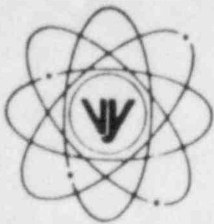
VERMONT YANKEE NUCLEAR POWER CORPORATION



RD 5, Box 169, Ferry Road, Brattleboro, VT 05301

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FVY 83-60

REPLY TO
ENGINEERING OFFICE
1671 WORCESTER ROAD
FRAMINGHAM, MASSACHUSETTS 01701
TELEPHONE 617-872-8100

June 16, 1983

U.S. Nuclear Regulatory Commission
Office of Inspection and Enforcement
Washington, D.C. 20555

Attention: Mr. Richard C. DeYoung, Director

References:
a) License No. DPR-28 (Docket 50-271)
b) USNRC Letter to VYNPC dated 5/10/83; Proposed Civil Penalty (EA 83-34) and NRC Inspection Report No. 50-271/83-04
c) USNRC Letter to VYNPC dated 3/30/83; Inspection Report 50-271/83-04

Dear Sir:

Subject: Response to Notice of Violation and Proposed Imposition of Civil Penalty (EA 83-34)

This letter is written in response to Reference (b) which indicates that certain of our activities were not conducted in full compliance with Nuclear Regulatory Commission requirements. These alleged violations were identified as a result of special investigations conducted by USNRC representatives on March 21 - 25, 1983, following a brief loss of secondary containment integrity on March 21, 1983.

Pursuant to 10 CFR 2.201, we submit the following in response to the alleged violations; for clarity, each violation is discussed separately.

"I. Violation Assessed A Civil Penalty

Technical Specification Limiting Condition for Operation (LCO) 3.7.C.1.d requires that secondary containment integrity be maintained whenever irradiated fuel is being moved in the reactor building. Section 1.U of the Technical Specifications defines secondary containment integrity and specifies as two of its conditions that (1) the standby gas treatment system (SBGT) is operable and (2) all reactor building automatic ventilation system isolation valves are operable or are secured in the isolated position.

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Contrary to the above, between 8:17 and 10:23 a.m. on March 21, 1983, secondary containment integrity was not maintained, as required when 15 irradiated fuel rods and three irradiated fuel bundles were moved within the spent fuel pool in the reactor building, in that the automatic start capability of both trains of SBGT was inoperable and the automatic isolation feature of the reactor building ventilation system isolation valves was inoperable and these valves were not secured in the isolated position. This resulted from the failure to follow an administrative procedure as required by Technical Specification 6.5.A:

> A.P. 0020, Revision 6, entitled Temporary Electrical Jumpers, Lifted Lead (LLJ) and Mechanical Bypasses, requires that, during modification of plant equipment involving installation of temporary electrical jumpers or mechanical bypasses, or lifting of electrical leads, this procedure must be followed to assure safe plant operation. Section II.A of the procedure requires that VYAPF 0020.01 (Temporary Electrical Lifted Lead/Installed Jumper (LLJ) be completed; reviewed by the originating department supervisor for need, accuracy and pertinent comments; reviewed by the operations department for impact on plant conditions and technical specification compliance; and reviewed by the shift supervisor and the implementing department before performance by two qualified individuals.
>
> However, on March 21, 1983, at 8:17 a.m. a temporary modification was performed in that slide links TAC-3 and TP-1 were opened at control room panel (CRP) 9-26 by a qualified Instrument and Control (I&C) technician and witnessed by the on-duty senior control room operator (SCRO) without preparation and completion of an approved LLJ request.
>
> The activity had not been reviewed by the originating department supervisor, the operations department, nor the shift supervisor. The opening of the slide links rendered the auto-start capability of SBGT inoperable and also rendered the automatic isolation feature of the ventilation system isolation valves inoperable.
>
> This is a Severity Level III Violation (Supplement 1)
> Civil Penalty - $40,000"

Response

1. Admission or Denial of the Alleged Violation

   We acknowledge that certain events did occur on March 21, 1983, and that those events are accurately delineated in the NRC's Notice of Violation. Further, we admit that certain activities did occur which were not in full compliance with procedures required by Technical Specification 6.5.A. However, based on our own independent assessment we agree with the NRC's statement, as documented in Reference (c), that there was no impact on public health and safety.

2. Reasons for the Violation

Our investigations, which included in-depth interviews with the individuals involved, lead us to believe that the actions of these individuals, while careless, did not constitute a willful or intentional disregard for management controls. The unique series of activities and conditions occurring during the same period of time, i.e., no fuel in the reactor, the reactor protection system tagged out for implementation of a design change and preventive maintenance, may have given the individuals reason to believe that their actions were acceptable. We do not, however, sanction their actions nor dispute that the violation occurred due to a failure to follow prescribed, procedural requirements.

3/4. Corrective Steps Taken (Immediate and Subsequent)

A. Immediate Actions

As described in Reference (c), steps were immediately taken to terminate the movement of fuel within the spent fuel pool and to restore the automatic features of the Standby Gas Treatment system and Reactor Building Ventilation system. Following a thorough review of the prior events and the establishment of secondary containment, it was determined that fuel moves could recommence. Likewise, a lifted leads/installed jumper (LL/J) was implemented, following appropriate reviews and approval, to allow the return of the normal reactor building ventilation to service without defeating SBGT or RB ventilation logic.

