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Perry Nuclear Power Plant
Docket No. 50-440
Reply to a Notice of Violation

Ladies and Gentlemen:

Enclosed is the Perry Nuclear Power Plant reply to the Notice of Violation contained in NRC Integrated Inspection Report No. 50-440/96-05, which was transmitted by letter dated October 8, 1996. The Notice of Violation involves a case where a deficiency in a safety-related valve was not formally documented in a timely manner.

If you have questions or require additional information, please contact Mr. James D. Kloosterman, Manager-Regulatory Affairs, at (216) 280-5833.

Very truly yours,

for

Lew W. Myers
Vice President-Nuclear

Enclosure

cc: NRC Region III Administrator
NRC Resident Inspector
NRC Project Manager

IE01

REPLY TO A NOTICE OF VIOLATION

Violation 96005-02

Restatement of the Violation

10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action" requires that measures be established to assure that conditions adverse to quality such as deficiencies, deviations and nonconformances, are promptly identified and corrected.

Contrary to the above, a condition adverse to quality discovered on July 22, 1996, regarding a containment vacuum breaker valve deficiency was not processed promptly. Specifically, the associated Potential Issue Forms were not brought to the control room as required for prompt review and evaluation for safety significance until July 24 and 25, 1996. (50-440/96005-02)

This is a Severity Level IV violation (Supplement 1)

Background

On July 22, 1996, Instrument and Controls (I&C) were performing corrective maintenance to investigate and repair a dual position indication on a containment vacuum breaker in the Containment Vacuum Relief system (M17). During the work evolution, which was also being observed as part of a maintenance self-assessment, maintenance workers discovered that a bolt was not sufficiently depressing the actuating pin to provide an OPEN position signal. It was determined that a linkage arm which connects the actuating bolt to the arm which opens the vacuum breaker pallet was bent.

The workers removed and straightened the linkage arm and replaced the indicating light switch. The vacuum breaker was then operated and the pallet stop was adjusted to prevent overtravel, which was believed to be the cause of the bent linkage. The workers then returned to the shop. Upon returning to the shop, the workers discussed the job with an I&C supervisor. The I&C supervisor decided that a Potential Issue Form (PIF) was not needed since the problem had been corrected, and there were no current indications of problems with the other three M17 vacuum breakers.

On July 22, 1996, independent of the discussion between the I&C supervisor and the I&C technicians, the Maintenance self-assessment team performed an evaluation of the work activity. The cause of the dual position indication, which was believed to be bent linkage, was discussed and a decision was made to initiate a PIF to identify the as-found condition of the vacuum breaker. The Maintenance self-assessment job observer was a supervisor-in-training. However, he was not performing any supervisory duties at the time and was assigned the specific assignment to initiate the PIF.

On July 23, 1996, the Maintenance self-assessment observer initiated the PIF; however, he did not take the PIF to the control room. The following day the Maintenance self-assessment observer was off-site for the entire day and the PIF was not delivered to the control room on this day either.

On July 24, 1996, the Maintenance Manager followed-up on the PIF initiation status and discovered that a PIF had not been submitted to the control room. The Maintenance Manager directed an I&C supervisor to initiate a PIF to identify the as found condition of the M17 vacuum breaker, and subsequently PIF 96-2573 was submitted to the control room.

On July 25, 1996, the Maintenance self-assessment observer returned to the site and was questioned by his supervisor about the PIF he had been assigned to write. The Maintenance self-assessment observer then delivered PIF 96-2578 to the control room as well.

Reason for the Violation

Communication weaknesses was determined to be the primary cause of this event. The Perry Maintenance Section (PMS) has a Maintenance Section Policy #9612, "PIF Process for PMS" which directs Maintenance supervisors to ensure that any item requiring a PIF is written before the end of shift. The Policy also states that PMS personnel will write PIFs when warranted during the performance of work.

The I&C supervisor who performed the post-job review with the technicians did not recognize the M17 valve deficiency as an issue which needed further evaluation via the PIF process. Because the vacuum breaker was not indicating properly and a troubleshooting work order had been initiated, the I&C supervisor expected that if a deficiency with the vacuum breaker was identified, it would be documented and repaired via the work order process. The deficiency identified, which affected position indication only and not valve operability, was identified and corrected on July 22, 1996, and successfully retested the following day. Additionally, the control room was aware of the work activity, the deficiency identified, and the corrective actions being taken. Also, there were no indications that this deficiency was affecting other vacuum breaker indications; therefore, the supervisor did not recognize the need to initiate a PIF.

The Maintenance self-assessment observer was a supervisor-in-training and had been working at the Perry Nuclear Power Plant (PNPP) for five days when he received the assignment to observe the M17 work activity as part of the Maintenance self-assessment. Although he had nuclear maintenance supervisory experience at another plant, he was unfamiliar with the PNPP corrective action process and expectations. He did not understand the expectation to deliver the PIF to the control room as quickly as possible. Additionally, he also took time to verify some of his assumptions before he initiated the PIF to ensure the issue was properly characterized. These factors contributed to the delay in submitting the PIF to the control room.

Corrective Steps Taken and Results Achieved

PIF 96-3187 was initiated to identify and evaluate the untimely reporting of a deficiency in a safety-related valve via the corrective action process.

The I&C superintendent coached and counseled the supervisors involved in this issue regarding expectations for the prompt identification of conditions with the potential to adversely affect quality.

Discussions were held with the Maintenance self-assessment observer to communicate expectations regarding PIF initiation. He now fully understands the need to submit PIFs to the control room in an expeditious manner to prevent delays in the corrective action process.

Corrective Steps that Will Be Taken to Avoid Further Violations

Timely reporting of conditions adverse to quality will be discussed in the next continuing training session for PMS, which will be completed by May 1, 1997. The training will cover the specific instance discussed in this Reply to Notice of Violation, the guidance in PAP-1608, "Corrective Action Program," pertaining to PIF initiation, and Maintenance Section Policy #9612, which requires supervisors to ensure any item requiring a PIF is written before the end of each shift.

Date When Full Compliance Will Be Achieved

Full compliance has been achieved.

The Maintenance Manager, Superintendents, and Supervisors will continue to reinforce expectations regarding the prompt identification of conditions with the potential to adversely affect quality during maintenance "tailgate" sessions.

Additionally, during the next PMS continuing training session, which is scheduled for completion by May 1, 1997, the specific example discussed in this Reply to a Notice of Violation will be discussed, including lessons learned, reinforcement of management expectations, PAP-1608, and Maintenance Section Policy #9612 requirements.

As an additional enhancement, Maintenance Section Policy #9612, was revised to clarify that "PIFs are the most effective way to identify areas that need improvement. The PIF process is not intended to be punitive or used as a method to identify personnel performance deficiencies, but rather, as a vehicle for improvement and lessons learned. The process allows us the opportunity to be self critical by identifying problems, apply uniform and consistent corrective actions, and to evaluate the effectiveness of corrective actions." Although there was not a "reluctance" to initiate a PIF for this issue, it is expected that this philosophy will promote consistent utilization of the PIF process within PMS.

The following table identifies those actions which are considered to be regulatory commitments. Any other actions discussed in this document represent intended or planned actions, are described for the NRC's information, and are not regulatory commitments.

COMMITMENT
None