NRC FORM 195 (2-76) U.S. NUCLEAR REGULATORY COMMISSION

NRC DISTRIBUTION FOR PART 50 DOCKET MATERIAL

DOCKET NUMBER: 50-335
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
☐ ORIGINAL ☒ UNCLASSIFIED
☒ COPY

PROP

INPUT FORM

NUMBER OF COPIES RECEIVED: 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 ACESS 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						
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☒	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

[illegible]

[illegible]

[illegible]

[illegible]

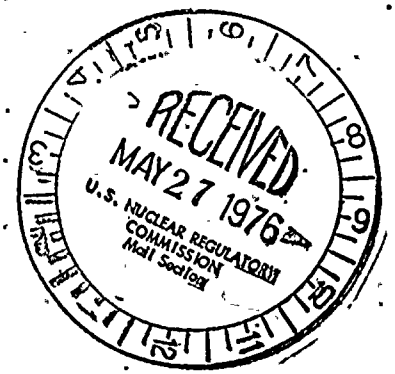
[illegible]

P.O. BOX 013100, MIAMI, FLORIDA 33101

FLORIDA POWER & LIGHT COMPANY

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 Benson
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)

LICENSEE EVENT REPORT

CONTROL BLOCK: [ ] (1–6) [PLEASE PRINT ALL REQUIRED INFORMATION]

	LICENSEE NAME	LICENSE NUMBER	LICENSE TYPE	EVENT TYPE
01	FLSLS 1	00–00000–00	4111 1	03
(7–8)	(9–14)	(15–25)	(26–30)	(31–32)

	CATEGORY	REPORT TYPE	REPORT SOURCE	DOCKET NUMBER	EVENT DATE	REPORT DATE
01 CONT	[ ] [ ]	L	L	05 0–03 35	04 18 76	05 18 76
(7–8)	(57–58)	(59)	(60)	(61–68)	(69–74)	(75–80)

EVENT DESCRIPTION

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

	SYSTEM CODE	CAUSE CODE	COMPONENT CODE	PRIME COMPONENT SUPPLIER	COMPONENT MANUFACTURER	VIOLATION
07	SA	E	PENETR	A	C310	N
(7–8)	(9–10)	(11)	(12–17)	(43)	(44–47)	(48)

CAUSE DESCRIPTION

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

	FACILITY STATUS	% POWER	OTHER STATUS	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION
11	B	000	N/A	b	N/A
(7–8)	(9)	(10–12)	(13–44)	(45)	(46–80)

	FORM OF ACTIVITY RELEASED	CONTENT OF RELEASE	AMOUNT OF ACTIVITY	LOCATION OF RELEASE
12	Z	Z	N/A	N/A
(7–8)	(9)	(10)	(11–44)	(45–80)

PERSONNEL EXPOSURES

	NUMBER	TYPE	DESCRIPTION
13	000	Z	N/A
(7–8)	(9–11)	(12)	(13–80)

PERSONNEL INJURIES

	NUMBER	DESCRIPTION
14	000	N/A
(7–8)	(9–11)	(12–80)

PROBABLE CONSEQUENCES

15 N/A

LOSS OR DAMAGE TO FACILITY

	TYPE	DESCRIPTION
16	Z	N/A
(7–8)	(9)	(10–80)

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

GPO 881-847

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.