

## LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Oconee Nuclear Station,										DOCKET NUMBER (2) 0   5   0   0   0   2   6   9										PAGE (3) 1 OF 03																													
TITLE (4) Reactor Building Tendon Inspection and Reporting Intervals Exceeded																																																	
EVENT DATE (5) MONTH   DAY   YEAR 0   8   1   9   8   5										LER NUMBER (6) YEAR   SEQUENTIAL NUMBER   REVISION NUMBER 8   5   -   0   1   2   -   0   0   0   9   1   9   8   5										REPORT DATE (7) MONTH   DAY   YEAR 0   0   0   9   1   9   8   5										OTHER FACILITIES INVOLVED (8) FACILITY NAMES ONS, Unit 2 ONS, Unit 3 DOCKET NUMBER(S) 0   5   0   0   0   2   7   0 0   5   0   0   0   2   8   7																			
OPERATING MODE (9) POWER LEVEL (10)										THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)																																							
										20.402(b)										20.405(c)										50.73(a)(2)(iv)										73.71(b)									
										20.405(a)(1)(i)										50.38(c)(1)										50.73(a)(2)(v)										73.71(c)									
										20.405(a)(1)(ii)										50.38(c)(2)										50.73(a)(2)(vi)										OTHER (Specify in Abstract below and in Text, NRC Form 366A)									
										20.405(a)(1)(iii)										X 50.73(a)(2)(i)										50.73(a)(2)(vii)(A)																			
										20.405(a)(1)(iv)										50.73(a)(2)(ii)										50.73(a)(2)(viii)(B)																			
20.405(a)(1)(v)										50.73(a)(2)(iii)										50.73(a)(2)(ix)																													
NAME S. G. Godwin - Licensing																				TELEPHONE NUMBER AREA CODE 7   0   4   3   7   3   -   2   3   6   2																													
COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)																																																	
CAUSE   SYSTEM   COMPONENT   MANUFACTURER   REPORTABLE TO NPDs															CAUSE   SYSTEM   COMPONENT   MANUFACTURER   REPORTABLE TO NPDs																																		
SUPPLEMENTAL REPORT EXPECTED (14) YES (If yes, complete EXPECTED SUBMISSION DATE) X NO																				EXPECTED SUBMISSION DATE (15) MONTH   DAY   YEAR																													

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

On August 19, 1985, it was determined that several Reactor Building (RB) tendon inspections had not been performed on time and that some RB tendon inspection reports had not been sent to the NRC pursuant to ONS Technical Specification (TS) 4.4.2.2. Upon a subsequent review of records, it was determined that all the required RB tendon surveillances had been completed, but seven out of ten had exceeded the due dates and three reports had not been sent to the NRC.

The cause of this incident has been determined to be Management/Quality Assurance Deficiency because the RB tendon surveillance program has lacked the means for monitoring the inspection and reporting requirements as specified by TS 4.4.2.2. However, evidence indicates that although many RB tendon inspections were delayed, confidence in the integrity of the RB exist; therefore, the health and safety of the public were not affected.

Unit 1 was at 100% FP, Unit 2 was at 95% FP, and Unit 3 was shutdown for refueling.

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## LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

APPROVED OMB NO. 3150-0104  
EXPIRES: 8/31/85

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
Oconee Nuclear Station	0 5 0 0 0 2 6 9 8 5 -	0	1	2	-	0	0 0 2 OF 0 3

TEXT (If more space is required, use additional NRC Form 368A's) (17)

Description of Occurrence:

On August 19, 1985, the present status of the Reactor Building (RB) tendon surveillance program was discussed. A review of records indicated that several RB tendon inspections had not been performed on time and that some RB tendon inspection reports had not been sent to the NRC pursuant to TS 4.4.2.2, "Inspection Intervals and Reports".

To determine the extent of this TS violation, appropriate personnel were asked to interpret the RB tendon surveillance intervals as specified in TS 4.4.2.2. With this interpretation, it was determined which RB tendon surveillance test were performed on time and which reports were submitted on time for each unit.

According to the interpretation of TS 4.4.2.2, out of ten RB tendon inspections performed, three were started late and four more were completed late. In addition, a review of records showed that three RB tendon inspection reports were not sent to the NRC. Two reports (Unit 1 due July 26, 1985 and Unit 2 due August 29, 1984) were written but not sent to the correct place within Duke Power to assure they were sent to the NRC. For Unit 3, the surveillance test was performed; however, a test report was never written and thus never sent to the NRC. This report was due on October 31, 1980.

