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PARRISH,J.V. Washington Public Power Supply System

SUBJECT: Advises of planned insp effort resulting from Washington plant performance review for period of 970924-980422. Historical listing of plant issues considered to arrive at integrated view of licensee performance trends encl.

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June 8, 1998

Mr. J. V. Parrish (Mail Drop 1023)
Chief Executive Officer
Washington Public Power Supply System
P.O. Box 968
Richland, Washington 99352-0968

SUBJECT: PLANT PERFORMANCE REVIEW (PPR) - **WASHINGTON NUCLEAR PLANT UNIT 2 (WNP-2)**

Dear Mr. Parrish:

On May 15, 1998, the NRC staff completed the semiannual Plant Performance Review (PPR) of WNP-2. The staff conducts these reviews for all operating nuclear power plants to develop an integrated understanding of safety performance. The results are used by NRC management to facilitate planning and allocation of inspection resources. The PPR for WNP-2 involved the participation of all technical divisions in evaluating inspection results and safety performance information for the period September 24, 1997, to April 22, 1998. PPRs provide NRC management with a current summary of licensee performance and serve as input to the NRC Systematic Assessment of Licensee Performance (SALP) and Senior Management Meeting (SMM) reviews.

Overall safety performance remained steady. Performance in the area of Operations demonstrated weakness in the operators understanding of plant transient response and post trip reviews. Maintenance activities were generally good, with Engineering performance mixed. While the corrective actions resulting from the reactor core isolation cooling system downgrade were performed in a thorough and comprehensive manner, the post trip reviews of the main steam line isolation event did not promptly identify operational problems with the reactor core isolation cooling system. Also, weaknesses in vendor oversight resulted in the use of incorrect and non-conservative core operating limits. Performance in Plant Support has been generally good with the exception of weaknesses in the implementation of radiation protection programs. Based on the results of this assessment, no change in inspection resources for review of your performance was warranted.

Enclosure 1 contains a historical listing of plant issues, referred to as the Plant Issues Matrix (PIM), that was considered during this PPR process to arrive at an integrated view of licensee performance trends. The PIM includes only items from inspection reports or other docketed correspondence between the NRC and Washington Public Power Supply System. 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 the last NRC inspection report was issued, but had not yet received full review and consideration. Enclosure 2 is a general description of the PIM table labels. This material will be

placed in the PDR as part of the normal issuance of NRC inspection reports and other correspondence.

This letter advises you of our planned inspection effort resulting from the WNP-2 PPR review. It is provided to minimize the resource impact on your staff and to allow for scheduling conflicts and personnel availability to be resolved in advance of inspector arrival onsite. Enclosure 3 details our inspection plan for the next 8 months. The rationale or basis for each inspection outside the core inspection program is provided so that you are aware of the reason for emphasis in these program areas. Resident inspections are not listed due to their ongoing and continuous nature. We will inform you of any changes to the inspection plan.

If you have any questions, please contact Howard Wong at 925-975-0296.

Sincerely,

Howard J. Wong, Chief
Project Branch E
Division of reactor Projects

Docket Nos. 50-397
License Nos. NPF-21

Enclosures:
1. Plant Issues Matrix
2. General Description of PIM Table Labels
3. Inspection Plan

