



Log # TXX-93150
File # 10130
IR 92-60
Ref. # 10CFR2.201

TUELECTRIC

April 8, 1993

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 50-445/92-60; 50-446/92-60
RESPONSE TO NOTICE OF VIOLATION

- REF: 1) TU Electric letter logged TXX-93001 from
W. J. Cahill, Jr. to the NRC dated January 30, 1993
- 2) NRC memorandum from James L. Milhoan, Region
Administrator, Region IV to Thomas E. Murley,
Director, Office of Nuclear Reactor Regulation,
dated March 29, 1993

Gentlemen:

TU Electric has reviewed the NRC's letter dated March 11, 1993, concerning the inspection conducted by the NRC staff during the period December 6, 1992, through January 30, 1993. This inspection covered activities authorized by NRC Operating License NPF-87 and Construction Permit CPPR-127. Attached to the March 11, 1993, letter was a Notice of Violation.

TU Electric understands the concerns identified in the letter pertaining to the control and status of plant systems and abnormal operating procedures. TU Electric believes the actions identified in the enclosed response to the Notices of Violation and the actions defined in Reference 1 provide additional assurance that system status and operating procedures are correct and are being properly maintained. A number of these actions were reassessed during the NRC Operational Readiness Assessment Team (ORAT) inspection which occurred from March 24 through March 28, 1993. Comments by the inspectors during the exit meeting on March 29, 1993, relevant to configuration control and procedure adequacy were positive. TU Electric's assessment of these areas indicates that the enhanced controls have been effective. The conclusions are supported by NRC Region IV's recommendation (Reference 2) that CPSES Unit 2 be issued a full-power operating license in which Region IV provides that the ORAT concerns have been satisfactorily addressed.

120068

9304120275 930408
PDR ADDCK 05000445
G PDR

400 N. Olive Street L.B. 81 Dallas, Texas 75201

TEO 11

The March 11, 1993, letter also identified commitments made by TU Electric during the January 29, 1993, exit meeting. The commitments as stated in the letter are correct. Valve lineup verifications on the Unit 2 safety-related systems were performed prior to entering Mode 6 and field verifications of the Unit 2 and common abnormal operating procedures were performed prior to entering specified operating modes.

TU Electric hereby responds to the Notice of Violation (NOV) in the attachments to this letter.

Sincerely,

William J. Cahill, Jr.
William J. Cahill, Jr.

By: *Roger D. Walker*
Roger D. Walker
Manager of Regulatory
Affairs

TRT:ds
Attachments

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

VIOLATION A
(445/9260-01)

10CFR Part 50, Appendix B, Criterion V, states, in part, that activities affecting quality shall be accomplished in accordance with procedures of a type appropriate to the circumstances.

Operations Department Administrative Procedure ODA-410, "System Status Control." Revision 4, Section 6, states, in part, that the documentation of the position of components other than that specified in the system status file will be maintained within the document controlling the activity that repositioned the component.

Contrary to the above, on December 30, 1992, several valves in the Chemical and Volume Control System were not in the positions specified by the document controlling the activity that repositioned the component.

Response to Violation A
(446/9260-01)

TU Electric accepts the violation and the requested information follows:

1. Reason for Violation

In December 1992, TU Electric management had the Nuclear Overview Organization perform an independent investigation to determine how the valves were positioned in the as-found condition. The investigation identified seven cases of mispositioned valves or valves missing remote operator covers. The investigation found the following.

- a. 2-8471A, CCP 2-01 Suction Valve (found closed) - The valve was closed during an authorized system flush. An operator discovered the valve in the closed position after the flush had been completed but before the system was restored. Therefore, the valves position was explainable.
- b. 2CS-8419, VCT Drain Valve (found open) - The valve was part of an authorized clearance which positioned it open. However, the clearance did not require the valve to be restored in accordance with the SOP valve lineup position of closed. Therefore, the valves position was explainable.

- c. Remote Operator Valve Covers (found removed) - Although the covers were removed, the investigation revealed the valves had not been mispositioned and the covers were removed as part of maintenance to find and correct leakage.

2. Corrective Actions Taken and Results Achieved

The following corrective actions were initiated immediately following the event:

- a. A team was assembled from the Nuclear Overview Organization to perform an independent investigation of these events. The team was to determine if sufficient evidence existed to substantiate a generic concern of unauthorized manipulation of station components. The investigation concluded that unauthorized manipulation was not a generic concern relative to the events.
- b. A ONE Form and Plant Incident Report (PIR) were generated to document this event. A root cause analysis was performed by a Task Team. Task Team results are discussed throughout this response.
- c. Valve lineups were performed for the following Unit 1 systems to assure correct positioning with its operating procedure.

