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Document Control Branch (Document Control Desk)

SUBJECT: Responds to NRC 970421 ltr re violations noted in insp repts 50-269/97-01,50-270/97-01 & 50-287/97-01.Corrective actions: personnel involved in reversing wiring leads on valves 3LP-1 & 3LP-2 mod were counseled concerning actions.

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CATEGORY 1 DOCUMENT

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DUKE POWER

May 21, 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, -287/97-01
Reply to Notice of Violation

Gentlemen:

By letter dated April 21, 1997, the NRC issued a Notice of Violation as described in Inspection Report No. 50-269/97-01, 50-270/97-01, and 50-287/97-01.

The violation involves reversed motor leads at the motor control center and valve operator for valves LP-1 and LP-2 on Units 2 and 3. Duke Power acknowledges this violation and agrees that the maintenance work practices associated with these valves were inadequate. Duke is implementing corrective actions to address human performance issues.

Pursuant to the provisions of 10 CFR 2.201, Attachment 1 provides a written response to the violation identified in the subject Inspection Report.

In response to the mispositioning of 3HP-5, an example of Violation, 50-270, -287/96-17-06, Attachment 2 provides a summary of additional steps taken to improve configuration management.

Very truly yours,

J. W. Hampton

J. W. Hampton

Attachments

IE01

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
Violation 97-01-03, Severity Level IV

Restatement of Violation 97-01-03:

Technical Specifications 6.4.1 provides that the station shall be operated and maintained in accordance with approved procedures. Technical Specification 6.4.1.e states that written procedures with appropriate check-off lists and instructions shall be provided for preventative or corrective maintenance which could affect nuclear safety or radiation exposure to personnel.

Within Instrumentation Procedure IP/0/A/3001/010, Maintenance of Limitorque Valve Operators, the note following step 10.19.2 states, "For Appendix R related valves, (CF-1,2 and LP-1,2) motor leads at the motor control center and penetration SHALL remain as designated by drawings. Corrections to motor rotation SHALL be made at the operator."

Contrary to the above, the station was not maintained in accordance with approved procedures, in that, for an indeterminate time since the compliance audit with Appendix "R" in 1987, the motor leads at the motor control center and the valve operator for LP-1 and LP-2 on Units 2 and 3 were reversed at the motor control center.

RESPONSE:

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

Duke Power Company acknowledges the violation.

The root cause analysis concluded that this violation resulted from inadequate work practices. Specifically, the required procedure, IP/0/A/3001/010, Maintenance of Limitorque Valve Operators, was not followed correctly. As a result, Appendix R Limitorque valve operators for valves LP-1 and LP-2 were not installed properly. A contributing factor to the failure to follow procedure was that the procedure IP/0/A/3001/010 has generic instructions for all Limitorque valve operators with specific requirements for Appendix R applications stated in a note. The note, however, was overlooked by the technicians.

Attachment 1
Reply to Notice of Violation
Violation 97-01-03, Severity Level IV

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

a) Personnel involved in reversing the wiring leads on valves 3LP-1 and 3LP-2 modification were counseled concerning their actions.

b) The wiring on valves 3LP-1 and 3LP-2 was corrected and tested satisfactory.

c) The wiring problem was identified on Unit 3. As a result of this finding, other valves with similar Appendix R configurations were inspected. Valves 1LP-1, 1LP-2, 1CF-1, 1CF-2, 2CF-1, 3CF-1, and 3CF-2 were found wired correctly. Wiring deficiencies were identified and corrected on 2LP-1, 2LP-2 and 2CF-2. An engineering evaluation of 2CF-2 concluded that the wiring, even though not in accordance with the drawing, would not have affected the motor rotation. Therefore, 2CF-2 would have opened to perform the safety function during an Appendix R event.

d) An investigation to determine the cause of the incorrect wiring was performed. The Appendix R Damage Repair Valve Control Panel was built in 1987 and included in the Appendix R procedures. At that time the wiring was inspected and verified to match the drawings. Post-maintenance or periodic testing utilizing the damage control panel has not been required because it is not permanently installed plant equipment. It could not be determined when, after 1987, the wiring was incorrectly installed on valves 2LP-1, 2LP-2 and 2CF-2.

Attachment 1
Reply to Notice of Violation
Violation 97-01-03, Severity Level IV

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

a) Revise procedure IP/0/A/3001/010 to provide more specific guidance for Appendix R valves and the required action to achieve correct motor rotation.

b) Install tags in Motor Control Centers (MCC) containing Appendix R components to caution against changing motor wiring at the MCC.

c) Perform a one time test per unit to verify proper operation of components using the Appendix R Damage Repair Valve Control Panel.

4) The date when full compliance will be achieved:

Oconee Nuclear Station is in full compliance.

Attachment 2
Additional Response to Configuration Control
3HP-5 Mispositioning

The primary cause of the mispositioning of valve 3HP-5 is that self-checking was not adequately applied to ensure the valve was correctly positioned. In response to Violation 50-270, -287/96-17-06, a Continuous Improvement Team (CIT) was formed to address the issue of an adverse trend of configuration control events. The CIT has reviewed all configuration control events at ONS for the past year. The results of this review have shown that the largest area needing improvement is in the area of self-checking. As a result, there are two corrective actions being considered to address the problem of inadequate self-checking.

- Develop a self-checking improvement and enhancement program. This program is still in the development stage. The intent of the program is to establish improvements in self-checking prior to the next refueling outage and then monitor the outage for improvements. Further enhancements will occur after this evaluation.
- Operations is evaluating and developing enhancements to its current valve verification program. The current program allows the operator to use a single method to verify valve position. The proposed program will require the operator to verify valve position using at least two different indications, such as light indication, local valve indication, or stem position. Contingency plans will be available if two different indications are not available.

While the above corrective actions may be somewhat altered, the intent of the corrective actions should not change. The overall goal is to improve the trend of mispositionings and improve human performance at ONS.