



Log # TXX-92512
File # 10130
IR 92-34
Ref. # 10CFR2.201

TUELECTRIC

November 4, 1992

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) - UNIT 2
DOCKET NO. 50-446
NRC INSPECTION REPORT NO. 50-445/92-34; 50-446/92-34
RESPONSE TO NOTICE OF VIOLATION

Gentlemen:

TU Electric has reviewed the NRC's letter dated October 5, 1992, concerning the inspection conducted by the NRC staff during the period August 2 through September 12, 1992. Attached to the October 5, 1992, letter was a Notice of Violation.

TU Electric hereby responds to the Notice of Violation in the attachment to this letter.

Sincerely,

William J. Cahill, Jr.

GLM/tg

Attachment

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

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NOTICE OF VIOLATION
(446/9234-01)

Criterion V of Appendix B to 10 CFR 50, as implemented by Section 5 of the TU Electric Quality Assurance Manual, 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"

- (1) Contrary to the above, on June 29, 1992, it was determined that a blank flange had been left installed in a lubricating oil branch header in the No. 2-02 emergency diesel generator which resulted in significant engine damage. The documents controlling the work activities associated with the engine at the time, Flush Plan ZFP-3000-07 and Construction Work Document M2-0215-76958, were inadequate in ensuring that a condition adverse to quality did not occur.
- (2) Operations Department Administrative Procedure ODA-410, "System Status Control," Revision 4, Step 6.1.3, states, in part, that components in positions other than that specified in the system status file will have documentation of the position in the procedure controlling the activity, a clearance report, unit log, or shift turnover sheet.

Contrary to the above, on September 3, 1992, the Residual Heat Removal Pump 2-02 discharge valve, 2-8724B, was found closed when its position as specified by the system status file would have been open. No documentation or justification for the valve being out-of-position could be determined.

RESPONSE TO NOTICE OF VIOLATION
(446/9234-01)

TU Electric accepts the violation and the requested information follows:

ITEM 1

(1) Reason For Violation

The blank flange was inadvertently left installed in a diesel generator lubricating oil line as a result of inadequate work documents and procedures. The work procedures failed to provide proper control and accountability of blanks used during startup pipe flushing.

(2) Corrective Steps Taken and Results Achieved

This incident was identified and evaluated in accordance with the Unit 2 Procedures for handling deficiencies. The deficiency was reported to the NRC via TXX-92418 dated, September 12, 1992, per the requirements of 10CFR50.55(e).

A formal evaluation of this incident concluded that since no other unaccounted blanks have been found in any other systems, this is considered an isolated occurrence. This blank has been removed and the diesel generator damage has been repaired. Preoperational testing has successfully demonstrated the operation of the diesel generator.

(3) Corrective Steps to Prevent Recurrence

The procedure governing installation of ANSI B31.1 piping and the procedure governing control of temporary modifications by Startup have been revised to require enhanced control and accountability of blanks.

Training has been provided to appropriate construction, startup, and maintenance personnel on the need for thorough documentation on work documents.

(4) Date When Full Compliance Will Be Achieved

Full compliance has been achieved.

ITEM 2

(1) Reason For Violation

TU Electric performed a comprehensive investigation of the applicable documents and interviewed cognizant personnel to determine how the discharge valve (2-8724B) became mispositioned. No testing activities or work activities were in progress or recently completed which would have caused the valve to be manipulated. No additional clearances or releases had been initiated for this valve.

(2) Corrective Steps Taken and Results Achieved

The Unit 2 Shift Supervisor was immediately notified and directed that a complete valve lineup be performed on both trains of the Residual Heat Removal (RHR) system. No additional valves were identified out of position on the "B" train. Four valves in Train "A" were found mispositioned. Valve 2RH-0026, the Train "A" RHR pump to the post accident sampling system isolation valve, was found open when it should have been closed, per the RHR valve pump lineup. This valve was determined to have been repositioned during the performance of and in accordance with Procedure 2CP-PT-59-01, "Post Accident Sample System". The other three valves identified out of position (2SI-0028, 2SI-0029,

and 2SI-0134), were valves associated with the valve tank enclosure for valve 2-8811A, the Train "A" containment sump to RHR suction valve, and were not connected directly to the RHR system. ONE Form 92-952 (formerly ONE Form 92-879) was written to document this event. All of the mispositioned valves were correctly positioned.

(3) Corrective Steps Taken to Avoid Further Violations

Operations management issued a lessons learned notification per ODA-106, "Review of Documents and Operational Feedback", to Unit 2 Operations personnel emphasizing the continued need to ensure flow path adequacy prior to pump starts and that changes in valve status not controlled by a specific procedure should be logged in the Unit log.

As a part of the corrective actions for a prior event, the Operations department has implemented actions which include the training of Operations personnel in the practice of self-verification, establishing goals whereby first line supervisors are normally expected to spend half of their time with their workers, and placing emphasis on supervisory accountability for individual performance and managerial accountability for supervisory performance.

(4) Date When Full Compliance Will Be Achieved

Full compliance has been achieved.