UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
ATLANTA FEDERAL CENTER
61 FORSYTH STREET, SW, SUITE 23T85
ATLANTA, GEORGIA 30303-3415

June 4, 1998

[redacted] 7C

SUBJECT: RII-98-A-0011 - CONCERNS REGARDING CORRECTIVE ACTION PROBLEMS

Dear [redacted] 7C

This is in reference to the Nuclear Regulatory Commission (NRC) letter of February 5, 1998, which indicated that we would initiate action to review your concerns related to the way Condition Reports (CR) were investigated, CR program ineffectiveness in preventing error recurrence, and CR investigation results often being turned down by management.

The NRC has completed its follow up in response to the concerns you brought to our attention on [redacted] and our evaluation is provided in the enclosures. Based on the information you provided, the concerns were partially substantiated. Violations or deviations of regulatory requirements were not identified. 7C

Thank you for informing us of your concerns. We feel that our actions in this matter have been responsive to those concerns. We take our safety responsibilities to the public very seriously and will continue to do so within the bounds of our lawful authority. Unless the NRC receives additional information that suggests that our conclusions should be altered, we plan no further action on this matter. Should you have additional questions, or if I can be of further assistance in this matter, you may contact me at 800/577-8510 or 404/562-4540 or by mail at P.O. Box 845, Atlanta, Georgia 30301.

Sincerely,

Michael E. Ernstes

Michael E. Ernstes, Acting Chief
Reactor Projects Branch 4
Division of Reactor Projects

Enclosure: (See page 2)

Certified Mail No. P 485 920 218
RETURN RECEIPT REQUESTED

In accordance with the Freedom of Information Act, exemptions 7C
FOIA- 2001-0130

D116

[redacted]

Enclosures:
1. Allegation Evaluation Report
2. NRC Inspection Report 50-400/97-04, Section 08.1 and NOV
3. Harris SALP Report 50-400/98-99
4. NRC Inspection Report 50-400/97-12, Sections 07.2 and 07.3
5. NRC Inspection Report 50-400/98-01, NOV's Sections 08.1 and E8.1

[redacted] TC

Enclosures:
1. Allegation Evaluation Report
2. NRC Inspection Report 50-400/97-04, Section 08.1 and NOV
3. Harris SALP Report 50-400/98-99
4. NRC Inspection Report 50-400/97-12, Sections 07.2 and 07.3
5. NRC Inspection Report 50-400/98-01, NOV's Sections 08.1 and E8.1

bcc w/encls: O. DeMiranda, EICS (Signed Letterhead & ~~E-Mail~~) Disc

* WARNING * NO COPIES SENT TO PUBLIC DOCUMENT ROOM				
OFFICE	RII:DRS	RII:DRS		RII:
Signature		ODM		
NAME	JBrady	ODeMiranda		
DATE	5/ /98	6/4 /98	9/ /97	9/ /97
COPY	YES NO	YES NO	YES NO	YES NO
OFFICIAL RECORD COPY:EICS				

[redacted] TC

Enclosures:
1. Allegation Evaluation Report
2. NRC Inspection Report 50-400/97-04, Section 08.1 and NOV
3. Harris SALP Report 50-400/98-99
4. NRC Inspection Report 50-400/97-12, Sections 07.2 and 07.3
5. NRC Inspection Report 50-400/98-01, NOV's Sections 08.1 and E8.1

bcc w/encls: O. DeMiranda, EICS (Signed Letterhead & E-Mail)

* WARNING * NO COPIES SENT TO PUBLIC DOCUMENT ROOM				
OFFICE	RII:DRS	RII:DRS		RII:
Signature	JBB			
NAME	JBrady	ODemiranda		
DATE	6/2 /98	6/ /98	9/ /97	9/ /97
COPY	YES NO	YES NO	YES NO	YES NO
OFFICIAL RECORD COPY:EICS				

ALLEGATION EVALUATION REPORT

ALLEGATION RII-98-A-0011

HARRIS NUCLEAR PLANT

DOCKET NO. 50-400

CONCERN:

Real causes and root causes are not always being addressed for the following two reasons:

1. Supervisors are allowed and often encouraged to do Condition Report investigations for their own errors. At times they counsel themselves as corrective action. This may be one reason the CR program is ineffective in preventing error recurrence.

2. Condition report investigation results are often turned down by management if they make management look unfavorable (CR 97-05121).

DISCUSSION ITEM 1:

Condition Report 97-02173, [redacted] identified where an event review team leader was not independent of the event (CR 97-01348). The root cause investigation was for NRC Violation 50-400/97-04-02, example 1, boron dilution event, which was led as event team leader by the shift superintendent of operations responsible for the operations shift involved. Procedure AP-605, Root Cause Investigation, revision 16, section 5.2 indicated that the event review team leader should be independent of the event. The CR was initiated from a PNSC review of the root cause investigation. The root cause investigation for CR 97-1252, issued for violation 50-400/97-04-02, example 3, was also led by the shift supervisor. LER 97-007-00, written from the root cause investigation, was identified as not addressing a root cause in Inspection Report 97-04-02, section 08.1. This was not attributed to a lack of independence. The contention by the [redacted] related to investigation independence was true for these two cases. The operations organization stopped assigning root cause investigations to shift personnel due to CR 97-02173 and policy established by the new operations manager.

