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 AUTH. NAME AUTHOR AFFILIATION
 BAKER, J.W. Washington Public Power Supply System
 RECIP. NAME RECIPIENT AFFILIATION
 Document Control Branch (Document Control Desk)

SUBJECT: Responds to NRC 920831 request for addl info re LER 92-035
 on inadequate testing of scram discharge vol vent & drain
 valves. Improvements to plant evaluation requests underway &
 Incident Review Board established in June 1992.

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 TITLE: 50.73/50.9 Licensee Event Report (LER), Incident Rpt, etc.

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December 23, 1992
GO2-92-272

Docket No. 50-397

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

Gentlemen:

Subject: WNP-2 OPERATING LICENSE NPF-21,
LICENSEE EVENT REPORT NO. 92-035,
SUPPLEMENTAL INFORMATION

- References:
- a) Letter, dated August 13, 1992, J.W. Baker (SS) to NRC Document Control Desk, "Licensee Event Report No. 92-035"
 - b) Letter, dated August 31, 1992, K.E. Perkins (NRC) to GC Sorensen (SS), "Licensee Event Report 50-397/92-035, Inadequate Testing of the Scram Discharge Volume Vent and Drain Valves"
 - c) Letter GO2-92-232, dated October 1, 1992, J.W. Baker (SS) to NRC Document Control Desk, "Licensee Event Report No. 92-035-01"

In Reference b), you requested information relating to a need for a management assessment to determine if our root cause program is effective in determining root causes of plant problems and implementing effective corrective actions in order to preclude recurrence. In Reference c), the Supply System indicated that general concerns regarding root cause assessments would be addressed separately. On October 5, 1992, Supply System staff met with NRC staff in Walnut Creek, California to present information relative to a management assessment that was conducted relative to the effectiveness of this program. The following presents some of the more significant information that was presented at that meeting.

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Our internal problem reporting system involves identification of an actual or potential plant problem by any employee (including contractor employees) in accordance with PPM 1.3.12, Plant Problems - Problem Evaluation Request. This procedure involves generation of a Plant Evaluation Request (PER) which is presented to the Shift Manager for immediate evaluation for corrective action(s) and reportability and then presented to our Management Review Committee for review and disposition.

We expect about 1500 PERs to be documented during CY-92 based upon our current generation rate. The more significant problems (including all LERs and NOVs) are processed in accordance with PPM 1.3.15, Plant Problem Reports, which involves the generation of a formal root cause analysis by the Operating Experience Analysis & Resolutions (OEAR) Department and development of corrective actions in accordance with PPM 1.3.48, Root Cause Analysis. PPM 1.3.45, Human Performance Enhancement System Program, is another closely aligned procedure which relates to identification and resolution of personnel performance and management factors.

OEAR uses various root cause evaluation techniques to identify personnel specific and contributing causes. These evaluations are performed with involvement of line personnel and corrective actions are developed in a team approach between OEAR and line personnel. The line manager implementing the corrective action(s) is responsible for the corrective action commitment(s), including adequacy of the corrective action(s), schedule for completing the corrective action(s) and the effectiveness of the corrective action(s) implementation. The root cause analysis and proposed corrective action(s) is also reviewed for adequacy by an independent Technical Review Committee with appeals referred to the Management Review Committee.

Problems documented on PERs which are less significant are corrected. However, they do not normally get a root cause evaluation including development of corrective actions to prevent recurrence. Trending, as discussed below, determines if these problems recur frequently, thus warranting further action. Improvements are being implemented to improve the effectiveness of this program.

A number of program effectiveness evaluations have occurred over recent years. These have included self-assessments initiated by the OEAR staff, internal Quality Assurance audits and surveillances, consultant reviews, NRC inspections, INPO reviews and benchmarking activities by OEAR staff with programs of other utilities. These reviews have identified areas where improvements could be implemented to improve the efficiency and effectiveness of this program. A number of improvements have been implemented from these efforts.

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The Quality Assurance Annual Report, issued in September 1992, identified Corrective Action Effectiveness as a major programmatic concern. A Quality Finding Report (QFR TA-92-014-01) was issued with the Annual Report to obtain an evaluation and formal response of corrective actions to be initiated to improve this area. A management review was also performed in September 1992 in response to reference b) request. Conclusions from these evaluations have resulted in several additional corrective actions to improve the effectiveness of this program. Most of these were discussed at the aforementioned October 5, 1992 meeting. A summary is provided below for completeness and ease of review.

