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SUBJECT: Provides response to violations noted in Insp Repts
50-269/96-17, 50-270/96-17 & 50-287/96-17. Corrective actions:
site continuous improvement team (CIT) formed to address
area of configuration control from operations & maint.

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DUKE POWER

February 26, 1997

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

Subject: Oconee Nuclear Site
Docket Nos. 50-269, -270, -287
Inspection Report 50-269, -270, -287/96-17
Reply to Notice of Violation

Gentlemen:

By letter dated January 27, 1997, the NRC issued three Notices of Violation as described in Inspection Report No. 50-269/96-17, 50-270/96-17, and 50-287/96-17.

Violation A identifies two examples of valve configuration control problems. Violation B involves evaluations of out of tolerance test equipment. Violation C concerns ASME Code Class 3 welds on Low Pressure Service Water piping that did not receive the proper examination.

Duke Power acknowledges these three violations. Accordingly, Duke is proposing corrective actions, as described in the attachments, to address the root causes of Violation A and Violation B.

Regarding the reply to Violation C, Duke has not completed the detailed root cause investigation. Based on conversations between Duke and Region II, the results of this root cause investigation and the corresponding corrective actions will be submitted by March 12, 1997.

Pursuant to the provisions of 10 CFR 2.201, Attachment 1 provides a written response to Violation A and Attachment 2 provides a written response to Violation B as identified in

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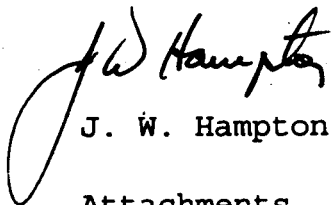
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the subject Inspection Report. Attachment 3 provides a partial response to Violation C.

Very truly yours,


J. W. Hampton

Attachments

NRC Document Control Desk

February 26, 1997

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cc: Mr. L. A. Reyes, Regional Administrator
U. S. Nuclear Regulatory Commission, Region II

Mr. D. E. LaBarge, Project Manager
Office of Nuclear Reactor Regulation

Mr. M. A. Scott
Senior Resident Inspector
Oconee Nuclear Site

Attachment 1
Reply to Notice of Violation (Reply)
Violation 50-270, 287/96-17-06

Restatement of the Violation

Technical Specification 6.4.1 requires that the station shall be operated and maintained in accordance with approved procedures. Written procedures with appropriate check-off lists and instructions shall be provided for the following conditions:

- Normal startup, operation, and shutdown of the complete facility and all systems and components involving nuclear safety of the facility.
- Preventive or corrective maintenance which could affect nuclear safety or radiation exposure to personnel.

Operations Procedure OP/2/A/1103/02, Filling and Venting the RC System, provides instructions to fill and vent the RC system. Enclosure 4.13, Valve Checklist, requires 2RC-196, 2B Once Through Steam Generator (OTSG) Hot Leg High Point Vent Valve, to be open.

Maintenance Procedure IP/0/B/203/1G, Low Pressure Injection System Inaccessible Flow Instruments Calibration, Enclosure 11.4.1, required that the pressure transmitter for valve 3LP-2 be returned to service prior to exiting the procedure.

Contrary to the above, the station was not operated and maintained in accordance with approved procedures, in that:

1. On December 10, 1996, valve 2RC-196 was found in the closed position. This caused inadequate venting and the formation of a void in the 2B OTSG hot leg piping.
2. On October 12, 1996, the isolation valve associated with the low pressure transmitter for 3LP-2 was found shut. This prevented normal valve operation during a unit shutdown. Additional operator and maintenance actions would have been necessary in certain emergency situations if valve operation was required.

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Reply to Notice of Violation (Reply)
Violation 50-270, 287/96-17-06

Reply to the Notice of Violation

1. The reason for the violation:

Duke Power Company acknowledges this violation.

On October 12, 1996, Maintenance discovered Reactor Coolant Isolation Valve 3RC-IV-0096 mispositioned. This valve is the isolation valve for pressure switch 3RCPS-0364 which controls 3LP-2. The valve should have been in the open position but was found in the closed position. The last known manipulation of 3RC-IV-0096 was on January 11, 1994, per IP/0/B/203/1G, for a calibration check on the 3RCPS-0364 switch. The calibration data sheet documents by double verification that the system was returned to normal. No other work could be identified that could have manipulated this valve.

On December 10, 1996, 2RC-196 was found closed. The normal position for the 2B hot leg high point vent valve (2RC-196) is open. The last documented position of 2RC-196 was open, as required by procedure OP/2/A/1103/02, Enclosure 4.1, Filling the RCS to >100" Pressurizer Level. A valve checklist verified that 2RC-196 was in the open position on October 18, 1996. 2RC-196 had to be in the open position for this procedure evolution to be successful. The evolution was successful. Access to the platform where 2RC-196 is located in the reactor building (under the 4th floor grating level) requires the lifting of a heavy deck grating. The valve is properly labeled and is not located in an area that is typically accessed during an outage. The detailed root cause investigation revealed no opportunity for the valve to be mispositioned.

