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SHIELDS L. DALTROFF
VICE PRESIDENT
ELECTRIC PRODUCTION

October 6, 1980

Re: Docket Nos. 50-277
50-278

Inspection No. 50-277/80-16
50-278/80-14

Mr. Eldon J. Brunner, Chief
Reactor Operations & Nuclear Support Branch
US Nuclear Regulatory Commission
Region I
631 Park Avenue
King of Prussia, PA 19406

Dear Mr. Brunner:

Your letter of September 15, 1980 forwarded combined Inspection Reports 50-277/80-16 and 50-278/80-14. Appendix A addresses one item which did not appear to be in full compliance with Nuclear Regulatory Commission requirements. This item is categorized as a deficiency and is restated below with our response.

> Technical Specification 4.7.D.2 states in part..."Whenever an isolation valve listed in Table 3.7.1 is inoperable, the position of at least one other valve in each line having an inoperable valve shall be recorded daily."
>
> Technical Specification Table 3.7.1 lists drywell purge inlet isolation valves as applicable valves. Surveillance Test 5.3 "Inoperable Isolation Valve Position Daily Log," Revision 3, dated August 14, 1979 references Technical Specification 4.7.D.2 and states in part, "The purpose of this log is to record the position of at least one other valve in each line having an inoperable isolation valve."

Contrary to the above, from May 24 to June 19, 1980, there was no valve position logged for three parallel lines, each of which was in-line with inoperable isolation valve AO-3520. The parallel lines for which no valve position was logged contained valves AO-3519, AO-3521A, and AO-3521B, respectively.

Response

When it was discovered that valves AO-3519, AO-3521A, and AO-3521B were not being logged in Surveillance Test 5.3, Inoperable Isolation Valve Position Duty Log, they were expeditiously added to the surveillance test as noted in the details of the inspection report.

The incident was caused by individual operator error. The operator made an incorrect determination of which isolation valves were required to be closed according to ST 5.3 during the period when AO-3520 was inoperable. This failure to log all required valve positions did not present the potential for an abnormal occurrence because each of the three valves of concern were included in the closed panel checks conducted by the operator each shift as noted in the details of the inspection report. The checks would have revealed any abnormal positioning of these valves and administrative controls were in effect restricting the opening of containment ventilation valves during operation.

The responsible operator was counseled and the importance of correctly implementing the surveillance test was reemphasized. A review of the circumstances leading to this incident indicates that this was an isolated occurrence and requires no further action to prevent recurrence.

Very truly yours,