

VIRGINIA ELECTRIC AND POWER COMPANY
RICHMOND, VIRGINIA 23261

May 10, 1991

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

Serial No. 91-222
NAPS/JHLR2
Docket Nos. 50-338
50-339
License Nos. NPF-4
NPF-7

Gentlemen:

VIRGINIA ELECTRIC AND POWER COMPANY
NORTH ANNA POWER STATION UNITS 1 AND 2
INSPECTION REPORT NOS. 50-338/91-06 AND 50-339/91-06
RESPONSES TO THE NOTICES OF VIOLATION


We have reviewed your letter of April 12, 1991 which referred to the inspection conducted at North Anna from February 17, 1991 - March 16, 1991 and reported in Inspection Report Nos. 50-338/91-06 and 50-339/91-06.

In your cover letter, you expressed concerns regarding each of the three violations in terms of inadequate corrective actions, personnel errors and procedural inadequacies. As part of the management review for those violations, it appears that a common thread in the violations is the implementation of existing programs. In each of the three events cited, generally effective programs were already in place. Had those programs been adequately implemented, it is our judgment that the violations would not have occurred. Program implementation and effectiveness of corrective actions are an integral part of Quality Assurance and Corporate Nuclear Safety's assessments and will be specifically addressed in future assessments.

Virginia Electric and Power Company continues to emphasize the importance of attention to detail. The Self Check Program, the Nuclear Safety Policy, and the Nuclear Monthly Newsletter are but a few examples of ongoing efforts by management to emphasize the need for individuals to be accountable for their activities and the need to attend to the details in every activity affecting nuclear safety. Attention to detail is an integral part of our nuclear safety philosophy and will continue to receive the highest levels of management attention.

Our responses to the specific Notices of Violation are attached.

Very truly yours,


W. L. Stewart
Senior Vice President - Nuclear

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Attachment

cc: U. S. Nuclear Regulatory Commission
101 Marietta Street, N.W.
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Atlanta, Georgia 30323

Mr. M. S. Lesser
NRC Senior Resident Inspector
North Anna Power Station

RESPONSE TO THE NOTICE OF VIOLATION
REPORTED DURING THE NRC INSPECTION CONDUCTED
BETWEEN FEBRUARY 17, 1991 AND MARCH 16, 1991
INSPECTION REPORT NOS. 50-338/91-06 A'D 50-339/91-06

NRC COMMENT

During an NRC inspection conducted between the period of February 17 through March 16, 1991, violations of NRC requirements were identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," 10 CFR Part 2, Appendix C, (1990), the violations are listed below:

- A. Technical Specification 3.11.2.5 requires the concentration of oxygen in the waste gas decay tanks be limited to less than or equal to 2 percent whenever the hydrogen concentration is between 4 and 96 percent. With the concentration of oxygen greater than 2 percent but less than 4 percent, reduce the oxygen concentration to the above limits within 48 hours. With the concentration of oxygen greater than 4 percent, immediately suspend all additions of waste gas to the system and reduce the concentration of oxygen to less than or equal to 2 percent without delay.

10 CFR 50, Appendix B, Criterion XVI as implemented by Operational Quality Assurance Program Topical Report (VEP 1-5A) requires in part that measures be established to assure that conditions adverse to quality such as deviations and nonconformances are promptly identified and corrected. In the case of significant conditions adverse to quality, the measures shall assure that the cause of the condition is determined and corrective action taken to preclude repetition.

Contrary to the above, corrective action, initiated in response to Quality Assurance finding N-90-03-02 of February 23, 1990 involving an explosive gas mixture in a waste gas decay tank, was ineffective and failed to preclude repetition. Although corrective action was completed on November 1, 1990, a similar event occurred on March 5, 1991, where a waste gas decay tank with oxygen concentration of 2.3 percent was not reduced to less than or equal to 2 percent within 48 hours.

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

- B. Technical Specification 6.8.1 requires that written procedures be implemented covering the applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978. Included in Appendix A of Regulatory Guide 1.33 are procedures for performing maintenance and surveillances.

Contrary to the above, procedures were not followed or used as evidenced by the following examples:

1. Maintenance Procedure 0-ECM-1701-01, dated January 10, 1991, Troubleshooting and Repair of the Personnel Airlock Electrical System, is required to be used to provide instructions for troubleshooting, repairing and replacing components of the personnel airlock electrical system. Virginia Power Administrative Procedure (VPAP) 2002, Work Requests and Work Orders, dated July 1, 1990, paragraph 6.4, requires a Troubleshooting Pre Job Review Sheet and Instruction form be completed for troubleshooting activities. VPAP 2002, paragraph 6.4, requires the determination of the "as

found" condition of a failed component requiring corrective maintenance and recording on the work request, the work actually performed. 0-ECM-1701-01 and VPAP-2002 were not adequately implemented, in that on March 9, 1991 following the failure of an interlock on the personnel airlock provided by limit switch LS-7, troubleshooting activities were conducted on the personnel airlock outer door without the use of 0-ECM-1701-01. In addition, the Troubleshooting Pre Job Review Sheet and Instructions form was not completed to establish and approve job steps, a craftsman failed to determine the "as found" condition of LS-7 by inappropriately exercising it, and also the craftsman failed to record these actions on the associated work request.

