NOTATION VOTE

RESPONSE SHEET

TO: SAMUEL J. CHILK, SECRETARY OF THE COMMISSION

FROM: COMMISSIONER REMICK

SUBJECT: SECY-92-346 - ADDITIONAL MODIFICATIONS TO A CHANGE TO THE GENERAL STATEMENT OF POLICY AND PROCEDURE FOR NRC ENFORCEMENT ACTIONS, 10 CFR PART 2, APPENDIX C

APPROVED X DISAPPROVED ____ ABSTAIN ____

NOT PARTICIPATING ____ REQUEST DISCUSSION ____

COMMENTS:

SIGNATURE

RELEASE VOTE ☐

19 Oct 92
DATE

WITHHOLD VOTE ☐

ENTERED ON "AS" YES ✓ NO ____

9/26

NOTATION VOTE

RESPONSE SHEET

TO: SAMUEL J. CHILK, SECRETARY OF THE COMMISSION

FROM: COMMISSIONER DE PLANQUE

SUBJECT: SECY-92-346 - ADDITIONAL MODIFICATIONS TO A CHANGE TO THE GENERAL STATEMENT OF POLICY AND PROCEDURE FOR NRC ENFORCEMENT ACTIONS, 10 CFR PART 2, APPENDIX C

APPROVED X DISAPPROVED ____ ABSTAIN ____

NOT PARTICIPATING ____ REQUEST DISCUSSION ____

COMMENTS:

E. Gail de Planque
SIGNATURE

RELEASE VOTE /XX/

October 30, 1992
DATE

WITHHOLD VOTE / /

ENTERED ON "AS" YES XX NO ___

9212170335 1p

9/21

NOTATION VOTE

RESPONSE SHEET

TO: SAMUEL J. CHILK, SECRETARY OF THE COMMISSION

FROM: THE CHAIRMAN

SUBJECT: SECY-92-346 - ADDITIONAL MODIFICATIONS TO A CHANGE TO THE GENERAL STATEMENT OF POLICY AND PROCEDURE FOR NRC ENFORCEMENT ACTIONS, 10 CFR PART 2, APPENDIX C

APPROVED X DISAPPROVED ____ ABSTAIN ____

NOT PARTICIPATING ____ REQUEST DISCUSSION ____

COMMENTS:

SIGNATURE

RELEASE VOTE /X/

November 5, 1992
DATE

WITHHOLD VOTE / /

ENTERED ON "AS" YES ✓ NO ___

~~9212170248~~ ID

[DOCUMENT 6 - RELEASE] 1/28

JAN 19 1993

JAN 28 1993

Closeout ltr attached 1/29 93

Docket Nos. 50-413 and 50-414
License Nos. NPF-35 and NPF-52

Duke Power Company
ATTN: Mr. M. S. Tuckman
Vice President
Catawba Site
P. O. Box 1439
York, SC 29745-9635

SUBJECT: TEMPORARY WAIVER OF COMPLIANCE FOR CATAWBA UNITS 1 AND 2 DOCKET NOS. 50-413 AND 50-414

This letter acknowledges your letter dated January 15, 1993, requesting a Temporary Waiver of Compliance (TWOC) from Technical Specification (TS) 3.7.6(a), Control Room Area Ventilation System. The TS requires two independent Control Room Area Ventilation Systems to be OPERABLE at all times.

The Control Room Area Ventilation and Air Conditioning Systems (VC/YC) are designed to maintain the environment in the control room, control room area and switchgear rooms within acceptable limits for the operation of unit controls, for required maintenance and testing of the controls, and for uninterrupted safe occupancy of the control room during post-accident shutdown. The control room and other support areas are designed to be maintained at approximately 74 degrees F and 50 percent relative humidity. The maximum control room temperature permitted by TS 4.5.6(a) is 90 degrees F. Continuous pressurization of the control room area is required to prevent entry of dust, smoke, and radioactive particulate and gaseous matter originating outside the pressurized zones.

The Control Room Area Ventilation Systems are provided with two 100 percent capacity trains which are shared between Units 1 and 2. If one train fails, indication is provided in the control room and the operators can manually switchover to the redundant train.

The TS 3.7.6(a) ACTION statement for MODES 1 through 4 requires that with one VC/YC System inoperable for reasons other than the filter train heaters, the inoperable system must be restored to OPERABLE status within 7 days or be in at least HOT STANDBY within the next 6 hours and in COLD SHUTDOWN within the following 30 hours.

