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ACCESSION NBR:9602130071 DOC.DATE: 96/02/09 NOTARIZED: NO DOCKET #
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50-270 Oconee Nuclear Station, Unit 2, Duke Power Co. 05000270
50-287 Oconee Nuclear Station, Unit 3, Duke Power Co. 05000287
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SUBJECT: Forwards response to NRC 960111 ltr re violations noted in insp repts 50-269/95-27,50-270/95-27 & 50-287/95-27 on 961105-1216.C/As:non-licensed operators informed CR of event.

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CATEGORY 1 DOCUMENT

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DUKE POWER

February 9, 1996

U.S. Nuclear Regulatory Commission
Attention: Document Control Desk
Washington, DC 20555

Subject: Oconee Nuclear Site
Reply to Notice of Violation
Inspection Report Nos. 50-269/95-27,
50-270/95-27, and 50-287/95-27

Gentlemen:

By letter dated January 11, 1996, the NRC transmitted a Notice of Violation related to an NRC inspection conducted from November 5 - December 16, 1995. This Severity Level IV violation involves two inadequate procedures. Duke Power Company acknowledges this violation. Pursuant to 10 CFR 2.201, Attachment 1 provides a written reply to the Notice of Violation identified in the subject inspection report.

Based on a detailed review of the circumstances surrounding these events, the two procedural inadequacies identified in the subject violation appear to be isolated events involving unrelated portions of Duke's procedural development and review process. Therefore, these two items are addressed independently in Attachment 1.

Two additional procedural inadequacies were also identified in the subject inspection report as non-cited violations. Based on this identification, Duke is conducting a review to determine whether a common cause exists in this area which may indicate programmatic deficiencies. The results of this review will determine if any action is necessary regarding programmatic improvements in the procedure development and review process.

NRC commitments associated with this correspondence are provided in Attachment 1.

Very truly yours,

J. W. Hampton

JE01

cc: Mr. S. D. Ebneter, Regional Administrator
U.S. Nuclear Regulatory Commission, Region II

Mr. L. A. Wiens, Project Manager
Office of Nuclear Reactor Regulation

Mr. P. E. Harmon
Senior Resident Inspector
Oconee Nuclear Site

Attachment 1
Reply to Notice of Violation (Reply)
Severity Level IV
Violation 50-269, -270, -287/95-27-01

Restatement of Violation

10CFR50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings", and the licensee's Quality Assurance Program (Duke-1-A, Section 17.3.2.13) require in part that activities affecting quality shall be prescribed by documented instructions, procedures, or drawings of a type appropriate to the circumstances.

Oconee Nuclear System Directive 202, 10CFR50.72 Reports, Revision 5, provides the guidance for station personnel to determine whether an event or situation should be reportable per the requirements of 10CFR50.72.

Oconee Block Tagout Procedure, OP/1/B/1502/08, Enclosure 4-10B, BTO Tagout 10B-HPI Makeup/Seal Injection/Seal Return provides the requirements for establishing the isolation boundaries for portions of the High Pressure Injection System under the Block Tagout Program.

Contrary to the above:

1. Nuclear System Directive 202 was inadequate in that a condition which required a 4 hour report per 10CFR50.72 (b) 2.i, was not identified by the procedure. As a consequence, licensee personnel using the directive as guidance for reportability, did not recognize that a reportability condition existed after determining on December 7, 1995, that one train of Low Pressure Injection had been inoperable from December 12, 1992, to November 2, 1995.

2. Block Tagout Procedure OP/1/B/1502/08 was inadequate in that it did not include 1HP-79, or its downstream isolation valves, as an isolation boundary. As a consequence, when 1HP-79 was removed for maintenance a breach was created in the Block Tagout 10B isolation boundary. This resulted in a spill of approximately 350 gallons of contaminated water into the Unit 1 Letdown Storage Tank Room on November 20, 1995.

Attachment 1
Reply to Notice of Violation (Reply)
Severity Level IV
Violation 50-269, -270, -287/95-27-01

Reply to Notice of Violation 95-27-01

Item 1:

1. The reason for the violation:

Duke Power Company acknowledges that this is a violation. Nuclear System Directive (NSD) 202 guidance on reportability requirements for 10CFR50.72(b)(2)(i) was found to be misinterpreted with respect to the NRC guidance in NUREG 1022. The condition involving an inoperable train of Low Pressure Injection (LPI) should have been determined to be reportable under 10CFR50.72 (b)(2)(i). When the NSD was reviewed in order to determine reportability, it was initially concluded that the condition was not reportable under 10CFR50.72(b)(2)(i).

