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WASHINGTON PUBLIC POWER SUPPLY SYSTEM

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April 20, 1993
G02-93-091

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 92-43
RESPONSE TO NOTICE OF VIOLATION

The Washington Public Power Supply System hereby replies to the Notice of Violation contained in your letter dated March 22, 1993. 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, the violations are 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

KBL/bk

Attachments

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

930427053

Appendix A

During an NRC inspection conducted on December 28, 1992 through February 6, 1993, 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. Section 4.6.8.1.2 of the Technical Specifications states that, at least once per 6 months, each 24- and 30-inch drywell and suppression chamber purge supply and exhaust isolation valve with resilient material shall be demonstrated OPERABLE by verifying that the measured leakage is either (a) less than $0.05 L_a$, or (b) greater than $0.05 L_a$, provided that the valves are secured closed and maintenance is performed at the next plant cold shutdown to reduce leakage to less than $0.05 L_a$.

Contrary to this requirement, leakage from drywell purge exhaust valves CEP-V-3A and -4A exceeded $0.05 L_a$ during a leak test performed on November 23, 1992, and maintenance was not performed during the next cold shutdown (beginning on January 21, 1993) to reduce leakage to less than $0.05 L_a$.

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

Validity of Violation

The Supply System acknowledges the validity of this violation. There were two root causes for this event. The primary root cause involved failure of the Shift Manager to fully and/or correctly document the maintenance requirement described within Technical Specification Surveillance Requirement 4.6.1.8.2.b on either the LCO/INOP status sheet or the PER. This root cause receives an INPO classification of Technical Inaccuracies in Written Procedures.

The second root cause involved four instances whereby the Technical Specification required Action to perform valve maintenance was not identified. These examples involved a Personnel - Work Practices category deficiency that resulted from required verifications that were not adequately performed. The first two examples involved errors by licensed, utility personnel, and the last two examples involved an error by non-licensed, utility personnel.

The first example resulted when requirements to repair Wetwell Purge Exhaust Valves CEP-V-3A and 4A were not recognized as a constraint for restart from Operational Condition 4 during performance of the Minimum Startup Checklist. As directed in procedures, the review of the LCO/INOP Status Sheet that is associated with this checklist should have identified this constraint.

The second example resulted when maintenance activities necessary to return the Wetwell Purge Exhaust Valves to operable status were not recognized to be a constraint to restart from Operational Condition 4 by personnel in Work Planning. In accordance with plant procedures, it is the responsibility of [what was then called] the Operations Work Control Coordinator to ensure that work control activities are adequately identified and scheduled to maintain compliance with the plant Technical Specifications.

The third example involved failure to recognize that repair of CEP-V-3A and 4A was a constraint for restart from Operational Condition 4 during MRC review of the PER. This review did not fully satisfy requirements established in plant procedures.

The fourth example involved the Plant Operations Committee (POC) review in accordance with PPM 1.1.7, Restart Evaluation Process. The POC review did not identify repair of these valves as a plant startup constraint, as the POC relied on the Shift Manager's associated entry in the LCO/INOP Status Sheet Logbook, rather than reviewing the Technical Specification maintenance requirements independently.

Corrective Steps Taken/Results Achieved

1. The Shift Manager was counseled on the importance of fully and correctly documenting requirements. Additionally, Operations were issued Night Orders that addressed lessons learned from this event.
2. Procedure 1.3.1.D, Conduct of Operations, has been revised to provide more detailed direction regarding information that should be provided on LCO/INOP Status Sheets. Also, the revised procedure and a copy of this LER has been completed as part of required reading for license personnel.
3. PPM 1.16.6, Rev 8, has been revised to clearly identify the Work Control Shift Manager's primary responsibility as "[maintaining] knowledge of existing and near term planned plant configurations, [ensuring] there are no scheduling conflicts, and [maintaining] Technical Specification Compliance." This change will enhance Work Control's function as a barrier.
4. PPM 1.3.12, Problem Evaluation Request (PER), has been extensively revised to improve its function as a barrier. This improvement was principally achieved by modifying the MRC review process.

