

WOLF CREEK

NUCLEAR OPERATING CORPORATION

December 30, 1994

Otto L. Maynard
Vice President Plant Operations

WO 94-0221

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

Reference: Letter dated November 16, 1994, from A. B. Beach,
NRC, to N. S. Carns, WCNOG
Subject: Docket No. 50-482: Reply to Notices of Violation
482/9412-01, -02 and -03

Gentlemen:

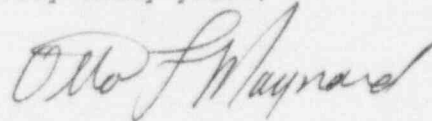
Attached is Wolf Creek Nuclear Operating Corporation's (WCNOG's) Reply to Notices of Violation 482/9412-01, -02, and -03 which were documented in the Reference (NRC Inspection Report 50-482/94-12).

Violation 482/9412-01 concerned four examples of WCNOG personnel failure to follow procedures. Violation 482/9412-02 concerned two examples of WCNOG's failure to ensure personnel adhered to the policy on the use of overtime. Violation 482/9412-03 concerned three examples of WCNOG's failure to correctly implement the Radiation Protection Program.

WCNOG's response to these Notices of Violation is in the Attachment to this letter. The corrective actions for these violations are comprehensive and will ensure WCNOG's compliance with the applicable regulations and procedure requirements.

If you should have any questions regarding this response, please contact me at (316) 354-8831, extension 4450, or Mr. R. D. Flannigan at extension 4500.

Very truly yours,



Otto L. Maynard

OLM/jad

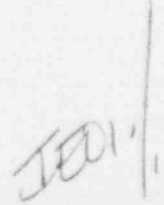
Attachment

cc: L. J. Callan (NRC), w/a
D. D. Chamberlain (NRC), w/a
J. F. Ringwald (NRC), w/a
J. C. Stone (NRC), w/a

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Reply to Notices of Violation 9412-01, -02, and -03

Violation 482/9412-01: Failure to follow procedure.

"A. Technical Specification 6.8.1.a states, in part, that written procedures shall be established and implemented covering the applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2.

- (1) Regulatory Guide 1.33, Appendix A, Section 7.a, requires procedures covering the liquid radioactive waste system. Procedure SYS HE-201, "Boron Recycle Holdup Tank Operations," Revision 9, Step 4.4.1, requires that the operator perform Section 4.2 for proper system alignment for recycling and sampling to transfer water from the Recycle Holdup Tank B to the spent fuel pool.

Contrary to the above, on September 30, 1994, an operator failed to perform Section 4.2 of Procedure SYS HE-201, and thereby incorrectly transferred unsampled Recycle Holdup Tank A to the spent fuel pool instead of Tank B as planned.

- (2) Regulatory Guide 1.33, Appendix A, Section 1.c, requires administrative procedures covering equipment control. Administrative Procedure ADM 02-102, "Control of Locked Component Status," Revision 28, Step 4.12, requires that all valves required to be locked be rechecked prior to entry into Mode 4.

Contrary to the above, on October 26, 1994, Valve BB V0149 was found inadequately locked such that it could be repositioned without removing the locking device.

- (3) Regulatory Guide 1.33, Appendix A, Section 10, requires procedures covering chemical and radiochemical control. Chemistry Procedure CHM 02-050, "Determination of Boron (Titration Method)," Revision 6, Step 9.2.15, requires that two scoops of mannitol and five drops of phenolphthalein be added to the sample container in preparation for the titration.

Contrary to the above, on October 30, 1994, a chemistry technician added three partial scoops of mannitol and an indeterminate amount of phenolphthalein to the sample container.

- (4) Regulatory Guide 1.33, Appendix A, Item 1.d, requires administrative procedures to address procedure adherence. Procedure AP 15C-002, "Procedure Use and Adherence," Revision 0, Section 6.3.4, requires that the intent and direction provided in the procedure be followed during the course of activities. Attachment 2 of Procedure KGP 1210, "Performance Improvement Requests," Revision 10, identifies the failure of a

safety-related piece of equipment to perform its intended safety function on demand or as expected as significant. Procedure KGP-1201, "Corrective Action," Revision 1, requires that a Performance Improvement Request (PIR) be initiated to determine the cause and corrective actions to prevent recurrence for significant hardware failures.

