Duke Power Company
Oconee Unit 3

Report No: UE-287/74-2

Report Date: October 22, 1974

Event Date: September 10, 1974

Facility: Oconee Nuclear Station, Unit 3

Identification of Event: Modification of 4 Kv Switchgear without proper authorization

Conditions Prior to Event: Startup testing below 15% power

Description of Event:

On May 1, 1974 the Design Engineering Department of Duke Power Company originated Station Modification Report (SMR) 0-225-D, which involved several major alterations to the 7 Kv and 4 Kv Switchgear transfer circuits. When the SMR was sent to the station on July 25, 1974 only the 7 Kv portion of the SMR had been cleared for accomplishment. This was due to the fact that the 4 Kv Switchgear was safety-related and a safety analysis had not been performed at that time. On August 5, 1974, approval was obtained to commence work on the 7 Kv Switchgear and a work request was originated. On August 28, 1974, work was completed by a Construction Department electrician on both the 7 Kv and the 4 Kv Switchgear under the supervision of Oconee Operations personnel. The fact that unauthorized work had been performed on the 4 Kv Switchgear was determined on September 10, 1974.

Designation of Apparent Cause of Event:

The electrician in charge of the work recognized the fact that the 4 Kv portion of the SMR was minor, since it only involved connecting cables to the switchgear for computer indication. However, the required safety analysis had not been completed. This event occurred as a result of personnel not following established work procedures.

Analysis of Event:

The modification to the 4 Kv Switchgear transfer circuits added indication of the type of transfer (rapid or delayed). The time delay in the transfer schemes had already been included in the 4 Kv circuits, and were not affected by the modification. Therefore, this incident did not affect the safe operation of the Switchgear or the health and safety of the public.

Corrective Action:

The Safety Analysis of the 4 Kv portion of the SMR was completed prior to discovering the unauthorized modification, therefore immediate corrective action was not necessary. The incident has been reviewed with personnel involved and the importance of complying with established procedures has been reiterated.