On January 11, 1993, during a swapover from Train A to Train B of the VC/YC Systems, the Train B chiller would not start. Troubleshooting efforts identified a ground fault in the Train B chiller compressor motor. This compressor motor housing functions as the chiller pressure boundary and the motor is located internal to the housing. Major disassembly was required to accomplish the repair effort. Given the magnitude of the repair process and the post-maintenance testing required prior to returning the chiller to service, the possibility existed that the repairs and testing would not be completed within the 7 days allowed by TS 3.7.6(a).

1/29

9303020232 SPP

You requested a temporary waiver from TS 3.7.6(a) to permit Units 1 and 2 to remain at 100 percent power until the Train B chiller could be repaired, tested and returned to service. Specifically, you requested a 3 day extension to the 7 days allowed by TS 3.7.6(a). This extension would extend through January 21, 1993, until 1:30 a.m., and would allow sufficient time to repair the Train B VC/YC Chiller and complete the necessary post-maintenance testing.

Region II granted this TWOC from the TS requirements and permitted Units 1 and 2 to continue to operate at full power until the Train B VC/YC Chiller was repaired and restored to operable status.

Prior to granting the TWOC, the technical issues and the extent of the proposed waiver were reviewed. They were discussed during a telephone conference on January 14, 1993, between A. R. Herdt, G. A. Belisle, G. A. Harris and J. Zeiler of Region II; D. B. Matthews, L. A. Wiens, R. E. Martin and W. T. Lefave, Office of Nuclear Reactor Regulation (NRR); and W. R. McCollum, T. P. Harrall and others of your staff. Specifically, as described in your request, the items discussed included the requirements for which the waiver was requested, the circumstances and need for prompt action, compensatory actions implemented, evaluation of the safety significance and potential consequences, justification for the duration of the request, and the basis for your conclusion that a significant hazard was not involved.

It was our understanding that the existing chiller motor would be replaced with a new motor and sufficient testing performed following installation to verify operability of the B Train VC/YC System. The A Train VC/YC System would be maintained fully operable. The failure of the A Train would result in both Catawba units entering TS 3.0.3 which requires both units to be shutdown and brought to COLD SHUTDOWN. To mitigate the effects of the loss of both trains of VC/YC, the following measures, as determined by the Shift Supervisor, would be implemented: opening control room instrument cabinet doors to provide increased air flow; utilizing temporary fans to cool interior of cabinets; maintaining control room doors in the open position with temporary fans in place to utilize computer area ventilation/chilled water system for control room cooling; deenergizing filter heaters in the VC/YC filter trains; and utilizing portable coolers for control room cooling.

As agreed upon, in addition to maintaining the A Train VC/YC System operable and initiating preparations to have the specified temporary equipment readily available, your compensatory actions included the following: Diesel Generators 1A and 2A would not be removed from service for preplanned maintenance; monitoring of A Train VC/YC by operations staff would be increased; and detailed discussions would be given to all on-coming new shift personnel to explain the circumstances regarding VC/YC operation and the compensatory measures required if A Train became inoperable.

The NRC granted this TWOC for three days (72 hours) on January 15, 1993. The NRC was subsequently informed that the B Train VC/YC Chiller had been repaired and the Control Room Area Ventilation System restored to the requirements of TS 3.7.6 prior to the expiration of the original time specified in TS ACTION

STATEMENT, i.e., 7 days. Unit 1 and Unit 2 are now in full compliance with the TS. Since full compliance was attained within the time limitations imposed by the original TS, the provisions of the TWOC did not have to be implemented.

Sincerely,

Orig. signed by Stewart Ebneter

Stewart D. Ebneter
Regional Administrator

cc: R. C. Futrell
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RII	RII	RII	RII	NRR	RII
WMiller	GBelisle	AHerdt	JJohnson	GLainas	GJenkins
1/14/93	1/14/93	1/19/93	1/19/93	1/14/93	1/19/93

RII	RII
CEvans	LReyes
1/19/93	1/19/93

FEB 23 1993

Docket Nos. 50-413 and 50-414
License Nos. NPF-35 and NPF-52

Duke Power Company
ATTN: Mr. M. S. Tuckman
Vice President, Catawba Site
4800 Concord Road
York, SC 29745

Gentlemen:

SUBJECT: NRC INSPECTION REPORT NOS. 50-413/93-03 AND 50-414/93-03

This refers to the inspection conducted by Mr. William Orders of this office on January 10, 1993 - February 6, 1993. The inspection included a review of activities authorized for your Catawba facility. At the conclusion of the inspection, the findings were discussed with those members of your staff identified in the enclosed report.

