

DUKE POWER COMPANY

POWER BUILDING

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

WILLIAM O. PARKER, JR.
VICE PRESIDENT
STEAM PRODUCTION

September 22, 1980

TELEPHONE: AREA 704
373-4083

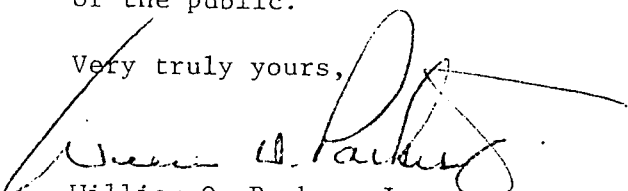
Mr. James P. O'Reilly, Director
U. S. Nuclear Regulatory Commission
Region II
101 Marietta Street, Suite 3100
Atlanta, Georgia 30303

Re: Oconee Unit 3
Docket No. 50-287

Dear Mr. O'Reilly:

Please find attached Reportable Occurrence Report RO-287/80-12. This report is submitted pursuant to Oconee Nuclear Station Technical Specification 6.6.2.1(2), which concerns operation with a parameter subject to a limiting condition for operation less conservative than the least conservative aspect of that limiting condition for operation, and describes an incident which is considered to be of no significance with respect to the health and safety of the public.

Very truly yours,


William O. Parker, Jr.

JLJ:scs
Attachment

cc: Director
Office of Management & Program Analysis
U. S. Nuclear Regulatory Commission
Washington, D. C. 20555

Mr. Bill Evallee
Nuclear Safety Analysis Center
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DUKE POWER COMPANY
OCONEE UNIT 3

Report Number: RO-287/80-12

Report Date: September 22, 1980

Occurrence Date: September 8, 1980

Facility: Oconee Unit 3, Seneca, South Carolina

Identification of Occurrence: Time Exceeded for Technical Specification Sampling
Frequency on Unit 3 CBAST

Conditions Prior to Occurrence: Oconee 3 - Hot Shutdown

Description of Occurrence:

At approximately 0815 on September 8, 1980, Chemistry Supervision "A" discovered that a boron analysis on the Unit 3 Concentrated Boric Acid Storage Tank (CBAST) had not been done since September 1, 1980, at 1030. This time interval exceeds the minimum sampling frequency of twice per week with a five-day maximum interval between samples. Unit 3 was not at cold shutdown for a period exceeding the sample frequency as described in Technical Specification Table 4.1-3, Item 6. Therefore, this specification was exceeded on September 7, 1980 at 1030, and no minimum boron concentration was assured prior to criticality pursuant to Technical Specification 3.2.2. A sample taken on the Unit 3 CBAST on September 9, 1980 at 0100 verified that the source of boron exceeded the minimum amount.

Apparent Cause of Occurrence:

The cause of this incident was the failure of Chemistry personnel to ensure that a sample was taken within the allotted time period.

Analysis of Occurrence:

Technical Specification Table 4.1-3, Item 6 and 4.0.2 requires the CBAST's to be sampled for boron twice per week with a maximum interval between samples of 5 days. These samples are normally taken on Tuesdays and Fridays on dayshift. To qualify a sample as being representative of the contents, a 4-hour recirculation is made before a sample is drawn. After the first sample of the week was taken on September 2, 1980 at 1030, arrangements for the second sample to be taken on September 5, 1980, were delayed due to boration of the Reactor Coolant System (RCS) using the CBAST. Beginning at 0300 on September 5, 1980 requests to place the CBAST in recirculation for a sample were made by Chemistry to the Unit 3 Control Room. These requests were noted from shift to shift using the Chemistry turnover log. However, no further action was taken to ensure that either a sample was taken or instructions were given to evening personnel to sample the CBAST. Hence, the CBAST "missed" sample was not discovered until September 8, 1980 at 0815 by the Primary Chemistry Supervisor.

Exceeding the surveillance sampling frequency of the Unit 3 CBAST for boron was identified. The sample taken at 0100 on September 9, 1980 verified that a minimum boron concentration was maintained in the CBAST from 1030 on September 2, 1980 thru 0100 on September 9, 1980. This incident must be reported pursuant to Technical Specification 6.6.2.1(2). However, it was not considered significant with respect to safe operation, and the health and safety of the public were not affected.

Corrective Action:

The immediate corrective action was the verification of the minimum boron concentration in 3 CBAST at 0100 on September 9, 1980. Appropriate disciplinary action has been taken against Duty Supervisor "B" and ANCT "A". This incident will be reviewed with all Chemistry personnel, and emphasis will be placed upon following existing methods of ensuring a surveillance sample requirement is met. The Duty Chemistry Supervisor and technicians should verify that all samples have been taken by visually checking the chemistry status boards in the labs. In addition, to the Duty Supervisor, the technicians working in each of the chemistry areas are responsible for ensuring that all samples have been taken and are properly documented.