The first contributing factor in the reportability decision was a result of information provided in NSD 202. In Section 202.6.4 of NSD 202, Definitions, the definition for "significantly compromises plant safety" implies that a principal safety barrier would already have to be seriously degraded at the time of reportability in order for the reporting criterion for 10CFR50.72(b)(2)(i) to be met.

A second contributing factor in the decision not to report the 1LPSW-254 condition was the indeterminate conclusion of the operability evaluation. At Duke Power, engineering operability determinations provide the input necessary to make reportability determinations on issues related to plant design and licensing. In this case, Engineering concluded that the potential existed for 1LPSW-254 to fail in a partially closed or closed position at some time during an accident. A review of reportability requirements with this indeterminate operability condition resulted in an initial determination of no reportability since the station personnel making this determination concluded that no safety barrier had actually been degraded.

NSD 202, "10CFR50.72 Reports", is based on a combination of industry guidance and the draft NRC guidance document NUREG 1022 updated through Revision 1 Draft 2. There is additional information in NUREG 1022, Rev 1, Draft 2, which would have assisted in the reportability determination for this condition. However, not all of this information is

currently included in NSD 202 because of the draft nature of the NUREG.

2. The corrective steps that have been taken and the results achieved:

Upon further review of available NRC guidance, it was determined that the event should have been reported. Therefore, the event was reported as required by 10CFR50.72(b)(2)(i).

3. The corrective steps that will be taken to avoid further violations:

NSD 202 will be reviewed and revised as necessary to prevent recurrence of this event. Specifically, Section 202.6.4 of NSD 202, Definitions, will be revised to clarify that potential degradation of a principal safety barrier can also result in an unanalyzed condition and resultant reportability condition. In addition, the NSD will be revised to emphasize that if evaluations performed to determine reportability are not conclusive, then a report should be made under the most applicable requirement.

4. The date when full compliance will be achieved:

Full compliance will be achieved when NSD 202 is updated to clarify reportability requirements for 10CFR50.72(b)(2)(i). NSD 202 will be updated to provide this clarification by 6/30/96.

Attachment 1
Reply to Notice of Violation (Reply)
Severity Level IV
Violation 50-269, -270, -287/95-27-01

Item 2:

1. The reason for the violation:

Duke Power Company acknowledges that this is a violation. A detailed event and causal factors analysis was performed for this occurrence. The analysis indicated that the root cause of this event was that relief valves that interconnect with lower pressure systems were not typically considered as BTO boundary valves. This root cause resulted in use of the BTO during removal of relief valve 1HP-79 without appropriate precautionary measures for removal of this valve.

2. The corrective steps that have been taken and the results achieved:

Upon discovery of the spill from the location where valve 1HP-79 had been removed, the non-licensed operators informed the control room of the event. The control room operators secured the 1A Bleed Holdup Tank Pump in order to stop any further spillage from the valve location due to backflow through the bleed transfer pump recirculation line. All maintenance was secured on 1HP-79 until the 1A Bleed Holdup Tank Pump could be tagged out to isolate this water source from the maintenance area. In addition, a review was conducted by Operations to determine if a similar configuration control issue existed for all other BTOs in effect. This review determined that no similar configuration control issues existed. The subject BTOs for all three units have been placed on hold, not to be used until the appropriate revisions are completed.

3. The corrective steps that will be taken to avoid further violations:

a. For operations personnel involved with procedure preparation, the importance of listing all changes made in the description of changes for the revised procedure will be reemphasized. This will ensure that the procedure reviewer is fully informed of all revisions to the changed procedure.

b. The Block Tagout procedures for all three units have been placed on hold, not to be used until they can be revised to designate relief valves which interface with other systems as boundary valves. The designation of

relief valves as BTO boundary valves will allow for configuration control of these valves during maintenance. This action will provide an adequate barrier to prevent recurrence of this type of event.

c. This event will be presented as a training example for Operations to reemphasize the need for self checking during task preparation/review and task performance respectively.

4. The date when full compliance will be achieved:

The affected procedures have been identified and will be revised prior to future use. Therefore, Oconee is in full compliance.