



any kcp
8.1.7

WASHINGTON PUBLIC POWER SUPPLY SYSTEM

P.O. Box 968 • 3000 George Washington Way • Richland, Washington 99352

December 21, 1988
G02-88-274

Docket No. 50-397

U. S. Nuclear Regulatory Commission
Attn: Document Control Desk
Mail Station P1-137
Washington, D.C. 20555

Gentlemen:

Subject: NUCLEAR PLANT NO. 2
LICENSE NO. NPF-21
NRC INSPECTION REPORT 88-24
RESPONSE TO NOTICE OF VIOLATION

The Washington Public Power Supply System hereby replies to the Notice of Violation contained in your letter dated November 23, 1988. Our reply, pursuant to the provisions of Section 2.201, Title 10, Code of Federal Regulations, consists of this letter and Appendix A (attached).

In Appendix A, each violation is addressed with an explanation of our position regarding validity, corrective action and date of full compliance.

Very truly yours,


G. C. Sorensen, Manager
Regulatory Programs

REF/bk
Attachments

cc: JB Martin - NRC RV
NS Reynolds - BCP&R
RB Samworth - NRC
DL Williams - BPA
NRC Site Inspector - 901A

8812280272-881221
PDR ADDCK 05000397
Q FDC

gpo

DE01
11

88-357.

APPENDIX A

During an NRC inspection conducted from August 22 to September 2, 1988, several violations of NRC requirements were identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," 10 CFR Part 2, Appendix C (1988), as modified by 53 Fed. Reg. 40019 (October 13, 1988), the violations are listed below:

- A. Paragraph 6.8.1 of the Technical Specifications requires written procedures to be established, implemented, and maintained for surveillance and test activities of safety-related equipment.

Paragraph 6.8.2 of the Technical Specifications requires these procedures and changes to these procedures to be reviewed by the POC and approved by the Plant Manager, as set forth in administrative procedures.

Paragraph 6.8.3 of the Technical Specifications allows temporary changes to be made to procedures provided that the intent of the original procedure is not altered, the change is approved by two members of management staff (at least one of whom holds a Senior Operator license), and the change is documented, reviewed by the POC, and approved by the Plant Manager within 14 days of implementation.

Administrative Procedure 1.2.3, "Use of Procedures" (Rev. 12 dated September 18, 1987), requires procedures to be followed in the performance of plant activities. When procedures cannot be followed, a revision to the procedure or a procedure deviation must be completed. In the case of a procedure deviation, documentation prior to its implementation is not required provided the deviation has been approved by two members of plant management/supervisory staff and the Shift Manager is of the opinion that the work must continue.

Contrary to the above, changes were made to Surveillance Procedure 7.4.4.3.1.4 during the performance of a drywell sump flow monitor calibration on August 24, 1988, and a procedure revision or procedure deviation was not completed.

This is a Severity Level IV violation (Supplement I).

Validity of Violation

The Supply System does not acknowledge the validity of this violation.

Just prior to August 22, 1988 the Drywell Sump Flow Monitor indicated a flow that was approaching the Tech Spec limit, Section 3.4.3.2b, 5 gpm unidentified leakage. A volumetric flow test (using buckets), PPMs 2.11.3 and 2.11.5 was performed which determined that the indicated flow was greater than the actual flow. Operations requested that the loop be recalibrated. On August 22, 1988 at 0958, surveillance procedure 7.4.4.3.1.4, "Drywell Sump Flow Monitors," was started. During the performance of the procedure the Technicians noted that there were problems with the procedure which required

a deviation. The Technicians obtained the assistance from the Maintenance Engineers to provide guidance on the procedure deviation required to remedy the problems identified with the procedure and ensure the deviation would not cause new problems. Permission was then obtained from the Shift Manager and the I&C Maintenance Supervisor to deviate from the procedure as necessary per PPM 1.2.3.C.3, and to provide the deviation and completed procedure for signature and approval prior to declaring the flow monitor back in service. This was considered acceptable because the floor drain sump flow monitoring instrumentation system does not provide any automatic actuation, but instead, provides indication and high flow alarm only. Therefore, volumetric flow tests were performed within the required frequency to monitor leakage flow rates relative to the allowable Technical Specification limits. The Shift Manager had decided the work must continue because the accuracy of the drywell sump flow monitor system was in question and the sump flow indicator was approaching the Technical Specification limit.

