

**REPORT OF ABNORMAL OCCURRENCE AND/OR INCIDENT**  
**NRC DISTRIBUTION FOR PART 50 DOCKET MATERIAL**  
**(TEMPORARY FORM)**

CONTROL NO: 3306

FILE: INCIDENT REPORT FILE

FROM: Duke Power Company Charlotte, N.C. 28201 A.C. Thies		DATE OF DOC 3-25-75	DATE REC'D 3-28-75	LTR XX	TWX	RPT	OTHER
TO: Mr. Norman C. Moseley		ORIG	CC 1	OTHER	SENT AEC PDR SENT LOCAL PDR		XX XX
CLASS	UNCLASS XX	PROP INFO	INPUT	NO CYS REC'D 1	DOCKET NO: 50-270/287		

DESCRIPTION: Ltr trans the following:

ENCLOSURES: Unusual Event UE-270/75-3 & UE-287/75-2 on 2-10-75 & 3-19-75 re failure of manual feature of Decay Heat Removal system valves..

(1 cy encl rec'd)

PLANT NAME: Oconee Units 2 & 3

FOR ACTION/INFORMATION

DHL 3-31-75

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	SPELS W/ Copies
KNIEL (L) W/ Copies	PURPLE (L) W/ Copies	YOUNGBLOOD (E) W/ Copies	

INTERNAL DISTRIBUTION

<del>REG FILE (2)</del>	TECH REVIEW	DENTON	LIC ASST	A/T IND.
<del>NRC PDR (2)</del>	<del>SCHROEDER</del>	**GRIMES	R. DIGGS (L)	BRAITMAN
OGC, ROOM P-506A	MACCARY	GAMMILL	H. GEARIN (L)	SALTZMAN
GOSSICK/STAFF	KNIGHT	KASTNER	E. GOULBOURNE (L)	MELTZ
<del>CASE</del>	PAWLICKI	BALLARD	P. KREUTZER (E)	
GIAMBUSO	SHAO	SPANGLER	J. LEE (L)	PLANS
BOYD	**STELLO		M. MAIGRET (L)	MCDONALD
MOORE (L)	**HOUSTON	ENVIRO	S. REED (E)	CHAPMAN
DEYOUNG (L)	**NOVAK	MULLER	M. SERVICE (L)	DUBE (Ltr)
SKOVHOLT (L)	ROSS	DICKER	<del>S. SHEPPARD (L)</del>	E. COUPE
GOLLER (L) (Ltr)	IPPOLITO	KNIGHTON	M. SLATER (E)	PETERSON
P. COLLINS	TEDESCO	YOUNGBLOOD	H. SMITH (L)	HARTFIELD (2)
DENISE	LONG	REGAN	S. TEETS (L)	<del>KLECKER</del>
REG OPR	LAINAS	PROJECT LDR	G. WILLIAMS (E)	EISENHUT
<del>FILE &amp; REGION (2)</del>	BENAROYA		V. WILSON (L)	WIGGINTON
<del>T.R. WILSON (3)</del>	<del>VOLLMER</del>	HARLESS	R. INGRAM (L)	<del>F. WILLIAMS</del>
STEELE				<del>HANAUER</del>

EXTERNAL DISTRIBUTION

<del>1 - LOCAL PDR</del> Walhalla, S.C.	1 - NATIONAL LABS	1 - PDR-SAN/LA/NY
<del>1 - TIC (ABERNATHY)</del> (1)(2)(10)	1 - W. PENNINGTON, Rm E-201 GT	1 - BROOKHAVEN NAT LAB
<del>1 - NSIC (BUCHANAN)</del>	1 - CONSULTANTS	1 - G. ULRIKSON, ORNL
1 - ASLB	NEWMARK/BLUME/AGBABIAN	1 - AGMED (RUTH GUSSMAN)
1 - Newton Anderson		Rm B-127 GT
<del>5 - ACRS</del> SENT TO LIC ASST Sheppard 3-31-75		1 - J. D. RUNKLES, Rm E-201
** SEND ONLY TEN DAY REPORTS		GT

