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ACCESSION NBR: 9410070145 DOC. DATE: 94/09/30 NOTARIZED: NO DOCKET #
 FACIL: 50-397 WPPSS Nuclear Project, Unit 2, Washington Public Powe 05000397
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SUBJECT: Responds to NRC 940831 ltr re violations noted in Insp Rept
 50-397/94-24.C/A: event discussed w/operating crew on 940728,
 emphasizing formal entry into EOPs & lessons learned from
 event incorporated into operator regualification training.

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 TITLE: General (50 Dkt)-Insp Rept/Notice of Violation Response

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September 30, 1994
GO2-94-230

Docket No. 50-397

U. S. Nuclear Regulatory Commission
Attn: Document Control Desk
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Gentlemen:

Subject: WNP-2, OPERATING LICENSE NO. NPF-21
NRC INSPECTION REPORT 94-24
REPLY TO A NOTICE OF VIOLATION

- 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) Letter GO2-94-211, dated September 9, 1994, JV Parrish (SS) to NRC, "NRC Inspection Report 94-24, Request for Reconsideration of Cited Violations"
 - 3) Letter, dated May 14, 1991, JB Martin (NRC) to DW Mazur (SS), "WNP-2 Requalification Examination Report 50-397/OL-91-01"

The Washington Public Power Supply System (Supply System) hereby replies to the Notice of Violation contained in Reference 1. Our reply, pursuant to the provisions of Section 2.201, Title 10, Code of Federal Regulations, consists of this letter and Appendix A (attached).

In Reference 2 the Supply System requested that these licensee identified problems be reconsidered for issuance as non-cited violations based on the corrective actions taken and proposed. These corrective actions are also described in Appendix A. A reply to this request has not yet been received by the Supply System; the Supply Systems continues to believe that violations B and C should be reclassified as non-cited violations.

Regarding the first proposed violation, the Supply System shares your concerns with operator performance in dealing with a high suppression chamber water level condition during plant startup. However, we feel the performance weaknesses, which were identified by the Supply System, were not procedural noncompliances. The operators did fail to meet management expectations to formally enter the EOPs as they were trained; however, our detailed review of the event revealed that the actions they carried out did meet the applicable EOP procedural requirements. The cause and corrective actions for this problem are described in Appendix A.

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NRC INSPECTION REPORT 94-24, REPLY TO A NOTICE OF VIOLATION

For the second proposed violation, in each example cited the crew failed to meet procedural requirements because they had not recognized that a condition existed warranting actions prescribed by procedures. The Supply Systems accepts this violation, but notes that there was no misuse or disregard for procedures involved. The failure to recognize these conditions existed was clearly a personnel performance problem; the cause and corrective actions are described in Appendix A.

The Supply System does not believe that there are significant similarities between this event and the 1991 operator requalification failures as asserted in Reference 1 for the following reasons:

1. As noted in Reference 3, the primary deficiency in 1991 related to EOPs was the belief by operators that the EOPs were guidance only, and their resulting low threshold for departing from the EOPs. During simulated emergency conditions, operators varied from the EOPs to meet other operational concerns.

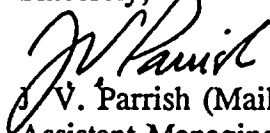
In contrast, in the July 1994 event the operators involved understood the directive nature of the EOPs. The Shift Manager for this event had been directly involved in the Supply System's recovery from the 1991 operator requalification failures. The Shift Manager, Control Room Supervisor, and the Reactor Operator recognized that an EOP entry condition existed, and they made a conscious decision not to carry out any further actions directed by the EOP since an emergency condition clearly did not exist.

2. Since the 1991 operator requalification exam failures, WNP-2's EOPs and EOP training program have been significantly upgraded. This has resulted in an improvement in operator use of EOPs, such that operator use of EOPs was described as a strength in the March 1994 Institute of Nuclear Power Operations evaluation of WNP-2.

Appendix B to this letter lists the commitments made in this letter and Appendix A.

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

cc: LJ Callan - NRC RIV
KE Perkins, Jr. - NRC RIV, Walnut Creek Field Office
NS Reynolds - Winston & Strawn
JW Clifford - NRC
DL Williams - BPA/399
NRC Sr. Resident Inspector - 927N

Appendix A

Violation A

10 CFR Part 50, Appendix B, Criterion V states, in part, "Activities affecting quality shall be prescribed by documented instructions, procedures, or drawings of a type appropriate to the circumstances and shall be accomplished in accordance with these instructions, procedures, or drawings."

Plant Procedures Manual (PPM) 1.3.1C, Revision 1, "Procedure Usage and Plant Manipulations," paragraph 4.3.7a, "Volume 5 Emergency Operating Procedures (EOPs)," states that the EOPs "shall be entered whenever any EOP entry condition exists."

EOP PPM 5.2.1, "Primary Containment Control," Revision 8, lists as an entry condition: suppression Pool water level greater than or equal to +2.0 inches.

Contrary to the above, on July 27, 1994, operators noted that suppression pool water level was at +2.5 inches, but did not enter EOP PPM 5.2.1, "Primary Containment Control."

