

WOLF CREEK

NUCLEAR OPERATING CORPORATION

John A. Bailey
Vice President
Operations

April 24, 1992

NO 92-0126

U. S. Nuclear Regulatory Commission
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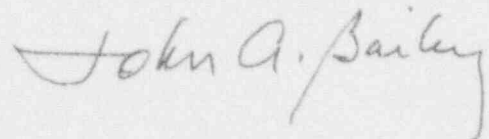
Reference: Letter dated March 26, 1992 from A. B. Beach, NRC
to B. D. Withers, WCNOG
Subject: Docket No. 50-482: Response to Violations
482/91202-01, 91202-02 and 91202-03

Gentlemen:

Attached is Wolf Creek Nuclear Operating Corporation's (WCNOG) response to violations 482/91202-01, 91202-02 and 91202-03 which were documented in the Reference. Violation 482/91202-01 concerns a determination that an alarm response procedure was inadequate. Violation 482/91202-02 concerns the failure of a radiation protection technician to perform a whole body frisk upon exiting the radiological control area. Violation 482/91202-03 concerns a missed Technical Specification Surveillance Test.

If you have any questions concerning this matter, please contact me or Mr S. G. Wideman of my staff.

Very truly yours,



John A. Bailey
Vice President
Operations

JAD/jra

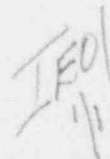
Attachment

cc: A. T. Howell (NRC), w/a
R. D. Martin (NRC), w/a
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W. D. Reckley (NRC), w/a

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Reply To A Notice Of Violation

Violation (482/91202-01): Inadequate Procedure

Finding:

Technical Specification (TS) 6.8.1.a states "Written procedures shall be established, implemented, and maintained covering the activities in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978. Paragraph 5 of Appendix A requires that procedures for abnormal, offnormal, or alarm conditions be written for safety-related annunciators, which should normally contain: (1) the meaning of the annunciator; (2) the source of the signal, (3) the immediate action that is to occur automatically; (4) the immediate operator action, and (5) their long-range action. This is accomplished, in part, by Alarm Response Procedure ALR 00-128C, "TD APP BRG OIL TEMP HI."

10 CFR Part 50, Appendix B, Criterion V, requires, in part, that activities affecting quality shall be prescribed by procedures of a type appropriate to the circumstances.

Contrary to the above, during an NRC inspection conducted from July 14 through August 2, 1991, ALR 00-128C was determined to be inappropriate to the circumstances for immediate and long-range operator action. The procedure incorrectly referenced the instrumentation to be used in determining the immediate and long-range actions. The computer points referenced in ALR 00-128C to be used to monitor the turbine-driven auxiliary feedwater pump (TDAFWP) lube oil temperature, actually sensed the inner and outer bearing temperatures. The alarm response procedure required that the TDAFWP be shutdown if a high lube oil temperature was reached. Therefore, the reactor operator would have been required to shut down the TDAFWP prior to reaching an actual high lube oil temperature. The lube oil cooler outlet temperature limits, requiring shutdown of the TDAFWP during emergency and nonemergency operation, can only be determined locally at the cooler. No guidance was provided in ALR 00-128C and no reference was made as to which local temperatures should be monitored during TDAFWP operation.

Reason For The Violation:

The incorrectly referenced instrumentation was identified as being present since revision 0 of alarm response procedure ALR 00-128C. Therefore, this violation is attributed to personnel error during the initial development of the procedure. The reason as to why this occurred cannot be determined because of the long time since occurrence and the absence of personnel involved in the initial procedure development.

Corrective Action That Has Been Taken And Results Achieved:

Alarm response procedure ALR 00-128C was revised on August 28, 1991, to indicate the correct temperature indicators for review upon the receipt of a high bearing oil temperature alarm on the Turbine Drive Auxiliary Feedwater Pump Turbine.

