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DUKE POWER

November 16, 1995

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

Subject: McGuire Nuclear Station, Units 1 and 2
Docket Nos. 50-369 and 50-370
NRC Inspection Report No. 50-369, 370/95-23
Violation 50-369, 370/95-23-01, 50-369, 370/95-23-03 and Deviation 369, 370/95-23-02
Reply to a Notice of Violation and Notice of Deviation

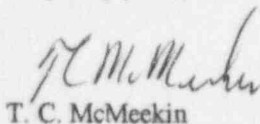
Gentlemen:

Enclosed is a response to a Notice of Violation and a Notice of Deviation dated October 27, 1995.

Please note that our response to Violation 50-369, 370/94-17-01 dated December 30, 1994, committed to implement a double verification for operator medical exams, requiring a second nurse to review the exam results. In addressing the corrective measures for Deviation 50-369, 370/95-23-02, this commitment was changed to require a separate verification of operator medical exam results by an individual knowledgeable of ANSI regulations and medical criteria for clearance. This change will allow more flexibility in processing operator exam results while ensuring qualified personnel review the results.

Should there be any questions concerning this response, contact Randy Cross at (704) 875-4179.

Very truly yours,



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Attachment

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McGuire Nuclear Station
Reply to a Notice of Violation

Violation 50-369, 370/95-23-01

10 CFR 50 Appendix B, Criterion XVI, "Corrective Actions," states that measures shall be established to ensure that conditions adverse to quality, such as failures, malfunctions, deficiencies, deviations, defective material and equipment, and nonconformances are promptly identified and corrected. In the case of significant conditions adverse to quality, the measures shall assure that the cause of the condition is determined and corrective action is taken to preclude repetition.

Contrary to the above, on April 15, 1995, and September 15, 1995, the licensee's measures to correct two previous violations in the area of licensed operator medical conditions did not 1) ensure that conditions adverse to quality were promptly identified and 2) assure that the cause of the condition was determined and that corrective action was taken to preclude repetition as evidenced by the following examples:

1. The licensee was issued Violation 50-369, 370/94-17-01 on November 22, 1994, for failing to identify a change in a licensed operator's medical status which required NRC notification within 30 days. On April 19, 1995 an audit was conducted and a similar condition for another operator was identified which required NRC notification within 30 days.

2. The licensee was issued Violation 50-369, 370/93-300-03 on August 12, 1993, for failing to report a change in a licensed operator medical status within 30 days. On July 19, 1995, the facility licensee's physician made the determination that an operator's eyesight no longer met the minimum standards required by 10 CFR 55.53 (a) (1). The licensee failed to notify the NRC within 30 days.

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

Reply to Violation 50-369, 370/95-23-01

1. Reason for the violation:

   The reason for the violation is inadequate root cause analysis performed for the two previous violations. The root cause analysis focused on the apparent cause and, as a result, work processes were not enhanced to preclude repetition of the events addressed in examples 1 and 2 above.

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

   a) Improved human error root cause methodologies were initiated at McGuire Nuclear Station in April 1995. The use of improved root cause methodologies has resulted in improved accuracy in identifying the root cause, resulting in more effective corrective measures.

   b) A detailed root cause analysis (SA-95-79MC)(SRG)(IPR-96-40) was conducted by Safety Review Group and Safety personnel during the period October 3 through 26, 1995 to identify the root cause of Violations 369, 370/93-300-03, 369, 370/94-17-01, the events addressed in examples 1 and 2 above and a similar event that occurred on September 28, 1995 concerning

failure to notify the NRC. The corrective actions taken as a result of the root cause analysis are addressed in section 2.c and 2.d below.

c) Management expectations have been communicated to McGuire Operations Training personnel and Medical personnel on the importance of promptly identifying changes in licensed operator medical status and notifying the NRC of any changes within 30 days. This corrective action was completed on October 2, 1995.

d) The existing processes for the identification of changes in licensed operator medical status and reporting any identified changes to the NRC have been enhanced and documented in approved station procedures/guidelines. This corrective action was completed on November 16, 1995.

No similar events have occurred since implementation of these corrective actions.

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

A self-assessment of the effectiveness of processes implemented to ensure the prompt identification and reporting of changes in licensed operator medical status will be conducted by January 31, 1996.

4. Date when full compliance will be achieved:

All corrective actions will be completed by January 31, 1996.

