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SUBJECT: Responds to NRC 951003 ltr re violation noted in insp repts O
50-269/9518, 50-270/95-18 & 50-287/95-18 on 950730-0909.
Corrective actions:discussed configuration control in 950914 R
operations shift managers meeting.

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DUKE POWER

November 2, 1995

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

Subject: Oconee Nuclear Site
Reply to Notice of Violation
Inspection Report Nos.50-269/95-18,
50-270/95-18, and 50-287/95-18

Gentlemen:

By letter dated October 3, 1995, the NRC transmitted a Notice of Violation related to an NRC inspection conducted from July 30 - September 9, 1995. The violation involves multiple examples of failure to maintain configuration control. 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.

Oconee management agrees with the assessment in inspection report 50-269,270,287/95-18 that the multiple examples of failure to maintain configuration control are indicative of a programmatic weakness. Our corrective action program identified an adverse trend in configuration control in late July. On August 1, 1995, Problem Investigation Process (PIP) report O-95-1002 was initiated. A team was formed to investigate the adverse trend and the resultant corrective actions from this investigation are summarized in the attached reply to this violation.

Configuration control is considered a top site issue by the Oconee management team. In addition to the corrective actions described in our violation reply, the importance of configuration control will also be stressed to nonassigned individuals who perform work at Oconee Nuclear Site. The management team will monitor implementation of these corrective actions to ensure configuration control weaknesses are eliminated.

JKO
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Document Control Desk

November 2, 1995

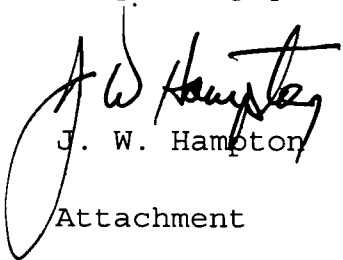
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Inspection report 50-269,270,287/95-18 also summarized recent delays in implementing a modification at Keowee Hydro Station that led to a request for a Notice of Enforcement Discretion. The inspection report states that an incident investigation team was chartered, but that the investigation was not completed at the end of the inspection period.

The root cause and corrective actions determined by this investigation team were discussed at an NRC management meeting on September 14, 1995. We believe that the actions taken as a result of this experience will prevent recurrence of similar delays which could challenge LCO action times. Site personnel will continue to keep the resident inspectors apprised of progress on this modification.

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

Very truly yours,



J. W. Hampton

Attachment

cc: Mr. S. D. Ebnetter, 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)
Violation 50-269, 270, 287/95-18-01

Restatement of Violation

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

Oconee Nuclear Site Directive 1.3.2, Activities Affecting Station Operation, states that all personnel performing functions which may affect unit or station operation, or control room indications shall notify the control room operator before initiating such action. When it is desired to remove an instrument or component from service or return it to service, permission must be obtained from the Unit Supervisor prior to removing the instrument or component from service or returning it to service.

Oconee Nuclear Site Directive 500.4, Safety Tags-Red Safety Tags, requires that the work group supervisor/designee verify the correct device is or has been positioned or operated by ensuring the equipment entry on the tag and the equipment identification label match. Implicit in this requirement is control over the equipment/device to which the tag is attached.

Contrary to the above:

1. On June 25, 1995, the feeder breaker for Unit 2 Low Pressure Injection Valve 2LP-2 was inadvertently opened during testing of 3LP-2 and was reclosed without notifying the control room operator.
2. On June 20, 1995, Low Pressure Service Water valves 3LPSW-337 and 3LPSW-342 were found in the open position despite attached red safety tags which indicated the required position for the valves was closed.
3. On June 21, 1995, Unit 3 feedwater valves 3FDW-141, 142, 143, and 144 were removed from the system with the red safety tags attached.

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Reply to Notice of Violation (Reply)
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4. On July 16, 1995, the 3B2 Reactor Coolant Pump lower bearing oil cooler Low Pressure Service Water inlet and outlet valves (3LPSW-106 and 3LPSW-236) were found to be throttled instead of in the full open position as required by Operating Procedure OP/3/A/1104/10, Low Pressure Service Water.
5. On August 1, 1995, Red Safety Tag (OPS-95-2209-4) was hung on "Feeder Bkr for MCC X0D3-1" and should have been on "X0D3 Alt Incoming FDR Bkr."
6. On August 30, 1995, NRC inspectors observed the position of Keowee sliding link R95 to be closed while the attached configuration control tag indicated the link should be open. Licensee personnel subsequently opened the link in the belief that the tag was correct; however, the required position of link R95 was closed per controlling Procedure TN/5/A/2966/BL1/02.

Reply to Notice of Violation 95-18-01 (Configuration Control)

1. The reason for the violation:

Duke Power Company acknowledges this violation. NRC Violation 95-18-01 addresses six examples of inadequate configuration control. Two additional examples of inadequate configuration control were discussed at the exit meeting for NRC inspection report 50-269,270,287/95-20. Duke Power Company believes that all eight examples are indicative of a programmatic weakness in the configuration control area. Thus, although not specifically listed in Violation 95-18-01, the root cause and corrective actions described below also apply to the two configuration control examples discussed at the exit meeting for inspection report 50-269,270,287/95-20. The root cause and corrective actions associated with this Reply focus on the programmatic aspects of configuration control and not the specific examples that were cited.