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PLANT ISSUES MATRIX

DATE	TYPE	SOURCE	ID	SFA	TEMPLATE CODES			ITEM
03/31/98	NCV	IR 98-03	SELF	OPS	1A	5B	5C	Inadequate self-checking and peer checking resulted in an operator error that deenergized non-vital Bus SM-2 and started the Division III emergency diesel generator. Operations personnel actions in response to the transient were appropriate and prompt. The licensee's root cause analysis and corrective actions effectively addressed the human performance concerns. NCV - Section VII.B.1 of the Enforcement Policy.
03/31/98	Negative	IR 98-03	NRC	OPS	1A	5A		One instance was identified in which an operating crew did not demonstrate a conservative approach to equipment operation when a non-vital lighting panel, with an unidentified ground, was reenergized without an understanding of the source of the ground or a troubleshooting plan to identify the source.
03/17/98	Negative	IR 98-05	NRC	OPS	5A	5B	5C	The initial event review was not fully effective in providing a comprehensive understanding of equipment problems, procedural weaknesses and operator performance issues. The plant restart evaluation process was needed to fully identify the issues that were missed by the post scram review. This resulted in an iterative approach to identify, analyze and resolve each of the performance issues.
03/17/98	VIO SL IV	IR 98-05	NRC	OPS	1C	4C		A violation of Technical Specification 5.4.1a and Regulatory Guide 1.33, with two examples of inadequate procedures, was identified for a Division II logic system functional test and the Division III emergency diesel generator restoration. Temporary Change Notice TCN 98-113, made to Procedure TSP-DG2/LOCA-B501, Step 7.1.33, Substep a, to override the opening of the injection valve, was inadequate and resulted in low pressure coolant injection to the reactor vessel during the conduct of the March 12, 1998, logic system functional test. Procedure PPM 2.7.3, "High Pressure Core Spray Diesel," Revision 29, did not provide adequate direction for the shutdown of the high pressure core spray system.
03/17/98	Weakness	IR 98-05	NRC	OPS	1C			The licensee's 10 CFR 55.59, Licensed Operator Requalification Program, did not address the make up of crew complement used in simulator training vs the control room and was considered a significant weakness in the licensed operator requalification training program.
03/17/98	VIO SL IV	IR 98-05	NRC	OPS	1B	1C		A violation was identified for the failure to provide the one hour event notification in accordance with 10 CFR 50.72, paragraph (b)(1)(iv) for the valid high pressure coolant injection into the reactor vessel.

PLANT ISSUES MATRIX

DATE	TYPE	SOURCE	ID	SFA	TEMPLATE CODES			ITEM
03/17/98	Negative	IR 98-05	NRC	OPS	1B	3B	4B	Although the licensee's actions prior to the main steam line isolation valve nitrogen supply line failure and overall response to the complex transient were appropriate, weaknesses with operators' knowledge, skills and abilities were identified involving recognition of the plant response, and verifying the appropriate engineered safety feature and emergency core cooling systems actuations. Management oversight of the control room actions was not well focused on evolving plant conditions and assuring recovery actions were appropriately implemented. Effective management control was not implemented for the procedure temporary change process and control of infrequently performed tests and surveillance. Operator workarounds appeared in significant areas involving vessel level and pressure control, temperature monitoring and forced circulation. Communication within the control room and with the NRC headquarters operations officer was poor and did not ensure that key control room personnel were cognizant of the overall plant and systems.
03/17/98	VIO SL IV	IR 98-05	LICENSEE	OPS	1B	1C		A violation of Technical Specification 5.4.1a and Regulatory Guide 1.33 was identified for the failure to maintain the reactor vessel temperature and upper head pressure indications within the acceptable area of the temperature/pressure curve provided in Procedure OSP-RCS-C102, "RPV Vessel Cooldown Surveillance," Revision 0, Attachment 9.1, "Minimum Vessel Metal Temperature VS Reactor Vessel Pressure."
02/19/98	NCV	IR 97-20	SELF	OPS	3A			A personnel error on the part of an equipment operator during the performance of clearance order activities resulted in the momentary deenergization of the Division II 4160V vital bus and the loss of residual heat removal assist cooling of the spent fuel pool. A noncited violation was identified for the failure to follow procedures (associated with this 1996 licensee event report). Section VII.B.1 of the Enforcement Policy.
02/19/98	Negative	IR 97-20	NRC	OPS	1A	1C		The licensee's program to assure that corrective lenses for self contained breathing apparatus (SCBA) for operators requiring them was implemented successfully. However, procedural guidance for maintenance of the SCBA corrective lens program was considered weak, in that periodic inventories were not required and written expectations were not provided to operators on the need to have SCBA qualified lenses, regardless of the type of corrective lenses normally used.
02/19/98	Positive	IR 97-20	NRC	OPS	1A	3B		The professionalism of the control room operators and shift management ownership of crew activities supported good operational performance over the inspection period. Operators were generally knowledgeable of plant and equipment status with several minor exceptions.
02/09/98	VIO SL IV	IR 97-13	NRC	OPS	5A	5C		There was a failure to issue a problem evaluation request that would have promptly identified and provided corrective actions for the inadvertent start of a reactor recirculation pump. This item was considered to be an example of a violation of 10 CFR Part 50, Appendix B, Criterion XVI.