- a. To provide an initial review of the PER, the Administration Manager ensures that copies of the original PER are distributed to MRC members, the assigned dispositioning manager, and Licensing in support of MRC needs. The MRC reviews the PER disposition assignment and corrective actions taken; Licensing reviews the PER for reportability; dispositioning Department Management reviews the PER assignments and seeks resolution as necessary.
 - b. Following this initial review process, the cognizant department manager and subordinate dispositioner perform in-depth, expert analysis of the problem and identify actions that need to be tracked as Reactor Startup Issues (RXSU). By placing the major responsibility for performing a critical review and analysis on individual department personnel, rather than solely on MRC personnel, the current PER process better serves as a barrier.
5. As part of WNP-2's restart effort, the Supply System conducted a "Management Time Out," the purpose of which was to investigate the Event Base for common causes and to brainstorm other issues that needed addressing prior to restart. The Management Time Out results committed to defining "an effective forced outage organization" and defining "the key elements of a forced outage policy." The Supply System subsequently requested Failure Prevention Incorporated (FPI) International to perform an Organizational & Programmatic Common Cause Assessment, the purpose of which was to determine the common causes of the January 1993, forced outage experienced by WNP-2. The results of FPI's analyses was submitted to the Supply System on March 30, 1993, for evaluation.

Corrective Action to be Taken

1. Plant Procedure PPM 1.1.7, (POC) Restart Evaluation Process, and Incident Review Board process procedures will be evaluated and revised (revisions as applicable) to incorporate improvements identified in the Management Time Out and the review by FPI International. Applicable lessons learned from these two evaluations will be used in the R-8 Restart Review process and will subsequently be incorporated into the necessary procedures. All associated, applicable procedural revisions will be completed by October 1993.

Date of Full Compliance

The plant was in full compliance with Technical Specifications when both valves were returned to operable status at 1747 hours on February 4, 1993.

B. 10 CFR 50, Appendix B, Criterion V states in part: "Activities affecting quality shall be prescribed by documented instructions, procedures, or drawings of a type appropriate to the circumstances and shall be accomplished in accordance with these instructions, procedures, or drawings. Instructions, procedures, or drawings shall include appropriate quantitative or qualitative acceptance criteria for determining that important activities have been satisfactorily accomplished."

1. Plant Procedures Manual (PPM) 4.601.A1, Revision 3, describes the following required actions for responding to a 125 VDC Battery HPCS B1 Bus Undervoltage:

1. Notify Electrical Maintenance.
2. Correct the fault.

Contrary to this requirement, on January 25, 1993, Control Room Operators received and observed the 125 VDC Battery HPCS B1 Bus Undervoltage annunciator, and failed to notify electrical maintenance or to correct the fault.

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

Validity of Violation

The Supply System acknowledges the validity of this violation. The root cause for control room personnel failing to respond to control room alarm 125 VDC BATT HPCS B1 BUS UNDERVOLTAGE was a failure to follow work documents correctly. Had the electric shop been notified of the alarm and had the electric shop responded, the electricians could have mitigated the severity of the battery degradation.

At approximately 1125 hours on January 24, 1993, WNP-2 operators removed the HPCS System from service to facilitate repair of several HPCS fire seals per Maintenance Work Request (MWR) AR9551. The operators secured the HPCS battery charger to ensure all seals passing through the fire seals were deenergized. Because the battery charger was out of service and DC loads had not been removed from the battery bus, the HPCS battery continuously discharged during the maintenance.

At approximately 0545 hours on January 25, 1993, alarm 125 VDC BATT HPCS B1 BUS UNDERVOLTAGE annunciated in the main control room. Control room personnel initially responding to this alarm remembered referencing a voltage meter on panel P-601 for the HPCS 125 VDC Bus. Personnel recalled that the meter was reading approximately 119 VDC; the time of the reading was about 17 to 18 hours after the tag out was performed to isolate the AC bus

to the HPCS battery charger. The control room supervisor (CRS) did not take the subsequent actions in the alarm response procedure, the first of which was to notify electrical maintenance of the low voltage, as the voltage was considered to be low due to the ongoing maintenance.

