

DUKE POWER COMPANY

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HAL B. TUCKER
VICE PRESIDENT
NUCLEAR PRODUCTION

83 MAY 12 AIO: 27
May 5, 1983

TELEPHONE
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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 Nos. 50-269, -270, -287

Dear Mr. O'Reilly:

Please find attached the Reportable Occurrence Report RO-269/83-12 supplement. 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.

Also attached is a corrected copy of RO-269/83-12 which replaces in its entirety the report sent April 22, 1983. It mistakenly reported the incident as occurring on March 8, 1983 instead of on the correct date of April 8, 1983.

Very truly yours,

Hal B. Tucker

Hal B. Tucker

JCP/php
Attachment

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

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

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

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

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Duke Power Company
Oconee Nuclear Station

Report Number: RO-269/83-12 Supplement

Report Date: May 5, 1983

Occurrence Date: April 21, 1983

Facility: Oconee Units 1, 2, and 3, Seneca, South Carolina

Identification of Occurrence: Loss of Prime on Condenser Circulating Water (CCW) Emergency Discharge Line - Supplement

Conditions Prior to Occurrence:

Oconee 1	100% FP
Oconee 2	100% FP
Oconee 3	100% FP

Description of Occurrence: On April 21, 1983 at 0935 while performing Corrective Actions for Report RO-269/83-12, both Control Rooms received indication that the Emergency Discharge Valve to the Keowee Tailrace, CCW-8, was partially open, without having had any open command. This resulted in the loss of prime to all three units' emergency discharge and rendered the Emergency Condenser Discharge System inoperable per Technical Specification 3.4.5.

Apparent Cause of Occurrence: This incident was caused by component failure/malfunction. Investigation discovered the DC ground to be in the cable that goes to valve CCW-9 (the valve that allows emergency discharge to the Intake Canal). CCW-9 is interlocked with CCW-8 such that when CCW-9 is called on to be open and is not fully open, then CCW-8 will remain open. Apparently, the insulation on the CCW-9 cable is slowly degrading, and while searching for the ground as part of the Corrective Actions for RO-269/83-12, the meter used for this search completed a circuit through the ground and the CCW-8 open coil. This caused CCW-8 to open.

Analysis of Occurrence: During the period of time the Emergency CCW System was inoperable, the normal mode of condenser cooling was in service using the CCW pumps. In the event of loss of all station power or Keowee Dam failure, the atmosphere relief valves were available to remove heat to the atmosphere until the CCW Emergency Discharge System could be returned to service. The probability of a loss of all station power or dam failure during the 75 minutes in question is very low. Therefore, the health and safety of the public were not affected by this incident.

Corrective Action: The valve CCW-8 was electrically closed from the Control Room, and the system was subsequently reprimed, thus returning the system to operability. The cable is to be replaced. Future modifications will be made to physically protect the cable leading to CCW-8 and CCW-9. A procedure has been written that will provide a method of designating the location of underground cables.