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DUKE POWER

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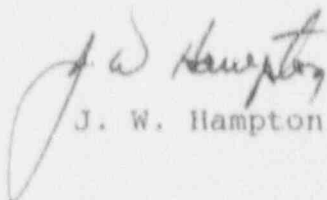
U.S. Nuclear Regulatory Commission
Attention: Document Control Desk
Washington, DC 20555

Subject: Oconee Nuclear Station
Doc'tet Nos. 50-269, -270, -287
Inspection Report 50-269, -270, -287/92-03
Reply to Notice of Violation

Dear Sir:

By letter dated February 27, 1992, the NRC issued Inspection Report No. 50-269/92-03, 50-270/92-03, and 50-287/92-03 with a Notice of Violation. Pursuant to the provision of 10 CFR 2.201, I am submitting a written response to the violations identified in the above Inspection Report.

Very truly yours,


J. W. Hampton

cc: Mr. S. D. Ebner, Regional Administrator
U. S. Nuclear Regulatory Commission, Region II
101 Marietta Street, NW Suite 2900
Atlanta, GA 30323

Mr. L. A. Wiens, Project Manager
Office of Nuclear Reactor Regulation
U. S. Nuclear Regulatory Commission
One White Flint North, Mail Stop 9H3
Washington, DC 20555

P. E. Harmon
Senior Resident Inspector
Oconee Nuclear Station

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Violation 269,270,287/92-03-01, Severity Level IV

Technical Specification 6.4.1 requires that the station be operated and maintained in accordance with approved procedures.

Operating Procedure OP/0/A/1107/03A, Charging Standby Busses From Lee Steam Station, Step 3.2.3 requires that a Lee gas turbine be started per section 3.0 of the Lee Steam Station Emergency Power or Backup Power to Oconee procedure.

Contrary to the above, OP/0/A/1107/03A was not followed in that on January 13, 1992, Step 3.2.3 was not performed and the Oconee Standby Busses were connected to the Lee station switchyard rather than an isolated Lee gas turbine resulting in an unqualified power source being connected to the standby busses.

RESPONSE:

1. The reason for the violation, or, if contested, the basis for disputing the violation:

The reason for this violation was a failure to follow procedure. This was due to the operating crew misinterpreting the intent of step 2.3 of Enclosure 3.3 of OP/0/A/1107/03, 100 KV Power Supply. This procedure was the "controlling procedure" for the charging of the Standby Busses (SBBs) from Lee Steam Station. The crew mistakenly assumed that since they were not supplying emergency power to the SBBs, and since they were just energizing the SBBs for a test of the associated protective relays, (for PT/2/A/610/1C, ONS Emergency Power Switching Logic Standby Bus 1&2 Voltage Sensing Logic) that the isolation of the gas turbine at Lee Steam Station was not required. The step in OP/0/A/1107/03 requiring that the Lee Steam Station gas turbine be isolated was, therefore, determined to be "Not Applicable" (N/A) and documented as such.

Although the necessity for isolating a Lee Gas Turbine to energize the SBBs for any reason was pointed out during training in the past, none of the procedures specifically stated that this isolation was necessary.

2. The corrective steps that have been taken and the results achieved:

The SL1 and SL2 breakers were opened to restore the SBBs to full operability immediately after the SBB degradation was realized.

OP/0/A/1107/03, 100 KV Power Supply, was revised, adding Limit and Precaution steps specifically describing the conditions under which the SBBs may be energized from the 100 KV line.

The operating crew involved has reviewed the steps necessary for determining that a procedure step is N/A.

The approval level for determining that a procedure step is N/A was raised to the Shift Supervisor or Unit Manager level for the duration of the Unit 2 refueling outage.

The use of provisions allowing the operators to determine if a step is N/A and to perform a procedure "Out of Sequence" (OOS) has been discussed with the Operations Shift Supervisors. Emphasis on not changing the intent of the procedure with an N/A or OOS was clearly communicated. The fact that non-conditional procedure steps which are truly not applicable need to be reviewed very closely was also emphasized.

An inplant review was initiated by the Oconee Safety Review Group. This review concerns Operations' use of the provisions allotted for determining that a step is N/A or that a step can be performed out of sequence. Since these are administrative tools used to implement procedures, the effectiveness of these controls will be assessed. Results of the inplant review will be used to evaluate the extent of any weaknesses, in addition to proposing any administrative changes to Operations current policies.

3. The corrective steps that will be taken to avoid further violations:

A training package will be issued for review by all licensed operators with emphasis on the proper use of procedures including the process for determining whether a procedure step is N/A.

4. The date when full compliance will be achieved:

The training package will be issued by June 1, 1992.

Violation 269,270,287/92-'93-02. Severity Level IV

Technical Specification 5.4.1 requires that the station be operated and maintained in accordance with approved procedures and that appropriate written instructions be provided for activities involving nuclear safety.

Procedure OP/0/A/1503/09, Documentation of Fuel Assemblies and/or Component Shuffle Within a Spent Fuel Pool, controls the movement of fuel assemblies and control elements within the spent fuel pool.

Contrary to the above, procedure OP/0/A/1503/09 was inadequate in that it did not contain guidance or precautions against moving a fuel assembly containing a control element to the holddown spring replacement storage rack location. This resulted in damage to a Unit 2 fuel assembly and control rod on January 29, 1992.

RESPONSE:

1. The reason for the violation, or, if contested, the basis for disputing the violation:

Failure to follow procedure - PT/0/A/750/04 is the controlling procedure for movement of fuel assemblies/control components for fuel assembly holddown spring replacement. It clearly states that the control component be removed from the fuel assembly prior to placing the fuel assembly in a spent fuel pool (SFP) rack location containing a pedestal.

