



WASHINGTON PUBLIC POWER SUPPLY SYSTEM

P.O. Box 968 • 3000 George Washington Way • Richland, Washington 99352-0968 • (509) 372-5000

Docket No. 50-397

September 25, 1995
G02-95-194

Mr. James Lieberman
Director, Office of Enforcement
U. S. Nuclear Regulatory Commission
One White Flint North
11555 Rockville Pike
Rockville, MD 20852-2738

Dear Mr. Lieberman:

Subject: **WNP-2, OPERATING LICENSE NO. NPF-21
NRC INSPECTION REPORTS 95-07 AND 95-13
REPLY TO A NOTICE OF VIOLATION**

- References:
- (1) Letter, dated June 2, 1995, AB Beach (NRC) to JV Parrish (SS), "NRC Inspection Report 95-07"
 - (2) Letter, dated June 12, 1995, LJ Callan (NRC) to JV Parrish (SS), "NRC Augmented Inspection Team Report 95-13"
 - (3) Letter, dated August 17, 1995, LJ Callan (NRC) to JV Parrish (SS), "Notice Of Violation And Proposed Imposition Of Civil Penalty - \$50,000"

The Supply System hereby replies to the Notice of Violation (NOV) contained in reference 3. Our reply, pursuant to the provisions of Section 2.201, Title 10, Code of Federal Regulations, consists of this letter and Attachment A.

In an effort to fulfill our goal of superior performance and to address the more generic performance aspects related to these violations and past Supply System performance, the Supply System has implemented an extensive performance enhancement strategy. The performance enhancement program implements comprehensive corrective actions which were derived from a self-critical evaluation performed in January and February of this year. This program has been discussed on several occasions with members of the staff and was recently docketed.

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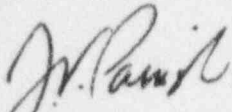
Page 2 of 2

**NRC INSPECTION REPORTS 95-07 AND 95-13
REPLY TO A NOTICE OF VIOLATION**

The original due date for responding to the NOV was September 16, 1995. This due date was extended to September 25, 1995, during a telephone conversation between James Dyer, Region IV, and PR Bemis of my staff.

The civil penalty was paid on September 11, 1995 via electronic transfer to the Treasurer of the United States. 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)
Vice President, Nuclear Operations

JMP
Attachment

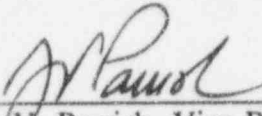
cc: LJ Callan - NRC RIV
JW Clifford - NRC
NS Reynolds - Winston & Strawn
DL Williams - BPA/399
NRC Sr. Resident Inspector - 927N

STATE OF WASHINGTON)
)
COUNTY OF BENTON)

Subject: NRC Enforcement Action 95-096
NRC Inspection Reports 95-07 and 95-13
Reply to Notice of Violation

I, J. V. PARRISH, being duly sworn, subscribe to and say that I am the Vice President, Nuclear Operations for the WASHINGTON PUBLIC POWER SUPPLY SYSTEM, the applicant herein; that I have the full authority to execute this oath; that I have reviewed the foregoing; and that to the best of my knowledge, information, and belief the statements made in it are true.


DATE Sept 25, 1995



J. V. Parrish, Vice President
Nuclear Operations

On this date personally appeared before me J. V. PARRISH, to me known to be the individual who executed the foregoing instrument, and acknowledged that he signed the same as his free act and deed for the uses and purposes herein mentioned.

GIVEN under my hand and seal this 25 day of September 1995.



Notary Public in and for the
STATE OF WASHINGTON

Residing at Kennecott, WA

My Commission Expires 4/28/98

Attachment A

Violation A

Technical Specification 6.8.1 states written procedures shall be established, implemented, and maintained covering, in part, the applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978.

Regulatory Guide 1.33, Appendix A, item 4.c, recommends procedures for the operation of the reactor cleanup system.

WNP-2 Procedure 2.2.3, "Reactor Water Cleanup System," Revision 20, states in section 4.7 that "RWCU-V-31, Orifice Bypass valve, shall not be open with Reactor pressure GT [greater than] 125 psig, to prevent over pressurization of the RWCU blowdown piping." This same prohibition is contained in a caution box in Section 5.7, just prior to Step 10.

Contrary to the above, on April 9, 1995, with the reactor coolant system pressure at approximately 215 psig, the Control Room Supervisor opened Valve RWCU-V-31, a bypass valve around the reactor water cleanup system letdown line flow restricting orifice, and allowed it to remain partially open for approximately 2 hours. The Control Room Supervisor did not take action to correct this situation despite other control room personnel questioning the appropriateness of his actions and despite his acknowledgement that he reviewed the applicable procedure after these questions were raised. (01013)

Response to Violation A

The Supply System accepts this violation.

