

50.55(e) Report

ARIZONA



PUBLIC SERVICE COMPANY

STA. \_\_\_\_\_

P.O. BOX 21666 - PHOENIX, ARIZONA 85036

December 30, 1981  
ANPP-19799-GHD/BSK

U. S. Nuclear Regulatory Commission  
Region V  
Creskide Oaks Office Park  
1450 Maria Lane - Suite 210  
Walnut Creek, California 94596-5368

Attention: Mr. B. H. Faulkenberry, Chief  
Reactor Construction and  
Engineering Support Branch

Subject: Final Report - DER 81-18  
A 50.55(e) Report Relating to G.E. Motor Control  
Centers Containing Varglas Tie Material Which May  
Unravel and Loosen  
File: 81-019-026  
D.4.33.2

Reference: (A) Telephone Conversation between J. Eckhardt and  
B. Kaplan on June 24, 1981  
(B) ANPP-18455, dated July 21, 1981, Interim  
Report

Dear Sir:

Attached, is our final written report of the deficiency referenced  
above, which has been determined to be Not Reportable under the  
requirements of 10CFR50.55(e).

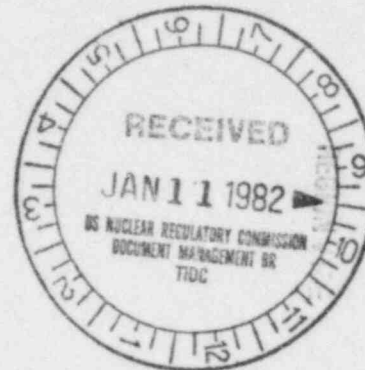
Very truly yours,

E. E. Van Brunt, Jr.  
APS Vice President  
Nuclear Projects  
ANPP Project Director

EEVB Jr/GHD:bj

Attachment

cc: See Page 2



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81-248

U. S. Nuclear Regulatory Commission  
Mr. B. H. Faulkenberry, Chief  
ANPP-19799-GHD/BSK  
December 30, 1981  
Page 2

cc: Richard DeYoung, Director  
U. S. Nuclear Regulatory Commission  
Office of Inspection and Enforcement  
Washington, D.C. 20555

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D. B. Fasnacht  
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6413 South 26th Street  
Phoenix, Arizona 85040

FINAL REPORT -- DER 81-18

DEFICIENCY EVALUATION 50.55(e)

ARIZONA PUBLIC SERVICE COMPANY (APS)

PVNGS UNITS 1 AND 2

I. DESCRIPTION OF DEFICIENCY

During a Bechtel witnessed test of a General Electric Class IE Motor Control Center at Mebane, N.C., a test failure was documented on 3/27/81 which was caused by a piece of "Varglas" wire tie material becoming lodged between N.O. contacts of relay FX (Points 7 & 8 on Dwg. 221B5925). This prevented relay contacts from closing when the relay was energized.

A follow-up surveillance was completed for the related GE equipment delivered to the jobsite. This activity found that some "Varglas" wire ties were loose on wiring bundles and some were found in the bottom of the MCC panels. The following Nonconformance Reports have been issued to identify these conditions as follows:

NCR

E-J-1094	1E-PHA-M31 and 1E-PHB-M32
E-J-1095	2E-PHA-M31 and 2E-PHB-M32
E-A-106	2E-NHN-M20 (Non Class IE)

II. ANALYSIS OF SAFETY IMPLICATIONS

Bechtel contacted GE regarding these conditions and concurs with their evaluation that the identified failure is an isolated case and does not meet any of the reportability criteria of 10CFR50.55(e). See attached G.E. letter. The observed condition of loose "Varglas" wire ties has been evaluated by Bechtel Engineering as not safety significant since the condition does not represent a significant deviation from the procurement specification. None of the observed wire ties were in a position to interfere with the functional equipment within the cabinet.

Should this condition not have been detected and corrected, it would not represent a safety significant condition.

III. CORRECTIVE ACTION

The applicable nonconformance reports will be dispositioned to remove any loose wire tie material and to tighten any excessive loose "Varglas" wire ties, and to assure that the wire tie bundles are positioned away from the DC devices which have normally open contacts.

# GENERAL ELECTRIC

ELECTRIC UTILITY

SALES DIVISION

GENERAL ELECTRIC COMPANY, 9350 E. FLAIR DR., EL MONTE, CALIFORNIA 91734  
Phone: (213) 572-5200  
MAILING ADDRESS: P.O. BOX 2830, TERMINAL ANNEX, LOS ANGELES, CALIF. 90051

October 28, 1981

Bechtel Power Corporation  
P.O. Box 60860, Terminal Annex  
Los Angeles, California 90060

Attention: W. G. Bingham

Reference: Arizona Nuclear Power Project  
Bechtel Job 10407  
480V MCC  
Purchase Order 13-EM-018  
DER 81-18

Gentlemen:

We have investigated the conditions described in your Deficiency Report 81-18.

The failure described occurred during factory acceptance test of a DC Motor Control Center for Bechtel's, Hope Creek nuclear project. This was a single failure due to Varglas.

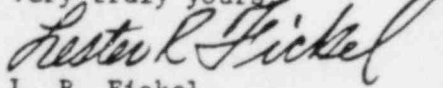
The failure mode was a contact on a DC device which would not close (make contact) due to a strand of Varglas being in between the moving and stationary contacts. The failure was due to an operator error. The ends of a Varglas tie had been left unusually long and were inadvertently pushed into the DC device area during inspection and subsequent handling.

Our corrective action was to shorten this tie and reposition the wire bundle away from the DC device. This was the only failure noted during reinspection. This was a maverick failure due solely to human error in workmanship, and does not represent our product quality or acceptability of Varglas ties.

As reported, the equipment supplied to PVNGS has Varglas. All Varglas ties have a tendency to unravel to the knot, but this does not cause the knot to loosen if the knot was properly tied at the factory. Each MCC may have several hundred Varglas ties. The failure of one tie should not result in the wire bundles falling down, or the failure of any IE devices.

As stated above, the reported failure was a maverick failure and could be prevented by positioning the wire bundles away from DC devices which have normally open contacts.

Very truly yours

  
L. R. Fickel  
Sales Engineer

153612  
JOB 10407  
FILE 13-EM-018  
OCT 30 '81

R		A
3	PLN BINGHAM	
2	PL STEINS	
	APR KLETH	
	APR MAJARDIAN	
	APR ALEY	
	PL BLACK	
	COORD 1	
	COORD 2	
	PGE	
	PL	
	PL/WHY CSJO	
	PA	DA
	ARCH	
	C/S	
	CONTROLS	
	ELECT	
	MED	
	NUCLEAR	
	PLANT DESIGN	
	SUP & SUP	
	CLIENT	
	PG FILE	
	Evaluation	

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