The procedure was completed the afternoon of August 24, 1988 and the procedure deviation was written from the notes made during the performance of the procedure. The deviation received approval signatures on August 25, 1988 at 0800 and the procedure was signed off as completed satisfactorily at 0826 on August 25, 1988. The equipment was not returned to service prior to implementation and sign off of the procedure deviation.

Per Plant Procedure 1.2.3, Section C.3, the deviation is not required to be documented prior to its implementation providing it has been approved verbally by two members of the Plant Management Supervisory Staff. This process should be followed only when, in the judgment of the Shift Manager, work must continue as was the case here.

Corrective Steps Taken/Results Achieved

PPM successfully performed.

Corrective Action to be Taken

No further corrective action is planned.

Date of Full Compliance

The Supply System is currently in full compliance.



- B. 10 CFR 50.72(b)(2)(ii) requires the licensee to notify the NRC as soon as practical and in all cases within four hours of any event or condition that results in an automatic Reactor Protection System (RPS) actuation that is not part of a preplanned sequence during testing or reactor operation.

Contrary to the above, the following RPS actuation were not part of the preplanned sequence during testing or reactor operation, and were not reported to the NRC as required:

- o At 0844 on May 29, 1988, during Mode 5 operation, an RPS actuation occurred during initial testing of the alternate rod insertion (ARI) system. The RPS actuation occurred when air pressure bled off the scram valves after the ARI system was placed in the test mode and the scram air header was isolated. Control rod drive air system leakage resulted from undocumented air system leaks, and the RPS actuation was not a normal occurrence and was not anticipated in the ARI system test procedure.
- o At 1553 on August 26, 1988, during Mode 5 operation, an RPS actuation occurred when Division II RPS power was transferred from the alternate to the normal source. The RPS actuation was due to switch over-travel during the power transfer evolution. The control room logs did not indicate that testing was in progress at the time of the RPS actuation, and the licensee could not produce a maintenance work order or other documentation to demonstrate that testing was in progress during the August 26 event.

This is a Severity Level IV violation (Supplement I).

Validity of Violation

The Supply System does not acknowledge the validity of this violation:

"Actuation of an ESF, including the RPS, that results from and is part of the preplanned sequence during testing or reactor operation need not be reported" (10CFR50.72(b)(2)(ii) and 10CFR50.73(2)(2)(iv)). "Operation of an ESF as part of a planned operational procedure or test (e.g., startup testing) need not be reported. However, if during the planned operating procedure or test, the ESF actuates in a way that is not part of the planned procedure that actuation must be reported." (Page 13 NUREG 1022)

Scram Discharge Volume High High Reactor Protection System Actuation.

As stated in the regulations quoted above, any RPS actuation that is part of a preplanned sequence during testing need not be reported. The event cited in this violation occurred as part of a preplanned testing sequence and therefore is not reportable. Performance of the Pre-Operational (pre-op) Test Procedure for the Anticipated Transient Without Scram (ATWS) Alternate Rod Insertion (ARI) System was the cause

of this event. A step in the ARI Pre-Operational Test Procedure required isolation of the Control Rod Drive Scram Air Header. Some bleed off of air pressure in the header was expected, and in fact, there was a procedure step to record the amount of pressure lost during the test. While the amount of bleed down was not known prior to the test, the consequences of a large decrease in air header pressure were known. That is the scram valves open and the Scram Discharge Volume (SDV) drain valves close whereby the scram water fills the SDV and causes an RPS actuation on high water level. The test procedure purposely did not open the bypass valve which would have prevented the actuation. The Event Precursor reviewer stated to the Reactor Systems Supervisor that if the sequence of events in the procedure establish a condition where an RPS actuation could occur, this would constitute preplanning. Therefore, the RPS actuation was the result of a preplanned sequence of testing, and the actuation did not occur in a way that was not part of the procedure.

The condition of the control rod drive system having "undocumented air system leaks" is irrelevant since the Control Rod Drive System, including the scram air header meets all operational requirements. The scram header air leaks were investigated following this event because of concerns expressed about the rapidity of the bleed down. No major leaks were discovered and it was judged to be determined impractical to fix most of the minor leaks found during power operation. Those leaks which can be repaired without major piping disassembly scheduled to be repaired in R-4.

August 26, 1988 RPS Actuation.

