



**UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
REGION IV  
611 RYAN PLAZA DRIVE, SUITE 400  
ARLINGTON, TEXAS 76011-8064**

March 31, 2000

Mr. J. V. Parrish (Mail Drop 1023)  
Chief Executive Officer  
Energy Northwest  
P.O. Box 968  
Richland, Washington 99352-0968

**SUBJECT: PLANT PERFORMANCE REVIEW - WNP-2**

Dear Mr. Parrish:

The purpose of this letter is to communicate our assessment of your performance and to inform you of our planned inspections at your facility. On March 2, 2000, we completed a Plant Performance Review (PPR) of the WNP-2 facility. We conduct these reviews to develop an integrated overview of the safety performance of each operating nuclear power plant. We use the results of the PPR in planning and allocating inspection resources and as inputs to our senior management meeting (SMM) process. This PPR evaluated inspection results and safety performance information for the period from January 25, 1999, through February 11, 2000, but emphasized the last 6 months to ensure that our assessment reflected your current performance. Our most recent summary of plant performance at WNP-2 was provided to you in a letter dated September 16, 1999.

The NRC has been developing a revised reactor oversight process that will replace our existing inspection and assessment processes, including the PPR, the SMM, and the Systematic Assessment of Licensee Performance (SALP). We recently completed a pilot program for the revised reactor oversight process at nine participating sites and are making necessary adjustments based on feedback and lessons learned. We are beginning initial implementation of the revised reactor oversight process industry-wide, including your facility, on April 2, 2000.

This PPR reflects continued process improvements as we make the transition into the revised reactor oversight process. You will notice that the following summary of plant performance is organized differently from our previous performance summaries. Instead of characterizing our assessment results by SALP functional area, we are organizing the results into the strategic performance arenas embodied in the revised reactor oversight process. Additionally, in assessing your performance, we have considered the historical performance indicator data that you submitted in January 2000 in conjunction with the inspection results. The results of this PPR were used to establish the inspection plan in accordance with the new risk-informed inspection program (consisting of baseline and supplemental inspections). Although this letter incorporates some terms and concepts associated with the new oversight process, it does not reflect the much broader changes in inspection and assessment that will be evident after we have fully implemented our revised reactor oversight process.

During the last 6 months, WNP-2 completed a refueling outage and otherwise typically operated at or near full power. We noted that you conservatively reduced power to 80 percent during the Year 2000 transition.

Based on a review of inspection results and the performance indicators, we did not identify any significant performance issues in the reactor safety, radiation safety, or safeguards strategic performance arenas.

As a result, only baseline inspections are planned. However, during the assessment period we noted numerous instances of minor inaccuracies in your Technical Specifications. We plan to monitor your development of an electronic design basis as it relates to this issue.

Enclosure 1 contains a historical listing of plant issues, referred to as the Plant Issues Matrix (PIM), that was used during this PPR process to arrive at our integrated view of your performance trends. The PIM for this assessment is grouped by the prior SALP functional areas of operations, maintenance, engineering, and plant support, although the future PIM will be organized along the cornerstones of safety as described in the revised reactor oversight process. The enclosed PIM includes items summarized from inspection reports or other docketed correspondence regarding WNP-2. We did not document all aspects of licensee programs and performance that may be functioning appropriately. Rather, we only documented issues that we believe warrant management attention or represent noteworthy aspects of performance. In addition, the PPR may also have considered some predecisional and draft material that does not appear in the attached PIM, including observations from events and inspections that had occurred since our last inspection report was issued but had not yet received full review and consideration. We will make this material publically available as part of the normal issuance of our inspection reports and other correspondence.

Enclosure 2 lists our planned inspections for the period April 2000 through March 2001 at WNP-2 to allow you to resolve scheduling conflicts and personnel availability in advance of our inspector arrival onsite. The inspection schedule for the latter half of the period is more tentative and may be adjusted in the future because of emerging performance issues at WNP-2 or other Region IV facilities. Routine resident inspections are not listed because of their ongoing and continuous nature.

We will inform you of any changes to the inspection plan. If you have any questions, please contact me at 817/860-8137.

Sincerely,

**/RA/**

Linda Joy Smith, Chief  
Project Branch E  
Division of Reactor Projects

Docket No.: 50-397  
License No.: NPF-21

Enclosures:

1. Plant Issues Matrix
2. Inspection Plan

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# United States Nuclear Regulatory Commission

## PLANT ISSUE MATRIX

By Primary Functional Area

Region IV  
 WASH. NUCLEAR PROJECT

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
10/16/1999	1999010	<b>Pri:</b> OPS <b>Sec:</b>	NRC	STR	<b>Pri:</b> 1A <b>Sec:</b> <b>Ter:</b>	<b>Error free fuel movements for three consecutive outages</b>  Operators performed error free fuel movements for the third consecutive refueling outage, which demonstrated sustained superior refueling performance.
<b>Dockets Discussed:</b> 05000397 WNP2						
10/16/1999	1999010	<b>Pri:</b> OPS <b>Sec:</b>	NRC	STR	<b>Pri:</b> 1C <b>Sec:</b> 3A <b>Ter:</b>	<b>Good outage management and control.</b>  Overall, the licensee managed the outage well, and work reflected an appropriate focus on safety. The licensee addressed and dispositioned emergent issues, such as fuel bundle assembly problems and unexpected loss-of-fill alarms during reactor core isolation cooling system operation, in a thorough and effective manner.
<b>Dockets Discussed:</b> 05000397 WNP2						
09/18/1999	1999010	<b>Pri:</b> OPS <b>Sec:</b>	Self	NEG	<b>Pri:</b> 1A <b>Sec:</b> <b>Ter:</b>	<b>Poor control of reactor water level during shutdown</b>  Operators did not meet licensee expectations with respect to reactor water level control on one occasion during the shutdown. Shortly after the planned reactor scram, operators entered the emergency operating procedures, as expected, on low vessel level. After operators initiated the reactor core isolation cooling system, they did not maintain reactor water level lower than the system trip setpoint, which was part of the emergency operating procedure recommended band.
<b>Dockets Discussed:</b> 05000397 WNP2						
07/26/1999	1999009-01	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 1A <b>Sec:</b> <b>Ter:</b>	<b>Failure to declare HPCS inoperable and perform action</b>  The inspectors identified a violation of Technical Specification 3.5.1, in that operators, with the high pressure core spray system inoperable, did not immediately verify by administrative means that the reactor core isolation cooling system was operable. Operators had isolated the minimum flow line in support of planned maintenance and failed to recognize that the condition rendered the high pressure core spray system inoperable. This Severity Level IV violation is being treated as a noncited violation, consistent with Appendix C of the NRC Enforcement Policy. The violation is in the licensee's corrective action program as Problem Evaluation Request 299-1557.
<b>Dockets Discussed:</b> 05000397 WNP2						
07/24/1999	1999008	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 5C <b>Sec:</b> <b>Ter:</b>	<b>Control Room Supervisor/good questioning ability</b>  A control room supervisor demonstrated an excellent questioning attitude and plant ownership when reviewing engineering work. The control room supervisor refused to accept an operability evaluation associated with Residual Heat Removal Pump-2C control circuit time delay relays because the conclusions were based on minimal test information. As a result, engineers performed additional testing and found that local magnetic interference affected relay timing and could, under some circumstances, affect pump operability. Planned corrective measures to address the problem were acceptable.
<b>Dockets Discussed:</b> 05000397 WNP2						
06/30/1999	1999008	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Procedure 3.1.1 inconsistent</b>  The inspectors identified that Procedure 3.1.1, "Master Startup Checklist," Revision 24, provided inconsistent guidance and required a high level of operator knowledge to properly implement. The procedure recommended that all steps be performed in a sequence that was not possible to implement.
<b>Dockets Discussed:</b> 05000397 WNP2						

