CATEGORY 1

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SUBJECT: Responds to NRC 970328 ltr re violations noted in insp rept 50-397/97-03.Corrective actions:Operations Manager issued night order stressing importance of reviewing impact statement prior to removing equipment from svc.

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April 28, 1997
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Docket No. 50-397

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

Gentlemen:

Subject: **WNP-2, OPERATING LICENSE NPF-21, NRC INSPECTION REPORT 97-03, RESPONSE TO NOTICE OF VIOLATION**

References:
1) Letter dated March 28, 1997, TP Gwynn (NRC) to JV Parrish (SS), "NRC Inspection Report 50-397/97-03 and Notice of Violation"

2) Letter dated April 3, 1997, DA Swank (SS) to NRC, "Transmittal of Revision 19 to the WNP-2 Emergency Plan"

3) NRC Information Notice 95-48: "Results of Shift Staffing Study" dated October 10, 1995

The Supply System's response to the referenced Notice of Violation, pursuant to the provisions of Section 2.201, Title 10, Code of Federal Regulations, is enclosed as Attachment A.

Violation C of Reference 1 cited an example where the requirements of WNP-2 procedures were not met. The Supply System accepts this violation and agrees that inadequate communications occurred associated with a change of staffing on-shift such that Chemistry Technicians and the Shift Managers were unaware that the Chemistry Technicians were filling one of the procedurally required on-shift health physics support positions.

IE01

NRC INSPECTION REPORT 97-03, RESPONSE TO NOTICE OF VIOLATION

In the cover letter for Reference 1 and Inspection Report 97-03, the NRC identified a concern with the use of Chemistry Technicians to meet the NUREG 0654 health physics on-shift coverage recommendations. NUREG 0654 provides flexibility, as identified by note "**" in Table B-1, to provide the recommended on-shift coverage using personnel performing more than one function. In fact, the heading for this column is "Position Title or Expertise." The implied expectation of this note and the Table is that the personnel be qualified for the tasks they will be assigned.

As discussed in detail in Reference 2, the Supply System concludes that the Chemistry Technicians are qualified, through training and experience, to perform the limited health physics duties they would be asked to perform during the first 60 minutes of an emergency. Additional, more complex, activities would be assigned after staffing by the call-in Emergency Response Organization staff (including certified Health Physics Technicians). Since the Chemistry Technicians were qualified to fill one of the health physics support positions on-shift when they assumed this role in June 1995, and since the evaluation provided in Reference 2 confirmed that these personnel are qualified to fill these rolls on-shift, the minimum staffing requirements for WNP-2 for the health physics support position have remained satisfied.

On page 16 of Reference 1, the staff states "The licensee and NRC personnel (including Region IV and NRR personnel) participated in a conference call on March 3, 1997." In this conference call, the Supply System informed the staff that it was the Supply System's understanding that over 50% of the plants in Region IV used qualified personnel, other than certified health physics technicians, to fill one or more of the on-shift health physics support personnel positions. In addition, in a follow-up discussion, the Supply System informed Region IV personnel that a staff commissioned study (Reference 3) identified in 1995 that licensees were staffing some of the three NUREG 0654 recommended health physics support positions on-shift with personnel other than health physics technicians. As described above, NUREG 0654 provides allowance for personnel other than certified health physics technicians to provide this on-shift coverage. This information is necessary to present a clear understanding of this issue and the industry perspective of the recommendations of NUREG 0654. As such, the Supply System believes the addition of this information would have provided a more complete and accurate presentation of the concerns at hand for the reader of the report.

On page 14 of Reference 1 the staff stated that "The inspector raised the concern to licensee management and the licensee subsequently took immediate actions to ensure that at least three qualified HPTs were on-shift at all times." Although the Supply System did take action on February 10, 1997, to ensure the adequate coverage on-shift was provided, the Plant Support Services Manager took this action without prompting. Since the event was being dealt with on day shift, resolution of the staffing concern prior to end of day shift was planned and did occurr. This fact was later explained to the inspector. It is the Supply System's belief, as confirmed in Reference 2, that the on-shift staffing was adequate prior to the actions taken on February 10, 1997.

