

OFFICIAL COPY

DUKE POWER COMPANY

POWER BUILDING

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

WILLIAM O. PARKER, JR.
VICE PRESIDENT
STEAM PRODUCTION

May 28, 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-369/81-74. This report concerns an inadvertent safety injection. 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 Lavalley
Nuclear Safety Analysis Center
Post Office Box 10412
Palo Alto, CA 94303

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

IE22
5/11

8107310360 810528
PDR ADOCK 05000369
S PDR

McGUIRE NUCLEAR STATION
INCIDENT REPORT

Report Number: 81-74

Report Date: May 29, 1981

Occurrence Date: April 29, 1981

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

Identification of Occurrence: An inadvertent safety injection was initiated on Train A when the Train A Solid State Protection System (SSPS) cabinets were returned to service without blocking the safety injection signals.

Condition Prior to Occurrence: Mode 5, Cold Shutdown

Description of Occurrence: On April 29, 1981, modifications were being made to the A Train logic cabinets of the SSPS. When the cabinets were to be returned to normal operation, the appropriate permissive blocks were to be inserted in the SSPS logic. There was some confusion by the technicians about exactly what steps needed to be taken as most of the Train A equipment was tagged out. The "Input Error Inhibit Switch" was placed in the normal position. An immediate safety injection was initiated on Train A. The control operators took the appropriate steps to recover from the safety injection.

Apparent Cause: During the modification work, certain safety injection permissive blocks were cleared from the SSPS Train A logic. When the system was returned to service without the signals blocked, safety injection was initiated.

Analysis of Occurrence: A procedure was available for restoring the SSPS cabinets to service. (Procedure For Troubleshooting Solid State Protection System (SSPS) During Critical Operation), but was not being used. The intent of the procedure was followed in that the permissive blocks were attempted to be inserted in the logic before the cabinets were returned to service. The safety injection itself had minimal effect on the plant because all of the Train A safety related pumps and diesel generator were tagged out. Some ventilation units started and the Train A valves included in Phase A isolation cycled but no significant water volume was transferred.

Safety Analysis: This safety injection had no effect on the plant operation because most of the associated equipment was de-energized and tagged out. The health and safety of the public were not affected for the same reason. An error of this type could have been significant if more of the associated equipment had been operational and/or the plant had been under a different mode of operation.

Corrective Action: The immediate corrective action was to recover from the safety injection. Station management met with the individuals involved and it was stressed that this type of incident should not be repeated. To prevent a recurrence of the incident, procedures governing work (either testing or maintenance) on the SSPS were rewritten to include specific steps to return the cabinets to service. Each of the steps included a sign off. The steps concerning the permissive block insertions included sign offs for a control operator as well as the technician. It was further agreed that no work would be done on the SSPS cabinets without one of the controlling procedures (either a periodic test procedure or the troubleshooting procedure).