Corrective Action That Will Be Taken To Avoid Further Violations:

Wolf Creek Nuclear Operating Corporation is aggressively addressing performance and program improvement issues through development of the Management Action Program (MAP) discussed in WM 92-0040, Reply to Notice of Violation (EA 91-161). In addition to the items discussed in WM 92-0040, the MAP also specifically addresses improvements in procedural guidance to enhance procedure usability and compliance. MAP issue V specifically addresses overall enhancements in this area and ensures that it receives continuing attention.

Date When Full Compliance Will Be Achieved:

Immediate and remedial corrective actions have been completed and therefore full compliance has been achieved. Long term enhancements are being addressed by those actions being performed as part of the MAP.

Violation (482/91202-02): Failure To Follow A Radiological Control Procedure

Finding:

TS 6.11, "Radiation Protection Program," requires that procedures for personnel radiation protection shall be prepared consistent with the requirements of 10 CFR Part 20 and shall be approved, maintained, and adhered to for all operations involving personnel radiation exposure. This is accomplished, in part, by Administrative Procedure ADM 03-002, "Radiation Worker Guidelines."

ADM 03-002, paragraph 6.6, requires that upon exiting the radiological control area, at access control, an individual will perform a whole-body frisk.

Contrary to the above, on July 24, 1991, a radiation protection technician failed to perform a whole body frisk upon exiting the radiological control area, at the access control point.

Reason For The Violation:

Immediately prior to this event, the individual had previously performed a whole body frisk upon exiting the radiological control area (RCA). Subsequent to exiting, the individual re-entered the RCA to go to one of the rooms located at the exit where the frisk-all is located. At this time, upon exiting the RCA, the individual failed to perform the whole body frisk.

The reason for this violation was a cognizant personnel error for failing to follow procedure ADM 03-002. The individual believed that because a whole-body frisk had previously been performed an additional frisk was not required. A contributor to this violation was inadequate communication of management's expectations on performance standards to radiation protection technicians.

Corrective Action That Has Been Taken And The Results Achieved:

Radiological Occurrence Report 91-016 was initiated to evaluate the event. Additionally, the daily radiological survey of the area performed subsequent to the event did not indicate the presence of contamination to areas outside the RCA.

The Health Physics Supervisor Operations orally reprimanded the individual involved. The supervisor discussed with the individual the importance of contamination control and procedural compliance.

Corrective Action That Will Be Taken To Avoid Further Violations:

On August 2, 1991, the Manager Radiation Protection met with the Health Physics Group and discussed management's expectations for adherence to proper radiation protection practices. Additionally, Quality Assurance performed a surveillance, "Radiological Access Controls," on September 16 - 28, 1991. The surveillance noted that plant personnel were properly using the frisk-all's upon exiting the RCA and that no problems were identified.

Wolf Creek Nuclear Operating Corporation is aggressively addressing performance and program improvement issues through development of the Management Action Program (MAP) discussed in WM 92-0040, Reply to Notice of Violation (EA 91-161). Radiation worker practices of both radiation protection technicians and other plant workers have received considerable attention and oversight. Observation of practices is included in a management monitoring program and significant improvement has been noted. MAP issue VII specifically addresses overall enhancements in this area and ensures that it receives continuing attention.

Date When Full Compliance Will Be Achieved:

Immediate and remedial corrective actions have been completed and therefore full compliance has been achieved. Long term enhancements are being addressed by those actions being performed as part of the MAP.

Violation (482/91202-03): Missed TS Surveillance Test

Finding:

TS 4.0.2 states that "Each surveillance shall be performed within the specified surveillance interval with a maximum allowable extension not to exceed 25 percent of the specified interval." One example of failure to implement the requirement of TS 4.0.2 is noted below:

TS 3/4.3.2, "Engineered Safety Features Actuation System [ESFAS] Instrumentation," Surveillance Requirement 4.3.2.1, states that "Each ESFAS instrumentation channel and interlock and the automatic actuation logic and relays shall be demonstrated OPERABLE by the performance of the ESFAS instrumentation surveillance requirements specified in Table 4.3-2. Surveillance Requirement 4.3-2.9.c, "Automatic Actuation Logic and Actuation Relays [Balance of Plant (BOP) ESFAS]," is required to be performed in all modes. Each train shall be tested at least every 62 days on a STAGGERED TEST BASIS (one train every 31 days).