PLANT ISSUES MATRIX

DATE	TYPE	SOURCE	ID	SFA	TEMPLATE CODES			ITEM
02/09/98	VIO SL IV	IR 97-13	NRC	OPS	3B	5C		While corrective actions to resolve the material buildup problem in Valves FDR V-3 and FDR V-4 were effective, corrective actions to resolve a required reading problem were not. An example of a violation of 10 CFR Part 50, Appendix B, Criterion XVI, was identified for the failure to correct the required reading issue.
02/09/98	NCV	IR 97-13	NRC	OPS	4C	4B		The failure to update the Final Safety Analysis Report fire protection sections was considered a noncited violation of 10 CFR 50.71(e) (Section VII. B.3 of the Enforcement Policy).
02/09/98	VIO SL IV	IR 97-13	NRC	OPS	5C	2A		The corrective actions to resolve continuing failures of the motor-to-pump coupling on the ac standby lubricating oil pump were inadequate. [Planned corrective actions were not implemented.] This inadequacy was considered to be an example of a violation of 10 CFR Part 50, Appendix B, Criterion XVI.
02/09/98	Positive	IR 97-13	LICENSEE	OPS	3B	3A		Actions to address the occurrence of shorting electrical terminals during the performance of maintenance or surveillance activities were adequate and effective toward preventing a recurrence of the events.
02/09/98	Positive	IR 97-13	LICENSEE	OPS	5C			The corrective actions that addressed the inadvertent initiation of drywell to suppression chamber bypass flow were appropriate for the circumstances and adequate to prevent a recurrence of the events.
01/15/98	VIO SL IV	IR 97-18	NRC	OPS	2A	1C		A number of inspector identified deficiencies in the control of transient equipment indicated weak implementation of the licensee's program to prevent seismic interactions between the equipment and safety-related components. Three examples of a violation of plant procedures were identified.
11/08/97	Positive	IR 97-17	NRC	OPS	1A	1C	3B	Management involvement in the plant curtailment for maintenance on the reactor feedwater drive turbines (RFWDT) was notable for reemphasizing expectations and raising personnel sensitivity to a significant evolution. The operations staff also demonstrated conservative decision-making when maintenance on the first drive turbine was delayed while operability concerns with the high pressure core spray (HPCS) system were addressed.

PLANT ISSUES MATRIX

DATE	TYPE	SOURCE	ID	SFA	TEMPLATE CODES			ITEM
03/31/98	Negative	IR 98-03	LICENSEE	MAINT	2A			Poor material condition of the plant service water system resulted in a leak that challenged the integrity of the control room envelope as water was able to penetrate through a concrete slab interface in the control room ceiling, a boundary credited by the licensee's flooding analysis. The licensee is currently implementing an improvement plan that should adequately address the material condition deficiencies in the plant service water system.
03/31/98	VIO SL IV	IR 98-03	NRC	MAINT	2B	3B		Licensee personnel improperly applied surveillance requirement 3.0.2 to program surveillances in the administrative section of Technical Specifications. As a result, a 25 percent surveillance interval extension was inappropriately utilized for several technical programs.
02/19/98	Positive	IR 97-20	NRC	MAINT	3A	4B		Observed maintenance and surveillance activities were generally well coordinated and executed with appropriate craft supervision and system engineering participation.
02/19/98	NCV	IR 97-20	SELF	MAINT	3A			The failure of maintenance personnel to read and adhere to the instructions on a caution tag prior to manipulating a breaker, resulted in the loss of the Division I 125VDC critical instrument power inverter and the initiation of several essential safety features and isolation of several containment isolation valves. The event occurred while the plant was defueled in Mode 5. A noncited violation was identified associated with this 1996 licensee event report. (Section VII.B.1. of the Enforcement Policy)
01/15/98	Weakness	IR 97-18	NRC	MAINT	2B	2A		The licensee's material condition inspection program was not fully implemented to maintain and assess those areas of the reactor building not routinely accessed by plant personnel. As a result, a lower standard was established for these areas and equipment and housekeeping deficiencies were allowed to persist.
11/08/97	Positive	IR 97-17	NRC	MAINT	4B	4C	4A	The licensee's troubleshooting and repair efforts associated with the reactor feedwater pumps were well planned and executed. The efforts resulted in improved drive turbine performance while identifying potential design improvements to the turbine governor control oil system.