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Reply to Notice of Violation (Reply)
Violation 50-269, 270, 287/95-18-01

Oconee site management recognized that there was an adverse trend in configuration control prior to the Notice of Violation. Problem Investigation Process (PIP) report O-95-1002 identified the adverse trend on August 1, 1995, and a detailed root cause analysis was initiated as a result of this PIP. Additional examples of lack of configuration control, beyond the eight examples listed in the inspection reports, were included in the analysis. A common cause analysis was performed and interviews with approximately 60 personnel were conducted. Although the interviews were primarily with Operations personnel, a representative sampling of personnel from other station organizations was included. The analysis was based on FPI methodology which is geared toward human performance observations. The data was analyzed using organizational, program, stream analysis, and human error coding to determine the root cause.

The root cause of the configuration control incidents is a lack of personal accountability. Duke Power Company believes inadequate communication within the organization contributed to the lack of personal accountability. To be held accountable for an expectation, that expectation must be clearly communicated, taught, and reinforced on a continual basis. The three key root cause failure modes were shortcuts evoked, habit intrusion, and unawareness. These three failure modes are indicative of poor individual work habits that result from expectations not being known and reinforced by supervision.

2. The corrective steps that have been taken and the results achieved:
 - a. On August 29, 1995, the adverse trend in configuration control was communicated to all Operations Shift Managers. This communication included a brief description of PIPs associated with configuration control events. The adverse trend was subsequently emphasized to shift personnel.

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- b. Configuration control was discussed in the September 14, 1995, Operations Shift Managers' meeting. This discussion reinforced Operations Shift Managers' awareness of the adverse trend in configuration control. The adverse trend was again emphasized to shift personnel.
- c. On October 1, 1995, the Site VP communicated that all affected supervisors are expected to perform field surveillances to reinforce proper human performance practices. The expectations for performing field observations will be included in the new site directive described in Section 3 of this Reply. Although the site directive has not been implemented, supervisors have been performing field observations since early October.
- d. The importance of proper configuration control was stressed in an October 25, 1995, pre-outage meeting for the Unit 1 refueling outage starting November 2, 1995. This meeting was for station supervisors and managers.
- e. In accordance with the company Duke Power Corrective Action Management Procedure, appropriate employee disciplinary action was taken.
- f. PIP O-95-0640 was written May 28, 1995, by Chemistry to address the negative trend of mispositioned components in Chemistry. The corrective action taken was to increase management involvement in the observation of chemistry technicians operating equipment. An outside assessment of chemistry work practices was requested and completed by the General Office Operational Assessment section. Additional training on proper work practices, including the proper placement of safety tags, has been completed. This training has been added to the Chemistry Continuing Training course.

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- g. On September 5, 1995, Maintenance supervisors and managers met with Maintenance employees to reemphasize and clarify management expectations on tagging, use of controlled drawings, procedure use and adherence, STAR and other work practices. Maintenance personnel are receiving additional training on STAR, Repeatbacks and Touch the Label. The expectations communicated in the September 5, 1995 meeting and the training on STAR, Repeatbacks and Touch the Label have been covered with all nonassigned workers.
3. The corrective steps that will be taken to avoid further violations:
- a. A site directive will be written delineating the expectations for ongoing field surveillances by supervisors. These field surveillances will aid in improving human performance at Oconee Nuclear Site. The site directive will be written by January 1, 1996.
- b. Management's expectations concerning STAR, pre-job briefing, questioning attitude(QVV), accountabilities, supervisor field surveillances, and the red tag program will be communicated in the following meetings:
- The Superintendent of Operations (or designee) will meet with all Operations Shift Personnel.
 - The Superintendent of Maintenance (or designee) will meet with all site Maintenance Personnel.
 - The Manager of Chemistry (or designee) will meet with all site Chemistry Personnel.

These meetings will be completed by January 1, 1996.

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Violation 50-269, 270, 287/95-18-01

- c. Maintenance Directive 4.4.13, ONS I&E Configuration Control Work Practices, will be reviewed to determine if changes to the equipment out-of-normal program are required. If changes are needed, an evaluation will be performed to determine if additional training will be necessary. Changes, if required, and any necessary training will be completed by January 1, 1996.
- d. Pre-job briefing guidelines will be established in Operations. In the past, the issue of a pre-job briefing was left to the discretion of the crew/supervisor performing the job. The new pre-job briefing guidelines will ensure consistency on what should be included in a good pre-job briefing.

4.. The date when full compliance will be achieved:

Duke Power Company believes that the corrective actions described in Section 2 of this Reply assure compliance with Technical Specification 6.4.1 and Nuclear Site Directives 1.3.2 and 500.4. The corrective actions described in Section 3 of this Reply provide the foundation for further enhancements in the area of configuration control.

The PIP program is used to identify and monitor trends. Site management will use this tool to monitor the effectiveness of the corrective actions contained in this Reply.