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 PARRISH, J.V.    Washington Public Power Supply System  
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SUBJECT: Responds to violations noted in insp rept 50-397/94-33.  
 Corrective actions: redundant outboard containment isolation  
 valve deactivated isolating associated sample line.

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April 12, 1995  
GO2-95-070  
Docket No. 50-397

U. S. Nuclear Regulatory Commission  
Attn: Document Control Desk  
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Gentlemen:

Subject: **WNP-2, OPERATING LICENSE NO. NPF-21  
NRC INSPECTION REPORT 94-33  
REPLY TO A NOTICE OF VIOLATION**

Reference: Letter, dated March 14, 1995, AB Beach (NRC) to JV Parrish (SS), "Notice of Violation (NRC Inspection Report 50-397/94-33)"

The Washington Public Power Supply System (Supply System) hereby replies to the Notice of Violation (NOV) contained in the referenced letter. Our reply, pursuant to the provisions of Section 2.201, Title 10, Code of Federal Regulations, consists of this letter and Attachments A and B.

If you have any questions or desire additional information regarding this matter please contact me or D. A. Swank at (509) 377-4563.

Sincerely,

J.V. Parrish (Mail Drop 1023)  
Vice President, Nuclear Operations

JMP  
Attachments

cc: LJ Callan - NRC RIV  
KE Perkins, Jr. - NRC RIV, Walnut Creek Field Office  
NS Reynolds - Winston & Strawn  
JW Clifford - NRC  
DL Williams - BPA/399  
NRC Sr. Resident Inspector - 927N

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## Attachment A

### Violation A

Technical Specification (TS) Section 3.3.7.5 states "The accident monitoring instrumentation channels shown in Table 3.3.7.5-1 shall be operable ... With one or more accident monitoring channels inoperable, take the action required by Table 3.3.7.5-1."

Item 27 of Table 3.3.7.5-1 lists "Primary Containment Valve Position" as accident monitoring instrumentation, and references Action 80 as the required action to be performed if one channel is inoperable. Action 80.a of TS 3.3.7.5 states "With the number of operable accident monitoring instrumentation channels less than the required number of channels shown in Table 3.3.7.5-1, restore the inoperable channel(s) to Operable status within 7 days or be in at least Hot Shutdown within the next 12 hours."

Contrary to the above, as of January 18, 1995, primary containment valve position accident monitoring instrumentation was inoperable for greater than 7 days, but the plant was not placed in at least hot shutdown within the next 12 hours. Specifically, the valve position indication for PSR-V-X77A1, a primary containment isolation valve, was inoperable from January 6-19, 1995, but the plant was not placed in at least hot shutdown.

This is a Severity Level IV violation (Supplement I) (397/9433-02).

### Response to Violation

The Supply System accepts this violation.

#### 1. Reason for the violation

On January 18, 1995 following a surveillance to verify operability of the Post Accident Sample System (PASS) valves it was determined that control room indication for PSR-V-X77A1 (inboard containment isolation valve) failed to provide the required closed/not closed control room indication. A review showed that this condition had existed since August 17, 1994 with no compensatory action taken. The failure to comply with Technical Specification ACTION statement resulted from Technical Specification 3.3.7.5 not clearly identifying that control room indication was required to meet the Limiting Condition for Operation (LCO) requirements. A contributing cause for the event involved a communications weakness between Operations and Licensing regarding the required valve position indication.

Technical Specification 3.3.7.5, "Accident Monitoring Instrumentation," specifies the instrumentation necessary to ensure sufficient information is available to monitor plant conditions following an accident. To meet this Technical Specification the recommendations of Regulatory Guide 1.97, "Instrumentation For Light-Water-Cooled Nuclear Power Plants To Access Plant and Environs Conditions During and Following



An Accident," were implemented. The Regulatory Guide recommends closed/not closed control room indication for primary containment isolation valves.

Technical Specification 3.3.7.5 did not provide adequate detail on which valve position indication could be credited with satisfying the LCO. The Technical Specification Bases states that accident monitoring instrumentation capability is consistent with the recommendations of Regulatory Guide 1.97 but does not specify that control room indication is required. The plant's FSAR specifies control room indication as the required Regulatory Guide 1.97 indication for containment isolation valve position indication. Since the requirement that only control room indication be used to satisfy the Technical Specification LCO was not specified in the Technical Specification or Bases, operators had incorrectly credited the local PASS panel indication with satisfying the LCO.

During a previous concern over PASS valve indication on January 6, 1995 a Shift Manager contacted the Licensing Department to determine if open indication was required for PSR-V-X77A/1. The Shift Manager failed to inform Licensing that he had continuous closed indication in the control room for PSR-V-X77A/1. Licensing informed the Shift Manager that the required indication was closed/not closed indication; but failed to inform him that control room indication was required to meet the Technical Specification LCO.

2. Corrective steps that have been taken and the results achieved.

The redundant outboard containment isolation valve was deactivated isolating the associated sample line.

Operations crews were informed, via night order, that containment isolation valve indication in the control room was required to meet the LCO requirements for Technical Specification 3.3.7.5.

