

DUKE POWER COMPANY  
OCONEE UNIT 1

Report No.: UE-269/74-8

Report Date: January 3, 1975

Event Date: November 18, 1974

Facility: Oconee Unit 1, Seneca, South Carolina

Identification of Event: Improper system valve lineup following maintenance

Conditions Prior to Event: Unit in refueling shutdown

Description of Event:

On November 18, 1974, decay heat cooler 1A and associated low pressure injection piping for Oconee Unit 1 were being refilled following maintenance work on low pressure injection pump discharge valve LLP-12. All red tags associated with the maintenance work had been properly removed; however, it was not realized that a high point vent GWD-153 had been left open since the system had been drained. When the system was filled to the high point vent, water began to spray into the east penetration room. Personnel present in the penetration room detected the leakage and notified the Shift Supervisor. The leakage was stopped by closing valve LLP-12. The water which spilled in the penetration room was collected and the affected areas were decontaminated.

Designation of Apparent Cause of Event:

The apparent cause of this incident was the failure to completely verify the condition of a system upon completion of a maintenance action. The red tags, which had been installed for personnel safety, had been properly cleared and removed. High point vent valve GWD-153 had not been red tagged as part of this maintenance action as it did not contribute to personnel safety.

Analysis of Event:

The reactor was in refueling shutdown with the reactor vessel head removed at the time of this incident. The loss of water from the open vent valve resulted in a decrease in the level of the reactor vessel. This level was being monitored and only decreased seven inches before action was taken to raise the level using water from the borated water storage tank. The decrease in reactor vessel level did not cause radiation levels to increase significantly, thus personnel working in the Reactor Building were not affected.

The water which sprayed into the penetration room was contained within the Auxiliary Building. There was no incidence of personnel contamination as a result of this spill. It is concluded that the health and safety of the public was not affected by this incident.

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Corrective Action:

Oconee Nuclear Station Administrative Procedure 9, "Equipment Removal and Restoration Control," is being changed to provide better control of maintenance evolutions which require the isolation and returning to service of equipment. Procedures and checklists will be generated which will list equipment which is manipulated for the isolation and draining of the system. These procedures will be utilized to ensure that conditions are returned to normal after maintenance is complete prior to refilling systems and returning them to service. This change will be implemented by February 15, 1975.