NRC FORM 366 U.S. NUCLEAR REGULATORY COMMISSION
(6-1998)

LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

APPROVED BY OMB NO. 3150-0104 EXPIRES 06/30/2001

Estimated burden per response to comply with this mandatory information collection request: 50 hrs. Reported lessons learned are incorporated into the licensing process and fed back to industry. Forward comments regarding burden estimate to the Records Management Branch (T-6 F33), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, and to the Paperwork Reduction Project (3150-0104), Office of Management and Budget, Washington, DC 20503. If an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
River Bend Station	05000-458	1 OF 4

TITLE (4)
Inadequate Drywell Air and Suppression Pool Average Water Temperature Surveillances during a Plant Modification of Control Room Recorders Due to Communication Failures and Inadequate Procedure

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
01	15	1999	99	--01 --	01	02	01	2000	FACILITY NAME	DOCKET NUMBER

		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)			
OPERATING	1	20.2201(b)	20.2203(a)(2)(v)	X 50.73(a)(2)(i)	50.73(a)(2)(viii)
POWER	92	20.2203(a)(1)	20.2203(a)(3)(i)	50.73(a)(2)(ii)	50.73(a)(2)(x)
		20.2203(a)(2)(i)	20.2203(a)(3)(ii)	50.73(a)(2)(iii)	73.71
		20.2203(a)(2)(ii)	20.2203(a)(4)	50.73(a)(2)(iv)	OTHER
		20.2203(a)(2)(iii)	50.36(c)(1)	50.73(a)(2)(v)	Specify in Abstract below or in NRC Form 366A
		20.2203(a)(2)(iv)	50.36(c)(2)	50.73(a)(2)(vii)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER (Include Area Code)
D. N. Lorfing, Supervisor – Licensing	225-381-4157

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX

SUPPLEMENTAL REPORT EXPECTED (14)		EXPECTED	MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE).	X NO				

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

ABSTRACT

On January 15, 1999, with the plant in mode 1, inadequate performance of the suppression pool average temperature surveillance was identified. The inadequate performance occurred during implementation of a Containment Monitoring System (CMS) (*IK*) recorder modification. On the morning of January 11, 1999, the modification removed indication at the Division II CMS recorders in the main control room but did not affect back panel indication availability. On January 12, 1999, Control Room operators recorded notes on Surveillance Test Procedure (STP)-000-0001, Daily Operating Logs, which noted that Division II CMS recorders were out-of-service due to the recorder modification. The suppression pool average water temperature surveillance was performed using five indicators available from Division I. The bases for the surveillance requires the use of all functional indicators. Since the back panel information was not accessed, this resulted in an inadequate surveillance for suppression pool average temperature in that all functional indicators were not used. Upon discovery, the Control Room Supervisor (CRS) directed the operators to use back panel indications. The suppression pool average temperature surveillance was performed properly. During the investigation for the suppression pool average temperature, discovery was made that the drywell average temperature surveillance, SR 3.6.5.5.1, was also incorrectly performed during the modification. These events were not safety significant.

REPORTED CONDITION

On January 15, 1999, with the plant in mode 1 (power operation), inadequate performance of the suppression pool average temperature surveillance was identified. The inadequate performance occurred during implementation of a Containment Monitoring System (CMS) (*IK*) recorder modification. On the morning of January 11, 1999, the modification removed indication at the Division II CMS recorders in the main control room. These recorders are normally used to perform the subject surveillance. Back panel suppression pool temperature indication availability was not impacted. On January 12, 1999, the suppression pool average temperature surveillance was inadequately performed. Surveillance Requirement 3.6.2.1.1 requires the suppression pool average temperature be determined using all functional indicators every 24 hours and every 5 minutes when activities are in progress that could add heat to the suppression pool. All functional indicators were not used for the surveillance. The condition was not discovered until January 15, 1999. During the investigation, the drywell air temperature surveillance, SR 3.6.5.5.1, was found to be similarly affected. These conditions constitute operation prohibited by technical specifications that is reportable under 10 CFR 50.73(a)(2)(i)(B).

