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VIRGINIA ELECTRIC AND POWER COMPANY
RICHMOND, VIRGINIA 23261

W. L. STEWART
VICE PRESIDENT
NUCLEAR OPERATIONS

September 19, 1985

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

Serial No. 85-543
NAPS/JHL:cfm
Docket Nos. 50-338
50-339
License Nos. NPF-4
NPF-7

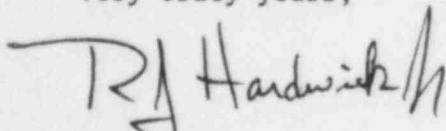
Dear Dr. Grace:

We have reviewed your letter of July 19, 1985, in reference to the inspection conducted at North Anna Power Station from June 3 to July 7, 1985, and reported in Inspection Report Nos. 50-338/85-16 and 50-339/85-16. Our response to the Notice of Violation is addressed in the attachment.

Also attached are responses to additional examples of items that are related to the items in the Notice of Violation. These additional examples were detailed in Inspection Report Nos. 50-338/85-18 and 50-339/85-18. This expanded response was discussed by telephone on August 19, 1985 between Mr. S. A. Elrod and Mr. R. J. Hardwick and between Mr. M. W. Branch and Mr. E. R. Smith, Jr. It was understood during these conversations, that the response to Inspection Report Nos. 85-16 would be delayed to include responses to the additional, related examples cited in Inspection Report Nos. 85-18.

We have determined that no proprietary information is contained in the report. Accordingly, Vepco 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 ELECTRIC AND POWER COMPANY TO Dr. J. Nelson Grace

(w/attachment)

cc: Mr. Roger D. Walker, Director
Division of Project and Resident Programs

Mr. Edward J. Butcher, Acting Chief
Operating Reactors Branch No. 3
Division of Licensing

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

RESPONSE TO NOTICE OF VIOLATION
ITEM REPORTED DURING NRC INSPECTION
CONDUCTED FROM JUNE 3 TO JULY 7, 1985
INSPECTION REPORT NOS. 50-338/85-16 AND 50-339/85-16

NRC COMMENT:

Technical Specification (TS) 6.8.1 requires that written procedures be established, implemented and maintained covering the areas recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978, which includes the areas of equipment control (tagging and locking), Emergency Core Cooling Systems, record retention and review and control of maintenance, repair, replacement and modification work.

1. North Anna Power Station Administrative Procedure (ADM) 14.0, Tagging of Systems and/or Components (March 31, 1983), references the VEPCO Accident Prevention Manual to provide the requirements for using tags to provide isolation to perform work activities. On June 25, 1985, mechanical danger tag number 403180 (tag-out N1203091) was found on the floor unattached to the designated valve while the tag was still active and required.
2. 1 and 2-OP-7.10A, Casing Cooling (July 13, 1983 - May 30, 1985), and 1 and 2-OP-7.10, Casing Cooling Subsystem of the Recirculation Spray System (December 31, 1983 and May 24, 1984), are procedures that provide guidance for aligning and operating the casing cooling subsystem. These procedures require that both the inlet and outlet isolation valves of the secured casing cooling chiller unit be closed. On June 20, 1985, the secured chiller for the casing cooling subsystem on each unit was found with the outlet valve open.
3. ADM 6.5, Completing and Forwarding Documents to Station Records (November 8, 1984), requires station departments to forward completed documents to Station Records. On June 25, 1985, Operating Procedure 1-OP-12.3, High Radiation Liquid Sampling System (May 16, 1985), was found still laying in the work area.
4. ADM 9.6, Control of Welding Materials (December 4, 1984), specifies the proper controls for welding materials. On June 25, 1985, one stick of welding wire (No. 21960/308-1/16) was found unattended on the floor of the auxiliary building.
5. Design Change Package (DCP) 84-26, Addition of Emergency Lighting North Anna 1 and 2, requires that all lamp heads in the designated areas be mounted eight feet plus or minus one foot above finished floor. Various lamp heads in areas where the above requirement applied were mounted above or below the specified heights.
6. On July 22, 1985, the plant developed a primary leak that placed it in the action statement for high unidentified leakage. The leak

was subsequently found to be in a primary sample line which was isolated, satisfying the action statement and preventing plant shutdown. During this event the licensee discovered that a sample system trip valve 1-TV-SS-109B had been left open. The mis-positioning of this valve allowed the licensee to identify the leak, since, if the valve had been shut there would have been no path from the primary to the sample line failure.

