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 TUCKER, H.B. Duke Power Co.
 RECIP. NAME RECIPIENT AFFILIATION

SUBJECT: LER 89-001-00: on 890117, violation of emergency power Tech
 Spec due to mgt deficiency & defective procedure. W/8 ltr.

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 TITLE: 50.73 Licensee Event Report (LER), Incident Rpt, etc.

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LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Oconee Nuclear Station, Unit 2	DOCKET NUMBER (2) 0 5 0 0 0 2 7 1 0	PAGE (3) 1 OF 0 8
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TITLE (4) Violation of Emergency Power Technical Specifications Due to Management Deficiency and Defective Procedure

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)			
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES			DOCKET NUMBER(S)
0 1 1	7	8 9	8 9	0 0 1	0 0	0 2	1 6	8 9	Oconee Unit 3			0 5 0 0 0 2 8 7
												0 5 0 0 0

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)

OPERATING MODE (9) N	20.402(b)	20.406(c)	50.73(a)(2)(iv)	73.71(b)
POWER LEVEL (10) 1 0 0	20.406(a)(1)(i)	50.38(c)(1)	50.73(a)(2)(v)	73.71(e)
	20.406(a)(1)(ii)	50.38(c)(2)	50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
	20.406(a)(1)(iii)	X 50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	
	20.406(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(viii)(B)	
	20.406(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME Philip J. North, Regulatory Compliance	TELEPHONE NUMBER 7 0 1 4 3 1 7 1 3 1 - 1 7 1 4 1 5 6
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COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE) NO

EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

At 1730 hours on January 17, 1989 with Units 2 and 3 at 100 % full power, a violation of a Technical Specifications was discovered. This violation stemmed from the use of a procedure to energize the Standby Buses via the CT-5 Transformer. The procedure gave instructions to place all three Oconee units' Standby Bus Auto-Manual Transfer Switches in "manual", thus rendering inoperable the automatic alignment of the station emergency power path from the Keowee Hydro Generator via the CT-4 Transformer. The procedure did not give guidance regarding required auxiliary power path testing. Therefore, the root cause of this event is a Defective Procedure, due to incomplete information. Later investigation revealed that a similar incident occurred on January 13, 1989. Subsequent investigation also revealed that on January 16, 1989 the station was placed in an unanalyzed electrical power configuration. The root cause of this event is classified as a Management Deficiency, due to deficient supervision. Significant corrective actions included revision to the 100KV Power Supply procedure.

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		89	001	00	02	08

TEXT (if more space is required, use additional NRC Form 308A's) (17)

INTRODUCTION

On January 17, 1989, at approximately 1730 hours, concerns raised by a Control Room Operator led to the discovery of a Technical Specification violation. This violation stemmed from the use of a procedure to energize the Standby Buses via the CT-5 Transformer [EIIS:XFMR]. The procedure gave instructions to place all three Oconee units' Standby Bus Auto-Manual Transfer Switches in "manual", thus rendering inoperable the automatic alignment of the station emergency power path from the Keowee Hydro Generator [EIIS:EK] via the CT-4 Transformer. The procedure did not give guidance regarding required auxiliary power path testing. Therefore, the root cause of this event is a Defective Procedure, due to incomplete information. Later investigation revealed that a similar incident occurred on January 13, 1989.

Subsequent investigation also revealed that on January 16, 1989, a Control Room Operator and Unit Supervisor placed the station in an unanalyzed electrical power configuration. An earlier event (reference LER 269/88-13) had identified certain scenarios in which transient voltage on the Standby Buses may be inadequate. On January 16, 1989, the station was placed in an electrical power configuration in which transient voltage may have been inadequate in the event of a simultaneous three unit Loss of Offsite Power (LOOP) or a one unit LOCA concurrent with a LOOP on the other two units. The Unit Supervisor failed to instruct the Control Room Operator to use the applicable procedure when energizing Standby Bus #1 via the CT-5 Transformer. This failure to utilize the appropriate procedure was in direct conflict with guidance given by Operations staff personnel. Therefore the root cause of this event is classified as a Management Deficiency, due to deficient supervision. Significant corrective actions included revision to OP/O/A/1107/03 (100KV Power Supply procedure). At the time of each of these incidents, unit 1 was in a refueling outage with Units 2 and 3 at 100% power.

SEQUENCE OF EVENTS

October 17, 1988

- Design Engineering calculations indicated inadequate voltage conditions may occur on the Standby Buses during certain accident scenarios.

October 18

- Operations procedures were changed to reflect Standby Bus voltage concerns.

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TEXT (If more space is required, use additional NRC Form 366A's) (17)

January 13, 1989

0926

Unit 2 B1 Standby Bus Auto Transfer Switch placed in "manual".