Increased monitoring of the DC bus voltage was not asked for. Personnel on the next shift (approximately 3/4 to one hour later) stated that they too recognized the bus undervoltage alarm, but they decided not to notify electrical maintenance either, because they expected the alarm to be in due to the system tag out.

At 1530 hours on January 25, 1993, an Equipment Operator (EO) discovered that the HPCS soakback pump (125 VDC power) was energized, but not rotating. The EO notified the Control Room Operators. Plant electricians found the HPCS battery voltage to be approximately 54 volts.

Corrective Steps Taken/Results Achieved

1. After plant electricians discovered the low voltage condition of the HPCS battery, Control Room Operators subsequently removed DC loads from the battery (activities commenced at approximately 1530 hours on January 25, 1993). An emergency work request (MWR AP2192) was subsequently issued to connect temporary power to the HPCS battery charger. This power connection was completed at about 1825 hours on January 25, 1993. Plant electricians slowly recharged the battery over the next three days.
2. On January 26, 1993, the battery manufacturer (C&D) was consulted to identify constraints or concerns during the recharge process. MWR AP2193 was issued the same day to inspect for possible battery cell damage.
3. Problem Evaluation Report (PER) 293-80 was dispositioned to investigate the event on January 28, 1993. Results of the investigation verified that the battery cells did not experience severe degradation and that all cells were returned to within Technical Specification requirements.
4. The Operations Manager counseled all individuals involved with this event. Night Orders were issued to emphasize following through with procedural steps, and the Conduct of Operations procedure was revised to require completion of all procedural steps when a new alarm comes in.

5. The Operations Manager has conducted discussions with licensed operations personnel to reemphasize the importance of performing alarm response procedures to completion. Topics for discussion included this event, as well as the October 12, 1992, incident in which control room personnel did not perform the necessary verifications to identify the source of activity measured by a main control room remote intake radiation monitoring switch.

Corrective Action to be Taken

No further corrective action is being taken.

Date of Full Compliance

The Supply System was in full compliance with this violation when the HPCS Battery was restored to normal voltage at approximately 1144 hours on January 28, 1993.

- B2. Paragraph 2.1 of PPM 1.3.12, "Problem Evaluation Request" (PER), states in part:

"... A problem is defined as a condition where:

- 2.1.1 A physical or performance characteristic of a system, component, or part does not perform to the requirements of design documents, applicable standards, procurement documents, or regulatory requirements for the item;

Paragraph 6.1 states in part that "... Any person who observes an actual problem or perceives a potentially significant problem shall initiate a PER."

Contrary to the above, on January 21, 1993, licensee personnel observed and were aware of a potentially significant problem in that they observed anomalous reactor vessel level indication, indicative of degassing, but did not initiate a PER.

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

Validity of Violation

The Supply System acknowledges the validity of this violation. The root cause for failing to write a PER was a failure to comply with the requirements of PPM 1.3.12, Problem Evaluation Request (PER). This receives an INPO classification of Personnel, Work Practices, Documents not followed.

On January 21, 1993, Crew C assumed Swing Shift duties in the main control room. Reactor cooldown to cold shutdown was in progress. At about 0613 hours, operators noticed indication on reactor water level narrow range Channel B instrumentation drifted up to about 42" and then back down to 35". The operators changed to Channel A and continued to monitor water level. At approximately 1900 hours, the operators noticed Channel B and Channel C indicators were both drifting. Channel C went upscale high. Both B and C channels continued to bounce between 35" and 42" before drifting to a stable indicating level of 36". Instrument and Control (I&C) technicians were requested to troubleshoot the problem. The I&C technicians investigated the instrumentation at a control room backpanel, but did not discover anything unusual.

