Washington Public Power Supply System
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Docket No. 50-397
September 20, 1984
G02-84-521

Mr. T.W. Bishop, Director
Division of Reactor Safety and Projects
U.S. Nuclear Regulatory Commission
Region V
1450 Maria Lane, Suite 210
Walnut Creek, California 94596

Subject: NUCLEAR PLANT NO. 2
LICENSE NO. NPF-21
NRC INSPECTION 84-15
MAY 29 - JUNE 8, 1984

Reference: Letter G02-84-476, 08/23/84, Supply System/NRC

On August 23, 1984, the Washington Public Power Supply System replied to observations contained in your letter of July 24, 1984. Subsequent to this, the Resident Inspector brought to our attention an inaccuracy in the wording of our response.

The response to the "Awareness of Plant/System Status" observation made reference to the implementation of a procedure deviation. As the Resident Inspector correctly pointed out, no procedure deviation had been processed. In actual fact, a procedure "revision" was being processed and therefore the deviation was not initiated. The intent of this portion of our response, which was to correct the procedure, is not affected by this discrepancy.

As a result of the Resident Inspector's observation concerning our response, we reverified the other positions stated in our 8/23/84 letter. An additional inaccuracy was noted in our response to the "Adherence to Procedures and Controls" response. We stated in this section that PPM 2.7.2 and 7.4.8.1.1.2.11 had been changed to specify the diesel generator emergency bypass switch be left in the "off" position. At the time of our initial response, PPM 7.4.8.1.1.2.11 was, in fact, changed; but PPM 2.7.2 was not. PPM 2.7.2 has since had a procedure deviation processed to correct this situation.

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Since the Supply System became aware of these discrepancies, management has identified and corrected the cause. All plant personnel have been directed to verify the accuracy of our statements. In addition the Compliance Engineer has been instructed to establish a follow-up action tracking process for uncompleted commitments with respect to Notice of Violation responses. These efforts have received the highest corporate level attention. The Supply System has always recognized the importance of making accurate statements and sincerely believes this type of error was an isolated event and will not reoccur.

In Appendix A our amended responses to the "Awareness of Plant/System Status" and "Adherence to Procedures and Controls" observations are presented. The vertical line in the margin indicates the amended portion.

Should you have any questions concerning this amended response, do not hesitate to contact me.

GC Sorensen

G. C. Sorensen
Manager, Regulatory Programs

GCS:RLK:mm
Attachment

APPENDIX A

OBSERVATION: Awareness of Plant/System Status

Operator response to alarms appeared casual in many instances, very seldom were operators observed referencing the alarm response procedures. An inspector questioned the shift supervisor as to the reason that a fire alarm on the turbine deck was sealed in (there was no information tag on the alarm). The shift supervisor responded that there was something wrong with the system. The shift supervisor pursued the matter and later that day (approximately 7 hours) the alarm cleared when the system engineer cleaned the ionization detector.

An operator was questioned as to the reason for the LPCS pump discharge pressure high/low alarm, (alarms at greater than 450 psig or less than 40 psig). The operator said alarm must be low because pump was not running. The alarm response procedure says: 1. verify pressure ≤ 450 and ≥ 40 as read on LPCS-PI-57 on P612 and 3. if low, verify water leg pump is running and fill and vent system per PPM 2.4.3. Low pressure core spray. Pressure gauge LPCS-PI-57 does not exist in the control room on panel PG12. No procedure deviation form had been originated to correct the procedure. The inspector checked the pressure on the instrument rack E21-R002 (LPCS-PI-2) read 90 lbs and E21-R001 (LPCS-P15-1) read 80 lbs. The operator generated a maintenance work request based on the inspector's observations.

A team member questioned the shift supervisor as to the reason for the RCIC suction pressure high alarm. The supervisor responded that it was a result of water trapped in the suction lines expanding. The inspector noted that the control room panel RCIC suction pressure gauge was off scale high. This gauge only reads to 85 psig while the alarm comes in at ≥ 91 psig. The shift supervisor originated a problem report.

The lack of awareness of plant status annunciators was considered to be a weakness in plant operations.

RESPONSE:

Although operator response may have appeared casual, we believe this to be a misinterpretation of the situation. The operator's knowledge of system configurations, problems, past occurrences and the system's ability to function as designed, leads to responses that could appear casual at first appearance. Operators do not always routinely reference the alarm response procedures. If the procedure had been previously used, the operator would not have to reference the procedure every time an alarm came in. During the course of plant life it would be expected that response to the more common alarms become routine and not require reference to the alarm response procedures. Administrative procedures (PPM 1.2.3) allow the performance of "routine" procedures without referencing the written procedures.

