JUL 27 1990

Docket No. 50-344

Portland General Electric Company
Trojan Nuclear Plant
71760 Columbia River Hwy.
Rainier, Oregon 97048

Attention: Mr. J. E. Cross
Vice President, Nuclear

Gentlemen:

Thank you for your letter of July 6, 1990, in response to our Notice of Violation and Inspection Report No. 50-344/90-11, dated June 7, 1990, informing us of the steps you have taken to correct the items which we brought to your attention. Your corrective actions will be verified during a future inspection.

Your cooperation with us is appreciated.

Sincerely,

by S.A. Richards

S. A. Richards, Chief
Reactor Projects Branch

bcc w/copy of ltr dated 7/6/90:
Docket File
Resident Inspector
Project Inspector
G. Cook
B. Faulkenberry
J. Martin
J. Zollicoffer

bcc w/o copy of ltr dated 7/6/90:
M. Smith

REGION V
BJOlson
7/27/90

PMorrill
7/27/90

SARichards
7/27/90

REQUEST COPY	REQUEST COPY	REQUEST COPY
YES / NO	YES / NO	YES / NO

SEND TO PDR
YES / NO

1/1
IE01

Portland General Electric Company

July 6, 1990

Trojan Nuclear Plant
Docket 50-344
License NPF-1

U.S. Nuclear Regulatory Commission
Attn: Document Control Desk
Washington DC 20555

Dear Sirs:

Reply to a Notice of Violation

Your letter of June 7, 1990 transmitted a Notice of Violation (NOV) associated with Nuclear Regulatory Commission (NRC) Inspection Report 50-344/90-11. Attachment 1 to this letter contains Portland General Electric Company's (PGE's) response to the violation contained in the inspection report. Please note your inspection report Appendix A references Corrective Action Request (CAR) C90-3075. The correct CAR number pertaining to the NOV (90-11-02) is CAR C90-3073. We have incorporated this correction into our NOV Response.

Sincerely,

T. D. Walt
Acting Vice President, Nuclear

Attachment

c: Mr. John B. Martin
Regional Administrator, Region V
U.S. Nuclear Regulatory Commission

Mr. David Stewart-Smith
State of Oregon
Department of Energy

Mr. R. C. Barr
NRC Resident Inspector
Trojan Nuclear Plant

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REPLY TO A NOTICE OF VIOLATION

Violation A

Title 10, of the Code of Federal Regulations, Part 50 (10 CFR 50), Appendix B, Criterion V, states in part: "Activities affecting quality shall be prescribed by documented instruction, procedures or drawings, of a type appropriate to the circumstances and shall be accomplished in accordance with these instructions, procedures, or drawings."

1. Nuclear Division Procedure (NDP) 600-0, Revision 4, "Corrective Action Program (CAP)," dated February 23, 1990, Paragraph A.3.3 of Attachment H states: "Where the Evaluating Supervisor disagrees with MCAC's conclusion that the condition constitutes a nonconformance, the following actions shall be taken:

   A. Review the CAR with MCAC and obtain concurrence that a nonconformance does not exist and . . .

   C. Once concurrences have been achieved, document why the nonconformance does not exist and return the CAR with concurrence from the next higher level of management to Quality Services. If the nonconformance involved hardware, concurrence must also be obtained from the Manager, NPE."

   Contrary to the above, on April 14, 1990, the Evaluating Supervisor for Corrective Action Request (CAR) C90-3073 did not perform Paragraphs A.3.3.A and A.3.3.C of Attachment H to NDP 600-0, Revision 4, when he disagreed with the Management Corrective Action Committee's (MCAC's) conclusion that C90-3073 was a nonconformance.

2. Administrative Order (AO) 13-1, "Inspection Control", Revision 6, dated March 5, 1990, Paragraph 4.5.1 requires, "Prior to reaching a step which requires Quality Inspection (QI) inspection, the assigned work group supervisor or designee shall notify the Mechanical or Electrical QIS or designee."

   Contrary to the above, on April 10, 1990, while conducting maintenance per Maintenance Request (MR) 90-0528 on MO-2053A, a designated work group supervisor did not notify the Electrical Quality Inspection Supervisor (QIS) or designee for the inspection hold point designated for Step 6.b.

3. AO-12-4, "Material Issuing and Installation", Revision 27, dated March 6, 1990, Paragraph 4.1.3.a requires, "If the identification for an item becomes lost or illegible: the item shall be documented and controlled as specified in NDP 600-0 (Reference 5.2.8)."

Contrary to the above, on April 10, 1990, the identification of the torque switch for MO-2053A was not legible and was not controlled per NDP 600-0, i.e., CAR tag attached.

Response for A.1

1. Reason for the Violation:

Root Cause

The reason for the violation is personnel error, failure to follow the detailed steps of NDP 600-0, Revision 4, "Corrective Action Program".

Contributing Cause

Ineffective communication between work groups also contributed to this event.

