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**DUKE POWER**

DATE: March 7, 1996

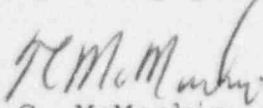
U.S. Nuclear Regulatory Commission  
Document Control Desk  
Washington, D.C. 20555

Subject: McGuire Nuclear Station, Unit 2  
Special Report No.: 96-001  
Problem Investigation Process No.: 2-M96-0331

Gentlemen:

Attached for your information is Special Report 96-001 concerning a valid failure of Diesel Generator 2B due to a low lube oil pressure trip. This event and past inoperability of the Emergency Diesel Generator 2B will be the subject of Licensee Event Report 370/96-002.

Very truly yours,

  
T.C. McMeekin

JWP/gts

Attachment

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DUKE POWER COMPANY  
McGUIRE NUCLEAR STATION  
SAFETY REVIEW GROUP SPECIAL REPORT

Diesel Generator Special Report due to a valid failure of Diesel Generator 2B on February 6, 1996, as documented on Problem Investigation Report (PIP) 2-M96-0331.

**Special Report No: 96-01**

**Date of Report: March 7, 1996**

On February 6, 1996, Diesel Generator 2B was being run for the monthly Tech Spec surveillance start and load test per PT/2/A/4350/02B, Diesel Generator 2B Operability Test. The diesel generator tripped on low lube oil pressure 39 seconds after start initiation.

This was the second valid failure in the last 20 valid tests and the third valid failure in the last 100 valid tests of Diesel Generator 2B. On a unit basis, this was the fifth valid failure in the last 100 valid tests of Diesel Generators 2A and 2B. Surveillance testing increases to weekly frequency per the requirements of Technical Specification 4.8-1 (Diesel Generator Test Schedule).

Investigation revealed that the low lube oil pressure trip was caused by the combination of inadequate impulse line design for the low lube oil pressure switches, air leakage with insufficient venting of the impulse lines, and low room temperature. Diesel Generator 2B was determined to have been past inoperable during periods of low room temperature. An immediate notification of past inoperability was made on March 6, 1996. Additional analysis is ongoing and will be reported in Licensee Event Report 370/96-02.