WOLF CREEK
NUCLEAR OPERATING CORPORATION

Neil S. "Buzz" Carns
Chairman, President and
Chief Executive Officer

November 5, 1996

WM 96-0120

U. S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Mail Station P1-137
Washington, D. C. 20555

Reference: Letter dated September 23, 1996, from T. P. Gwynn, NRC, to N. S. Carns, WCNOC
Subject: Docket No. 50-482: Response to Notice of Violations 50-482/9614-01, -02, and -03

Gentlemen:

This letter transmits Wolf Creek Nuclear Operating Corporation's (WCNOC) response to Notice of Violations 50-482/9614-01, -02, and -03. The first violation concerns WCNOC's failure to have procedures appropriate to the circumstances. The second violation concerns WCNOC's failure to correctly utilize locking hasps. The third violation concerns WCNOC's failure to follow established corrective action procedures. This response letter is being submitted after the thirty day due date with the concurrence of the Senior Resident Inspector and Mr. D. Graves, NRC Regior IV, per verbal discussion and telecon, with T. Damashek, WCNOC, on October 22, 1996, respectively.

WCNOC's response to these violations are in the attachment. If you have any questions regarding this response, please contact me at (316) 364-8831, extension 4100, or Mr. Terry S. Morrill at extension 8707.

Very truly yours,

Neil S. Carns

Neil S. Carns

NSC/jad

Attachment

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

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Reply to Notice of Violations 50-482/9614-01, -02, and -03

Violation 50-482/9614-01: Failure to establish procedures appropriate to the circumstances.

"A. Criterion V of Appendix B to 10 CFR Part 50 requires, in part, that activities affecting quality shall be prescribed by documented instructions, procedures, and drawings appropriate to the circumstances and shall be accomplished in accordance with these instructions, procedures, and drawings.

Contrary to the above, for work performed on July 31, 1996, licensee procedures were inappropriate to the circumstances in that they failed to control the planning of that work to specify criterion for when a work planner could mark the permission to start block on a work package "Not Applicable," and also permitted a single work package task to require work on both trains of safety-related system. Consequently, these programmatic deficiencies contributed to a work package being worked in the field without permission to start from the shift supervisor or central work authority per the approved schedule on Motor-Drive Auxiliary Feedwater Pump A, while Motor-Drive Auxiliary Feedwater Pump B was declared inoperable and removed from service for planned maintenance.

This is a Severity Level IV violation (Supplement I) (482/9614-01."

Admission of Violation:

Wolf Creek Nuclear Operating Corporation (WCNOC) acknowledges and agrees that a violation of Criterion V of Appendix B to 10 CFR Part 50 occurred on July 31, 1996, when work control procedures inappropriately allowed work to commence without the shift supervisor's permission and allowed one work package task to perform work on both trains of a safety system. This event was discovered by WCNOC system engineering personnel during field inspections associated with the work activity.

Reason for Violation:

Root Cause:

Two root causes and several contributing factors for this event were identified. The root causes are:

1. Management failed to reinforce previously established requirements pertaining to separation of train related work.

2. Inadequate placement of physical barrier - the sign placed on the door of the auxiliary feedwater pump room was intended to prevent exactly what happened. Due primarily to its placement it was not effective.

6. When work was approved to restart, all permissions to restart/start had to be re-authorized by the central work authority.

Additionally, the following corrective actions were implemented to control work on only the authorized train:

1. The daily risk awareness boards (which are posted at the plant entrance, work control center, and the control room) are prominently labeled with the authorized train for work that day. Plant personnel have been trained as to what the meaning is of this "authorized train" indication.

2. The authorized train is prominently discussed as the opening item in both the 0730 hour shift supervisor work meeting and the 0830 plant manager's meeting.

3. The authorized train is prominently displayed on the work group bulletin board by color coded engraved signs. These signs are placed on the bulletin board in advance of the maintenance personnel reporting for work at the beginning of each workday.

4. The workers and the work week manager involved were counseled as to the proper procedures to follow to prevent cross-train work.

5. Administrative Procedure AP 16C-003, "Work Package Task Planning," was revised. This revision clearly establish when the shift supervisor permission to start is required and to provide guidance on separate work package tasks for separate trains.

6. MIB-79 was revised to reflect the guidance placed in AP 16C-003.

7. Training was provided to the maintenance planning personnel to ensure they are aware of the requirements concerning when to notify the shift supervisor prior to starting work.

8. The work planning requirements were revised, to ensure a clear description of the scope and the train involved are contained in the work package. These requirements are part of the changes to AP 16C-003. The revision ensures that modifications or corrective maintenance which affect both trains, will be implemented by separate work package tasks.

9. Training was provided to all maintenance first line supervisors, maintenance planners, and work week managers, in the requirements to prevent cross-train work.

