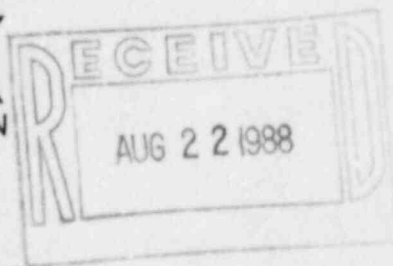


WOLF CREEK

NUCLEAR OPERATING CORPORATION



Bart D. Withers
President and
Chief Executive Officer

August 19, 1988

WM 88-0207

R. D. Martin, Regional Administrator
U. S. Nuclear Regulatory Commission
Region IV
611 Ryan Plaza Drive, Suite 1000
Arlington, Texas 76011

Reference: Letter dated June 23, 1988 from R. D. Martin, NRC to
B. D. Withers, WCNOG
Subject: Docket No. 50-482: Response to Systematic Assessment
of Licensee Performance Inspection Report 50-482/88-14

Gentlemen:

Attached is Wolf Creek Nuclear Operating Corporation's (WCNOG) response to the Systematic Assessment of Licensee Performance (SALP) Report transmitted in the Reference. This response reflects discussions held during the SALP conference between WCNOG and the NRC Staff on July 20, 1988, at Wolf Creek Generating Station Education Center.

If you have any questions concerning this matter, please contact me or Mr. O. L. Maynard of my staff.

Very truly yours,

Bart D. Withers
President and
Chief Executive Officer

Attachment

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Table of Contents

	<u>Page</u>
Introduction	1
Section I. General Overview	2
Section II. Detailed Responses	3
A. Plant Operations	3
B. Radiological Controls	4
C. Maintenance	5
D. Surveillance	6
E. Fire Protection	6
F. Emergency Preparedness	7
G. Security	8
H. Outages	9
I. Quality Programs and Administrative Controls Affecting Quality	10
J. Licensing Activities	16
K. Training and Qualification Effectiveness	17
Section III. Additional Comments on SAI.P Report	19

INTRODUCTION

Wolf Creek Nuclear Operating Corporation (WCNOC) has reviewed the Systematic Assessment of Licensee Performance (SALP) report and has prepared responses to address the "Recommended Licensee Actions" for each of the functional areas evaluated. Section I provides a general overview of enhancements that have been made or initiated and Section II provides detailed responses to each of the areas evaluated. The detailed responses are presented in the same order in which they were presented in the SALP report. It should be noted that WCNOC did not address each example discussed in the report as the majority of these examples have been addressed in previous correspondence. Instead, it responds to the Recommended Licensee Actions identified in each functional area and also responds to selected items that WCNOC feels need clarification. Section III provides editorial comments that address what WCNOC believes to be administrative errors in the report.

SECTION I

GENERAL OVERVIEW

The SALP report covered the period between March 1, 1987, and March 31, 1988 and identified the areas in which the NRC believed improvements could be made. WCNOG's own assessment of performance during this period had also identified the need for improvements in several of the same areas. Therefore, many of the actions recommended in the SALP report had already been implemented or initiated even before the SALP Board met.

As discussed in more detail in Section II and in other previously docketed correspondence, WCNOG has made or is making enhancements in several areas. Some of the more significant changes made are outlined below:

- Re-organization of Maintenance to combine Maintenance and Modifications under a single manager and eliminate unnecessary levels of supervision in order to provide more direct management control of work activities.
- Changes in the Outage Management organization to provide additional experienced personnel and to more clearly reflect the Outage Manager's function and authority.
- Restructuring of the daily planning meetings to focus more on problems and corrective actions than on work status. This provides significant improvement in cooperation and coordination among work groups and gets the technical support groups involved earlier when problems arise.
- Selected personnel have been trained in Root Cause Analysis and programmatic changes are being developed to provide a stronger program for determination of root cause.
- An independent assessment of the WCNOG organization has been commissioned to identify and recommend enhancements to improve the overall effectiveness and efficiency of WCNOG.

