

DUKE POWER COMPANY
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HAL B. TUCKER
VICE PRESIDENT
NUCLEAR PRODUCTION

TELEPHONE
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June 28, 1985

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

Re: RII:JLM/GAS/MT/KWV
50-414/85-12

Dear Dr. Grace:

Please find attached responses to Violation No. 414/85-12-01 and Violation No. 414/85-12-02, as identified in the above referenced inspection report. The two events from which these violations originated were previously reported to you under 10CFR 50.55(e), as Report No. SD 414/85-06, dated May 22, 1985 and Report No. SD 414/85-08, dated May 31, 1985.

Very truly yours,

H. B. Tucker
Hal B. Tucker

LTP/mjf

Attachment

cc: NRC Resident Inspector
Catawba Nuclear Station

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DUKE POWER COMPANY
CATAWBA NUCLEAR STATION

VIOLATIONS:

1. 10 CFR 50, Appendix B, Criterion V, and the accepted Quality Assurance (QA) program, Topical Report Duke 1A, require that activities affecting quality shall be prescribed by and accomplished in accordance with documented instructions, procedures, or drawings.

Contrary to the above, on April 19, 1985, temporary operating instruction TOI/2/A/6150/01, Initial Filling and Venting of the Reactor Coolant System and Control of NC System for NC Cold Hydro, was inadequate and was not followed during Unit 2 cold hydrostatic testing activities in the following instances:

- a. It was not identified in TOI/2/A/6150/01 that there was no overpressure protection for a portion of the Residual Heat Removal (RHR) system in that the header into which RHR relief valve 2ND31 discharged was isolated and not alternate relief path had been provided.
- b. Motor-operated valves 2NI17EA and 2NI178B were not closed as required by TOI/2/A/6150/01 when the reactor coolant system (RCS) was being pressurized, thereby allowing RCS pressure into the RHR system.

Items a. and b. above resulted in various piping, valves, and equipment in portions of the RHR system, boron recycle system, sampling system, and chemical and volume control system being overpressurized to approximately 2000 psig for approximately three hours on April 19, 1985.

2. 10 CFR 50, Appendix B, Criterion V, and the accepted QA program, Topical Report Duke 1A, require that activities affecting quality shall be prescribed by documented instructions, procedures, drawings...

Contrary to the above, on April 20, 1985, TOI/2/A/6150/01 was inadequate in that it did not identify that there was no overpressure protection for the Volume Control Tank (VCT) due to the header into which VCT relief valve 2NV223 discharged being isolated, and no alternate relief path had been provided. This resulted in total destruction of the VCT when it was inadvertently overpressurized and ruptured during hydrostatic testing activities.

RESPONSE:

1. Duke Power Company admits the violations.
2. These violations occurred as a result of poor communication, a lack of familiarity with existing administrative controls, and an error in technical judgement by key management personnel. These items are detailed as follows:
 - a. Operations management personnel with Unit Two responsibility had not adequately communicated with the Unit One personnel in evaluating the effect of Unit One operations on Unit Two startup. This was due in part to a deficiency in technical training of the Unit Two personnel.
 - b. Unit Two management personnel gave the Operations shift personnel directions different from normal requirements for the use of procedures, specifically when the same procedure is to be utilized more than once. This was due in part to an unfamiliarity with existing administrative controls.
 - c. Following the initial overpressurization event, a survey was made to determine what additional piping and components may not have adequate overpressure protection. As a result of the survey, two relief valve discharge headers were cut and vented to assure relief protection prior to recommencing reactor coolant system cold hydro. However, due to a deficiency in the technical training of the reviewer, the volume control tank relief valve discharge was overlooked.
3. The individual whose primary responsibility was management of Unit Two Operations during the pre-operational stage had not had adequate training and plant experience to properly fulfill his responsibilities. This position has been reassigned to a individual with extensive plant experience who holds a current SRO license for Unit One. The need to comply with established administrative controls has been re-emphasized.
4. The actions described in (3) above should prevent recurrence of these problems.
5. Catawba is in full compliance at this time.