

VIRGINIA ELECTRIC AND POWER COMPANY
RICHMOND, VIRGINIA 23261

October 8, 1996

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

Serial No.	96-483
NAPS/JHL	R4
Docket Nos.	50-338
	50-339
License Nos.	NPF-4
	NPF-7

Gentlemen:

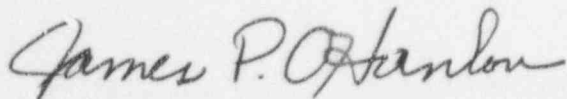
VIRGINIA ELECTRIC AND POWER COMPANY
NORTH ANNA POWER STATION UNITS 1 AND 2
INSPECTION REPORT NOS. 50-338/96-07 AND 50-339/96-07
REPLY TO THE NOTICES OF VIOLATION

We have reviewed your letter of September 9, 1996, which referred to the inspection conducted at North Anna Power Station from June 30, 1996 through August 10, 1996, and the associated Notices of Violation which were reported in Inspection Report Nos. 50-338/96-07 and 50-339/96-07. Our reply to the Notices of Violation is provided in Attachment 1. A summary of commitments is provided in Attachment 2.

We are concerned with the ongoing potential for a developing attitude of complacency as evidenced in some of the enclosed violations. A task team was previously established to identify complacency factors and recommend corrective actions. In response to this concern, complacency factors have been incorporated into the Station Performance Annunciator Program. We will continue to focus management attention in this area.

If you have any further questions, please contact us.

Very truly yours,



James P. O'Hanlon
Senior Vice President - Nuclear

Attachments

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cc: U. S. Nuclear Regulatory Commission
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Mr. R. D. McWhorter
NRC Senior Resident Inspector
North Anna Power Station

ATTACHMENT 1

REPLY TO NOTICES OF VIOLATION INSPECTION REPORT NOS. 50-338/96-07 AND 50-339/96-07

NRC COMMENT

During an NRC inspection conducted on June 30 through August 10, 1996, violations of NRC requirements were identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," NUREG 1600, the violations are listed below:

- A. 10 CFR 50, Appendix B, Criterion V, and the licensee's Quality Assurance Program (Updated Final Safety Analysis Report, Chapter 17, Quality Assurance, Section 17.2.5, Instructions, Procedures and Drawings) collectively require that activities affecting quality shall be prescribed by documented procedures of a type appropriate to the circumstances and shall be accomplished in accordance with these procedures. Technical Specification 3.6.3.1 requires that one isolation valve be maintained operable in each containment penetration.

Contrary to the above, on August 2, 1994, an inadequate maintenance procedure was used to control maintenance activities affecting quality. Specifically, Maintenance Operating Procedure 1-MOP-51.03, Installation and Removal of N2 or Air Rig for Residual Heat Removal (RHR) HX CC Valve Actuators, revision 0-P1, was inadequate, in that, it was used to control maintenance activities which disabled all isolation valves in a Unit 1 containment penetration for approximately four hours.

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

- B. 10 CFR 20.1904 (a) requires that each container of licensed material bear a durable, clearly visible label bearing the radiation symbol and the words "CAUTION, RADIOACTIVE MATERIAL" or "DANGER, RADIOACTIVE MATERIAL," and the label must also provide sufficient information (such as the radionuclide(s) present, an estimate of the quantity of radioactivity, the date for which the activity is estimated, radiation levels, kinds of materials, and mass enrichment) to permit individuals handling or using the containers, or working in the vicinity of the containers, to take precautions to avoid or minimize exposures.

Contrary to the above, at approximately 1:45 p.m., on August 6, 1996, a full trailer container, designated as number 4A, with licensed material was found inside the protected area without the required label information. The label did not provide sufficient information (e.g., an estimate of the quantity of radioactivity, the date for which the activity is estimated, radiation levels, kinds of materials, and mass enrichment) to permit individuals handling or using the containers, or working in the vicinity of the containers, to take precautions to avoid or minimize exposures.

