

DUKE POWER COMPANY

POWER BUILDING

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

WILLIAM O. PARKER, JR.  
VICE PRESIDENT  
STEAM PRODUCTION

November 6, 1979

TELEPHONE: AREA 704  
373-4083

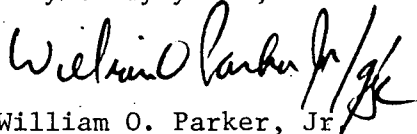
Mr. James P. O'Reilly, Director  
U.S. Nuclear Regulatory Commission  
Region II  
101 Marietta Street, Suite 3100  
Atlanta, GA 30303

Re: Oconee Unit 2  
Docket No. 50-270

Dear Mr. O'Reilly:

Please find attached Reportable Occurrence Report RO-270/79-7. This report is submitted pursuant to Oconee Nuclear Station Technical Specifications 6.2 and 6.6.2.1.a(6), which concerns a procedural inadequacy which could have prevented fulfillment of the functional requirements of the Low Pressure Injection cooler, and describes an incident which is considered to be of no significance with respect to its effect on the health and safety of the public.

Very truly yours,



William O. Parker, Jr.

SRL/sch  
Attachment

cc: Director, Office of Management Information  
and Program Control



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DUKE POWER COMPANY  
Oconee Unit 2

Report Number: RO-270/79-7

Report Date: November 6, 1979

Occurrence Date: October 24, 1979

Facility: Oconee 2, Seneca, South Carolina

Identification of Occurrence: LPI Cooler Outlet Valves Misaligned

Conditions Prior to Occurrence: 49% Full Power

Description of Occurrence:

On October 24, 1979, it was discovered that the Low Pressure Service Water (LPSW) outlet valves for the Oconee 2 Low Pressure Injection (LPI) coolers were not in the proper lineup. On October 18, 1979, the procedure for the LPI system had been revised to correct the checklist used for double verification of valve alignment. During heatup of the unit on October 22, 1979, the procedure for Engineered Safeguards (ES) alignment of the LPI system was performed. On October 24, operations personnel discovered that ES valves LPSW-4 and -5, the LPI cooler shell outlet valves were open although they should have been closed, and valves LPSW-251 and -252, the outlet control valves for the coolers, were closed although they should have been 50% open. The valves were returned to the correct alignment.

Apparent Cause of Occurrence:

When the LPI system procedure was revised on October 18, the alignment positions for a number of valves were deleted from the body of the procedure and placed in an attached checklist which was subject to double verification. Valves LPSW-4, -5, -251 and -252 should also have been included in the checklist, but were left in the body of the procedure. The temporary copy of the procedure which was available when the ES lineup was performed had the deleted portion crossed out. The personnel performing the lineup assumed that the entire affected section of the procedure had been revised so that all valves were listed in the checklist, and failed to note that the LPSW valves were still in the procedure body. Thus, the misalignment resulted from the combination of a defective procedure and the failure of the personnel performing the alignment to note all the steps which had not been revised.

Analysis of Occurrence:

With valves LPSW-251 and -252 closed, LPSW flow was not automatically available in the event that operation of the LPI coolers had been required. In the unlikely event of a loss-of-coolant accident requiring LPI flow, borated water would be injected into the reactor core until the borated water storage tank was emptied, at which time the LPI pumps would take suction from the Reactor Building sump. LPSW flow to the LPI coolers would then be required in order to cool the sump water sufficiently prior to reinjecting it into the core. Operation of the LPI coolers would therefore not be required until at least 30 minutes into the transient. This would provide sufficient time for valves LPSW-251 and -252, which are pneumatically operated, to be opened.

from the control room. Since the attention of the operations personnel would be directed to the ES panels, there is a high degree of assurance that the misalignment would have been recognized and corrected. However, this incident constituted a procedural inadequacy which could have prevented fulfillment of the functional requirements of the LPI System, and must therefore be reported pursuant to Oconee Nuclear Station Technical Specification 6.6.2.1.a(6), although it is considered not to have affected safe operation of the unit or the health and safety of the public.

Corrective Action:

The immediate corrective action was to return the affected valves to the correct positions. The LPI procedure has been rewritten and retyped to add the LPSW valves to the checklist and to make the procedure easier to follow. The operations personnel who performed the valve lineup have been counseled in the proper use of procedures. In order to provide further reassurance that a similar incident will not occur, Duke Power Company is conducting a thorough audit of procedural controls and their proper implementation. Based on the results of this audit, appropriate corrective actions will be taken.