DUKE POWER COMPANY P.O. BOX 33189 CHARLOTTE, N.C. 28242

HAL B. TUCKER VICE PRESIDENT NUCLEAR PRODUCTION TELEPHONE (704) 373-4531

November 25, 1987

Director, Office of Enforcement U.S. Nuclear Regulatory Commission ATTN: Document Control Desk Washington, D.C. 20555

Subject: McGuire Nuclear Station Docket Nos. 50-369 and 50-370 Answer to Notice of Violation Reply to Notice of Violation Enforcement Action 87-163

Gentlemen:

Pursuant to 10CFR 2.201, please find attached the response to the violation identified in the subject Enforcement Action. Although Duke is admitting the subject violation occurred and does not contest imposition of the Base Civil Penalty in the amount of \$50,000, Duke does not believe that escalation of the Base Civil Penalty is warranted. Duke believes the bases cited by the NRC for escalation are either inconsistent with the factors set forth in the Enforcement Policy or are otherwise improper. Duke has reviewed the events, including relevant documentation, cited by the NRC as the bases for its action, as well as McGuire's enforcement history. Duke believes the NRC has incorrectly interpreted the events and drawn inferences not supportable when measured against its Enforcement Policy. Therefore, Attachment I is the Answer to Notice of Violation and Attachment II is the Reply to Notice of Violation.

I declare under penalty of perjury that the statements set forth herein are true and correct to the best of my knowledge.

Very truly yours,

Hac B. Jacken

Hal B. Tucker

SEL/168/jgc

Attachment

xc: Dr. J. Nelson Grace Regional Administrator, Region II U.S. Nuclear Regulatory Commission 101 Marietta St., NW, Suite 2900 Atlanta, GA 30323

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

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ATTACHMENT I DUKE POWER COMPANY McGUIRE NUCLEAR STATION

Answer to Notice of Violation Enforcement Action 87-163 Inspection Report Nos. 50-369/87-26 and 50-370/87-26

DISCUSSION IN OPPOSITION TO ESCALATION

A. GENERAL

As noted in Attachment II, Duke admits the violations and does not contest imposition of the \$50,000 base civil penalty. Duke does believe however, that the 100% escalation of the base civil penalty is not warranted. The NRC increased the base civil penalty by 100 percent because of:

(1) past poor performance in the area of concern as documented generally by Systematic Assessment of License Performance (SALP) in the operations area and specifically by the similar occurrences discussed earlier, (2) the corrective actions taken on July 29, 1987 were not only inadequate and non-conservative, in that it was assumed the problem was in the control pagel indicators and not in the diesel generator itself, but untimely in that it was not recognized promptly that the indicator light was out. Specifically, multiple shift turnovers occurred during the time the diesel generator was inoperable yet, none of the licensed operators involved recognized the significance of the multiple indications of the problem available to them.

In short, the NRC has escalated the base civil penalty because of alleged past poor performance and allaged inadequate corrective action related to independent verification and fatlure to follow procedures in the area of plant operation. Duke believes that measons given by the NRC for escalation, quoted above, are either inconsistant with the factors set forth in the Enforcement Policy or are otherwise improper. In the discussion set out below Duke will examine each of the elements of the Emforcement Policy in the light of this particular matter and show why it believes escalation is not warranted. Before turning to a discussion of the specifics, however, Duke wishes to make some general observations regarding the appropriateness of the WRC's escalation of the base civil penalty. Duke regards such escalation as a punitive measure. It is difficult to read either the Enforcement Policy or the Notice of Violation in any other fashion. Therefore the conclusion is ineccapable that Duke is being punished for an the unwillingness or inability to take effective corrective action in the areas of concern. The facts set out below will show that is not the case. The facts will show that in the past few years Duke has made substantial efforts, and achieved significant results, in the area of plant operations. As a result of these efforts the number of events associated with lack of compliance with the Independent Verification Program and personnel error have steadily declined.

