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

WILLIAM O. PARKER, JR.
VICE PRESIDENT
STEAM PRODUCTION

TELEPHONE: AREA 704
373-4083

April 10, 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-287/81-04. 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

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-287/81-04

Report Date: April 10, 1981

Occurrence Date: March 12, 1981

Facility: Oconee Unit 3, Seneca, South Carolina

Identification of Occurrence: Failure of Value 3FDW-105 To Close Electrically

Conditions Prior to Occurrence: Hot shutdown

Description of Occurrence: At 0420 hours on March 12, 1981 valve 3FDW-105 failed to close electrically after the chemical sampling of Steam Generator "B" was complete. This 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: Investigation found no apparent problems with the valve operation. However, initially there was no open indication light in the control room when the valve was cycled. After one complete cycle and each subsequent cycleing of the valve, all indications of valve position worked properly.

Analysis of Occurrence: The unit was in hot shutdown, and manual isolation was obtained within the time permitted by the Technical Specifications. Also, the redundant automatic isolation valve was operable. Thus, the health and safety of the public were not endangered by this incident.

Corrective Action: Immediate corrective action consisted of manually closing 3FDW-105 and operning the circuit breaker disabling the valve per Technical Specification 3.6.3. The existing troubleshooting procedure is not entirely adequate regarding troubleshooting motor operated valves, therefore, a procedure will be written to cover troubleshooting motor operated valves. The current procedure is a generic troubleshooting procedure and does not specifically address items necessary to diagnose EMO problems.