B 04/27/18

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DUKE PWR

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SUBJECT:

DOCTYPE: LETTER

NOTARIZED: NO

LTR 1

ENCL 1

LICENSEE EVENT REPT. NO. RO 50-287/78-9 CONCERNING VALVE 3HP-24 INOPERABILITY.

PLANT NAME: OCONEE - UNIT 3

REVIEWER INITIAL:

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NOTES:

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

INCIDENT REPORTS (DISTRIBUTION CODE A002)

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CONTROL NBR:

781150044

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

THE END

DUKE POWER COMPANY

POWER BUILDING

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

WILLIAM O. PARKER, JR.
VICE PRESIDENT
STEAM PRODUCTION

TELEPHONE: AREA 704 373-4083

April 19, 1978

Mr. James P. O'Reilly, Director U. S. Nuclear Regulatory Commission Suite 1217 230 Peachtree Street, Northwest Atlanta, GA 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-287/78-9.

Very truly yours,

William O. Parker Jr. William O. Parker, Jr. by WAH

KRW/vmb

cc:

Attachment

Director, Office of Management Information and Program Control

REGULATORY DOCKET FILE COPY



A002/5 *

DUKE POWER COMPANY

OCONEE UNIT 3

Report Number: R0-287/78-9

Report Date: April 19, 1978

Occurrence Date: March 20, 1978

Facility: Oconee Unit 3, Seneca, South Carolina

Identification of Occurrence: Valve 3HP-24 Inoperability

Conditions Prior to Occurrence: 100% Full Power

Description of Occurrence:

At 0924, on March 20, 1978, during the performance of PT/0/A/0310/12A &12B (monthly ES test), Valve 3HP-24 failed to operate on manual actuation from the control room. At 0945, during subsequent investigation of the incident, a second attempt was made to open the valve and it functioned properly. The contacts in the valve operator were cleaned and the valve was cycled to verify operability. At 1030, the valve was returned to service.

Apparent Cause of Occurrence:

The cause of the failure was foreign material on the contacts of the valve's operator.

Analysis of Occurrence:

Technical Specification 3.3.2(b) requires the operability of all Engineered safeguard valves related to the HPI System, but Technical Specification 3.3.5 allows up to 24 hours to repair inoperable components (with some exceptions). Valve 3HP-24 was inoperable for a maximum of 66 minutes and operated properly without any corrective action shortly subsequent to the initial failure to function. It is considered that this incident did not adversely effect public health and safety.

Corrective Actions:

Valve 3HP-24 was examined, repaired and returned to service.

LICENSEE EVENT REPORT

EXHIBIT A

	CONTROL BLOCK:	TYPE ALL REQUIRED INFORMATION)
0 1	S C N E E 3 2 0 0 - 0 0 0 0 0 - 0 0 0 0 0 0 0 0 0 0	28 LICENSE TYPE 10 57 CAT 65
0 1	REPORT L 6 0 5 0 0 0 2 8 7 7 0 3 2 0 7 SOURCE 50 61 DOCKET NUMBER 58 69 EVENT DATE	and the second second
0 2	During performance test PT/0/A/0310/12A & 12B valv	
03	flow from the BWST to the A&B HPI pumps failed to	
04	manual pushbutton. It was examined, its operator	s contacts were cleaned, and
05	it was returned to service in 66 minutes. No Tech	nnical Specification limits
06	were exceeded. It is considered that the event di	d not adversely effect
07	public health and safety.	
08		
09	SYSTEM CAUSE CODE SUBCODE COMPONENT CODE S F 10 E 12 A 13 V A L V O P	CDMP. VALVE SUBCODE 14 A 15 Z 16
	17 REPORT 7 8 21 22 23 24 25 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28 27 28	CE REPORT REVISION. TYPE NO. 10 11 12 12 12 131 132 NPRO-4 PRIME COMP. COMPONENT MANUFACTURER Y 24 L 25 L 2 0 0
10	The probable cause of the failure was "dirt" on the	ne operator's contacts.
	The contacts were cleaned and the valve operated p	
1 2	corrective action was required.	
13		
<u>III</u>		
15	TACILITY SAFOWER OTHER STATUS OBJECTIVITY OTHER STATUS OBJECTIVITY ON OBJECTIVITY ON OBJECTIVITY ON OBJECTIVITY OBJECTIVITY	DISCOVERY DESCRIPTION (32) HONTHLY ES test.
	ELEASED OF RELEASE AMOUNT OF ACTIVITY (35) Z (32) Z (34) NA PERSONNEL EXPOSURES AMOUNT OF ACTIVITY (35) NA 44 45	LOCATION OF RELEASE (36) NA
17	NA NA	
18	PERSONNEL INJURIES NUMBER DESCRIPTION 41) O O O 40 NA	50
1 9	LOSS OF OR DAMAGE TO FACILITY (43) TYPE DESCRIPTION 7 42 NA	80
20	PUBLICITY SSUED DESCRIPTION 45 NA NA	NAC USE ONLY = 0
	NAME OF PREPARER K. R. Wilson	63 69 80 PHONE: (704) 373-8197