

CATEGORY 2

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 PARRISH, J.V. Washington Public Power Supply System

SUBJECT: Advises of planned insp effort resulting from WNP-2 Insp Planning Review held on 981202. Historical listing of plant issues, general description of PIM table labels & Insp plan for next eight months encl.

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UNITED STATES
NUCLEAR REGULATORY COMMISSION

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DEC 29 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: INSPECTION PLANNING REVIEW (IPR) - WASHINGTON NUCLEAR PROJECT,
UNIT 2 (WNP-2)**

Dear Mr. Parrish:

On December 2, 1998, the NRC staff completed a unique Inspection Planning Review (IPR) of WNP-2. The staff normally conducts Semiannual Plant Performance Reviews for all operating nuclear power plants to develop an integrated understanding of safety performance and adjust inspection resources. However, because of the suspension of the Systematic Assessment of Licensee Performance process, we implemented an abbreviated IPR for plant issues and to develop inspection plans. The IPR for WNP-2 involved the participation of both the Reactor Projects and the Reactor Safety divisions in evaluating inspection results and safety performance trends for the period April 23 to October 28, 1998.

Based on the results of this review, inspection resources have been prioritized and scheduled as listed in the inspection plan. The inspection resources for review of your radiological controls program implementation were increased by one inspection-week of direct inspection effort.

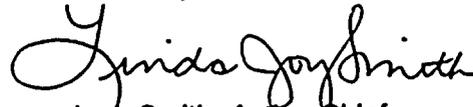
Enclosure 1 contains an historical listing of plant issues, referred to as the Plant Issues Matrix (PIM), that was considered during this IPR process to arrive at an integrated view of licensee performance trends. The PIM includes only items from inspection reports or other docketed correspondence between the NRC and Washington Public Power Supply System. The IPR 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 NRC Public Document Room.

This letter also advises you of our planned inspection effort resulting from the WNP-2 IPR 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 because of their ongoing and continuous nature. We will inform you of any changes to the inspection plan.

9901120038 981229
PDR ADOCK 05000397
Q PDR

If you have any questions, please contact me at 817-860-8137.

Sincerely,



L. J. Smith, Acting Chief
Project Branch E
Division of Reactor Projects

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

Enclosures:

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

cc w/enclosures:

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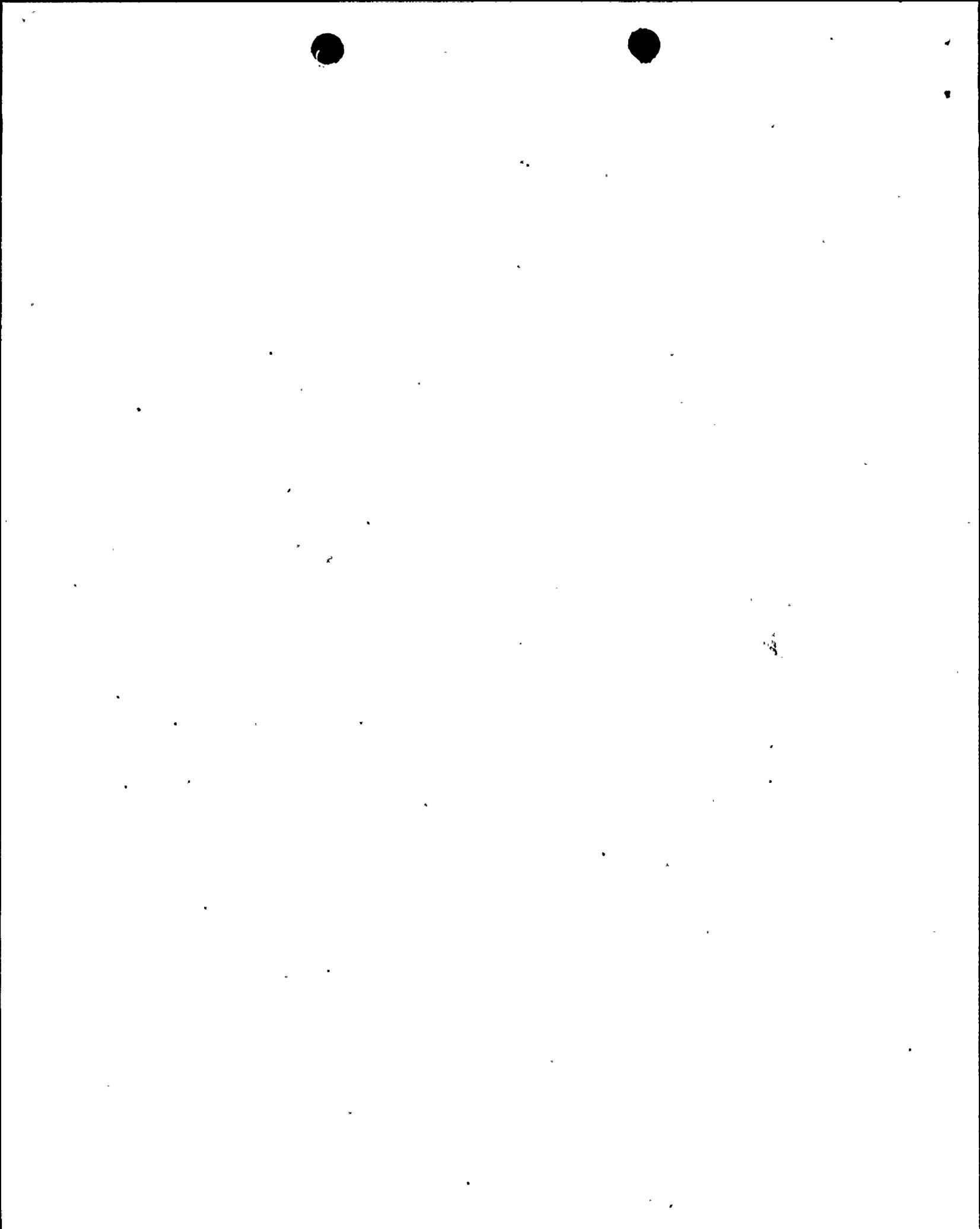
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DEC 29 1998

E-Mail report to T. Frye (TJF)
 E-Mail report to D. Lange (DJL)
 E-Mail report to NRR Event Tracking System (IPAS)
 E-Mail report to Document Control Desk (DOCDESK)
 E-Mail report to Richard Correia (RPC)
 E-Mail report to Frank Talbot (FXT)

