

WOLF CREEK

NUCLEAR OPERATING CORPORATION

Bart D. Withers
President and
Chief Executive Officer

March 15, 1990
WM 90-0067

U. S. Nuclear Regulatory Commission
ATTN: Document Control Desk
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Washington, D. C. 20555

Reference: Letter dated February 13, 1990 from S. J. Collins, NRC,
to B. D. Withers, WCNOC

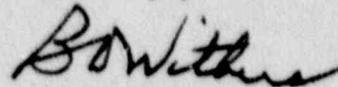
Subject: Docket No. 50-482: Response to NRC Inspection Report
482/8926

Gentlemen:

Attached is Wolf Creek Nuclear Operating Corporation's (WCNOC) response to violations 482/8926-01 and 02 which were documented in the Reference. Violation 482/8926-01 involved a failure to appropriately log a Safeguards Events and violation 482/8926-01 involved the failure to adequately control Safeguards Information. The response to these violations does not contain any Safeguards Information.

If you have any questions concerning this matter, please contact me or Mr. H. K. Chernoff of my staff.

Very truly yours,



Bart D. Withers
President and
Chief Executive Officer

cc: R. D. Martin (NRC), w/a
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Violation (482/8926-01) Failure to Log Safeguards Events

Finding:

10CFR73.71(c)(1) states, in part, that each licensee subject to the provisions of 10CFR73.55 shall maintain a current log and record the safeguards events described in Appendix G, of this part. Recording within 24 hours of discovery by the licensee is required. Paragraph II(a) of Appendix G specifies events that include failures, degradations and vulnerabilities of the safeguards system.

Contrary to the above, the inspector identified eight licensee-identified safeguards events that involved inadequate controls over Safeguards Information that occurred during the period September 1987 through September 1989 but which were not logged.

Reason For Violation:

The reason for this violation was failure of the Security group to log within 24 hours the loss of control of Safeguards Information (SI) that could not significantly assist an individual in an act of radiological sabotage or theft of special nuclear material. The first loss of control of SI that occurred following the revision to 10 CFR 73.71, which was effective on October 8, 1987, was discovered on December 1, 1987. Within two hours of discovery, this event was properly logged in accordance with the requirements of 10 CFR 73.71(c)(1). Initially after the issuance of the revisions to 10 CFR 73.71 in October, 1987, the Security organization conservatively addressed the first SI control event identified to that organization by logging the event. However, when the next SI control event was identified to the Security organization, a review of Regulatory Guide 5.62 led Security personnel to conclude that if a SI control event was not determined to be "one-hour" reportable that no further reporting/logging was required. Security personnel were not cognizant of the additional guidance related to this subject provided by NUREG-1304, "Reporting of Safeguards Events". This resulted in a failure to properly log all subsequent SI control events prior to October 25, 1989.

Corrective Steps Which Have Been Taken and Results Achieved:

The following activities have been completed.

1. 10 CFR 73.71, Appendix G was reviewed to determine if any reporting requirements were not properly reflected in Security and Operations procedures. No overlooked requirements were discovered. Regulatory Guide 5.62 and NUREG-1304 were also reviewed to ensure a thorough understanding of the guidance was provided in these documents.
2. KGP-1106, "Controlling Safeguards Information" has been revised to require timely reporting of SI control events to Security management so that significance determinations are initiated promptly.

3. The appropriate Security personnel have been trained and the Security procedure has been revised to ensure that future SI control problems which are determined to be not significant are appropriately logged.
4. In order to assist in determining reportability of potential SI compromises, SI event significance guidelines have been developed to ensure that each such occurrence is reviewed consistently and correctly.

On October 25, 1989 as a result of an NRC inspection it was identified that SI control events had not been properly logged since December 1, 1987. On October 26, 1989, a generic log entry was made concerning this situation indicating that the specific details of each event would be provided in LER 482/89-S02. Since that time, all SI control events have been properly logged or reported in accordance with 10 CFR 73.71.

Corrective Steps Which Will be Taken to Avoid Further Violations:

The corrective actions described above will ensure correct reporting of SI events.

Date When Full Compliance Will be Achieved:

Full compliance has been achieved.

Violation (482/8926-02): Failure to Adequately Control Safeguards Information

Finding:

10CFR73.21(d)(2) states, in part, that "While unattended, Safeguards Information shall be stored in a locked security container."

Contrary to the above, the licensee identified 16 instances when unattended Safeguards Information was not stored in a locked security container. The events occurred between September of 1987 and November of 1989.

Reason For Violation:

As a result of the problems identified with the control of Safeguards Information (SI) and an increase in the frequency of SI control events during the summer of 1989, Wolf Creek Nuclear Operating Corporation (WCNOC) established two successive task forces to address problems with control of SI. In addition, self-imposed SI work stoppages were instituted by Nuclear Plant Engineering and subsequently Management Systems. These organizations were required to handle the largest volume of SI on a daily basis and were involved in majority of SI control events (this work stoppage was subsequently rescinded based on the implementation of enhancements to the SI control programs). Furthermore, Quality Assurance issued a Corrective Action Request (CAR) 26 to address adverse conditions related to the control of SI. A CAR is the highest tier corrective action document initiated by Quality Assurance to obtain corrective action to conditions adverse to quality. Personnel assigned to the task forces and responding to the CAR were directed to determine the root cause(s) for the excessive number of SI control events.