The Enforcement Policy states that its purpose is to

"promote and protect the radiological health and safety of the public, including employees' health and safety, the common defense and security, and the environment by:

Ensuring compliance with NRC regulations and license conditions:

Obtaining prompt correction of violations and adverse quality conditions which may affect safety;

Deterring future violations and occurrences of conditions adverse to quality; and

Encouraging improvement of licensee and vendor performance, and by example, that of industry, including the prompt identification and reporting of potential safety problems".

It is difficult to reconcile the purposes enunciated above with the NRC's action in this regard. Indeed, for the NRC to impose punitive sanctioning on Duke in this instance is to send precisely the wrong signal not only to Duke but to the industry as a whole.

B. ALLEGED PAST POOR PERFORMANCE

The Enforcement Policy provides that the

"base civil penalty may be increased as much as 100% for prior poor performance in the general area of concern. In weighing this factor, consideration will be given to, among other things, the effectiveness of previous corrective action for similar problems, overall performance such as Systematic Assessment of Licensee Performance (SALP) evaluations for power reactors, and prior enforcement history including Severity Level IV and V violations in the area of concern." 10 CFR Part 2, App.C. V.B.

Duke does not believe that escalation of the base civil penalty can be justified on the basis of examining its past performance at McGuire in the area of concern, Independent Verification Program and failure of personnel to follow procedures in plant operations. In reaching this conclusion, Duke has reviewed the events, including the relevant documentation, cited by the NRC as the bases for their action, as well as the totality of McGuire's enforcement history. Duke believes that the NRC has incorrectly interpreted the events and drawn inferences not supportable, when measuring them against its Enforcement Policy. Duke has reviewed and wishes to set forth, the totality of its efforts at McGuire regarding Duke's efforts to correct weaknesses in the McGuire operations area with respect both to McGuire's IVP and personnel areas related to failure to follow procedures.

1. Effectiveness of Previous Corrective Action

The discussion that follows traces the course of Duke's efforts with respect both to independent verification and procedural compliance, efforts undertaken both on Duke's own initiative and in response to SALP Reports, to correct weaknesses in these areas. Duke also will provide information with respect to events occurring because of deficiencies in the Independent Verification Program and lack of procedural compliance. That information clearly shows a marked decline in these events because of Duke's efforts. When the totality of the information is examined by the NRC, Duke is confident that the NRC will conclude that escalation on this basis is unwarranted.

a. The Independent Verification Program

As a result of a March, 1983 incident at Oconee, Duke undertook an effort substantially to upgrade the Independent Verification Programs (IVP) at all its nuclear stations, including McGuire. The actions included revision of Duke's Administrative Policy Manual (APM) for Nuclear Stations to include a broader IVP, as well as steps to expand markedly the scope of the IVP and the methods used to implement IVP. The revisions included clarification and further guidance in defining independent verification, personnel qualifications, the independence of personnel performing the independent verification process, means of performing independent verification and applicability of the IVP. The revisions to the APM became effective October 21, 1983 and the upgraded requirements were implemented at McGuire on January 1, 1984.

Following adoption of the revised IVP at McGuire, but prior to its full implementation, an event (later addressed in Enforcement Action EA 84-37) occurred, in October, 1983 which raised questions as to the adequacy of the program. Therefore, Duke General Office personnel performed, in October, 1983, an informal audit of the McGuire IVP. That audit demonstrated that, though McGuire personnel clearly understood the technical concept of independent verification, there was a need for additional training in the application of the concept. Therefore, a Duke working group developed a detailed departmental directive on independent verification, emphasizing purpose, definition and procedures relating to independent verification. Other improvements to the program included the development of a comprehensive training program for independent verification, procedures, and quality of operations for new employee training.

In sum, following the March, 1983, incident at Oconee, and the October, 1983, incident at McGuire Duke made the following changes to McGuires' IVP:

- A Nuclear Production Department Directive was implemented to establish Department standards of Independent Verification;
- The Departments' APM was revised to include a definition of Independent Verification and its use in station procedures;

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- In 1983 Department management held meetings with all station employees concerning the IVP;
- Follow-up meetings were conducted by station management with all station employees concerning the IVP; and,
- 5. Video tape presentations concerning the IVP were shown to all station employees.