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PLANT ISSUES MATRIX

DATE	TYPE	SOURCE	ID	SFA	TEMPLATE CODES	ITEM DESCRIPTION
10/10/98	NEG	IR 98-21	NRC	OPS	1A 3A	During a walkdown of the service water supply to the System A residual heat removal pump room cooler, the inspectors determined that the locking device to an isolation valve was unattached, contrary to plant procedures. Since the valve was found in the correct position, no safety impact would have resulted. This failure to properly lock the valve is a violation of minor significance and is not subject to formal enforcement action.
09/28/98	POS	IR 98-11	NRC	OPS	5A 5C	Operations personnel were effective in the identification and resolution of conditions adverse quality.
09/28/98	NCV	IR 98-11	NRC	OPS	5A	The gold card program was useful to identify human performance issues. However, it was occasionally used to improperly include procedural violations and equipment issues. This was due to a combination of factors, which included a lack of questioning attitude and minimal manager involvement. The failure to initiate performance evaluation requests (two examples) circumvented the corrective action program and was identified as a non-cited violation, pursuant to Section VII.B.1 of the NRC Enforcement Policy, of Procedure PPM*1.3.12.
09/17/98	NEG	IR 98-20	SELF	OPS	3A	As a result of human error, the watertight door between the reactor building northeast stairwell and residual heat removal pump Room C was left open prior to the flooding event. The open door resulted in substantial flooding of Room C, rendering Residual Heat Removal C inoperable and complicating operator recovery from the event.
09/17/98	POS	IR 98-20	NRC	OPS	1B	The licensee responded well to the flooding event. The shift manager made an appropriate decision to declare an Unusual Event and activate the onsite emergency response organization to quickly bring resources to bear on an unusual and complex event. Declaration and notification of the emergency were both timely. Actions to stop the flooding and dewater the reactor building were prompt and effective.
09/17/98	NCV	IR 98-20	LIC	OPS	1B 3A	The Technical Support Center manager failed to confer with the emergency director prior to authorizing the discharge of the stairwell floodwater to the storm drains. The error was the result of the improper placement of an emergency response requirement into an operations procedure instead of the emergency plan implementing procedures. The corrective actions taken to address this deficiency and evaluate the generic implications were appropriate. A noncited violation of Technical Specification 5.4.1.a was identified for failure to follow procedure, in accordance with Section VII.B.1 of the Enforcement Policy.

PLANT ISSUES MATRIX

DATE	TYPE	SOURCE	ID	SFA	TEMPLATE CODES	ITEM DESCRIPTION
09/17/98	NEG	IR 98-20	NRC	OPS	1B 3A	The actions of the operators to start the low pressure core spray pump during the flooding event, while in compliance with the wording of plant procedures, did not display conservative decision making. Although the actions were an attempt to maintain the maximum number of operable/available emergency core cooling system pumps, the operators failed to recognize that other potential effects could have occurred because of the flooding.
07/18/98	POS	IR 98-13	NRC	OPS	1A 2B	The licensee was well prepared for plant restart from the 1998 refueling outage as evidenced by proper closure of outage activities, completion of required Technical Specification surveillances, and adequate configuration of plant systems to support power operation. This was improved performance over previous refueling outages.
07/07/98	POS	IR 98-13	NRC	OPS	1A 2B	Control room operators took appropriate steps to limit outside interference and maintain control of the plant during the performance of postmaintenance testing on the reactor feedwater pumps following modifications to their associated hydraulic control system. Effective command and control and three-way communication were observed.
07/02/98	POS	IR 98-09	NRC	OPS	1A 1C	The routine shutdown for Refueling Outage R13 was properly executed with a detailed preevolution brief and good command and control. Operations performance in monitoring and controlling the cooldown was improved over that observed during the March 1998 forced outage.
06/07/98	VIO SL IV	IR 98-13	NRC	OPS	1A 3A	Poor procedure use during the restoration from an inadvertent engineered safety feature actuator resulted in the mispositioning of the minimum flow bypass valve for the low pressure core spray system. Numerous control board walkdowns performed by operators failed to identify the discrepancy. A violation of Technical Specification 5.4.1.a was identified for failure to follow procedure when returning the low pressure core spray system to its standby lineup.
04/25/98	POS	IR 98-06	NRC	OPS	1A	Good command and control of the March 18 reactor startup and April 3 feedwater temperature reduction was evidenced by adequate planning, proper assignment of personnel responsibilities, clear communications, and a conservative approach to implementing the activities.
04/25/98	VIO SL IV	IR 98-06	NRC	OPS	1A 5A	Control of plant equipment was generally effective in maintaining proper plant configuration. However, two examples were identified where a lack of understanding of the impact of plant configuration changes resulted in the failure to identify discrepancies between the configuration changes and the plant's licensing bases. Specifically, operators failed to 1) recognize that inoperable drain valves for the service water spray rings were required by the final safety analysis report for freeze protection, and 2) recognize entry into a Technical Specification action statement when the emergency cooling coils for control room air conditioning, Train A, were isolated for planned maintenance. The second example was identified as a violation of Technical Specification 5.4.1.a for failure to properly implement written procedures for control of plant equipment.

PLANT ISSUES MATRIX

DATE	TYPE	SOURCE	ID	SFA	TEMPLATE CODES	ITEM DESCRIPTION
03/17/98	VIO SL IV	IR 98-05	SELF	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	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.
03/17/98	WK	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	NEG	IR 98-05	SELF	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 operator knowledge, skills and abilities were identified involving recognition of the plant response, 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 area involving vessel level and pressure control, temperature monitoring and forced circulation. Communication within the control room and with the NRC headquarters operations officer was and did not ensure that key control room personnel were cognizant of the overall plant and systems.
03/17/98	NOV SL IV	IR 98-05	LIC	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."

PLANT ISSUES MATRIX

DATE	TYPE	SOURCE	ID	SFA	TEMPLATE CODES			ITEM DESCRIPTION
03/17/98	NEG	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.
03/14/98	NEG	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.
03/14/98	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.
02/19/98	NEG	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	STR	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.
02/19/98	NCV LER	IR 97-20 96-002	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 associated with this 1996 licensee event report.

PLANT ISSUES MATRIX

DATE	TYPE	SOURCE	ID	SFA	TEMPLATE CODES		ITEM DESCRIPTION
02/09/98	VIO SL IV	IR 97-13	NRC	OPS	5A	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. Violation 50-397/9611-04 will be closed, however, an example of a new violation of 10 CFR Part 50, Appendix B, Criterion XVI, was identified for the failure to correct the required reading issue. The corrective actions to resolve continuing failures of the motor-to-pump coupling on the ac standby lubricating oil pump were inadequate. This inadequacy was considered to be an example of a violation of 10 CFR Part 50, Appendix B, Criterion XVI. 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.
02/09/98	POS	IR 97-13	LIC	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	NCV	IR 97-13	NRC	OPS	4C	4B	The new nuclear safety assurance division procedure properly addressed the technical specification procedural requirements. In addition, licensee conducted surveillances were effective in assuring that other canceled procedure activities were properly conducted. However, there was a failure to update the Final Safety Analysis Report fire protection sections.
02/09/98	POS	IR 97-13	LIC	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	STR	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.
09/28/98	POS	IR 98-11	NRC	MAINT	5A	5C	Maintenance personnel were effective in the identification and resolution of conditions adverse to quality. The work control process was properly implemented with respect to the corrective actions program.



