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Southern Nuclear Operating Company
the southern electric system

June 7, 1995

Docket Nos.: 50-348
50-364

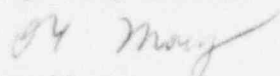
U. S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, DC 20555

Joseph M. Farley Nuclear Plant
Reply to the Notice of Violation
NRC Inspection Report Nos. 50-348/95-08 and 50-364/95-08

Ladies and Gentlemen:

As requested by your transmittal dated May 2, 1995, this letter responds to VIO 50-364/95-08-03, "Inadequate Tagging Order Preparation and Execution." The Southern Nuclear Operating Company (SNC) response to VIO 50-364/95-08-03 is provided in the Attachment.

Respectfully submitted,


Dave Morey

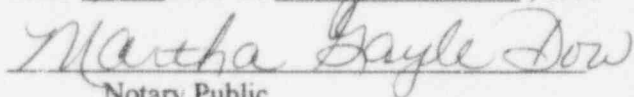
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Attachment

Mr. S. D. Ebnetter
Mr. B. L. Siegel
Mr. T. M. Ross

SWORN TO AND SUBSCRIBED BEFORE ME

THIS 7th DAY OF June, 1995


Notary Public

My Commission Expires: November 1, 1997

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ATTACHMENT

RESPONSE TO VIO 50-364/95-08-03

RESPONSE TO VIO 50-364/95-08-03

VIO 50-364/95-08-03 states the following:

10 CFR Part 50, Appendix B, Criterion XVI, and the J. M. Farley Plant Operations Quality Assurance Policy Manual, require that the licensee take measures to assure that conditions adverse to quality are promptly identified and corrected. Such measures are to be taken to assure that the cause of the condition is determined and corrective actions are taken to preclude repetition.

Technical Specification 6.8.1.a requires that applicable written procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2, 1978, shall be established, implemented and maintained. Appendix A, Section I.c., recommends administrative procedures for "Equipment Control (Locking and Tagging)".

Administrative Procedure FNP-AP-14, Safety Tagging, requires that tagging order officials will carefully review applicable tagging orders to assure that execution of such orders are acceptable with regard to their effects on plant status. FNP-AP-14 also states that designated operators will position components as specified in the tagging order.

Contrary to the above, in March and April 1995, four examples of inadequate tagging order preparation and execution resulted in instances of improper system configuration and clearance control. The corrective actions for previous tagging Incidents, violations 50-348, 364/94-13-01 and 94-30-01, were not effective.

- On March 23, during preparations for MOVATS testing of emergency core cooling system (ECCS) valves, the B charging pump suction header isolation valve (MOV8131B) was found open; however, a red tag on the main control board required valve closure. The licensee found that revisions to the original tagging order did not adequately call for the valve to be closed.
- On March 31, the B train residual heat removal system (RHR) was tagged out and drained for the Unit 2 refueling outage. Component cooling water (CCW) to the RHR pump seal cooler was isolated by the tagging order. During the outage, other vent and drain valves had been added to the seal cooler piping and when the system was placed back into service, the desired position of these valves was not verified on the tagging order. The desired position of the valves was to be closed; however, the valves were found open.
- On April 1, a work order for inspection of a charging pump suction header isolation valve, MOV8130A, was issued without the motor operated valve (MOV) breaker being tagged in an open position. Fortunately, an associated MOV disconnect was open and in a locked position. When the condition was found, work on the valve was stopped and the breaker was tagged open.
- On April 2, an operator, who was monitoring outside outage work, noted a "red tagged" flange on the ground. The operator removed the tag and discussed details of the issue with the Unit 2 shift supervisor. Upon investigation, the shift supervisor (SS) noted that the tag was being used strictly as an "identifier" for a temporary valve being used in the place of a removed main steam line safety valve.

Admission or Denial

The violation occurred in part as described in the Notice of Violation. A preliminary broadness review has been performed on the Safety Tagging System incidents occurring after March 1, 1994. This preliminary review found that the seriousness of the consequences has decreased. Errors in general were discovered and corrected prior to returning the equipment to service, without rendering safety related equipment inoperable, without causing personnel contamination events or without inadvertent starting of ESF equipment. Incidents resulting from communication errors decreased from three to zero when comparing unit one refueling outage twelve (U1RF12) to unit two refueling outage ten (U2RF10). Therefore, from the preliminary broadness review, it appears previous corrective actions were partly effective. However, it is recognized that the number of Safety Tagging System incidents is at a level not acceptable to Farley Nuclear Plant personnel and that further strengthening of corrective action to reduce the number of incidents is necessary.

Reason for Violation

These events are generic in that multiple personnel errors associated with Tag Order incidents occurred. The broad underlying root causes have not been fully determined. (As addressed later in this response, a broadness review is being performed.) The specific cause for the referenced Tag Order incidents are as follows:

1. MOV8131B found open while Tag Order specified that it be closed.

Personnel error in that the Reactor Operators did not adequately check and verify valve position indication during the tagging process.