1. Reason for the violation

The cause of the violation was a willful non-compliance on the part of the control room supervisor (CRS) to adhere with the requirements of Plant Procedures Manual (PPM) 2.2.3. Contributing factors were poor supervisory oversight by the CRS and poor crew communications and teamwork. The CRS's direct involvement with the operation of RWCU-V-31 interfered with his supervisory oversight function.

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

After determining that the valve was open an on-coming reactor operator questioned the CRS and obtained permission to close the valve.

An engineering evaluation concluded that the RWCU low pressure blowdown piping was operable and was not over pressurized while RWCU-V-31 was cracked open.

The CRS and Shift Manager involved in the event were removed from licensed duties and termination of their operating licenses was requested. Appropriate disciplinary action was later taken against the CRS and Shift Manager.

The Operations Manager met with Shift Managers and supervisors to reemphasize management's expectations regarding procedural compliance and oversight responsibilities.

An information HOT LINE notice was sent to WNP-2 employees and a site wide timeout was held to review procedural adherence expectations and management's responsibilities regarding employee concerns.

The Operations Manager, Plant General Manager and Vice President of Nuclear Operations held mandatory meetings with managers to discuss the event and its significance.

A control room management oversight team was established for an interim period to confirm control room activities met management expectations.

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

Manager and supervisor training emphasizing the handling of employee concerns will be completed by December 31, 1995.

Teamwork refresher training will be included in licensed operator requalification training. This training is scheduled to be completed by December 31, 1995.

4. Date when full compliance will be achieved.

Full compliance was achieved on April 9, 1995 when RWCU-V-31 was closed.

Violation B

Technical Specification 6.8.1 states written procedures shall be established, implemented, and maintained covering, in part, the applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978.

Regulatory Guide 1.33, Appendix A, item 4.q, recommends procedures for the operation of the service water system.

Procedure 2.4.5, Revision 26, "Standby Service Water System," attachment 6.1, requires the position of SW-V-128A to be "Throttled per PPM [Plant Procedures Manual] 7.4.7.1.1.1." Procedure 7.4.7.1.1.1, Revision 18, "Standby Service Water Loop A Valve Position Verification," paragraph 7.2, step 7, requires personnel to: "verify the following valves are sealed in their throttled positions following final flow adjustment ... SW-V-128A."

Contrary to the above, on February 7, 1995, Valve SW-V-128A was not lock-sealed in its throttled position following final flow adjustment. (01023)

Response to Violation B

The Supply System accepts this violation.

1. Reason for the violation

A review of plant records and interviews could not identify when the lock seal was broken. Troubleshooting of a related valve occurred before discovering the broken lock seal, but SW-V-128A was not manipulated during the troubleshooting activities. When the broken lock seal was discovered it was still attached to the valve and the valve was in the correct position. The monthly surveillance performed to verify the valve is sealed in its throttled position did not require direct inspection of the seal. Thus, the time the seal was broken is indeterminate.

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

Valve SW-V-128A was re-lockwired and a partial surveillance was performed to check standby service water component flows and valves lock sealed. The results of the surveillance were satisfactory.

Surveillance procedures were revised to require verification that lock seals are intact and will prevent significant valve movement.

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

Based on the corrective actions taken, along with a heightened awareness of the need for proper self-checking and verification, no further corrective actions are planned.

4. Date when full compliance will be achieved.

Full compliance was achieved on February 7, 1995 when SW-V-128A was verified to be lock sealed in its properly throttled position.

Violation C

Technical Specification 6.8.1 states written procedures shall be established, implemented, and maintained covering, in part, the applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978.

Regulatory Guide 1.33, Appendix A, item 1.c, recommends procedures for equipment control (e.g., locking and tagging).

Plant Procedures Manual Procedure 1.3.8, "Danger Tag Clearance Order," implements the requirements for locking and tagging.

- (1) Section 3.1.11 of Procedure 1.3.8 discusses requirements for independent verification of component status and requires the first operator to verify or position the component as required by the clearance order and the second operator to verify the "as left" status of the component.

Contrary to the above, on February 8, 1995, the resident inspector found that the control room switch for CAC-FCV-4A was in the AUTO position, but was danger tagged under Clearance Order 95-2-0005 to be in the OFF position. The switch had been positioned by a control room operator and verified by an equipment operator. (01033)

- (2) Step 6.11.2 of Procedure 1.3.8 states that the shift manager ensures the clearance order provides the safe conditions necessary for the protection of personnel and ensures the clearance order is adequate for the tasks and hazards involved.

Contrary to the above, on February 14, 1995, the shift manager designee (the control room supervisor) authorized Clearance Order 95-02-0075 for electricians to replace relay CVB-RLY-V/1EF/R3 using Work Order SV62 01, without ensuring that the clearance order removed power from the relay. (01043)

- (3) Step 6.12.2.c of Procedure 1.3.8 states, that if the names or labels on the clearance order form do not match the equipment field labels, the operator resolves the difference with the shift manager before hanging the tag.

