UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION IV
611 RYAN PLAZA DRIVE, SUITE 400
ARLINGTON, TEXAS 76011-8064

SEP 21 1995

Wolf Creek Nuclear Operating Corporation
ATTN: Neil S. Carns, President and
Chief Executive Officer
P.O. Box 411
Burlington, Kansas 66839

SUBJECT: NRC INSPECTION REPORT 50-482/95-13

Thank you for your letter of September 7, 1995, in response to our letter and Notice of Violation dated August 8, 1995. We have reviewed your reply and find it responsive to the concerns raised in our Notice of Violation. We will review the implementation of your corrective actions during a future inspection to determine that full compliance has been achieved and will be maintained.

Sincerely,

W. D. Johnson for
J. E. Dyer, Director
Division of Reactor Projects

Docket: 50-482
License: NPF-42

cc:
Wolf Creek Nuclear Operating Corp.
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P.O. Box 411
Burlington, Kansas 66839

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Wolf Creek Nuclear Operating Corp.
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Jefferson City, Missouri 65102

Kansas Corporation Commission
ATTN: Chief Engineer
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Topeka, Kansas 66604-4027

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Topeka, Kansas 66612

Attorney General
Judicial Center
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Burlington, Kansas 66839-1798

Kansas Department of Health
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bcc to DMB (IE01)

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Leah Tremper (OC/LFDCB, MS: TWFN 9E10)

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bcc to DMB (IE01)

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WOLF CREEK
NUCLEAR OPERATING CORPORATION

SEP 11 1995

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

September 7, 1995

WM 95-0125

U. S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Mail Station P1-137
Washington, D. C. 20555

Reference: Letter dated August 8, 1995, from J. E Dyer, NRC/RIV, to N. S. Carns, WCNOC (Inspection Report 50-482/95-13)
Subject: Docket No. 50-482: Reply to Notice of Violation 50-482/9513-01

Gentlemen:

Attached is Wolf Creek Nuclear Operating Corporation's (WCNOC's) reply to Notice of Violation 50-482/9513-01. This violation concerned an example of WCNOC's failure to adequately implement its Clearance Order Program.

WCNOC's response to this Notice of Violation is in the attachment to this letter. If you should have any questions regarding this response, please contact me at (316) 364-8831, extension 4000, or Mr. William M. Lindsay at extension 8760.

Very truly yours,

Neil S. Carns

Neil S. Carns

NSC/jad

Attachment

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

95-2064

P.O. Box 411 / Burlington, KS 66839 / Phone: (316) 364-8831

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Reply to Notice of Violation 50-482/9513-01

Violation 50-482/9513-01: One example of the Wolf Creek Nuclear Operating Corporation's (WCNOC) failure to adequately implement its Clearance Order Program.

"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 1.c, requires procedures for equipment control (e.g., locking and tagging).

Procedure AP 21E-001, "Clearance Orders," Revision 2, Step 6.1.4.6, requires that 480 volt molded breaker contacts be verified open prior to acceptance of the clearance.

Contrary to the above, on July 7, 1995, three individuals accepted Clearance Order 95-0583-AK without completion of the breaker contact open electrical checks (482/9513-01)."

Admission of Violation:

Wolf Creek Nuclear Operating Corporation (WCNOC) acknowledges and agrees that a violation of Technical Specification 6.8.1.a occurred for the above discussed concern.

Reason for Violation:

Root Cause:

The root cause of this violation has two separate but distinctly equal parts, involving cognitive personnel error. The first part is the Shift Supervisor's failure to ensure a breaker verification check was completed prior to allowing the workers to accept the clearance order and authorizing them to start work. The second part is the failure of the three Mechanical Maintenance personnel to carefully review the clearance order prior to commencing work.

Contributing Factors:

The failure of Control Room personnel to correctly use the Breaker Verification Basket, Shift Supervisor's Basket, and the Shift Clerk's Basket for assuring clearance orders are correctly reviewed and that the proper checks are completed prior to authorization of work.

The failure of Control Room personnel to carefully discuss the status of the clearance order during the shift turnover process. This error resulted in the relieving Shift Supervisor (the individual who released the clearance order for work) assuming that the breaker verification check had been completed.

Corrective Steps Taken and Results Achieved:

This event was discovered by the on duty Shift Supervisor when Electrical Maintenance personnel reported to the Control Room and requested permission to sign as an acceptor on the clearance order. The Shift Supervisor immediately stopped all work related to the clearance. Control Room personnel then requested the Electrical Maintenance Group to perform a verification that the breakers were de-energized. Work associated with the clearance order was allowed to resume after satisfactory completion of the breaker verification check.

