WOLF CREEK
NUCLEAR OPERATING CORPORATION

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President and Chief Executive Officer

July 7, 1997

WM 97-0081

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

Reference: Letter dated June 6, 1997, from T. P. Gwynn, NRC, to O. L. Maynard, WCNOC
Subject: Docket No. 50-482: Response to Notice of Violations 50-482/9709-01, -03, -04, -06 and -07

Gentlemen:

This letter transmits Wolf Creek Nuclear Operating Corporation's (WCNOC) response to Notice of Violations 50-482/9709-01, -03, -04, -06 and -07. Violation 9709-01 cites a failure to identify and remove debris from containment following fire barrier replacement. Violation 9709-03 addresses a shift supervisor's failure to complete a form for documenting debris discovered in the containment building. Violation 9709-04 cites that corrective action of the identification of an inoperable containment isolation valve was inadequate. Violation 9709-06 addresses the result of a miscommunication between engineering and operations personnel regarding cold overpressure mitigation requirements for the normal charging pump. Violation 9709-07 cites a failure to comply with security escort requirements.

Violation 9709-01 is characterized as an event which could have potentially restricted the emergency core cooling system pump suctions. The report stated that a "significant amount of trash and debris" (approximately 180 square inches) was discovered in the containment; this represents a potential blockage of 1.9 percent of the inner screen. However, the report continues by stating: "Design basis allows for up to 50 percent blockage of both screens without effect on the net positive suction head of the pumps." WCNOC contends that a characterization of "significant" is inappropriate for this small amount of debris. WCNOC acknowledges that procedure STS EJ-001, "Containment Inspection," was violated, but that there is no safety significance to this finding.

WCNOC's response to these violations is provided in the attachment. If you have any questions regarding this response, please contact me at (316) 364-8831, extension 4000, or Mr. Richard D. Flannigan at extension 4500.

Very truly yours,

Otto L. Maynard

OLM/jad

Attachment

cc: W. D. Johnson (NRC), w/a
E. W. Merschoff (NRC), w/a
J. F. Ringwald (NRC), w/a
J. C. Stone (NRC), w/a

IE01

100050

Reply to Notice of Violations 50-482/9709-01, -03, -04, -06, and -07

Violation 50-482/9709-01:

"A. 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 8.b, requires procedures for conducting surveillance tests listed in the Technical Specifications.

Following each Containment entry, Technical Specification 4.5.2, Action c.2, requires a visual inspection of the affected areas in the containment to verify that no loose debris is present which could be transported to the containment sumps and cause restriction of the pumps' suctions during a loss-of-coolant condition.

Procedure STS EJ-001, "Containment Inspection," Revision 9, Step 8.1.1, requires that the licensee verify by a visual inspection of all accessible areas that no loose debris is present in the containment.

Contrary to the above, between September 20, 1996, and April 30, 1997, the licensee failed to identify and remove debris from the containment.

This is a Severity Level IV violation (Supplement I) (482/9709-01)."

Admission of Violation:

Wolf Creek acknowledges that a violation of Technical Specification 6.8.1 occurred when procedures were not followed.

Reason for Violation:

On March 20, 1997, during a routine containment entry, an NRC inspector identified concerns with the presence of debris within the Wolf Creek Generating Station (WCGS) containment.

This material was left in the containment due to personnel inattention to detail. Personnel demonstrated inadequate work practices, specifically, the test performers did not conduct adequate containment walkdowns for STS EJ-001, "Containment Inspection," Revision 10. Interviews revealed that Health Physics personnel do not have a clear understanding of Management's expectations on implementing STS EJ-001. Several of the Health Physics personnel did not demonstrate a clear understanding of where, when, and how to inspect an area; nor what constitutes correct securing of a temporary piece of equipment. Training on the performance of STS EJ-001 had not previously been provided to Health Physics personnel.

Corrective Steps to Be Taken to Prevent Recurrence:

Management meetings will be held with the individuals who performed STS EJ-001. The meetings will focus on this issue, the acceptance criteria specified in the procedure, and a restatement of management's expectations on procedural adherence, and will be completed by August 29, 1997. Training will be provided to Health Physics personnel by August 29, 1997.

Date When Full Compliance Will Be Achieved:

The requirements of STS EJ-001 have been satisfied at this time, and full compliance has been achieved. Additional corrective actions will be completed by August 29, 1997.

Violation 50-482/9709-03:

"B. Criterion V of Appendix B to 10 CFR Part 50 requires, in part, that activities affecting quality shall be prescribed by documented instructions, procedures, and drawings appropriate to the circumstances and shall be accomplished in accordance with these instructions, procedures, or drawings.

Procedure AP 26C-004 requires operability determinations be documented in a log entry that includes a justification for the operability determination and completion of Form APF 26C-004-001.

