VIRGINIA ELECTRIC AND POWER COMPANY
RICHMOND, VIRGINIA 23261

R. H. LEASBURG
VICE PRESIDENT
NUCLEAR OPERATIONS

July 29, 1982

Mr. James P. O'Reilly,
Regional Administrator
U. S. Nuclear Regulatory Commission
Region II
101 Marietta Street, Suite 3100
Atlanta, Georgia 30303

Serial No. 310A
NO/RMT:acm
Docket Nos. 50-338
50-339
License Nos. NPF-4
NPF-7

Dear Sir:

By Letter Serial Number 310, dated June 11, 1982 we forwarded our response to your Inspection Reports numbered 50-338/82-08 and 50-339/82-08. The purpose of this letter is to resubmit our responses to two of the items shown in your report as there were minor errors in our initial response. Only those two items have been enclosed in this submittal.

If you have any questions or require any further information, please contact this office.

Very truly yours,

R. H. Leasburg

Attachment

cc: Mr. Robert A. Clark, Chief
Operating Reactors Branch No. 3
Division of Licensing

IE01

C. NRC COMMENT

Technical Specification 6.12.1 requires that a radiation monitoring device which continuously indicates the radiation dose rate in the area is required upon entry into a high radiation area. T.S.6.8.1 requires that procedures be implemented and maintained. Health Physics Procedure, Section 6, Exposure Control, states that an "RWP, pocket dosimeter, and dose rate meter are required for entry into a high radiation area".

Contrary to the above,

(1) On January 10, 1982, an operator entered a high radiation area to check an instrument, (PI-1-152) and did not have in his possession a radiation dose rate meter.

(2) On February 19, 1982, two engineers were observed taking data readings adjacent to the charging pumps, which is a high radiation area. They did not have a radiation measuring device, nor were they qualified in the use of a dose rate meter.

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

RESPONSE

1. ADMISSION OR DENIAL OF THE ALLEGED VIOLATION

The Notice of Violation is correct as stated.

2. REASONS FOR THE VIOLATION

The operator was under the impression that he could enter the high radiation area without notifying Health Physics personnel or obtaining a radiation dose rate meter if the situation was an emergency. He ascertained that time was of the essence to protect plant equipment important to safety. He was aware that the high radiation area existed and he did not obtain the Shift Supervisor's permission prior to entering the area.

The two engineers that were observed within a high radiation area taking data readings were aware of the Health Physics requirements to enter a high radiation area.

3. CORRECTIVE STEPS TAKEN RESULTS ACHIEVED

The Health Physics Technician who observed the operator exiting a high radiation area without a proper radiation device (dose rate meter) informed him of the violation. He was later counselled as to the correct procedures which must be followed when entering a high radiation area.

When the engineers were discovered in a high radiation area in violation with Health Physics Regulations, they were provided with health physics coverage until they obtained the required data in the area. They were then counselled by the Health Physicist for disregarding the high radiation barrier and disciplined accordingly.

4. CORRECTIVE STEPS WHICH WILL BE TAKEN TO AVOID FURTHER VIOLATIONS

The correct procedures for entering high radiation areas are emphasized in the General Employee Training Class which is mandatory before new employees may obtain security clearances to enter the exclusion area without an escort. This information is also re-emphasized in detail to every employee yearly in the annual Employee Retraining Program. An examination must be completed for each training class and a passing grade must be attained before an employee is issued a clearance or is allowed to maintain a current clearance.

On March 4, 1982, the Station Manager issued a memorandum to all Supervisors to ensure that all personnel are aware of their responsibilities in the area of Health Physics. It mentioned that violations of Health Physics barriers and regulations are in direct conflict with our policy of ALARA and will not be tolerated.

5. DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

Full compliance has been achieved.

D. NRC COMMENT

Technical Specification 6.8.1 requires that written procedures be established, implemented and maintained. Maintenance Procedure MMP-C-GP-1 section 5.3 requires approval of the Mechanical Maintenance Supervisor and Quality control prior to pump disassembly. Maintenance Procedure MMP-ADM-1.0, section III, states that approved maintenance procedures will be used on safety-related systems.

