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 AUTH. NAME: AUTH. AFFILIATION: Washington Public Power Supply System
 RECIP. NAME: RECIPIENT AFFILIATION: Document Control Branch (Document Control Desk)

SUBJECT: Responds to NRC 921214 ltr re violations noted in insp rept
 50-397/92-36. Corrective action: labels on approx 200 pieces
 of plant equipment that have been painted recently were
 verified w/ respect to plant drawings & HP time-out held.

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January 20, 1993
G02-93-017

Docket No. 50-397

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

Gentlemen:

Subject: **WNP-2, OPERATING LICENSE NO. NPF-21
NRC INSPECTION REPORT 92-36
RESPONSE TO NOTICE OF VIOLATION**

The Washington Public Power Supply System hereby replies to the Notice of Violation contained in your letter dated December 14, 1992. Our reply, pursuant to the provisions of Section 2.201, Title 10, Code of Federal Regulations, consists of this letter and Appendix A (attached). As previously discussed with Mr. Phil Johnson of your staff, the submittal schedule for this response was extended to January 20, 1993 due to delayed receipt of the inspection report.

This Inspection Report also reflected NRC concerns regarding the WNP-2 Plant Tracking Log (PTL) system. Supply System management acknowledges and shares the Commission's concerns in this area. Management initiated organizational efficiency studies had previously identified commitment tracking and PTL as areas for improvement. A Quality Action Team has been commissioned to recommend enhancements in the commitment and action tracking system. It is envisioned that near term upgrades will be implemented for the PTL system and that a more sophisticated, integrated data base will be implemented later. The QAT is scheduled to start in April 1993 and be complete by August, 1993.

With regard to outstanding supplemental LERs and potential 10 CFR Part 21 issues, management commits to closure of these items by September 30, 1993. If an item cannot be closed by this date, the Resident Inspector will be advised, the reason for the necessary extension explained, and a new completion date provided.

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NRC INSPECTION REPORT 92-36
RESPONSE TO NOTICE OF VIOLATION

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

Sincerely,



J. V. Parrish (Mail Drop 1023)
Assistant Managing Director, Operations

REP/bk

Attachments

cc: JB Martin - NRC RV
NS Reynolds - Winston & Strawn
JW Clifford - NRR
DL Williams - BPA/399
NRC Site Inspector - 901A

Appendix A

During an NRC inspection conducted on October 5 through November 15, 1992, 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, the violations are listed below:

- A. 10 CFR 50, Appendix B, Criterion V, and section 5.2.1 of the WPPSS Operational Quality Assurance Program Description (OQAPD) require in part that activities affecting quality be performed in accordance with approved drawings. WNP-2 Top Tier drawings E535, sheet 58A, and E503, sheet 8 implement these requirements for electrical cubicle 2-E-MCC-8CA.

WNP-2 Technical Specification 6.8.1, states in part, "Written procedures shall be established, implemented, and maintained covering... a. The applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978."

Regulatory Guide 1.33, Appendix A, Section 1.c, recommends a procedure for "Equipment Control (e.g., locking and tagging)."

Plant Procedures Manual (PPM) 1.3.8, "Danger Tag Clearance Order," revision 16, paragraph 6.11.2 states in part:

"The operator performs the tagging operation as follows...

- b. When hanging the Clearance Order the operator shall pay particular attention to nameplate and control switch labeling.
- c. If the names and labels on the Clearance Order form do not match the equipment field labels, the operator resolves the difference with the Shift Manager before hanging the tag.
- d. If labeling discrepancies between field equipment and plant drawings exist, initiates a Labeling Request Form to correct labeling or a Request for Technical Services (RFTS) to correct drawings as appropriate."

Contrary to the above,

- 1. As of October 13, 1992, painters had removed the labeling for components located on electrical cubicle MCC-8CA, and had replaced the labels for MCC-8CA-1C and MCC-8CA-1D on the wrong cubicles, and
- 2. On October 4, 1992, an operator placed a danger tag specified for "EDR-P-5" and "MCC-8CA-1D" on a breaker labeled "MCC-8CA-1C," without first notifying the Shift Manager to resolve the discrepancy; and a RFTS or Labeling Request Form was not initiated.

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



Validity of Violation

Supply System acknowledges the validity of the cited example as a violation of the requirement to implement the procedure for protective tagging. Discrepancies between a Clearance Order and field equipment labeling were not identified while performing protective tagging operations, as required by plant procedure PPM 1.3.8, Danger Tag Clearance Order. The root cause of this event was personnel work practices that were less than adequate, and involved requirements within the procedure for protective tagging that were not fully implemented.

