

NRC DISTRIBUTION FOR PART 50 DOCKET MATERIAL
(TEMPORARY FORM)

CONTROL NO: 2483

FILE: INCIDENT REPORT

FROM: Duke Power Co. Charlotte, N.C. A.C. Thes			DATE OF DOC 2-24-75	DATE REC'D 3-5-75	LTR xxx	TWX	RPT	OTHER
TO: Mr. Norman C. Moseley			ORIG 1-signed	CC	OTHER	SENT AEC PDR <u>xxxx</u> SENT LOCAL PDR <u>xxxx</u>		
CLASS	UNCLASS xxxxxx	PROP INFO	INPUT	NO CYS REC'D 1		DOCKET NO: 50-287		

DESCRIPTION:

Ltr trans the following:

ENCLOSURES:

Abnormal Occurrence #75-3 on 2-9-75 concerning failure to provide proper overlap between control rod groups

PLANT NAME:

Oconee #3

FOR ACTION/INFORMATION

3-7-75 JGB

BUTLER (S) W/ Copies	SCHWENCER (S) W/ Copies	ZIEMANN (S) W/ Copies	REGAN (E) W/ Copies
CLARK (S) W/ Copies	STOLZ (S) W/ Copies	DICKER (E) W/ Copies	LEAR (S) W/ Copies
PARR (S) W/ Copies	VASSALLO (S) W/ Copies	KNIGHTON (E) W/ Copies	SPEIS (S) W/ Copies
KNIEL (S) W/ Copies	PURPLE (S) W/ 4 Copies	YOUNGBLOOD (E) W/ Copies	

INTERNAL DISTRIBUTION

<u>REC FILE</u>	<u>TECH REVIEW</u>	<u>DENTON</u>	<u>LIC. ASST.</u>	<u>A/T IND</u>
✓NRC PDR	✓SCHROEDER	GRIMES	DIGGS (S)	BRAITMAN
✓OCC. ROOM P-506-A	✓MACCARRY	GAMMILL	GEARIN (S)	SALTZMAN
✓GOSSICK /STAFF	✓KNIGHT	LASTNER	GOULBOURNE (S)	B. HURT
✓CASE	✓PAWLICKI	BALLARD	KREUTZER (E)	
GIAMBUSSO	✓SHAO	SPANGLER	LEE (S)	<u>PLANS</u>
BOYD	✓STELLO		MAIGRET (S)	MCDONALD
MOORE (S) (BWR)	✓HOUSTON	<u>ENVIRO</u>	REED (E)	CHAPMAN
DEYOUNG (S) (PWR)	✓NOVAK	MULLER	SERVICE (S)	DUBE w/input
SKOVHOLT (S)	✓ROSS	DICKER	✓SHEPPARD (S)	E. COUPE
GOLLER (S)	✓IPPOLITO	KNIGHTON	SLATER (E)	✓R. Hartfield (2)
P. COLLINS	✓TEDESCO	YOUNGBLOOD	SMITH (S)	✓KLECKER
DENISE	✓LONG	REGAN	TEETS (S)	✓F. WILLIAMS
REG OPR	✓LAINAS	PROJECT LDR	WILLIAMS (E)	
✓FILE & REGION ②	✓BENAROYA		WILSON (S)	
✓T.R. WILSON	✓STEELE	HARLESS	INGRAM (S)	
	✓VOLIMER			

EXTERNAL DISTRIBUTION

✓1-LOCAL PDR <u>Walhalla, S.C.</u>	(1) (2) (10) -NATIONAL LABS	1-PDR ⁿ SAN/LA/NY
✓1-TIC (ABERNATHY)	1-W. PENNINGTON, RM E-201 G.T.	1-BROOKHAVEN NAT LAB
✓1-NSIC (BUCHANAN)	1-CONSULTANTS	1-G. ULRIKSON, ORNL
1-ASLB	NEWMARK/BLUME/ASBABIAN	1-AGMED (RUTH GUSSMAN)
1-NEWTON ANDERSON		RM B-127 G.T.
✓5-ACRS SENT TO LIC. ASST.		1-J. RUNKLES, RM E-201
		G.T.

