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ACCESSION NBR: 9610160049 DOC. DATE: 96/10/02 NOTARIZED: NO DOCKET #
FACIL: 50-397 WPPSS Nuclear Project, Unit 2, Washington Public Powe 05000397
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WEBRING, R.L. Washington Public Power Supply System
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SUBJECT: Responds to exercise weakness in insp rept 50-397/96-13.
Corrective actions: each operating crew has received addl
training on use of high range stack monitor & participated
in simulator training.

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October 2, 1996
GO2-96-190

Docket No. 50-397

U. S. Nuclear Regulatory Commission
Attn: Document Control Desk
Mail Station P1-37
Washington, D. C. 20555

Gentlemen:

Subject: **WNP-2, OPERATING LICENSE NO. NPF-21
NRC INSPECTION REPORT 96-13
RESPONSE TO EXERCISE WEAKNESS**

Reference: Letter, dated August 22, 1996, KE Brockman (NRC) to JV Parrish (SS), "NRC Inspection Report 50-397/96-13"

The Washington Public Power Supply System hereby replies to the exercise weakness identified in your letter dated August 22, 1996. Our reply, pursuant to the provisions of 10 CFR Part 50, Appendix E.IV.F, provides a description of the corrective measures to be taken and the schedule for completion of the actions.

Section P4, "Observations and Findings," of the Reference Inspection Report includes the following observed weakness during emergency preparedness exercise walkthroughs with three operating crews using a dynamic simulation on the plant specific control room simulator:

One of the crew's performance was unsatisfactory in its implementation of the emergency plan procedures. Most noticeably, was the inability of the shift technical advisor to produce an offsite dosage calculation in order to assist in recommending additional protective action recommendations (PARs). The failure to perform an offsite dose estimate calculation was due in part to the shift technical advisor's unfamiliarity with the digital recorder for the reactor building release radiation monitor. The individual erroneously selected a voltage output rather than a radiation measurement output. When the individual attempted to use the value in the offsite dose estimate, the computer would not accept the value. The individual attempted to use the backup system, but was unfamiliar with it and could not enter the correct inputs.

Additionally, during the same time period alternate instruments (area radiation monitors) had indicated maximum readings (10,000 Rem/hr) for over five minutes. The shift manager and

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the control room supervisor did not question the incongruence between the low readings of the shift technical advisor and what the alternate instruments indicated. Had a second individual been dispatched to verify the shift technical advisor's PRM-RE-1C readings the error could have been detected. As such, the shift manager erroneously concluded that no core damage had been sustained.

Further, local notifications from the control room were not made within the required 15 minutes by the second [same] crew. The facsimile was sent out 17 minutes after the general emergency declaration and the "Crash Call" was made 18 minutes after the General Emergency declaration. The failure to make a timely notification of the General Emergency and the failure of the shift technical advisor to make an appropriate dose assessment calculation were identified as an exercise weakness.

Corrective Measures

The Supply System concurs with the weakness identified with the one crew. However, we believe it was an isolated case based on observation that the two other crews performed well in the simulator and conclude that the weakness was an isolated case. Appropriate corrective measures were implemented.

Each operating crew has received additional training on the use of the high range stack monitor and participated in a simulator training exercise involving a radioactive release. The shift technical advisor with the identified weakness received remedial training on the operation of the stack monitor readout and reviewed procedures for performing offsite dose calculations. The individual also performed as the shift technical advisor in a simulator training exercise involving a radioactive release that required additional PARs with evacuation and sheltering.

Contrary to management expectations, the shift manager and control room supervisor failed to recognize that an offsite release was in progress during the training exercise. Both the shift manager and control room supervisor were aware of the area radiation monitor alarms throughout the reactor building, but failed to question the erroneously low dose readings provided by the shift technical advisor. Consequently, the shift manager and control room supervisor involved received remedial training to ensure that they clearly understand the necessity to "peer-check" and critically evaluate issues that are not thoroughly understood. They were also reminded of the importance of performing followup actions as necessary to validate previous conclusions.

As a preventive measure, the shift manager and control room supervisor will be reevaluated on a similar emergency plan scenario.

Completion Schedule

All of the identified corrective measures have been completed.

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Should you have any questions or desire additional information regarding this matter, please call me or Ms. L. C. Fernandez at (509) 377-4147.

Respectfully,



R. L. Webring
Vice President, Operations Support/PIO
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