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DUKE POWER COMPANY
POWER BUILDING
422 SOUTH CHURCH STREET, CHARLOTTE, N. C. 28242

WILLIAM O. PARKER, JR.
VICE PRESIDENT
STEAM PRODUCTION

March 3, 1980

TELEPHONE: AREA 704
373-4083

Mr. James P. O'Reilly, Director
U. S. Nuclear Regulatory Commission
Region II
101 Marietta Street, Suite 3100
Atlanta, Georgia 30303

Re: RII:DRQ
50-269/79-37
50-270/79-34
50-287/79-37

Dear Sir:

With regard to Mr. R. C. Lewis' letter of February 6, 1980 which transmitted the subject inspection report, Duke Power Company does not consider the information contained therein to be proprietary.

Please find attached responses to the cited items of noncompliance.

Very truly yours,

William O. Parker, Jr.

KRW:scs
Attachment

Item

A. As required by Technical Specification 6.4.1.c, the station shall be operated and maintained in accordance with approved procedures. Written procedures with appropriate check-off lists and instructions shall be provided for actions taken to correct specific and foreseen potential malfunctions of systems or components involving nuclear safety and radiation levels, including responses to alarms, suspected primary system leaks and abnormal reactivity changes.

Contrary to the above, adequate procedures did not exist to guide the operator properly during the loss of most control board indications, which occurred on November 10, 1979, as a result of loss of the KI inverter power supply for the Integrated Control System and most control board indications. Procedures were also inadequate to guide the operator during recovery from this event in that maximum allowable Reactor Coolant System cooldown rates were exceeded.

This is an infraction.

Response

Duke Power does not consider this to be a valid citation. Technical Specification 6.4.1.c states that "written procedures . . . shall be provided for . . . actions taken to correct specific and foreseen potential malfunctions of systems or components involving nuclear safety and radiation levels, including responses to alarms, suspected primary system leaks and abnormal reactivity changes." Within the context of this statement, the "specific and foreseen potential malfunctions" were analyzed in the FSAR prior to licensing the facility, and procedures were written to cover these particular malfunctions. It is our interpretation of this specification that procedures are not required, nor can be written, for unforeseen potential malfunctions such as the event cited. Therefore, we feel that the specification was met.

As a result of the incident, several actions have been or will be taken to help prevent recurrence of or reduce the effects of a similar incident.

As immediate corrective action, all shift operating personnel were instructed on manual transfer of ICS power, and they reviewed Alarm Procedures AP/1702/23 (ICS Auto Power Failure) and AP/1702/24 (ICS Manual Power Failure).

Further corrective action included the issuance of a new Emergency Procedure EP/0/A/1800/31 (Loss of KI Bus and Control Room Indication Powered from KI). This procedure provides guidance for the operators in the event of a loss of KI bus power, including symptoms of the condition, immediate action to be taken, and action to be taken when ICS power is restored. The following Alarm Procedures were revised to reflect the addition of a redundant ICS automatic transfer switch: AP/3/1713/19 (ICS Inverter Output Voltage Low); AP/3/1702/47 (Emergency Feedwater Power Failure); AP/3/1703/25 (ICS Emergency Power Failure); AP/3/1703/23 (ICS Automatic Power Failure); and AP/3/1702/24 (ICS Manual Power Failure). The last two procedures listed were also revised to list equipment failures and failure modes upon loss of ICS power. The same changes will be made to the Unit 1 and 2 procedures when the redundant ICS automatic transfer switches are installed on these units. Finally, all operators have reviewed the loss of ICS power incident.

Item

B. As required by Technical Specification 3.1.2.1, Oconee Unit 3 Reactor Coolant System cooldown rates shall be limited in accordance with Figure 3.1.2-2.c. This figure specifies that, the maximum cooldown rate between 532°F and 432°F will be less than or equal to 100°F per hour.

Contrary to the above, during recovery from the transient event on November 10, 1979, the Unit 3 Reactor Coolant System was cooled down approximately 140°F, within thirty minutes, from an indicated 560°F to an indicated 420°F.

This is an infraction.

Response

Corrective actions taken for this item are the same as for Item A. An overall evaluation of the excessive cooldown presently indicates that the cooldown was not as severe as the one which occurred at Rancho Seco plant on March 20, 1978. Steam generator tube to shell temperature differences and tube weld stresses during the cooldown are being compared to those that occurred at Rancho Seco. This comparison is expected to show that the structural integrity of the steam generator was not affected.

Deviation

Item 6 of IE Bulletin 79-05B, dated April 21, 1979, required that you review your prompt reporting procedures for NRC notification to assure that NRC is notified within one hour of the time the reactor is not in a controlled or expected condition of operation. Further, at that time an open continuous communication channel shall be established and maintained with NRC.

Your response to IE Bulletin 79-05B indicated that the following actions were taken to assure compliance with the Bulletin requirements:

> The Oconee Nuclear Station Emergency Plan (Station Directive 3.8.5) includes prompt reporting procedures for NRC notification of serious events. The section of the Emergency Plan pertaining to reports and notifications has been revised to include the following statement under those events requiring immediate notification of the Nuclear Regulatory Commission, Office of Inspection and Enforcement, Region II:
>
> > "Any situation whereby the reactor is not in a controlled or expected condition of operation. A situation such as this could be defined as any unscheduled event involving the reactor which cannot be controlled or stabilized by use of normal operating procedures.
> >
> > NOTE: In a situation whereby the reactor is not in a controlled or expected condition, the NRC shall be notified no later than one (1) hour following determination of the uncontrolled or unexpected condition. Upon notification, an open, continuous communications channel shall be established and maintained from the station to the NRC."

Item B Continued

To provide additional assurance that the NRC is promptly notified, Station Directive 3.1.5 (Notification of Station Management) has been revised to include the following event which will require prompt notification of the Station Manager:

> Unscheduled event involving the reactor which cannot be controlled or stabilized by use of normal operating procedures.

Contrary to the above, at 3:15 p.m. on November 10, 1979, Oconee Unit 3 experienced a transient during which the loss of the KI Inverter resulted in the unit being in an unexpected condition of operation, and the NRC was not notified until approximately 8:30 p.m. on the same date.

This is a Deviation.

Response

The deviation cited is not considered to be valid or justified. The Station Directives noted in the deviation limit reportability to "any unscheduled event involving the reactor which cannot be controlled or stabilized by use of normal operating procedures." The transient and loss of ICS power were controlled by use of existing operating procedures; therefore, notification of the NRC within one hour was not required.

Several operator actions significantly contributed to the control and safety of the unit. HPI was initiated early, during the ICS power loss, so that reactor coolant system pressure was recovered and maintained. The Power Operated Relief Valve was not opened during the overheating transient. Although RC system cooldown limits were exceeded, at least 79^{o}F subcooling margin was maintained. No Engineered Safety features actuation setpoints were reached and, except for the ICS inverter failure, there were no component malfunctions. Operator action through existing procedures kept the unit in a controlled condition of operation.