DUKE POWER COMPANY
OCONEE UNIT 2

Report No.: UE-270/75-17

Report Date: November 3, 1975

Event Date: September 25, 1975

Facility: Oconee Unit 2, Seneca, South Carolina

Identification of Event: Improper communications resulting in inadvertent isolation of letdown flow

Conditions Prior to Event: Unit at 99 percent full power

Description of Event:

On September 25, 1975, a work request was initiated to check the indication of valve 2HP-14, a three-way valve diverting letdown flow to either the letdown storage tank (LDST) or the reactor coolant bleed holdup tanks (BHUT). The valve was cycled several times by the control operator, and it was determined that the limit switch would require adjustment. Valve 2CS-26, isolation to the bleed holdup tanks, was closed by the control operator.

To adjust the limit switch, the maintenance mechanic manually positioned valve 2HP-14 to the bleed holdup tank position. This resulted in letdown flow being diverted to a closed line and consequently relief valves 2RV-154 and 2RV-168 relieved to the miscellaneous waste holdup tank (MWHUT) and relief valve 2RV-53 relieved to the high activity waste tank (HAWT). Radiation monitors RIA-43 and -45 indicated an increase in activity and the control operator closed valve 2HP-5 momentarily to stop letdown flow and allow the relief valves to reseat. Valve 2HP-14 was placed in the normal position and letdown flow was reinitiated.

Designation of Apparent Cause of Event:

The apparent cause of this event was a misunderstanding between the maintenance mechanic and the control operator. The maintenance mechanic informed the control operator that adjustment of valve 2HP-14 limit switch would be necessary; however, the operator did not realize that this would necessitate operation of the valve and therefore did not leave valve 2CS-26 open to divert flow to the bleed holdup tanks.

Analysis of Event:

This event resulted in the momentary isolation of letdown flow from the reactor coolant system and actuation of relief valves to direct reactor coolant letdown flow to the miscellaneous and high activity waste tanks. Safe unit operation was not affected by this incident. Analysis of the activity indicated on the radiation monitors showed that approximately 29 curies of gaseous activity was released to the Auxiliary Building. This is 0.5737 percent of the total annual gaseous release limit. It is therefore concluded that the health and safety of the public was not affected.

Corrective Action:

In order to prevent recurrence, operating and maintenance personnel have been cautioned that complete and accurate communications must occur in order to prevent misunderstanding between groups.