10 CFR 2.201

BOSTON EDISON

Pilgrim Nuclear Power Station Rocky Hill Road Plymouth, Massachusetts 02360

> September 3, 1992 BECo Ltr. 92-106

Roy A. Anderson Senior Vice President - Nuclear

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

> Docket No. 10-293 License No. DPR-35

Subject: REPLY TO NOTICE OF VIOLATION (REFERENCE NRC REGION 1 INSPECTION REPORT NO. 50-293/92-14)

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.

./A. Anderson

GJB/bal

Enclosure: Reply to Notice of Violation 50-293/92-14-01

cc: Mr. Thomas T. Martin Regional Administrator, Region I U.S. Nuclear Regulatory Commission 475 Allendale Rd. King of Prussia, PA 19406

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REPLY TO NOTICE OF VIOLATION 50-293/92-14-01

Boston Edison Company Pilgrim Nuclear Power Station Docket No. 50-293 License No. DPR-35

During a NRC inspection conducted June 16 - July 27, 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, Criteria XVI, states that measures shall be established to assure that conditions adverse to safety are promptly identified and corrected. The identification of the condition adverse to quality, the cause of the condition, and the corrective action taken shall be documented and reported to appropriate levels of management.

Boston Edison Quality Assurance Manual Section 16.2.3 states that it is the responsibility of all Nuclear Organization personnel to make sure that any incipient, suspected, or actual conditions adverse to quality are promptly identified and Section 16.2.4 states that all identified conditions adverse to quality shall be corrected and reported to appropriate levels of management via the appropriate corrective action documentation process.

Contrary to the above, prior to November 14, 1991, an unauthorized and undocumented repair was made to an ASME Class 3 section of the "B" train of the Salt Service Water System. Specifically, a wooden plug was installed in a 3/4 inch pipe flange. The unauthorized repair did not conform with the code standards for ASME Class 3 components required by 10 CFR 50.55a nor with the guidance of NRC Generic Letter 90-05, for temporary non-code repair of ASME Code 1, 2, or 3 piping. Additionally, appropriate corrective actions following identification of the unauthorized repair were not completed in a timely manner, and an approved code repair was not accomplished until June 25, 1992.

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

VIOLATION RESPONSE

B CKGROUND

On November 14, 1991, a test engineer found a wooden plug installed in a 3/4 inch pipe flange on an ASME Class 3 section of the "B" Salt Service Water (SSW) System loop discharge piping. The wooden plug repair did not meet code standards for ASME Class 3 components as required by 10CFR50.55(a). In addition, the repair did not conform with the guidance of NRC Generic Letter (G.L.) 90-05, "Guidance for Performing Temporary Non-Code Repair of ASME Code Class 1,2, and 3 Piping", as it was implemented without requesting written relief from the NRC. The piping had previously served as a sodium hypochlorite sample tap but was abandoned in place in 1988 in acc. Hance with Plant Design Change (PDC) 86-528-146. Upon finding the wooden plug, the test engineer initiated the corrective action process by writing a Mork Request Tag (WRT). The WRT was subsequently reviewed and processed into a Maintena C Request (MR) in accordance with Procedure 1.5.3, Maintenance Requests". Althoug the MR (19104873) was initially assigned a high priority (level 2), during the review process it was inappropriately determined the MR had to be worked during an outage. The incorrectly concluded the repair could not be made on-line because a pressure boundary had to be breached and the plant condition block on the MR was changed from "running repair" to "outage". As such, the MR is not scheduled to be worked until the next refueling outage (No. 9) scheduled for A to 1993. Subsequent review of the MR refueling and the plant control personnel determined the wooden plug was a frequent and a problem report was initiated to address this non-control process.

A (19101893) had been initiated on March 13, 1991, that identified a leaking compton short distance below the wooden plug location. A job planning walkdown for short performed is a maintenance supervisor and it was determined the letking was actually the wooden plug. Later, a planner incorrectly issumed the affected be replaced during the implementation of an upcoming plant design change (FRN 85-1.1 The MR was then closed to an existing open MR (19101677) that was the complete nuring the installation of the plant design change. Work scope we openly transferred when the MR was closed, and the wooden plug remained in plant

REASON FOR V TION

The wooden plug was installed in the SSW pipe flange in an attempt to astore temporarily the pressure boundary after the system had teen breach. The breach most likely occurred as a result of damage to the piping at the threaded flance onnection. A search was conducted of maintenance records to identify the Louis and imment that controlled the installation. This repair. A review of the Records information Management System data base as well a. Maintenance Request logs and hand copies of MRs from 1987 to present was performed and no included be found. It was concluded the plug was installed between the ability inment of the pipe in 1988 and initial discovery in March of 1991.