PLANT ISSUES MATRIX

DATE	TYPE	SOURCE	ID	SFA	TEMPLATE CODES	ITEM DESCRIPTION
09/17/98	VIO SL IV	IR 98-20 EA 98-452	NRC	MAINT	2A 2B	The licensee failed to assign a level of importance to the emergency core cooling system pump room floor drain cross-connect valves that was commensurate with their design function. As a result, the maintenance and surveillance program for ensuring their reliability, when called upon to perform that function, was inadequate as evidenced by the failure of Valve FDR-V-609, residual heat removal pump Room C and low pressure core spray pump room floor drain cross-connect, during the flooding event. The failure of Valve FDR-V-609 to perform its intended function resulted in the flooding of the low pressure core spray pump room and complicated recovery from the transient. The failure to monitor the performance of the valves against established goals or to demonstrate reliability of the valves through an effective preventive maintenance program was identified as a violation of 10 CFR 50.65 (EA 98-452).
08/29/98	NEG	IR 98-19	NRC	MAINT	2A 5A	Material condition deficiencies were identified in the Division I 125V DC battery (low electrolyte level) and emergency diesel generator starting air system (multiple air leaks). Although neither condition, by itself, rendered a safety-related system or component inoperable, both conditions have the potential to adversely affect equipment performance. The processes for identifying these conditions adverse to quality, including operator rounds, system engineer walkdowns, and surveillances, were ineffective in these instances.
08/29/98	POS	IR 98-19	NRC	MAINT	2B 3B	The planning and implementation of the repair of a reactor recirculation system instrument sensing line socket weld were thorough and generally well executed. The repair plan and mockup were notable strengths. Some minor deficiencies were identified during execution of the repair.
07/18/98	POS	IR 98-13	NRC	MAINT	2B 5A	The licensee's actions were comprehensive in identifying and inspecting equipment in the emergency core cooling system pump rooms that was affected by the June 17 flooding event. Efforts to dry equipment and conduct calibrations and functional tests were sufficient to verify operability. However, walkdown inspections of the fire protection system were weak in that subsequent to the walkdowns the inspectors identified ten failed system pressure gauges and a loose pipe hanger on the standby gas treatment system deluge supply piping.
07/02/98	NEG	IR 98-09	LIC	MAINT	1A 3A	Both the reactor disassembly and the fuel shuffle were generally well executed between the control room and the refueling floor. However, two instances of weak procedure use resulted in: 1) the failure to identify an incorrect precaution in the maintenance procedure for the reactor building overhead crane, and 2) failure to verify that appropriate minimum temperature requirements were being met prior to lifting the drywell upper shield blocks.

PLANT ISSUES MATRIX

DATE	TYPE	SOURCE	ID	SFA	TEMPLATE CODES			ITEM DESCRIPTION
07/02/98	VIO SL IV	IR 98-09	NRC	MAINT	1A	2B	3A	Personnel performance in the conduct of testing excess flow check valves was inadequate, as evidenced by: 1) multiple examples of poor procedural adherence and procedure adequacy, 2) personnel knowledge deficiencies on testing requirements and plant impact, 3) weak use of procedures in the field, and 4) weak command and control. In one case, performance deficiencies resulted in the initiation of an engineered safety features actuation signal and plant transient. Two violations of TS 5.4.1.a, each with two examples, were identified regarding adequacy and use of surveillance procedures. The violations included inadequate procedure guidance for establishing and restoring from test conditions and failure to independently verify a valve location prior to valve manipulation.
07/02/98	POS	IR 98-09	NRC	MAINT	3A	5C		The licensee's actions to address previously-identified weaknesses in implementing their foreign material controls (FMC) program for plant systems and containment have been effective in raising the sensitivity and improving performance of plant personnel.
07/02/98	NEG	IR 98-09	LIC	MAINT	1A	3A		Licensee performance in implementing FMC for the spent fuel pool, reactor cavity and reactor pressure vessel (RPV) was mixed. Weaknesses were identified mainly in the administrative controls of foreign materials. These included the failure to perform inventories of the spent fuel and equipment pools prior to removal of the RPV head. The failure to perform the inventories eliminated an objective measure of the effectiveness of FMC and was identified as a noncited violation of Plant Procedure 6.1.1.
07/02/98	NEG	IR 98-09	NRC	MAINT	2A	5B		The Division I emergency diesel generator (EDG) experienced multiple material deficiencies during Refueling Outage R13 which resulted in several failures to run and/or load. The material deficiencies included: (1) the failure of the mechanical governor's motor operated potentiometer, (2) failure of the lube oil low pressure switch to reset, and (3) failure of the diesel generator output breaker to close due to improper setting of the breaker's trip latch check switch. The licensee's short-term corrective actions for the failures were appropriate. Long-term actions will be reviewed in future inspection activities.
06/15/98	NEG LER	IR 98-13 98-010	LIC	MAINT	3A			A cognitive error on the part of maintenance personnel installing the traversing incore probe instrument tubing resulted in the separation of the undervessel connection on one of the 41 tubes. Consequently, the drive cable for one of the probes became mechanically bound when it was inadvertently spooled into the undervessel area during a system alignment. The failure of the drive cable precluded the ability to close its associated containment isolation ball valve and necessitated a plant shutdown in accordance with Technical Specifications.

