WOLF CREEK
NUCLEAR OPERATING CORPORATION

March 10, 1995

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

WM 95-0044

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

Reference: 1) Letter dated November 16, 1994, from T. P. Gwynn, NRC, to N. S. Carns, WCNOC
2) Letter WO 94-0220 dated December 30, 1994, from O. L. Maynard, WCNOC, to the NRC
3) Letter dated February 10, 1995, from J. M. Montgomery, NRC, to N. S. Carns, WCNOC

Subject: Docket No. 50-482: Reply to Notice of Violation 482/9413-02

Gentlemen:

Attached is Wolf Creek Nuclear Operating Corporation's (WCNOC's) response in reply to your request (reference #3) for revised corrective actions for Notice of Violation 482/9413-02 (reference #1). WCNOC submitted its initial response to the notice of violation in reference 2.

Violation 482/9413-02 concerned WCNOC's failure to implement corrective action requirements in accordance with 10 CFR 50, Appendix B, Criterion XVI.

WCNOC has re-reviewed Violation 9413-02 and agrees that a violation of Criterion XVI did occur and that the additional corrective actions discussed in the attachment will ensure the proper implementation of the Corrective Action Program. WCNOC's revised response to the Notice of Violation is in the Attachment to this letter.

If you should have any questions regarding this response, please contact me at (316) 354-8831, extension 4001, or Mr. Richard D. Flannigan at extension 4500.

Very truly yours,

Neil S. Carns

NSC/jra
Attachment

cc: L. J. Callan (NRC), w/a
D. F. Kirsch (NRC), w/a
J. M. Montgomery (NRC), w/a
J. F. Ringwald (NRC), w/a
J. C. Stone (NRC), w/a

JE01

Reply to Notice of Violation 9413-02

Violation 482/9413-02: Failure to implement corrective action requirements in accordance with 10 CFR 50, Appendix B, Criterion XVI.

"B. Criterion XVI of Appendix B to 10 CFR Part 50 requires, in part, that measures shall be established to assure that conditions adverse to quality, such as failures, malfunctions, deficiencies, deviations, defective material and equipment and nonconformances are promptly identified and corrected. Licensee Procedure KGP-1210, "Performance Improvement Requests," Revision 10, requires that reported conditions be screened for significance, reportability, and operability.

Contrary to the above, the licensee failed to perform an adequate screening for significance, reportability, and operability following the "B" emergency diesel generator static exciter-voltage regulator failure 2 weeks after the near identical "A" unit failure. A performance improvement request was not initiated and no documented screening was available during the inspection. This failure to use the corrective action system as designed resulted in a failure to adequately evaluate the continued operability of the emergency power sources with the potential for a known failure mechanism not previously recognized or considered. Therefore, the operability of both emergency power sources was questionable from October 11, 1994, until administrative controls to assure operability were established just prior to entering Mode 4 on October 24, 1994."

Admission of Violation:

WCNOC agrees that a failure to meet the requirements of 10 CFR 50, Appendix B, Criterion XVI occurred when the responsible Wolf Creek Nuclear Operating Corporation (WCNOC) personnel failed to initiate a Performance Improvement Request (PIR) subsequent to the "B" Emergency Diesel Generator (EDG) Static Exciter-Voltage Regulator (EDGSEVR) failure.

Reason for Violation:

Root cause:

The root cause of this violation is cognitive personnel error, in that the responsible WCNOC personnel failed to follow procedure KGP-1201, "Corrective Action," and initiate a PIR subsequent to the EDGSEVR "B" failure. Responsible personnel involved with the incident investigation team (IIT) were unaware of, or misunderstood the requirement to issue a PIR to document the hardware failure analysis investigation of the EDGSEVR "B" failure. The root cause of this portion of the violation is, therefore, a failure to ensure that personnel were aware of and understood the administrative procedural requirements. Also, the following contributing factors led to this violation. Note that these factors state situations at the time of the event.

Contributing Factors:

The requirement to initiate a PIR for formal root cause evaluation of significant hardware failures is contained in procedure KGP-1201, "Corrective Action." This procedure serves to provide an overall program description and guidance to the user of the program. Procedure KGP-1210, "Performance Improvement Request," indicated that the initiation of a PIR to document root cause and corrective action for hardware failures is optional. The lack of clear and consistent guidance is considered a contributing factor to this problem.

Procedure AP 34E-001, "Self Assessment," defined the self assessment program used by WCNOC. The program is utilized for systematic incident investigation of management issues or significant events. This program is also utilized to evaluate the effectiveness of organizational and/or program performance. Although the IIT process meets the requirements of a corrective action program, it is not clearly identified as such. The previous IIT procedure revision which combined the IIT process with the self assessment process made it less clear as to the purpose and function of an IIT.

