

DUKE POWER COMPANY

POWER BUILDING

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

WILLIAM O. PARKER, JR.
VICE PRESIDENT
STEAM PRODUCTION

January 29, 1982

USNRC REGION II
ATLANTA, GEORGIA
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TELEPHONE: AREA 704
373-4083

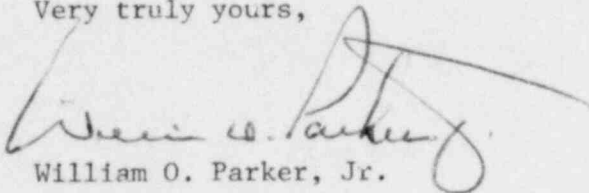
Mr. James P. O'Reilly, Regional Administrator
U. S. Nuclear Regulatory Commission
Region II
101 Marietta Street, Suite 3100
Atlanta, Georgia 30303

Re: Oconee Nuclear Station
Docket No. 50-270

Dear Mr. O'Reilly:

Please find attached Reportable Occurrence Report RO-270/82-01. 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.

Very truly yours,



William O. Parker, Jr.

JFK/php
Attachment

cc: Director
Office of Management & Program Analysis
U. S. Nuclear Regulatory Commission
Washington, D. C. 20555

Records Center
Institute of Nuclear Power Operations
1820 Water Place
Atlanta, Georgia 30339

Mr. W. T. Orders
NRC Resident Inspector
Oconee Nuclear Station



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DUKE POWER COMPANY
OCONEE NUCLEAR STATION UNIT 2

Report Number: RO-270/82-01

Report Date: January 29, 1982

Occurrence Date: January 17, 1982

Facility: Oconee Unit 2, Seneca, South Carolina

Identification of Occurrence: Reactor Building Equipment Hatch not properly seated.

Conditions Prior to Occurrence: Refueling Shutdown

Description of Occurrence: On January 17, 1982, during defueling operations, the Reactor Building equipment hatch was found to be leaking air through a gap of approximately $\frac{1}{4}$ to $\frac{1}{2}$ inch in the seal at the bottom of the hatch.

Apparent Cause of Occurrence: The apparent cause of this incident was personnel error, in that the crew that reinstalled and secured the hatch did not verify that a good metal-to-gasket seal had been made.

Analysis of Occurrence: Twenty-six fuel assemblies had been moved during the fourteen hour period with the hatch improperly seated. The Reactor Building purge fan was on during this period, and air flow through the gap was into the Reactor Building. If a fuel assembly had been dropped during this time, the fuel would not have been uncovered since the refueling canal was full of borated water. Due to the small size of the gap and the short duration of the incident, it is felt that this incident had no significant effect on the health and safety of the public.

Corrective Action: Fuel handling was stopped and the equipment hatch was properly sealed. The appropriate procedure has been revised to require an inspection of the sealing surfaces to meet the intent of Technical Specification 3.8.6, during fuel handling operations. The crew involved in this incident has been counseled, and appropriate maintenance personnel will review this incident by February 10, 1982.