

ENCLOSURE

April 12, 1985

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February 12, 1985 AIC 03

Dr. J. Nelson Grace, Regional Administrator  
U. S. Nuclear Regulatory Commission  
Region II  
101 Marietta Street, NW, Suite 2900  
Atlanta, Georgia 30323

Subject: Report Nos. 50-269/84-31  
50-270/84-31  
50-287/84-35  
50-369/84-36  
50-370/84-34

Dear Dr. Grace:

By letter dated December 31, 1984, NRC transmitted the Systematic Assessment of Licensee Performance (SALP) report for Oconee and McGuire. The period of assessment was May 1, 1983 through August 31, 1984. A meeting was held to discuss this report on January 8, 1985.

Attached please find our comments on the evaluation. As requested, specific comments have been made in response to the Category 3 rating in the plant operations functional area at McGuire. Also included are comments on the areas of Oconee Licensing Activities and Radiological Controls.

Duke believes that on the whole, this SALP adequately represents the quality of performance at our stations with the notable exception of the characterization of McGuire plant operations. As discussed in the attached, we believe that the Category 3 rating of McGuire Plant Operations is not warranted by the facts.

Very truly yours,

*H.B. Tucker*

Hal B. Tucker

HBT:slb

Attachment

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Attachment 1  
Duke Power Company  
Oconee Nuclear Station  
Response to SALP Report  
Dated December 31, 1984

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Introduction

Duke Power Company has reviewed the SALP Report for Oconee Nuclear Station and, in general, endorses the observations and findings made in the report regarding Oconee's performance. Overall, the Report accurately and effectively appraised Oconee's performance, except in the areas of Licensing activities and Radiological Control. In these areas, (Licensing activities and Radiological Control), the Report assigned a Category 2 and identified weaknesses. Duke's comments, contained herein, addresses the weaknesses which were identified in the report.

Licensing Activities

The Report noted weaknesses in the areas where responses were needed from the Licensee regarding amendments to the Technical Specifications and written responses to requests for additional information; and that licensee management attention should be focused in anticipating problems, the scheduling of major issue submittals, and in the reviewing of submittals for their thoroughness, completeness and timeliness. Examples of this cited in the Report are: III.D.3.4 - "Control Room Habitability; Commission audit of all B&W plants on their status in implementing NUREG-0737 modifications; and Reload Amendments.

Duke has had a history of providing timely and thorough responses to NRC regulatory items. Duke believes that changes in NRC Project Managers as well as in Duke/Oconee licensing personnel may have contributed to cases cited in the SALP Report.

Radiological Controls

The Report noted some weakness in Duke's ability to adequately assess non-routine Radiological evolutions at Oconee and in identifying deficiencies and trends as well. The report specifically identified the non-routine radioactive material shipments and potential sources of neutron radiation; as well as the buildup of radioactivity on the turbine building roof and in chemical treatment pond 3 as examples of the noted weakness in Oconee's Radiological Surveillance and control programs.

Duke management recognizes that additional improvements in Oconee compliance with the regulations can be made and agrees that the violations identified during the evaluation period are not indicative of a programmatic breakdown. To this end, Duke is pursuing a meeting with the NRC in order to gain a better understanding of the inspection and enforcement criteria in the Radiological Control area.

Attachment 2  
McGuire Nuclear Station  
Response to SALP Report  
Dated December 31, 1984

April 12, 1985

### Introduction

The Plant Operations functional area at McGuire was rated Category 3 in the SALP report. It was specifically requested that Duke advise NRC of actions which are planned to be taken in response to this rating. Based on the details provided in the SALP report, it appears that this rating is based upon weaknesses identified with procedural compliance, the number of violations, the number of reactor trips, and weaknesses in implementing independent verification. Specific examples in these aspects are discussed in the functional areas of plant operations, maintenance, and surveillance. As these areas are inter-related, the Duke response will address these areas collectively.

### Incidents

Virtually all the violations identified in these areas were the result of plant incidents. Each plant incident is reviewed and a root cause determined as well as the appropriate corrective action. The program of incident review is extensive in that completed incident reports and Licensee Event Reports are reviewed by Duke personnel both at the station and by corporate office. Monthly summary reports are prepared for management review which track the trend of incidents according to root cause. It is the goal of management to reduce the number of incidents that occur not only from a safety perspective but also from an availability standpoint. Incidents at one plant are reviewed through our operating experience program at the other plants.

Contributing factors to the number of incidents occurring at McGuire include the complexity of the plant design, the significant number of activities required to be conducted under procedure, and the relative inexperience of qualified plant personnel. Duke personnel are encouraged to identify to supervision any incidents that may impact safety. The openness of communications allows Duke to address problem areas in a professional manner without fear of retribution.

For each incident that has occurred, Duke believes that responsive corrective measures have been taken. Where Licensee Event Reports were filed, such actions are described therein. Likewise, corrective actions are contained in our responses to the Notices of Violation. Such actions have included revising procedures involved to include explicit details to assure proper performance of the procedures and to prevent recurrence of the event. Also, personnel have undergone training to assure an adequate knowledge level of surveillance and maintenance activities.

Corporate Management has discussed with station personnel the importance of procedural compliance. This was initially accomplished in the fall of 1983 and is continually emphasized by Station Management on a routine basis. There exists an ongoing program to review and improve procedures associated with the 7300 Process Control System.

