WOLF CREEK
NUCLEAR OPERATING CORPORATION

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President and
Chief Executive Officer

February 28, 1997

WM 97-0025

U. S. Nuclear Regulatory Commission
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Washington, D. C. 20555

Reference: Letter dated January 30, 1997, from J. E. Dyer, NRC, to N. S. Carns, WCNOC
Subject: Docket No. 50-482: Response to Notice of Violations 50-482/9624-01, -02 and -05

Gentlemen:

This letter transmits Wolf Creek Nuclear Operating Corporation's (WCNOC) response to Notice of Violations 50-482/9624-01, 02, and -05. Violation 9624-01 involves an operability evaluation for moisture intrusion into the turbine-driven auxiliary feedwater pump governor oil which was made without acknowledging or evaluating vendor requirements for the equipment. Violation 9624-02 involved Maintenance workers failing to follow procedures in not installing the spindle nut cotter pin in one of the main steam safety valves. Violation 9624-05 involved the failure to accurately document the basis for why a change to the Updated Safety Analysis Report did not involve an unreviewed safety question.

WCNOC's responses to these violations are in the attachment. If you have any questions regarding this response, please contact me at (316) 364-8831, extension 4000, or Mr. Richard D. Flannigan at extension 4500.

Very truly yours,

Otto L. Maynard

Otto L. Maynard

OLM/jad

Attachment

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

IE01

Reply to Notice of Violations 50-482/9624-01, -02, and -05

Violation 50-482/9624-01: An operability evaluation of moisture intrusion into the turbine-driven auxiliary feedwater pump governor oil was made without acknowledging or evaluating vendor requirements for the equipment.

"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, or drawings.

Procedure ADM 02-024, "Technical Specification Operability," requires operability determinations to include a determination of the requirement or commitment established for the equipment.

Contrary to the above, on December 6, 1996, at 2:38 p.m., the shift supervisor documented an operability determination for the turbine-driven auxiliary feedwater pump that identified a governor oil sample result of 3915 ppm water, but failed to acknowledge the vendor's technical manual limit of 5000 ppm and an intrusion rate of approximately 700 ppm per hour."

Admission of Violation:

Wolf Creek acknowledges and agrees that a violation of Criterion V of Appendix B to 10 CFR Part 50 occurred on December 6, 1996, when an operability determination for the turbine-driven auxiliary feedwater pump failed to consider relevant information in the vendor's technical manual.

Reason for Violation:

Root Cause:

The root cause for this event was personnel error on the part of the Shift Supervisor in that he did not exhibit a thorough questioning attitude. The Shift Supervisor accepted System Engineering input and conclusions without requiring System Engineering to perform an Evaluation of Nonconforming Conditions per procedure AP 28-001, "Evaluation of Nonconforming Conditions of Installed Plant Equipment." Poor communications between the Shift Supervisor and the System Engineer contributed to the Shift Supervisor's impression that no further information was needed to determine operability. All of the information evaluated by the System Engineer, concerning the ability of the turbine-driven auxiliary feedwater pump to perform its safety function, was not communicated to the Shift Supervisor.

The System Engineer had called the vendor, Dresser-Rand, to resolve the initial question of water intrusion in the turbine lube oil, but was unable to reach the appropriate person. The vendor manual, M-021-0086, available at the time of the event, indicated a limit of 5000 ppm water intrusion into the oil. The system was experiencing a water-intrusion rate of 700 ppm per hour while the pump was operating. The System Engineer then consulted a former employee of Dresser-Rand who is respected in the industry. That conversation led the System Engineer to conclude there was no operability concern, and that conclusion was given to the Shift Supervisor. On December 12, 1996, Dresser-Rand faxed information to the System Engineer which clarified the acceptability limits for moisture intrusion.

Based on the System Engineer's information, the log entry on December 6, 1996, briefly summarized the System Engineer's efforts to gather definitive

information, and the conclusion of there being no operability concern. On December 9, 1996, the Shift Supervisor supplemented the log entry to address concerns that the December 6, 1996, log entry was inadequate in that it did not meet the Manager Operations' expectations to make detailed log entries for operability evaluations. The extended evaluation on December 9, 1996, confirmed that the turbine-driven auxiliary feedwater pump was operable.

Corrective Steps Taken:

Procedure ADM 02-024, Revision 3, "Technical Specification Operability," was revised and is now AP 26C-004, Revision 0, "Technical Specification Operability." This revision added form APF 26C-004-01, "Technical Specification Operability Screening Checklist," which aids the Shift Supervisor in ensuring thoroughness of operability evaluations and consistency in documentation. This revision states that "When Technical Specification Operability is in question. . . an entry shall be made in the Shift Supervisor Log defining the concern, the potentially degraded safety function, the Technical Specification and/or USAR section affected, and the justification for the operability determination."

Performance Improvement Request (PIR 97-0181) which documented corrective actions to prevent recurrence of this event, was placed into Operations required reading on February 28, 1997.

The Shift Supervisor was counseled on December 7, 1996, and the Auxiliary Feedwater backup System Engineer was counseled on February 26, 1997, regarding lessons learned from this event.

Corrective Steps to Be Taken:

System Engineering will issue a revision to vendor manual M-021-0086 ensuring the manual reflects the correct information regarding acceptable moisture content in the turbine lube oil. This will be complete by July 25, 1997.

Violation 50-482/9624-02: The failure by Maintenance workers to follow procedures in not installing the spindle nut cotter pin in one of the main steam safety valves.

"B. 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 8.b.(a)(x), requires procedures for surveillance tests of main steam safety valves.

