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April 15, 1983

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-269/83-10. 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. My letter of March 30, 1983 addressed the delay in preparation of this report.

Very truly yours,

Hal B. Tucker

Hal B. Tucker

JCP/php
Attachment

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

INPO Records Center
Suite 1500
1100 Circle 75 Parkway
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Mr. J. C. Bryant
NRC Resident Inspector
Oconee Nuclear Station

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-269/83-10

Report Date: April 15, 1983

Occurrence Date: March 17, 1983

Facility: Oconee Unit 1, Seneca, South Carolina

Identification of Occurrence: The Unit 1 Emergency Hatch Inner Door was found opened.

Conditions Prior to Occurrence: Oconee 1 - 100% Full Power

Description of Occurrence: On March 17, 1983, plant technicians entered the Emergency Hatch through the outer door to perform the Reactor Building Emergency Lock Leak Rate Test. After completing testing and leaving the Emergency Hatch area through the outer door, the outer hatch door was closed and due to personnel error the inner hatch door was inadvertently opened. During the performance of the test as well as after, the Emergency Hatch inner/outer door open statalarm in the control room was actuated. At the time of the incident, the statalarm was considered to be inoperable and a work request was written to have it checked. As a result, upon completion of the Air Lock Test, the operators did not acknowledge that the air lock had not been returned to normal. At approximately 0930 on March 21, 1983 it was visually verified that the inner door was open approximately 6 to 10 inches, which violates Technical Specification 3.6.3.(a). See Attachment 1 for a drawing of the Emergency Hatch.

Apparent Cause of Occurrence: The apparent cause of this incident has been classified as a personnel error and defective procedures. The person involved in the closing of the hatch door positioned the pointer on the handwheel outside the "both doors closed and latched" indication marks. The procedure used to perform the Leak Rate Test did not include a step to close the outer door. There was no step in the procedure to perform an independent verification to assure both doors are properly closed. The indicator lights on the outside of the outer hatch door were not labeled and one of the two lights was not working. The light covers for both lights were missing. The statalarm was checked on March 18, 1983 and determined to be working satisfactorily. On March 21, 1983, in preparation for investigating the door limit switches, the inner door was found open 6 to 10 inches.

Analysis of Occurrence: During the time that the inner door was open 6 to 10 inches, the outer door was closed. The design of the inner/outer Emergency Hatch is such that only one door can be open at a time. Thus, if entry into the Emergency Hatch area through the outer door was attempted, while the inner door was open, the inner door would have closed first prior to opening the outer door. Operation with an Emergency Hatch door inoperable does not impair the integrity of the containment, since either door will meet the design specifications for structural integrity and leak rate. Thus, the health and safety of the public were not endangered by this incident.

Corrective Action: The immediate corrective action taken was to close the inner door and to verify that the Emergency Hatch doors and the Personnel Hatch doors on all three units were properly closed. The Reactor Building Emergency Hatch Leak Rate Test procedure has been changed to include steps to properly close the Emergency Hatch doors. The procedure was revised to require that an independent verification be performed to assure that both hatch doors are properly closed. The analogous changes have also been made to the Leak Rate Test procedure for the Personnel Hatch. The local indicator lights located outside the outer hatch door for all three units were repaired as illustrated in Attachment 2. The remote indicator lights located in the control room and associated circuitry for all three units were verified to be functioning properly. The personnel involved in this incident have been counseled. In addition, a task force was formed to review all plant procedures/ practices and to make the necessary changes to assure containment integrity is not compromised.