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TO:	FROM:	DATE OF DOCUMENT
Mr. Norman C. Moseley	Duke Power Company Charlotte, North Carolina William O. Parker Jr.	5/9/77
		DATE RECEIVED: 6/13/77

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PLANT NAME: Oconee Unit No. 1

RJL 6/14/77 (1-P)

ENCLOSURE

Licensee Event Report (50-269/77-13) on 4/9/77, 4/12/77 and 4/16/77 concerning one channel of borated water storage tank level instrumentation inoperable.....

(2-P)

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

FOR ACTION/INFORMATION

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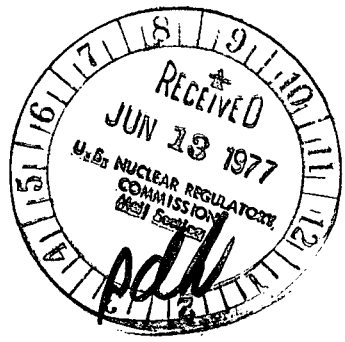
NRC FORM 195 (2-76)

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 9, 1977



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:

REGULATORY DOCKET FILE COPY

Pursuant to Sections 6.2 and 6.6.2 of the Oconee Nuclear Station Technical Specifications, please find attached Reportable Occurrence Report RO-269/77-13.

Very truly yours,

William O. Parker, Jr.

LJB:ge
Attachment

cc: Director, Office of Management Information
and Program Control

771660032

DUKE POWER COMPANY
OCONEE UNIT 1

Report No.: RO-269/77-13

Report Date: May 9, 1977

Occurrence Date: April 9, 1977, April 12, 1977 and April 16, 1977

Facility: Oconee Unit 1, Seneca, South Carolina

Identification of Occurrence: One channel of borated water storage tank level instrumentation inoperable

Conditions Prior to Occurrence: Unit at 100 percent full power

Description of Occurrence:

From April 9, 1977 to April 16, 1977, three incidents occurred during which one of the two redundant channels of the Oconee Unit 1 borated water storage tank (BWST) level instruments indicated a fluctuating tank water level. The remaining instrument in all three cases indicated that the level of borated water required by Technical Specifications was being maintained. The BWST level indicator was inoperable for a total of 5 hours during the 8 day period. In each incident, work requests were promptly issued and investigation revealed that the BWST level instrument process line was obstructed. The line was cleared and the level indicator declared operable in each case.

On April 18, 1977, during the on-going investigation of the incidents, it was discovered that the BWST level instrument process line heat trace thermostats on both channels were not installed under the process line insulation. This caused continuous heating of the water in the process line resulting in boiling of the borated water, bubbles of steam and postulated deposit of a residue of boric acid on the walls of the process line. It is felt that in the first incident clogging of the process line was caused by deposits. In the second and third incidents, the entrainment of bubbles in the line caused the faulty indications.

Apparent Cause of Occurrence:

It is postulated that the first incident was caused by clogging of the process line due to buildup of boric acid residue in the process line. The second and third incident were caused by the entrainment of bubbles in the line possibly formed when the lines were overheated. An improperly placed thermostat had caused the overheating of the process line.

Analysis of Occurrence:

This condition is considered to be reportable since it constituted operation in a degraded mode permitted by a Limiting Condition for operation. Technical Specification 3.3.5 makes provision for the removal from service for test or monitoring of any component of high

pressure injection, low pressure injection or reactor building spray for a period of 24 hours provided not more than one train of each system is afflicted. This occurrence resulted in the loss of one of two redundant channels of BWST level indication for two hours on April 9, 1977, for one hour on April 12, 1977 and for two hours on April 16, 1977. During these periods, the redundant level transmitter properly indicated the true level of the BWST. The conditions of the BWST required by Technical Specification 3.2 were maintained and the emergency core cooling systems would have performed as required in the unlikely event they were needed. It is concluded that the health and safety of the public were not affected by this incident.

Corrective Action:

The process line was initially bled in each incident and upon discovery of the improperly installed thermostats, the thermostats were reinstalled under the process line installation on both channels.

The heat tracing on Oconee Unit 2 and 3 will be checked for similar conditions by June 1, 1977. It is felt that this corrective action will eliminate future occurrences of this type.

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