PLANT ISSUES MATRIX

DATE	TYPE	SOURCE	ID	SFA	TEMPLATE CODES			ITEM
03/31/98	VIO SL IV	IR 98-03	NRC	ENG	4C	2B		A number of deficiencies were identified in the implementation of the licensee's leakage surveillance and prevention program. Specifically, procedures for performing visual and integrated leakage inspections on the standby gas treatment system, the containment monitoring system, and the post accident sampling system, were inadequate in that they failed to identify all of the appropriate system components to be monitored
03/31/98	Positive	IR 98-03	NRC	ENG	4B	5C		In reviewing the testing requirements for the standby gas treatment system, the inspector identified the potential for the system floor drains to present a bypass pathway around the filters. In response to the inspector's concerns, the licensee took appropriate action to verify that the current leakage is acceptable, and to develop a long-term monitoring program for this potential unfiltered leakage path.
03/17/98	Negative	IR 98-05	NRC	ENG	4B	4C	5A	The effectiveness of the system walkdowns was mixed. The licensee appropriately identified concerns with the containment instrument air system; however, concerns with the reactor core isolation cooling system performance and post operation condition were not promptly identified by walkdowns or plant data review.
03/17/98	Positive	IR 98-05	NRC	ENG	4B	5B	4C	The licensee effectively identified and corrected the cause of the main steam line isolation valve containment air supply line failure. Common cause failure of the other main steam line isolation valve instrument air lines was appropriately considered. The licensee aggressively addressed concerns with the Division II logic system performance during the event and verified the Division II logic system functionality.
03/17/98	VIO SL IV	IR 98-05	NRC	ENG	4C	1C		A violation of Technical Specification 5.4.1a and Regulatory Guide 1.33 was identified for changing the intent of the logic system test to allow low pressure coolant injection into the reactor vessel using the temporary change notice process.
02/19/98	NCV	IR 97-20	LICENSEE	ENG	4A			Licensee procedures for controlling the configuration of the 4160V vital switchgear breakers did not ensure that configurations would be consistent with the seismic qualification of the switchgear. A noncited violation was identified associated with this 1996 licensee event report (section VII.B.1. of the Enforcement Policy).
02/19/98	NCV	IR 97-20	LICENSEE	ENG	1C			Calibration and surveillance procedures for the rod block monitor system were found to be inadequate to ensure the rod block monitors were operable prior to exceeding 30 percent rated thermal power as required by Technical Specifications. As a result, the system did not enforce rod blocks until power was approximately 33 percent. A noncited violation was identified associated with this 1997 licensee event report (Section VII.B.1 of the Enforcement Policy).

