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TO: Mr. Norman C. Moseley

FROM: Duke Power Co.
Charlotte, N.C. 28242
Wm. O. Parker

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6-23-76

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DESCRIPTION: Ltr trans the following:

PLANT NAME: Oconee Unit 3

ENCLOSURE Reportable Occurrence R0-287/76-8 on
6-9-76 re faulure of both pallel Group 7
control rod power Supplies...

(1 cy encl rec'd)

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ACKNOWLEDGED

NOTE: IF PERSONNEL EXPOSURE IS INVOLVED
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SAFETY

FOR ACTION/INFORMATION

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LPDR: WAHANA, S.C.
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6839

DUKE POWER COMPANY

POWER BUILDING

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

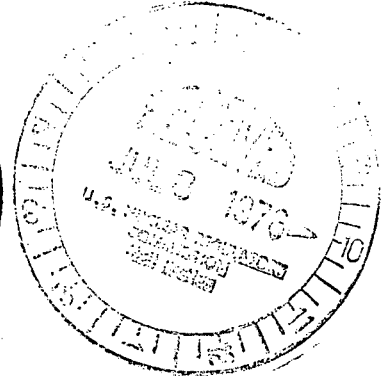
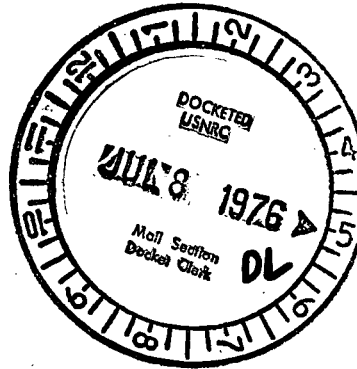
Regulatory Docket File

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 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-287/76-8.

Very truly yours,

W.O. Parker, Jr.
William O. Parker, Jr. *By HSB*

EDB:vr
Attachment

cc: Director, Office of Management Information
and Program Control

6839

DUKE POWER COMPANY
OCONEE UNIT 3

Report No.: RO-287/76-8

Report w/for Entry 6-23-76

Report Date: June 23, 1976

Occurrence Date: June 9, 1976

Facility: Oconee Unit 3, Seneca, South Carolina

Identification of Occurrence: Control rod overlap in excess of Technical Specification limit due to a dropped control rod group

Conditions Prior to Occurrence: Unit at 100 percent full power

Description of Occurrence:

On June 9, 1976, during full power operation of Oconee Unit 3, the Group 7 control rods dropped into the core resulting in a control rod overlap condition of less than $25\% \pm 5\%$. This overlap is required by Oconee Technical Specification 3.5.2.5.b. The control operator promptly placed the control rod drive system in manual control and decreased reactor power to 88 percent full power with Group 6 control rods at 80 percent withdrawn to re-establish the required overlap. Control rod Group 7 was then placed on auxiliary power and reactor power was increased to 97 percent full power while maintaining the required overlap. Repairs to control rod Group 7 were completed within four hours and the group was returned to its normal power supply.

Apparent Cause of Occurrence:

This incident resulted from the failure of both parallel Group 7 control rod power supplies. One power supply was inoperable due to a blown fuse and a tripped breaker. No apparent cause for this failure was determined. The other power supply failure was due to a failed transistor in the A phase output of the programmer feeding the gate drives. As a result of the failure of these power supplies, the Group 7 control rods dropped into the core when it became necessary to energize the A phase.

Analysis of Occurrence:

This incident resulted in control rod Group 7 dropping into the core and a condition of approximately 18 percent control rod overlap existing for approximately five minutes until Group 6 control rods were re-positioned and the required overlap was re-established. This reduction in control rod overlap did not affect the safe operation of the reactor and no core protection limits were approached. It is therefore concluded that this occurrence did not affect the health and safety of the public.

Corrective Action:

Within four hours following the incident, the faulty programmer and fuse were replaced, the breaker reset, and the Group 7 normal power supply returned to service and verified operable.