

DUKE POWER COMPANY

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June 14, 1985

Dr. J. Nelson Grace, Regional Administrator
U.S. Nuclear Regulatory Commission
Region II
101 Marietta Street, NW, Suite 2900
Atlanta, Georgia 30302

Subject: McGuire Nuclear Station
Docket Nos. 50-369, 30-370

Reference: RII:WTO
NRC/OIE Inspection Report 50-369/85-03,
50-370/85-03

Dear Dr. Grace:

Pursuant to 10 CFR 2.201, please find attached responses to violations 370/85-03-01, 369/85-03-03, 370/85-03-02, and 369/85-03-04 which were identified in the above referenced Inspection Report.

Very truly yours,

H.B. Tucker

Hal B. Tucker

WHM:smh

Attachments

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

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DUKE POWER COMPANY
McGuire Nuclear Station

RESPONSES TO NRC/OIE INSPECTION REPORT 50-369/85-03

Violation 369/85-03-03, 370/85-03-02 Severity Level IV

Technical Specification (TS) 3.7.6 requires that two independent Control Area Ventilation Systems (VC) be operable in all modes. With both VC systems inoperable the exigencies of TS 3.0.3 become applicable. TS 3.0.3 requires that when a Limiting Condition for Operation is not met, within one hour, action shall be initiated to place the unit in a mode in which the specification does not apply.

Contrary to the above, on June 4, 1984, at 8:02 p.m., with train A of VC out of service for maintenance, VC train B chiller tripped placing both McGuire Units 1 and 2 in the exigencies of TS 3.0.3, and no action was taken to place the units in a mode in which TS 3.7.6 was not applicable until 10:05 p.m. a period of two hours and three minutes.

Response:

1. Admission or denial of the alleged violation:

Duke Power Company agrees that the violation occurred as stated.

2. Reasons for the violation:

This violation occurred due to an administrative inadequacy resulting in a misinterpretation of Technical Specifications. When the train B chiller of the Control Area Ventilation System (VC) tripped at 8:02 p.m. due to low oil level, two attempts were made to restart it. After the attempts proved to be unsuccessful, the VC system was declared inoperable at 9:05 p.m. Since train A had previously been declared inoperable for maintenance, both trains of VC were inoperable with a unit on line. Based on the station's interpretation of inoperability, in this case the control operator started to reduce power on Units 1 and 2 at 10:05 p.m. as required by Technical Specifications, rather than at 9:02 p.m. (one hour after the initial chiller trip).

3. Corrective steps which have been taken and the results achieved:

Following the initiation of power reduction, five gallons of oil were added to the train B chiller and the chiller was restarted. With VC Train B then operable, the operators stopped reducing power. Additional details of this event are contained in LER 369/84-18 and LER 369/84-18 Revision 1.

4. Corrective steps which will be taken to avoid further violations:

A Technical Specification interpretation was issued on March 27, 1985 which describes components which must be operable in order for the VC system to be operable. This list includes the A/B Train Control Room Chillers, therefore, in the future, if a chiller trips, the chiller will be declared inoperable.

5. McGuire Nuclear Station is presently in full compliance.

Violation 370/85-03-01, Severity Level IV:

Technical Specification 6.8.1 requires that current written approved procedures be established, implemented and maintained covering the activities referenced in Appendix A of Regulatory Guide 1.33, Revision 2, which includes startup, operation and shutdown of safety-related systems.

Contrary to the above, on December 21, 1984, Operations Procedure OP/O/A 6350/01A, 125VDC/120 VAC Instrument and Control Power Inverter Shutdown, was not adequately implemented in that the Unit 2 inverter was selected for deenergization instead of the Unit 1 inverter and the Unit 2 inverter "IN SYNC" light was not verified illuminated prior to deenergizing.

Response:

1. Admission or denial of the alleged violation:

Duke Power Company agrees that the violation occurred as stated in Licensee Event Report (LER) 370/84-34 which was submitted to the NRC on January 22, 1985.

2. Reason for violation:

This event occurred due to personnel error, because an operator and independent verifier failed to properly identify the equipment which was to be removed from service. Additional details of this event are contained in LER 370/84-34.

3. Corrective steps which have been taken and the results achieved:

The operators restored AC power to the Channel II circuits approximately 8 minutes after the resulting reactor trip and proceeded to remove the Unit 1 inverter from service as originally planned. Further details of the event and resultant actions are discussed in LER 370/84-34.

4. Corrective steps which will be taken to avoid further violations:

The importance of following procedures and verifying action by the use of indicator lights was re-emphasized to all operating shift personnel. Additional details of the event and corrective actions are contained in LER 370/84-34.

5. Date when full compliance will be achieved:

McGuire Nuclear Station is presently in full compliance.

Violation 369/85-03-04, Severity Level V:

Technical Specification 4.0.5 delineates surveillance requirements for Inservice Inspection and Testing of ASME Code Class 1, 2 and 3 components. Technical Specification 4.0.2b states that the maximum combined time of three consecutive surveillance intervals for quarterly surveillance is 3.25 times the stated surveillance interval. The maximum allowed time for PT/11A/4350/17A Diesel Generator 1A Fuel Oil Transfer Pump Performance Test, was 299 days.

Contrary to the above, PT/11A/4350/17A was performed on March 20, 1984, July 9, 1984, October 3, 1984 and January 15, 1985. The actual combined time for the last three consecutive surveillance intervals was 301 days.

Response:

1. Admission or denial of the alleged violation:

Duke Power Company agrees that the violation occurred as stated in Licensee Event Report (LER) 369/85-02 which was submitted to the NRC on February 14, 1985.

2. Reason for violation:

This event occurred due to a personnel error, because personnel failed to schedule the test before the end of the surveillance interval. A contributing factor was an administrative deficiency since the required surveillance was not listed as a quarterly computer listing of procedures to be performed in the next 12 week period. Additional details of this event are contained in LER 369/85-02.

3. Corrective steps which have been taken and the results achieved:

When the Test Supervisor noted that the transfer pump test had not been performed, the Test Engineer was notified. Performance Technicians were sent out to perform the procedure and satisfactory results were obtained. Further details of the event and resultant actions are discussed in LER 369/85-02.

4. Corrective steps which will be taken to avoid further violations:

The fuel oil transfer pump test for each diesel generator was added to the quarterly computer listing. In addition, this listing is being reviewed by the Outage Coordinator on a weekly basis rather than only during outages. Additional details of the event and corrective actions are contained in LER 369/85-02.

5. Date when full compliance will be achieved:

McGuire Nuclear Station is presently in full compliance.