Cause of Occurrence:

The cause of this incident was determined to be Management/Quality Assurance Deficiency since the RB tendon surveillance program has lacked the means for monitoring the inspection and reporting requirements as specified by Technical Specification 4.4.2.2. Specifically, a grace period should not have been used to calculate the latest date that a RB tendon inspection was due, and the NRC reporting requirement should not have been overlooked.

Technical Specification 4.4.2.2 has been interpreted differently by different people in the past. In addition, the responsibility of the RB tendon surveillance program was transferred between different groups. There was never a uniform interpretation or a program established stating exactly what the requirements of TS 4.4.2.2 were. From the beginning of the RB tendon surveillance program, a grace period (not authorized by the TS) allowed the RB tendon surveillance to be overdue in most cases. Also, the procedures followed in performing the surveillance do not mention the requirement to provide the NRC with a quantitative analytical report covering the results of the inspection within 90 days.

This incident involves missed surveillances and not meeting the NRC reporting requirements as described in the TS. Since this happened repeatedly throughout the RB tendon surveillance program, the incident is considered a recurring event.

## LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104

EXPIRES: 8/31/85

FACILITY NAME (1)  Oconee Nuclear Station	DOCKET NUMBER (2)  0 5 0 0 0 2 6 9 8 5 - 0 1 2 - 0 0	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
					0 3	OF	0 3

TEXT (If more space is required, use additional NRC Form 366A's) (17)

Analysis of Occurrence:

The RB Tendons are used to reinforce the concrete cylinder and dome of the RB. This concept is known as post-tensioning. It is used as an opposing external pressure to balance out any internal pressure loads. The FSAR, Section 3.8.1.1 states that the post-tensioning is used to more than balance the internal pressure so that a margin of external pressure exists beyond that required to resist the design accident pressure. The RB tendon surveillance program (Technical Specification 4.4.2) was established to maintain a confidence in the integrity of the RB by inspecting the RB tendons periodically for deterioration. The RB tendon surveillances completed to date have found no sufficient deterioration; therefore, confidence in the integrity of the RB has been maintained. No other structural events, seismic or otherwise, have occurred that would cause suspicion to the deterioration of the RB tendons. Evidence shows that although many RB tendon inspections were delayed, per the present Technical Specification 4.4.2.2 interpretation, confidence in the integrity of the RB exists; therefore, the health and safety of the public were not affected.

Corrective Action:

To assure RB tendon surveillances are tested and that reports are submitted in a timely manner, Administrative Directives will be revised to include time frames for RB tendon surveillance and reporting requirements in accordance with TS 4.4.2.2. In addition, a TS interpretation will be written to assure that all people involved in the testing and reporting have a clear understanding of the requirements of TS 4.4.2.2. These actions should be completed by November 1, 1985.

The July 4, 1984, Unit 2 and the August 17, 1985, Unit 1 RB tendon inspection reports will be forwarded to the NRC by October 1, 1985. A new report will be developed to replace the report not found for the second RB tendon inspection for Unit 3. This report will be submitted to the NRC as soon as it is available.

Finally, procedures will be revised to assure testing is done in a time frame in accordance with TS 4.4.2.2, and that the reports are forwarded to the NRC in a timely manner.

**DUKE POWER COMPANY**

P.O. BOX 33189

CHARLOTTE, N.C. 28242

**HAL B. TUCKER**

VICE PRESIDENT  
NUCLEAR PRODUCTION

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September 19, 1985

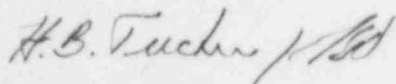
Document Control Desk  
U. S. Nuclear Regulatory Commission  
Washington, D. C. 20555

Subject: Oconee Nuclear Station  
Docket Nos. 50-269, -270, -287  
LER 269/85-12

Gentlemen:

Pursuant to 10 CFR 50.73 Sections (a) (1) and (d), attached is Licensee Event Report 269/85-12 concerning Reactor Building inspection and reporting intervals being exceeded. This report is submitted in accordance with §50.73(a)(2)(i). This event was considered to be of no significance with respect to the health and safety of the public.

Very truly yours,



Hal B. Tucker

SGG:slb

Attachment

cc: Dr. J. Nelson Grace, Regional Administrator  
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