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Washington Public Power Supply System

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REGION V IRE

Docket No. 50-397
July 12, 1984
G02-84-426

Mr. T. W. Bishop, Director
Division of Reactor Safety and Projects
U.S. Nuclear Regulatory Commission
Region V
1450 Maria Lane, Suite 210
Walnut Creek, California 94596

Subject: NUCLEAR PLANT NO. 2
LICENSE NO. NPF-21
NRC INSPECTION 84-09
APRIL 1-30, 1984

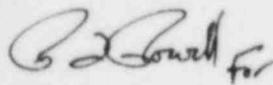
The Washington Public Power Supply System hereby replies to the Notice of Violation contained in Appendix A of your letter dated June 13, 1984. Our reply pursuant to the provisions of Section 2.201, Title 10 Code of Federal Regulations, consists of this letter and Appendix A (attached).

Your transmittal letter dated June 13, 1984 requested the Supply System address NRC's concern "...with the failure of the (procedure) review process and the performance of plant staff in proceeding with clearly incomplete procedures."

This concern developed from the violation citing improper Feedwater Control Valve Testing activities. We do not consider this item a violation of our license or any regulatory requirements and our justification for this position is presented in Appendix A, Section B.

In Appendix A, an explanation of the violations is presented, the corrective steps taken with results achieved are outlined, and the dates of full compliance are specified.

Should you have any questions concerning our response, please do not hesitate to contact me.



G. C. Sorensen (by direction)
Manager, Regulatory Programs

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Attachment

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APPENDIX A

As a result of an inspection conducted during April 1-30, 1984 of activities authorized by NRC Operating License NPF-21 and in accordance with the provisions of NRC Enforcement Policy, 10 CFR 2, Appendix C, the following violations were identified.

A. Notice of Violation

"Technical Specifications Section 3.6.1.3 required, in part, that "Each primary containment air lock shall be OPERABLE, . . . With one primary containment air lock door inoperable: . . . Maintain at least the OPERABLE door closed and either restore the inoperable air lock door to OPERABLE status within 24 hours or lock the OPERABLE air lock door closed . . . Otherwise, be in at least HOT SHUTDOWN within the next 12 hours and in COLD SHUTDOWN within the following 24 hours." This specification is applicable in Operational Conditions 1, 2 and 3.

Contrary to the above requirements, on April 17, 1984 at 10:30 p.m. the gears in the interlock mechanism for the containment air lock doors were found to be broken, rendering the device inoperable. The mechanism was repaired and returned to service at 5:00 p.m. on April 19, 1984. During the period that the interlock was out of service, several entries into the containment were made by licensee personnel. Further, on April 18, 1984, the inner door was locked closed. However, on April 19, 1984, with the outer door open, the inner door, although closed, was not locked. Reactor operational condition 2 was in effect during the entire period."

This is a severity level IV violation (Supplement I).

Validity of Violation

The drywell air lock interlock mechanism was determined to be inoperable at 1030 hours on April 17, 1984 and returned to service at 1700 hours on April 19, 1984. During this time period the plant imposed administrative controls to prevent inadvertently having both doors open at one time. These administrative controls included the requirement for an operator trained in the use of the doors to be present to operate the doors upon entry to the drywell. In addition, access to the drywell was also limited by locking one of the doors beginning at 1636 hours on April 18, 1984.

Despite the precautionary steps taken to satisfy the Technical Specification requirements, the air lock was found to be unlocked subsequent to the time locking was required by the action statement.

The plant was in Mode 2 and less than 5% power throughout the event. At least one air lock door was maintained closed and containment integrity was maintained at all times.

Corrective Steps Taken/Results Achieved

- 1) Upon discovery that the air lock was unlocked, the Shift Manager on duty immediately initiated action to have the door relocked.
- 2) The air lock was repaired and returned to service on April 19, 1984.
- 3) The plant was removed from TSAS 3.6.1.3.a.1 at 1700 hours on April 19, 1984.

Corrective Steps to be Taken

In any future events involving loss of operability of the air lock door interlock mechanism, repairs will be completed within 24 hours; otherwise one of the operable doors will be locked at all times. Access to the drywell during these periods will be controlled through the use of the locks on the doors under the control of operations.

Specific instructions will be provided to the operating crews to ensure implementation of this policy and to ensure full compliance with Technical Specification requirements.

Date of Full Compliance

The air lock is operable and the plant is currently in compliance with Technical Specification requirements. Upon issuance of the management direction on air lock operation following failure, all actions concerning this issue will be completed. This direction will be provided by July 20, 1984.

B. Notice of Violation

"Technical Specifications Section 6.8.1 requires that 'written procedures shall be established, implemented and maintained covering the activities referenced below.

d. Surveillance and Test Activities of Safety-Related Equipment.

Contrary to the above, on April 23, 1984, testing activities of the safety-related Feedwater Control Valve RFW-V-10 were initiated without the applicable procedures being established and implemented. Although the governing procedure had been issued, it was incomplete in that a section related to the adjustment and use of a test box (8.2.23A.9.A.1.b) had not yet been included in the procedure as approved by the Plant Operations Committee. Nevertheless, a feedwater test box was inserted between the reactor water level sensor and the feedwater control valve controller. Connection of the feedwater test box resulted in an unplanned reactor water level transient and reactor protection system trip due to improper positions of switches on the test box. This is a severity Level IV Violation (Supplement I)."

