

DUKE POWER COMPANY

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HAL B. TUCKER
VICE PRESIDENT
NUCLEAR PRODUCTION

March 4, 1983

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US NRC REGION II
ATLANTA REGION III

Mr. James P. O'Reilly, Regional Administrator
U. S. Nuclear Regulatory Commission
Region II
101 Marietta Street, NW, Suite 2900
Atlanta, Georgia 30303

Re: Oconee Nuclear Station
Docket No. 50-269

Dear Mr. O'Reilly:

Please find attached Reportable Occurrence Report RO-269/83-04. This report is submitted pursuant to Oconee Nuclear Station Technical Specification 6.6.2.1.b(2) which concerns conditions leading to operation in a degraded mode permitted by a limiting condition of operation per Technical Specification 3.7.2(e)1., 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,

H.B. Tucker / BT

Hal B. Tucker

PFC/php
Attachment

cc: Document Control Desk
U. S. Nuclear Regulatory Commission
Washington, D. C. 20555

Mr. J. C. Bryant
NRC Resident Inspector
Oconee Nuclear Station

INPO Records Center
Suite 1500
1100 Circle 75 Parkway
Atlanta, Georgia 30339

Mr. E. L. Conner, Jr.
Office of Nuclear Reactor Regulation
U. S. Nuclear Regulatory Commission
Washington, D. C. 20555

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Duke Power Company
Oconee Nuclear Station

Report Number: RO-269/83-04

Report Date: March 4, 1983

Occurrence Date: February 2, 1983

Facility: Oconee Units 1, 2, 3, Seneca, South Carolina

Identification of Occurrence: AC Power was lost to the 125V DC 230 KV Switching Station Power System SY-1 battery charger.

Conditions Prior to Occurrence:

Oconee 1	100% Full Power
Oconee 2	100% Full Power
Oconee 3	100% Full Power

Description of Occurrence: On February 2, 1983 at 0920, while the yearly periodic maintenance (PM) was being performed on Power Circuit Breaker (PCB) -15, a screwdriver that was being used slipped off a piece of equipment and inadvertently short circuited one 480V phase to ground on the switchyard 480 VAC system. A 70 amp breaker at the Switchyard Power Panel Board (SPA) malfunctioned and did not trip as it should have, causing the 350 amp breaker, which feeds AC power to the SPA, to trip. When the 350 amp fuse tripped, AC power was lost to battery charger SY-1, SY-S and PCBs 7 through 16 as well. Loss of the SY-1 battery placed Units 1, 2, and 3 under a Limiting Condition for Operation (LCO) per Technical Specification 3.7.2(e)1.

Apparent Cause of Occurrence: The cause of this incident was component malfunction and procedure deficiency. Had the 70 amp breaker functioned properly and tripped as designed, it would have prevented the tripping of the 350 amp breaker. Thus, AC power would have been maintained to the SPA and AC power would not have been lost to the SY-1 battery charger. The PM work was performed per normal and acceptable operating practices, but because of the minor accident, two terminal strips were shorted. The procedure should have taken into account the possibility that this type of accident could occur, and also, the possible safety hazard of working in close proximity of exposed and energized terminal strips.

Analysis of Occurrence: When the 480V AC supply to battery chargers SY-1 and SY-S was lost, battery SY-1 kept the SY-1 DC bus energized. Had a fault developed resulting in a loss of power to the SY-1 DC bus, redundant relaying is provided by the SY-2 DC bus. The health and safety of the public were not compromised by this event.

Corrective Action: The immediate corrective action was to reset the 350 amp feeder breaker. In less than one hour from the time AC power was lost, the Keowee underground power path was tested and was determined to be operable. The 70 amp breaker and the trip unit of the 350 amp breaker will be replaced. It is recommended that the Transmission Department evaluate the work which led up to the short circuit and change their procedures/operating practices, as necessary, to prevent personnel from contacting energized equipment.