

NRC CONTRIBUTION FOR PART 50 DOCKET MATERIAL  
(TEMPORARY FORM)

CONTROL NO: 6376

FILE: INCIDENT REPORT FILE

FROM: Duke Power Co. Charlotte, N.C. 28201 A.C. Thies		DATE OF DOC 6-12-75	DATE REC'D 6-17-75	LTR XX	TWX	RPT	OTHER
TO: Mr. Norman C. Moseley		ORIG 1 signed	CC	OTHER	SENT AEC PDR <u>XX</u>		SENT LOCAL PDR <u>XX</u>
CLASS	UNCLASS XXX	PROP INFO	INPUT	NO CYS REC'D 1	DOCKET NO: 50-269		
DESCRIPTION: Ltr trans the following:				ENCLOSURES: Unusual Evaent 50-269/75-6 on 5-14-75 re valve operation on an incorrect unit....			
PLANT NAME: Oconee Unit 1				<p style="text-align: right;"><b>Do Not Remove</b></p> <p style="text-align: right;"><b>ACKNOWLEDGED</b></p>			

FOR ACTION/INFORMATION

DHL 6-17-75

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

INTERNAL DISTRIBUTION

<del>REG FILE</del> NRC PDR OGC, ROOM P-506A GOSSICK/STAFF CASE GIAMBUSSO BOYD MOORE (L) DEYOUNG (L) SKOVHOLT (L) GOLLER (L) (Ltr) P. COLLINS DENISE REG OPR FILE & REGION (2) MIPC/PE (3) STEELE	TECH REVIEW SCHROEDER MACCARY KNIGHT PAWLICKI SHAO **STELLO **HOUSTON **NOVAK ROSS IPPOLITO TEDESCO J. COLLINS LAINAS BENAROYA VOLLMER	DENTON **GRIMES GAMMILL KASTNER BALLARD SPANGLER  ENVIRO MULLER DICKER KNIGHTON YOUNGBLOOD REGAN PROJECT LDR HARLESS	LIC ASST R. DIGGS (L) H. GEARIN (L) E. GOULBOURNE (L) P. KREUTZER (E) J. LEE (L) M. MAIGRET (L) S. REED (E) M. SERVICE (L) S. SHEPPARD (L) M. SLATER (E) H. SMITH (L) S. TEETS (L) G. WILLIAMS (E) V. WILSON (L) R. INGRAM (L)	A/T IND. BRAITMAN SALTZMAN MELTZ  PLANS MCDONALD CHAPMAN DUBE (Ltr) E. COUPE PETERSON HARTFIELD (2) KLECKER EISENHUT WIGGINTON F. WILLIAMS HANAUER
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EXTERNAL DISTRIBUTION

1 - LOCAL PDR <u>Walhalla, S.C.</u>	1 - NATIONAL LABS	1 - PDR-SAN/LA/NY
1 - TIC (ABERNATHY) (1)(2)(10)	1 - W. PENNINGTON, Rm E-201 GT	1 - BROOKHAVEN NAT LAB
1 - NSIC (BUCHANAN)	1 - CONSULTANTS	1 - G. ULRIKSON, ORNL
1 - ASLB	NEWMARK/BLUME/AGBABIAN	1 - AGMED (RUTH GUSSMAN) Rm B-127 GT
1 - Newton Anderson		1 - J. D. RUNKLES, Rm E-201 GT
1 - ACRS SENT TO LIC ASSTS. Sheppard 6-17-75		
** SEND ONLY TEN DAY REPORTS		

DUKE POWER COMPANY

POWER BUILDING

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

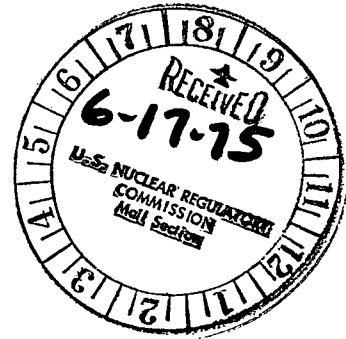
Regulatory Docket File

A. C. THIES  
SENIOR VICE PRESIDENT  
PRODUCTION AND TRANSMISSION

P. O. Box 2178

June 12, 1975

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

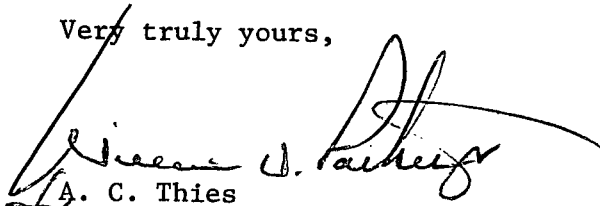


Re: Oconee Unit 1  
Docket No. 50-269

Dear Mr. Moseley:

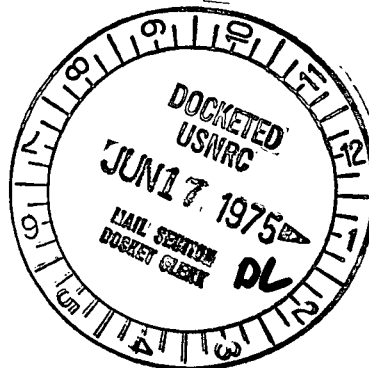
Pursuant to Section 6.2 and 6.6.2 of the Oconee Nuclear Station Technical Specifications, please find attached Unusual Event Report UE-269/75-6.

Very truly yours,

  
A. C. Thies

ACT/gdd  
Attachment

xc: Mr. Angelo Giambusso



6376

DUKE POWER COMPANY  
OCONEE UNIT 1~~OCONEE UNIT 1~~ 6-12-75

Report No.: UE-269/75-6

Report Date: June 12, 1975

Event Date: May 14, 1975

Facility: Oconee Unit 1, Seneca, South Carolina

Identification of Event: Valve operation on an incorrect unit

Conditions Prior to Event: Oconee Units 1 and 2 at 100 percent full power

Description of Event:

On May 14, 1975, during replacement of the Oconee Unit 2 purification demineralizer resin, the drain valve for Unit 1 purification demineralizer was inadvertently opened instead of the drain valve for Unit 2 purification demineralizer. The Control Operator immediately identified a decreasing level in the Unit 1 Letdown Storage Tank (LDST). Monitoring of various tanks and process radiation instrumentation revealed that the spent resin storage tank level was increasing. The Unit 1 purification demineralizer drain valve was shut, and the leakage isolated.

Designation of Apparent Cause of Event:

Valves at the Oconee Nuclear Station are normally identified through the use of black identification tags. In this instance, the valve had been labeled with a marker, which had subsequently been wetted, making it difficult to distinguish whether the valves were for Unit 1 or Unit 2. The apparent cause of this event was failure by the operator to adequately identify the valve which he operated. The condition of the valve identifier was a contributing cause to this error.

Analysis of Event:

This incident resulted in the purification demineralizer drain valve being opened on the wrong unit, with the resultant bleed of reactor coolant letdown from the high pressure injection system. The decreasing letdown storage tank level was detected before an alarm occurred, and was promptly isolated. The resin sluice line and the spent resin storage tank were monitored during this evolution, and no increases in radiation level were detected. Therefore, little, if any, resin had been transferred from the purification demineralizer. It is concluded that the health and safety of the public were not affected by this incident.

Corrective Action:

New identification tags for these valves have been manufactured and have been installed. The Utility Operator involved in this incident has been instructed as to the importance of ensuring that the correct valves have been identified prior to their manipulation.

JUN 13 10 25 AM '79

U.S. AIR FORCE  
REGISTRATION  
WASHINGTON, D.C.