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ACCESSION NBR: 9603270090 DOC.DATE: 96/03/21 NOTARIZED: NO DOCKET #
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 50-270 Oconee Nuclear Station, Unit 2, Duke Power Co. 05000270
 50-287 Oconee Nuclear Station, Unit 3, Duke Power Co. 05000287

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SUBJECT: Responds to NRC 960222 ltr re violations & deviations noted
 in insp rept 50-269,270,287/95-30 on 951217-960127.
 Corrective actions: workers trained on self-checking
 techniques. Procedure changes made to PT/0/A/0600/01.

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DUKE POWER

March 21, 1996

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

Subject: Oconee Nuclear Site
Reply to Notice of Violation
Reply to Notice of Deviation
Inspection Report Nos.50-269/95-30,
50-270/95-30, and 50-287/95-30

Gentlemen:

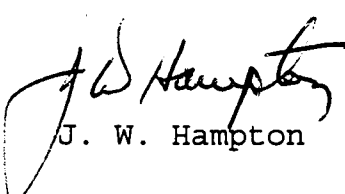
By letter dated February 22, 1996, the NRC transmitted a Notice of Violation and Notice of Deviation related to an NRC inspection conducted from December 17, 1995, to January 27, 1996.

The violation involves examples of procedural errors resulting in wrong unit or component events. Duke Power Company acknowledges this violation. Oconee Management agrees with the concern noted in the subject inspection report that inadequate self checking caused the procedural error. Oconee Management is stressing the importance of good work practices to all individuals. Pursuant to 10 CFR 2.201, Attachment 1 provides a written reply to the Notice of Violation identified in the subject inspection report.

The deviation from Section 9.1.4.2.3 of the Final Safety Analysis Report is acknowledged by Duke Power Company. Pursuant to 10 CFR 2.201, Attachment 2 provides a written reply to the Notice of Deviation identified in the subject inspection report.

NRC commitments associated with this correspondence are provided in Attachments 1 and 2.

Very truly yours,


J. W. Hampton

Attachment

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Document Control Desk

March 21, 1996

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cc: Mr. S. D. Ebnetter, Regional Administrator
U.S. Nuclear Regulatory Commission, Region II

Mr. L. A. Wiens, Project Manager
Office of Nuclear Reactor Regulation

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

Attachment 1
Reply to Notice of Violation (Reply)
Violation 50-269, 270, 287/95-30-01

Restatement of the violation:

Technical Specification 6.4.1 requires, in part, that the station shall be operated and maintained in accordance with approved procedures.

Performance Test Procedure PT/1/A/150/22/L, Turbine Driven Emergency Feedwater (TDEFW) Pump Cooling Water Supply Valve Test, provides instructions to test the Unit 1 Turbine Driven Emergency Feedwater Pump cooling water supply valve. Step 12.9 requires placing the Unit 1 TDEFW pump switch in RUN.

Removal and Restoration Procedure OP/O/A/1102/06, Enclosure 3.1, in conjunction with information on equipment and component tags, provides specific instructions to isolate and remove equipment from service.

Contrary to the above, these requirements were not met in that:

1. On January 22, 1996, a licensed operator placed the Unit 2 TDEFW pump switch in RUN instead of the Unit 1 TDEFW pump switch as required by step 12.9 of PT/1/A/150/22/L. This resulted in the inadvertent starting of the Unit 2 TDEFW pump.
2. On January 23, 1996, a non-licensed operator isolated and tagged Air Handling Unit 2-16 instead of Auxiliary Building Exhaust Fan 1-16 as required by Restoration and Removal tag #96-0081-5.

Attachment 1
Reply to Notice of Violation (Reply)
Violation 50-269, 270, 287/95-30-01

1. Reason for the violation

Duke Power Company acknowledges this violation. NRC Violation 95-30-01 addresses two incidents where components were mispositioned. For both events, a Human Performance Analysis was performed to determine the reason for the mispositioned components. The Human Performance Analysis determined that in both events the mispositioned component was the result of inadequate self-checking techniques. The actions involved in these events do not indicate a programmatic problem because rules are in place and workers have been trained on self-checking techniques. The results show an individual accountability issue because adequate skills were not used to perform the task.

2. Corrective Actions taken

- a. A Problem Investigation Report (PIP) was written on each event. Operations also requested a Human Performance Analysis to be performed on each event. The Human Performance Analysis determined the cause of the events was misuse of self-checking techniques.
- b. The individuals involved in these events were counseled on the importance of using the STAR (Stop, Think, Act, Review) self-checking technique. The Operations Shift Manager (OSM) personally addressed the individuals involved and expressed his expectations concerning STAR.
- c. Following each event, the Operations Shift Manager for the shift called a 'work stand down' to discuss the events, and to refocus shift personnel on using good work practices.