Areas examined during the inspection are identified in the report. Within these areas, the inspection consisted of selective examinations of procedures and representative records, interviews with personnel, and observation of activities in progress.

Within the scope of the inspection, no violations or deviations were identified.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosures will be placed in the NRC Public Document Room.

Should you have any questions concerning this letter, please contact us.

Sincerely,
ORIGINAL SIGNED BY
ALAN R. HERDT
Alan R. Herdt, Chief
Reactor Projects Branch 3
Division of Reactor Projects

Enclosures:
NRC Inspection Report

cc w/encl:
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Compliance
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cc w/encl: Continued see page 2

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County Manager of York County
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RII
WMiller
02/22/93

UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
101 MARIETTA STREET, N.W.
ATLANTA, GEORGIA 30323

Report Nos.: 50-413/93-03 and 50-414/93-03

Licensee: Duke Power Company
422 South Church Street
Charlotte, N.C. 28242

Docket Nos.: 50-413 and 50-414 License Nos.: NPF-35 and NPF-52

Facility Name: Catawba Nuclear Station Units 1 and 2

Inspection Conducted: January 10, 1993 - February 6, 1993

Inspector: W. H. Miller, Jr. 2/22/93
FOR W. T. Orders, Senior Resident Inspector Date Signed

Inspector: W. H. Miller, Jr. 2/22/93
FOR P. C. Hopkins, Resident Inspector Date Signed

Inspector: W. H. Miller, Jr. 2/22/93
FOR J. Zeiler, Resident Inspector Date Signed

Inspector: W. H. Miller, Jr. 2/22/93
W. H. Miller, Jr., Project Engineer Date Signed

Approved by: Alan R. Herdt 2/23/93
A. R. Herdt, Branch Chief Date Signed
Reactor Projects Branch 3
Division of Reactor Projects

SUMMARY

Scope: This routine, resident inspection included but was not limited to, evaluations of plant operations; temporary waiver of compliance; control room annunciator improvements; Residual Heat Removal System Train A transient event; Control rod wear measurement inaccuracies; surveillance testing; maintenance activities; licensee event reports; and follow-up of previously identified items.

Results: No violations on deviations were identified.

One Unresolved Item was identified involving a water hammer induced reactor coolant leak event that occurred while placing the Unit 2 Residual Heat Removal System in service (paragraph 6).

In the area of maintenance, a strength was identified involving the repair of Train B Control Room Ventilation and Chill Water System (VC/YC) chiller compressor motor (paragraph 9.b).

REPORT DETAILS

1. Persons Contacted

Licensee Employees

S. Bradshaw, Shift Operations Manager
*J. Cox, Acting Regulatory Compliance Manager
*T. Crawford, Systems Engineering Manager
J. Forbes, Engineering Manager
*R. Futrell, Regulatory Compliance Manager
*T. Harrall, Safety Assurance Manager
*J. Lowery, Compliance
W. McCollum, Station Manager
W. Miller, Operations Superintendent
M. Tuckman, Catawba Site Vice-President

Other licensee employees contacted included technicians, operators, mechanics, security force members, and office personnel.

NRC Resident Inspectors

W. Orders
*P. Hopkins
*J. Zeiler

* Attended exit interview.

2. Plant Status

Unit 1 Summary

Unit 1 operated at essentially 100% power for the entire report period with no major problems.

Unit 2 Summary

Unit 2 began the report period at 100 percent power. On January 29, the licensee began reducing power on the unit for a scheduled refueling outage. The unit was taken off line later that evening. Hot standby (Mode 3) was achieved on the morning of January 30, hot shutdown (Mode 4) that evening and cold shutdown (Mode 5) the following evening. The report period ended with the unit in Mode 5.

3. Plant Operations Review (71707)

The inspectors reviewed plant operations throughout the report period to verify conformance with regulatory requirements, and administrative controls. Control Room logs, the Technical Specification (TS) Action Item Log, and the Removal and Restoration (R&R) log were routinely reviewed. Shift turnovers were observed to verify that they were conducted in accordance with approved procedures. The complement of licensed personnel

on each shift inspected, met or exceeded the requirements of Technical Specifications. Further, daily plant status meetings were routinely attended.

