New Hampshire
Yankee

**Ted C. Feigenbaum**
Senior Vice President and
Chief Operating Officer

NYN-90130

June 25, 1990

United States Nuclear Regulatory Commission
Washington, DC 20555

Attention: Document Control Desk

References: (a) Facility Operating License No. NPF-86, Docket No. 50-443

(b) USNRC Letter dated May 24, 1990, "Inspection Report 50-443/90-10," J.R. Johnson to E.A. Brown

Subject: Reply to a Notice of Violation

Gentlemen:

In accordance with the requirements of the Notice of Violation contained in Reference (b), the New Hampshire Yankee response to the cited violation is provided as Enclosure 1.

Should you have any questions concerning our response, please contact Mr. James M. Peschel, Regulatory Compliance Manager, at (603) 474-9521, extension 3772.

Very truly yours,

Ted C. Feigenbaum

TCF/CLB:jt/
Enclosure

cc: Mr. Thomas T. Martin
Regional Administrator
United States Nuclear Regulatory Commission
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New Hampshire Yankee
June 25, 1990

ENCLOSURE 1 TO NYN-90130

REPLY TO A NOTICE OF VIOLATION

New Hampshire Yankee
June 25, 1990

## Reply to a Notice of Violation

Violation:

During an NRC inspection from April 10 - May 13, 1990, a violation of NRC requirements was identified in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," 10 CFR, Part 2, Appendix C. That violation is listed below:

> Technical Specification 6.7.1.a requires that the procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978, be established and implemented. Regulatory Guide 1.33, Revision 2, February 1978, Appendix A specifies procedures for energizing, startup, operation, shutdown, and changing modes of operation of PWR (pressurized water reactor) main steam systems (Section 3.i), for PWR stack and ventilation air monitoring (Section 7.c), and for maintenance that can affect the performance of safety-related equipment (Section 9.a).
>
> Contrary to the above, as of April 3, 1990, no procedure had been established for operation of an isolation valve for turbine first stage pressure instrument PT-506, which provides an input signal to the Reactor Protection System. Closure of the isolation valve rendered PT-506 inoperable when its operability was required.
>
> Contrary to the above, as of January 1, 1990, no procedure had been established covering the required position for purge isolation valves for the wide range gas monitor in the station ventilation stack system. Mispositioned purge isolation valves rendered the monitor inoperable when it was required to be operable.
>
> Contrary to the above, about April 4, 1990, improper implementation of procedure steps for restoring the main turbine to proper operating line-up after maintenance resulted in a turbine trip during turbine startup.

Response:

Each of the cited examples of this violation were related to configuration control. However, each event had a unique root cause. The root cause of the violation's first cited example was determined to be the failure to identify and control a second instrument isolation valve by either procedure or valve line-up. After the incident, a complete walkdown of all the vendor-supplied, rack-

mounted instruments was performed. Corrective actions implemented or planned to preclude recurrence include: issuance of a Maintenance Group Instruction (MGI) for required reading which describes valve verification when the valves are not covered by a procedure; discussion of the same topic at department meetings; changing all calibration procedures to include verification of the second process isolation valve where applicable; changing Repetitive Task Sheets (RTSs) involving technical specification protection instrument valve line-ups to include all valves associated with the instrument; and lock-wiring open all second process isolation valves. The last of these actions, the calibration procedures, is scheduled to be completed by September 28, 1990.

The second cited example, involving the Wide Range Gas Monitor, was due to the inability to accurately determine the required position of purge air line valves. In response to this event, the valves involved were added to Procedure OS1090.05, "Component Configuration Control," and additional requirements for determining the required position of equipment during tagging order restoration were added to procedure MA 4.2, "Equipment Tagging and Isolation."

The root cause of the third event, involving a turbine trip, was determined to be improper action and lack of attention in the performance of a system readiness review. As discussed in reference (b), corrective actions were identified and tracked on the Integrated Commitment Tracking System. Short term corrective actions were completed and included the removal of system test engineers as Test Directors for testing of systems under their cognizance; Station Manager's approval for restarting major equipment with troubleshooting in progress; management's presence onsite for starting major equipment; additional management review of open work packages; increased formality of maintenance technician turnovers; dissemination of lessons learned to plant personnel; and revisions to the work control program. Long term actions include revising the Operations Management Manual and the Station Management Manual to provide additional guidance regarding the restart of activities when troubleshooting has not determined the cause and to provide additional control of contractors in troubleshooting. These actions are scheduled to be completed by September 1, 1990.

Due to our concerns regarding configuration control as a result of these events, other improvements were considered. The radiation monitoring skids were identified as an area requiring further enhancements. Therefore, procedures are being developed to address each radiation monitoring skid as a single unit. This will require the individual involved to consider the entire radiation monitoring skid and all associated components when completing a restoration valve line-up. This action is expected to be completed by August 3, 1990.

We will be conducting an evaluation of our total Work Control Program for configuration control considerations. Input from our Power Ascension Test Program Self Assessment Team will be used as part of this evaluation. One of

our employees, who is currently on loan to the Institute of Nuclear Power Operations, has had extensive maintenance evaluation experience. He will be returning to New Hampshire Yankee at the end of the month. He will be a member of the team that will review our Configuration Control Program and should bring a valuable industry insight to this review. We expect to complete this review by July 30, 1990.

The walkdowns conducted in response to the first cited example, which was the most recently occurring event, ensured full compliance and verified that the valves within the scope of the review are positioned correctly. New Hampshire Yankee believes that with the actions discussed herein, configuration control at Seabrook Station is effective.