NRC FORM 195 (2-76)

U.S. NUCLEAR REGULATORY COMMISSION

DOCKET NUMBER: 50-269

FILE NUMBER: INCIDENT REPORT

NRC DISTRIBUTION FOR PART 50 DOCKET MATERIAL

TO:	FROM:	DATE OF DOCUMENT
Mr. Norman C. Moseley	Duke Power Company Charlotte, North Carolina Mr. William O. Parker, Jr.	7/7/76
		DATE RECEIVED: 7/28/76

LETTER / ORIGINAL / COPY	NOTORIZED / UNCLASSIFIED	PROP	INPUT FORM	NUMBER OF COPIES RECEIVED
X / X / DC	☐ / X			One signed

DESCRIPTION

Ltr. trans the following:

DO NOT REMOVE

ACKNOWLEDGED (1-P)

PLANT NAME:

Oconee 1

ENCLOSURE

Licensee Event Report (RO 50-269/76-8) on 7/7/76 concerning Keowee Unit 1 unavailable to the overhead line due to breaker failure.

(2-P)

NOTE: IF PERSONNEL EXPOSURE IS INVOLVED SEND DIRECTLY TO KREGER/J. COLLINS

FOR ACTION/INFORMATION 7/30/76 RJL

X	BRANCH CHIEF:	Schwencer	
	W/3 CYS FOR ACTION		
X	LIC. ASST.:	Sheppard	
	W/ / CYS		
	ACRS 16 CYS HOLDING/SENT TO LA		

INTERNAL DISTRIBUTION

X	REG FILE		
X	NRC PDR		
X	I & E (2)		
X	MIPC		
X	SCHROEDER/IPPOLITO		
X	HOUSTON		
X	NOVAK/CHECK		
X	GRIMES		
X	CASE		
X	BUTLER		
X	HANAUER		
X	TEDESCO/MACCARY		
X	EISENHUT		
X	BAER		
X	SHAO		
X	VOLLMER/BUNCH		
X	KREGER/J.COLLINS		

EXTERNAL DISTRIBUTION

X	LPDR: Walhalla, S.C.		
X	TIC:		
X	NSIC:		

CONTROL NUMBER: 7604

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

July 7, 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-269/76-8.

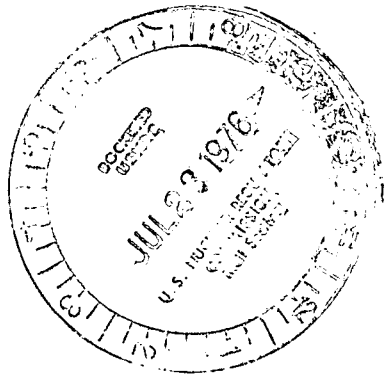
Very truly yours,

William O. Parker Jr.

William O. Parker, Jr. by WAH

EDB:vr
Attachment

cc: Director, Office of Management Information and Program Control



7604

DUKE POWER COMPANY
OCONEE UNIT 1

Report No.: RO-269/76-8

Report Date: July 7, 1976

Occurrence Date: June 7, 1976

Facility: Oconee Unit 1, Seneca, South Carolina

Identification of Occurrence: Keowee Unit 1 unavailable to the overhead line due to breaker failure

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

Description of Occurrence:

On June 7, 1976, following the performance of routine preventative maintenance on Keowee Unit 1 air circuit breaker (ACB) #1, inspection revealed that the open/close indicator flag was hitting a nut on the linkage arm causing the arm to bend slightly. Both the flag and linkage arm were straightened and tested and the breaker returned to service. Approximately five hours later, both the field breaker and supply breaker failed to trip when ACB #1 was tripped to remove the unit from the overhead line. An investigation of the breaker indicated that the linkage arm to the auxiliary switch was bent and the indicator flag was jammed through the window in the indicator flag housing. Repairs were made and ACB #1 was returned to service within 19 hours. During this period, Keowee Unit 1 was unavailable to provide power through the overhead line resulting in a degraded mode of operation.

Apparent Cause of Occurrence:

When the breaker open/close indicator flag was bent to prevent it from hitting a nut on the linkage arm, it allowed the tip of the flag to strike the edge of the window in the indicator flag housing. Each successive breaker operation resulted in the flag bending further. When the breaker was tripped, the flag jammed through the window, bending the linkage arm and preventing the auxiliary switches from opening. Consequently, the field breaker and supply breaker failed to trip as required.

Analysis of Occurrence:

This incident resulted in making Keowee Unit 1 unavailable to the overhead line for a period of approximately 19 hours. However, Keowee Unit 2 was still available via the overhead line and was connected to the underground feeder circuit. Either unit could have been made available through the underground feeder circuit. It is concluded, therefore, that the health and safety of the public was not affected by this occurrence.

Corrective Action:

The end of the indicator flag for ACB #1 was cut off to prevent it from striking either the nut or the housing window. A new linkage arm was made and installed. Additionally, all other indicator flags on ACB's at Keowee Hydro Station were inspected and this problem was not found to exist.