



BOSTON EDISON

Pilgrim Nuclear Power Station
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Roy A. Anderson
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June 4, 1992
BECO Ltr. 92- 060

U.S. Nuclear Regulatory Commission
Attn: Document Control Desk
Washington, D.C. 20555


Docket No. 50-293
License No. DPR-35

**SUBJECT: REPLY TO NOTICE OF VIOLATION (REFERENCE NRC REGION I
INSPECTION REPORT NO. 50-293/92-80)**

Dear Sir:

Enclosed is Boston Edison Company's reply to the Notice of Violation contained in the subject inspection report.

Please do not hesitate to contact me if there are any questions regarding the enclosed reply.


R. A. Anderson

RLC/bal

Enclosure: Reply to Notice of Violation 50-293/92-80-01

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BECO Ltr. 92- 060

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Standard BECO Distribution

ENCLOSURE

REPLY TO NOTICE OF VIOLATION 50-293/92-80-01

Boston Edison Company
Pilgrim Nuclear Power Station

Docket No. 50-293
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During an NRC inspection conducted on March 9-13, 1992, 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 (1991), the violation is listed below followed by Boston Edison Company's (BECO's) written response.

NOTICE OF VIOLATION

10 CFR 50, Appendix B, Criterion XVI, states, in part that, "Measures shall be established to assure that conditions adverse to quality... are promptly identified and corrected... and corrective actions taken to preclude repetition.

The Boston Edison Company Quality Assurance Manual, Section 16.2.4a states, in part, that "Each manager is responsible for taking prompt and effective action to satisfactorily resolve any items or conditions adverse to quality."

Contrary to the above, as of March 13, 1992, a Plant Condition Adverse to Quality (PCAQ 91-85) which identified the potential of inadequate motor-operated valve torque switch settings was not promptly corrected.

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

REASON FOR VIOLATION

During March 1991, a self-assessment was conducted on the Motor Operated Valve (MOV) program at Pilgrim Station. The purpose of the self-assessment was to identify and address any discrepancies resulting from maintenance activities following the RFO #7 Overhaul Project and from BECO's existing commitments to IE Bulletin 85-03 and to prevent recurrence when expanding the commitments to Generic Letter 89-10. The results of the self-assessment identified twenty-four (24) MOVs as potentially having documented torque switch settings that were not in accordance with their applicable setpoint specified in the M-MOV design drawings. On April 8, 1991, PCAQ 91-85 was issued to document the potential discrepancies in the torque switch settings. PCAQ 91-85 was presented to the Problem Assessment Committee (PAC) as a potential problem since torque switch setting data from the documenting Maintenance Requests was not clearly understandable. The PCAQ originator stated, at the time of initial PAC review, despite the lack of clarity he believed the MOVs were operable and there was reasonable expectation a detailed review would substantiate the valves were operable.

Following BECO's PAC review of the discrepancies identified by PCAQ 91-85, action was assigned to the Maintenance Section in accordance with Nuclear Organization Procedure, NOP 83A9 "Management Corrective Action Process" to respond to the discrepancies. NOP83A9 required an initial response by May 8, 1991. Contrary to that requirement, no response was received by the PCAQ Administrator until May 29, 1991, which requested a date extension to August 15, 1991. On October 10, 1991, the PCAQ Administrator received another date extension request to extend completion to January 16, 1992. On February 13, 1992, the PCAQ Administrator received the last change request to extend the completion to December 1, 1992. No other action was taken on this PCAQ until March 11, 1992 when Failure and Malfunction Reports (F&MRs) 92-065, -066, and -067, were written to elevate the significance of the identified discrepancies.

Six factors contributed to the failure to complete the detailed review of MOV torque switch settings:

- There was no graded severity level indicator on the PCAQ form. This inhibited easy identification of the PCAQ and its associated action items as important issues. Other less important problems are also documented in the same manner.
- The PCAQ process did not require a formal declaration of system operability or basis for the determination. Lack of a formal documented operability declaration made it difficult to validate decisions made during the review process.
- No clear action statement or closure requirements were listed on the action document issued as an assignment to the Maintenance Section. PCAQ assignments were generally made with only a problem description. Occasionally the initiator provided recommended actions.
- The PCAQ procedure did not provide a process for adjustment of action assignment time limits based on significance. Adjusting due dates based on significance would have had the effect of elevating the significance of the identified discrepancies.
- The PCAQ process did not provide sufficient tracking and management notification to help ensure completion of action assignments by their due dates.
- The PCAQ process did not require a technical review of due date change requests.

CORRECTIVE ACTION TAKEN AND RESULTS ACHIEVED

Of the 24 valves documented in PCAQ 91-85, Maintenance Request (MR) records for 19 MOV's that were coincidentally worked during RFO #8 were reviewed to verify the latest recorded torque switch settings. Inspections were performed for four (4) of the valves subsequent to RFO #8 to verify torque switch settings and were found acceptable. Review of maintenance records for the remaining valve, MO2301-6, verified that its existing torque switch setting was acceptable. Based on the above reviews and inspections, three (3) of the twenty-four (24) valves were initially declared inoperable on March 13, 1992.

