

CONTROL BLOCK

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

01 N C M G S 2 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 0 0 3 7 0 1 1 1 4 8 3 1 2 2 0 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)

012 While in Mode 1, on 11/14/83 (90% power) and again on 11/20/83 (89% power), per-

013 formance of the "Semi-daily Surveillance Items" periodic test revealed that

014 pressurizer level instrumentation channel II indicated >4% higher than the aver-

015 age of the other 2 channels and was subsequently declared inoperable. This con-

016 stitutes a degradation of the reactor trip system instrumentation (T.S.3.3.1)

017 which is reportable per T.S.6.9.1.11(b) and similar to RO's 369/81-140, 81-169,

018 82-49, and 370/83-68. The channel was placed in the "trip" condition making the
019 trip logic more conservative. Health and safety of the public were unaffected.019 I A 11 E 12 B 13 P I P E X X 14 A 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 10017 LER/RO
REPORT
NUMBER
8 3
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 100ACTION TAKEN FUTURE ACTION EFFECT ON PLANT SHUTDOWN METHOD HOURS ATTACHMENT SUBMITTED NPD-4 FORM SUB. PRIME COMP. SUPPLIER COMPONENT MANUFACTURER
X 18 X 19 Z 20 Z 21 0 0 0 0 N 23 N 24 L 25 P 0 7 1 0
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 These are attributed to component failure. One leak was found around a solid plug

11 in the side of the manifold valve. The plug was tightened, the reference leg re-

12 filled and the channel declared operable (11/17/83). One leak at a tubing fitting

13 (Parker Hannifin Compression Fitting) was found (11/23/83) on the high side im-

14 pulse line. A section of impulse line was replaced and new fittings installed.

Couplings on impulse lines will be welded to prevent further leaks.

15 B 28 0 9 0 29 NA B 31 Routine Surveillance
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 10016 Z 33 Z 34 NA NA
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 10017 0 0 0 37 Z 38 NA
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 10018 0 0 0 40 NA
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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 10020 N 44 NA
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

NAME OF PREPARER Phillip B. Nardoci

PHONE (704) 373-7432

DUKE POWER COMPANY

P.O. BOX 33189
CHARLOTTE, N.C. 28242

HAL B. TUCKER
VICE PRESIDENT
NUCLEAR PRODUCTION

December 20, 1983

TELEPHONE
(704) 373-4531

93 DEC 29 4:58

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 2
Docket No. 50-370
LER/RO-370/83-79

Dear Mr. O'Reilly:

Please find attached Reportable Occurrence Report RO-370/83-79. This report concerns T.S.3.3.1, "As a minimum, the reactor trip system instrumentation channels and interlocks of Table 3.3-1 shall be operable with response times as shown in Table 3.3-2". 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 / BT

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

Records Center
Institute of Nuclear Power Operations
1100 Circle 75 Parkway, Suite 1500
Atlanta, Georgia 30339

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