DCS

AFFIRMATION

U.S. Nuclear Regulatory Commission, Region IV
Reply to a Notice of Violation (EA 95-105)

I, John Michael Gallagher, declare under the penalty of perjury under the laws of the United States of America, that the foregoing document consisting of seventeen (17) pages is true and accurate to the best of my knowledge and belief.

D A T E D this 14 day of September, 1995, at Richland, Benton County, Washington, U.S.A.

J. Mich Gallagher
JOHN M. GALLAGHER

On this 14 day of September, 1995, John Michael Gallagher, personally known to me, appeared before me and signed this document of his free will.

SUBSCRIBED AND SWORN to before me this 14 day of Sept., 1995.

Yvette H. Berard
NOTARY PUBLIC in and for the State of Washington, residing at Kennewick

My Commission Expires: 1-17-96.

ljs\195166\affirm.jmg

IE14
1/1

J. Mike Gallagher
[redacted]

September 12, 1995

Mr. L.J. Callan, Regional Administrator
U.S. Nuclear Regulatory Commission, Region IV
611 Ryan Plaza Drive, Suite 400
Arlington, TX 76011

Subject: Reply to a Notice of Violation (EA 95-105)

Dear Mr. Callan:

This refers to: 1) Notice of Violation (EA 95-105) issued on August 17, 1995; 2) Washington Public Power Supply System presentation document at WNP-2/NRC Region IV Enforcement Conference (EA 95-096) presented on July 28, 1995; 3) Augmented Inspection Team (AIT) Report 50-397/95-13 issued June 12, 1995; 4) NRC Inspection Report 50-397/95-07 issued June 2, 1995; 5) My appeal letter issued June 12, 1995 to the Washington Public Power Supply System and submitted into evidence at NRC Enforcement Conference (EA 95-105) on July 17, 1995; 6) Washington Public Power Supply System letter to NRC Requesting Termination of Operator Licenses dated April 20, 1995; 7) NRC letter to me, Notification of License No. SOP-50300-1 expiration issued April 27, 1995; 8) NRC letter to me, Notice of Enforcement Conference issued June 14, 1995, 9) E-Mail from Operations Manager to control room staff dated March 3, 1995.

I agree with your determination that my actions were not deliberate decisions to violate plant procedures. I agree with your determination that my actions did not place the plant in an unsafe condition. I agree with your determination to not propose any further enforcement actions against me. I agree with your determination to not restrict any future involvement I may have in NRC-licensed activities.

However, I respectfully request a re-evaluation of the enforcement action taken against me in the form of, and deny, a Severity Level III Violation. I request a re-evaluation of your determination, and deny, that my actions were willful in any way shape or form and specifically as defined by careless disregard. I request a re-evaluation of your determination, and deny, that my actions constituted careless disregard.

210047

Redacted by OE

IE14

OBJECTIVE REALITY -

What really matters are the facts of this event. The facts are based on the actions and or inactions of the individuals involved. Statements are personal perceptions and interpretations of an experience. These personal perceptions and interpretations expressed in words are routinely skewed by the individuals state of mind and view point during and after the experience. It is also possible, one's boss could affect individual's statements during investigation interviews. The only thing that is fact about personal statements is that no two people will describe an experience the same, unless there was a script. Even the consistency of a script will waiver as the time away from the script. Therefore, it is very important to seek substantiation of statements based on the action or inaction of the individuals involved.

Please accept the following as FACTS of this event:

1 - I looked at the procedure. (uncontested testimony)

2 - I made the Shift Manager, my boss, aware of our level control method and the reasons for it. (uncontested testimony)

3 - The Shift Manager approved of our level control method. (uncontested testimony)

4 - The Shift Manager did not look at the procedure that night. (uncontested testimony)

5 - The Shift Manager looked at the procedure the night before and was aware of a different method of level control using throttling of the RWCU-V-42. (uncontested testimony)

6 - The Shift Manager never offered me an alternative level control method that he was aware had been used the night before while I was off. (uncontested testimony)

7 - None of the Reactor Operators ever offered me an alternative to control level and prevent feed water piping damage. (uncontested testimony)

8 - Our level control method did exactly what we wanted it to. (plant charts and computer historical data)

9 - Our level control method was in accordance with the procedures the last time the plant was in hot shutdown. (WPPSS PER 295-0317 root cause analysis)