2. Periodic Test 1-PT-62.4, dated February 20, 1990, Personnel Airlock Seal Leakage Test, requires the "as found" condition of the test to be recorded in step 4.11.1. Further, if the test results in a frequency of greater than 60 bubbles per minute observed at the bubble flow detector, a calibrated rotometer shall be used to record flow. VPAP 2002, paragraph 6.1, requires a work request be written for performing maintenance on permanently installed equipment which is not considered minor maintenance or work required as a result of a station deviation report. 1-PT-62.4 and VPAP-2002 were not adequately implemented in that on March 15, 1991, after the personnel airlock seal leakage test failed to meet the acceptance criteria due to a faulty LS-7 limit switch, the operators failed to record the results of the test following the use of the bubble flow detector and failed to use a calibrated rotometer to obtain the leakage. Also, following failure of the test, corrective maintenance was performed on the LS-7 limit switch without authorization and without a work request or procedures.

This is a Severity Level IV violation applicable to Unit 1 only (Supplement 1).

- C. Technical Specification 6.8.1 requires that written procedures be established covering the applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978. Included in Appendix A of Regulatory Guide 1.33 are procedures for performing surveillances.

Contrary to the above, surveillance procedures were inadequate in that, test and calibration procedures implementing Technical Specification 4.4.3.2.1.b did not fully test the automatic high pressure portion of the Unit 2 power operated relief valve 2-RC-PC-2455C channel.

This is a Severity Level IV violation applicable to Unit 2 only (Supplement I).

RESPONSE TO VIOLATION A

1. ADMISSION OR DENIAL OF THE ALLEGED VIOLATION

The violation is correct as stated.

2. REASON FOR THE VIOLATION

The violation was caused by inadequate implementation of corrective actions associated with a previously identified Quality Assurance audit finding.

3. CORRECTIVE STEPS WHICH HAVE BEEN TAKEN AND THE RESULTS ACHIEVED

When the violation of Technical Specification 3.11.2.5 was identified, the release of the "A" Waste Gas Decay Tank (WGDT) was secured, nitrogen was added and the oxygen concentration was reduced to less than 2 percent.

A Technical Specification change which will provide appropriate guidance is currently pending NRC approval.

In the interim, an Operations Department Memorandum was written to clarify Technical Specification 3.11.2.5 requirements. This memorandum was provided to each Senior Reactor Operator (SRO). The SRO discussed the memorandum with their respective shift to ensure understanding and compliance with the Technical Specification.

The WGDT procedure (1-OP-23.2) has been revised to specifically identify actions required to reduce oxygen concentration to less than 2 percent.

4. CORRECTIVE STEPS WHICH WILL BE TAKEN TO AVOID FURTHER VIOLATIONS

No further corrective actions are required.

5. THE DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

Full compliance has been achieved.

RESPONSE TO VIOLATION B

1. ADMISSION OR DENIAL OF THE ALLEGED VIOLATION

The violation is correct as stated.

2. REASON FOR THE VIOLATION

The violation was caused by personnel error in that the personnel involved in the maintenance evolution during non-normal work hours took actions outside the scope of the work request system in troubleshooting the problem.

3. CORRECTIVE STEPS WHICH HAVE BEEN TAKEN AND THE RESULTS ACHIEVED

The personnel involved were counseled by management regarding their unacceptable performance and coaching was conducted to assure acceptable performance in the future.

An Operations Department Memorandum was written to more clearly specify the requirements for and scope of work requests prepared during non-normal work hours. Each operating shift discussed the requirements of the memorandum and the importance of following procedures.

4. CORRECTIVE STEPS WHICH WILL BE TAKEN TO AVOID FURTHER VIOLATIONS

No further corrective actions are required.

5. THE DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

Full compliance has been achieved.

RESPONSE TO VIOLATION C**1. ADMISSION OR DENIAL OF THE ALLEGED VIOLATION**

The violation is correct as stated.

2. REASON FOR THE VIOLATION

The violation was caused by the incorrect interpretation of surveillance requirement 4.4.3.2.1.b and an administrative error. In an effort to provide additional information to NRC regarding this previously unresolved item which was identified in Inspection Report 90-02 dated March 2, 1990, we had performed a review in March 1991 to verify that testing was performed during the Unit 2 1990 refueling outage and the Unit 1 1991 refueling outage. The review determined that a set of contacts on the control room benchboard switch for the automatic high pressure portion of the Unit 2 power operated relief valve, 2-RC-PCV-2455C, were not tested due to an administrative error.

3. CORRECTIVE STEPS WHICH HAVE BEEN TAKEN AND THE RESULTS ACHIEVED

As an immediate corrective action, the appropriate action statement of Technical Specification 3.4.3.2 was entered and 2-RC-PCV-2455C was declared inoperable and its associated block valve was shut.

The appropriate procedure was temporarily revised to allow a one-time functional test of the contacts and associated wiring. This testing was satisfactorily performed.

4. CORRECTIVE STEPS WHICH WILL BE TAKEN TO AVOID FURTHER VIOLATIONS

Appropriate procedures will be revised to ensure each contact and associated wiring in the PORV control circuitry is adequately tested. Assurance that the appropriate revisions will be made prior to their next scheduled use is provided by assigning the actions through the commitment tracking system.

5. THE DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

Contacts and associated wiring in the PORV control circuitry have been successfully tested, therefore full compliance has been achieved. However, to maintain full compliance the required procedures will be revised prior to their next scheduled performance.