

DUKE POWER COMPANY

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November 4, 1982

22 NOV 8 3:00

Mr. James P. O'Reilly, Regional Administrator
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-270/82-13. 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,

H.B. Tucker / AB

Hal B. Tucker

JCP/php
Attachment

cc: Document Control Desk
U. S. Nuclear Regulatory Commission
Washington, D. C. 20555

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

INPO Records Center
Suite 1500
1100 Circle 75 Parkway
Atlanta, Georgia 30339

Mr. Philip C. Wagner
Office of Nuclear Reactor Regulation
U. S. Nuclear Regulatory Commission
Washington, D. C. 20555

DUKE POWER COMPANY
OCONEE NUCLEAR STATION

Report Number: RO-270/82-13

Report Date: November 4, 1982

Occurrence Date: October 5, 1982

Facility: Oconee Unit 2, Seneca, South Carolina

Identification of Occurrence: The Unit 2 Turbine Driven Emergency Feedwater Pump Trip/Throttle (TDEFWPT) Stop Valve was accidentally tripped closed, thus causing the TDEFW Pump to be inoperable.

Conditions Prior to Occurrence: 100% FP

Description of Occurrence: On October 5, 1982, at approximately 1400, two lagging crew members began insulating 2MS-94 (TDEFWP Trip/Throttle Valve). At 1432 while attempting to place insulation around 2MS-94 the latching spring for that valve was bumped and the valve tripped. The lagging crew members, upon noticing the valve tripping, attempted to contact Operations personnel. Prior to their notifying Operations, a Nuclear Equipment Operator was at the scene and reset the valve, restoring the pump to operability. The operator was sent to investigate after the Control Room received a computer video alarm stating 2MS-94 had tripped.

Apparent Cause of Occurrence: The cause of the valve tripping was determined to be insulation material striking the trip level on 2MS-94. This normally should not cause a trip. The latching mechanism on valve 2MS-94 is suspected to be very sensitive. There have been previous incidents of spurious tripping of this valve described in RO-270/82-08 and RO-270/82-12, where the cause for the tripping of valve 2MS-94 was unknown. The cause of occurrence in this case will be attributed to both component failure and personnel error.

Analysis of Occurrence: Due to 2MS-94 being tripped the TDEFWP could not start automatically; however, the pump could have been manually started. In addition, during the 13 minutes in which the pump's automatic start feature was inoperable, both Motor Driven EFWPs were operable. Should the need have arisen, the MDEFWPs would have provided sufficient cooling water to the Steam Generators. Technical Specification 3.4.2.6 states if one EFW pump or EFW flow path is inoperable, restore it to operable status within 72 hours, The TDEFWP was restored to operable status well within the time permitted. Thus, the health and safety of the public were not endangered.

Corrective Action: The immediate corrective action was to reset 2MS-94. This was done by 1445; therefore, the pump was out of service for only 13 minutes. Lagging crew members involved have been instructed to use more caution when insulating around 2MS-94. A work request has been written to inspect and repair the latching mechanism on 2MS-94. This is to be completed by November 15, 1982.