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November 30, 1984

Mr. James P. O'Reilly, Regional Administrator
U. S. Nuclear Regulatory Commission
Region II
101 Marietta Street, N.W., Suite 2900
Atlanta, Georgia 30323

Subject: McGuire Nuclear Station
Docket Nos. 50-369 and 50-370

Reference: NRC/OIE Inspection Report 50-369/84-25 and 50-370/84-22

Dear Mr. O'Reilly:

Pursuant to 10CFR 2.201, please find attached a response to the violation identified in the above referenced inspection report.

Please note that also included is a statement which addresses the additional example of non-compliance (i.e. inadequate procedure for nuclear instrumentation testing). This incident is described in LER 370/84-21.

Duke Power Company does not consider any information contained in this report to be proprietary.

Very truly yours,

Hal B. Tucker

Hal B. Tucker

RLG/mjf

Attachment

cc: Mr. W. T. Orders
Senior Resident Inspector - NRC
McGuire Nuclear Station

DUKE POWER COMPANY

McGuire Nuclear Station

Response to NRC/OIE Inspection Report 50-369/84-25 & 50-370/84-22

VIOLATION

The following violation was identified during an inspection conducted on August 20 - September 20, 1984. The Severity Level was assigned in accordance with the NRC Enforcement Policy (10 CFR Part 2, Appendix C).

> Code of Federal Regulations, Part 50.73, "License Event Report System," Part (2)(V)(c) states, in part, that the licensee shall report within 30 days of any event or condition that alone could have prevented the fulfillment of the safety function of structures or systems that are needed to control the release of radioactive material.
>
> Contrary to the above requirement, containment integrity was degraded when containment spray vent valve 1NS-68 was left open and this event was not reported as required.
>
> This is a Severity Level IV violation (Supplement I).

RESPONSE

a. The alleged violation as written is denied.

b. The identified incident was not initially considered to be reportable based on an engineering assessment of impact on system performance. Additionally, the safety consequences of degraded containment were assessed, with the result that there was no appreciable impact on offsite dose consequences. Therefore, it does not appear that this incident alone "could have prevented the fulfillment of the safety function" of containment.

   Such conclusion is consistent with that contained in IE Inspection Report 50-369/84-21, 50-370/84-18, "The NRC Region II office also evaluated the radiological consequences and system performance during accident conditions with the vent valve being open and found it to have minimal impact on containment integrity and design function of the system".

   The Commission has recognized that the application of this section of the rule involves the use of engineering judgement on the part of licenses (FR 33854). It is this engineering judgement which is in question. The results of further detailed engineering analysis have confirmed the incident not to be reportable. The potential release of radioactivity was still controlled such that off-site dose consequences previously predicted were not exceeded.

RESPONSE (continued)

c. Licensee Event Report (LER 369/84-25) was submitted November 9, 1984 for informational purposes.

d. Personnel involved in determining reportability will conduct thorough assessments of station incidents and consult with additional technical resources to provide assurance that incidents are properly evaluated and, as necessary, reported.

e. Since the violation is denied the station was/is not in non-compliance. Item d was emphasized to applicable station personnel in September, 1984.

Inadequate Procedure for Nuclear Instrument Testing

This Inspection Report identifies this as an additional example of non-compliance and requests that Duke address the item. The test procedure and its implementation are stated to have contributed to a reactor trip of Unit 2 on August 31, 1984.

As required by 10 CFR 50.73, Duke prepared and submitted Licensee Event Report 370/84-22 concerning the event on October 1, 1984. Within this LER, a committment was made to identify appropriate procedural improvements. In response to this, the following actions were taken. Procedure IP/0/A/3207/03B was deleted. A new procedure IP/0/A/3207/03/K was implemented which emcompasses the Power Range Channel Calibration and includes independent verification at all steps requiring detector cable removal/reinstallation, jumpers and fuse removal. In addition, the NIS cabinets and cables have been labeled in order to facilitate positive identification.

With these corrective actions, it is considered that this item has been adequately addressed.