Portland General Electric Company
Trojan Nuclear Plant
P.O. Box 439
Rainier, Oregon 97048
(503) 556-3713

May 29, 1981
CPY-428-81

Mr. R. H. Engelken, Director
Nuclear Regulatory Commission, Region V
1990 North California Boulevard
Walnut Creek, California 94596

Dear Sir:

In accordance with the Trojan Plant Operating License, Appendix A, US NRC Technical Specifications, Paragraph 6.9.1.7, attached is Licensee Event Report No. 81-010, concerning a situation where Technical Specifications for Containment integrity were not satisfied due to a Containment airlock door being left open.

Sincerely,

C. P. Yundt
General Manager

CPY/GGB:mae

Attachments

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81-132

REPORTABLE OCCURRENCE

1. Report No.: 81-010

2. a. Report Date: June 1, 1981

   b. Occurrence Date: May 7, 1981

3. Facility: Trojan Nuclear Plant, P.O. Box 439, Rainier, Oregon 97048

4. Identification of Occurrence:

   The outer door of the airlock at the 93' elevation of Containment was left open for approximately 10 hours. The plant was in Mode 3 at this time and Technical Specifications require that both airlock doors be closed except when the airlock is being used for normal transit. With the outer door left open, the requirements of this specification were not met.

5. Conditions Prior to Occurrence:

   The plant was in Mode 3, Hot Standby.

6. Description of Occurrence:

   A plant security guard had been stationed in the airlock to assist personnel in entering and exiting from the Containment. Security personnel had been instructed on the requirements for proper operation of the airlock doors while in this mode. The plant security guard did not appreciate the significance of these requirements and wanted to leave the outer door open and man his station from outside the airlock. The guard asked a member of the contract radiation protection work force if this was permissible and after receiving what he thought to be an affirmative answer, opened the outer door. The door remained open for approximately 10 hours when it was noticed by plant Operations personnel and closed.

7. Designation of Apparent Cause of Occurrence:

   The cause of this event is attributed to personnel error. The security guard did not appreciate the signficance of the requirements and did not understand that Operations should have been contacted for permission to change the way in which he was instructed to operate the airlock.

8. Significance of Occurrence:

   This event had no effect on either plant or public safety. The other airlock door was shut during this time period and system interlocks prevent both doors from being opened simultaneously.

9. Corrective Action:

   A letter and training guide for security guards manning the airlock has been developed and is being used to instruct personnel. This includes requirements to clear changes with the Shift Supervisor. A copy of this is also posted in the airlock for reference.