

A 03/14/78

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DOC DATE: 03/03/78
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DOCTYPE: LETTER NOTARIZED: NO

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SUBJECT:
LICENSEE EVENT REPT (RO 50-287/78-4) ON 02/03/78 CONCERNING ELEC
FAILURE OF BS-3 VALVE'S TORQUE SWITCH.

PLANT NAME: OCONEE - UNIT 3

REVIEWER INITIAL: XJM
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NOTES:

1. M. CUNNINGHAM - ALL AMENDMENTS TO FSAR AND CHANGES TO TECH SPECS

INCIDENT REPORTS
(DISTRIBUTION CODE A002)

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SHAO**W/ENCL
KREGER/J. COLLINS**W/ENCL
K SEYFRIT/IE**W/ENCL

NRC PDR**W/ENCL
MIPC**W/3 ENCL
HOUSTON**W/ENCL
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BUTLER**W/ENCL
TEDESCO**W/ENCL
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VOLLMER/BUNCH**W/ENCL
ROSA**W/ENCL

EXTERNAL: LPDR'S
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REGULATORY GUIDE 10.1

DISTRIBUTION: LTR 45 ENCL 45
SIZE: 1P+1P+1P

CONTROL NBR: 780720035

***** THE END *****

007
T

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

WILLIAM O. PARKER, JR.
VICE PRESIDENT
STEAM PRODUCTION

March 3, 1978

TELEPHONE: AREA 704
373-4083

Mr. James P. O'Reilly, Director
U. S. Nuclear Regulatory Commission
Suite 1217
230 Peachtree Street, Northwest
Atlanta, Georgia 30303



RE: Oconee Unit 3
Docket No. 50-287

Dear Mr. O'Reilly:

Pursuant to Sections 6.2 and 6.6.2 of the Oconee Nuclear Station
Technical Specifications, please find attached Reportable Occurrence
Report RO-287/78-4.

Very truly yours,

William O. Parker, Jr.
William O. Parker, Jr. *By Hand*

KRW:ge
Attachment

cc: Director, Office of Management Information
and Program Control

*A002
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DUKE POWER COMPANY
OCONEE UNIT 3

Report No.: RO-287/78-4

Report Date: March 3, 1978

Occurrence Date: February 3, 1978

Facility: Oconee Unit 3, Seneca, South Carolina

Description of Occurrence: 3BS-3, Building Spray Pump Suction Valve
Inoperable

Conditions Prior to Occurrence: 100% Full Power

Description of Occurrence:

On February 3, 1978, at 1005, during the performance of PT/3/A/150/15A (valve operational test) 3BS-3 failed to open. The valve was closed in order to test its ability to assume its post-LOCA position (open) and failed to do so. The valve's torque switch was replaced and the valve was operable by 1515.

Apparent Cause of Occurrence:

The valve's torque switch evidently failed thereby preventing the valve from properly operating.

Analysis of Occurrence:

The reactor building spray system consists of two separate trains with independent spray headers. The 3BS-3 failure rendered the "A" train inoperable, but the other train was available to mitigate the consequences of accidents considered in the FSAR, and the train was returned to service within the 24 hours allowed for repair in Technical Specification 3.3.5. Therefore, the health and safety of the public were not endangered by this incident.

Corrective Action:

The valve's torque switch was replaced and the valve was verified operable.

LICENSEE EVENT REPORT

EXHIBIT A

CONTROL BLOCK: [][][][][][] (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

[01] 8 [S][C][N][E][E][3][2][0] 8
7 9 14 15 25 26 30 37 57 CAT 58 (5)

CONT [01] 8
7 8 REPORT SOURCE [L][6][0][5][0][0][0][2][8][7][7][0][2][0][3][7][8][8][0][3][0][3][7][8] 9
60 61 DOCKET NUMBER 58 59 EVENT DATE 74 75 REPORT DATE 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

[02] On February 3, 1978, during a valve operability test, BS-3 was to be closed
[03] and then opened to simulate its actions during and after a postulated
[04] accident. It failed to open. The failure caused one of the two reactor
[05] building spray trains to be inoperable. However, the other train was
[06] available at all times and the repairs were accomplished within the Tech
[07] Spec allowances in T.S. 3.5.3. Therefore, public health and safety were
[08] not affected.

[09] 8 [S][B][11][E][12][A][13][V][A][L][V][O][P][14][A][15][Z][16] 80
9 10 11 12 13 18 19 20

[17] LER/RO REPORT NUMBER [7][8] 21 22 [] 23 SEQUENTIAL REPORT NO. [0][0][4] 24 26 [] 27 OCCURRENCE CODE [0][3] 28 29 [L] 30 [] 31 REVISION NO. [0] 32
ACTION TAKEN [A][18] FUTURE ACTION [Z][19] EFFECT ON PLANT [Z][20] SHUTDOWN METHOD [Z][21] HOURS [0][0][0][0] 33 34 35 36 37 40 ATTACHMENT SUBMITTED [Y][23] 41 42 NPRO-4 FORM SUB. [Y][24] 43 PRIME COMP. SUPPLIER [N][25] 44 COMPONENT MANUFACTURER [L][2][0][0] 45 47

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

[10] The cause of the incident was the electrical failure of the valve's
[11] torque switch. The corrective action was the replacement of the switch
[12] and verification of the valve's operability.

[15] 8 [E][28] [1][0][0][0] 29 [NA] 30 [B][31] During PT/3/A/0150/15A 32 80
9 10 12 13 44 45 46

[16] 8 [Z][33] [Z][34] [NA] 35 [NA] 36 80
9 10 11 44 45 46

[17] 8 [0][0][0][0] 37 [Z][38] [NA] 39 80
9 10 11 12 13

[18] 8 [0][0][0][0] 40 [NA] 41 80
9 10 11 12

[19] 8 [Z][42] [NA] 43 80
9 10

[20] 8 [N][44] [NA] 45 80
9 10

NAME OF PREPARER: K. R. Wilson

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