

ACCELERATED DISTRIBUTION DEMONSTRATION SYSTEM

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

SESSION NBR:9008060033 DOC.DATE: 90/07/18 NOTARIZED: NO DOCKET #
 FACIL:50-269 Oconee Nuclear Station, Unit 1, Duke Power Co. 05000269
 50-270 Oconee Nuclear Station, Unit 2, Duke Power Co. 05000270
 50-287 Oconee Nuclear Station, Unit 3, Duke Power Co. 05000287

AUTH.NAME AUTHOR AFFILIATION
 TUCKER,H.B. Duke Power Co.
 RECIP.NAME RECIPIENT AFFILIATION
 Document Control Branch (Document Control Desk)

SUBJECT: Responds to NRC 900618 ltr re violations noted in Insp Repts
 50-269/90-16,50-270/90-16 & 50-287/90-16.

DISTRIBUTION CODE: IE01D COPIES RECEIVED:LTR 1 ENCL 1 SIZE: 5
 TITLE: General (50 Dkt)-Insp Rept/Notice of Violation Response

NOTES:

	RECIPIENT ID CODE/NAME	COPIES LTTR ENCL	RECIPIENT ID CODE/NAME	COPIES LTTR ENCL
	PD2-3 PD	1 1	WIENS,L	1 1
INTERNAL:	ACRS	2 2	AEOD	1 1
	AEOD/DEIIB	1 1	AEOD/TPAD	1 1
	DEDRO	1 1	NRR MORISSEAU,D	1 1
	NRR SHANKMAN,S	1 1	NRR/DLPQ/LPEB10	1 1
	NRR/DOEA DIR 11	1 1	NRR/DREP/PEPB9D	1 1
	NRR/DRIS/DIR	1 1	NRR/DST/DIR 8E2	1 1
	NRR/PMAS/ILRB12	1 1	NUDOCS-ABSTRACT	1 1
	OE DIR	1 1	OGC/HDS2	1 1
	<u>REG FILE</u> 02	1 1	RGN2 FILE 01	1 1
EXTERNAL:	LPDR	1 1	NRC PDR	1 1
	NSIC	1 1		

NOTE TO ALL "RIDS" RECIPIENTS:

PLEASE HELP US TO REDUCE WASTE! CONTACT THE DOCUMENT CONTROL DESK.
 ROOM PI-37 (EXT. 20079) TO ELIMINATE YOUR NAME FROM DISTRIBUTION
 LISTS FOR DOCUMENTS YOU DON'T NEED!

TOTAL NUMBER OF COPIES REQUIRED: LTTR 24 ENCL 24

Indy Post Company
P.O. Box 1111
Channah, N.C. 28012

Hal B. Tucker
Vice President
Nuclear Production
(704)373-4531

DUKE POWER

July 18, 1990

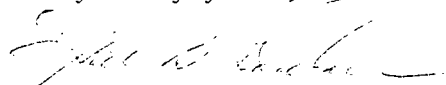
Document Control Desk
U. S. Nuclear Regulatory Commission
Washington, D.C. 20555

Subject: Oconee Nuclear Station
Docket Nos. 50-269, -270, -287
Inspection Report 50-269, -270, -287/90-16

Dear Sir:

By a letter dated June 18, 1990, the NRC issued Inspection Report 50-269,270,287/90-16 and a notice of violation. In addition, Inspection Report 50-269,270,287/90-12 also provided additional examples of the violation cited within Inspection Report 50-269,270,287/90-16. Pursuant to the provisions of 10 CFR 2.201, I am submitting a written response to the violation identified in Inspection report 50-269,270,287/90-16.

Very truly yours, -



Hal B. Tucker

rsp90-16/pfg

xc: Mr S. D. Ebnetter
Regional Administrator
U. S. Nuclear Regulatory Commission
Region II
101 Marietta St. NW
Atlanta, GA 30323

Mr. P. H. Skinner
NRC Resident Inspector
Oconee Nuclear Station

Mr. L. A. Wiens
Office of Nuclear Reactor Regulation
U. S. Nuclear Regulatory Commission
Washington, DC 20555

2000060005 20010
FBI
FBI
FBI

TEO/
11

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

Contrary to the above, the station was not operated in accordance with approved procedures in that Operations Management Procedure 1-9, Use of Procedures, Section 6.3 requires that no deviation from the original intent of the procedure shall be allowed without an approved procedure change. On May 17, 1990, a deviation to procedure OP/1/A/1102/15, Filling and Draining Fuel Transfer Canal dated 4/25/90 occurred without an approved procedure change resulting in the overflow of the Spent Fuel Pool. The spill contaminated various areas in the Auxiliary Building and an area outside of the fuel receipt bay.

RESPONSE:

1. Admission or denial of the violation:

Duke Power Company admits the violation as stated.

2. Reason for the violation:

The reason for the violation was lack of attention to detail and failure to follow procedures.

The first failure to follow procedures occurred when the Spent Fuel Pool (SFP) level alarmed. The alarm response procedure calls for the level to be lowered to clear the alarm. Operations staff and shift personnel discussed lowering the SFP level, but decided not to due to several factors: (a) maintenance on the reactors building purge system, (b) the Borated Water Storage Tank (BWST) was out of service, therefore unavailable for use, (c) no other recoverable storage capacity was available, (d) the excess water was needed in the BWST after pumping down the Fuel Transfer Canal (FTC) and lowering the reactor vessel level. By not lowering the SFP level, additional compensatory action should have been taken, specifically, an operator should have been assigned to monitor the SFP level.

