REPORT OF ABNORMAL OCCURRENCE AND/OR INCIDENT

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CONTROL NO: 12972

FILE: INCIDENT REPORT FILE

FROM:	Duke Power Co. Charlotte, N.C. Willaim O. Parker	DATE OF DOC 11-10-75	DATE REC'D 11-12-75	LTR XXX	TWX	RPT	OTHER
TO:	Mr. Norman Moseley	ORIG None	CC 1	OTHER	SENT AEC PDR XXX SENT LOCAL PDR XXX		
CLASS	UNCLASS XXX	PROP INFO	INPUT	NO CYS REC'D 1	DOCKET NO: 50-287		

DESCRIPTION:
Letter trans the following........

ENCLOSURES:
Unusual Evnet Repott # 75-11, on 10-8-75, Concerning Valve Failure resulting in restricted PSW flow......

(1 Copy Received)

PLANT NAME: Oconee # 3

FOR ACTION/INFORMATION — SAB 11-14-75

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** SEND ONLY TEN DAY REPORTS

DUKE POWER COMPANY
POWER BUILDING
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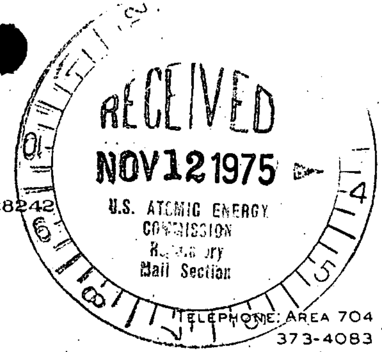


TELEPHONE: AREA 704
373-4083

WILLIAM O. PARKER, JR.
VICE PRESIDENT
STEAM PRODUCTION

November 10, 1975

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

Regulatory File Cy

Re: Oconee Unit 3
Docket No. 50-287

Dear Mr. Moseley:

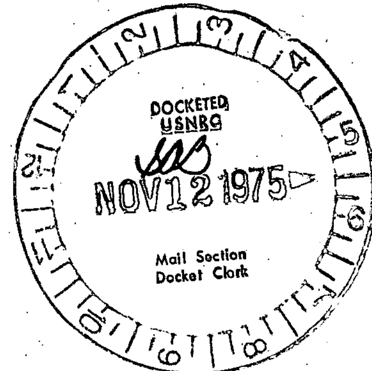
Pursuant to Sections 6.2 and 6.6.2 of the Oconee Nuclear Station Technical Specifications, please find attached Unusual Event Report UE-287/75-11.

Very truly yours,

William O. Parker, Jr

MST/esw
Attachment

cc: Mr. Benard C. Rusche



12972

DUKE POWER COMPANY
OCONEE UNIT 3

Report No.: UE-287/75-11

Report Date: November 10, 1975

Event Date: October 8, 1975

Facility: Oconee Unit 3, Seneca, South Carolina

Identification of Event: Valve failure resulting in restricted LPSW flow

Conditions Prior to Event: Unit in cold shutdown

Description of Event:

On October 8, 1975 during an Oconee Unit 3 outage, difficulty was encountered in maintaining low pressure service water (LPSW) flow to the "3B" decay heat cooler above 1800 gpm. The "3A" decay heat cooler was placed into service to provide adequate heat removal. Subsequent investigation revealed that Valve 3LPSW-78, LPSW outlet from the decay heat cooler, had failed in the partially closed position restricting the service water flow.

Designation of Apparent Cause of Event:

This incident was apparently caused by improper installation of a coupling pin in the valve operating mechanism. The function of the pin is to couple the valve operator sleeve to the valve shaft. Due to a misalignment of the guide holes, the pin was apparently improperly installed from the bottom rather than from the top of the sleeve. Subsequently, the pin vibrated loose and fell out, allowing the throttle valve to close.

Analysis of Event:

This incident resulted in partial blocking of LPSW flow to one of two redundant decay heat coolers while the reactor was in a cold shutdown condition. Adequate decay heat removal capability was provided throughout this incident. It is concluded that the health and safety of the public was not affected.

Corrective Action:

The tapered pin fastening the operator sleeve to the valve shaft has been properly installed and the valve returned to service. This is the first of this type failure experienced at Oconee and is considered to be an isolated incident.