"On August 25, 1988, at 2211 hours, while performing a channel functional test and calibration of the Reactor Protection System RPS Bus "A" EPA breakers, a full RPS actuation occurred due to momentary loss of power to both divisions of RPS. The cause of this event is switch overtravel, which deenergized both divisions of RPS simultaneously" (from WNP-2 Licensee Event Report 88-30).

On August 26, 1988, Control Room Operators (CROs) (Licensed Reactor Operators) were preparing to transfer RPS "B" power from its alternate to normal power supply. Because of the full RPS trip of the previous day, the Shift Manager, Control Room Supervisor, and System Engineer determined that an opportunity existed to investigate the August 25, 1988 event. This process was consistent with the approved Plant Troubleshooting Procedure. The same CRO who performed the power transfer the previous day was instructed to do the power transfer in the exact manner of the previous day with RPS System Engineer watching. CRO duties are rotated daily and it is unlikely that the same CRO would have performed this task on both days and by observing the August 26, 1988 RPS power transfer, the RPS System Engineer was able to determine the cause of the August 25, 1988 event. Therefore, this RPS actuation is considered a preplanned test and is not reportable.

Corrective Steps Taken/Results Achieved

Pre-op procedures were successfully performed.

Corrective Action to be Taken

No further corrective action is planned.

Date of Full Compliance

The Supply System is currently in full compliance.

ACCELERATED DISTRIBUTION DEMONSTRATION SYSTEM

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR:8812280272 DOC.DATE: 88/12/21 NOTARIZED: NO DOCKET #
 FACIL:50-397 WPPSS Nuclear Project, Unit 2, Washington Public Powe 05000397
 AUTH.NAME AUTHOR AFFILIATION
 SORESENSEN, G.C. Washington Public Power Supply System
 RECIP.NAME RECIPIENT AFFILIATION
 Document Control Branch (Document Control Desk)

SUBJECT: Responds to NRC 881123 ltr re violations noted in Insp Rept
 50-397/88-24.

DISTRIBUTION CODE: IE01D COPIES RECEIVED: LTTR 1 ENCL 1 SIZE: 9
 TITLE: General (50 Dkt)-Insp Rept/Notice of Violation Response

NOTES:

	RECIPIENT		COPIES			RECIPIENT		COPIES		
	ID	CODE/NAME	LTTR	ENCL		ID	CODE/NAME	LTTR	ENCL	
	PD5	PD	1	1		SAMWORTH, R	1	1		
INTERNAL:	ACRS		2	2		AEOD	1	1		
	AEOD/DEIIB		1	1		DEDRO	1	1		
	NRR SHANKMAN, S		1	1		NRR/DLPQ/PEB 11	1	1		
	NRR/DLPQ/QAB 10		1	1		NRR/DOEA DIR 11	1	1		
	NRR/DREP/EPB 10		1	1		NRR/DREP/RPB 10	2	2		
	NRR/DRIS DIR 9A		1	1		NRR/PMAS/ILRB12	1	1		
	NUDOCS-ABSTRACT		1	1		OE LIEBERMAN, J	1	1		
	OGC/HDS2		1	1		<u>REG FILE</u> 02	1	1		
	RGN5 FILE 01		1	1						
EXTERNAL:	LPDR		1	1		NRC PDR	1	1		
	NSIC		1	1		RESL MARTIN, D	1	1		

NOTE TO ALL "RIDS" RECIPIENTS:

PLEASE HELP US TO REDUCE WASTE! CONTACT THE DOCUMENT CONTROL DESK,
 ROOM P1-37 (EXT. 20079) TO ELIMINATE YOUR NAME FROM DISTRIBUTION
 LISTS FOR DOCUMENTS YOU DON'T NEED!

TOTAL NUMBER OF COPIES REQUIRED: LTTR 25 ENCL 25

WASHINGTON PUBLIC POWER SUPPLY SYSTEM

P.O. Box 968 • 3000 George Washington Way • Richland, Washington 99352

December 21, 1988
G02-88-274

Docket No. 50-397

U. S. Nuclear Regulatory Commission
Attn: Document Control Desk
Mail Station P1-137
Washington, D.C. 20555

Gentlemen:

Subject: NUCLEAR PLANT NO. 2
LICENSE NO. NPF-21
NRC INSPECTION REPORT 88-24
RESPONSE TO NOTICE OF VIOLATION

The Washington Public Power Supply System hereby replies to the Notice of Violation contained in your letter dated November 23, 1988. Our reply, pursuant to the provisions of Section 2.201, Title 10, Code of Federal Regulations, consists of this letter and Appendix A (attached).

