

DUKE POWER COMPANY

POWER BUILDING

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

WILLIAM O. PARKER, JR.
VICE PRESIDENT
STEAM PRODUCTION

November 12, 1980

TELEPHONE AREA 704
373-4083

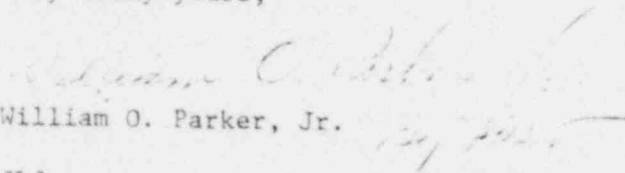
Mr. James P. O'Reilly, Director
U. S. Nuclear Regulatory Commission
Region II
101 Marietta Street, Suite 3100
Atlanta, Georgia 30303

Re: Oconee Nuclear Station
Docket No. 50-270

Dear Mr. O'Reilly:

Please find attached Reportable Occurrence Report RO-270/80-20. This report is submitted pursuant to Oconee Nuclear Station Technical Specification 6.6.2.1.b(2), which concerns operation in a degraded mode permitted by a limiting condition for operation, 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.

JLJ:scs
Attachment

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

Mr. Bill Lavalley
Nuclear Safety Analysis Center
P. O. Box 10412
Palo Alto, California 94303

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DUKE POWER COMPANY
OCONEE NUCLEAR STATION, UNIT 2

Report Number: RO-270/80-20

Report Date: November 12, 1980

Occurrence Date: October 13, 1980

Facility: Oconee Unit 2, Seneca, South Carolina

Identification of Occurrence: Valve 2FDW-103 Inoperable Due to Failed
Torque Switch and Motor

Conditions Prior to Occurrence: Oconee 2 - 100% FP

Description of Occurrence:

At 1014 on October 13, 1980, during the performance of the E.S. On-Line Test, valve 2FDW-103 failed to close during cycling. The valve was manually closed and its breaker locked open at 1350 the same day. The torque switch on valve 2FDW-103 failed while the valve was going closed during the E.S. On-Line Test. The failure of the torque switch disabled the valve's close circuit. The bad torque switch was replaced, but an error was made in the wiring of the new switch. The valve was closed from the Control Room when it was observed that there was no closed indication. The switch had been wired in a manner that it would not open the circuit when the valve was closed. Therefore, the motor was still energized when the valve was fully closed and burned up a short time later. This incident constitutes operation in a degraded mode per Technical Specification 3.6.3:b(2) and is thus reportable pursuant to Technical Specification 6.6.2.1.b(2).

Apparent Cause of Occurrence:

The actual cause of this incident was due to the failure of the torque switch. It is not known what caused the failure of the switch, but this is the eighth failure in four years on Limitorque valves. The subsequent failure of the motor was due to a wiring error on the replacement switch.

Analysis of Occurrence:

Had the valve remained in the open position, the failed torque switch would have prevented it from performing its E.S. function during an E.S. actuation. The valve's normal position is "closed."

The FSAR requires only one automatic remote operated (E.S.) valve for isolation of the system piping Reactor Building penetrations if the system is not directly connected to the Reactor Coolant system and is not exposed to the Reactor Building atmosphere. This is the case for 2FDW-103 which is part of the feed-water system and, in particular, the "A" Steam Generator shell side drain system. Technical Specification 3.6.3.b.2 requires that if a containment isolation

valve becomes remotely inoperable, the affected penetration must be isolated within four hours by the use of a de-activated automatic valve secured and locked in the isolated position. This specification was met by the personnel on duty at the time of the incident. Furthermore, a Steam Generator tube rupture would have to occur simultaneously with a L.O.C.A. before this particular penetration would become a containment isolation valve as defined by 10CFR Appendix J. Therefore, this incident was of no significance with respect to safe operation, and the health and safety of the public were not affected.

Corrective Action:

The immediate action was to manually close the valve and lock the breaker open. The limitorque switch which caused the initial valve failure was replaced. This is the eighth recorded torque switch failure on Limitorque valves in four years, six of which have been on E.S. valves. In January of this year, a failed torque switch from an E.S. valve was sent to Limitorque for inspection and analysis. After the analysis, Limitorque reported that no defects were found. Due to the fact that this is the eighth recorded failure of the torque switch in four years, personnel will continue to analyze the failures and try to determine whether or not a generic problem with the switch does exist.

The burned up motor, which resulted from a wiring error of the torque switch, has been sent out for repair. Until the motor is reinstalled, the valve will remain locked closed and its breaker will remain open.