DUKE POWER COMPANY
OCONEE UNIT 3

Report No.: UE-287/75-8

Report Date: July 14, 1975

Event Date: June 14, 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, it was determined that the interlock mechanism on the personnel hatch had failed. Administrative controls were taken to assure that both doors were not opened simultaneously 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. The apparent cause of this event was a pinched cable which restricted movement of the pawls.

Analysis of Event:

The unit was in cold shutdown at the time of this incident; hence, containment integrity was not required. In addition to the action taken to prevent simultaneous opening of the doors, a control room alarm also monitors the status of the personnel hatch doors. It is concluded that the health and safety of the public was not affected.

Corrective Action:

The interlocks were adjusted and the personnel hatch was returned to service. The interlocks were tested approximately 15 times to verify operability.

Failure Data:

A previous failure of the personnel hatch interlocks on Oconee Unit 3 was experienced and reported as UE-287/75-3.