Inadequate procedure - OP/0/A/1503/09 does not contain an adequate procedural step or limit and precaution to prevent a fuel assembly with component to be placed in a SFP rack location containing a pedestal.

2. The corrective steps that have been taken and the results achieved:

The damaged control rod was replaced with a new control rod.

The fuel rods from the damaged fuel assembly cage were ultrasonically tested and eddy current tested following removal from the damaged cage. The fuel rods were placed into a new fuel assembly cage.

The engineer responsible for the mistake has been counselled and trained for awareness of the importance and necessity to operate from controlling procedures.

No damage was identified in any of the fuel rods. Following a recage of the fuel rods, the fuel assembly was placed into the core for Unit 2 Cycle 13 operation.

OP/O/A/1503/09 was revised to preclude use of this procedure for moving fuel assemblies for repair, inspection, etc.

3. The corrective steps that will be taken to avoid further violations:

B&W is studying various options to reduce the size or height of the pedestal from 12 inches to 4 inches, to provide for adequate clearance between the bridge mast and fuel assembly control component.

Procedures that control movement of fuel assemblies in the SFP or that should address control of fuel assembly movement in the SFP will be reviewed for instructional completeness and synergistic inter-relationship, especially as regards this event. Special attention will be placed on making each procedure (that requires SFP fuel moves) stand alone in addressing those moves. Changes to these procedures will be made as appropriate and documented using this violation as reference.

Instructional awareness training will be conducted for the Reactor Engineers for those procedures identified, especially in regards to the controls that the procedures contain concerning development of fuel assembly moves.

4. The date when full compliance will be achieved:

December 31, 1992

Violation 269/92-03-03, Severity Level IV

Technical Specification 6.4.1 requires that the station be operated and maintained in accordance with approved procedures.

Maintenance Procedure MP/0/A/1720/10, System/Component Hydrostatic Test requires that loosened instrument test tee fittings be tightened and independently verified prior to returning instruments to service.

Contrary to the above, on January 27, 1992, the Unit 1 reactor coolant makeup pump pressure and flow instruments were returned to service after a hydrostatic test without the test tees being tightened resulting in a test tee cap blowing off when the pump was started for performance testing. The procedure steps verifying that the test tees had been tightened had been signed off in the procedure as having been accomplished.

RESPONSE:

1. The reason for the violation, or, if contested, the basis for disputing the violation:

Personnel returning the associated instrumentation to service took inappropriate actions while performing the task. They did not have a copy of the procedure with them while they were returning instrumentation to service and therefore overlooked tightening the test tee caps because they had been loosened instead of being removed. After the personnel exited the work area, they signed the procedure off as if they had tightened the caps.

2. The corrective steps that have been taken and the results achieved:

Because this was a violation of approved work practices pertaining to control of ongoing work, appropriate disciplinary action was administered to the individuals involved. The individuals were counseled about the importance of having procedures, which require sign-off, with them at all times. The requirement of signing steps as they are accomplished was also stressed.

3. The corrective steps that will be taken to avoid further violations:

This incident will be covered in I&E continuing training which will give others the benefit of reviewing the poor work practices that were used. I&E will provide additional training on component verification and independent verification as part of continuing training.

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In addition, Maintenance Procedure MP/0/A/1720/10, System/Component Hydrostatic Test will be revised to require that test tee caps be completely removed during isolation of instrumentation

4. The date when full compliance will be achieved:

The above items will be implemented by the beginning of the Unit 3 End Of Cycle 13 Refueling Outage, currently scheduled to begin July 15, 1992.

Violation 270/92-03-04, Severity Level IV

Technical Specification 6.4.1 requires that the station be operated and maintained in accordance with approved procedures.

Maintenance Directive 7.5.3, Work Request Implementation, requires that disconnection/reconnection of wiring be documented and independently verified on Section V of the work request "Additional Sheet".

Contrary to the above, on January 12, 1992, Maintenance Directive 7.5.3 was not followed during the performance of work request 91020832, Perform Diagnostic Test on 2HP-26, in that wires were disconnected/reconnected and replaced during the performance of the work request and not properly documented and independently verified on Section V of the work request.

RESPONSE:

1. The reason for the violation, or, if contested, the basis for disputing the violation:

The personnel involved failed to follow the requirements of Maintenance Directive 7.5.3 which requires the documentation and independent verification of disconnected/re-connected leads.

The I&E technician should have obtained a corrective action work request and procedure to perform the replacement of the fuses and jumper wire. A contributing cause in the violation was the fact that changes in the VOTES Testing Program prior to the outage permitted some repairs without the need to initiate a corrective action work request.

2. The corrective steps that have been taken and the results achieved:

Work request 51357L was written to replace the jumper that was installed.

Engineering reviewed test data to determine potential damage to valve 2HP-26. The results of the engineering review indicated no damage and no further testing was required.

I&E work teams and managers were notified of this incident and the requirement to adhere to processes and procedures for documenting work in the field was stressed.

Formal counseling was given to the two I&E technicians involved in the work activities. This counseling related to the failure of the technicians to document work activities as required by established work control procedures.

3. The corrective steps that will be taken to avoid further violations:

I&E and Component Engineering personnel will review the VOTES testing procedures and processes to further define the corrective maintenance activities permitted by the VOTES testing program. This review will more clearly define the permissible corrective activities in the VOTES Preventive Maintenance program for the technicians accomplishing the work. Where appropriate, revise the documents and provide necessary training prior to the next refueling outage.

4. The date when full compliance will be achieved:

Full compliance will be achieved by July 1, 1992.