Contrary to the above, on April 30, 1997, the shift supervisor documented an operability determination for debris and other material found in containment without providing a justification for the operability determination and without completing Form APF 26C-004-001.

This is a Severity Level IV violation (Supplement I) (50-482/9709-03)."

Admission of Violation:

WCNOC acknowledges that on April 30, 1997, a violation of procedure AP 26C-004, "Technical Specification Operability," Revision 0, occurred when the shift supervisor did not complete form APF 26C-004-01, "Technical Specification Screening Checklist," Revision 0, as a supplement to the operability decision in the shift supervisor log.

Reason for Violation:

On April 30, 1997, debris was found during a routine containment entry. The discovery of the debris and the concerns expressed by NRC inspectors were conveyed to the shift supervisor. The shift supervisor considered the information, and concluded in the shift supervisor log that no Technical Specification operability issue existed as a result of the small amount of debris. Since the shift supervisor did not consider the small amount of debris to be an operability question, he did not consider that entry into AP 26C-004 was required, and therefore, the shift supervisor did not complete form APF 26C-004-01, "Technical Specification Screening Checklist," as a supplement to the operability call in the shift supervisor log. The shift supervisor's operability call was correct; however, he did not document operability in accordance with AP 26C-004.

Corrective Steps to Be Taken to Prevent Recurrence:

Shift supervisors have been notified to apply AP 26C-004 to all operability decisions until the guidance on the use of this procedure is revised. AP 26C-004 will be revised to provide improved guidance on when Form APF 26C-004-01 must be used. This will be completed by August 15, 1997.

Date When Full Compliance Will Be Achieved:

Full compliance has been achieved. Additional corrective actions will be completed by August 15, 1997.

Violation 50-482/9709-04:

"C. Technical Specification 3.6.3 states, in part, that containment isolation valves shall be operable and, with one or more containment isolation valves inoperable, the licensee must restore the valve to operable status within 4 hours, isolate the penetration, or be in hot standby within the next 6 hours and in cold shutdown within the following 30 hours.

Contrary to the above, on March 29, 1996, the licensee entered Mode 4 with Containment Isolation Valve EF HV0034 inoperable and operated in Mode 4 or higher until the penetration was isolated on October 9, 1996.

This is a Severity Level IV violation (Supplement I) (50-482/9709-04)."

Admission of Violation:

The failure to comply with Technical Specification 3.6.3 was originally identified and reported by WCNOC in LER 96-010-00, letter ET 96-095, dated November 7, 1997; and LER 96-010-01, letter WO 97-0049, dated April 30, 1997. Root cause and corrective actions were identified in these LERs; however, these LERs failed to address that a PIR had not been initiated.

WCNOC acknowledges that a violation of Technical Specification 3.6.3 occurred when WCGS entered Mode 4 with Containment Isolation Valve EFHV0034 inoperable.

Reason for Violation:

Although an Action Request was initiated documenting a functional failure of EF HV0034, System Engineering did not recognize that a Performance Improvement Request (PIR) should also have been initiated in accordance with AP 28A-001, "Performance Improvement Request," Revision 7, and AI 23M-001, Maintenance Rule SSC Monitoring," Revision 0. Contributing to the reason for this violation is that personnel erroneously interpreted the corrective action program and concluded that the effectiveness follow-up on another PIR could be used rather than generate a new PIR.

Corrective Steps to Be Taken to Prevent Recurrence:

PIR 97-1484 was initiated in response to Violation 9709-04.
PIRs 96-2528, 97-1484, and 97-1995 address the programmatic needs to document previous dual indication failures on EF HV0034.

PIR 97-1484 will be entered into required reading for System Engineering. In addition, to further emphasize the importance of ensuring that PIRs are initiated appropriately, each System Engineer Supervisor will discuss with their reports the lessons learned from this event. Completion date for the required reading and the supervisory discussions is July 25, 1997.

Date When Full Compliance Will Be Achieved:

Full compliance has been achieved.

Violation 50-482/9709-06:

"D. 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 2j, requires general plant operating procedures for hot standby to cold shutdown operations.

Contrary to the above, on February 11, 1997, licensee personnel failed to properly establish Procedure GEN 00-006 in that it permitted operation of the normal charging pump with reactor coolant system temperature as low as 325°F, when engineering guidance in Design Change Package 04590 required that the normal charging pump be stopped and placed in pull-to-lock when the plant operated below 368°F.

This is a Severity Level IV Violation (Supplement I) (50-482/9709-06)."

Admission of Violation:

WCNOC acknowledges that a violation of Technical Specification 6.8.1 occurred when a conflict existed in operating conditions for the normal charging pump in procedure GEN 00-006 and Design Change Package 04590.

Reason for Violation:

WCNOC inappropriately revised procedure GEN 00-006, "Hot Standby to Cold Shutdown," to allow operation of the normal charging pump below the low temperature overpressure protection limits, contrary to the engineering disposition for DCP 04590, Revision 3.