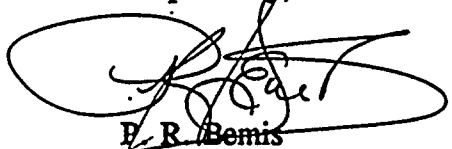
NRC INSPECTION REPORT 97-03, RESPONSE TO NOTICE OF VIOLATION

On page 17 of Reference 1, the staff states "In addition, the licensee described that the procedures allowed shift managers to assign responsibilities in emergencies." The staff goes on to state that this is an inappropriate use of 10 CFR 50.54(x). The Supply System does not consider the assignment of Chemistry Technicians to perform limited health physics support functions for which they are qualified to be a use of 10 CFR 50.54(x), and would not expect the assignment of personnel during an emergency, by the shift managers, to be viewed by them as a use of 10 CFR 50.54(x).

The Supply System looks forward to supporting the staff's review of the Reference 2 submittal.

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

Respectfully,



P. R. Bemis
Vice President, Nuclear Operations
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Attachment

cc: EJ Merschoff, NRC RIV
KE Perkins, Jr., NRC RIV, WCFO
TG Colburn, NRR
NRC Sr. Resident Inspector, MD927N
DL Williams, BPA, MD399
PD Robinson, Winston & Strawn

VIOLATION A

Restatement of Violation

A. TS 6.8.1 states, in part, "Written procedures shall be . . . implemented . . . covering the activities referenced below:

a. The applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978.

Appendix A of Regulatory Guide 1.33 requires, in part, procedures for the control of maintenance that can affect the performance of safety-related equipment; and equipment control (locking and tagging).

d. Surveillance and test activities of safety-related equipment."

Contrary to the above, between January 6 and February 1, 1997, three examples of a TS 6.8.1 violation were identified in the area of Operations. Specifically:

- PPM 1.16.6B, "Voluntary Entry into Technical Specification Activities [Actions] During Power Operations," Revision 6, requires the production scheduling shift manager (PSSM) to identify TS Action Statements that are required to be entered prior to performing requested work. Additionally, PPM 1.16.6B requires the PSSM to request a probabilistic safety assessment if the TS entry involved risk-significant TS systems. However, on January 6, 1997, the standby service water Pump A (SSW-A) and Diesel Generator 1 (DG), both identified as risk-significant systems, were rendered inoperable during work associated with SSW-A building ventilation fan (Work Order DGZ6), but the PSSM had not previously identified that the DG and SSW TS Action Statements required entry and additionally failed to request a probabilistic safety assessment for the work.

- PPM 7.4.1.3.1.2, "Control Rod Exercise" Revision 15, states, in part: "For each control rod that has been exercised satisfactorily . . . initial the appropriate location on core map . . ." However, on January 17, 1997, a reactor operator documented that Control Rod 54-19 was positioned to Position 48 by initialing the location on the core map that corresponded to Control Rod 54-19, but the control rod was not exercised satisfactorily and was at Position 46.

- PPM 1.3.8, "Plant Clearance Orders,". Revision 30, Section 3.9, specifies that equipment operators are responsible for positioning components in the plant as determined by clearance order. However, on January 20, 1997, equipment operators failed to close Valve RHR-V-176B in accordance with Clearance Order 96-12-0074.

These are examples of a Severity Level IV violation (Supplement 1).

Response to Violation A

The Supply System accepts the violation.

Reason for Violation A, Example 1

Pumphouse Return Air fan (PRA-FN-1A) was removed from service for routine preventative maintenance to lubricate and inspect the fan bearings. The on-shift control room crew did not recognize that removing this fan from service would render Service Water (SW) loop A inoperable. Shortly after the pump was removed from service, control room annunciators actuated indicating loss of power to the fan. The crew then concluded that the PRA fan did affect SW operability. Subsequently, entry was made into the Technical Specification Action Statement (TSAS) for SW loop A and Diesel Generator DG-1 inoperability. The clearance tags were then cleared and the fan returned to service.

