

## DUKE POWER COMPANY

POWER BUILDING

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

WILLIAM O. PARKER, JR.  
VICE PRESIDENT  
STEAM PRODUCTION

June 4, 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-369/81-78. 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 Lavallee  
Nuclear Safety Analysis Center  
P. O. Box 10412  
Palo Alto, CA 94303

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

IE22  
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MCGUIRE NUCLEAR STATION  
INCIDENT REPORT

Report Number: 81-78

Report Date: June 4, 1981

Occurrence Date: May 7, 1981

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

Identification of Occurrence: An inadvertent safety injection was initiated on Train B when the wrong button on the control board was pushed.

Condition Prior to Occurrence: Mode 6, Cold Shutdown with head unbolted. Prior to initial criticality.

Description of Occurrence: Valve timing tests were being conducted using a computer program on the Operational Aid Computer (OAC). The safety injection reset pushbutton was to be depressed to reset the program. Inadvertently the reset pushbutton on the "Pressurizer Safety Injection Train B" Reset/Block switch was depressed. The "Pressurizer Safety Injection Train B" Reset/Block switch is about three inches above the "Safety Injection Reset Train 1B" switch.

Apparent Cause: The wrong pushbutton was depressed unblocking the pressurizer low pressure signal to the Solid State Protection System (SSPS).

Analysis of Occurrence: The safety injection had little effect on the plant because the safety injection and centrifugal charging pumps on B Train were tagged out. No significant change in Reactor Coolant (NC) System water volume occurred. The "Safety Injection Reset Train 1B" Switch has one red pushbutton marked "Reset" (the switch name on both of these switches appears on a plastic tag directly above each switch). The "Pzr. Safety Injection Train B" switch has a red pushbutton marked "Reset" and a green pushbutton marked "Blocking". The reset pushbutton on the "Pzr. Safety Injection Train B" switch was depressed rather than the "Safety Injection Reset Train 1B" switch three inches lower.

Safety Analysis: Since the unit was shutdown and no water volume was transferred, the incident had no effect on the plant nor on the health and safety of the public. A similar incident in which water was transferred to the NC System could have been more serious. Depressing the reset pushbutton the "Pzr Safety Injection Train B" switch with the unit at power would have had no effect because the pressurizer pressure would not have been low.

Corrective Action: Immediate corrective action was taken to recover from the safety injection. Another method will be used to reset the computer program involved in the valve timing without depressing the safety injection reset switch. A collar has been placed around the pushbuttons used to block and unblock signals to the SSPS. A clear plastic cover will slide into the collar covering the pushbuttons. This will prevent depressing the pushbuttons accidentally.