7. On June 1, 1985, with projected doses to the unrestricted areas within TS limits and, with a health physics recommendation to use the demineralizers, liquid radwaste was again discharged without treatment. In this case, an improper valve lineup allowed much of the liquid clarifier flow to bypass the operational demineralizer. As a result of prior instances, the licensee committed to instructing operations personnel on the importance of clarifier demineralizer status and reviewing operating procedures for adequacy. The last instance, though not a violation of TS, reinforced the need to complete these actions.
8. During a routine inspection of the plant, the inspectors found a piece of measuring equipment marked NQC-PSE 2676. The calibration sticker indicated the equipment had been due for calibration March 7, 1985. This resulted from a failure to follow ADM 12.0.
9. ADM 2.19, ISI (Inservice Inspection) Personnel Certification and Training for Visual Examinations VT-2, VT-3, and VT-4 (September 27, 1984) , in part requires that the station maintain the qualification records of the visual inspectors and those of the ISI supervisor. A review of selected training records revealed that some inspection qualification records were missing or incomplete.
10. ADM 19.27, Control and Use of Operator Aids (August 8, 1983), requires quarterly audits of the operator aid log and prescribes the required documentation of these audits. The audits are not being documented as required, making it impossible to determine if the audits are being done.

Contrary to the above TS, the referenced procedures were not fully implemented.

This is a Severity Level V violation (Supplement I) and applies to both units.

RESPONSE:

1. ADMISSION OR DENIAL OF THE ALLEGED VIOLATION:

Violation example 1 is correct as stated.

Violation example 2 is correct as stated.

Violation example 3 is correct as stated.

Violation example 4 is correct as stated.

Violation example 5 is not correct as stated. Design Change Package (DCP) 84-26 did state that all lamp heads were to be mounted at an elevation of 8 feet plus or minus 1 foot. The note in section 4.0, Instructions, was intended to be used as construction guide only. The construction drawing (#739122/8426-FE-68B) has general notes for placement of the lamp heads. The exact location was to be determined in the field to permit adequate access/egress paths and for illumination of specified equipment.

Vepco evaluated the DCP to determine if a field change was needed in order to install the lamp heads in their current position. It was determined that no field change was needed since the note in Section 4.0, Instructions, was to be used as a construction guide only.

Violation example 6 is correct as stated.

Violation example 7 is correct as stated.

Violation example 8 is correct as stated.

Violation example 9 is correct as stated.

Violation example 10 is correct as stated.

2. REASONS FOR THE VIOLATION:

Violation example 1. This violation was the result of a personnel error. The mechanical danger tag was inadvertently detached from the designated valve.

Violation example 2. An operator was working with maintenance personnel that were troubleshooting the casing cooling chillers. The operator failed to use an operating procedure while shifting the valve lineup of the chillers.

Violation example 3. 1-CP-12.3 was being used as a checkoff for maintenance activities and was not used for the performance of liquid sampling of the post accident sampling system. The procedure should still have been forwarded to station records in accordance with ADM 6.5.

Violation example 4. Maintenance personnel received some equipment from Stores in order to perform their work. When they arrived on the job site, it was realized that additional equipment was needed to perform the job. The maintenance personnel left the weld wire on the job scene and went back to Stores for the additional equipment needed. Maintenance personnel did not follow the requirements of ADM 9.6.

Violation example 5. Vepco does not consider this to be a violation as explained in section 1 above.

Violation example 6. TV-SS-109B was in the open position and was not identified as being open because the position indication light was burned out. An operator was sent to cycle the valve and found that it was in the open position thus creating a leakage path. The operator closed the valve.

Violation example 7. Flushing of radiation monitor RM-LW-111 was in progress to clear the high background levels following resin transfer from the clarifier demineralizer. The operation was performed without administrative controls over locked valves in the flush path.

Violation example 8. The violation was due to personnel error. The individual that checked out NQC-PSE-2676 did not return it after work was complete. In addition, the notices of certification due and restriction of use were inadvertently sent to the wrong department. These circumstances resulted in the subject violation.

Violation example 9. Administrative requirements addressing the forwarding of visual examination verification records of inspection personnel to the Training Department did not exist.

