

DGD

DUKE POWER COMPANY

P.O. BOX 33189  
CHARLOTTE, N.C. 28242

TELEPHONE  
(704) 373-4531

HAL B. TUCKER  
VICE PRESIDENT  
NUCLEAR PRODUCTION

86 AUG 20 A 9: 25

August 13, 1986

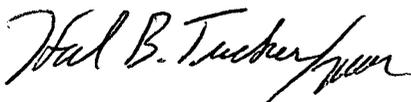
Dr. J. Nelson Grace, Regional Administrator  
U. S. Nuclear Regulatory Commission  
Region II  
101 Marietta Street, NW, Suite 2900  
Atlanta, Georgia 30323

Subject: Oconee Nuclear Station  
IE Inspection Report  
50-269, -270, -287/86-18

Dear Sir:

In response to your letter dated July 18, 1986, which transmitted the subject  
Inspection Report, the attached response to the cited items of non-compliance is  
provided.

Very truly yours,



Hal B. Tucker

PJN/02/slb

Attachment

xc: Mr. J. C. Bryant  
NRC Resident Inspector  
Oconee Nuclear Station

8609030002 860813  
PDR ADOCK 05000269  
Q PDR

IE 01 1/1

## Violation

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

Contrary to the above, on April 4, 1986, during surveillance testing on valve 1LP-21, the technician inaccurately signed the procedure step stating that acceptance criteria had been met; whereas, in fact the valve had not passed its exercise test. The valve required 16 seconds to open while the maximum stroke time allowed by the procedure is 15 seconds. The completed test was subsequently reviewed and approved. While the valve was technically inoperable during the period April 4 until it passed a surveillance test on June 4, the operability of the low pressure injection system was not in question since the valve is open for normal operation. The valve would be required to be open following engineered safety features actuation.

This is a Severity Level IV violation (Supplement I).

## Response

- 1) Admission or denial of the alleged violation:

The violation is correct as stated.

- 2) Reasons for the violation:

The violation resulted from personnel error, failure of Performance personnel to adequately follow approved procedures. Valve 1LP-21 has two acceptance criteria, one associated with stroke time degradation from the previous test and one associated with maximum stroke time. The procedure is clear on this matter, and the technician had been properly trained and understood both criteria. In this instance, 1LP-21 met one acceptance criterion but not the other. Thus, the procedure step indicating that both acceptance criteria were met was incorrectly signed.

This violation was identified by licensee personnel during procedural review in preparation for the next scheduled quarterly stroke time tests. Prior to the NRC becoming aware of this incident, it was reviewed by Performance and Compliance personnel against all reportability requirements specified in the CFR, including 10 CFR 50.72, 10 CFR 50.73, and 10 CFR 21. It was determined that no reportability requirement existed. Thus, it was not reported. Corrective actions to prevent recurrence had been initiated promptly and were in progress at the time the NRC became aware of the incident. No additional corrective measures were adopted as a result of this notice of violation. No corrective actions taken as a result of a previous violation have been identified that could reasonably be expected to have prevented this violation.

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

In order to reduce the likelihood of similar occurrences, a number of corrective steps have been completed. The technician who committed the error has been counselled. This incident has been discussed in staff and crew meetings with all Performance Section personnel. A letter discussing this incident and emphasizing the importance of giving proper attention to detail has been distributed to all Section personnel. Followup discussion also addressed the need for adequate procedural review and the fact that all personnel involved in performance and review of procedures share responsibility for their accuracy.

The results of other stroke time tests done at the time of and subsequent to the incident have been reviewed. No similar errors were identified. Procedures and training have been reviewed and determined to be adequate. No revisions to procedures or training were considered appropriate as a result of this incident. It is believed that this incident is an isolated occurrence.

- 4) The corrective steps which will be taken to avoid further violations:

No further corrective steps are planned or anticipated.

- 5) Date when full compliance will be achieved:

The valve at issue was repaired and tested immediately upon discovery by licensee personnel. Full compliance was achieved upon successful testing on June 4, 1986.