Investigation revealed that the maintenance work order impact statement did not provide specific details of the impact of the maintenance but, did meet the minimum requirement of referring to the plant procedure for making Voluntary Entry into Technical Specifications (VETS). Had the on-shift crew reviewed the impact statement before removing power to the fan this problem could have been avoided. Further investigation showed that this task had been previously performed under a VETS and that the impact statement was adequate. The causes identified for this event are Operations shift management not adequately assessing the impact of the PRA fan clearance on SW operability and the Control Room Supervisor (CRS) authorizing removal of equipment from service without reviewing the impact statement. Contributing causes are the Work Control Shift Manager (WCSM) not fully developing the impact statement and an incorrect work condition code on the work order which implied that there was no plant impact for performing the work.

Corrective Actions Taken and Results Achieved

The Operations Manager issued a night order stressing the importance of reviewing the impact statement prior to removing equipment from service.

Operations shift management for the affected crew was counselled to be particularly careful in removing safety-related equipment from service to ensure compliance with the applicable Technical Specifications.

The CRS who approved the work was counselled concerning the necessity to review the impact statements of work orders prior to removing equipment from service.

The WCSM was counselled concerning the importance of completing required impact statement reviews.

Revised the model work order impact statement to provide more specific details of plant impact.

Corrective Steps That Will Be Taken to Avoid Further Violations

The CRS will spend eight hours observing the WCSM performing work order impact determinations to become familiar with this process.

Operations training department will enhance requalification lesson plans and training objectives to include safety-related HVAC fans and their impact on operability.

Date of Full Compliance

Full compliance was achieved when the affected Technical Specification Action Statements for SW loop A and DG-1 were entered on January 6, 1997.

Reason for Violation A, Example 2

While performing the verification steps of the surveillance procedure for control rod exercise, control room personnel noticed that control rod 54-19 was at position 46 instead of the required position of 48. Operations shift management was notified and the control rod was repositioned to 48. The Operations crew referred to the abnormal condition procedure for control rod mispositioning and the plant procedures for reactivity management. It was confirmed that fuel preconditioning limits were not exceeded.

During performance of the surveillance, the CRS and the lead Control Room Operator performed and documented observations for the operators moving control rods. These observations revealed that the operators performing this evolution met or exceeded expectations.

Investigation revealed that human error caused the mispositioning of the control rod. Possible contributors to the human error were the high activity level in the control room at the time of the surveillance and operator fatigue due to the long duration and monotonous nature of the control rod exercise surveillance.

Corrective Actions Taken and Results Achieved

Revised the control rod exercise surveillance procedure to add guidance to rotate personnel performing this test to maintain the level of alertness, to include dual verification on the final rod position, and to provide guidance to check final rod position after the settle function light has cleared.

Counselled the CRS regarding minimizing distractions in the control room during complex or lengthy reactivity management exercises.

Counselled the operators involved concerning the importance of maintaining proper work practices throughout reactivity manipulation evolutions.

Corrective Steps That Will Be Taken to Avoid Further Violations

The corrective actions already taken are sufficient to avoid further violations.

Date of Full Compliance

Full compliance was achieved when the subject control rod was moved to its required position of 48 on January 17, 1997.

Reason for Violation A, Example 3

On January 20, 1997, Containment Atmosphere Control (CAC) system B was cleared for maintenance. The clearance order included tagging of manual valve RHR-V-176B in the closed position. The clearance activities associated with this valve were complicated by the physical orientation of the valve which necessitated the equipment operators (EOs) stand to the side of the valve during manipulation and position verification. Two EOs performed the closed position verification.

On January 23, 1997, while releasing the clearance following CAC system maintenance, RHR-V-176B was found open. After attempting to open RHR-V-176B by normal means, the releasing EO recognized that the valve was already open as indicated by the raised handwheel and the grease mark on the valve stem. The releasing EO established that the valve was tightly backseated and required an assist device to break the valve loose from the backseat.