Contrary to the above, with the plant in Modes 5 and 6, TS Surveillance Requirement 4.3-2.9.c was completed 14 days after the maximum allowable extension of the specified interval. Surveillance Test STS ML-001, Revision 10, "Monthly Surveillance Log," implemented TS Surveillance Requirements 4.3-2.9.c. Surveillance Procedure STS ML-001 was performed on March 17, 1990, and, with the 25 percent extension of the specified interval, was required to be performed again by April 25, 1990. However, the test was not completed until May 9, 1990.

Reason For The Violation:

On July 30, 1991, during a review of past performances of surveillance procedure STS ML-001, "Monthly Surveillance Log," for the Control Room Isolation Automatic Actuation Logic and Actuation Relays Actuation Logic Test, it was discovered that it had not been performed within the required time frame during the fourth refueling outage (Spring 1990).

Investigation into this event identified that following performance of surveillance procedure STS ML-001 on March 17, 1990, the Technical Specification - Procedure Data Base (utilized by the computerized surveillance scheduling program) was apparently changed to indicate that surveillance procedure STS ML-001 was only required to be performed during Mode 1, Power Operation, thru Mode 4, Hot Shutdown. Because the next scheduled performance fell within the time period that the plant was in Mode 5, Cold Shutdown, and Mode 6, Refueling and the data base only required performance in Modes 1 thru 4, the computer generated schedule for the fourth refueling outage did not schedule surveillance procedure STS ML-001 for performance.

It is believed that the initial conditions stated in surveillance procedure STS ML-001 implied that the performance of the procedure was only required in Modes 1 thru 4 and the Technical Specification-Procedure Data Base was erroneously changed to reflect this. Although investigations were unsuccessful in clearly identifying the root cause of this event, partially as a result of the time delay between the occurrence of the event and its discovery, a major causal factor was a lack of administrative controls involving changes to the Technical Specification - Procedure Data Base.

Corrective Action That Has Been Taken And Results Achieved:

The review of the past performances of surveillance procedure STS ML-001 revealed that the performance subsequent to the missed performance was completed satisfactorily. This indicates that the system would have performed its required safety function had it been needed. This event was reported in Licensee Event Report 482/90-027-00.

Corrective Action That Will Be Taken To Avoid Further Violations:

Surveillance procedure STS ML-001 has been revised to clearly state that the procedure is required in all plant modes. The mode requirements for STS ML-001 have also been changed in the Technical Specification-Procedure Data Base to indicate that this surveillance requirement is required in all modes. Surveillance scheduling personnel reviewed the Technical

Specification - Procedure Data Base to identify and correct any similar inaccuracies. Additionally, administrative procedure ADM 02-311 "Surveillance Test Master Cross-Reference and Review Requirements," was revised to provide a means of documenting change to the Technical Specification - Procedure Data Base. The revision also requires that a comparison of the proposed change and the actual change to the data base be made to verify the accuracy of the data base.

Subsequent to the time this event occurred, Wolf Creek Nuclear Operating Corporation (WCNOC) identified other deficiencies in the surveillance testing program and has taken actions to improve the program. The actions taken include implementing enhancements to the software that assist the surveillance coordinator in scheduling surveillances. Overall monitoring of the surveillance program has been enhanced by the assignment of a full time coordinator who previously held a Senior Reactor Operator license. Additionally, as the result of another missed surveillance, occurring subsequent to the discussed events, an enhancement to the surveillance program was implemented which requires that surveillances with a regular periodic performance greater than or equal to 30 days be reviewed by the surveillance scheduling group two days prior to the extended late date to ensure that the surveillance has been completed.

Date When Full Compliance Will Be Achieved:

Full compliance has been achieved.