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GEORGE C. CREEL
SENIOR VICE PRESIDENT
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September 11, 1992

U. S. Nuclear Regulatory Commission
Washington, DC 20555

ATTENTION: Document Control Desk

SUBJECT: Calvert Cliffs Nuclear Power Plant
Unit Nos. 1 & 2; Docket Nos. 50-317 & 50-318
Reply to Notice of Violation, Inspection Report No. 92-18

REFERENCE: (a) Letter from Mr. J. P. Durr (NRC) to Mr. G. C. Creel (BG&E), dated August 5, 1992, Inservice Testing Inspection at Calvert Cliffs Units 1 and 2, NRC Combined Inspection Report Nos. 50-317/92-18 and 50-318/92-18

Gentlemen:

Attachment (1) is provided as our response to Reference (a).

Should you have any further questions regarding this matter, we will be pleased to discuss them with you.

Very truly yours,

GCC/JV/jv/bjd

Attachment

cc: D. A. Brune, Esquire
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ATTACHMENT (1)

**REPLY TO NOTICE OF VIOLATION
INSPECTION REPORT NO. 92-18**

Notice of Violation 50-318/92-18-01 states that as of June 26, 1992, Baltimore Gas and Electric Company had not taken measures to identify the cause of repeated failures of valve 2-SW-5173-CV on December 8-10, 1991, April 4, 1992, May 10, 1992, and May 22, 1992. Corrective actions to preclude repetition had also not been identified.

I. DESCRIPTION AND CAUSE OF EVENT.

On December 10, 1991, Unit 2 Salt Water system valve 2-SW-5173-CV failed to pass Surveillance Test Procedure (STP) O-65-2, Quarterly Valve Operability Verification, by not positioning to full open. Valve 2-SW-5173-CV is an air-operated butterfly valve used for controlling the Salt Water system flow to the 22 Emergency Core Cooling System (ECCS) pump room air cooler. The normal operating position of the valve is shut, and the valve safety position is open, ensuring a cooling water flow path to the coolers. STP O-65-2 is used to stroke the valve and verify the full range of motion of the valve. In response to the failed test, the valve was manually opened and a Temporary Note was attached to the switch for the valve. The Temporary Note indicated the valve was to be left in the open position because it had failed STP O-65-2. A Maintenance Request (MR) for the valve was initiated. An MR tag was also hung next to the switch. A Maintenance Order (MO) was generated from the MR and included specified hardware changes necessary for the proper operation of the valve. Because the valve was kept in a safe position, a high priority was not placed on the MO when replacement parts were hard to obtain.

On February 29, 1992, STP O-65-2 was performed on 2-SW-5173-CV per the routine STP schedule. The valve passed the STP, but was kept locked open. On April 4, 1992, STP O-65-2 was performed again and the valve failed the STP. No further action was taken because the associated MO was still open.

On May 1, 1992, the valve was manually fully shut for work unrelated to the valve problems. The valve subsequently operated properly. Maintenance personnel reported to the Control Room Supervisor (CRS) that 2-SW-5173-CV would probably pass STP O-65-2. STP O-65-2 was performed and the valve passed. The CRS then shut 2-SW-5173-CV, which is its normal position. Both the CRS and the Maintenance personnel knew that the associated MO existed, but felt that appropriate action had been taken to restore the valve to its normal position. The CRS did not want to have the MO closed out, but the Temporary Note and the MR tag on the valve switch were removed.

On May 10, 1992, valve 2-SW-5173-CV was positioned open to complete a system evaluation. Personnel noticed that 2-SW-5173-CV would not fully open. Though the valve was manually opened for the evaluation, when the evaluation was completed, the valve was closed and an MR written to address the issue. On May 22, 1992, after a question by an NRC Resident Inspector, it was identified that 2-SW-5173-CV should have been left open, the valve was opened and a Temporary Note attached to the switch regarding the problem.

Maintenance and Engineering intended to remove, inspect, and repair the valve. Until this could be done, a Temporary Note on the valve was used to ensure it remained in the open position. When the CRS was told that the valve worked properly and it subsequently passed STP O-65-2, he determined this satisfied the requirements on the note and was sufficient reason to remove the Temporary Note control without further discussion with the technical staff. The lack of pertinent background information available and not clearly understanding

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the necessary corrective measures resulted in the CFS making an incorrect decision on control of the valve.

II. CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED.

The General Supervisor - Nuclear Plant Operations has discussed with Operations shift personnel the importance of verifying that deficient components are fully operational and emphasized the importance of better understanding the nature of corrective measures required before removing temporary controls. The Temporary Note on the valve switch now states that the note cannot be removed until associated maintenance and post maintenance testing are complete.

III. CORRECTIVE STEPS WHICH WILL BE TAKEN TO AVOID FURTHER VIOLATIONS.

Applicable procedures to address equipment maintained outside its normal position to meet design requirements will be changed. Such equipment will not be made fully operational unless applicable MOs, associated documentation and post maintenance testing are complete or a recommendation is received from the appropriate technical support organization stating that the equipment can be made fully operational without violation of applicable MOs. Temporary Notes will be attached to appropriate equipment with improved descriptions of why the equipment must be left in its accident condition.

IV. DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED.

Full compliance was achieved when 2-SW-5173-CV was opened on May 22, 1992.