

LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (MNBB 7714), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1)

WOLF CREEK GENERATING STATION

DOCKET NUMBER (2)

05000482

PAGE (3)

1 OF 6

TITLE (4)

Failure To Comply With Technical Specification 3.6.1.1, "Containment Integrity"

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REV NUMBER	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
10	23	96	96	015	01	01	31	97	FACILITY NAME	DOCKET NUMBER
OPERATING			THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5: (Check one or more) (11)							
MODE 1			20.402(b)			20.405(c)			50.73(a)(2)(iv)	73.71(b)
POWER			20.405(a)(1)(i)			50.36(c)(1)			50.73(a)(2)(v)	73.71(c)
100%			20.405(a)(1)(ii)			50.36(c)(2)			50.73(a)(2)(vii)	OTHER
			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)	

LICENSEE CONTACT FOR THIS LER (12)

NAME

R. D. Flannigan
Manager Nuclear Engineering, Safety and
Licensing

TELEPHONE NUMBER (Include Area Code)

316-364-8831, ext. 4500

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
		N/A							

SUPPLEMENTAL REPORT EXPECTED (14)

EXPECTED

MONTH

DAY

YEAR

YES	X	NO
(If yes, completed EXPECTED SUBMISSION DATE)		

ABSTRACT:

On October 23, 1996, during the cause and extent evaluation performed as part of the corrective action process for Licensee Event Report (LER) 96-011-00, it was determined that Technical Specification Clarification (TSC) 033-85 may have constituted a change to Technical Specification 3.6.1.1, "Containment Integrity," because it allowed opening of penetration vent or drain valves to facilitate testing. Subsequent review determined that the last three instances that Wolf Creek Nuclear Operating Corporation (WCNOC) utilized TSC 033-85 was between June 1, 1996 and October 3, 1996. Root cause was determined to be a misalignment between the Wolf Creek organization culture and the regulatory environment. Corrective actions include deletion of TSC 033-85, extensive revision of the TSC procedure and process, inclusion of the deletion notice for TSC 033-85 in the Operations Essential Reading Program, and periodic training on verbatim compliance. The failure to comply with the Technical Specification is reportable per 10 CFR 50.73(a)(2)(i).

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TEXT (If more space is required, use additional copies of NRC Form 366A) (17)

Plant Conditions Prior to the Event:

MODE = 1

Reactor Coolant Pressure = 2234

Reactor Power = 100%

Basis for Reportability:

10 CFR 50.73(a)(2)(i)(B) requires each licensee to report any operation or condition prohibited by the plant's Technical Specifications.

Technical Specification 3.6.1.1 is applicable to MODES 1, 2, 3, and 4, and states:

"Without primary CONTAINMENT INTEGRITY, restore CONTAINMENT INTEGRITY within 1 hour or be in at least HOT STANDBY within the next 6 hours and in COLD SHUTDOWN within the following 30 hours."

Technical Specification Clarification (TSC) 033-85 stated:

"For the purpose of Local Leak Rate Testing, opening of the vent and drain valves simultaneously shall not be construed as a breach of containment [NH] integrity, so long as an individual is in constant communication with the Control Room, is stationed at the appropriate valve or valves, this individual's sole responsibility shall be to re-establish isolation in the event so instructed or upon loss of communication. This individual shall be designated by the Shift Supervisor and the individual's name shall be entered as a test performer on the surveillance cover sheet."

The TSC allowed for the use of a dedicated operator when maintaining containment integrity. The Technical Specification required that all penetrations not capable of being closed by operable containment automatic isolation valve and required to be closed during accident conditions are closed by valves, blind flanges or deactivated automatic valves secured in their positions.

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Description of Event:

On October 23, 1996, during the cause and extent evaluation performed as part of the corrective action process for Licensee Event Report (LER) 96-011-00, it was determined that Technical Specification Clarification (TSC) 033-85 was inappropriate to the circumstances. TSC 033-85 allowed a violation of Technical Specification 3.6.1.1, "Containment Integrity" as well as Technical Specification Definition 1.7 "Containment Integrity." Subsequent review determined that Technical Specification 3.6.1.1 has been violated a number of times in the past, with the most recent instances occurring June 1, 1996; September 30, 1996; and October 3, 1996.

Root Cause and Corrective Actions:Root Cause and Contributing Factors:

Root cause was determined to be a misalignment between the Wolf Creek organization culture and the regulatory environment. This misalignment was evidenced in the following three areas:

- Technical Specification Application

Wolf Creek's "mind set" was to assess plant conditions and use operational knowledge in the application of the Technical Specifications. In some cases verbatim Technical Specification compliance was compromised. The regulatory environment requires verbatim compliance while preserving an understanding of how the bases for the Technical Specifications are to be applied.