PLANT ISSUES MATRIX

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04/25/98	WK	IR 98-06	NRC	MAINT	2A	2B	Although overall plant material condition remained good, the inspectors continued to find material condition deficiencies that had not been previously identified and tracked for resolution by the licensee. Deficiencies included leakage from components outside containment that could contain highly radioactive fluid following a loss-of-coolant accident, and a locked spring hanger on the residual heat removal system's minimum flow bypass line.
03/14/98	VIO SL IV	IR 98-03	NRC	MAINT	2B	3B	Licensee personnel improperly applied surveillance requirement 3.0.2 to program surveillance the administrative section of Technical Specifications. As a result, a 25 percent surveillance interval extension was inappropriately utilized for several technical programs.
03/14/98	NEG	IR 98-03	LIC	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.
02/19/98	NCV LER	IR 97-20 96-001	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.
02/19/98	POS	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.
01/15/98	NCV	IR 97-18	NRC	MAINT	2B		The methodology utilized by the licensee for testing the control room emergency charcoal filters was identified as being from a different, more recent version of the standard specified in Technical Specifications (TS). Based, in part, upon the staff's acceptance of the version of the standard utilized by the licensee, and the more conservative results produced by its methodology, the noncompliance was viewed as a minor violation.
01/15/98	WK	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, lower standard was established for these areas and equipment and housekeeping deficiencies were allowed to persist.
11/08/97	STR	IR 97-17	NRC	MAINT	4B	4C 4A	The licensee's troubleshooting and repair efforts associated with the RFWDTs 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 DESCRIPTION
10/10/98	NEG	IR 98-21 IR 98-05 EA 98-203	NRC	ENG	4C	The manual startup and shutdown of the reactor core isolation cooling system for level control, following the March 1998 main steam isolation valve closure, challenged the operators. The proceduralized method to control reactor vessel level by diverting reactor core isolation cooling flow through the test return line could not be accomplished because of valve design deficiencies. The method used to maintain the reactor core isolation cooling system test return line isolation valves decreased the reliability of the system and challenged the containment isolation function since the valves may not have closed against high differential pressure. Unresolved Item 50-397/98005 involving exclusion of the reactor core isolation cooling test return line valves from the scope of maintenance rule, was determined not to be a violation of NRC requirements (EA 98-203)
09/28/98	NCV	IR 98-11	NRC	ENG	4B 5A 5C	Engineering personnel were not always effective in the resolution of conditions adverse to quality. The engineering personnel's performance was indicative of a lack of attention to detail. This was evidenced by the non-cited violation of Criterion XVI to Appendix B of 10 CFR Part 50, pursuant to Section VII.B.1 of the NRC Enforcement Policy, for the untimely implementation of corrective actions for a condition adverse to quality. In addition, the license actions associated with the potential bypass of primary containment and water hammer evaluations indicated a lack of a questioning attitude.
09/17/98	EEI	IR 98-20 EA 98-480	SELF	ENG	1C 4A	The root cause evaluation for the flooding event accurately concluded that the event resulted from design inadequacies of the fire protection water supply system. Those inadequacies allowed for the generation of destructive forces within the system that ultimately failed Valve FP-V-29D, reactor building fire protection standpipe isolation. The design inadequacies were attributed, in part, to noncompliances related to the installation of the fire pumps compared to the requirements of the National Fire Protection Association code. The failure of the fire protection system pressure boundary upon a demand actuation would preclude the ability of the system to provide an adequate capacity of water to suppress a postulated fire and was identified as an apparent violation of 10 CFR 50, Appendix A, General Design Criterion 3, "Fire Protection" (EA 98-480)
09/17/98	NCV	IR 98-20	LIC	ENG	4A	The discrepancy between the actual performance of the reactor building watertight doors and their description in the Final Safety Analysis Report as being watertight was previously identified and analyzed by the licensee. Although the analyses were found to be technically sound in concluding that the doors could continue to perform their function with the amount of leakage predicted, they did not result in appropriate changes to the FSAR. The licensee identified this discrepancy during its followup to the flooding event and initiated appropriate action to address it. A noncited violation of 10 CFR 50.71(e) was identified for failure to update Final Safety Analysis Report, in accordance with Section VII.B.1 of the Enforcement Policy.



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DATE	TYPE	SOURCE	ID	SFA	TEMPLATE CODES	ITEM DESCRIPTION
08/29/98	VIO	IR 98-19	NRC	ENG	2B 4B	The postmaintenance and operability testing of the Division II emergency diesel generator were found to be thorough in assuring that the identified deficiencies were corrected. However, the evaluation of the operability test procedure failed to identify that Technical Specifications prohibited the performance of portions of the procedure during plant operations. The failure of licensee personnel to properly review Technical Specifications during procedure development and approval was identified as a violation of the requirements of 10 CFR 50.59.
08/29/98	NCV	IR 98-19	LIC	ENG	2B 4B	The instructions established for troubleshooting the Division II emergency diesel generator failed to identify the inherent risk of loading the inoperable diesel generator onto its associated vital bus and, as such, failed to include appropriate contingencies and precautions. As a result, operators did not have sufficient guidance to protect the vital bus when the voltage regulator failed and the bus deenergized on a timed overcurrent lockout. The corrective actions in response to this event were appropriate. A noncited violation of 10 CFR Part 50, Appendix B, Criterion V, was identified for inadequate instructions during troubleshooting.
07/18/98	POS	IR 98-13	NRC	ENG	4A 4C	The licensee has maintained an appropriate program to address the requirements of 10 CFR 50.59. Program implementing procedures were generally of sufficient detail to ensure that proposed activities would precipitate safety evaluations. However, two areas were noted where procedure guidance was either weak or inconsistent with requirements. Although the quality of the 12 safety evaluations reviewed was not always consistent, overall the quality was good. Strengths were noted in the training and oversight programs with regards to maintaining a sufficient pool of qualified safety evaluation preparers and providing timely, critical feedback on their products.
07/18/98	NEG	IR 98-13	NRC	ENG	4A 5C	Compensatory and corrective actions taken to address design deficiencies in the fire protection system and minimize dynamic loads were generally appropriate. However, the licensee's evaluation of the modified system's performance failed to identify a vulnerability to water hammer following a loss of offsite power. The vulnerability was adequately addressed when the system configuration was modified to maintain a diesel driven fire water pump operating.
07/18/98	VIO SL IV	IR 98-13	NRC	ENG	4A 5A	The configuration of the reactor building equipment drains did not conform to the description in the Final Safety Analysis Report in that a cap was not installed on the drain line from residual heat removal pump Room B. The cap was required as part of the licensee's physical controls to protect against common mode flooding. A violation of 10 CFR 50.59 was identified for failure to document a written safety evaluation for this defect change to the facility. The licensee's corrective actions to install a cap on the drain line and review the generic implications for other portions of the drain systems, were found to be appropriate.

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DATE	TYPE	SOURCE	ID	SFA	TEMPLATE CODES	ITEM DESCRIPTION
04/25/98	VIO SL IV	IR 98-06	NRC	ENG	4A 4B	The licensee failed to provide adequate controls for the position of the residual heat removal system's suppression pool return valves to ensure that during operations with the return valves open, the valves' position would be limited to meet the injection times assumed in the loss-of-coolant-accident analyses. Specifically, with the return valves greater than approximately 40 percent open, full low pressure coolant injection flow to the vessel would not be achieved within the 66 seconds assumed by the analyses. The failure to adequately translate the design requirement of the RHR system to plant operating procedures and instructions was identified as a violation 10 CFR Part 50, Appendix B, Criterion III (Design Control).
04/25/98	NEG	IR 98-06	NRC	ENG	4B	Following the identification of leakage from the safety-related nitrogen supply to the automatic depressurization system, engineering personnel established an adequate technical basis for system operability. However, the technical justification was not appropriately documented in the associated problem evaluation request. Additionally, the problem evaluation request was closed without addressing the root cause of the degraded condition.
04/25/98	VIO SL IV	IR 98-06	NRC	ENG	4A 5B	The licensee failed to recognize that operation of the residual heat removal system, with the minimum flow bypass valves closed in standby, constituted a change to the facility as described in the Final Safety Analysis Report (FSAR) in that the original FSAR showed the valves to be open. The licensee missed several opportunities to identify the need for a written safety evaluation to support the change. These included the development of original system operating procedures, a 1993 revision to the FSAR that changed the valves' position on the process data sheet, and the licensee's current FSAR upgrade project. A violation of 10 CFR 50.59(b)(1) was identified.
04/22/98	WK	IR 98-01	NRC	ENG	4B 4C	The licensee operated the Siemens Power Corporation's fuel in Core Cycles 7-12 in excess of a revised operating limit minimum critical power ratio based on revised and conservative ANFB-112 correlation constant uncertainty.
04/22/98	NEG	IR 98-01	NRC	ENG	4B 4C	On the basis of the November 25, 1997, licensee response, the safety limit minimum critical power ratio was not exceeded during the actual events and transients experienced by the plant during Core Cycles 8-12. The licensee's analysis to determine if the limit could have been exceeded during Core Cycles 8-12 did not use licensing bases assumptions, bounds, and parameters.
04/22/98	NEG	IR 98-01	NRC	ENG	4B 4C	Administrative controls and operating limits in place during Core Cycle 7-12 would not have ensured operation within the envelope of the licensing basis. Therefore, had the limiting transient occurred with design basis operating conditions, the revised safety limit could have been reached or exceeded.

