NRC FORM 366 (7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

EXHIBIT A

CONTROL BLOCK: [| | | | | |] (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

01 | LICENSEE CODE: S C N E E 3 (2) | LICENSE NUMBER: 0 0 - 0 0 0 0 0 - 0 0 (3) | LICENSE TYPE: 4 1 1 1 1 (4) | CAT: (5)

CON'T 01 | REPORT SOURCE: L (6) | DOCKET NUMBER: 0 5 0 0 0 2 8 7 (7) | EVENT DATE: 0 2 0 8 7 8 (8) | REPORT DATE: 0 3 1 3 7 8 (9)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 During startup of 3B LPSW pump operator noticed that the suction valve,
03 3LPSW-123 was closed. He ceased startup immediately. The pump was restarted
04 after the valve was opened and found to be undamaged. The valve closure
05 removed one train of the LPSW system from service but the other train was
06 available to handle any accident situations. No adverse effect on public
07 health and safety was caused by this incident.
08

09 | SYSTEM CODE: W D (11) | CAUSE CODE: A (12) | CAUSE SUBCODE: X (13) | COMPONENT CODE: Z Z Z Z Z Z (14) | COMP. SUBCODE: Z (15) | VALVE SUBCODE: Z (16)

(17) LER/RO REPORT NUMBER | EVENT YEAR: 7 8 | — | SEQUENTIAL REPORT NO.: 0 0 7 | / | OCCURRENCE CODE: 0 3 | REPORT TYPE: L | — | REVISION NO.: 0

ACTION TAKEN: X (18) | FUTURE ACTION: Z (19) | EFFECT ON PLANT: Z (20) | SHUTDOWN METHOD: Z (21) | HOURS (22): 0 0 0 0 0 | ATTACHMENT SUBMITTED: Y (23) | NPRD-4 FORM SUB.: N (24) | PRIME COMP. SUPPLIER: Z (25) | COMPONENT MANUFACTURER: Z 9 9 9 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 The actual cause of the valve closure is unknown. Evidently someone erron-
11 eously closed the valve during repairs in the area on the day before. Since
12 the exact cause is unknown, the applicable corrective action was the opening
13 of the valve and checking the pump for any damage.
14

15 | FACILITY STATUS: E (28) | % POWER: 1 0 0 (29) | OTHER STATUS (30): NA | METHOD OF DISCOVERY: A (31) | DISCOVERY DESCRIPTION (32): Operator Observation

16 | ACTIVITY RELEASED: Z (33) | CONTENT OF RELEASE: Z (34) | AMOUNT OF ACTIVITY (35): NA | LOCATION OF RELEASE (36): NA

PERSONNEL EXPOSURES

17 | NUMBER: 0 0 0 (37) | TYPE: Z (38) | DESCRIPTION (39): NA

PERSONNEL INJURIES

18 | NUMBER: 0 0 0 (40) | DESCRIPTION (41): NA

LOSS OF OR DAMAGE TO FACILITY (43)

19 | TYPE: Z (42) | DESCRIPTION: NA

PUBLICITY

20 | ISSUED: N (44) | DESCRIPTION (45): NA | NRC USE ONLY

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8001090526

DUKE POWER COMPANY
OCONEE UNIT 3

Report Number: RO-287/78-7

Report Date: March 13, 1978

Occurrence Date: February 8, 1978

Facility: Oconee Unit 3, Seneca, South Carolina

Identification of Occurrence: 3LPSW-123 Found Closed

Conditions Prior to Occurrence: 100% Full Power

Description of Occurrence:

On February 8, 1978, at 0940, the 3B Low Pressure Service Water (LPSW) pump was started. When the operator noticed that the pump suction valve, 3LPSW-123, was closed, the pump was stopped. Investigation by operating personnel determined that the valve had been closed since approximately 1600 on February 7, 1978. Therefore, the pump had been effectively out-of-service for about 17 hours. The pump suction strainer had been serviced the previous day at about the time of the valve closure, but the valve had not been required to be closed by the procedure. The valve was opened and the pump was verified as being undamaged by the incident.

Apparent Cause of Occurrence:

The exact cause of the valve closure is unknown. There are two controls for the valve, one in the control room and one in the area of the pump. Discussions were held with personnel in both areas, but none had any recollection as to how the valve was closed or with regard as to who closed it.

Analysis of Occurrence:

The closure of 3LPSW-123 rendered one train of the LPSW system inoperable. However, the control room could have opened the valve at any time if the train was needed. Technical Specification 3.3.5 allows one train to be inoperable for a period of 24 hours for test or maintenance, since one train is sufficient to provide necessary cooling in an accident situation. One train was operable although the second train was inoperable for a cause other than test or maintenance. Public health and safety were not endangered by this incident.

Corrective Action:

The valve was opened after evaluation of the occurrence. The pump was vented, restarted, and tested to assure that it had not sustained damage.