

DUKE POWER COMPANY

POWER BUILDING

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

WILLIAM O. PARKER, JR.  
VICE PRESIDENT  
STEAM PRODUCTION

August 5, 1981

TELEPHONE: AREA 704  
373-4083

Mr. J. P. O'Reilly, Director  
U. S. Nuclear Regulatory Commission  
Region II  
101 Marietta Street, Suite 310)  
Atlanta, GA 30303



Re: McGuire Nuclear Station Unit 1  
Docket No. 50-369

Dear Mr. O'Reilly:

Please find attached Reportable Occurrence Report RO-369/81-113. This report concerns TS.3.3.2, "The Engineered Safety Feature Actuation System (EFAS) instrumentation channels and interlocks shown in table 3.3-3 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,

A handwritten signature in dark ink, appearing to read "William O. Parker, Jr." with a stylized flourish at the end.

William O. Parker, Jr.

PBN/nsp

Attachment

cc: Director  
Office of Management and Program Analysis  
U. S. Nuclear Regulatory Commission  
Washington, D. C. 20555

Mr. Bill Lavalee  
Nuclear Safety Analysis Center  
Post Office Box 10412  
Palo Alto, California 94303

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

*I. P. 22*  
*6/11*

McGUIRE NUCLEAR STATION  
REPORTABLE OCCURRENCE

REPORT NUMBER: 81-113

REPORT DATE: August 5, 1981

OCCURRENCE DATE: July 6, 1981

FACILITY: McGuire Unit 1, Cornelius, NC

IDENTIFICATION OF OCCURRENCE: One channel of the steam line pressure instrumentation for steam generator "D" was declared inoperable.

CONDITIONS PRIOR TO OCCURRENCE: Mode 3, prior to initial criticality.

DESCRIPTION OF OCCURRENCE: On July 6, 1981, routine inspection discovered that some low range (0-60PSIG) pressure gauges on the main steam (SM) lines were pegged high. Suspecting that the gauges were not properly isolated from the SM line, which was over 200 PSIG, the Operations duty engineer called Instrumentation and Electrical (IAE) to have them check the instrument isolation valves on the affected gauges. During the conversation the technicians wrote down the instrument numbers. However, pressure transmitter numbers were inadvertently substituted for pressure gauge numbers (1SMPT 5180 for 1SMPG 5180). The technician then isolated the instruments on his list, which included a main steam pressure transmitter. Control room operators noticed the corresponding main steam gauge was reading higher than the other channels and declared it inoperable. The affected channel was placed in the tripped position and a work request was written to repair the defective channel. The technician assigned to the work request was the same one who had isolated the transmitter. After some discussion with Operations, the technicians realized the error and the transmitter was returned to service.

APPARENT CAUSE OF OCCURRENCE: The error was caused by a misunderstanding between the duty engineer and the technician about which instruments needed to be isolated.

ANALYSIS OF OCCURRENCE: It is difficult to accurately convey information such as instrument numbers over the phone. The technician went strictly by his list in isolating the instruments, as he had no previous experience working on the SM system. A technician familiar with the system would have known that the transmitters were essential, and would also have known that the transmitters were designed for 0-1300 PSIG and could not be overranged at 200-400 PSIG.

SAFETY ANALYSIS: Since the main steam pressure transmitter failed high, it was unavailable for tripping the 2/3 low pressure main steam line logic, but two channels remained operable. The logic associated with the transmitter was placed in the tripped position so that the low steam line pressure safety injection trip was blocked. With the signal blocked, the isolation of one channel of "D" SM pressure had no effect on the plant or the health and safety of the public.

CORRECTIVE ACTION: The immediate corrective action was to place the affected channel of the SM safety injection trip logic in the tripped position, and then return the transmitter to service. It was also decided that Operations will submit lists of instruments to IAE in the future with signoffs by each instrument listed. Operations and IAE personnel involved were cautioned to be more careful in transmitting this type of information.