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December 4, 2001

U. S. Nuclear Regulatory Commission ATTENTION: Document Control Desk Washington, DC 20555-0001

SUBJECT: Duke Energy Corporation Catawba Nuclear Station Unit 1 and 2 Docket Nos. 50-413 and 50-414 Response to NRC Integrated Inspection Report 50-413/01-05 and 50-414-01-05 dated October 22, 2001

Please find the attached comments on the Catawba Nuclear Station - NRC Integrated Inspection Report 50-413/01-05 and 50-414-01-05 dated October 22, 2001. While Catawba is not formally denying any of the violations, we are providing these comments for your consideration.

This letter does not contain any commitments.

Questions regarding this letter should be directed to R. L. Sweigart at 803-831-3008 or G. D. Gilbert at 803-831-3231.

Sincerely,

G. R. Peterson

1/201

Attachment

U.S. Nuclear Regulatory Commission December 4, 2001 Page 2 xc: L. A. Reves U. S. Nuclear Regulatory Commission Regional Administrator, Region II Atlanta Federal Center 61 Forsyth St., SW, Suite 23T85 Atlanta, GA 30303 B. S. Mallett U. S. Nuclear Regulatory Commission Regional Administrator, Region II - acting Atlanta Federal Center 61 Forsyth St., SW, Suite 23T85 Atlanta, GA 30303 L. R. Plisco U. S. Nuclear Regulatory Commission Deputy Regional Administrator, Region II - acting Atlanta Federal Center 61 Forsyth St., SW, Suite 23T85 Atlanta, GA 30303 V. M. McCree U. S. Nuclear Regulatory Commission Acting Director Atlanta Federal Center 61 Forsyth St., SW, Suite 23T85 Atlanta, GA 30303 R. C. Haaq U. S. Nuclear Regulatory Commission Branch Chief Atlanta Federal Center 61 Forsyth St., SW, Suite 23T85 Atlanta, GA 30303 D. E. Billings U. S. Nuclear Regulatory Commission Senior Resident Inspector, Catawba - acting Catawba Nuclear Site

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Attachment 1

Comments on NCV 50-414/01-05-01 Failure to Implement Effective Corrective Actions Associated with the Unit 2 FWST (Refueling Water Storage Tank) Level Channel Failures

Catawba station has historically been reluctant to submit written comments to the NRC to clarify proposed violations. We would prefer to establish an open dialog with the inspectors to resolve any issues prior to the NRC report approval. However, the proposed violation for the FWST instrumentation contains several errors that, if we fail to respond, may be incorrectly assumed to be agreement or factual. We take exception to the NRC conclusions that the FWST instrumentation is unreliable:

"The failure to implement timely corrective actions for this degraded condition had a credible impact on safety in that reliable operation of FWST level channels 1 and 3 was not assured from 1996 to 2001."

The NRC report states that the level channels are unreliable and posed a credible impact on safety. Our review of plant performance results, probability risk assessment analysis, and system health reports do not support the NRC conclusions.

The Catawba Technical Specifications define the number of level channels required for plant operations and the action time limits when an instrument is out-ofservice. Instruments are verified operable through 'channel checks every shift, channel operational tests every month, channel calibrations every 18-months, and response time tests every 18-months. These instruments are, and will be, maintained operable within their surveillance test program and licensing basis.

In addition to the licensing requirements defined by Technical Specifications, the FWST level channels are included in the Maintenance Rule program as required by 10CFR50.65. Performance goals are established with limits of 99.8% system availability and 100% system reliability. The Unit 2 FWST system performance results from previous cycles are listed below:

	System	System
	Availability	Reliability
Cycle 12		
9/01 to present	100%	100%
Cycle 11		
4/00 - 9/01	100%	100%
Cycle 10 and		
earlier cycles	> 99.8%	100%

The Unit 2 FWST level system has always met or exceeded the Maintenance Rule availability and reliability goals.

In response to the 15 Problem Investigation Process reports (PIPs) listed in the NRC report, there were three (not 15) instrument failure events since 1996 one in 1996, one in 1998, and one in 2000. Of the three events, two were following lightning activity (1998 and 2000). Catawba initiated a root cause investigation and is developing corrective actions following the second lightning induced failure in 2000 to further strengthen the FWST level indication system. An intolerance for equipment failures, regardless of cause, is our key philosophy to maintain high standards for equipment reliability.

Catawba station management encourages a self-critical culture, and, therefore, promotes plant personnel to document all concerns in PIP - including minor issues. Listing 15 PIPs in the NRC report may provide the incorrect perception that all events were instrument failures.

Therefore, based on Catawba's compliance with all licensing requirements, adherence to the maintenance rule goals for reliability and availability, and three instrument failures since 1996, we do not agree that the FWST channels are unreliable. These instruments, as well as other safety systems, are maintained reliable and available. Comments on NCV 50-414/01-05-03 Failure to Identify a Condition Adverse to Quality that Rendered the "A" Chiller Inoperable

1. The NRC Inspection Report dated July 23, 2001 documents licensee identified violation NCV 50-414, 414/01-04-02:

> "Technical Specification 5.4.1.a, and Regulatory Guide 1.33, Section 9, Procedures for Performing Maintenance, required that maintenance that can affect the performance of safety related equipment should be properly planned and performed in accordance with written procedures and documented instructions. Contrary to this, on May 3, 2001, the licensee failed to develop appropriate written procedures or documented instructions for maintenance activities performed on the A train YC chiller as described in PIP C-01-1994 (Green)."

This May 3, 2001 chiller event is documented again as a violation in the October 22, 2001 inspection report but is listed as an inspector identified finding (vice licensee identified). For the May 3 event, Catawba personnel initiated all problem identification reports, root cause investigations, and corrective actions independent of the resident inspector comments. This event, if significant enough to warrant multiple violations, should be credited as a licensee identified finding as originally documented July 23, 2001.