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May 26, 1992

William J. Cahill, Jr.
Group Vice President

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

SUBJECT: COMANCHE PEAK STEAM ELECTRIC STATION (CPSES)
DOCKET NOS. 50-445 AND 50-446
NRC INSPECTION REPORT NOS. 50-445/92-08 and 50-446/92-08
RESPONSE TO NOTICE OF VIOLATION

Gentlemen:

TU Electric has reviewed the NRC's letter dated April 23, 1992, the inspection conducted by the NRC staff during the period February 2 through March 21, 1992. These inspections covered activities authorized by NRC Operating License NFP-87 and Construction Permit CPPR-127. Attached to the April 23, 1992, letter were two Notices of Violation.

TU Electric hereby responds to the Notices of Violation in the attachments to this letter.

In addition, during an NRC Resident Inspector's exit meeting conducted April 24, 1992, TU Electric committed to provide information involving corrective actions relative to the disassembly of a wrong valve by maintenance personnel. This information is included in the attached response.

Sincerely,

William J. Cahill, Jr.

JET/tg
Attachments

c - Mr. R. D. Martin, Region IV
Resident Inspectors, CPSES (2)

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NOTICE OF VIOLATION
(445/9208-01)
(446/9208-01)

Criterion V of Appendix B to 10 CFR Part 50, as implemented by Section 5.0 of the TU Electric Quality Assurance Manual, states, in part, "Activities affecting quality shall be prescribed by documented instructions, procedures or drawings, of a type appropriate to the circumstances and shall be accomplished in accordance with these instructions, procedures, or drawings."

- (A) Maintenance Section of Mechanical Manual Procedure MSM-CO-8801, Revision 3, "Borg-Warner Check Valve Maintenance," Steps 8.2.1.10 and 8.3.1.22, specify the removal of the weld which retains the arm pin in the swing arm prior to removing the swing arm pivot pin.

Contrary to the above, the NRC inspectors determined through the review of Operations Notification Evaluation Form 92-227 and TU Evaluation Form 91-3054, that the arm pins on Valves 1AF-0075, 1AF-0078, 2FW-201, and 2FW-202 and other Units 1 and 2 Borg-Warner swing check valves were improperly removed by shearing of the associated arm pins with dynamic force.

RESPONSE TO NOTICE OF VIOLATION
(445/9208-01)
(446/9208-01)

TU Electric accepts the violation and the requested information follows:

(1) Reason For Violation

TU Electric performed a comprehensive review of the applicable documents and interviewed cognizant personnel. It was concluded by this review that the cause for this violation was the perception by craft personnel that the procedure allowed the latitude to remove the pin in an alternate method.

(2) Corrective Steps Taken and Results Achieved

Deficiency documents for Unit 1 and Unit 2, were issued to address both the programmatic issues as well as to evaluate the possible residual effects on the hardware. A task team was appointed by CPSES management to resolve the procedural and hardware implications. Evaluations concluded that the disassembly technique was not detrimental to the operability of the valve. The practice of employing disassembly methods on Borg Warner check valves, other than those delineated in the procedure was prohibited by Maintenance through the issuance of a letter to the Mechanical Maintenance supervisors. Similar direction was also

provided to appropriate Unit 2 personnel in a memorandum from the Unit 2 Startup Manager.

(3) Corrective Steps Taken to Avoid Further Violations

The Unit 2 Startup Mechanical craft and supervision shall receive training on compliance with approved work packages. This training shall emphasize the process to be followed when a procedural step cannot be performed. The Maintenance department shall promulgate a "Lessons Learned" to Maintenance personnel to ensure craft and supervision are sensitive to the importance of assuring work activities reflect accurately the steps specified in the work documents.

(4) Date When Full Compliance Will Be Achieved

Full compliance will be achieved by July 31, 1992.

NOTICE OF VIOLATION
(50-445/9208-02)
(50-446/9208-02)

Criterion V of Appendix B to 10 CFR Part 50, as implemented by Section 5.0 of the TU Electric Quality Assurance Manual, states, in part, "Activities affecting quality shall be prescribed by documented instructions, procedures, or drawings, of a type appropriate to the circumstances and shall be accomplished in accordance with these instructions, procedures, or drawings."

