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DUKE POWER

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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, 414/90-30
Violations 413, 414/90-30-01 and 414/90-30-03
Reply to a Notice of Violation

Gentlemen:

Enclosed is the response to the Notice of Violation issued December 21, 1990 by Alan R. Herdt concerning failure to follow procedures and failure to perform required post maintenance testing.

Very truly yours,

M. S. Tuckman

M. S. Tuckman, Vice President
Nuclear Operations

WRC/220/lcs

xc: Mr. Stewart D. Ebneter
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U. S. Nuclear Regulatory Commission
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NRC Resident Inspector
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DUKE POWER COMPANY
REPLY TO NOTICE OF VIOLATION
413, 414/90-30-01

Technical Specification 6.8.1 requires that written procedures shall be established, implemented, and maintained covering the activities referenced in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978. Implicit in this is the stipulation that the procedures be adequate for the task being performed.

Station Directive 2.12.7, Section 4.3, requires that any group/section (person) responsible for degrading any fire barrier, including fire doors, is responsible for ensuring that a fire watch is provided until the barrier is returned to service.

Operations Management Procedure 2-17, Control Room and Unit Supervisor Logbooks, requires in Section 7.0, General Instructions, that sufficient logbook entries shall be made to permit the reconstruction of the sequence of events during a shift. Further, section 10.0, Unit Supervisor Logbook Entries, requires that entries in the unit supervisor's logbook shall provide a detailed chronological work description of problems identified during the shift and corrective action initiated.

Station Directive 2.8.1, Problem Investigation Process and Regulatory Reporting, section 4.0, requires that any employee who has knowledge of a problem that meets the criteria of Enclosure 3 of the same directive, is responsible to inform his supervisor or responsible technical contact to initiate an investigation. Section 5.1 of the directive requires that a identified problem that meets the criteria in Enclosure 3 shall be documented as soon as practical and delivered promptly to the Compliance Section, thus initiating the investigation process.

Procedure OP/2/A/6250/06, Main Steam, Enclosure 4.3, requires that valve 2SV-66, the Steam Generator Power Operated Relief Valve (PORV) Line Drain, be closed, and its associated pipe cap installed when the system is aligned for plant operation.

Contrary to the above:

A. On November 30, 1990, maintenance personnel degraded fire barrier TS27#1, the fire door to Unit 1 Auxiliary Feedwater Turbine Pump (CAPT) control panel room, but failed to follow Station Directive 2.12.7, in that the personnel blocked the door open and departed the area without establishing a fire watch.

B. On November 30, 1990, the Unit 1 operations supervisor was informed that fire door TS27#1 had been degraded and a fire watch had not been posted. Subsequently, when the Control Room and Unit Supervisor Logbooks were reviewed, it was detected that the licensee had failed to document the event/problem.

C. On November 30, 1990, an event occurred involving the licensee's failure to post a fire watch for a degraded fire barrier. A Problem Investigation Report (PIR) was required to have been initiated as soon

as practical after detection of the problem, but the licensee failed to initiate the Report until December 5, 1990, after conversations between the licensee and the resident inspectors concluded that a PIR was appropriate.

D. On November 14, 1990, during a stroke test on the 2B Steam Generator PORV 2SV-13, the licensee failed to follow OP/2/A/6250/06, in that 2SV-66 was found open and its pipe cap had not been installed. This resulted in an inadvertent steam release during the performance of the stroke test.

RESPONSE:

1. Reasons for Violation if Admitted

Item A. Personnel error was the cause of the violation of Station Directive 2.12.7, Fire Detection and Protection, in that Mechanical Maintenance (M/M) personnel failed to implement fire watch requirements as required by Section 4.3 of Station Directive 2.12.7.

Item B. and Item C. The operator failed to log the event in the Unit Supervisor Logbook and follow through with the formal PIR process. The operations supervisor discussed this incident with the crew involved in opening the door and considered that to be sufficient.

Item D. The operator failed to review the tagout when identifying tags to be lifted for testing of the PORV. Contributing to this was an inadequate procedure in that the tag removal procedure did not provide a checklist of other means to aid in lifting tags for testing.

2. Corrective Actions Taken and Results Achieved

Item A. Problem Investigation Report (PIR) 1-C90-0355 was originated to address the root cause of this incident.

Involved personnel were counseled as to the severity of this incident.

Appropriate disciplinary action has been administered in accordance with the Duke Power Policy Manual.

