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(TEMPORARY FORM)

CONTROL NO: 10104

FILE: \_\_\_\_\_

FROM: Duke Power CO. Charlotte, N.C. A.C.Thies		DATE OF DOC 9-27-74	DATE REC'D 10-1-74	LTR xxx	TWX	RPT	OTHER
TO: Mr. Norman C. Moseley		ORIG 1-signed	CC	OTHER	SENT AEC PDR <u>xxxxxxxxxx</u>		SENT LOCAL PDR <u>xxxxxxxxxx</u>
CLASS	UNCLASS xxxxxxx	PROP INFO	INPUT	NO CYS REC'D 1	DOCKET NO: 50-287y		

DESCRIPTION:

Ltr Trans the Following:

**ACKNOWLEDGED**

**DO NOT REMOVE**

PLANT NAME:

Oconee Unit 3

ENCLOSURES:

Abnormal Occurrence on 9-15-74 concerning Failure to maintain containment integrity during repairs to Engineered Safeguards valve 3CS-5.....

FOR ACTION/INFORMATION **11-23-74** JGB

BUTLER (L) W/ Copies	SCHWENCER (L) W/ Copies	ZIEMANN (L) W/ Copies	REGAN (E) W/ Copies
CLARK (L) W/ Copies	STOLZ (L) W/ Copies	DICKER (E) W/ Copies	LEAR (L) W/ Copies
PARR (L) W/ Copies	VASSALLO (L) W/ Copies	KNIGHTON (E) W/ Copies	W/ Copies
KNIEL (L) W/ Copies	<del>PURPLE (L)</del> W/ Copies	YOUNGBLOOD (E) W/ Copies	W/ Copies

INTERNAL DISTRIBUTION

<del>REG FILE</del>	<u>TECH REVIEW</u>	<u>DENTON</u>	<u>LIC ASST</u>	<u>A/T IND</u>
<del>AEC PDR</del>	<del>SCHROEDER</del>	GRIMES	DIGGS (L)	BRAITMAN
<del>CGC, ROOM P-506A</del>	<del>MACCARY</del>	GAMMILL	GEARIN (L)	SALTZMAN
<del>MUNTZING/STAFF</del>	<del>KNIGHT</del>	<del>KASTNER</del>	GOULBOURNE (L)	B. HURT
<del>CASE</del>	<del>AWLICKI</del>	BALLARD	KREUTZER (E)	<u>PLANS</u>
GIAMBUSSO	<del>SHAO</del>	SPANGLER	LEE (L)	MCDONALD
BOYD	<del>STELLO</del>	<u>ENVIRO</u>	MAIGRET (L)	CHAPMAN
MOORE (L) (BWR)	<del>HOUSTON</del>	MULLER	REED (E)	DUBE w/input
DEYOUNG (L) (PWR)	<del>NOVAK</del>	DICKER	SERVICE (L)	E. COUPE
SKOVHOLT (L)	<del>ROSS</del>	KNIGHTON	<del>SHEPPARD (L)</del>	<del>THOMPSON (2)</del>
GOLLER (L)	<del>PPOLITO</del>	YOUNGBLOOD	SLATER (E)	<del>LECKER</del>
P. COLLINS	<del>TEDESCO</del>	REGAN	SMITH (L)	<del>EISENHUT</del>
DENISE	<del>LONG</del>	PROJECT LDR	TEETS (L)	
<del>REG OPR</del>	<del>SAINAS</del>	<u>HARLESS</u>	WILLIAMS (E)	
<del>FILE &amp; REGION (3)</del>	<del>GENAROYA</del>		WILSON (L)	
<del>MORRIS</del>	<del>VOLIMER</del>			
<del>STEELE</del>				

EXTERNAL DISTRIBUTION

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<del>TIC (ABERNATHY)</del> (1)(2)(10)	1 - ASLBP (E/W Bldg, Rm 529)	1 - BROOKHAVEN NAT LAB
<del>NSIC (BUCHANAN)</del>	1 - W. PENNINGTON, Rm E-201 GT	1 - G. ULRIKSON, ORNL
1 - ASLB	1 - B&M SWINEBROAD, Rm E-201 GT	1 - AGMED (RUTH GUSMAN)
1 - Newton Anderson	1 - CONSULTANTS	Rm B-127 GT
16 - ACRS <del>XXXXXXXXXX</del>	NEWMARK/BLUME/AGBAGIAN	1 - R. D. MUELLER, Rm E-201 GT
Sent to Lic Asst <u>Sheppard</u>		

DUKE POWER COMPANY  
POWER BUILDING  
422 SOUTH CHURCH STREET, CHARLOTTE, N. C. 28201

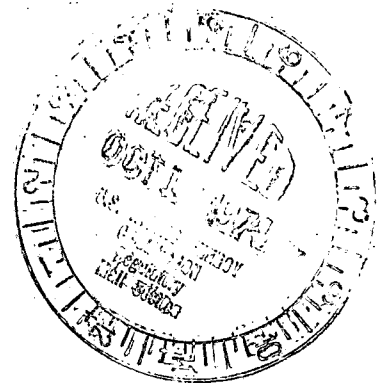
A. C. THIES  
SENIOR VICE PRESIDENT  
PRODUCTION AND TRANSMISSION

P. O. Box 2178

September 27, 1974

Regulatory

File Cy.



