

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

SUBJECT: Responds to NRC 970916 ltr re violations noted in insp rept
50-397/97-14. Corrective actions: issued operations night
order directing review of event & reinforcing mgt
expectation that plant procedure 4.1.1.7A be used.

NOTES:

NOTE TO ALL "RIDS" RECIPIENTS:

TOTAL NUMBER OF COPIES REQUIRED: LTTR 20 ENCL 20



WASHINGTON PUBLIC POWER SUPPLY SYSTEM

P.O. Box 968 • Richland, Washington 99352-0968

October 16, 1997
GO2-97-192

Docket No. 50-397

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

Gentlemen:

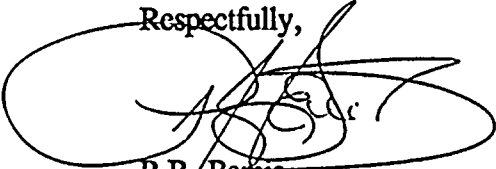
Subject: **WNP-2, OPERATING LICENSE NPF-21,
NRC INSPECTION REPORT 97-14, RESPONSE
TO NOTICE OF VIOLATION**

Reference: Letter dated September 16, 1997, TP Gwynn (NRC) to JV Parrish (SS), "NRC
Inspection Report 50-397/97-14 and Notice of Violation

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.

Should you have any questions or desire additional information regarding this matter, please call
Mr. P. J. Inserra at (509) 377-4147.

Respectfully,


P.R. Bernis
Vice President, Nuclear Operations
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Attachment

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NRC INSPECTION REPORT 97-14, RESPONSE TO NOTICE OF VIOLATION

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VIOLATION A

Restatement of Violation

WNP-2 Technical Specification (TS) 5.4.1.a requires written procedures to be established, implemented and maintained for the activities outlined in Regulatory Guide 1.33, Revision 2, Appendix A, February 1978. Appendix A to Regulatory Guide 1.33 requires, in part, written procedures for each TS required surveillance test, as described in Section 8.b, and for combating emergencies and other significant events, including mispositioned control rod(s), as described in Section 6.

Procedure TSP-CRD-C101, Revision 0, "CRD Scram Timing With Autoscramtimer System," provides instructions for performing control rod scram timing in accordance with TS requirements. Step 7.1.13 directs operators to verify the rod to be scrambled is at position 48 or to move the rod to position 48, in accordance with approved rod withdrawal sheets.

Procedure 4.1.1.7A, Revision 3, "Recovery From Mispositioned Control Rods," directs operators, in part, to run a core monitoring program to identify any preconditioning overpower and to inform plant management prior to recovering the control rod(s).

Contrary to the above, on July 11, 1997, while the unit was in Mode 1, operators failed in two instances to follow plant procedures as follows:

1. Operators withdrew Control Rod 18-55 out of sequence from that defined in the approved rod withdrawal sheets for Procedure TSP-CRD-C101.
2. Subsequent to withdrawing Control Rod 18-55 out of sequence, operators failed to recognize the action as a mispositioned control rod and, therefore, failed to implement the requirements of Procedure 4.1.1.7A to run a core monitoring program and inform plant management prior to repositioning the rod.

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

Response to Violation A

The Supply System accepts the violation.

Reason for Violation A

The Supply System agrees with the staff's characterization of this event as given in the Violation and Report Details of the Reference.



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The reason for the control rod mispositioning event was failure of control room staff members to self-check their rod manipulation actions against the requirements of the rod pull sheet while performing scram time testing. A contributing factor to this error was confusion in the wording of an attachment to the scram time testing procedure which directed withdrawal of the selected rod rather than specifically directing the performers to the rod pull sheet.

Additionally, the control room staff did not recognize the event as a mispositioned control rod, and consequently did not meet management's expectation for use of plant procedure 4.1.1.7A, Recovery from Mispositioned Control Rods, and for recording events of this type in the control room log.

Further, it is recognized that the corrective actions taken as a result of a similar event in 1994 did not prevent recurrence.

Corrective Actions Taken and Results Achieved

Issued an Operations Night Order directing review of this event and reinforcing the management expectation that plant procedure 4.1.1.7A be used whenever a control rod is positioned to a position other than specified on the rod pull sheet.

Operations Manager met with the control room personnel involved in this event to discuss the expectation that plant procedure 4.1.1.7A be used any time the existing control rod pattern is not in full compliance with the rod pull sheet, and the expectation that events of this kind be recorded in the control room log.

The Control Room Operator involved has been placed on a personal performance improvement plan.

Observation of the involved Shift Technical Advisor's (STA) performance has been conducted and documented in ten subsequent successful rod manipulations. The STA has also been coached to reinforce the need for attention to detail and to minimize distractions when moving control rods.

