REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

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FACIL:50-287 Oconee Nuclear Station, Unit 3, Duke Power Co. 0500028
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Region 2, Atlanta, Office of the Director

SUBJECT: LER 79-003/01T-0 on 790118:core flood tank pressure reached 632 psig due to nitrogen header isolation valve being mistakenly opened w/o closing of containment isolation valve.Personnel disciplined & pressure regulator adjusted.

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TITLE: INCIDENT REPORTS

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DUKE POWER COMPANY
OCONEE UNIT 3

Report Number: RO-287/79-3

Report Date: February 1, 1979

Occurrence Date: January 18, 1979

Facility: Oconee Unit 1, Seneca, South Carolina

Identification of Occurrence: Core Flood Tank Pressurized Above 625 psig

Conditions Prior to Occurrence: 98% Full Power

Description of Occurrence:

At 2225 on January 18, 1979, nitrogen was required to be added to the 3B Core Flood Tank (CFT). Operations personnel went to the second level of the Auxiliary Building to open Valve 3N-137, which is the nitrogen high pressure header isolation valve to the Unit 3 CFT supply line. Valve 3N-137 is normally open, but had previously been used as a block valve. The valve was closed in error. The operator then proceeded to open Valve 3N-130, which is the nitrogen supply line containment isolation valve and is located on the fourth level in the Penetration Room. He opened Valve 3N-130, and when the CFT pressure failed to increase, he returned to the Auxiliary Building to check Valve 3N-137, without first closing Valve 3N-130. When he discovered that he had inadvertently closed Valve 3N-137, he reopened it and CFT pressure began to increase. Control Room personnel, noting the increasing pressure, attempted to page the operator, but were unsuccessful. The Control Room then sent another operator to close Valve 3N-137, but by the time this was accomplished CFT pressure had reached 632 psig. Oconee Nuclear Station Technical Specification 3.3.(a) limits CFT pressure to not more than 625 psig. Control Room personnel returned CFT pressure to within specification by 2240, less than 15 minutes from the time Valve 3N-137 was initially closed. No structural damage to the Core Flood Tank or associated piping resulted from the excess pressure.

Apparent Cause of Occurrence:

The excessive CFT pressure resulted from two errors by operations personnel. The first was the erroneous closure of Valve 3N-137. The second was failure to close Valve 3N-130 prior to opening valve 3N-137. The incident could still have been avoided if the Control Room had been able to establish contact with the operator subsequent to the reopening of Valve 3N-137.

Analysis of Occurrence:

The Core Flood Tank is designed for a pressure of 700 psig and was hydrostatically tested to 1050 psig during preoperational structural testing, so

the maximum pressure reached was well within its limits. In addition, the CFT relief valve would have limited the pressure to 660 psig if the make-up valve had not been closed. It is considered that there would have been no significant impact on the performance of the Core Flood System in the event of a postulated accident. Therefore, safe operation of the unit was not affected, and the health and safety of the public were not endangered.

Corrective Action:

The operator responsible for the errors has been disciplined. In addition, the nitrogen header pressure regulator between the two valves will be adjusted to preclude a similar occurrence.

NRC FORM 366 (7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

EXHIBIT A

CONTROL BLOCK: [| | | | |] (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0 1	LICENSEE CODE: S C N E E 3 (2) LICENSE NUMBER: 0 0 - 0 0 0 0 0 - 0 0 (3) LICENSE TYPE: 4 1 1 1 1 (4) CAT: (5)
CON'T 0 1	REPORT SOURCE: L (6) DOCKET NUMBER: 0 5 0 0 0 2 8 7 (7) EVENT DATE: 0 1 1 8 7 9 (8) REPORT DATE: 0 2 0 1 7 9 (9)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 On January 18, 1979, while adding nitrogen to the 3B Core Flood Tank, CFT
0 3 pressure reached 632 psig. Pressure was reduced to within specification
0 4 within 15 minutes after initiating nitrogen addition. The maximum pressure is
0 5 well within CFT design limits, and no significant effect would have resulted
0 6 from this incident in the event of a postulated accident. Therefore, public
0 7 health and safety were not endangered.
0 8

0 9	SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
	S F (11)	A (12)	B (13)	V A L V E X (14)	F (15)	H (16)

(17) LER/RO REPORT NUMBER	EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
	7 9	—	0 0 3	/	0 1	T	—	0

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS (22)	ATTACHMENT SUBMITTED	NPRD-4 FORM SUB.	PRIME COMP. SUPPLIER	COMPONENT MANUFACTURER
H (18)	E (19)	Z (20)	Z (21)	0 0 0 0 0	Y (23)	N (24)	L (25)	Z 9 9 9 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The excess pressure resulted from two personnel errors, when the nitrogen
1 1 header isolation valve was mistakenly closed, and then opened without first
1 2 closing the containment isolation valve. The operator responsible has been
1 3 disciplined. The nitrogen header pressure regulator will be adjusted to
1 4 prevent future such occurrences.

1 5	FACILITY STATUS: E (28)	% POWER: 0 9 5 (29)	OTHER STATUS (30): NA	METHOD OF DISCOVERY: A (31)	DISCOVERY DESCRIPTION (32): Operator Observation
1 6	ACTIVITY RELEASED: Z (33)	CONTENT OF RELEASE: Z (34)	AMOUNT OF ACTIVITY (35): NA		LOCATION OF RELEASE (36): NA
1 7	PERSONNEL EXPOSURES NUMBER: 0 0 0 (37)	TYPE: Z (38)	DESCRIPTION (39): NA		
1 8	PERSONNEL INJURIES NUMBER: 0 0 0 (40)	DESCRIPTION (41): NA			
1 9	LOSS OF OR DAMAGE TO FACILITY (43) TYPE: Z (42)	DESCRIPTION: NA			
2 0	PUBLICITY ISSUED: N (44)	DESCRIPTION (45): NA			NRC USE ONLY

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