BACKGROUND

The suppression pool is a large volume of water at the bottom of the containment building that provides a medium for steam suppression during postulated design basis events. The suppression pool average temperature is monitored to ensure that the temperature remains within required limits necessary for the protection of the containment. The suppression pool average temperature surveillance, SR 3.6.2.1.1, is required, in modes 1,2 and 3, to be performed once every 24 hours and every 5 minutes when activities are in progress which could add heat to the suppression pool.

River Bend was upgrading Division II CMS recorders in the control room in January, 1999. A design modification had been developed, reviewed and approved to change the CMS recorders on a control room panel.

INVESTIGATION

Investigation of the event revealed that preparation and implementation of the modification/design package for the CMS recorders did not adequately consider impact on the performance of affected technical specification (TS) surveillances. The Operations Department review of the recorder replacement identified the post accident monitor technical specification but not the surveillance requirement for the suppression pool average temperature, or as was discovered later, the drywell air temperature.

When the work package was first presented to the work management center, a Senior Reactor Operator (SRO) rejected the work because he noted the need for alternate monitoring of the suppression pool temperature during the installation period while the Division II recorders were out-of-service. The SRO notified the Operations procedure group to request a temporary change to the Surveillance Test Procedure (STP). The Operations procedure group discussed the use of a temporary change and decided to use a note in the STP vice a change. The SRO's request was not documented or communicated to the group supervision. Additionally, the SRO contacted the plant modification and construction (PM & C) group and annotated the Operations Responsibility Checklist to note a need for a change to STP-000-0001; the change was marked as needed for return to service, (i.e. a permanent change to the procedure).

When the modification work package was being prepared for work again, the Plant Modification & Construction (PM & C) group checked on the change to the STP to ensure the change was made. PM & C was not aware of any information concerning a temporary change to the procedure. PM & C received a verbal response that the procedure was ready. Likewise when the modification work package was presented for work again, the work center SRO (the same SRO who had stopped the work earlier), asked about the procedure change and accepted a verbal response from PM & C that the procedure was ready for the modification. The SRO did not physically review the procedure. The work was permitted to commence and on day shift of January 11, 1999, the CMS recorder modification for Division II was started. Limiting Condition for Operation (LCO) 99-0003 was written on the post-accident monitors (PAM) technical specification and the day shift operators correctly annotated the STP for work on the PAM instruments. On night shift January 12, 1999, the STP surveillances were affected by the removal of the CMS recorders that were not PAM instruments. The control room operators incorrectly annotated the STP for LCO 99-0003 work and took only the data for the recorders that were available (Division I). At this time, SR 3.6.2.1.1 was inadequately performed because only five functional suppression pool temperature indicators were used to calculate the average temperature. This did not meet the requirements of Surveillance Requirement (SR) 3.6.2.1.1.

This condition continued for three days. Therefore, the condition was undetected until the original work center SRO, who was standing watch as the Control Room Supervisor (CRS), discovered the condition. He saw the discrepancy in STP-000-0001 and told the operators to commence using back panel indication to perform the surveillance.

During the investigation for the suppression pool average temperature, discovery was made that the drywell average temperature surveillance, SR 3.6.5.5.1, was also incorrectly performed during the modification. Only two indicators were used to perform the average temperature surveillance for drywell air temperature. The causes are considered to be the same as those related to the suppression pool average temperature surveillance problem.

ROOT CAUSE

After investigation and root cause analysis, the root causes were determined. Communications on the modification impact review did not identify all Technical Specification requirements affected by the modification. Second, verbal communications were also identified as a root cause due to the misunderstanding about the change needed to the STP for the modification to be implemented. The third root cause was written communication due to the STP omitting relevant information concerning the minimum number of indicators needed.

CORRECTIVE ACTIONS

Immediate action upon recognition of the event was to commence using the back panel indications to properly perform the STP. The condition report was initiated and work for the Division I CMS recorders was placed on hold.

Actions planned to correct deficiencies and prevent recurrence are:

- Qualification criteria required for Operations personnel reviewing the design package will be established.
- A method to track work package rejection will be developed.
- STP-000-0001 will be revised to specify the number of operable indicators required.