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06/12/1999	1999007	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> 1C <b>Ter:</b>	<b>Prompt, conservative operator response to establish containment prior to moving fuel</b> Licensee requirements for establishment of secondary containment prior to moving new fuel into the spent fuel pool in Mode 4 were unclear. Operations responded promptly and conservatively. The licensee conducted a thorough 10 CFR 50.59 safety evaluation. The resultant procedure change clarified conditions required for movement of all loads over the spent fuel pool.
<b>Dockets Discussed:</b> 05000397 WNP2						
06/12/1999	1999007	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> 1C <b>Ter:</b>	<b>In-depth, prompt investigation of valve out of position</b> The licensee's investigation of a valve out of position was in-depth and promptly performed. The licensee identified several other problems and corrective actions in valve position verification processes. Minor tagging and clearance order process problems were also identified and corrective actions were initiated.
<b>Dockets Discussed:</b> 05000397 WNP2						
06/12/1999	1999007	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> 1C <b>Ter:</b> 5B	<b>Licensee application of shutdown TS focused on reactor safety</b> Licensee actions with respect to interpretation and application of shutdown Technical Specifications were focused on reactor and public safety concerns. Conduct of management meetings fostered open and frank discussions that were focused on reactor safety and compliance with the intent of Technical Specification Bases.
<b>Dockets Discussed:</b> 05000397 WNP2						
06/11/1999	1999005	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 1A <b>Sec:</b> <b>Ter:</b>	<b>Negative performance issues indicated a need for continued training focus</b> Some negative performance issues were identified indicating that personnel performance could be improved. The negative performance issues did not show overall inadequate crew performance but reinforced the need for continued training focus. This assessment was corroborated by operators performance during recent plant events
<b>Dockets Discussed:</b> 05000397 WNP2						
06/11/1999	1999005	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> <b>Ter:</b>	<b>Good operator control board awareness</b> Operators monitored critical parameters well and demonstrated good control board awareness
<b>Dockets Discussed:</b> 05000397 WNP2						
06/11/1999	1999005	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 5A <b>Sec:</b> 5C <b>Ter:</b>	<b>Effective self assessment process identified findings</b> The licensee's self-assessment process identified worthwhile findings, and tracked and corrected them in a timely manner. However, operation's performance indicators outside those monitored by the licensed requalification program were primarily quantitative and provided limited trending data
<b>Dockets Discussed:</b> 05000397 WNP2						

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05/11/1999	1999007-01	<b>Pri:</b> OPS <b>Sec:</b>	Self	NCV	<b>Pri:</b> 1A <b>Sec:</b> 3A <b>Ter:</b>	<b>Violation of TS 5.4.1: failure to adequately monitor weir flow; failure to adequately monitor RX level</b> The root cause for the inadvertent draindown of the spent fuel pool skimmer surge tank and the inadvertent draindown of the reactor pressure vessel was poor control room operator board awareness and monitoring of key parameters in the plant. This is a Severity Level IV violation of Technical Specification 5.4.1.a, with two examples, which is being treated as a noncited violation, consistent with Appendix C of the NRC Enforcement Policy, and is in the licensee's corrective action program as Problem Evaluation Requests 299-0882 and 299-1021.
<b>Dockets Discussed:</b> 05000397 WNP2						
05/01/1999	1999004	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 5C <b>Sec:</b> <b>Ter:</b>	<b>Operator responded promptly to resolve the color banding issue</b> The inspectors' questions about the adequacy of control room instrumentation color banding were promptly addressed by the operators. In addition, the operators demonstrated a good questioning attitude and a desire to resolve the issue
<b>Dockets Discussed:</b> 05000397 WNP2						
05/01/1999	1999004-01	<b>Pri:</b> OPS <b>Sec:</b>	NRC	URI	<b>Pri:</b> 1B <b>Sec:</b> 4A <b>Ter:</b>	<b>Adequacy of the design basis of the RHR system</b> The design basis of the residual heat removal system did not support the full range of applicability for Technical Specification, Limiting Condition of Operation 3.4.9, "Residual Heat Removal (RHR) Shutdown Cooling System - Hot Shutdown" and the associated Technical Specification Bases. The design basis was also inconsistently implemented in procedures and in instructions for the residual heat removal system in the shutdown cooling mode of operation. Because the licensee is continuing to research the design basis for the system and because additional information is required on (1) related accident analysis assumptions, (2) generic implications, (3) prior system evaluations, and (4) notification, the issue is being identified as an unresolved item
<b>Dockets Discussed:</b> 05000397 WNP2						
05/01/1999	1999004-02	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 5A <b>Sec:</b> <b>Ter:</b>	<b>Failure to complete corrective actions associated with color banding of instrumentation,</b> Corrective actions resulting from a 1996 problem evaluation request were never completed. The problem evaluation request had been generated to address the failure to resolve control room design deficiencies associated with color banding of control room instrumentation, as required by License Condition 16. The problem evaluation request was closed and the work order to resolve the color banding issue was canceled during a backlog item review, without evaluating the work order cancellation for conflict with the license condition. This problem is a violation of 10 CFR Part 50, Appendix B, Criterion XVI; however, this Severity Level IV violation is being treated as a noncited violation, and is in the licensee's corrective action program as Problem Evaluation Request 299-0745
<b>Dockets Discussed:</b> 05000397 WNP2						
04/17/1999	1999004	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1B <b>Sec:</b> 3A <b>Ter:</b>	<b>Safe and deliberate licensee performance during reactor shutdown</b> Key managers as well as quality assurance personnel were present in the control room to monitor the shutdown, which was conducted in a safe and deliberate manner. Communications were good. Supervisory oversight and direction of the operating crew and operator performance during the shutdown were good
<b>Dockets Discussed:</b> 05000397 WNP2						
03/20/1999	1999002	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> 3B <b>Ter:</b>	<b>Thorough and rigorous Plant Operating Committee performance</b> The Plant Operating Committee (POC) meeting was thorough and rigorous. The diversity of committee members contributed positively to the depth and breadth of questions, and the review packages were well prepared and presented.
<b>Dockets Discussed:</b> 05000397 WNP2						