PLANT ISSUES MATRIX

DATE	TYPE	SOURCE	ID	SFA	TEMPLATE CODES			ITEM
02/19/98	NCV	IR 97-20	LICENSEE	ENG	4A			In establishing the flow switch high flow isolation setpoint for the reactor water cleanup system blowdown line, engineering personnel did not adequately review the instrument loop design. This resulted in the application of an improper conversion factor for the flow switch and a nonconservative high flow isolation setpoint that exceeded the maximum allowable technical specification value. A noncited violation was identified associated with this 1997 licensee event report (Section VII.B.1 of the Enforcement Policy).
02/19/98	NCV	IR 97-20	NRC	ENG	4A	4C		Three examples were identified in which the licensee had evaluated and implemented a change to the facility, as described in the Final Safety Analysis Report, but failed to update the report in accordance with 10 CFR 50.71(e). The licensee is implementing a broad review of the Final Safety Analysis Report to identify and correct any additional errors. A noncited violation was identified (Section VII.B.3 of the Enforcement Policy).
02/09/98	EEI	IR 97-13	NRC	ENG	4A	4B	5A	The reactor core isolation cooling system was downgraded from safety related to nonsafety related. While the system was found to be operable, it was also found to be nonconforming. The reclassification plan and schedule for returning the reactor core isolation cooling system to safety related were thorough. As the result of these downgrade activities, six reactor core isolation cooling valves were not being tested. The failure to test these valves was considered to be an apparent violation of 10 CFR 50.55a(f). The failure to obtain NRC approval prior to downgrading the system from safety related to nonsafety related was considered to be an apparent violation of 10 CFR Part 50.59 because it apparently involved an unreviewed safety question.
02/09/98	Positive	IR 97-13	LICENSEE	ENG	4B	4A		An adequate evaluation of the March 3, 1996, residual heat removal system test results was performed that demonstrated that the results were within the design basis.
02/09/98	NCV	IR 97-13	NRC	ENG	4A	5C		Multiple examples of Final Safety Analysis Report inaccuracies were identified. While no safety issues or operability issues were identified, these multiple examples were indicative of a failure to update the Final Safety Analysis Report. However, the ongoing implementation of a Final Safety Analysis Report update program permitted the exercising of enforcement discretion in accordance with the revised enforcement policy.
02/09/98	Negative	IR 97-13	NRC	ENG	5C	4B		Engineering Directorate Manual 2.15 was properly implemented and actions were being taken to further control the number of calculation modification records for plant calculations; however, a self-assessment performed by the licensee did not identify if the outstanding calculation modification records potentially affected the technical content of the calculations.
02/09/98	Positive	IR 97-13	NRC	ENG	4C	5C	4A	The lack of inclusion of the high pressure core spray service water loop in the corrosion program was appropriate considering the type of failure that occurred. In addition, the inclusion of the high pressure core spray service water system in the wall thickness measurement program was considered to be a proactive approach toward eliminating any future problems.

PLANT ISSUES MATRIX

DATE	TYPE	SOURCE	ID	SFA	TEMPLATE CODES		ITEM
01/15/98	Weakness	IR 97-18	NRC	ENG	4C		Identified performance issues in the leakage surveillance and prevention program, regarding plant staff knowledge, program implementation, and procedural inconsistencies, were indicative of weak management involvement and poor program maintenance. However, these issues did not result in any significant safety concerns.
01/15/98	Negative	IR 97-18	NRC	ENG	4A		The licensee's use of an uncontrolled database during its power uprate implementation resulted in an affected design calculation for the ultimate heat sink being missed in the review process. The existing revision of the calculation bounded the parameters of the power uprate.
01/15/98	NCV	IR 97-18	LICENSEE	ENG	4A	5A	The licensee identified that plant procedures for testing the automatic isolation function of reactor core isolation cooling were inadequate in that they did not verify the proper operation of the Division II isolation seal-in logic contact. A noncited violation was issued (Section VII.B.1. of the Enforcement Policy).
10/01/97	Negative	IR 97-11	NRC	ENG	5A	5C	The licensee's initial methodology used for confirmation of the ABB/CE correlation to predict the thermal behavior of Siemens fuel was deficient in that it could not detect absolute errors in the Siemens correlation, or in the application of the Siemens correlation to obtain the data matrix used for the development of the ABB/CE correlation.
10/01/97	Negative	IR 97-11	NRC	ENG	5A	5C	The licensee operated Cycles 7-12 with incorrect and nonconservative core operating limit report (COLR) values for the OLMCPR. The OLMCPR was not calculated in accordance with NRC-approved topical reports referenced in Technical Specification 5.6.5.b. The licensee's staff determined that the corrected and more conservative OLMCPR was exceeded during each of the Cycles 7-12.
10/01/97	Negative	IR 97-11	NRC	ENG	5C	5A	A proposed facility license amendment did not assure conservative limits for Cycle 13 operation and, thus, was not acceptable.
10/01/97	Positive	IR 97-11	LICENSEE	ENG	5A		The licensee's fuel assembly examination and review of vendor information provided an adequate basis to conclude that significant fretting damage to fuel cladding, due to broken fuel assembly debris filter springs, had not occurred.