Contrary to the above, on October 16, 1994, Essential Service Water Self-Cleaning Strainer A, a safety-related component, failed to operate when the drive motor thermal overloads tripped on actuation and a PIR was not initiated."

Admission of Violation:

The Wolf Creek Nuclear Operating Corporation (WCNOC) agrees with the above noted violations.

Reason for Violation:

Root cause:

Example # 1:

The root cause for this example is cognitive personnel error, in that, the operator failed follow procedure step 4.2.

Example # 2:

The root cause for this example is cognitive personnel error, in that, the individual who secured and locked Valve BB V0149, failed to apply good self checking practices. The individual should have verified the chain was correctly run and that the slack was removed, prior to securing the valve and leaving the area.

Example # 3:

The root cause for this example is cognitive personnel error, in that, the individual did not perform the titration as required by the procedure.

Example # 4:

The root cause for this example is cognitive personnel error, in that, the individual did not initiate a Performance Improvement Request (PIR) for the ESW Strainer failure as required by the WCNOC Corrective Action Program.

The root cause for the generic aspects of the above noted examples is inconsistent enforcement of Management's expectations to all plant personnel.

Contributing Factors:

A contributing factor to generic aspects of this violation is the failure on the part of WCNOC to develop clearly defined consequences for procedure non-compliance problems.

Corrective Steps Taken and Results Achieved:

PIR 94-1675 was initiated to address the specific aspects of the first example. Procedure SYS HE-201 was revised. This revision clarified the requirements for placing the "B" tank in recirculation.

PIR 94-1911 was initiated to address the specific aspects of the second example. The chain on Valve BB V0149 was repositioned and correctly secured. The individual who locked Valve BB V0149 was counseled by the Shift Supervisor.

PIR 94-1943 was initiated to address the specific aspects of the third example. The individual who failed to follow procedure CHM 02-050 was counseled on the need for verbatim procedural compliance. PIR 94-1943 was placed in Chemistry Required Reading to make all Chemistry personnel aware management's expectations on procedural compliance. Chemistry personnel were notified at the weekly chemistry meeting (on November 23, 1994) to identify other procedural enhancements, that were needed, and that any procedural problem that prevented a task from being completed must be corrected prior to performing the task.

PIR 94-2116 was initiated to address the specific aspects of the fourth example.

PIR 94-2133 was initiated to address the generic aspects of this violation. As a result the following corrective actions were implemented.

Corrective Steps That Will Be Taken to Avoid Further Violations:

WCNOC Management will communicate its expectation-consequence standard to all plant personnel. This action will be completed by January 30, 1995.

WCNOC will set aside a day dedicated to the subject of the "Use Of Procedures." During this day, there will be meetings with all groups where the Vice President Plant Operations reemphasize what management's expectations for the use of procedures and review the disciplinary actions for failure to follow procedure.

Managers and supervisors will meet with their people to review the procedures they frequently use to ensure everyone is aware of what the requirements are in the procedures. Additionally, management's expectations will be discussed to ensure plant personnel have a clear understanding of management's expectations. During these meetings the disciplinary policy will be reviewed to ensure all personnel have a clear understanding of the consequences of not following procedures.

The Vice President Operations has established a "Topic Of The Week" program. This program will focus management attention on procedures which personnel have experienced problems following properly. This program will be used as long as it is deemed appropriate by plant management. The implementation of this program is considered by WCNOC as an enhancement to the operation of the station and not as a regulatory commitment.

Date When Full Compliance Will Be Achieved:

Full compliance with Technical Specification 6.8.1.a has been achieved. Corrective actions to prevent recurrence of the problem will be completed by January 30, 1995.

Violation 482/9412-02: Concerned two examples of WCNOC's failure to assure personnel adhered to its policy on the use of overtime.

"B. Technical Specification 6.2.2.f. requires that the amount of overtime worked by unit staff members performing safety-related functions shall be limited in accordance with the NRC Policy Statement on work hours (Generic Letter No. 82-12). Generic Letter No. 82-12 states that individuals should not be permitted to work more than 24 hours in 48 hours or 72 hours in 7 days.