In Appendix A, each violation is addressed with an explanation of our position regarding validity, corrective action and date of full compliance.

Very truly yours,


G. C. Sorensen, Manager
Regulatory Programs

REF/bk
Attachments

cc: JB Martin - NRC RV
NS Reynolds - BCP&R
RB Samworth - NRC
DL Williams - BPA
NRC Site Inspector - 901A

8812280272 881221
PDR ADOCK 05000397
Q PIC

DE01
11



APPENDIX A

During an NRC inspection conducted from August 22 to September 2, 1988, several violations of NRC requirements were identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," 10 CFR Part 2, Appendix C (1988), as modified by 53 Fed. Reg. 40019 (October 13, 1988), the violations are listed below:

- A. Paragraph 6.8.1 of the Technical Specifications requires written procedures to be established, implemented, and maintained for surveillance and test activities of safety-related equipment.

Paragraph 6.8.2 of the Technical Specifications requires these procedures and changes to these procedures to be reviewed by the POC and approved by the Plant Manager, as set forth in administrative procedures.

Paragraph 6.8.3 of the Technical Specifications allows temporary changes to be made to procedures provided that the intent of the original procedure is not altered, the change is approved by two members of management staff (at least one of whom holds a Senior Operator license), and the change is documented, reviewed by the POC, and approved by the Plant Manager within 14 days of implementation.

Administrative Procedure 1.2.3, "Use of Procedures" (Rev. 12 dated September 18, 1987), requires procedures to be followed in the performance of plant activities. When procedures cannot be followed, a revision to the procedure or a procedure deviation must be completed. In the case of a procedure deviation, documentation prior to its implementation is not required provided the deviation has been approved by two members of plant management/supervisory staff and the Shift Manager is of the opinion that the work must continue.

Contrary to the above, changes were made to Surveillance Procedure 7.4.4.3.1.4 during the performance of a drywell sump flow monitor calibration on August 24, 1988, and a procedure revision or procedure deviation was not completed.

This is a Severity Level IV violation (Supplement I).

Validity of Violation

The Supply System does not acknowledge the validity of this violation.

Just prior to August 22, 1988 the Drywell Sump Flow Monitor indicated a flow that was approaching the Tech Spec limit, Section 3.4.3.2b, 5 gpm unidentified leakage. A volumetric flow test (using buckets), PPMs 2.11.3 and 2.11.5 was performed which determined that the indicated flow was greater than the actual flow. Operations requested that the loop be recalibrated. On August 22, 1988 at 0958, surveillance procedure 7.4.4.3.1.4, "Drywell Sump Flow Monitors," was started. During the performance of the procedure the Technicians noted that there were problems with the procedure which required

a deviation. The Technicians obtained the assistance from the Maintenance Engineers to provide guidance on the procedure deviation required to remedy the problems identified with the procedure and ensure the deviation would not cause new problems. Permission was then obtained from the Shift Manager and the I&C Maintenance Supervisor to deviate from the procedure as necessary per PPM 1.2.3.C.3, and to provide the deviation and completed procedure for signature and approval prior to declaring the flow monitor back in service. This was considered acceptable because the floor drain sump flow monitoring instrumentation system does not provide any automatic actuation, but instead, provides indication and high flow alarm only. Therefore, volumetric flow tests were performed within the required frequency to monitor leakage flow rates relative to the allowable Technical Specification limits. The Shift Manager had decided the work must continue because the accuracy of the drywell sump flow monitor system was in question and the sump flow indicator was approaching the Technical Specification limit.

The procedure was completed the afternoon of August 24, 1988 and the procedure deviation was written from the notes made during the performance of the procedure. The deviation received approval signatures on August 25, 1988 at 0800 and the procedure was signed off as completed satisfactorily at 0826 on August 25, 1988. The equipment was not returned to service prior to implementation and sign off of the procedure deviation.

Per Plant Procedure 1.2.3, Section C.3, the deviation is not required to be documented prior to its implementation providing it has been approved verbally by two members of the Plant Management Supervisory Staff. This process should be followed only when, in the judgment of the Shift Manager, work must continue as was the case here.

Corrective Steps Taken/Results Achieved

PPM successfully performed.

Corrective Action to be Taken

No further corrective action is planned.

