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DUKE POWER

June 18, 1991

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

Subject: Catawba Nuclear Station, Units 1 and 2
Docket Nos. 50-413 and 50-414
Maintenance Team Inspection (50-413/90-201 and 50-414/90-201)

Duke Power has reviewed the Maintenance Team Inspection (MTI) report for Catawba Nuclear Station dated January 4, 1991. The inspection was conducted during the weeks of November 12-16 and November 26-30, 1990. The report was thoroughly reviewed and action plans were formed to address the areas needing improvement. Items noted in the report were also compared with other assessment results.

In conducting the review, a number of items were noted that may have been given undeserved significance and not representative of the performance in these areas. Attached is a list of specific comments which are referenced to the items in Appendix A of the MTI report.

Thank you for providing the opportunity to present these viewpoints. Once again, it should be emphasized that actions are being taken to improve in all areas mentioned in the MTI report.

Very truly yours,

M. S. Tuckman

Attachment

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11

U. S. Nuclear Regulatory Commission
June 18, 1991
Page 2

xc: S. D. Ebnetter
Regional Administrator, Region II

R. E. Martin, ONRR

W. T. Orders
Senior Resident Inspector

S. A. Varga, Director
Division of Reactor Projects I/II, ONRR

1. Inadequate Procedures

Duke Power recognizes the need to upgrade the technical quality of our maintenance procedures. A significant effort has been underway to enhance the technical quality and useability of our procedures. Management has shown strong support for this effort by dedicating a large amount of resources, people, and equipment to upgrade procedures. One of the largest crews in Mechanical Maintenance is the procedure writers crew and top of the line computer resources have been dedicated to the procedure area to streamline the writing process and enhance graphics.

Another major part of the procedure upgrade program is crew involvement through the validation process to ensure the procedure is useable. It is also Duke's expectation that if personnel in the field encounter a situation in which a procedure is obviously incorrect, unsafe, will damage equipment, or will result in incorrect data, the work is to be stopped until the procedure can be changed using the methods outlined in the Station Directive.

The following specifics are to be noted:

Item (3), page A-1; a review of the wording differences noted in the report had previously been conducted by Nuclear Production Department personnel, and it was concluded that the differences were either of low significance or that station policy was more conservative.

Item (4), page A-2; did not give consideration to the impact of mock-up training. The process was performed on a mock-up prior to the actual field work. The process used was verified during multiple sessions on the mock-up by the same personnel who performed the actual field work. The ability to verify correct dimensions and results through mock-up disassembly reduced the need for field measurements which would have been made in a high radiation area. The total process of mock-up work and field guidance, when used in conjunction with the procedure, provides results that are superior to the results achieved from using the procedure alone.

Item (5), page A-2; Duke Power admits that the emergency DC lighting issue was not handled in a timely manner as stated on page A-7. However, the DC Emergency Lighting Maintenance Program has been upgraded based on recommendations from a Design Engineering analysis. As a result, the "DE Emergency Lighting (ELD) System Periodic Maintenance and Testing Procedure" (IP/O/B/3450/02) has been revised to implement these engineering recommendations. This revision includes a requirement for 100% annual capacity testing and monthly operability testing of all emergency lighting units. This should

keep the battery plates clean and the acid active, thus improving the reliability of the DC emergency lighting units.

Duke Power believes that the combination of increased resources dedicated to upgrading the technical quality of procedures along with increased involvement from field personnel will increase the accuracy and useability of our procedures.

2. Failure to Follow Procedures

Duke Power has aggressively worked to reinforce its expectations for conformance to procedures and feels that the performance generally meets expectations. If personnel in the field encounter a problem with performing a procedure as written, they are expected to stop the work until the procedure can be changed using methods outlined in the Station Directive.

The following specifics are to be noted:

Items (1), (5), (6), and (7), pages A-4 and A-5; these findings are cases where the procedure was not followed literally, but the intent of the procedure was met. These procedures have been revised to provide more realistic criteria for meeting the original intent upon which the procedure was based or training is being provided to ensure that the literal requirements are met.

3. Failure to Promptly Identify and Correct Deficiencies

Duke Power is developing a "lower tier" deficiency system to reinforce and improve this area. The "lower tier" system is a system for documenting and tracking items of lower significance with provisions for escalating issues up to the PIR level when the appropriate conditions are met.

The following specifics are to be noted:

Items (b), (c), and (d), page A-7; Duke admits that PIR's should have been written for these instances. However, in each case Duke knew that the event occurred, knew why the event occurred, and had undertaken means to prevent these events from reoccurring.

Item (c), page A-8; Duke Power believes that the appropriate priority had been assigned to the original work request. Other indications of steam generator level were available and there were also other means available for trending this parameter. The work request priority was increased by a plant staff member only in response to the inspectors repeated instance that the work be performed sooner.

4. Shelf-Life

This deficiency was entirely corrected before the MTI team left Catawba. Duke Power feels that while this is a correctly identified deficiency in the control process in Materials, this one deficiency was not representative of the performance in this area. An assessment of the Materials functions performed two weeks after the MTI visit, by an independent group outside of Duke Power, found the functions to be a strength.

5. Independent Verification

It is Duke Power's policy for both individuals performing a procedure to verify an action prior to the manipulation of a component. Even though the two individuals are working closely together, each individual is independently responsible for performing verification. Should an individual perform a task alone and make a mistake, the mistake would not be discovered until after any potential damage had occurred. It is Duke's position that, by acting together, wrong train and unit type mistakes will be stopped before they happen.

This method for performing Independent Verification also has a safety benefit because the two individuals working closely together form a buddy system. This helps to reduce the potential for injury that exists in the harsh environment of a nuclear station.

Therefore, there was no failure to adhere to the Independent Verification requirements detailed in the procedures because the Duke Power policy for Independent Verification was followed.