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DATE	TYPE	SOURCE	ID	SFA	TEMPLATE CODES		ITEM DESCRIPTION	
04/22/98	POS	IR 98-01 EA 98-228	NRC	ENG	4B	4C	Based on a review of all available information, and in particular the information provided at the conference, the NRC has determined that there was no violation of NRC requirements in this case. Despite NRC's concern over the fuel vendor's use of a limited number of data points in deriving uncertainty values, which the NRC believes resulted in nonconservative limits, the NRC agrees fundamentally with the Supply System's position that those efforts were consistent with NRC-approved guidance documents. In that the NRC is satisfied with the corrective actions taken by the Supply System, the NRC does not believe that this matter warrants further evaluation. The vendor development and implementation of the minimum critical power ratio operating and safety limits for WNP-2 fuel were not adequate to assure that the limits were accurate and conservative. Licensee oversight of the fuel vendors' design processes and controls for the nuclear fuel supplied to WNP-2 failed to detect that an inadequate technical specification limit was developed. The failure to establish measures to assure that the design bases were correctly translated into technical specifications was identified as an apparent violation of Criterion III, Appendix B to 10 CFR Part 50.	
03/17/98	URI	IR 98-05	NRC	ENG	4C		An unresolved item was identified for the reactor core isolation cooling system test return line throttle and isolation valves. The item involves whether the valves' performance should have been effectively controlled through the performance of appropriate preventive maintenance in accordance with the requirements of 10 CFR 50.65(a)(2).	
03/17/98	NEG	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	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.
03/17/98	POS	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.
03/14/98	VIO SL IV	IR 98-03	NRC	ENG	2B	4C		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.

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DATE	TYPE	SOURCE	ID	SFA	TEMPLATE CODES		ITEM DESCRIPTION
03/14/98	NEG	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.
02/19/98	NCV LER	IR 97-20 96-007	LIC	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.
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(ENG). 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.
02/19/98	NCV LER	IR 97-20 97-001	LIC	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.
02/19/98	NCV LER	IR 97-20 97-002	LIC	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.
02/09/98	POS	IR 97-13	LIC	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	WK	IR 97-13	NRC	ENG	5C	4B	While Engineering Directorate Manual 2.15 was properly implemented, actions were being taken to further control the number of calculation modification records for plant calculations. A self-assessment performed by the licensee did not identify if the outstanding calculation modification records potentially affected the technical content of the calculations. The NRC plans further review of this area during a future inspection.

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DATE	TYPE	SOURCE	ID	SFA	TEMPLATE CODES		ITEM DESCRIPTION
02/09/98	NCV VII.B.3	IR 97-13 EA 97-612	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	POS	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.
02/09/98	VIO SL III	IR 97-13 EA 97-573	NRC	ENG	4A	4B 5A	<p>Contrary to 50.59(a)(1 and (a)(2) in 1985, without prior Commission approval, a change was made to the facility as described in the safety analysis report involving an unreviewed safety question. The reactor core isolation cooling system, a system required for safe shutdown, was downgraded from safety-related to nonsafety-related which also redesignated the system such that it was no longer Seismic Category I. This change constituted an unreviewed safety question in that it increased the probability of occurrence of an accident or malfunction of equipment important to safety previously evaluated in the safety analysis report.</p> <p>Contrary to 50.55a(f) and ASME IWB-1100, as of December 1994, the inservice testing for certain reactor core isolation cooling valves, whose function was required for safety, was not implemented as required by Section XI of the appropriate edition and addenda of the ASME Boiler and Pressure Vessel Code. Specifically, as the result of downgrading the reactor core isolation cooling system from safety-related to nonsafety-related, Valves RCIC-V-13, the head spray isolation valve; RCIC-V-19, the minimum-flow to suppression pool isolation valve; RCIC-V-28, the auxiliary cooling to suppression pool isolation valve; RCIC-V-31, the suppression pool to RCIC suction valve; RCIC-V-40, the turbine exhaust to suppression pool isolation valve; and RCIC-V-66, the head spray isolation valve were not timed during stroke testing in the open direction to assure that they met specified acceptance criteria. In addition, Valve RCIC-V-45, the turbine steam supply isolation valve, was no longer tested for either opening or closing stroke times. No response required.</p>
01/15/98	NCV	IR 97-18	LIC	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.
01/15/98	WK	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.

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DATE	TYPE	SOURCE	ID	SFA	TEMPLATE CODES		ITEM DESCRIPTION
01/15/98	NEG	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.
10/01/97	POS	IR 97-11	LIC	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.
10/01/97	NEG	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	POS	IR 97-11	NRC	ENG	5A	5C	The licensee's on-line monitoring of the nodal core operating limits with the Powerplex Monitoring Program was adequate.
10/01/97	NEG	IR 97-11	NRC	ENG	5B		There were fuel assembly debris filters whose springs failed in Cycle 12. The potential for the failures might have been detected by a better testing and examination program of the debris filters prior to their commercial introduction.
10/01/97	NEG	IR 97-11	NRC	ENG	5C	5A	The licensee had not completed a planned review and, as a result, had not yet determined if the SLMCPR would have been exceeded for anticipated operational transients.
10/01/97	POS	IR 97-11	SELF	ENG	5A		The corrective action by the licensee to remove the fuel assembly debris filters and modify the lower support pieces was satisfactory.
10/01/97	POS	IR 97-11	LIC	ENG	5A	5C	For Cycle 13 operation, (1) the licensee applied a 0.975 conservative multiplier to the operating limit minimum critical power ratio (OLMCPR) calculated using the ABB/CE methodology for SPC resident fuel and (2) the power level of the most reactive (twice-burned) SPC resident fuel will be lower than in the previous cycle. These conditions provided sufficient confidence that operating SPC fuel at the OLMCPR, would not challenge the safety limit minimum critical power ratio (SLMCPR) should an anticipated operational transient occur during Cycle 13.
10/01/97	NEG	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	NEG	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 SPC fuel was deficient in that it could not detect absolute errors in the SPC correlation, or in the application of the SPC correlation to obtain the data matrix used for the development of the ABB/CE correlation.

