VERMONT YANKEE
NUCLEAR POWER CORPORATION

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BVY 92-044

REPLY TO
ENGINEERING OFFICE
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BOLTON, MA 01740
(508) 779-6711

April 16, 1992

U.S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, DC 20555

References:
a) License No. DPR-28 (Docket No. 50-271)
b) Letter, USNRC to VYNPC, Inspection Report 92-04 (NVY 92-42), dated 3/17/92
c) Licensee Event Report 92-004, dated 3/20/92

Dear Sir:

Subject: Inspection Report 92-04, Reply to Notice of Violation

This letter is written in response to Reference b), which indicates that one of our activities was not conducted in full compliance with NRC requirements. The apparent violation, classified as a Severity Level IV, was identified during a routine safety inspection conducted on February 11 - March 6, 1992. In addition, Reference b) requested information relative to on-shift reporting expertise. Our response to these items is provided below.

VIOLATION

"Technical Specification 6.0 requires, in part, that administrative procedures shall be adhered to. Vermont Yankee administrative procedure AP 0156, Rev. 16, "Notification of Significant Events" requires, in part, that if any single-train systems such as the high pressure coolant injection (HPCI) system fail, or are found degraded in such a manner that it would not perform its intended function, then it is reportable to the NRC as a 10 CFR 50.72 4-hour report. Vermont Yankee administrative procedure AP 0010, Rev. 22, "Occurrence Reports/Notifications and Reports Due" requires in part, that the Engineering Support Supervisor immediately inform the Shift Supervisor if a more restrictive notification is required.

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Contrary to the above, on February 20, 1992, the Shift Supervisor failed to effectively implement the requirements of AP 0156 requiring the identification of the HPCI system in a degraded status and to initiate a subsequent event report to the NRC; and on February 24, 1992, the Engineering Support Supervisor failed to immediately notify the Shift Supervisor as required by AP 0010 that the HPCI system was in a degraded status following his determination that the event was reportable. On February 26, 1992 Vermont Yankee notified the NRC that the event was reportable in accordance with 10 CFR 50.72."

This is a Severity Level IV Violation (Supplement I)

RESPONSE

The results of our review indicate that the notification was missed due to a combination of a procedural inadequacy and personnel error. The alarm response sheet (ARS) in effect at the time of the event implied that if the DC inverter could be reset, then HPCI need not be considered inoperable. This conclusion was in error. Because the inverter had tripped, HPCI was not capable of performing it's safety function and therefore a 4-hour report, per 10 CFR 50.72(b)(2)(iii) should have been made. Subsequently, the Operations Supervisor conducted reviews with the other Shift Supervisors to determine if the misunderstanding was a generic issue. It was determined that the other Shift Supervisors would have recognized HPCI to be inoperable and made the required notification. In addition, an interview with the Shift Supervisor involved revealed that he was aware of the reporting requirement for instances when HPCI was declared inoperable.

To prevent recurrence, the following corrective actions have, or will occur:

- The alarm response sheet has been revised to remove the misleading statements and specifically state that HPCI should be considered inoperable anytime the inverter trips.

- Discussions between the Operations Supervisor and the involved Shift Supervisor were conducted to ensure his understanding of 10 CFR 50.72 requirements and the status of HPCI with a tripped inverter.

- At the next Shift Supervisor meeting, the Operations Supervisor will review this incident with the Shift Supervisors and reiterate the need for accurate operability determinations and reporting.

With regard to the AP 0010 issue, the failure of an engineering supervisor to immediately notify the Shift Supervisor was determined to be a personnel error. The individual involved, when interviewed, indicated that he was aware of the procedure requirement, but simply overlooked it. The requirement was discussed with the other engineering supervisors and all indicated they understood their responsibilities as defined in AP 0010. To ensure that the engineering supervisors were absolutely clear on the requirements, the Engineering Director provided re-training to the supervisors on March 24, 1992.

ADDITIONAL INFORMATION

Despite the fact that the specific failures discussed above were deemed to be isolated events, we have taken additional measures to further improve our event assessment/notification process. The Operations Department will establish the Shift Engineer as the on-shift individual knowledgeable in 10 CFR 50.72 requirements, including the basis for such requirements, and for providing the Shift Supervisor with engineering input. Previously, training was focused on the specific procedure requirements contained in AP 0156. The overall reporting and operability responsibility will remain with the Shift Supervisor. To support this change, appropriate reference material will be placed in the Control Room to assist the Shift Engineer and crew members in making reportability determinations. Additionally, the Shift Engineer initial and continuing training programs will be revised to include more 10 CFR 50.72 elements, including related NUREG and industry guidance documents.

The reference material will be available in the Control Room by May 1, 1992 and the training programs revised and presented by December 1, 1992.

We believe that the actions described above address the specific incident and resolve any concerns that may have existed about on-shift reporting expertise. Should you have any questions about our response, please do not hesitate to contact us.

Very truly yours,

Vermont Yankee Nuclear Power Corporation

Warren P. Murphy
Senior Vice President, Operations

cc: USNRC Regional Administrator, Region I
USNRC Resident Inspector, VYNPS
USNRC Project Manager, VYNPS