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SUBJECT: Responds to NRC 920325 ltr re violations noted in Insp Repts 50-269/92-08,50-270/92-08 & 50-287/92-08.Corrective actions: TS change will be proposed to clarify role of HPI & core flood deactivation to maintain PORV operability.

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DUKE POWER

April 23, 1992

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

Subject: Oconee Nuclear Station
Docket Nos. 50-269, -270, -287
Inspection Report 50-269, -270, -287/92-08
Reply to Notice of Violation

Dear Sir:

By letter dated March 25, 1992, the NRC issued Inspection Report No. 50-269/92-08, 50-270/92-08, and 50-287/92-08 with a Notice of Violation. Pursuant to the provision of 10 CFR 2.201, I am submitting a written response to the violations identified in the above Inspection Report.

Very truly yours,

for Joe M. Davis
J. W. Hampton

cc: Mr. S. D. Ebneter, Regional Administrator
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IE01
1/1

Violation 92-08-01, Severity Level IV

Oconee Technical Specification (TS) 6.4.1 requires that the station be operated and maintained in accordance with approved procedures.

Procedure OP/2/A/1104/49, Low Temperature Overpressure Protection (LTOP), requires the High Pressure Injection (HPI) trains to be deactivated when LTOP is required.

Work Request 91083607-01 required that the turbine test be performed on Unit 2 using procedure IP/0/A/280/12A, Turbine and Auxiliaries Turbine Generator Trip.

Contrary to the above, these requirements were not met in that:

(1) On February 26, 1992, when the LTOP was required, the HPI system was not deactivated as required by OP/2/A/1104/49.

(2) On February 27, 1992, Instrument and Electrical (I&E) personnel performed a surveillance test on Unit 3 instead of Unit 2 as required by Work Request 91083607-01 causing a reactor trip on Unit 3.

RESPONSE TO EXAMPLE A:

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

   LTOP requirements call for either the HPI pumps to be deactivated, or the HPI system isolated from the RCS with deactivated valves. Pre-startup testing requirements call for either the pumps to be placed in service, or the valves to be energized at various times when LTOP requirements are in effect.

   As part of the Controlling Procedure for Unit Startup, LTOP requirements are to be reviewed, per OP/2/A/1104/49, prior to placing the HPI system in service. A Limit and Precaution in the Controlling Procedure for Unit Startup explicitly states the LTOP requirements must be reviewed by the Control Room Supervisor. Instead of reviewing the LTOP procedures personally, the Control Room Supervisor delegated the responsibility of reviewing the LTOP procedure to a Reactor Operator prior to giving authorization for energizing and starting the HPI pumps.

   The Reactor Operator reviewed the LTOP requirements as part of the Controlling Procedure for Unit Startup, but did not determine that energizing the HPI pumps would violate LTOP requirements, even though the procedure specifically stated that LTOP requirements were being maintained by deactivation of the HPI pumps.

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

Immediate corrective actions: The on-coming crew identified the violation as a part of performing a detailed walkdown of the control boards immediately following turnover. Valves 2HP-26 and 2HP-27 breakers were opened and safety tagged and valves 2HP-409 and 2HP-410 handwheels were safety tagged closed following discovery of the breach of LTOP requirements. This was accomplished within 2 hours, 55 minutes of the violation occurrence.

The approval level for determining that a non-conditional procedure step is not applicable to the task being performed was raised to the Shift Supervisor or Unit Manager level for the duration of the Unit 2 outage. A review of a large number of procedures used during the Unit 2 outage was done to evaluate the use of marking steps not applicable. The results of this review are being evaluated by the Superintendent of Operations and the Station Manager to determine the appropriate approval level that should be required for marking a non-conditional step as not applicable.

Operations Management emphasized proper use of procedures and stronger supervisor involvement with all the Operations Shift Supervisors. No additional examples of failure to follow procedures were noted during the remainder of the Unit 2 startup. No other LTOP issues or errors were noted during the Unit 2 refueling outage.

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

a) An analysis will be performed to determine the benefits of developing a computer logic display related to shutdown activities including LTOP requirements.

b) A change to Technical Specifications will be proposed to clarify the role of HPI and Core Flood deactivation in maintaining Pressurizer Power Operated Relief Valve operability with respect to LTOP requirements.

c) An Individual Personnel Performance Improvement Plan will be implemented to address the identified supervisory deficiency.

d) Procedure OP/1,2,3/A/1104/09, Low Temperature Overpressure Protection, will be revised to clarify administrative rules.

4. The date when full compliance will be achieved:

   a) The analysis will be performed by December 31, 1992.

   b) The Technical Specification change will be submitted by July 1, 1992.

   c) The Individual Personnel Performance Improvement Plan will be implemented by October 1, 1992.

   d) The Operating Procedure will be revised prior to the Unit 3 End Of Cycle 13 refueling outage, currently scheduled to begin July 15, 1992.

RESPONSE TO EXAMPLE B:

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

   The technicians involved failed to identify the correct unit prior to placing the jumper. The Unit 3 equipment is in very close proximity to some Unit 2 equipment which the technicians had been working on earlier in the shift. Rather than performing proper independent verification, one technician followed the lead of the other one to Unit 3's stator cooling panel. Once they were there, they did not identify the unit or question which unit they were on. This violates established work practices and policies.

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

   Following the reactor trip, Operators took appropriate actions per the Emergency Operating Procedure to bring the unit to stable conditions.

   The actions of the two I&E technicians involved have been addressed concerning their inappropriate actions in this event in accordance with Duke Power's corrective discipline policy.

   The Station Manager met with I&E staff and technicians in a specially called meeting to discuss and emphasize the importance of utilizing the correct techniques in performing component identification and independent verification. The expectation of physically touching the label on the component prior to commencing work was communicated.

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

   a) All employees that utilize independent verification and/or component identification in their work will receive in-depth training on the revised directive on independent verification/component identification.

   b) Operations group will initiate a complete review of the station labeling program described in Station Directive 3.1.6. Work groups that utilize the labeling program will work with Operations to review, redefine and implement the program.

   c) More information will be included in IP/0/B/0280/12A, Turbine and Auxiliaries Turbine-Generator Trips, data sheets to aid the I&E technician in component identification in the performance of this procedure.

4. The date when full compliance will be achieved:

   a) Training on independent verification/component identification will be completed by July 31, 1992.

   b) The station labeling program will be reviewed, redefined and have changes implemented by July 1, 1993.

   c) The Instrumentation Procedure will be revised by July 15, 1992.