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SUBJECT: Responds to NRC 940831 ltr re violation noted in insp rept 50-397/94-24.Corrective action:lessons learned from event will be incorporated into licensed operator refresher training by 940930.

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WASHINGTON PUBLIC POWER SUPPLY SYSTEM

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September 9, 1994
GO2-94-211

Docket No. 50-397

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

Gentlemen:

Subject: **WNP-2, OPERATING LICENSE NO. NPF-21**
NRC INSPECTION REPORT 94-24
REQUEST FOR RECONSIDERATION OF CITED VIOLATIONS

References:
1) Letter, dated August 31, 1994, AB Beach (NRC) to JV Parrish (SS), "NRC Inspection Report 50-397/94-24 (Notice of Violation)"

2) Title 10 to the Code of Federal Regulations Part 2 Appendix C, "General Statement of Policy and Procedure for NRC Enforcement Actions"

3) NRC Enforcement Manual

Reference 1 transmits Notices of Violation for errors committed by an operating crew on July 27, 1994, in response to a high suppression chamber water level condition. The Supply System requests that these violations be reconsidered for issuance as non-cited violations for the reasons described below.

Reference 2 allows the NRC to refrain from issuing a Notice of Violation under certain circumstances to encourage and support licensee initiative for self identification and correction of problems. For these Supply System identified severity level IV violations, the following criteria would apply:

1. The violation must be identified by the licensee;

2. It was not a violation that could reasonably be expected to have been prevented by corrective actions for a previous violation or licensee finding within the past two years;

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3. It was or will be corrected within a reasonable time, by specific corrective action committed to by the licensee by the end of the inspection, including immediate corrective action and comprehensive corrective action to prevent recurrence; and

4. It was not a willful violation.

The Supply System believes the above criteria have been satisfied:

1. The fact that suppression chamber water level had exceeded the EOP entry condition and Technical Specification limit for several hours was identified by the relieving crew at 0140 hours based on their review of Control Room strip chart traces and computer records. A Problem Evaluation Request (PER) was written during the shift documenting this problem. Follow up evaluation of this event by an Incident Review Board and the PER evaluator identified the other aspects of this event (procedure noncompliances and untimely corrective actions) described in Reference 1.

2. Consistent with Reference 1, the Supply System believes this event was an isolated occurrence. Also, we are not aware of previous similar enforcement actions or Supply System findings within the last two years.

3. The NRC was notified via the resident inspector within hours of discovery of the event, and the results of the investigation and proposed corrective actions were shared with the resident inspector as they became available. The following corrective actions have either been taken or are planned:

   a. The Operations Division Manager discussed the event with the crew on July 28. Emphasis was placed on crew responsibility to closely monitor and respond conservatively to plant parameters including formal entry into the Emergency Operating Procedures (EOPs) when an entry condition is met. The crew was reminded that increased awareness is necessary during periods of high activity.

   b. On July 28, after the Operations Division Manager's discussion with the crew, the Shift Manager met with the Control Room Supervisor to restate management's expectations of crew supervision's responsibilities concerning Technical Specification and procedural compliance including formal EOP entry when required. The Control Room Supervisor was counseled to ensure plant parameters are monitored as required and that actions are taken to conservatively control and maintain values within specified bands. He was further reminded of the need to ensure follow-up monitoring is sufficient to preclude unknowingly exceeding Technical Specification and Emergency Plan time limits. The Control Room

Supervisor was instructed to exercise greater caution and to ask for support in reducing the level of activity when he feels it may adversely affect his or the crew's ability to properly execute planned or in-progress evolutions.

c. The Shift Manager was counseled by the Operations Manager on August 1 on his failure to meet management expectations to provide adequate oversight to ensure appropriate response to plant parameter trends and values, including formal entry into the EOPs. He was reminded of his specific role and responsibility for ensuring plant equipment is operated and maintained per the plant Technical Specifications. Further, he was coached on ways to conservatively limit the level of Control Room activity by evaluating the potential impact of performing multiple concurrent complex activities.

d. A detailed review of this event was entered in the Operations department night order book on August 3. Each crew supervisor is responsible for reading this entry and signing for understanding.

e. The applicable Annunciator Response Procedure will be enhanced by September 30, 1994, to reflect the relationship between and give specific values for suppression chamber Technical Specification and EOP entry condition level limits, and Emergency Plan Implementing Procedure level limits and time constraints.

f. The lessons learned from the event will be incorporated into licensed operator refresher training by September 30, 1994.

g. The Operations Manager will reinforce the expectation that Shift Managers control the tempo of shift evolutions to ensure correct priorities are established. This action will be completed by September 30, 1994.

h. Guidance or training will be provided by October 30, 1994, to oversight management personnel to raise their awareness of potential problems that may result from pressures induced by schedules, workloads, and perceived urgency. Their shared accountability and responsibility for plant operation will be stressed.

Thus, immediate corrective actions were taken to address the individual errors associated with this event and comprehensive actions have been scheduled to implement the remaining lessons learned by October 30, 1994.

4. The Supply System does not believe these violations were willful as defined by Reference 3 since there was neither a deliberate violation of requirements nor a careless disregard for requirements involved in the event.

In view of the above, the Supply System requests that you reconsider classifying these violations as non-cited.

If you have any questions or desire additional information regarding this matter please contact me or D. A. Swank at (509) 377-4563.

Sincerely,

J. V. Parrish (Mail Drop 1023)
Assistant Managing Director, Operations

BRH/bk
Attachments

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