

VIRGINIA ELECTRIC AND POWER COMPANY
RICHMOND, VIRGINIA 23261

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W. L. STEWART
VICE PRESIDENT
NUCLEAR OPERATIONS

September 26, 1984

Mr. James P. O'Reilly
Regional Administrator
Region II
U. S. Nuclear Regulatory Commission
101 Marietta Street, Suite 2900
Atlanta, Georgia 30323

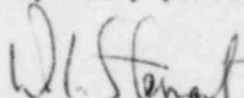
Serial No. 529
NO/JHL:lms
Docket Nos. 50-338
50-339
License Nos. NPF-4
NPF-7

Dear Mr. O'Reilly:

We have reviewed your letter of August 27, 1984, in reference to the inspection conducted at North Anna Power Station between July 6, 1984 and August 5, 1984 and reported in IE Inspection Report Nos. 50-338/84-27 and 50-339/84-27. Our responses to the infraction and deviation are attached.

We have determined that no proprietary information is contained in the report. Accordingly, the Virginia Electric and Power Company has no objection to this inspection report being made a matter of public disclosure. The information contained in the attached pages is true and accurate to the best of my knowledge and belief.

Very truly yours,


W. L. Stewart

Attachments

cc: Mr. Richard C. Lewis, Director
Division of Project and Resident Programs

Mr. James R. Miller, Chief
Operating Reactors Branch No. 3
Division of Licensing

Mr. M. W. Branch
NRC Resident Inspector
North Anna Power Station

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RESPONSE TO NOTICE OF VIOLATION
ITEM REPORTED DURING NRC INSPECTION
CONDUCTED FROM JULY 6 TO AUGUST 5, 1984
INSPECTION REPORT 50-338/84-27 AND 50-339/84-27

NRC COMMENT

Technical Specification 3.3.3.10 (3.3.3.9 - Unit 2) requires that with less than the minimum number of radioactive liquid effluent monitoring instrumentation channels operable, for reasons other than an alarm/trip setpoint less conservative than required, action 26 of Table 3.3-13 must be taken. This requires 12 hour grab samples during discharge.

Contrary to the above, with RM SW 108 inoperable during the period July 2-9, 1984, and service water being discharged to Lake Anna, the 12 hour grab samples required by action 26 of Table 3.3-13 were not obtained.

This is a Severity Level IV violation (Supplement 1).

RESPONSE

1. ADMISSION OR DENIAL OF THE ALLEGED VIOLATION

This violation is correct as stated.

2. REASON FOR THE VIOLATION

This violation was caused by a series of personnel errors resulting from the following root causes:

- a. The radiation monitoring systems are high maintenance items that are frequently inoperable. Some Control Room Operators have become desensitized to these failures and have not consistently recognized the status of required radiation monitors.
- b. The radiation monitoring systems are often inoperable for long periods of time awaiting repair parts from the manufacturer. Obtaining spare and replacement parts has not been given sufficient priority. This contributes further to the inoperability concerns.
- c. The radiation monitoring system includes both the channels required by Technical Specifications and the channels that are less important. As such, the inoperability of a channel required by Technical Specifications during special conditions, such as while discharging, is easier to overlook.

The specific errors that occurred include:

- a. The Instrument Maintenance Technician that declared the channel (RM-SW-108) inoperable submitted a work order to repair and placed a sticker indicating the submittal of a work order on the monitor. However, the inoperability was not positively communicated to the Shift Supervisor to ensure the action statement would be entered. This normally occurs by the submittal of a Station Deviation Report.

- b. The Instrument Maintenance Technician entered on the work order that the monitor would not source check which indicated that there was an electronic failure. However, this did not completely describe the cause of the monitor inoperability.
- c. When the operator performed the source check, the monitor operated normally. There was no further investigation into the reasons for the work order. Consequently, the 12 hour grab samples which would normally be required when the monitor is inoperable, were not obtained.
- d. In addition, the surveillance (1-PT-37) of the monitor conducted once per shift (every 8 hours) includes a source check of the monitor. The record of these surveillances indicates an inconsistency in the results of the test. On several occasions, the source check was performed satisfactorily. In other cases, the check was not performed and the notation was made that the system was under repair. There was no record of the inoperability being investigated and no further effort to initiate the required Technical Specification action statement.

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

The corrective actions to resolve the root causes are discussed in paragraph 4. The immediate corrective actions were to halt discharge operations until the monitor was restored to operability and to reinstruct Operations personnel on the importance of being fully aware of the inoperability of radiation monitoring equipment at all times.

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

The following corrective steps will be taken:

- a. The surveillance procedures for the radiation monitoring system will be revised to include a sign-off step by the Shift Supervisor acknowledging the inoperability of radiation monitoring channels and the appropriate action statement entry, if required. This will be completed by October 31, 1984.
- b. An evaluation of the frequent failures of radiation monitoring channels will be initiated. This evaluation will focus on the system enhancements that can be made to improve operability. This evaluation will be completed by January 15, 1985.
- c. The problem of obtaining spare and replacement parts will be given priority consideration. The maintenance necessary to repair all inoperable radiation monitors will be actively pursued. A target completion date for restoring inoperable radiation monitors to operable status is January 15, 1985. The monitors that are used for releases will be given first priority. During the time period that the monitors are inoperable, grab samples will be taken in accordance with the Technical Specifications for discharges.

A monthly status report of the condition of the radiation monitoring system will be provided to the Station Management (including the Station Manager) until the concerns have been addressed.

5. DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

The dates associated with the corrective actions to prevent recurrence are included in paragraph 4.

RESPONSE TO NOTICE OF DEVIATION
ITEM REPORTED DURING NRC INSPECTION
CONDUCTED FROM JULY 6 TO AUGUST 5, 1984
INSPECTION REPORT 50-338/84-27 AND 50-339/84-27

NRC COMMENT

Paragraph 11.4.2.9 of the North Anna Power Station Units 1 and 2 updated Final Safety Analysis Report discusses the service-water-discharge-to-reservoir monitor and states in part "this channel continuously monitors the service water discharge to the service water reservoir".

Contrary to the above, this channel (RM SW 109) has been inoperable since February 9, 1983, when the sample pump was isolated and tagged out.

This deviation applies to both units.

RESPONSE

The corrective actions, actions taken to prevent further deviations and completion dates for these actions that are identified in the response to the notice of violation in the Inspection Report (84-27) will include the inoperability of this radiation monitor.