Cubicles 1C and 1D of MCC-8CA each have two descriptive identification labels. One of these labels identifies the MCC cubicle location (i.e. 1C or 1D), and the other identifies the principal plant equipment served by that circuit. As identified in the Inspection Report, cubicle location labels for MCC-8CA-1C and MCC-8CA-1D were juxtaposed. The labels describing principal plant equipment served by each cubicle were correct.

The protective tag involved in this event specified that it was to be hung on the breaker for cubicle 1D of MCC-8CA, serving component EDR-P-5. The Equipment Operator (EO) who was assigned to perform the tagging operation verified the tagout location by checking the label that identifies the plant equipment served, which was located on the appropriate cubicle, but did not check the cubicle location label. Consequently, although the tag was hung on the proper breaker, the labeling discrepancy was not identified.

Plant procedure PPM 1.3.8 states that the operator shall pay particular attention to nameplate and control switch labeling when performing tagging operations. Failure to observe the information provided on the cubicle location label was not in accordance with this procedure, and resulted in delayed identification of labeling discrepancies for cubicles MCC-8CA-1C and MCC-8CA-1D.

It was initially believed that cubicle location labeling errors occurred when labels were replaced following painting. Based on the results of continued investigation, it is now believed that the labels were replaced in their original positions. At the time when this event occurred, a program was in place for control of labels removed during painting. This program required sketches of affected equipment to be made prior to removing labels. A review of these sketches for MCC-8CA indicates that the as found position of cubicle location labels for MCC-8CA-1C and MCC-8CA-1D corresponded with the locations shown on the sketches.

An effort was made to identify photographs or other documentation that could conclusively identify when the cubicle location labeling errors occurred for MCC-8CA. Due to a lack of information, it was not possible to determine the cause or exact time of occurrence for the cubicle labeling errors. However, it is known that cubicle location labels were originally installed on plant motor control centers in the approximate 1988 time frame, and it is probable that the cubicle location labeling errors involved in this event have existed since this time.

Corrective Steps Taken/Results Achieved

1. Labels on approximately 200 pieces of plant equipment that have been painted recently were verified with respect to plant drawings. No other labeling discrepancies were identified by this verification.
2. The operator involved in this event was counseled with regard to performance expectations and the requirement to completely verify equipment labeling when performing tagging operations.
3. A training session was held with painters. The training reflected concerns related to paint on moving parts and critical equipment.

Corrective Action to be Taken

The circumstances involved of this event will be addressed with Operations Department personnel who may be involved in hanging protective tags through required reading. This action is scheduled for completion by March 19, 1993.

Date of Full Compliance

WNP-2 was in full compliance with procedural requirements to identify and remedy field labeling discrepancies when labels for MCC-8CA-1C and MCC-8CA-1D were corrected on October 22, 1993.

- B. Technical Specification 6.8.1 states in part, "Written procedures shall be established, implemented and maintained covering...k. Health Physics/Chemistry Support."

WNP-2 Plant Procedures Manual procedure number 1.11.11, Revision 2, Entry into, Conduct and Exit from Radiologically Controlled Areas, paragraph 4.6 states that "Persons entering a radiologically controlled area shall return barriers, altered for access, to their original position after passing."

Contrary to the above, as of approximately 9:00 a.m. on November 15, 1992, the radiation area barrier and posting at the entrance to the Northwest Reactor Core Isolation Cooling (RCIC) pipe space on the reactor building 471 foot elevation had been removed from one side of the entrance, and both ends of the barrier rope were hanging on the other side of the entrance such that the barrier and posting were not readily recognizable. Nobody was in the pipe space, and the barrier had not been returned to its original position.

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

Validity of Violation

Supply System acknowledges the validity of this violation. PPM 1.11.11, Entry Into, Conduct In, and Exit From Radiologically Controlled Areas, states that persons entering a radiologically controlled area shall return barriers, altered for access, to their original position after passing. The cause of this event was personnel work practices that were less than adequate, and involved failure to perform intended and procedurally required verification of radiation barrier restoration.

At approximately 0345 hours on November 15, plant personnel entered the NW RCIC Pipe Space area in order to perform surveillance testing under plant procedure PPM 7.4.7.3.3.C, RCIC Quarterly Valve Operability Test. The personnel who entered the RCIC Pipe Space area included an Equipment Operator (EO) and Plant Technical Engineer who were assigned to the test, and a Health Physics (HP) Technician. The RCIC pipe space area is not typically a high radiation area. However, it is posted as a radiation area because a potential for high radiation levels exists if RCIC is operating.