These actions were completed in, and the program has been fully in place since, 1984. The attached Table shows the declining trend in IVP and personnel related errors since that time. Therefore, Duke believes there is justification for its conclusion that the IVP in place at McGuire has been highly successful in reducing the number of incidents attributable to adequacy of the IVP.

b. Fersonnel Failure To Follow Procedures

There is a question though, regarding personnel error for failure to follow procedures. In that regard, Duke acknowledges that, as pointed out by the NRC in its SALPs, and as its McGuire enforcement history indicates, failure of personnel to follow procedures has been a weakness in the McGuire operations area in the past. However, Duke believes that it has taken action during the last few years that have achieved positive results in this area.

In June of 1984, the Station initiated Abnormal Plant Event Meetings. At those meetings, Station Management, personnel involved, and Duke General Office groups, if appropriate, discuss the root cause of Abnormal Events and any necessary corrective action to prevent recurrence.

In June and July, 1985, the Station Manager conducted meetings with all supervisory (exempt) employees emphasizing the need to follow procedures and to take time to perform work correctly. At these meetings a letter signed by both Duke's General Manager, Nuclear Stations, and the McGuire Station Manager was delivered to each supervisory employee. The letter, which was discussed during the meeting, emphasized that Duke's philosophy is to place high-quality error-free work and safety considerations above plant schedules. Each supervisor subsequently discussed the letter, and the meeting, itself, with his subordinates (hourly employees). It has also been Duke's practice to impress upon new hourly employees that professionalism, operational quality and procedural compliance are required of them as Duke employees.

In March 1986, the McGuire Station Manager took further action to emphasize the importance of strict adherence to procedures by conducting meetings with approximately 70% of the supervisory and staff personnel. The remainder of staff not attending were informed of the meetings through meeting notes. The Station Manager emphasized the need for all personnel to be conservative and thorough in making operational determinations, the urgent need to assure compliance with Tech Spec Surveillance requirements; and the need for line supervision to observe and to enforce strict adherence to safety practices and station procedures. That message was in turn relayed to station employees by their supervisor. The Station Manager routinely conducts this type of meeting with Supervisory and Staff personnel. At each meeting quality and nuclear safety are emphasized.

Duke believes that these actions, taken at McGuire over the past three and one-half years, have achieved very positive results in reducing personnel errors for failure to follow procedures. The positive trend in reduction of personnel failure to follow procedures is shown in the attached Tables. For example, in 1985 the average rate of error involving personnel error LERs was 1.75/month. In 1986, the rate was 1.0/month. Through November 1, 1987 the rate has been 1.0/month. During the time from 1984 to the present, reactor trips attributable to personnel error were reduced from 4 in 1984 to 1 as of November 1, 1987. It should be noted that during 1986 and 1987 none of the personnel errors which resulted in reactor trips were attributed to operators.

Duke believes that these improvements in the rate of personnel failures to follow procedures are reflected in improved SALP ratings. Certainly it is not inconsistent with improved ratings and the factors outlined above for the NRC to recognize Duke's efforts and improvements in this area and not escalate the civil penalty. Duke's goal is to achieve zero personnel errors; however, as the NRC understands, as a practical matter no program, no matter how well designed and implemented, can ever be entirely free of personnel error. Duke submits, however, that it should be given credit for its actions in this regard. Certainly its accomplishments in this area should not be penalized.