The root cause for the valve mispositioning events is unknown.

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However, the investigation into this event identified two items that appear to be significant contributors. These are:

- Operation's procedures for filling the Reactor Coolant System loops were not written in enough detail to allow the operators to know when a proper vent is established on each hot leg loop.
 - During the recent three-unit outage, an increase in the number of configuration control problems occurred. Though it does not appear that the rate of error has increased, Operations is taking steps to reduce human errors that may contribute to these problems.
2. The corrective steps that have been taken and the results achieved:
- a. 3RC-IV-0096 was opened. This placed the control for 3LP-2 to the normal operating position.
 - b. The following steps were taken to identify and remove an air pocket at the top of the Unit 2 "B" RCS hot leg, which resulted from the mispositioning of 2RC-196:
 - An investigation into the valve lineup found 2RC-196 closed, preventing the Unit 2 "B" RCS hot leg from venting.
 - A special procedure change was made to OP/2/A/1103/02, Filling and Venting the RC System. This change vented the gas pocket off the Unit 2 loop.
 - Approximately 1922 gallons of makeup was added to the RCS to fill the void.

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- c. The following actions have been taken to ensure improved procedural controls to prevent recurrence of the type problem associated with 2RC-196:

Unit 1: OP/1/A/1103/02, Filling and Venting the RC System, was revised to improve the process in which the Reactor Coolant Systems (RCS) hot legs are vented. The RCS hot legs are now vented in a manner to assure the RCS loops are full of water. This change was approved on December 26, 1996.

Unit 2: OP/2/A/1103/02, Filling and Venting the RC System, Enclosure 4.3, Raising RCS Loops, was removed from service. This administratively prevents this procedure enclosure from being used until appropriate changes are implemented. The removal from service of Enclosure 4.3 was performed on December 12, 1996.

Unit 3: OP/3/A/1103/02, Filling and Venting the RC System, was revised to improve the process in which the hot legs are vented. The RCS hot legs are now vented in a manner to assure the RCS loops are full of water. This procedure change occurred on February 8, 1997.

- d. On February 10, 1997, a note was sent to the five Operations Shift Managers (OSMs) and the Shift Operations Manager stressing the urgency of improving configuration control. Several one-on-one conversations between the OSMs and Operations management occurred to ensure the OSMs understand the significance of this issue. The message has been communicated during shift turnover to Reactor Operators and Nuclear Licensed Operators and has

Attachment 1
Reply to Notice of Violation (Reply)
Violation 50-270, 287/96-17-06

increased their awareness of configuration control. The Superintendent of Operations has also covered the issue of several mispositioned events in his Operations Team notes and expressed his expectations for using proper tools/skills to reduce human errors. Furthermore, an Operations Shift Manager Meeting, on February 20, 1997, included a discussion on configuration control led by the Shift Operations Manager.

3. The corrective steps that will be taken to avoid further violations:
 - a. A site Continuous Improvement Team (CIT) has been formed to address the area of configuration control from a site perspective, with representatives from Operations, Maintenance and Chemistry. This will allow a consistent approach to configuration control by the groups on site. Lessons learned from each site group will also be shared with other groups. The Superintendent of Operations will sponsor this CIT. The first meeting of this CIT was on February 18, 1997.
 - b. Operations will develop a method of evaluating RCS inventory during cold shutdown conditions. This will include evaluating RCS makeup and losses. This corrective action will be in place by August 30, 1997.
 - c. Maintenance will review the procedure used to verify isolation valve lineup to determine if expanding the checklists to include additional isolation valves is a feasible method to prevent recurrence.

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Reply to Notice of Violation (Reply)
Violation 50-270, 287/96-17-06

4. The date when full compliance will be achieved:

Duke Power believes that the corrective actions described in Section 2 of this Reply assure compliance with Technical Specifications and company policy. The corrective actions listed in Section 3 of this Reply provide the foundation for further enhancements in configuration control.

Attachment 2
Reply to Notice of Violation
Violation 50-269, 270, 287/96-17-02

Restatement of the Violation

10 CFR 50 Appendix B, Criterion XII, Control of Measuring and Test Equipment (M&TE), as implemented by the Duke Power Quality Assurance Topical Report (Duke 1-A) section 17.3.2.9, Measuring and Test Equipment Control, requires that items and processes determined to be acceptable based on measurements made with devices subsequently found to be out of calibration are to be reevaluated. Additionally, Table 17.0-01 of the QA Topical Report references Regulatory Guide 1.28, QA Program Requirements, which incorporates ANSI N45.2-1977. Section 13 of ANSI N45.2, Control of Measuring and Test Equipment, requires that when M&TE are found to be out of calibration, an evaluation shall be made of the validity of previous inspection or test results for acceptability.

