

CONTROL BLOCK

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

01 N C M G S 1 2 0 0 - 0 0 0 0 0 0 - 0 0 C 3 4 1 1 1 1 4 5
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

CONT

01 REPORT SOURCE L 6 0 5 0 0 0 3 6 9 7 0 9 0 1 8 3 8 0 9 3 0 8 3 9
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

1 2 While in Mode 1, routine auxiliary building surveillance discovered that the screws
3 3 attaching the door hinges to the door frame of fire door 819A had been removed, and
4 4 the door was found propped up against a wall. This constitutes a degradation of fire
5 5 barrier penetrations (T.S.3.7.11) which is reportable per T.S.6.9.1.11(b) and sim-
6 6 ilar to RO's 369/81-117, 83-24. An hourly fire watch patrol was established in
7 7 accordance with the T.S. action statements. The fire detectors in the vicinity of
8 8 the fire door were operable which would have provided early warning of a fire.

09 SYSTEM CODE AB 11 CAUSE CODE A 12 CAUSE SUBCODE X 13 COMPONENT CODE P E N E T R 14 X 15 VALVE SUBCODE Z 16
17 LER/RO REPORT NUMBER 8 3 21 EVENT YEAR 8 3 22 SEQUENTIAL REPORT NO. 0 7 6 23 OCCURRENCE CODE 0 3 24 REPORT TYPE L 25 REVISION NO. 0 26
ACTION TAKEN D 18 FUTURE ACTION H 19 EFFECT ON PLANT Z 20 SHUTDOWN METHOD Z 21 HOURS 0 0 0 0 22 ATTACHMENT SUBMITTED N 23 NPRO-4 FORM SUB. N 24 PRIME COMP. SUPPLIER L 25 COMPONENT MANUFACTURER Z 9 9 9 26

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The bottom of the door had previously been dragging on the floor and a work request
1 1 written to correct the problem had not yet been performed (the door could be closed
1 2 manually). Evidently the dragging problem became worse and the door was apparently
1 3 deliberately removed from the door frame. The door was repaired. All station personnel
1 4 will be counseled on the importance of reporting inoperable fire doors to the control

room.
FACILITY STATUS E 28 % POWER 1 0 0 29 OTHER STATUS NA 30 METHOD OF DISCOVERY B 31 DISCOVERY DESCRIPTION Routine Surveillance 32
ACTIVITY CONTENT RELEASED OF RELEASE Z 33 AMOUNT OF ACTIVITY NA 34 LOCATION OF RELEASE NA 35
PERSONNEL EXPOSURES NUMBER 0 0 0 36 TYPE Z 37 DESCRIPTION NA 38
PERSONNEL INJURIES NUMBER 0 0 0 39 DESCRIPTION NA 40
LOSS OF OR DAMAGE TO FACILITY TYPE Z 41 DESCRIPTION NA 42
PUBLICITY ISSUED DESCRIPTION N 43
8310170248 830930
PDR ADOCK 05000369
S PDR

NAME OF PREPARER Phillip B. Nardoci

PHONE (704) 373-7432

DUKE POWER COMPANY

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CHARLOTTE, N.C. 28242

September 30, 1983

HAL B. TUCKER
VICE PRESIDENT
NUCLEAR PRODUCTION

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83 OCT 11 P 1:51

Mr. James P. O'Reilly, Regional Administrator
U. S. Nuclear Regulatory Commission
Region II
101 Marietta Street NW, Suite 2900
Atlanta, Georgia 30303

Subject: McGuire Nuclear Station Unit 1
Docket No. 50-369
LER/RO-369/83-76

Dear Mr. O'Reilly:

Please find attached Reportable Occurrence Report RO-369/83-76. This report concerns T.S. 3.7.11, "...All Sealing Devices in Fire Rated Assembly Penetrations (Fire Doors, Fire Windows, Fire Dampers, Cable Piping, and Ventilation Duct Penetration Seals) Shall Be Operable". This incident was considered to be of no significance with respect to the health and safety of the public.

Very truly yours,

H.B. Tucker / BT

Hal B. Tucker

PBN:jfw
Attachment

cc: Document Control Desk
U. S. Nuclear Regulatory Commission
Washington, D. C. 20555

Mr. W. T. Orders
NRC Resident Inspector
McGuire Nuclear Station

Records Center
Institute of Nuclear Power Operations
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