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CONTROL NO: 22

FILE: INCIDENT REPORT FILE

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## Duke Power Company

Power Building

422 South Church Street, Charlotte, N. C. 28201

A. C. THIES SENIOR VICE PRESIDENT PRODUCTION AND TRANSMISSION

April 30, 1975

P. O. Box 2178



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 Unusual Event Report UE-270/75-4.

Very truly yours,

A. C. Thies

ACT:vr Attachment

cc: Mr. Angelo Giambusso

DUKE POWER COMPANY OCONEE UNIT 2

<u>Report No.:</u> UE-270/75-4

Report Date: April 30, 1975

Event Date: March 26, 1975

Facility: Oconee Unit 2, Seneca, South Carolina

Identification of Event: Quench tank low level

Conditions Prior to Event: Unit at 100 percent full power

### Description of Event:

On March 26, 1975, a quench tank low level alarm was received in the Oconee Unit 2 control room. The alarm was acknowledged; however, it was incorrectly identified. Approximately 20 minutes later, the Assistant Control Operator observed a low quench tank level of 40 inches. Corrective action was taken and normal quench tank level was regained 45 minutes after the initial alarm.

### Designation of Apparent Cause of Event:

Immediately prior to this incident, the alarm next to the quench tank low level alarm had been intermittently alarming. The operator heard the audio portion of the alarm, looked up, and mistakenly thought this alarm was the intermittent alarm again. The apparent cause of this event was misidentification of an alarm due to the proximity of the alarm panels.

### Analysis of Event:

The quench tank is used to condense steam from the pressurizer relief valves. In the event the pressurizer relief valves had actuated and the water level in the quench tank been below the spray nozzles, it is probable that the quench tank rupture discs would have actuated. This would have allowed steam to be relieved to the steam generator cavity. However, all radioactive effluent would have been contained in the reactor building. In addition, this incident would not affect the safe operation of the unit. It is concluded that the health and safety of the public was not affected.

#### Corrective Action:

Personnel involved in this incident have been reminded of the importance of considering each alarm as a new and different alarm. It is considered that further corrective action as a result of this incident is not warranted.