Surveillance Procedure STS MT-008, "Main Steam Safety Valve Settings," Revision 5, Step 7.11.1, required workers to install the spindle nut and spindle nut cotter pin.

Contrary to the above, on March 3, 1993, maintenance workers failed to install the spindle nut cotter pin on Valve AB V0046."

Admission of Violation:

Wolf Creek acknowledges that a violation of Technical Specification 6.8.1.a occurred on March 3, 1993, when Maintenance workers failed to install the spindle nut cotter pin on Valve ABV0046.

Reason for Violation:

Root Cause:

During November 1996, Wolf Creek inspected all of the Main Steam Safety Valves (MSSVs) specifically for verification that all spindle nut cotter pins were in place. This was the result of information of an event at another plant. During that inspection, one cotter pin was found missing on Valve ABV0046.

The root cause is failure to follow procedure due to procedure weakness. Steps are included in the procedure to install the cotter pin. However, the procedure, STS MT-008, Revision 7, "Main Steam Safety Valve Settings," had some weaknesses that could have contributed to the event. Section 4.0, "Precautions/Limitations," did not include a precaution that not installing the spindle nut cotter pin could, following an actuation, result in the valve not completely reclosing. Prior to step 8.11.1 which called for installation of the cotter pin, no information alerted the mechanic of the importance of ensuring the cotter pin is installed. After reassembly, the Quality Control verification only verified that a tag and safety seal were installed.

Corrective Steps Taken:

The spindle nut cotter pin was installed on valve ABV0046.

All installed and spare MSSVs were inspected to ensure the spindle nut cotter pin was installed.

Procedure STS MT-008, "Main Steam Safety Valve Settings," Revision 8, was issued December 20, 1996. This revision strengthens the procedure with an added note of precaution of specific information on the importance of the cotter pin being installed; an added specific sign-off for the installation of the cotter pin; and an added independent verification by Quality Control for the installation of the cotter pin.

Corrective Steps to Be Taken:

Maintenance personnel who supervise work on the subject equipment, and Quality Control inspectors who are qualified to independently verify the installation of the cotter pin, will receive retraining on this issue to reinforce the importance of the function of this cotter pin. Past procedure weaknesses will be part of this training to be completed by March 14, 1997.

Mechanical Maintenance and Maintenance Planning personnel who may perform or supervise performance of these functions will be retrained in the reassembly aspect of STS MT-008, Revision 8, "Main Steam Safety Valve Settings." This will be completed by March 14, 1997.

Procedure MCM M140-01, Revision 1, "Main Steam Safety Valve Maintenance," will be revised to provide further enhancements to correct similar weaknesses regarding installation of the spindle nut cotter pin. This will be completed by March 14, 1997.

Violation 50-482/9624-05: The failure to accurately document the basis that a change to the Updated Safety Analysis Report did not involve an unreviewed safety question.

"C. 10CFR 50.59 requires, in part, that licensees maintain a written safety evaluation which provides the bases for the determination that the change does not involve an unreviewed safety question.

Contrary to the above, on July 3, 1996, the licensee changed Section 16.3.1.5 and other sections of the Updated Safety Analysis Report without documenting an adequate basis that an unreviewed safety question was not involved in that the unreviewed safety question determination contained substantive errors.

Admission of Violation:

WCNOC acknowledges and agrees that a violation of 10CFR 50.59 occurred on July 3, 1996, when Section 16.3.1.5 and other sections of the Updated Safety Analysis Report (USAR) were changed without documenting an adequate basis that an unreviewed safety question was not involved in that the unreviewed safety question determination contained substantive errors.

Reason for Violation:

Root Cause:

The root cause of this event is personnel error in that the preparer and approver of the Unreviewed Safety Question Determination (USQD) 59 96-0075 for USAR Change Request 96-051 did not comply with section 5.2.4 and 6.7.2 of AP 26A-003, "Screening and Evaluating Changes, Tables, and Experiments."

Procedure AP 26A-003, Revision 1, "Screening and Evaluating Changes, Tables, and Experiments," indicates that preparers and approvers, by their signatures, certify that the information contained in the Regulatory Screening and USQD is complete and accurate. The USQD 59 96-0075 stated that the change to delete a requirement to report to the NRC on an inoperable monitoring system was not a regulatory requirement. However, for the Regulatory Guide 1.133, Section 5.b, WCNOC states that this reporting requirement should be in technical specifications. WCNOC USAR, Appendix 3A, indicates that WCNOC meets the requirements of this Regulatory Guide, with the exception being that this specification has been relocated to the USAR.

Corrective Steps Taken:

Performance Improvement Request (PIR) 97-0083 was initiated to evaluate this event.

The preparer and approvers of the USAR Change Request, Regulatory Screening, and USQD have been counseled relative to the errors made in the USAR Change Request and associated Screening and USQD.

Corrective Steps to Be Taken:

USAR Change Request 96-051 will be revised to include necessary changes to USAR Appendix 3A, as will the associated 50.59 Screening and USQD. This will be completed by March 14, 1997.

The content of all other USQDs performed by the preparer of USQD 59 96-0075 will be reviewed for error. This will be completed by March 14, 1997.

Since the occurrence of this problem, Engineering has implemented a Work Product Evaluation Process. Letter WM 96-0081, "Response to Enforcement Action EA 96-124," describes the implementation of this process.

Engineering Work Product Evaluations are used to re-inforce expectations involving completeness of documentation of work, attention to detail, and procedural compliance. Engineering Work Product Evaluations will assist in preventing problems such as the error made in USQD 59 96-0075.