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DUKE POWER

July 8, 1992

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

Subject: Oconee Nuclear Site
Docket Nos. 50-269, -270, -287
Inspection Report 50-269, -270, -287/92-11
Reply to Notice of Violation

Dear Sir:

By letter dated May 20, 1992 the NRC issued Inspection Report No. 50-269/92-11, 50-270/92-11, and 50-287/92-11 with a Notice of Violation.

Pursuant to the provision of 10 CFR 2.201, I am submitting a written response to the violation identified in the above Inspection Report.

Very truly yours,

J. W. Hampton

cc: Mr. S. D. Ebnetter, 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 Site

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Handwritten initials/signature

VIOLATION 269/92-11-01, SEVERITY LEVEL IV

Technical Specification 5.4.1 requires that the station be operated in accordance with approved procedures.

Operating Procedure OP/1/A/1102/01, Unit Startup, requires that Reactivity Balance Procedure, PT/1/A/1103/15, be used to calculate Estimated Critical Position (ECP) and Estimated Boron Concentration (ECB) prior to going critical.

Contrary to the above, the station was not operated in accordance with OP/1/A/1102/01 in that the Unit 2 Reactivity Balance Procedure, PT/2/A/1103/15 was used on several occasions on May 11 to calculate the Unit 1 ECP and ECB.

RESPONSE:

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

The reactivity curves for both Units 1 and 2 were located in similar notebooks in a common bookshelf. Each notebook also contained the Control Copy of the procedure and working copies. (Generally, the Control Copy of Operating Procedures and Periodic Tests specific to a unit are contained in color coded folders and filed in separate cabinets.) The Unit Supervisor inadvertently pulled the notebook for Unit 2 instead of the notebook for Unit 1. He performed the Estimated Critical Boron (ECB) calculation using the curves and procedure for Unit 2. The calculations were repeated for verification by the Shift Manager, using the same procedure and curves.

When it was determined that criticality would not be reached during the calculated time period, the ECB calculation was repeated by the Unit Supervisor and verified by the Shift Manager. Unit 2 curves and procedure were used again.

The Estimated Critical Rod Position (ECP) was calculated by the Unit Supervisor and verified by the Shift Manager, using the Unit 2 curves and procedure.

The procedure was turned over to the evening shift, where power escalation was continued to 62%. Nearing the end of the evening shift, the Unit Supervisor reviewed the completed procedures from his shift and discovered that Unit 2 enclosures were used to perform ECB and ECP calculations on Unit 1.

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

The ECP was calculated and verified using the Unit 1 reactivity curves.

The Shutdown Margin available was calculated and verified to assure that an adequate shutdown margin existed. Results indicated an adequate shutdown margin was available.

The reactivity curves were placed in unit specific, color coded notebooks.

The working copies of the Reactivity Balance Procedure were placed into Working Copy file cabinets.

Other procedures and notebooks in the Units 1 and 2 Control Room were considered for similar possibility of using the wrong unit's procedure. It was determined that the only procedures for both units located on the same bookshelf were the Emergency and Abnormal Operating Procedures. The Emergency Operating Procedures are contained in a red binder and the Abnormal Operating Procedures are contained in a blue binder. These procedures are clearly marked with the unit designator.

The personnel involved in this event were counseled concerning their responsibility to use correct procedures and properly perform independent verification.

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

This incident will be discussed in the Shift Supervisor's meeting and with licensed personnel in Operations.

4. The date when full compliance will be achieved:

Discussions will be completed by September 30, 1992.