Contrary to the above, on November 21, 1996, it was identified that items and processes determined to be acceptable based on measurements made by M&TE devices were not appropriately reevaluated following identification that the devices were out of calibration. Numerous examples were identified in which the evaluations were not performed. Other examples were identified in which the evaluations were not adequate.

Reply to the Notice of Violation

1. The reason for the violation, or if contested, the basis for disputing the violation:

The cause for the Instrument and Electrical (I&E) M&TE evaluations being overdue without approved extensions was a failure by the responsible individual to ensure that the requirements of Maintenance Directive 4.4.1 were met. It is the responsibility of this person to ensure that out of tolerance evaluations are either completed or extended before the 14 working day limit is reached.

Attachment 2
Reply to Notice of Violation
Violation 50-269, 270, 287/96-17-02

The Mechanical M&TE out of tolerance evaluations are performed in accordance with Engineering guidelines. These guidelines prescribe that Post Maintenance/Modification testing can be an acceptable method to evaluate out of tolerance M&TE for linear measuring tools.

The multi-amp breaker tester in Commodities and Facilities (C&F) that did not receive the out of tolerance evaluation within seven working days as specified in Testing Inspection Procedure (TIP) 701, Section 4.4.3, was caused by inattention to detail by the responsible individual.

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

- The requirements of Maintenance Directive 4.4.1 have been recommunicated to the responsible individual, the M&TE Team and the M&TE Technical Support person.
- Appropriate disciplinary action has been taken in accordance with Duke Power Policies and Management Procedures.
- I&E M&TE Out of Tolerance reports that had exceeded the 14 working days without approval for extensions have been reviewed and approvals have been documented.
- Additional management oversight has been assigned to the I&E M&TE Team.
- An evaluation of the outstanding out of tolerance reports in C&F has been completed and the reports were determined to be acceptable.
- TIP 701, Instructions for Control of M&TE, has been revised to require that out of tolerance evaluations be performed in 30 calendar days instead of seven working days. The Procurement Engineering QC Receiving inspection personnel have been instructed on meeting the requirements of this procedure.

Attachment 2
Reply to Notice of Violation
Violation 50-269, 270, 287/96-17-02

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

Maintenance Directive 4.4.1 will be reviewed and revised to provide enhanced directions on managing out of tolerance evaluations. The requirement of completing the evaluations within 14 working days will be changed to 30 calendar days. This is per Nuclear Site Directive 406, Control of Measuring and Test Equipment, and ensures consistency at the three Duke Power Nuclear sites.

A review will be performed to re-verify the technically justified method of performing out of tolerance evaluations for Mechanical M&TE. Changes, if required, will be implemented based on the results of this evaluation. This corrective action will be completed by June 1, 1997.

The following will be communicated to all M&TE users:

- the importance of performing timely evaluations
- the impact of out of tolerance M&TE on field installed equipment
- the revisions to Maintenance Directive 4.4.1.

4. The date when full compliance will be achieved:

Oconee Nuclear Station is in full compliance.

Attachment 3
Reply to Notice of Violation (Reply)
Violation 50-269/96-17-09

Restatement of the Violation

10 CFR 50 Appendix B, Criterion V, "Instructions, Procedures and Drawings" as implemented by the Duke Power Company Topical Report Quality Assurance Program (Duke-1-A), requires in part that activities affecting quality shall be accomplished in accordance with prescribed procedures, instructions or drawings.

Oconee Station Procedure QAL-5, Table C, Rev. 0, requires that ASME Code Class 3 welds, tested per ASME Code Case N-416-1, in lieu of the hydrostatic pressure test required by paragraph IWA-4000, shall have surface examinations performed on the root and final pass. Also, following the examination and prior to or immediately upon returning to service, a visual examination (VT-2) shall be performed in conjunction with a system leakage test, at normal operating pressure and temperature.

Contrary to the above, on October 17, 1995, activities affecting quality were not accomplished in accordance with prescribed procedures. Specifically, eight new Code Section XI Class 3 welds that were fabricated during Nuclear Station Modification (NSM) 52972, Low Pressure Service Water "B" Line Header modification did not undergo surface examination at the root and final pass as required.

Reply to the Notice of Violation

A detailed root cause investigation is in progress to determine why this event occurred. A team has been chartered to evaluate the circumstances surrounding this violation. The team is also including other related events previously identified through the ONS corrective action program. The process for visual examinations of Nuclear Station Modifications involves several groups. Because of

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Violation 50-269/96-17-09

the different organizations being interviewed by the team, along with the consideration of other relevant modification inspection problems identified through the corrective action program, the root cause analysis is taking longer than anticipated. The results of this root cause investigation and the corresponding corrective actions will be submitted by March 12, 1997.