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SUBJECT: Responds to violations noted in Insp Rept 50-397/93-31. Corrective actions:technicians performing Tech Specs surveillance Procedure 7.4.3.3.1.58, "HPCS Sys Transfer on CST Low Level," did not stop & get resolution.

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November 8, 1993
G02-93-265

Docket No. 50-397

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

Gentlemen:

Subject: **WNP-2, OPERATING LICENSE NO. NPF-21**
NRC INSPECTION REPORT 93-31
RESPONSE TO NOTICE OF VIOLATION

The Washington Public Power Supply System hereby replies to the Notice of Violation contained in your letter dated October 7, 1993. Our reply, pursuant to the provisions of Section 2.201, Title 10, Code of Federal Regulations, consists of this letter and Appendix A (attached).

In Appendix A, the violation is addressed with an explanation of our position regarding validity, corrective action and date of full compliance.

Sincerely,

J. V. Parrish (Mail Drop 1023)
Assistant Managing Director, Operations

KBL/bk

Attachments

cc: BH Faulkenberry - NRC RV
NS Reynolds - Winston & Strawn
JW Clifford - NRR
DL Williams - BPA/399
NRC Site Inspector - 927N

IE01

Appendix A

During an NRC inspection conducted on August 3 through September 6, 1993, a violation of NRC requirements was identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," 10 CFR Part 2, Appendix C, the violation is listed below:

Technical Specification 6.8.1 states that "Written procedures shall be established, implemented and maintained covering ... applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978..." Appendix A of Regulatory Guide 1.33 recommends procedures for temporary changes, procedure adherence, surveillance tests and performing maintenance.

1. PPM 1.2.3, "Use of Controlled Plant Procedures," Revision 20, dated July 6, 1993, subsection 5.3.4c required that: "If the procedure is wrong or cannot be performed as written, stop and get resolution prior to proceeding."

   Contrary to the above, on August 18, 1993, technicians performing Technical Specifications Surveillance Procedure 7.4.3.3.1.58, "HPCS System Transfer on CST Low Level," did not stop and get resolution prior to deviating from Step 23 of subsection 7.2, which required that the system be filled with water "...until it just reaches the top of the high point vent..."

2. PPM 1.3.12, "Problem Evaluation Requests" (PERs), Revision 17, defined a condition adverse to quality as "any deficiency identified on safety-related equipment that significantly degrades its performance or renders it inoperable." Also, Section 6.1 of this PPM stated that "Any person who observes an actual problem or perceives a potential problem shall initiate a PER."

   Contrary to the above, on June 15, 1993, a QC Inspector, craftsmen, and craft supervisor observed an actual problem, the incorrect reassembly of MS-V-22, a safety-related solenoid valve, and did not initiate a PER.

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

EXAMPLE ONE: VIOLATION OF PROCEDURE PPM 7.4.3.3.1.58 "HPCS SYSTEM TRANSFER ON CST LOW LEVEL"

Validity of Violation

The Supply System acknowledges the validity of example one. This example consists of a failure to complete a procedure step as written, as well as a failure to obtain Shift Manager approval to deviate from the step. The root cause of the problem was less than adequate work practices. This inadequacy involved the associated Instrument and Control (I&C) technicians' perception of the manner in which they performed the procedure step. Specifically, the technicians believed that their actions satisfied the intent of the procedure; therefore, the technicians believed that it was unnecessary to get approval to deviate the procedure.

On August 18, 1993, I&C technicians began performing Technical Specifications Surveillance Procedure 7.4.3.3.1.58, "HPCS System Transfer on CST Low Level," Revision 5. Step 23 of the procedure directed the technicians to fill an instrument line until the water just reached the top of an associated high-point vent. Recognizing the associated water was potentially contaminated, the technicians believed they met the intent of the procedure step by filling to below the top of the line; thus, the technicians prevented spreading contamination from spillage. However, by not strictly following the procedure, the technicians violated the criterion of Technical Specification (TS) Administrative Limit 6.8.1. Additionally, failure to obtain the Shift Manager's approval to deviate from the exact wording of the procedure is a violation of plant procedure PPM 1.2.3 "Use of Controlled Procedures."

