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 50-287 Oconee Nuclear Station, Unit 3, Duke Power Co. 05000287

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SUBJECT: Responds to NRC 890314 ltr re violations noted in Insp Repts
 50-269/89-05, 50-270/89-05 & 50-287/89-05.

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LOW POWER

April 13, 1989

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

Subject: Oconee Nuclear Station
Docket Nos. 50-269, -270, -287
Inspection Report 50-269, -270, -287/89-05

Gentlemen:

By a NRC letter dated March 14, 1989, a Notice of Violation and Inspection Report 50-269, -270, and -287/89-05 was transmitted to me. As required by the provisions of 10CFR2.201, I am submitting a written response to the violations identified in the inspection report.

Very truly yours,

Hal B. Tucker
Hal B. Tucker

RRE/34/td

Attachment

cc: Mr. S. D. Ebnetter
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U. S. Nuclear Regulatory Commission
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Duke Power Company

Oconee Nuclear Station

Reply to a Notice of Violation

Inspection Report 50-269, -270, -287/89-05

Violation A

Oconee Nuclear Station Technical Specification (TS) 6.4.1 states that the station shall be operated and maintained in accordance with approved procedures and that these procedures shall contain appropriate check-off lists and instructions. The Oconee Nuclear Station Emergency Operating Procedure (EP/1/A/1800/01) contains procedures to be used to place and maintain the reactor in a safe condition following certain events.

Contrary to the above, portions of the procedures concerning actions to be taken by the operators were inadequate, in that guidance was insufficient in the areas of the Thermal Shock Operating Range (TSOR) and use of Auxiliary Pressurizer Spray as indicated in the following examples:

1. Management was uncertain whether existing plant conditions required entry into the TSOR. Analysis after the event indicates that the TSOR should have been entered.
2. Auxiliary Pressurizer Spray was initiated with a differential temperature (spray-pressurizer) in excess of the 410 degrees F which resulted in a violation of TS 3.1.2.6.
3. Management was reluctant to utilize the Power Operated Relief Valve (PORV) to reduce pressure to the TSOR, consequently the TSOR was not entered. The EOP does not specify how to reduce pressure to get into the TSOR, only to do so. Additionally the guidance does not specify how time sensitive entry into the TSOR is.

Response

1. Admission or denial of the violation:

Duke Power Company admits the violation occurred as stated.

2. Reason for violation:

The violation occurred because the Emergency Operating Procedure (EP/1/A/1800/01) did not give adequate guidance for determining a starting point for calculating cooldown rates and for determining whether operation in the TSOR was required. It did not specify what constituted emergency injection, nor did it give proper guidance for reducing RCS pressure without normal pressurizer spray. Management was reluctant to use the Power Operated Relief Valve (PORV) because its switch was located in a cabinet behind the Control Room "horseshoe" and was configured with a spring-return to "close" such that an operator would have been required to hold the switch in the open position.

The auxiliary pressurizer spray was initiated in order to verify the flow path after finding a closed valve in the lineup. Earlier, during the incident, the auxiliary pressurizer spray would not function when operators tried to use it to reduce the RCS pressure while in natural circulation.

3. The corrective steps which have been taken and the results achieved:

A training package was prepared and distributed which addressed cooldown rates, limits and criteria, and methods for entering the TSOR.

A NSM was performed on Units 1 and 3 which moved the switch for the Power Operated Relief Valve to an appropriate location within the Control Room.

4. Corrective steps which will be taken to avoid further violations:

This event will be covered in Licensed Operator Requalification training and will include all lessons learned from this event, including the use of the auxiliary pressurizer spray. The Emergency Operating Procedure (EOP) will be revised, validated and reissued to correct the deficiencies identified in this violation.

A NSM will be implemented on Unit 2 which will move the switch for the PORV to the appropriate location within the control room.

5. Date of full compliance:

The corrective actions already taken ensure that full compliance is achieved at the present time. The EOP will be reissued by June 1989. The PORV switch NSMs will be complete after the Unit 2 refueling outage scheduled for May 1989. The requalification training will be completed by June 1989.

Violation B

Oconee Nuclear Station Technical Specification 6.4.1 states that the station shall be operated and maintained in accordance with approved procedures. Oconee Nuclear Station Directive 2.2.2 "Independent Verification" and Directive 3.2.1 "Work Request" contain specific procedures to be followed to accomplish Independent Verification and Correct Component Verification during work.

Contrary to the above, due to programmatic weaknesses in the training and qualification of Construction and Maintenance Division (CMD) workers performing Nuclear Station Modification (NSM) work, these procedures were not followed. The below listed incidents are examples resulting from these weaknesses in the training and qualification areas:

1. The cutting of an incorrect pipe in the Unit One High Pressure Injection Pump room.
2. A Unit 2 reactor trip due to an improperly installed wire which caused a ground on the 125VDC system.

Response

1. Admission or denial of alleged violation:

Duke Power Company admits the violation occurred as stated. This problem is and has been recognized by CMD Management.

2. Reason for violation:

The incidents related to this notice of violation resulted from improper completion of Correct Component Verification and Independent Verification. The individuals involved in these incidents did not possess an adequate knowledge in the intent of, nor the procedure for, Correct Component Identification and Independent Verification. Therefore, appropriate procedures were not followed. It should be noted that the individuals involved had received training in appropriate procedures but the effectiveness/trainee retention of the attended training had not been verified in the past.

3. Corrective steps which have been taken and the results achieved:

As a result of the first incident (the cutting of a pipe in the wrong line), formal counseling of supervisory personnel was conducted. This counsel emphasized the importance of assigning qualified personnel to perform the needed work as well as the intent and requirements of Independent Verification. To assist in the assignment of qualified individuals to perform the required work, formal pre-implementation meetings are conducted with the craft supervisor responsible for implementing the NSM. This meeting includes a review of the scope of the modification, the tasks involved to implement each activity and the personnel qualification requirements needed to perform each task.

In addition, all NSM supervisors and craft personnel received a formal communication detailing the intent and importance of Independent Verification.

As a result of the second incident, disciplinary action was taken with personnel involved.

4. Corrective steps which will be taken to avoid further violations.

All CMD Craft personnel will be re-instructed in the requirements of Independent Verification with each individual being tested to ensure the training's effectiveness.

The long term plan consists of a training program for two general categories of NSM personnel:

- 1) NSM Administrator
- 2) NSM Worker

The NSM Administrator program is designed to improve the ability to control the administrative aspects of the nuclear station work. Craft supervisors, selected craft crew personnel and selected engineering technicians will be "qualified" as NSM Administrators. These individuals will be the "hub" of the craft crews responsible for implementing NSM's. The NSM Administrator will have the responsibility of ensuring that all administrative aspects of the work are carried out properly.

The NSM Worker program is established to allow CMD NSM craft personnel to have the background necessary to work on systems vital to the safe operation of nuclear power plants and to have a better understanding on how to properly execute procedures, work requests, station interfaces as well as General Employee Training (GET).

5. Date of Full Compliance:

Duke is committed to have full qualification of all NSM Workers by December 1990.