2. Overall Performance (Prior SALP Reports)

The NRC believes that past poor performance in the area of concern has been documented in the McGuire SALPs. While Duke's prior history in the area of concern has been below average, recent events weigh against the NRC's reliance upon the SALPs for the purpose of escalation. Taken collectively, the SALP ratings reflect a problem that, as the result of substantial efforts on the part of Duke over the last few years, has shown marked improvement. Had Duke received two recent Category 3 SALP ratings in operations, it would agree that those ratings might be used to escalate the base civil penalty. However, since the most recent rating in plant operations is a Category 2, 1/ Duke does not consider it appropriate to be penalized as it improves, and obviously has improved, to "satisfactory performance with respect to operational" matters. More importantly, Duke believes that the NRC has drawn incorrect inferences through an examination of only the SALPs. Duke believes that in this instance, where the NRC seeks to impose what are in effect punitive damages on Duke, what must be examined is the totality of Duke's program with particular emphasis on responses to weaknesses identified both by Duke and by the NRC. For example, the NRC points to Duke's past SALP reports at McGuire in the operations area as a partial basis for the escalation. Duke believes, however, when the SALP reports are reviewed in conjunction with the actions taken by Duke to improve in this area (many in response to the Category 3 ratings) over the past few years, (as discussed in Section B. 1. above), and assesses the effectiveness of that corrective action, the totality of Duke's program will not support a conclusion that the civil penalty should be escalated.

There are two SALP Reports in which Duke received a Category 3 rating in the operations area at McGuire. The first was issued December 31, 1984, the second June 19, 1986. The most recent SALP Report was issued October 28, 1987, and as noted above, McGuire received a Category 2 rating in operations.

The December 31, 1984, SALP Report covered the period May 1, 1983 through August 31, 1984. As the basis for the Category 3 rating in the operational area the SALP Board noted that "a weakness was observed in procedural compliance" and that during the period of time covered the failure rate of plant personnel to follow procedures increased. (1984 McGuire SALP, pp 3,5) The SALP Board also counted as a weakness Duke's implementation of an independent verification program at McGuire.

The June 19, 1986, SALP Report covered the period September 1, 1984, through February 28, 1986. As the basis for the Category 3 rating in

^{1/} Category 2: NRC attention should be maintained at normal levels. Licensee management attention and involvement are evident and are concerned with nuclear safety; licensee resources are adequate and are reasonably effective such that satisfactory performance with respect to operational safety or construction quality is being achieved.

operations, the Board noted that though operating procedures were adequate, on a number of occasions the procedures were not followed by Plant personnel, which resulted in enforcement action. The Board concluded by expressing its concern with the number of violations in the Plant operations category, but noted its encouragement with "an apparent positive trend during the SALP period that corresponds in time with changes in onsite management." (1986 McGuire SALP, pp. 4,8).

Clearly the 1984 and 1986 SALP reports indicated that the SALP Board found weaknesses both with respect to Duke's independent verification program at McGuire and with following procedures. However, the October 28, 1987, SALP Report which covered the period from March 1, 1986 through July 31, 1987, found "significant improvement in overall plant operations over that of the previous SALP period", and rated Plant operations as a Category 2. Specifically, the SALP report stated:

The quality of operations at McGuire has improved and is improving. Licensee upper management has been extensively involved in the establishment of corrective actions for violations and for other abnormal plant events. It has stressed the importance of following plant procedures and identifying deficiencies in those procedures. Senior plant management is involved in the day-to-day operation of the plant and tracks the daily status of known equipment operability deficiencies in management meetings. The more active management involvement in daily operations has had a positive effect on plant operations and personnel morale. The effect has been most evident in the marked decrease in the number of personnel errors which have historically resulted in unit trips and ESF actuations. The ability to operate the units for extended periods of time without significant problems or unplanned trips has also had a positive impact on personnel morale.

Duke is mindful of the SALP Board's statement that: "Yet, procedural compliance continues to be a weakness in the McGuire Operations Program." However, as the discussion in Section B. 1. indicates, matters have been improving in this area such that the punitive measure of doubling the base civil penalty is unwarranted.

