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SUBJECT: Responds to NRC 951113 ltr re violations noted in insp rept 50-397/95-29.Corrective actions:valve tested & degraded. Exercising frequency for RCIC-V-28 increased from weekly to daily.RCIC-V-28 replaced w/swing type check valve.

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December 13, 1995
GO2-95-272

Docket No. 50-397

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

Gentlemen:

Subject: **WNP-2, OPERATING LICENSE NO. NPF-21**
NRC INSPECTION REPORT 95-29
REPLY TO A NOTICE OF VIOLATION

Reference: Letter, dated November 13, 1995, JE Dyer (NRC) to JV Parrish (SS), "Notice of Violation (NRC Inspection Report 50-397/95-29)"

The Washington Public Power Supply System hereby replies to the Notice of Violation contained in the referenced letter. Our reply, pursuant to the provisions of Section 2.201, Title 10, Code of Federal Regulations, consists of this letter and Attachment A.

In your referenced letter, you identified a concern with continuing problems in Operations and Engineering dealing with component and system operability assessments and in the implementation of corrective actions. This concern is being addressed through initiatives in the Performance Enhancement Strategy (PES) and corrective actions associated with the violation response included as Attachment A to this letter.

Implementation of PES initiatives in the Engineering area are establishing activities to improve the depth and quality of operability assessments. These activities comprise an extensive training program for the Engineering staff and increased management oversight of engineering activities. The training activities deal with integrated system knowledge training, design and licensing basis training, plant Technical Specifications training, and training involving the application of NRC Generic Letter 91-18 for operability assessments. These initiatives are also directed at improving all levels of interdepartmental communications, which is necessary for developing prompt and correct operability assessments.

In the Operations area there are PES initiatives which are fostering the development of a conservative decision making environment and improving interdepartmental communications. The corrective actions outlined in Attachment A will enhance the ability of those individuals involved with operability assessments to make timely and accurate operability assessments, along with improving the process.

JE01

The specific operability assessment concerns identified during your review of the subject violation and identified in the inspection report are discussed in Attachment B. If you have any questions or desire additional information regarding our response to the subject violation and identified concerns please contact me or D. A. Swank at (509) 377-4563.

Sincerely,

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

JMP
Attachment

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

Attachment A

Violation A

Technical Specification 6.8.1.a. requires, in part, that written procedures be established, implemented, and maintained covering the activities recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978.

Plant Procedure Manual (PPM) 1.3.12A, Revision 3, requires an operability determination be performed for degraded plant equipment.

Contrary to the above, on October 16, 1995, operators did not perform an operability determination for the failure of Valve RCIC-V-28 to open (a degraded condition) during increased frequency surveillance testing.

This is a Severity Level IV violation (Supplement I) (397/9529-01).

Response to Violation

The Supply System accepts this violation.

1. Reason for the violation

On September 16, 1995, RCIC-V-28 was declared inoperable when it failed to open during quarterly surveillance testing. The valve was subsequently disassembled, inspected, repaired, reassembled, and tested satisfactorily. Due to the inability to determine a conclusive cause for the valve failing to open, the valve was declared operable but degraded. A Followup Assessment of Operability (FAO) was performed which required the valve to be exercised weekly for at least four weeks and, if results were acceptable, exercised monthly thereafter. The plant subsequently failed to perform the FAO required weekly testing until October 16, 1995, when RCIC-V-28 failed to open.

Following the failure of the valve to open, the Shift Manager failed to question the valve's failure and its impact on system operability. At the same time, the System Engineer was focusing on the cause of the valve failure instead of questioning operability of the valve and its impact on system operability. When the System Engineer returned a short-time later (approximately 30 minutes) and requested the test be rerun, the individuals involved failed to realize that they were no-longer verifying operability of the valve but were troubleshooting the failure of the valve to open.

The cause of the failure to perform an operability determination following the RCIC-V-28 failure was determined to be an error by the Shift Manager in failing to ensure appropriate information was available to support his decision. The Shift Manager incorrectly interpreted information in the FAO which led him to believe that the FAO

allowed an alternate testing methodology could be used in determining the operability of RCIC-V-28. A contributing cause for this event was that the FAO failed to describe the impact on component and system operability when the testing acceptance criteria was not met. An additional contributing cause was determined to be inadequate interdepartmental communications following the failure of the valve to open. The Shift Manager failed to involve Operations or Engineering management in the operability determination process. Communications between the System Engineer, NSSS Supervisor, and the Shift Manager focused on the cause of the valve failure instead of valve operability.

