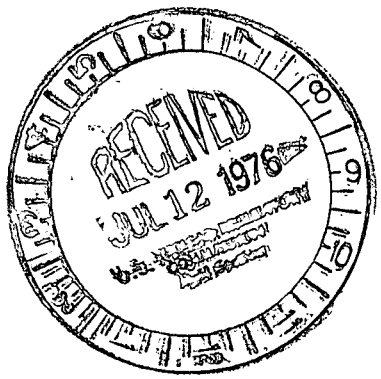
DUKE POWER COMPANY
POWER BUILDING
422 SOUTH CHURCH STREET, CHARLOTTE, N. C. 28242

WILLIAM O. PARKER, JR.
VICE PRESIDENT
STEAM PRODUCTION

TELEPHONE: AREA 704
373-4083

June 23, 1976



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

Re: Oconee Unit 1
Docket No. 50-269

Dear Mr. Moseley:

Pursuant to Sections 6.2 and 6.6.2 of the Oconee Nuclear Station Technical Specifications, please find attached Reportable Occurrence Report RO-269/76-9.

Very truly yours,

W. O. Parker, Jr.

William O. Parker, Jr. By MST

MST:vr
Attachment

cc: Director, Office of Management Information
and Program Control

5928

DUKE POWER COMPANY
OCONEE UNIT 1

Report No.: RO-269/76-9

Report Date: June 23, 1976

Occurrence Date: June 8, 1976

Facility: Oconee Unit 1, Seneca, South Carolina

Identification of Occurrence: Keowee Hydro Station inadvertently separated from underground and overhead transmission lines

Conditions Prior to Occurrence: Unit 1 and 3 at 100 percent full power
Unit 2 in refueling shutdown

Description of Occurrence:

On June 8, 1976, Keowee Hydro Station Unit 1 was taken out of service in order to perform electrical breaker preventative maintenance. Keowee Unit 2 was connected to the underground feeder circuit as required by Technical Specification 3.7.2(b). In the process of testing the Unit 1 breaker, ACB-3, the Keowee Unit 2 breaker, ACB-4, tripped and Keowee Unit 2 was separated from both the underground feeder circuit and the overhead transmission line. This condition existed for approximately 1½ minutes until Keowee Unit 2 could be reconnected to the underground circuit. In the process of removing the test equipment utilized in ACB-3 testing, breaker ACB-4 again tripped and Keowee Unit 2 was out of service again for approximately 1½ minutes. Keowee Unit 2 was reconnected to the underground circuit and normal conditions were restored.

Apparent Cause of Occurrence:

This incident occurred while testing ACB-3 using an analyzer to time the open and close speed of the breaker. The analyzer was mistakenly connected to a 110 volt AC source on ACB-3 rather than to the fused positive battery terminal. When the breaker was closed with the analyzer controls, 110 volt AC was put on the closing coil of ACB-3 and the Keowee station battery. This action resulted in a series of simultaneous electrical breaker trips which isolated the overhead and underground transmission lines. The cause of this subsequent isolation has not yet been determined.

Analysis of Occurrence:

This occurrence resulted in the isolation of Keowee Unit 2 from the underground feeder for two brief periods of approximately 1½ minutes each. During this time period, other sources of power available to the Oconee Nuclear Station included the 230 kV, 500 kV, and 100 kV transmission systems. Due to the very short period of time that the Keowee units were unavailable and the remote possibility of the necessity for emergency power, it is

concluded that this incident did not affect the health and safety of the public.

Corrective Action:

A procedure revision will be implemented to assure that a volt meter is used to check terminal voltages prior to connecting analyzer leads to breaker terminals. This action will prevent incorrectly connecting AC voltage to a breaker terminal as occurred in this instance. This revision will be implemented by July 15, 1976, and this test will not be performed again prior to this time.

Additionally, further investigation of this incident will be made to assure a complete understanding of this occurrence and to assure that no problems exist. This report will be supplemented by August 1, 1976.