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DATE	TYPE	SOURCE	ID	SFA	TEMPLATE CODES	ITEM DESCRIPTION
09/28/98	POS	IR 98-18	NRC	PS	3A	The EOF staff's performance was good. Emergency classifications and protective action recommendations were correct and timely. Offsite agency notifications were timely with one licensee-identified exception. The Department of Energy notification for the site area emergency was slightly delayed due to the loss of the primary notification system and incorrect backup telephone numbers. One notification form was not properly completed; the date and time were omitted from the site area emergency notification form. The error was quickly recognized and verbally corrected. A discrepancy between the emergency plan and implementing procedures identified concerning followup notifications. Appropriate corrective actions were taken to resolve the discrepancy. Dose assessment and field team control activities were properly performed to support protective action recommendations and validate dose projections. Interactions with offsite agency representatives were candid and supportive.
09/28/98	POS	IR 98-18	NRC	PS	3A	The OSC staff's performance was generally satisfactory. Three-part communications were frequently used. Facility briefings were frequent and contained sufficient detail. Health physics briefings tended to delay repair team dispatch because only one person conducted the briefings. The process used to select field team members for tasks requiring self-contained breathing apparatus did not verify corrective lense availability. Repair team documentation was incomplete and could have affected airborne dose reconstruction. There was no emergency lighting installed in the OSC, although emergency electrical generators were available. Appropriate corrective actions were taken to address the lack of battery-powered air samplers. Public address announcements and station alarms could not be heard in all areas of the plant. A health physics emergency locker contained degraded supplies and insufficient quantities of protective clothing.
09/28/98	POS	IR 98-18	NRC	PS	3A	The TSC staff's performance was good. Changing plant conditions were promptly and correctly analyzed to support EOF emergency classifications. Staff briefings and technical discussions were effective. Some key technical issues, including recirculation pump vibration, reactor coolant makeup and leak rate, and standby gas treatment performance were not aggressively pursued. The method used to assign and track repair team priorities was unclear and hampered the operations support center's (OSC's) ability to manage repair team resources. Habitability was challenged because: (1) the outer airlock door was not fully closed, (2) at least one person did not frisk prior to reentry, and (3) emergency ventilation system operation was not verified until late in the exercise.
09/18/98	STR	IR 98-18	NRC	PS	1C 3A 3B	Overall, performance was good. The control room, technical support center, and emergency operations facility successfully implemented most essential emergency plan functions including classification, protective action recommendations, and dose assessment. Critiques were thorough and self-critical.

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DATE	TYPE	SOURCE	ID	SFA	TEMPLATE CODES			ITEM DESCRIPTION
09/18/98	WK	IR 98-18	NRC	PS	2B	-3A	3C	An exercise weakness was identified in the operations support center for failure to properly monitor habitability. Airborne, contamination, and area surveys were either never performed or were not regularly performed in all areas.
09/18/98	NEG	IR 98-18	NRC	PS	3C			A discrepancy between the emergency plan and implementing procedures was identified concerning followup notifications.
09/18/98	NEG	IR 98-18	NRC	PS	3A	5A		The exercise objectives were appropriate to meet emergency plan requirements. The initially submitted scenario was not acceptable because offsite doses were not challenging and would limit demonstration of some exercise objectives. Projected offsite doses were increased to an acceptable level in the revised scenario; however, the scenario developers incorrectly computed the offsite field team sample data. As a result, the offsite doses were not consistent with expected projected doses and did not challenge the dose assessment staff, field team members, and decision-makers. Scenario development has been a historical problem. In addition, the scenario developers failed to recognize that the loss of offsite power would affect OSC operations. Last minute controller instructions and impromptu controller actions during the exercise were thorough and conscientious.
09/18/98	NEG	IR 98-18	LIC	PS	2A	3A	3C	The Department of Energy notification for the site area emergency was slightly delayed due to the loss of the primary notification system and incorrect backup telephone numbers.
09/17/98	VIO SL IV	IR 98-20	NRC	PS	1C	3A		Because of competing priorities in responding to the June 17 fire protection system rupture and flooding event, required fire watches were not established within 1 hour of the system impairment. The delay of approximately 2 hours in implementing the compensatory measures was found to be reasonable based upon the nature of the event. A second example of a failure to implement compensatory measures for a fire protection system impairment was identified by the inspectors during planned corrective maintenance on June 26. A violation of Technical Specification 5.4.1 was identified for failure to follow fire protection program implementing procedures; however, because the corrective actions were appropriate to address the root cause, no response is required.
09/17/98	NEG	IR 98-20	NRC	PS	1C	5B	5C	The fire protection corrective action program was ineffective in addressing water hammer in the fire protection water supply system. The corrective actions taken in 1984 for known water hammer concerns were only partially effective in addressing the impact of multiple pump starts on the hydraulic transients resulting from system initiation. Subsequent indications of severe hydraulic transients in the fire protection system were not evaluated and resultant component failures were treated as broke-fix maintenance items. These component failures and industry operating experience on water hammer both represented missed opportunities to ferret out continuing system design problems.

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DATE	TYPE	SOURCE	ID	SFA	TEMPLATE CODES		ITEM DESCRIPTION
09/17/98	VIO SL IV	IR 98-20	NRC	PS	1C	5C	The corrective actions from previous inadvertent actuations of the fire protection system were either ineffective in addressing personnel knowledge and procedure weaknesses in the ignition source permit process or not promptly implemented. The inadvertent actuation of the diesel generator building corridor preaction system (System 66) on June 17, occurred over 4 months after an almost identical event in February 1998. Although procedural enhancements were defined shortly after the event, the implementation of the enhancements was not scheduled until as late as August 1998. A violation of License Condition 2.C.(14) and the fire protection corrective action program was identified; however, because the corrective actions for the violation were appropriate, no response is required.
07/23/98	NEG	IR 98-14	NRC	PS	3B	3C	Department staffing was lacking in health physics expertise.
07/23/98	STR	IR 98-14	NRC	PS	3C	2B	A new emergency preparedness manager strengthened department problem resolution and self-assessments. With upper management support, emergency response organization callout capabilities were improved by expanding the use of pagers and initiating the use of cellular telephones.
07/23/98	VIO SL IV	IR 98-14	NRC	PS	3C	3A	A reduction in initial training requirements and the lack of training/retraining program descriptions in the emergency plan were identified as a violation of 10 CFR 50.54(q).
07/23/98	POS	IR 98-14	NRC	PS	1C	2B 3B	Overall, implementation of the emergency preparedness program was good. Self critical and thorough assessments of emergency plan implementation were made for two actual events. Emergency response facilities were operationally maintained and appropriate equipment and supplies were readily available at the primary facilities. The alternate emergency operations facility was upgraded to avoid the need to transfer equipment and materials from the primary facility. A recent audit led to increased emphasis on establishing and maintaining emergency response organization personnel qualifications. There was enough depth in the emergency response organization to ensure continuous staffing.
07/23/98	WK	IR 98-14	NRC	PS	1B	3B	During the simulator walkthroughs, a performance weakness was identified for failure of two crews to recognize that dose projections indicated a need for protective action recommendations beyond 10 miles.
07/16/98	NCV	IR 98-12	NRC	PS	1C	3A	Pursuant to Section VII.B.1 of the NRC Enforcement Policy, a noncited violation was identified involving failure to complete employment checks on two individuals before granting temporary unescorted access.
07/16/98	STR	IR 98-12	NRC	PS	1C		An excellent fitness-for-duty program was in place. Precautions had been taken to insure detection if individuals attempted to circumvent the test with false specimens. All testing was properly conducted and monitored. The licensee's fitness-for-duty procedures were in-depth, comprehensive, and of excellent quality.