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

Following the test failure on October 16, 1995, the valve was subsequently tested on October 16, 1995 and declared operable but degraded.

The exercising frequency for RCIC-V-28 was increased from weekly to daily. The daily exercising was conducted through November 22, 1995, when the exercising frequency was changed to weekly.

The Shift Manager, System Engineer, and System Engineering Supervisor involved with this event have been counseled regarding the event and how it applies to operability determination requirements.

RCIC-V-28 was recently replaced during a system outage with a stainless steel swing type check valve.

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

Operations and Engineering Management will discuss with their respective departments the responsibility each individual has in the operability determination process.

To address the failure to perform FAO required weekly testing, the FAO procedure will be revised to ensure that an FAO, when required, contains specific testing acceptance criteria and its impact on component and system operability. The FAO revision will also ensure that actions designated to validate operability are appropriately scheduled and tracked to completion.

An Operations policy providing guidance related to the use of FAOs for operability determinations will be developed and implemented.

Attachment B

The following is the Supply System's response to concerns identified in NRC Inspection Report 95-29 related to the failure to perform an operability assessment for the October 16, 1995 failure of RCIC-V-28.

1. Operators did not promptly and accurately assess the operability of the RCIC system or of Valve RCIC-V-28 after the October 16 failure.

   The concern is addressed by the Notice of Violation response provided in Attachment A to this letter.

2. Operators did not log the performance or failure of the operability test for RCIC-V-28 after the October 16 failure.

   The Shift Manager had instructed the control room operator (CRO) to make the appropriate log entry but the CRO failed to make the entry due to his involvement with shift change. The CRO was counseled by the Shift Manager for his failure to make the log entry.

3. Supply System personnel continue the practice of striking plant components to get the component to function properly.

   The Supply System does not authorize the use of mechanical agitation of equipment to make equipment operate properly. In this case the individuals involved believed that the valve was stuck due to a build-up of rust on the operating components of the valve. A build-up of rust in the valve had been determined to be the cause of a previous failure of the valve. When the valve was mechanically agitated the individuals involved were focusing on troubleshooting activities to determine if the valve was stuck. They were not trying to make the valve operable by striking it, although subsequent testing did lead to the conclusion that the valve was operable but degraded.

4. No attempt was made to identify the root cause of the October 16, 1995 failure of RCIC-V-28 to open.

   At the time of the valve failure Engineering believed the cause to be the build-up of rust in the valve operating components preventing the valve plug from operating. This belief focused the individuals involved in a troubleshooting/repair mode instead of in a mode to determine the valve's operability and the cause of the failure. The cause of the valve failure on October 16, 1995 was believed to be the same as that on September 16, 1995, rust particles. The same individuals involved with the evaluation of the first failure were also involved with the October 16, 1995 determination.

5. The repeated failure of Valve RCIC-V-28 was not initially considered a significant PER.

   Following the October 16, 1995 failure of the valve a Problem Evaluation Request (PER) was written which documented the failure to perform FAO required testing. The PER declared the valve operable but degraded based on the initial FAO performed for the initial failure of the valve on September 16, 1995. The PER also recommended that the October 16, 1995 failure be addressed in the disposition of the initial failure. The PER Program Lead, who has responsibility for designating a PER as significant, did not designate the PER as a significant PER because he believed it did not meet the criteria for a significant PER. At the daily PER meeting, where initiated PERs are reviewed by plant management, the reviewers focused their review on the failure to perform the FAO required testing and the actions required to meet the FAO requirements. The PER process presently allows for the elevation of a PER to a significant PER at any point in the processing of the PER. In an effort to ensure significant PERs are appropriately designated, the PER initiation procedure is in the process of being revised to allow the PER initiator and validator to identify a PER as a significant PER.

6. Accelerated testing of the valve was not performed due to ineffective administrative controls.

   This concern is addressed by FAO procedural changes outlined in the Notice of Violation response provided in Attachment A.