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SUBJECT: Responds to concerns noted in Insp Rept 50-397/89-01 re
 implementation of root cause analysis program.

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WASHINGTON PUBLIC POWER SUPPLY SYSTEM

P.O. Box 968 • 3000 George Washington Way • Richland, Washington 99352

July 12, 1989
G02-89-119

Docket No. 50-397

U.S. Nuclear Regulatory Commission
Attn: Document Control Desk
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Washington, D.C. 20555

Gentlemen:

Subject: NUCLEAR PLANT NO. 2
LICENSE NO. NPF-21
NRC INSPECTION REPORT 89-11

In the cover letter to the subject Inspection Report, the NRC presented concerns with regard to implementation of the Root Cause Analysis (RCA) Program and the RCA report prepared for the March 11, 1989 rod drift event. The NRC also requested that the Supply System respond to these concerns within 30 days. Accordingly, the purpose of this letter is to 1) provide an assessment of the Supply System RCA program as currently implemented, and 2) describe those actions that have been or will be taken to resolve the concerns identified by the Commission.

An evaluation of the technical adequacy of the Root Cause Analysis Program was completed by the Supply System Engineering Assurance Group on June 26, 1989. The results of the evaluation indicated an improving trend in the quality of the higher level analyses, and also noted that improvements should be made in the analyses performed for the lower level problems.

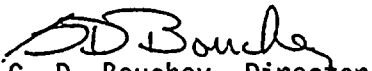
We believe that our program has been effective in addressing personnel, procedure and hardware issues as evidenced by analyses of events such as the last two scrams (89-01 and 89-02) and the low pressure turbine blade cracks. With each RCA performed, experience is gained and feedback is used to identify those areas where improvement is needed. As previously stated, continued improvement has been noted in the quality of the RCAs being performed. Additional improvements in the RCA program are also planned and budgeted for this fiscal year (1990). Included in these improvements are the development of an in-house training program on root cause analysis and training for additional plant personnel.

Regarding the analysis of the rod drift event, although some corrective actions were taken within two days, it is agreed that too much time was taken to complete the analysis and issue the report. As a result, there is increased sensitivity on the part of management to the timeliness of responding to events of this nature. Accordingly, changes are being made to the process whereby, for each Category 1 Analysis (the highest level), team members will be formally assigned by management and major milestone expectations will promptly be established to track completion of the entire process.

Regarding the specific concerns associated with the rod drift RCA report, each element has since been included in a revised report. However, it should be noted that all of these issues were previously analyzed and were addressed in other reports (e.g., HPES Report and LER). During the root cause process for this event, these particular issues were considered to be items which did not contribute to the causes of the event and, as such, they were not included in the final report. The scope of the RCA report was intended to include only those issues directly related to the event which required corrective action to prevent recurrence. The original report was not intended to serve as a stand-alone paper which addressed all aspects of the event without reference to associated documents such as the HPES report. However, the investigation of the rod drift event, and associated documents, addressed all concerns discussed in the subject Inspection Report.

The Supply System recognizes that further improvements can be made in the root cause process. Accordingly, we plan to combine the elements of our review process (e.g., Peer Review, HPES Evaluation, RCA, etc.) and document the results in an Incident Investigation Report for selected events which normally would be assigned a Category 1 RCA. An incident investigation would differ from an RCA in that all issues raised during the investigative process would be included in one report. Therefore, the corrective actions associated with an incident investigation would, in most cases, consist of more than those to prevent recurrence of a specific event. These investigations also would most likely be concerned with events where programmatic issues are involved.

Very truly yours,


G. D. Bouchey, Director
Licensing and Assurance

JDA/bk

cc: JB Martin - NRC RV
NS Reynolds - BCP&R
RB Samworth - NRC
DL Williams - BPA/399
NRC Site Inspector - 901A

