PRIORITY 1
(ACCELERATED RIDS PROCESSING)
REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR:9408020174 DOC.DATE: 94/07/25 NOTARIZED: NO DOCKET #
FACIL:50-397 WPPSS Nuclear Project, Unit 2, Washington Public Powe 05000397
AUTH.NAME AUTHOR AFFILIATION
PARRISH,J.V. Washington Public Power Supply System
RECIP.NAME RECIPIENT AFFILIATION
Document Control Branch (Document Control Desk)

SUBJECT: Responds to NRC 940623 ltr re violation noted in insp rept 50-397/94-14.Corrective action:transmitter has been replaced preventing recurrence.

DISTRIBUTION CODE: IE01D COPIES RECEIVED:LTR 1 ENCL 1 SIZE: 8
TITLE: General (50 Dkt)-Insp Rept/Notice of Violation Response

NOTES:

	RECIPIENT ID CODE/NAME	COPIES LTTR	COPIES ENCL	RECIPIENT ID CODE/NAME	COPIES LTTR	COPIES ENCL
	PDIV-3 PD	1	1	CLIFFORD,J	1	1
INTERNAL:	ACRS	2	2	AEOD/DEIB	1	1
	AEOD/DSP/ROAB	1	1	AEOD/DSP/TPAB	1	1
	AEOD/TTC	1	1	DEDRO	1	1
	NRR/DORS/OEAB	1	1	NRR/DRCH/HHFB	1	1
	NRR/PMAS/IRCB-E	1	1	NUDOCS-ABSTRACT	1	1
	OE DIR	1	1	OGC/HDS3	1	1
	REG FILE 02	1	1	RES/HFB	1	1
	RGN4 FILE 01	1	1			
EXTERNAL:	EG&G/BRYCE,J.H.	1	1	NRC PDR	1	1
	NSIC	1	1			

NOTE TO ALL "RIDS" RECIPIENTS:
PLEASE HELP US TO REDUCE WASTE! CONTACT THE DOCUMENT CONTROL DESK, ROOM P1-37 (EXT. 504-2083) TO ELIMINATE YOUR NAME FROM DISTRIBUTION LISTS FOR DOCUMENTS YOU DON'T NEED!

TOTAL NUMBER OF COPIES REQUIRED: LTTR 21 ENCL 21

PRIORITY 1 DOCUMENT

WASHINGTON PUBLIC POWER SUPPLY SYSTEM

P.O. Box 968 • 3000 George Washington Way • Richland, Washington 99352-0968 • (509) 372-5000

July 25, 1994
G02-94-173

Docket No. 50-397

U. S. Nuclear Regulatory Commission
Attn: Document Control Desk
Mail Station P1-37
Washington, D. C. 20555

Gentlemen:

Subject: **WNP-2, OPERATING LICENSE NO. NPF-21**
NRC INSPECTION REPORT 94-14
REPLY TO NOTICE OF VIOLATION

Reference: Letter, dated June 23, 1994, AB Beach (NRC) to JV Parrish (SS), "NRC Inspection Report 50-397/94-14 (Notice of Violation)"

The Washington Public Power Supply System (Supply System) hereby replies to the Notice of Violation contained in your letter dated June 23, 1994. Our reply, pursuant to the provisions of Section 2.201, Title 10, Code of Federal Regulations, consists of this letter and Appendix A (attached).

Appendix B to this letter lists the commitments made in this letter and Appendix A.

The Supply System shares your concerns described in the reference that there were an unacceptable number of refueling errors made during the inspection period. We plan to evaluate these events and implement an action plan by October 17, 1994, to incorporate the lessons learned. This timing will support preparation for the Spring 1995 refueling outage. Nevertheless, the Supply System provides the following information regarding two of the conclusions reached in the reference.

Paragraph 8.6 of the reference concludes that since one refueling crew did not appear to have full knowledge of core alterations, the training program for refueling operations requires enhancement. The Supply System implemented a significant training program upgrade for refueling operations prior to the Spring 1994 outage. These upgrades included:

1. The operations refueling group had attended a one week General Electric refueling operations course within two months of the start of the outage.

IE01
1/1

2. Refueling training was provided to operations personnel using plant refueling equipment by the WNP-2 training staff prior to the outage.

