THE CLEVELAND ELECTRIC ILLUMINATING COMPANY
P.O. BOX 97 ■ PERRY, OHIO 44081 ■ TELEPHONE (216) 259-3737 ■ ADDRESS: 10 CENTER ROAD
Serving The Best Location in the Nation
PERRY NUCLEAR POWER PLANT

Al Kaplan
VICE PRESIDENT
NUCLEAR GROUP

October 19, 1988
PY-CEI/NRR-0926 L

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

Perry Nuclear Power Plant
Docket No. 50-440
Responses to Notice of
Violations 50-440/88012-01, -02 & -06

Gentlemen:

This letter acknowledges receipt of the Notice of Violations contained within Inspection Report 50-440/88012 dated September 14, 1988. The report identified areas examined by Messrs. K. Connaughton, and G. O'Dwyer during their inspection conducted from July 1, 1988 through August 23, 1988 of activities at the Perry Nuclear Power Plant, Unit 1.

Our responses to Notice of Violations 50-440/88012-01, -02 and -06 are attached. Please call should you have any additional questions.

Very truly yours,

Al Kaplan
Vice President
Nuclear Group

AK:njc

Attachment

cc: T. Colburn
K. Connaughton
R. C. Knop - USNRC, Region III

8810250174 881013
PDR ADOCK 05000440
Q PNU

IE01
1/1

50-440/88012-01
Restatement of Violation

Technical Specification 6.8.1 requires implementation of applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978, which includes administrative procedures which address procedure adherence.

Plant Administrative Procedure (PAP) 0201, "Conduct of Operations," Revision 3, Section 6.2.1 stated that plant equipment shall be operated in accordance with written, approved instructions.

Contrary to the above, on March 22 and 23, 1988, licensee personnel performed the venting and filling of the residual heat removal system without written procedural guidance, even though a plant rounds instruction existed to direct the filling and venting operation.

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

Background

Two instances of operator failure to comply with approved procedures during the performance of plant equipment operations were identified during the Operational Safety Team Inspection in March, 1988. Both instances involved Residual Heat Removal (RHR) System fill and vent operations, necessary due to leakage in system boundary isolation valves which were causing undesired heating of RHR system piping. The causes of these incidents have been identified as insufficient emphasis towards procedural compliance by operating personnel, and a lack of direct supervisory involvement in evolutions performed outside the control room. Written programs and policies are considered to be adequate.

Corrective Actions Taken and Results Achieved

At the time of the event, personnel involved were made aware of their errors, and were counseled by supervision with respect to the need for procedural compliance. Since these events occurred, operations management has reemphasized the importance of procedural compliance through Management Directives to Shift Supervisors. Supervisory personnel have additionally been reminded of the need for increased supervisory attention towards evolutions carried out by non-licensed operations personnel.

Requalification training on current events is now being taught by the Operations Section Manager. This forum allows management to discuss operating problems directly with operating personnel, to ensure policies are effectively communicated. The need for improved procedural compliance is currently being emphasized in this manner.

Corrective Actions to Avoid Further Violations

Insufiicient supervisory involvement in plant evolutions is directly related to control room workload and staffing levels. Efforts to increase the overall number of operations supervisory personnel include a NRC Operator License Training Program currently in progress, and the recent promotion of non-licensed operations personnel to supervisory positions.

Date of Full Compliance

Full compliance has been achieved.

50-440/88012-02
Restatement of Violation

Technical Specification 6.2.2.a requires that administrative procedures be developed and implemented to limit the working hours of unit staff who perform safety related functions in accordance with the NRC Policy Statement on working hours (Generic Letter No. 82-12).

Plant Administrative Procedure (PAP)-0110, "Shift Staffing and Overtime," Revision 2, which implemented the above requirements, stated that when circumstances require deviation from specified guidelines, an Overtime Deviation Request, PAP-0110-1, shall be completed.

Contrary to the above, on seven occasions between January and March 1988, the overtime guidelines were exceeded without an approved Overtime Deviation Request having been completed. Additionally, on one occasion, a blanket authorization to exceed the overtime guidelines was approved.

