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U. S. Nuclear Regulatory Commission
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Washington, DC 20555

ULNRC-2977

Gentlemen:

REPLY TO NOTICE OF VIOLATION
INSPECTION REPORT NO. 50-483/93020
CALLAWAY PLANT

This responds to Mr. L. Robert Greger's letter dated February 25, 1994, which transmitted a Notice of Violation for events discussed in Inspection Report 50-483/93020. Our response to the violation is presented in the attachment.

None of the material in the response is considered proprietary by Union Electric Company.

If you have any questions regarding this response, or if additional information is required, please let me know.

Very truly yours,

Donald F. Schnell

DFS/tmw

Attachment: 1) Response to Violation

cc: J. B. Martin - Regional Administrator, USNRC Region III
M. J. Farber - Chief, Reactor Projects Section 3A, USNRC Region III
L. R. Wharton - USNRC Licensing Project Manager (2 copies)
USNRC Document Control Desk (Original)
Manager - Electric Department, Missouri Public Service Commission
B. L. Bartlett - USNRC Senior Resident Inspector
T. A. Baxter - Shaw, Pittman, Potts, and Trowbridge

IE01

Statement of Violation

During an NRC inspection conducted November 21, 1993, through January 22, 1994 a violation of NRC requirements was identified. In accordance with the "General Statement of Policy and Procedures for NRC Enforcement Actions," 10 CFR Part 2, Appendix C, the violation is listed below:

Callaway Plant Technical Specification 6.8.1 states, in part, that written procedures shall be established, implemented, and maintained covering the applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978.

Regulatory Guide 1.33, Appendix A, 1.c, requires administrative procedures be established for procedure adherence.

Procedure OTN-BG-00001, Revision 15, "Normal Operating Procedure for chemical and Volume Control System," procedure step 5.3.1 specifies that the seal water injection filter, which is to be placed in service, be verified filled and vented.

Callaway Operations Department Procedure ODP-ZZ-00004, Revision 16, "Locked Component Control," Attachment 1, "Locked Component List (Q)," specifies that valve AP V-0006 be locked open with a seal type locking device.

Procedure MDP-ZZ-S0001, Revision 7, "Scaffolding Installation and Evaluation," procedure step 7.2.2.1 specifies that the supervisor evaluate the scaffold against the criteria established in section 5.0 (specific guidance for the installation of scaffolding to meet seismic requirements).

Contrary to the above:

1. On January 13, 1994, seal water injection filter FBG04B was not verified to be filled and vented prior to being placed in service (483/93020-01b).

2. On December 6, 1993, valve AP V-0006 was found by the NRC inspectors to be open but was not locked with a seal type locking device (483/93020-01a).

3. On January 5, 1994, NRC inspectors identified scaffolding that was installed in contact with safety related electrical conduit and duct work on the 2047 foot elevation of the auxiliary building (483/93020-01c).

4. On January 5, 1994, NRC inspectors identified "anti-tipping" restraints that were not installed in the top 1/3 of the scaffold on the 1974 foot elevation of the auxiliary building (483/93020-01d).

This is a Severity Level IV violation (Supplement I).

Reason for the Violation - Item 1

Review of this incident identified several contributing causes, including:

a. Poor procedural adherence while returning the filter to service.

b. An improper decision on the part of Radwaste management to stop filter replacement at the end of the day shift instead of completing the job.

c. Lack of procedural coordination in that the Radwaste procedure, RTN-HC-00500, called for Operations personnel to remove the filter from service and return the filter to service using Operations procedure OTN-BG-00001. These two procedures did not provide continuous positive status control of each valve.

d. Insufficient questioning attitude on the part of the evening shift Control Room supervisor when Radwaste personnel were unable to verify the condition of the filter housing prior to making the decision to return the filter to service.

Elimination of any of these errors would have been sufficient to prevent returning the filter to service without verifying the proper line-up.

Corrective Steps taken and results achieved - Item 1:

The improper valve line-up at the seal water filter was noted by the reactor operator and actions were taken to isolate the filter. Subsequent investigation revealed that the filter had never been replaced and that vent and drain valves were still open when Operations personnel returned the filter to service. The new filter was installed and the filter was properly returned to service. Waste from the vent and drain line was collected in the radwaste storage system for processing.