10 - This method of reactor level control had been used in the past, but the last time the plant was in hot shutdown, the procedure caution did not state that the valve "shall not be opened". (WPPSS PER 295-0317 root cause analysis)

11 - There was no specific guidance provided in procedures or other documents relating to hot shutdown conditions for RPV level control and RWCU/FW line thermal stresses. (WPPSS PER 295-0317 root cause analysis)

12 - Training was not provided to practice control of RPV level while in hot shutdown conditions. (WPPSS PER 295-0317 root cause analysis)

13 - The RWCU system lesson had not been updated after the crucial change to the procedure. (WPPSS PER 295-0317 root cause analysis)

14 - The crucial procedure change was not included in training prior to the event. (WPPSS PER 295-0317 root cause analysis)

15 - All involved personnel were aware of possible damage to feed water piping/components if we did not take action to remove inventory from the reactor. (uncontested testimony)

16 - The feed water piping/components had been damaged recently increasing our awareness of this concern. (uncontested testimony and PER ? of that event)

17 - Our level control method had no physical or engineering based safety significance even if RWCU-V-31 had been opened fully. (WPPSS PER 295-0317 engineering evaluation dated April 27, 1995)

18 - The low pressure (150# design) section of the RWCU blow down line is 6 inches in diameter from beginning to end and is open ended (ie. no valves or anything that could block flow) directly into the main condenser, a very large atmospheric or sub-atmospheric vessel. (mechanical piping diagrams, M523, M526, M534, M506)

19 - You can not make a larger opening in this 6" diameter pipe than already exists. (physical impossibility)

20 - A relief valve uses this 6" low pressure RWCU blow down piping as it's tailpipe which by code is required to be unrestricted and not capable of being pressurized. (ASME code)

21 - If a high pressure alarm comes in at greater than 140 psig on the high pressure (1420# design) portion of the RWCU blow down line, alarm response procedures direct the Reactor Operators to relieve this high pressure into the low pressure portion of the RWCU blow down line and thus to the main condenser. (alarm response procedure)

22 - CRO1 did not turnover our level control method to relief CRO1. (uncontested testimony)

23 - CRO1 stayed over for approximately 30 minutes after turnover and did not attempt to talk to anyone concerning our level control method. (uncontested testimony)

24 - I ensured relief CRO1 was aware of our level control method. (uncontested testimony)

25 - I told my relief of what our level control method had been. (uncontested testimony)

26 - The Shift Manager, my boss, along with approving our level control method directed me to have the valve closed by the end of our shift. (uncontested testimony)

27 - I directed the Reactor Operators to have the valve closed by the end of shift in accordance with direction from the Shift Manager and to ensure it would not be forgotten during shift change like it had been already. (uncontested testimony)

28 - The Reactor Operators did not inform me of CRD flow reductions and RWCU-V-31 valve closure. (uncontested testimony)

29 - The Reactor Operators did not initiate a procedure deviation (P.D.F.). (uncontested testimony and no deviation exists)

30 - The Reactor Operators did not initiate a problem evaluation request (P.E.R.). (uncontested testimony)

31 - None of the Reactor Operators discussed our level control method with the Shift Manager or any other operations management personnel who were there at that time. (uncontested testimony)

32 - The Reactor Operators did not inform the lead Reactor Operator of our level control method. (uncontested testimony)

33 - The lead Reactor Operator did not make a log entry concerning the method of level control. (uncontested testimony and no log entry exists)

34 - The lead Reactor Operator does not have to receive direction from me or ask me to make log entries. (uncontested testimony and accepted practice)

35 - I never told the lead Reactor Operator to not make a log entry. (uncontested testimony)

36 - The new Operations Manager regarded me, in his own written words, as a "FALL GUY". (WPPSS PER 295-0317 individual mitigating issues)

37 - I am not interested in being a "FALL GUY"! (my appeal letter to WPPSS dated June 12, 1995)

38 - Discretion was allowed by supervisors concerning their involvement in evolutions on a case by case basis. We were allowed to use our judgement in determining when it was appropriate to become physically involved in an evolution. (E-Mail dated March 3, 1995)

39 - Expectations or procedures are not provided for motor operated valves that are throttled without throttled indication. (my appeal letter to WPPSS dated June 12, 1995)

40 - The new Operations Manager knew of interpersonal problems between CRO2 and the Shift Manager and failed to resolve these issues. (uncontested testimony & NRC AIT report of June 12, 1995)

These facts are represented as such to the best of my knowledge at the time of this writing. It is possible, I have misinterpreted and/or more information could surface in the future that could subtract from and/or add to this list of facts. If you have any questions or other information that supports or refutes these facts as stated please contact me. I may also be able to assist you in understanding my assertion as to the factual bases of the items in the above list.

