

March 4, 1985

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VIRGINIA POWER

Dr. J. Nelson Grace
Regional Administrator
Region II
U. S. Nuclear Regulatory Commission
101 Marietta Street, Suite 2900
Atlanta, Georgia 30323

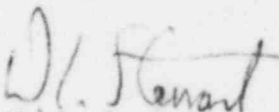
Serial No. 85-091
NO/sbe:bep
Docket Nos. 50-280 A
50-281
50-338
50-339
License Nos. DPR-32
DPR-37
NPF-4
NPF-7

Dear Dr. Grace:

We have reviewed your letter of February 1, 1985, in reference to the inspections conducted at Surry and North Anna Power Stations from March 6 through April 5, 1984 and reported in IE Inspection Report 50-280/84-10, 50-281/84-10, 50-338/84-06 and 50-339/84-06. Our response to the violations and deviations are addressed individually in the enclosure. A check in the amount of forty thousand dollars (\$40,000) is also enclosed as requested.

We have determined that no proprietary information is contained in the report. Accordingly, Virginia Power has no objection to this inspection report being made a matter of public disclosure. The information contained in the attached pages is true and accurate to the best of my knowledge and belief.

Very truly yours,


W. L. Stewart

Attachment

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VIRGINIA POWER

cc: Mr. Rodger D. Walker, Director
Division of Reactor Projects

Mr. James R. Miller, Chief
Operating Reactors Branch No. 3
Division of Licensing

Mr. Steven Varga, Chief
Operating Reactors Branch No. 1
Division of Licensing

Mr. M. W. Branch
NRC Resident Inspector
North Anna Power Station

Mr. D. J. Burke
NRC Resident Inspector
Surry Power Station

RESPONSE TO NOTICE OF VIOLATION
ITEM REPORTED DURING NRC INSPECTIONS
CONDUCTED FROM MARCH 6 TO APRIL 5, 1984
REPORT 50-280/84-10, 50-281/84-10, 50-338/84-06 AND 50-339/84-06

NRC COMMENT

As a result of the resident inspections performed on March 6 through April 5, 1984 and documented in Inspection Reports Nos. 50-280/84-10, 50-281/84-10, 50-338/84-06, and 50-339/84-06, the Nuclear Regulatory Commission (NRC) has determined violations of its requirements have occurred. In accordance with the NRC Enforcement Policy in effect at the time of the violations, 10 CFR Part 2, Appendix C, 47 FR 9987 (March 9, 1982), and pursuant to Section 234 of the Atomic Energy Act of 1954, as amended, 42 U.S.C. 2282, PL 96-295, and 10 CFR 2.205, the violations are set forth below:

1. The following examples are material false statements within the meaning of Section 186 of the Atomic Energy Act of 1954, as amended.

- a. In an October 28, 1983 letter to NRC, Virginia Electric Power Company (VEPCO) made the following statement:

North Anna Unit Nos. 1 and 2 have complied with the rule by having the RCS (reactor coolant system) vents installed and operational by the first outage of sufficient duration beginning after July 1, 1982. The RCS vents have been functionally tested but currently are electrically disconnected. In the event of an emergency, the RCS vents could be energized and they could be used with the guidance of the generic procedures.

Contrary to the above, the RCS vents could not be energized and used with the guidance of the generic procedure at North Anna Unit 2 because the manual isolation valve for the reactor head vent was closed; thus remote operation was not possible. The statement is false because the reactor head vent could not have been remotely operated. It is material because it caused the NRC staff to believe that the reactor head vent system could have been used if an accident requiring its use had occurred.

- b. In a November 4, 1983 letter to NRC, VEPCO made the following statement: "Maintenance and testing procedures for the Reactor Protection System contain the latest vendor information received by the stations."

Contrary to the above, the North Anna Electrical Maintenance Procedure EMP-P-EP-7, Reactor Trip Breakers, did not include the requirements recommended in Westinghouse Technical Bulletin NSD-TB-83-02. The statement is false because the Westinghouse Technical Bulletin contained vendor information and had been

in the licensee's possession during a previous March 6 to April 5, 1983 inspection, over seven months before the statement was made. It is material because had the NRC known that the licensee had not incorporated the vendor's revised recommended lubrication procedures for the reactor trip breakers, the NRC would have required that they be immediately incorporated.

These examples constitute a Severity Level III violation (Supplement VII).

RESPONSE

1. ADMISSION OR DENIAL OF THE ALLEGED VIOLATION

This violation is correct as stated.

2. REASON FOR THE VIOLATION

Part a:

The failure to adequately describe the condition of the Reactor Head Vent System was due to personnel error. The information used to support the status of the system was obtained from outdated reference information and was not properly reviewed to ensure correctness prior to the issuance of the letter.

Part b:

The failure to adequately describe the inclusion of the vendor recommended changes into the maintenance procedures was due to the improper handling of vendor related information and a failure to properly review the letter prior to submittal.

3. CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED

Management involvement in licensing activities has been significantly increased to provide additional direction and overview to prevent further occurrences of this nature. The Nuclear Operations Department was reorganized at both the corporate and station level in order to provide the increased management attention. Specifically, an additional Assistant Station Manager position was established with responsibility for nuclear safety and regulatory compliance, and the position of Manager, Nuclear Programs and Licensing was established at the corporate level with responsibility for licensing. All positions were filled June 1, 1984. As a result of these changes, the review process for outgoing correspondence has been strengthened.

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

No further corrective actions are required.

5. DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

Full compliance has been achieved.

NRC COMMENT

2. 10 CFR 50.44(c)(3)(iii) requires that RCS vents be operable (remotely) from the control room by the completion of the first scheduled outage of sufficient duration after July 1, 1982.

Contrary to the above, the NRC Resident Inspectors discovered the Reactor Vessel Head Vent system on North Anna Unit 2 was not operable (remotely) following the spring 1983 Unit 2 fifty-five day outage that commenced on April 2, 1983. Also, the Reactor Vessel Head Vent system for Surry Units 1 and 2 were not operable (remotely) following the Unit 1 and Unit 2 refueling outages on June 30, 1983 and February 8, 1983, respectively.

This is a Severity Level III violation (Supplement I). This violation applies to North Anna Unit 2 and Surry Units 1 and 2. (Civil Penalty \$40,000).

RESPONSE

1. ADMISSION OR DENIAL OF THE ALLEGED VIOLATION

This violation is correct as stated.

2. REASON FOR THE VIOLATION

The issuance of the rule change that required operability of the reactor vessel head vent system was not properly assessed to determine its effect on the status of the installed systems. The situation was further complicated by the lack of governing procedures which were still under development by the Westinghouse Owners Group.

It was specifically stated in correspondence, relating to the operability of the system, that Vepco would not operate the system until completion of the following.

1. The Reactor Vessel Level Indicating System was operable to provide Reactor Vessel Level Indication to the operator.
2. The governing procedures were implemented and the operations personnel were trained.
3. The approval of the Technical Specification Amendment was received and implemented.

Vepco considered that the implementation of head venting portion of the system without the above actions completed could endanger the safe operation of the units.

When continued compliance with the previously submitted NUREG 0737 schedule was determined to be inconsistent with 10CFR50.44,

VEPCO submitted an exemption request for North Anna which was subsequently approved. The RCS vents were made operable for both Surry units during the March 1984 outages.

3. CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED

North Anna:

The exemption request issued on April 13, 1984 stated that the manual isolation valve on the Reactor Head Vent System would be opened on Unit 2 and the system made operable by April 15, 1984. The manual valve was opened and verified on April 6, 1984. On Unit 2, the proposed technical specifications were implemented and the system declared operable on April 15, 1984 consistent with the implementation of the Emergency Operating Procedures. On Unit 1, the exemption allowed implementation of the system during the next outage of sufficient duration. Unit 1 was taken off line on May 13, 1984 for a scheduled refueling outage. The governing valve line-up checklist was revised to require opening and locking of the manual isolation valve prior to startup as part of the startup checklist. Because of various problems encountered during the outage, startup from the outage was delayed until September 27, 1984. The manual isolation valve was opened on September 14, 1984 and the system was declared operable.

Surry:

RCS vents were made operable for Unit 1 on March 5, 1984 and for Unit 2 on March 27, 1984.

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

The increased management attention to Licensing issues identified in the previous section have been implemented to preclude occurrences of a similar nature.

5. DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

Full compliance has been achieved.

NRC COMMENT

3. 10 CFR 50.54(a)(1) requires the licensee to implement the quality assurance program described or referenced in its safety analysis report. Section 17.2.2 of the licensee quality assurance program which endorses 10 CFR Part 50, Appendix B requires that adequate procedures be implemented and followed and that the procedures include criteria for determining that important activities have been satisfactorily accomplished.

Contrary to the above, the licensee did not provide adequate instructions to control valve lineups in that during valve lineups conducted on November 25, 1980, May 14, 1982, and May 19, 1983 the licensee examined a number of valves in the auxiliary feedwater pump room, determined that all were closed, and indicated that all valves on the checklist were closed. As a result, valve FW-327 was improperly indicated as being shut when the valve did not exist.

This is Severity Level IV violation (Supplement 1). This violation applies to North Anna Units 1 and 2.

RESPONSE

1. ADMISSION OR DENIAL OF THE ALLEGED VIOLATION

The violation is correct as stated.

2. REASON FOR THE VIOLATION

This violation for North Anna was caused by the failure to properly verify the valve position as required by the existing administrative controls. In addition, the actions taken in response to the procedure deviations were inadequate. As a result, when the operator noted the discrepancy, improper actions were taken. When notified of the violation, a walkdown was conducted and an Engineering Work Request was developed to address the difference between the system drawing and the valve line-up checklist. It was determined that the valve 2-FW-207 was mislabelled as 2-FW-327 (drain isolation valve on suction line to 2-FW-P-3B) on the system drawing and the valve lineup checklist.

3. CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED

The checklist was revised to remove the valve number 2-FW-327 and the correct valve number 2-FW-207 for this valve was added. The system drawing (12050-FM-74A) was revised to provide the correct number. Additionally, the administrative controls placed on the methods for verifying valve position verification were strengthened by revising the governing administrative procedure. A memorandum from the Superintendent of Operations to Operations personnel was also sent to reemphasize the Operator's responsibility and to provide policy guidance for accurate operator verifications, including verification of valve positions. A valve labelling program has been initiated to research and correct errors noted during the performance of routine work activities.

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

No further corrective actions are required.

5. DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

Full compliance has been achieved.

NRC COMMENT

4. Technical Specification 3.1.B.1 requires that the Unit 2 reactor coolant system temperature cooldown rate shall not exceed 50 degrees F per hour below 440 degrees F.

Contrary to the above, on March 16, 1984, the Unit 2 reactor coolant system temperature was decreased by 55 degrees F in one hour from about 440 degrees F to 350 degrees F during cooldown.

This is Severity Level V violation (Supplement 1). This violation applies to Surry Unit 2.

RESPONSE

1. ADMISSION OR DENIAL OF THE ALLEGED VIOLATION

The violation for Surry Unit 2 is correct as stated.

2. REASON FOR THE VIOLATION

The reason for the violation was operator error.

3. CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED

Personnel involved have been appropriately instructed on adherence to the heatup and cooldown rates in the operating procedure.

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

No additional actions are required.

5. DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

Full compliance was achieved on March 17, 1984.

RESPONSE TO NOTICE OF DEVIATION
ITEM REPORTED DURING NRC INSPECTIONS
CONDUCTED FROM MARCH 6 TO APRIL 5, 1984
REPORT 50-338/84-06 AND 50-339/84-06

NRC COMMENT

1. In response to IE Bulletin 80-05, Virginia Electric and Power Company's (VEPCO) commitment in their letter (June 9, 1980) the vents on the three Boric Acid Storage Tanks would be locked open and administratively controlled. The response also committed to institute a Periodic Operability Verification Program by September 9, 1980, for the Boron Evaporator Bottoms Tank Vacuum Breaker (PCV-BR-861).

Contrary to the above, no administrative controls have been established to ensure the Boric Acid Storage Tanks Vents are locked open, in that the valve lineup only requires the valves to be open. Additionally, no Periodic Operability Verification Program has been established for the Boron Evaporation Bottom Tank Vacuum Breaker (PCV-BR-161).

This deviation applies to North Anna Units 1 and 2.

RESPONSE

1. DESCRIPTION OF CORRECTIVE ACTIONS

The Administrative Control Program (ADM-19.29) at North Anna was revised to include the locked open condition for the Boric Acid Storage Tank Vent Valves (1-CH-66, 107, and 125). The vent valves were locked open. The Operability Program for the Boron Evaporator Bottoms Tank vacuum breaker was implemented by the development of a Periodic Test Procedure.

2. ACTIONS TAKEN TO AVOID FURTHER DEVIATIONS

Based on a review of these events, it has been determined that they are isolated occurrences and that the administrative controls are adequate as demonstrated by the large number of items that have been satisfactorily controlled.

3. DATES WHEN THESE ACTIONS WERE OR WILL BE COMPLETED

No further actions required.

NRC COMMENT

2. VEPCO's response and commitments to NUREG 0737, TMI Action Plan,

are described, in part, in their November 10, 1980 report that was revised May 31, 1981; October 31, 1981; and May 31, 1982. In response to Item II.F.1.6 (Containment Hydrogen Monitor), VEPCO stated in Paragraph 2, "Continuous indication of containment hydrogen content is available in the control room within 30 minutes of the initiation of safety injection." Additionally, the Nuclear Reactor Regulation (NRR) Safety Evaluation dated April 21, 1983, which accepted VEPCO's resolution of Item II.F.1.6, was based on the above submittals.

Contrary to the above, neither procedures nor training were established to ensure continuous indication of containment hydrogen content in the control room within 30 minutes of the initiation of safety injection. This condition existed from the January 1, 1983 implementation date to March 16, 1984, when standing order No. 123 was issued to provide interim instructions.

This deviation applies to both units.

RESPONSE

1. DESCRIPTION OF CORRECTIVE ACTIONS

When informed of this deviation, a standing order was written to require the verification of the start of the Hydrogen Analyzers and the Heat Tracing System. When the Emergency Operating Procedures were implemented at North Anna, Procedure 1-EOP-0 "Reactor Trip or Safety Injection" was revised to require the verification of the start of the Hydrogen Analyzers and the associated Heat Tracing as an immediate action and then the standing order was cancelled. Training of licensed operating personnel has been conducted.

2. ACTIONS TAKEN TO AVOID FURTHER DEVIATIONS

No further actions are required.

3. DATES WHEN THESE ACTIONS WERE OR WILL BE COMPLETED

No further actions are required.