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RECIP.NAME RECIPIENT AFFILIATION
DAVIS,A.B. Region 3 (Post 820201)

SUBJECT: Responds to NRC ltr re violations noted in Insp Rept 50-331/90-17.Corrective actions:CRD line freeze-sealed & addl controls added including,positive line identification & marking line to be cut.

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Iowa Electric Light and Power Company

December 13, 1990
NG-90-2910

Mr. A. Bert Davis
Regional Administrator
Region III
U. S. Nuclear Regulatory Commission
799 Roosevelt Road
Glen Ellyn, IL 60137

Subject: Duane Arnold Energy Center
Docket No: 50-331
Op. License DPR-49
Response to Notice of Violation
Transmitted with NRC Inspection
Report 90017

File: A-102, A-103

Dear Mr. Davis:

This letter and attachment are provided in response to the Notice of Violation concerning certain activities at the Duane Arnold Energy Center.

If you have any questions regarding this response, please feel free to contact our office.

Very truly yours,

Daniel L. Mineck
Manager, Nuclear Division

DLM/SC/pwj

Attachment: 1) Response to Notice of Violation

cc: U. S. NRC Document Control Desk (Original)
L. Liu
L. Root
R. McGaughy
S. P. Sands (NRR)
NRC Resident Inspector - DAEC
Commitment Control No. 900365

IE01

Iowa Electric Light and Power Company
Response to Notice of Violation
Transmitted with Inspection Report 90-017

NRC NOTICE OF VIOLATION

10 CFR 50, Appendix B, Criterion V, states that activities affecting quality shall be accomplished in accordance with prescribed instructions, procedures, or drawings.

Contrary to the above:

a. On or about August 6, 1990, the licensee failed to accomplish the cutting of Control Rod Drive (CRD) withdrawal lines as required by Design Change Procedure (DCP) 1501. Specifically, CRD line 10-07 was cut instead of the required line 14-07. Line 10-07 did not have a freeze seal installed at the time of the cut, and resulted in gross leakage of the line into the reactor building (331/90017-05a).

b. On or about August 6, 1990, the licensee failed to accomplish the cutting of CRD insert line 26-43 as required by DCP 1501. Specifically, CRD line 26-43 was initially cut on the wrong side of a coupling weld from what the DCP had specified (331/90017-05b).

c. On or about August 5, 1990, the licensee failed to accomplish the bolt torquing activities required in Corrective Maintenance Action Request (CMAR) 98620. Specifically, the yoke to bonnet bolts for Motor Operated Valves MO4627 and MO4628 were not torqued as required by the CMAR. As a result, the yoke of valve MO4627 turned and caused the valve motor to trip during operability testing (331/90017-05c).

d. On or about August 11, 1990, the licensee failed to accomplish maintenance activities required by the CMAR associated with Safety Relief Valve Nitrogen Supply Valve V-14-15. Specifically, maintenance was performed on valve V-14-14 in error, rather than valve V-14-15 as required by the CMAR. In addition, after the mistake was realized, field workers removed the internals from V-14-15 and replaced them with the modified internals from V-14-14 without a work order to correct the original error (331/90017-05d).

e. On or about August 22, 1990, the licensee failed to accomplish modification activities as required by DCP 1492. Specifically, the tubing for excess flow check valves XFV2443B and D were improperly connected to the wrong valves. Tubing designated by DCP 1492 to be connected to XFV2443B was connected to XFV2443D, while that tubing designated for connection to XFV2443D was connected to XFV2443B (331/90017-05e).

f. On or about August 24, 1990, the licensee failed to correct an identified error in a Surveillance Test Procedure (STP) as required by Administrative Procedure 1406.3. Specifically, the licensee continued to perform STP 43B001 using an incorrect procedure, in that they were aware the specified incorrect annunciator locations, without making the necessary temporary or permanent revision to correct the errors (331/90017-05f).

Collectively, these are considered a Severity Level IV Violation (Supplement I).

RESPONSE TO NOTICE OF VIOLATION

1. Corrective Actions Taken and the Results Achieved:

Item a:

Immediately following the cutting of the incorrect Control Rod Drive (CRD) line, the line was freeze-sealed to stop the leakage. A Non Conformance Report was issued on August 6, 1990 by the Iowa Electric Quality Assurance organization to investigate the cause of the event and to document corrective actions. The cause was determined to be inadequate review and communication of the procedure steps, resulting in misidentification of the line to be cut. Additional controls were subsequently added to the work process for the CRD repair project to ensure adequate pre-work verification. These included positive line identification by the Responsible Construction Engineer and marking the line to be cut. Work on the CRD project was temporarily suspended by outage management pending implementation of these corrective actions.

