

DUKE POWER COMPANY

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HAL B. TUCKER

VICE PRESIDENT

NUCLEAR PRODUCTION

84 AUG 15 P 1:35

August 7, 1984

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(704) 373-4531

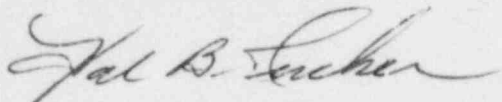
Mr. James P. O'Reilly, Regional Administrator
U. S. Nuclear Regulatory Commission
Region II
101 Marietta Street, NW, Suite 2900
Atlanta, Georgia 30323

Re: RII:GAB/LEF/CFS
50-413/84-18
50-414/84-182

Dear Mr. O'Reilly:

Please find attached amended responses to Violations No. 413/84-18-02
(Violation 1) and 413/84-18-03 (Violation 3), as requested by your letter
of July 18, 1984.

Very truly yours,



Hal B. Tucker

LTP:slb

Attachment

cc: NRC Resident Inspector
Catawba Nuclear Station

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Palmetto Alliance
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DUKE POWER COMPANY
CATAWBA NUCLEAR STATION

VIOLATION 84-18-02:

Measures had not been established to assure adequate control of packaging, storage and handling activities. Lack of procedures and instructions resulted in improper packaging and storage of 11 printed circuit boards and storage of several different items in the same shelves. Storage of items in a random fashion, without proper planning and instructions, could result in physical damage, distortion and improper handling of delicate or precision machine parts.

RESPONSE:

1. Duke admits the violation. We agree that the subject 11 circuit boards should not have been stored in plastic bags without protective packaging. We do not subscribe to this practice for any electronic components.
2. Our material personnel were not sufficiently trained to recognize need for protective packaging of sensitive electronic components while in QA hold area. We interpreted ANSI N45.2.2-1978 "In Storage" to be after "Receipt" by QA, not prior to QA receipt inspection. This interpretation stems from our returning items to manufacturer if the items do not meet packaging, shipping or other Quality Assurance standards that were specified.
3. The subject circuit boards have been packaged and returned to final storage.
4. We will train material handling personnel. This training will include training in quality orientation to prevent damage to all equipment, not just that sensitive to environmental conditions. This training should prevent recurrence.
5. Training will be implemented by August 31, 1984.

VIOLATION 84-18-03:

- a. The licensee's preventive maintenance programs do not include all safety related structures, systems and components turned over for operational control.
- b. The station lubrication program is not being implemented relative to the Safety Injection System (NI). This system was turned over for operational control on August 27, 1982. Lubrication is required for the Safety Injection Pump Motors semiannually, pumps annually and pump motor couplings semiannually. Maintenance was performed January 27 and February 8, 1983. Additional maintenance has not been performed as of the date of this inspection. This example is not intended to be all inclusive.

RESPONSE

1. Duke admits the violation in part.

- a. We have developed and implemented a preliminary preventive maintenance (PM) program based on manufacturers' recommendations, good maintenance practices and service conditions. Items of equipment, safety related and non-safety related, are continually being evaluated for the Station Preventative Maintenance Program. Once systems or structures are turned over for operational control, they are reviewed for applicability to the PM program. Each system is assigned to one of the PM staff for additional review and evaluation for type and extent of preventive maintenance. If lubrication is required, the items are placed on the lubrication schedule for appropriate action. Each system is evaluated based on its operational control date. We feel this meets the requirements of the appropriate ANSI Standards and regulatory guidelines. However, the above review was not documented formally.
- b. Duke admits the lubrication program was not being implemented on the Safety Injection System (NI) as indicated in the violation. This system was reviewed for the PM program in March 1983. Based on equipment history of maintenance type work performed in January 1983, August 1983 and October 1983 on pump A, and February 1983, May 1983 and January 1984 on pump B, we concluded that sufficient preventative maintenance had been performed. However, this decision was not documented in a formal manner. To assure that preventative maintenance requirements would be met, routine periodic work requests were prepared during the initial review of all systems.

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2. The reason the violation occurred was lack of formal documentation of preliminary PM reviews. This same lack of formal documentation also led to the discrepancy identified as Violation 413/84-44-01 (part 2). The corrective and preventive steps listed below also serve as a supplemental response to 413/84-44-01 (part 2). The Waste Gas Hydrogen Recombiners identified in this violation have had their formal review completed as part of the technical review indicated in item (3) below.
3. A technical review has been conducted and documented on systems required for fuel load. This review ensured that all preventative maintenance requirements were met or were determined to be not applicable and that each system is presently operable from a preventative maintenance view-point. In addition, the storage requirements which were in use prior to the system turnover have been examined to determine if any are applicable to the period after turnover of the system. Those found applicable will be implemented on Unit Two systems as they are turned over. Unit One systems are now fully covered under the operational PM program.
4. A formal technical review and evaluation of remaining systems will be performed and documented prior to entry into the mode for which the system is required. This review will include the aspects listed in Paragraph 3 above. Station procedures will be changed to reflect the need for documenting this review.
5. The technical review for systems required for mode six has been completed. Station procedures will be changed by August 31, 1984. The remaining technical reviews will be completed as stated in item (4) above.