The cognizant Shift Manager did not write a PER, because indicated RPV water levels trended back toward normal and narrow range RPV water level recorded on an associated stripchart did not resemble the indications described in previous training on this phenomena. On the following day, an I&C engineer retrieved high resolution RPV water level data from the Technical Data Acquisition System (TDAS). This data was retrieved to assist the Boiling Water Reactor Owners Group (BWROG) in understanding the notching and degassing phenomena. Analysis of this data showed significant degassing activity on Channel C of the RPV narrow range water level instrumentation; however, since Channel C is not recorded, the control room could not see a trace of the channel response over time (TDAS is not a tool normally accessed by the Control Room Operator, Control Room Supervisor, or Shift Manager).

Upon initial review of the notching data within Engineering, it was concluded that the notching recorded was at a reactor pressure condition well below that level causing concern as understood by industry experience and did not warrant a PER. The initial data was transferred to the BWROG for evaluation and analysis, and the Supply System initiated an internal review of the data. The data and event became more meaningful after a period of Engineering review and evaluation of the data revealed that the existence of noncondensable gases in RPV reference legs could have inhibited an RPV Level 3 Isolation trip. This trip mitigates a postulated moderate energy line crack in Residual Heat Removal (RHR) system piping during the Shutdown Cooling mode of RHR operation.

A meeting addressing the January 21, 1993, RPV water level notching event was held on February 9, 1993, between Engineering, Plant Technical, QA, and Plant Operations. One of the action items from this meeting was for the Engineering Department to write a PER for the notching event. Engineering wrote the PER on February 10, 1993.

Corrective Steps Taken/Results Achieved

1. PER 293-160, dated February 10, 1993, was submitted by the Technical Staff Engineering Manager. PER 293-169, which provided a more complete description of the problem, was written on February 12, 1993.

2. A Level 1 Quality Finding Report (QFR) 293-0009-01 (dated February 18, 1993) was issued by Plant QA to the WNP-2 Plant Manager and the Supply System Engineering Director for failure to write PERs to document significant problems. The failure to write a PER for the January 21, 1993, RPV notching event was one of ten instances identified by the QFR in which PERs were not written to document significant conditions adverse to quality.

Corrective Action to be Taken

As a result of the Level I QFR written by QA, PPM 1.3.12 is currently being revised, in part, to provide clear directions on how to complete a preliminary operability statement that "shall not result in an extensive delay in bringing the problem to Management's attention." This procedure is also being revised to provide the Shift Manager with explicit directions for assessing the operability of affected equipment. Additionally, a clear, focused set of criteria for writing a PER will be developed; all necessary training for implementation of this procedural criteria will be presented to nonlicensed personnel by July 2, 1993. For Licensed and Equipment Operator personnel, all necessary training for implementation will be completed by October 22, 1993.

Date of Full Compliance

The Supply System was in full procedural compliance when PER 293-160 was written by the Technical Staff Engineering Manager on February 10, 1993.

B.3 Paragraph 6.1.4 of PPM 1.3.10 requires the Shift Manager to issue a PER upon discovery of a fire protection system impairment violation.

Contrary to this requirement, the Shift Manager did not issue a PER on January 11, 1993, when notified of a fire protection system impairment violation by the NRC inspector (a PER was issued on January 14, 1993 when this was again questioned by the NRC inspector).

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

Validity of Violation

The Supply System acknowledges the validity of this violation. The root cause for this event was personnel error involving a failure to know the requirements of PPM 1.3.10, Fire Protection Program.

On January 11, 1993, two contract employees were performing work in the Reactor Building which required securing fire door R107, Reactor Building, EL. 441 NE, in the open position to run lighting cable through the door. The two contract employees contacted the Shift Support Supervisor (SSS) to verify the need for a Fire Impairment Checklist. The SSS told the two workers that he believed an impairment checklist was not required if the two workers remained in the vicinity of the work; however, the SSS also told the two workers that he would verify his statement and get back to them with confirmation.