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03/20/1999	1999002	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3B <b>Sec:</b> <b>Ter:</b>	<b>Operators improved in self-identification of poor work practices.</b>  Operations department personnel identified multiple occurrences of poor work planning, scheduling, and coordinating. This was recognized as an improvement in performance on the part of operators because of a conscious effort on the part of operations department management to raise the standards for performance and expectations inside the department and across the station as a whole.
<b>Dockets Discussed:</b> 05000397 WNP2						
03/20/1999	1999002-01	<b>Pri:</b> OPS <b>Sec:</b> MAINT	NRC	NCV	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>Violations of TS 5.4.1: LPRM found on prohibited SFP hanger; APRM improperly returned to service; improv</b>  A noncited violation (NRC Enforcement Policy, Appendix C) of Technical Specification 5.4.1 was identified with three examples: (1) The first example occurred when operators failed to comply with a work instruction precaution and placed a local power range monitor on a damaged spent fuel pool rack. This violation is in the corrective action program as PER 299-0470 (Section O4.1); (2) The second example occurred when the licensee failed to implement a Technical Specification surveillance procedure, which resulted in data that determined the need for an instrument gain adjust not being documented and reviewed when required. This violation is in the licensee's corrective action program as PER 299-0377 (Section M1.3); and (3) The third example occurred when maintenance technicians inappropriately left two upright ladders and an unrestrained hydraulic control unit accumulator cart immediately adjacent to safety-related equipment, which was contrary to procedures. Additionally, the technicians demonstrated poor housekeeping. This violation is in the licensee's corrective action program as PER 299-0335
<b>Dockets Discussed:</b> 05000397 WNP2						
03/11/1999	1999301	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 3B <b>Sec:</b> <b>Ter:</b>	<b>weak key parameter monitoring during dynamic scenarios</b>  Operators demonstrated weak key parameter monitoring related to reactor building differential pressure during the dynamic scenarios. Two of the four crews examined failed to recognize that reactor building differential pressure went positive and thus missed an Emergency Operating Procedures entry condition.
<b>Dockets Discussed:</b> 05000397 WNP2						
03/11/1999	1999301	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3B <b>Sec:</b> <b>Ter:</b>	<b>licensing exam/test material, pass rate</b>  The 11 initial license applicants passed the examination. Operators demonstrated good communications practices, peer checks, and crew briefings. The licensee developed good test material which was adequate for administration as submitted, with only one postexamination change identified.
<b>Dockets Discussed:</b> 05000397 WNP2						
02/06/1999	1998025	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 1A <b>Sec:</b> <b>Ter:</b>	<b>Inattention to detail missed a procedure step.</b>  The inspectors noted that operators did not initially recognize a procedure step as being required. Specifically, operators had become accustomed to performing a relatively simple repetitive procedure other than as written because of inattention to detail.
<b>Dockets Discussed:</b> 05000397 WNP2						
02/06/1999	1998025	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> <b>Ter:</b>	<b>Good operator performance during control rod exercise test</b>  During the performance of a control rod exercise test, operators demonstrated good coordination, communications, and peer checks. An operator, when presented with a procedural compliance problem, promptly notified the control room supervisor, appropriately requested authorization to use a different procedure, and initiated steps to change the subject procedure.
<b>Dockets Discussed:</b> 05000397 WNP2						

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02/06/1999	1998025	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1B <b>Sec:</b> <b>Ter:</b>	<b>Good operator knowledge of possible system interactions during work.</b>  Operators demonstrated good system knowledge and an awareness of ongoing work by recognizing that a reactor scram, potentially required because of a stator cooling water high conductivity, could flood the work area where personnel performed work on the circulating water system because of swell following pump shutdown. The Incident Review Board report for the deficiency identified underlying problems and was self-critical.
<b>Dockets Discussed:</b> 05000397 WNP2						
01/08/2000	1999014	<b>Pri:</b> MAINT <b>Sec:</b>	Self	NEG	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>Technicians work on wrong DG bearing temperature switch</b>  Instrument and Controls technicians mistakenly initiated work on the Division II diesel generator nonsafety-related bearing temperature switch when the maintenance was specified for the Division I unit. The work package specified the correct diesel but the job planner had inadvertently included a determination sheet for the Division II unit in the work package. The craftsmen missed several opportunities to identify the problem and other barriers were not effective at precluding the event. The operators' response to the ensuing alarm was prompt and effective. The management response was immediate and several additional work controls were implemented. Since the switch was nonsafety-related, no violation of NRC requirements occurred .
<b>Dockets Discussed:</b> 05000397 WNP2						
10/27/1999	1999014-01	<b>Pri:</b> MAINT <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 2B <b>Sec:</b> <b>Ter:</b>	<b>TS violation because of failure to properly restore identified leak rate instrument following outage</b>  Operations personnel identified that drywell identified leakage instrumentation was inoperable between October 22 and 27, 1999, which resulted in a Technical Specification Surveillance Requirement 3.4.5.1 violation. This Technical Specification requires, in part, that identified leakage be monitored every 12 hours. Power was secured to the leak rate instrument during the last refueling outage and the equipment was not properly reset, following the power loss, because of inadequate restoration procedures. This Severity level IV violation is being treated as a noncited violation, consistent with Section VII.B.1.a of the NRC Enforcement Policy. The problem is in the licensee's corrective action program as Problem Evaluation Request 299-2404
<b>Dockets Discussed:</b> 05000397 WNP2						
10/16/1999	1999010	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 5A <b>Sec:</b> <b>Ter:</b>	<b>Excellent response to two human performance errors</b>  Management response to the inadvertent de-energization of an electrical bus was excellent. No consequences resulted because of the loss of the electrical bus that occurred when an electrician opened an incorrect electrical cabinet door. Management recognized that, had the mistake occurred when the Division III diesel generator was required to be operable, an emergency safety features actuation would have occurred. Consequently, management utilized the occurrence to reinforce important attention-to-detail concepts with the staff
<b>Dockets Discussed:</b> 05000397 WNP2						
10/01/1999	1999011	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2B <b>Sec:</b> <b>Ter:</b>	<b>Inservice inspection program plan was well defined.</b>  The licensee had developed a well-defined second 10-year interval inservice inspection examination program plan, in that, the examination categories, examination methods, augmented inspections, relief requests, code cases implemented, and changes to the examination plan were clearly identified. The licensee had implemented the program requirements appropriately.
<b>Dockets Discussed:</b> 05000397 WNP2						
09/22/1999	1999010-01	<b>Pri:</b> MAINT <b>Sec:</b>	Self	NCV	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>Electricians de-energize wrong valve</b>  The inspectors identified a violation of Technical Specification 5.4.1.a in that electricians failed to follow procedures and opened the breaker to the wrong valve. The breaker de-energized the low pressure core spray system minimum flow valve, which rendered the system inoperable. Operators identified the problem and restored the low pressure core spray valve to service within 10 minutes. This Severity Level IV violation is being treated as a noncited violation, consistent with Appendix C of the NRC Enforcement Policy. The problem is in the licensee's corrective action program as Problem Evaluation Request 299-1903.
<b>Dockets Discussed:</b> 05000397 WNP2						

