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**DUKE POWER**

July 7, 1995

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

Subject: Catawba Nuclear Station  
Dockets 50-413 and 50-414  
Reply to Notice of Violation (NOV)  
Inspection Report 50-413, 414/95-12

Attached is Duke Power Company's response to the one (1) Level IV violation cited in Inspection Report 50-413, 414/95-12, dated June 9, 1995. This violation was identified during the Resident's Monthly Inspection conducted April 9, 1995 through May 13, 1995.

In the NOV cover letter, it was indicated that the examples cited are of concern because they point to continuing human performance issues. We acknowledge this and in May, 1995, human error reduction was established as a focal point for the Catawba management team. In response to NOV 413,414/95-07, we stated that we have initiated actions to reduce human errors at Catawba. This was also the subject of meetings held with NRC Region II management at Catawba on May 17 and June 23, 1995. As we discussed at these meetings we are taking a broad approach to human error reduction and we are addressing this issue through many initiatives. To ensure that we continue to maintain this focus, we have consolidated these initiatives into the Catawba Human Error Reduction Plan. The details of this plan have been communicated to our NRC Resident Inspectors and we will continue to keep them informed of our progress.

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If there are any questions concerning this response, please contact  
Kay Nicholson at (803) 831-3237.

Sincerely,

*DL Rehn*  
D. L. Rehn *by [Signature]*

\KEN:RESP95.12

xc: S. D. Ebnetter, Regional Administrator

R. E. Martin, ONRR

R. J. Freudenberger, SRI

DUKE POWER COMPANY  
CATAWBA NUCLEAR STATION  
REPLY TO NOTICE OF VIOLATION  
413, 414/95-12-01

Notice of Violation

Technical Specification 6.8.1, Procedures and Programs, requires, in part, that written procedures be established, implemented, and maintained covering the activities referenced in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978. As referenced, this includes licensee administrative procedures controlling safety-related activities such as: equipment tagouts, personnel self-checking and verification, and procedure use and adherence.

Nuclear System Directive 500, Safety Tags/Equipment Protection Tags, Section 500.6.1, requires that operations personnel determine the appropriate sequence when placing and removing equipment protection (white) tagouts.

Operations Management Procedure 2-29, Technical Specifications Action Item Log, Section 7.0. Tech Spec Log Entries, Step 7.7 requires, in part, to verify the Technical Specification ACTION requirements are satisfied prior to removal of equipment from service.

Nuclear System Directive 704, Technician Procedure Use and Adherence, Appendix A, Management Expectations for Procedure Use and Adherence, requires that personnel shall be qualified to the procedure/task being performed or be directed by qualified personnel.

Nuclear System Directive 700, Independent Verification, describes the licensee's requirements for conducting proper self-checking techniques. Section 700.6.1, Self-Checking, requires that personnel understand specifically what is to be done prior to manipulating any equipment and to consider the expected responses associated with intended actions.

Contrary to the above requirements:

1. On April 20, 1995, operations personnel failed to adequately implement Nuclear System Directive 500 while performing Removal and Restoration White Tagout 15-1322 for realigning nuclear service water system valves to their normal position following maintenance. Specifically, adequate valve sequencing was not performed, resulting in the isolation of cooling water to the Train B Control Room Ventilation Chiller and subsequent entry into the action requirement of Technical Specification 3.0.3 due to both control room ventilation system trains being inoperable.

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2. On April 24, 1995, the requirements of Operations Management Procedure 2-29 were not met when a senior reactor operator failed to adequately verify the ACTION requirement of Technical Specification 3.6.3, Containment Isolation Valves, were satisfied. Specifically, four inside containment isolations valves (2NM-197B, 2NM-200B, 2NM-217B, and 2NM-220B) were not deactivated prior to removing the associated outside containment isolations valves from service (2NM-201A and 2NM-221A).
3. On April 27, 1995, a plant employee providing oversight for troubleshooting activities of a malfunction in the Unit 2 Train A Reactor Trip Breaker failed to follow Nuclear System Directive 704. Specifically, the individual was not qualified to the maintenance procedure/task that was being performed when he manipulated a mechanical switch inside the breaker compartment. Manipulation of the breaker switch resulted in the generation of a feedwater system isolation signal while the unit operated in Mode 3, Hot Standby.
4. On May 1, 1995, a non-licensed operator failed to adequately implement proper self-checking techniques in accordance with Nuclear System Directive 700. Specifically, while aligning the Unit 2 "F" and "G" low pressure feedwater heaters, the non-licensed operator did not adequately understand the necessary actions to accomplish the task nor adequately consider the expected responses associated with his intended actions. As a result, the operator isolated flow to the main feedwater pumps when he closed the feedwater heater bypass valve prior to opening both the feedwater heater inlet and outlet valves. This resulting in an automatic trip of both feedwater pumps and subsequent manual reactor trip from 14 percent power.