Contrary to the above, on February 14, 1995, operators could not match the equipment field labels with the fuse name on Clearance Order 95-02-0076 for E-FUSE-VB2-TBB1F31 and did not resolve the difference with the shift manager prior to pulling Fuse E-FUSE-VB2-TBB1F3-1. (010053)

Response to Violation C, Example (1)

The Supply System accepts this violation.

1. Reason for the violation

The cause of this event was human performance error, attributed to inadequate self-checking and inattention to detail by the operators involved with the clearance order process.

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

The individuals involved were counselled regarding management's expectations for clearance orders and the need for attention to detail and proper self-checking practices.

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

Based on the corrective actions taken, along with a heightened awareness of the need for proper self-checking and verification, no further corrective actions are planned.

4. Date when full compliance will be achieved.

Full compliance was achieved on February 8, 1995 when the control switch for CAC-FCV-4A was danger tagged in the proper position.

Response to Violation C, Example (2)

The Supply System accepts this violation.

1. Reason for the violation

The cause was personnel error on the part of the clearance order preparer. A contributing cause dealt with the failure of the clearance order second reviewer to identify that the clearance order was not adequate for the work activity.

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

An Incident Review Board (IRB) investigation was performed. The IRB investigation report for this event was required reading for Clearance Order Review Committee (CORC) members. Reviewing the IRB report reinforced the importance for attention to detail in the clearance order process.

The CORC member involved in the clearance order preparation error was counseled.

A table top guide was developed delineating clearance order policy and responsibilities.

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

An Operations Senior Reactor Operator will be assigned as the full-time CORC supervisor by October 31, 1995.

Control room operators will receive refresher training on print reading techniques. This training will be completed by October 1, 1995.

Control room operators will spend part of their relief week working with CORC as an on the job training task to improve their clearance order skills. This training task will be completed by October 1, 1995.

4. Date when full compliance will be achieved.

Full compliance was achieved on February 14, 1995 when the work task to replace relay CVB-RLY-V/1EF/R3 was completed under an energized condition and Clearance Order 95-02-0075 was cleared.

Response to Violation C, Example (3)

The Supply System accepts this violation.

1. Reason for the violation

The cause of this event was inadequate labeling of panel internals. A contributing cause dealt with less than adequate equipment operator training regarding wire identification within panels.

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

The removal of the wrong fuse resulted in momentary loss of power to an indication circuit that had already been declared inoperable. The error was discovered immediately upon pulling the fuse and corrected.

The equipment operators involved were counselled regarding the proper use of wire and fuse identification techniques.

Equipment operators were trained on reading and interpreting drawings. This training included wire identification techniques.

An E559 terminal board and fuse arrangement drawing was generated for the affected electrical panel (E-CP-VB/2). This drawing provides information related to fuses, fuse blocks, and terminal blocks installed in the panel.

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

Based on the corrective actions taken, along with an existing fuse identification program and ongoing efforts to improve plant labeling, no further corrective actions are planned.

4. Date when full compliance will be achieved.

Full compliance was achieved on February 14, 1995 when the incorrectly pulled fuse was replaced and the correct fuse was removed.

Violation D

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

Contrary to the above, on February 18, 1995, operators failed to follow the instructions in Plant Procedures Manual 2.5.7, "Main Turbine Functional Test," Revision 23. Specifically, operators performing monthly turbine valve surveillance testing manipulated the wrong level, resulting in a turbine trip and reactor scram. (01063)

Response to Violation D

The Supply System accepts this violation.

1. Reason for the violation

The cause for this event was determined to be personnel error due to a failure to self-check. Factors contributing to the event were an inadequate pre-job briefing, insufficient supervisory oversight, poor labeling, and an adverse work environment (high radiation, temperature, and noise).

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

The turbine front standard trip test and reset levers were painted in contrasting colors and labeling for the levers was improved.

Plant Procedures Manual (PPM) 2.5.7 was revised to refer to the levers by both label name and color. The procedure was also revised to refer to an illustration of the front standard showing the location of the levers, gauges, and valves associated with turbine testing.

Training dealing with self-checking techniques was provided to the equipment operators; while operating crew supervision received training in self-checking techniques and training reemphasizing the role of a supervisor.

Operations Instruction (OI) 22 was developed outlining management's expectations for when pre-job briefings should be conducted, what should be covered, and who should be involved with the briefing. Control room crews were trained on the use of OI 22 for performing a pre-job briefing.

Non-licensed and licensed operators reviewed the human performance aspects and the failure to use self-check techniques associated with this event during requalification training.

The equipment operator and Shift Support Supervisor involved with the event were appropriately disciplined.