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09/04/1999	1999009	<b>Pri:</b> MAINT <b>Sec:</b>	Licensee	NEG	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>Damage to safety-related cables during Thermolag removal.</b>  During Thermolag removal, contractors inadvertently severed electrical cables to 5 components and damaged approximately 70 other cables. While operability of some components was affected, all system safety functions were maintained. Planned corrective measures were acceptable.
<b>Dockets Discussed:</b> 05000397 WNP2						
07/24/1999	1999008	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2A <b>Sec:</b> <b>Ter:</b>	<b>Material condition improvements.</b>  Overall, plant material condition was very good. Several material condition improvements were completed during the fuel savings dispatch outage including repair of: Reactor Water Cleanup Pump B, the turbine building roof, 100 control room deficiencies, and 70 steam leaks. Additionally, the fire protection control circuits were modified to minimize the potential for water hammer on the system.
<b>Dockets Discussed:</b> 05000397 WNP2						
06/17/1999	1999008-01	<b>Pri:</b> MAINT <b>Sec:</b>	Self	NCV	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>Failure to properly implement surveillance procedure results in drywell high pressure alarm</b>  A noncited violation of Technical Specification 5.4.1.a resulted because an instrument and controls technician failed to properly isolate a drywell pressure switch in accordance with a surveillance procedure. Consequently, the misoperation resulted in an unexpected control room alarm and satisfied one-half of the high pressure core spray system injection logic. In response to the event, the licensee performed a credible investigation and planned appropriate corrective measures. This deficiency is in the corrective action program as Problem Evaluation Request 299-1336.
<b>Dockets Discussed:</b> 05000397 WNP2						
06/17/1999	1999009-02	<b>Pri:</b> MAINT <b>Sec:</b> ENG	NRC	NCV	<b>Pri:</b> 3A <b>Sec:</b> 4B <b>Ter:</b>	<b>Failure to implement procedures for crane hook measurements and plant scaffolding engineering evaluation</b>  The inspectors identified a Technical Specification 5.4.1.a violation with two examples. First, maintenance craftsmen did not properly implement a procedure for checking the refueling floor crane hook for yielding. The craftsmen did not obtain the original as-built dimensions to compare with the as-found dimensions, as required. Additionally, they did not question unexpected and illogical data and results, and the licensee had not independently reviewed all the results. Second, engineers failed to complete an engineering evaluation, as required by a plant procedure, for a scaffolding storage rack on the 422-foot reactor building elevation. Annual inspections were not effective at catching the problem earlier. These Severity Level IV violation examples are being treated as a noncited violation. The violation was in the licensee's corrective action program as Problem Evaluation Requests 299-1759, -1760, and -1591 (Sections M1.3 and E2.2)
<b>Dockets Discussed:</b> 05000397 WNP2						
06/12/1999	1999007	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2B <b>Sec:</b> 3A <b>Ter:</b>	<b>Maintenance work conducted reliably with management oversight</b>  Maintenance work observed by the inspectors was conducted in a manner that ensured reliable, safe operation of the station. More effective and frequent management observation of maintenance activities was observed.
<b>Dockets Discussed:</b> 05000397 WNP2						
05/27/1999	1999006	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>Satisfactory testing program for the control room emergency filtration system</b>  The licensee implemented a satisfactory testing program for the control room emergency filtration system. The testing interval and method met Technical Specification requirements.
<b>Dockets Discussed:</b> 05000397 WNP2						

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05/17/1999	1999007	<b>Pri:</b> MAINT <b>Sec:</b>	Licensee	NEG	<b>Pri:</b> 2B <b>Sec:</b> 3C <b>Ter:</b>	<b>Interim repairs to turbine building roof not successful resulting electrical panel fire due to rain</b> The licensee made comprehensive repairs to the turbine building roof to prevent further rainwater intrusion into the turbine building. However, interim protective measures, during installation, were not totally successful since a sudden rainstorm resulted in a small fire in a lighting panel.
<b>Dockets Discussed:</b> 05000397 WNP2						
04/25/1999	1999004-03	<b>Pri:</b> MAINT <b>Sec:</b> PLTSUP	NRC	NCV	<b>Pri:</b> 2A <b>Sec:</b> 3A <b>Ter:</b>	<b>Violations of Technical Specification 5.4.1: unsecured eyewash station and failure to post a CA</b> Plant housekeeping and material condition were generally good; however, the inspectors found an unsecured portable eye wash station too close to the high pressure core spray batteries in violation of procedural requirements. This is one example of a Severity Level IV violation of Technical Specification 5.4.1.a, which is being treated as a noncited violation and is in the licensee's corrective action program as Problem Evaluation Request 299-0889  Radiological controls associated with the unloading of fresh fuel were generally good and health physics oversight helped personnel maintain exposure ALARA. However, the licensee failed to post or mark a contaminated area as required by procedure. This is one example of a Severity Level IV violation of Technical Specification 5.4.1.a and is being treated as a noncited violation. This deficiency is in the licensee's corrective action program as Problem Evaluation Request 299-0718
<b>Dockets Discussed:</b> 05000397 WNP2						
04/11/1999	1999004	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 2B <b>Sec:</b> <b>Ter:</b>	<b>Procedural weakness for scaffold erection</b> The inspectors identified a procedure weakness that allowed potential interferences between scaffolding and instrument sensing lines to be evaluated by the craft erecting the scaffolding. This was inconsistent with other guidance in the procedure which required engineering evaluation and a 10 CFR 50.59 review for potential interferences between scaffolding and important-to-safety components. At the close of the inspection, engineering was planning to revise the scaffolding procedure to ensure that potential interferences with instrument sensing lines will receive a similar degree of evaluation as other safety-related components
<b>Dockets Discussed:</b> 05000397 WNP2						
03/20/1999	1999002	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 2B <b>Sec:</b> 3A <b>Ter:</b>	<b>Licensee identification of poor work planning.</b> During review of licensee-generated PERs, the inspector noted several instances of poor planning, coordination, and execution of maintenance activities. These resulted in: (1) safety-related equipment being inoperable longer than was necessary, (2) safety-related equipment being unnecessarily rendered inoperable, (3) SFP temperature exceeding expected values, and (4) the potential for fire protection system compensatory measures to be incorrectly sequenced.
<b>Dockets Discussed:</b> 05000397 WNP2						
02/06/1999	1998025	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> 3B <b>Ter:</b>	<b>Maintenance personnel used good 3-way communications, peer checking during SDV maintenance</b> Personnel performing a surveillance test at the scram discharge volume limit switches used good three-way communications, peer verification, procedure adherence and place-keeping, and ALARA (as low as reasonably achievable) practices.
<b>Dockets Discussed:</b> 05000397 WNP2						