Station Directive 2.12.7 was reviewed by Mechanical Maintenance Management to ensure proper guidance and instruction was provided to personnel. The review concluded that sufficient detail and instruction had been provided to meet Technical Specification 6.8.1 requirements when administered to M/M personnel.

Item B. The logging of this event is not considered necessary. The increased attention to the PIR process will ensure proper follow-up actions when an event occurs.

Item C. The Operations philosophy on generation of PIRs was initially discussed with all shifts at the Shift Supervisors meeting on December 7, 1990. Operations Management determined that we need to increase our sensitivity to initiating PIRs. If there is any doubt on the need for a PIR, then write one.

A representative from the Compliance group attended the Shift Supervisors meeting of 1-4-91. The PIR threshold was discussed by all present. It was re-emphasized that PIRs would be generated, as required, based upon the initiating criteria in S.D. 2.8.1.

Item D. The test was secured and 2SV-66 was closed. The policy of lifting tags for testing was temporarily suspended until a tag lifted for testing checklist is developed; which is to provide increased controls over the process of lifting tags for testing.

3. Corrective Actions to be Taken to Avoid Further Violations

Item A. The involved personnel will cover the details of this incident with all M/M crews at their weekly safety meetings. This will allow the significance and impact of this violation to be communicated and heighten awareness to detail to all personnel in M/M. This communication will be documented on a weekly safety meeting sheet and will be completed by 3/1/91.

Item B. and Item C. Actions taken in Section 2 above ensure avoidance of further violations.

Item D. "A Tags Lifted for Testing checklist" is to be developed by 4/1/91 for inclusion in the OMP 2-18, Tagout Removal and Restoration (R&R) Procedure.

4. Date of Full Compliance

Duke Power is now in full compliance.

DUKE POWER COMPANY
REPLY TO NOTICE OF VIOLATION
414/90-30-03

10 CFR 50, Appendix B, Criterion XI requires in part that a test program be established to assure that all testing required to demonstrate that structures, systems, and components will perform satisfactorily inservice is identified and performed in accordance with written test procedures.

Contrary to the above, on September 21, 1990, required stroke-time and leak rate tests were not performed on containment isolation valve VP 17A after the valve had been cycled during maintenance. This resulted in the licensee's failure to detect that the valve had not closed properly when cycled, which in turn rendered the valve inoperable. The Unit was operated from September 25, until November 7 in Modes 1-4 during which time the valve was required to be operable.

RESPONSE:

1. Reasons for Violation if Admitted

   The required leak rate test was not performed due to the lack of adequate administrative controls to ensure that testing is conducted following any cycling of the Containment Purge Ventilation (VP) system isolation valves.

   The maintenance work and the subsequent valve cycling was correctly determined to require no stroke-time retest. An optical isolator which provides Operator Aid Computer (OAC) indication of valve position was replaced under the original repair work request. As required by the Post Maintenance Retest program a functional was completed which verified correct OAC valve position indication after the isolator was replaced. Isolator replacement does not require a stroke-time test since it in no way affects the stroke time of the valve. The functional that was performed required a leak rate test but again this activity did not require a stroke-time test since it also did not affect the stroke time of the valve.

2. Corrective Actions Taken and Results Achieved

   a. SWR50325 was issued on 11/7/90 to repair valve 2VP17A following failure of the semi-annual surveillance. The leakage was repaired and the valve was successfully tested on 11/8/90.

   b. The Catawba Nuclear Station Post Maintenance Retest Manual was revised 11/30/90 and approved 12/3/90 for all 18/unit VP system containment isolation valves to specify that a leak rate test is required following any valve cycling, including functionals.

3. Corrective Actions to be Taken to Avoid Further Violations

a. The test procedure for leak rate testing the VP system containment isolation valves will be revised by June 1, 1991 to specify that if VP penetrations are to be leak rate tested due to VP System operation then all nine penetrations must be tested. If all nine penetrations had been tested on 9/25/90 following the Unit 2 forced outage, the failure of valve 2VP 17A to fully close would have been detected.

b. The Operations procedure for VP System operation will be revised by June 1, 1991 to require notification of Performance when the VP system is shutdown for the last time prior to the unit entering mode 4. This change will provide added assurance that the VP system containment isolation valves are leak tested following valve cycling due to system operation prior to entering modes requiring containment integrity.

4. Date of Full Compliance

Duke Power Company is now in full compliance.