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

- C. Technical Specification 6.8.1 requires, in part, that written procedures be established, implemented and maintained covering the activities referenced in the applicable procedures recommended in Appendix A of NRC Regulatory Guide 1.33, revision 2, dated February 1978. Paragraph 7.e of Appendix A to Regulatory Guide 1.33 states that the licensee should have written radiation protection procedures.

Virginia Power Administrative Procedure 2101, Radiation Protection Program, revision 10, dated June 25, 1996, section 6.7, Control of Radioactive Material, states, "Radioactive material controls shall be implemented to minimize the potential for uncontrolled spread of radioactivity to unrestricted areas where the public might be affected."

Contrary to the above, at approximately 4:55 a.m., on February 29, 1996, radioactive material controls were not implemented to minimize the potential for uncontrolled spread of radioactivity to unrestricted areas, in that, a contract employee with contaminated clothing above free release limits was permitted to exit the site from the West Security Portal.

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

REPLY TO NOTICE OF VIOLATION A

1. REASON FOR THE VIOLATION

The reason for the violation was an improper understanding and application of a Technical Specification requirement.

In order to replace the solenoid for trip valve 1-CC-TV-103B (B Residual Heat Removal Heat Exchanger (RHR) to Component Cooling outlet isolation valve), the valve was jumpered open in accordance with Maintenance Operating Procedure 1-MOP-51.03, Installation and Removal of N2 or Air Rig for RHR HX CC Outlet Valve Actuators. This evolution rendered the trip valve's automatic containment isolation function inoperable. With the automatic containment isolation function for 1-CC-TV-103B inoperable, the requirements of Technical Specification 3.6.3.1 could no longer be met since 1-CC-TV-103B provides only single isolation. The requirements of Technical Specification 3.0.3 should have been entered when 1-CC-TV-103B was rendered inoperable.

Prior to the repair, containment isolation requirements for the affected penetration had been evaluated. The Station Nuclear Safety and Operating Committee (SNSOC) approved the use of the component cooling water system piping as the containment isolation boundary, based on an interpretation that the component cooling water system is a closed system and the associated piping system boundary fulfills the requirements for a containment isolation barrier that can withstand a single active failure.

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

The SOV replacement was satisfactorily completed and trip valve 1-CC-TV-103B was returned to service. The duration of 1-CC-TV-103B inoperability was less than the four hour Action Statement requirement of Technical Specification 3.6.3.1.

1-MOP-51.03 has been deleted. A review of similar procedures associated with containment isolation valves in penetrations with only one isolation valve was performed. This review identified additional procedures that provide instructions to jumper the RHR Heat Exchanger to Component Cooling outlet isolation valves to maintain RHR operable. These procedures were subsequently revised to enter Technical Specification 3.0.3 if jumpers were to be installed to maintain RHR operable.

SNSOC members have been coached on maintaining verbatim compliance with Technical Specification requirements.

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

A Technical Specification change will be considered to address the issue of containment penetrations with only one isolation valve as part of the North Anna conversion to the Improved Technical Specifications.

4. THE DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

Full compliance has been achieved.

REPLY TO NOTICE OF VIOLATION B

1. REASON FOR THE VIOLATION

The reason for the violation was personnel error in labeling. Health Physics (HP) personnel did not correctly maintain a radioactive material label on a container that was being stored in the protected area yard. The radioactive material label that was applied to the container showed residual data entry, however, due to improper application of the label, the data had deteriorated to the point where it was no longer legible. The label employs a clear adhesive laminate to cover and protect the data written on the underlying label. The label removed from the container appears to have had data written on the top of the laminate cover after it was sealed to the label.

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

The label on the container was removed, the container was surveyed for radiation and contamination levels, the contents were visually verified, and the container was properly relabeled in accordance with 10 CFR 20.1904(a).

An inspection was performed to ensure other applications of this type label were adequate. No additional discrepancies were identified.

This event and associated corrective actions were discussed with HP personnel during a departmental meeting.

Personnel performing routine posting walkdowns have been coached on proper labeling and instructed to ensure proper labeling of equipment as part of their walkdown.

Contract Health Physics Technician Training materials were revised to include a discussion of this event.

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

This event will be included in the next cycle of the Health Physics Technician Continuing Training Program.