3. The Operations Division Manager and Operations Manager met with refueling crew members at the beginning of the outage to review lessons learned from WNP-2 and other BWRs 1993-1994 refueling operations and to emphasize the importance of error free operation and the need not to succumb to real or perceived schedule pressures during refueling operations.

As noted in the reference, most of the refueling errors were attributed to one crew. Other refueling crews who participated in the same training did not display similar performance. The refueling Senior Reactor Operator (SRO) on this crew was performing this task for the first time.

The Supply System concludes that the refueling crew errors were primarily due to personnel errors. We are reevaluating our training program to incorporate the lessons learned from the Spring 1994 refueling outage and address these issues to preclude recurrence.

Paragraph 8.6 of the reference concludes that management's oversight of refueling requires substantial strengthening, and that management was closely involved only after each problem surfaced. In fact, the Supply System planned several management oversight activities before the outage began, and implemented those plans throughout the outage. For example, there was 24 hour senior management oversight of refueling operations, including a Director and the Engineering Programs Manager. These managers and outage management were cautioned by operations management to insulate the refuel floor crews from production pressures, allowing them to focus only on moving fuel safely and correctly. Also, the Operations Division Manager performed several oversight tours on the refueling bridge, observing the operations and ensuring management expectations were being met. In addition, senior management was on site and in the plant throughout the outage, both attending outage related meetings and making visible presence in the plant working areas.

If you have any questions or desire additional information regarding this matter please contact me or D. A. Swank at (509) 377-4563.

Sincerely,

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

BRH/bk
Attachments

cc: LJ Callan - NRC RIV
KE Perkins, Jr. - NRC RIV, Walnut Creek Field Office
NS Reynolds - Winston & Strawn
JW Clifford - NRC
DL Williams - BPA/399
NRC Sr. Resident Inspector - 927N

Appendix A

Violation A

Technical Specification 6.8.1 states, in part, "Written procedures shall be established, implemented, and maintained covering the activities referenced below:

c. Refueling operations."

WNP-2 Plant Procedures Manual (PPM) 2.14.1, Revision 9, "Refueling Bridge Operation," paragraph 5.2, Step 11, states "CAUTION: Raising the mast into the uptravel stop at high speed may cause overshoot which could cause the top of active fuel to be less than 7' 6" below the water level. DO NOT let (the) mast come above -0.75" on the HOIST position readout."

Contrary to the above, on May 11, 1994, during Step 689 of the refueling sequence (for Irradiated Bundle AN3030), the refueling mast operator raised the mast up to -0.87 inches on the hoist position readout.

This is a Severity Level IV violation (Supplement I) (50-397/9414-03)

Response to Violation A

The Supply System accepts this violation.

1. Reason for the violation

The reason for the violation was personnel error. The refueling Senior Reactor Operator (SRO) failed to meet management expectations by failing to review the appropriate procedures for changes before assuming shift duties. Additionally, the refueling SRO erred in not reestablishing conformance with the caution statement before moving the bundle to the spent fuel pool.

This failure to review the refueling bridge operation procedure before use was not a generic problem. The other crews who used the procedure were aware of the recent procedure change that added the caution statement and performed their duties accordingly.

2. Corrective steps that have been taken and the results achieved.

The Operations Manager temporarily stopped refueling operations on May 11, 1994.

The refueling SRO was verbally counseled on May 11, 1994, by the Operations Manager and the Plant Manager on procedural compliance and review of procedures before use.

The refueling SRO reviewed PPM 2.14.1 with his crew on May 11, 1994.

The refueling SRO was relieved of refueling duties on May 11, 1994, pending receipt of additional training.

The Operations Manager held an "Operations Time Out" with operating and refuel crews to discuss this event. This action was completed on May 14, 1994.

These actions ensured the crews understand management expectations for review of procedure changes and reinforced the requirement to conform with all inviolate procedure cautions.

3. Corrective steps that will be taken to avoid further violations.

Based on the actions taken, no additional corrective actions are required.

4. Date when full compliance will be achieved.

Full compliance with respect to the matter identified above was achieved on May 11, 1994, when the irradiated bundle was lowered below the height stated in the caution statement.