In the specific case of the turbine deck fire alarm, an operator had been immediately sent to determine if there was indeed a fire, smoke in the area or water running. Since no evidence of fire was found, an MWR was written to initiate repairs. The Shift Manager would not specifically know what the problem was until either the Instrument and Control Technician or System Engineer reported back.

The LPCS pump discharge pressure high/low alarm will alarm at pressure ≥ 442 psig and is an indication of primary system leakage through the system isolation valves alerting the operator to possible system overpressurization. The low alarm comes in at pressures below 64 psig. A procedure revision has been processed to correct the gauge identification and setpoint information (high alarm ≥ 442 psig, low alarm ≤ 64 psig).

The RCIC suction pressure high alarm normally alarms due to the water leg pump discharging into the RCIC pump suction line. A Plant Modification Request (PMR) has been initiated to evaluate the alarm setpoint requirements and gauge range.

The need to follow up on alarm situations and to initiate plant problem reports where equipment usage and/or indication is not consistent with plant operations has been reemphasized to all plant operators. The need for a review of plant safety related annunciator procedures is being evaluated at this time. Appropriate action will be taken based on results of this evaluation. In the meantime operators have been advised to initiate procedure deviations when procedural errors are discovered.

OBSERVATION: Adherence to Procedures and Controls

The inspectors reviewed select procedures. This review included: operating, alarm response, surveillance and administrative procedures. The licensed operators were observed using these procedures during startup, paralleling the generator to the grid, controlled shutdown, control room surveillance observations and tests, and reactor trip recovery.

On June 1, the inspectors, during an operability check of the No. 2 diesel generator, found that the emergency bypass switch (bypasses minor diesel trip inputs during ESF actuation) was in the off position during standby instead of on as required by its line-up procedure (PPM 2.7.2.5B) and surveillance procedure (PPM 7.4.8.1.1.2.11). It appears that independent verification has not been fully implemented.

On June 5, the inspectors observed, that for a brief period, there were no operators "at the controls" as required in plant administrative procedure PPM 1.3.2 Shift Compliment and Functions. PPM 1.3.2 part 5A states: "At least one licensed operator shall be at the controls in the control room when fuel is in the reactor." "At the controls" is defined and outlined, as a sketch, in Attachment 1 to PPM 1.3.2. The team did note, during this period, that the shift supervisor was with the shift manager in his office. The administrative procedure sketch of "at the controls" differs from the FSAR in that the FSAR includes the shift manager's office while the PPM excludes the shift manager's office. The

regulatory position (Regulatory Guide 1.114 - Guidance On Being Operator At The Controls Of A Nuclear Power Plant) is that: "The operator at the controls should not under any circumstances leave the surveillance area defined by Regulatory Position 3 for any nonemergency reason without a qualified relief at the controls." Regulatory position 3 (see Reg. Guide) states: "Administrative procedures should be established to define the outline (preferably with sketches) specific areas within the control room where the operator at the controls should remain. The Supply System has committed to this position during the operational phase (FSAR Appendix C.3). The failure to comply with the licensee's own procedures, even though more restrictive that the FSAR, is considered a weakness in adherence to management control.

RESPONSE:

Upon investigation of this concern, it was noted that the position of the diesel generator bypass was not left in the position specified by procedure. The diesel generator was indeed lined up with the emergency bypass switch in the off position. However, this in no way compromised the system response during accident conditions since contacts of relay K15A open during an accident to bypass unwanted trips regardless of the emergency bypass switch position.

Implementation of our Independent Verification Program is described in our response to NUREG 0737. Specifically, return to normal status at the completion of a surveillance test which requires signature acknowledgement for each step does not require independent verification. In this case when the diesel generator #2 was realigned to standby per PPM 7.4.8.1.1.2.11, independent verification was not required.

As a result of investigating this concern, PPM 7.4.8.1.1.2.11 was changed to specify the emergency bypass switch be left in the off position. Also, a procedure deviation was processed to bring PPM 2.7.2 into agreement with PPM 7.4.8.1.1.2.11.

On June 5, there was a Control Room Operator, sitting at the Shift Technical Advisor's desk, who was apparently not observed by the NRC inspector. This was within the outlined boundary of PPM 1.3.2. Subsequent to this inspection PPM 1.3.2 was revised to eliminate further questions on this issue. Plant management has observed that control room personnel have been extremely conscientious regarding adherence to this procedure. We believe the issue of "at the controls" has been appropriately addressed and adhered to. This will continue to receive management and supervisory attention.