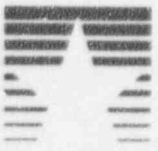

TU ELECTRIC

Log # TXX-96455
File # 10130
IR 96-08
Ref. # 10CFR2.201

September 12, 1996

C. Lance Terry
Group Vice President

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

SUBJECT: COMANCHE PEAK STEAM ELECTRIC STATION (CPSES)
DOCKET NO. 50-445 and 50-446
NRC INSPECTION REPORT NOS. 50-445/96-08 and 50-446/96-08
RESPONSE TO NOTICE OF VIOLATION

Gentlemen:

TU Electric has reviewed the NRC's letter dated August 16, 1996, concerning the inspections conducted by the NRC Resident Inspectors during the period of May 12 through March 30, 1996. Attached to the report was a Notice of Violation.

Via Attachment 1 TU Electric hereby responds to the specific Notice of Violation (445/96-08). Please note that these matters have been discussed with the NRC Resident Inspectors by my staff. Should you have any comments or require additional information, please do not hesitate to contact Obaid Bhatty at (817)-897-5839 to coordinate this effort.

Sincerely,

C. L. Terry

C. L. Terry

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

200066

OB:ob
Attachment

cc: Mr. L. J. Callan, Region IV
Mr. J. I. Tapia, Region IV
Resident Inspectors

IE01

details). The reinstallation of the penetration seal was suspended due to modification and material availability, however, the tracking LCOAR was left open.

During the time period of the suspension and reassumption of the penetration breach work (which was more than 6 months), plant personnel reviewing the LCOAR(s) did not realize that the work was in suspension and closed the tracking LCOAR issued for the penetration breach work.

The unintentional closure of the Fuel Building penetration breach LCOAR was caused due to less than sufficient verification of Work Order. TU Electric believes that, had the reviewer verified that the work order was still open a violation would not have occurred.

2. Corrective Steps Taken and Results Achieved

Immediately after the discovery of the unintentional closure of the LCOAR. Plant Operations Staff reestablished the LCOAR and the required compensatory measures.

3. Corrective Actions Taken to Preclude Recurrence

Managements expectation with respect to a diligent review of related documents, prior to closure of a tracking LCOAR has been reemphasized.

4. Date of Full Compliance

TU Electric is in full compliance.

RESTATEMENT OF THE VIOLATION
(445;446/9608-03)

B. Technical Specification 6.8.1 requires that written procedures be established, implemented, and maintained covering the applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978. Regulatory Guide 1.33, Appendix A, recommends procedures for operating the reactor coolant system and for operating the chemical and volume control system.

Contrary to the above, two activities which affected quality were prescribed by documented instructions which were not adequately maintained:

- Inadequate instructions contained in Procedure IPO-010B, "Reactor Coolant System Reduced Inventory Operations," Revision 1, caused a partial loss of reactor vessel level indication on March 30, 1996, while performing a vacuum fill of the Unit 2 reactor coolant system, and

- Inadequate instructions contained in Procedure SOP-106B, "Boron Thermal Regeneration System," Revision 2, caused an inadvertent boration on June 2, 1996, in Unit 2 while attempting to fill and vent the boron thermal regeneration system.

RESPONSE TO THE VIOLATION
(445;446/9608-03)

TU Electric accepts the violation, the response as requested is provided below:

1. Reason for Violation

- Procedure IPO-010B, "Reactor Coolant System Reduced Inventory Operations,":

The valve line up procedure did not include instrument vent valves. This caused the partial loss of reactor vessel level indication on March 30, 1996, while performing a vacuum fill of the Unit 2 reactor coolant system (RCS).

- Procedure SOP-106B, "Boron Thermal Regeneration System,"

The procedure steps did not prevent flow through the boron thermal regeneration system (BTRS), prior to ensuring that system chemistry would not effect the RCS. This caused an inadvertent boration on June 2, 1996, in Unit 2 while attempting to fill and vent the boron thermal regeneration system.

TU Electric believes that the above stated procedures were not comprehensive enough to prevent the events.

2. Corrective Steps Taken and Results Achieved

Procedure IPO-010B, "Reactor Coolant System Reduced Inventory Operations," and Procedure SOP-106B, "Boron Thermal Regeneration System," were revised to provide sufficient guidance for valve line up/venting, and to insure that a flow path through the BTRS is not initiated until the water chemistry has been verified respectively. Additionally, a review of approximately 1152 Operation Notification and Evaluation Forms was performed. The scope of the evaluation was to determine generic implications, no matters of concern were identified.

3. Corrective Actions Taken to Preclude Recurrence

TU Electric believes that revision to the procedures will prevent recurrence. Additionally, the revision of both procedures have been incorporated in the licensed operator training to ensure sufficient understanding of the process.

4. Date of Full Compliance

TU Electric is in full compliance.

RESTATEMENT OF THE VIOLATION
(445;446/9608-04)

C. Technical Specification 6.12.2 requires, in part, that areas accessible to personnel with radiation levels such that a major portion of the body could receive in 1 hour a dose greater than 1000 millirem shall be provided with locked doors to prevent unauthorized entry.

Contrary to the above, on June 5, 1996, the inspectors identified that the licensee failed to lock a locked high radiation area on the 810-foot elevation of the fuel building.

RESPONSE TO THE VIOLATION
(445;446/9608-04)

TU Electric accepts the violation, the response as requested is provided below:

1. Reason for Violation

On June 5, 1996 a radioactive filter storage shield was moved into room 250 of the Fuel Building in preparation of transferring the filters into a disposal container. The radiation levels on the storage shield were greater than 1000 mrem/hr, therefore a Radiation Protection Technician posted the room as a Locked High Radiation Area and replaced the existing door lock core with a "RAD" lock core in accordance with procedures. Rooms in the plant which are designed to be locked have automatic locking sets, but room 250 was not designed to be locked. The Radiation Protection Technician assumed the door would automatically lock when closed, but it did not. The Radiation Protection Technician then failed to verify that the door was indeed locked.

2. Corrective Steps Taken and Results Achieved

Upon discovery of the issue, TU Electric performed the following corrective actions :

- The door was immediately locked by Radiation Protection (RP) personnel.
- The door lock set to room 250 was changed to the automatically locking type. The filter storage shield was eventually moved out of room 250, the room was deposted and the "RAD" lock removed.
- Other locked high radiation area doors were confirmed locked.

3. Corrective Actions Taken to Preclude Recurrence

To ensure compliance with Technical Specification 6.12.2, the applicable procedure was revised to include guidance on establishing and verifying locked appropriate high radiation areas and requirements for issuing and returning "RAD" keys.

4. Date of Full Compliance

TU Electric is in full compliance.