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Additionally, Duke continues to support generic efforts designed to relax requirements that "over test" the plant systems. Duke believes that all of these efforts are responsive to the concern related to plant operation.

#### Independent Verification

NRC has also identified independent verification as an area of concern. The particular subject has been discussed several times in the past. The lessons learned from Oconee incidents have been used to develop generic guidance for all Duke stations. Duke believes that the present program is responsive to commitments previously made. We acknowledge the comments made by individual reviewers. However, we believe that our program is reasonable and effective. While it is difficult to achieve perfection, Duke will continue to strive to implement independent verification effectively.

#### Reactor Trips

A few explanatory comments may be helpful in placing the reactor trip frequency at McGuire in perspective. First, McGuire is a young plant, having just completed startup testing for the second unit in 1984. Consequently it has been going through its "shake-down" period of system tuning and modification. A higher frequency of unplanned trips during this period is to be expected, followed by decreasing incidence of trips as systems are debugged. We are beginning to see this behavior.

During 1982, 1983 and 1984, there were a total of 65 unplanned automatic and manual reactor trips, (as defined in current LER rule), as detailed in the following table:

	<u>Number of Reactor Trips</u>			
	<u>1982</u>	<u>1983</u>	<u>1984</u>	<u>Total</u>
McGuire Unit 1	16	15	5	36
McGuire Unit 2	-	11*	18	29
Total	16	26	23	65

\*McGuire Unit 2 not commercial for full year

Clearly, with sufficient maturity an improvement in trip frequency is expected and is occurring. Similar behavior is expected on Unit 2, particularly after its first refueling outage when a number of important modifications will be implemented.

A second comment pertains to reactor trips caused by personnel error. During the period from May 1, 1983 to August 31, 1984, approximately 30% of all reactor trips were attributed to personnel error, including procedural compliance problems. Approximately 60% of the trips during this period were caused by equipment failure or malfunction. These data indicate that personnel errors are not the leading cause of trips and are comparable to industry averages for the last five years (personnel error - 20%, equipment malfunction - 67%; source - INPO).

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A third comment pertains to the emphasis placed upon learning from our trip experience. Following every reactor trip at McGuire a thorough reactor trip investigation is performed. This investigation consists of three phases: post-trip review, incident investigation, and transient assessment. The post-trip review seeks to determine the immediate cause of the trip, identify abnormal performance of personnel and equipment, and assess the impact on safe plant operation. The incident investigation determines the root cause of the event, evaluates the corrective actions taken, and recommends additional corrective action if needed. The transient assessment ensures that all aspects of the event are fully evaluated and documented, with particular emphasis on the transient response of important plant systems. This review expands upon areas of identified abnormal performance.

In addition to the reactor trip investigation, a Management Followup of Abnormal Events meeting is held after every reactor trip. At this meeting, the station manager (or his designee) and the station superintendents discuss the event, make sure that the root causes have been identified, and that the right corrective actions are identified and assigned for follow-up.

As a long-term program, periodic trending of reactor trips is performed. Reactor trip data is included in monthly Management Information System summaries and annual Operating Experience reports. A Reactor Trip Reduction Program has been established at the corporate level to evaluate and implement corrective actions based on trend data and items of generic applicability.

In summary, although there have been a significant number of reactor trips at McGuire, station and corporate management have been involved in extensive efforts to reduce recurrences of reactor trips and to obtain maximum benefit from those that do occur. The effectiveness of these programs can be seen in the sharp reduction in reactor trips at McGuire 1 in 1984.

#### Quality Assurance

The Quality Assurance (QA) Department's program for evaluating the operations area consists of periodic audits by audit teams from the general office as well as routine surveillances by site-based QA personnel. This process is effective in identifying weaknesses, and we plan to strengthen this effort by increased staffing and training in both groups. We agree that there have been some concerns in the past regarding promptness of corrective action; however, management has taken steps to resolve this issue. Contrary to the findings of the SALP report, we find that there has been a positive trend in the responsiveness by line management to Quality Assurance identified items.

#### Conclusion

The NRC has identified 21 violations and 1 deviation in the three functional areas previously identified. Duke notes that the distribution of these was as follows:

- . 5 Violations, 1 deviation denied by Duke.
- . 12 identified and reported by Duke via LER's.
- . 2 identified by Duke and determined not to be reportable.
- . 2 identified by NRC (These were for failure to report events which are more appropriately under Licensing Activities functional area instead of Plant Operations).

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It is also noted that several incidents occurred that were termed by the inspector as "non-cited" violations, and that one Plant Operation Violation Severity III, was in fact classified Severity Level IV by Inspection Report 50-369/84-10, this being the one associated with the CCF breaker.

Duke believes that the actions taken in response to the violations have been appropriate. Duke management also recognizes that additional improvement in plant operations can be made, and has programs in place to achieve that end.

Thus, while the record at McGuire is not perfect, it does not appear to Duke that the level of concern which resulted in a Category 3 rating in plant operation is warranted.

As the above indicates, Duke has been very effective in identifying and correcting problems which in itself is an indication of the quality of our plant operations. We feel that our aggressive program of self identification, correcting and reporting should be interpreted as a positive indication of quality plant operations.