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

November 13, 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. 50-270

Dear Mr. O'Reilly:

Please find attached Reportable Occurrence Report RO-270/81-17. This report is submitted pursuant to Oconee Nuclear Station Technical Specification 6.6.2.1.a(5), which describes a component malfunction which prevents, by itself, the fulfillment of the functional requirements of a system required to cope with an accident analyzed in the Safety Analysis Report. This report 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.

JFK/php
Attachment

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

Records Center
Insititute of Nuclear Power Operations
1820 Water Place
Atlanta, Georgia 30339

Mr. W. T. Orders
NRC Resident Inspector
Oconee Nuclear Station

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DUKE POWER COMPANY
OCONEE UNIT 2

Report Number: RO-270/81-17

Report Date: November 13, 1981

Occurrence Date: September 19, 1981

Facility: Oconee Unit 2, Seneca, South Carolina

Identification of Occurrence: Inability to initiate decay heat cooling due to valve 2LP-2 failing to open electrically.

Conditions Prior to Occurrence: Reactor shutdown, cooldown in progress

Description of Occurrence: On September 19, 1981, while attempting to initiate decay heat cooling, valve 2LP-2 failed to open electrically. Three subsequent attempts to open valve LP-2 manually were unsuccessful. Valve 2LP-2 was opened using manual hoists after the operator was removed.

Apparent Cause of Occurrence: The apparent cause of the failure of valve 2LP-2 to operate was a bent valve stem, which was identified when the valve was disassembled and inspected.

Analysis of Occurrence: This unit shutdown and cooldown were being conducted due to a steam generator tube leak. The inability to initiate decay heat cooling resulted in a 17 hour delay in reducing reactor coolant pressure and stopping the steam generator tube leakage. Personnel and plant systems adequately controlled this event; thus, the health and safety of the public were not adversely affected.

Corrective Action: After three attempts to open valve 2LP-2 using the manual operator, the operator was removed and the valve opened using manual hoists. The valve stem was replaced, and the operator was tested after the torque settings were recalibrated. Inspection and testing of valve 2LP-2 have verified that the valve is operating correctly. The need to modify or to change the size of the valve operator will be evaluated. Also, an evaluation of the safety analysis credit taken for the ability to go in to the LPI decay heat cooling mode during a steam generator tube rupture accident will be conducted.