Investigation revealed the valve was not properly positioned when it was danger tagged. The operators mistakenly thought the valve was closed because the handwheel would not move. The valve was actually hard backseated. The cause of the event is that the procedural guidelines cautioning against hard backseating valves were not followed. Lack of self checking while verifying the valve in the closed position is a contributing cause.

Corrective Actions Taken and Results Achieved

A performance improvement plan was initiated for the involved equipment operators.

This incident was reviewed with operating crews emphasizing proper valve operation techniques.

Corrective Steps That Will Be Taken to Avoid Further Violations

Refresher training stressing proper backseating techniques, use of leverage devices, and alternate position indication means, will be provided to appropriate Operations personnel.

Date of Full Compliance

Full compliance was achieved on January 23, 1997, when valve RHR-V-176B was unseated from the hard backseated position and left in the open position required by the governing clearance order.

VIOLATION B

Restatement of Violation

B. TS 6.8.1 states, in part, "Written procedures shall be ...implemented...covering the activities referenced below:

a. The applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978.

Appendix A of Regulatory Guide 1.33 requires, in part, procedures for the control of radioactivity and maintenance that can affect the operability of safety-related equipment.

d. Surveillance and test activities of safety-related equipment."

Contrary to the above, between January 13, 1997, and February 1, 1997, three examples of a TS 6.8.1 violation were identified in the area of Maintenance. Examples included:

- PPM 7.4.8.1.1.2.12, "High Pressure Core Spray Diesel Generator Monthly Operability Test," Revision 27, including Temporary Change Notice 96-079, dated February 29, 1996, Step 17a, states: "At E-CP-DG/RP3 (Inside Cabinet), place the Droop Switch in the DROOP position." However, on January 13, 1997, during the performance of PPM 7.4.8.1.1.2.12, an equipment operator failed to place the Droop Switch in the DROOP position.

- PPM 1.11.11, "Entry Into, Conduct in, and Exit from Radiologically Controlled Areas," Revision 11, requires, in part, that "Persons entering a radiological controlled area shall adhere to all requirements specified by Health Physics Personnel (i.e., radiological work permit requirements, posted instructions, verbal instructions, etc.)." RWP 9600375 00 required workers, in part, to don a complete set of anticontamination clothing prior to entering a contamination area. However, on January 23, 1997, three workers (who were signed onto RWP 96000375 00) entered a contamination area without first donning a complete set of anticontamination clothing.

- PPM 1.3.7G, "Work Implementation," Revision 10, prohibits "minor maintenance" on safety-related equipment where the work could affect the operability of the equipment. However, on February 1, 1997, mechanics performed work on safety-related damper DMA-AD-22/2, which could affect the operability of the damper, under the minor maintenance controls of PPM 1.3.7G.

These are examples of a Severity Level IV violation (Supplement I).

Response to Violation B

The Supply System accepts the violation.

Reason for Violation B, Example 1

During the performance of the plant surveillance procedure for High Pressure Core Spray (HPCS) diesel generator (DG) monthly operability test, the diesel generator was paralleled to the electrical bus with the "droop switch" mispositioned. The EO performing the local panel switch lineup failed to perform the procedural step which would have properly positioned the switch. This error resulted in a failed attempt to parallel the generator. The CRO paralleling the diesel generator was unable to control load, resulting in a diesel generator trip and lockout due to reverse power and tripping of the output breaker. This resulted in the HPCS diesel generator being declared inoperable and entry into the associated Technical Specification Action Statements.

Investigation revealed a contributor to the switch mispositioning error was that the procedure step to position the droop switch had recently been added and was numbered as a sub-step of a larger step directing verification of fuel oil storage tank volume. This recent procedure change was not addressed in the pre-job brief for performance of the surveillance.

Corrective Actions Taken and Results Achieved

The equipment operator involved was placed on a human performance improvement plan.

Added a statement to plant procedure PPM 1.3.1, "Operations Department Policies, Programs and Practices," to specify when the control room is performing a surveillance with actions in the field, verification of individual field steps will be verified by control room personnel.

