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WASHINGTON PUBLIC POWER SUPPLY SYSTEM

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

March 31, 1989
G02-89-053

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
ADDITIONAL INFORMATION

Reference:
1) Letter, G02-88-274, GC Sorensen (SS) to NRC, same subject, dated December 21, 1988
2) Letter, AE Chaffee (NRC RV) to GC Sorensen (SS), dated March 2, 1989
3) Letter, JB Martin (NRC RV) to GC Sorensen (SS), dated November 23, 1988

The Washington Public Power Supply System hereby submits a revised response to the Notice of Violation (Violation "B" only) contained in your letter dated November 23, 1988, as requested in your letter dated March 2, 1989. Our reply pursuant to the provisions of Section 2.201, Title 10, Code of Federal Regulations consists of this letter and Appendices A and B (attached).

In Appendix A, Violation B is amended with an explanation of our position regarding validity, corrective action, and date of full compliance. Appendix B contains the Supply System response to your request for information concerning verbal procedure deviations.

Very truly yours,

G. D. Bouchey, ~~Director~~
Licensing & Assurance

SLW/bk
Attachments

cc: JB Martin - NRC RV
NS Reynolds - BCP&R
RB Samworth - NRC
DL Williams - BPA/399
NRC Site Inspector - 901A

IE01
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APPENDIX A

B. 10CFR 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 actuations were not part of the preplanned sequence during testing or reactor operation, and were not reported to the NRC as required:

- 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.

- 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 acknowledges the validity of the violation.

The cause of this violation was an initial interpretation of 10CFR 50.72/.73 and NUREG 1022 by the Supply System that these events were not reportable.

Corrective Steps Taken/Results Achieved

The ATWS preoperational tests were successfully performed.

Corrective Action to be Taken

1. An LER will be written for the ATWS preoperational test.

2. LER 88-30-00 will be revised to include the August 26, 1988 event as a reportable ESF actuation.

3. The Plant troubleshooting procedure will be revised to require documentation of troubleshooting activities which may cause a scram.

4. A guidance document will be developed to aid Plant personnel in determining when an ESF actuation is reportable.

Date of Full Compliance

The Supply System is currently in full compliance. The additional corrective actions to be taken will be completed by April 28, 1989

APPENDIX B

As requested in your letter dated March 2, 1989 (with regard to Violation A), this Appendix describes the manner in which the Supply System ensures that verbally approved deviations from procedures are only used under appropriate circumstances and in such a manner that the possibility of errors or misunderstandings is minimized. In addition, the circumstances surrounding the work on the Drywell Sump Flow monitor, which supported continuing the work by means of a verbal procedure deviation are also described.

The following addresses the controlled method of applying the use of verbal deviations to appropriate circumstances.

The involvement of appropriate Plant Management/Supervisory Staff of WNP-2 ensures that deviations from procedures are only used under appropriate circumstances. The "Use of Plant Procedures" procedure (PPM 1.2.3) requires that a deviation be approved by two members of the Plant Management/Supervisory Staff prior to its implementation. Both approvers of the deviation must be knowledgeable in the affected area, and at least one approver must be a licensed Senior Reactor Operator, usually the on-duty Shift Manager. A verbal procedure deviation requires an additional determination to be made by the Shift Manager that work must continue. The Shift Manager, is the highest level Manager directly involved in Plant operations. In the case of the Drywell Sump Flow Monitor, the procedure deviation was approved by the Maintenance Instrument and Control (I&C) Supervisor and the on-duty Shift Manager.

However, to aid Plant Management/Supervisory Staff in the future in determining appropriate circumstances for use of a verbal procedure deviation, the following criteria will be added to PPM 1.2.3:

- Use only for minor changes which are easily understood, and, where work continuity is important to efficient task completion, or
- Completion of the work is essential to plant operation.

With the above procedure changes, use of the verbal procedure deviation process for the Drywell Sump Flow Monitor calibration would not have been allowed since more than minor changes were involved and the work was not essential to Plant operations.

The following addresses minimizing errors and misunderstandings with regard to verbally approved deviations.

The use of a verbal deviation for a period greater than one or two shifts was not envisioned when PPM 1.2.3 was written, and as a result, this incident highlighted a procedural weakness. To ensure that the possibility of errors or misunderstandings are minimized, PPM 1.2.3 will be revised to include:

- The requirement for documenting verbal deviations prior to the end of shift of the personnel performing the work activity.
- The documentation of approval of verbal deviations in the Shift Manager's Log at the time of authorization.

If the above procedure changes had been in place at the time of the Drywell Sump Flow Monitor calibration, approval of the verbal deviation would have been documented in the Shift Manager's log and the verbal deviation process would not have been allowed to continue beyond the initial shift the I&C Technicians were working.

The circumstances surrounding the work on the Drywell Sump Monitor which supported continuing work are as follows.

The Drywell Sump Flow Transmitter had been replaced with a new type of transmitter during the plant maintenance and refueling outage in 1987. At that time, the equipment was unique in the plant and the I&C staff had no hands-on experience with this type of instrumentation. The initial revision of the calibration procedure was written by using the vendor manual and by consultation with the vendor. The results of the initial calibration of the instrument were not satisfactory because volumetric flow tests had shown a discrepancy between actual and indicated flow. The Drywell Sump Flow Transmitter indication was high (in a conservative direction). The calibration procedure was reviewed and revised and recalibrations were performed; however, the discrepancy between the volumetric flow and the instrument indication persisted.

Just prior to August 22, 1988 the Drywell Sump Flow Monitor indicated a flow that was approaching the Technical Specification limit of 5 gpm unidentified reactor coolant system leakage. A volumetric flow test (bucket test) was performed which verified that the Drywell Sump Flow Monitor indicated flow was greater than the actual flow. Operations requested that the Drywell Sump Flow Monitor be recalibrated. On August 22, 1988 at 0958 hours, surveillance procedure 7.4.4.3.1.4, "Drywell Sump Flow Monitors", was started. The Technicians were instructed to take a very critical look at the procedure as they performed the calibration. The I&C technicians found an initial problem and, looking ahead in the procedure, they also noted other potential problems. At that time, I&C Supervision decided to ask the Shift Manager to verbally approve the procedure deviation and that the I&C staff would write the deviation when the procedure was complete.

The Shift Manager agreed that the work must continue because, with the higher than normal unidentified leakage, it was desirable to have an accurate and timely readout of unidentified leakage in the control room.

Under normal circumstances, when this many problems are evident in a procedure, I&C personnel would have stopped the calibration and revised the procedure rather than continuing. However in this case, I&C Supervision was convinced that they could not produce the correct procedure without continuing in the field.