Corrective steps to avoid further violations - Item 1:

The following actions have been taken to prevent recurrence of problems similar to those described in Item 1:

a. The importance of procedure adherence will be emphatically conveyed to all equipment operators by July 1, 1994. In our discussions, we will point out how ineffective control of the seal water filter changeout threatened the mechanical performance of the reactor coolant pumps.

b. Radwaste personnel have been counseled concerning the inappropriate decision to stop filter change-out in the middle of the job. Through this process we have focused the entire department on the importance of providing exact and detailed information to the Control Room regarding status of plant equipment.

c. Procedures will be revised by July 1, 1994, so that the Operations procedure is the controlling procedure for this evolution. Prior to returning the filter to service, the Operations procedure will require verification of the position of all valves manipulated during the filter change evolution.

d. The need to maintain a questioning attitude has been specifically discussed with the personnel involved with this event.

Reason for the Violation - Item 2

The specific root cause for AP-V-0006 being open but unlocked could not be positively identified. The valve had been verified locked open on November 14, 1993. No subsequent work or tagging associated with this valve could be identified that would have repositioned or unlocked this component. However, in evaluating our programmatic controls for locked components, weaknesses were identified which could have allowed components to be left unlocked. For instance, components that were unlocked under a procedure or Workman's Protection tagout could be excluded from the locked component deviation log. We also identified cases where procedures and workman's protection tagging did not positively require verification that the locking device was restored.

Corrective Steps taken and results achieved - Item 2:

When the Control Room Supervisor was notified of the absence of the locking device on AP-V-0006, the valve was verified to be in its proper position and was locked.

Corrective steps to avoid further violations - Item 2:

Several corrective actions have been taken to ensure all locked components are verified as locked, including:

a. Accessible locked components were verified to be properly locked. Three other discrepancies were found during this walkdown and were corrected. This verification will be repeated monthly until we are satisfied that programmatic compliance is maintained.

b. Operations issued a standing order requiring that prior to removing any locking device, the Shift Supervisor/Operating Supervisor must be notified. Unless the procedure or tagging control sheet is verified to positively restore the locking device, the component must be entered in the deviation log.

c. An enhancement to the computerized Workman's Protection tagging system will be implemented to ensure that the lock is restored on a component when it is released from the tagout. This enhancement will be implemented by July 1, 1994.

d. The Manager, Callaway Plant and Superintendent, Operations have stressed the need for strict program compliance and control of all locked components with all Operation's crews.

Reason for the Violation - Items 3 and 4

Management evaluation of the scaffold installation problems identified several contributors, including:

a. Absence of a single point of accountability for proper scaffold erection.

b. Lack of clear understanding of the requirements outlined in the scaffolding procedure, MDP-ZZ-S0001.

c. Inadequate means of tracking erection and removal of scaffolding.

Corrective Steps taken and results achieved - Items 3 and 4 :

Engineering personnel performed an evaluation of both scaffolds and determined that the as-found conditions did not present seismic II/I hazards. Maintenance subsequently modified both sets of scaffolding to comply with the requirements of the scaffolding installation procedure. Also, the responsible engineers performed walkdowns in safety-related areas to verify compliance of existing scaffolding.

Corrective steps to avoid further violations - Items 3 and 4:

a. A Maintenance engineer has been assigned responsibility to perform independent verification that any scaffolding erected in safety-related areas complies with our procedure. This independent verification will cease when management is satisfied that persons building scaffolding have demonstrated adequate proficiency and familiarity with the procedural requirements.

b. Procedure MDP-ZZ-S0001 will be revised by April 30, 1994 to clarify the requirements for building scaffolding to meet II/I requirements. First line supervisors and other personnel required to be familiar with MDP-ZZ-S0001 will receive additional training by July 30, 1994.

c. Future scaffolding in safety-related areas will be built and erected only under the control of a work authorizing document.

Date when full compliance was achieved:

Full compliance was achieved by March 1, 1994.

In his next set of all employee meetings scheduled for April and May, 1994, the Vice President-Nuclear Operations will utilize these examples to emphasize the importance of constant attention to procedural adherence and the need to maintain a questioning attitude.

Additionally, the Independent Safety Engineering Group (ISEG) will review recent cases of failure to follow procedure. The results of the review will be reported to line management and other actions will be considered if deemed necessary. The ISEG will complete the review by August 1, 1994.