Plant tours were performed on a routine basis. The areas toured included but were not limited to the following:

Turbine Buildings
Auxiliary Building
Units 1 and 2 Diesel Generator Rooms
Units 1 and 2 Vital Switchgear Rooms
Units 1 and 2 Vital Battery Rooms
Standby Shutdown Facility

During the plant tours, the inspectors verified by observation and interviews that measures taken to assure physical protection of the facility met current requirements. Areas inspected included the security organization, the establishment and maintenance of gates, doors, and isolation zones in the proper conditions, and that access control badging were proper and procedures followed.

In addition, the areas toured were observed for fire prevention and protection activities and radiological control practices. The inspectors also reviewed Problem Investigation Reports (PIRs) to determine if the licensee was appropriately documenting problems and implementing corrective actions.

No violations or deviations were identified.

4. Temporary Waiver of Compliance (71707)

At 1:30 a.m., on January 11, Train B of the Control Room Area Ventilation and Chilled Water System (VC/YC) was declared inoperable after the chiller failed to start. TS 3.7.6 requires that an inoperable VC/YC Train be returned to service within 7 days or both units must be shutdown. Troubleshooting efforts identified a ground fault in the Train B chiller compressor motor. The compressor motor housing functions as the chiller pressure boundary and the motor is located internal to the housing. Major disassembly was required to accomplish the repair effort.

Due to the magnitude of the repair process and the post-maintenance testing required to return the chiller to service, the licensee was uncertain if VC/YC Train B could be returned to service within the 7 day action statement which was due to expire at 1:30 a.m., on January 18.

On January 14, a conference call was held between the licensee, NRC Region II, and NRR to discuss the problem and the potential need for a Temporary Waiver of Compliance to extend the action statement to allow sufficient time to complete the necessary repairs. The waiver was submitted to the NRC on the morning of January 15 and was approved that afternoon. The

waiver allowed an extension of the 7 day action statement to 10 days. The licensee also established compensatory actions to mitigate the effects of a failure of VC/YC Train A during this period.

VC/YC Train B was returned to service at 12:01 a.m. on January 18, prior to the expiration of the original time specified in the TS Action Statement. Since full compliance was attained within the time limitations imposed by the original TS, the provisions of the waiver were not implemented. VC/YC Train A remained operable during the entire period.

No violations or deviations were identified.

5. Control Room Annunciator Status Improvements (71707)

In December 1992, licensee management renewed their efforts toward a goal of achieving a "dark board" Control Room Annunciator status. Significant resources were expended to repair equipment and modify annunciator logic to reduce the number of illuminated and intermittently illuminated annunciators. In order to track their progress, the status of outstanding annunciators was presented to management on a weekly basis. By the end of the report period, a significant reduction in the number of nuisance annunciators was obtained on both units. Although less progress was attained on Unit 2, the licensee plans to make the necessary equipment repairs and/or annunciator modifications on the remaining items during the current refueling outage in order to startup with as few outstanding items as possible. The status of these items are being tracked on the outage schedule to ensure that they receive greater attention.

No violations or deviations were identified.

6. Residual Heat Removal System Train 2A Transient Event (71707)

On January 31, Unit 2 was in Mode 4 with the Reactor Coolant (NC) System at 375 psig and 340°F in day 2 of a planned 65 day refueling outage. Operations personnel were preparing to establish Residual Heat Removal (ND) cooling using ND Train A. Prior to placing the train in service, Boron concentration in the ND piping had to be increased to match NC concentration. Therefore, between 4:19 a.m. and 5:00 a.m., ND Boron concentration was increased by operating the ND pump in miniflow recirculation while letting down to the Chemical and Volume Control System through the ND train piping.

Subsequent to the boron mixing evolution, between 5:40 a.m. and 6:07 a.m., valves 2ND-1B and 2ND-2A, the ND suction valves from NC, were stroked as part of testing to verify that the valves would close automatically upon receipt of a high NC pressure signal.

At 6:44 a.m., ND Pump 2A was restarted in miniflow recirculation. Shortly after starting the pump, operations personnel noticed an unexpected increase in the Pressurizer Relief Tank (PRT) level and a decrease in pressurizer level. Believing that the ND suction relief valve, 2ND-3, had lifted, ND Pump 2A was shutdown and valves 2ND-1B and 2ND-2A were closed,

isolating ND from the NC System. Pressurizer and PRT levels stabilized at this time, indicating that the leakage had stopped.

