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NOP-LP-2001-01

CONDITION REPORT

CR Number 02-01850

TITLE: COMPROMISED STANDARDS

The effectiveness review for CR 1998-0020 (QAD-00-80159) documents that the preventive actions resulted in reviews being performed that generally determined no substantial changes were required or implemented. The effectiveness review was reviewed by and approved by the SRB. A thorough root cause for CR 2002-00891 would have included a review of these failed opportunities to correct organizational and management weaknesses and consequently proposed more rigorous, effective preventive actions to ensure we actually improve versus deciding everything is fine the way it is.

The publishing of the root cause for CR 2002-00891 to the world despite that fact it clearly does not meet our procedural requirements and expectations compromises our standards. It falsely communicates to the world that we have low standards for our corrective action process, when in fact the majority of our root and basic causes are rigorous and performed in a thorough manner utilizing appropriate root cause techniques.

The issue of not following our process for processing CR 2002-00891 is compounded by the fact we have elected to not enter the preventive actions into the CREST system. This increases the likelihood we will not take timely corrective action since we are not utilizing the normal method for assigning and tracking work.

SUPV COMMENTS / IMMEDIATE ACTIONS TAKEN (Discuss CORRECTIVE ACTIONS completed, basis for closure.)

The purpose of this CR a to request a root cause investigation into the management culture that allowed us to publish a document to the world that we knew did not meet our expectations. It is acknowledged that we technically have not violated our procedures yet, because we have not closed the CR in CREST. However, this does not nullify the cultural issues that exist that allowed us to reach our present state.

QUALITY ORGANIZATION USE ONLY	IDENTIFIED BY (Check one)	ATTACHMENTS
Quality Org. Initiated ☐ Yes	☐ Individual/Work Group ☐ Self-Revealed	
Quality Org. Follow-up ☐ Yes ☐ No	☑ Supervision/Management ☐ Internal Oversight	☐ Yes ☑ No
	☐ External Oversight	

ORIGINATOR	ORGANIZATION	DATE	SUPERVISOR	DATE	PHONE EXT.
MCALLISTER, A	PE	5/3/2002	MCALLISTER, A	5/3/2002	7420

PLANT OPERATIONS

SRO REVIEW	EQUIPMENT OPERABLE	EVALUATION REQUIRED	IMMEDIATE INVESTIGATION REQUIRED	ORGANIZATION NOTIFIED	MODE CHANGE RESTRAINT
☐ Yes ☑ No	☐ Yes ☐ No ☑ N/A	☐ Yes ☑ No	☐ Yes ☑ No	N/A	☐ Yes ☑ No

MODE	ASSOCIATED TECH SPEC NUMBER(S)	ASSOCIATED LCO ACTION STATEMENT(S)
N/A	N/A	N/A
		#2

DECLARED INOPERABLE (Date / Time)	REPORTABLE?		APPLICABLE UNIT(S)
N/A	☐ Yes ☑ No	One Hour N/A	☑ U1 ☐ U2 ☐ Both
	☐ Eval Required	Other N/A	

COMMENTS

N/A

Current Mode - Unit 1	Power Level - Unit 1	Current Mode - Unit 2	Power Level - Unit 2
N/A	N/A	N/A	N/A

SRO - UNIT 1	SRO - UNIT 2	DATE
Approved By Supv	N/A	5/3/2002

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CONDITION REPORT

CR Number 02-01850

TITLE: COMPROMISED STANDARDS

DISCOVERY DATE	TIME	EVENT DATE	TIME	SYSTEM / ASSET#
5/3/2002	N/A	4/17/02	N/A	N/A N/A

EQUIPMENT DESCRIPTION N/A

ORIGINATION

DESCRIPTION OF CONDITION and PROBABLE CAUSE (If known) Summarize any attachments. Identify what, when, where, why, how.

The root cause completed for CR 2002-00891 (Significant Degradation of the Reactor Pressure Vessel Head) did not comply with the procedural requirements of NOP-LP-2001 and the Davis-Besse Condition Report Process Programmatic Guideline. The quality of this root cause report is significantly below that of root and basic causes that have been rejected by the Corrective Action Review Board (CARB).

Some of the deficiencies in CR 2002-00891 root cause report are as follows:
- There is no connection between the data collected, the identified causes, and the preventive actions. The conclusions reached are disconnected from the data presented, with no supporting data for many of the conclusions.
- Preventive Actions do not adequately prevent or mitigate the causes identified. For example, there is no action to eliminate the alloy 600 material for the CRDM nozzles, therefore PWSCC cracking of the nozzles will continue.
- Preventive actions do not exist for some of the identified causes. For example, no preventive action is proposed for correcting the fact that engineering supervisors are reassigned to outage tasks and therefore not available to provide adequate supervisory control during outages.
- The Management portion of the investigation was not performed by qualified individuals, nor was a root cause technique employed for this portion of the investigation.
- The Management portion of the investigation was superficial and did not adequately investigate why the corrective actions from CR 1998-0020 (Lack of comprehensive actions for RC-2 boric acid wastage) were not effective in preventing this event.

The root cause report correctly identifies that "rigorous adherence to the corrective action process would have provided an opportunity to address head leakage at an earlier time." Likewise, if we rigorously adhere to the corrective action process in the investigation of this condition report, we would be much more likely to identify the true root causes and implement effective preventive actions.

CR 1998-0020 (Lack of comprehensive actions for RC-2 boric acid wastage), was initiated to conduct an independent review of the management issues associated with the RC-2 packing leak. The CR identified the root causes as 1) Less than adequate (LTA) Management expectations/standards that resulted in: LTA problem solving and condition evaluations, LTA decision making, LTA RCS leakage standards, LTA procedure requirements for boric acid corrosion control, Lack of Nuclear Assurance oversight of a significant issue. 2) LTA Management follow-up and monitoring of emerging issues that resulted in: being reactive, rather than proactive, over-reliance on the Corrective Action Program to manage a significant issue, Lack of priorities for completing work considering the significance and potential consequences of the condition. 3) LTA vertical/lateral integration (pertinent information not transmitted) that resulted in: incomplete and misleading communication, incomplete awareness of the boric acid buildup, lack of management awareness of the extent of condition results, responsibilities of personnel not well defined. Contributing Causes listed were: 1) LTA Supervisory Oversight that resulted in: not following procedures and maintenance work orders, poor field work practices, poor job planning, LTA work completion as planned, poor tracking of work progress or follow-up. 2) LTA training and qualifications that resulted in: low experience with boric acid leakage, little appreciation for the rapid boric acid corrosion effects. These causes appear to have still been present for the condition documented on CR 2002-00891.