Revised Operations instructions to require the pre-job brief to address any recent changes to the procedures used during the job.

The Operations Manager discussed this event with Operations personnel to reiterate that the root cause was not following step-by-step through the procedure and that pre-job briefs should include a discussion of any recent changes to the procedure.

Revised Operator observation instruction for procedure usage to specify step-by-step sign off of all steps completed in the field when a procedure is being controlled from the control room.

Corrective Steps That Will Be Taken to Avoid Further Violations

The corrective actions already taken are sufficient to avoid further violations.

Date of Full Compliance

Full compliance was achieved when the HPCS DG was declared inoperable and the associated Technical Specification Action Statements were entered on January 13, 1997.

Reason for Violation B, Example 2

Three reasons contributed to the failure of contractor personnel to don protective clothing prior to entry into a contaminated area as required.

1) Inadequate communication during a pre-job discussion with HP technicians.

The contract workers involved described the work location in general terms during this discussion, but the fact that work was to be performed on the scaffold was not specifically described. The workers assumed that HP was aware of the work location since HP personnel requested the work (shielding of piping) be performed.

2) Marginal identification of the area as contaminated.

The contaminated area on the scaffolding was identified with a yellow and magenta sign attached at approximately waist height to the scaffolding access ladder. The sign read "Contact Health Physics Prior to Entry" and "Contaminated Area on Pipe Surfaces." This posting was marginal because there was no yellow and magenta rope indicating a contaminated area boundary and there was no step off pad or contaminated clothing hampers. These are features commonly present at contaminated areas requiring dressout. Had the workers encountered a roped off area and step off pad it is unlikely they would have proceeded without protective clothing.

3) Inadequate self-checking by the workers when assessing requirements for entering the scaffold.

The workers did not exhibit a questioning attitude when encountering the contaminated area sign posted on the ladder. The sign directed them to contact HP prior to entering the scaffold and informed them of contamination in the area of their job activities.

Corrective Actions Taken and Results Achieved

A discussion of this event has been incorporated into the contractor's lessons learned program for newly hired personnel. Direction has also been provided for contractor personnel to provide HP with an adequate description of work location, work activities, and which Radiation Work Permit (RWP) or ALARA work order task is being used for the work activity.

A discussion of this event has been added into the Radiation Worker Training reading text.

A three hour time out session has been held with the contractor's personnel on site to discuss this event.

A discussion of this event was held during a regularly scheduled maintenance shop meeting.

Corrective Steps That Will Be Taken to Avoid Further Violations

The RWP program will be enhanced to include a process for updating information pertaining to radiological conditions described in RWP and ALARA tasks.

The current practice of demarcating contaminated areas will be evaluated for development of new standards and expectations.

A job questionnaire will be developed to be used by work groups as a guide for information exchange with HP when entering the Radiologically Controlled Area to perform job tasks.

Date of Full Compliance

Full compliance was achieved when the contractor personnel exited the contaminated area and were decontaminated by plant HP personnel.

Reason for Violation B, Example 3

After receiving a report that the Division 2 diesel generator room air temperature was higher than normal, an investigative walkdown by Operations and Plant Support personnel determined that the actuator arm for damper DMA-AD-22/2 required repair. The Work Week Leader and the Maintenance Craft Supervisor processed the work as "minor maintenance." Neither the Work Week Leader nor the Maintenance Craft Supervisor in charge of the work verified the safety classification of the damper. In addition, the plant procedure for work implementation was not referenced to review the limitations of minor maintenance. The work to be performed on DMA-AD-22/2 did not meet all of the criteria for work under the minor maintenance work process, and therefore should have been performed using the regular work order process. Specifically, plant procedures do not allow minor maintenance work on safety-related systems or components if the work could affect their safety function. In this case, the maintenance could have affected component operability because it involved the linkage between the damper and the motor actuator which positions the damper. Both the Work Week Leader and the Maintenance Craft Supervisor failed to verify the procedural requirements prior to authorizing and proceeding with the work.