At 7:12 a.m., operations personnel re-opened the NC Loop suction isolation valves in an attempt to determine if 2ND-3 had reseated. Coincident with opening the valves, a momentary alarm was received which indicated that one or more of the ice condenser doors had opened. The operators also noted that pressurizer level had decreased slightly, and containment pressure and Containment Floor and Equipment Sump level had increased. At 7:18 a.m., the NC Loop suction isolation valves were closed and pressurizer level stabilized indicating that leakage had stopped.

Operations personnel stated that the system parameters observed when the valves were re-opened were unexpected, in that PRT level had remained steady but pressurizer level had decreased. Based on this unexpected response, operations personnel decided to re-open the isolation valves once more to assess the situation. At 7:39 a.m. valves 2ND-1B and 2ND-2A were again re-opened and the same system responses were noted as during the prior opening of the valves. At this time, it was concluded that system integrity had been breached downstream of the isolation valves. At 7:44 a.m., the valves were closed and plant conditions stabilized once again.

The licensee subsequently discovered that a pipe break had occurred in a 3/4 inch line located directly upstream of valve 2ND-5. This is a 3/4 inch vent valve off the ND suction line. ND Train 2A was declared inoperable and an investigation of the event was initiated.

Preliminary licensee analysis of the event determined that a water hammer in the ND Train A suction piping had caused the ND suction relief valve to lift and had also resulted in the failure of the ND vent valve piping. The water hammer was reported to have been induced by isolating hot NC water in the ND suction piping after the ND pump was operated with letdown established at 4:19 a.m. ND System pressure then decayed to saturation pressure due to a small leak in the system. This resulted in the formation of voids in the ND suction piping. The subsequent re-pressurization of the suction piping just prior to starting the ND pump at 6:44 a.m. resulted in the first water hammer. Transient data indicates that water hammers also occurred when the valves were opened the second and third times.

Preliminary metallurgical analysis of the piping failure indicated that fatigue failure may have occurred. There was also evidence of pre-existing cracks in the vent piping. A detailed metallurgical evaluation was being performed at the end of this inspection period. The results of the evaluation will be summarized in a subsequent report.

Much of the data required to evaluate this event was not available by the end of this report period. However, based on a preliminary review, the inspectors have concerns regarding the operator's compliance with procedures that were in effect at the time of the event, and operator actions taken in response to the incident. Until this review can be

completed, this issue will be carried as an Unresolved Item (URI). This item is documented as URI 414/93-03-01: Review ND Train 2A Water Hammer Event.

One URI was identified. No violations or deviations were identified.

7. Control Rod Wear Measurement Inaccuracies (71707)

On October 21, 1992, the licensee discovered that the ultrasonic test (UT) method used by Babcock & Wilcox (B&W) to quantify wear of control rod fingers at Catawba was not as accurate as previously assumed. As a result of this finding, the structural integrity of the control rods had to be reassessed. The inspectors were concerned about the possibility that the contractor had performed this service for other utilities, and were interested in the generic implication and the safety significance of the finding.

In discussions with the licensee's engineering staff, the inspectors determined that the licensee and the contractor had performed a detailed evaluation to determine the true accuracy of the test method. The evaluation is documented in B&W calculations 32-1212251-00 and 32-1212865 and is based on tests performed in the contractor's shop and a demonstration performed at the McGuire Nuclear Station.

After re-evaluating the methodology, the licensee considers its use acceptable. All previous control rod wear data was reassessed using more conservative criteria which indicated that the data remained valid. The inspectors also determined that B&W had performed similar control rod evaluations at Seabrook Nuclear Station, and that a similar re-analysis was performed which confirmed that their test data also remained valid. The inspectors were informed that no other United States facility was affected.

No violations or deviations were identified.

8. Surveillance Observation (61726)

a. General

During the inspection period, the inspectors verified plant operations were in compliance with various TS requirements. Typical of these requirements were confirmation of compliance with the TS for reactivity control systems, reactor coolant systems, safety injection systems, emergency safeguards systems, emergency power systems, containment, and other important plant support systems. The inspectors verified that: surveillance testing was performed in accordance with approved written procedures, test instrumentation was calibrated, limiting conditions for operation were met, appropriate removal and restoration of the affected equipment was accomplished, test results met acceptance criteria and were reviewed

by personnel other than the individual directing the test, and any deficiencies identified during the testing were properly reviewed and resolved by appropriate management personnel.

b. Surveillance Activities Reviewed

The inspectors witnessed or reviewed the following surveillances:

PT/1/A/4250/02C	Turbine Control Valve Movement Test
PT/1/A/4250/03C	Turbine Driven Auxiliary Feedwater Pump No. 1 Performance Test
PT/1/A/4250/06	Turbine Driven Auxiliary Feedwater Pump Head and Valve Verification
IP/1/A/3145/01B	Containment Pressure Control System Train B Operability Test
PT/2/A/4200/08F	Auxiliary Feedwater Pump Suction Valve Partial Stroke Valve Test

No violations or deviations were identified.