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DATE	TYPE	SOURCE	ID	SFA	TEMPLATE CODES	ITEM DESCRIPTION
07/16/98	NEG	IR 98-12	NRC	PS	1C 2A	One detection zone failed to alarm during a test simulating jumping into the protected area. This single failure was not identifiable or predictable.
07/16/98	STR	IR 98-12	NRC	PS	1C	In general, performance in the security and access authorization was excellent. An effective program for searching personnel, packages, and vehicles was maintained. Proper procedures were in place to control personnel, package, and vehicle access to the protected area. Very good protected area barriers and detection systems were maintained. Testing of the detection aids wa performance based and ensured that system failures were discovered and corrected. An effect testing and maintenance program was conducted. The timely response to repair detection aids access control equipment, and vital area door locks and closures was instrumental in the low number of compensatory postings. The security training program and documentation of training were excellent. Security officers displayed excellent knowledge of the procedural requirements for the task they were performing. An excellent security event log system was in place for reporting safeguards events. The licensee audits and self-assessment programs were excellent.
07/02/98	STR	IR 98-17	NRC	PS	1A 1C	Overall, good radiological and meteorological monitoring programs were implemented. Replacement of all environmental air sampler units in 1997 reduced the number of equipment malfunctions from 19 in 1996 to 4 in 1997. The annual land use censuses were properly conducted. Sample collection logs, shipment and release forms, and sample analyses reports were meticulously maintained at a high level of quality. Meteorological data recovery was greater than 92 percent from 1995 through 1997.
07/02/98	NEG	IR 98-17	LIC	PS	2B 5A	The licensee identified that the procedures used to calibrate wind speed and delta temperature instrument loops allowed for tolerances outside the limits specified in the Final Safety Analyses Report from 1983 through 1996. A review of calibration records indicated that the actual tolerances of meteorological instruments from 1995 through 1997 were within the Final Safety Analyses Report limits. Inadequate procedural reviews coupled with maintenance personnel performing the calibrations not being familiar with the requirements were identified as the primary contributors for this long-term procedural error.
07/02/98	POS	IR 98-17	NRC	PS	5A	Comprehensive radiological environmental operating reports were submitted in a timely manner. These reports discussed such anomalies as detectable levels of cesium-137 and cobalt-60 found river sediment and soil samples which were attributed to releases from the Department of Energy during the operation of the old Hanford Reservation reactors.
07/02/98	VIO SL IV	IR 98-09	NRC	PS	1C	The licensee decreased the effectiveness of its emergency plan between February 1997 and April 1998, when it reduced on-shift health physics expertise and overburdened the chemistry technician with health physics responsibilities during emergencies. A violation of 10 CFR 50.54(q) was identified. The licensee returned a third health physics technician to on-shift following notification of the noncompliance.

PLANT ISSUES MATRIX

DATE	TYPE	SOURCE	ID	SFA	TEMPLATE CODES		ITEM DESCRIPTION
06/26/98	STR	IR 98-08	NRC	PS	1A	1C	Overall, good solid radioactive waste management and radioactive waste/materials transportation programs were implemented. Documentation and packages were properly prepared for shipment. Good facilities were maintained for the processing, storage, and management of solid radioactive wastes and transportation activities. An effective radioactive waste inventory/accountability system was maintained. The volume and radioactivity of solid radioactive waste generated during the time period 1993 through 1997 showed a continuing decline; even though, during this same time period the station's 3-year rolling averages of the amount of solid radioactive waste generated were greater than the industry median for solid radioactive waste production at boiling water reactor facilities. Challenging solid radioactive waste generation goals for fiscal years 1997 and 1998 were met indicating the effective implementation of an improved solid radioactive waste minimization program.
06/26/98	POS	IR 98-08	NRC	PS	5A	5B 5C	Good performance based biennial audits of the solid radioactive waste and transportation programs were performed. In 1997, the chemistry department performed a comprehensive self assessment of the solid radioactive waste processing program and shipping activities. In response to these assessments, timely corrective actions and program improvements were implemented.
06/26/98	POS	IR 98-08	NRC	PS	1A	1C	Modifications to the condensate filter demineralizer system resulted in a significant reduction in the amount of spent resin generated. The personnel dose from radwaste activities showed a decrease between 1994 and 1997.
06/26/98	POS	IR 98-08	NRC	PS	3B		Good training and qualification programs were implemented. Personnel involved in the processing, packaging, and shipping of radioactive materials and wastes were properly trained and qualified.
06/15/98	POS	IR 98-13	NRC	PS	3A		As-low-as-reasonably-achievable planning for the troubleshooting and repair of a traversing incore probe drive cable was effective in evaluating the potential radiological hazards and communicating them to the involved personnel. Good radiological controls practices and health physics support also contributed to dose reduction for the work.
06/05/98	POS	IR 98-10	NRC	PS	1A		Overall, quality department oversight of radiation protection activities was good. The quality department included a member with a strong operational radiation protection background. Quality department operational radiation protection surveillances performed since January 1997 were intrusive and provided management with a very good assessment of program performance. The timeliness of problem evaluation requests improved during the past 6 months.
06/05/98	POS	IR 98-10	NRC	PS	1A		Overall, a good training program was effectively implemented. Lesson plans were well organized, developed, and site and industry lessons learned were incorporated. The radiation protection department was appropriately involved in developing the training topics to ensure that the practical and technical competence of the radiation protection staff was maintained.



PLANT ISSUES MATRIX

DATE	TYPE	SOURCE	ID	SFA	TEMPLATE CODES	ITEM DESCRIPTION
06/05/98	NEG	IR 98-10	NRC	PS	1A	The content of ALARA work packages needed improvement. Site lessons learned for similar work were properly recorded in ALARA work history packages; however, industry lessons learned were not included. Job improvement ideas and suggestions were normally not captured from craft level licensee or contractor personnel at the completion of job activities. The senior site ALARA committee was not fully supported by the operations department. Between January 1, 1997, and June 3, 1998, the operations representative only attended three of the five ALARA Committee meetings. The station had not established a hot spot reduction program. Therefore, the licensee did not know how many hot spots were present or which ones contributed significant exposure to station workers. The licensee did not have an ALARA suggestion tracking system to ensure suggestions were not misplaced or forgotten.
06/05/98	VIO SL IV	IR 98-10	NRC	PS	1A 3A	A violation of Technical Specification 5.4.1 was identified involving the failure of the senior site ALARA Committee to review the 1998 refueling outage (R-13) exposure goal and ALARA reviews and exposure reduction effectiveness evaluations were not performed for shielding installations.
06/05/98	POS	IR 98-10	NRC	PS	1A	In general, the external exposure control program was effectively implemented. Radiological areas were properly controlled and posted. Radiation protection personnel stationed at the radiological controlled area egress point provided appropriate and timely guidance to workers who alarmed the personnel contamination monitors. Housekeeping within the radiological controlled area was good. Trash and laundry containers were properly maintained.
05/19/98	NCV	IR 98-07	NRC	PS	1A 3A	A noncited violation of Technical Specification 5.4.1.a was identified involving the failure to barricade and conspicuously post a high-high radiation areas.
05/19/98	STR	IR 98-07	NRC	PS	1A	Overall, good external exposure control and dosimetry programs were implemented. All Technical Specification high, and high-high radiation areas observed were properly controlled and posted. Dosimeter placement was proper to monitor exposure from both uniform and nonuniform photon radiation fields. Housekeeping within the radiological controlled area was good. Materials and equipment used for outage activities were properly stored and controlled. An effective training program for contract radiation protection technicians had been implemented.
05/19/98	VIO SL IV	IR 98-07	LIC	PS	1A 3A	A violation of Technical Specification 5.4.1.a, with three examples, was identified involving the failure to perform proper radiological surveys.
05/19/98	STR	IR 98-07	NRC	PS	1A	An effective ALARA program had been implemented. The licensee has made significant improvement to reduce person-rem for the period 1994-1997 as evident by yearly person-rem totals of 867 and 248 respectively. The 1998 person-rem projected dose is 255. Outage and nonoutage ALARA person-rem goals were challenging and in close agreement with actual results.