- (B.1) Station Administrative Procedure STA-606, "Work Requests and Work Orders," Revision 17, Section 5.5, states, in part, "QC is responsible for reviewing and approving Work Orders."

Station Administrative Procedure STA-606, "Work Requests and Work Orders," Revision 17, Step 6.6.3.9, states, in part, "Perform work in accordance with the instructions and in the sequence listed."

Station Administrative Procedure STA-607, "Housekeeping Control," Revision 12, Step 6.3.3.2, states, in part, "After the system is opened, if the work group member(s) leaves the area, the pressure boundary opening shall be capped, plugged, or sealed." Attachment 8.A to STA-607 requires that personnel accountability logs be maintained during the activity.

Station Administration Procedure STA-731, "ASME Section XI Repair and Replacement Activities," Revision 3, Step 2.3, states, in part, "On a piping system prior to ASME III N-5 certification, the piping to component connections under the jurisdiction of ASME Section III and cannot be completed under this section."

Procedure CPSES-P-2018, "Field Fabrication and Erection of Pipe Supports," Revision 0, Step 6.8.1.7, states, in part, "Lumber shall not be used except as shoring or wedges in sleeves." Step 6.8.5.4, states, in part, "Engineering approval is required prior to a modification to existing temporary supports."

Contrary to the above, on February 23, 1992, Valve 2HV-4515 was removed from its installed position utilizing a rigging configuration which was not in conformance with the work document. The pipe openings were not sealed following valve removal and personnel accountability logs were not maintained. The temporary supports originally installed utilized lumber and were removed without engineering approval. Contracted motor operated valve quality control personnel were utilized to witness the disassembly of the valve flange fasteners as opposed to the required ASME quality control personnel and construction personnel performed activities outside the scope of their work document.

- (B.2) Startup Work Authorization No. 82270 specified maintenance to be performed on Valve 2CS-7048A.

Contrary to the above, on March 17, 1992, construction personnel disassembled and reassembled a Unit 1 valve, 1CS-7048A, when the work document specified a Unit 2 valve, 2CS-7048A.

RESPONSE TO NOTICE OF VIOLATION
(50-445/9208-02)
(50-446/9208-02)

TU Electric accepts the violation and the requested information follows:

(Item B.1.)

(1) Reason for Violation

The personnel responsible for implementing the work documents issued to repair valve 2HV-4515 failed to properly adhere to the requirements of the prescribed station administrative procedures. Additionally, lack of attention to detail and oversight regarding non-routine dual unit interface requirements led to this violation.

The specific causes, contributing factors and corrective actions are stated in section 2 below.

(2) Corrective Steps Taken and Results Achieved

The event resulted from a Unit 2 startup maintenance activity which physically removed valve 2HV-4515 from the Unit 2 Component Cooling Water (CCW) system. This portion of the Unit 2 CCW system is within the Unit 1 CCW stress boundary. The events surrounding the removal of 2HV-4515 potentially impacted Unit 1 CCW system operability and could have prevented Unit 1 from satisfying technical specification requirements, therefore a deficiency document was generated to evaluate Unit 1 operability. The evaluation determined that the CCW System was operable. Due to the seriousness of this event and the need to fully understand how it occurred, TU Electric management established a task team. The causes, contributing factors and corrective actions taken are as follows:

Rigging Configuration Not in Conformance With Work Documents (and) Construction Work Performed Outside of Scope

Initially, the Motor Operated Valve Contractor (MOVATS) was assigned to remove valve 2HV-4515 via work order. A Technical Evaluation was issued with the work order to provide rigging instructions. After several attempts to remove the valve failed, another work order was issued to cut associated piping to facilitate valve removal. At the time the second work order was initiated, a Brown & Root Superintendent was requested to perform the work. After evaluating the as-built condition of the valve, the Superintendent believed the valve could be removed without cutting adjacent piping. The valve was subsequently removed via rigging. However, at the time, this method was unauthorized. In addition, the method for rigging the valve was not in accordance with the Technical Evaluation instructions previously specified by Engineering.