RHR	Train A	OPT-203A
SI	Train A	OPT-204A
CT	Train A & B	OPT-205A
SSW	Train A	OPT-207A
CCW	Train A	OPT-208A
BA	Flow Path	OPT-202A
ECCS/CVCS		OPT-201A

- d. Valve lineups were performed for CVCS in Unit 2 using the SOP.

3. Corrective Actions to Prevent Recurrence

- a. The Task Team assembled to determine the root cause also investigated valve mispositionings in seven other similar events in other systems. These events are discussed in Inspection Report 50-446/92-201 and had been documented on ONE forms. The team concluded that the events were caused by 1) lack of thorough technical reviews of in-process work clearances, 2) lack of thorough impact reviews for clearances, 3) the need to promptly backout of a procedure when appropriate (for shift change, when problems are encountered, etc.), 4) failure to take appropriate operator action when inconsistencies are encountered.

- b. The team also identified numerous contributing factors and short term and long term corrective actions. The intent of the corrective actions was to correct all causes and contributing factors associated with the CVCS event and those identified in other systems. In general, the corrective actions included providing feedback to the operations staff on lessons learned, increased monitoring of plant configuration changes, procedure enhancements, increased and enhanced communications, and a restatement by management to all responsible personnel concerning who has the authority to operate plant equipment.

4. Date When Full Compliance Will Be Achieved

Full compliance has been achieved.

VIOLATION B
(446/9260-02)

Appendix B of 10CFR Part 50, Criterion V, states, in part, that activities affecting quality shall be prescribed by documented procedures of a type appropriate to the circumstances and that procedures shall include appropriate acceptance criteria for determining that important activities have been satisfactorily accomplished.

Contrary to the above, the licensee did not incorporate valves 2RH-0031 and 2RH-0032 into the valve lineup in Procedure SOP-102B, "Residual Heat Removal System," and, consequently, the valves' positions had not been verified on the valve lineup contained in the active system status file.

Response to Violation B
(446/9260-02)

TU Electric accepts the violation and the requested information follows:

1. Reason for the Violation

The two valves had previously been identified on the valve lineup performed during Hot Functional Testing and noted as missing in the System Operating Procedure (SOP). However, the SOP was not revised to include these two valves because of a lack of communication between Startup and Operations.

2. Corrective Action Taken and Results Achieved

The Unit 2 System Operating Procedure (SOP) Valve lineup for Residual Heat Removal (RHR) was revised to include the two vent valves.

3. Corrective Actions to Prevent Recurrence

A comparison was made between SOP valve lineups and the system flow diagrams for the following systems: Residual Heat Removal, Chemical Volume Control (CVC) System, Safety Injection, Reactor Coolant, Station Service Water, Containment Spray, and Auxiliary Feedwater. The comparison identified minor discrepancies which have been corrected.

In addition, a review was made of the valve lineups performed during Unit 2 Hot Functional testing to determine if there were any other valves that may not have been incorporated into system operating procedures. The review indicated that four vent valves in the CVC System were similarly identified during Unit 2 Hot Functional testing. The associated SOPs have been revised to include these four valves.

4. Date When Full Compliance Will Be Achieved

Full compliance has been achieved.

VIOLATION C
(446/9260-03)

Appendix B of 10CFR Part 50, Criterion XVI, states, in part, that measures shall be established to assure that conditions adverse to quality, such as deficiencies, are promptly identified and corrected.

Contrary to the above, following the identification of abnormal operating procedure deficiencies on two separate occasions, the licensee did not identify and implement effective corrective actions regarding additional abnormal operating procedural deficiencies. Specifically, Procedure ABN-104, "Residual Heat Removal System Malfunctions," directed the operator to manipulate valves in Unit 2 when the valve numbers referenced in the procedure were applicable only to Unit 1.

Response to Violation C
(446/9260-03)

TU Electric accepts the violation and the requested information follows:

1. Reason for Violation

Unit 2 ABNs were written based on their Unit 1 counter parts; however, controls to identify differences between the two units did not preclude the noted errors.

2. Corrective Action Taken and Results Achieved

A walkdown was performed to compare the ABN against the actual plant installations. Identified discrepancies have been corrected.

3. Corrective Actions to Prevent Recurrence

Additional reviews and walkdowns of the Unit 2 and Common ABN procedures have been performed to verify that components used in the ABNs are correctly identified and located by procedure. The ABNs were divided into three groups (Mode 6, Mode 4 and Mode 2) for this review depending on complexity and mode requirements. Errors were corrected prior to the mode for which the applicable procedure was required.

4. Date When Full Compliance Will be Achieved

Full compliance has been achieved.