REPORT OF ABNORMAL OCCURRENCE AND/OR INCIDENT

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CONTROL NO: 2861

FILE: INCIDENT REPORT FILE

FROM: Duke Power Company Charlotte, N.C. 28201 A. C. Thies	DATE OF DOC 3-12-75	DATE REC'D 3-15-75	LTR XX	TWX	RPT	OTHER
TO: Mr. Norman C. Moseley	ORIG	CC 1	OTHER	SENT AEC PDR XX SENT LOCAL PDR XX		
CLASS UNCLASS XXX	PROP INFO	INPUT	NO CYS REC'D 1	DOCKET NO: 50-269		

DESCRIPTION: Ltr trans the following:

ENCLOSURES: Abnormal Occurrence AO-50-269/75-3 on 2-3-75 re failure of emergency hatch interlocks...

(1 cy encl rec'd)

ACKNOWLEDGE

DO NOT REMOVE

PLANT NAME: Oconee Unit 1

FOR ACTION/INFORMATION

DHL 3-17-75

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** SEND ONLY TEN DAY REPORTS

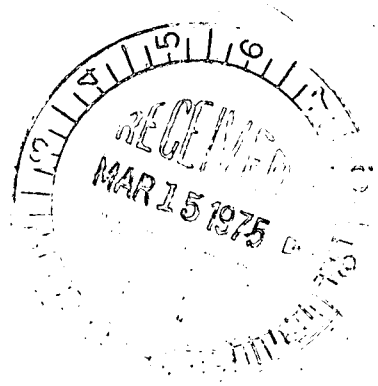
DUKE POWER COMPANY
POWER BUILDING
422 SOUTH CHURCH STREET, CHARLOTTE, N. C. 28201

A. C. THIES
SENIOR VICE PRESIDENT
PRODUCTION AND TRANSMISSION

P. O. BOX 2178

March 12, 1975

Regulatory Work File



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

Re: Oconee Unit 1
Docket No. 50-269

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-269/75-3.

Very truly yours,

A. C. Thies

ACT:vr
Attachment

cc: Mr. Angelo Giambusso

2861

DUKE POWER COMPANY
OCONEE UNIT 1

Regulatory [illegible] File

Report No.: UE-269/75-3

Report Date: March 12, 1975

3-12-75

Event Date: February 3, 1975

Facility: Oconee Unit 1, Seneca, South Carolina

Identification of Event: Failure of emergency hatch interlocks

Conditions Prior to Event: Unit in cold shutdown

Description of Event:

On February 3, 1975, entry to the Oconee Unit 1 Reactor Building was attempted through the emergency hatch while the personnel hatch leak rate test was in progress. In attempting the entry from outside containment, the operator turned the handwheel in the wrong direction and opened the inner door. In attempting to close the inner door, the interlock mechanism became out of alignment and resulted in the outer door opening at the same time the inner door was open. Attempts to close either door were unsuccessful.

Designation of Apparent Cause of Event:

The apparent cause of this event was the failure of the hatch interlock mechanism which permitted both doors of the hatch to be opened simultaneously.

Analysis of Event:

The unit was in cold shutdown at the time of this incident; hence, containment integrity was not required. This incident did not affect the health and safety of the public.

Corrective Action:

The interlocks were adjusted and the emergency hatch was returned to service. A preventative maintenance program is being developed, in conjunction with the designer of the hatch, which will provide periodic surveillance of the personnel and emergency hatches to prevent future recurrence of this incident. This program will be implemented by May 1, 1975. In addition, an investigation is in progress to determine the necessity for modifications to the personnel and emergency hatch interlock mechanism.