The control rod scram time testing procedure has been changed to direct performers to refer to the rod pull sheet for identification of required rod manipulations.

Corrective Steps That Will Be Taken to Avoid Further Violations

Format requirements for better human factored rod pull sheets will be developed.

Plant procedures directing manipulation of control rods will be revised to refer to plant procedure 4.1.1.7A any time a control rod is placed in a position other than that specified on the control rod pull sheet.

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The definition of mispositioned control rods given in plant procedure 1.3.59, Reactivity Management, will be revised to be the same as the criteria given in plant procedure 4.1.1.7A to eliminate potential confusion.

Date of Full Compliance

The immediate corrective action of returning the control rod to its intended position and verification that the event had no detrimental impact on the core occurred shortly after the event. However, full compliance was not achieved until three days later, on July 14, 1997, when management was informed of the control rod mispositioning event per the requirements of plant procedure 4.1.1.7A.

VIOLATION B

Restatement of Violation

TS 5.5 requires that the Inservice Testing (IST) program described in TS 5.5.6 be properly implemented. The WNP-2 IST Program requires that surveillance testing for Valve TIP-V-6 be performed on a refueling outage interval.

Contrary to the above, at the completion of Refueling Outage R12 (July 4, 1997), surveillance testing in accordance with the requirements of the IST program had not been performed on Valve TIP-V-6. This is a repetition of previous violations described in NRC Inspection Report 50-397/96019.

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

Response to Violation B

The Supply System accepts the violation.

Reason for Violation B

The Supply System agrees with the staff's characterization of this event as given in the Violation and Report Details of the Reference.

The Inservice Testing Program Lead Engineer discovered an error in the recently performed IST procedure OSP-TIP/IST-R701. The procedure is required to be performed each refueling outage and is used to exercise the TIP purge inboard containment isolation check valve, TIP-V-6, as required by the WNP-2 IST Program Plan. The procedure allows credit to be taken for successful completion of a LLRT to demonstrate the exercise of TIP-V-6. However, the procedure did not specify that the LLRT had to be performed during the most recent refueling

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outage to be acceptable. No LLRT of TIP-V-6 was required to be performed during the 1997 refueling outage. LLRT results for this valve from the 1996 refueling outage were used and the procedure was erroneously accepted as complete.

The reason for the violation was a procedure inadequacy in that the IST procedure did not contain direction to specify that the use of LLRT data to verify the exercise of TIP-V-6 was acceptable only if the LLRT had been performed during the most recent refueling outage.

As pointed out in the Report Details of the Reference, there were two previous occurrences of the IST Program Lead identifying missed surveillances after the components had been returned to service. In recognition of this continuing problem, corrective actions to improve the quality of review of the performed IST procedures prior to returning the equipment to service have been taken as specified below.

Corrective Actions Taken and Results Achieved

Revised IST procedure to clarify the need for TIP-V-6 exercise if LLRT was not performed within one year prior to performance of the procedure.

Performed a review of IST procedures performed during the most recent refueling outage to verify other IST Program Plan requirements have been met.

Corrective Steps That Will Be Taken to Avoid Further Violations

Other IST Program Plan procedures will be reviewed and revised as necessary to clearly specify the IST Program Plan acceptance criteria requirements.

TIP-V-6 will be stroked closed in accordance with the exigent Technical Specification Amendment approved on September 18, 1997.

Preoutage training for control room staff will be completed on IST Program acceptance criteria to enable the control room staff's adequate review of performed IST procedures.

The plant Master Startup Checklist will be revised to add a verification step for the IST Program Lead Engineer to verify that the IST procedures necessary for plant startup have been performed as required.

Date of Full Compliance

Full compliance was achieved on September 18, 1997 when the exigent Technical Specification Amendment for TIP-V-6 was approved.

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VIOLATION C

Restatement of Violation

TS Limiting Condition for Operation (LCO) 3.6.1.3 requires each primary containment isolation valve to be operable while in Modes 1, 2, and 3.

TS 3.6.1.3.A.1 (the applicable conditions) requires, in part, with one or more primary containment isolation valves inoperable, isolate the affected penetration flow path by use of at least one closed and deactivated automatic valve within 4 hours. The penetration may be unisolated intermittently under administrative controls.

TS 5.5.6.c states that the provisions of TS Surveillance Requirement (SR) 3.0.3 are applicable to inservice testing activities.

TS SR 3.0.3 states, in part, "If it is discovered that a Surveillance was not performed within its specified Frequency, then compliance with the requirement to declare the LCO not met may be delayed, from the time of discovery, up to 24 hours or up to the limit of the specified Frequency, whichever is less . . . If the Surveillance is not performed within the delay period, the LCO must immediately be declared not met and the applicable condition(s) must be entered . . ."

