

CONTROL BLOCK: [] [] [] [] [] [] [] [] [] [] (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

[0] [1] [S] [C] [N] [E] [E] [1] [2] [0] [0] [-] [0] [0] [0] [0] [0] [-] [0] [0] [3] [4] [1] [1] [1] [1] [4] [] [] [5]

CONT

[0] [1] [R] [E] [P] [O] [R] [T] [S] [O] [U] [R] [C] [E] [L] [6] [0] [5] [0] [0] [0] [2] [6] [9] [7] [0] [2] [2] [4] [8] [3] [8] [0] [3] [0] [9] [8] [3] [9]

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

[0] [2] The operability of Keowee Unit 2 emergency power path (EPP) was not checked
[0] [3] within 8 hours of its initial operability check per Technical Specification (TS)
[0] [4] 3.7.2(a). Keowee Unit 2 was verified to be operable, 13 minutes after violation
[0] [5] of TS 3.7.2(a) by starting the unit. The emergency power path was operable and
[0] [6] all the other sources of emergency power, as described in the TS and Final
[C] [7] Safety Analysis Report, were available. The health and safety of the public
[0] [8] were not endangered by this incident.

[0] [9] [E] [D] [11] [A] [12] [A] [13] [Z] [Z] [Z] [Z] [Z] [Z] [14] [Z] [15] [Z] [16]

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

[1] [0] Personnel error caused this incident. The control room operators failed to
[1] [1] verify operability of Keowee Unit 2 EPP within the allowable time period. The
[1] [2] immediate corrective action was to verify operability and to counsel the control
[1] [3] room operators. It is planned to change procedures to assure that required
[1] [4] testing/inspection will be performed.

[1] [5] [E] [28] [1] [0] [0] [29] [NA] [A] [30] Operator observation

[1] [6] [Z] [33] [Z] [34] [NA] [NA]

[1] [7] [0] [0] [0] [37] [Z] [38] [NA]

[1] [8] [0] [0] [0] [40] [NA]

[1] [9] [Z] [42] [NA]

[2] [0] [N] [44] [NA]

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Report Number: RO-269/83-06

Report Date: March 9, 1983

Occurrence Date: February 24, 1983

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

Identification of Occurrence: The operability of Keowee Unit 2 emergency power path was not checked within eight hours of its initial operability check.

Conditions Prior to Occurrence:

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

Description of Occurrence: On February 23, 1983, the eight hour time limit for testing the alternate Keowee emergency power path expired. This violates Technical Specification 3.7.2(a). Keowee Unit 1 had been removed from service for periodic maintenance. Ten minutes after the Technical Specification violation occurred, it was determined by control room operators that the operability test had been missed at which time the procedure to verify the Keowee emergency power path was begun. The time limit was exceeded by 13 minutes.

Apparent Cause of Occurrence: The cause of this incident was personnel error. The control room operators did not verify the operability of Keowee at the appropriate time. The Keowee status board was appropriately updated to show that a Keowee operability verification was due. The time on the board was one hour prior to the Technical Specification 3.7.2(a) violation. The operators failed to utilize this aid.

Analysis of Occurrence: Keowee Unit 2 was verified to be operable by starting the unit and energizing the standby buses through the underground feeder. The Technical Specification requires that the unit be tested within eight hours, which starts from the time the unit was first tested. The time limit was exceeded by 13 minutes. The emergency power path was operable during the entire time Keowee Unit 1 was out of service and all the other sources of emergency power (230 KV transmission system, 100 KV transmission system, and two nuclear units) were available. Thus, the health and safety of the public were not compromised by this incident.

Corrective Action: The immediate corrective action was to perform a Keowee Unit 2 operability verification. In addition, an alarm clock has been placed in the Unit 1 and 2 control room and is available as an operator aid. The appropriate personnel have been counseled in regard to this incident. It is planned to add a step to Enclosure 5.6 (shift turnover sheet) of OP/0/A/1102/20. The step will require documentation of systems/components which are in need of testing/inspection pursuant to a Technical Specification degraded mode and the frequency at which the system/component needs to be tested. PT/1,2,3/A/600/01 (Periodic Instrument Surveillance) will be revised to require a periodic review of the shift turnover sheet to assure that Technical Specification required testing/inspections have been and are being performed.