Item b:

Prior to completion of the CRD line repair work, the cut that was begun in the incorrect place was repaired. A Non Conformance Report was initiated on August 6, 1990 to address this event. Corrective actions were developed simultaneously for this item and item a. The additional verifications of correct CRD line freeze-sealing and cutting discussed in item a were applied.

Item c:

Following determination of the cause of the MO4627 motor over-current trip, a Non Conformance Report was issued on August 7, 1990. The yoke to bonnet bolts of MO4627 were inspected and found to be in an acceptable condition. The bolts on MO4627 and MO4628 were properly torqued. Two additional valves (MO4629 and MO4630) which were worked on at the same time were inspected and their bolts were found to be properly torqued. Experienced permanent

site personnel were subsequently assigned to this work area to furnish additional guidance to contract personnel with limited plant experience in order to provide greater assurance of procedural adherence.

Item d:

As a result of the work having been performed on the incorrect valve and the subsequent exchange of valve internals, a Non Conformance Report was issued on August 11, 1990. Maintenance workers had failed to verify the valve number against the work control document. The workers were counseled on the necessity to verify the correct plant components and to obtain proper authorization prior to beginning work. An engineering evaluation performed prior to declaring V-14-15 operable determined that the as-left condition of the valve was acceptable.

Item e:

The incorrect connection of the tubing to the two excess flow check valves was discovered during modification acceptance testing related to DCP 1492. The tubing for these valves was subsequently reconnected properly.

Item f:

As noted in the Inspection Report, the identified error in the surveillance test procedure was corrected by Operations management on August 25, 1990. It is recognized that the procedure was not amended in a timely manner as was appropriate.

2. Corrective Actions to be Taken to Prevent Recurrence:

Items a-e:

Items a through e occurred during the recent refueling outage at the Duane Arnold Energy Center, and involved contract personnel on temporary assignment to the site. Immediate corrective actions were taken following each of the events. While efforts were undertaken during the planning process to fully integrate the contract work force into the DAEC outage effort via training and supervision, we acknowledge the referenced events indicate additional steps need to be taken to assure quality is maintained in the future. In the course of monitoring the outage activities, Iowa Electric Corporate Quality Assurance (QA) noted these instances and others as being collectively indicative of a significant condition adverse to quality. On August 13, 1990, QA issued a Corrective Action Report (CAR) for management review and action. The first four items in the Notice of Violation were cited as examples of instances of inadequate control of work activities assigned to contract personnel.

A review of the corrective actions taken for each event identified by QA in the Corrective Action Report indicated that further programmatic changes would be required to ensure proper control of the work of contract personnel. A task force was initiated by Iowa Electric Nuclear Generation Division management in October 1990 to review these events, and develop corrective actions to prevent recurrence. This Task Force is currently examining

issues related to control of contract work activities and compliance with procedures. The review will include such areas as contract structures and specifications, work planning, Iowa Electric overview, document control, quality control, level of supervision, and pre-job training.

The task force will make its recommendations to improve the effectiveness of work contracted by Iowa Electric at DAEC by March 31, 1991. Following management review and approval, implementation of the appropriate corrective actions will be initiated. The next use of extensive short-term contractor support on site will be during the Spring, 1992 refueling outage. Iowa Electric will implement the corrective actions in a timely manner to ensure full inclusion in the planning process for this outage. This implementation will be complete by October 31, 1991.

Item f:

The event in question has been reviewed by Iowa Electric management. We acknowledge this instance as a violation of our standard for procedural compliance. Iowa Electric requires that procedures be adhered to at all times. Difficulties in this area are the subject of a Corrective Action Request recently issued by Iowa Electric Corporate Quality Assurance. A management review of the controls and policy regarding procedure use and our current procedure modification process has been initiated. This review will be complete by February 1, 1991. Following the necessary procedure revisions and worker training, full implementation of the improved controls will be complete by March 31, 1991.

3. Date When Full Compliance Will be Achieved:

Items a-f:

As noted, the problems which occurred due to the procedural non-compliances were rectified soon after the events in question. Full compliance was achieved prior to startup from the 1990 refueling outage of the DAEC upon completion of all immediate corrective actions. As discussed, further actions are planned to prevent recurrence.