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TO:

Mr. Norman C. Moseley

FROM:

Duke Power Company
Charlotte, NC
William O. Parker, Jr.

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PLANT NAME:

Oconee Nuclear Station
VT

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(1-P)

ENCLOSURE

Licensee Event Report #R0-50-269/77-21 on 6/29/77
concerning two trains of penetration room
ventilation inadvertently removed from service

(2-P)

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

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CONTROL NUMBER

772140275

DUKE POWER COMPANY

POWER BUILDING

422 SOUTH CHURCH STREET, CHARLOTTE, N. C. 28242

WILLIAM O. PARKER, JR.
VICE PRESIDENT
STEAM PRODUCTION

July 13, 1977

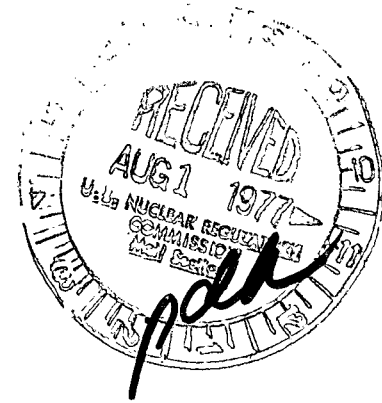
TELEPHONE: AREA 704
373-4083

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

Regulatory

File Cy



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 R0-269/77-21.

Very truly yours,

W. O. Parker, Jr.

William O. Parker, Jr. *By [Signature]*

MST:ge
Attachment

cc: Director, Office of Management Information
and Program Control

772140275

DUKE POWER COMPANY
OCONEE UNIT 1

Report No.: RO-269/77-21

Report Date: July 13, 1977

Occurrence Date: June 29, 1977

Facility: Oconee Unit 1, Seneca, South Carolina

Identification of Occurrence: Two trains of penetration room ventilation inadvertently removed from service

Conditions Prior to Occurrence: Unit at 100 percent full power

Description of Occurrence:

On June 28, 1977, the "A" train of penetration room ventilation was to be removed from service to permit replacement of the carbon filters. In the process of tagging out the "A" train of the penetration room ventilation, the "A" train fan was tagged out and the "B" train suction isolation valve PR-16 was mistakenly closed, tagged and locked. This action resulted in both trains of the penetration room ventilation being inoperable although it was not realized at that time. Maintenance personnel observing the red tag on valve PR-16 believed this was the filter to be replaced and hence the "B" train penetration room filter was replaced.

Approximately 24 hours later a test was performed on the "B" train of the penetration room ventilation system in order to assure its operability in accordance with Technical Specification 3.15. During conduct of this test, valve PR-16 was found to be closed, however, it was not locked and the red tag was missing. The valve was opened and locked to satisfy the normal conditions for that valve and the test of active components was performed.

Approximately 30 hours after both trains were removed from service, it was discovered that the filter had been replaced in the "B" train rather than the "A" train. A test was immediately performed on the "A" train and it was restored to operable status within approximately 33 hours after the incident occurred.

Designation of Apparent Cause of Occurrence:

This incident resulted from personnel errors in identifying the correct components to be isolated for this particular maintenance action. Additionally, another error occurred in identifying the filter housing in which the filter was to be replaced.

Analysis of Occurrence:

The penetration room ventilation system is provided to reduce the leakage of radioactive material to the atmosphere by way of the penetration room in the unlikely event of a loss of coolant accident. In this incident, both trains of penetration room ventilation were not automatically operable

upon receipt of an engineered safeguards signal. Both trains could have been made operable within a very short period of time following an accident. Considering the relatively short period of time in which both trains were inoperable and the highly unlikely probability of a loss of coolant accident, it is considered that the health and safety of the public was not affected by this incident.

Corrective Action:

In order to prevent recurrence of this particular incident, all pieces of equipment which are tested by the Performance Section have been clearly identified by use of bright yellow paint and stencils. Additionally, the personnel involved with this particular incident have been consulted concerning the importance of careful work practices in relation to removing safety-related components from service.

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