3. Prior Enforcement History

The NRC states that:

There were two earlier events documented which contained a number of similarities to the incident for which this Notice is written. The first occurred on January 3, 1985 and is addressed in Station Investigation Report 2-85-01 which concerned an incident where a control board switch with indicator lights extinguished went unnoticed for an unknown period of time. The second incident occurred on October 22, 1985, and was addressed in Station Investigation Report 1-85-47 and Licensee Event Report 369/85-37. This second event listed improper independent verification as a primary cause in a Train "A" Engineered Safety Features actuation.

The NRC further asserts that these events are specific documentation of weaknesses in the operations area which support increasing the civil penalty

amount by 100%. Duke does not agree. As noted above, prior enforcement history, including Severity Level IV and V violations in the area of concern are matters which will be considered in determining whether escalation is appropriate. (10 CFR Part 2, App. C.V.B) Under that guidance consideration of either of these matters is inappropriate. The first event, documented in Station Investigation Report 2-85-01, never even rose to the level of a Licensee Event Report, let alone became the subject of an NRC Notice of Violation. Therefore, for this reason alone this event should not be relied on by the NRC as the basis for escalation. $\underline{2}/$

There is an additional reason, however, why the NRC should not rely on either of these events as support for escalating the base civil penalty. The first event occurred in January of 1985, the second in October of 1985, both more than two years ago. As Duke has shown above, there has been a consistent downwards trend in events attributable to Independent Verification and failure to follow procedures. For the NRC in late 1987 to reach back in time more than two years to choose two events as support for escalation of a base civil penalty for an event which occurred in mid-1987 is to ignore the substantial efforts, resulting in significant positive results, which Duke has made over the past few years to correct weaknesses in plant operations at McGuire. This action would appear to be in conflict with the goals of the Enforcement Policy.

C. ALLEGED INADEQUATE CORRECTIVE ACTIONS

The Enforcement Policy recognizes that corrective actions can be considered in assessing whether to mitigate or escalate civil penalties. Specifically, the Enforcement Policy states:

promptness and extent to which the licensee takes corrective action, including actions to prevent recurrence, may be considered in modifying the civil penalty to be assessed. Unusually prompt and extensive corrective action may result in reducing the proposed civil penalty as much as 50% ... On the other hand, the civil penalty may be increased as much as 50% ... In weighing this factor, consideration will be given to, among other things, the timeliness of the corrective action, degree of licensee initiative and comprehensiveness of the corrective action...

2/ Duke realizes, of course, that the Enforcement Policy (V.B.4) "Prior Notice of Similar Events" permits an increase up to 50% for "cases where the licensee had prior notice of a problem as a result of a licensee audit, or specific NRC or industry notification..."and fails to take effective preventive steps. Duke does not believe the referenced event properly falls within this category. First, the event is not a matter discovered from a licensee audit or NRC or industry notification. Instead, this event was discovered through "operator control board scan" and reported in an Incident Investigation Report. Second, the incident occurred in January of 1985. As discussed in the text, above, to use this event as a basis for escalation of the base civil penalty is to ignore the efforts Duke has made to correct problems in operations at McGuire. There are two separate reasons for objecting to the Staff's assertion that improper corrective action should serve as the basis for escalating the base civil penalty: (1) such use constitutes improper double counting, and/or (2) conflict with Enforcement Policy.

First, Violation C states:

"Contrary to [10 C.F.R., Part 50, Appendix B, Criterion XVI], the inoperability of the 1A diesel generator which occurred on July 26, 1987, was not promptly identified in that, despite multiple indications of the problem in the control room the inoperable condition continued to exist, through multiple control room shift turnovers, until July 30, 1987. Additionally, this condition was not properly corrected in that, when the indications of the problem with the 1A diesel generator control power were recognized, a work request was issued to correct only a perceived control room indicator problem."

This violation served as one of the three grounds for the base civil penalty. (Violation C) However, in its discussion of escalation, the NRC relies upon the same circumstances, stating:

The corrective actions taken on July 29, 1987 were not only inadequate and non-conservative, in that it was assumed the problem was in the control panel indicators and not in the diesel generator itself, but untimely in that it was not recognized promptly that the indicator light was out. Specifically, multiple shift turnovers occurred during the time the diesel generator was inoperable yet, none of the licensed operators involved recognized the significance of the multiple indications of the problem available to them.