9. Maintenance Observations (62703)

a. General

Station maintenance activities of selected systems and components were observed/reviewed to ensure that they were conducted in accordance with the applicable requirements. The inspectors verified licensee conformance to the requirements in the following areas of inspection: activities were accomplished using approved procedures, and functional testing and/or calibrations were performed prior to returning components or systems to service; quality control records were maintained; activities performed were accomplished by qualified personnel; and materials used were properly certified. Work requests were reviewed to determine the status of outstanding jobs and to assure that priority was assigned to safety-related equipment maintenance which may affect system performance.

b. Maintenance Activities Reviewed

The inspectors witnessed or reviewed maintenance activities associated with the following maintenance Work Requests (WOs):

92085575-01	Pre-Outage Electrical Instrumentation Work to Diesel Generator 2A
92087367-01	Destrap and Clean Corrosion on Standby Shutdown Facility Battery SDB2
93002812-01	Replace Motor on Control Room Ventilation Chiller B
93006236-01	Inspect/Replace Bearings on Control Room Ventilation Chill Water Pump 1

On January 11, Train B of the VC/YC System was declared inoperable after its associated chiller failed to start. Troubleshooting efforts identified a ground fault in the chiller compressor motor requiring replacement of the motor. Since the compressor motor housing functions as the chiller pressure boundary and the motor is located internal to the housing, major disassembly was necessary to accomplish the motor replacement.

Between January 12 and 16, the inspectors reviewed the work package (WO 9300812-01) associated with the compressor motor replacement, frequently visited the job site to observe work in progress, and held discussions with the maintenance engineers and craft personnel concerning the work. The inspectors consider that this maintenance was completed in an efficient manner, and there appeared to be good cooperation between maintenance engineering, operations, and craft personnel. This activity was identified as a strength in the area of maintenance.

c. Generic Diesel Generator Staring Air Question

On January 27, 1993, the NRC issued an event follow-up report pertaining to a failure of one of the emergency diesel generators at Vogtle Nuclear Station.

The diesel is a Transamerica Delaval engine similar to those installed at Catawba. The problem was identified as a missing vent path in the starting air distributor housing. This problem could ultimately result in an engine's failure to start. On January 15, 1993, Cooper-Bessemer Inc., the current manufacturer of the engines, issued a 10 CFR, Part 21 report describing the problem and proposed corrective actions. The licensee has initiated inspections of the air start distributors but expects to find no problems based on successful surveillance data. The inspectors will continue to follow this issue until corrective actions are complete.

No violations or deviations were identified.

10. Review of Licensee Event Reports (92700)

The below listed Licensee Event Reports (LERs) were reviewed to determine report adequacy. The determination included: adequacy of description, verification of compliance with applicable regulatory requirements, corrective actions taken, existence of potential generic problems, reporting requirements satisfied, and the relative safety significance of each event.

a. (Closed) LER 413/91-01: Both Trains of Residual Heat Removal and Auxiliary Containment Spray Inoperable Due to Defective Procedures and Inappropriate Action.

This LER reported the licensee's identification that the Auxiliary Containment Spray Systems had been inoperable during performance testing activities.

The inspectors verified that the following corrective action for this item had been implemented by the licensee.

- Procedures PT/1&2/A/4200/26, NS Valve Inservice Test, Enclosures 13.9, 13.9.1, 13.10 and 13.10.1 have been revised to reschedule the stroke testing of valves 1(2) NS38B and 1(2) NS43A to be accomplished during cold shutdown.

- The Duke Power Company General Office was to provide the Catawba Station with the results of a design study of the problem identified at McGuire in which RHR valves were inoperable during stroke valve testing. This problem was resolved through the Problem Investigation Report program and a design study was not made. Therefore, this planned action is not applicable for Catawba.

- FSAR Section 6.2.2 was revised to address the periodic testing to be performed on the Containment Spray Systems.

- TS Interpretation 3.5.2 has been written to provide guidance in the containment spray operability concerns.