Date of Full Compliance

The Supply System is currently in full compliance.



- B. 10 CFR 50.72(b)(2)(ii) requires the licensee to notify the NRC as soon as practical and in all cases within four hours of any event or condition that results in an automatic Reactor Protection System (RPS) actuation that is not part of a preplanned sequence during testing or reactor operation.

Contrary to the above, the following RPS actuation were not part of the preplanned sequence during testing or reactor operation, and were not reported to the NRC as required:

- o At 0844 on May 29, 1988, during Mode 5 operation, an RPS actuation occurred during initial testing of the alternate rod insertion (ARI) system. The RPS actuation occurred when air pressure bled off the scram valves after the ARI system was placed in the test mode and the scram air header was isolated. Control rod drive air system leakage resulted from undocumented air system leaks, and the RPS actuation was not a normal occurrence and was not anticipated in the ARI system test procedure.
- o At 1553 on August 26, 1988, during Mode 5 operation, an RPS actuation occurred when Division II RPS power was transferred from the alternate to the normal source. The RPS actuation was due to switch over-travel during the power transfer evolution. The control room logs did not indicate that testing was in progress at the time of the RPS actuation, and the licensee could not produce a maintenance work order or other documentation to demonstrate that testing was in progress during the August 26 event.

This is a Severity Level IV violation (Supplement I).

Validity of Violation

The Supply System does not acknowledge the validity of this violation:

"Actuation of an ESF, including the RPS, that results from and is part of the preplanned sequence during testing or reactor operation need not be reported" (10CFR50.72(b)(2)(ii) and 10CFR50.73(2)(2)(iv)). "Operation of an ESF as part of a planned operational procedure or test (e.g., startup testing) need not be reported. However, if during the planned operating procedure or test, the ESF actuates in a way that is not part of the planned procedure that actuation must be reported." (Page 13 NUREG 1022)

Scram Discharge Volume High High Reactor Protection System Actuation.

As stated in the regulations quoted above, any RPS actuation that is part of a preplanned sequence during testing need not be reported. The event cited in this violation occurred as part of a preplanned testing sequence and therefore is not reportable. Performance of the Pre-Operational (pre-op) Test Procedure for the Anticipated Transient Without Scram (ATWS) Alternate Rod Insertion (ARI) System was the cause

of this event. A step in the ARI Pre-Operational Test Procedure required isolation of the Control Rod Drive Scram Air Header. Some bleed off of air pressure in the header was expected, and in fact, there was a procedure step to record the amount of pressure lost during the test. While the amount of bleed down was not known prior to the test, the consequences of a large decrease in air header pressure were known. That is the scram valves open and the Scram Discharge Volume (SDV) drain valves close whereby the scram water fills the SDV and causes an RPS actuation on high water level. The test procedure purposely did not open the bypass valve which would have prevented the actuation. The Event Precursor reviewer stated to the Reactor Systems Supervisor that if the sequence of events in the procedure establish a condition where an RPS actuation could occur, this would constitute preplanning. Therefore, the RPS actuation was the result of a preplanned sequence of testing, and the actuation did not occur in a way that was not part of the procedure.

The condition of the control rod drive system having "undocumented air system leaks" is irrelevant since the Control Rod Drive System, including the scram air header meets all operational requirements. The scram header air leaks were investigated following this event because of concerns expressed about the rapidity of the bleed down. No major leaks were discovered and it was judged to be determined impractical to fix most of the minor leaks found during power operation. Those leaks which can be repaired without major piping disassembly scheduled to be repaired in R-4.

August 26, 1988 RPS Actuation.

"On August 25, 1988, at 2211 hours, while performing a channel functional test and calibration of the Reactor Protection System RPS Bus "A" EPA breakers, a full RPS actuation occurred due to momentary loss of power to both divisions of RPS. The cause of this event is switch overtravel, which deenergized both divisions of RPS simultaneously" (from WNP-2 Licensee Event Report 88-30).

On August 26, 1988, Control Room Operators (CROs) (Licensed Reactor Operators) were preparing to transfer RPS "B" power from its alternate to normal power supply. Because of the full RPS trip of the previous day, the Shift Manager, Control Room Supervisor, and System Engineer determined that an opportunity existed to investigate the August 25, 1988 event. This process was consistent with the approved Plant Troubleshooting Procedure. The same CRO who performed the power transfer the previous day was instructed to do the power transfer in the exact manner of the previous day with RPS System Engineer watching. CRO duties are rotated daily and it is unlikely that the same CRO would have performed this task on both days and by observing the August 26, 1988 RPS power transfer, the RPS System Engineer was able to determine the cause of the August 25, 1988 event. Therefore, this RPS actuation is considered a preplanned test and is not reportable.



