VIRGINIA ELECTRIC AND POWER COMPANY

RICHMOND, VIRGINIA 23261

January 9, 1996

U. S. Nuclear Regulatory Commission
Attention: Document Control Desk
Washington, D. C. 20555

Serial No. 95-640
NAPS/MPW/MAE R2
Docket Nos. 50-338
50-339
License Nos. NPF-4
NPF-7

Gentlemen:

VIRGINIA ELECTRIC AND POWER COMPANY
NORTH ANNA POWER STATION UNITS 1 AND 2
INSPECTION REPORT NOS. 50-338/95-20 AND 50-339/95-20
REPLY TO A NOTICE OF VIOLATION

We have reviewed your letter of December 11, 1995, which referred to the inspection conducted at North Anna Power Station from October 22 through November 18, 1995 and the associated Notice of Violation which was reported in Inspection Report Nos. 50-338/95-20 and 50-339/95-20. Our reply to the Notice of Violation is attached.

A potential adverse trend in human performance was previously identified by both the NRC and Virginia Power. Actions to address the issue include implementing INPO Human Performance Recommendations and developing a plan of continuing Human Performance activities. We have completed Human Performance actions in 1995 and identified activities that will be periodically conducted throughout the year and methods to measure Virginia Power performance against the INPO Human Performance Recommendations. Since the time of this violation, North Anna has performed a second Human Performance "stand down" day designed to provide identification and feedback on human performance issues. These sessions allow the employees to brainstorm human performance enhancements and opportunities for success along with providing a forum for open discussions between management and employees on how to improve performance. A third Human Performance "stand down" day has been scheduled for February 1996. We will continue to monitor Human Performance to ensure improvement.

If you have any further questions, please contact us.

Very truly yours,

James P. O'Hanlon

James P. O'Hanlon
Senior Vice President - Nuclear

Attachment

IE01
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cc: U. S. Nuclear Regulatory Commission
Region II
101 Marietta Street, N.W.
Suite 2900
Atlanta, Georgia 30323

Mr. R. D. McWhorter
NRC Senior Resident Inspector
North Anna Power Station

REPLY TO A NOTICE OF VIOLATION
INSPECTION REPORT NOS. 50-338/95-20 AND 50-339/95-20

NRC COMMENT

During an NRC inspection conducted on October 22 through November 18, 1995, a violation of NRC requirements was identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," NUREG 1600, the violation is listed below:

A. Unit 2 Technical Specifications Limiting Condition for Operation 3.6.1.3.a requires that each containment airlock be operable with both doors closed except when used for transit. With one air lock door inoperable, Technical Specifications Limiting Condition for Operation 3.6.1.3, action "a" requires that the operable door be maintained closed and locked within 24 hours or that the plant be placed in hot standby within the next 6 hours and placed in cold shutdown within the following 30 hours.

Contrary to this requirement, during the period from approximately 4:00 p.m. on November 1, until approximately 4:30 p.m. on November 6, the Unit 2 containment air lock outer door was inoperable due to valve 2-CE-4 being left opened and uncapped. During this time period, the remaining operable air lock door was not locked nor was the plant placed in hot standby followed by cold shutdown.

This is a Severity Level IV violation (Supplement I).

REPLY TO NOTICE OF VIOLATION

1. REASON FOR THE VIOLATION

The reason for the violation was failure of plant personnel including supervision assigned to a plant operations support group outside of the rotating shifts to adhere to a set of well known operations standards and management expectations for implementing work at the power station. A minor contributing factor was a procedure step requiring multiple actions.

Technical Specifications Surveillance Requirement 4.6.1.3.b involves the performance of an overall air lock leakage test by pressurizing the containment personnel air lock with air. On November 1, 1995, operations support personnel were assigned to perform a periodic test on the containment personnel air lock. The containment personnel hatch was subsequently tested and vent valve 2-CE-4 was left open and uncapped. This vent valve is used to pressurize and depressurize the personnel air lock. After the test was completed, a procedure step required disconnecting the test apparatus, from vent valve 2-CE-4, in accordance with attached instructions. The second action required by the procedure step was to replace the cap on the test connection. When the first action was completed, the step in the procedure was signed off while the hatch was being depressurized through this connection even though the step required additional actions to be performed. Subsequently, the personnel hatch vent valve was not closed and capped after venting was complete. The independent verification was inappropriately signed by one of the operators performing the hatch leakage test. It should be noted that the inappropriate actions occurred at the end of the shift for the personnel performing the test. Since the operations shift was unaware of the mispositioned vent valve, Technical Specifications 3.6.1.3 Action Statement (a) was not implemented.

The pre-job brief between the operations support supervisor and personnel performing the PT was not performed as required. The operations standards for pre-job briefs and system status during periodic testing were not followed. These standards include formal communications, review of PTs to determine if testing will result in alignment of the system in a configuration in which its intended function can not be performed, verifying redundant systems are operable, discussion of actions necessary to return a system to operable status, and applicable action statement determination. The standards of self checking and independent verification were not followed as required by station procedure.

Prior to the violation pre-job briefs, for work performed by the operations support group, were not held in the same manner as all other pre-job briefs (i.e. Shift Supervisor conducting the brief).

2. CORRECTIVE STEPS WHICH HAVE BEEN TAKEN AND THE RESULTS ACHIEVED

Upon the identification of the open vent valve 2-CE-4 operations personnel determined that the containment personnel air lock inner door remained operable by locally verifying that air was not being drawn through the valve into the inner hatch space. This determination was appropriate because the containment is maintained subatmospheric.

The Shift Supervisor was notified, and the valve was closed and capped by the operator discovering the mispositioned valve. All hatch test connections for Units 1 and 2 were verified properly aligned.

Personnel involved in the event were disqualified from performing in-plant operations tasks until remedial training was completed. Additionally, involved personnel were held fully accountable for their failure to perform in accordance with their training.

Station management emphasized their expectations to improve human performance during a human performance focus day that was held with all on site personnel on November 15, 1995.

Operations management has re-emphasized to all departmental personnel that expectations and standards apply to all operators, including those not assigned to the rotating shifts. Concentrated efforts are being made to ensure that those operators assigned to duties off shift are especially sensitive to their unique roles and responsibilities in how they interact with the operating shifts.

Periodic Test Procedures 1/2-PT-62.1 were revised to reflect enhancements identified as the result of the procedure validation walkdown and the results of this event. As part of our increased focus on human performance, enhancements to procedures that provide better opportunities for success will be emphasized.

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

As an enhancement, this event will be discussed during Licensed Operator Requalification Program (LORP) training and the LER will be placed in the licensed operator required reading. Furthermore, a Category 2 Root Cause Evaluation was initiated by the Human Performance Enhancement System Coordinator to investigate this event. Upon completion of this evaluation, corrective actions will be implemented as applicable.

4. THE DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

Full compliance has been achieved.