Mr. Norman C. Moseley, Director  
Directorate of Regulatory Operations  
U. S. Atomic Energy Commission  
Region II - Suite 818  
230 Peachtree Street, Northwest  
Atlanta, Georgia 30303

Re: Oconee Unit 3  
Docket No. 50-287

Dear Mr. Moseley:

Pursuant to Sections 6.2 and 6.6.2 of the Oconee Nuclear Station  
Technical Specifications, please find attached Abnormal Occurrence  
Report AO-287/74-3.

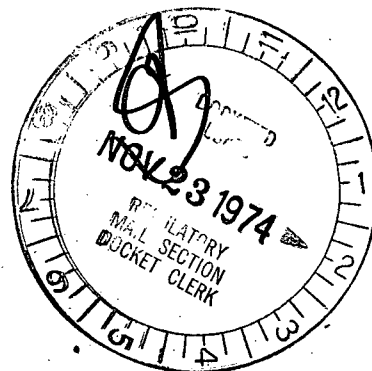
Very truly yours,

*A. C. Thies* *TH*

A. C. Thies

ACT:vr  
Attachment

cc: Mr. Angelo Giambusso



10104

DUKE POWER COMPANY  
OCONEE UNIT 3

Report No.: AO-287/74-3

Report Date: September 27, 1974

Occurrence Date: September 15, 1974

Facility: Oconee Unit 3, Seneca, South Carolina

Identification of Occurrence: Failure to maintain containment integrity during repairs to Engineered Safeguards valve 3CS-5

Conditions Prior to Occurrence: Power operation at approximately 14 percent full power

Description of Occurrence:

On September 11, 1974, the valve 3CS-5 appeared to be intermittently inoperable. Engineered Safeguards Reactor Building isolation valve 3CS-5 in the quench tank drain line, located in the Reactor Building. Preliminary investigation by operations and maintenance personnel indicated a malfunction of the control switch in the control room. On September 11, 1974, a work request was initiated to have 3CS-5 checked, and the work was scheduled for September 14 during a scheduled maintenance outage. Between September 11 and 14, power escalation testing continued at 14 percent power, then the unit was brought to a hot shutdown condition at 531°F and 900 psi. The second Engineered Safeguards Reactor Building isolation valve in the quench tank drain line, 3CS-6, was tagged closed prior to commencement of maintenance activities on 3CS-5.

On September 14, the valve was disassembled, checked, and reassembled. Electricians checking the motor operator found that the valve had been jammed in the open position, and the operator motor burned.

The burned motor was replaced, but on the morning of September 15, it was found that the replacement motor was drawing excessive current, and additional adjustments had to be made on the motor operator.

At approximately 0800 on September 15, 1974, it was realized that the requirements for containment integrity were not met. Section 1.7d of the Oconee Technical Specifications requires that all automatic containment isolation valves be operable or locked closed for containment integrity to exist. The valve 3CS-5 was manually closed, and pressure and temperature were reduced to 190°F and 410 psi.

Designation of Apparent Cause of Occurrence:

The apparent cause of this occurrence was the incorrect evaluation of the cause for the intermittent operability of valve 3CS-5. Early investigation

of the problem indicated the problem was caused by a faulty switch in the control room. This control circuit is in parallel with the Engineered Safeguards actuation circuitry. The first indication that the valve itself was inoperable was found during actual maintenance on the valve on September 14.

Contributing to the cause of the occurrence was failure by operations personnel to realize that all conditions required for maintenance on the containment isolation valve had not been met.

Analysis of Occurrence:

If Engineered Safeguards actuation had occurred during the interval of this occurrence, containment integrity would have been maintained. The redundant valve in the quench tank drain line, 3CS-6, was fully operable during unit operation and was locked closed during maintenance on 3CS-5. Therefore, it is concluded that this incident did not affect the health and safety of the public.

Corrective Action:

Immediate corrective action upon discovery of the occurrence was to reduce reactor coolant system temperature and pressure to 190°F and 410 psi. To prevent recurrence, the events of this incident and the appropriate action that should have been taken have been reviewed with all operations personnel.