Unit 2 B2 Standby Bus Auto Transfer Switch placed in "manual".

0931

Unit 3 B1 Standby Bus Auto Transfer Switch placed in "manual".

Unit 3 B2 Standby Bus Auto Transfer Switch placed in "manual".

1033

Unit 2 B1 Standby Bus Auto Transfer Switch placed in "auto".

Unit 2 B2 Standby Bus Auto Transfer Switch placed in "auto".

1034

Unit 3 B1 Standby Bus Auto Transfer Switch placed in "auto".

Unit 3 B2 Standby Bus Auto Transfer Switch placed in "auto".

January 16

0930

Operations Engineer 'A' informed Unit Supervisor (US) 'A' of planned test on 1B High Pressure Injection (HPI) pump.

1000

US 'A' conferred with Control Room Operator (CRO) 'A' regarding supplying power for the HPI pump test.

1015

Request for power for HPI pump test received in Control Room.

US 'A' instructed CRO 'A' on providing power for HPI pump test.

1023

CRO 'A' energized Standby Bus #1 via CT-5 with all Oconee Units' Standby Bus Auto Transfer Switches left in "auto".

1109

Standby Bus #1 de-energized.

January 17

1458

Unit 2 B1 Standby Bus Auto Transfer Switch placed in "manual".

1459

Unit 2 B2 Standby Bus Auto Transfer Switch placed in "manual".

Unit 3 B1 Standby Bus Auto Transfer Switch placed in "manual".

Unit 3 B2 Standby Bus Auto Transfer Switch placed in "manual".

1700

CRO 'B' conferred with Shift Engineer (SE) 'A' regarding Technical Specification (TS) requirements for emergency electrical power.

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TEXT (If more space is required, use additional NRC Form 366A's) (17)

January 17 (continued)

- 1710 — SE 'A' concluded that current electrical breaker arrangement did not satisfy TS.
- 1720 — SE 'A' conferred with Unit Operating Engineer (UOE) 'A' regarding TS electrical requirements.
- 1720 — SE 'A' and UOE 'A' concluded that TS had been violated.
- 1730 — SE 'A' and UOE 'A' made decision to test Keowee Hydro overhead transmission circuit.
- 1740 — Keowee Hydro overhead transmission circuit verified operable by testing.
- 2145 — Unit 2 B1 Standby Bus Auto Transfer Switch placed in "auto".
- Unit 2 B2 Standby Bus Auto Transfer Switch placed in "auto".
- Unit 3 B1 Standby Bus Auto Transfer Switch placed in "auto".
- Unit 3 B2 Standby Bus Auto Transfer Switch placed in "auto".

BACKGROUND

The emergency power system for Oconee makes power available from various sources. Via these sources, the Standby Buses may be energized to provide power in an emergency situation. The Standby Buses may be energized via: the CT-4 Transformer (which receives power via a dedicated underground feeder from Keowee Hydro Station), the 230 KV switchyard via an overhead transmission line from the Keowee Hydro Station, or the CT-5 Transformer (which may receive power from the Central Substation or a dedicated line from Lee Steam Station).

Technical Specification 3.7.1 states that before the reactor may be heated above 200 degrees F two independent on-site emergency power paths shall be operable and shall consist of one Keowee hydro unit through the underground feeder path through transformer CT-4 and the second Keowee hydro unit through an overhead transmission circuit to the 230 KV switchyard. Technical Specification 3.7.2 states that one of the two on-site emergency power paths may be inoperable for periods not exceeding 72 hours for test or maintenance provided the alternate power path is verified operable within one hour of the loss and every eight hours thereafter. In an emergency situation a High Pressure Injection (HPI) pump on each unit may be energized via the Auxiliary Service Water Pump (ASWP) Switchgear.

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TEXT (if more space is required, use additional NRC Form 366A (9/83))

In this situation, the ASWP Switchgear would receive power from Standby Bus #1.

DESCRIPTION OF INCIDENT

In October of 1988, a Design Engineering calculation revealed that voltage on the Standby Buses, when powered from Lee Steam Station Combustion Turbines via CT-5, may be inadequate for certain accident scenarios (reference LER 269/88-13). These scenarios were a simultaneous Loss of Offsite Power (LOOP) on all three (3) Oconee units, or a LOCA on one (1) unit with a concurrent LOOP on the other two (2) units. In response to this discovery, changes to Operations procedures were made to allow the sequencing of loads onto the Standby Buses in these scenarios. The sequencing of loads onto the Standby Buses would alleviate the voltage concerns. Changes to these procedures included guidance to place all three (3) units' Standby Bus Auto Transfer Switches in "manual" whenever the Standby Buses are energized via the CT-5 Transformer.

