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SUBJECT: LER 92-023-02:on 920519,review of non-licensed operator tour log revealed missed TS surveillance & fire tour data due to less than adequate work practices.Investigation into event expanded.No violations noted.W/930611 ltr.

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June 11, 1993
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Docket No. 50-397

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

Subject: **NUCLEAR PLANT WNP-2, OPERATING LICENSE NPF-21**
LICENSEE EVENT REPORT NO. 92-023-02

Transmitted herewith is Licensee Event Report No. 92-023-02 for the WNP-2 Plant. This report is submitted in response to the report requirements of 10CFR50.73 and incorporates only minor administrative changes.

Sincerely,

J. V. Parrish (Mail Drop 1023)
Assistant Managing Director, Operations

JVP/MPR/jd
Enclosure

cc: Mr. B. H. Faulkenberry, NRC - Region V
Mr. R. Barr, NRC Resident Inspector (Mail Drop 901A, 2 Copies)
INPO Records Center - Atlanta, GA
Mr. D. L. Williams, BPA (Mail Drop 399)

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LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Washington Nuclear Plant - Unit 2	0 5 0 0 0 3 9 7	1 OF 5

TITLE (4)
MISSED TECHNICAL SPECIFICATION SURVEILLANCE AND FIRE TOUR DATA DUE TO LESS THAN ADEQUATE WORK PRACTICES

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES	DOCKET NUMBERS(S)
0 5	1 9	9 2	9 2	0 2 3	0 2	0 6	1 1	9 3		0 5 0 0 0
										0 5 0 0 0

OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)			
POWER LEVEL (10) 0 0 0	X	20.402(b)	20.405(C)	50.73(a)(2)(iv)	77.71(b)
		20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.73(c)
		20.405(a)(1)(ii)	50.36(c)(2)	50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
		20.405(a)(1)(iii)	X 50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	
		20.405(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(viii)(B)	
		20.405(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)	10CFR50.9

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
M. P. Reis, Compliance Supervisor	AREA CODE 5 0 9 3 7 7 - 4 1 5 2

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS

SUPPLEMENTAL REPORT EXPECTED (14)	EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE) X NO				

ABSTRACT (16)

Management review of nonlicensed operator tour log data revealed missed data which constituted Technical Specification violations. No immediate corrective action was necessary since all data was current at time of the discovery.

The root cause is less than adequate personnel work practices. Personnel involved were subjected to disciplinary measures. Management expectations regarding conduct of tours and accuracy of records and data have been communicated to station personnel.

Further investigations were performed to verify tour and logkeeping activities in selected other organizations. No additional findings of regulatory significance were discovered.

This event had no significance to the health and safety of the public. The Supply System believes it has high significance with respect to the Supply System's mission and the public trust and confidence.

Plant Conditions

Power Level - 0%
Plant Mode - Reactor Defueled

Event Description

On May 19, 1992, a Management Review Team concluded that a surveillance data point required by Technical Specifications had not been properly verified by a nonlicensed Equipment Operator and, hence, constituted a missed surveillance. The data point was the Area Temperature Monitoring surveillance for the Division I Emergency Diesel Generator.

Management had initiated reviews of Plant Equipment Operator (EO) Log data, which revealed a discrepancy for the area temperature data taken on February 28, 1992. The EO Log entries were compared against security computer records. The comparison revealed that entry into the Diesel Generator Room, within the time frame allowed for the surveillance, could not be verified by security logs. Entry into the area is necessary since the temperature indicator must be locally read.

Similar discrepancies between recorded data and operator location were found in Fire Tour Log information. Fire Tours are also part of EO duties.

Immediate Corrective Action

Since the missing data was sporadic and historical, no immediate corrective action was necessary. Area temperature surveillances and fire tours were current at the time reportability was determined.

Further Evaluation and Corrective Action

Further Evaluation

1. The investigation was undertaken, at Management initiative, in order to reaffirm that log keeping problems experienced at other utilities were not present at WNP-2. However, management expectations were not verified since discrepant information was discovered in the log records of twenty Equipment Operators. Nineteen other EOs had no instance of log information which disagreed with security records.

   Of the 20 EOs, three had between 20 and 40 unexplained discrepancies, seven had four to eight discrepancies and 10 had two or fewer.

2. Of the over three months of fire tour logs reviewed, 128 inspections were missed. The investigation revealed that six operator tour data points were also missed. One missed operator tour data point resulted in a violation of the Area Temperature Monitoring Technical Specification (3/4.7.8). This condition is reportable under 10CFR50.73(a)(2)(i)(B), a condition prohibited by Technical Specifications.