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01/29/1999	1998025-01	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	VIO IV	<b>Pri:</b> 3A <b>Sec:</b> 4B <b>Ter:</b>	<b>Scaffolding installed without a required evaluation and failure to properly adjust the scram valve limit switch</b>  The first example of a violation of Technical Specification 5.4.1.a was identified because the licensee failed to perform the required evaluations for scaffolding that was supported by a non-load bearing member of a Class 1 component. The second example of a violation of Technical Specification 5.4.1.a and plant procedures occurred because personnel failed to follow the written procedures for adjusting the outlet scram valve limit switch. Because the licensee implemented appropriate corrective actions, no response was required. Maintenance personnel performance during control rod drive hydraulic control unit refurbishment demonstrated knowledge deficiencies in the proper use of, adherence to, and change of procedures. In addition, mechanic's knowledge on the proper adjustment of limit switches was insufficient and postmaintenance testing did not identify that the outlet scram valve limit switch was improperly adjusted. Because the licensee implemented appropriate corrective actions, no response was required.
<b>Dockets Discussed:</b> 05000397 WNP2						
01/08/2000	1999014-02	<b>Pri:</b> ENG <b>Sec:</b>	NRC	URI	<b>Pri:</b> 4B <b>Sec:</b> <b>Ter:</b>	<b>Failure to meet TS submittal commitments.</b>  The inspector identified that the licensee failed to meet commitments made to support a December 8, 1995, amendment request for Improved Technical Specification 3.6.1.3, "Primary Containment Isolation Valves." Specifically, the licensee had committed to include all containment isolation valves identified in the Final Safety Analysis Report within a listing of valves subject to the Technical Specification controls. Contrary to the commitment, however, the subject list was not updated to include all of the necessary valves. In addition, one of the omitted containment isolation valves was stuck partially open during this inspection period, but the penetration was subsequently isolated in response to the inspector's finding. Pending further review of problem significance and the adequacy of the amendment request, this is an unresolved item (Section E2.1).
<b>Dockets Discussed:</b> 05000397 WNP2						
11/27/1999	1999013-01	<b>Pri:</b> ENG <b>Sec:</b>	NRC	VIO IV	<b>Pri:</b> 4B <b>Sec:</b> 5C <b>Ter:</b>	<b>Inadequate corrective actions to address RCIC unreviewed safety question</b>  The licensee failed to restore compliance within a reasonable time frame after a violation of 10 CFR 50.59 was identified. In 1998, the NRC identified that the licensee inappropriately downgraded the reactor core isolation cooling (RCIC) system to nonsafety status via the 10 CFR 50.59 process. The licensee took corrective action to upgrade the system, but left some of the system in a nonsafety-status based on inadequate engineering analysis. Specifically, the RCIC system keepfill pump and barometric condenser level switch were maintained as nonsafety components based on inadequate water hammer and flooding calculations, respectively. This resulted in a continuing violation of 10 CFR 50.59. These inadequate corrective measures were cited as a violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action."
<b>Dockets Discussed:</b> 05000397 WNP2						
11/27/1999	1999013-02	<b>Pri:</b> ENG <b>Sec:</b>	NRC	URI	<b>Pri:</b> 4B <b>Sec:</b> 5C <b>Ter:</b>	<b>Potential unreviewed safety question for unanalyzed flooding vulnerability.</b>  The inspectors identified that reactor building flooding protection was not consistent with Final Safety Analysis Report commitments. The Final Safety Analysis Report states that all reactor building pump enclosure rooms are watertight, but the RCIC and the control rod drive pump rooms were connected via an unisolable equipment drain line. Further, this condition was not consistent with the licensee's flooding analysis, which assumed that flooding could not occur in both rooms simultaneously. The licensee maintained that even with the unisolable connection, safe shutdown could be achieved for design basis floods in these rooms. Pending further review of the licensee's revised flooding analysis and risk evaluation to determine the safety significance of the design deficiency, this is an unresolved item.
<b>Dockets Discussed:</b> 05000397 WNP2						

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10/16/1999	1999010	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4B <b>Sec:</b> <b>Ter:</b>	<b>Good engineering assessment of apparent RCIC loss of fill.</b> Engineers performed a thorough evaluation of an unexpected reactor core isolation cooling system loss-of-fill annunciator. The annunciator alarmed after the system automatically secured on high reactor water level. Engineers determined that the system remained full, but the pressure was less than expected because of known system out-leakage through a lube oil cooler. Short-term corrective measures were acceptable.
<b>Dockets Discussed:</b> 05000397 WNP2						
09/04/1999	1999009	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4B <b>Sec:</b> <b>Ter:</b>	<b>Engineering and chemistry provide good support in response to hydraulic fluid intrusion.</b> Engineering and chemistry provided good support to operations in response to inadvertent Fyrquel hydraulic fluid in-leakage into the primary system. The departments: 1) determined that no more than 2 pints were injected; 2) determined that the fuel would not be affected; and 3) verified that no other plant equipment would be impacted by the incident. The assessment was thorough and comprehensive.
<b>Dockets Discussed:</b> 05000397 WNP2						
09/04/1999	1999009-03	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 4A <b>Sec:</b> 4C <b>Ter:</b>	<b>Design control violation for three Technical Specification inconsistencies.</b> The inspectors identified a 10 CFR Part 50, Appendix B, Criterion III (Design Control) violation, with three examples. First, the inspectors found that design constraints associated with the residual heat removal system in the shutdown cooling mode were not properly incorporated into Technical Specification 3.4.9. As such, the system was not always operable consistent with Technical Specification requirements. Second, the inspectors identified that a plant modification had removed the outboard shutdown cooling isolation valve controls from the alternate remote shutdown panel, but Technical Specification 3.3.6.1, Note (d), which was rendered obsolete by the modification, was not removed from the Technical Specifications. Third, the licensee identified that Technical Specifications Bases 3.3.1.1.3 incorrectly states that four instrumentation channels of reactor vessel steam dome pressure - high are available. Only two instrument channels are actually available. These Severity Level IV violation examples are being treated as a noncited violation. The violation was in the licensee's corrective action program as Problem Evaluation Requests 299-0574, -0691, and -0548.
<b>Dockets Discussed:</b> 05000397 WNP2						
09/04/1999	1999009-04	<b>Pri:</b> ENG <b>Sec:</b>	NRC	IFI	<b>Pri:</b> 5A <b>Sec:</b> 4A <b>Ter:</b> 4C	<b>Adverse trend related to Technical Specification fidelity issues.</b> The inspectors identified a negative trend with respect to Technical Specification fidelity. In addition to the three problems identified in this report, four other Technical Specification accuracy and implementation problems were identified as a result of NRC questions during the past 18 months (see NRC Inspection Reports 50-397/98-15 and -99-07). The licensee acknowledged the performance trend and planned to evaluate the condition through the corrective action program.
<b>Dockets Discussed:</b> 05000397 WNP2						
06/28/1999	1999008	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4B <b>Sec:</b> 5C <b>Ter:</b>	<b>Thorough engineering investigation/MSIV closure</b> The engineering investigation into an automatic main steam isolation valve closure was thorough. Engineers instrumented the control circuit and found that a degraded relay erroneously changed states in response to minor vibrations. The relay misoperation, in conjunction with expected system logic operation during surveillance testing, resulted in the system isolation
<b>Dockets Discussed:</b> 05000397 WNP2						