On January 13, 1989, PT/1/A/0610/01C (EPSL Standby Bus 1&2 Voltage Sensing Circuits) was in progress. Unit 1 was in a refueling outage and Units 2 and 3 were at 100% power. A portion of PT/1/A/0610/01C required energizing the Standby Buses via the CT-5 Transformer. At 0934 hours, the Standby Buses were energized via CT-5 by procedure. Prior to energizing the Standby Buses, all three Oconee units placed their Standby Bus Auto Transfer Switches in "manual" (at 0926 hours for Unit 2 and 0931 hours for Unit 3) as required by OP/O/A/1107/03 (100KV Power Supply). This action defeated a portion of the Emergency Power Switching Logic (EPSL) circuitry rendering inoperable the automatic Standby Bus energization via the Keowee Hydro underground feeder. The Keowee underground feeder is required by Technical Specifications (TS) to be operable whenever the reactor is above 200 degrees F. The feeder is permitted to be out of service for up to 72 hours provided the Keowee overhead transmission circuit is verified operable within one hour and every eight hours thereafter. This operability verification was not performed. Consequently a TS violation occurred, but was not discovered at this time. At 1033 hours and 1034 hours, on Unit 2 and 3 respectively, the Standby Bus Auto Transfer Switches were returned to "auto". This returned the EPSL function of the Keowee Hydro underground feeder to an operable state.

On January 16, 1989 a test was to be performed testing the ability to quickly and effectively power up the 1B High Pressure Injection (HPI) [EIIS:BQ] from the Auxiliary Service Water Pump (ASWP) Switchgear. The ASWP Switchgear is powered from Standby Bus #1. Operations Engineer "A" contacted Unit Supervisor (US) 'A' in preparation for this test and instructed US 'A' to energize Standby Bus #1 by procedure. OP/O/A/1107/03

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TEXT (If more space is required, use additional NRC Form 388A's (17))

gives guidance regarding this task. US 'A' and Control Room Operator (CRO) 'A' reviewed OP/O/A/1107/03 and determined the applicable sections. However, US 'A' recalled his past experiences in energizing the ASWP Switchgear via CT-5 and remembered that all that had to be done, from the Control Room, was to simply close in the breaker energizing Standby Bus #1 from CT-5. Consequently, US 'A' gave guidance to CRO 'A' on energizing the Standby Bus based on his past experience rather than procedural guidance. The guidance given by US 'A' did not include instructions to place all three Oconee units Standby Bus Auto Transfer Switches in "manual" as called for by the procedure. At 1023 hours, CRO 'A' energized Standby Bus #1 via CT-5. For this operation, no procedure was used. During the time that Standby Bus #1 was energized, all three Oconee Units' Standby Bus Auto Transfer Switches were left in "auto". Leaving these switches in "auto" caused plant operation in an unanalyzed electrical power configuration.

A Design Engineering (DE) calculation in October 1988, identified two scenarios in which Standby Bus voltage may be inadequate for accident mitigation. These scenarios involved situations where the Standby Buses were energized via CT-5. A later DE calculation showed that Standby Bus voltage, when powered via CT-5, would be adequate for two Oconee units at power operation and the other unit at cold shutdown. This was the case during this incident. However, the DE calculation also assumes that the shutdown unit has its Standby Bus Auto Transfer Switches in "manual". This action was not performed, thus placing the plant in an unanalyzed electrical power configuration. At 1109 hours, Standby Bus #1 was de-energized.

On January 17, 1989, an incident occurred which was similar to the January 13, 1989 incident discussed earlier. However, on January 17, work on plant switchgear required that the Standby Buses be energized. The Standby Buses were energized at 1500 hours per OP/O/A/1107/03. In accordance with the procedure Units 2 and 3 Standby Bus Auto Transfer Switches were placed in "manual" at 1458 hours and 1459 hours respectively. Again, this action defeated a portion of the EPSL circuitry rendering inoperable the automatic Standby Bus energization via the Keowee Hydro underground feeder.

At approximately 1700 hours, CRO 'B' began to question the position ("manual") of the Standby Bus Auto Transfer Switches. CRO 'B' contacted Shift Engineer (SE) 'A' and consulted with him on this subject. SE 'A' concluded, at approximately 1710 hours, that the current breaker arrangement did not satisfy TS. SE 'A' contacted Unit Operating Engineer (UOE) 'A' regarding this matter. At approximately 1720 hours, SE 'A' and UOE 'A' agreed that a TS violation had occurred. A decision was made to verify the operability of the Keowee overhead transmission circuit to come into compliance with TS. At 1740 hours, the Keowee overhead transmission circuit was verified operable. At 2145 hours, Units 2 and 3 Standby Bus

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TEXT (if more space is required, use additional NRC Form 306A's) (17)

Auto Transfer Switches were returned to "auto". This returned the Keowee Hydro underground feeder to operability.

