DUKE POWER COMPANY
POWER BUILDING
422 SOUTH CHURCH STREET, CHARLOTTE, N. C. 28242

WILLIAM O. PARKER, JR.
VICE PRESIDENT
STEAM PRODUCTION

TELEPHONE: AREA 704
373-4083

October 9, 1981

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

Re: Oconee Nuclear Station
Docket No. 50-269

Dear Mr. O'Reilly:

Please find attached Reportable Occurrence Report RO-269/81-18. This report is submitted pursuant to Oconee Nuclear Station Technical Specification 6.6.2.1.b(3). which concerns observed inadequacies in the implementation of procedural controls during operation of a unit which could cause a reduction in the degree of redundancy provided by the Reactor Protection and Engineered Safety Feature Systems, and describes an incident which is considered to be of no significance with respect to its effect on the health and safety of the public.

Very truly yours,

William O. Parker, Jr.

JFK/php
Attachment

cc: Director
Office of Management & Program Analysis
U. S. Nuclear Regulatory Commission
Washington, D. C. 20555

Records Center
Institute of Nuclear Power Operations
1820 Water Place
Atlanta, Georgia 30339

Mr. F. Jape
NRC Resident Inspector
Oconee Nuclear Station

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DUKE POWER COMPANY
OCONEE NUCLEAR STATION

REPORT NUMBER: RO-269/81-18

REPORT DATE: October 9, 1981

OCCURRENCE DATE: September 11, 1981

FACILITY: Oconee Nuclear Station, Seneca, South Carolina

IDENTIFICATION OF OCCURRENCE: Safety-related battery surveillance procedures not in compliance with Technical Specifications.

CONDITIONS PRIOR TO OCCURRENCE: Oconee 1 Cold Shutdown
Oconee 2 Cold Shutdown
Oconee 3 100% FP

DESCRIPTION OF OCCURRENCE: On September 11, 1981 it was determined that the safety-related battery surveillance procedures did not fully comply with the requirements of Technical Specification 4.6.9. This Technical Specification was revised in May 1980; therefore this discrepancy existed for approximately sixteen months.

APPARENT CAUSE OF OCCURRENCE: Personnel failed to identify necessary changes to safety-related battery surveillance procedures after implementation of a change to Technical Specification 4.6.9.

ANALYSIS OF OCCURRENCE: The safety-related batteries were not rendered inoperable due to the surveillance procedure inadequacies; thus, the health and safety of the public were not affected by this incident.

CORRECTIVE ACTION: Changes have been initiated to the appropriate surveillance procedures to incorporate the Technical Specification requirements for safety-related battery surveillance. Personnel involved in the review of Technical Specification changes have been counselled relative to this incident.