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

Corrective Action Taken and Results Achieved

The cause of this violation was personnel error; existing programs were adequate but not properly implemented by plant supervision. Contributing to the procedural violations was the fact that the plant was in a major maintenance outage.

A review was conducted to determine the extent of this problem and no additional deviations were identified. Additionally, no adverse impacts of the above noted violations have been identified.

The blanket authorization cited in the inspection involved overtime worked by 97 Maintenance Section personnel between January 4 and January 22, 1988 during a maintenance outage. Only one instance was identified in which an overtime guideline was exceeded without prior approval.

Records of time worked are maintained for all personnel. These records indicate all hours worked such that satisfaction of all PAP-0110 requirements can be verified. When making overtime assignments the appropriate supervisor is required to verify that no guidelines of PAP-0110 are exceeded. If it is absolutely necessary to exceed the stated guidelines, an Overtime Deviation Request must be approved by the Department Manager.

Appropriate supervisors have been reminded of their responsibility to implement the requirements of PAP-0110. It is expected that these limitations will only be approached during periods of excessive overtime, such as an outage.

Corrective Actions to be Taken to Prevent Recurrence

The actions discussed above are considered adequate. No further actions are required.

Date of Full Compliance

Full compliance was achieved.

50-440/88012-06
Restatement of Violation

Technical Specification 6.8.1. requires implementation of applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978 which includes administrative procedures which address procedure adherence.

Plant Administrative Procedure (PAP)-0701, "Conduct of Operations," Revision 3, Section 6.2.2.d. required that surveillance instructions (SVIs) be performed in a step-by-step manner throughout the instruction, or step-by-step within a section if only a partial SVI is required.

Contrary to the above, on August 12, 1988, during the performance of SVI-C41-T2001, "Standby Liquid Control Pump and Valve Operability Test," Revision 4, Valve 1C41-F002B was not reopened and locked as required by Step 5.1.2.10. As a result, both trains of the Standby Liquid Control System were simultaneously rendered inoperable during the performance of subsequent procedural steps.

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

Corrective Actions Taken and Results Achieved

The cause of this event was personnel error. The operators involved failed to fully complete each step of the surveillance instruction (SVI) or verify that each step was fully complete prior to signing off the verification checklist for the SVI. Contributing factors to these personnel errors were inadequate communication/teamwork skills, lack of sufficient supervision, and an improvable procedure.

As a result of this event, a counseling session was conducted with the individuals involved in this even which included:

- The importance of repeat-back communication to verify that each step is performed.
- The importance of strict procedural compliance such that each step is performed fully prior to proceeding.
- The benefits associated with one team member taking lead responsibility when performing a surveillance.
- The necessity to notify and consult supervision when difficulty is encountered in performing a task.
- The importance of proper teamwork methods necessary to successfully perform such tasks.

Additionally, a Management Directive was issued to all Shift Supervisors reemphasizing their responsibility to ensure strict procedural compliance and to ensure that only the individual performing the procedural step signs the procedure indicating completion.

Since these corrective actions have only been recently completed, it is difficult to qualitatively assess the effectiveness of these actions. However, CEI does believe that these actions are appropriate and will be effective in improving operations procedural compliance at Perry.

Corrective Action to be Taken to Avoid Further Violations

In order to prevent recurrence of this violation the following corrective actions will be taken.

1. This event will be revieved by all operators as part of the existing Requalification Training Program. The need for supervisory involvement before, during and after task performance will be reemphasized. This will be completed by December 31, 1988.

2. SVI-C41-T2001 will be revised to require independent verification of proper system lineup prior to proceeding to the alternate train. This will be completed by December 31, 1988.

3. A review of similar SVIs will be conducted to determine if the described deficiencies exist elsewhere. Revisions will be made accordingly. This will be completed by December 31, 1988.

Date of Full Compliance

Full compliance will be achieved by December 31, 1988 upon completion of above corrective actions.