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DUKE POWER COMPANY

POWER BUILDING

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

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WILLIAM O. PARKER, JR.

VICE PRESIDENT

STEAM PRODUCTION

May 29, 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-369/81-76. This report concerns the operability of the noble gas activity monitor for the Condenser Evacuation System. 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 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, CA 94303

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

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McGUIRE NUCLEAR STATION
INCIDENT REPORT

Report Number: 81-76

Report Date: June 1, 1981

Occurrence Date: May 2, 1981

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

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

Condition Prior to Occurrence: Mode 6; Initial fuel loading

Description of Occurrence: On May 2, 1981, the annunciator alarm for EMF-33 sounded in the Control Room, indicating a loss of sample flow, and would not clear. The flow indicator fluctuated considerably and did not function properly. This system was declared inoperable, and it was reportable pursuant to Technical Specification 3.3.3.9.

Apparent Cause: During the process of previous maintenance work on this EMF's pump, the pump seals were replaced. However, the bolts securing the seals were apparently not tightened sufficiently.

Analysis of Occurrence: The annunciator alarm for EMF-33 indicated a loss of sample flow and would not clear. Health Physics was notified and was requested to investigate the problem. The flow indicator fluctuated erratically and the EMF would function only in the "MANUAL" mode.

EMF-33 was declared inoperable and Health Physics took and analyzed a grab sample every eight hours as stipulated by action statement #37 of Table 3.3-13. A work request was initiated to have the system repaired; the EMF was examined and the seal bolts inside the vacuum pump were tightened. The system was returned to service at 1610 hours on May 5, 1981.

Safety Analysis: Only new, non-irradiated fuel existed in the core at the time of this incident; and Health Physics sample results confirmed that no radiation above background was present in this system. The safe operation of the plant and the health and safety of the public were, therefore, not affected.

Corrective Action: The station implemented the appropriate action statement in accordance with Technical Specification 3.3.3.9, and initiated a work request to have the system repaired. The EMF vacuum pump was repaired.