Contrary to the above, on October 13, and October 19, 1994, operators worked in excess of the Technical Specifications guidelines without authorization in that a refueling SRO worked 12 hours in excess of 72 hours in 7 days and a licensed operator performing valve lineups in the containment exceeded 24 hours in 48 hour period."

Admission of Violation:

WCNOC agrees with the above noted violations.

Reason for Violation:

Root cause:

Example # 1:

The root cause for this example is cognitive personnel error, in that, the Operations Supervisor within the Wolf Creek Outage Control Center failed to communicate to his relief and to the individual the limits of the working hours extension, and the individual involved did not verify the hours authorized prior to commencing work.

Example # 2:

The root cause for this example is cognitive personnel error, in that, the Operations Supervisor and the individual involved thought that by being sent home and directed to return later that evening the working day was reset, consequently no authorization to exceed working hours was required or requested.

Contributing Factors:

Review of previous violations of working hour limits indicates that the greatest potential for exceeding working hour limits occur during refueling outages. When workers are scheduled for consecutive 12 hour shifts any holdover can cascade to cause the 24 hour in a 48 hour period to be exceeded.

Corrective Steps Taken and Results Achieved:

Several actions have been taken which helped prevent WCNOC personnel from exceeding the working hour limits. These included periodic reinforcement of

the working hour policy by management, placing the working hours limits in the General Employee Training, and listing the working hour limits in the Refueling VII Outage Handbook. These actions were not totally effective and the following was also done:

PIR 94-1770 was initiated to address the specific aspects of the first example. The individual involved was aware of the working hour limitation and, in fact, initiated a request to get approval to exceed the administrative limit. However, due to an inaccurate estimate of the number of hours to complete the assigned task and a miscommunication between the individual and his supervisor and the on-coming supervisor during the shift change, the individual worked more hours than approved. Upon discovery the approval was received. This PIR was placed in Operation's required reading to ensure all personnel, including supervisors, are aware of the circumstances of the event.

PIR 94-1842 was initiated to address the specific aspects of the second example. The Operations Outage Manager failed to recognize the effect on exceeding working hour guideline on an individual working a partial shift, returning home for a rest period and then returning later to work an entire shift, in the same 24 hour period. The individual involved also failed to recognize the impact of working a partial shift followed by a full shift. Since another working hour incident had recently occurred and was being routed in required reading, an electronic mail message was sent to all Operation's personnel emphasizing the importance of complying with working hour guidelines. The individual who failed to comply with the policy on working hours was counseled by his Shift Supervisor on the importance of following administrative procedures.

These are the only instances of the individuals involved exceeding working hour requirements. All individuals were aware of the policy requirements on working hours.

PIR 94-2135 was initiated to address the generic aspects of this violation. As a result, the following corrective actions were implemented.

Procedure ADM 01-023, "Guidelines For WCGS Staff Working Hours" was revised and re-issued as AP 13-001, Revision 0, "Guidelines For WCGS Staff Working Hours." The revision included adding a section on responsibilities. Specifically, Step 5.3 requires that all personnel are responsible for being cognizant of their hours worked, complying with the work hour limitations of the procedure and informing their supervisor that an overtime assignment may violate the requirements of this procedure. Managers and supervisors were notified concerning the changes to this procedure. Additionally, information concerning this procedure and individual responsibilities were published in a weekly publication available to all personnel.

Integrated Plant Scheduling has included in the outage preparation program a need to reinforce the working hour policy. In addition to listing the working hour limits in the outage handbook, prior to each outage, the policy statement on working hours and management's expectations will be issued to all outage personnel.

Management will continue to reinforce the working hour policy by periodically issuing policy statements reviewing the working hour limitations and management's expectations that all personnel will be personally responsible for ensuring they do not exceed the limits.

Procedure compliance was addressed in PIR 94-21. This PIR was issued to address the generic aspects of Notice Of Violation 02/9412-01.

The "Guideline For WCGS Staff Working Hours" procedure will be the "Topic Of The Week" during the week of March 20, 1995.

Date When Full Compliance Will Be Achieved:

Full compliance with Technical Specification 6.2.2.f has been achieved.

Violation 482/9412-03: Concerned three examples of WCNO's failure to correctly implement its Radiation Protection Program.

