

OFFICIAL COPY

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

01 MAY 22 10:20

WILLIAM O. PARKER, JR.  
VICE PRESIDENT  
STEAM PRODUCTION

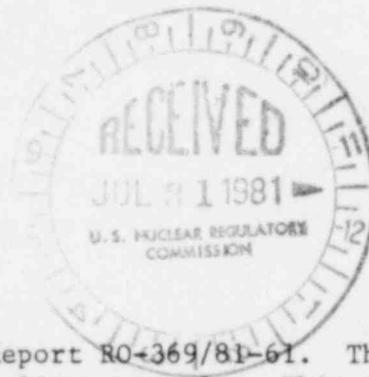
May 19, 1981

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-369/81-61. This report concerns the lower personnel air lock not sealing properly. 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.*  
by *[Signature]*

William O. Parker, Jr.

RWO:pw  
Attachment

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

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

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

IE22  
S/11

McGUIRE NUCLEAR STATION  
INCIDENT REPORT

Report Number: 81-61

Report Date: May 8, 1981

Occurrence Date: April 20, 1981

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

Identification of Occurrence: The lower personnel air lock was not sealed closed.

Condition Prior to Occurrence: Mode 3, Hot Standby

Description of Occurrence: Primary containment integrity was lost. The outer door of the lower personnel air lock was open, and the inner door was closed but not sealed. This represented a degraded mode of operation, and was reportable pursuant to Technical Specification 3.6.1.1.

Apparent Cause of Occurrence: The outer door of the lower personnel air lock was found wide open, and the hydraulic motor for the door was running. This apparently resulted from a faulty limit switch. The inner door had apparently closed too quickly causing it to bounce back open. While it was open but after tripping the limit switch, the locking pins extended and the seals inflated.

Analysis of Occurrence: On April 20, 1981 at 0745 hours, it was discovered that the lower personnel air lock was not sealed. The outer door was wide open with the hydraulic motor still running. The inner door was partly closed. The locking pins were extended but not in their receiving holes. The seals were inflated; however, only one seal was actually sealing against the door frame. The Control Room was notified of the situation and the doors were declared inoperable. The inner door was cycled several times, and it operated properly. At 0845 hours the doors were returned to an operable status. Since the outer door was open, and there was no assurance that the inner door was actually sealing, it has to be assumed that containment integrity was lost.

Corrective Action: The doors were cycled several times and they operated properly. Discussions with the manufacturer are being conducted to investigate redesigning the door's hydraulic system.

Safety Analysis: Since there was only new fuel in the core, no radiation existed in the containment. Therefore, the open personnel air lock did not endanger the health or safety of the public. If this incident had occurred while the plant was operating, immediate shutdown would have been required.