This is a Severity Level IV violation (Supplement I). (397/9424-01)

Response to Violation A

The Supply System denies this violation.

The Supply System believes the procedure requirements for EOP flowchart entry were met. The first step of the EOP PPM 5.2.1 flowchart describes the suppression pool water level greater than or equal to +2.0 inches entry condition. The Control Room Supervisor recognized this entry condition and discussed the need to carry out the EOP actions with the Shift Manager. By recognizing the entry condition had been met and discussing the EOP requirements, the crew had complied with the EOP PPM 5.2.1 flowchart. PPM 1.3.1C allows the Shift Manager to exit an EOP when he determines an emergency no longer exists. The Shift Manager did make this evaluation and therefore the decision to not carry out further EOP actions was appropriate and allowed by procedure.

Although the procedure requirements were met, crew performance did not comply with management expectations or their training. Regarding formal entry into the EOP (i.e., by verbal announcement and marking completed EOP steps with a colored pen), the following actions were taken to address this matter:

1. The Operations Division Manager discussed the event with the crew on July 28. Emphasis was placed on formal entry into the Emergency Operating Procedures (EOPs) when an entry condition is met.

2. 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 for formal EOP entry when required.
3. The Shift Manager was counseled by the Operations Manager on August 1 on his failure to meet management expectations to formally enter the EOPs.
4. 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.
5. The lessons learned from the event were incorporated into licensed operator requalification training. This training was provided to the operating crews by September 26, 1994.

Violation B

10 CFR Part 50, Appendix B, Criterion V states, in part, "Activities affecting quality shall be prescribed by documented instructions, procedures, or drawings of a type appropriate to the circumstances and shall be accomplished in accordance with these instructions, procedures, or drawings."

1. PPM 1.3.1D, Revision 2, "Conduct of Operations - Administrative Requirements," paragraph 4.8.4 states, in part, "The Shift Manager or Control Room Supervisor will initiate a Technical Specification Inoperable Equipment/LCO/ODCM Status Sheet similar to Attachment 5.8 whenever any of the following conditions exist:
 - a. A system or component required by Technical Specifications as a limiting condition for operation in the present plant Mode becomes inoperable (LCO)."

Contrary to the above, on July 27, 1994, the Shift Manager and Control Room Supervisor noted suppression pool level to be in excess of +1.75 inches, the Technical Specification Limiting Condition for Operation, but did not initiate a Technical Specification Inoperable Equipment/LCO/ODCM status sheet to track compliance with the action statement.

2. PPM 3.1.10, Revision 2, "Operating Data and Logs," paragraph 4.14, "Control Room Log" states, in part, " . . . The following shall be entered as a minimum:

4.14.3 Timed entries for all log entries, including but not restricted to the following . . .

- i. Entering and leaving a Technical Specification action statement and reason."

Contrary to the above, on July 27, 1994, operators noted suppression pool level to be in excess of its Technical Specification Limiting Condition for Operation limit of +1.75 inches, but did not make a timed log entry in the Control Room Log to document the occurrence.

3. Technical Specification 6.8.1 states, in part, "Written procedures shall be established, implemented, and maintained covering the activities referenced below:

"f. Emergency Planning Implementation"

PPM 13.1.1, Revision 20, "Classifying the Emergency," states in the Symptomatic Condition Emergency Action Levels for an Unusual Event, on page 6 of 31: "Suppression Pool Water Level - GE [greater than or equal to] +2 inches for more than 1 hour."

Contrary to the above, on July 27 and 28, 1994, emergency planning procedures were not implemented in that suppression pool water level was allowed to exceed +2 inches for approximately 4 hours, and an Unusual Event was not declared.

This is a Severity Level IV violation (Supplement I). (397/9424-02)

Response to Violation B Examples 1 and 2

The Supply System accepts these examples. Because these examples resulted from a failure to adequately recognize the condition adverse to quality cited in Violation C, we would characterize them as additional examples of Violation C and not as procedural noncompliances.

The Shift Manager and Control Room Supervisor did fail to initiate a Technical Specification Inoperable Equipment/LCO/ODCM status sheet and make a timed Control Room Log entry as noted in the Notice of Violation; however, this failure did not constitute a procedural violation. When suppression pool level was noted to be above +2 inches the Control Room Supervisor referred to the Technical Specifications to determine if any action was prescribed. Two Technical Specifications contain restrictions on suppression pool level: the Emergency Core Cooling Systems specification (3.5.3) specifies a minimum level, and the Containment specification (3.6.2.1) specifies both a minimum and a maximum level. The Control Room Supervisor found the Emergency Core Cooling Systems specification requirement first and concluded that the high suppression pool level condition did not have any Technical Specification compliance implications. He did not check for additional requirements and thus did not identify the more restrictive Technical Specification 3.6.2.1.

Since the Control Room Supervisor did not identify that a Technical Specification Limiting Condition for Operation should have been entered, he did not initiate a Technical Specification Inoperable Equipment/LCO/ODCM status sheet or make a timed Control Room Log entry. These failures were not the result of any misuse or disregard for procedures. In fact, the Control Room Supervisor had been initiating LCO status sheets and making Control Room Log entries for the other LCOs that were entered during the shift.