SAFETY EVALUATION

The suppression pool temperature did not exceed 95 degrees F (the TS limit is 100 degrees F) and no alarms were received in the control room for this parameter. Additionally, no activities were in progress that could have added heat to the suppression pool.

The high drywell ambient temperature alarm did not annunciate during the modification period and no changes were made in the drywell unit cooler alignment.

The systems affected by the inadequate surveillances were determined to be operable and capable of performing their safety function. Therefore, these events were not safety significant.

PREVIOUS EVENTS EVALUATION

Searches were performed on the site condition report database and INPO databases. No other events were identified that resulted in an inadequate surveillance with a similar root cause.

Note: Energy Industry Identification codes are identified in the text as (*XX*).

Department of Energy
Idaho Operations Office
850 Energy Drive
Idaho Falls, Idaho 83401-1563

February 4, 2000

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

SUBJECT: Reply to Notice of Violation (Docket 72-09) (INTEC-NRC-00-01)

REFERENCE: Letter, Chamberlain to Cook, NRC Inspection Report 72-09/99-02 and Notice of Violation, dated January 5, 2000.

Dear Sir/Madam:

Pursuant to the requirements of 10 CFR 2.201 and the instructions contained in the referenced Inspection Report and Notice of Violation, the Department of Energy Idaho Operations Office hereby submits a written statement concerning the violation and associated corrective actions. This transmittal contains no safeguards information.

If you have any questions concerning the written response to the violations, please contact Mark D. Gardner at (208) 526-5655.

Sincerely,

Beverly A. Cook
Manager

Enclosure

cc: Regional Administrator, Region IV

Notice of Violation.

License Condition 12 of the Fort St. Vrain Independent Spent Fuel Storage Installation Materials License SNM 2504, dated June 4, 1999, requires that the licensee shall follow the physical security protection plan entitled: DOE-ID Independent Spent Fuel Storage Installation Security Plan dated October 9, 1998 with subsequent modifications and as it may be further amended under the provisions of 10 CFR Parts 72.44(e) and 72.186.

Paragraph 3.2.12 of the Physical Security Plan, Revision 1, states that security procedures are established and maintained detailing the duties of security force members and other individuals responsible for security.

Paragraph 4.3.1 of FSV Security Procedure MCP-324, Revision 0, requires, upon receipt of an alarm, the Warning Communication Center (WCC) (secondary alarm station) operator to contact the FSV operator and request authentication to ensure the FSV alarm station operator is not under duress. Further, if contact cannot be made or the authentication indicates duress, the WCC operator contacts the Weld County Sheriff's Office and requests a response to the site.

Contrary to the above, during a demonstration of the procedure on December 16, 1999, the WCC operator failed to initiate authentication. In addition, the operator, after being informed of his failure, was not sufficiently familiar with the authentication system to recognize a correct authentication.

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

Reason for the Violation.

This violation is admitted. The Department of Energy's Idaho Operations Office (DOE-ID) acknowledges that failure to train the WCC Operators resulted in the lack of effectiveness of a security program implementing procedure.

Corrective Actions Taken and Results Achieved.

The WCC was contacted after the failed test and the reason for the failure was determined to be a failure to provide adequate instructions to personnel operating the WCC. The WCC operators were subsequently provided the appropriate instructions, including MCP-324. The reading of these instructions by WCC operators was documented and the test was repeated successfully on December 17, 1999 (the next day) in the presence of the NRC inspector.

The deficiency was entered in the deficiency tracking system. (This system provides for the documentation of deficiencies, assignment of responsible management, and tracking of corrective actions.)

Corrective Actions Planned to Avoid Further Violations.

To prevent recurrence of this deficiency, the appropriate instructions will be added to the WCC operators' training plans by February 24, 2000.

The corrective action described above to prevent recurrence is not an explicit commitment. The only commitment identified in this response is to achieve full compliance by December 17, 1999. Changes to the corrective action described above may be reviewed and approved as appropriate in accordance with the quality assurance controls on corrective actions.

Date When Full Compliance Will Be Achieved.

Full compliance was restored on December 17, 1999.