

50-335

NRC DISTRIBUTION FOR PART 50 DOCKET MATERIAL

FILE NUMBER

INCIDENT REPORT

TO:

MR. NORMAN C. MOSELEY

FROM:

FLORIDA POWER & LIGHT COMPANY
MIAMI, FLORIDA
A. D. SCHMIDT

DATE OF DOCUMENT

5/18/76

DATE RECEIVED

5/27/76

☒ LETTER☐ NOTORIZED

PROP

INPUT FORM

NUMBER OF COPIES RECEIVED

☐ ORIGINAL☒ UNCLASSIFIED☒ COPY

NONE SIGNED

DESCRIPTION

LTR. TRANS THE FOLLOWING:

(1-P)

PLANT NAME:

ST LUCIE #1

ENCLOSURE

LICENSEE EVENT RPT. (RO 50-335/76-14) ON
4/18/76 CONCERNING THE OUTER PERSONNEL ACCESS
DOOR TO CONTAINMENT WHICH WOULD NOT PASS THE
AIR LEAKAGE TEST.

ACKNOWLEDGED

DO NOT REMOVE

(2-P)

NOTE: IF PERSONNEL EXPOSURE IS INVOLVED
SEND DIRECTLY TO KREGER/J. COLLINS

SAFETY

FOR ACTION/INFORMATION

ENVIRO

5/27/76

RJL

☒ BRANCH CHIEF: ZIEMANN
☐ W/3 CYS FOR ACTION
☒ LIC. ASST: DIGGS
☐ W/1 CYS
ACRS 16 CYS HOLDING/SENT TO LA

INTERNAL DISTRIBUTION

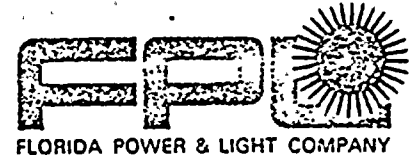
☒ REG FILE
☒ NRC PDR
☒ I & E (2)
☒ MIRC (3)
☒ SCHROEDER/IPPOLITO
☒ HOUSTON
☒ NOVAK/CHECK
☒ GRIMES/SCHWENCER (1) EA
☒ CASE
☒ E. WILLIAMS
☒ HANAUER
☒ TEDESCO/MACCARY
☒ EISENHUT
☒ BAER
☒ SHAO
☒ VOLLMER/BUNCH
☒ KREGER/J. COLLINS

EXTERNAL DISTRIBUTION

☒ LPDR: FT. PIERCE, FLA.
☒ TIC
☒ NSIC

CONTROL NUMBER

5324



May 18, 1976

PRN-LI-76-122

Mr. Norman C. Moseley, Director, Region II
Office of Inspection and Enforcement
U. S. Nuclear Regulatory Commission
230 Peachtree Street, N. W., Suite 818
Atlanta, Georgia 30303

Dear Mr. Moseley:

REPORTABLE OCCURRENCE 335-76-14
ST. LUCIE UNIT 1
DATE OF OCCURRENCE: APRIL 18, 1976

PERSONNEL AIRLOCK

The attached Licensee Event Report is being submitted in accordance with Technical Specification 6.9 to provide 30-day notification of the subject occurrence.

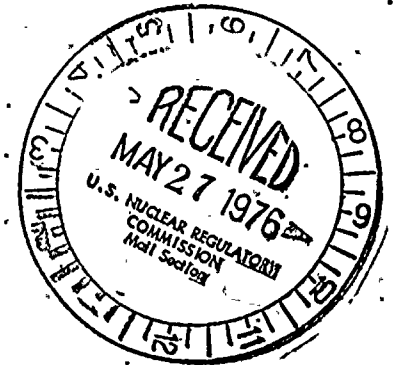
Very truly yours,

for J.R. Bensen
A. D. Schmidt
Vice President
Power Resources

MAS/cpc

Attachment

cc: Jack R. Newman, Esquire
Director, Office of Inspection and Enforcement (30)
Director, Office of Management Information and
Program Control (3)



Regulatory Docket File



LICENSEE EVENT REPORT

CONTROL BLOCK: [] [] [] [] [] []

[PLEASE PRINT ALL REQUIRED INFORMATION]

LICENSEE NAME [01] F L S L S 1														LICENSE NUMBER [00] - [00] [00] [00] - [00] [00]														LICENSE TYPE [4] [1] [1] [1] [1]						EVENT TYPE [0] [3]					
CATEGORY [01] CONT														REPORT TYPE [L]		REPORT SOURCE [L]		DOCKET NUMBER [05] [0] - [03] [3] [5]										EVENT DATE [04] [1] [8] [7] [6]						REPORT DATE [05] [1] [8] [7] [6]					

EVENT DESCRIPTION

[02] At one point during preoperational testing, the outer personnel access door to containment would not pass the air leakage test. The door would not latch properly because of a misaligned latching device. The latching device was repaired, and the outer airlock door was satisfactorily leak tested and returned to service within 24 hours as required by Technical

SYSTEM CODE [S] [A]		CAUSE CODE [E]		COMPONENT CODE [P] [E] [N] [E] [T] [R]				PRIME COMPONENT SUPPLIER [A]		COMPONENT MANUFACTURER [C] [3] [1] [0]				VIOLATION [N]	
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CAUSE DESCRIPTION

[08] The cause of the occurrence was a bent holding pin in the door latching device. The pivot arm in the latching device became loose, causing the device to misalign and bend the holding pin. The door would not latch

FACILITY STATUS [B]		% POWER [0] [0] [0]		OTHER STATUS N/A				METHOD OF DISCOVERY [b]		DISCOVERY DESCRIPTION N/A					
FORM OF ACTIVITY RELEASED [Z]		CONTENT OF RELEASE [Z]		AMOUNT OF ACTIVITY N/A				LOCATION OF RELEASE N/A							

PERSONNEL EXPOSURES

NUMBER [0] [0] [0]		TYPE [Z]		DESCRIPTION N/A					
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PERSONNEL INJURIES

NUMBER [0] [0] [0]		DESCRIPTION N/A					
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PROBABLE CONSEQUENCES

[15] N/A

LOSS OR DAMAGE TO FACILITY

TYPE [Z]		DESCRIPTION N/A					
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PUBLICITY

[17] N/A

ADDITIONAL FACTORS

[18] See Page Two for continuation of Event Description and Cause Description

[19]

NAME: M. A. Schoppman

PHONE: 305/552-3779

REPORTABLE OCCURRENCE 335-76-14
LICENSEE EVENT REPORT.
PAGE TWO

EVENT DESCRIPTION (Continued)

Specification 3.6.1.3. The inner door was kept closed the entire time that the outer door was out of service. This was the first occurrence of this type. (335-76-14).

CAUSE DESCRIPTION (Continued)

tightly while the holding pin was bent. It is believed that the pivot arm became loose because of slamming of the access door or because of the high frequency of airlock usage necessitated by preparations for initial criticality. Signs have been posted which instruct personnel to operate the airlock doors carefully.