1. Reason for the violation

The failure of the Control Room Supervisor to identify all applicable Technical Specification limits resulted from the high level of activity in the Control Room during performance of startup activities.

2. Corrective steps that have been taken and the results achieved.

The Operations Division Manager discussed the event with the crew on July 28. The crew was reminded that increased awareness is necessary during periods of high activity.

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 compliance. 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.

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. 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.

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.

The lessons learned from the event were incorporated into licensed operator requalification training. This training was provided to the operating crews by September 26, 1994.

The applicable Annunciator Response Procedures were changed on September 26, 1994, to reflect the relationship between and give specific values for suppression chamber Technical Specification level limits and time constraints.

The Operations Manager met with the operating crew Shift Managers on August 29, 1994, to reinforce his expectation that Shift Managers control the tempo of shift evolutions to ensure correct priorities are established.

As a result of these corrective actions, the crew involved in the event understands the errors they made and how to avoid recurrence, and the lessons learned have been shared with the other operating crews.

3. Corrective steps that will be taken to avoid further violations.

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.

4. Date when full compliance will be achieved.

Full compliance with respect to the matter identified above was achieved at 0140 hours on July 28, 1994, when the next crew entered the Technical Specification action statement for suppression pool water level, made the required control room log entry, and initiated a Technical Specification Inoperable Equipment/LCO/ODCM status sheet.

Response to Violation B Example 3

The Supply System accepts this example. Because this example resulted from a failure to adequately recognize the condition adverse to quality cited in Violation C, we would characterize this as an additional example of Violation C and not as a procedural noncompliance.

The fact that suppression pool level had exceeded +2 inches for more than 1 hour was identified by the mid shift crew based on a review of recorder traces and computer records, after level had been reduced below this threshold. Declaration of an Unusual Event at this time was therefore not required.

The failure of the swing shift crew to recognize that suppression pool level had exceeded +2 inches for more than 1 hour was a significant error but not a procedural noncompliance. The failure to declare an Unusual Event was not the result of any misuse or disregard for procedures. Corrective actions to address this problem are described in the response to examples 1 and 2 above.

1. Reason for the violation

The cause of the failure to recognize that a condition requiring declaration of an Unusual Event was the high level of activity in the Control Room during performance of startup activities.

2. Corrective steps that have been taken and the results achieved.

Same as described in the response to examples 1 and 2 above.

3. Corrective steps that will be taken to avoid further violations.

Same as described in the response to examples 1 and 2 above.

4. Date when full compliance will be achieved.

Full compliance with respect to the matter identified above was achieved at 0146 hours on July 28, 1994, when suppression pool level was reduced below +2 inches, the threshold for declaring an Unusual Event.

Violation C

10 CFR Part 50, Appendix B, Criterion XVI states, in part, "Measures shall be established to assure that conditions adverse to quality . . . are promptly identified and corrected."

Contrary to the above, on July 27, 1994, a condition adverse to quality was identified but was not promptly or adequately corrected. Specifically, operators noted that suppression pool water level was greater than the Technical Specification Limiting Condition for Operation limit, but did not take effective corrective action to ensure that the level was corrected within the Technical Specifications action statement limit of 1 hour. Suppression pool water level remained greater than the Technical Specification limit for approximately 7 hours.

This is a Severity Level IV violation (Supplement I). (397/9424-03)

Response to Violation C

The Supply System accepts this licensee identified violation.

1. Reason for the violation

The reason for the violation was that a large number of concurrent control room activities distracted the operating crew from the high suppression level condition. Also, the crew allowed schedule pressures to influence the method they selected to correct the high level condition, in that a slow drain-down was used to allow an in-progress leakage surveillance test to continue.

2. Corrective steps that have been taken and the results achieved.

Prior to identification of this problem by the Supply System, the suppression pool was returned to a normal operating level by the mid shift crew.

The problem was identified by a review of recorder traces and computer records and a Problem Evaluation Request was written to document it.

The NRC resident inspector was contacted by the mid shift and briefed on the event.

An Incident Review Board was convened to quickly collect the facts relevant to the event. The purpose of this board is to investigate the event promptly and interview those involved while their memory of the event is still fresh.

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. The crew was reminded that increased awareness is necessary during periods of high activity.

On July 28, after the Operations Division Manager's discussion with the crew, the Shift Manager counseled the Control Room Supervisor on his responsibility 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.

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. 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.

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.

The Operations Manager met with the operating crew Shift Managers on August 29, 1994, to reinforce his expectation that Shift Managers control the tempo of shift evolutions to ensure correct priorities are established.

The lessons learned from the event were incorporated into licensed operator requalification training. This training was provided to the operating crews by September 26, 1994.

The corrective actions have resulted in the event being thoroughly investigated and minimizing the possibility of a similar event occurring pending completion of the action described below.

3. Corrective steps that will be taken to avoid further violations.

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.

4. Date when full compliance will be achieved.

Full compliance with respect to the matter identified above was achieved at 0205 hours on July 28, 1994, when suppression pool level was returned to normal.

Appendix B

Commitment

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.