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

WILLIAM O. PARKER, JR.
VICE PRESIDENT
STEAM PRODUCTION

TELEPHONE: AREA 704
373-4083

August 31, 1981

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-369/81-127. This report concerns T.S. 3.0.4, "Entry into an operational mode or other specified condition shall not be made unless the conditions of the limiting condition for operation are met without reliance on provisions contained in the action requirements." 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 PBN

William O. Parker, Jr.

PBN/php
Attachment

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

Mr. Bill Lavallee
Nuclear Safety Analysis Center
P. O. Box 10412
Palo Alto, California 94303

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

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McGUIRE NUCLEAR STATION

REPORTABLE OCCURRENCE

REPORT NUMBER: 81-127

REPORT DATE: August 31, 1981

OCCURRENCE DATE: August 14, 1981; August 16, 1981

FACILITY: McGuire Unit 1; Cornelius, NC

IDENTIFICATION OF OCCURRENCE: The Unit entered mode 2 from mode 3 with train "B" of the Control Area Ventilation (VC) System inoperable. The outside air filters on "B" train of the VC System had been changed but not retested prior to two startups as required by Technical Specification 3.0.4.

CONDITIONS PRIOR TO OCCURRENCE: Mode 2, Startup

DESCRIPTION OF OCCURRENCE: The Unit #1 reactor was started up (changed from mode 3 to mode 2) on August 14, 1981 and again on August 16, 1981 with one train of VC inoperable. During Zero Power Physics Testing on August 14, 1981 some leaks were found in the pressurizer level instrument tubing. After the repairs were complete the reactor was brought up to criticality. The operators on duty checked the Technical Specification Action Item Log and noted that one train of VC was inoperable. They then checked the Technical Specifications and misconstrued them to mean that the inoperable train of VC would not prevent a mode change.

On August 16, 1981 the reactor was restarted following a trip that was part of the Zero Power Physics Test program. The operators on duty again evaluated the items in the Technical Specification Action Item Log and misinterpreted the specifications regarding a mode change with one train of VC inoperable.

APPARENT CAUSE OF OCCURRENCE: The incidents were caused by misinterpretation of the Technical Specifications by Operations personnel.

ANALYSIS OF OCCURRENCE: On August 12, 1981, Operators noticed that the pressure drop (ΔP) across the outside air filters on the "B" train of VC was approaching the Technical Specification limit of four inches water column. Performance was notified that the filters would be changed and a work request was written to cover the work. Performance measured the ΔP across the filters and pointed out to the Shift Supervisor that the filters still met the limits for operability. Performance requested that Operations swap to "A" train of VC and void the work request already written because they wanted to complete a new filter testing procedure before writing a work request to change the filters, and scheduling the retest required by the filter change. The performance personnel thought that this arrangement had been agreed upon but the original work request was processed and the "B" train filters were changed on August 12, 1981. The work request was then processed through the normal retest program channels and Performance was informed on August 14, 1981 that the "B" train outside air filters had been replaced and a retest was required

by August 19, 1981. Performance decided to do the test on August 17, 1981 when the new procedure would be available. The erroneous interpretation of the Technical Specifications by the first Shift Supervisor may have influenced the opinion of the second Shift Supervisor on the same shift and also the opinion of the Shift Supervisor on the following shift. Shift Supervisors involved with both of the startups were together when the first startup (August 14, 1981) occurred since the shift turnover was in progress at that time.

SAFETY ANALYSIS: The outside air filters on "B" train of VC were functional throughout the incident as verified by subsequent testing. Therefore, VC train "B" was actually functional and the safe operation of the plant as well as the health and safety of the public were not affected.

CORRECTIVE ACTION: All Operations personnel including the individuals involved in this incident will be cautioned to read and interpret Technical Specifications carefully. Personnel will also be encouraged to evaluate decisions independently and not be swayed by the opinions of others.