

50-269

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FILE NUMBER

INCIDENT REPORT

TO:

Mr. Norman C. Moseley

FROM:

Duke Power Company
Charlotte, NC
William O. Parker

DATE OF DOCUMENT

7/21/77

DATE RECEIVED

8/1/77

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PLANT NAME:

Oconee Nuclear Station Technical
VT 8/2/77 (2-P)

ENCLOSURE

Licensee Event Report #RO 50-269/77-22 on 7/7/77 concerning the pressurizer water sample valve which was discovered inoperable during a periodic test, RC-6.

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

1 CY ENCL Rec'd

FOR ACTION/INFORMATION

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L.PDR: **WALHALLA, S.C.**

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DUKE POWER COMPANY

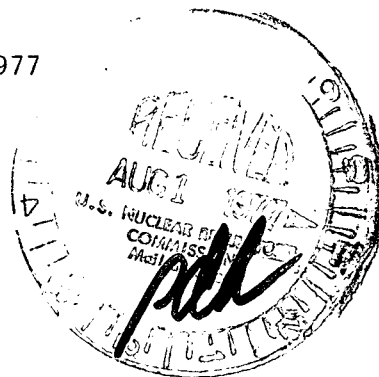
POWER BUILDING

422 SOUTH CHURCH STREET, CHARLOTTE, N. C. 28242

WILLIAM O. PARKER, JR.
VICE PRESIDENT
STEAM PRODUCTION

July 21, 1977

TELEPHONE: AREA 704
373-4083



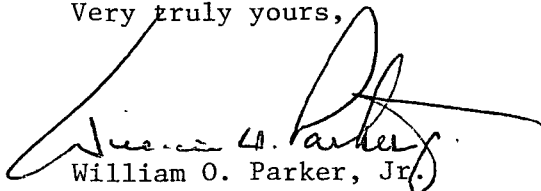
Mr. Norman C. Moseley, Director
U. S. Nuclear Regulatory Commission
Suite 818
230 Peachtree Street, Northwest
Atlanta, Georgia 30303

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 Reportable Occurrence Report RO-269/77-22.

Very truly yours,


William O. Parker, Jr.

LJB:ge
Attachment

cc: Director, Office of Management Information
and Program Control

772140274

DUKE POWER COMPANY
OCONEE UNIT 1

Report No.: RO-269/77-22

Report Date: July 21, 1977

Occurrence Date: July 7, 1977

Facility: Oconee Unit 1, Seneca, South Carolina

Identification of Occurrence: Pressurizer water sample valve, RC-6,
discovered inoperable

Conditions Prior to Occurrence: Unit at 55 percent full power

Description of Occurrence:

On July 7, 1977 after performing a periodic test, RC-6, the pressurizer water sample valve was discovered inoperable. This valve, which is located inside the Reactor Building in the pressurizer water sampling piping, provides containment isolation following an ES actuation. Valve RC-6 could not be cycled to a fully closed position from the normal control switch. Valve RC-6 was isolated by redundant valve RC-7 which was in the closed position. However, due to personnel error, valve RC-7 was not locked closed as required by Technical Specification 3.6.4.b.2. Valve RC-6 was also isolated by locking closed valve, RC-53, which is located downstream of valve RC-7 in the pressurizer sample line. Valve RC-6 was returned to service within 5 and 1/2 hours.

Designation of Apparent Cause of Occurrence:

Investigation revealed that a "finger" on the motor contactor was dirty preventing the contactor from energizing and properly closing the valve.

Analysis of Occurrence:

Valve RC-6 was isolated by redundant valve RC-7 which was in the closed ES position. In the event that containment integrity had been required valve RC-7 would have remained closed upon an ES actuation. Containment integrity was further assured by valve RC-53 which was locked closed and thus isolated the pressurizer sample line. Containment integrity was not affected by this incident and it is, thus, concluded that the health and safety of the public were not affected.

Corrective Action:

Valve RC-6 has been repaired and its operability verified. In order to assure that the provisions of Technical Specification 3.6.4.b.2 are complied with in the future, this incident will be reviewed by appropriate personnel.

RO REGION II
ATLANTA, GEORGIA

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