

Duke Power Company
McGuire Nuclear Generation Department
12700 Hagers Ferry Road (MOB1A)
Huntersville, NC 28078-8985

T. C. McMEEKIN
Vice President
(704)875-4800
(704)875-4809 Fax



DUKE POWER

March 2, 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, -370/91-31

Gentlemen:

Pursuant to 10CFR 2.201, please find attached Duke Power Company's response to Violation 369, 370/91-31-01.

Should there be any questions concerning this matter, contact Larry Kunka at (704)875-4032.

Very truly yours,


T. C. McMeekin
McGuire Nuclear Site Vice President

LJK/cbl

Attachment

cc: (w/Attachment)
Mr. S. D. Ebner
Administrator, Region II
U.S. Nuclear Regulatory Commission
1001 Marietta St., NW, Suite 2900
Atlanta, GA 30323

Mr. Tim Reed
U.S. Nuclear Regulatory Commission
Office of Nuclear Reactor Regulation
Washington, DC 20555

Mr. P. K. Van Doorn
NRC Resident Inspector
McGuire Nuclear Station

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PDR ADOCK 05000369
G PDR

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MCGUIRE NUCLEAR STATION
RESPONSE TO VIOLATION 369/370/91-31

VIOLATION 369,370/91-31-01

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 performing procedures for equipment calibration.

Technical Specification 3.6.1.8 requires that two independent annulus ventilation systems shall be operable in Modes 1 through 4.

Procedure IP/O/B/3190/26, Volumetric Leak Rate Calibration, has been performed semi-annually on each unit to verify operability of the access airlocks since initial unit startup.

Contrary to the above, procedure IP/O/B/3190/26, Volumetric Leak Rate Calibration, was inadequate in that since initial unit startup, the procedure failed to establish adequate compensatory measures to be taken during this operability test resulting in the inoperability of both trains of annulus ventilation each time the test was performed.

This is a Severity Level IV violation (Supplement 1).

RESPONSE TO VIOLATION 369,370/91-31-01

Reason for Violation

On December 18, 1991, Instrumentation and Electrical (IAE) personnel were performing the semi-annual calibration on the lower personnel airlock leak rate monitor using IP/O/B/3190/26, Volumetric Leak Rate Calibration. The IAE personnel consulted with the Senior Reactor Operator (SRO) for permission to begin work. The SRO understood the work to be performed involved the volumetric equipment inside the air locks but did not associate the work with the Annulus Ventilation (VE) system door. No note or caution was included in the procedure or the work requests about the VE system or the VE system doors. Therefore, no discussion was held concerning the VE system. After receiving permission to begin work, the IAE personnel contacted Radiation Protection and Security (SEC) personnel for support in performing the calibration.

Because of the physical proximity of the annulus ventilation bypass door, door AD3321, to the lower air lock, it was necessary to latch door AD3321 open as well as leave the air lock door open for communications between personnel performing the calibration. IAE personnel stated this was the normal way this calibration had been performed in the past and the need to contact Operations (OPS) personnel again was not recognized. When door AD3321 was opened,

alarms were received by SEC personnel in the Central and Secondary Alarm Stations. The SEC personnel stationed at the door questioned IAE personnel as to the length of time the door would be open, and if OPS was aware of the work. IAE personnel stated the door would remain open during the calibration testing and that OPS was aware of the work in progress. Later another SEC person questioned the SRO and asked if he was aware of the annulus ventilation door being kept open. The SRO replied that he was aware of the testing but was not aware that the annulus ventilation door was being kept open. OPS personnel were dispatched to the door to investigate. IAE had completed their work and the door was verified closed at that time.

Corrective Steps Taken and Results Achieved

1. SEC personnel were instructed to prohibit access to any of the VE doors without consent from the Shift Manager.
2. A meeting was held by Station Management personnel to ensure that positive control existed for the VE doors.
3. Chains and padlocks were installed on all VE doors with the keys controlled by OPS personnel.
4. Signs were installed on all VE doors to direct personnel requiring access to contact the Control Room SRO.
5. OPS personnel developed requirements to govern issuance of the keys for the VE doors.
6. SEC personnel committed to continuously monitor any unlocked VE door to ensure that the doors are kept closed except during normal access or that compensatory measures are in place.
7. SEC and OPS personnel committed to verify that the lock and chain are replaced on the door in question before the key is returned each time.
8. Planning personnel reviewed the Maintenance Management Procedure for planning of work associated with the vicinity of the VE doors to ensure that appropriate precautionary statements are placed on work requests to alert personnel of the requirements associated with the doors.

Corrective steps that will be taken to avoid further violations

1. IAE, Mechanical Maintenance and OPS personnel will review any procedures which could potentially have effect on the VE doors and add appropriate precautionary statements to alert personnel using the procedures of the requirements associated with the doors.
2. Projects Services personnel will expedite NSM MG-12400 and NSM MG-22400 to add Control Room alarms for the VE doors on Unit 1 and Unit 2 respectively.
3. Safety Review Group personnel in conjunction with McGuire Training personnel will develop an information package covering the event which will be covered with all appropriate site personnel.
4. OPS, Work Control, Radiation Protection and SEC Management will evaluate the program currently in place for control of VE doors and make appropriate changes as required.

Date when full compliance is achieved

McGuire is in full compliance.