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06/12/1999	1999007-02	<b>Pri:</b> ENG <b>Sec:</b>	Self	NCV	<b>Pri:</b> 4C <b>Sec:</b> <b>Ter:</b>	<b>Violations of Criterion III related to overcurrent relay setpoints; new fuel vault TS; and lifting bail for new fue</b>  A Severity Level IV violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," with three examples was identified. This Severity Level IV violation is being treated as a noncited violation, consistent with Appendix C of the NRC Enforcement Policy. (1) Incorrect overcurrent relay setpoints were installed on four Division II safety-related pump breakers when correct design information was available but not accurately translated into procedures (Problem Evaluation Request 299-1193). (2) Technical Specification 4.3.1.2.b allowed less restrictive spacing of new fuel assemblies in the new fuel vault than that required by plant procedures and analysis (Problem Evaluation Request 299-1238). (3) Final Safety Analysis Report Section 9.1.1.3.2 stated, "lifting bail will yield at a pull up force less than 1000 lb," however, Siemens and ASEA Brown Boveri fuel lifting bails yield at a pull up force between 1500 and 1700 pounds (Problem Evaluation Requests 299-1289).
<b>Dockets Discussed:</b> 05000397 WNP2						
06/12/1999	1999007-03	<b>Pri:</b> ENG <b>Sec:</b>	Licensee	URI	<b>Pri:</b> 1A <b>Sec:</b> 3A <b>Ter:</b>	<b>Analysis for potential effects on ABB fuel assemblies during long-term operation with missing or borken spr</b>  An unresolved item was identified related to a new fuel manufacturing defect. The licensee identified missing external compression springs on two new fuel assemblies. This item is unresolved pending NRC review of the facilities resolution of this condition.
<b>Dockets Discussed:</b> 05000397 WNP2						
05/01/1999	1999004-04	<b>Pri:</b> ENG <b>Sec:</b>	NRC	URI	<b>Pri:</b> 4A <b>Sec:</b> 5A <b>Ter:</b>	<b>violation of 10 CFR 50.59; Technical Specification Table 3.3.1.1-1 note (d) no longer applicable.</b>  Technical Specification 3.3.6.1, "Primary Containment Isolation Instrumentation," Function 5, "Residual Heat Removal Shutdown Cooling System Isolation," and the associated bases section were incorrect. The Technical Specifications were not updated when the controls for the outboard isolation valve were removed from the alternate remote shutdown panel. In addition, the bases section incorrectly stated that there are four pressure switches associated with the reactor high pressure isolation instrumentation, when only two exist. This issue is identified as an unresolved item because additional information is required in order to confirm the facility was originally licensed with only two pressure switches and to review the 10 CFR 50.59 evaluation for the change
<b>Dockets Discussed:</b> 05000397 WNP2						
03/20/1999	1999002-02	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 4B <b>Sec:</b> <b>Ter:</b>	<b>Violations of Criterion III: Undersized pwr supply &amp; insufficient penetration overcurrent protection</b>  In 1988, the licensee had installed an undersized power supply in the emergency diesel generator (EDG) speed interlock circuits. The inspectors concluded that the marginal design of the power supply did not pose a significant risk for common mode failure of the Divisions I and II EDGs. However, the failure to correctly size the power supply is one example of a noncited violation (NRC Enforcement Policy, Appendix C) of 10 CFR Part 50, Appendix B, Criterion III, "Design Control."  In 1998, the licensee discovered that the primary containment penetration for Valve RHR-MO-9 did not meet the overcurrent protection requirements of Regulatory Guide 1.63, "Penetration Assemblies in Containment Structures for Light-Water-Cooled Nuclear Power Plants," Revision 0, as committed to in the WNP-2 Final Safety Analysis Report (FSAR). The failure to translate the design basis specified in the license application into the design of the facility is one example of a noncited violation (NRC Enforcement Policy, Appendix C) of 10 CFR Part 50, Appendix B, Criterion III, "Design Control."
<b>Dockets Discussed:</b> 05000397 WNP2						
02/01/1999	1998025	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3B <b>Sec:</b> 4B <b>Ter:</b>	<b>PMT review identified a need for a TS change.</b>  The evaluation of postmaintenance testing required for the repair of Circulating Water Pump C, including any impact on plant operations and Technical Specification requirements, identified the need for a Technical Specification change. The licensee completed the repair and testing of Circulating Water Pump C without incident.
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01/13/2000	2000003-01	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 5A <b>Sec:</b> <b>Ter:</b>	<b>Failure to perform an audit of the radiological environmental monitoring program thermoluminescent dosimetry.</b> A violation of Technical Specification 5.4.1.c was identified for the failure to audit a contract supplier's environmental thermoluminescent dosimeter quality assurance program (part of the radiological environmental monitoring program). This Severity Level IV violation is being treated as a noncited violation, consistent with Section VII.B.1.a of the NRC Enforcement Policy. On January 13, 2000, the licensee wrote Problem Evaluation Request 200-0078 documenting this issue (Section R7.1).
<b>Dockets Discussed:</b> 05000397 WNP2						
10/28/1999	1999012	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	STR	<b>Pri:</b> 3A <b>Sec:</b> 3B <b>Ter:</b>	<b>Effective, performance-based security program</b> The security program continues to be implemented in a very effective and performance-based manner. The alarm stations were redundant and well protected. Alarm station operators were alert and well trained. Very good radio and telephone communication systems were maintained. A sufficient number of portable radios were available for members of the security organization. An excellent testing and maintenance program was conducted and documented. Timely repair of security equipment resulted in a low number of compensatory postings. Very good protected area barriers and detection systems were maintained. During performance testing of the detection system at the protected area, all attempts to intrude into the protected area were detected. An excellent vehicle barrier system was in place that was routinely inspected and effectively maintained.
<b>Dockets Discussed:</b> 05000397 WNP2						
07/24/1999	1999008	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	STR	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Improvement in liquid effluent discharges</b> The inspectors noted a significant improvement with respect to liquid effluent discharges to the Columbia River. As a result of concentrated efforts at minimizing liquid waste and treating and reusing waste water, no discharges were made to the river in the past 10 months. This was a substantial improvement from prior years when discharges sometimes totaled more than a million gallons per year.
<b>Dockets Discussed:</b> 05000397 WNP2						
07/24/1999	1999009	<b>Pri:</b> PLTSUP <b>Sec:</b>	Licensee	NEG	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>Failure to man two chemistry technicians during off-hours call-in drill.</b> During the off-hours call-in drill, a 6-year event, the licensee failed to meet the emergency plan commitment to staff two chemistry technicians within 1 hour of declaring the Alert. Further, the operations support center manager and the team tracker failed to recognize the problem, as they were misled by an erroneous sign-in board that only contained one slot for a chemistry technician signature. Corrective actions were adequate.
<b>Dockets Discussed:</b> 05000397 WNP2						
06/12/1999	1999007	<b>Pri:</b> PLTSUP <b>Sec:</b>	Licensee	POS	<b>Pri:</b> 1A <b>Sec:</b> 5A <b>Ter:</b>	<b>Good radiological controls.</b> The inspectors observed that radiological controls were generally good and that the facility appropriately identified an adverse trend in contractor radiation work practices.
<b>Dockets Discussed:</b> 05000397 WNP2						
05/27/1999	1999006	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	STR	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>Good radioactive effluent management program</b> The licensee maintained a good radioactive effluent management program. Radioactivity in effluent releases was low. The licensee's radioactive effluent sampling, analysis, and dose projection program met the requirements of the Offsite Dose Calculation Manual. Effluent radiation monitors were calibrated at intervals typically used by nuclear power facilities. Quality assurance personnel conducted a good audit of the radioactive effluent monitoring program in 1998. The audit team included a technical specialist who provided performance-based findings and recommendations. The audit scope, while not completely comprehensive, provided licensee management with good insights into the program performance.
<b>Dockets Discussed:</b> 05000397 WNP2						