The information provided by the [redacted] indicated that corrective actions for operator performance problems had not been effective. In addition, the information, which related to components found in unexpected/undocumented conditions, indicated a trend of problems which had not been effectively corrected.

The SALP Report (50-400/98-99) cover letter to CP&L stated that Operations management has reversed a negative trend of operator performance errors that occurred early in the assessment period. Continued management focus on the reduction of operator errors is needed to prevent the cyclic performance

observed in this and previous assessments. It further stated that trending and corrective action was not always effective.

The SALP Report stated in the Operations section that early in the period, there was a negative trend in the number and significance of operator performance errors. Many of the errors were caused by operator inattention to detail and poor communications. Some of the causes of the errors were attributed to training program deficiencies. Management has taken a number of initiatives to strengthen the performance of the operations and training staff, and returned performance to superior. It further stated that the ineffective trending of identified problems and the lack of effective corrective action in some cases has contributed to the recurrence and longevity of some performance problems.

Inspection Report 50-400/97-12 Section 07.2 concluded that improper classification of significance and inconsistent trending of adverse conditions has contributed to the recurrence and longevity of some performance issues. Section 07.3 concluded from a sampling of significant condition reports that root cause investigations, if performed, were effective. However, justification of root cause waivers, closure documentation errors, and implementation of corrective actions resulted in missed opportunities to conduct complete and comprehensive reviews.

Inspection Report 50-400/98-01, Section E8.1 concluded that condition report trending had not revealed a trend related to the steam generator blowdown events, which had resulted in a lack of management attention prior to the event. NRC Inspection Report 50-400/97-12 reviewed trending and concluded that inconsistent trending had contributed to the significance and longevity of some performance issues. The steam generator blowdown water hammer event was an example consistent with those conclusions.

The information provided by the [redacted] is consistent with NRC conclusions about the corrective action program and corrective action program trending. The condition reports provided by the [redacted] in some cases related to NRC violations for inadequate corrective action. The Inspection Reports and SALP report provided the licensee a message that the corrective action program was not always effective. When not effective, and repetition of a problem occurred, trending was not always effective in identifying the repetitive nature. These factors have contributed to the longevity of some problems.

DISCUSSION ITEM 2:

The inspectors reviewed Condition Report 97-05121 during review of Violation 50-400/97-09-02, Failure to properly check main control room chart recorder, in NRC Inspection Report 50-400/98-01, Section 08.1 as discussed below:

> (Open) Violation 50-400/97-09-02: Failure to properly check main control room chart recorder. The inspector reviewed the violation response, dated November 12, 1997 and the licensee's corrective actions which were described to be complete by December 1, 1997. The corrective actions were completed, but were not effective, as evidenced by an additional occurrence identified by the licensee. However, the licensee

also chose not to close the condition report for the violation based on the additional occurrence. Condition Reports 97-05121 and 97-05167 were written to address the additional instance which occurred on November 30, 1997 where main control room chart recorders were not properly marking and were not detected by the operators over two shift turnovers and one marking period.

The inspector reviewed the root cause investigation for the additional occurrence, completed on December 18, 1997, which identified that the wide range recorder for steam generator "B" was not marking on recorder LR-477 (green pen). In addition, the root cause investigation identified that the chart had not been set on the correct time and was approximately 12 hours off. Procedure OMM-16, Operator Logs, Revision 14, states in paragraph 5.1.2.b that the chart recorders are to be checked once per shift to ensure that they are marking properly and timing correctly. The chart had not been timing correctly and nine different individuals had not identified this although the chart was initialed and marked with the time the check was performed. The inspector found that the root cause investigation findings collectively displayed a general misunderstanding of the OMM-16 requirement and management expectations for its implementation.

The inspector discussed this root cause investigation with the licensee who intends to address the timing aspect during real time training for the operators (an identified corrective action in the root cause investigation). The licensee stated that the failure to time the recorder properly was listed as an inappropriate act in the initial version of the root cause investigation, but was removed in the final version. That decision was based on focussing on recorder pen marking as opposed to the broader issue of operators checking the recorders once per shift to ensure they would perform their function of trend recording (marking and timing correctly). After discussion with the licensee, the licensee informed the inspector that corrective actions identified in the root cause were being reassessed and that a revised response to violation 50-400/97-09-02 was being prepared.

This is considered an additional example of failing to implement procedure OMM-16 as required by TS 6.8.1.a. This failure to follow procedures is designated violation 50-400/98-01-01, example 1; Failure to Properly Check Main Control Room Chart Recorders.

The licensee identified an additional example of failing to ensure main control room chart recorders were properly marking and timing, which was identified as a violation. Corrective action for violation 50-400/97-09-02 had not been effective and additional corrective actions were identified from a root cause investigation of the additional occurrence. The root cause investigation found that chart recorder timing had not been properly checked but it was not addressed as an inappropriate act because the investigation was focussed on marking only. The narrow focus diluted the significance of the overall finding of the investigation.

The inspector found that licensee management was narrowly focussed on this issue, but found no evidence that the inappropriate act was deleted to prevent management from looking unfavorable. The inspectors were aware of the CR 97-05121 and its relation to the previous violation prior to receiving the allegation. This CR was already planned to be reviewed by the inspectors during violation followup and closeout.

CONCLUSION:

Based on the information provided, this allegation was partially substantiated in that independence problems existed and that the NRC has concluded that corrective action problems exist which have contributed to the recurrence and longevity of some problems.