

20149336

Common

~~TARP Procedure Non-Compliance (QA)~~

6/20/03

Station QA

~~observation 2003:0161~~

Functional Location: C COMMON TO ALL NBU GENERATING Mrule Code: NA

STATIONS

During the 5/24/03 TARP for 13 AFW Pump Trip QA observed that: some staffing and notification requirements were not met.

A) The LCO was entered at 2340. TARP was called at 0115; QA was beeped at 0335. When QA arrived, the team consisted of the Team Lead, a work management superintendent and an electrical engineer. The following TARP positions were not filled: Operations, Maintenance, and Human Performance. The team needed mechanical expertise on the valve and additional expertise was not mobilized as required by the procedure.

When questioned about who was the Operations team member, the Team Lead said the position was being filled by the on duty operating shifts Shift Technical Advisor (STA). The Operations slot on the team should not have been filled by the shift STA. Personnel to fill these positions are provided on the duty call-out list.

B) A review of Figure 1, Post Transient Response Flowchart was conducted and noted the requirement for the TARP Team Lead to contact FORT-SOM. When questioned, the TARP Team Lead stated that he had elected to not contact the FORT-SOM.

Potential existed for Safety Related equipment problems to not be properly investigated and evaluated.

Not in compliance with SH.OP-AP.ZZ-0101(Q), Post Transient Response Requirements,

The cause is not known.

E/6

Discussed with QA Management and generated this notification.

Train Tarp Leads on TARP and the use of associated procedures.

See QA observation 2003-0161.

**Significance Level 2**

20150391

Common

~~TARP Process Not Consistently Followed~~

7/1/2003

See NRC  
Reference at  
END

Functional Location: C COMMON TO ALL NBU GENERATING Mrule Code: NA

STATIONS

Procedural requirements for TARP activities, as described in SH.OP-AP.ZZ-0101(Q), Post-Transient Response Requirements (SHOP-101) are not consistently followed. Due to the current threshold for implementing TARP for both major and minor transients/equipment problems, the number of TARPs that occur results in the process not being fully implemented for lower threshold problems. Utilizing TARP for lower threshold problems also impacts those members of the organization who respond because it diverts them from their normal job responsibilities. Lower threshold transients and equipment problems should be handled within the normal Work Management process.

Procedural issues related to SH.OP-AP.ZZ-0101(Q), Post-Transient Response Requirements has the potential for the following significant procedural requirements not being met: SHOP-101 requires the TARP Team to review "After the Fact" ECG classifications, determine the cause of transients/events, ensure all key safety related equipment functioned appropriately, ensure that the transient/event did not cause any detrimental effects on plant equipment, and determine any corrective actions that are required.

Not in compliance with SH.OP-AP.ZZ-0101(Q), Post-Transient Response Requirements (SHOP-101)

Portions of the TARP process are ineffective, and insufficient training for TARP Team Leads and Team members have contributed to this inconsistency.

Captured issue in QA Assessment Report 2003-0182, reviewed issue with Director of Operations, and initiated this notification.

Recommend that the TARP process be evaluated and changed to reflect the lessons learned since implementation in the Fall of 1999. Benchmarking against the industry should also be considered during the process review. (It should be noted that the Director of Operations has an initiative already underway to assess the TARP process and make changes as appropriate.)

The procedural issues should also be reviewed with the TARP Team Leads to ensure that all Leads understand the procedural issues, and have a common understanding of the most effective way to implement the TARP process. Recommend that the EVAL be assigned to Director-Operations.

The following are SHOP-101 procedure issues that were identified during QA oversight of TARP activities over the last five months:

- During the Hope Creek RF11 refueling outage, the Immediate Response Teams (IRT) responded, assessed and provided recommendations to events that met criteria for TARP as described in Attachment 1 of SHOP-101, but the TARP process was not completely followed. Contributing to this problem is the misunderstanding that the IRT process meets the intent of TARP. SHOP-101 requires additional actions, including communicating the event to senior management and QA. Reference the TARP Events of April 18th and 24th, 2003. This issue was previously identified by QA in May 2002, in SL3 notification 20099631.
  
- TARP Team Leads do not always contact QA, per Figure 1 of SHOP-101, when TARPs are initiated. The most recent examples were two TARPs initiated on Sunday June 15, 2002. SL3 notification 2014881 was written to document this procedural non-compliance. In this notification there were nine other examples provided for the second quarter of 2003 where QA was not notified of TARP initiation. The following level 3 notifications have been previously

written by QA to document this issue, 20077260, 20079140, 20079826 and 20117408.