B. Subsequent Actions

o A critique was held between all parties involved with the situation and plant management to determine the chronology of the events and to ascertain how these events occurred. After being assured that the senior I&C technician and the I&C Supervisor showed an understanding of the errors made, and their responsibilities to comply in the future to all administrative requirements they were allowed to continue normal duties. The involved senior licensed personnel were removed from license duties until management could be assured that they understood their duties and responsibilities and would implement them in the future.

The Senior Control Room Operator was subsequently allowed to resume licensed duties; the Shift Supervisor was reassigned to a non-licensed position.

- Additional clarification was made to the administrative procedure involved in the situation. A.P. 0020, Lifted Lead/Jumper Request, was modified by Departmental Instruction to specifically address the fact that the originating department head review must constitute an independent detailed technical evaluation of the necessity for the lifted lead, the methodology for obtaining the desired end result, and the consequences of implementing the request as far as loss of function and impact to other plant operations. Signature by the originating department now specifies that all the above reviews are complete and satisfactory.

- The Engineering Support Supervisor was directed to review an adequate and random sampling of previously issued Lifted Lead/Jumper Requests to ensure that adequate technical reviews were completed on each request. He was also directed to review the description of loss of function and consequences associated with each request to ensure completeness and correctness. The results of this investigation was presented to the Plant Manager and PORC on April 9, 1983; no technical deficiencies were identified.

- A meeting of plant Department Heads and Superintendents was held on 3/26/83 to thoroughly review the facts in the situation and to assess the problems identified. Each Department Head and Superintendent was tasked with relaying the below listed information to each and every member of their departments and to document such briefing/training sessions and present the results of this action to the Plant Manager by April 2, 1983. Key topics to be incorporated into the discussion were:

    1. Factors which could influence personnel to bypass procedural requirements.

    2. Interfacing with the Operations Department.

    3. The necessity for a thorough understanding of the impact of an action prior to doing work even when the event seems insignificant.

    4. The need to comply with all procedures.

- On March 29, 1983, the Vice President and Manager of Operations requested the Manager of Operational Quality Assurance of Yankee Atomic Electric Company's Nuclear Services Division to conduct an independent review of design change work packages which were

being implemented and monitor job performance with emphasis on how procedural requirements were being satisfied. The results of that review provide the opinion that there is no loss of management control or breakdown in implementation of the quality assurance program at Vermont Yankee.

5. Compliance Dates

Dates are as discussed in the above response.

"II. VIOLATION NOT ASSESSED A CIVIL PENALTY

10 CFR 50.72 (a) requires, in part, that the NRC Operations Center be notified as soon as possible and in all cases within one hour of any significant event resulting from failure to follow procedures which, during normal operations, anticipated operational occurrences, or accident conditions prevents or could prevent, by itself, the fulfillment of the safety function of those systems important to safety that are needed to limit the release of radioactive material to acceptable levels.

A.P. 0010, section VI, written pursuant to 10 CFR 50.72 requires that plant management, the duty shift supervisor, or the duty and call officer notify the NRC via the Red Telephone within one hour when an event or condition described in Appendix D of A.P. 0010 occurs. Appendix D of A.P. 0010 requires that in the absence of higher plant management, the duty shift supervisor or the duty and call officer shall notify the NRC Operations Center as soon as possible and in all cases within one hour by telephone of the occurrence of significant events and shall identify that event as being reported pursuant to 10 CFR 50.72.

Contrary to the above, as of approximately 12:00 noon on March 21, 1983, plant management was aware that secondary containment integrity had not been maintained as required between 8:17 a.m. and 10:23 a.m. on March 21, 1983, a condition which resulted from personnel error involving a failure to follow a procedure, and the NRC Operations Center was not notified of this occurrence.

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

Response

1. Admission or Denial of the Alleged Violation

We admit that station personnel failed to properly evaluate the event and notify the NRC Operations Center in accordance with the provisions of 10 CFR 50.72 and station procedure.

2. Reasons for Violation

This failure resulted from an inadequacy in the implementing procedure in that it did not clearly identify the review and subsequent notification responsibilities.

3/4. Corrective Steps Taken and Planned

- o Immediate actions were to issue orders to all operators specifying that the Shift Supervisor has the primary responsibility for 10 CFR 50.72 report determinations. A detailed review of A.P. 0010 is in progress to identify if additional clarifications/enhancements are warranted. It is expected that the procedure will be revised and reissued by August 1, 1983.

- o Other corrective actions taken were previously described in our response to the first violation and included certain disciplinary actions and meetings with all plant employees.

5. Compliance Dates

Dates are as discussed in the above response.

We trust that the information provided above is acceptable; however, should you have any questions or desire additional information, please contact us.

Very truly yours,

VERMONT YANKEE NUCLEAR POWER CORPORATION

Warren P. Murphy

Warren P. Murphy
Vice President and
Manager of Operations

STATE OF VERMONT)
)ss
WINDHAM COUNTY)

Then personally appeared before me, W.P. Murphy, who, being duly sworn, did state that he is Vice President and Manager of Operations of Vermont Yankee Nuclear Power Corporation, that he is duly authorized to execute and file the foregoing document in the name and on the behalf of Vermont Yankee Nuclear Power Corporation and that the statements therein are true to the best of his knowledge and belief.

Diane M. McCue

Diane M. McCue Notary Public
My Commission Expires February 10, 1987

DIANE M. McCUE
NOTARY
PUBLIC
WINDHAM COUNTY VERMONT