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CONTROL NO: 5818

FILE: INCIDENT REPORT FILE

FROM: Duke Power Co. Charlotte, N.C. A.C. Thies		DATE OF DOC 5-23-75	DATE REC'D 5-28-75	LTR xx	TWX	RPT	OTHER
TO: Mr. Norman C. Moseley		ORIG non	CC 1	OTHER	SENT AEC PDR <u>xxx</u>		
CLASS xxxx		UNCLASS	PROP INFO	INPUT	NO CYS REC'D 1	DOCKET NO: 50-287	
DESCRIPTION: Ltr trans the following: <i>AC...</i>				ENCLOSURES: Unusual Event #75-3 on 4-13-75 concerning failure of personnel hatch interlocks			
PLANT NAME: Oconee Unit 3							

FOR ACTION/INFORMATION 5-30-75 JGB

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1 - Newton Anderson		1 - J. D. RUNKLES, Rm E-201 GT
1 - ACRS SENT TO LIC ASST		
** 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

May 23, 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:

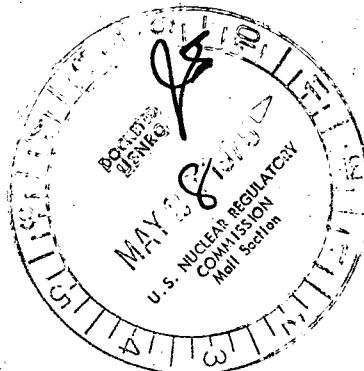
Pursuant to Sections 6.2 and 6.6.2 of the Oconee Nuclear Station
Technical Specifications, please find attached Unusual Event Report
UE-287/75-3.

Very truly yours,

A. C. Thies

ACT:vr
Attachment

cc: Mr. Angelo Giambusso



5818

DUKE POWER COMPANY
OCONEE UNIT 3

Report No.: UE-287/75-3

Report Date: May 23, 1975

Event Date: April 13, 1975

Facility: Oconee Unit 3, Seneca, South Carolina

Identification of Event: Failure of personnel hatch interlocks

Conditions Prior to Event: Unit in cold shutdown

Description of Event:

During a maintenance outage for Oconee Unit 3, the control operator received control panel indication that both doors to the personnel hatch were open simultaneously. Investigation revealed that the personnel hatch interlock mechanism had become out of adjustment and resulted in the interlocks being inoperable. An operator was immediately dispatched to the personnel hatch to prevent personnel from simultaneously opening both doors even though containment integrity was not required.

Designation of Apparent Cause of Event:

Each door of the personnel hatch has a gear which is rotated by the door handwheel. A pawl mechanism, in conjunction with this gear, creates a ratchet mechanism to prevent rotation of the door handwheel should the opposite door be open. The pawls are raised from or lowered on the gear by motion of the opposite door transmitted through a cable and linkage mechanism. Adjustments of the interlocks consist of adjusting the effective length of the cable and return springs such that the pawls will properly engage the gears and create a ratchet mechanism when the opposite door is opened. The apparent cause of this event was excessive wear of the ratchet gear teeth making the cable length adjustment extremely sensitive.

Analysis of Event:

The unit was in cold shutdown at the time of this incident; hence, containment integrity was not required. A control room alarm monitors the status of the personnel hatch doors; hence, the status of the personnel hatch was rapidly determined. It is concluded that the health and safety of the public was not affected.

Corrective Action:

A representative of the designer of the hatch has been on site and inspected the hatches. A new ratchet gear and another intermediate gear have been replaced on the Unit 3 personnel hatch door. In addition, a spring assist

has been added to give more positive displacement of the interlock cable. The designer's recommended spare parts have been procured and are now on site. The personnel hatches have been added to the periodic surveillance program. It is considered that the above action should prevent future recurrence of interlock failures of the personnel hatches.