Duke maintains that this is improper double counting. Either this issue (i.e., earlier identification and correction of the problem) is part of the violation, or is part of the bases for escalation. It cannot be both. The Enforcement Policy does not permit the Staff to count each violation to establish a severity level and civil penalty and then to count again the same violation to escalate that civil penalty.

Second, reference to actions during the violation period should not be viowed as "corrective action to prevent recurrence." 10 C.F.R. Part 2, /opendix C, §V.B.2 discusses "immediate actions to correct the problem <u>upon</u> <u>discovery</u> (emphasis added)." The discovery of the violation did not occur until July 30, 1987. Therefore, corrective action must be assessed from that time forward. As our discussion indicates, prompt and extensive corrective actions were taken subsequent to this discovery. As discussed at the September 15, 1987 Enforcement Conference, Duke has been very responsive to the need for extensive corrective actions that will prevent a similar violation from occurring in the future. These corrective actions as discussed in Attachment II, were promptly taken upon the discovery of the violation and are extensive in their scope. Corrective actions that have been taken include the following:

- a) The Nuclear Equipment Operators involved in the incident were disciplined for their failure to adequately follow independent verification and removal and restoration procedures.
- b) New tags stating that "pulling fuses will not prevent a diesel generator start" were placed on all diesel generator 4160 volt breakers.
- c) In addressing one of the root causes of the incident, a tagging policy, developed at a shift supervisors meeting was changed to delete the pulling of fuses for nuclear service water pump work. Instead, a more reliable white tagging system, which indicates that the associated breaker is open, is being used.
- d) Continuing increased emphasis is being placed on all control board deficiencies, including the 1.47 bypass panel. The problems associated with this panel contributed to how the operator responded to the unlit indicator light and is therefore considered to also be a root cause of the incident. The pace of correcting the panel and other Control Board deficiencies is trended in the Station Managers' daily plant status meeting.
- e) A Nuclear Station Modification to change the control board annunciator for diesel generator control power to alarm, whenever the control power breaker is open, has been approved and will be implemented.
- f) The computerized Removal and Restoration procedure form has been revised to be McGuire specific and has been made similar to the manual form.
- g) The reactor operator and nuclear equipment operators turnover check sheets have been revised to include the diesel generator as a check-off item.
- A need to perform more thorough control board walk-downs is being emphasized in control room operator training sessions and on a daily basis.

In addition, McGuire is currently incorporating in licensed operator and non-licensed operator training programs a review of this incident to emphasize the importance of independent verification of equipment status. Further, Duke will re-emphasize, by a periodic review, of the relevant Operations Management Procedure, the need to strictly adhere to all plant procedures and the need for attention to detail.

In sum, the issue of corrective action should not be viewed as an escalation factor. The Staff cannot argue otherwise since the Notice of Violation does not refer to corrective actions subsequent to July 30, 1987. If any mention is to be made of corrective action, Duke would argue that, rather than escalation, the corrective action taken should be viewed as an appropriate consideration for mitigation.

D. CONCLUSION

For the reasons set forth above, Duke believes the base civil penalty should not be escalated.

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YEAR	TOTAL NUMBER OF LERS	LERS INVOLVING PERSONNEL ERROR		
1984	60	16		
1985	69	21		
1986	41	12		
1987*	41	10		

TABLE 1 - LICENSEE EVENT REPORTS

TABLE 2 - REACTOR TRIPS

YEAR	TOTAL NUMBER REACTOR TRIPS	REACTOR TRIPS INVOLVING PERSONNEL ERROR
1984	19	r.
1985	15	2
1986	9	2
1987*	5	1

TABLE 3 - VIOLATIONS**

	YEAR	TOTAL NUMBER OF VIOLATIONS		V	VIOLATIONS INVOLVING PERSONNEL ERROR					
-	1984	21		4	-	3	involved	inadequate	IV	
	1985	33		9	-	2	involved	inadequate	IV	
	1986	25	***	7		2	involved	inadequate	IV	
	1987*	17		3		1	involved	inadequate	IV	