Following the EDGSEVR failure and fire in EDG "A" on September 30, 1994, PIR 94-1680 documented the event and was issued on October 1, 1994. Since a PIR (i.e., a corrective action vehicle) had already been issued after the EDG "A" failure and was open at the time of the similar EDG "B" failure on October 11, 1994, and a formal IIT had already been formed, it was deemed that there was no need for a separate PIR concerning the EDG "B" failure in the minds of management personnel involved in this investigation. This thought process established a preconceived mind-set that reinforced the lack of concern regarding the fact that a new PIR was not initiated.

Corrective Steps Taken and Results Achieved:

Although no PIR was initiated upon the failure of EDGSEVR "B," several actions were taken to consider the significance of the event and to ensure the operability of both EDGs:

- On October 10, 1994, work request (WR) 05374-94 was initiated to identify the hardware nonconformance and correct the equipment failure. Procedure ADM 01-057, "Work Request," requires a screening for operability and reportability be performed by the Shift Supervisor. This evaluation was performed as required for WR 05374-94.

- The Vice President Plant Operations requested the initiation of an IIT which was to be directed by the Vice President Engineering. The IIT was formed due to the significance of the failed equipment and the potential for a common mode failure mechanism.

- Operability and reportability were considered for the subject failures both before and throughout the IIT investigation. The Operations Department and the IIT were confident that the "A" EDG remained operable following the "B" EDG transformer failure. EDG "B" was out-of-service following the EDGSEVR failure and remained out of service during the IIT investigation. In

addition, as stated in IIT Report 94-05, the operability of the EDG "A" was uppermost in the minds of the team throughout the investigation. At no time was EDG "A" considered to be inoperable based upon the known facts.

In addition several conservative actions were taken to minimize the risk while the investigation proceeded. These actions were consistent with the guidance provided in Generic Letter 91-18, "Information To Licensees Regarding Two NRC Inspection Manual Sections On Resolution Of Degraded And Nonconforming Conditions And On Operability." These actions included:

- On October 11, 1994, the Vice President Plant Operations established an administrative requirement which required the Operations Department to obtain his permission prior to lowering the level in the refueling pool below 23 feet above the reactor vessel flange.

- On October 12, 1994, at the request of the IIT, the Shift Supervisor authorized electrical maintenance to check the input fuses to each of the redundant power amplifiers for the "A" EDG exciter. After determining that all input fuses were satisfactory the Shift Supervisor was instructed not to operate the EDG's in parallel pending further investigation by the IIT.

- The IIT requested that electrical maintenance check the power amplifier fuses after each EDG run. This requirement was noted on the Operations Outage Turnover sheet until a formal contingency plan was developed and implemented on October 20, 1994.

- On October 24, 1994, procedure changes and training, for the operating crews, were completed and the necessary administrative controls were in place prior to entering MODE 4.

Work requests were initiated immediately upon discovery for both EDGSEVR failures in accordance with procedure ADM 01-057 which fulfilled the requirement for identification of the nonconformances. The purpose of the IIT was to investigate the transformer failures, determine the root cause(s), recommend corrective actions and to provide the necessary documentation. The completion of the IIT effort met the requirement for identification of the cause(s), specifying action to preclude recurrence and documentation of significant conditions adverse to quality. The involvement of the Vice President Plant Operations and Vice President Engineering in the initiation and implementation of the IIT met the requirement for appropriate management involvement in the significant condition adverse to quality. Therefore, the essential requirements of 10 CFR 50, Appendix B, Criterion XVI were met through the work request and IIT activities.

WCNOC revised PIR 94-1680 on October 25, 1994, to include the scope of the EDGSEVR "B" failure. This revision resulted in the PIR being considered significant. Corrective actions associated with PIR 94-1680 were completed on January 31, 1995.

Procedure AP 34E-001 has been divided into two separate documents to provide clear administrative guidance on (1) IITs (instruction AI 28B-003, "Incident Investigation Team"); and (2) other types of self assessments (procedure AP 28D-

001, "Self Assessment Process"). Instruction AI 28B-003 includes the requirement to initiate a PIR each time an IIT is formed.

The procedure utilized to control the use of PIRs has been revised. This revision supersedes procedure KGP-1210 with the issuance of procedure AP 28A-001, "Performance Improvement Request." Procedure AP 28A-001 requires a PIR be initiated to evaluate equipment problems that require a formal root cause analysis which is consistent with the requirements already contained in KGP-1201, "Corrective Action."

WCNOC management issued an Interoffice Correspondence Memo to all WCNOC personnel addressing the importance of issuing a PIR to evaluate equipment problems requiring a root cause analysis.

Date When Full Compliance Will Be Achieved:

Full compliance with the requirements of 10 CFR 50, Appendix B, Criterion XVI has been achieved.