- Duke transmitted Nuclear Network Entry QE 4385 to advise other utilities of the concerns identified with the testing of RHR and containment spray system valves during plant operations.

b. (Closed) LER 413/91-21: Turbine/Reactor Trip Due to Installation Deficiency.

This turbine/reactor trip occurred during turbine building cleaning operations when a vendor inadvertently sprayed water into an electrical termination box. The water caused erroneous high water level signals for Moisture Separator Reheater D. This initiated a turbine trip and subsequent reactor trip. The licensee's corrective actions included the identification of all non-safety related NEMA 4 electrical termination boxes installed in the Turbine Building, and the issuance of work requests to inspect and seal each of these boxes were required. The inspection and sealing of these boxes has been assigned a "Priority 4" category and will be worked as a "filler job" until completion. Work is presently in process but a completion date has not been established. To prevent recurrence, the site cleaning contractor has written a procedure pertaining to the proper use of the pressure washer which is used for cleaning activities in the Turbine Building and other site areas. This procedure contains operational and safety measures which includes

instructions pertaining to spraying electrical cabinets, panels, motors, etc. Adherence to this procedure should prevent recurrence of this problem until the electrical boxes are properly sealed. Therefore, this LER is closed.

c. (Closed) LER 413/91-22: Technical Specification Violation As A Result of a Missed Grab Sample on Radiation Monitor EMF-36 Due to Inappropriate Action and Management Deficiency.

This LER involved the licensee's failure to collect a grab sample while Radiation Monitor EMF-36 was inoperable. The corrective actions included: communicating this incident to all appropriate Radiation Protection personnel; revisions to procedure HP/0/B/1009/11, EMF loss, to clarify the requirements for collection and analysis of EMF samples; and the training of Radiation Protection shift personnel on the proper use of this procedure. The inspector verified that the corrective actions were completed.

d. (Closed) LER 413/91-29: Technical Specification Violation from Failure to Perform Reactor Trip System Surveillance Due to Inappropriate Action.

This LER reported the licensee discovery that the surveillance requirements for the Turbine Startup Pressure Switch Alarm had not been performed on Unit 1 during the 1991 refueling outage and subsequent Turbine startups. The corrective actions on this item included a revision to procedure PT/1/A/4250/028, Weekly Main Turbine Valve Movement Test, to properly document the Turbine Emergency Trip System Response. Also, this event was discussed with the Operations Support Group. The inspector verified that the corrective action had been completed.

e. (Closed) LER 414/91-15: Technical Specification Violation Due to Lack of Boration Flow Path During Refueling Activities Due to Deficient Communication.

This LER reported the addition of water to the Refueling Water Storage Tank (FWST) from the Boric Acid Tank (BAT) which resulted in the FWST boron concentration being decreased to 1975 ppm. This concentration was less than the TS requirements of 2000 ppm. The licensee's corrective action included additional make up to the FWST until a boron concentration of 2031 ppm was achieved and discussion with Chemistry and Operations Supervisors involved in the boron addition activities to improve the communication between Chemistry and Operations concerning boron concentration requirements for the FWST. The inspector verified that the corrective action had been completed.

No violations or deviations were identified.

11. Followup on Previous Inspection Findings (92701 and 92702)

a. (Closed) Inspector Followup Item 413, 414/90-32-02: Review Licensee Resolution of EMF-34 Problems.

EMF-34, a liquid effluent monitor, was provided for the detection of activity in the water sample taken from the shell side of the steam generators. As originally designed, EMF-34 monitored the flow from all four steam generators through piping connected to the Steam Generator Blowdown System and the Nuclear Sampling System. Upon reaching the high activity setpoint, EMF-34 would activate an alarm in the Control Room and initiate a signal to close several valves to isolate the unit's steam generators from the Steam Generator Blowdown and Nuclear Sampling Systems. However, due to several operational problems, the EMF-34 System was found useless for continuous duty and was unable to meet its operability requirements.

Another radiation monitor, airborne monitor EMF-33, is provided to continuously monitor the gaseous exhaust from the condensate air ejector exhaust to the unit vent but had no control functions. The Selected Licensee Commitments (SLC) originally required EMF-34 to be operable at all times and EMF-33 to be operable in Modes 1, 2, 3 or 4.

Due to the operational problems associated with EMF-34, modification projects CN-11245 and CN-20635 were initiated which removed the control functions from EMF-34 and transferred them to EMF-33. EMF-34 has been removed from continuous on-line status and placed in a "wet lay up" configuration. If steam generator tube leak is detected and the faulted generator identified, EMF-34 can be placed on line for that generator to "trend" the tube leak.