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

Based on the corrective actions taken, along with an increased awareness for proper self-checking, no further corrective actions are planned.

4. Date when full compliance will be achieved.

Full compliance was achieved on February 18, 1995 when after the turbine had tripped the equipment operator released the lever he had inappropriately manipulated.

Violation E

Technical Specification 3.0.4 states, that entry into an OPERATIONAL CONDITION or other specified condition shall not be made unless the conditions for the limiting condition for operation are met without reliance on provisions contained in the ACTION requirements.

- (1) Technical Specification 3.6.1.4 requires two independent MSIV leakage control subsystems be operable in Operational Conditions 1, 2, and 3.

Contrary to the above, on February 21, 1995, operators entered Operational Condition 2 and 3 with one of the two independent MSIV leakage control subsystems inoperable. (01073)

- (2) Technical Specification 3.6.4.1 requires that all nine pairs of suppression chamber - drywell vacuum breakers be closed in Operational Condition 1, 2, and 3.

Contrary to the above, on February 22, 1995, operators entered Operational Condition 1 with a suppression chamber - drywell vacuum breaker open which rendered a pair of suppression chamber - drywell vacuum breakers inoperable. (01083)

Response to Violation E Examples (1) and (2)

The Supply System accepts this violation.

1. Reason for the violation

The cause of the Technical Specification 3.0.4 violations during the plant startup process was attributed to the plant startup procedure not prompting the operators to verify compliance with Technical Specification 3.0.4 before making an Operational Condition change. An additional cause for example 1 resulted from a communications breakdown between I&C personnel when a troubleshooting work task was exited prior to completion. The communication breakdown resulted in a failure of the I&C personnel to properly restore the system to an operable condition when the work task was exited at an intermediate step.

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

Plant startup procedures were changed to require a review of Technical Specification/Licensee Control Specification tracking logs, the Barrier Impairment log, and to perform a panel walkdown prior to making an Operational Condition change.

An I&C shop timeout was held reinforcing management's expectations concerning the use and need for formal communications to prevent personnel errors, procedural non-compliances, and plant transients.

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

Based on the corrective actions taken, along with an increased awareness for proper communications and attention to detail, no further corrective actions are planned.

4. Date when full compliance will be achieved.

Full compliance for Example 1 was achieved on February 22, 1995 when the appropriate surveillance procedure was completed and the MSIV leakage control subsystem was returned to an operable condition. Full compliance for Example 2 was achieved on February 22, 1995 when the surveillance procedure verified the vacuum breaker operable and the valve disc closed.

Violation F

Technical Specification 3/4.3.1 requires that for the intermediate range monitors, two of four instrument channels in each trip system be operable when the plant is in MODE 3 or 4. The Technical Specification requires three of the four instruments channels in each trip system be operable when the plant is in MODE 2 or 5. If these conditions cannot be met, the Technical Specifications require the inoperable channels(s) and or trip system be placed in tripped condition within 12 hours.

Contrary to the above, on February 22, 1995, the licensee failed to meet the T.S. requirement for entry into operational condition of Startup/Hot Standby because two of four instrument channels in one trip system were inoperable. Specifically, July 26, 1994, the licensee made a decision not to repair IRM E which had failed a time delay refractometry (TDR) test indicating that the component was inoperable. The Licensee then declared IRM E operable based on engineering judgement following a reactor scram on February 18, 1995, without performing an additional TDR to verify operability. On February 22, 1995, during reactor startup, IRM E was again declared inoperable due to failing to indicate properly on increasing power and since another IRM in the same trip system was already inoperable, three out of four of the instrument channels within the trip system were no longer operable. (01093)

Response to Violation F

The Supply System accepts this violation.

1. Reason for the violation

The failure to comply with Technical Specifications resulted from the reliance on a deficient operability assessment which had inappropriately concluded IRM channel E was operable. The deficient operability assessment was the result of a lack of understanding by the system engineer of the critical system operating characteristics and the lack of a questioning attitude directed at how the IRM could be operable with no repairs performed. Contributing causes included failure to ensure sufficient information was available to support the operability assessment and failure to recognize that engineering judgement was used in the assessment without independent technical review.

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

The system knowledge gained from this event has been incorporated into appropriate system reference material for the IRM system engineer.

Those individuals involved with the performance of operability assessments were provided refresher training.

Individuals involved with the deficient operability assessment received appropriate disciplinary action.

To ensure their adequacy and thoroughness, operability assessments are now required to be reviewed and approved by engineering management.

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

The Supply System arranged for enhanced IRM system diagnostic training for individuals involved with the IRM system. This training will be completed by November 1, 1995.

4. Date when full compliance will be achieved.

Full compliance was achieved on February 22, 1995 when the plant entered Operational Condition 1 where IRM E was not required to meet the minimum Technical Specification requirements.