shipped

A0-4

DUKE POWER COMPANY

POWER BUILDING

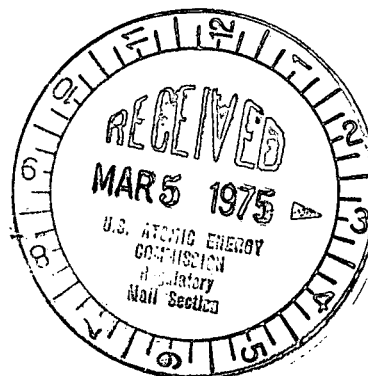
422 SOUTH CHURCH STREET, CHARLOTTE, N. C. 28201

A. C. THIES
SENIOR VICE PRESIDENT
PRODUCTION AND TRANSMISSION

P. O. Box 2178

February 24, 1975

Mr. Norman C. Moseley, Director
U. S. Nuclear Regulatory Commission
Suite 818
230 Peachtree Street, Northwest
Atlanta, Georgia 30303



Re: Oconee Unit 3
Docket No. 50-287

Dear Mr. Moseley:

Pursuant to Sections 6.2 and 6.6.2 of the Oconee Nuclear Station Technical Specifications, please find attached Abnormal Occurrence Report AO-287/75-3.

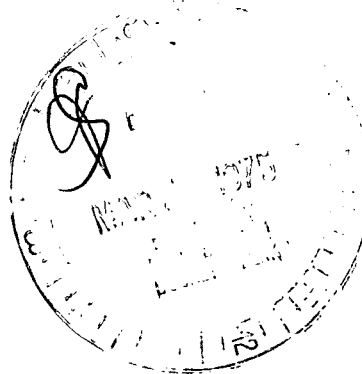
Very truly yours,

A handwritten signature in cursive script, appearing to read "A. C. Thies".

A. C. Thies

ACT:vr
Attachment

cc: Mr. Angelo Giambusso



2483

DUKE POWER COMPANY
OCONEE UNIT 3

Report No.: AO-287/75-3

Report Date: February 24, 1975

Occurrence Date: February 9, 1975

Facility: Oconee Unit 3, Seneca, South Carolina

Identification of Occurrence: Failure to provide proper overlap between control rod groups

Conditions Prior to Occurrence: Unit at approximately 60 percent full power

Description of Occurrence:

On February 9, 1975 Oconee Unit 3 was being maintained at approximately 60 percent full power. The Integrated Control System (ICS) initiated a run-back from 58 to 55 percent power at 2134. At 2140 it was observed that control rod groups 6 and 7 did not have the required 25 ± 5 percent overlap specified in Technical Specification 3.5.2.5.b. The control room operator took manual control of, and repositioned, the control rod groups.

Designation of Apparent Cause of Occurrence:

The position indication switch which provides absolute position indication (API) for rod 5 in group 6 had failed prior to this occurrence. The control operator was aware of the status and implication of operating with an inoperable API. The API provides input to the plant computer for use in computing the rod group average position. The rod group average position is displayed on the video and vertical control board displays. The faulty API for rod 5, group 6 provided a zero indication to be averaged with the remainder of the group 6 rods, thus the group 6 average position indicated lower than the actual position.

During the recovery from the runback, the control room operator failed to monitor the individual rod positions of the group 6 and 7 rods as they were withdrawing in order to maintain an overlap of 25 ± 5 percent. Instead, he monitored the computer video and the group average on the control board which were both in error due to the inoperable API switch on rod 5 of group 6.

Analysis of Occurrence:

The control rod groups 6 and 7 are specified to have overlap limits of 25 ± 5 percent. A smaller overlap will result in excessive control rod motion due to the small reactivity effects of the control rods at the beginning and end of travel. A greater overlap will result in a higher than desired reactivity insertion rate. In this instance, the overlap of 16 percent exceeded the limits of 25 ± 5 percent by 4 percent. This was in the safe,

conservative direction because this limited the maximum reactivity insertion rate when moving both groups of rods. No reactor core protection limits were approached. It is concluded that the health and safety of the public was not affected.

Corrective Action:

Operations personnel have been informed of the potential sequence problems which can exist during operation with an inoperable PI switch. This problem will also be included in the training program to ensure that operators are informed of control rod sequence problems.

TO : DIRECTOR, FEDERAL BUREAU OF INVESTIGATION
FROM : SAC, NEW YORK (100-157344)
SUBJECT: [Illegible]

RE: NEW YORK TELETYPE TO BUREAU, FEBRUARY 25, 1975.
[Illegible]

U.S.A.E.C.
REGULATORY OPERATIONS
REGION II
ATLANTA, GA.
FEB 26 7 45 AM '75