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August 5, 1982

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

Re: Oconee Nuclear Station
IE Inspection Report
50-269/82-23
50-270/82-23
50-287/82-23

Dear Sir:

With regard to Mr. R. C. Lewis's letter of July 12, 1982 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.

I declare under penalty of perjury that the statements set forth herein are true and correct to the best of my knowledge, executed on August 5, 1982.

Very truly yours,

Hal B. Tucker

H. B. Tucker, Vice President
Nuclear Production Department

JFN/php
Attachment

Violation A

Technical Specification 6.4.1 requires the station be operated in accordance with approved procedures for the normal startup of the complete facility and of all systems involving nuclear safety of the facility.

Contrary to the above, on May 19, 1982, the licensee failed to reset the main turbine trip contact buffers as required by setp 3.2.112 of facility start-up procedure OP/2/A/1102/01 resulting in a reactor trip.

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

Response

1) Admission or denial of the alleged violation:

This violation is correct as stated.

2) Reasons for the violation:

This violation was the result of personnel error. The procedures being used by Operations (OP/2/A/1102/01, Unit Start-up, and OP/2/A/1106/01, Turbine Generator) required the turbine to be tripped several times and reset. Although the operators reset the turbine trip buffers following the first and second overspeed trip tests, they neglected to reset the buffers after the last test.

3) Corrective actions taken and results:

All Operations personnel involved in the incident have been counseled. The Unit Start-up procedure has been revised to require a verification of trip buffer reset after testing but prior to reaching 20% full power.

4) Corrective actions to be taken to avoid further violations:

This incident will be reviewed by all Control and Assistant Control Operators.

5) Date when full compliance will be achieved:

The review noted in (4) will be completed by August 31, 1982.

Violation B

10 CFR 50, Appendix B Criterion XVI as implemented by Duke Power Company Topical Report Duke-1A, Section 17.2.16 requires the licensee to report and document conditions adverse to quality to appropriate levels of management.

Contrary to the above, on February 23, 1982 an operator neither reported nor documented that reactor building spray pump 1A had been run for approximately three hours with no flow which resulted in the destruction of the pump.

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

Response

1) Admission or denial of the alleged violation:

This violation is correct as stated. This incident was reported to NRC as RO-269/82-05 dated April 1, 1982.

2) Reasons for the violation:

This violation resulted from personnel error. A Control Room operator discovered that he had run the "1A" Reactor Building Spray Pump for several hours with the valve on the suction line closed. After stopping the pump, he opened the valve and restarted the pump several times. Due to the apparent normal restart and indication of normal starting current, the operator erroneously concluded that the pump was undamaged. He failed to notify his supervisor or document that the pump was run for several hours with the suction valve closed.

3) Corrective actions taken and results:

The surveillance test subsequent to this incident revealed the inability of the "1A" RB Spray Pump to meet its flow requirements. This was due to the damage incurred during the cited incident. The inoperable pump was replaced, tested, and that train declared operable.

The Control Room operator responsible for this incident was counseled and made aware of the results of his actions. He was also counseled as to the importance of keeping the Unit Supervisor informed of any problems involving his unit.

4) Corrective actions to be taken to avoid further violations:

No further corrective actions are considered necessary.

5) Date when full compliance will be achieved:

All corrective actions have been completed.

Violation C

Technical Specification 6.4 requires written procedures with appropriate instructions to be provided for corrective maintenance which could affect safety.

Contrary to the above, Technical Specification 6.4 was not met in that on April 15, 1982, corrective maintenance was performed on safety-related valve 2HP-14 using a maintenance procedure that did not contain the appropriate instructions necessary to correctly reassemble the valve.

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

Response

1) Admission or denial of the alleged violation:

Although the cited procedure, like any other, could be improved, it is felt that the procedure was adequate to properly perform the job. There was a personnel error on the part of the Maintenance personnel performing the job. This is discussed below. Testing after maintenance showed that the valve was not properly assembled. This was prior to any safety related need for the valve.

2) Reasons for the violation:

Performance of maintenance which could affect safety at Oconee has always depended both on procedures with adequate instructions and on the skill of the personnel implementing the procedure, based on training and experience. Procedures are designed to be detailed enough for qualified personnel to correctly perform the work.

In the cited incident, the maintenance procedure did not contain a caution or instructions to prevent misorienting the valve during reassembly. However, good working practices expected of a maintenance technician qualified to repair this valve have always included "match-marking" the components before disassembly to assure proper reassembly. This was not done by the maintenance technician involved.

3) Corrective actions taken and results:

When Valve 2HP-14 was found to be misoriented, it was cut out and properly reinstalled. The procedure involved was revised to include instructions to prevent misorientation during reassembly. The maintenance technician involved was counseled.

4) Corrective actions to be taken to avoid further violations:

No further corrective action is considered necessary.

5) Date when full compliance will be achieved:

All corrective actions have been completed.