

DUKE POWER COMPANY

POWER BUILDING

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

WILLIAM O. PARKER, JR.
VICE PRESIDENT
STEAM PRODUCTION

June 25, 1979

TELEPHONE: AREA 704
373-4083

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

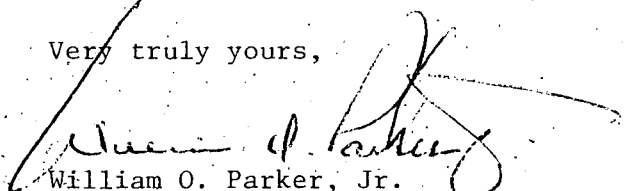
REGULATORY DOCKET FILE COPY

Re: Oconee Nuclear Station, Units 1 and 2
Docket Nos. 50-269, and 50-270

Dear Mr. O'Reilly:

Reportable Occurrence Report RO-269/79-15 was transmitted by my letter of June 7, 1979. Subsequent to that submittal an error was discovered in the "Analysis of Occurrence" portion of the report. The countrate observed during the release of a laundry tank was erroneously reported. Please find attached a revised copy of that report, which supercedes the original submittal.

Very truly yours,


William O. Parker, Jr.

SRL/sch
Attachment

cc: Director, Office of Management Information
and Program Control



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DUKE POWER COMPANY

Oconee Units 1 and 2

Report Number: RO-269/79-15

Report Date: June 25, 1979

Occurrence Date: May 24, 1979

Facility: Oconee Nuclear Station, Seneca, South Carolina

Identification of Occurrence: Inadvertent Release from Laundry & Hot Shower Tank

Conditions Prior to Occurrence: Unit 1 100% Full Power
Unit 2 Cooldown, 290°F and 550 psig

Description of Occurrence:

On May 24, 1979 2335 gallons of water was inadvertently released from laundry and hot shower tank (LHST) A without a sample being taken prior to the release, as required by Oconee Nuclear Station Technical Specification 3.9.8. At approximately 1300 on May 24, an attempt was made to discharge water from LHST B, which had been sampled previously, but no flow was indicated. Since a review of valve positions revealed no misalignment, the decision was made to align the LHST A discharge pump to LHST B. At 1319 the discharge was secured, and it was discovered that the LHST B pump had inadvertently been aligned to LHST A, emptying that tank rather than LHST B. Prior to admitting any further liquid to LHST A, a sample was taken from the tank's pump drain, and an analysis indicated that the quantity released was very small with respect to Technical Specification limits.

Apparent Cause of Occurrence:

Unsampled liquid was released from LHST A due to a personnel error in performing the pump alignment. When the LHST B pump discharge filter was found to be obstructed, an attempt was made to align the LHST A pump to LHST B. However, when the discharge was secured, it was discovered that the LHST B pump had been aligned to LHST A. Prior to performing the realignment, a change should have been made to the procedures for draining the tank, but this was not done. In addition, the error was facilitated by a lack of identifying markings on the tanks and their associated piping and pumps.

Analysis of Occurrence:

During the time the tank was being discharged, at least one Keowee Hydro Unit was operating, providing dilution flow. An analysis of the sample taken from LHST A subsequent to the release indicated that radionuclide concentrations were low enough to permit a discharge flowrate of approximately 460 gpm without exceeding any Technical Specification limits. In addition, the release was monitored by two detectors on the discharge line, one of which was calibrated to trip at a countrate of 33,000 cpm, and the other at 500 cpm, so the release would have been terminated if the concentration had been too high. The maximum

Analysis of Occurrence (cont'd)

count rates recorded by the two detectors were 17,000 cpm and 10 cpm, respectively. However, Technical Specification 3.9.8 requires that the hot shower tank be sampled prior to releasing its contents. Therefore, this incident constitutes a situation which is less conservative than the least conservative aspect of a limiting condition for operation and must be reported pursuant to Technical Specification 6.6.2.1.a(2), although it was of no significance with respect to the health and safety of the public.

Corrective Action:

The two tanks and their associated equipment have been clearly marked and color-coded to eliminate confusion in the future. All valves which could allow unsampled liquid to enter LHST B during a release will be locked in the closed position, and the operating procedures have been changed to reflect that fact. Additional changes have been made to all liquid waste disposal procedures to assure that the correct pump/tank combination is verified both before and during releases. In addition, the personnel involved in the incident have been counseled to assure correct understanding of the procedures.