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

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RESPONSE

Example 1:

The details concerning this event were included in Licensee Event Report (LER) 413/95-001, Technical Specification 3.0.3 Entry Due to Both Trains of Control Room Ventilation Being Inoperable, submitted under our docket number 50-413 on May 22, 1995.

1. Reason for Violation

Refer to 'Conclusion' section of LER 413/95-001.

2. Corrective Actions Taken and Results Achieved

Refer to "Subsequent Corrective Action" section of LER 413/95-001.

3. Corrective Action to be Taken to Avoid Future Violations

Operations Management Procedure (OMP) 2-18, "Tagout Removal and Restoration (R&R) Procedure" will be revised by 10/22/95, to require all tagouts to receive a second review by a Senior Reactor Operator (SRO) for technical accuracy.

Corrective actions listed in this section are those which are considered regulatory commitments per our Nuclear System Directive 214, "Commitment Management Program".

4. Date of Full Compliance

Duke Power Company is now in full compliance.

DUKE POWER COMPANY  
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RESPONSE

Example 2:

The details concerning this event were included in Licensee Event Report (LER) 414/95-003, Technical Specification Violation Involving Containment Isolation Valves, submitted under our docket number 50-414 on May 24, 1995.

1. Reason for Violation

Refer to 'Conclusion' section of LER 414/95-003.

2. Corrective Actions Taken and Results Achieved

Refer to "Subsequent Corrective Action" section of LER 414/95-003.

The TSAIL program has been modified to require an independent SRO review for each entry placed into or removed from TSAIL.

3. Corrective Action to be Taken to Avoid Future Violations

OMP 2-18, "Tagout Removal and Restoration Procedure" will be revised by 10/22/95, to require all tagouts to receive a second review by a SRO for technical accuracy.

Corrective actions listed in this section are those which are considered regulatory commitments per our Nuclear System Directive 214, "Commitment Management Program".

4. Date of Full Compliance

Duke Power Company is now in full compliance.

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RESPONSE

Example 3:

The details concerning this event were included in Licensee Event Report (LER) 414/95-004, Reactor Trip Due to Component Failure and Inadvertent Feedwater Isolation, submitted under our docket number 50-414 on May 24, 1995.

1. Reason for Violation

Refer to 'Conclusion' section of LER 414/95-004.

This violation is a result of a maintenance manager, who was serving on a Failure Investigation Process (FIP) Team, acting inappropriately by exercising a reactor trip breaker cell switch without an approved plan or qualification to do so. The individual involved did not fully understand the roles and responsibilities for providing management oversight of the troubleshooting process during the FIP.

2. Corrective Actions Taken and Results Achieved

Refer to "Feedwater Isolation Subsequent Corrective Action" section of LER 414/95-004. The Maintenance Manager was counseled concerning the procedure use and adherence expectations and the roles and responsibilities of management in the FIP.

In addition, the roles and responsibilities of maintenance personnel involved in the FIP have been communicated to appropriate Maintenance personnel.

3. Corrective Action to be Taken to Avoid Future Violations

No additional corrective actions are planned.

4. Date of Full Compliance

Duke Power Company is now in full compliance.

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RESPONSE

Example 4:

The details concerning this event were included in Licensee Event Report (LER) 414/95-005, Manual Reactor Trip Due to Loss of Main Feedwater, submitted under our docket number 50-414 on May 24, 1995.

1. Reason for Violation

Refer to 'Conclusion' section of LER 414/95-005.

2. Corrective Actions Taken and Results Achieved

Refer to "Subsequent Corrective Action" section of LER 414/95-005.

This event is attributed to work practices, in that there was a performance problem with an individual non-licensed operator (NLO). As stated in the subsequent action 1 contained in the LER, appropriate corrective action was taken with the NLO involved in this event.

In addition, operating procedures for both units have been revised to include guidance to ensure that low pressure feedwater heaters "F" and "G" are placed in service at a more stable plant condition, above 40 percent power. These heaters will now remain bypassed at lower power levels, below 40 percent power.

Procedure enhancements have also been made to the annunciator response associated with "F" and "G" heater isolation to provide improved guidance for restoring feedwater alignment as appropriate for the power level at which the isolation occurs.

3. Corrective Action to be Taken to Avoid Future Violations

No additional corrective actions are planned.

4. Date of Full Compliance

Duke Power Company is now in full compliance.