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

MAY 27 AM 8:23

WILLIAM O. PARKER, JR.
VICE PRESIDENT
STEAM PRODUCTION

May 21, 1981

TELEPHONE: AREA 704
373-4083

Mr. James 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-369/81-63. This report concerns the outer 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.

William O. Parker, Jr.

RWO:pw
Attachment

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

Ms. M. J. Graham
Resident Inspector - NRC
McGuire Nuclear Station

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

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McGUIRE NUCLEAR STATION
INCIDENT REPORT

Report Number: 81-63

Report Date: May 7, 1981

Occurrence Date: April 22, 1981

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

Identification of Occurrence: The outer door of the lower personnel air lock was declared inoperable.

Condition Prior to Occurrence: Mode 3, Hot Standby

Description of Occurrence: The outer door of the lower personnel air lock closed; however, the locking pins would not move and the seals would not inflate. The door was declared inoperable at 0750 hours on April 22, 1981. This placed the plant in a degraded mode of operation pursuant to Technical Specification 3.6.1.3.

Apparent Cause of Occurrence: It was discovered that a shear pin which holds the limit switch actuating shaft in place was missing. This prevented the limit switch from being actuated, and therefore prevented the seals from inflating and sealing the door.

nalysis of Occurrence: On April 22, 1981 at 0750 hours, the outder door of the lower personnel air lock was declared inoperable. It closed; however, it would not lock in place or seal. The Control Room was notified and the door was declared inoperable. It was determined that a shear pin was missing which prevented the limit switch from operating properly. The pin was replaced and the door was returned to an operable status at 0938 hours on April 22, 1981.

Corrective Action: The shear pin in the limit switch mechanism was replaced. No further problems are anticipated.

Safety Analysis: The safety of the plant was not degraded by this event. The inner door of the lower personnel air lock remained closed while the outer door was inoperable. Containment integrity remained intact.