

50-287

NRC DISTRIBUTION FOR PART 50 DOCKET MATERIAL

FILE NUMBER

INCIDENT REPORT

TO: MR N. C MOSELEY

FROM: DUKE POWER COMPANY  
CHARLOTTE, NC  
W O PARKER, JR

DATE OF DOCUMENT

4-2-76

DATE RECEIVED

4-5-76

LETTER  
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1 Signed

DESCRIPTION

REPORTABLE OCCURENCE ON 3-3-76 287/76-2  
RE STANDBY BUS BREAKER IMPROPERLY TAKEN OUT  
OF SERVECE.....

ENCLOSURE

**DO NOT REMOVE**  
**ACKNOWLEDGED**

PLANT NAME: OCONEE #3

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

SAFETY

FOR ACTION/INFORMATION

ENVIRO

RKB 4-8-76

<input checked="" type="checkbox"/>	BRANCH CHIEF:	Purple
	W/3 CYS FOR ACTION	
<input checked="" type="checkbox"/>	LIC. ASST:	SHEPPARD
	W/ CYS	
	ACRS CYS HOLDING/SENT TO LA	

INTERNAL DISTRIBUTION

<input checked="" type="checkbox"/>	REG FILE				
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<input checked="" type="checkbox"/>	HANAUER				
<input checked="" type="checkbox"/>	TEDESCO/MACCARY				
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<input checked="" type="checkbox"/>	BAER				
<input checked="" type="checkbox"/>	SHAO				
<input checked="" type="checkbox"/>	VOLLMER/BUNCH				
<input checked="" type="checkbox"/>	KREGER/J. COLLINS				

EXTERNAL DISTRIBUTION

<input checked="" type="checkbox"/>	LPDR: WALHALLA, SC				
<input checked="" type="checkbox"/>	TIC				
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CONTROL NUMBER

B429

DUKE POWER COMPANY

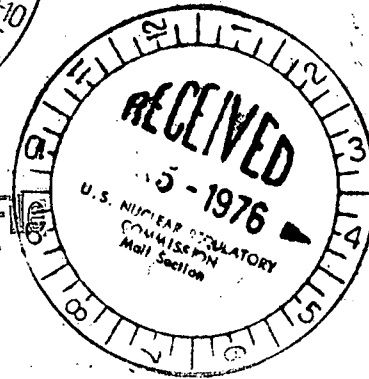
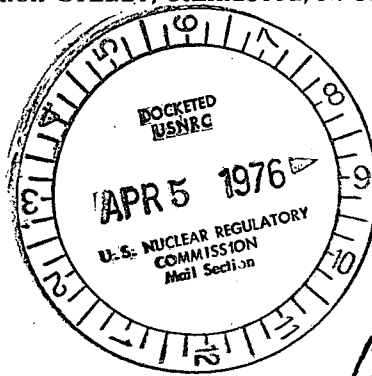
POWER BUILDING

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

WILLIAM O. PARKER, JR.  
VICE PRESIDENT  
STEAM PRODUCTION

TELEPHONE: AREA 704  
373-4083

April 2, 1976



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

Regulatory Docket File

Re: Oconee Unit 3  
Docket No. 50-287

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-287/76-2.

Very truly yours,

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

MST:mmb

Attachment

CC Director, Office of Management Information  
and Program Control

3429

Duke Power Company  
Oconee Unit 3

Report No: RO-287/76-2

Report Date: April 2, 1976

Occurrence Date: March 3, 1976

Facility: Oconee Unit 3, Seneca, South Carolina

Identification of Occurrence: Standby bus breaker improperly taken out of service.

Conditions Prior to Occurrence: Unit 1 at refueling shutdown  
Unit 2 at 100% full power  
Unit 3 in startup mode, reactor power approximately 18% full power

Description of Occurrence:

On March 3, 1976, annual preventative maintenance was performed on the Oconee Nuclear Station 4160 volt switchgear. This work required that one standby bus breaker at a time be removed from service. The Oconee Units 1 and 2 work was completed and the standby bus breakers returned to service. Permission was then received to remove Oconee Unit 3 standby bus breaker No. 1 from service at 1100 hours.

On the next shift, at 2245 hours, the Oconee Unit 3 control operator observed that there was no indication on the control room switch for this breaker. Investigation revealed that this breaker had been racked out, and no tag or Out of Normal Check Sheet identified the reason for the breaker's being out of service. The breaker was restored to service at 2300 March 3, 1976.

Designation of Apparent Cause of Occurrence:

The apparent cause of this occurrence was inadequate communication between the operations personnel which resulted in an "Out of Normal Check Sheet" not being completed for the removal of this breaker from service. Two individuals were under the impression that the other had completed the "Out of Normal Check Sheet" when neither had done so. The status of the breaker was, therefore, not adequately communicated between shifts.

Analysis of Occurrence:

Oconee Nuclear Station Technical Specification 3.7.2 permits one of the two redundant standby bus breakers to be removed from service, for test or maintenance, during power operation of the reactor. A time period of 24 hours is permitted for this maintenance because of the extremely low probability of a postulated accident and the simultaneous failure of the redundant standby bus breaker. In this incident, one of the two standby bus breakers was inoperable for a period of 12 hours. It is concluded that the health and safety of the public was not affected by this occurrence.

Corrective Action:

This occurrence has been discussed with the personnel involved, and the deficiency in their actions identified. All operating personnel will review this incident to prevent its future repetition.