- LERs summarize root causes but contributing causes and other conditions not related to the reportable event that have been discovered and corrected are not always detailed in the report sent to the NRC. Future LERs will contain these additional details.
- Additional root causes and corrective actions may result from evaluations not yet complete at the time the LER must be submitted. Supplemental LERs will be submitted to provide this information if it is considered significant. Several supplemental LERs are currently being processed to provide additional information to the initial LER.
- Although most of the current OEAR staff billeted for the root cause analysis function have received the Human Performance Enhancement System (HPES) training module and MORT training, those that have not received this training, which focuses on human performance and management program deficiencies, will be scheduled in the near future. Evaluations performed by these staff members are reviewed by OEAR management to assure complete evaluations.
- The implementation of the Incident Review Board, PPM 1.1.8, focuses primarily on human performance deficiencies. The Board is on call and convenes in a timely manner to gather information and develop causes for significant events which occur and may have human performance deficiencies. This Board was begun in June 1992 and has helped to get facts and address the human performance and implementation deficiencies in management programs and processes.
- Sensitivity of management has been heightened by review of the NRC response evaluation for LER 92-035 to assure that personnel performance and management factors are consistently explored in root cause analyses.

- Training by a leading root cause analysis expert on human error and organizational and programmatic issues (Dr. Chiu) is scheduled to be provided to Supply System staff in February 1993. This two day course will be provided to at least twenty first-line supervisory staff in addition to OEAR staff and WNP-2 management. This training will give first-line supervisors better tools to use when they evaluate less significant PERs. This training is also intended to provide first-line supervisors a better understanding of the methods used by OEAR and how they can support the process.

A follow-on three day course for OEAR staff and other personnel involved in formal root cause investigations is also in the process of being scheduled.

- Improving the timeliness of completing root cause evaluations and reducing corrective action backlogs is receiving significant management attention. Corporate goals have been established and additional resources have been recently secured for this area to reduce the backlog. Tracking of progress for management information and action is performed on at least a monthly basis.
- An overall priority system is being developed which will be used to evaluate the significance of problems and ensure prompt corrective action is initiated based upon significance to plant nuclear safety, reliability and other criteria factors. This system is expected to be implemented by June 1993.
- Improvements in monitoring effectiveness of corrective actions have been initiated by our Quality Assurance organization. These activities will provide additional information for management to determine whether the above actions are accomplishing the desired improvements in our overall corrective action process. They also will provide information where specific attention needs to be applied to develop corrective actions to prevent recurrence of specific problems.

A pilot corrective action team audit was recently performed on the Standby Liquid Control System which focused on effectiveness of corrective actions specific to this system. This audit report was issued in November, 1992 and identified several concerns related to the effectiveness of our corrective actions. A second corrective action team audit is planned to commence in January 1993 on the effectiveness of procedural adequacy and compliance actions that have been recently taken by several organizations.

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Improvements to our PER trending system were proposed in a report that was issued in October 1992 based upon several benchmarking trips to utilities recommended by INPO. This system involves trending of plant problems documented by PERs which do not receive a formal root cause analysis. A report is presently being developed which will be presented to management for review in December 1992. The improvements primarily involve more frequent reporting of adverse trends to line management with detailed analysis of the issues involved for the problems that are included in the trend. The purpose of this system is the early detection of the recurrence of similar plant problems so that corrective actions may be initiated to address the root cause.

We believe that our current corrective action and root cause analysis processes are adequate and meet regulatory requirements. Recent feedback by NRC on the recent power oscillation root cause analysis acknowledged the maturing Supply System root cause analysis capability to identify accountability and management program deficiencies. However, we believe that further improvements can, and must, be achieved. We believe that the above actions will improve our corrective action program, including root cause analysis, development and implementation of effective corrective actions and subsequent monitoring to verify the improving effectiveness of our corrective action process.

Sincerely,



JW Baker

WNP-2 Plant Manager (Mail Drop 927M)

LLG:mb

cc: JB Martin, NRC RV
JW Clifford, NRC
NRC Resident Inspector (901A)
DL Williams, BPA (399)