

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR: 7812180188 DOC. DATE: 78/12/05 NOTARIZED: NO
 FACIL: 50-270 OCONEE #2, DUKE POWER CO.
 AUTH. NAME: PARKER, W.O. AUTHOR AFFILIATION: DUKE POWER CO.
 RECIP. NAME: O'REILLY, J.P. RECIPIENT AFFILIATION: **REG. 2, ATLANTA, OFF. OF THE DIRECTOR

DOCKET #
05.000270

SUBJECT: Forwards LER#78-012/01T-0.

DISTRIBUTION CODE: A002S. COPIES RECEIVED: LTR ___ ENCL ___ SIZE: _____
 TITLE: INCIDENT REPORTS

NOTES:

ACTION:	RECIPIENT	COPIES		RECIPIENT	COPIES	
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	05 BC	4	4			
INTERNAL:	01 REG FILE	1	1	02 NRC PDR	1	1
	09 I&E	2	2	11 MPA	3	3
	14 HANAUER	1	1	15 NOVAK/CHECK	1	1
	16 EEB	1	1	17 AD FOR ENGR	1	1
	18 PLANT SYS BR	1	1	19 I&C SYS BR	1	1
	20 AD PLANT SYS	1	1	21 AD SYS/PROJ	1	1
	22 REAC SAFT BR	1	1	23 ENGR BR	1	1
	24 COLLINS	0	0	24 KREGER	1	1
	25 PWR SYS BR	1	1	26 HOUSTON	0	0
	26 VOLLMER	1	1	E JORDAN/IE	1	1
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	27 ACRS	16	16			

TOTAL NUMBER OF COPIES REQUIRED: LTR 43 ENCL 43

DUKE POWER COMPANY
OCONEE UNIT 2

Report Number: RO-270/78-12

Report Date: December 5, 1978

Occurrence Date: November 5, 1978

Facility: Oconee Unit 2, Seneca, South Carolina

Identification of Occurrence: 2HP-127, RC Loop A1 HPI Stop Check Valve
Found Closed

Conditions Prior to Occurrence: Shutting Down for Refueling

Description of Occurrence:

On November 5, at 1400, during the performance of PT/2/A/0251/6 (HPI Check Valve Functional Test), it was determined that valve 2HP-127, the stop check valve on the 1A HPI Injection Line, was closed. This valve is not known to have been operated since the completion of an Integrated Leak Rate Test (ILRT) on August 1, 1977. Subsequent checklists indicating the valve to be in the open position were apparently in error.

Apparent Cause of Occurrence:

The valve was apparently not positioned properly following the ILRT, and the checklists indicating this positioning were also in error.

Analysis of Occurrence:

The mispositioning of 2HP-127 would have prevented one injection line from operating as required. Considering the low probability of an accident requiring HPI operation and periodic testing to verify HPI operability, this occurrence did not adversely affect the health and safety of the general public.

Corrective Action:

All Operations personnel have been re-instructed in this area to review the proper methods to be used in valve position verification. The procedures involved are thought to be adequate in this regard if properly carried out. The valve was properly positioned following this occurrence.

7812180 196

LICENSEE EVENT REPORT

EXHIBIT A

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

01 | S | C | N | E | E | 2 | 2 | 0 | 0 | - | 0 | 0 | 0 | 0 | 0 | - | 0 | 0 | 3 | 4 | 1 | 1 | 1 | 1 | 4 | 5
7 8 9 14 15 25 28 30 57 CAT 58

CONT
01 | L | 6 | 0 | 5 | 0 | 0 | 0 | 2 | 7 | 0 | 7 | 1 | 1 | 0 | 5 | 7 | 8 | 8 | 1 | 2 | 0 | 5 | 7 | 8 | 9
7 8 60 61 68 69 74 75 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 | Valve 2HP-127, RC Loop A1 HPI Stop Check Valve, was found to be in the closed
03 | position during the HPI Check Valve Functional Test. The failure of this
04 | valve to be in its proper (open) position removed one of four injection lines
05 | from service. Considering the low probability of needing this particular
06 | injection line along with the periodic testing program, this occurrence did
07 | not adversely affect public health and safety.

08 | _____

09 | S | F | 11 | A | 12 | A | 13 | V | A | L | V | E | X | 14 | C | 15 | D | 16
7 8 9 10 11 12 13 18 19 20

17 | 7 | 8 | 0 | 1 | 2 | 0 | 1 | T | 0
21 22 24 25 27 28 29 30 31
18 | H | 19 | Z | 20 | Z | 21 | 0 | 0 | 0 | 0 | Y | 23 | N | 24 | N | 25 | B | 0 | 1 | 1 | 5 | 26
33 34 35 36 37 40 41 42 43 44 47

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 | The cause of this occurrence was personnel error. All Operations personnel
11 | were re-instructed to prevent recurrence.
12 | _____
13 | _____
14 | _____

15 | D | 28 | 0 | 0 | 0 | 29 | NA | 30 | B | 31 | HPI Check Valve Functional Test | 32
7 8 9 10 12 13 44 45 46

16 | Z | 33 | Z | 34 | NA | 35 | NA | 36
7 8 9 10 44 45

17 | 0 | 0 | 0 | 37 | Z | 38 | NA | 39
7 8 9 10 11 12 13

18 | 0 | 0 | 0 | 40 | NA | 41
7 8 9 10 11 12 13

19 | Z | 42 | NA | 43
7 8 9 10 11 12

20 | N | 44 | NA | 45
7 8 9 10

NAME OF PREPARER K. R. Wilson

PHONE: (704) 373-8197

NRC USE ONLY

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

December 5, 1978

WILLIAM O. PARKER, JR.
VICE PRESIDENT
STEAM PRODUCTION

TELEPHONE: AREA 704
373-4083

REGULATORY DOCKET FILE COPY

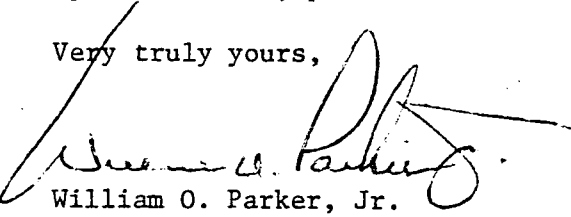
Mr. James P. O'Reilly, Director
U. S. Nuclear Regulatory Commission
Region II
101 Marietta Street, Suite 3100
Atlanta, Georgia 30303

RE: Oconee Unit 2
Docket No. 050-270

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-270/78-12.

Very truly yours,


William O. Parker, Jr.

KRW:cg

Attachment

cc: Director, Office of Management Information
and Program Control

7812180188

A002
3/11

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