

# PRIORITY 1

(ACCELERATED RIDS PROCESSING)

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RECIP.NAME RECIPIENT AFFILIATION  
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SUBJECT: Forwards response to NRC 950816 ltr re violations noted in  
insp rept 50-397/95-20 on 950604-0715. Corrective actions:  
new maint procedure will be developed to include necessary  
precautions.

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September 15, 1995  
GO2-95-178

Docket No. 50-397

U. S. Nuclear Regulatory Commission  
Attn: Document Control Desk  
Washington, D. C. 20555

Gentlemen:

Subject: **WNP-2, OPERATING LICENSE NO. NPF-21  
NRC INSPECTION REPORT 95-20  
RESPONSE TO NOTICE OF VIOLATION**

Reference: Letter GI2-95-187, dated August 16, 1995, JE Dyer (NRC) to JV Parrish (SS),  
"NRC Inspection Report 50-397/95-20 and Notice of Violation"

The Washington Public Power Supply System hereby replies to the Notice of Violation contained in your letter dated August 16, 1995. Our reply, pursuant to the provisions of Section 2.201, Title 10, Code of Federal Regulations, consists of this letter and Appendix A (attached).

The Notice of Violation describes three violations (A, B, and C) cited at Severity Level IV. The Supply System respectfully requests that Violation B be reconsidered with regard to severity level in light of the recently revised NRC Enforcement Policy (herein after referred to as "the Policy") guidance.

Violation B deals with a condition identified through an event where Technicians lifted a wrong lead during testing and caused a fluctuation in reactor vessel water level. This event was responded to in a rapid and conservative fashion by Operations. For violations identified through events, the Policy states:

"the NRC may choose to give credit ... simply because no prior opportunities (e.g., procedural cautions, post-maintenance testing, quality control failures, readily observable parameter trends, or repeated or locked-in annunciator warnings) existed to identify the problem."

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Page 2

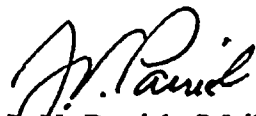
**NRC INSPECTION REPORT 95-20, RESPONSE TO NOTICE OF VIOLATION**

The general issue of human performance is a recognized area for improvement for WNP-2 as has been discussed with the staff frequently in the recent past. Numerous corrective actions for this problem area are either in-process or are under development. The corrective actions are part of the Performance Enhancement Strategy for WNP-2, which will be reviewed with the staff on a periodic basis.

As also stated in the Policy, enforcement action should be used "as a deterrent to emphasize the importance of compliance with requirements, and to encourage prompt identification and prompt, comprehensive correction of violations." For this violation, the staff stated in the Report that "The licensee's corrective actions were adequate." Both the specific and general corrective actions have been or are being addressed.

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

Sincerely,



J. V. Parrish (Mail Drop 1023)  
Vice President, Nuclear Operations

CDM/ml  
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

### VIOLATIONS

During an NRC inspection conducted on June 4 through July 15, 1995, three violations of NRC requirements were identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," (Enforcement Policy), 60 FR 34381, June 30, 1995, the violations are listed below:

- A. 10 CFR Part 50, Appendix B, Criterion V, states "procedures shall include appropriate quantitative or qualitative acceptance criteria for determining that important activities have been satisfactorily accomplished."

Contrary to the above, on June 6, 1995, Plant Procedure Manual (PPM) 3.1.1, "Master Startup Checklist," did not contain appropriate qualitative or quantitative acceptance criteria to assure proper installation of the control rod housing support which resulted in the housing support being installed improperly (a jam nut was missing and gaps were not properly adjusted).

This is a Severity Level IV violation (Supplement I) (397/9520-01).

- B. Technical Specification 6.8.1.d requires that surveillance procedures be implemented.

Surveillance Procedure PPM 7.4.3.7.5.18, Revision 6, Steps 7.3.2 and 7.3.3 required technicians to identify and lift leads for Terminal Block E51A-SRU-1 in the rear of Cabinet H13-P612.

Contrary to the above, on July 12, 1995, while performing Surveillance Procedure PPM 7.4.3.7.5.18, Revision 6, Steps 7.3.2 and 7.3.3, technicians did not identify and lift leads for Terminal Block E51A-SRU-1 in the rear of Cabinet H13-P612 and lifted the incorrect lead.

This is a Severity Level IV violation (Supplement I) (397/9520-02).

- C. 10 CFR 50.59(b)(1) states "The licensee shall maintain records of changes in the facility. . . made pursuant to this section, to the extent that these changes constitute a change to the facility and described in the safety analysis report. These changes must include a written safety evaluation which provides a basis for determination that the change, test, or experiment does not involve an unreviewed safety question."

Contrary to the above, as of July 3, 1994 [sic], Temporary Modification Request (TMR) 95-030 resulted in a change to the facility as described in the Final Safety Analysis Report (FSAR), but a written safety evaluation was not performed.

This is a Severity Level IV violation (Supplement I) (397/9520-03).

### RESPONSE TO VIOLATION A

The Supply System accepts this violation.

### REASON FOR THE VIOLATION

A review of the details relating to the physical misadjustments and missing jam nut indicate that the errors likely occurred in previous years since no work was done on the control rod drive housing support steel during the 1995 outage. The portion of plant procedure PPM 3.1.1 relating to verification of the correct arrangement of the control rod drive housing support steel was the same during both 1994 and 1995, and provided no explicit acceptance criteria. Therefore, the cause of the violation was over-reliance on the skill and knowledge of personnel charged with assuring that the control rod drive housing support steel was correctly configured.

### CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED

The missing jam nut was installed and the misadjustments were corrected on June 8, 1995 in support of the restart after the 1995 outage.

