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DUKE POWER

February 11, 1993

U. S. Nuclear Regulatory Commission
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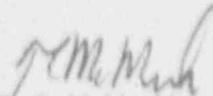
Subject: McGuire Nuclear Station, Units 1 and 2
Docket Nos. 50-369 and 50-370
NRC Inspection Report No. 50-369, 370/92-28
Violation 50-369, 370/92-28-02
Reply to a Notice of Violation

Gentlemen:

Enclosed is the response to the Notice of Violation issued January 13, 1993 concerning failure to follow the Problem Investigation Process procedure.

Should there be any questions concerning this response, contact Randy Cross at (704) 875-4179.

Very Truly Yours,


T. C. McMeekin

Attachment

cc: (w/attachment)
Mr. S. D. Ebner
Regional Administrator, Region II
U. S. Nuclear Regulatory Commission
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Mr. T. A. Reed
U. S. Nuclear Regulatory Commission
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One White Flint North, Mail Stop 9H3
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Mr. P. K. VanDoorn
NRC Senior Resident Inspector
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**McGuire Nuclear Station
Reply to a Notice of Violation**

Violation 369, 370/92-28-02

10 CFR 50, Appendix B, Criterion V, and the licensee's accepted Quality Assurance Program (Duke Topical Report, Duke-1-A), Section 17.3.2.14, require that activities affecting quality shall be prescribed by documented instructions, procedures, or drawings, of a type appropriate to the circumstances and shall be accomplished in accordance with these instructions, procedures, or drawings.

The licensee's procedure, Station Directive 2.8.1, Problem Investigation Process, paragraph 5.2.5.2.2 requires that a Problem Investigation Report (PIR) resolution be sufficiently detailed to clearly identify the root cause, when possible, and identify actions necessary to prevent recurrence.

Contrary to the above, on November 5, 1992, the licensee completed PIR-0-M92-0140 without identifying a root cause or actions necessary to prevent recurrence. This resulted in no preventive corrective actions being implemented as a result of a wiring configuration control problem affecting operability of a radioactive effluent monitor.

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

Reply to Violation 369, 370/92-28-02

1. Reason for the violation:

The reason for the violation was the individual who was performing the root cause determination failed to follow existing guidelines even though he had been trained in root cause determinations. Additionally, individuals reviewing and approving this root cause determination failed to identify the root cause for this PIR as inadequate. Therefore, PIR 0-M92-0140 did not have an adequate root cause determination documented as required by Station Directive 2.8.1, Problem Investigation Process.

2. Corrective steps that have been taken and the results achieved:

- A. PIR 0-M92-0140 was re-opened and assigned to the appropriate group for root cause determination, development of new proposed resolutions, and new corrective actions.
- B. A letter from T.C. McMeekin, Site VP, was sent to his staff, Section Managers, Superintendents and PIP Coordinators to address this problem. The letter stated that even though we have made improvements in this area, our performance was not where it must be.

3. Corrective steps that will be taken to avoid further violations:

In order to achieve the required level of performance, the following corrective actions were implemented on February 1, 1993:

- A. Root Cause training will be required for all personnel generating a cause analysis for a PIP and for all approvers of root causes.
- B. The level of approval for the root cause determination for the PIP process will be at the Section Manager level, Superintendent level or higher.
- C. All outstanding items processed through the old PIR process will be signed off by Safety Review to insure proper root causes. Any problems will be returned for correction prior to their approval.

4. Date when full compliance will be achieved:

McGuire is now in full compliance. The effectiveness of implemented corrective actions will be evaluated in June 1993 to determine if they should be continued, expanded or reduced.