

USNRG REGION II  
ATLANTA, GEORGIA  
DUKE POWER COMPANY  
POWER BUILDING

422 SOUTH CHURCH STREET, CHARLOTTE, N. C. 28242

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WILLIAM O. PARKER, JR.  
VICE PRESIDENT  
STEAM PRODUCTION

TELEPHONE: AREA 704  
373-4083

November 4, 1981

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

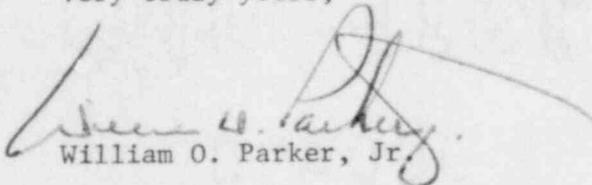


Re: Oconee Nuclear Station  
Docket No. 50-269

Dear Mr. O'Reilly:

Please find attached Reportable Occurrence Report RO-269/81-19. This report is submitted pursuant to Oconee Nuclear Station Technical Specification 6.6.2.1.a(2), which concerns an operation subject to a limiting condition for operation which was less conservative than the least conservative aspect of the limiting condition for operation established in the Technical Specifications, 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. W. T. Orders  
NRC Resident Inspector  
Oconee Nuclear Station

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Duke Power Company  
Oconee Unit 1

Report Number: RO-269/81-19

Report Date: November 4, 1981

Occurrence Date: October 19, 1981 thru October 21, 1981

Facility: Oconee Unit 1, Seneca, South Carolina

Identification of Occurrence: Inadequate sampling of Liquid Waste Releases

Condition Prior to Occurrence: Cold Shutdown, fuel removed from core.

Description of Occurrence: Four separate liquid waste releases were made with inoperable effluent monitors. Prior to each release redundant samples were taken and analyzed. However, the sample point did not permit sampling the correct water inventory batch; thus, the samples taken were inadequate. This constitutes a violation of Technical Specification 3.9.7 and is thus reportable pursuant to Technical Specification 6.6.2.1.a(2).

Apparent Cause of Occurrence: The apparent cause of this occurrence was the failure to identify a change in sample point location required as a result of a system realignment.

Analysis of Occurrence: Oconee Nuclear Station has been processing and releasing a large volume of slightly contaminated, secondary system water resulting from a steam generator tube leak on Oconee Unit 2. In order to facilitate this processing, several temporary modifications were made to existing secondary plant equipment in order to utilize existing tanks and pumps for holdup, sampling, and eventual discharge of effluent through the normal effluent monitors (RIAs 33 and 34) to the Keowee tailrace.

On October 19, 1981 at 0940 RIAs 33 and 34 were administratively declared inoperable as a result of lower than expected RIA indications on a preceding liquid waste release. Although administratively inoperable, the RIAs remained "in service" and responded to subsequent releases. Subsequent releases were made at 1953 on October 19, 1981 and at 1115 and 2217 on October 20, 1981. The redundant samples addressed by Technical Specification 3.9.7 were requested and taken to each release. However, as a result of the modified system configuration, the sample point for the tank involved, Unit 1 Condensate Storage Tank, did not provide a representative sample of the water being released. All of the water being processed and released via this path was of similar origin and activity level. Using sample results from batch releases prior to and following the unsampled releases, and the available data from the RIAs, the activity of the unsampled batches was conservatively estimated. These estimates indicate that the quantity of activity and the release rates were well within regulatory limits. Thus, it is considered that this event is of no consequence with respect to safe operation and that the health and safety of the public were not affected by this incident.

Corrective Action: Immediately after discovery of the incorrect sampling point, the Chemistry sampling procedure was revised to reflect the proper method for sampling the Condensate Storage Tank in the modified configuration. All Chemistry personnel responsible for taking the chemistry sample were notified of the procedural change.