PLANT ISSUES MATRIX

DATE	TYPE	SOURCE	ID	SFA	TEMPLATE CODES			ITEM
03/31/98	VIO SL IV	IR 98-03	NRC	PS	1C	3B	5B	Licensee corrective actions to address weaknesses in implementing the transient combustible control program have not been effective in addressing the root cause and precluding repeat noncompliances with procedural requirements. The root cause of these non-compliances appeared to be a lack of understanding of fire protection requirements and inattentiveness to fire protection labeling on the part of plant personnel.
02/19/98	VIO SL IV	IR 97-20	NRC	PS	5C	1C		Corrective actions to address inadequate labeling of radioactive material containers have not been effective in preventing recurrence, as evidenced by several recent noncompliances identified by the inspectors and the licensee, and resulted in a violation of 10 CFR 20.1904(a). Additionally, a lack of defined ownership of areas in the radwaste building contributed to poor radiological housekeeping practices on the 507 foot elevation.
02/19/98	Negative	IR 97-20	SELF	PS	1C	4B		Engineering controls placed upon the traversing in-core probe drive C were insufficient in preventing movement of the probe during troubleshooting activities. The unexpected movement of the probe required personnel action to prevent the probe from withdrawing from its shielded location and into the area where the troubleshooting was being performed. Based upon other barriers to personnel overexposure that were in place, and the immediate actions taken in response to the event, the likelihood of a significant overexposure was low.
02/19/98	Positive	IR 97-20	NRC	PS	5A	5B		The licensee's analysis and root cause evaluation of the unexpected movement of the traversing in-core probe accurately characterized the event and identified a number of areas for improvement, including personnel level of knowledge of TIP system operation and level of involvement of radiation protection supervision in the ALARA planning process for high radiological risk jobs.
01/15/98	VIO SL IV	IR 97-18	NRC	PS	1C	4B	5A	Implementation of the licensee's program for monitoring and control of combustibles in the plant has been inconsistent in that 1) materials have been allowed to accumulate in limited access areas without being properly evaluated or tracked, and 2) inconsistencies in the licensee's combustible loading calculation, coupled with a relatively large backlog of modifications to the current revision of the calculation, reduced the value of the calculation as a tool in supporting plant modifications. This was considered a failure to follow plant procedures.
01/15/98	NCV	IR 97-18	SELF	PS	1C	5A		The licensee's failure to test the control room facsimile machine contributed to an inoperable piece of emergency response equipment going undetected until it was required to be used during an actual event. A noncited violation was identified (Section VII.B.1. of the Enforcement Policy).
11/21/97	Negative	IR 97-19	NRC	PS	1C			The radioactive material control program needed improved procedural guidance to ensure accountability of items conditionally released from the radiological controlled area. Sealed radioactive sources were maintained and leak tested properly

PLANT ISSUES MATRIX

DATE	TYPE	SOURCE	ID	SFA	TEMPLATE CODES		ITEM
11/21/97	VIO SL IV	IR 97-19	NRC	PS	1C		Problems with high radiation area controls and radiological hazard evaluations were identified; however, exposure controls were adequate, overall. A violation of control of access to a high radiation area was identified (TS 5.7.2.a).
11/21/97	Weakness	IR 97-19	NRC	PS	5C		Corrective actions by the radiation protection organization were slow and sometimes ineffective
11/21/97	Positive	IR 97-19	NRC	PS	5A	5B	An excellent audit of the radiation protection program was conducted by the quality department. The audit was comprehensive and effective in identifying areas of potential improvement
11/21/97	VIO SL IV	IR 97-19	NRC	PS	5A	5B	Failure to evaluate radiological hazards associated with potential intakes of radioactive material was identified as a violation of 10 CFR 20.1501(a).
11/21/97	Weakness	IR 97-19 LER 97-037	NRC	PS	1C		Improved guidance was needed in implementing procedures involving the evaluation of potential internal radiological hazards, radioactive materials control, personnel contamination events, and portable radiation instruments
11/21/97	Strength	IR 97-19	NRC	PS	3A	1C	Significant improvement was made in reducing the number of personnel contamination events
11/08/97	Negative	IR 97-17	NRC	PS	1C	5C	The unavailability of members of the emergency response organization, along with technical and training issues related to the use of the licensee's automatic notification system, have challenged the licensee in demonstrating its ability to staff the onsite emergency response facilities in accordance with the emergency plan. The licensee's short term corrective actions to address this concern appear appropriate.
11/08/97	Positive	IR 97-17	NRC	PS	1C		As low as reasonably achievable (ALARA) planning for several steam leak repair activities identified effective radiological controls and work practices.

