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FACIL:50-269 Oconee Nuclear Station, Unit 1, Duke Power Co. 05000269
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Region 2, Atlanta, Office of the Director

SUBJECT: LER 80-020/01T-0:on 800619,at 74% power,backup 125 VDC power to instrumentation & control power sys removed from svc to investigate ground exceeding 24-h limit.Caused by personnel error misinterpreting Tech Spec limitation.

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TITLE: Incident Reports

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DUKE POWER COMPANY
OCONEE NUCLEAR STATION

Report Number: RO-269/80-20

Report Date: July 3, 1980

Occurrence Date: June 19, 1980

Facility: Oconee Nuclear Station, Seneca, South Carolina

Identification of Occurrence: Lack of 125 VDC Instrumentation and Control Power System Redundancy

Conditions Prior to Occurrence: Oconee 1 - 75% Full Power
Oconee 2 - RCS Heatup
Oconee 3 - Cold Shutdown

Description of Occurrence:

During an investigation of a ground alarm on the 2CA and 2CB Instrumentation and Control (I&C) batteries, backup 125V DC power to the I&C Power System was removed from service by the disconnection of the isolating transfer diodes. This occurred at 2322 hours on June 18, 1980. The isolating transfer diodes were not reconnected until 0930 hours on June 21, 1980. This exceeds the 24 hour limit on inoperability allowed by Technical Specification 3.7.2(d).

Apparent Cause of Occurrence:

Although the Technical Specifications had been consulted to determine whether the transfer diodes could be isolated, the personnel involved failed to note the requirement to restore operability within 24 hours.

The disconnection of the isolating transfer diodes was not noted in either the Control Room (CR) or Senior Reactor Operators' (SRO) Log. In addition, this information was not passed along during the Shift Relief and Turnover.

Analysis of Occurrence:

Units 1 and 2 were without the required automatic backup DC power to the I&C DC Power Systems for a period of 58 hours. However, both CA and CB batteries, their respective chargers, and distribution centers for Units 1, 2, and 3 were at all times available and could have been restored to normal status had the need arisen. Thus, although the incident is reportable pursuant to Technical Specification 6.6.2.1.a(2), it is not considered significant with respect to safe operation, and the health and safety of the public were not affected.

Corrective Action:

The 125 VDC I&C Power Systems for Units 1, 2, and 3 were restored to normal operation at 0930 hours on June 21, 1980.

All involved personnel have been counseled on the importance of logging events pertaining to safety-related equipment in the Unit SRO or Unit RO logs. In addition, it has been proposed that the CR Operator fill out a shift turnover sheet similar to that now filled out by the Unit Supervisor. Finally, a detailed training session on Technical Specification 3.7, Auxiliary Electrical Systems, is to be given to involved personnel to allow better interpretation and understanding.

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)

01 LICENSEE CODE: S C N E E 1 (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 01 REPORT SOURCE: L (6) DOCKET NUMBER: 0 5 0 0 0 2 6 9 (7) EVENT DATE: 0 6 1 9 8 0 (8) REPORT DATE: 0 7 0 3 8 0 (9)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 On June 18, 1980, with Unit 1 at 74% FP, the backup 125 VDC power to the I&C
03 Power System was removed from service by disconnecting the isolating transfer
04 diodes, in order to investigate a ground. Power was restored on June 21, 1980.
05 This exceeded the 24 hour limit allowed by T. S. 3.7.2(d). However, the back-
06 up DC system was available and could have been restored if needed. Thus, this
07 incident was not significant with respect to safe operation, and the health
08 and safety of the public were not affected.

09 SYSTEM CODE: E C (11) CAUSE CODE: A (12) CAUSE SUBCODE: A (13) COMPONENT CODE: Z Z Z Z Z Z (14) COMP. SUBCODE: Z (15) VALVE SUBCODE: Z (16)

(17) LER/RO REPORT NUMBER: EVENT YEAR: 8 0; — ; SEQUENTIAL REPORT NO.: 0 2 0; /; OCCURRENCE CODE: 0 1; REPORT TYPE: T; —; REVISION NO.: 0

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

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 Personnel misinterpreted T. S. 3.7, failing to note the 24 hour limit on un-
11 availability of the backup DC power. In addition, the removal of backup DC
12 power from service was not properly documented in the appropriate logs. Per-
13 sonnel have been counseled on proper documentation of events, and will be trained
14 in the interpretation and understanding of T. S. 3.7. Finally, the CRO may be required to fill out a detailed shift turnover sheet.

15 FACILITY STATUS: E (28) % POWER: 0 7 4 (29) OTHER STATUS (30): NA METHOD OF DISCOVERY: B (31) DISCOVERY DESCRIPTION (32): Completion of maintenance procedure.

16 ACTIVITY RELEASED: Z (33) CONTENT OF RELEASE: Z (34) AMOUNT OF ACTIVITY (35): NA LOCATION OF RELEASE (36): NA

17 PERSONNEL EXPOSURES NUMBER: 0 0 0 (37) TYPE: Z (38) DESCRIPTION (39): NA

18 PERSONNEL INJURIES NUMBER: 0 0 0 (40) DESCRIPTION (41): NA

19 LOSS OF OR DAMAGE TO FACILITY (43) TYPE: Z (42) DESCRIPTION: NA

20 PUBLICITY ISSUED: N (44) DESCRIPTION (45): NA NRC USE ONLY

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