- * Through November 1, 1987.
- ** From 1984 to November 1, 1987 McGuire has received 96 violations. Eight of the 96 violations involved inadequate independent verification. Only twelve involved errors committed by Operations.
- *** Three violations categorized as personnel error in NRC inspection reports were determined, by Duke, to be attributed to other causes and stated as such in Duke's response to the violations. Subsequently, NRC transmitted a response to Duke stating that Duke's response to the violations met the requirements of 10CFR 2.201. Therefore, this listing of violations does not categorize the three violations as personnel error.

ATTACHMENT II

DUKE FOWER COMPANY MCGUIRE NUCLEAR STATION

Reply To Notice Of Violation Enforcement Action 87-163 Inspection Report Nos. 50-369/87-26 and 50-370/87-26

A. Technical Specification 3.8.1.1 requires that two physically independent circuits between the offsite transmission network and the onsite essential auxiliary power system, and two separate and independent diesel generators be operable in Modes 1, 2, 3, and 4. With only one diesel generator operable restore the inoperable diesel generator to operable status within 72 hours or place the plant in HOT STANDBY within the next 6 hours and COLD SHUTDOWN within the following 30 hours.

Contrary to the above, from 6:00 p.m. on July 26, 1987, until 12:30 p.m., on July 30, 1987, a total of 90.5 hours, while in Mode 1, diesel generator 1A was inoperable in that it was unable to be automatically started by an initiating signal due to the lack of control power. Further, the plant was not placed in HOT STANDBY as required.

RESPONSE

1. Admission or denial of violation:

Duke admits the violation occurred.

2. Reason for the violation if admitted:

The violation occurred as a result of personnel error. Nuclear Equipment Operators (NEOs) responsible for restoring the Diesel Generator 1A Control Power Breaker to the closed position did not fulfill the requirements of the Tagout/Removal And Restoration Procedure, (OMP 2-17) in that they did not perform proper independent verification. Because of this error, the Diesel Generator 1A Emergency Breaker Control Power Fuses were verified instead of the Diesel Generator 1A Control Power Breaker.

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

The NEOs involved have been disciplined and their supervision was counselled.

4. Corrective steps planned to avoid further violations:

A "case study" of this event will be included in Operator Requalification Training for all licensed and non-licensed operators. The case study consists of a lesson plan using the Enforcement Conference presentation package. The following items are discussed:

1. Description of events;

- Mistakes made with respect to handling the Removal and Restoration document, supervisory instructions, and review of the work package;
- Control Board review mistakes, why they occurred, and emphasis on improved performance of Control Board reviews;
- Improper independent verification, how it happened, why, and how it should have been performed; and,
- 5. 1.47 panel, its use, the reason for it and emphasis on compliance with REG GUIDE 1.47 in that appropriate control room review of the 1.47 panel is mandatory.
- 5. The date when full compliance will be achieved:

The case study was incorporated into Segment V of the Operations Requalification Training program which began October 12, 1987 and will be completed December 15, 1987. As of November 25, 1987, four of the five Operation shifts (approximately 120 Operations personnel) have received the "case study" training.

B. Technical Specification 6.8.1 requires in part that written procedures shall be implemented for the activities recommended in NUREG-0737, Item I.C.6 Independent Verification. Operations Management Procedure (OMP) 2-17 in part, implements these requirements for independent verification.

Contrary to the above, following the failure of the Nuclear Equipment Operators (NEO) to close the diesel generator 1A control power breaker which led to the July 26, 1987, violation of Technical Specification 3.8.1.1, OMP 2-17 was not properly implemented in that, the closure of the control power breaker for diesel generator 1A was not independently verified.

