

DUKE POWER COMPANY

POWER BUILDING

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USNRC REGION II  
ATLANTA, GEORGIA

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WILLIAM O. PARKER, JR.  
VICE PRESIDENT  
STEAM PRODUCTION

TELEPHONE: AREA 704  
373-4083

August 7, 1981

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

Subject: McGuire Nuclear Station  
Docket Nos. 50-369

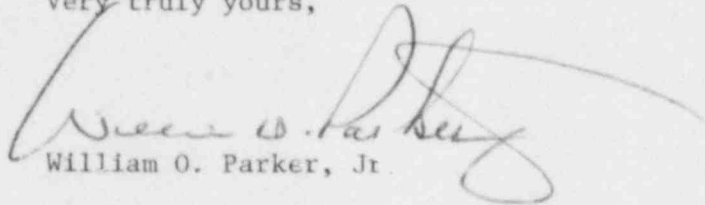
Re: RII: MJG  
50-369/81-15

Dear Mr. O'Reilly:

Please find attached a response to violations 50-369/81-15-01, 50-369/81-15-02, and 50-369/81-15-03 which were identified in the above referenced inspection report. Duke Power Company does not consider any information contained in this report to be proprietary.

I declare under penalty of perjury that the statements set forth herein are true and correct to the best of my knowledge.

Very truly yours,



William O. Parker, Jr.

PBN/nsp

Attachment

McGUIRE 1 JCLEAR STATION  
RESPONSE TO IE INSPECTION REPORT 50-369/81-15

Violation: 50-369/81-15-01, Severity Level V:

10 CFR 50, Appendix B, Criterion V, as implemented by Duke Power Company Topical Report, Quality Assurance Program, part 17.2.5 requires that activities affecting quality shall be prescribed by written approved procedures and that the procedures shall be followed. Technical Specification 3.0.4 requires that entry into an Operational Mode or other specified condition shall not be made unless the conditions of the limiting conditions for Operations are met without reliance or provisions contained in the Action Statements. McGuire Nuclear Station Directive 3.1.4, Conduct of Operations, requires in part that "The Shift Supervisor... must be cognizant of all operational conditions affecting the safety of the plant...(and)... of all maintenance activities affecting plant operation being performed while he is on duty".

Contrary to technical specification requirement 3.0.4, on May 8, 1981, while the plant was in an Action Statement due to an inoperable decay heat removal train, the reactor vessel head was torqued down thus changing plant status from Mode 6 to Mode 5. Contrary to Station Directives 3.1.4, the shift supervisor and control room staff for more than three hours were unaware that maintenance activities in progress had taken the plant from Mode 6 to Mode 5.

Response:

1. On May 8, 1981, the reactor vessel head was torqued down changing plant status from Mode 6 to Mode 5. At this time, the plant was in an Action Statement due to an inoperable decay heat removal train.
2. Operations personnel were not fully aware that the head tensioning was complete and did not take the steps necessary to prevent entering Mode 5 without having both decay heat removal trains operable. In addition, there were no procedures indicating which prerequisites must be met prior to entering Mode 5.
3. An operating procedure has been written to verify that prerequisites are met prior to entering Mode 5 from Mode 6.

The Maintenance Procedure "Reactor Vessel Head Removal and Replacement", has been revised to require a sign-off by the shift supervisor prior to tensioning or detensioning the head.

4. A start-up procedure which outlines the steps necessary to take the plant from a cold shut down (Mode 5) to 15% full power (Mode 1) had been written prior to the incident.
5. The station is presently in full compliance.

Violation: 50-369/81-15-02, Severity Level V:

10 CFR 50, Appendix B, Criterion V, as implemented by Duke Power Company Topical Report, Quality Assurance Program, 17.2.5 requires that adequate written, approved procedures be established, implemented and maintained concerning activities pertaining to safety-related equipment.

Contrary to the above requirements, on March 30 and April 29, 1981, licensee personnel did not employ a procedure during maintenance and operation of a solid state protection system. This resulted in three inadvertent safety injection initiations. Also, a review of the applicable procedures, IP/O/A/3010/07 and AP/1/A/5500/35 do not appear to provide adequate information to preclude the occurrences had they been used.

Response:

1. On March 30 and April 29, 1981, three inadvertent safety injections were caused by station personnel failing to use a procedure during maintenance and operation of the solid state protection system (SSPS).
2. During maintenance of the SSPS certain safety injection permissive blocks were cleared from the Train A SSPS logic. When the system was returned to service without the signals blocked a safety injection was initiated. Personnel should have verified that the blocks were properly inserted before the cabinets were returned to service.
3. Station management met with the individuals involved stressing the severity of the incidents and the absolute necessity of following procedures.