– The TARP Report for the .B. Diesel Generator fuel pump failure at Hope Creek, which occurred on February 24, 2003, was entered into notification 20133053. However, all recommendations made by TARP were not considered nor addressed in the evaluation or corrective actions. Section 3.10 of SHOP-101 lists the TARP Team Lead responsibilities, which includes, .Provide information and guidance to the evaluation manager that develops long-term plans and corrective actions.. This issue was raised by QA after the evaluation was performed with the evaluation manager. The evaluation manager agreed to address the missed TARP recommendation.

– Two TARPs were initiated during the observation period where no TARP Report was written. The first TARP was initiated on February 18, 2003, as a result of entering a 12-hour LCO for the FRVS System. The second TARP was initiated on March 31, 2003 as a result of increased condenser in-leakage. In both cases no TARP Report was written to document the event response. One of the responsibilities of the TARP Team Lead under Section 3.10 of SHOP-101 is to generate a TARP Report.

– During the Hope Creek RF11 refueling outage, Operations Management made a decision that the Operations AOM Shift at Salem could assume the TARP Team Lead position for TARPs at Salem if the cause of the initiating event was a human performance issue. SHOP-101 currently does not have provisions to allow this. The TARPs initiated on April 3rd and April 17th are examples of where this occurred. In both of these examples the TARP process was not fully followed.

– Prior to RF11, TARP Team Leads were not notified of any changes to their TARP Teams as a result of assignments to RF11. The TARP Team Leads were contacted on this issue and some were not surprised that changes had been made and that they were not communicated with.

Some stated that this issue occurs during the on-line periods as well. It should be noted that the FORT Team roster was updated just prior to the outage to reflect the changes made for people who were supporting RF11.

This was not done for the TARP Teams.

– Notifications/actions initiated as a result of TARP Team investigations are not always addressed in a timely manner. One of the TARP Team Leads wrote SL2 notification 20145614, to document TARP related notifications that did not get rolled to orders in a timely manner.

This was identified by QA oversight of TARP activities and collective analysis of TARP ineffectiveness.

**20150497 Salem Ineffective Performance of Procedures**

**Functional Location: S SALEM GENERATING STATION Mrule Code: NA**

This Notification identifies a failure to perform work identified in a work order. This was identified during a history search associated with an NRC review of Significance Level 2 NUCR Orders. Order 70030623, valve 1CC17 failure to stroke closed on 4/4/2003, the problem was associated with hardened grease on the stem. The repair work performed included removing the hardened grease from portions of the stem. Research identified Order 30011424, for the PM inspection of the operator was performed on 5/14/2002. The confirmation for this order states "Performed PM IAW procedure. No deficiencies found. Performed functional strokes. SAT." Step 5.2.25 of this procedure states: "CLEAN and LUBRICATE valve stem (rising stem only) IAW applicable section of SC.MD-PM.ZZ-0118(Q), Valve Stem Lubrication for Motor Operated Rising Stem Valves. RECORD on Attachment 5." The record copy of this procedure in DCRMS indicates the step was signed off and checked SAT. No comments were provided to adjust the scope of work. Performance of this step and the referenced procedure would have cleaned the entire stem of the old grease and added new lubricant.

Visual inspection of the stem after the 4/4/2003 stroke failure identified that there is at least a three-inch section of stem, above the full closed position, in which the stem threads are packed solid with old grease. The oil has separated from this grease, indicating it has been on the stem for many years.

The condition identified is a failure to perform the work identified in the PM procedure and failure to correctly document the work performed. Additionally, this failure was a precursor to the 4/4/2003 stroke failure of the valve and caused an unplanned entry into a 72-hour Technical Specification shutdown LCO.

There is no present operability concern with MOV S1CC -1CC17-MTRY.

No impact to personnel safety, plant safety indirectly affected by failure to maintain equipment in a good condition.

The requirement for following procedures and correctly documenting work performed was not followed.

Failure to perform work identified in the order and procedure. Failure to correctly document the work performed.

As part of NUCR 70030623, the other similar valves were inspected and no direct problem associated with stem lubrication was identified. As part of the corrective actions for order 70030623, Notifications will be written to clean excessive grease off of stems and operators in the area. The nature of the failure indicated it was primarily associated with valves that have the motor operator mounted below the horizontal axis of the valve.

This Notification was generated to document the precursor event and failure to follow

procedures and/or document the work performed.

The recommended corrective action is to assign this order to maintenance, review the condition and determine corrective actions for the work order and documentation errors. This is a Human Performance error.

This was identified during review of documentation for an NRC quarterly inspection of the corrective action process.

Reference order 30011424 PM for S1CC -1CC17-MTRY Motor Operator PM inspection.