

CONTROL BLOCK

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

01 N C M I G S 1 2 0 0 - 0 0 0 0 0 0 - 0 0 3 4 1 1 1 1 4 5
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

CONT

01 REPORT SOURCE L 5 0 5 0 0 0 3 6 9 7 0 8 0 6 8 3 8 0 9 0 2 8 3 9
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 While in Mode 3, performance of routine surveillance revealed that one of the
03 four UHI level switch's setpoints was out of tolerance (72.78 inches). This
04 violates T.S.3.5.1.2 (switch assumed to have been out of tolerance during power
05 operation) which is reportable per T.S.6.9.1.11(a), and similar to RO's 369/82-
06 38, 83-13, and 370/83-35. The UHI water volume uncertainty analysis assumes one
07 valve fails to close. Therefore the UHI system would have functioned within the
08 limits of the safety analysis had it been challenged. Health and safety of the
09 public were unaffected.

09 S F 11 B 12 A 13 I N S T R U 14 S 15 Z 16
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 This is attributed to design deficiency, since there is evidence indicating that
11 the switches (Barton Model 288A Differential Pressure Indicating Switches) are
12 not capable of consistently actuating within the required tolerance. The switch
13 was recalibrated. Calibration frequency will be increased until a modification
14 to replace the switches with transmitters is implemented.

15 X 28 0 0 0 29 Mode 3 30 B 31 Routine Surveillance 32
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

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HAL B. TUCKER
VICE PRESIDENT
NUCLEAR PRODUCTION

September 2, 1983

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ATLANTA, GEORGIA
TELEPHONE
(704) 373-4531
83 SEP 12 4:19

Mr. James P. O'Reilly, Regional Administrator
U. S. Nuclear Regulatory Commission
Region II
101 Marietta Street, NW, Suite 2900
Atlanta, Georgia 30303

Subject: McGuire Nuclear Station Unit 1
Docket No. 50-369
LER/RO-369/83-67

Dear Mr. O'Reilly:

Please find attached Reportable Occurrence Report RO-369/83-67. This report concerns T.S. 3.5.1.2, "Each Upper Head Injection Accumulator System Shall be Operable...". This incident was considered to be of no significance with respect to the health and safety of the public.

Very truly yours,

H.B. Tucker

Hal B. Tucker

PBN:jfw
Attachment

cc: Document Control Desk
U. S. Nuclear Regulatory Commission
Washington, D. C. 20555

Mr. W. T. Orders
NRC Resident Inspector
McGuire Nuclear Station

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Institute of Nuclear Power Operations
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