"C. Technical Specification 6.11 states that procedures for personnel radiation protection shall be prepared consistent with the requirements of 10 CFR 20 and shall be approved, maintained, and adhered to for all operations involving personnel radiation exposures.

- (1) Radiation Protection Procedure RPP 02-105, "RWP [Radiation Work Permit]," Revision 6, Step 9.3.1, states that the protective equipment specified on the radiation work permit is to be per Procedure RPP 03-505, "Selection of Protective Clothing," Revision 1. Procedure RPP 03-505 requires protective clothing to be selected based on the known or expected contamination levels in the work area. Radiation Work Permit 941200, Revision 0, requires a full set of protective clothing for access to contaminated areas.

Contrary to the above, on September 28, 1994, a licensee employee removed contaminated packing from a valve in a known contaminated system without wearing a full set of protective clothing.

- (2) Procedure RPP 02-105, "RWP," Revision 6, Step 9.3.1, states that the protective equipment specified on the RWP is a minimum requirement, which all personnel accessing the RWP must comply with.

Radiation Work Permit 940005, Revision 0, requires a full set of protective clothing for contaminated access.

Contrary to the above, on October 6, 1994, a licensee employee accessed a contaminated area in centrifugal charging pump room B without a full set of protective clothing in that the coveralls were not zipped up prior to entry.

- (3) Procedure AP 25B-100 "Radiation Worker Guidelines," Revision 0, Step 6.6.3, requires radiation workers to perform a hands, feet, and face frisk after exiting a contaminated area.

Contrary to the above, on October 30, 1994, a chemistry technician failed to frisk after exiting a contaminated area." [This involved an individual reaching across a radiological control area boundary to manipulate a valve.]

Admission of Violation:

WCNO's agrees with the above noted violations.

Reason for Violation:

Root cause:

Example # 1:

The root cause for this example is cognitive personnel error, in that, the Health Physics Technician failed to follow the Radiation Work Permit (RWP) revision requirements set forth in procedure RPP 02-105, Revision 6, "RWP." WCNO's Health Physics Program allows the Health Physics Technician to reduce protective requirements, when the environmental conditions permit, as long as the RWP is revised to reflect the reduction.

Example # 2:

Although the environmental conditions did not warrant, nor did the RWP require plant personnel to don coveralls the operator voluntarily elected to use coveralls. The root cause for this example is cognitive personnel error, in that, the individual contrary to the WCNO's Health Physics Program, failed to correctly wear the coveralls.

Example # 3:

The root cause of this example is an inadequate procedure, in that, procedure AP 25B-100 did not address frisking requirements for a reach across situation as described in the above noted example.

Corrective Steps Taken and Results Achieved:

PIR 94-1672 was initiated to address the specific aspects of the first example.

PIR 94-1936 was initiated to address the specific aspects of the second example. PIR 94-1936 was placed in the Operations Required Reading Program. This action was taken to familiarize personnel with the event and the requirement to don protective clothing correctly.

PIR 94-1938 was initiated to address the specific aspects of the third example.

PIR 94-2134 was initiated to identify the above noted concerns, to insure a root cause evaluation for the above noted concerns was performed, and to assure corrective actions to prevent recurrence were implemented.

PIR 94-2134 was placed in the Health Physics Required Reading Program. This action was taken to familiarize personnel with the events, their root causes, and the corrective actions implemented to prevent recurrence.

Corrective Steps That Will Be Taken to Avoid Further Violations:

Procedure AP 25B-100, "Radiation Worker Guidelines" will be revised. This revision will clarify the frisking requirements for reach across situations. This revision will be completed by January 30, 1995.

The Vice President Operations has established a "Topic Of The Week" program. This program will focus management attention on procedures which personnel have experienced problems following properly. This program will be used as long as it is deemed appropriate by plant management. The implementation of this program is viewed by WCNOG as an enhancement to the operation of the station and not as a regulatory commitment.

During the week of January 9, 1995, various procedures associated with Radiation Worker Practices will be the "Topic Of The Week." These events and similar events will be discussed.

Date When Full Compliance Will Be Achieved:

Full compliance with Technical Specification 6.11 has been achieved. Corrective actions to prevent recurrence of the problem will be completed by January 30, 1995.