2. The Corrective Steps That Have Been Taken and the Results Achieved:

CAR C90-3118 was written on April 25, 1990 by the Quality Inspections (QI) Branch to document that CAR C90-3073 was not processed in accordance with NDP 600-0, Revision 4 and to properly process the concerns of CAR C90-3073. As a result of the CAR C90-3118 evaluation, the following corrective actions occurred:

a. The QI supervisor responsible for not following the procedure requirements of NDP 600-0, Revision 4, Part A.3.3 of Paragraph H was counseled by the QI Branch Manager and General Manager, Nuclear Quality Assurance Department (NQAD) on the importance of procedural compliance and management expectations regarding identification and resolution of Plant problems and was also disciplined. This event and the role of the supervisor in the CAR Program was discussed with the NQAD managers and supervisors at NQAD staff meetings. The supervisor responsible for evaluating the CAR was also counseled on the need to return to MCAC and discuss any changes required in a CAR that MCAC has assigned.

b. Procedure NDP 600-0, Section A.3.3 was revised April 16, 1990 to change the sequence of actions when the CAR evaluating supervisor disagrees with the MCAC's conclusion that the condition constitutes a nonconformance. This change ensures the disagreement with the CAR assigned by MCAC is discussed with the initiator or the initiator's supervisor prior to going back to MCAC for discussion of the disagreement.

c. The importance of bringing problems to management attention when one employee has a disagreement with the next level of management on a concern affecting the reliability or safety of Trojan was addressed in a Lessons Learned Summary April 24, 1990 by the Trojan Plant General Manager and sent to all Nuclear Division personnel. It was emphasized that this type of problem is the responsibility of management and supervisory personnel to resolve.

3. Corrective Steps That Will be Taken to Avoid Further Violations:

a. The generic issues that contributed to this violation will be discussed periodically during management meetings conducted over the next quarter to emphasize supervisory responsibilities with respect to the CAR Program.

b. Lessons Learned from this event will be incorporated into the Frontline Leadership training module on communications.

c. PGE will monitor the CAR/Excellence Response Programs for the next six months to ensure CARs are properly addressed by Managers and Supervisors.

4. Date When Full Compliance Will Be Achieved:

Full compliance was achieved when the supervisors responsible for not complying with the requirements of NDP 600-0 were counseled and the CAR was properly dispositioned in accordance with the procedure.

Response for A.2

1. Reason for the Violation:

Root Cause

The reason for the violation is personnel error, failure to correctly follow the instructions of AO-13-1, "Inspection Control", Revision 6. The Maintenance personnel involved with this event were aware of the requirements of AO-13-1, but incorrectly interpreted the instructions to MR 90-0528 and did not contact QI at the intended Circle Q hold point.

Contributing Cause

a. Poorly organized work instructions contributed to the personnel error. Step 6.b "Determine as found displacement of torque switch to be replaced using calibration tool as follows . . .

(i.e., in the 'Test Stand')" contained the required Circle Q hold point, but was listed prior to the torque switch removal (Step 6.b.1). Had the provisions of Step 6.b.1 been repositioned in the work instructions to precede the "Determine as found displacement of the torque switch", the possibility of missing the Circle Q hold point could have been reduced.

b. MP 12-5.03, Revision 0, "Motor-Operated Valves Preventative Maintenance Procedure 3-Year Inspection", was incorrectly referenced as the procedure to use under Maintenance Request (MR) 90-528. MP 12-5.04, "Motor-Operated Valves Switch Inspection, Overhaul, Replacement, and Adjustment of Limitorque Size SMB-000 Through SMB-5", Revision 0, was the appropriate procedure for this MR.

2. The Corrective Steps That Have Been Taken and the Results Achieved:

a. The electrical craftsmen involved with not complying with the requirement of AO-13-1 were counseled, May 10, 1990.

b. The requirements of AO-13-1 regarding the need to notify QI before commencing a step with a Circle Q hold point was communicated to the Electrical Maintenance Branch during shop meetings April 23, 1990 and again on May 3, 1990.

c. AO-13-1 was revised April 20, 1990 to more clearly state when QI is to be notified regarding a Circle Q hold point. Although this concern did not contribute directly to this event, the revision to AO-13-1 that was made should eliminate any misinterpretation of the requirement.

3. Corrective Steps That Will Be Taken to Avoid Further Violations:

a. MP 12-5.04, Revision 0, "Motor-Operated Valves Switch Inspection, Overhaul, Replacement, and Adjustment for Limitorque size SMB-000 through SMB-5", will be revised prior to performing this work again.

b. The Mechanical and Instrumentation and Control (I&C) Branches of the Maintenance Department will be instructed on the revision to AO-13-1 addressing the actions to be taken concerning when to notify a QI inspector for a QI hold point by July 31, 1990.

c. The violation associated with this inspection report will be reviewed with the Maintenance Department and Plant Modifications Department as part of Lessons Learned Training by July 31, 1990.

4. Date When Full Compliance Will Be Achieved:

Full compliance was achieved following the counseling of the individuals involved with the misinterpretation of AO-13-1.

Response for A.3:

1. Reason for Violation:

The reason for the violation is procedural inadequacy. The provisions of Procedure AO-12-4, "Material Issuing and Installation", Revision 27 were inadequate regarding the removal of quality-related components from the field.

The torque switch involved in this event was to be tested to obtain an optimum setting value for the new torque switch being installed. This value would have been used only if the as found setting was within acceptable values. No as found setting was used and the torque switch was discarded.

2. Corrective Steps That Have Been Taken and the Results achieved.

AO-12-4 was revised July 6, 1990 to include provisions for controlling and maintaining traceability of quality-related components removed from the field.

3. Corrective Steps That Will Be Taken to Avoid Further Violations:

The Maintenance Department will review this event as a Lessons Learned and will emphasize the need for maintaining traceability and control of quality-related parts and components during removal from the field, as well as, during installation from the warehouse. This review will include the revision to AO-12-4 and will be completed by July 31, 1990.

4. Date When Full Compliance Will Be Achieved:

Full compliance will be achieved following the issuance and training review of the revision to procedure AO-12-4 for maintaining control and traceability of quality-related components removed from the field.

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