Contrary to the above:

(1) On March 10, 1982, two valves associated with the Casing Cooling System which were specified to be closed were erroneously left open. This event resulted in pumping of approximately 20,000 gallons of water onto the containment floor.

(2) On February 5, 1982, a safety-related service water pump was disassembled without the specific approval of the Mechanical Maintenance Supervisor and Quality Control as required by MMP-C-GP-1.

(3) On March 16, 1982, maintenance activities were performed on safety-related valves 2-FW-192, 2-FW-127 and 2-FW-129 without required procedures.

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

RESPONSE

1. ADMISSION OR DENIAL OF THE ALLEGED VIOLATION

(1) The notice of violation is correct as stated.

(2) The notice of violation is correct as stated.

(3) The notice of violation is denied.

2. REASONS FOR THE VIOLATION

(1) The periodic surveillance for the Containment Depressurization and Cooling System (2-PT-66.3) was being performed on March 10, 1982. One portion of this test is to verify that the Casing Cooling pumps start and discharge valves open on a containment depressurization actuation (CDA) signal. This portion of the test requires the manual isolation valve to be closed on the discharge of each Casing Cooling system to the suction of each outside recirculation spray pump suction. These valves are closed while cycling the series motor operated valves to prevent the Casing Cooling tank from draining by gravity into the recirculation spray sump and onto the containment floor. The manual isolation valves are located in the safeguards valve pit. The operator that was responsible for closing the valves did not personally verify that the normally open valves had been closed. The operator asked Maintenance personnel that were in the valve pit as to the valve positions in question. The Maintenance personnel that checked the valve position were not qualified to determine the valve positions and consequently reported the valves as being closed when they were actually open. The Casing Cooling discharge motor operated valves were opened during the test and the water was pumped into the containment.

(2) On February 5, 1982 the Unit 2 Service Water Pump 1A was removed from the Service Water Pump House and transferred to the No. 1 track bay for maintenance.

The work to remove the pump was commenced on day shift with no procedure. The night crew arrived on site and initiated a general pump procedure for repairing the pump. The general pump procedure requires the prior approval of the Mechanical Maintenance Supervisor and Quality Control to perform specific steps for pump disassembly. The signatures of the Mechanical Maintenance Supervisor and Quality Control were not obtained prior to disassembling the pump. The approval was obtained on February 6th. The failure to obtain the appropriate approval was identified by North Anna Quality Control Inspection Report IR-N-82-161 on February 6, 1982.

(3) On March 16, 1982, inspection of the valve internals was performed on safety-related valves 2-FW-127, 2-FW-129, 2-FW-172, 2-FW-192 without the procedures being at the work location. This is contrary to the VEPCO Nuclear Power Station Quality Assurance Manual Section 16, Part 6.5.4.j but not contrary to T.S. 6.8.1.

3. CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED

(1) The responsible operator was made aware of the correct procedure for verifying a valve line-up and appropriate disciplinary action was taken.

(2) The Mechanical Foreman was notified by a Quality Control inspection report as to the proper sequence of signatures required to perform maintenance on safety-related equipment and disciplinary action was taken. The appropriate signatures were obtained within 12 hours of the work being started to disassemble the pump.

(3) The Maintenance personnel responsible were instructed to maintain a copy of the procedure in use at the work location.

In all cases, these actions resulted in full compliance with Station Procedures.

4. CORRECTIVE STEPS WHICH WILL BE TAKEN TO AVOID FURTHER VIOLATION

The Company has embarked on a program that emphasizes adherence to procedures and that jobs be accomplished in a quality manner. The Vice-President, Nuclear Operations has personally held meetings with Station employees to stress the importance of following procedures and to ensure that all employees understand the expectations of management.

5. DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

Full compliance has been achieved.