Validity of Violation

The safety-related feedwater check valve (RFW-V-10) referenced in the violation was not being tested or affected in any way and was in fact subject to the rigorous controls of our established management system. The Feedwater Control System and the Startup Flow Control Valve RFW-FCV-10 are not safety-related systems and were being subjected to troubleshooting activities by knowledgeable craft personnel with engineering attention and management cognizance. Plant conditions were established and maintained within previously analyzed conditions during and after the event and all systems performed as designed. There was no violation of NRC or management guidelines. This was a personnel error and represented an acceptable risk incurred during troubleshooting by qualified personnel within their abilities and with controls commensurate with the non safety-related aspect of this task.

Therefore, we do not consider this item a violation of our license or any regulatory requirement.

The violation reiterates our Technical Specification requirement for the establishment of written procedures covering surveillance and test activities of safety-related equipment. It should be noted, Surveillance Procedure 7.4.3.1.1.61 (Scram Discharge Volume High Level) was being performed the entire time which resulted in a planned 1/2 scram (subchannel A) and which represented the only activity germane to the scram which involved safety-related testing. The presence of the subchannel A 1/2 scram is significant because any subchannel B activity can result in a full scram.

The violation correctly identifies the fact that a "feedwater test box was inserted between the reactor water level sensor and the feedwater control valve controller. The connection of the feedwater test box resulted in an unplanned water level transient. . ." The transient caused a neutron flux trip of the neutron monitor IRM F which completed the subchannel B-1/2 scram logic and shutdown the reactor.

Preparatory to testing under *8.2.23A, it was necessary to perform troubleshooting of the non safety-related startup level control valve utilizing a Maintenance Work Request. Troubleshooting is an off-normal activity which does not allow rigorous procedural controls normally associated with scheduled maintenance, test, or repair activities.

The actual situation was reported on NCR 284-0335 as "Troubleshooting/signal injection. . . for investigation of RFW-FCV-10 hunting problem." The LER 84-036 specifically stated we were in initial power operation under troubleshooting conditions. The performance of troubleshooting of RFW-FCV-10 was performed by craft personnel under the direction of the Technical Staff and observation of the General Electric Technical Director with the knowledge and concurrence of the Shift Manager.

We do not feel the procedure referenced in the violation was necessary to have been completed at the time in question as the test activity the procedure governed was not being performed. The referenced section of the Volume 8 procedure was completed prior to performance of the startup test.

C. Notice of Violation

"Criterion V of 10 CFR 50 Appendix B, as applicable to the fire protection system, requires, in part, that "Inspections, tests, administrative controls, . . . that govern the fire protection program should be prescribed by documented instructions, procedures, or drawings and shall be accomplished in accordance with these documents." The FSAR Appendix F3-29 describes the fact that Burns and Roe has documented instructions, procedures and drawings which control the design and procurement of the fire protection system. The procurement and fabrication of eight fire protection deluge valve assemblies for the standby gas treatment system filter units (SGT-DV-1A1, 1A2, 1A3, 1B1, 1B2, 1B3) were prescribed by Farr Company drawing D-54898-S dated July 20, 1977. These assemblies were identified as Quality Class I in Note 6 of FSAR drawing 3.2-16.

Contrary to the above, subsequent to February 18, 1983 construction personnel removed 12 of 38 U-clamp supports of the actuating fluid piping for these deluge valve units, and failed to secure 6 of the remaining 26, resulting in an installation which did not conform to the documented drawings."

Validity of Violation

The violation correctly identifies that:

1. The principal clamp on one side of the Reactor Building Sump Vent Filter deluge valve was missing.
2. The small bore trim piping for the Standby Gas Treatment and Reactor Building sump vent filter deluge assemblies were not secured with U-bolts as shown by the vendor drawings.
3. Discrepancies existed in Quality Class designation of PED-217-B-0242 and the Quality Class specified in M544. (PED 217-B-0242 was issued designated Quality Class II, although Drawing M544 designates the assemblies as Quality Class I.)

Corrective Steps Taken/Results Achieved

(Items 1-3 correspond to violation items 1-3 respectively)

1. The principal clamp missing from the reactor sump vent filter was replaced the day it was pointed out, with a clamp from a spare assembly which had been furnished by the vendor (Farr Company).

2. Design Change S215-H-7409 was issued to provide direction on the installation of U-bolts and supports in accordance with pipe support span chart criteria.
3. An analysis was performed to determine if the deluge valve piping assembly, as found, would have failed under Seismic I loading potentially rendering the Standby Gas Treatment System inoperable. Analysis results indicate the piping would not have failed, therefore operability of SBTG was not compromised.

Corrective Steps to be Taken

1. SPED S215-H-7409 will be implemented restoring the design margins of the original design specification.
2. Quality Class discrepancies on M544 will be corrected to specify QC II, Seismic I supports.

Date of Full Compliance

September 1, 1984