

DUKE POWER COMPANY

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POWER BUILDING

422 SOUTH CHURCH STREET, CHARLOTTE, N. C. 28242

100-7-17-50

WILLIAM O. PARKER, JR.  
VICE PRESIDENT  
STEAM PRODUCTION

June 29, 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-369/81-93. This report concerns Technical Specification 6.9.1.12F, "Personnel Error or Procedural Inadequacy which prevents or could prevent, by itself, the fulfillment of the functional requirements of system(s) used to cope with accidents analyzed in the SAR. 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.

PBN: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, CA 94303

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

IF22  
S/11

McGUIRE NUCLEAR STATION  
INCIDENT REPORT

LER/RO Report Number: 81-093/01T-0

Report Date: June 29, 1981

Occurrence Date: Unknown - Discovered June 15, 1981

Licensee: Duke Power Company

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

Docket No.: 05000369

Identification of Occurrence: Three instrument lines which penetrate containment were discovered to not be closed when containment integrity was established.

Condition Prior to Occurrence: Mode 5

Description of Occurrence: There are three pressure gauges used to measure the pressure in the upper containment, lower containment and the ice condenser during the Integrated Leak Rate Test (ILRT). Each line penetrates the containment and terminates in the Restricted Area Instrumentation Room. The lines are provided with containment isolation valves which should always remain closed except during the performance of the ILRT. However, these valves were open, and they did not appear on the list of penetrations requiring a Type C leak test. This represents a degraded mode of operation per Technical Specification 6.9.1.12(f). It is unknown how long the valves had been in the open position.

Apparent Cause of Occurrence: FSAR Tables 6.2.4-1, 6.2.4-2 and 6.2.4-3 are used by station personnel to complete a list of containment penetrations. These tables did not include the penetration for the three pressure instrumentation lines used in the ILRT.

Analysis of Occurrence: FSAR Tables 6.2.4-1, 6.2.4-2 and 6.2.4-3 list process line penetrations. They are compiled by the Systems Group of Design Engineering. Station personnel interpreted the list to be all containment penetrations and as a result, the instrumentation lines used in the ILRT were overlooked.

Corrective Action: As soon as the open containment isolation valves were discovered, they were locked closed. A Type C penetration leak test was performed and the ILRT was amended to account for the added leakage through this penetration. A temporary procedure ("Containment Integrity Verification on Penetration M-255") was written to verify that these valves were closed so as to verify containment integrity. The quarterly containment integrity verification procedure will be revised to include these valves in all future tests. In addition, the ILRT was reviewed to verify that no further containment penetrations have been omitted.

Safety Analysis: Since there was no occurrence which required containment isolation, this accident did not affect the health and safety of the public. If an accident had occurred, excessive radiation could have been released off site. However, the VA filters in the Auxiliary Building would have helped to lessen the effect of this type of release.