In your Notice of Violation (EA 95-105) cover letter you state, it is fact that I displayed careless disregard. I disagree with that statement. It is fact an error was made. It is an interpretation of the evidence gathered which includes false statements, opinions and hearsay that I displayed careless disregard. Your assertion that I displayed careless disregard is not fact and has no basis in fact.

The mere fact that I approached my boss, explained to him our level control method, the reasons for it, and received his approval is fact enough to disprove any conclusions of careless disregard on my part. The fact that my boss had looked at the procedure the very day before because they had this same problem and used a different method to control level and did not mention this other method to me, is fact that I tried to do the right thing but others did not. The fact that others did not talk with the Shift Manager is proof that others acted with careless disregard especially after they said they knew it was a procedure violation. Double checking my actions with my boss is not the action of a licensed SRO exhibiting careless disregard.

The mere fact that I looked at the procedure is positive evidence that I tried to do the right thing. There is no motive or benefit to me to carelessly disregard plant procedures. Looking at the procedure is not the action of a licensed SRO exhibiting careless disregard.

Another fact which supports my actions as not being careless disregard is that I approached and initiated a conversation with relief CRO1 about the level control method. To ensure a newly arriving CRO1 on our shift understood the level control method is not the action of an SRO licensed CRS acting with careless disregard. This fact is positive evidence that my actions were not careless disregard.

Another fact which supports my actions as not being careless disregard is that I informed my relief, an SRO licensed CRS, of the level control method that had been used on our shift. To ensure the next shift's SRO licensed CRS is aware of the level control method employed on my shift is not the action of an SRO licensed CRS acting with careless disregard. This fact is positive evidence that at shift turnover, I believed my actions were within the procedural rules. This fact is positive evidence that my actions were not careless disregard.

It is fact that I have no prior history of misinterpreting procedures or procedure non-compliance. It is fact that I have never been disciplined before for procedure misinterpretations or procedure non-compliance.

I made an honest attempt to verify our level control method was within the words used in the procedure. If I had not looked at the procedure I would have exhibited careless disregard. It is possible, I was distracted from the procedure while reading it and thought I had read it and understood it. It appears, I was distracted and then looked back down at the procedure possibly not picking up where I had left off. I may have looked down and saw the "should" just above step 4.7 in the precautions and limitations section of the procedure during a distraction and interpreted this should to be associated with step 4.7. I have been trying to understand this instant in my life since I became aware it occurred and can only think this is what may have happened.

I have never disputed my actions as being an error in procedure interpretation. I have always taken full responsibility for that non-safety significant misinterpretation. The facts of my actions are that I searched out the procedure, received approval from my boss and ensured others were informed. These actions are facts and as such do not support a determination of careless disregard.

Any licensed individual who does <u>not</u> look at the procedure, or does <u>not</u> receive his bosses approval, or does <u>not</u> keep relief CRO's informed, or does <u>not</u> inform his relief is acting with careless disregard. But, I did all of these things as factual actions. These actions were never and are not in dispute. I fully believe, ones actions speak louder than others words.

Therefore, I am respectfully requesting a determination by the NRC that my actions at the most constitute a procedure interpretation error of no safety significance. I am respectfully requesting a determination by the NRC that I did not exhibit careless disregard. As such, I am respectfully requesting Notice of Violation (EA 95-105) be reevaluated to take no enforcement action against me.

TESTIMONIES -

In transcribed testimony CRO2 states in part, he thought the procedure said can not, he thought the first one said can not and the second one said shall not but the procedure says shall not in both places. It is possible, CRO2 did not understand what the procedure said given these statements.

CRO2 did not relate to me his apparent understanding that the valve can not be open. If he had this understanding he should have initiated a procedure deviation, or double checked our level control method that night with any one of the other management personnel in the control room at the time. I did not direct him to not do these things. His inaction does not correlate with his words. I am sure it was my expectation and the Supply System's and NRC's expectation to do these things under any condition when any Reactor Operator becomes aware of an evolution that is not in compliance with procedures.

