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DUKE POWER COMPANY

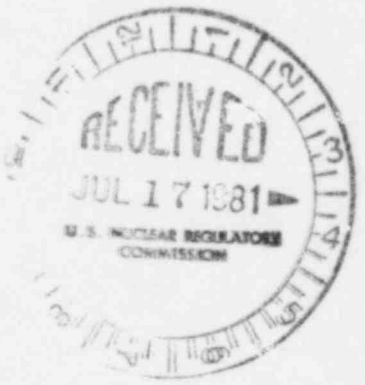
POWER BUILDING
422 SOUTH CHURCH STREET, CHARLOTTE, N. C. 28242

81-011-032

WILLIAM O. PARKER, JR.
VICE PRESIDENT
STEAM PRODUCTION

TELEPHONE: AREA 704
373-4083

March 12, 1981



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. 50-287

Dear Mr. O'Reilly:

Please find attached Reportable Occurrence Report RO-287/81-3. This report is submitted pursuant to Oconee Nuclear Station Technical Specification 6.6.2.1(2), which concerns operation in a mode less conservative than the least conservative aspect of a LCO, 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:pw
Attachment

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

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

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DUKE POWER COMPANY
OCONEE UNIT 3

Report Number: RO-287/81-3

Report Date: March 12, 1981

Occurrence Date: February 26, 1981

Facility: Oconee Unit 3, Seneca, South Carolina

Identification of Occurrence: Over-Pressurization of "B" OTSG Secondary Side

Conditions Prior to Occurrence: Cold shutdown

Description of Occurrence: At approximately 1600 hours on February 26, 1981, the Unit 3 "B" Steam Generator was pressurized to 550 psig. The Steam Generator was overfilled, and water got in the main steam line. This was a violation of Technical Specification 3.1.2.4 and is thus reportable pursuant to Technical Specification 6.6.2.1.a(2).

Apparent Cause of Occurrence: This incident was apparently caused by the startup control valve leaking through and filling the "B" OTSG and main steam line. Since nothing could be found wrong with the control valve either electrically or mechanically, the reason for the excess valve leakage is unknown. However, the leakage through the control valve is not inconsistent with the design of the valve. (i.e. The valve is not designed to shut off flow completely). Thus the major cause of the incident was the result of a procedural deficiency in that the block valves are not specified as shut in that particular mode of operation.

Analysis of Occurrence: No systems or piping were damaged by this incident. The integrity of the main steam lines, hangers, inspection and the OTSG itself were verified by inspection and analyses. Thus, 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 corrective action was to open valves 3SD-5 and 3Sd-290 in order to lower the OTSG pressure. Procedures will be revised to specify that the startup block valves be shut prior to entering feedwater on condenser cleanup mode.