



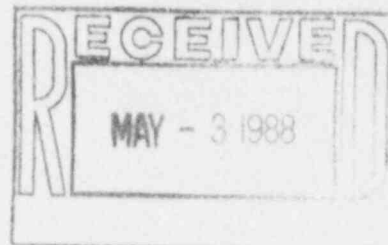
Public Service™

April 29, 1988
Fort St. Vrain
Unit No. 1
P-88149

Public Service
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R.O. WILLIAMS, JR.
VICE PRESIDENT
NUCLEAR OPERATIONS

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



Docket No. 50-267

SUBJECT: NRC Inspection
Report 88-03

REFERENCE: (1) NRC letter, Callan
to Williams, dated
March 31, 1988
(G-88082)

(2) PSC letter, Williams
to Document Control
Desk, dated March
11, 1988 (P-88090)

Gentlemen:

This letter is in response to the Notice of Violation (Reference 1) received as a result of the inspection conducted by Messrs. R. E. Farrell and P. W. Michaud during the period February 1 through February 29, 1988. The following response to the items contained in the Notice of Violation is hereby submitted:

Failure to Follow Procedure

Technical Specification 7.4.a requires that written procedures shall be established, implemented, and maintained for activities including plant operations, surveillance testing, and maintenance.

Criterion V of 10 CFR 50, Appendix B and the licensee's approved quality assurance program require that activities effecting quality be done in accordance with approved procedures.

Licensee Administrative Procedure P-7, Issue 12, "Station Service Request Processing," provides administrative control of maintenance activities.

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Licensee System Operating Procedure SOP 46, Issue 39, "Reactor Plant Cooling Water System," describes which valves are to be manipulated during the venting process.

Contrary to the above, on February 2, 1988, a technician interchanged two cables on the speed controls of helium circulators "A" and "B," a maintenance activity, without implementing the administrative controls of Procedure P-7.

Contrary to the above, on February 10, 1988, a licensed reactor operator manipulating manual valves in accordance with licensee Procedure SOP 46, Issue 39, "Reactor Plant Cooling Water System," opened the wrong valves in violation of the procedure and vented radioactive gas to the atmosphere.

This is a Severity Level IV violation. (Supplement I.D.)
(267/8803-01)

(1) The reason for violation if admitted:

The violation is admitted. Licensee Event Report 88-02 (Reference 2) described the first instance of failure to follow procedure cited in the Notice of Violation. An Instrument Technician was calibrating the speed modules for the Helium Circulators using Procedure SR-RE-17-W, "Circulator Speed Modifier Weekly Check." One of the modules could not be adjusted to meet the acceptance criteria stated in the procedure. Corrective action required in this case was to remove the in-service speed cable from service and substitute an available alternate (spare) cable and readjust the module. The speed cable change was accomplished following the guidance of an operator aide posted at the work area. Procedure SR-RE-17-W did not contain guidance or specific instructions for changing cables. The actions taken by the Technician were consistent with past practices for performing the activity. Past practices did not require the use of Administrative Procedure P-7, "Station Service Request Processing," because the activity was commonly viewed not as a maintenance activity but as an operating type of function such as switching to a spare pump. The result of the activity was that a spare speed cable sensing "B" circulator speed was misconnected to a speed control channel on "A" circulator.

Although the past practice utilized an approved operator aide for performing the activity, the process was deficient in that it did not provide necessary controls to ensure that the cables were changed properly. Other factors which contributed to the inadvertent misconnection of the speed cables were inadequate field markings on the cables and unreliable speed cable performance which required relatively frequent cable changes.

In the second instance of the violation, Procedure SOP 46, "Reactor Plant Cooling Water System," clearly listed the valves to be opened to vent the reactor plant cooling water system. The valves were marked with small stamped metal tags which identified the valves by number but not by function. The small size of the tags and the lack of identification by function caused the Operator to misidentify the valves specified in the procedure leading to the wrong valves being manipulated. Other factors which contributed to the manipulation of the incorrect valves were poor access to the work location, and the complex configuration of associated equipment and piping. Access constraints made it difficult for the Operator to reach and identify valves by the small tags. The piping configuration made it difficult for the Operator to trace specific associated systems and to verify proper valve manipulation for the operation desired.

(2) Corrective steps which have been taken and the results achieved:

In the first instance, Procedure SR-RE-17-W has been revised to include step by step instructions for accomplishing speed cable changes. Related enhancements to the procedure include provisions for improved identification and documentation of in-service and spare cables. The revised procedure also provides for independent verification of cable change activities. The circulator speed modules and input cables at the work location have been color coded to provide additional assurance that speed cables will not be cross connected between circulators. In addition, troubleshooting and corrective maintenance has been performed to improve the reliability of the speed cables and thereby minimize the number of cable changes.

In the second instance, Procedure SOP 46 was reviewed to determine its adequacy. Although the procedure was found to be adequate it was revised to include caution statements prior to important Operator actions. The revision was reviewed by the Plant Operations Review Committee on February 19, 1988. New supplemental tags were added which are larger, easier to read and include valve functions as well as valve numbers. The Operator involved received a verbal reprimand for failure to follow procedure in accordance with station progressive discipline policies.

No similar incidents have occurred since the corrective steps described above were taken.

(3) Corrective steps which will be taken to avoid further violations:

A task force was assembled to develop and formalize an overall station policy for lifting and landing electrical leads/cables. The effort will ensure that these activities are conducted using formalized procedures which include steps to minimize the incorrect lifting and termination of cables and other leads. The policy will also ensure that the impact of these activities are adequately evaluated prior to work being performed. A draft procedure has been prepared by the task force. The new procedure is currently being reviewed prior to policy implementation.

No additional corrective action is necessary for the System 46 valve lineup problem.

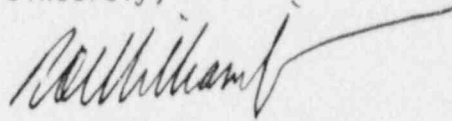
(4) Date when full compliance will be achieved:

The new procedure which will provide an overall station policy for activities which involve the lifting and landing of electrical leads will be implemented, including necessary training, by June 30, 1988, in accordance with Licensee Event Report 88-02.

April 29, 1988

Should you have further questions, please contact Mr. M. H. Holmes
(303) 480-6960.

Sincerely,



R. O. Williams, Jr.
Vice President, Nuclear Operations

ROW:DLW/djc

cc: Regional Administration, Region IV
ATTN: Mr. T. F. Westerman, Chief
Projects Section B

Mr. Robert Farrell
Senior Resident Inspector
Fort St. Vrain