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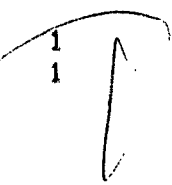
DOCKET #
05000270

SUBJECT: LER 80-010/03L-0: on 800820, 2 Low Pressure Svc Water-19 valve failed to open from control room switch after closing to perform operational valve functional test. Caused by failure of torque switch preventing valve opening.

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 TITLE: Incident Reports

NOTES: M Cunningham: all amends to FSAR & changes to Tech Specs. 05000270
 AEOD, Ornstein: lcc.

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LICENSEE EVENT REPORT

EXHIBIT A

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

01 | S | C | N | E | E | 2 | 0 | 0 | - | 0 | 0 | 0 | 0 | 0 | - | 0 | 0 | 0 | 4 | 1 | 1 | 1 | 1 | 0 | 5

01 | L | 6 | 0 | 5 | 0 | 0 | 0 | 2 | 7 | 0 | 7 | 0 | 8 | 2 | 0 | 8 | 0 | 8 | 0 | 9 | 1 | 9 | 8 | 0 | 9

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES

02 | On August 20, 1980, the 2LPSW-19 valve failed to open from the Control Room
03 | switch after it was closed while performing the "Operational Valve Functional
04 | Test." The "2B" RBCU was declared inoperable as a result of this failure. Two
05 | of the RB spray trains were operable and available for ES actuation to alleviate
06 | RB temperature and pressure in the event of an accident. Thus, this incident
07 | was of no significance with respect to safe operation, and the health and
08 | safety of the public were not affected.

09 | SYSTEM CODE: S B; CAUSE CODE: E; CAUSE SUBCODE: B; COMPONENT CODE: V A L V E X; COMP. SUBCODE: E; VALVE SUBCODE: D; LER/RQ REPORT NUMBER: 17; EVENT YEAR: 80; SEQUENTIAL REPORT NO.: 010; OCCURRENCE CODE: 03; REPORT TYPE: L; REVISION NO.: 0; ACTION TAKEN: X; FUTURE ACTION: B; EFFECT ON PLANT: Z; SHUTDOWN METHOD: Z; HOURS: 0000; ATTACHMENT SUBMITTED: Y; NPRO-4 FORM SUB.: Y; PRIME COMP. SUPPLIER: L; COMPONENT MANUFACTURER: W030

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS

10 | It was determined that a bad torque switch prevented the opening of the valve
11 | from the Control Room. It is not known why this switch failed to operate. Due
12 | to high temperature in the Penetration Room, the valve was unable to be repaired.
13 | The valve was White Tagged open and an "R&R" issued to insure that it remains
14 | open until it is repaired. The valve will be repaired during the next outage.

15 | FACILITY STATUS: E; % POWER: 059; OTHER STATUS: NA; METHOD OF DISCOVERY: B; DISCOVERY DESCRIPTION: "Operational Valve Functional Test"

16 | ACTIVITY CONTENT RELEASED OF RELEASE: Z; AMOUNT OF ACTIVITY: NA; LOCATION OF RELEASE: NA

17 | PERSONNEL EXPOSURES NUMBER: 000; TYPE: Z; DESCRIPTION: NA

18 | PERSONNEL INJURIES NUMBER: 000; DESCRIPTION: NA

19 | LOSS OF OR DAMAGE TO FACILITY TYPE: Z; DESCRIPTION: NA

20 | PUBLICITY ISSUED DESCRIPTION: N; NAME OF PREPARER: J. L. Jones; PHONE: (704) 373-8197

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DUKE POWER COMPANY
OCONEE NUCLEAR STATION

Report Number: RO-270/80-10

Report Date: September 19, 1980

Occurrence Date: August 20, 1980

Facility: Oconee Unit 2, Seneca, South Carolina

Identification of Occurrence: Power Operation Failure of Valve 2LPSW-19

Conditions Prior to Occurrence: 59% FP

Description of Occurrence:

At 0910 on August 20, 1980, Unit 2 was operating at 59% FP when the 2LPSW-19 valve failed to open from the Control Room switch after it was closed while performing the "Operational Valve Functional Test." The "2B" Reactor Building Cooling Unit (RBCU) was declared inoperable as a result of this failure. This constitutes operation in a degraded mode per Technical Specification 3.3.5.c(2) and is therefore reportable pursuant to Technical Specification 6.6.2.1b(2).

Apparent Cause of Occurrence:

It was determined that a bad torque switch prevented the opening of the valve from the Control Room. This valve is normally left in the open position and is cycled quarterly per ASME Section XI IWV code requirements. No maintenance has been performed on 2LPSW-19 since the last time it was satisfactorily cycled on April 10, 1980. It is not known why the torque switch failed to operate properly, but this failure has been known to occur on other EMO valves of this type. However, this is not a frequent occurrence.

Analysis of Occurrence:

Two of the RB spray trains, the "2A" and "2C", and the "2B" RBCU fan were operable and available for ES actuation to alleviate RB temperature and pressure in the event of an accident. After 2LPSW-19 was opened, the "2B" RBCU cooler was available if needed. Also, all other equipment required to cope with accidents analyzed in the FSAR at this power level were operable and available if needed. Therefore, this incident is not considered to be significant with respect to safe operation and the health and safety of the public were not affected.

Corrective Action:

Due to high temperatures in the Penetration Room, the valve was unable to be repaired immediately. 2LPSW-19 was White Tagged open and an "R&R" issued to insure that the valve remains open until repaired. The valve will be repaired during the next outage. No further corrective action is deemed necessary.