The Control Room personnel then conducted a review of all active clearance orders to ensure no similar conditions existed. This review showed that all active clearance orders had the required breaker verifications correctly completed.

Control Room personnel issued Performance Improvement Request (PIR) 95-1724 to document this problem and to assure a root cause was identified and corrective actions were implemented.

The Manager Operations issued letter OP 95-0061 to Operations and Central Work Authority (CWA) personnel. This letter outlined management's expectations for how the Breaker Verification Basket should be used and reminded the Shift Supervisors and the CWA to look for missing initials in blanks on the white copy (controlled copy) when personnel accept a clearance order. This letter also stressed the Clearance Order Verification Basket was not to be used for activities outside the intended purpose. To assist in assuring the correct usage of the breaker verification basket, it was moved from the Shift Supervisor's office to the Control Room, adjacent to the other clearance order baskets.

Work groups who accept clearance orders were also briefed by their supervision. This briefing outlined management's expectations that the workers check the white copy when accepting a clearance order for missing initials.

Corrective Steps That Will Be Taken To Avoid Further Violations:

The Manager Operations incorporated a review of this event into the License Operator Requalification Training Program and the Nuclear Station Operator Requalification Training Program during Operator Training Cycle 95-5. This training will reinforce the lessons learned. This training will be completed by October 20, 1995.

Work groups who accept clearance orders are receiving training on their duties and responsibilities as they relate to clearance orders. This training will address the actions that must be performed prior to the acceptance of a clearance order. This training will be performed under Lesson Plan TIN: MB0336603 and will be completed by September 12, 1995.

Date When Full Compliance Will Be Achieved:

Full compliance with the above noted requirements has been achieved and all corrective actions to prevent recurrence will be completed by September 12, 1995.

WCNOC's Assessment Of Previous Similar Events And Corrective Actions:

The cover letter and Section 2.1 of NRC Inspection Report 50-482/95-13 states that the event cited in the above discussed violation is the fifth time this type of problem has occurred since March, 1994, and that WCNOC's corrective actions have failed repeatedly to prevent recurrence. The discussion, as documented below, is provided to clarify the events surrounding the violation and to summarize WCNOC's evaluation of these events.

The event which resulted in this violation occurred on July 7, 1995. This event was self identified and documented in accordance with the WCNOC corrective action program (the Performance Improvement Request Program [PIR]). During WCNOC's initial investigation of this event, it was identified that WCNOC had experienced previous problems with clearance order breaker verifications. Based on this information WCNOC classified the event significant due to the potential of it being a recurring problem. Because of the potential significance of this event, WCNOC immediately informed the resident inspectors both of the event and the historical information related to the event. Copies of the applicable documents were provided to the resident inspectors at that time.

The previous occurrences included three events which occurred in March, 1994 (as documented in PIRs 94-0502, 94-0565, and 94-0614) and one event which occurred in 1993 (as documented in PIR 94-1378). The 1993 event was identified approximately nine months after its date of occurrence, during the performance of an internal audit. WCNOC carefully evaluated each of these events. This evaluation showed:

- Two of the March, 1994 events were related to personnel failing to assure the required breaker verifications were performed.
- The third March, 1994, event resulted from an inadequately developed clearance order.
- The age of the 1993 event at the time of its discovery precluded the determination of its root cause.
- Between March, 1994, and July 7, 1995, WCNOC had not experienced a repeat occurrence of this type of problem.

The intent of the previous corrective actions was to ensure the clearance order process provides a very high level of assurance that personnel and plant equipment would be protected. The corrective actions implemented changes to the process for handling clearance orders with breaker verifications, and communications which heightened awareness of these changes. As a result of these corrective actions, personnel performance problems in the clearance order process have improved significantly and the previous identified programmatic weaknesses were corrected. This is demonstrated by:

- WCNOC's successful processing of several hundred clearance orders, requiring breaker verifications, in the 15 month period since the March, 1994 events.

- WCNOC's successful completion of a planned refueling outage and a forced outage during the same time period without recurrence of the previous events.

Unlike the March, 1994 events, this violation resulted solely from a personnel performance issue. No programmatic weaknesses contributed tc the event. This event represents an opportunity for WCNOC to strengthen the clearance order process by implementing an enhancement to the March, 1994, corrective actions. This enhancement should prevent recurrence of the personnel performance problems related to this violation. The event does not represent a recurring problem or an issue indicative of a breakdown of the corrective action program.