ENCLOSURE 2

GENERAL DESCRIPTION OF PIM TABLE LABELS

Date	Actual date of an event or significant issue for those items that have a clear date of occurrence, the date the source of the information was issued (such as the LER date), or, for inspection reports, the last date of the inspection period.
Type	The categorization of the issue - see the Type Item Code table.
SFA	SALP Functional Area Codes: OPS for Operations; MAINT for Maintenance; ENG for Engineering; and PS for Plant Support.
Sources	The document that contains the issue information: IR for NRC Inspection Report or LER for Licensee Event Report.
ID	Identification of who discovered issue: N for NRC; L for Licensee; or S for Self Identifying (events).
Issue Description	Details of the issue from the LER text or from the IR Executive Summaries.
Codes	Template Codes - see table.

TYPE ITEM CODES

EA	Enforcement Action Letter with Civil Penalty
ED	Enforcement Discretion - No Civil Penalty
Strength	Overall Strong Licensee Performance
Weakness	Overall Weak Licensee Performance
EEI *	Escalated Enforcement Item - Waiting Final NRC Action
VIO	Violation Level I, II, III, or IV
NCV	Non-Cited Violation
DEV	Deviation from Licensee Commitment to NRC
Positive	Individual Good Inspection Finding
Negative	Individual Poor Inspection Finding
LER	Licensee Event Report to the NRC
URI **	Unresolved Item from Inspection Report
Licensing	Licensing Issue from NRR
MISC	Miscellaneous - Emergency Preparedness Finding (EP), Declared Emergency, Nonconformance Issue, etc.

TEMPLATE CODES

1	Operational Performance: A - Normal Operations; B - Operations During Transients; and C - Programs and Processes
2	Material Condition: A - Equipment Condition or B - Programs and Processes
3	Human Performance: A - Work Performance; B - Knowledge, Skills, and Abilities / Training; C - Work Environment
4	Engineering/Design: A - Design; B - Engineering Support; C - Programs and Processes
5	Problem Identification and Resolution: A - Identification; B - Analysis; and C - Resolution

NOTES:

* EEIs 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 EEIs and the PIM entries may be modified when the final decisions are made. Before the NRC makes its enforcement decision, the licensee will be provided with an opportunity to either (1) respond to the apparent violation or (2) request a predecisional enforcement conference.

** 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. 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.

ENCLOSURE 3

WASHINGTON NUCLEAR PLANT, UNIT 2

INSPECTION PLAN

IP - Inspection Procedure
TI - Temporary Instruction
Core Inspection - Minimum NRC Inspection Program (mandatory all plants)

INSPECTION	TITLE/ PROGRAM AREA	NUMBER OF INSPECTORS	DATES	TYPE OF INSPECTION/COMMENTS
IP 83750	Occupational Exposure	1	6/1-5/98	Core Inspection
IP 86750	Solid Radwaste Management and Transportation of Radioactive Materials	1	6/22-26/98	Core Inspection
IP 84750	Environmental Monitoring	1	6/29-7/3/98	Core Inspection
IP 37001	50.59	1	6/29-7/3/98	Core Inspection
IP 40500	Effectiveness of Licensee Controls in Identifying, Resolving, and Preventing Problems	5	7/6-10/98 7/20-24/98	Core Inspection
IP 81700	Physical Security Program	1	7/13-17/98	Core Inspection
IP 64704	Fire Protection	1	7/13-17/98	Core Inspection
IP 93809	Safety System Engineering Inspection	3	7/13-17/98 7/27-8/1/98	Core Inspection
IP 82701	Operational Status of EP Program	1	7/20-24/98	Core Inspection
IP 82301	EP Exercise	1	9/14-18/98	Core Inspection
IP 81110	Operational Safeguards Response Evaluation	7	9/21-25/98	Periodic Inspection
TI-130	Improved Technical Specifications	3	10/5-9/98	Temporary Instruction