McGuire Nuclear Station
Reply to a Notice of Violation

Violation 50-369, 370/95-23-03

Technical Specification 6.8.1 requires that written procedures shall be established, implemented and maintained in accordance with Regulatory Guide 1.33, Revision 2, February 1978, Appendix A, which refers to specific procedures for surveillance tests, inspections, and calibrations.

Technical Specification 4.6.4.2.a, requires that each Hydrogen Recombiner System be demonstrated operable at least once per six months by performing a functional test. PT/1/A/4450/04A, "Hydrogen Recombiners 1A and 1B Operability Test," Revision 8, implements Technical Specification 4.6.4.2.a.

Contrary to the above, on September 29, 1995, Surveillance Procedure PT/1/A/4450/04A, "Hydrogen Recombiners 1A and 1B Operability Test," Revision 8, was not adequately maintained as evidenced by the following examples:

1. PT/1/A 4450/04A, "Acceptance Criteria 11.1," did not adequately specify which "instrumentation and controls" were required to be functioning properly to satisfactorily complete the surveillance.

2. PT/1/A/4450/04A did not require the technician to verify Hydrogen Recombiner Junction temperature in the required band. Operation of the Hydrogen Recombiner Junction temperature in the specified band is required to ensure accurate Hydrogen Recombiner temperature indications. Hydrogen Recombiner temperature is a required parameter for the operability test.

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

Reply to Violation 50-369, 370/95-23-03

1. Reason for the violation:

   The reason for the violation is an inadequate procedure.

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

   Minor Modifications (MM-7807; Unit 1) and (MM-7808; Unit 2) have been initiated to replace existing Hydrogen Recombiner temperature instrumentation with instrumentation that will allow remote reference junction compensation. Upon implementation MM-7807 and MM-7808, verification of the Hydrogen Recombiner reference junction temperature by the technician will no longer be necessary to ensure accurate temperature indications. If the surveillance is required to be performed prior to the installation of new instrumentation, PT/1,2/A/4450/04A will be revised to require the technician to verify the Hydrogen Recombiner reference junction temperature in the required band.

   No similar events have occurred since implementation of these corrective actions.

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

Procedures PT/1,2/A/4450/04A will be revised to delete the step requiring verification of Acceptance Criteria 11.1. Per McGuire Technical Specifications, operability of the Hydrogen Recombiners is dependent on indications of sheath temperature and power consumption only. Procedures PT/1,2/A/4450/04A will be revised by April 2, 1996.

4. Date when full compliance will be achieved:

All corrective actions will be completed by April 2, 1996.

McGuire Nuclear Station
Reply to a Notice of Deviation

Deviation 50-369, 370/95-23-02

Duke Power Company's December 30, 1994 response to NRC Violation 50-369, 50-370/94-17-01, which specified your corrective actions to ensure medical applications would receive a double verification for operator medical exams. You indicated that you would require a second nurse to review these exam results.

Contrary to the above, it was identified on September 18, 21 and 22 (two examples) 1995 that you had deviated from the commitments in the December 30, 1994 response to NRC Violation 50-369, 50-370/94-17-01 in that only one nurse had reviewed the required medical records.

Reply to Deviation 50-369, 370/95-23-02

1. Reason for the deviation:

   The reason for the deviation is a lack of a well defined work process to ensure the commitment was implemented.

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

   a) McGuire Medical personnel were counseled on the importance of a separate verification of exam results by a qualified individual. This corrective action was completed on October 2, 1995.

   b) McGuire Medical personnel implemented Interim Guideline # 1 to ensure the commitment as stated in the response to Violation 94-17-01 was implemented until a comprehensive Guideline could be developed and implemented. This corrective action was completed on September 28, 1995.

   c) The Nuclear Operator Examination Guideline # 1, Revision 0 was revised to better define the process for the identification of changes in licensed operator medical status, reinforce the requirement for a separate verification of exam results by a qualified individual and to ensure the communication of exam results to Operations Training personnel for subsequent written notification to the NRC. Revision 1 was implemented on November 16, 1995.

   No similar events have occurred since implementation of these corrective actions.

3. Corrective steps that will be taken to avoid further deviations:

   No additional corrective actions are planned.

4. Date when corrective actions will be completed:

   All corrective actions were completed by November 16, 1995.