- Misapplication of the Technical Specification Clarification (TSC) Process

This "mind set" was a key contributor to misapplication of the TSC process. This misapplication resulted in instances where the clarification constituted a change to the Technical Specifications, or their bases, without proper regulatory evaluation or approval.

- Standards

This "mind set" also influenced the standards applied to TSC review and approval, and internal assessments of the health of the TSC process.

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Corrective Actions

Immediate:

- The on-duty Shift Supervisor was notified of the concern.
- TSC 033-85 was deleted, and removed from the Control Room on November 12, 1996.
- The deletion notice for TSC 033-85 was placed in the Operations Essential Reading Program on November 13, 1996. This action was taken to assure all licensed personnel were made aware of the concern related to this clarification prior to assuming their next watch.
- Operations' staff initiated Performance Improvement Request 96-2709 on October 23, 1996, to document the concern, investigation results, and the implementation of corrective actions.
- Operations' staff performed an internal detailed review of all developed TSCs to determine the extent of the concern. This review identified a total of fourteen clarifications which could have potentially caused a violation of the associated Technical Specification. PIRs were written for each occurrence. A total of six Technical Specification violations were identified. LERs were issued for each violation.
- WCNOG established Incident Investigation Team (IIT) 96-004, on October 23, 1996, to evaluate the TSC Process. This IIT determined the root cause for this event and recommended corrective actions to prevent recurrence.

Corrective Actions to Prevent Recurrence:

- The Chief Operating Officer will complete follow-up sessions with all departments, communicating management expectations regarding the need for verbatim compliance with Nuclear Regulatory requirements. This activity will be completed by February 28, 1997.
- Periodic training will be provided to ensure the proper alignment between the Wolf Creek culture and the regulatory environment on verbatim compliance.
- WCGS Administrative Procedure AP 26C-003, Revision 0, "Technical Specification Clarifications" will be enhanced by March 15, 1997, to incorporate additional programmatic improvements.

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- During the initial cause and extent investigation activities associated with WCNOE evaluation of TSC 033-85, it was determined that approximately 50 leak-rate testing procedures referenced this TSC. Each procedure will be revised prior to use; all procedures associated with this TSC will be corrected by July 1, 1997.

Safety Significance:

During the operating history of Wolf Creek Generating Station no releases from the containment atmosphere to the outside atmosphere have been experienced during Modes 1, 2, 3 and 4. The safety evaluation for the Wolf Creek Generating Station Technical Specification 3.6.1.1 was based on NUREG 0830, "Safety Evaluation Report Related To The Operation Of The Callaway Plant Unit No. 1." Section 6.2.3 of this NUREG describes the requirements for the containment isolation system. For each penetration at least two barriers are required between the containment atmosphere and the outside atmosphere, so that a failure of a single barrier does not prevent isolation.

TSC 033-85 allowed for the use of a dedicated operator for maintaining containment integrity during Modes 1, 2, 3 and 4. With dedicated operators at each opening (drain or vent valve) and in direct communication with the control room the ability to ensure a release could be prevented is maintained, while meeting the single barrier failure criteria. Procedures also require that if communication with the dedicated operator is lost, the dedicated operator will immediately close the valve he is monitoring. This would indicate that although Technical Specifications were violated the safety significance of this practice was very small. Had one dedicated operator been unable to close the open valve, a second dedicated operator is still available to close the other open valve.

Other Previous Occurrences:

WCNOE LERs 96-011-00, 96-012-00, 96-013-00, 96-014-00, and 96-016-00 document similar events of inappropriate use of TSCs. The event documented in the original LER (96-015-00) to this supplement (96-015-01) was discovered during the review of the first of these LERs (LER 96-0011-00). Therefore, the root cause and corrective actions to prevent recurrence associated with LER 96-011-00, and subsequent LERs of a similar nature, were still under evaluation, and could not have prevented the occurrence of this event.

Two previous occurrences of containment integrity violations were reported in LER 92-005-00 and LER 92-014-00.

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LER 92-005-00: Documents that on February 27, 1992, Surveillance Test Procedure (STS) GP-007 failed to provide adequate restoration instructions. Corrective actions were the revision of STS GP-007 to include the necessary system restoration instructions. The corrective actions associated with this LER would not have prevented the incorrect application of TSC 033-85.

LER 92-014-00: Documents that on August 17, 1992, a cognitive personnel error occurred, in that the individual failed to follow the restoration instructions provided in STS GP-007. Additionally, it was determined the procedural enhancements (human-factoring) were needed. Corrective actions included counseling the individual and enhancements to the procedure. The corrective actions associated with this LER would not have prevented the incorrect application of TSC 033-85.