To prevent a re-occurrence of this type of incident all procedures governing work (either testing or maintenance on the SSPS) were revised to include specific steps detailing the proper method of returning the system to service. Each of the steps include a sign off for the technician. The steps concerning the permissive block insertions includes a sign off for the control operator as well as the technician.

Additionally the Operation procedure, ECCS Actuation during plant shutdown, was modified to include inserting the permissive blocks as a part of the recovery process.

4. All planned corrective actions have been implemented.
5. The station is presently in full compliance.

Violation: 50-369/81-15-03, Severity Level V:

Technical Specification 6.8.1 requires that written procedures be established, implemented and maintained for safety-related activities, including administrative control of safety-related equipment.

Contrary to the above, on April 24, 1981, the waste monitor tank discharge flow monitor required by Technical Specifications 3.3.3.8 was removed from service for calibration without executing procedure OP/O/B/6200/44. Radwaste Chemistry Procedure for Component Removal from and Restoration to Service. Procedure OP/O/A/6100/09, Removal and Restoration of Station Equipment was inadequately implemented in that the flow monitor was incorrectly identified as not safety-related, therefore the portions of the procedure for safety-related equipment were not implemented, and the subsystem was not removed from service. As a result, a discharge from the waste monitor tank was initiated without the knowledge that the system was operable only with compliance with the Action Statement.

## Response:

1. On April 24, 1981, the waste monitor tank discharge flow monitor required by Technical Specification 3.3.3.8 was removed from service for calibration without executing procedure 02/0/B/6200/44, Radwaste Chemistry Procedure for Component Removal from and Restoration to Service. As a result, a discharge from the waste monitor tank was initiated without the knowledge that the system was operable only with compliance with the Action statement.

Contrary to statements in the Notice of Violation, this flow monitor, while Technical Specification related, is not a safety related piece of equipment.

2. On January 21, 1981, a work request was written to implement a modification requiring the installation of a Foxboro 557 square root extractor to the transmitters of the flow rate measurement device on each waste monitor tank ("A" and "B"). The flow gauges and the chart recorder were to be changed from logarithmic to linear scales. This work was in progress prior to the date of the occurrence but it did not hamper the operability of the liquid waste disposal system.

The planning section issued preventive maintenance work requests to perform the regularly scheduled preventative maintenance/periodic testing (PM/PT) on both loops. They failed, however, to stipulate that clearance to begin the work was to be given only by a member of the Radwaste Chemistry group. This requirement was supposed to be incorporated into all preventive maintenance work requests involving radwaste systems.

The supervisor responsible for performing this work, identified this problem and notified the radwaste supervisor. It was agreed to perform the two PM/PT's following completion of the modification work request.

Two technicians reporting to work on the evening shift of April 24, 1981, found the two work requests laying on their supervisor's desk and decided to perform these PM/PT's. They received clearance to begin the work from the Shift supervisor on duty. They disconnected the flow transmitter for the waste monitor tank (WMT)-B pump discharge flow but were unable to complete the calibration because of the modification work in progress. They left the work area, but failed to reconnect the flow transmitter. Meanwhile, radwaste chemistry, unaware of the aforementioned work by the technicians, was making preparations to discharge WMT-B by radwaste procedure 0P/0/B/6200/35, Revision 1.

By procedure, the Health Physics technician monitored the liquid waste chart recorder; the radwaste technician operated the throttle valves; and the Nuclear Equipment Operator (NEO) started the pump. After the discharge was initiated, the Health Physics technician informed the NEO that the chart recorder indicated no flow. The operator immediately started back tracking the flow signal. He checked the flow gauge at the panel to insure it was not isolated, and then went to the flow transmitter root valves and found them open. Next, he traced the impulse lines to the flow transmitter and discovered that the valves at the equalization block were closed. On further investigation he determined that the transmitter was isolated and being worked on. The release was terminated and it was calculated that approximately 270 gallons of water had been discharged.

3. The Radwaste Chemistry Procedure for discharge from the waste monitor tank has been revised to include verification of the operability of flow instrumentation required by Technical Specifications. In addition, all preventive maintenance work requests involving radwaste systems have been changed to

require that clearance to begin work be given only by a member of the Radwaste Chemistry group.

4. Procedures governing the discharge of waste to the environment from all systems have been modified to include verification of the operability of flow instrumentation required by Technical Specifications.
5. The station is presently in full compliance.