



UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
101 MARIETTA STREET, N.W.
ATLANTA, GEORGIA 30323

Report No.: 50-414/86-14

Licensee: Duke Power Company
422 South Church Street
Charlotte, NC 28242

Docket No.: 50-414

License No.: CPPR-117

Facility Name: Catawba 2

Inspection Conducted: February 10-21, 1986

Inspector: McKenzie Thomas 3/10/86
M. Thomas Date Signed

Approved by: F. Jape 3/10/86
F. Jape, Chief, Test Programs Section Date Signed
Engineering Branch
Division of Reactor Safety

SUMMARY

Scope: This routine announced inspection involved 66 inspector-hours on site in the areas of preoperational test results review and review of previously identified items.

Results: No violations or deviations were identified.

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REPORT DETAILS

1. Persons Contacted

Licensee Employees

- *#J. W. Hampton, Station Manager
- *H. B. Barron, Operations Superintendent
- *W. F. Beaver, Performance Engineer
- *#J. W. Cox, Technical Services Superintendent
- *#C. L. Hartzell, Compliance Engineer
- *#R. A. Jones, Performance Test Engineer
- *P. G. LeRoy, Licensing Engineer
- *D. M. Robinson, Performance Reactor Engineer
- *#F. P. Schiffley II, Licensing Engineer
- #G. Smith, Maintenance Superintendent

Other licensee employees contacted included test coordinators, engineers, technicians, operators, security office members and office personnel.

NRC Resident Inspectors

- *P. H. Skinner, Senior Resident Inspector - Operations
- *P. K. VanDoorn, Senior Resident Inspector - Construction

- *Attended exit interview February 13, 1986
- #Attended exit interview February 21, 1986

2. Exit Interview

The inspection scope and findings were summarized on February 13 and 21, 1986, with those persons indicated in paragraph 1 above. The inspector described the areas inspected and discussed the inspection findings. No dissenting comments were received from the licensee. One new item identified during this inspection is listed below.

- Inspector Followup Item 414/86-14-01, Guidance for Correcting In-process Procedure Documentation Errors, paragraph 5.

The licensee did not identify as proprietary any of the material provided to or reviewed by the inspector during this inspection.

3. Licensee Action on Previous Enforcement Matters

This subject was not addressed in the inspection.

4. Unresolved Items

Unresolved items were not identified during the inspection.

5. Preoperational Test Results Review (70322, 70324, 70325, 70326, 70329, 70400)

The inspector reviewed the completed test data packages for the following preoperational (preop) tests:

IP/2/A/3200/03, Reactor Protection/Safeguards Features Response Time Testing

TP/2/A/1100/01, Controlling Procedure for Hot Functional Testing

TP/2/A/1100/06, Diesel Generator 2B Post Inspection Run

TP/2/A/1200/01, Component Cooling System Functional Test

TP/2/A/1200/01A, Component Cooling System Operation During Hot Functional Testing

TP/2/A/1200/02B, Residual Heat Removal System (Hot) Functional Test

TP/2/A/1200/03A, Engineered Safeguards Features Functional Test

TP/2/A/1200/03D, Safety Injection Accumulator Functional Test

TP/2/A/1200/04, Containment Spray System Functional Test

TP/2/A/1200/05, Chemical and Volume Control Functional Test

TP/2/A/1250/04, Auxiliary Feedwater System Functional Test

TP/2/A/1350/25A, Diesel Generator 2A Blackout and Load Rejection Preoperational Test

TP/2/A/1350/25B, Diesel Generator 2B, Blackout and Load Rejection Preoperational Test

TP/2/A/1400/01, Nuclear Service Water System Functional Test

The test data packages were reviewed to verify that:

- Test changes were approved in accordance with administrative procedures.
- Test changes did not change the basic objectives of the test.
- Actions required by test changes had been completed.
- Test deficiencies had been resolved, including retesting where required.
- Individual test steps and data sheets were completed properly.
- Test data were within the acceptance criteria specified.

- Evaluation and approval of the test results had been completed by appropriate engineering and management personnel.

