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DUKE POWER

January 22, 1992

U.S. Nuclear Regulatory Commission
Attn: Document Control Desk
Washington, DC 20555

Subject: McGuire Nuclear Station
Docket Nos. 50-369, -370
Inspection Report No. 50-369, -370/91-21

Gentlemen:

Please find attached the revised response to violation 370/91-21-01 and the second example of this violation given in Inspection Report No. 50-369, -370/91-22 as requested in your letter of December 23, 1991. Corrective actions to be taken B and C have been added to the response to address planned changes to the independent verification program and generic ventilation issues.

The planned completion date for these new corrective actions is July 1, 1992.

If there are any questions, call Larry Jenka at (704)875-4032.

Very truly yours,

T. C. McMeekin

LJK/cbl

Attachment

xc: Mr. S. D. Ebneter
Administrator, Region II
U.S. Nuclear Regulatory Commission
101 Marietta ST., NW, Suite 2900
Atlanta, GA 30323

Mr. Tim Reed
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Office of Nuclear Reactor Regulation
Washington, D.C. 20555

Mr. P. K. Van Doorn
NRC Resident Inspector
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McGUIRE NUCLEAR STATION
RESPONSE TO VIOLATION

Violation 370/91-21-01

Technical Specification 6.8.1.a requires written procedures to be established, implemented, and maintained covering the applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978, which includes equipment control procedures.

Station Directive 4.2.2, Independent Verification, requires, in part, that independent verification be performed for the removal from operability and restoration to operability of all systems or components which affect the ability of a system to perform a safety related function.

Contrary to the above, on August 14, 1991, following maintenance on the Unit 2 annulus doors, independent verification was not performed on the closure of the doors, which remained in an open configuration. This configuration resulted in both trains of annulus ventilation being inoperable for approximately six hours.

This is a Severity Level IV violation (Supplement I) and applies to Unit 2 only.

Response to First Example of Violation 370/91-21-01

1. Reason for violation:

On August 14, 1991, Construction and Maintenance Department (CMD) personnel were performing a modification on the Unit 2 annulus enclosure door. This modification required Control Access Door (CAD) hardware to be removed and the door modified to extend the security boundary.

Before beginning work, a direct line of communication with the responsible Senior Reactor Operator was established. One person was posted at the door in case the Control Room called and the door had to be closed immediately. A temporary nuclear station procedure was in place to control this portion of the modification.

After work was completed on August 14, 1991, at 4:30 p.m., the craft personnel removed the fire tag from the annulus door and proceeded to the Control Room to clear the fire tag. Due to inattention to detail, the CMD craft personnel failed to close the door per Technical Specifications and

procedural requirements. Therefore the VE system was inoperable.

2. Corrective actions taken and results achieved:

The annulus door was closed.

A communication package was issued by Station Management to reemphasize the importance of attention to detail to all station personnel.

Training on the importance of attention to detail has been conducted with all Operations personnel in shift meetings.

Meetings were held with appropriate CMD employees to heighten awareness and describe various events that have occurred during the year.

3. Corrective actions to be taken to avoid further violations:

A. Operations management will incorporate Independent Verification provisions into the Fire Watch Barrier Tag Program.

B. McGuire will revise appropriate directives to be in agreement with Nuclear Generation Department Directive 3.1.1(0), Independent Verification, Revision 6 dated December 19, 1991.

C. In the above referenced revisions there will be special attention given to generic ventilation issues, such as the opening of access doors and ductwork which will require independent verification to assure system operability.

4. Date when full compliance will be achieved:

McGuire is in full compliance.

Second example of Violation 370/91-21-01

On September 21, 1991, Security notified Operations at 8:15 a.m., that a guard stationed at the lower containment access door had found the annulus access door open approximately four inches. At the time the unit was in Mode 4, in the process of shutting down for the refueling outage. Evaluation by Operations determined the door being ajar had rendered the VE system inoperable.

Response to Second Example of Violation 370/91-21-01

1. Reason for violation:

   On September 20, 1991, a security guard was posted at the path to Unit 1 Annulus Ventilation bypass door, AD3311, for security badge and access control. Door AD3311 is a Selected Licensee Commitment Fire Door. Because the door also serves as a security boundary, it sends an alarm to the Security Alarm Stations when opened. To eliminate excessive alarms due to traffic through the door, Security personnel placed the "open" alarm "in access" since the alarm was not required at that time due to the guard being stationed at the door. At 0530 on September 21, 1991, the door was opened for four janitorial contract (K-Mac) and two Radiation Protection (RP) personnel. All personnel had exited prior to 0600. Security personnel in the area after this time stated that the door appeared to be closed. There was no other personnel traffic through the door at that time. At 0810 the oncoming Security Officer noticed the door was opened approximately four inches. Further investigation showed the door had been pushed closed but not latched for prolonged periods of time from 0904 on September 20, 1991 until 0834 on September 21, 1991.

2. Corrective actions taken and results achieved:

   A. Door AD3311 was closed by the Security Officer who discovered it open.

   B. The door was taken out of the "in access" mode to enable Security personnel to monitor status of the door continuously by receiving an alarm each time the door was opened.

   C. The event was discussed with all appropriate K-Mac employees and the need to close and latch the VE system doors was emphasized.

   D. A meeting was held between Operations (OPS), Security, Project Services and MSRG personnel to discuss actions needed to prevent recurrence of similar events.

3. Corrective actions to be taken to avoid further violations:

   A. OPS management personnel will implement appropriate procedure changes to ensure that whenever the VE system doors are opened, appropriate compensatory measures are implemented and fire barrier watches are established.

B. OPS management personnel will implement appropriate training for OPS and Security personnel on the proper procedure for maintaining control of VE system doors.

C. OPS and Project Services personnel will examine signs and paint colors currently on the VE system doors and make appropriate changes to alert personnel accessing the doors of the need to close and latch them after each entry.

4. Date when full compliance will be achieved:

McGuire is in full compliance.