4. THE DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

Full compliance was achieved when the seavan was surveyed for radiation and contamination levels, the contents were visually verified, and the seavan was properly relabeled in accordance with 10 CFR 20.1904(a).

REPLY TO NOTICE OF VIOLATION C

1. REASON FOR THE VIOLATION

The reason for the violation was personnel error and failure to follow procedure. Health Physics (HP) personnel did not correctly resolve the source of contamination on an individual following the alarming of a portal monitor. In addition, personnel did not follow the requirements of VPAP-2101 and HP Procedure 1041.052 for controlling radioactive material.

Following the alarming of a portal monitor at the personnel decontamination area, a HP technician surveyed the contaminated individual and instructed the individual to take a decontamination shower. After the decontamination shower, the HP technician concluded that the contamination source may have been internal. The contaminated individual was subsequently sent to Exposure Control for a whole body count. The specialist performing the whole body count identified an uptake and communicated this to the HP technician designated as the night shift Exposure Control lead technician. This technician advised the specialist to follow HP procedures which required the contaminated individual to remove his clothing and don a paper suit for another whole body count. The same specialist performed the second whole body count. The second whole body count was significantly less than the initial whole body count and below procedure action levels. The individual was informed of his exposure and he redressed in the contaminated clothing.

The contaminated individual subsequently alarmed the portal monitor at the Security Building and a Security Officer reported the alarm to HP. An inadequate review of the whole body count documentation was performed and Security was informed that the alarm was due to an internal uptake and the individual was allowed to leave the site.

In addition, HP Procedure 1041.052 was not followed. The procedure requires the approval of HP Supervision to authorize the release of an individual from an RCA with contamination greater than 100 counts per minute (cpm). The procedure also requires the Supervisor HP Operations (or designee) to authorize the release of an individual from the site with contamination greater than 100 cpm. The required authorizations were not obtained prior to the release of the individual from the RCA and subsequently from the site.

The next morning the positive whole body counts were reviewed by supervision and it was determined that the individual's contaminated clothing had been released offsite.

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

Upon discovery that contaminated clothing was released from the site, HP technicians were dispatched to retrieve the garment and survey the individual's room and vehicle. Area surveys confirmed that there had been no spread of contamination. The contaminated clothing was retrieved.

HP personnel involved in the event were appropriately disciplined.

Standing Order #46, Response to positive whole body count with suspected clothing contamination, was issued to provide guidance to HP personnel for dealing with personnel that alarm portal or personnel contamination monitors (e.g., notify the HP Shift Supervisor if a personnel contamination monitor alarms but activity is less than or equal to 100 cpm). This standing order and the description of the event were discussed during HP group meetings to enhance HP personnel awareness.

HP Procedures 1041.052 and 1061.020 were revised to include the requirements of Standing Order #46. Standing Order #46 was subsequently deleted.

The event description and the revised requirements of HP-1041.052, and HP-1061.020 were discussed during HP continuing training. In addition, appropriate HP personnel practiced with the procedure for handling personnel with significant intakes / uptakes during HP continuing training.

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

No further corrective actions are required.

4. THE DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

Full compliance has been achieved.

ATTACHMENT 2

COMMITMENTS SUMMARY

Violation A

1-MOP-51.03 has been deleted. A review of similar procedures associated with containment isolation valves in penetrations with only one isolation valve was performed. This review identified additional procedures that provide instructions to jumper the RHR Heat Exchanger to Component Cooling outlet isolation valves to maintain RHR operable. These procedures were subsequently revised to enter Technical Specification 3.0.3 if jumpers were to be installed to maintain RHR operable.

Enhancement Item

A Technical Specification change will be considered to address the issue of containment penetrations with only one isolation valve as part of the North Anna conversion to the Improved Technical Specifications.

Violation B

None.

Enhancement Item

This event will be included in the next cycle of the Health Physics Technician Continuing Training Program.

Violation C

HP Procedures 1041.052 and 1061.020 were revised to provide guidance to HP personnel for dealing with personnel that alarm portal or personnel contamination monitors (e.g., notify the HP Shift Supervisor if a personnel contamination monitor alarms but activity is less than or equal to 100 cpm).