Corrective Steps Taken/Results Achieved

Pre-op procedures were successfully performed.

Corrective Action to be Taken

No further corrective action is planned.

Date of Full Compliance

The Supply System is currently in full compliance.

- C. Technical Specification 6.8.1 states, in part, that "Written procedures shall be established, implemented, and maintained covering ... the applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978." These include "Procedures for Performing Maintenance".

Paragraph E of Administrative Procedure 1.3.9, Revision 9, "Control of Electrical and Mechanical Jumpers and Lifted Leads," states in part that any deviations to the determination/retermination data sheet following Shift Manager approval shall be reauthorized by the Shift Manager.

Contrary to the above, each of the "determination/retermination" sheets associated with completed maintenance work requests MWR-A-0110 (trouble-shooting blown fuses on the power supply to solenoid pilot valves for MS-V22A-D) and MWR-AU9257 (repair of leaking valve RHR-V53-B) contained a cable which had been determined but not reterminated. The changes to the work instruction had not been authorized by the Shift Manager.

This is a Severity Level IV violation (Supplement I).

Validity of Violation

The Supply System acknowledges the validity of the violation relative to the incompleteness of data sheets.

Changes to the work scope require Shift Manager approval. However, changes to the work instructions do not require authorization from the Shift Manager provided the work scope is not changed.

Successful operability tests demonstrated the cables with undocumented retermination had been properly reterminated. This indicates that the scope of work had not been changed, but that checkoff and verification had not been documented on the data sheets.

Corrective Steps Taken/Results Achieved

Training was performed on 10-21-88 on PPM 1.3.9, Control of Electrical and Mechanical Jumpers and Lifted Leads, emphasizing Determ/ReTerm requirements.

Corrective Action to be Taken

The procedures and Determ/ReTerm Data Sheet in PPM 1.3.9 will be revised to provide more overview that will reduce the probability of documentation omissions.

Date of Full Compliance

Revise PPM 1.3.9 prior to R-4 outage, expected to begin during April 1989.



- D. 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action", requires measures to be established to assure that conditions adverse to quality, such as defective equipment and nonconformances, are promptly identified and corrected.

Contrary to the above as of September 2, 1988, two torque wrenches and one leak rate monitoring instrument had been identified 12-18 months prior to the inspection as being out of calibration, but an evaluation of the impact of this lack of calibration had not been performed.

This is a Severity Level IV violation (Supplement I).

Validity of Violation

The Supply System agrees with the violation in that the resolution corrective action was not taken in a timely manner.

Corrective Steps Taken/Results Achieved

A review was completed of the Plant installed equipment that was calibrated and torqued using the three pieces of M&TE in question. The results were as follows:

- o Torque Wrench #39433
 - Corrective Action - None
 - Any work performed utilizing this torque wrench had been redone under later work packages prior to the discovery of this violation.
- o Torque Wrench #43121
 - Corrective Action - None
 - A review of the MWRs utilizing this torque wrench indicated the bolting was QC-II non-pressure boundary or that it was a temporary installaton (AV1144, Spool Piece).
- o Leak Rate Monitor #27221
 - Corrective Action - None
 - The calibration error was in the conservative direction, i.e., indicated leakage higher than the actual leakage. On all plant equipment the monitor was used during the period of out-of-calibration, the total leakage indications for each were well below the allowable limits.

The review revealed that recalibration and/or retorquing was not necessary and the disposition was closed. If the review would have revealed a recalibration was needed, an NCR/PDR would have been generated and appropriate action taken.



Corrective Action to be Taken

The I&C Supervisor and/or Engineer will be counseled as to their responsibility per PPM 1.5.4 and the timeliness of any required corrective action. The procedure, PPM 1.5.4, will be revised to include time limits for review and corrective actions on all out-of-calibration measuring and test equipment. Also, the procedure is void on the tracking of these deficiencies. A tracking mechanism will be incorporated in this revision to the procedure.

All supervisors will be reminded of their need to take prompt action in helping resolve outstanding deficiencies of measuring and test equipment.

Date of Full Compliance:

February 1, 1989.