CAUSE OF OCCURRENCE

It is concluded that a defective procedure caused the Technical Specification (TS) violations on January 13 and 17, 1989. The procedure did not provide adequate guidance to ensure TS adherence. Specifically, the procedure did not instruct the operator to verify the operability of the Keowee Hydro overhead transmission circuit prior to placing the Standby Bus Auto Transfer Switches in "manual". Therefore, the events on January 13 and 17, 1989 are classified as a Defective Procedure, due to incomplete information. It is noted that the action of questioning the electrical power configuration, performed by Control Room Operator (CRO) 'B', led to the discovery of the TS violation and subsequent correction.

It is concluded that deficient supervision caused the plant to be operated in an unanalyzed electrical power configuration on January 16, 1989. Unit Supervisor (US) 'A' did not instruct CRO 'A' to place Standby Bus #1 in service using OP/O/A/1107/03 (100KV Power Supply). Earlier in the day, Operations Engineer 'A' had instructed US 'A' to use this procedure when energizing the Standby Bus; however, US 'A' made the decision on how to energize Standby Bus #1 based on his past experience rather than on procedural guidance. Failure to use this procedure allowed operation of the station in an unanalyzed electrical power configuration. Therefore, the January 16, 1989 event is classified as a Management Deficiency, due to deficient supervision. It is recognized that the use of OP/O/A/1107/03, to energize the Standby Bus, would have resulted in a Technical Specification violation similar to those on January 13 and 17, 1989. However, this fact was not known by US 'A' and it is the Operations group policy to use applicable procedures when performing work.

A review of the events occurring during the past year revealed several Technical Specification violations; however, none of these violations were due to a defective procedure. This review also did not reveal any cases where the plant had been operated in an unanalyzed electrical power configuration. Based on these facts, this event is classified as a non-recurring event. No radioactive material releases, radiation exposures or personnel injuries occurred as a result of this event. The health and safety of the public were not compromised. This incident did not involve any component failures; therefore, it is not NPRDS reportable.

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TEXT (If more space is required, use additional NRC Form 306A (1) (17))

CORRECTIVE ACTIONS

The immediate corrective action was to verify the Keowee Hydro overhead transmission circuit was verified operable.

The subsequent corrective action was to revise OP/O/A/1107/03 (100KV Power Supply) to include guidance which ensures compliance with Technical Specification electrical requirements.

Planned corrective actions are for:

Operations to counsel Unit Supervisor 'A' on the need to use and follow applicable procedures.

The Projects group to ensure implementation and testing of a Nuclear Station Modification which will ensure that adequate voltage levels are maintained on the Standby Buses, when energized via the Lee gas turbines, during all Loss of Offsite Power and Loss of Coolant Accident/Loss of Offsite Power events.

ANALYSIS OF OCCURRENCE

Concerning the January 13 and 17, 1989 events, it can be assumed that the Keowee Hydro overhead transmission circuit was operable throughout both incidents. This assumption is based on the fact that this circuit was verified operable at 1740 hours on January 17, 1989, and no Keowee Hydro overhead transmission circuit problems were documented in the time frame of concern. Also, the emergency power supply, via CT-5, remained operable throughout the events. Both power supplies to CT-5, Central Substation and Lee Steam Station Combustion Turbines, also remained available throughout both events. Additionally, had the Keowee underground feeder been required, it could have been manually aligned by Control Room personnel within approximately six (6) minutes. This time period is based upon observed simulator performance during the previous year. This period is well within the time frame assumed in FSAR Chapter 15 for a loss of all station power (23 minutes until the Pressurizer goes solid and an additional 83 minutes before the core is damaged).

Regarding the January 16, 1989 event, it should be noted that all emergency power sources to the station remained operable throughout the event. The only concern arises in the scenarios of a three (3) unit Loss of Offsite Power (LOOP) or a LOCA on one unit concurrent with a LOOP on the other two units. The probability of these scenarios is extremely small and does not represent a significant safety concern (reference LER 269/88-13). Based on the above discussion, it is concluded that the health and safety of the public were not compromised.

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Hal B. Tucker
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DUKE POWER

February 16, 1989

U.S. Nuclear Regulatory Commission
Document Control Desk
Washington, DC 20555

Subject: **Oconee Nuclear Station**
Docket Nos. 50-269, -270, -287
LER 270/89-01

Gentlemen:

Pursuant to 10CFR 50.73 Sections (a) (1) and (d), attached is Licensee Event Report (LER) 270/89-01 concerning violations of emergency power technical specifications.

This report is being submitted in accordance with 10 CFR 50.73(a)(2)(i)(B). This event is considered to be of no significance with respect to the health and safety of the public.

Very truly yours,

Hal B. Tucker

PJN/ler7

Attachment

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