NRC FORM 366 (12-81) APPROVED BY OMB U.S. NUCLEAR REGULATORY COMMISSION 3150-0011 EXPIRES 4-30-82 LICENSEE EVENT REPORT (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION) CONTROL BLOCK S C NE E 2 0 0 0 - 10 0 1 CON'T REPORT L 6 0 5 0 0 0 2 7 0 7 0 8 2 2 8 3 8 0 9 1 2 8 3 9 0 1 EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10) | On 08-22-83, it was discovered that using conservative interpretations, an 0 2 "inoperable" LPI snubber was noted and not made operable within the 72 hour time 0 3 limit, thus violating T.S. 3.14.2. Later testing proved the snubber inoperable. 0 4 Design Engineering determined that the pipe would not have failed during a 0 5 seismic event. Since no seismic event occurred during this time and the probabi-0 6 lity of one was low, the piping nor components would have been damaged. Therefore, 0 7 the health and safety of the public was not affected by this incident. 0 8 8 0 CAUSE CODE CAUSE COMP VALVE COMPONENT CODE SUBCODE Z (16) D (15) J X (12) Z (13) IS UI P | OR T (14) 0 9 10 12 20 13 1.8 SEQUENTIAL OCCURRENCE REPORT REVISION REPORT NO CODE TYPE NO LER/RO REPORT NUMBER 8 0101 0 1 T 3 9 10 1 28 30 31 32 24 ATTACHMENT MANUFACTURER 26 FUTURE EFFECT SHUTDOWN NPRD-4 PRIME COMP. ACTION (22) ACTION ON PLANT METHOD HOURS SUBMITTED FORM SUB SUPPLIER Z 21 N 23 C 13 X 19 0 0 0 1 0 Y 24 L 25 Z (20) G 2 5 5 CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27) The cause of this occurrence was component failure and personnel error. The 10 snubber O-rings were worn and could no longer hold the pressure of the hydraulic 1 1 fluid. Personnel error caused the snubber to exist in this state past the given 1 2 time limit. The snubber was replaced. Personnel involved have been counseled. 3 Procedures will be revised. Refresher training will be given. 4 1 80 FACILITY METHOD OF OTHER STATUS (30) (32) DISCOVERY DESCRIPTION STATUS POWER B [3] Operator Observation E 28 1 0 0 29 NA 5 10 CONTENT 80 12 13 4.8 ACTIVITY AMOUNT OF ACTIVITY LOCATION OF RELEASE (36) RELEASED OF RELEASE 6 Z 33 Z 34 NA NA 10 44 45 80 1.1 PERSONNEL EXPOSURES DESCRIPTION (39) NUMBER TYPE NA 7 80 PERSONNEL INJURIES NUMBER 1800000 NA LOSS OF OR DAMAGE TO FACILITY 80 NΔ Z (42) 1 9 8309200076 830912 80 PDR ADOCK 05000270 PUBLICITY ISSUED DESCRIPTION (45) NRC USE ONLY PDR N 44 NA 2 0 Jocelyn C. Petty 704-373-8270 NAME OF PREPARER PHONE:

DUKE POWER GOMPANY P.O. BOX 33189 CHARLOTTE, N.C. 28242

HAL B. TUCKER VICE PRESIDENT NUCLEAR PRODUCTION

September 12, 1983

Mr. James P. O'Reilly, Regional Administrator U. S. Nuclear Regulatory Commission Region II 101 Marietta Street, NW, Suite 2900 Atlanta, Georgia 30303

Subject: Oconee Nuclear Station Docket No. 50-270

Dear Mr. O'Reilly:

Please find attached Reportable Occurrence Report RO-270/83-09. This report is submitted pursuant to Oconee Nuclear Station Technical Specification 6.6.2.1.a.(2) which concerns an operation subject to a limiting condition for operation which was less conservative than the least conservative aspect of the limiting condition for operation established in the Technical Specifications, 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. My letter of September 6, 1983 addressed the delay in preparation of this report.

Very truly yours,

H.B. Tucher 1.150

Hal B. Tucker

JCP/php

Attachment

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

> Mr. J. C. Bryant NRC Resident Inspector Oconee Nuclear Station

Mr. John F. Suermann Office of Nuclear Reactor Regulation U. S. Nuclear Regulatory Commission Washington, D. C. 20555

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

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JPO/JCP September 12, 1983

DUKE POWER COMPANY OCONEE NUCLEAR STATION

<u>Report Number</u>: RO-270/83-09
<u>Report Date</u>: September 12, 1983
<u>Occurrence Date</u>: August 22, 1983
<u>Facility</u>: Oconee Unit 2, Seneca, South Carolina
<u>Identification of Occurrence</u>: Inoperable LPI Hydraulic Snubber
Conditions Prior to Occurrence: 100% FP

Description of Occurrence: On August 4, 1983 at 1030 with Unit 2 at 100 percent full power, a hydraulic snubber on the Low Pressure Injection (LPI) System after being removed from service was found to be functionally inoperative. This constituted a degraded mode per Technical Specification 3.14.2 which allows continued operation for a period not to exceed 72 hours after a snubber is determined to be inoperable, unless the snubber is sooner made operable. The snubber was replaced with a functionally tested operative snubber 15 minutes after the removal of the snubber in question and 25 minutes before the subject snubber was tested and found inoperable.

On August 22, 1983, in the course of the investigation of this incident, it was discovered that the snubber was noted as slowly leaking on July 11, 1983 at 0850. A conservative interpretation was made, identifying the suspect snubber as inoperable and defining the 72 hour time limit as starting when the snubber was noted as leaking. The incident at that time now constituted a condition that was less conservative than Technical Specification 3.14.2 because the 72 hour time limit was exceeded.

<u>Apparent Cause of Occurrence</u>: What caused the snubber to leak was that the snubber valve O-ring seals were worn and could no longer hold the pressure of the hydraulic fluid. What caused the status of this LER to change from a degraded mode per Technical Specification 3.14.2 to a violation of that Technical Specification were personnel errors which prevented or delayed actions that would have ensured a timely repair/replacement of the snubber subsequently avoiding the violation.

<u>Analysis of Occurrence</u>: The leaking snubber would not lock up when functionally tested. Therefore, the snubber would not have acted as a rigid hanger (i.e., not allowing the pipe to move) during a seismic event. Even with the loss of this snubber on the LPI System, Design Engineering has determined that the pipe would not have failed during a seismic event. Since no seismic event occurred and the probability of one occurring is very low, the inoperability of this snubber and the loss of the snubber hanger would not have damaged the pipe or other connecting components. Therefore, the health and safety of the public were not affected by this incident. <u>Corrective Action</u>: The snubber was replaced with a functionally tested operable snubber. The snubber and snubber seal failures were appropriately noted. Personnel involved have been counseled on the requirement to follow procedures. The snubber inspection procedures will be revised to require documented notification to the appropriate personnel of outstanding repair work, possible operability problems, etc. Refresher training will be given to all Maintenance Supervisors on the Station Directive covering "Maintenance Work Requests".

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