Corrective Steps That Will Be Taken And The Date When Full Compliance Will Be Achieved:

Management will provide communication of requirements and standards concerning cross-train work to all personnel reporting to the chief operating officer. This will be completed by November 15, 1996.

Physical barriers intended to prevent work form being performed on opposite train equipment during LCOs were assessed. These barriers will continue to be utilized where appropriate. They are adequate for use as an aid in reminding personnel of train work prohibitions, however, they are not the primary means to control cross-train work.

Contributing Factors:

1. Work instructions were inadequate. Though the work package contained instructions for work on both A and B trains, the "equipment listing" block of the work instructions only had room to list one train.

2. Scheduling was inadequate. Because the work package "equipment listing" block only referred to "B" train, the WCNOC Plan of the Day (POD), did not make reference to "A" train work as scheduled work. Thus, improper train work was scheduled.

3. Procedure guidance was inadequate. Guidance contained in Maintenance Information Bulletin (MIB-79) on when the shift supervisor's permission was required was weak and did not provide adequate instruction for the planner on when the shift supervisor permission to start block could be marked not applicable (N/A). In addition, this guidance was contained in a MIB and would have been more appropriately placed in the procedure.

Corrective Steps Taken and Results Achieved:

The auxiliary feedwater system engineer immediately reported the concern to the shift supervisor and the work control center. Subsequently the mechanical maintenance superintendent, the maintenance manager, and the plant manager were briefed.

Operability of the "A" train components was immediately assessed as satisfactory.

Representatives from operations, the work control center, maintenance, and system engineering met with the plant manager. The plant manager provided directions on long and short term actions.

All technical specification limiting condition for operation (LCO) work was immediately halted until the following actions were completed:

1. All packages were reviewed to verify that no additional "A" train work was included.

2. The schedule for the "B" train was reviewed to determine if any other "A" train work was scheduled. No other "A" train work had been scheduled

3. An assessment of ongoing work was conducted to determine if any other cross train work had occurred. No other cross-train work had occurred.

4. A "Stand-down" meeting with all craft personnel from the maintenance organization was held to re-emphasize: communications, self-checking, questioning attitudes, attention to detail and the prohibition of opposite train work.

5. Walkdowns were conducted for the "A" train auxiliary feedwater system, emergency diesel generator system, and the essential service water system by operations personnel to verify that no other work had been conducted. The "A" train was found to be satisfactory with no other work being performed on it during the period in question.

Full compliance has been achieved by implementation of the immediate corrective actions identified. All long term corrective actions to prevent recurrence will be completed by December 1, 1996.

Violation 50-482/9614-02: Failure to correctly utilize locking hasps.

"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.

Regulatory Guide 1.33, Appendix A, Section 1.c. requires procedures for equipment control (locking and tagging).

Administrative Procedure AP 21E-001, "Clearance Orders," Revision 3, Step 5.1.5, requires the 480 volt molded case motor control center breakers to be physically impaired by a secured lock hasp when used as an isolation device for a clearance order prior to the acceptance of the clearance.

Contrary to the above, on August 2, 1996, the electricians failed to install a secured lock hasp to 480 volt molded case Motor Control Center Breaker NG04DDF3 prior to maintenance technicians accepting the clearance.

This is a Severity Level IV violation (Supplement I) (482/9614-02)."

Admission of Violation:

Wolf Creek Nuclear Operating Corporation (WCNOC) acknowledges and agrees that a violation of Technical Specification 6.8.1.a, Regulatory Guide 1.33, and Administrative Procedure (AP) 21E-001 occurred on August 2, 1996, when the electricians failed to utilize the required locking hasps. This event was discovered by WCNOC operation's personnel during normal building watch tours.

Reason for Violation:

Root Cause:

The root cause of this violation is cognitive personnel error, in that, the responsible electrical maintenance personnel failed to demonstrate and use adequate attention to detail/self checking techniques during the breaker verification process for clearance order 96-1157KJ.

Contributing Factor:

Form APF 21E-001-01, "Clearance Order," did not contain a locking hasp installation signoff block that would remind the individual performing the verification that the hasp must be hung prior to accepting and signing the clearance order.

Corrective Steps Taken and Results Achieved:

Immediately upon discovery of the missing locking hasp the shift supervisor and supervising operator were notified.

The shift supervisor contacted electrical maintenance to re-verify breaker NG04DDF3 was de-energized and ordered a locking hasp be immediately installed on the breaker.

Performance improvement request 96-1942 was initiated to document the concern and its root cause and the appropriate corrective actions.

The appropriate disciplinary actions were implemented for the individuals who failed to install and verify installation of the locking hasp.

A meeting was held by the Chief Operating Officer (COO), with the Electrical Maintenance Superintendent, the responsible individual and the responsible individual's supervisor. This meeting was held to reinforce the COO's position on clearance order errors.

Form APF 21E-001-01 was revised, by On The Spot Change 96-0790. This change added a signoff block for the installation of the locking hasp.