Violation B

10 CFR 50, Appendix B, Criterion XVI states, in part, "Measures shall be established to ensure that conditions adverse to quality, such as failures, malfunctions, deficiencies, deviations, defective material and equipment, and nonconformances are promptly identified and corrected. In the case of significant conditions adverse to quality, the measures shall assure the cause of the condition is determined and corrective action taken to preclude repetition."

In August 1993, to preclude erratic operation of RRC-V-60A and reactor power fluctuations, the licensee revised PPM 2.1.1, "Reactor Recirculation System," to require RRC-V-60A to be locked in place when operating at reduced flows, but did not specify the timeliness for hydraulically locking the valve.

Contrary to the above, corrective actions taken were not adequate to preclude repetition of erratic operation of RRC-V-60A and reactor power fluctuations. On April 26, 1994, RRC-V-60A was not locked during reduced flow operations and operated erratically, causing power fluctuations which resulted in a manual reactor scram.

This is a Severity Level IV violation (Supplement I) (50-397/9414-01)

Response to Violation B

The Supply System accepts this violation.

1. Reason for the violation

The reason for the violation was a lack of rigor in the transfer of technical information regarding the locking of the recirculation flow control valve. The engineer who recommended the change to recirculation flow control valve operation was not involved in the implementation of his recommended procedure change, and was not required by the Supply System's procedure change process to review or approve the procedure change. As a result, PPM 2.1.1 did not provide sufficient guidance on minimizing the time the valve was unlocked.

2. Corrective steps that have been taken and the results achieved.

Troubleshooting identified that the position feedback transmitter on RRC-V-60A was faulty. The transmitter has been replaced preventing recurrence of erratic flow control valve operation.

3. Corrective steps that will be taken to avoid further violations.

The operations procedure change process will be reviewed and modified as necessary to ensure appropriate technical resolution of the originator's recommendations in procedure implementation. This action will be completed by August 31, 1994.

4. Date when full compliance will be achieved.

Full compliance with respect to the matter identified above was achieved on June 23, 1994, when the position transmitter was replaced, preventing repetition of erratic operation.

Violation C

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."

WNP-2 PPM 1.3.19, "Plant Material Condition Inspection Program," Revision 15, Paragraph 4.1.5(a)(8) states, "When using gas bottles, whether flammable or nonflammable, they must be properly secured against a substantial structural member with heavy rope or, preferable, chain or cable, in such a manner as to preclude them from falling over. Bottles are to be tied off both at top and at bottom (to prevent 'kick out' and falling to the floor)."

Contrary to the above, on April 21, 1994, two compressed gas cylinders were found unattended and unrestrained near safety-related equipment on the 522 foot elevation of the reactor building.

This is a Severity Level IV violation (Supplement I) (50-397/9414-02).

Response to Violation C

The Supply System accepts this violation.

1. Reason for the violation

The reason for the violation was the failure to provide adequate training on the requirements of PPM 1.3.19 to two groups (Operations and Chemistry) who use compressed gas cylinders. These groups were not provided with this training following a similar problem December 1993 since the investigation of that event concluded that the problem was limited to the Maintenance department.

2. Corrective steps that have been taken and the results achieved.

The compressed gas bottles were properly restrained following identification by the NRC inspector.

3. Corrective steps that will be taken to avoid further violations.

Training will be provided to those groups who use or handle compressed gas cylinders (except the maintenance personnel who received similar training following the December 1993 event) on the compressed gas cylinder requirements of PPM 1.3.19 by August 31, 1994.

4. Date when full compliance will be achieved.

Full compliance with respect to the matter identified above was achieved on April 21, 1994, when the compressed gas bottles were properly restrained.

Appendix B

Commitments

The refueling errors made during the 1994 refueling outage will be reviewed and an action plan implemented by October 17, 1994, to implement the lessons learned.

The operations procedure change process will be reviewed and modified as necessary by August 31, 1994, to ensure appropriate technical resolution of the originator's recommendations in procedure implementation.

Training will be provided to those groups who use or handle compressed gas cylinders (except for the maintenance personnel who received similar training following the December 1993 event) on the compressed gas cylinder requirements of PPM 1.3.19 by August 31, 1994.