Wolf Creek Licensee Event Report (LER) 89-S02-00 dated October 25, 1989, described the first task force's determination that the identified events occurred as a result of human performance problems. Although no single root cause could be identified, two causal factors related to the majority of the events were identified. The first causal factor identified was a poor understanding of SI handling requirements, significance of errors and the resulting consequences. This poor understanding was determined to be the result of a lack of effective training. The other major causal factor was identified as a lack of self-verification or inattention to detail. The sheer volume of SI handled on a daily basis by Nuclear Plant Engineering and Management Systems personnel was identified as being a prominent contributing factor.

The first task force reviewed corrective actions taken in response to each event in an effort to evaluate the effectiveness of these actions in preventing event recurrence. This task force concluded that the corrective actions were event specific and therefore not completely effective in preventing subsequent SI control events for the overall project. Therefore, several immediate and long term corrective actions were undertaken to strengthen the overall programmatic controls of SI.

However, before sufficient time had passed to see effective results from these corrective actions additional SI control events occurred. As a result, organizations which were still having problems working with SI imposed work stoppages on themselves. The Quality Assurance organization issued CAR 26 to the Vice-President Engineering and Technical Services on December 19, 1989 because of these continuing events. At this time the initial task force was disbanded and a second task force was formed to address CAR 26.

The second task force reviewed all SI control events since September 1987 and came to essentially the same conclusions concerning root causes as did the first task force:

- 1) The governing procedure for SI control activities was poorly written;
- 2) Training associated with the understanding of the governing procedure was inadequate and;
- 3) Personnel possessed an indifferent attitude towards SI protection.

Additionally, the task force identified another root cause not previously pointed out, that WCNO's focus on the SI events was diffused due to the lack of a centralized identification process of and adequate management or third party trending program.

WCNO's root cause determinations have found that several reasons played a part in this violation including ineffective training, inattention to detail, weak procedures, lack of trending, and personnel indifference towards SI.

Corrective Steps Which Have Been Taken and Results Achieved:

Several Programmatic Deficiency Reports and the CAR have been initiated to track and document SI program corrective actions. During the course of completing these corrective actions, additional missing SI documents have been identified and additional SI control events have occurred. Each event has been evaluated and it has been determined that no significant SI compromises have occurred.

The following activities described in the LER or undertaken as a result of the CAR have been completed:

1. The General Employee Training (GET) Handbook and lesson materials have been revised to emphasize that SI is required to be protected and to identify the required actions if an event involving potential loss or compromise of SI is discovered.
2. General procedure KGP-1106, "Controlling Safeguards Information", has been revised to clarify the requirements listed above in 1. All safeguards information custodians (SICs) and SI recipients received training on these initial revisions to KGP-1106.
3. KGP-1106 was further revised to improve its level of readability and to focus on detailed instructions for:
 - a. responsibility
 - b. authority
 - c. accountability
 - d. event and control problem identification and follow-up
 - e. magnetic media handling

KGP-1106 was also revised to require retraining on SI handling requirements on an annual basis or when the procedure is significantly revised for all SICs and SI Recipients.

4. A centralized SI indexing system has been developed.
5. A company wide audit of all SI cabinets was completed.
6. SI cabinets have been relocated out of high traffic areas. SI cabinets have been consolidated into centralized locations where practicable.
7. Lockable SI "working areas" have been established in the Northrock Office Building and the Construction Administration Building. The majority of SI work in these two buildings now takes place in these "working areas".
8. Work practices have been changed to emphasize the need to maintain separation of SI and non-SI documents during normal activities.
9. Security procedures have been revised to ensure that the appropriate compensatory measures requirements are considered upon determination of an SI event.

Corrective Steps Which Will Be Taken To Avoid Further Violations:

The following activities described in the LER or undertaken as a result of the CAR are still in process:

1. Through the establishment of the SI centralized indexing system and SI cabinet contents audits, material is being identified for declassification and destruction. These SI volume reduction activities are being handled as a long-term improvement item. Training material on SI handling given to SICs will stress that volume reduction activities they undertake will reduce the complexity of their custodial responsibilities.
2. SICs and SI Recipients will be trained on the revised KGP-1106.
3. Reviews will be made to determine if all SI events since January 1, 1987 have been discovered. An evaluation will be conducted of any additional events identified.
4. Reviews will be made to identify and resolve sub-tier procedural conflicts with KGP-1106.
5. Reviews of SI event precursors and corrective actions will be undertaken to determine appropriate future trending activities.
6. The trending program implemented by Quality Assurance will be revised to include SI control events.

Date When Full Compliance Will Be Achieved:

The corrective actions described above which are still in process will be complete by July 30, 1990.