

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

June 25, 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-369/81-90. This report concerns Technical Specification 3.3.3.5; "The Remote Shutdown Monitoring Instrumentation Channels shall be Operable with Readouts Displayed External to the Control Room." 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.

PBN: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
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Ms. M. J. Graham
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McGUIRE NUCLEAR STATION
INCIDENT REPORT

LER/RO Report Number: 81-090/03L-0

Report Date: June 25, 1981

Occurrence Date: May 30, 1981

Licensee: Duke Power Company

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

Docket No.: 05000369

Identification of Occurrence: The Steam Generator (S/G) "1B" level instrumentation for Remote Shutdown Monitoring was declared inoperable.

Condition Prior to Occurrence: Mode 3, Hot Standby

Description of Occurrence: On May 30, 1981 at 2000 hours, the S/G "1B" wide range level instrumentation was declared inoperable. The S/G "1A" and "1B" wide range level recorder in the Control Room and the S/G level indicators on the Auxiliary Feedwater Pump (AFP) A Panel, Auxiliary Feedwater Pump Turbine Panel and Standby Shutdown Facility (SSF) Panel, respectively, had been pegged high. The instruments were declared inoperable because Unit 1 was entering Mode 3 from Mode 4. This was a reportable incident pursuant to Technical Specification 3.3.3.5.

Apparent Cause of Occurrence: S/G "1B" wide range level is monitored by two transmitters, 1CFLT5620 and 1CFLT6090. 1CFLT5620 supplies a signal (4-20 ma) to the Process Control Cabinets. From these cabinets, a signal is sent to the AFP Panels indicators, recorder and the computer. 1CFLT6090 provides a signal to the indicator in the SSF Panel. These indicators and recorder were pegged high because both of the level transmitters were valved out. The equalizer valve on transmitter 1CFLT5620 was open causing the high pressure (HP) reference leg to drain out. Both transmitters were supplied by common HP/LP reference legs.

Analysis of Occurrence: On May 12, 1981, a work request was initiated to investigate and repair the S/G "1B" wide range level instrumentation which had failed high. On May 30, 1981 at 2000 hours, Unit 1 was entering Mode 3 from Mode 4 but the S/G "1B" wide range level instrumentation trouble had not been fixed. Hence, the Shift Supervisor declared the instrument inoperable per Technical Specification 3.3.3.5. On June 1, 1981 at 0239 hours, Unit 1 went down to Mode 4 from Mode 3 (due to non-related reason). Personnel found that the equalizer valve on transmitter 1CFLT5620 had been valved open. This resulted in draining of the HP reference leg to a level equal to the S/G level which in turn caused the indicators and recorder to fail high. It is unknown how the equalizer valve was left open. The equalizer valve was closed and the HP reference leg was filled. The transmitters were valved in and the instruments were checked for proper operation. The S/G "1B" wide range level instrumentation was declared operable on June 3, 1981 at 0100 hours.

Safety Analysis: The S/G wide range level transmitters send signals to the remote indicators to provide S/G level indication outside the Control Room. These instruments serve as the only S/G level indicators should it become necessary to evacuate the Control Room to the Auxiliary Shutdown Panel. There are several S/G narrow range level indicators in the Control Room. The narrow range transmitters are also used to provide control signals to the Reactor Protection and Control Cabinets and to the accident monitoring instrumentation. Since the Control Room was available at the time the S/G "1B" wide range level instrumentation was inoperable, the safe operation of the plant and the health and safety of the public were not affected.

Corrective Action: A work request was initiated to troubleshoot the failed instruments. Personnel filled the partially drained HP reference leg and closed the equalizer valve. The instruments were checked for proper operation. The S/G "1B" wide range level instrumentation was declared operable on June 3, 1981 at 0100 hours.