The SSS subsequently determined that a checklist was required by PPM 1.3.10 Fire Protection Program, so the SSS proceeded to the work area to inform the two workers of the necessity for a checklist. Upon arrival at the work location, the SSS found the fire door closed and the workers vacant from the area. The SSS assumed the work was finished, so the SSS pursued the issue no further; however, unbeknown to the SSS, the workers had secured the door and vacated the work area to take their lunch break.

After their lunch break, the two workers returned to the work area, reopened the fire door, climbed the scaffolding, and began working again approximately 20 to 30 feet above the open fire door. An NRC inspector touring through the work area observed this work condition and reported the condition to the Shift Manager. The Shift Manager responded to the inspector's comments by having an SSS initiate an impairment checklist. However, the Shift Manager did not write a PER against the Fire Impairment Checklist violation, as he was not aware that PPM 1.3.10 required a PER be written against fire impairment violations.

On January 14, 1993, the NRC inspector prompted a different Shift Manager concerning PPM 1.3.10's requirement for a PER against fire impairment violations. Upon that prompt, the Shift Manager directed the SSS to write the PER, which the SSS completed.

Corrective Steps Taken/Results Achieved

1. PPM 1.3.10 was overly restrictive in that it required a PER be written against any fire impairment. The procedure has therefore been deviated to allow the Shift Manager to first evaluate the violation and write a PER only if the violation is a threat to the fire protection of the plant.
2. PPM 1.3.10 has been deviated to require an individual to be "within line of sight" for impairments that do not require a permit, rather than saying the person must be in the vicinity as the preceding revision was worded.
3. The involved Shift Manager has been counseled on PPM 1.3.10 compliance.



Corrective Action to be Taken

The Manager of License Operator Requalification Training will ensure Procedural learning objectives adequately measure the knowledge required for RO/SROs to comply with the PER procedure (PPM 1.3.12) revised by WNP-2 Licensing. This will be completed by July 16, 1993.

Date of Full Compliance

The Supply System was in full compliance with procedural requirements when the Shift Manager wrote the required PER on January 14, 1993.



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9304270153 930422
PDR ADOCK 05000397
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JEO

Appendix A

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2. Procedure 1.3.1.D, Conduct of Operations, has been revised to provide more detailed direction regarding information that should be provided on LCO/INOP Status Sheets. Also, the revised procedure and a copy of this LER has been completed as part of required reading for license personnel.
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Validity of Violation

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At 1530 hours on January 25, 1993, an Equipment Operator (EO) discovered that the HPCS soakback pump (125 VDC power) was energized, but not rotating. The EO notified the Control Room Operators. Plant electricians found the HPCS battery voltage to be approximately 54 volts.

Corrective Steps Taken/Results Achieved

1. After plant electricians discovered the low voltage condition of the HPCS battery, Control Room Operators subsequently removed DC loads from the battery (activities commenced at approximately 1530 hours on January 25, 1993). An emergency work request (MWR AP2192) was subsequently issued to connect temporary power to the HPCS battery charger. This power connection was completed at about 1825 hours on January 25, 1993. Plant electricians slowly recharged the battery over the next three days.
2. On January 26, 1993, the battery manufacturer (C&D) was consulted to identify constraints or concerns during the recharge process. MWR AP2193 was issued the same day to inspect for possible battery cell damage.
3. Problem Evaluation Report (PER) 293-80 was dispositioned to investigate the event on January 28, 1993. Results of the investigation verified that the battery cells did not experience severe degradation and that all cells were returned to within Technical Specification requirements.
4. The Operations Manager counseled all individuals involved with this event. Night Orders were issued to emphasize following through with procedural steps, and the Conduct of Operations procedure was revised to require completion of all procedural steps when a new alarm comes in.

5. The Operations Manager has conducted discussions with licensed operations personnel to reemphasize the importance of performing alarm response procedures to completion. Topics for discussion included this event, as well as the October 12, 1992, incident in which control room personnel did not perform the necessary verifications to identify the source of activity measured by a main control room remote intake radiation monitoring switch.