Violation example 10. The audits of the operator aid log were not in strict conformance with ADM 19.27 because the operator aid log index was not signed and dated. The audits of the operator aid log were however performed in accordance with 1-MISC-31.

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

Violation example 1. The group that was performing the particular job function were given immediate training in the area and on the importance of following ADM 14.0, Tagging of Systems and/or Components.

Violation example 2. The Shift Supervisor and operator involved were counseled on adherence to 1/2-OP-7.10 and 7.10A.

Violation example 3. 1-OP-12.3 was forwarded to station records and the technicians using the procedure were reinstructed in following ADM 6.5 for proper handling of station procedures.

Violation example 4. The weld wire was removed from the floor and was properly stored. Welding personnel were reinstructed to follow the requirements of ADM 9.6, Control of Welding Materials.

In addition, ADM 13.0, Handling, Storage and Shipping was revised to incorporate additional controls on storage facility access. The controls are to ensure that non-company employees sign in and out of storage areas via an access authorization list.

Violation example 5. No corrective actions are necessary.

Violation example 6. The position indication light was repaired and TV-SS-109B was closed. The leak was then isolated.

Chemistry Department personnel have been reinstructed on procedures in regard to positioning sample system trip valves.

Violation example 7. Operations personnel were instructed with regard to the proper use of administrative controls and especially the meaning of pad locked valves. This instruction also dealt with the importance on verifying clarifier demineralizer status.

1-LOG-6E was revised to add verification of demineralizer bypass valve position to ensure valves are closed and locked.

Violation example 8. The following actions were performed:

- a. A Certification Due Form was initiated in accordance with Administrative Procedure 12.1. This notifies the responsible department that the equipment calibration was due.
- b. A Notice of Restriction Form was initiated in accordance with Administrative Procedure 12.1. This notice informs the responsible department that calibration is overdue and not to use the equipment.
- c. NQC-PSE-2676 was returned and was calibrated satisfactorily.

In the initiation of items a and b above, it was discovered that NQC-PSE-2676 was misidentified as belonging to Environmental Services versus Engineering and Construction. In other words, the two notices were issued to the wrong department. As a result, the NQC computer list was corrected to indicate the proper department responsible for the device.

Violation example 9. The visual examination certifications and records have been identified as being retained on file at the corporate office. Missing station training records are being identified and copies will be obtained.

Violation example 10. ADM 19.27 was revised to require the audit of the operator and log index to be conducted in accordance with 1-MISC-31.

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

Violation example 1. Personnel assigned to the maintenance department are attending formal classroom training that includes station administrative procedures which govern and define station policy.

Violation example 2. An operations directive will be issued to operations personnel requiring adherence to station procedures.

Violation example 3. No further corrective actions are necessary.

Violation example 4. No further corrective actions are necessary.

Violation example 5. No further corrective actions are necessary.

Violation example 6. No further corrective actions are necessary.

Violation example 7. 1-OP-22.14, Clarifier Discharge Demineralizers, will be revised to add verification of demineralizer bypass valve position being closed and locked.

Violation example 8. The NQC computer list will be reviewed to identify and correct other discrepancies in equipment responsibility assignments.

A training module is being written and training is being planned for supervisors and maintenance and test equipment (M&TE) check out point personnel.

Violation example 9. Copies of training records are being gathered to be transmitted to the Training Department.

Administrative Procedure 2.19 will be revised to require supervisors to transmit visual examination certifications and records to the Training Department.

Violation example 10. No further corrective actions are necessary.

5. THE DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED:

Violation example 1. Station Administrative Procedure training is expected to be completed by August 28, 1985.

Violation example 2. The operations directive will be issued to operations personnel by October 1, 1985.

Violation example 3. Full compliance has been achieved.

Violation example 4. Full compliance has been achieved.

Violation example 5. Full compliance has been achieved.

Violation example 6. Full compliance has been achieved.

Violation example 7. 1-OP-22.14 will be revised by November 1, 1985.

Violation example 8. The NQC computer list will be reviewed to identify and correct further discrepancies by December 1, 1985.

Training for supervisors and M&TE checkout point personnel will be completed by April 1, 1986.

Violation example 9. Records will be forwarded to the Training Department and ADM 2.19 will be revised by October 4, 1985.

Violation example 10. Full compliance has been achieved.