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DUKE POWER

January 13, 1994

U. S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, D.C. 20555

Subject: McGuire Nuclear Station, Units 1 and 2
Docket Nos. 50-369 and 50-370
NRC Inspection Report No. 50-369, 370/93-24
Violation 50-369/93-24-01
Reply to a Notice of Violation

Gentlemen:

Enclosed is the response to the Notice of Violation issued December 16, 1993 concerning an inadequate examination of a Steam Generator tube plug weld.

Should there be any questions concerning this response, contact Randy Cross at (704) 875-4179.

Very Truly Yours,

T. C. McMeekin

Attachment

xc: (w/attachment)

Mr. S. D. Ebneter
Regional Administrator, Region II
U.S. Nuclear Regulatory Commission
101 Marietta St., NW, Suite 2900
Atlanta, Georgia 30323

Mr. George Maxwell
NRC Senior Resident Inspector
McGuire Nuclear Station

Mr. Victor Nerses
U.S. Nuclear Regulatory Commission
Office of Nuclear Reactor Regulation
One White Flint North, Mail Stop 9H3
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McGuire Nuclear Station
Reply to a Notice of Violation

Violation 369/93-24-01

10 CFR 50 Appendix B, Criterion X, Inspection requires in part that a program for inspection of activities affecting quality be established and executed by or for the organization performing the activity to verify conformance with the documented instructions, procedures, and drawings for accomplishing the activity. Examination, measurements, or tests of material or products processed are required to be performed for each work operation where necessary to ensure quality.

Contrary to the above on September 9, 1993 the remote visual Quality Assurance examination performed on the weld of tube plug 39-72 in the Unit 1 "A" steam generator was inadequate in that the weld was defective but was not detected. The defective weld led to a primary to secondary leak that was identified following the unit start up on October 5, 1993, forcing the unit to shut down.

This is a Severity Level IV (Supplement 1) violation.

Reply to Violation 369/93-24-01

1. Reason for the Violation:

   Lack of experience of the welding inspector utilizing a camera for remote inspection. The inspector failed to take into consideration the magnification of the camera (6X) and the total area of interest.

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

   1. Reviewed the video of the welded plug with the inspector involved to determine what his inspection covered initially. The inspector had not taken into consideration the total area of interest (camera's magnification 6X).

   2. The Welding Inspection Supervisor and General Supervisor for QA reviewed the video independently of each other and identified the same area needing more clarification. Reviewed the video with another welding inspector and he pointed out the area in question needing more clarification.

   3. The General Supervisor, QA met with welding inspectors to stress attention to detail when performing video remote inspection.

   4. Supervision will provide more risk assessment and management oversight for medium to high risk jobs in the future.

   As a result of the above corrective steps taken the welding inspectors and supervisors have an enhanced awareness of the need for attention to detail.

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

   1. A Quality Improvement Team (QIT) is being assembled for the purpose of addressing S/G tube welded plug inspection. This team will address quality, training and procedural issues that may have contributed to the failure of the tapered welded plug. Direct vs remote inspection quality techniques will also be reviewed to identify potential misunderstanding/training problems that may exist in the welding inspection discipline.

4. Date when full compliance will be achieved:

   The QIT investigation shall be completed by April 1, 1994 and approved recommendations implemented prior to 1EOC9 presently scheduled to begin September 1994.