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

WILLIAM O. PARKER, JR.
VICE PRESIDENT
STEAM PRODUCTION

March 5, 1980

TELEPHONE: AREA 704
373-4083

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

Re: Oconee Unit 2
Docket No. 50-270

Dear Mr. O'Reilly:

Please find attached Reportable Occurrence Report RO-270/80-1. This report is submitted pursuant to Oconee Nuclear Station Technical Specification 6.6.2.1.a(2), which concerns operation with a parameter subject to a limiting condition for operation less conservative than the least conservative aspect of that limiting condition for operation, and describes an incident which is considered to be of no significance with respect to the health and safety of the public .

Very truly yours,

William O. Parker, Jr.

SRL:scs

Attachment

cc: Director, Office of Management & Program Analysis
U. S. Nuclear Regulatory Commission
Washington, D. C. 20555

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DUKE POWER COMPANY
OCONEE UNIT 2

Report Number: RO-270/80-1

Report Date: March 5, 1980

Occurrence Date: February 20, 1980

Facility: Oconee 2, Seneca, South Carolina

Identification of Occurrence: Core Flood Tank Pressurized in Excess of Technical Specification Limit

Conditions Prior to Occurrence: 69% Full Power

Description of Occurrence:

At 0908 on February 20, 1980, Oconee 2 core flood tank (CFT) 2A pressure reached approximately 631 psig when valve 2N-128, the CFT 2A nitrogen supply valve, failed to close. Valve 2N-128 was isolated by 0924, and CFT 2A pressure was returned to 625 psig, within the limits of Oconee Nuclear Station Technical Specification 3.3.3(a). The valve was repaired and cycled to verify its operability.

Apparent Cause of Occurrence:

The pressure limit for CFT 2A was exceeded when its nitrogen supply valve, valve 2N-128, could not be closed due to failure of its yoke nut threads.

Analysis of Occurrence:

CFT 2A pressure exceeded the Technical Specification limit by approximately 6 psig for a brief period as a result of this incident. In the unlikely event that operation of the core flood tanks had been required in an accident condition, this slightly excessive pressure would have been of no significance. However, this incident must be reported pursuant to Technical Specification 6.6.2.1.a(2), although it did not affect safe operation of the unit or the health and safety of the public.

Corrective Action:

The immediate corrective action was to isolate valve 2N-128 in order to allow CFT 2A pressure to return to within allowable limits. The valve's yoke stem was then replaced, and the valve was cycled to verify its operability. Further measures to assure against occurrence of a similar incident are under consideration, and any additional corrective actions which are taken will be reported.