DUKE POWER COMPANY
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VICE PRESIDENT
NUCLEAR PRODUCTION

TELEPHONE
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April 27, 1984

Mr. James P. O'Reilly, Regional Administrator
U. S. Nuclear Regulatory Commission
Region II
101 Marietta Street, NW, Suite 2900
Atlanta, Georgia 30303

Subject: McGuire Nuclear Station
Docket Nos. 50-369 and 50-370

Subject: RII:WTO
IE Inspection Report 50-369/84-04, 50-370/84-04

Dear Mr. O'Reilly:

Please find attached a response to Violation 50-370/84-04-01 which was identified in the subject report.

Duke Power Company does not consider any information contained in this report to be proprietary.

Very truly yours,

H. B. Tucker

Hal. B. Tucker

WHM:glb

Attachment

cc: Mr. W. T. Orders
NRC Resident Inspector
McGuire Nuclear Station

DUKE POWER COMPANY
McGUIRE NUCLEAR STATION
RESPONSE TO VIOLATION 50-370/84-04-01

Violation 50-370/84-04-01, Severity Level IV:

Technical Specifications 6.8.1 requires current written approved procedures be established, implemented and maintained covering startup of safety related equipment, annunciator/alarm response and surveillance testing of safety related equipment.

Station Directive 3.1.4 requires the operator to monitor and acknowledge instrumentation displays and alarms, and to initiate prompt corrective action on receipt of irregular operating conditions.

Contrary to the above, approved procedures and Station Directive 3.1.4 were not followed in that the following conditions were noted:

1. On January 15, operations personnel failed to follow procedure OP/2/A/6200/01, Chemical and Volume Control System, by not verifying suction header valve to be open prior to pump start. This resulted in the destruction of the 2-B centrifugal charging pump.

2. On January 15, operations personnel failed to abide by the requirements of Station Directive 3.1.4, Conduct of Operations, in that during a 12 minute period immediately preceding the destruction of the 2-B centrifugal charging pump, 18 high VCT pressure and/or high VCT level alarms were received without prompt corrective action.

3. On February 2, an electronics technician failed to follow Step 10.6.2 of Procedure IP/0/A/3010/05 by erroneously tripping the main Train B reactor trip breaker instead of the bypass breaker. This resulted in a unit trip from 89% power.

Response:

Duke Power Company agrees that McGuire Nuclear Station personnel did not follow the Chemical and Volume Control System (NV) operating procedure when valve positions were not verified prior to starting NV pump 2A. During operation of NV pump 2A, personnel did not immediately identify the loss of suction to the pump, despite control board indications and indirect Operator Aid Computer Alarms. These events resulted in pump damage. An explanation of the circumstances leading up to the event and corrective actions taken are described in Licensee Event Reports 50-370/84-02 and 50-370-84-04.

In a separate incident, a McGuire Nuclear Station electronics technician did not properly follow the periodic test procedure when he inadvertently open the Train B reactor trip breaker. This occured during performance of the SSPS Periodic Test above Reactor Coolant System Pressure of 1955 psi and resulted in a Unit 2 reactor trip. Licensee Event Report 50-370/84-05 provides an explanation of the circumstances leading up to this event and the corrective actions taken. In addition to the corrective actions described in the LER, additional breaker labels have been

placed on the interior of breaker compartments to assist in properly identifying breakers.

In order to make other personnel aware of incidents caused by personnel error, McGuire Nuclear Station Incident Investigation Reports involving personnel error are reviewed during all crew meetings. McGuire is presently in full compliance.