DUKE POWER COMPANY

POWER BUILDING

422 SOUTH CHURCH STREET, CHARLOTTE, N. C. 28201

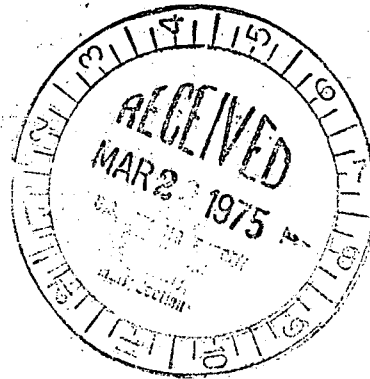
A. C. THIES  
SENIOR VICE PRESIDENT  
PRODUCTION AND TRANSMISSION

P. O. Box 2178

March 25, 1975

Regulatory Docket File

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



Re: Oconee Units 2 and 3  
Docket Nos. 50-270, 50-287

Dear Mr. Moseley:

Pursuant to Sections 6.2 and 6.6.2 of the Oconee Nuclear Station Technical Specifications, please find attached a report which describes two similar events. The report is designated Unusual Event Report UE-270/75-3/UE-287/75-2.

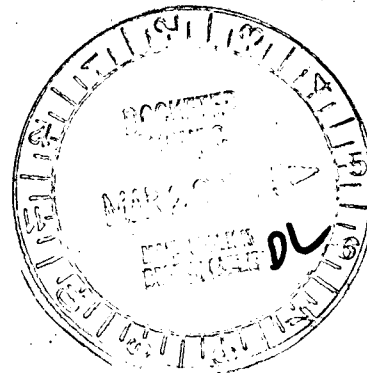
Very truly yours,

A handwritten signature in cursive script that reads "A. C. Thies".

A. C. Thies

ACT:vr  
Attachment

cc: Mr. Angelo Giambusso



3306

Regulation

DUKE POWER COMPANY  
OCONEE UNITS 2 AND 3

Report No.: UE-270/75-3/UE-287/75-2

3-25-75

Report Date: March 25, 1975

Event Date: February 10, 1975 and March 19, 1975

Facility: Oconee Units 2 and 3, Seneca, South Carolina

Identification of Event: Failure of manual feature of Decay Heat Removal System valves

Conditions Prior to Event: Unit 2 in cold shutdown  
Unit 3 at 75 percent full power

Description of Event:

On February 10 and March 19, 1975, the Decay Heat Removal System Power Operated Valve Annual Performance Test was performed to Oconee Units 2 and 3, respectively. In the performance of these tests, five valves could not be manually operated as required by Technical Specification 4.5.1.2.2. The valves and a description of the malfunction of each is provided below:

1. Low Pressure Injection (LPI) discharge crossconnect between the A and C LPI pumps, 2LP-9, was missing a handwheel.
2. LPI discharge throttle valve for A decay heat removal cooler, 2LP-12, started electrically when the manual clutch was engaged.
3. LPI header isolation valve, 2LP-17, speed handle had interference with two adjacent pipes. The clutch would not engage for manual operation.
4. LPI discharge throttle valve for A decay heat removal cooler, 3LP-12, handwheel stem was bent preventing rotation.
5. LPI discharge throttle valve for B decay heat removal cooler, 3LP-14, was missing a handwheel.

Work requests were prepared and all valves were made manually operable.

Designation of Apparent Cause of Event:

The surveillance test to ensure manual operability of these low pressure injection valves is performed on an annual basis. However, this was the first time that the test had been performed on Units 2 and 3. All pre-operational testing of these components is performed using the remote, power operated features; hence, manual operability was never verified. There was no indication that these valves had ever been manually operated since the initial construction of the units.

Analysis of Event:

The purpose of the periodic test is to ensure that selected LPI valves can be manually operated to provide long-term emergency core cooling should remote or local operation of system components not be possible. This is intended as a backup to the normal automatic initiation or manual remote initiation.

In the case of Unit 2, only one string of LPI was affected; thus, one of two redundant backup methods of supplying LPI was inoperable. The inoperable discharge crossover valve would have only affected the spare LPI pump.

In the case of Unit 3, both cooler outlet throttle valves were manually inoperable; however, they are normally open valves and would not have prevented LPI flow.

It is concluded that the health and safety of the public was not affected.

Corrective Action:

As a result of the test results on Unit 2, the test was performed on Unit 3 ahead of its scheduled time. All valves on Units 2 and 3 were repaired and tested to ensure manual operability. Since this test has now been performed on all three units, and problems corrected, it is believed that continued annual surveillance is adequate to prevent future occurrences.