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SUBJECT: Responds to NRC 890908 ltr re violations noted in Insp Repts
 50-269/89-25, 50-270/89-25 & 50-287/89-25.

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October 9, 1989

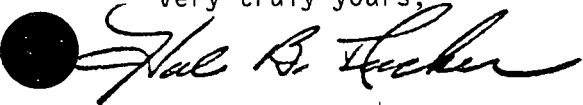
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Subject: Oconee Nuclear Station
Docket Nos. 50-269, -270, -287
Inspection Report 50-269, -270, -287/89-25-02

Gentlemen:

By a NRC letter dated September 8, 1989 a notice of violation and Inspection Report 50-269, -270, and 287-89-25 was transmitted to me. As required by 10 CFR 2.201, I am submitting a written response to the violation identified in the inspection report.

Very truly yours,



Hal B. Tucker

RRE/82/td

Attachment

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October 9, 1989
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OS-815.01

Duke Power Company
Oconee Nuclear Station

VIOLATION

10 CFR 50 Appendix B, Criterion XVI and Section 17.2.16 of the Accepted Quality Assurance Program require that measures be established to assure that significant conditions adverse to quality are promptly identified, corrected and action be taken to preclude repetition.

Contrary to the above, the corrective actions to preclude repetition of significant conditions adverse to quality were not adequate, in that:

- a. Instrument Procedure IP/O/A/0301/003U: Procedure to reset the flux/imbalance/flow and high flux trips for operation with excessive power tilt or other conditions, was not revised sufficiently to address performance with dummy bistables installed after a previous reactor trip under similar conditions. This contributed to a subsequent reactor trip.
- b. Improvements to Maintenance Work Request directives and specific work groups methods of implementing those directives taken as a result of inadequate testing of a containment isolation valve (as identified in LER 269/88-01) were not adequate to prevent a second incident of an Engineered Safeguards Containment Isolation valve being returned to service with adequate testing.

RESPONSE A:

1. Admission or denial of the alleged violation:

We admit the violation as stated. Both events were with the RPS and with a dummy bistable in place. Both events were a result of personnel error. Beyond these similarities there were significant differences in the two events.

The first event involved an on-line procedure that was formatted with separate data and instruction packages. While specific precautions were in the instruction package, they were not in the data package. A personnel error occurred when the technician did not follow information in the instruction package and subsequently tripped the unit.

The second event involved the use of a procedure written to accomplish a specific action (i.e. Reset the Flux/Imbalance/Flow and high flux trips for operation with excessive power tilt). This procedure contained limit, precautions, data, sign-offs, in one package (i.e. one package, not separate instruction and data packages). Specific information existed in the procedure for accomplishing the objectives while dummy bistables were installed. A personnel error occurred with the technician did not accurately complete a specific/clear step in the procedure.

LEO

2. Reason for Violation:

In the procedure reviews completed in January, changes were made to the on-line procedures to include specific precautions in the data packages to alert the technician. The event was also reviewed within the I&E group detailing what had occurred and the steps taken to resolve the problems. The other related RPS procedures were reviewed and felt to be adequate as they existed since they are not structured with separate instruction and data packages. Limits, precautions, notes, and cautions on the necessary actions required if a dummy bistable was installed were included in the body of these procedures.

As a result of the August trip further review of other than on-line RPS procedures indicates that while adequate instructions are in the procedures, additional information, independent verification or operation interaction can enhance the procedures and limit opportunities for unit trips when performing the procedures.

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

Procedure IP/O/A/0301/003U has been reviewed and changes incorporated to address the concerns of the incident. The procedure changes include interaction with the Operations group to ensure that the RPS Channel where work is being performed is in the appropriate condition prior to removal/returning the Channel to service and independent verification sign-offs included to verify that the proper conditions exist prior to performing the next step. Also, the method of handling a dummy bistable has been changed to avoid having a Channel tripped while working on another Channel. This means that if dummy bistable is installed, the Channel with the dummy will not be tripped. The Channel to be worked on will be tripped instead (if the Channel to be worked in contains the Dummy it will be placed in Manual Bypass). This approach meets the intent of Tech Specs and FSAR for ensuring that the necessary system logic is maintained. This will prevent the Channel from tripping with another Channel already tripped when being returned to service (if the Channel is tripped it must be reset to return to service). Sign-off steps have been added to the final actions for returning the system to service. The calculations have been provided in an enclosure.

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

All other RPS procedures will be reviewed and the items discussed in step 3 incorporated as necessary.

5. Date of full compliance:

The balance of the RPS procedures will be complete April 1, 1990.

RESPONSE B.

1. Admission or denial of the alleged violation:

The violation is admitted as stated.

2. Reason for violation:

- A. The actual scope of the work was not known until after trouble-shooting had occurred.
- B. The Planner failed to list the retest requirements in Section VIII of the Work Request although the retest group (Performance) was identified in Section II of the Work Request.
- C. Mis-communications between the retest group and craft.
- D. Performance failed to review the Action Taken (Section V) Section of the Work Request after the maintenance work was completed in order to verify what was actually done so the proper retest could be determined and then performed.

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

- A. The significance and details of this incident has been communicated to Planning & Scheduling personnel.

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

- A. The person completing Section II of the Work Request will notify all involved test groups outside of Maintenance of the expected work scope and schedule. This contact should include discussion of potential work scope, potentially required tests, required test conditions which might require deferral of maintenance, and the preliminary schedule.
- B. The person completing Section II of the Work Request shall enter the type(s) of required Post Maintenance Test (stroke, leak rate, etc.) in Section VIII. On back shift or weekends, the Duty Planner will be consulted if necessary.

- C. The performance section directive will be revised to assure that predetermined testing requirements are properly specified by appropriate personnel. That at completion of the maintenance work defined in the work request, performance personnel will verify what work was done so that the appropriate test can be performed. The change in the directive will provide detailed instructions on how performance personnel will accomplish this task. Finally, the performance directive will be revised to provide additional instruction on how to complete Section VIII of the work request.

5. Date of full compliance:

Target date is December 22, 1989.