In transcribed testimony on April 22, 1995, CRO2 states in part, the Shift Manager and myself overlapped and double checked each other on everything, such as, "what do you think about this, here's how I see this but what do you think, yeah, or no that's probably not the most conservative way to handle that, why don't we go ahead and do it this way instead". He says this as a crew also, that we have kept the crew pretty much out of PER range, we don't have that many problems going on with our crew. I agree with CRO2's perspective on how our crew functioned.

CRO2 also states in part, he was hesitant to talk to the Shift Manager because of past behavior change coaching from the Shift Manager. CRO2 states in part, he felt the Shift Manager was extremely unlikely to listen to him. It is possible, CRO2 let personal problems with the Shift Manager interfere with the execution of his licensed duties.

In NRC Augmented Inspection Team (AIT) Report 50-397/95-13 issued June 12, 1995, section 6.2.1, page 25, first paragraph, it states in part, management knew of interpersonal problems that existed between the Shift Manager and CRO2. Management recognized problems on our crew and did not take any action to address them. Management acknowledged that it's resolution of the problems was slower than it should have been. I submit to you, resolution actions were non-existent prior to the event. Please see page 14 below concerning this management failure issue.

In transcribed testimony on April 22, 1995 CRO1 stated in part, he told me he believed there was a shall not statement in the procedure. CRO1 was asked if he told me that he thought there was a shall not statement. CRO1 answered that he had told me. NRC Augmented Inspection Team (AIT) Report 50-397/95-13 issued June 12, 1995, page 22, section 6.1.4, states in part, CRO1 told the CRS he did not think this could be done because the procedure specified shall not. When the team asked CRO1 to confirm that he had told the CRS the procedure said shall not, he responded, "yes". CRO1 said, he believed, the CRS not only knew his action was a procedural violation but also understood CRO1's concern.

In recorded testimony on August 14, 1995 CRO1 stated in part, he could not say he used or heard shall not, he did not look at the procedure, he was not sure if the CRS knew of the shall, he was not sure if he knew it was a shall, he was not sure if it was intentional. (I have not yet received copies of these transcripts. These statements are from my notes taken during CRO1's sworn testimony. I should be able to supply the NRC with these transcriptions when I receive them if you request so.) This is a very significant change in testimony by CRO1. I notified NRC Region IV of this change in testimony on August 15, 1995.

I found out on August 14, 1995 during recorded testimony, the length of my conversation with CRO2 changed from two to five minutes to approximately one minute. This is a significant change in time to present a concern and look at the procedure. But more importantly is the change in testimony. I notified NRC Region IV of this change in testimony on August 15, 1995.

I also found out on August 14, 1995 that CRO1 had stayed past his turnover with relief CRO1 until approximately 0300. This gave him more than ample opportunity to remember to turnover our level control method to relief CRO1. This gave him ample opportunity to further discuss our level control method with me or any other management individual that night. His inaction does not correlate with his words. The only conclusion that is supported by this evidence is there was not a concern at the time CRO1 left. This is very significant, in that, this individual's inaction does not support the testimony provided. I notified NRC Region IV of this change in testimony on August 15, 1995.

Obviously, there is a contradiction of testimony here and possibly false information was given to the Supply System and NRC. I believe CRO1 is now finally separating the ideas and opinions of CRO2 from what he actually heard and saw. I notified NRC Region IV of this change in testimony on August 15, 1995. This is just two days prior to the date of the Notice of Violation.

CRO2 was unusually not present at August 14, 1995 and September 5, 1995 Employment Security hearings in Richland, Washington. As such, we were not afforded the opportunity to cross examine this individual to bring out any inconsistencies under oath.

No one ever offered me an alternative to control level or feed water flow. I fully believed we had done the right thing for two days after the evolution. I fully believed, all the other individuals involved also believed what we had done was appropriate and procedurally acceptable for two days after the evolution. I did not realize until April 11, 1995 a violation of procedural requirements had occurred.

I believe if you look at my testimony and compare it to my actions and inactions you will find they are without conflict. But, if you compare the CRO's testimony with their actions and inactions you will find a lot of conflicts. I have pointed out just a few that I feel are very important.

