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FILE: INCIDENT REPORT FILE

FROM: Duke Power Co. Charlotte, N.C. William O. Parker, Jr.		DATE OF DOC 11-10-75	DATE REC'D 11-15-75	LTR XXX	TWX	RPT	OTHER
TO: Mr. Norman Moseley		ORIG 1 Signed	CC 0	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 Event Report # 75-11, On 10-8-75, Concerning a Valve Failure resulting in restricted LPSW flow..... (1 Copy Received)			
PLANT NAME: Oconee # 3							

FOR ACTION/INFORMATION

SAB 11-19-75

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JS

DUKE POWER COMPANY

POWER BUILDING

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

WILLIAM O. PARKER, JR.
VICE PRESIDENT
STEAM PRODUCTION

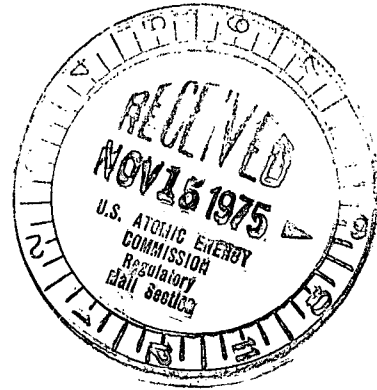
File Cycle

TELEPHONE: AREA 704
373-4083

Regulatory

November 10, 1975

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

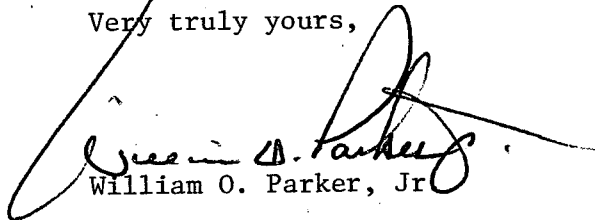


Re: Oconee Unit 3
Docket No. 50-287

Dear Mr. Moseley:

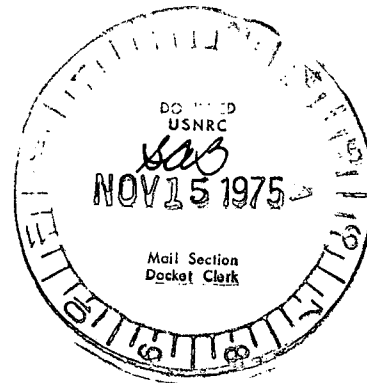
Pursuant to Sections 6.2 and 6.6.2 of the Oconee Nuclear Station
Technical Specifications, please find attached Unusual Event Report
UE-287/75-11.

Very truly yours,


William O. Parker, Jr.

MST/esw
Attachment

cc: Mr. Benard C. Rusche



13078

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.

U.S. AIR FORCE
REGULATORY OPERATIONS
REGION II
ATLANTA, GA.

Nov 13 10 39 AM '75