

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Oconee Nuclear Station, Unit 1	DOCKET NUMBER (2) 0 5 0 0 0 2 6 9	PAGE (3) 1 OF 1
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TITLE (4)
Momentary Suspension of PIE Gamma Scanner Over Spent Fuel Assembly

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)											
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES		DOCKET NUMBER(S)									
0	8	3	0	8	4	0	0	3	0	0	0	0	5	0	0	0	2	7	1	0
0	8	3	0	8	4	0	0	9	0	5	0	0	5	0	0	0				

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)

OPERATING MODE (9) 11010	20.402(b)	20.406(a)	50.73(a)(2)(iv)	73.71(b)
POWER LEVEL (10)	20.406(a)(1)(i)	50.38(a)(1)	50.73(a)(2)(v)	73.71(c)
	20.406(a)(1)(ii)	50.38(a)(2)	50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
	20.406(a)(1)(iii)	X 50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	
	20.407(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(viii)(B)	
	20.408(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(ix)	

LICENSEE CONTACT FOR THIS LER (12)

NAME Richard F. Haynes, Jr. Engineer, Licensing	TELEPHONE NUMBER 7 0 4 3 7 3 - 7 1 2 9
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COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE:) NO

EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

On August 30, 1984, the Post Irradiation Examination (PIE) gamma ray scanner was rotated so that one end was momentarily suspended over a spent fuel assembly in the Units 1 and 2 Spent Fuel Pool (SFP). The event occurred while Units 1 and 2 were operating at 100% full power. The PIE scanner and its associated equipment were in the process of being reinstalled after maintenance by the vendor. The immediate corrective action was to rotate the PIE gamma scanner away from the spent fuel assemblies. The apparent cause of this incident was an insufficient number of spent fuel assemblies moved from this area of the SFP. The immediate and supplemental corrective actions identified the problem and ensured that the gamma scanner was not suspended over any other spent fuel assemblies. The planned corrective action should eliminate this problem in the future by clearing a larger area in the SFP. No radioactive release occurred and the health and safety of the public were not affected.

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TEXT (If more space is required, use additional NRC Form 366A's) (17)

Description of Occurrence:

On July 9, 1984, maintenance was being performed on the Post Irradiation Examination (PIE) equipment located in the Units 1 and 2 Spent Fuel Pool (SFP), using a specific operational procedure. The maintenance process required removal of the PIE gamma scanner (hereafter referred to as the "scanner") from the SFP. Prior to removing the scanner, an area in the SFP was cleared in order to satisfy the Oconee technical specification limit which states that no suspended loads greater than 3000 lbs. shall be transported over spent fuel in the SFP. The scanner weighs approximately 3600 lbs. Three spent fuel assemblies were moved to provide sufficient area, and these were relocated within the SFP. Following preparation for removal on July 10, 1984, the scanner was lifted out of the SFP using the auxiliary hoist on the spent fuel bridge; the scanner was raised to the level of the spent fuel bridge despite obstructions in the southwest corner of the SFP. At this point, rotation of the scanner was necessary in order to clear the spent fuel bridge. Observation was not made as to whether the scanner was rotated over any spent fuel elements during this stage of the operation. The scanner was then moved horizontally and lowered outside the pool periphery. The positioning mechanism was unfastened from the scanner which was then transported offsite for required maintenance.

On August 29, 1984, the equipment was returned to the site, the scanner internals rebuilt, and the associated electronics checked out prior to reinstallation. On August 30, 1984, with the positioning mechanism reconnected, the scanner was reinstalled in the SFP, again using the spent fuel bridge auxiliary hoist. To clear the spent fuel bridge, the scanner was rotated during its descent. At this point, it was noted that one end of the gamma scanner was suspended over one spent fuel assembly. The problem was corrected by immediately rotating the scanner so that it was no longer above the spent fuel assembly. Subsequently, the scanner was carefully guided into the pool so as to keep it away from the spent fuel assemblies. The three spent fuel assemblies initially relocated to provide space for the operation were moved back to their original locations.

When the incident was reported on August 30, 1984, it was noted that the end of the scanner was probably over a spent fuel assembly during removal since circumstances involving geometry, etc... were similar for both removal and reinstallation of the scanner assembly.

Cause of Occurrence:

The event took place because the number of spent fuel assemblies relocated within the SFP was insufficient to provide adequate area for maneuvering the scanner during reinstallation. The procedure used for this operation does not specify how large an area must be cleared of spent fuel assemblies, nor does it contain a specific precaution referencing a technical specification limit. A review of past incident reports relating to this operation indicated that this problem has not occurred previously and is thus not a recurring problem.

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TEXT (If more space is required, use additional NRC Form 366A's) (17)

Analysis of Occurrence:

The scanner weighs approximately 3600 lbs. When the end of the scanner rotated over a spent fuel assembly, only a small portion of this weight was actually suspended over a spent fuel assembly. The positioning mechanism of the scanner was always connected to the scanner while it was in the SFP. If the scanner had fallen, the positioning mechanism would have guided the fall to the side of the pool away from all spent fuel assemblies. Therefore, the health and safety of the public were not affected.

Corrective Action:

Immediate corrective action was taken to rotate the scanner away from the spent fuel assembly. Special care was taken to guide the scanner, thereafter, and keep it away from other spent fuel assemblies. Personnel involved have been counseled concerning the personal error. Additionally, new procedures will be developed for performance of this operation which specify how large an area to clear in the SFP for adequate clearance and include specific precautions pertaining to technical specification requirements.

DUKE POWER COMPANY

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VICE PRESIDENT
NUCLEAR PRODUCTION

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September 28, 1984

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

Subject: Oconee Nuclear Station, Units 1 and 2
Docket Nos. 50-269 and 50-270
LER 269/84-03

Pursuant to 10 CFR 50.73 Sections (a)(1) and (d), attached is Licensee Event Report 269/84-03 concerning an incident involving momentary suspension of the Post Irradiation Examination gamma ray scanner, over a spent fuel element in the Units 1 and 2 Spent Fuel Pool; the report is submitted in accordance with §50.73 (a)(2)(i). Initial notification of this event was made (pursuant to §50.72 Section (b)(2)(ii)) with the NRC Operations Center via the ENS on August 31, 1984. This event was considered to be of no significance with respect to the health and safety of the public.

Very truly yours,

H. B. Tucker

Hal B. Tucker

RFH:slb

Attachment

cc: Mr. James P. O'Reilly, Regional Administrator
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Mr. J. C. Bryant
NRC Resident Inspector
Oconee Nuclear Station

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September 28, 1984
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cc: Ms. Helen Nicolaras
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