I have not even looked at the NRC Office of Investigations (OI) testimonies and compared them with each individuals earlier and later testimonies yet. I have requested information through the Freedom of Information Act that I felt would assist me in this response. The NRC FOIA Office indicates there could be some delays due to backlogs and the time needed to search for the records I requested. If I find it necessary, I may be providing you with more information after I have had an opportunity to review the OI documents.

I am respectfully requesting a determination by the NRC that my actions at the most constitute a procedure interpretation error of no safety significance. I am respectfully requesting a determination that I did not exhibit careless disregard. As such, I am respectfully requesting Notice of Violation (EA 95-105) be reevaluated to take no enforcement action against me.

COMPARATIVE SEVERITY -

The severity level of the Notice of Violation does not appear to match levels of severity of previous or later events. As an example, I will use just a couple of many Technical Specification violations which occurred at WNP-2. Specifically, two mode change Technical Specification violations occurred in February of 1995. As you already know, Technical Specifications and Emergency Operating Procedures (EOP) are the highest level procedures at a facility. Violation of a Technical Specification is much more serious than violating any plant normal operating procedure.

The purpose of Technical Specifications is to impose conditions and limitations upon power plant operation necessary to obviate any possibility of an abnormal situation or event giving rise to an immediate threat to the public health and safety by establishing conditions of operation which cannot be changed without prior NRC approval and by identifying features which are of controlling importance to safety. Specifically, Technical Specifications contain operation and maintenance requirements which have a bearing on the public health and safety. As such, violation of any Technical Specification criteria is in fact a violation of Federal law. Adherence to Technical Specifications is mandatory for all employees of a nuclear power plant facility. These above words relate the safety significance of violating any requirement of Technical Specifications.

Contrary to these requirements, Technical Specification violations have occurred at WNP-2. There are three or four copies of Technical Specifications in the main control room available to be referred to, as opposed to only two copies of normal operating procedures, indicating more than adequate procedure availability. The systems were not operational when the mode changes were made and were clearly identified in the logs and on the panels.

The personnel who made the mode changes knew the status of the plant, specifically, the out of service systems and did not refer to Technical Specifications to check for compliance prior to making the mode changes. The mode changes were made without the Technical Specification required systems operable. If this isn't careless disregard for the highest level procedure requirement which is of safety significance, I don't know what is. It is possible the SRO's involved in these errors and others have not had any discipline or increased training let alone termination of employment and license. Also, it is possible enforcement actions have not been issued to the individuals.

In the Supply System's enforcement conference document dated July 28, 1995, on page 13 they state in part, the only cause of these violations is that a plant procedure did not say to check for Technical Specification compliance. I disagree with this cause.

For 12 years the control room staff has not required a plant procedure to tell us to check to make sure we were in compliance with Technical Specifications. Technical Specifications are a stand alone document which require adherence to the highest degree without reliance on any other lower order plant procedure. The lower order plant procedures may include reference to Technical Specification requirements but we have never relied on plant procedures to ensure compliance with Technical Specifications.

In this same document dated July 28, 1995, on page 14 they state in part, the Technical Specification violations had no actual safety significance. I disagree with this analysis. All requirements of Technical Specifications by definition are safety significant.

The specification violated (3.0.4) has no allowed outage time. You are either in compliance or you are not. This is the specific usage criteria for all Limiting Conditions for Operation (LCO) and as such does not allow deviation times. To relate the LCO allowed outage time to specification 3.0.4 is sacrilege because 3.0.4 is the criteria which delineates outage times are not allowed when changing modes.

There are Technical Specification Surveillance test procedures which specifically and periodically test for compliance to Technical Specification requirements. These procedures, and there are roughly 30 to 50 books full of these procedures, have individual and specific sign offs for each step in a procedure.

It is normal practice and allowed by procedure to star, number and initial a step in these procedures if it could not or should not be performed. We then would write the reason for not performing the step on the front of the procedure and continue with the procedure.

This is an example of a more strict form of licensed supervisor discretion which was allowed and routinely practiced with the more safety significant Technical Specification surveillance procedures. With the less safety significant normal operating procedures we were allowed to use discretion with in specific verbiage such as should and may without documentation as determined by the supervisor. There are no sign off steps for approximately 99% of the normal operating procedures.