The testing performed on the damper after maintenance was in accordance with procedural requirements for assuring the operability of a safety-related damper.

Corrective Actions Taken and Results Achieved

Personnel associated with this event have received coaching concerning methods to prevent recurrence of this and similar events.

Corrective Steps That Will Be Taken to Avoid Further Violations

Operations, Maintenance, and Engineering Department personnel, as well as Work Week Leaders, will receive additional training on the minor maintenance work process and the use of WNP-2's work management computer program for the identification of equipment safety classification.

Date of Full Compliance

Full compliance was achieved on February 1, 1997 when testing demonstrated that the work performed on the damper did not affect damper operability.

VIOLATION C

Restatement of Violation

C. TS 6.8.1.f requires, in part, that procedures covering the Emergency Plan be implemented.

PPM 13.14.5, "Emergency Response Organization and Training," Revision 18, Step 4.1.5.2 states, "Upon completion of required training, a Letter of Assignment ... will be issued .... The letter of assignment documents an individual's assignment to an ERO position . . ."

Additionally, PPM 13.14.5, Step 4.2.4.2 states, "The requirements for each emergency position are detailed in the Emergency Position Training Matrix located in the Emergency Preparedness Training Course Catalog."

The "Emergency Preparedness Training Course Catalog," Revision 2, requires health physics technicians, in part, to complete the course entitled "Health Physics Emergency Functions," PDQ Code 82-EOS-P300-LP.

Contrary to the above, as of February 10, 1997, chemistry technicians were assigned the responsibilities of the emergency response organization on-shift health physics technicians but no "letter of assignment" was issued to document the assignments. Additionally, the chemistry technicians had not completed the course entitled "Health Physics Emergency Functions."

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

Response to Violation C

The Supply System accepts this violation.

Reason for Violation C

The procedure and training material guidance in effect at the time of this ERO staffing issue did not accurately reflect the intent of Supply System emergency response management for training and notification of Chemistry Technicians (CTs) performing Health Physics Technician (HPT) ERO duties.

The failure to adhere to PPM 13.14.5 guidance requiring CTs to complete HPT training prior to assignment of HPT ERO duties was due to an incorrect listing of the health physics training course in the EP Training Course Catalog. Although that course was not actually applicable to CT training, it still appeared as a training requirement.

The failure to adhere to guidance in PPM 13.14.5, to ensure "letters of assignment" be used to document the assignment of the CTs to perform HPT ERO duties was due to a misinterpretation of the guidance in the procedure by the Emergency Planning staff. The guidance in the procedure concerning the process for selection and assignment of ERO personnel was not intended to apply to the ERO category of On-Shift personnel, but only to the ERO categories of Support, Augmenting and Essential personnel. This procedure was being revised at the time of the inspection to clarify the selection and assignment process for ERO personnel, and to specify that personnel filling on-shift ERO positions are excluded from receiving letters of assignment because it is a condition of employment for on-shift personnel to fill ERO positions as assigned by management. The intent of the "letters of assignment" are to inform personnel of their specific ERO duties, if any.

Corrective Steps Taken and Results Achieved

Revisions to the WNP-2 Emergency Plan and PPM 13.14.5 have been completed to clarify the assignment letter and training requirements for CTs performing on-shift HPT ERO duties.

A revision to the EP Training Course Catalog has been approved to reflect the new training requirements identified in PPM 13.14.5.

An evaluation has been performed and reviewed as required by 10 CFR 50.54(q) for the Emergency Plan change adequately justifying using other on-shift personnel for certain HP functions, without reducing the effectiveness of the Emergency Plan as previously approved. This review was submitted with Reference 2.

Corrective Steps that Will Be Taken to Avoid Further Violations

The corrective actions already taken are sufficient to preclude further violations in this area.

Date of Full Compliance

Full compliance was achieved by March 31, 1997, following notification of the affected CTs of their ERO related HPT duties, when procedural guidance for issuing letters of assignment were clarified to reflect the requirements of the WNP-2 Emergency Plan, and the EP Training Course Catalog was changed to reflect the actual training requirements for HPTs.