Attachment 1
Reply to Notice of Violation (Reply)
Violation 50-269, 270, 287/95-30-01

- d. A special OSM meeting was held on January 23rd (the date of the second event) to address Operations work practices. The Station Manager, Shift Operations Manager, Superintendent of Operations designee and all five OSMs attended this meeting. This meeting covered the two events addressed in this violation and emphasized the use of STAR and other good work practices. This information was carried back to the Operations shift to increase awareness. Each OSM was asked to begin his shift with a 'work stand down' to address these events.
- e. Site wide 'work stand down' meetings were held on January 25th. These meetings were called by the Oconee Nuclear Site Vice President. Guidelines from the Vice President, in the form of a letter, were given to each supervisor who in turn discussed expectations with their employees. These meetings were held to increase awareness on a site level and to reemphasize the need for good work practices.
- f. The Oconee Nuclear Site Vice President called another site wide 'work stand down' on February 15th. This meeting covered success stories that have occurred this year as a result of using good work practices. The tools used to correct and maintain good work practices (such as STAR) were discussed during these meetings.

3. Planned Corrective Actions to be taken

No further corrective actions are planned for this event.

4. Date when full compliance will be achieved

All of the above corrective actions have been completed. Therefore, Duke Power is in full compliance.

Attachment 2
Reply to Notice of Deviation (Reply)
Deviation 50-269, 270, 287/95-30-03

Restatement of Deviation:

During an NRC inspection conducted December 17, 1995 - January 27, 1996, a deviation of your Final Safety Analysis Report was identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Action," NUREG-1600, the deviation is listed below:

Final Safety Analysis Report section 9.1.4.2.3 states, in part, "The fuel storage racks provide a minimum of 23.5 feet of water shielding over stored assemblies."

Contrary to the above, on January 17, 1996, the inspector identified that procedures PT/O/A/0600/01, Periodic Instrument Surveillance, and MP/O/A/1500/009, Defueling/Refueling Procedure, describe that the spent fuel pool level will be maintained greater than -2.0 feet from zero (i.e., normal operating level). The requirement of greater than -2.0 feet from zero, translates into a minimum of 21.5 feet of water shielding over the stored assemblies.

1. The reason for the deviation:

Duke Power Company acknowledges that this is a deviation. Research does not reveal the cause of the discrepancy but has revealed that the -2.0 feet lower level limit has been in effect since the first refueling outage of Oconee Unit 1 in 1974. Also, upon review it was determined that the statement regarding a minimum of 23.5 feet has been in Oconee's FSAR at least since 1971. Therefore, this discrepancy has been in existence since Oconee's original license.

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

Corrective actions were implemented to achieve compliance with the FSAR. Procedure changes were made to PT/O/A/0600/01 to raise the pool level lower limit to require at least 23.5 feet of

Attachment 2
Reply to Notice of Deviation (Reply)
Deviation 50-269, 270, 287/95-30-03

water over the storage racks. Also, MP/0/A/1500/009, Defueling/Refueling Procedure, was placed on administrative hold and will not be used until changes are made. A review of other procedures referencing spent fuel pool (SFP) level has been completed and those not meeting the minimum depth requirements have been placed on administrative hold until changes are made. The SFP Statalarm setpoint minimums have also been changed to alarm at a minimum level of 23.5 feet of water over the storage racks.

In addition, an engineering review of SFP dose rates was performed to assess the dose impact of a two-foot change in SFP level. The shielding calculations concluded that there is a negligible increase in dose rate if the level is decreased from 23.5 to 21.5 feet above the assemblies.

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

Because of the results of the shielding calculations, a minimum water depth over the storage racks of 21.5 feet (-2 feet level) has been justified. FSAR Section 9.1.4.2.3 will be revised to state that the 23.5 feet of water depth is a nominal depth, not a minimum depth. Following the planned FSAR revision, procedure limits and control room alarms for pool level will be set at, or above, the minimum of 21.5 feet according to operational and ALARA considerations. In addition, FSAR Section 9.1.4 is being reviewed and revised, as necessary, to reflect actual conditions at Oconee and to ensure that no other discrepancies exist.

4. The date when full compliance will be achieved:

Oconee is currently in compliance with its FSAR. Current procedural limits assure at least 23.5 feet of water over the stored assemblies. By completing the corrective actions outlined in paragraph 3, Oconee will remain in compliance with its FSAR.