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CONTROL NO: 14333

FILE: INCIDENT REPORT FILE

FROM: Duke Power Co Charlotte, NC W O Parker Jr		DATE OF DOC 12-18-75	DATE REC'D 12-30-75	LTR XXX	TWX	RPT	OTHER
TO: Mr Moseley		ORIG one signed	CC	OTHER	SENT AEC PDR <u>XX</u>		SENT LOCAL PDR <u>XX</u>
CLASS	UNCLASS XXXXXX	PROP INFO	INPUT	NO CYS REC'D 1	DOCKET NO: 50-269		
DESCRIPTION: Ltr trans the following:				ENCLOSURES: Unusual Event Report #75-9 on 11-23-75 concerning the inoperability of low pressure injection system valves to manually operate			
PLANT NAME: Oconee #1							

ACKNOWLEDGED
DO NOT REMOVE

FOR ACTION/INFORMATION 1-2-76 ehf

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** SEND ONLY TEN DAY REPORTS		

984

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

REGULATORY DOCUMENT FILE COPY

December 18, 1975

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

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 Unusual Event Report
UE-269/75-9.

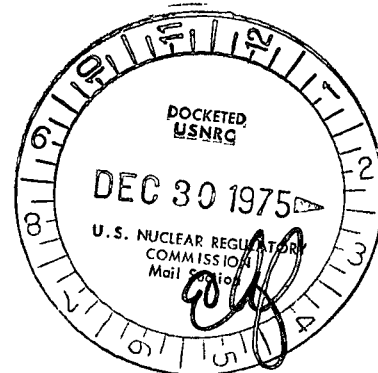
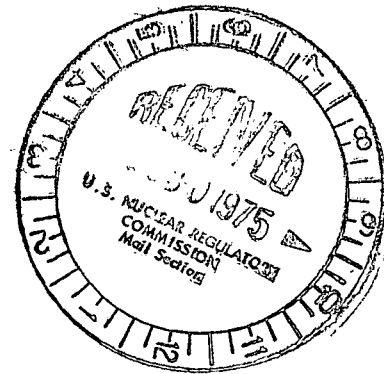
Very truly yours,

William O. Parker Jr.
William O. Parker, Jr. *WAW*

EDB:mmb

Attachment

CC Mr. Benard C. Rusche



DUKE POWER COMPANY
OCONEE UNIT 1

Report No.: UE-269/75-9

Report Date: December 18, 1975

Event Date: November 13, 1975

Facility: Oconee Unit 1, Seneca, South Carolina

Identification of Event: Low Pressure Injection System valves manually inoperable

Conditions Prior to Event: Unit at 100% full power

Description of Event:

On November 13, 1975, during performance of surveillance testing on the Oconee Unit 1 LPI System, valves 1LP-17 and 1LP-18 (LPI header isolation valves) could not be operated manually. These valves were cycled electrically to verify their operability in the Engineered Safeguards Mode.

Apparent Cause of Event:

Investigation indicated that the torque switch on the valve motor controllers had been improperly set causing the valve to seat too securely. Thus, manual operation was not possible. This condition was verified by manually operating both valves after they were first unseated by electric operation.

Analysis of Event: Periodic testing as required by Oconee Technical Specification 4.5.1.2.2.c is performed on these valves to assure that they can be manually operated to provide long-term emergency core cooling should electrical operation not be possible. In this event, both valves would have operated correctly had an ES actuation signal been received. It is concluded, therefore, that the health and safety of the public was not affected by this event.

Corrective Action:

The torque switch setting on each valve, 1LP-17 and 1LP-18, was properly adjusted, and the valves were successfully tested to assure correct operation on November 17, 1975. In addition, surveillance testing will be performed on similar LPI valves in Units 2 and 3 by December 26, 1975 to assure their proper manual operation. As a final measure, present maintenance procedures will be changed to require verification of manual operability of LPI System valves after adjustment of the torque switch setting. This change will be implemented prior to December 31, 1975.