The second failure to follow procedures occurred when a Control Room Operator signed off the first step of a procedure enclosure for draining the refueling transfer canal. The step states "the fuel transfer canal, incore tank, reactor coolant system components and the SFP are at normal refueling level". A note immediately preceding this step states that "normal refueling level" is defined as zero feet on the SFP level gauge. Had this step been properly reviewed, appropriate compensatory measures could have been taken to monitor the SFP level.

The lack of attention to detail occurred while performing the procedure for draining the FTC. During this evolution, water in the FTC is pumped to the BWST using one of the SFP cooling pumps. During refueling, the SFP and FTC are connected by fuel transfer tubes, which facilitates transfer of fuel assemblies between the reactor building and the SFP.

SFP Violation Response
Page Two

The SFP cooling system is aligned to cool the SFP by taking a suction on the FTC and discharging into the SFP with the return flow through the transfer tubes. The procedure for draining the FTC calls for the SFP cooling system to be realigned for normal cooling prior to shutting the transfer tube isolation valves. The unit Control operator and Control Room SRO discussed the procedure and decided to perform a step out of sequence and proceeded to have the transfer tube isolation valves shut prior to realigning the SFP cooling pumps. They did not review the procedure in sufficient detail to recognize that an additional step to secure the operating SFP pump needed to be performed prior to the out of sequence step. This set up the situation so that when the transfer tube isolation valves were shut the SFP cooling pump was taking a suction on the FTC and pumping it into the SFP at approximately 900 gpm. At this rate it only took a short time before the SFP overflowed.

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

After control room personnel were notified that the SFP was overflowing, they immediately stopped the SFP cooling pumps, thereby stopping the sources of the overflowing water. A transfer tube isolation valve was opened, which allowed water in the SFP to flow back into the FTC, thus lowering SFP level. Operations, Radiation Protection, and other site personnel took the necessary actions to contain the spill water from reaching yard drains and control cabinets. High priority areas, such as the control room, a small area on the ground outside of the fuel receiving area bay and the SFP change room were cleaned and decontaminated. Additional cleaning and decontamination continued on a priority basis until conditions were considered acceptable for routine treatment.

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

- (a) Operations will revise the out of sequence policy with respect to higher levels of approval and/or additional guidance.
- (b) Operations licensed personnel will review the Special Report that was written as a result of this incident.
- (c) An operator training package will be issued to address the out of sequence policy, alarm availability and evaluation, and compliance with initial conditions of procedures.
- (d) Operations will revise its procedure for filling and draining the FTC to provide notes and/or cautions to prevent this event from recurring.

5. Date of full compliance:

- (a) November 1, 1990
- (b) November 1, 1990
- (c) January 1, 1991
- (d) September 15, 1990

T.S. 6.4.1 requires the licensee to have adequate procedures and specifies that these procedures will be adhered to.

However, on May 10, 1990, the licensee informed the inspectors that a valve on Unit 2 had been inadvertently cut out of an operating system. On May 9, two mechanical technicians were directed to cut out a drain valve on Unit 1 Low Pressure Injection pump, in room 62 of the Auxiliary Building. Instead, the technician cut out the valve on Unit 2.

**** This violation is cited under Inspection Report 90-12, but is another example of the failure to follow procedure violation cited under Inspection Report 90-16. It is not a separate violation and is to be addressed in the response to Violation 90-16.**

RESPONSE:

1. Admission or denial of the violation:

Duke Power company admits the violation as stated .

2. Reason for the violation:

The reason for the violation was personnel error as the result of inattention to detail.

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

The responsible individuals recognized and identified the error to appropriate station personnel.

Valve 2LWD498 was replaced in accordance with the appropriate procedure.

Valve 1LWD498 was removed in accordance with appropriate procedure as intended per Work Request 54126I.

The responsible individuals were counseled concerning this error.

A counseling notice was issued to the individuals for incorrectly performing Independent Verification as per procedure.

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

All employees will be attending a training class entitled "Please Listen" which is designed to increase communication skills as well as develop attentiveness to detail.

5. Date of full compliance:

October 31, 1990

T.S. 6.4.1 requires the licensee to have adequate procedures and specifies that these procedures will be adhered to.

However, on May 17, 1990 two I&E technicians were assigned to replace a solenoid valve in the operating system to 1PR4, in accordance with WR 54611I. This valve is normally shut during operation with power removed so there was no effect on unit operation. After removing the solenoid valve and upon exiting from the area, they noted that the valve was labeled as a Unit 2 valve and not Unit 1.

** This violation is cited under Inspection Report 90-12, but is another example of the failure to follow procedure violation cited under Inspection Report 90-16. It is not a separate violation and is to be addressed in the response to Violation 90-16.

RESPONSE:

1. Admission or denial of the violation:

Duke Power Company admits the violation as stated.

2. Reason for the violation:

Inappropriate action on the part of two I&E technicians inasmuch as they failed to perform proper correct component verification as specified by Station Directive 3.2.1, Section 6.17 and Station Directive 2.2.2, Section 3.1.1.

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

Counseling, along with disciplinary action, was performed to ensure proper understanding by the individuals involved of the seriousness and possible consequences of their improper actions. Information on this event and its seriousness has been conveyed to all I&E technicians and supervisors. The controlling documents have been reviewed and determined to be comprehensively correct as applied to this event. A large scale evaluation of I&E work practices and discussion with I&E technicians indicates this is an isolated event.

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

Recognizing a need to address human performance factors overall, a training program intended for all technicians and supervision was developed. This training, entitled PLEASE LISTEN, is to provide a technique that when followed would minimize the chances of inappropriate actions during the course of work activities.

5. Date of full compliance:

September 5, 1990