

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

September 8, 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  
IE Inspection Report  
50-269/81-18  
50-270/81-18  
50-287/81-18

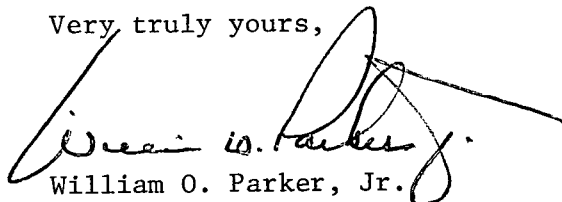
Dear Sir:

With regard to Mr. Paul J. Kellogg's letter of August 19, 1981 which transmitted the subject inspection report, Duke Power Company does not consider the information contained therein to be proprietary.

Please find the attached response to the cited item of noncompliance.

I declare under penalty of perjury that the statements set forth herein are true and correct to the best of my knowledge, executed on September 8, 1981.

Very truly yours,



William O. Parker, Jr.

JLJ/php  
Attachment

8109290673 810924  
PDR ADOCK 05000269  
Q PDR

DUKE POWER COMPANY  
OCONEE NUCLEAR STATION

Response to IE Inspection Report 50-269/81-18, -270/81-18, -287/81-18

Violation

Technical Specification 6.4.1 requires that the station be operated and maintained in accordance with written approved procedures.

Contrary to the above, station procedures were not followed on July 14 and July 17, 1981 in that operators went beyond the procedural requirements and opened equipment breakers not listed in the procedures. This resulted in High Pressure Service Water and Low Pressure Injection Pump B, respectively, being temporarily out of service.

Response

1) Admission or denial of the alleged violation:

The violation as stated is correct. Details of the HPSW incident have been reported as Reportable Occurrence RO-269/81-14, dated July 31, 1981. The LPI Pump incident was reported as Reportable Occurrence RO-287/81-15, dated August 17, 1981.

2) Reasons for the violation:

Both occurrences were the result of personnel error. In the HPSW incident, there was no detailed procedure available describing the proper removal from service of a 4160V breaker. When Unit 1 Startup Transformer CT-1 was isolated, the operator involved also opened the breaker switch for the HPSW control power. This action was not documented and thus was not discovered for several days. Similarly, after Operations had isolated the power supply for the "B" LPI pump on Unit 3 for maintenance, the spring charging motor switch for the 4160V LPI power supply breaker was turned off by a Maintenance person as additional assurance that the power to the pump was isolated. This action was also not documented and thus not discovered for several days.

3) Corrective actions taken and results achieved:

Operations and Maintenance personnel have been instructed on the proper methods of isolating equipment and on the consequences of de-energizing unknown equipment. This will continue as part of the continuing shift training. A procedure has been issued to cover proper removal from and returning to service of 6900/4160/600V breakers. This includes verification of the position of the spring charging motor switch. A minimum of 2 HPSW pumps are now verified operable every shift.

4) Corrective actions to be taken to avoid further violations:

Included in 3 above.

5) Date when full compliance will be achieved:

N/A