While reviewing the data package for Preop Test IP/2/A/3200/03, a concern was identified which pertained to several instances where, "white out" correction fluid was used to correct data entries and other documentation errors. The inspector discussed this concern with responsible licensee personnel and questioned whether this was an acceptable practice. The licensee agreed that "white out" should not be used when making corrections. The normal practice used to make corrections is to draw a line through the mistake, initial and date it. However, guidance on how to correct in-process procedure documentation errors does not appear to be addressed in any of the administrative procedures reviewed by the inspector. Use of "white out" in this procedure appears to be an isolated case since no similar problems were found during the inspector's review of other preop test data packages and completed procedures. The licensee stated that appropriate administrative procedures will be revised to address correction of in-process procedure documentation errors. The inspector informed the licensee that this item will be identified for followup during subsequent inspections as inspector followup item 414/86-14-01, Guidance For Correcting In-process Procedure Documentation Errors.

While reviewing the data packages for Preop Tests TP/2/A/1100/06, TP/2/A/1200/03A, and TP/2/A/1350/25B, the inspector discussed with responsible licensee personnel several diesel generator (DG) 2B trips which occurred both during and subsequent to the preop tests. Questions were raised concerning DG 2B reliability and whether the test frequency should be increased for periodic tests performed during plant operation (Based on the guidance in Regulatory Guide 1.108 and Table 4.8-1 of the combined Technical Specifications (TS) proposed for Catawba Units 1 and 2). Licensee personnel stated during discussions that per TS Table 4.8-1, they have determined that in the "last 100 valid tests", DG 2B has had two valid test failures since completion of the preop test requirements of Regulatory Guide 1.108. Therefore, the periodic test frequency will be increased for both DG 2A and DG 2B. This item is also discussed in the resident inspectors' report (414/86-15).

The licensee identified in its "Status for Fuel Loading" letters dated, January 24, 1986 and February 10, 1986, all of the preop tests that were not expected to be completed by fuel load. The inspector and resident inspectors verified that all other preop tests required for fuel load have been completed and the completed data packages have been reviewed and approved by appropriate engineering and management personnel. The inspector will review the status of those tests which have not been completed during subsequent inspections.

No violations or deviations were identified in the areas inspected.

6. Followup on Previously Identified Inspection Findings (92701)

The inspector reviewed the unresolved item and inspector followup items (IFI) discussed below.

- a. (Closed) Unresolved Item 414/85-67-01, concerning verifying the proper position of solid state protection system (SSPS) circuits. This item was discussed with responsible licensee personnel who stated that when systems are transferred from the construction department to the nuclear production department, all sliding links are supposed to be closed. There have been instances, such as those identified during ESF testing, where sliding links were found inadvertently left open. These were identified during preop testing also. The number of sliding links found open relative to the number installed in the plant was very small. Problems like this are expected to occur and the preop test program is designed to identify these problems. All sliding links installed in safety-related systems were tested during preop. The open sliding links identified during ESF testing were in portions of the system that were being tested for the first time since being transferred from the construction department. Thus, satisfactory completion of the ESF test demonstrated that all the sliding links installed in portions of the systems tested during ESF testing were in their proper position.

The inspector reviewed the licensee's administrative controls established to control activities performed by nuclear production or construction personnel on a system that has been transferred to the nuclear production department. These controls were determined to be adequate.

- b. (Closed) IFI 414/85-42-01, concerning the loss of oil from DG 2A governor. The licensee stated that the governor continued to leak oil after the internal seal was replaced, so the entire hydraulic actuator was replaced. Prior to replacing the hydraulic actuator, licensee personnel stated that oil would have to be added to the governor after approximately three to four hours of operations. After the actuator was replaced, the DG was operated for over nine consecutive hours on February 16-17, 1986. The governor oil level was checked hourly (per periodic test procedure PT/2/A/4350/10) and the oil level appeared to remain constant (at or above the line in the sight glass). No oil was added during operation.
- c. (Closed) IFI 414/86-06-01, concerning improper setting of the Train B sequencer timer. An investigation was performed to determine the cause of the timer being reset. After reviewing work performed in the sequencer cabinet the licensee stated that they could not find an apparent reason for the timer being reset. It is believed that the timer was inadvertently and unknowingly reset. The licensee issued a memorandum to file, dated February 14, 1986, advising maintenance

supervisors to instruct technicians not to perform work on equipment which has not been identified to be worked on. If work is inadvertently performed on equipment which has not been identified to be worked on, appropriate personnel should be notified so that an evaluation can be performed to analyze the consequences of the inadvertent actions.

No violations or deviations were identified in the areas inspected.