The Licensing staff has been advised of the need to investigate related documentation and to clearly communicate all information when assisting control room operators with Technical Specification LCO determinations.

3. Corrective steps that will be taken to avoid further violations.

The Technical Specification Bases will be revised by June 30, 1995 to clarify Technical Specification 3.3.7.5.

Control room operators will be instructed by April 30, 1995 to clearly communicate all information when determining a Technical Specification LCO applicability.

Control room operators will be advised by April 30, 1995 to investigate available and referenced documents, such as the FSAR, when determining Technical Specification LCO applicability.

Control room operators will review LER 95-03 and be briefed on the need for control room indication to meet Technical Specification 3.3.7.5 by April 30, 1995.

4. Date when full compliance will be achieved.

Full compliance was achieved on January 19, 1995 when the redundant containment isolation valve in the flow path with PSR-V-X77A1 was de-energized and secured in the closed position.

Attachment B

Violation B

TS 6.8.1 states, in part, "Written procedures shall be established, implemented, and maintained covering activities referenced below:

- a. The applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978."

Regulatory Guide 1.33 paragraph 8.b states that "implementing procedures are required for each surveillance test, inspection, or calibration listed in the technical specifications."

TS 4.1.3.6.b states "Each affected control rod shall be demonstrated to be coupled to its drive mechanism by ... verifying that the rod does not go to the overtravel position: anytime the control rod is withdrawn to the 'full out' position in subsequent operation."

TS 4.3.1.7.c states "the control rod position indication system shall be determined Operable by verifying: that the control position indicator corresponds to the control rod position indicated by the 'full out' position indicator when performing Surveillance Requirement 4.1.3.6.b."

The licensee formally implements these requirements by Plant Procedures Manual Procedure 9.3.9 which specifies the use of rod pull sheets that require signatures in reference to TS 4.1.3.6.b and 4.1.3.7.c.

Contrary to the above, as of January 11, 1995, on four occasions the licensee did not implement PPM 9.3.9, "Control Rod Development Sequence Withdrawal and Control," Revision 12, which documents the performance of TS Surveillance 4.1.3.6.b and 4.1.3.7.c. Specifically:

- On October 23, 1994, Control Rod 06-47 was pulled from Position 00 to 48, but the pull sheet was not signed off for the coupling check or the full-out lights.
- On October 29, 1994, Rod 42-59 was pulled from Position 00 to 48, but the pull sheet was not signed off for the coupling check or the full-out lights.
- On December 21, 1994, Rod 42-03 was pulled from Position 00 to 48, but the pull sheet was not signed off for the coupling check or the full-out lights.
- On January 5, 1995, Rod 02-19 was pulled from Position 46 to 48, but the pull sheet was not signed off for the coupling check or the full-out lights.

This is a Severity Level IV violation (Supplement I) (397/9433-01).



Response to Violation

The Supply System accepts this violation.

1. Reason for the violation

The failure to properly implement the requirements of PPM 9.3.9 following the movement of the identified control rods to position 48 resulted from operations personnel failing to adequately self-check and independently verify the completion of the coupling checks. A weekly surveillance which demonstrates control rod operability had been performed satisfactorily after each of the cited instances; thus reverifying the control rods in question were full out and coupled.

2. Corrective steps that have been taken and the results achieved.

Control room crews were coached regarding their responsibilities associated with control rod manipulations. This included the need for proper self-checking and independent verification; along with complete and accurate documentation of control rod manipulations.

The Control Room Supervisor has been assigned an oversight responsibility to review and initial control rod withdrawal sheets upon completion of rod movements that occur on his shift.

An Operation's supervisory audit task was created to review various documents generated by plant processes/programs and under the responsibility of the operators. This task involves an accuracy and completeness review of documents (e.g., Clearance Order book, Technical Specification Inoperable Equipment/LCO/Requirement for Operability book, Caution Tag book, Control Rod Pull Sheets, etc.) ensuring procedural requirements and management expectations are met.

In an effort to address the more generic concerns associated with inconsistent implementation of management's expectations regarding the self-checking and verification processes within Operations, the Operations department implemented the following actions:

- a. Issues related to human performance matters are discussed during crew meetings with the Operations Manager, Shift Manager meetings, Operations Manager group meetings, and Plant Manager vertical communications meetings with each crew.

- b. To reinforce the self-checking and verification processes, a program monitoring personnel performance has been implemented to provide feedback to the operators regarding performance issues.

The increased management/supervisory oversight of operator activities provides reinforcement of management's expectations for the self-checking and verification processes.

3. Corrective steps that will be taken to avoid further violations.

Based on the corrective actions taken, along with a heightened awareness of the need for proper self-checking and verification, no further corrective actions are planned at this time to address the associated self-checking and verification process failures. Corrective action 2.b provides continued monitoring and feedback to operators in this area.

4. Date when full compliance will be achieved.

Full compliance was achieved for each of the cited instances when the subsequent weekly rod exercising surveillance was performed and the controls rods in question were reverified to be operable.