Upon initial entry into the RCIC pipe space area, the HP Technician removed the radiation area barrier and performed a contamination survey. The survey indicated that contamination levels were low (< 1000 dpm/probe area on valve cap), and that the job could proceed. The HP Technician, in accordance with standard policy, exited the area following completion of his survey, and replaced the radiation area barrier upon leaving RCIC pipe space area. The EO and Plant Technical Engineer exited the RCIC pipe space area together following completion of surveillance testing activities.

During a subsequent plant tour, an NRC Inspector noticed that the radiation area barrier for the NW RCIC pipe space area was not posted correctly. The inspector notified HP of this discrepancy at approximately 0915 hours November 15. In response, a Problem Evaluation Request (PER) was written to document this condition, and a radiation survey was performed. The radiation survey verified that radiation levels were low (< 1 mr/hr), and the radiation area barrier was reposted.

The EO believes that he replaced the waist high barrier when he exited the RCIC pipe space area, but has stated that he is not absolutely certain that he performed this action. The Plant Technical engineer who was with the EO for the duration of the surveillance does not recall whether he checked the radiation barrier to verify that it was reinstalled after exiting the RCIC pipe space area. Both the EO and Plant Technical Engineer indicated they were aware that ensuring radiation area barriers are posted properly is a normal job function following completion of work within a radiation area.

According to the HP Log, the surveillance testing entry was the only entry into the radiation area associated with the NW RCIC pipe space during the graveyard shift on November 15, 1992. Although verbal permission is requested from HP prior to entering radiation areas that are posted, CAUTION -- RADIATION AREA, these verbal authorizations are not recorded in the HP log. Therefore, additional entries could have been made by other personnel following performance of RCIC Quarterly Valve Operability Test surveillance activities.

Corrective Steps Taken/Results Achieved.

Several actions have been undertaken in response to previous radiation area posting events. These previous corrective actions have included:

- Counseling of individuals involved in recent radiological protection infractions on the specific issues involved in their event and personnel performance standards.
- Evaluation of the methods used for posting radiation areas.
- Providing additional levels of overview to monitor compliance with radiation area postings.
- Issuance of a memo to plant personnel from the Plant Manager reinforcing the importance of preventing radiation protection violations.

Due to this and other recent radiological protection events, management has concluded that previous corrective actions have not been effective in preventing noncompliance with radiation area posting requirements. In response, the following actions have been taken:

1. A walkdown was performed to verify that radiation area barriers in the Radiological Controlled Area were posted properly. This walkdown, which was completed on November 15, 1992, did not identify any other improperly posted radiation areas.
2. Radiation protection issues were discussed with Plant Maintenance, Operations, Health Physics, and Plant Technical employees during a plant wide HP time-out session held on November 30, 1992. These discussions covered improper actions involved in this event, actions that should have been taken, use of self-checking, and management expectations for personnel performance.

The HP time-out also addressed recent problems associated with posting of radiation area barriers and failure to follow HP procedures, disciplinary policy, and preventative measures that can be taken. Management expectations were clearly outlined to include individual responsibilities within radiologically controlled areas, including reposting of radiation area barriers. Additionally, plant trends involving personally preventable radiation protection occurrences were reviewed, and the responsibility of each supervisor to help personnel perform successfully, and use of self-checking techniques were discussed.

Personnel were reminded of their responsibility to be knowledgeable of radiological conditions in the work environment, and HP technicians have been directed to question personnel working in radiologically controlled areas on a random basis in order to verify compliance with this requirement. It is intended that these spot-checks will increase awareness of plant radiological conditions. An effort has also been made to reevaluate postings that must be taken down prior to gaining access to a radiation area in order to determine if this type of barrier is needed to provide the necessary level of control.

3. This posting event was reviewed by Plant Maintenance, Operations, Health Physics, and Plant Technical managers.
4. Interactive management techniques will be employed to handle personnel performance inadequacies pertaining to radiological protection matters that involve personnel from departments outside the HP organization.

Corrective Action to be Taken

No further corrective actions were identified due to the extensive coverage this event received in the plant-wide HP timeout.

Date of Full Compliance

WNP-2 was in full compliance with procedural requirements on November 15, 1992 when the radiation area barrier for the NW RCIC pipe space area was reposted.