In your enforcement conference letter dated June 14, 1995 you state in part, "...the NRC...must be able to rely on licensed operators not only to comply with all requirements, but to set an example for all plant personnel with respect to, procedural compliance and attention to safe operations". To my knowledge and personnel file records, this is the first procedural compliance error I have made in my 12 years as a licensed operator/supervisor. I have never been disciplined by the Supply System or NRC for procedural compliance errors in the past. I have complied with all procedural requirements. I have set an excellent example for all plant personnel with respect to procedural compliance.

How can one non-safety significant error cause such a fury of attention and enforcement action? Yet others have violated not just procedures but Technical Specifications and nothing like this has happened to them. Why am I being singled out for enforcement action for a non-safety significant error? In your Notice of Violation letter you state in part, "While there may have been no safety consequences as a result of your actions". I agree, there was no safety consequences as a result of my actions.

If you compare the many recent Technical Specification violations which have occurred at WNP-2 with the non safety significant normal operating procedure error of April 9, 1995, you will find individual enforcement action against me is not warranted, necessary or required. I am respectfully requesting Notice of Violation (EA 95-105) be reevaluated to take no enforcement action against me.

POLICY ADHERENCE -

In your enforcement policy, section VIII titled Enforcement Actions Involving Individuals it states in part, "An enforcement action involving an individual will normally be taken only when the NRC is satisfied that the individual...failed to take required actions which have actual or potential safety significance." The Supply System and NRC have determined, the required action which the licensed individuals failed to take on April 9, 1995 had NO SAFETY SIGNIFICANCE. The RWCU-V-31 valve could have stayed open without safety significance. I respectfully request, this section of your policy be implemented in this case to not take enforcement action against me.

This same enforcement policy section states, "Most transgressions of individuals at the level of Severity Level III or IV violations will be handled by citing only the facility licensee." Contrary to this policy I was cited with a Severity Level III violation. I respectfully request, this section of your policy be implemented in this case to not take enforcement action against me.

This same enforcement policy in part states, "Action against the individual, however, will not be taken if the improper action by the individual was caused by management failures." It is well known and documented on more than one occasion that I informed management of Control Room Supervisor duties increasing to unacceptable levels. The majority of CRS's in September of 1994 voted and indicated to management that this was a concern.

In March of 1995, I had even asked to be moved to a crew which had subordinates requiring less supervision. The subordinates on my current shift where brand new or had behavior problems requiring increased attention. Other crews had more experienced Reactor Operators than my crew did. This detracted from my ability to adequately monitor the plant evolutions and verify procedure compliance. I would be very busy showing and explaining to the new RO's the what, where, how and why of what they were seeing on the panels. In the past only one brand new Reactor Operator has been placed on a crew at a time.

The CRS's were doing the job duties of the Shift Manager (SM), the Control Room Supervisor (CRS), and on my crew the Shift Engineer (SE) and Lead Reactor Operator (RO). The Shift Manager duties had been transferred to the CRS, such that he could attend meetings, tour the plant more and direct maintenance activities more. The Shift Engineer on my crew was brand new and needed assistance and guidance from the CRS as to the performance and function of his position. The brand new Reactor Operators were placed in the lead position without any training as to the performance and function of the lead position.

The CRS's were required and expected to assist and provide the guidance necessary for the new RO's to function in the lead position. My shift was the last to allow the new RO's to stand the lead position because of this concern. If you mix in with this, a brand new visiting RO was on duty the night the error occurred, you will find, I was set up to fail and management knew of these concerns and did not take any action.

Operations management felt it important to provide training to Reactor Operators to perform Equipment Operator tours but did not implement training for brand new Reactor Operators prior to allowing them to perform the lead Reactor Operator position. This is in effect, training to do jobs they have done before and no training to perform jobs they have not done before. Can you explain it to me?

Also, please see page 8 above concerning management failures dealing with their knowledge of interpersonal problems between the Shift Manager and CRO2 which caused CRO2 to not bring up his concern as expected and required of a licensed RO.

I respectfully request, the improper actions and inactions by the individuals by evaluated to be caused by management failures. I respectfully request, this section of your policy be implemented in this case to not take enforcement action against me.