   The missed fire tour data constituted a violation of Technical Specification 6.8.1.g, which requires that a Fire Protection Program be established, implemented and maintained. The investigation results indicate inadequate implementation of this program, which is also reportable under 10CFR50.73(a)(2)(i)(B), a condition prohibited by Technical Specifications.

3. The Supply System had been in contact with NRC Regional Management and the local NRC Resident Inspectors throughout the investigation. On May 19, 1992, Plant Management formally notified the NRC that the Supply System considered the combined inspection results to be a violation of 10CFR50.9, which requires that information provided to the NRC be complete and accurate in all material respects. As outlined in the Statements of Consideration for this rule, the standard for what constitutes "material" information is one of a licensee's own recognition of information with significant public health or safety or common defense or security implications.

   Approximately half of the Equipment Operators had discrepant log entries. Although the proportion of missed data points is small, the relatively large percentage of individuals with performance errors is considered a challenge to the credibility of station records. The Supply System believes that WNP-2 records and reputation must be without blemish. Any significant error or pervasive inaccuracy in these records is considered by the Supply System to be significant.

4. The root cause for these events is less than adequate Personnel Work Practices. Required verifications were not performed in that personnel performing the tours did not personally verify each data point. A minor contributing cause is Management Method - Policy not Adequately Disseminated. Some of the EOs expressed belief that it was not necessary to personally verify each point but that there were acceptable equivalent methods (e.g., someone exiting the room attesting to acceptable conditions in the room).

Further Corrective Action

1. All EOs with unexplained differences between tour log and security log data received disciplinary action. These actions ranged from unpaid suspension from assigned duties to formal reprimand. Specific individual action was related directly to the number of discrepancies found with the individual's logs.

2. Management expectations regarding the veracity of information were communicated to Operations Directorate personnel via memo on May 18, 1992.

3. Plant Management expectations regarding the conduct of tours were communicated, via memorandum, to personnel with plant access. This was completed on April 27, 1992.

4. As a result of the above findings, similar investigations were conducted in the areas of the Chemistry, Health Physics, Maintenance, Security and Quality Control. These audits evaluated departmental activities for the month of March, 1992. No findings of regulatory significance were revealed. However the investigation did discover opportunities for job performance improvement in the Health Physics, Maintenance and Security arenas. Management intends to capitalize on these opportunities.

   Chemistry investigations consisted of data evaluation for Chemistry Technician daily Channel and Source Checks. No discrepancies were discovered.

   Health Physics preliminary investigations showed that, in a small number of cases, the time spent conducting routine building surveys was less than management expectations for those tasks. The inquiry was expanded to further detail job performance of specific personnel and to ensure that the performance of each Senior HP Technician had been evaluated. The results of the expanded search revealed no violations of regulatory requirements.

   Security Operations analyzed security log entry reports against the WNP-2 Physical Security Plan and 10CFR73.55 inspection requirements. No violation of security plan or NRC requirements were discovered. Minor job performance issues were recognized and corrected.

   Twenty-six instances of Quality Control callout inspections, encompassing the month of March 1992, and representing various types of inspection activities and nine different inspectors, were reviewed against plant access records. No discrepancies were found.

Maintenance surveillance and preventive maintenance activities were also reviewed against plant access logs. Ninety-one randomly selected tasks were reviewed. No discrepancies of regulatory significance were found.

5. A periodic surveillance is being developed to assess the log keeping performance of various departments. This surveillance will be first implemented by September 30, 1992.

Safety significance

These missed data points presented no significant physical challenge to the operability of plant equipment. The area temperature in the Diesel Generator 1 Room, as measured the shift before and after, was within acceptable limits. The external ambient temperature for the day ranged from 43°F to 48°F, with an average wind speed of 2.6 mph. It is most unlikely that the room temperature could have significantly changed in the twelve hour interval during which the data was missed.

The missed Fire Tour data was sporadic and tours before and after verified no unacceptable conditions in the areas. In most cases, other plant personnel were in the area and could have alerted plant emergency personnel in the event of abnormal conditions in the area. Furthermore, other sensing and suppression systems in most of the areas were operable.

As noted above, the main significance of this event is related to the implications it has with respect to the veracity of station records. The Supply System requires and expects its records to be complete and accurate in all aspects. Potentially generic challenge to any record or group of records is considered by Supply System management to have high significance with respect to the Supply System's mission and the public trust and confidence. Even though the above instances of missed data presented no physical threat to the public, the Supply System considers these performance failures unacceptable.

Similar Events

There have been no similar events at WNP-2.

EIIS Information

None