

UNITED STATES NUCLEAR REGULATORY COMMISSION REGION II 101 MARIETTA STREET, N.W. ATLANTA, GEORGIA 30303

Report No.: 50-369/84-15

Licensee: Duke Power Company 422 South Church Street Charlotte, NC 28242

Docket No.: 50-369

License No.: NPF-9

Facility Name: McGuire Nuclear Station Unit 1

Enforcement Conference at the Region II Office

Approved by: A Queen H. C. Dance, Section Chief Division of Reactor Projects

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SUMMARY

An enforcement conference was held on May 9, 1984, to discuss the following items:

1. Improper restoration of safety-related equipment.

2. Failure to implement removal and restoration procedures.

3. Failure to perform local independent verification for performance of operating activities.

Details of the event are described in NRC Inspection Report 50-369/84-10.

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REPORT DETAILS

1. Personnel Attending Enforcement Conference

Duke Power Company

- H. B. Tucker, Executive Vice President, Power Operations
- G. E. Vaugh, General Manager, Nuclear Stations
- M. D. McIntosh, McGuire, Station Manager
- N. A. Rutherford, Licensing, System Engineer
- G. A. Copp, Licensing, Nuclear Engineer
- G. W. Cage, McGuire, Superintendent Operations
- B. Travis, McGuire, Operations Engineer

NRC Region II

James P. O'Reilly, Regional Administrator H. C. Dance, Chief, Reactor Projects Branch 2, Division of Reactor Projects (DRP)

- V. L. Brownlee, Chief, Reactor Projects Section, DRP
- W. T. Orders, McGuire, Senior Resident Inspector
- A. J. Ignatonis, Project Engineer, DRP
- J. M. Puckett, Director, Enforcement
- G. M. Nejfelt, Enforcement Specialist
- P. R. Farron, Inspection and Enforcement, Enforcement Staff, Bethesda
- A. F. Gibson, Chief, Operations Branch
- 2. Enforcement Conference on May 9, 1984

The NRC staff opened the discussions regarding the issues of improper restoration of safety-related equipment, failure to implement removal and restoration procedures and the failure to perform local independent verification for performance of operating activities. Duke Power Company (DPC) management provided the description of the events with associated corrective actions. The meeting summary notes are described below. The event details are discussed in NRC Inspection Report No. 50-369/84-10.

a. DPC Description of the Event

On February 13, 1984 at 10:00 a.m., the high pressure injection pump (NV Pump 1A) breaker (1ETA-10) was moved to the "Disconnect" position to obtain an oil sample for analysis under work request PMP 027391. At 12:00 noon, after the oil sample had been taken, the breaker was returned to the "Connect" position. The breaker status was independently verified in the control room via breaker status lights. From February 14-19, 1984, Nuclear Equipment Operators (NEO) verified the breaker to be in the "Connect" position during routine rounds. On February 20, 1984 at approximately 11:00 a.m., an unsuccessful attempt was made to start NV pump 1A. At approximately 11:05 a.m., a NEO found the NV pump 1A breaker racking lead screw approximately one-half turn from allowing the racking release lever (interlock) to be in the correct position to permit power connect to the breaker. NV pump 1A was started.

- b. DPC Description of the Root Causes and Contributing Factors:
 - (1) Personnel error in that the breaker was not properly racked in.
 - (2) The established program for removal and restoration of equipment (including independent verification) was not followed.
 - (3) Management controls (practice) permitted removal and restoration of safety-related equipment without the use of the removal and restoration procedure for activities completed on one shift (short time).
 - (4) Written procedures for breaker position, verification and operation were not developed.
 - (5) Different requirements exist for proper independent verification of 4160V breakers and 600V motor control center breakers. The power supply to most 600V components can be verified from the control room indication, whereas, this is not the case for the larger breakers.
- c. DPC Immediate Corrective Actions
 - (1) Require that the Removal and Restoration procedure be used when any safety-related equipment is removed from service.
 - (2) Operations Management Procedure 1-8, addressing breaker operation was written and training of personnel is presently taking place to properly train the operators.
 - (3) It was verified that no other "B" train redundant equipment was out of service during the seven-day period.
 - (4) The incident has been covered in crew meetings and other plant breakers verified properly connected.
 - (5) Station management requested a special QA audit of all station independent verification activities. This audit was performed March 12-23, 1984.
- d. DPC Subsequent Corrective Actions
 - Breaker operation is being formally taught and documented in NEO training segment 3 (beginning May 29, 1984). The training includes both classroom theory and in-plant practical training on 6900V, 4160V, and 600V breakers.

- (2) Personnel associated with this incident were appropriately disciplined for failure to adhere to established independent verification requirements.
- e. DPC Safety Analysis

DPC concluded that no potential adverse effects on public health and safety were created by this event, in that: 1) the redundant "B" pump was operating during the time of inoperability of "A" pump; 2) the "A" pump was made operable within approximately five minutes; 3) the boration function for overcooling transients could have been accomplished with upper head injection accumulator and safety injection pumps; and, 4) for Loss of Coolant Accidents and steam generator tube ruptures the peaking factors are not exceeded.

f. Summary and Comments

In summary, DPC has stated that they have evaluated the event, determined the root causes and contributing factors, determined and implemented appropriate immediate corrective and subsequent followup actions, and concluded that the event did not have a high potential for safety significance.

The NRC pointed out to the licensee that greater emphasis must be placed on procedural adherence, independent verification program adherence, and better managerial tools in maintaining good operations.