CONTROL NO: 1425

FILE: INCIDENT REPORT

FROM:	ROM: Duke Power Company Charlotte, NC 28201 A C Thies		DATE OF DOC 2-4-75	DATE REC'D 2-7-75		LTR XX	TWX	RPT	OTHER
TO: Mr Moseley			ORIG none signed	CC OTHER		1	SENT AEC PDR XX SENT LOCAL PDR XX		
CLASS	UNCLASS XXX	PROP INFO	INPUT	NO C	YS REC'D		OCKET 0-270	NO:	
DECCIDIO	TION	<u> </u>	L	ENCL	OSURES:				

DESCRIPTION:

Ltr trans the following:

ACKNOWLEDGED

DO NOT REMOVE

PLANT NAME: ORG

Abnormal Occurrence #75-3 on 1-21-75 concerning failure to tag core flood discharge valves...

PLANT NAME: 060	nee #2	•		
,		FOR ACTION/INFORM	ATION 2-7-7	75 ehf
BUTLER (S) W/ Copies CLARK (S) W/ Copies PARR (S) W/ Copies	SCHWENCER (S) W/ Copies STOLZ (S) W/ Copies VASSALLO (S) W/ Copies	ZIEMANN (S) W/ Copies DICKER (E) W/ Copies KNICHTON (E) W/ Copies	REGAN (E) W/ Copies LEAR (S) W/ Copies SPEIS (S) W/ Copies	
KNIEL (S) W/ Copies	PURPLE (S) W/4 Copies	YOUNGBLOOD (E) W/ Copies INTERNAL DISTRIBU	W/ Copies	
REG FILE	TECH REVIEW SCHROEDER	DENTON GRIMES GAMMILL	LIC. ASST. DIGGS (S) GEARIN (S)	A/T IND BRAITMAN SALTZMAN

W ookres				
		INTERNAL DISTR	IBUTION	
REG FILE	TECH REVIEW	DENTON	LIC. ASST. A/T IND	
MAEC PDR	SCHROEDER	GRIMES	DIGGS (S) BRAITMAN	
OGC, ROOM P-506-A	MACCARRY	GAMMILL	GEARIN (S) SALTZMAN	
✓GOSSICK /STAFF	KNIGHT	KASTNER	GOULBOURNE (S) B. HURT	
CCASE	PAWLICKI	BALLARD	KREUTZER (E)	
GIAMBUSSO	6∕ SHAO	SPANGLER	LEE (S) PLANS	
BOYD	E TELIO	7 - L	MAIGRET (S) MCDONALD	
MOORE (S) (BWR)	HOUSTON	ENVIRO	REED (E) CHAPMAN	
DEYOUNG (S) (PWR)	ONOV AK	MULLER	SERVICE (S) DUBE w/input	
SKOVHOLT (S)	eross .	DICKER	SHEPPARD (S) E. COUPE	
GOLLER (S)	PIPPOLITO	KNIGHTØN	SLATER (E) R. Hartfield (2)) .
P. COLLINS	TEDESCO	YOUNGBLOOD	SMITH (S) SKLEGKER	
DENISE	LONG	REGAN	TEETS (S) F. WILLIAMS	
REG_OPR	LAINAS	PROJECT LDR	WILLIAMS (E)	
FILE & REGION (2)	BENAROYA		WILSON (S)	
	TEELE VOLIMER	HARLESS	INGRAM (S)	
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EXTERNAL DISTRIBUTION 1-LOCAL PDR Walla, S.C. (1)(2)(10)-NATIONAL LABS

1-TIC(ABERNATHY)

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1-J. RUNKLES, RM E-201

DUKE POWER COMPANY

Power Building

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

A. C. THIES
SENIOR VICE PRESIDENT
PRODUCTION AND TRANSMISSION

February 4, 1975

A CONTRACTOR OF THE PARTY OF TH

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

Re: Oconee Unit 2

Docket No. 50-270

Dear Mr. Moseley:

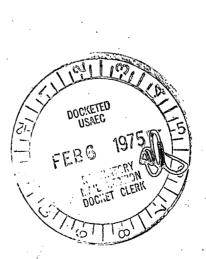
Pursuant to Sections 6.2 and 6.6.2 of the Oconee Nuclear Station Technical Specifications, please find attached Abnormal Occurrence Report AO-270/75-3.

Very truly yours,

A. C. Thies

ACT:vr Attachment

cc: Mr. Angelo Giambusso



DUKE POWER COMPANY OCONEE UNIT 2

Report No.: A0-270/75-3

Report Date: February 4, 1975

Occurrence Date: January 21, 1975

Facility: Oconee Unit 2, Seneca, South Carolina

Identification of Occurrence: Failure to tag core flood discharge valves

Conditions Prior to Occurrence: Startup mode 1150 psig, 330°F

Description of Occurrence:

On January 20, 1975, as part of the startup sequence for Oconee Unit 2, the control operator instructed the utility operator to lock open and tag the core flood tank discharge valves. The control operator signed this step in the procedure and Reactor Coolant System pressure was increased to 1400 psig. Corrective maintenance activities required depressurization of the unit. During the depressurization, it was discovered that although the core flood tank discharge valves were locked open, they were not tagged. Oconee Technical Specification 3.3.3.c requires that when Reactor Coolant System pressure is above 800 psi, the electrically-operated discharge valves from the core flood tanks shall be open and breakers locked open and tagged.

Designation of Apparent Cause of Occurrence:

The apparent cause of this occurrence was the utility operator's lack of familiarity with this procedure and poor communications between the utility and control operators. The utility operator reported that he had completed the task; however, he did not realize that tagging the breakers was required in addition to locking them open.

Analysis of Occurrence:

The core flood tank discharge valves were open, as required, when system pressure was above 800 psig. The discharge valve electrical breakers were locked open to prevent inadvertent operation of these valves. The key to the lock on the electrical breakers is under the control of the shift supervisor, who is knowledgeable of both plant conditions and the requirements for the Core Flood System. Thus, the omission of the tags did not reduce the reliability or operability of the Core Flood System. It is concluded that this incident did not affect the health and safety of the public.

Corrective Action:

The individuals involved in this incident have been counseled as to the importance of proper communications to ensure that procedures are fully complied with. In addition, procedures have been revised to require that tag numbers of all white tags required by procedures be recorded as part of the sign off steps of that procedure. This will ensure that formal acknowledgement of white tags being properly placed is received.