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DUKE POWER

October 15, 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, -287/92-18
Reply to Notice of Violation

Dear Sir:

By letter dated September 16, 1992 the NRC issued a Notice of Violation as described in Inspection Report No. 50-269/92-18, 50-270/92-18, and 50-287/92-18.

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. Ebneter, 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

190124 P. E. Harmon
Senior Resident Inspector
Oconee Nuclear Site

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VIOLATION 287/92-18-01, SEVERITY LEVEL IV

Oconee Technical Specification 6.4.1 requires that the station be operated and maintained in accordance with approved procedures. Step 2.3 of Enclosure 3.1 to OP/0/A/1103/11, Dropping the Loops, requires valve 3N-161 to be closed.

Contrary to the above, on July 26, 1992, OP/0/A/1103/11 was not followed in that nitrogen supply valve 3N-161 was not closed. This resulted in the inadvertent admission of nitrogen into the pressurizer and quench tank.

RESPONSE:

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

   The event was the result of a miscommunication between two Non Licensed Operators (NLOs) who were performing a sequence of valve manipulations in the reactor building. Proper communication techniques, including "repeat backs" on instructions and proper feedback on tasks performed, were not used.

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

   The control room operators immediately noticed the increase in the quench tank pressure and directed the NLOs to close the nitrogen supply valve they had just opened. Following closure of the valve, the quench tank was vented to prevent rupture disc failure. The operators reviewed the Oconee Flow Diagrams, checked the valves, and determined that 3N-161 was mispositioned. The valve was then positioned correctly.

   Following the event, these subsequent corrective actions were implemented:

   The Shift Supervisor had a discussion with the operators involved in this event. Emphasis was placed on identifying "lessons learned" from the event and these were shared with the remainder of the shift.

   The Shift Supervisor and the two NLOs involved in the event made presentations to the other Operations shifts describing the event in detail, what went wrong and the steps that could prevent recurrence. These presentations addressed the necessity of a proper pre-job briefing, proper control of working copies of a procedure, and proper communication techniques to be used by operators in the plant.

Other mispositioned components were found during the same time frame which were attributed to personnel error. Similar "lessons learned" training presentations were made by the personnel involved in these events. Since conducting this training, no additional instances of mispositioned components due to personnel error are known to have occurred.

The Operations database on mispositioned components was consulted to determine if miscommunications had been identified as a "root" or "secondary" cause for any previous mispositioned components. No mispositioning events attributed to miscommunications were identified over the last two years. Following evaluation, it has been determined that no further corrective action is required.

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

   The corrective actions listed in Item 2 should prevent future violations.

4. The date when full compliance will be achieved:

   Full compliance was achieved on July 26, 1992 when the valve was positioned correctly.