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CONTROL NO: 13628

FILE: INCIDENT REPORT FI

FROM: Duke Power Company Charlotte, N.C. 28242 Wm. O. Parker, Jr.		DATE OF DOC 12-8-75	DATE REC'D 12-16-75	LTR XX	TWX	RPT	OTHER
TO: Mr. Norman C. Moseley		ORIG 1 signed	CC	OTHER	SENT AEC PDR <u>XX</u>		SENT LOCAL PDR <u>XX</u>
CLASS	UNCLASS XXXX	PROP INFO	INPUT	NO CYS REC'D 1	DOCKET NO: 50-287		

DESCRIPTION: Ltr trans the following:

ENCLOSURES: Unusual Event 50-287/75-12 on 11-5-75 re failure of gasket on personnel hatch inner door...

(1 cy encl rec'd)

**ACKNOWLEDGED
Do Not Remove**

PLANT NAME: Oconee Unit 3

FOR ACTION/INFORMATION

DHL 12-20-75

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DUKE POWER COMPANY

POWER BUILDING

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

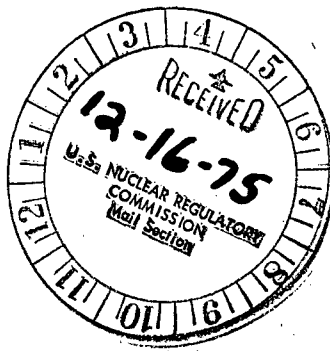
Regulatory Docket File

WILLIAM O. PARKER, JR.
VICE PRESIDENT
STEAM PRODUCTION

TELEPHONE: AREA 704
373-4083

December 8, 1975

Mr. Norman C. Moseley, Director
U. S. Nuclear Regulatory Commission
Suite 818
230 Peachtree Street, Northwest
Atlanta, Georgia 30303

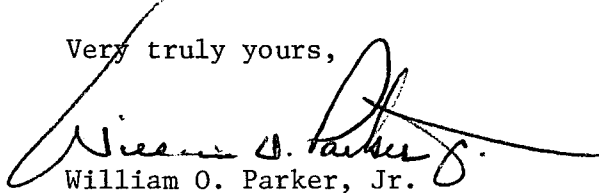


Re: Oconee Unit 3
Docket No. 50-287

Dear Mr. Moseley:

Pursuant to Sections 6.2 and 6.6.2 of the Oconee Nuclear Station
Technical Specifications, please find attached Unusual Event Report
UE-287/75-12.

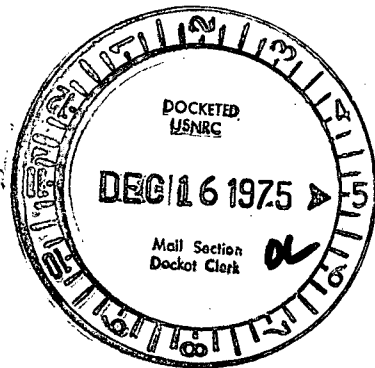
Very truly yours,


William O. Parker, Jr.

EDB:mmb

Attachment

CC Mr. Benard C. Rusche



13628

Report No.: UE-287/75-12

Report Date: December 5, 1975

~~Received by Ltr Docket 12-8-75~~

Event Date: November 5, 1975

Facility: Oconee Unit 3, Seneca, South Carolina

Identification of Event: Failure of gasket on personnel hatch inner door

Conditions Prior to Event: Unit at 95% full power

Description of Event:

On November 5, 1975, a leak rate test was performed on Oconee Unit 3 personnel hatch. After pressurizing the hatch to 50 psig, it was observed that the inner door gasket had failed. Further testing was immediately discontinued, and the outer personnel hatch door was locked in the closed position.

Apparent Cause of Event:

The personnel hatch leak rate test is performed by pressurizing the area between the inner and outer doors. The test tends to unseat the inner door; therefore, strongbacks are placed on the hatch side of the inner door to maintain the door in a closed condition. The apparent cause of this incident was the unseating of the inner door by the test pressure, resulting in failure of the gasket.

Analysis of Event:

The failure of the personnel hatch inner door gasket resulted in the loss of integrity of the inner door. However, it is highly probable that this door would have functioned properly during a loss-of-coolant accident since containment pressure tends to seat the inner door, compressing the gasket. Additionally, the outer door is capable of maintaining containment integrity. It is concluded that the health and safety of the public was not affected.

Corrective Action:

The personnel hatch outer door was locked closed pending approval of a change to Oconee Technical Specification 3.6.4. This change was received on November 11, 1975 and permitted the outer door to be opened during power operation for a maximum ten-minute interval to permit access for repair of the faulty inner door gasket. The inner door gasket was replaced, and the hatch successfully tested on November 12, 1975.