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WILLIAM O. PARKER, JR.
VICE PRESIDENT
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TELEPHONE: AREA 704
373-4083

May 13, 1981

Mr. James P. O'Reilly, Director
U. S. Nuclear Regulatory Commission
Region II
101 Marietta Street, Suite 3100
Atlanta, Georgia 30303

RECEIVED
JUL 17 1981
U.S. NUCLEAR REGULATORY COMMISSION

Re: McGuire Nuclear Station Unit 1
Docket No. 50-369

Dear Mr. O'Reilly:

Please find attached Reportable Occurrence Report RO-369/81-53. This report concerns liquid from the Ventilation Unit Condensation Drain Tank being released into the Condenser Discharge without prior analysis. 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 & Program Analysis
U.S. Nuclear Regulatory Commission
Washington, D.C. 20555

Mr. Bill Lavallee
Nuclear Safety Analysis Center
Post Office Box 10412
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MCGUIRE NUCLEAR STATION
INCIDENT REPORT

Report Number: 81-53

Report Date: May 5, 1981

Occurrence Date: April 13, 1981; 1620 hours

Facility: McGuire Nuclear Station - Unit 1; Cornelius, N. C.

Identification of Occurrence: Liquid from the Ventilation Unit Condensation Drain Tank (VUCDT) was released into the Condenser Discharge (RC) without prior analysis.

Conditions Prior to Occurrence: Mode 3; Hot Standby

Description of Occurrence: On the afternoon of April 13, an indication was received in the control room of a high level in the VUCDT. The tank was pumped out. The next shift noted that the tank was empty and realized that the tank contents had been released via the RC discharge to the environment without the proper analysis. This release violated the surveillance requirements stipulated by Technical Specification 4.11.1.1.1.

Apparent Cause: The Control Room personnel who made the release were unaware of the importance of monitoring a batch release from the VUCDT. Several releases had been made prior to fuel loading. It was assumed that since the unit had not yet become critical, and no radiation activity was present in any of the p[illegible] systems or atmospheres, monitoring of the tank at that time was not [illegible]ed. Furthermore, it was believed that the VUCDT was automatically shunted to the Floor Drain Tank (FDT) and not to the RC discharge. There was also a failure to follow step 2.4 of the procedure which stipulates: "The transfer and handling of all waste shall be coordinated with the Chemistry Radwaste Group."

Shift personnel were not informed that the VUCDT could not be released via the RC discharge without the flow proportional sampler installed. This led to some of the confusion which precipitated this incident.

Analysis of Occurrence: Weeks before this incident, several informal discussions had been conducted concerning the VUCDT; administrative controls sampling, releases, responsibilities, etc. Since the VUCDT flow proportional sampler was not installed at that time, it was agreed that the contents could not be released via the RC discharge but rather be pumped to the FDT and be released via the Radioactive liquid waste system.

On the afternoon of April 13, the level indication for the VUCDT read 90% full. Following confirmation of the level indication, the control room operators (unaware that the VUCDT was not lined up to go to the FDT, and unaware of any complications even if the contents were released to the environment) placed the pump in "AUTO" mode and proceeded to pump the tank contents into the RC discharge. The release began at 1620 hours and was terminated at 1930 hours.

About 2230-2300 that evening, the STA and Shift Supervisor who relieved the previous shift, became aware that the contents of the VUCDT had been released without the required sampling and analysis. A 1000 ml. sample was collected and delivered to H. P. for analysis. This sample was counted @ 0115 and the lower limits of detection were not met. Another sample was collected in a 3500 ml. container because the first sample did not meet the geometry requirements for proper analysis. A second sample was analyzed (no activity present) and the results were reported to the Control Room.

Safety Analysis: Radiation monitor EMF-44 was operable during the release and did not isolate or alarm.

The results of the analysis performed on the remaining contents of the tank confirmed that no detectable radioactivity was present in the VUCDT. The health and safety of the public were, therefore, not affected by this incident. A flow proportional sampler has now been installed in the release line so that a composite sample can be obtained and analyzed during any future releases.

Corrective Action: Health Physics counted and analyzed the sample drawn from the VUCDT and reported the results.

A technician was dispatched to 1 WM 222 on April 14, and locked the valve closed. A second lock was added to this valve for extra protection. A new procedure, "Ventilation Unit Condensate Drain Tank Operation", was written to eliminate the deficiencies found.

The flow proportional sampler for the VUCDT, which was in the process of being built at the time of incident, has been installed.