

DUKE POWER COMPANY

POWER BUILDING

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

WILLIAM O. PARKER, JR.
VICE PRESIDENT
STEAM PRODUCTION

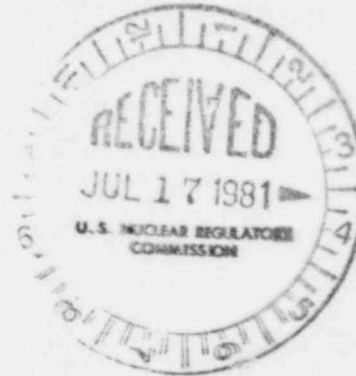
June 18, 1981

TELEPHONE AREA 704
373-4083

81-694-132

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-369/81-89. This report concerns the noble gas activity monitor, EMF-33 being declared inoperable. 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
P. O. Box 10412
Palo Alto, CA 94303

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

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McGUIRE NUCLEAR STATION
INCIDENT REPORT

Report Number: 81-89

Report Date: June 18, 1981

Occurrence Date: May 22, 1981

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

Identification of Occurrence: The noble gas activity monitor (EMF-33) on the Condenser Steam Air Ejector (ZJ) System was declared inoperable.

Condition Prior to Occurrence: Mode 5, Cold Shutdown. Prior to initial criticality.

Description of Occurrence: A loss of sample flow alarm sounded in the Control Room on the morning of May 22. An examination of the monitor revealed no evidence of water in the sample line but the system would not function in the 'Auto' mode. The Shift Supervisor declared EMF-33 inoperable. This was a reportable incident pursuant to Technical Specification 3.3.3.9 and required implementation of Action Statement No. 37 of Table 3.3-13.

Apparent Cause: Due to the recurrent problem of water being aspirated from the loop seal into the vacuum pump and causing damage to the system, the vacuum switch was adjusted from 8" W.C. to 2" W.C. This reduced the amount of water entering into EMF but possibly made the system more sensitive to minor fluctuations in the vacuum present in the ZJ System.

It is believed that a spurious fluctuation in the system's vacuum caused the low flow alarm to occur.

Analysis of Occurrence: On May 22 at 0840 hours a loss of sample flow alarm was received in the Control Room. Health Physics was notified and requested to investigate. At 0850 hours H.P. reported to Control Room personnel that the monitor would function in the 'Manual' mode; not in the 'Auto' mode. The Shift Supervisor declared the System inoperable at 0930 hours and instructed the H.P. technician to write a work request to have the system checked out and repaired as necessary.

The EMF was examined and the EMF vacuum pump was turned on again and functioned correctly. The system was declared operable at 1135 hours on May 22, 1981.

Safety Analysis: Only new, non-irradiated fuel existed in the core at the time of this incident. Sample analysis of the Reactor Coolant (NC) and the ZJ Systems confirmed that no radiation levels above background were present. Thus, the safe operation of the plant and the health and safety of the public were not affected by this incident.

Corrective Action: Grab samples were taken and analyzed every eight hours as required by Action Statement No. 37 of Table 3.3-13. Health Physics initiated a work request to have the system repaired. A technician checked out the system vacuum switch and restarted the vacuum pump.