

**LICENSEE EVENT REPORT**

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0	1	S	C	H	B	R	2	2	0	0	-	0	0	0	0	0	-	0	0	3	1	1	1	1	1	4			5	
7	8	LICENSEE CODE						14	15	LICENSE NUMBER										25	26	LICENSE TYPE					30	57	CAT	58

CON'T

7 8 60 61 68 69 74 75 80

REPORT SOURCE L 6 0 5 0 0 0 2 6 1 7 0 6 0 3 7 9 8 0 6 1 3 7 9 9

DOCKET NUMBER EVENT DATE REPORT DATE

### EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 At about 0830 hours on 6/3/79, with the plant in hot shutdown, due to a faulty door inter-

0 3 lock mechanism the reactor containment building integrity was breached when personnel

0 4 leaving the containment opened the inner air lock door not knowing that the outer door

0 5 was not sealed. The degraded condition was recognized immediately and the inner door

0 6 reclosed. The breach of containment integrity is contrary to Technical Specification

0 7 3.6.1.a. No release resulted due to a containment purge being in progress.

0 8 | \_\_\_\_\_ 80

09		SYSTEM CODE		CAUSE CODE		CAUSE SUBCODE		COMPONENT CODE				COMP. SUBCODE		VALVE SUBCODE	
7	8	S	A	11	E	12	B	13	P	E	N	E	T	R	14
		9	10	11	12	13	14	15	16	17	18	19	20	21	
(17) LER/RO REPORT NUMBER		EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE		REPORT TYPE		REVISION NO.					
21		79		22		23		24		25		26			
27		28		29		30		31		32		33			
ACTION TAKEN		FUTURE ACTION		EFFECT ON PLANT		SHUTDOWN METHOD		HOURS		ATTACHMENT SUBMITTED		NPRD-4 FORM SUB.			
33		34		35		36		37		38		39			
40		41		42		43		44		45		46			
47		48		49		50		51		52		53			

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 | The cause of the breach of containment integrity was a sheared bolt in the personnel

1 1 | air lock door interlock mechanism. Containment access was made using extra precautions

1 2 | to maintain containment integrity until the sheared bolt was replaced by maintenance

1 3 | personnel and the interlock mechanism was returned to service.

A horizontal number line is shown, starting at 0 on the left and ending at 80 on the right. There are tick marks every 10 units, labeled 0, 10, 20, 30, 40, 50, 60, 70, and 80. Above the tick mark for 7, there is a small box containing the number 1. Above the tick mark for 8, there is a small box containing the number 4.

8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50

FACILITY STATUS (28) 1 5 H 2 8 9 0 0 0 29 % POWER 10 11 12 13 OTHER STATUS (30) NA 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50

METHOD OF DISCOVERY (31) A 45 46 47 48 49 50

DISCOVERY DESCRIPTION (32) Operator Observation 45 46 47 48 49 50

ACTIVITY CONTENT  
RELEASED OF RELEASE AMOUNT OF ACTIVITY (35) LOCATION OF RELEASE (36)

1 6 Z (33) Z (34) NA 44 45 80

PERSONNEL EXPOSURES

NUMBER		TYPE	DESCRIPTION
1	7	000	NA

PERSONNEL INJURIES		DESCRIPTION	
NUMBER			
1	8	0	0
0	0	0	40
		NA	

1		2		3		4		5		6		7		8		9		10		11		12	
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PUBLICITY  
ISSUED DESCRIPTION (45) NA 7906180 506 NRC USE ONLY

2 0 [N] (44)

R. B. Starkey, Jr.

7906180506

NRC USE ONLY

PHONE: (803) 383-4524

SUPPLEMENTAL INFORMATION  
FOR  
LICENSEE EVENT REPORT 79-16

1. Cause Description and Analysis:

At about 0830 hours on June 3, 1979, with the plant in hot shutdown, due to a faulty door interlock mechanism, the reactor containment building integrity was breached when personnel leaving the containment opened the inner door of the personnel air lock not knowing that the outer door was not sealed. As the inner door opened, the person felt air come into containment and recognizing the outer door was open, immediately re-closed the inner door. The failure apparently occurred during a previous entry or exit. The interlock prevents both doors from being opened simultaneously, thereby preserving containment integrity. A failure of the interlock would not be apparent until one door was opened with the other not fully closed. The outer door, due to some unknown reason, had not been fully closed on this occasion. A containment purge was in progress at this time so there was no release of activity and no threat to the public safety or health. The breach of containment integrity is contrary to Technical Specifications 3.6.1.a and is reportable under 6.9.2.a.3.

2. Corrective Action:

The door interlock mechanism was inspected and a sheared bolt was identified as causing the defeat of the interlock. The bolt was replaced with a high tensile strength bolt.

3. Corrective Action to Prevent Further Occurrence:

A high tensile strength bolt was used to replace the sheared bolt in an effort to prevent a recurrence of this type failure. Due to an unusually high level of activity inside the containment, this outage, as a result of efforts such as base plate inspection (IE Bulletin 79-02) and implementation of Fire Protection Modifications, in addition to routine refueling activities, the airlock system including the interlock mechanism was subject to an unusual amount of use by a significant number of non-plant personnel. As a result of this type of use, the airlock operating mechanisms had experienced a number of failures during the outage, however, none of these had resulted in the breaking of containment integrity. It is believed that this type of use may have been instrumental in the above failure. Therefore, plant personnel whose routine responsibilities require frequent use of this system will review this event in an effort to reiterate the importance of the proper use of this airlock and to alert them to the potential consequences of misuse by non-plant personnel.

No further action at this time is considered necessary.