### CORRECTIVE STEPS TO BE TAKEN TO AVOID FURTHER VIOLATIONS

A new maintenance procedure will be developed to include the necessary precautions, methodology, acceptance criteria, and required documentation to govern proper removal and reinstallation of the control rod drive housing support steel. A new visual inspection procedure will also be developed to assure that the work is done in compliance with the new maintenance procedure. This new inspection procedure will constitute a Technical Specification surveillance procedure and will verify conformance with Technical Specifications 3.1.3.8 and 3.10.7 which require the control rod drive housing support steel to be in place during Modes 1, 2, and 3 and during reactor vessel inservice leak and hydrostatic testing, respectively. In addition, appropriate startup procedures will be revised to ensure that the visual inspection of the control rod drive housing support steel has been completed as part of the activities performed in support of startup after an outage. Plant procedure PPM 3.1.1 currently requires verification that the support steel is installed.

### DATE OF FULL COMPLIANCE

WNP-2 will be in full compliance on October 1, 1995 when the new surveillance procedure has been approved for use and the startup procedures have been revised.

## RESPONSE TO VIOLATION B

The Supply System accepts this violation.

## REASON FOR THE VIOLATION

Plant procedure PPM 7.4.3.7.5.18, "Accident Monitoring Instrumentation RCIC Flow Indication - CC," requires verification by two people that the correct component has been identified prior to lifting leads. This requirement was the result of a similar event that occurred in 1986. In addition, plant procedure PPM 1.3.60, "Verbal Communication Policy" requires 3-way communications which includes verbal "repeat back" of steps executed during the performance of critical procedures. Plant procedure PPM 1.2.3, "Use of Controlled Plant Procedures," requires the use of "STAR (Stop-Think-Act-Review)" to ensure adequate self-checking of actions prior to the performance of procedural steps. In this case, 3-way communications were not used and the "STAR" and two person verification processes were inadequately followed because both individuals did not fully verify the identifier of the terminal block for the leads they were lifting. Therefore, the cause of the violation was human error as evidenced by the failure to correctly implement procedural requirements. Based on panel inspections and interviews with the individuals involved, a contributing cause of the violation was that panel identification/labeling is confusing in some cases due to the use of General Electric (GE) identifier "codes" in lieu of standard WNP-2 system identifiers.

## CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED

The on-shift operations crew identified the lifted lead error and the Shift Manager directed the technicians to reland the lifted leads in less than one minute. The operations crew then monitored RPV level to ensure that the automatic controls restored level to the normal operating band. The prompt action by the on-shift operations crew prevented the transient from becoming a significant challenge to the plant.

A Problem Evaluation Request (PER) was initiated and a plant time-out was held on July 13, 1995 to emphasize self-checking and teamwork. The I&C shop time-out also reinforced management's expectations regarding formal 3-way communications. The technicians involved have been counseled and were required to attend additional laboratory training on the maintenance training instrumentation and control system mock-up facility to refresh their skills in these areas.

### CORRECTIVE STEPS TO BE TAKEN TO AVOID FURTHER VIOLATIONS

Signal Resistance Units (SRUs) in control room cabinets H13-P612 and H13-P613 will be relabeled as necessary to ensure clear identification. I&C craft personnel will be trained on GE identifiers and a cross-reference relating GE identifiers to WNP-2 system identifiers will be made available.

### DATE OF FULL COMPLIANCE

Full compliance was achieved on July 12, 1995 when the leads on the incorrect terminal block were relanded and the reactor pressure vessel level was restored to the normal operating band.

### RESPONSE TO VIOLATION C

The Supply System accepts this violation.

### REASON FOR THE VIOLATION

The cause for this violation was an inadequate review of the FSAR by the system engineer due to an over-reliance on a computer program which assists in reviewing Licensing Basis Documents (LBDs). TMR 95-30 removed the disk position indicating light bulbs for a testable check valve from a control room panel because the indicating lights were giving operators false position indication. The indicating lights are actuated by limit switches on the check valve. Prior to implementing the TMR, the system engineer performed a key word search of an electronic version of the FSAR using a computer program. Computer word searches assist in reviews of LBDs and help in providing a response to Question No. 4 of the 10CFR50.59 Review. Question No. 4 asks: "Does this implementing activity change or affect the intent of a procedure or process from the intent of the commitments described, outlined, or summarized in the LBD?" The word search did not identify a statement in the FSAR that reads: "... valve test provisions are provided [on testable check valves] including limit switches to indicate disc movement." Based solely on the key word search results, the system engineer incorrectly determined that implementation of the TMR would not change or affect the process for identifying disc movement as described in the LBD. Consequently, a safety evaluation was not performed to determine if implementation of the TMR represented an unreviewed safety question.

CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED

The system engineer involved was counseled on August 9, 1995. Additional guidance for performing computer word searches was provided to managers and supervisors on August 15, 1995 for distribution to personnel responsible for LBD searches. A 10CFR50.59 safety evaluation was performed for TMR 95-30 and approved by the Plant Operating Committee (POC) on September 6, 1995. The safety evaluation concluded that implementation of the TMR does not represent an unreviewed safety question.

CORRECTIVE STEPS TO BE TAKEN TO AVOID FURTHER VIOLATIONS

A similar event was identified on July 14, 1995 and it was recognized that there was generic impact. As a result, the lessons learned from this event as well as the subsequent event will be incorporated into Licensing Basis Impact Determinations initial and refresher training which are required for personnel performing 10CFR50.59 screening reviews and safety evaluations. These events will also be incorporated into the next Plant and Industry Events training.

DATE OF FULL COMPLIANCE

Full compliance was achieved on September 6, 1995 when the safety evaluation for TMR 95-30 was approved by POC.