

DUKE POWER COMPANY

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January 26, 1983 . 20

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. 50-269

Dear Mr. O'Reilly:

Please find attached Reportable Occurrence Report RO-269/83-02. 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.

Very truly yours,

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

Mr. E. L. Conner, Jr.
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-269/83-02

Report Date: January 26, 1983

Occurrence Date: January 12, 1983

Facility: Oconee Unit 1, Seneca, South Carolina

Identification of Occurrence: The overhead emergency power path from Keowee to CT-1 was made inoperable without testing the alternate power path as required.

Conditions Prior to Occurrence: 100% FP

Description of Occurrence: On January 12, 1983 at 1203, Power Circuit Breaker (PCB) 18 was opened and isolated for double testing. It was later realized that this was a part of one of the two emergency power paths required by Oconee Technical Specifications (T.S.), and thus, the path was inoperable. One of these paths may be inoperable provided the alternate power path is verified operable within one hour. During the two hours that the overhead emergency power path from the Keowee Hydro units to the transformer CT-1 was inoperable, the alternate (underground) power path was not tested for operability. This violated T.S. 3.7.2.(a) which required this testing.

Apparent Cause of Occurrence: The cause was personnel error. It was not realized that PCB-18 was part of the emergency power path. It was assumed that as long as CT-1 remained energized, the power path was unbroken. The Technical Specification importance of PCB-18 was not realized until the Technical Specifications were investigated concerning the opening of PCB-9 which is specifically mentioned in the Specifications, where PCB-18 is not.

Analysis of Occurrence: During the short period of time PCB-18 was open, the alternate power path was both operable and available. This was proved when the operability verification was done after the discovery that PCB-18 was part of a power path. Therefore, had an incident occurred causing the loss of all off-site power sources and the loss of all three Oconee units, backup power would still have been available. Thus, the health and safety of the public were not endangered.

Corrective Action: The immediate corrective action was to ensure operability of the alternate power path. The test was satisfactorily completed January 12, 1983 at 1515. All personnel involved in this incident have been counseled. This incident has been reviewed with all Shift Supervisors and all Operations Staff personnel, and the proper evaluation for taking equipment out of service was stressed.