The SLC document has been revised to remove EMF-34 from the listed required effluent monitors and transfer the EMF-34 Control requirements to EMF-33.

The licensee has completed evaluation CNC-1503.13-00-0464. This evaluation determined that there was no unreviewed safety questions associated with the modifications. The inspector reviewed the evaluation and had no further questions.

b. (Closed) Violation 413/91-11-01: Failure to Follow Procedures Resulting in Diesel Fuel Oil Spill.

The licensee responded to this violation by letter dated June 19, 1991. The corrective action taken to avoid further violations included discussions with the involved personnel concerning the need to pay attention to detail and follow procedures. This message was also communicated to all Operations shift personnel through special meetings conducted by supervision.

c. (Closed) Violation 413, 414/91-21-02: Failure to Follow Procedures or Inadequate Procedures.

The licensee responded to this violation by letters dated December 2, 1991 and January 31, 1992. The wording of Procedure OP/1/A/6400/05 has been enhanced to ensure clarity of intent. Work requests are to be completed before proceeding with work activities. Post maintenance testing required following maintenance or modification activities is to be completed prior to returning a system to service.

The plant operators have been given additional training on how to recognize and prioritize alarm response on diesel generator local alarm panels. Also, the annunciator response procedures, OP/1,2/A/6100/90A, have been enhanced to give reducing load or tripping diesel generator a higher priority in response to diesel generator overheating.

d. (Closed) Violation 413, 414/92-09-01: Failure to Follow Procedures Which Had the Potential to Result in an Overexposure of a Plant Employee.

The licensee responded to this violation by letter dated June 1, 1992. The corrective actions taken to avoid further violation included providing the Safety Group with additional training on radiation protection practices utilizing a mock-up which reflected actual plant conditions. The Catawba General Employee Training program has also been revised to cover the overexposure event and to provide additional instruction in the Catawba Frisking Policy.

No violations or deviations were identified.

12. Exit Interview

The inspection scope and findings were summarized on February 9, 1993, with those persons indicated in paragraph 1. The inspector described the areas inspected and discussed in detail the inspection findings listed below. No dissenting comments were received from the licensee. The licensee did not identify as proprietary any of the materials provided to or reviewed by the inspectors during this inspection.

Item Number	Description and Reference
URI 414/93-03-01	Review ND Train 2A Water Hammer Event (paragraph 6).

UNITED STATES
NUCLEAR REGULATORY COMMISSION
Office of Public Affairs
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FOR IMMEDIATE RELEASE
(Thursday, March 18, 1993)

NRC REVISES ENFORCEMENT POLICY

The Nuclear Regulatory is revising its Enforcement Policy to describe more fully the circumstances under which its staff may exercise its enforcement discretion in cases where a violation of a license technical specification or other license condition is involved.

On occasion, circumstances may arise where a licensee's compliance with a technical specification, limiting condition for operation or other license condition could lead to an unnecessary plant transient, or performance of testing, inspection or system realignment that is inappropriate with the specific plant conditions, or unnecessary delays in plant startup without a corresponding health and safety benefit.

In those circumstances, the NRC staff may choose not to enforce the applicable technical specification or other license condition. However, this enforcement discretion will only be exercised if the staff is clearly satisfied that the action is consistent with the public health and safety.

A licensee seeking the exercise of this enforcement discretion must provide a written justification or, in other circumstances where good cause is shown, oral justification followed as soon as possible by written justification documenting the safety basis for the request and providing whatever other information the staff deems necessary in making a decision on whether or not to exercise enforcement discretion.

A decision to exercise enforcement discretion does not change the fact that a violation will occur nor does it imply that enforcement discretion is being exercised for any violation that may have led to the violations at issue. In each case where the staff has chosen to exercise enforcement discretion, enforcement action normally will be taken for the root causes, if violations were involved.

In addition, the revisions to the Enforcement Policy make clear that actions taken by licensee employees pursuant to an

exercise of enforcement discretion by the NRC staff will not result in enforcement action against the individuals involved.

Finally, it is expected that the NRC staff will exercise enforcement discretion in this area infrequently and only if the staff is clearly satisfied that such action is warranted from a public health and safety perspective.

The revisions to Appendix C of Part 2 of the Commission's regulations became effective on March 17.

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NUCLEAR REGULATORY COMMISSION
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