RESPONSE

1. Admission or denial of violation:

Duke admits the violation occurred.

2. Reason for the violation if admitted:

The Tagout/Removal and Restoration Procedure (OMP 2-17) complied with Technical Specification 6.8.1 in that the procedure does require independent verification and documentation for the removal and restoration of components requiring independent verification. However, the NEOs responsible for carrying out the procedure used incorrect practices in performing the independent verification. In doing so, the NEOs verified the Diesel Generator 1A Emergency Breaker Control Power Fuses instead of the Diesel Generator 1A Control Power Breaker.



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

The following corrective actions have been taken:

- A) The NEOs involved have been disciplined and their supervisor has been counselled;
- B) Permanent identification tags have been placed at all Diesel Generator 4160V Breakers as a reminder to Operation's personnel that pulling fuses will not prevent a Diesel Generator start; and,
- C) The tagging policy has been changed to delete pulling fuses for Nuclear Service Water Pump work and to require white tagging the Diesel Generator Control Power Breaker.
- Corrective steps planned to avoid further violations:
 - A) A "case study" of this event will be included in Operator Regualification Training for all licensed and non-licensed operators.
 - B) OMP 1-6, Independent Verification, is being revised to more clearly give instructions to identify the steps in verifying equipment to make sure operators are on the right piece of equipment or component.
- 5. The date when full compliance will be achieved:

December 15, 1987 (Reference Response A.5 above)

C. 10CFR 50 Appendix B, Criterion XVI requires in part, that conditions adverse to quality be promptly identified and corrected.

Contrary to the above, the inoperability of the 1A diesel generator which occurred on July 26, 1987, was not promptly identified in that, despite multiple indications of the problem in the control room the inoperable condition continued to exist, through multiple control room shift turnovers, until July 30, 1987. Additionally, this condition was not properly corrected in that, when the indications of the problem with the 1A diesel generator control power were recognized, a work request was issued to correct only a perceived control room indicator problem.

RESPONSE

1. Admission or denial of violation:

Duke admits the violation occurred.

2. Reason for the violation if admitted:

The Control Board reviews were not thorough enough. Several factors contributed to this problem:

- A) The annunciator light for the Diesel Generator 1A Control Power Trouble does not illuminate when the Control Power Breaker is open;
- B) The 1.47 Rypass Panel check is not on the newly implemented computer generated "Removal and Restoration" sheets;
- C) The Diesel Generator Control Power is not listed on the Reactor Operator and NEO Turnover Sheets; and,
- D) The 1.47 Bypass Panel has not received the emphasis for the completion of outstanding work requests that other Control Room indication have, such as Control Room Annunciators, Meters, Alarms, or Control Switches.

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

The following corrective actions have been taken:

- A) A Nuclear Station Modification has been written and approved to add an audible alarm to the Control Board for Diesel Generator Control Power Trouble to alarm when the Control Power Breaker is open;
- B) The Reactor Operator and NEO Turnover Check Sheets have been revised to include instructions for an NEO to check the Diesel Generator Control Power at the breaker panel and a Control Room Operator to check the control board indicator;
- C) Operations supervision has emphasized to Control Room Operators that more thorough Control Board walkdowns must be performed; and,
- D) Station Management has placed increased emphasis on ail Control Board deficiencies to include the 1.47 Bypass Panel. Outstanding deficiencies are addressed daily in the Plant Manager's status meeting.

4. Corrective steps planned to avoid further violations:

The following are actions that will be taken:

- A) As a result of the Station Problem Reports above, Nuclear Station Modifications MG-1-2085 and MG-2-2085 have been written and are currently in the design process; and
- B) The computerized Removal and Restoration form has been revised, the revision approved, and the new forms will be ordered.

5. The date when full compliance will be achieved:

A) October 1, 1988.

B) When the new forms are delivered from the printer and reviewed to ensure the new forms are correct, they will be implemented for use. At this time, the date of completion cannot be determined; however, this matter will be handled expeditiously. ø

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