TU ELECTRIC

Log # TXX-93135
File # 10130
IR 93-08
Ref. # 10CFR2.201

March 24, 1993

William J. Cahill, Jr.
Group Vice President

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

SUBJECT: COMANCHE PEAK STEAM ELECTRIC STATION (CPSES)
DOCKET NOS. 50-445 AND 50-446
NRC INSPECTION REPORT 50-445/93-08; 50-446/93-08
RESPONSE TO NOTICE OF VIOLATION

REF: NRC Letter from Mr. A. Bill Beach to
Mr. William J. Cahill, Jr. dated February 23, 1993

Gentlemen:

TU Electric has reviewed the referenced letter with the enclosed Notice of Violation concerning an inspection conducted during the period of January 11 - 15, 1993. TU Electric's response to the Notice of Violation is attached.

Sincerely,

William J. Cahill, Jr.

By: D R Woodlan
D. R. Woodlan
Docket Licensing Manager

JTC/grp
Attachment

c - Mr. J. L. Milhoan, Region IV
Mr. L. A. Yandell, Region IV
Resident Inspectors, CPSES (2)
Mr. T. A. Bergman, NRR
Mr. B. E. Holian, NRR

A001
1

NOTICE OF VIOLATION
(446/9308-01)

Criterion V, Appendix B, 10 CFR 50 states, in part, that 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.

Contrary to the above, between December 15, 1992, and January 4, 1993, the startup organization disconnected an unknown number of safe shutdown emergency lanterns from their respective battery packs without documented instructions in order to preserve battery capacity while an outage of essential lighting was in progress. As a result, the Operations Department, which accepted the emergency lighting system as operational on December 21, 1992, had in its custody an unknown number of inoperative safe shutdown emergency lanterns.

RESPONSE TO NOTICE OF VIOLATION
(446/9308-01)

TU Electric accepts the violation and the requested information follows:

1) Reason for Violation

The reason for this violation was the failure to follow the approved procedure by not obtaining a File Number for the XCP-EE-24 test data package. If a File Number had been obtained, the test data package would have been reviewed as part of emergency lighting system turnover and the status of the battery packs would have been known.

Ineffective communications which resulted in the Startup Test Technicians (STT) not being aware of the changes in system status was identified as a secondary cause.

There were also two contributing factors:

a. The design of the low voltage cutout circuit on the Model E-16 battery packs does not prevent total discharge of the packs. Disconnecting the lead from the battery is necessary to prevent damage during an extended AC power outage.

b. The Startup Supervisor should have assured that the changing conditions of the system were clearly communicated and understood.

2) Corrective Steps Taken and Results Achieved

A work order was prepared to troubleshoot and correct the problems identified with the battery packs. The leads were reconnected.

A ONE Form (deficiency document) was initiated to document the test failures. During the ONE Form disposition phase, TU Electric management established a task team to perform a root cause analysis in accordance with existing site procedures. The task team report was made available to members of the inspection team and the results are incorporated into this letter.

A Preventive Maintenance Test was scheduled to ensure proper operation of the Unit 2 safe shutdown emergency lighting battery packs prior to entry into Mode 4. This has been completed and no additional determinated leads were found.

3) Corrective Actions Taken to Preclude Recurrence

Engineering may consider a design modification to the Model E-16 battery packs to prevent any current drain while AC power is not available. However, this is considered as an enhancement only and is not necessary to provide for proper operation.

Since the Unit 2 startup organization no longer exists, similar startup communication problems can not recur. The Operations Department uses daily meetings and system status assessments to ensure that work in progress is well documented.

The task team evaluation identified that there were no other similar systems which have the same lack of annunciation of system status as the Emergency Lighting System. Because of this, it is unlikely that the circumstances surrounding this event would exist with other systems.

4) Date of Full Compliance

Full compliance has been achieved.