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December 27, 1985

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

Subject: Oconee Nuclear Station
IE Inspection Report
50-269/85-37
50-270/85-37
50-287/85-37

Dear Sir:

In response to your letter dated November 22, 1985, which transmitted the subject Inspection Report, the attached response to the cited items of non-compliance is provided.

Very truly yours,

H. B. Tucker

Hal B. Tucker

SGG:slb

Attachment

cc: Mr. J. C. Bryant
NRC Resident Inspector
Oconee Nuclear Station

IE01 1/1

Violation

Technical Specification 6.4.1 requires the station be operated and maintained in accordance with approved procedures. Operations Management Procedure (OMP) 2-3. Reactor Operator Log, states that significant abnormalities which occur will be noted in the log. Examples include malfunction of any equipment normally operated from the control room. OMP 2-2, Unit Supervisor's Log Book, states that significant abnormalities which occur will be explained in greater detail than in the Reactor Operator's Log.

Contrary to the above, on October 15, 1985, neither the Reactor Operator or Unit Supervisor's log contained an entry discussing the failure of valve 3LP-2, the loop isolation valve for the decay heat removal system, to open on demand from its control room handswitch when it was desired to place the decay heat removal system in service. Though the valve was opened 55 minutes later and decay heat removal was maintained through the steam generators, failure to log the item or to write a work order provided no indication to management of possibly needed maintenance or modification.

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

Response

1) Admission or denial of the alleged violation:

This violation is correct as stated; however, the last sentence erroneously implies that management was unaware of the problem with valve 3LP-2. An Assistant Operating Engineer was in the Control Room when the valve failed to operate from the switch and was aware of this failure. A station Work Request was issued to repair the problem.

2) Reasons for the violation if admitted:

During past plant operations, some valves (particularly secondary system valves) have occassionally failed to open immediately from the Control Room switches. One of the common techniques for freeing these valves from their closed seats has been to manually override the torque switch from the breaker while operating the switch until the seats are cleared. When this technique was necessary on 3LP-2 the personnel involved did not consider it a significant abnormality and therefore did not enter it into the log.

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

The individuals involved were counseled, including the stressing of the importance of compliance with Operations Management Procedures concerning log entries. The appropriate information concerning 3LP-2 was written as a late entry in the RO and SRO Logs.

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

The importance of proper log entries has been and will continue to be stressed to all licensed Operations personnel. This will be accomplished through crew meetings and through the use of a training package on this subject issued for review by all licensed Operators.

5) Date when full compliance will be achieved:

Actions noted in (4) above will be completed by February 28, 1986.