- MO1001-26A: Drywell Spray Inlet Valve for 'A' Train Containment Cooling, normally closed.
- MO1001-36A: 'A' Train Suppression Chamber Cooling Jog Valve, normally closed.
- MO1001-43C: 'A' Train RHR Shutdown Cooling and Fuel Pool Cooling Pump P-203C Suction Valve, normally closed.

Immediate corrective action was taken to declare the 'A' train Containment Cooling System inoperative. MO1001-36A and MO1001-26A torque switch settings were then readjusted in accordance with the M-MOV drawings and the containment cooling system was declared operable and returned to service. MO1001-43C was tagged closed and remained tagged since it was not required to perform a safety function.

Evaluation for root cause determined that MO1001-36A was not inoperable and the discrepancy was caused by human error in reading the settings. The as-found closed torque switch setting was in accordance with the design; however, the open torque switch was below the minimum setting specified on the M-MOV drawing. The open torque switch setting was increased but since it is permanently bypassed there was no operability concern. The closed torque switch settings had not been adjusted since its initial diagnostic test.

The Nuclear Engineering Department (NED) completed calculation M505 to determine the original design criteria for MO1001-26A and MO1001-43C. Both valves were determined to have been operable at their as-found torque switch settings. During the March 1992 forced outage, both valves were diagnostically tested.

CORRECTIVE ACTION TAKEN TO PRECLUDE RECURRENCE

The internal corrective action process at PNPS has undergone significant improvement. These improvements address the issues stated above. In general, the improved process, called the Problem Report (PR) Program, consolidated the F&MR, PCAQ, Recommendation for Improvement/Investigation (RFI), Radiological Occurrence Report (ROR), and in-plant Nonconformance Report (NCR) process into one program. The Problem Report Program was implemented on March 30, 1992.

- All Problem Reports undergo a formal structured screening process. The screening process assigns a graded severity level. The Screening Coordinator makes the initial assignment of severity level. The recommended severity level is validated by a Problem Assessment Committee (PAC), which currently consists of the Day-Shift Watch Engineer with an active SRO license (as Chairman), and one senior representative from the QA Department, and the Compliance and Radiological Divisions.
- The new Problem Report process ensures significant problems are brought to the attention of the Nuclear Watch Engineer (NWE). The NWE is required to review significant problems and formally determine system operability and provide the basis for that determination. The review and operability determination is documented on the NWE review sheet and is later validated by the Screening Coordinator and PAC.
- Each action item assignment is required to detail the action necessary to respond to the assignment and the documentation necessary to support closure. All assigned actions are made by the PR Coordinators and validated by the Technical Programs Supervisor prior to assignment distribution. Closure documentation is validated by the PR Coordinators to ensure adequacy.
- The Problem Report NOP places time limit requirements on evaluation completion and allows shortening of evaluation time limits to meet regulatory requirements.
- The Problem Report Process provides several checks and balances to ensure action completion. The most effective is the "Notice" process. This process, similar to the Master Surveillance Tracking Program (MSTP) Notice process, provides automatic notification to Coordinators and action owners when certain milestones are reached. First, the "ALERT NOTICE" is issued one day after the action's due date, next the "PRIORITY NOTICE" is issued on the action's dead date. Finally the "FAILURE-TO-COMPLY NOTICE" is issued every day after an action has passed its dead date.

- Other checks and balances include a monthly past due list and a monthly PR Coordinator review of all open action assignments. We anticipate this process will be fully implemented by July 31, 1992.
- All change requests that change due dates, assigned work scope, or ownership must be approved by the owner's section manager. These section manager approved change requests are validated via a formal file review for acceptability by the PR Coordinator.
- During the month of June, 1992, all open problem reports will be distributed to assigned management personnel for review and updating of status. In conjunction with this effort, a copy of this violation response will also be distributed. The transmittal memorandum will request reviewers to screen their assigned PRs for similar conditions regarding prompt and effective action to satisfactorily resolve items or conditions adverse to quality.

In addition to the above actions, on April 28 and 29, 1992, five (5) BECo representatives participated in the NRC Generic Letter 91-18 workshop at NRC's Regional Headquarters in King of Prussia, PA. The information obtained by the representatives at the workshop is being utilized to develop additional guidance for Pilgrim Station personnel regarding the resolution of degraded and nonconforming conditions, in addition to improved guidance regarding operability determination for ensuring the functional capability of systems and components. Following development of the guidance, BECo plans to provide training to key station personnel such as management personnel, licensed personnel, Operations Review Committee (ORC) members, and PAC members. We believe the additional guidance and training will help to heighten the organization's sensitivity to conditions affecting system and component operability.

DATE WHEN FULL COMPLIANCE WAS ACHIEVED

Full compliance was achieved on April 1, 1992, following verification the torque switches for the twenty four (24) valves identified by PCAQ 91-85 were set in accordance with design requirements.