Corrective Action to be Taken

No further corrective action is being taken.

Date of Full Compliance

The Supply System was in full compliance with this violation when the HPCS Battery was restored to normal voltage at approximately 1144 hours on January 28, 1993.

- B2. Paragraph 2.1 of PPM 1.3.12, "Problem Evaluation Request" (PER), states in part:

"... A problem is defined as a condition where:

- 2.1.1 A physical or performance characteristic of a system, component, or part does not perform to the requirements of design documents, applicable standards, procurement documents, or regulatory requirements for the item;

Paragraph 6.1 states in part that "... Any person who observes an actual problem or perceives a potentially significant problem shall initiate a PER."

Contrary to the above, on January 21, 1993, licensee personnel observed and were aware of a potentially significant problem in that they observed anomalous reactor vessel level indication, indicative of degassing, but did not initiate a PER.

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

Validity of Violation

The Supply System acknowledges the validity of this violation. The root cause for failing to write a PER was a failure to comply with the requirements of PPM 1.3.12, Problem Evaluation Request (PER). This receives an INPO classification of Personnel, Work Practices, Documents not followed.



On January 21, 1993, Crew C assumed Swing Shift duties in the main control room. Reactor cooldown to cold shutdown was in progress. At about 0613 hours, operators noticed indication on reactor water level narrow range Channel B instrumentation drifted up to about 42" and then back down to 35". The operators changed to Channel A and continued to monitor water level. At approximately 1900 hours, the operators noticed Channel B and Channel C indicators were both drifting. Channel C went upscale high. Both B and C channels continued to bounce between 35" and 42" before drifting to a stable indicating level of 36". Instrument and Control (I&C) technicians were requested to troubleshoot the problem. The I&C technicians investigated the instrumentation at a control room backpanel, but did not discover anything unusual.

The cognizant Shift Manager did not write a PER, because indicated RPV water levels trended back toward normal and narrow range RPV water level recorded on an associated stripchart did not resemble the indications described in previous training on this phenomena. On the following day, an I&C engineer retrieved high resolution RPV water level data from the Technical Data Acquisition System (TDAS). This data was retrieved to assist the Boiling Water Reactor Owners Group (BWROG) in understanding the notching and degassing phenomena. Analysis of this data showed significant degassing activity on Channel C of the RPV narrow range water level instrumentation; however, since Channel C is not recorded, the control room could not see a trace of the channel response over time (TDAS is not a tool normally accessed by the Control Room Operator, Control Room Supervisor, or Shift Manager).

Upon initial review of the notching data within Engineering, it was concluded that the notching recorded was at a reactor pressure condition well below that level causing concern as understood by industry experience and did not warrant a PER. The initial data was transferred to the BWROG for evaluation and analysis, and the Supply System initiated an internal review of the data. The data and event became more meaningful after a period of Engineering review and evaluation of the data revealed that the existence of noncondensable gases in RPV reference legs could have inhibited an RPV Level 3 Isolation trip. This trip mitigates a postulated moderate energy line crack in Residual Heat Removal (RHR) system piping during the Shutdown Cooling mode of RHR operation.

A meeting addressing the January 21, 1993, RPV water level notching event was held on February 9, 1993, between Engineering, Plant Technical, QA, and Plant Operations. One of the action items from this meeting was for the Engineering Department to write a PER for the notching event. Engineering wrote the PER on February 10, 1993.

Corrective Steps Taken/Results Achieved

1. PER 293-160, dated February 10, 1993, was submitted by the Technical Staff Engineering Manager. PER 293-169, which provided a more complete description of the problem, was written on February 12, 1993.

2. A Level 1 Quality Finding Report (QFR) 293-0009-01 (dated February 18, 1993) was issued by Plant QA to the WNP-2 Plant Manager and the Supply System Engineering Director for failure to write PERs to document significant problems. The failure to write a PER for the January 21, 1993, RPV notching event was one of ten instances identified by the QFR in which PERs were not written to document significant conditions adverse to quality.