Corrective Actions Taken/Results Achieved

1. Acknowledging the potential for spreading contamination from spillage, on August 19, 1993, personnel promptly wrote a procedure deviation to reword PPM 7.4.3.3.1.58, "HPCS System Transfer on CST Low Level," Subsection 7.2, Step 23. Step 23 as revised directs the technicians to refill the instrument line without concern for overfilling the tubing. The procedure deviation was approved on September 1, 1993.

2. A review of this event was held with I&C Shop personnel by the I&C Supervisor. Additionally, the technicians directly involved in this event were advised of the lessons learned from this incident by the I&C Supervisor. These actions were completed by October 22, 1993.

3. A meeting of first-line supervisors was held on October 28, 1993, by senior management to reinforce the concept of strict adherence to procedures on a broad basis.

4. On October 6, 1993, the Managing Director issued an all-employee Interoffice Memorandum (IOM) concerning procedure compliance at WNP-2. In part, the IOM stated ... If a procedure is wrong or unclear, or it cannot or should not be completed in its present form, contact your supervisor for a decision about what is to be done before continuing."

Corrective Action to be Taken

No further corrective action is necessary.

Date of Full Compliance

The Supply System was in full compliance with procedures after discussing this example with applicable personnel and revising surveillance procedure PPM 7.4.3.3.1.58.

EXAMPLE TWO: "B" MAIN STEAM DUAL-SOLENOID PILOT VALVE MISORIENTATION

Validity of Violation

The Supply System acknowledges the validity of example two. The root cause of not writing a PER to document the misorientation of dual-solenoid pilot valve MS-SPV-22B2 was less than adequate work practices: a Quality Control (QC) Inspector, a Craft Supervisor, and craftsmen all observed the misorientation of MS-SPV-22B2 but did not question or fully investigate for cause.

On May 4, 1993, MWR AP1556 was signed by the Shift Manager to allow replacement of dual-solenoid pilot valve MS-SPV-22B2. On May 9, 1993, MWR AP1556 work instruction steps were completed, and the work package was transferred to operations for operability testing.

On June 13, 1993, operations commenced operability testing of MS-SPV-22B2. The test involved local testing by an equipment operator. As the operator restored MS-SPV-22B2's pneumatic supply to stroke the valve, the operator noticed that MS-SPV-22B2 unexpectedly leaked air. Shift management was informed of the problem and the test was subsequently terminated. Shift management requested Work Control to reissue another work request to troubleshoot and/or repair the valve in accordance with Revision 16 of PPM 1.3.7, "Maintenance Work Request."

On June 15, 1993, MWR AP4119 was implemented to troubleshoot, remove and rebuild MS-SPV-22B2. After rebuilding and reinstalling MS-SPV-22B2, it still leaked. A QC inspector witnessing the work determined that the valve was misoriented. After the valve was reoriented correctly, it stopped leaking; however, none of the persons immediately involved with the work (the QC Inspector, a Craft Supervisor, or the maintenance craftsmen) wrote a PER to address the problem.

Corrective Actions Taken/Results Achieved

1. The current PER Process (Revision 18 of PPM 1.3.12 "Problem Evaluation Request (PER)") and the associated maintenance work instructions (MWR AP4119) were evaluated to determine if they provided adequate direction to identify the root cause of problems associated with equipment being worked under the MWR process. Based on results of this evaluation, the Supply System believes that the MWR process provides an avenue to determine the root cause of events such as this incident. In this case, the work instructions written to troubleshoot the solenoid valve included words that directed technicians to "write a statement ... as to why ... the problem occurred." However, Supply System personnel did not effectively follow through with this direction, and thus, the root cause of the misorientation was not determined. The evaluation also determined that Revision 18 of PPM 1.3.12 adequately addresses the issue of writing a PER on equipment being worked under the MWR process.

2. The QC Inspector and the maintenance craftsmen directly involved with this incident were advised of the lessons learned from this incident on November 4, 1993.

Corrective Action to be Taken

Lessons learned from this event will be reviewed with Maintenance Shop, Operations, and QC personnel to emphasize the expectations for determining the root cause in similar cases and to restress the importance of a questioning approach in daily activities. This will be completed by January 31, 1994. In addition, these lessons learned will be incorporated in Post-Maintenance-Testing Training provided to Maintenance and System Engineers scheduled for November, 1993.

Date of Full Compliance

The Supply System was in full compliance with procedures when a PER was written on October 12, 1993 to document and investigate this violation.