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August 1, 1986

Dr. J. Nelson Grace, Regional Administrator
U.S. Nuclear Regulatory Commission
Region II
101 Marietta Street, NW, Suite 2900
Atlanta, Georgia 30323

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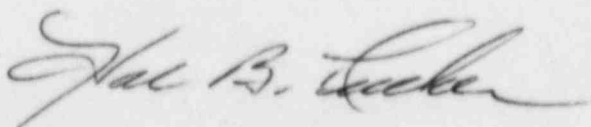
Subject: McGuire Nuclear Station
Docket No. 50-369, 50-370

Reference: RII:REW
NRC/OIE Inspection Report 50-369/86-08, 50-370/86-08

Dear Dr. Grace:

Pursuant to 10 CFR 2.201, please find attached a response to the violations which were identified in the above referenced Inspection Report.

Very truly yours,



Hal B. Tucker

JBD/59/jgm

Attachment

xc: Mr. W.T. Orders
NRC Resident Inspector
McGuire Nuclear Station

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DUKE POWER COMPANY
McGUIRE NUCLEAR STATION
RESPONSE TO VIOLATIONS IN INSPECTION REPORT
50-369/86-08 AND 50-370/86-08

Violation 50-369/86-08-01 and 50-370/86-08-01, Severity Level IV

Technical Specifications 4.11.1.2, 4.11.2.2, 4.11.2.3 and 4.11.4.1 require that the cumulative dose contributions from liquid and gaseous effluents for the current calendar quarter and year be determined at least once per 31 days.

Contrary to the above, the contributions from liquid and gaseous effluents for the current calendar quarter or year were not calculated within the 31 day span preceding January 29, 1986.

Response:

Correction to NRC Report Nos. 50-369/86-08 and 50-370/86-08; Report Details; paragraph 9, page 5, subparagraph 6. The reference to Tech. Spec. 4.11.1.1 is incorrect. This should be changed to read 4.11.2.2.

1. Admission or denial of the alleged violation:

Duke Power admits the violation in that while the periodic test procedure for December 1985, Cumulative Offsite Dose was performed within the 1.25 time interval, the 3.25 time interval criteria was exceeded during 3 consecutive tests. Even though the procedure was delinquent, the surveillance was performed within the required time interval by the issuance of the LADTAP/GASPAR computer program report from the General Office to the station.

2. Reasons for violation:

The violation occurred due to personnel error.

3. Corrective steps which have been taken and the results achieved:

When it was noticed that the PT was overdue, the necessary information was obtained and the PT completed.

The groups responsible for completing the PT's are now responsible for the PT Index. Other steps include closer attention to PT surveillance dates and weekly issuance of PT Index to personnel responsible for performing the PT.

4. Corrective steps which will be taken to avoid further violations:

No further corrective steps are planned.

5. Date when full compliance will be achieved:

McGuire Nuclear Station is presently in full compliance.

Violation 50-369/86-08-02, Severity Level IV

Technical Specifications 6.8.1.a requires that current written approved procedures, be established implemented and maintained covering reactor startup and safety related equipment operation.

1. The Reactivity Balance Calculation procedure (OP/O/A/6100/06), requires in step 2.6 that if the rods are withdrawn to the upper limit of the ECP band and criticality has not yet been reached, all control banks must be reinserted and a recheck of the calculations performed.
2. Operations Management Procedure 2.5, section 6.6 requires that the operator ensure redundant equipment is operable prior to removing equipment from service.

Contrary to the above:

1. On Marcy 11, 1986, McGuire Unit 1 was being taken critical when the control rods were withdrawn to the withdrawal limit specified in the reactivity balance procedure and the control rods were not inserted as required.
2. On March 12, 1986 train "B" of containment spray and train "A" of SSPS (solid state protection system) were removed from service simultaneously. Thus, both trains of containment spray were removed from service simultaneously.

Items 1. and 2. above, singularly and collectively constitute a Violation for failure to follow procedures.

Response to Example 1:

1. Admission or denial of the alleged violation:

Duke Power admits the failure to adhere to limits and precautions statement in OP/O/A/6100/06 (Reactivity Balance Calculation) of reinserting all control rods after reaching top of ECP window without attaining criticality.

2. Reasons for violation:

During the Unit 1 startup on 3/11/86, the operators were manipulating the controls in accordance with OP/1/A/6100/01 (Controlling Procedure for Unit Startup) and OP/1/A/6150/08 (Rod Control). These two procedures do not require insertion of control rods. As per the two procedures being used, rods were left "as is" and a reevaluation of ECP data was performed to proper ECP calculation.

3. Corrective steps which have been taken and the results achieved:

It was determined that the precaution to insert control rods had been erroneously reinserted into OP/0/A/6100/06 during a procedure rewrite.

On 3/12/86, the Reactor group implemented change #23 to OP/0/A/6100/06 which changed the requirement for rod insertion to a requirement to call the Reactor Engineer. The incident was discussed at the Shift Supervisors meeting of 4/4/86 stressing care when dealing with multiple procedures.

4. Corrective steps which will be taken to avoid further violation:

No further corrective steps are planned.

5. Date when full compliance will be achieved:

McGuire Nuclear Station is presently in full compliance.

Response to Example 2:

1. Admission or denial of the alleged violation:

Duke Power admits that although both trains of containment spray were never inoperable, both trains would have been inoperable had the NRC resident not questioned the control room SRO.

2. Reasons for violation:

The violation was a result of the failure to realize that "A" Train SSPS work would block the auto start feature of "A" Train NS Pump. The control room SRO questioned the technician working on SSPS and was lead to believe that "A" Train NS operability would not be affected.

3. Corrective steps which have been taken and the results achieved:

Following questioning by the NRC Resident, the control room SRO halted all work on "A" Train SSPS before it was actually started. "A" Train NS was maintained operable at all times.

The incident was covered in the Shift Supervisor's meeting of 4/4/86. The information was passed to licensed personnel to take great care with Technical Specifications, particularly for system interrelations.

4. Corrective steps which will be taken to avoid further violations:

Full implementation of the LIMCOM computer for tracking LCO status should prevent dual train operability.

5. Date when full compliance will be achieved:

The need for increased awareness for possible dual train inoperability has already been discussed with licensed personnel. LIMCOM is in a test/problem resolution status with no firm full implementation target date.