January 4, 1977, while performing a routine test of Reactor Building penetration room exhaust fan PR-EIB, the exhaust fan discharge valve, 1PR-19, was discovered inoperable. As required by Oconee Technical Specification 3.15-1, the operability of the redundant exhaust fan, PR-EIA, and exhaust fan discharge valve 1PR-15, was promptly verified. A dirty magnetic contactor which caused the problem was cleaned and 1PR-19 was tested and returned to service within the period allowed by Technical Specification 3.15-1.

Apparent Cause of Occurrence:

This incident was caused by a dirty auxiliary contact on magnetic contactor "M" of the Motor Control Center (MCC) which energized value 1PR-19.

Analysis of Occurrence:

This incident resulted in the loss of one train of the penetration room ventilation system for three hours. The redundant train, which had been verified operable, retains full capacity to perform its intended safety function in the event of an ES actuation. It is considered that due to the brief period of time during which the exhaust fan discharge valve, IPR-19, was inoperable and the operability of the redundant components, that the health and safety of the public was not affected by this occurrence.

Corrective Action:

The auxiliary contact on the magnetic contactor in the MCC was cleaned and the MCC was checked for loose wires. It is considered that routine preventive maintenance and ES tests are sufficient to detect and prevent similar problems. This is the first failure of this type.

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