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DUKE POWER

December 21, 1990

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

Subject: Catawba Nuclear Station, Units 1 and 2
Docket Nos. 50-413 and 50-414
NRC Inspection Report No. 50-413, 414/90-29
Violation 413/90-29-02
Reply to a Notice of Violation

Gentlemen:

Enclosed is the response to the Notice of Violation issued November 21, 1990 by Alan R. Herdt concerning failure to follow an operating procedure which resulted in valve misalignment and the spray down of the 1A ND pump room.

Very truly yours,

A handwritten signature in cursive script, appearing to read 'M. S. Tuckman'.

M. S. Tuckman, Vice President
Nuclear Operations

WRC/220/lcs

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

Mr. W. T. Orders
NRC Resident Inspector
Catawba Nuclear Station

TEO
1/1

Duke Power Company
Reply To A Notice Of Violation
413/90-29-02

Technical Specification 6.8.1 requires that written procedures be established, implemented, and maintained covering the activities referenced in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978 which includes surveillance testing.

Procedure PT/1/A/4200/53A, 1FW-28 Partial Stroke Test, Enclosure 13.2, step 8.0, requires that valve 1ND-7, the 1A Residual Heat Removal (ND) pump suction line drain valve, be closed and locked prior to opening 1FW-27A, the ND Pump suction valve from the Refueling Water Storage Tank in Step 11.0.

Contrary to the above, on October 18, 1990, a Non-Licensed Operator (NLO) failed to follow procedural requirements in that he signed-off Step 8.0 of PT/1/A/4200/53A indicating that valve 1ND-7 had been closed and locked when in fact the valve was locked open. Subsequently, the Control Room Operator performed Step 11.0 of the procedure which opened 1FW-27A, creating a direct flowpath from the Refueling Water Storage Tank, through an open vent valve downstream of 1ND-7, resulting in the spraydown of the ND pump room.

RESPONSE:

1. Admission or Denial of Violation

Duke Power admits the violation.

2. Reasons for Violation if Admitted

The incident is attributed to Inappropriate action.

The operator in question signed off the valve as being in the closed position. The operator became confused in dealing with the reach rod resulting in the valve actually being left open.

3. Corrective Actions Taken to Avoid Further Violations And Results Achieved

The operator involved in this event has been counseled on the importance of determining valve position and the need to notify supervision when questions arise. This was considered an isolated case.

A letter was written by Maintenance Engineering Services (MES) on 11/14/90 requesting Radiation Protection, Chemistry and Operations to provide contacts to help establish an appropriate Preventive Maintenance (PM) program for the reach rods.

4. Corrective Actions to be Taken To Avoid Further Violations

Maintenance Engineering Services will evaluate the reliability of valve reach rods and the need for a Preventive Maintenance program for reach rods and improve general reliability, (no PM is currently performed). This evaluation will be complete by 3/1/91.

5. Date of Full Compliance

Duke Power is now in full compliance.