Corrective Action to be Taken

As a result of the Level I QFR written by QA, PPM 1.3.12 is currently being revised, in part, to provide clear directions on how to complete a preliminary operability statement that "shall not result in an extensive delay in bringing the problem to Management's attention." This procedure is also being revised to provide the Shift Manager with explicit directions for assessing the operability of affected equipment. Additionally, a clear, focused set of criteria for writing a PER will be developed; all necessary training for implementation of this procedural criteria will be presented to nonlicensed personnel by July 2, 1993. For Licensed and Equipment Operator personnel, all necessary training for implementation will be completed by October 22, 1993.

Date of Full Compliance

The Supply System was in full procedural compliance when PER 293-160 was written by the Technical Staff Engineering Manager on February 10, 1993.

B.3 Paragraph 6.1.4 of PPM 1.3.10 requires the Shift Manager to issue a PER upon discovery of a fire protection system impairment violation.

Contrary to this requirement, the Shift Manager did not issue a PER on January 11, 1993, when notified of a fire protection system impairment violation by the NRC inspector (a PER was issued on January 14, 1993 when this was again questioned by the NRC inspector).

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

Validity of Violation

The Supply System acknowledges the validity of this violation. The root cause for this event was personnel error involving a failure to know the requirements of PPM 1.3.10, Fire Protection Program.

On January 11, 1993, two contract employees were performing work in the Reactor Building which required securing fire door R107, Reactor Building, EL. 441 NE, in the open position to run lighting cable through the door. The two contract employees contacted the Shift Support Supervisor (SSS) to verify the need for a Fire Impairment Checklist. The SSS told the two workers that he believed an impairment checklist was not required if the two workers remained in the vicinity of the work; however, the SSS also told the two workers that he would verify his statement and get back to them with confirmation.

The SSS subsequently determined that a checklist was required by PPM 1.3.10 Fire Protection Program, so the SSS proceeded to the work area to inform the two workers of the necessity for a checklist. Upon arrival at the work location, the SSS found the fire door closed and the workers vacant from the area. The SSS assumed the work was finished, so the SSS pursued the issue no further; however, unbeknown to the SSS, the workers had secured the door and vacated the work area to take their lunch break.

After their lunch break, the two workers returned to the work area, reopened the fire door, climbed the scaffolding, and began working again approximately 20 to 30 feet above the open fire door. An NRC inspector touring through the work area observed this work condition and reported the condition to the Shift Manager. The Shift Manager responded to the inspector's comments by having an SSS initiate an impairment checklist. However, the Shift Manager did not write a PER against the Fire Impairment Checklist violation, as he was not aware that PPM 1.3.10 required a PER be written against fire impairment violations.

On January 14, 1993, the NRC inspector prompted a different Shift Manager concerning PPM 1.3.10's requirement for a PER against fire impairment violations. Upon that prompt, the Shift Manager directed the SSS to write the PER, which the SSS completed.

Corrective Steps Taken/Results Achieved

1. PPM 1.3.10 was overly restrictive in that it required a PER be written against any fire impairment. The procedure has therefore been deviated to allow the Shift Manager to first evaluate the violation and write a PER only if the violation is a threat to the fire protection of the plant.
2. PPM 1.3.10 has been deviated to require an individual to be "within line of sight" for impairments that do not require a permit, rather than saying the person must be in the vicinity as the preceding revision was worded.
3. The involved Shift Manager has been counseled on PPM 1.3.10 compliance.



Corrective Action to be Taken

The Manager of License Operator Requalification Training will ensure Procedural learning objectives adequately measure the knowledge required for RO/SROs to comply with the PER procedure (PPM 1.3.12) revised by WNP-2 Licensing. This will be completed by July 16, 1993.

Date of Full Compliance

The Supply System was in full compliance with procedural requirements when the Shift Manager wrote the required PER on January 14, 1993.