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05/27/1999	1999006-01	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 3A <b>Sec:</b> 3C <b>Ter:</b>	<b>Effluent radiation monitor alarm setpoint calculation error.</b> The radwaste and turbine building effluent radiation monitor alarm setpoints were not calculated with Offsite Dose Calculation Manual methodology in violation of Technical Specification 5.5.1. This Severity Level IV violation is being treated as a noncited violation, consistent with Appendix C of the NRC Enforcement Policy. This violation is in the licensee's corrective action program as Problem Evaluation Request 299-1207. The licensee had an opportunity to identify and correct the alarm setpoint problem in September 1995, but the corrective action program was weak and did not ensure that the problem was addressed completely
<b>Dockets Discussed:</b> 05000397 WNP2						
03/20/1999	1999002-03	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 3A <b>Sec:</b> 4B <b>Ter:</b>	<b>Failure to ensure flame spread rate criterion was met for decontaminable floor coverings.</b> A noncited violation (NRC Enforcement Policy, Appendix C) of a License Condition was identified in that the licensee failed to implement and maintain in effect all provisions of the approved fire protection program as described in the FSAR. Specifically, the licensee failed to ensure that decontaminable coatings used on floors in the reactor building had a flame spread rate less than 25. This violation is in the licensee's corrective action program as PER 299-0278.
<b>Dockets Discussed:</b> 05000397 WNP2						
03/18/1999	1999003	<b>Pri:</b> PLTSUP <b>Sec:</b>	Licensee	NEG	<b>Pri:</b> 2B <b>Sec:</b> <b>Ter:</b>	<b>Poor pre-job planning for refurbishing CRD hydraulic control units</b> Poor pre-job planning and preparation for control rod hydraulic control unit refurbishment caused a significant underestimation of projected man-hours and personnel exposure. Specific licensee-identified deficiencies included not using a dedicated team as originally planned, ineffective mock-up training, no formal ALARA review of the job performed, inadequate procedural guidance, and ineffective use of industry experience.
<b>Dockets Discussed:</b> 05000397 WNP2						
03/18/1999	1999003	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Overall RP activities conducted well.</b> Overall, radiation protection activities were conducted well and demonstrated an improving trend. Decontamination of contaminated areas was effective in that the total number of contaminated areas was reduced from 77 to 56 since October 1998. Radiological areas were controlled and posted as required. Radiation work permits and radiological surveys were clearly written and provided accurate radiological conditions and established proper radiological controls. Portable radiation survey instrumentation and personnel contamination monitors were calibrated and response checked at the frequencies required by station procedures using National Institute of Standards and Technology traceable sources.
<b>Dockets Discussed:</b> 05000397 WNP2						
03/18/1999	1999003	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Licensee efforts resulted in ALARA dose reduction</b> The Senior Site ALARA Committee was actively involved in reducing station dose by implementing short- and long-term initiatives. The station 3-year average exposures have shown a declining trend since 1996; the 3-year average dose dropped from 565 person-rem in 1996 to 303 person rem in 1998. The station established challenging dose goals of 203 and 53 person-rem for 1999 and 2000, respectively.
<b>Dockets Discussed:</b> 05000397 WNP2						
03/18/1999	1999003	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2A <b>Sec:</b> <b>Ter:</b>	<b>Good housekeeping in contaminated areas</b> Housekeeping in the radiological controlled area was good. Equipment was stored in an orderly manner, areas were free of debris, and potentially contaminated trash was properly stored in labeled containers.
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03/18/1999	1999003	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 5A <b>Sec:</b> <b>Ter:</b>	<b>Thorough QA audits of RP program.</b>  The licensee performed a thorough evaluation of the radiation protection program in the past 8 months as indicated by five quality assurance surveillances, two quality assurance technical assessments, and six radiation protection department self assessments. These evaluations were probing and comprehensive, and provided management with accurate information on radiation protection program effectiveness.
<b>Dockets Discussed:</b> 05000397 WNP2						
03/05/1999	1999001	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>Security staffing and response to OSRE satisfactory</b>  On-shift staffing of security armed response personnel was in accordance with the minimum requirements of the physical security plan. During the OSRE, the licensee successfully demonstrated its ability to defend against the design basis threat.
<b>Dockets Discussed:</b> 05000397 WNP2						
02/06/1999	1998025	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 2A <b>Sec:</b> <b>Ter:</b>	<b>Plant material condition mixed</b>  Material condition of and housekeeping in areas toured was generally good. However, water was identified leaking from a flange below a control rod drive filter housing. A contaminated area was not completely marked. Specifically, yellow and magenta tape was not used on a small section of floor to designate a contaminated area.
<b>Dockets Discussed:</b> 05000397 WNP2						
02/04/1999	1999001	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Highly effective security program implementation.</b>  Security program implementation continued to be highly effective in most areas. An effective program for searching personnel, packages, and vehicles was maintained. The compensatory measures program was effectively implemented. A highly effective lock and key control program was maintained and implemented. Changes to security programs and plans were reported to the NRC within the required time frame. Overall, implementing procedures met the performance requirements in the physical security plan. The security staff correctly reported security events; event records were accurate and neat. An excellent training program was implemented. Security program management was effective.
<b>Dockets Discussed:</b> 05000397 WNP2						
02/04/1999	1999001	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	STR	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Excellent, intrusive fitness for duty audit</b>  The annual audit of the Fitness-for-Duty Program was excellent. The audit was intrusive and performance based.
<b>Dockets Discussed:</b> 05000397 WNP2						
01/28/2000	2000001	<b>Pri:</b> OTHER <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 1C <b>Sec:</b> 5C <b>Ter:</b>	<b>Incomplete corrective action timeliness tracking.</b>  The team identified some instances (e.g., a prior NCV) in which the corrective action tracking system showed the item complete but the action had not been completed or had been cancelled. The licensee's procedure allowed the tracking system items to be closed based on the assignment of action, rather than the completion of the specific corrective actions. Also, the team identified a few cases where licensee prioritization of the problem evaluation requests differed from the licensee's expectations, but none of the cases were significant. The team also identified that the tracking of corrective action timeliness was an incomplete measurement because some items were closed prior to completion of the corrective actions, as described above.
<b>Dockets Discussed:</b> 05000397 WNP2						

# United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area

Region IV

WASH. NUCLEAR PROJECT

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
01/28/2000	2000001	<b>Pri:</b> OTHER <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> 5A <b>Ter:</b> 5B	<b>Acceptable corrective action program and improving</b> The team concluded that the licensee had an acceptable and improving corrective action program. The licensee's corrective action processes provided adequate guidance for identifying, classifying, and prioritizing adverse conditions. Licensee personnel initiated Problem Evaluation Requests for adverse or questionable conditions

**Dockets Discussed:**  
05000397 WNP2

# United States Nuclear Regulatory Commission

## PLANT ISSUE MATRIX

By Primary Functional Area

### Legend

#### Type Codes:

BU	Bulletin
CDR	Construction
DEV	Deviation
EI	Escalated Enforcement Item
IFI	Inspector follow-up item
LER	Licensee Event Report
LIC	Licensing Issue
MISC	Miscellaneous
MV	Minor Violation
NCV	NonCited Violation
NEG	Negative
NOED	Notice of Enforcement Discretion
NON	Notice of Non-Conformance
OTHR	Other
P21	Part 21
POS	Positive
SGI	Safeguard Event Report
STR	Strength
URI	Unresolved item
VIO	Violation
WK	Weakness

#### Template Codes:

1A	Normal Operations
1B	Operations During Transients
1C	Programs and Processes
2A	Equipment Condition
2B	Programs and Processes
3A	Work Performance
3B	KSA
3C	Work Environment
4A	Design
4B	Engineering Support
4C	Programs and Processes
5A	Identification
5B	Analysis
5C	Resolution

#### ID Codes:

NRC	NRC
Self	Self-Revealed
Licensee	Licensee

#### Functional Areas:

OPS	Operations
MAINT	Maintenance
ENG	Engineering
PLTSUP	Plant Support
OTHER	Other

EIIs are apparent violations of NRC Requirements that are being considered for escalated enforcement action in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Action" (Enforcement Policy), NUREG-1600. However, the NRC has not reached its final enforcement decision on the issues identified by the EIIs and the PIM entries may be modified when the final decisions are made.

