81-063-03L

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DUKE POWER COMPANY
POWER BUILDING
422 SOUTH CHURCH STREET, CHARLOTTE, N. C. 28242

MAY 20 8:57

WILLIAM O. PARKER, JR.
VICE PRESIDENT
STEAM PRODUCTION

May 15, 1981

TELEPHONE: AREA 704
373-4083

Mr. J. P. O'Reilly, Director
U. S. Nuclear Regulatory Commission
Region II
101 Marietta Street, Suite 3100
Atlanta, Georgia 30303

Re: McGuire Nuclear Station Unit 1
Docket No. 50-369

Dear Mr. O'Reilly:

Please find attached Reportable Occurrence Report RO-369/81-56. This report concerns the inner door of the lower personnel air lock being declared inoperable. This incident was considered to be of no significance with respect to the health and safety of the public.

Very truly yours,

William O. Parker, Jr.

RWO/djs
Attachment

cc: Director
Office of Management and Program Analysis
U. S. Nuclear Regulatory Commission
Washington, D. C. 20555

Mr. Bill Lavalee
Nuclear Safety Analysis Center
Post Office Box 10412
Palo Alto, California 94303

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S1/1

McGUIRE NUCLEAR STATION

INCIDENT REPORT

REPORT NUMBER: 81- 56

REPORT DATE: May 5, 1981

OCCURRENCE DATE: April 17, 1981

FACILITY: McGuire Unit 1, Cornelius, N.C.

IDENTIFICATION OF OCCURRENCE: The inner door of the lower personnel air lock was declared inoperable.

CONDITION PRIOR TO OCCURRENCE: Mode 3, Hot Standby

DESCRIPTION OF OCCURRENCE: The inner door of the lower personnel air lock would not close completely. The door was declared inoperable at 1730 hours on April 17, 1981. This placed the plant in a degraded mode of operation pursuant to Technical Specification 3.6.1.3.

APPARENT CAUSE OF OCCURRENCE: The apparent cause could not be determined. Personnel were sent to investigate the inoperable door. It was cycled several times, and found to be working properly.

ANALYSIS OF OCCURRENCE: Personnel were stationed at the lower personnel air lock to restrict entry into containment. This was part of the program to prolong seal life. It was discovered that the inner door would not close completely. The Control Room was notified, and the door was declared inoperable. Maintenance was sent to investigate the problem. They found that the door was operable. It was cycled several times and declared operable again at 2330 hours on April 17, 1981.

CORRECTIVE ACTION: No corrective action was necessary. The door was working properly when maintenance investigated. Personnel were alerted to watch for similar problems in the future.

SAFETY ANALYSIS: The safety of the plant was not degraded by this event. The outer door of the lower personnel air lock remained closed while the inner door was inoperable. Therefore, containment integrity was maintained and the health and safety of the public were not affected.