PLANT ISSUES MATRIX

DATE	TYPE	SOURCE	ID	SFA	TEMPLATE CODES	ITEM DESCRIPTION
04/25/98	VIO SL IV	IR 98-06	NRC	PS	1A 3A	Inconsistent expectations for implementing radiological controls requirements resulted in several procedure noncompliances during an instrumentation and controls surveillance performed in a posted high radiation area. Specifically, an improper radiation work permit was utilized for the job, and positive access control to the high radiation area was not maintained by a qualified health physics technician. Although the actual and potential dose consequences of the event were considered to be low, the generic implications were considered significant in that several administrative barriers to personnel overexposure were not properly implemented. A violation of Technical Specification 5.4.1.a was identified for failure to properly implement written procedures for radiation protection.
04/09/98	STR	IR 98-02	NRC	PS	1A	Implementation of the security program continued to be highly effective. Management of the security program was excellent. An effective program for searching personnel, packages and vehicles was maintained. Excellent assessment aids provided effective and complete assessments of the perimeter detection zones. Alarm stations were redundant and well protected. Good radio and telephone communications systems were maintained. The compensatory measures program was effectively 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. An excellent training program that included conducting shift contingency drills had been implemented. The licensee's on-shift security staffing was properly maintained.
04/09/98	NCV LER	IR 98-02 97-S01	LIC	PS	1C 5A 5C	A noncited violation was identified involving the failure to implement compensatory measures for a nonoperative microwave security zone. This licensee identified violation is being treated as a noncited violation consistent with Section VII.B.1 of the NRC Enforcement Policy.
03/19/98	NEG	IR 98-04	NRC	PS	5A	The quality of oversight of the radioactive effluent monitoring program by the quality assurance organization declined. The 1996 quality assurance audit was good, but the 1997 audit was weak because the review lacked depth and performance-based input.
03/19/98	NCV	IR 98-04	LIC	PS	3A	A noncited violation related to the calibration of the radwaste building exhaust monitor was identified.
03/19/98	STR	IR 98-04	NRC	PS	3C	The licensee maintained a good radioactive effluent monitoring program. The licensee demonstrated an improving trend in the reduction of radioactive effluents during 1995-1997. Licensee personnel performed well in identifying and correcting a problem dealing with the calibration of the radwaste building exhaust monitor.
03/19/98	VIO SL IV	IR 98-04	NRC	PS	3B	A10 CFR Part 50, Appendix B, Criterion XVIII, violation was identified because the audit team members did not have experience or training in the special nature of the radioactive effluent monitoring program.

PLANT ISSUES MATRIX

DATE	TYPE	SOURCE	ID	SFA	TEMPLATE CODES			ITEM DESCRIPTION
03/14/98	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	POS	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.
02/19/98	NEG	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.
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 area 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.
01/15/98	NCV	IR 97-18	LIC	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.
11/21/97	NEG	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.
11/21/97	NEG	IR 97-19	NRC	PS	1C			Problems with high radiation area controls and radiological hazard evaluations were identified; however, exposure controls were adequate, overall.

PLANT ISSUES MATRIX

DATE	TYPE	SOURCE	ID	SFA	TEMPLATE CODES	ITEM DESCRIPTION
11/21/97	STR	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
11/21/97	POS	IR 97-19	NRC	PS	3A 1C	Significant improvement was made in reducing the number of personnel contamination events
11/21/97	VIO SL IV	IR 97-19	NRC	PS	1C	Control of access to a high high radiation area was identified. Other exposure controls were implemented appropriately.
11/21/97	WK	IR 97-19	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	WK	IR 97-19	NRC	PS	5C	Corrective actions by the radiation protection organization were slow and sometimes ineffective
11/08/97	POS	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.
11/08/97	NEG	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.
10/24/97	VIO SL IV	IR 97-07	NRC	PS	1C	Failure to establish required vehicle control measures
10/24/97	POS	IR 97-07	NRC	PS	4A	The installed vehicle barrier system was consistent with the summary description previously submitted to the NRC, encompassed all vital areas, and accurately described in the security plan
10/24/97	POS	IR 97-07	NRC	PS	1C	Procedures properly addressed security surveillance, maintenance, compensatory measures, vehicle access control, and the safe shutdown of the plant.
10/24/97	POS	IR 97-07	NRC	PS	4C	The bomb blast analysis was consistent with the summary description and met regulatory requirements

GENERAL DESCRIPTION OF PIM TABLE LABELS

<i>Date</i>	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.
<i>Type</i>	The categorization of the issue - see the Type Item Code table.
<i>SFA</i>	SALP Functional Area Codes: OPS for Operations; MAINT for Maintenance; ENG for Engineering; and PS for Plant Support.
<i>Sources</i>	The document that contains the issue information: IR for NRC Inspection Report or LER for Licensee Event Report.
<i>ID</i>	Identification of who discovered issue: N for NRC; L for Licensee; or S for Self Identifying (events).
<i>Issue Description</i>	Details of the issue from the LER text or from the IR Executive Summaries.
<i>Codes</i>	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 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 predecision 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.

WASHINGTON NUCLEAR PROJECT, 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 71001	REQUALIFICATION PROGRAM EVALUATION	3	12/7 - 11/98	CORE INSPECTION
IP 83750	OCCUPATIONAL RADIATION EXPOSURE	1	3/15 - 19/99	CORE INSPECTION
IP 81700	PHYSICAL SECURITY PROGRAM	1	3/29 - 4/2/99	CORE INSPECTION
IP 73753	INSERVICE INSPECTION	1	4/19 - 23/99	CORE INSPECTION
IP 84750	RADIOACTIVE WASTE TREATMENT, AND EFFLUENT AND ENVIRONMENTAL MONITORING	1	5/24 - 28/99	CORE INSPECTION
IP 84750	RADIOACTIVE WASTE TREATMENT, AND EFFLUENT AND ENVIRONMENTAL MONITORING	1	7/12 - 16/99	CORE INSPECTION