Contrary to the above, between July 18 and August 12, 1997, while the unit was in Mode 1 and with Valve TIP-V-6 inoperable, the affected penetration was unisolated continuously and without administrative controls. Valve TIP-V-6 should have been considered inoperable because the IST Surveillance for valve TIP-V-6 was not performed within its specified frequency and the surveillance could not be performed in the current operating mode (as such, TS LCO 3.6.1.3 was required to be declared "not met" and the applicable conditions were required to be entered).

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

Response to Violation C

The Supply System accepts the violation.

Reason for Violation C

The Supply System agrees with the staff's characterization of this event as given in the Violation and Report Details of the Reference.

The reason for this violation is misinterpretation of guidance contained in NUREG 1482 allowing use of Generic Letter (GL) 91-18 for determining operability of TIP-V-6. This misinterpretation resulted in inappropriate reopening of the TIP purge penetration.

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Additionally, the Supply System recognizes the similarity of the two previous issues involving misinterpretation of regulations identified in the Report Details of the Reference.

In all three cases, interpretations of TS, or generic correspondence relating to TS compliance, were made by plant Licensing personnel that, upon further review by the NRC staff, were determined to be incorrect. In all three cases, other guidance (non-Tech Spec) was used to interpret the requirements of Technical Specifications.

Corrective Actions Taken and Results Achieved

After receiving clarification from the NRC staff concerning the proper interpretation of NUREG 1482, the TIP-V-6 penetration was reclosed, isolating the TIP purge penetration to primary containment.

A Problem Evaluation Request initiated.

Corrective Steps That Will Be Taken to Avoid Further Violations

Plant Licensing staff will complete training regarding compliance with the current enforcement standards applied by the NRC staff. The training will specifically address the requirement that plant Technical Specifications are to be interpreted in a verbatim manner and the requirements therein are not modified by guidance contained in other documents.

Date of Full Compliance

After receiving clarification from the NRC staff concerning the proper interpretation of NUREG 1482, full compliance was achieved when the TIP-V-6 penetration was reclosed on August 12, 1997, isolating the TIP purge penetration to primary containment.

VIOLATION D

Restatement of Violation

TS 5.4.1.a requires written procedures to be established, implemented, and maintained for the activities outlined in Regulatory Guide 1.33, Revision 2, Appendix A, February 1978. Appendix A to Regulatory Guide 1.33 requires, in part, written procedures for implementation of the As Low As Reasonably Achievable (ALARA) program, as described in Section 7.e.

Procedure 11.2.2.5, Revision 6, "ALARA Job Planning and Reviews," requires both Level I and Level II ALARA review to be performed and approved for radiation work permits associated with work in areas where the general area dose rates exceed 100 mrem/hr deep dose equivalent.

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Contrary to the above, on August 6, 1997, while the unit was in Mode 1, work was performed in a reactor water cleanup pump room, with general area dose rates that exceeded 100 mrem/hr deep dose equivalent, under a radiation work permit that did not have completed and approved Level I and Level II ALARA reviews.

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

Response to Violation D

The Supply System accepts the violation.

Reason for Violation D

The Supply System agrees with the staff's characterization of this event as given in the Violation and Report Details of the Reference.

The failure to perform Level I & II ALARA reviews for the subject work was due to the oversight of two individuals in the radiation work permit (RWP) planning and approval process. First, the ALARA planner failed to include Level I & II reviews in the subject ALARA Task prior to routing the RWP for further review and approval. Second, the HP supervisor failed to note the missing Level I & II reviews as part of the RWP approval process because of his estimation of low importance for review of a recurring "generic" RWP, and because of unclear procedural guidance directing the review.

Further, it is recognized that the corrective actions taken as a result of an earlier similar event in 1997 did not adequately address the generic impact of the event and did not prevent recurrence.

Corrective Actions Taken and Results Achieved

The involved personnel have been counseled concerning the importance of attention to detail and following existing procedural guidance.

A review of ALARA Tasks attached to currently active RWPs has been completed to ensure the required Level I & II reviews have been completed.

Corrective Steps That Will Be Taken to Avoid Further Violations

The appropriate procedures will be revised to provide an action step in the RWP approval process to review the Level I & II ALARA reviews when required.

Procedural guidance will be developed to ensure appropriate use of generic ALARA Tasks in high radiation areas.

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Eliminate the procedural requirement to perform Level I & II ALARA reviews on recurring generic ALARA Tasks, and substitute pre-job briefings to provide current task information to the users of generic RWPs.

Develop computer-based search reports to verify completion of required Level I & II ALARA reviews on RWPs.

Rewrite the Level I & II ALARA review questions to better focus the review on the specific ALARA task being planned.

Date of Full Compliance

Level I and II ALARA reviews were completed for the subject work on 12 August, 1997.

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