2. CCW vent valve for 2B RHR pump seal cooler found open during execution of Tag Order.

Personnel error in that the Shift Foreman and Shift Supervisor did not utilize the drawing tabs on the P&IDs to identify outstanding design changes against the drawings when preparing the Tag Order revision for tagging in the CCW to the RHR pump seal coolers.

3. Work released on MOV8130A without breaker tagged open.

Personnel error in that:

- (a) The Shift Foreman preparing the Tag Order revision did not adequately review the work sequence of the Work Order to understand that electrical and mechanical isolation were needed for the work to be performed.
- (b) The Shift Foreman releasing the Work Order did not adequately review the work sequence of the Work Order to understand that both Electrical and Mechanical Maintenance would need to be issued clearance on the Tag Order.

(c) The EM Foreman did not adequately review the Tag Order to ensure that the MOV was electrically isolated prior to identifying EM as holding clearance on the Tag Order. Additionally, the EM Foreman is not authorized to add holders of clearance to an Operation Tag Order.

(d) The electricians determining the MOV motor relied only on the fact that the Work Order had been released earlier, and did not check with the Shift Foreman or check the breaker locally prior to beginning work to verify that the breaker for the MOV was tagged open.

4. Temporary valve and flange removed with Hold Tag attached.

Personnel error. Although the valve was not operated in the removal process, the contractor personnel removed the component with the hold tag attached without considering the consequences of breaching the system or questioning the purpose of the hold tag. (The original purpose for this hold tag was to maintain containment integrity. At the time of the event, containment integrity was no longer necessary; however, the hold tag had not been cleared.) Contractor personnel did not realize the significance of the hold tag on the valve and did not question the reason for the tag prior to removal of the flange.

Corrective Actions Taken and Results Achieved

1. Concerning the Safety Tagging System:

- a. Operations Supervision held individual discussions with all Operation Shift Foreman concerning Tag Order incidents that had occurred during the first several weeks of U2RF10. These talks emphasized the expectation that the Safety Tagging System be executed free from error and in accordance with applicable administrative guidelines. A similar discussion was held with each Operations crew at shift briefing.
- b. Various plant personnel and contractors have been made aware of these events via Operation News Letters or meetings as deemed appropriate.
- c. Personnel involved in these events were coached and/or disciplined as deemed necessary.
- d. Tag Order incidents, that are being covered in 1995 license and system operator retraining programs, include selected U2RF10 Tag Order incidents. Operations crews are obtaining this training at this time.

2. For the specific examples cited in this evaluation:

- a. MOV8131B found open while Tag Order specified that it be closed.

Upon discovering that there was still pressure on the portion of the system being tagged out, execution of the Tag Order was halted and the source of pressure determined. Actual valve position was determined for the MOV8131B. The Tag Order was revised to restore power to the MOV8131B, and the MOV was closed and tagged per the Tag Order.

- b. CCW vent valve for 2B RHR pump seal cooler found open during execution of Tag Order.

Upon discovery that the newly installed vent valve was open and a potential source of leakage, the valve was closed by the System Operator. A similar Tag Order for the 2A RHR pump was modified to include the newly installed valves. The 2A RHR pump was undergoing a similar modification.

- c. Work released on MOV8130A without breaker tagged open.

Upon discovery that the breaker for the MOV was not tagged open, work was stopped on the MOV, and the Tag Order revised to tag open the breaker.

- d. Temporary valve and flange removed with Hold Tag attached.

Upon discovery that the Hold Tag was still attached to a temporary valve that had been removed from the plant, the location and purpose for having the valve installed were determined. It was determined that the removal of the temporary valve had no adverse affect on the plant. Tag Order revision was completed to remove the tag.

Corrective Steps to Avoid Further Violation

1. Concerning the Safety Tagging System:

- a. A Broadness Review will be completed on errors associated with the Safety Tagging System. This review will examine Safety Tagging System incidents that have occurred for at least the last two years. Analysis of the review findings will be used to develop additional corrective actions as deemed necessary.
- b. Individuals involved with preparing and reviewing Tag Orders will participate in additional Safety Tagging System training. Training, in part will be developed from lessons learned and discoveries from the broadness review.
- c. On the job training for hot license class participants will be strengthened to provide more rigorous Safety Tagging System initial training.

- d. Additional guidance is being developed and will be issued to applicable plant personnel to improve their understanding concerning the duties of a Tag Order acceptor as delineated in FNP-0-AP-14
 - e. Procedure revisions to strengthen the review for Tag Order adequacy, when adding work activities not considered during development of the existing Tag Order, will be made.
 - f. Enhancements for determining the scope of training and familiarization required of contractors prior to their commencement of activities at FNP is being developed. The enhancements in part will strengthen assurance that Tag Order responsibilities and expectations are communicated to arriving vendors and contractors whose work activities will require knowledge of the Safety Tagging System.
2. Concerning Ineffective Corrective Action:
- a. The Incident Report trending program will be enhanced to better identify generic problems. Additionally, effectiveness of corrective actions will be periodically reassessed.

Date of Full Compliance

September 15, 1995