The installation of this undocumented repair was caused by a failure to follow station procedures. Although the documents governing installation of the wooden plug could not be located, it was determined Procedures 1.5.3, "Maintenance Requests" and 1.5.9, "Temporary Modifications" were not followed. The requirements to make modifications/repairs in accordance with governing codes and regulations were not fulfilled. In addition, although the originator of the repair could not be identified, interviews with plant personnel indicated a lack of understanding regarding ASME Code repairs. Some personnel were not aware of Generic Letter 90-05 requirements and their impact. Allhough the SSW System piping is ASME Class 3, the plug was in a low pressure/vacuum section of pipe and was of minimal safety significance, thereby contributing to the ASME code implications being overlocked.

The delays in the corrective action process can also be attributed to the lack of awareness of the problem. Since the repair involved low pressure discharge piping and did not praclude system operation, it was not considered a high priority and did not receive timely attention. The factors contributing to the untimely resolution including closing of the MR written in March of 1991 and changing the plant condition status on MR 19104873 would not have occurred if the appropriate priority was given to the problem.

CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED

On June 24, 1992, an operability evaluation was performed and, although the wooden plug was considered a non-conforming condition, the Sait Service Water System was determined to be sperable. Immediate corrective action taken included the installation of an approved code repair on June 25, 1992, and a complete walkdown of the Salt Service Water System that verified there were no additional non-code repairs installed in the system. Other action taken included a review of maintenance documents initiated since 1987 to determine if any installation details associated with the wooden plug existed. The review revealed no documents.

CORRECTIVE STEPS TAKEN/TO BE TAKEN TO PREVENT RECURRENCE

Several steps are being taken to enhance the awareness of modifications/repairs to ASME code piping and ensure compliance with station procedures gove: .g modifications. They include the following:

- The Training Department has incorporated the details of this event stressing the importance of code repairs into the Maintenance and Operations Continuing Training Programs. Training provided to new employees will also include the details of this event. The training will also focus on the need to strictly adhere to Station Procedures 1.5.3, "Maintenance Requests" and 1.5.9, "Temporary Modifications".
- Details of the event were reviewed with the following groups to enhance awareness of code repairs and ensure compliance with applicable procedures:
 - Maintenance Planning/Management
 - Work Coordination
 - Outage Planning
 - Field Engineering
 - System Engineering
 - Work Prioritization
- Details of the event were also reviewed with Station personnel during routike management meetings on July 30, 1992. The requirements associated with making modifications and repairs to plant systems, structures or equipment were discussed during the meetings. The significance of installing documented and ap, oved hodifications/repairs was stressed. Personnel were encouraged to review appropriate sections of station procedures.
- System F gineers are reviewing Maintenance Requests to ensure this condition does not exist in other systems. Field walkdowns are being conducted as necessary.
- To enhance the work control process, the Maintenance Department is revising Procedure 1.5.3, "Maintenance Requests" in the follow :g two areas:
 - The procedure will be revised by referencing Generic Letter 90-05, "Guidance for Performing Temporary Non-code Repair of ASME Code Class 1,2 & 3 Piping", where appropriate. The G.L. provides a general discussion regarding ASME code/non-code repairs and outlines the steps required before installing a temporary non-code repair.
 - The process used to close Maintenance Request is also being revised. Proper transfer of work scope will be required when closing one MR to another. The process will also require the documents (i.e., open and closed MRs) to reference each other for traceability.

These changes were discussed with Maintenance personnel during the group meetings regarding this event.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

Full code compliance was achieved on June 25, 1992, when the approved repair was installed. Remaining actions to be taken include system walkdowns, training, and changes to Procedure 1.5.3. Training of the Mechanical Maintenance personnel and the system walkdowns will be completed by October 1, 1992. Training of Operations personnel as well as the procedure changes will be completed by November 27, 1992. Training of the remaining Maintenance personnel including I&C and Electrical will be completed by the end of this year.