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DUKE POWER

September 1, 1994

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

Subject: McGuire Nuclear Station, Units 1 and 2
Docket Nos. 50-369 and 50-370
NRC Inspection Report No. 50-369, 370/93-13
Violation 50-370/93-13-02 (Example 2)
Supplemental Reply to a Notice of Violation

Gentlemen:

As a result of implementing a new computerized method to track NRC commitments on June 28, 1994, a small number of overdue NRC commitments were identified which require supplemental responses to previously submitted Notice of Violation responses.

Enclosed is a supplemental response to the Notice of Violation issued September 14, 1993 concerning failure to follow procedures. The initial response to violation 50-370/93-13-02 (Example 2) was submitted on October 14, 1993. All planned corrective actions outlined in the October 14, 1993 response have been completed and are addressed in the attached supplemental response.

Should there be any questions concerning this response, contact Randy Cross at (704) 875-4179.

Very Truly Yours,

T. C. McMeekin

Attachment

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PDR ADDCK 05000369
PDR

JED

U. S. Nuclear Regulatory Commission
September 1, 1994

xc: (w/attachment)

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**McGuire Nuclear Station
Supplemental Reply to a Notice of Violation**

Violation 370/93-13-02 (Example 2)

Technical Specification 6.8.1 requires that written procedures be implemented covering the applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February, 1978. Contrary to the above, plant personnel failed to implement the procedural requirements provided for:

- (2) Replacement of Unit 2 emergency diesel generator potential transformer fuses. On July 31, 1993, licensee personnel failed to follow instructions in an approved work order, which resulted in an inadvertent actuation of the Train B engineered safety features systems.

This is Severity Level IV (Supplement I) violation which applies to Unit 2 only.

Reply to Violation 370/93-13-02 (Example 2)

1. Reason for the Violation:

On July 31, 1993 at approximately 1000 hrs., Operations, IAE, and QA personnel were completing a verification on a replacement fuse that had been placed in service without QA observation causing an Engineered Safety Feature Actuation of Train B on Unit 2. This occurred due to the opening of the wrong fuse drawer on the B Safety Bus. This initiated a Black Out Signal and after the time check delay for low voltage, started the Sequencer. The 2B diesel did not start since it was tagged out for post maintenance testing activity. All other equipment activated and operated as designed.

The fuse had been broken initially during reinstallation after the refueling outage maintenance work was completed on July 27, 1993. It was then determined that there were no replacement fuses onsite and the Engineering Section approved a substitute fuse to be installed for the diesel break in runs. The temporary fuse was placed in the breaker cubicle early on July 28, 1993.

The proper rated fuse was received on site on July 28, 1993 and Operations personnel replaced the substitute fuse at approximately 1700 hrs. on July 28, 1993 in between diesel runs. Operations personnel routinely remove and replace fuses during the course of their duties. On July 29, 1993, an IAE Supervisor questioned the Operations engineer who had replaced the fuse to determine if QA had witnessed the fuse installation. The Operations Engineer replied that the fuse installation had not been witnessed by QA. QA does not witness Operations personnel replacing fuses on a normal basis. It was then agreed that QA would verify the correct fuse had been installed at a convenient time prior to declaring the diesel operable.

On July 31, 1993, 2B diesel testing was completed and prior to performing the final surveillance test, IAE and Operations personnel decided it was an appropriate time to wrap up the work order on the fuse. The IAE Supervisor, an Operations Senior Reactor Operator and a QA Inspector went to the 2 ETB Switchgear Room. Opening the front compartment of cubicle 2ETB-3, they located

the fuse drawer labeled "2ETB BUS PT FUSES". This drawer was opened and this action caused the Blackout signal to be generated. The actual location of the fuse that needed to be verified is located in the back of cubicle 2ETB-3 and is labelled "DG 2B BKR PT FUSES". The work order specified "SOURCE PT FUSE".

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

- a. The Senior Reactor Operator at the 2 ETB-3 cubicle closed the fuse drawer and Control Room personnel implemented AP/2/A/5500/07, Loss of Electrical Power, and returned the B train back to the pre-event status. This action is detailed in the McGuire Licensee Event Report 370/93-05, dated August 30, 1993.
- b. Engineering personnel revised the One line drawings for Unit 1 and Unit 2, 4.16 KV switchgear to clearly indicate the location of all potential transformers and their fuse drawers. This corrective action was completed on September 10, 1993.
- c. Labels were placed on Unit 1 and Unit 2, 4.16 KV switchgear to clearly identify the location of the potential transformer fuses and the possibility of causing train blackout. Bakelite tags were installed on all 4160 volt cabinets that housed fuses that if removed could impact the blackout of the bus or trip the diesel breaker. Specific instructions were included as to the consequences of opening the fuse drawer if the bus was in a condition that would make it susceptible to a blackout. This corrective action was completed on July 18, 1994.
- d. Site Communications personnel communicated this event to station management supervisors to be shared in team meetings on the importance of self verification and the effective communication of work to be performed (written and verbal) was stressed. This communication was provided to station supervision on September 30, 1993.
- e. IAE and Operations personnel defined and communicated the roles of each group as it relates to Operations versus Maintenance. This corrective action was completed on September 1, 1994.

No similar events have occurred since implementation of these corrective actions.

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

No further corrective actions are planned.

4. Date when full compliance will be achieved:

McGuire Nuclear Station is now in full compliance.