Corrective Steps That Will Be Taken And The Date When Full Compliance Will Be Achieved:

The above corrective actions have been reviewed and determined to be adequate to prevent recurrence of this violation. Full compliance with the above noted requirements has been obtained and all corrective actions to prevent recurrence have been completed.

Violation 50-482/9614-03: Failure to follow established corrective action procedures.

"Criterion V of Appendix B to 10 CFR 50 requires, in part, that activities affecting quality shall be prescribed by documented instructions, procedures, and drawings appropriate to the circumstances and shall be accomplished in accordance with these instructions, procedures, and drawings.

Administrative Procedure AP 28A-001, "Performance Improvement Request," Revision 5, Step 5.1.3, requires personnel to immediately notify the duty shift supervisor/central work authority if a problem has the potential to affect plant operability.

Contrary to the above, on August 21, 1996, the shift supervisor was not informed after a maintenance engineer discovered that a safety-related switchgear breaker cubicle door to Breaker NB0114 opened when it was pushed by hand, bringing into question the corrective actions taken to address failed door latches repaired earlier in August 1996.

This is a Severity Level IV violation (Supplement I) (482/9614-03)."

Admission of Violation:

Wolf Creek Nuclear Operating Corporation (WCNOC) acknowledges and agrees that a violation of Criterion V of Appendix B to 10 CFR 50 and AP 28A-001 occurred on August 21, 1996, when the maintenance engineer discovered a latch for a safety-related breaker cubical failed to correctly restrain the cubical door and he did not immediately notify the appropriate WCNOC personnel.

Reason for Violation:

Root Cause:

The root cause of this violation is cognitive personnel error, in that, the responsible electrical maintenance personnel failed to comply with the requirements as established in Procedure AP 28A-001, "Performance Improvement Request."

Contributing Factor:

The failure on the part of management to enforce the fundamental company **requirements**, in such a manner as to ensure employee knowledge/understanding of programmatic requirements and promote modification of employee behavior.

Corrective Steps Taken and Results Achieved:

Corrective Actions - For Latch Related Concerns:

On August 22, 1996, the control room was notified of the condition observed on August 21, 1996.

On August 22, 1996, the failed latch was repaired.

Action Requests 16912 and 16913 were initiated to place all 4160 volt safety-related switchgear doors in conformance with manufacture's design requirements. Additionally, the crimp nuts were adjusted on all doors as needed.

Work packages 114777 and 114678, and MSR 960165 were implemented. These packages reworked the cubicle door latches and replaced parts as needed, returning the doors to manufacture's design requirements.

Procedure MPE E009Q-01, "13.8kv and 4.16kv Switchgear Inspection and Test," was revised, on September 26, 1996. This revision added a requirement to ensure door latch mechanisms will be inspected for proper function, during the routinely scheduled preventative maintenance activities.

Corrective Actions - For Failure To Notify Control Room:

The activities associated with this event were discussed in a meeting with maintenance planners. This discussion included the need to prevent becoming "over" familiar with equipment, the need to notify the control room prior to and upon completion of any inspection, and to inform the control room of any unusual condition or change to plant equipment which may have been noted during the inspection.

The Plant Manager, on September 6, 1996, issued letter WO 96-126 to all site personnel. This letter was also included in the site weekly news-letter (called CURRENTS). This letter reiterated, to all site personnel, the importance/requirement to notify the control room when any change of plant equipment is identified.

Training was held with all maintenance personnel to reiterate the management expectations initially conveyed by letter MD 96-0031. This training stressed the importance of notifying the control room when doing work on safety-related equipment, to immediately notify the control room when a concern is safety-related equipment is identified, and/or to notify the control room when performing troubleshooting activities on safety-related equipment as proceduralized in AP 16 C-001. Further, this training reiterated the importance of notifying the control room when all work activities are completed.

The planner involved in this event received disciplinary action.

To correct this and provide a basis for current and future behavioral modification needs, letter WM 96-0107, dated September 25, 1996, by the President and Chief Executive Officer, regarding fundamental company requirements. An example of these requirements, the relocation of a radiological barrier and posting by an unqualified individual, was provided in the letter. Corrective disciplinary action was also shared to emphasized the importance of these fundamental requirements. Administrative Policy, HR-160, "Standards Of Conduct, Rules And Discipline," was recommended for review to identify other personnel behaviors serious enough to warrant disciplinary action. This policy covers any conduct of WCNOC personnel and contractors that might have an adverse affect on the operation of this facility and its employees, or its relationship with the public. Communication between the managers, supervisors, and employees was encouraged to ensure questions were answered. To further convey the message contained in this letter a copy of the letter was published in CURRENTS.

Corrective Steps That Will Be Taken And The Date When Full Compliance Will Be Achieved:

Full compliance with the above noted requirements has been obtained and all corrective actions to prevent recurrence have been completed.