The Task Team determined that the Superintendent removed the valve via rigging because he believed the work orders intent (remove the valve) was being met. Although the Task Team believed the rigging instructions were clear, the Superintendent stated that he misunderstood the technical evaluation instructions. The individual has been counseled on the importance of following prescribed instructions.

Non-Sealed Pipe Openings and Personnel Accountability Log

The evaluation team found that the work area had been posted Zone III in accordance with STA 607. However, both Construction and Contracted MOVATS personnel overlooked the requirement to cover the opened pipe upon leaving the work area and maintain the personnel accountability log. Personnel authorized to perform work in the Operation's controlled area have received instruction on STA-607 requirements. An engineering evaluation has determined that the piping throughout the valve removal process, was adequately and rigidly supported by the existing permanent supports.

Temporary Supports

The chronology within the Task Team Evaluation indicated that the temporary supports had been removed from the pipe for a minimum of 36 hours. However, the evaluation could not determine who removed the supports.

The Supervisor responsible for the installation of the temporary supports was aware of the applicable site specification requirements and had been properly trained. The responsible work group has been retrained.

ASME Code Jurisdiction Misapplication

Although STA-731 provided the necessary guidance for Code jurisdictional control of work, the personnel responsible for development/issuance of the work package did not implement the requirements of STA-606 in that they did not verify the jurisdictional status of the item as required by STA-731. STA-606 requires applicable work packages to be developed in accordance with STA-731, which requires that installation and removal activities of items from systems which have not been N-5 certified be performed by the Construction Contractor. Therefore, work was erroneously assigned to MOVATS instead of Construction.

Coincident with this violation, a deficiency document was issued documenting two other instances in which valves were removed by MOVATS from a system under construction jurisdiction. The work planning group personnel have been reinstructed to assure proper preparation and screening of work orders with respect to the responsible work organizations and their respective Code areas.

(3) Corrective Steps Taken to Avoid Further Violations

As detailed above, procedure enhancements, retraining and personnel counseling will prevent recurrence of this deficiency.

(4) Date When Full Compliance Will Be Achieved

TU Electric is in full compliance.

(Item B.2.)

(1) Reason for Violation

The individuals involved in this activity failed to perform a positive verification of the component on which they were to work. Thus, work was performed on the wrong component.

(2) Corrective Steps Taken and Results Achieved

TU Electric management suspended Unit 2 disassembly/reassembly work activities on permanent plant equipment within the Unit 1 Operations Controlled Area to assess the event. Deficiency documents for both Units were issued. Applicable Construction, Startup and Quality Control personnel were briefed and a Task Team was established to determine root cause and provide corrective/preventive actions.

Construction work in the operation controlled area was allowed to proceed after a two party component verification process was established.

(3) Corrective Steps Taken to Avoid Further Violations

The following actions will preclude recurrence:

- a) Construction and Startup work packages now contain sign-off steps for two party verification of correct components.
- b) Construction work rolling over to a new crew (e.g. day shift to night shift,) receives the same level of documented verification as described above.
- c) Highly visible clearance tag verification sheets are required to be included in construction work packages requiring clearances.
- d) For Prerequisite Testing, Startup personnel ensure that the correct loop, panel, or component is verified by a two party verification process prior to commencement of testing.
- e) CPSES organizations with physical field work activities will review and revise (as applicable) work control programs to ensure that proper verification requirements are included in work documents.
- f) Appropriate disciplinary actions have been taken for the individuals involved in these incidents.
- g) Quality Assurance has conducted surveillances of the two party verification process utilized during Unit 2 completion, the Unit Interface Program, and the Unit 2 Labeling Program.

(4) Date When Full Compliance Will Be Achieved

TU Electric will be in full compliance by June 30, 1992.

Additional Information

A separate event regarding maintenance disassembly work on valve 1-HV-2400-A0 (versus 1-HV-2400A-A0) was discussed during an NRC exit meeting on April 24, 1992. During this meeting, TU Electric committed to document our corrective actions. To document the incident, an Operations Notification and Evaluation (ONE) form was generated and the work order revised to reinstall the tubing. To preclude recurrence, maintenance personnel were informed of the details of the incident and provided instructions on the verification of work steps.