URIs are unresolved items about which more information is required to determine whether the issue in question is an acceptable item, a deviation, a nonconformance, or a violation. A URI may also be a potential violation that is not likely to be considered for escalated enforcement action. However, the NRC has not reached its final conclusions on the issues, and the PIM entries may be modified when the final conclusions are made.

## WASH. NUCLEAR PROJECT

## Inspection / Activity Plan

04/02/2000 - 03/31/2001

Units	Inspection Activity	Title	No. of Staff on Site	No. assigned to Procedure	Planned Dates Start	Planned Dates End	Inspection Type
	<b>PBE#20</b>	<b>- DRILL EVALUATIONS</b>	<b>2</b>				
2	IP 7111406	Drill Evaluation		2	04/02/2000	07/01/2000	Baseline Inspections
	<b>PBE#19</b>	<b>- TEMPORARY PLANT MODIFICATIONS</b>	<b>2</b>				
2	IP 7111123	Temporary Plant Modifications		2	04/02/2000	03/30/2001	Baseline Inspections
	<b>PSB-S1</b>	<b>- ACCESS AUTH/CONTROL, SEC PLAN, AND PIV</b>	<b>1</b>				
2	IP 7113001	Access Authorization Program (Behavior Observation Only)		1	04/10/2000	04/14/2000	Baseline Inspections
2	IP 7113002	Access Control (Search of Personnel, Packages, and Vehicles: Identification an		1	04/10/2000	04/14/2000	Baseline Inspections
2	IP 7113004	Security Plan Changes		1	04/10/2000	04/14/2000	Baseline Inspections
2	IP 71151	Performance Indicator Verification		1	04/10/2000	04/14/2000	Baseline Inspections
	<b>EMB</b>	<b>- BAGMAN TRIP FOR 71111.05T FIRE PROT</b>	<b>2</b>				
2	IP 7111105T	Fire Protection		2	04/17/2000	04/19/2000	Baseline Inspections
	<b>PSB-RP1</b>	<b>- ALARA PLANNING/CONTROL</b>	<b>1</b>				
2	IP 7112102	ALARA Planning and Controls		1	04/24/2000	04/28/2000	Baseline Inspections
	<b>EMB</b>	<b>- FIRE PROTECTION</b>	<b>5</b>				
2	IP 7111105T	Fire Protection		3	05/01/2000	05/05/2000	Baseline Inspections
	<b>PSB-RP2</b>	<b>- ACCESS TO RAD SIGN AREAS AND PIV</b>	<b>2</b>				
2	IP 7112101	Access Control to Radiologically Significant Areas		1	05/08/2000	05/12/2000	Baseline Inspections
2	IP 71151	Performance Indicator Verification		2	05/08/2000	05/12/2000	Baseline Inspections
	<b>PSB-RP3</b>	<b>- ALARA PLANNING/CONTROL 2</b>	<b>1</b>				
2	IP 7112102	ALARA Planning and Controls		1	05/08/2000	05/12/2000	Baseline Inspections
	<b>PBE-TI</b>	<b>- TI-144, PI DATA REVIEW</b>	<b>1</b>				
2	IP 2515/144	Performance Indicator Data Collecting and Reporting Process Review		1	05/14/2000	08/05/2000	Safety Issues
	<b>PBE#23</b>	<b>- EQUIPMENT ALIGNMENT</b>	<b>2</b>				
2	IP 7111104	Equipment Alignment		2	05/21/2000	07/08/2000	Baseline Inspections
	<b>PSB-RP4</b>	<b>- RAD MONITORING INSTR</b>	<b>1</b>				
2	IP 7112103	Radiation Monitoring Instrumentation		1	06/05/2000	06/09/2000	Baseline Inspections
	<b>EMB</b>	<b>- PERM PLANT MODS</b>	<b>2</b>				
2	IP 7111117B	Permanent Plant Modifications		2	08/28/2000	09/01/2000	Baseline Inspections
	<b>PSB-EP1</b>	<b>- DRILL/EXERCISE PERF, EAL/EP, AND PIV</b>	<b>2</b>				
2	IP 7111401	Exercise Evaluation		2	09/11/2000	09/15/2000	Baseline Inspections
2	IP 7111404	Emergency Action Level and Emergency Plan Changes		2	09/11/2000	09/15/2000	Baseline Inspections
2	IP 71151	Performance Indicator Verification		2	09/11/2000	09/15/2000	Baseline Inspections
	<b>PBE#26</b>	<b>- DRILL EVALUATION</b>	<b>2</b>				
2	IP 7111406	Drill Evaluation		2	10/01/2000	12/30/2000	Baseline Inspections
	<b>OB-EXAMS</b>	<b>- RO/SRO EXAMS</b>	<b>4</b>				
2	X02042	WNP2/INITIAL EXAMS		1	10/02/2000	10/06/2000	Not Applicable

This report does not include INPO and OUTAGE activities.  
This report shows only on-site and announced inspection procedures.

## WASH. NUCLEAR PROJECT

## Inspection / Activity Plan

04/02/2000 - 03/31/2001

Units	Inspection Activity	Title	No. of Staff on Site	No. assigned to Procedure	Planned Dates		Inspection Type
					Start	End	
2	X02042	WNP2/INITIAL EXAMS		4	10/23/2000	10/27/2000	Not Applicable
	<b>PBE#10 - ADVERSE WEATHER</b>		<b>2</b>				
2	IP 7111101	Adverse Weather Protection		2	10/08/2000	11/18/2000	Baseline Inspections
	<b>OB-PIR - PIR INSPECT</b>		<b>5</b>				
2	IP 71152	Identification and Resolution of Problems		2	11/13/2000	11/17/2000	Baseline Inspections
	<b>PBE#24 - EQUIPMENT ALIGNMENT</b>		<b>2</b>				
2	IP 7111104	Equipment Alignment		2	11/19/2000	01/06/2001	Baseline Inspections
	<b>EMB - 50.59</b>		<b>1</b>				
2	IP 7111102	Evaluation of Changes, Tests, or Experiments		1	12/04/2000	12/08/2000	Baseline Inspections
	<b>OB-RQ - REQUAL INSP</b>		<b>3</b>				
2	IP 7111111B	Licensed Operator Requalification		2	12/04/2000	12/08/2000	Baseline Inspections

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