Design Change Package (DCP) 04590 was developed by WCNOC to replace positive displacement pump (PDP) with a centrifugal charging pump (titled the normal charging pump).

This concern was self identified and documented in PIR 97-0439. All corrective actions had been completed, and the PIR was closed prior to this issue being considered an NRC violation. Upon this concern being identified to Operations as an NRC unresolved concern, PIR 97-1249 was initiated and screened as significant to ensure a root cause analysis was performed.

The root cause of this violation is that responsible personnel were aware of the information in the DCP, but justified interpretations of the information rather than implementing the DCP as literally stated. The interpretations were based on a knowledge of the previous operational limits for the PDP, and reviews of previous revisions of the General Operating Procedures.

Corrective Steps Taken and Results Achieved:

PIR 97-0439 was initiated.

Operations conducted a review of the concern and determined that adequate documentation was not available to support potential operation outside of the NCP requirements specified in DCP 04590.

- Based on the information obtained in the above performed review, on February 14, 1997, Operations revised the following procedures to establish necessary operational guidance: 1) SYS BB-112 (OTSC 97-0088), 2) SYS BB-113 (OTSC 97-0087), 3) SYS BB-114 (OTSC 97-0086), SYS BG-120 (OTSC 97-0102), SYS BG-201 (OTSC 97-0085), SYS BG-213 (OTSC 97-0084), GEN 00-001 (DRR 97-0527), GEN 00-002 (OTSC 97-0090), GEN 00-006

(OTSC 97-0089), ALR 00-049B (DRR 97-0324), ALR 00-049D (DRR 97-0325), ALR 00-050D (DRR 97-0326), and ALR 00-064B (DRR 97-0327).

PIR 97-0439 was placed in required reading for Operations Support personnel to alert them of a failure to adequately capture a design change, and to aid in ensuring future design changes are adequately identified and captured.

On April 25, 1997, PIR 97-1249 was initiated to facilitate a formal root cause analysis for this concern.

Corrective Steps That Will Be Taken to Prevent Recurrence:

Operations Management will meet with the Operations Support Group. This meeting will discuss the errors made in capturing the programmatic changes required by DCP 04590, management's expectations, verbatim compliance, the use of cross disciplinary reviews, and the potential consequences of improperly implementing requested procedure changes. This action will be completed by July 15, 1997.

Date When Full Compliance Will Be Achieved:

Full compliance has been achieved; additional corrective actions will be completed by August 31, 1997.

Violation 50-482/9709-07:

"E. Technical Specification 6.8.1.c requires that written procedures be established, implemented, and maintained covering the implementation of the security plan.

The security plan is implemented, in part, by Security Procedure SEC 01-202, "Personnel Access to Protected Area," Revision 31.

Security Procedure SEC 01-202, Step 6.5.2,6, requires the visitor-to-escort ratio to be no more than 10:1 in the protected area and 5:1 in the vital area, but may be increased on a case-by-case basis upon approval of the Vice President Plant Operations or designee.

Contrary to the above, on May 8, 1997, security escorts escorted more than five visitors into vital areas without specific approval of the Vice President Plant Operations or designee.

This is a Severity Level IV Violation (Supplement III) (50-482/9709-07)."

Admission of Violation:

WCNOC acknowledges that on May 8, 1997, the visitor-to-escort ratio as stated in procedure AP 27-001, "Escort of Individuals within the Protected Area," Revision 2, was exceeded without specific approval of the Vice President Operations or designee.

Reason for Violation:

On May 8, 1997, an NRC inspector identified two different escorts in vital areas with six visitors each. The requirement for escort to visitor ratio in a vital area is one to five. Both non-Security escorts entered the ESF switchgear room, and one of the escorts also entered the Control Room foyer.

The escort to visitor ratio is one escort to 10 visitors in the protected area and one escort to five visitors in vital area. This is a Security Plan requirement and is addressed in AP 27-001, "Escort of Individuals within the Protected Area," and in Plant Access Training (PAT).

Form APF 27-001-02, "Security Escort Responsibilities," Revision 1, is required to be read and understood by each escort prior to assuming escort responsibilities. The escort to visitor ratio is not included on this form, and this omission is considered the reason for the violation.

Corrective Steps Taken and Result Achieved:

The tour groups left the vital area, and PIR 97-1358 was initiated to investigate the cause of this event.

Corrective Steps to Be Taken to Prevent Recurrence:

Form APF 27-001-02 will be revised to add escort to visitor ratios. This will be completed by August 15, 1997.

Date When Full Compliance Will Be Achieved:

Compliance with procedure AP 27-001 and with the Security Plan was again achieved when the tour groups left the vital areas. Additional corrective actions will be completed by August 15, 1997.