

LICENSEE EVENT REPORT

EXHIBIT A

CONTROL BLOCK: 1										(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 3 4 1 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	
7		8		9		10		11		12		13		14		15		16		17		18		19		20		21		22		23		24		25		26		27		28		29		30	
7		8		9		10		11		12		13		14		15		16		17		18		19		20		21		22		23		24		25		26		27		28		29		30	
7		8		9		10		11		12		13		14		15		16		17		18		19		20		21		22		23		24		25		26		27		28		29		30	
7		8		9		10		11		12		13		14		15		16		17		18		19		20		21		22		23		24		25		26		27		28		29		30	
7		8		9		10		11		12		13		14		15		16		17		18		19		20		21		22		23		24		25		26		27		28		29		30	
7		8		9		10		11		12		13		14		15		16		17		18		19		20		21		22		23		24		25		26		27		28		29		30	
7		8		9		10		11		12		13		14		15		16		17		18		19		20		21		22		23		24		25		26		27		28		29		30	
7		8		9		10		11		12		13		14		15		16		17		18		19		20		21		22		23		24		25		26		27		28		29		30	
7		8		9		10		11		12		13		14		15		16		17		18		19		20		21		22		23		24		25		26		27		28		29		30	
7		8		9		10		11		12		13		14		15		16		17		18		19		20		21		22		23		24		25		26		27		28		29		30	
7		8		9		10		11		12		13		14		15		16		17		18		19		20		21		22		23		24		25		26		27		28		29		30	
7		8		9		10		11		12		13		14		15		16		17		18		19		20		21		22		23		24		25		26		27		28		29		30	
7		8		9		10		11		12		13		14		15		16		17		18		19		20		21		22		23		24		25		26		27		28		29		30	
7		8		9		10		11		12		13		14		15		16		17		18		19		20		21		22		23															

McGUIRE NUCLEAR STATION
INCIDENT REPORT

Report Number: 81-88

Report Date: June 18, 1981

Occurrence Date: May 21, 1981

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

Identification of Occurrence: An uncontrolled, gaseous waste release to the environment was made from a Waste Gas (WG) tank via a gas analyzer and out the unit vent.

Conditions Prior to Occurrence: Mode 5, cold shutdown, prior to initial criticality.

Description of Occurrence: During the calibration of the "B" catalytic hydrogen recombiner (B-CHR), a gas analyzer valve was inadvertently left open. When the system was placed into service, a pathway existed from Shutdown Decay Tank -B (SDT-B) to the environment. This uncontrolled release constituted a degraded mode of operation and was reportable pursuant to Technical Specification 4.11.2.1.1.

Apparent Cause: Part 4.2.21 of the procedure "Radwaste Procedure for the Routine Calibration of the Waste Gas System Analyzers (Zero and Span Calibration)" was inadvertently omitted during calibration of the analyzer.

As a result, the Building Exhaust Isolation Valve on the Hydrogen Inlet Analyzer (HARC-1104) was inadvertently left open, allowing some of the contents of SDT-B to escape, without being analyzed for radioactivity prior to release.

Analysis of Occurrence: On the morning of May 21, it was determined, by decreasing pressure gauge readings, that a small gas leak existed somewhere in the A-train of the Catalytic Hydrogen Recombiner System (A-CHR). It was decided, therefore, to remove the A-train from service in order to identify and correct the leak(s). Before the B-train could be placed into service its associated analyzer rack had to be calibrated.

At 1005 the B-analyzer rack was calibrated and placed into service. Between 1100 and 1130 hours, it was determined by decreasing pressure gauge readings that a leak also existed somewhere in the B-train of this system. Immediately, a team of technicians began searching for the leak(s).

At 2110 hours that same day, one of the technicians discovered that the Building Exhaust Isolation Valve was open on HARC-1104. This valve was closed and the HARC-1104 Sample Vent Compressor Suction Isolation Valve was opened to realign the system in its proper mode. The technician then notified Health Physics of the events that had occurred and requested that they analyze a sample of the contents of SDT-B. This was done and the results were reported to the Shift Supervisor at 2330 hours.

Corrective Action: Once it was suspected that a leak existed somewhere in the B-CHR system, several technicians began tracing out the system, checking for leaks by visual inspection and by the use of "Snoop" solution (a liquid soap which emits bubbles when applied to a gas leak from a pipe, fitting, or etc.).

When a technician discovered the Building Exhaust Isolation Valve on HARC-1104 open, he realigned the flow path to stop the release. The contents of SDT-B were analyzed and the volume of gas released was calculated.

To avoid an accident of this type in the future: (1) A double verification checklist has been added to all WG analyzer racks. (2) More stringent controls have been added (red tags) to all WG analyzer rack procedures. (3) The valve handles on the CHR's have been painted red to make the valve position more visible. (4) An investigation is underway to study the feasibility of installing 3-way, six-port valves. The installation of these valves would make it impossible to discharge a WG tank via the analyzer rack.

Safety Analysis: With the presence of only new, non-irradiated fuel on site at the time of this incident, no radiation above normal background could have been present in the gas released from SDT-B. This was confirmed by the analysis performed on the contents of SDT-B on May 21, 1981.

Had radiation been present in this system, the presence of such a leak may have been detected much sooner, as the gas would be monitored by EMF's 36 and 50.