This same enforcement policy states in part, as an example of situations which will not require action against individuals, "Inadvertent individual mistakes resulting from inadequate training or guidance provided by the facility licensee." A change was made to the specific procedural step that was misinterpreted. This change is documented in Supply System root cause analysis as being a crucial change from something which was allowed to something which was not allowed and no training was performed on this change.

Plant management had made the decision to stay in Hot Shutdown to avoid doing Technical Specification required Cold Shutdown surveillances. The plant had not stayed in Hot Shutdown in the last 5 to 6 years. The procedure had been changed approximately 3 years ago. Plant management did not ensure training had taken place to operate in Hot Shutdown prior to directing us to operate in Hot Shutdown. Specifically level control during Hot Shutdown operations.

I respectfully request a determination that the inadvertent individual mistakes resulted from inadequate training or guidance. I respectfully request, this section of your policy be implemented in this case to not take enforcement action against me.

EVOLVING AND MISCELLANEOUS ISSUES -

On September 6, 1995 I was informed, the new Operations Manager had entered into an agreement/promise with the NRC during the winter of 1994 regarding procedure interpretations of should's and shall's. It is possible, this agreement/promise was to treat all should's in procedure's as shall's. If so, this is a crucial change in procedure usage criteria that was not trained on or communicated to control room personnel. It is possible, a reactor coolant sulfate excursion and a decision to not shutdown, by the new Operation Manager when the procedure said we should shutdown, violated this agreement/promise.

It is possible, if this agreement/promise was true, then the new Operations Manager was not only increasing the consequences of procedure non-compliance but was also making procedure compliance rules more strict. Possibly without training as to the changes. It is possible this point could be an act of setting up the operations department personnel to fail.

It is possible, this is why the new Operations Manager regarded me, in his own words, as a "FALL GUY". This possibly supports my suppositions in my appeal document to the Supply System dated June 12, 1995 and supplied to the NRC on July 17, 1995. At this time, this point is just hearsay evidence as I have not had an opportunity to research it. I am respectfully requesting the NRC investigate the agreement/promise, sulfate excursion decisions and my value to the Supply System or new Operations Manager as a "FALL GUY" and inform me of your findings.

In your Notice of Violation (EA 95-096) to the Supply System you indicate higher levels of NRC officials were contacted to authorize the sanctions taken against WPPSS. In your enforcement policy, section VIII, Enforcement Action Involving Individuals it states in part, "Any proposed enforcement action involving individuals must be issued with the concurrence of the appropriate Deputy Executive Director". The Severity Level III violation (EA 95-105) is an enforcement action against me as an individual. I did not notice any indication in your letter or Notice of Violation (EA 95-105) that this requirement had been complied with. Please provide me this documentation from the appropriate Deputy Executive Director who provided his or her concurrence prior to the issuance of the Notice of Violation (EA 95-105).

PERSONAL OBSERVATIONS -

Through out my 22 years in the commercial steam electric generating industry, I have witnessed many individual errors, including my own. We are all humans who have and will make errors. The key to being a human is to try your best to limit your errors to non-safety significance and then learn from and understand all errors to reduce them as much as humanly possible.

On an operating crew the team helps limit individual errors to non-safety significance and provides the opportunity for learning and understanding. The operating crew team around me failed me during my moment of procedure interpretation error.

For possible reasons I have indicated above, the Supply System management team failed to provide the opportunity to learn from and understand the error. In your AIT report dated June 12, 1995, your team indicates just this point, that the Supply System incompletely and generally addressed symptoms rather than causes, emphasizing what happened rather than why, such that corrective actions were narrowly focused. The Plant Manager, Assistant Managing Director and the Managing Director have all refused to talk to me in spite of my repeated requests.

What is the probability of me succumbing to this type of failure in the future once I have experienced it? I offer you a probability of one in a trillion. For all the successes I have had during my 17 years in the nuclear industry, with very few errors, I find it very undeserving that I have not been treated consistent with the actual safety significance of the error.

Based on the facts of this case enforcement action against me is not warranted, is not required and is not necessary. If I can be of any assistance to you in reaching that conclusion please feel free to contact me. Thank you for your kind consideration in this trying matter.

Sincerely,

J. Mike Gallagher

J. Mike Gallagher

cc:
U.S. NRC
Document Control Desk
Washington, D.C. 20555

U.S. NRC Resident Inspector, WNP-2
P.O. Box 69
Richland, WA 99352