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DUKE POWER

June 24, 1991

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

Subject: McGuire Nuclear Station
Docket Nos. 50-369, -370
Inspection Report No. 50-369, -370/91-11
Reply to a Notice of Violation

Gentlemen:

Pursuant to 10CFR 2.201, please find attached Duke Power Company's response to Violations 369/370/91-11-01 and 370/91-11-02 for McGuire Nuclear Station.

Should there be any questions concerning this matter, contact L.J. Rudy at (704) 373-3413.

Very truly yours,

M.S. Tuckman for

LJR/s

Attachment

xc (W/Attachment):
S.D. Ebneter
Regional Administrator, Region II

T.A. Reed, ONRR

P.K. VanDoorn
Senior Resident Inspector

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MCGUIRE NUCLEAR STATION
RESPONSE TO NOTICE OF VIOLATION

Violation 369/370/91-11-01

10 CFR 50, Appendix B, Criterion XVI and the licensee's accepted Quality Assurance (QA) Program (Duke Power Company Topical Report, Quality Assurance Program, Duke-1), Section 17.2.16, collectively require that measures shall be established to assure that conditions adverse to quality are promptly identified and corrected.

Selected Licensee Commitment 16.9-7 requires that when the Standby Shutdown System is to be removed from operable status, Security is to be notified 10 minutes prior to removing it from service.

Contrary to the above, six examples of failure to notify Security prior to removing the Standby Shutdown Facility from operable status have occurred in the last two years and corrective actions have not been adequate to prevent recurrence.

This is a Severity Level IV Violation (Supplement I).

Response

1. Reason for Violation

On April 7, 1991 Maintenance personnel were to change the oil in the Unit 2 Turbine Driven Auxiliary Feedwater pump (TDCA) per their procedure. This would require Operations (OPS) to declare the TDCA pump inoperable. OPS personnel used their procedure (OP/2/A/6700/15) to tag the pump out. The Control Room Senior Reactor Operator (SRO) was made aware of the work activities and referenced the Technical Specifications manual section 3.7.1.2 for subsequent actions. When the pump was tagged out, he declared the TDCA pump inoperable. When the TDCA pump is declared inoperable, it also makes the Standby Shutdown Facility inoperable per the Selected Licensee Commitments Manual section 16.9-7 (SLC).

When the TDCA pump is to be declared inoperable the Control Room SRO must inform Security 10 minutes prior to the pump being inoperable, so Security can take appropriate compensatory actions.

On the day of April 17, 1991 at 0900 the Control Room SRO declared the TDCA pump inoperable and did not remember to notify Security at this time. The TDCA pump was returned to operable status at 1005 on the same day. Later that day at approximately 1425, Performance personnel were to run a performance test procedure (PT/2/A/4252/18) which also would make the TDCA pump inoperable. When the Control Room SRO was asked by another SRO about notifying Security, he remembered that he had not notified them that morning. He immediately called Security to inform them of his oversight.

The Control Room SRO used the Technical Specifications (Tech Specs) for reference as to the action to take for the TDCA pump being inoperable. He did not remember to use the Tech Spec Reference Manual, or the preexisting Tech Spec Action Item Log (TSAIL) stamp, which both of these had a reference to the SLC manual and Security notification.

2. Corrective Actions Taken and Results Achieved:

   A. Control Room SRO notified Security at approximately 1420 on 4/17/91 of the SSF inoperability that morning at 0900. Security logged this incident in their appropriate logbook for their quarterly reporting to the NRC.

   B. On 4/18/91 a note was placed in the Tech Specs manual section .7.1.2 to cross reference to the SLC manual anytime the TDCA pump will be declared inoperable.

   C. A note was added to both Unit OPS procedure (OP/1 or 2/A/6700/14) for tagging out TDCA pumps. This note was placed before the SRO signature which is required before making the pump inoperable. The note reads: "When declaring the TDCA pump inoperable, this makes the SSF inoperable. Inform Security 10 minutes prior to declaring TDCA pump inoperable." This procedure change was complete on 5/9/91.

3. Corrective Actions to be Taken to Avoid Further Violations:

   A. Operations Management Procedures (OMP) to be changed to require the use of the Tech Spec Reference Manual when considering the operability of components (Mechanical and Electrical).

   B. Operations Management Procedure (OMP) to be changed to require the use of the preexisting TSAIL stamps when logging components inoperable in the TSAIL.

4. Dates when Full Compliance will be Achieved:

   All procedure revisions will be completed by 8/1/91.

Violation 370/91-11-02

Technical Specification 6.8.1a requires written procedures to be established, implemented, and maintained covering the applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978, which includes general plant operating and administrative procedures.

Operations Management Procedure (OMP) 1-11, Operations Modification Implementation Process, requires control room drawings be red marked until final drawing updates are implemented upon implementation of modifications to assure that operators are aware of plant configuration.

Contrary to the above, operations personnel failed to follow OMP 1-11 relative to red marking the appropriate drawing for modification M6022264. This failure led to disabling of the diesel generator halon system when a breaker was opened for another modification.

This is a Severity Level IV Violation applicable to Unit 2 only (Supplement I).

Response

1. Reason for Violation:

   Drawing was not red marked because of confusion between OPS and Projects personnel wherein OPS personnel thought the work had not been completed yet.

2. Corrective Actions Taken and Results Achieved:

   The drawing was properly red marked immediately upon discovery and a fire watch was established in the D/G room.

3. Corrective Actions to be Taken to Avoid Further Violations:

   The McGuire Station Review Group (MSRG) is conducting an inplant review of the follow-up process used by groups affected by a Nuclear Station Modification as it applies to procedure revisions, training, and interim drawings.

4. Dates when Full Compliance will be Achieved:

   The MSRG inplant review will be completed by 9/1/91. If any corrective actions are identified by the inplant review, a schedule will be developed and submitted as an addendum to this violation response.