WCNOG believes the above initiatives along with others discussed in Section II will result in more effective and efficient control of work activities. WCNOG will assess the effectiveness of the improvements discussed in this response and make adjustments as necessary to assure the safe, reliable, and efficient operation of Wolf Creek Generating Station.

SECTION II

DETAILED RESPONSE

A. Plant Operations

Recommended Licensee Actions

Licensee management should ensure that there is an adequate and prompt QA, NSE, and Engineering involvement in operational events and in the technical resolution to safety issues.

Response to Recommended Licensee Actions

WCNOC agrees that management should ensure that adequate and prompt technical support group involvement in operational events and in the technical resolution of safety issues takes place. The untimely resolution of the ESW pipe wall thinning issue was caused by management's failure to solicit a timely engineering evaluation which included the potential for generic implications. Discussion of the issue focused on peripheral matters, rather than on the fundamental concern, and thus created needless delay. The corrective actions which WCNOC has implemented to address these problems have been extensive. These corrective actions are aimed at creating extensive interaction between operations and technical support groups and high visibility of problem areas to achieve timely resolution. The corrective actions include:

- Procedure requirements have been made ensuring that engineering is notified of technical concerns such as pipe wall thinning and that engineering evaluations are completed promptly to support operability determinations.
- Engineering has been included in work planning meetings to enhance communications between engineering and operations.
- Significant organizational restructuring has been implemented in the Maintenance and Modification areas to provide for close monitoring of engineering dispositions and their processing.
- More fundamentally, by restructuring the daily management meeting to include key managers for a review of work related issues, with an emphasis on the thorough airing of issues, WCNOC has created improved cooperation between Operations, Quality, Nuclear Safety Engineering, and other technical support groups for problem resolution.

The NRC has also identified examples of lack of attention to detail. Corrective actions taken or being taken to improve attention to detail include:

- The need for continual attention to detail was emphasized to all station employees through group meetings and written communication.
- Procedures have been and are being prepared for equipment outages of a complex nature such as a vital electrical bus.
- Miscommunication between the Outage Control Work Authority (CWA) and the Control Room, which resulted in the misuse of operator aids, resulted in the prompt relocation of the CWA into the Control Room.
- A review of operator aids was conducted to ensure they were being correctly utilized. It was also directed that such a review be done periodically.
- The clearance order and the control of information tagging procedures have been revised to properly control and remove operator aids used as a result of clearance orders.

The substantial corrective actions discussed above, coupled with close management attention, will result in improvement in the operations areas including significant and prompt Quality Assurance, Nuclear Safety Engineering, and Engineering involvement in operational events and in the technical resolution to safety issues.

B. Radiological Controls

Recommended Licensee Actions

Health Physics supervisory personnel should spend more time in the radiologically controlled areas evaluating and observing ongoing radiation protection work activities to ensure compliance with station procedures. Management should take action to provide training to technicians to enhance procedural compliance.

Response to Recommended Licensee Actions

WCNOC agrees with the Recommended Licensee Actions. Unresolved concerns were noted in the areas of steam generator mockup training and supervisory presence in the plant. Both of these issues are currently well underway towards complete resolution. A steam generator mockup training program is being fully implemented. The ongoing training program was initiated in July, 1988, using the onsite steam generator mockup facility. A majority of the Health Physics staff and numerous maintenance and contract personnel are scheduled for training for the upcoming outage.

To improve supervisory presence in the plant, Health Physics supervisors are being placed on shift during major work outages. In addition, management staff meetings with Health Physics supervisors have emphasized the need for close field supervision. They have been instructed to provide first hand observation of work activities and provide appropriate log entries for management review. This will remain a high priority for the entire organization, not just the Health Physics organization.

Further action to ensure procedural compliance in Health Physics was also recommended. The emphasis on procedural compliance was made clear by direct management involvement during the outage for Health Physics as well as other organizations. In addition, examples of procedural noncompliances have been incorporated as examples in Health Physics training programs. This, together with high priority by management on Health Physics training will ensure improved procedure compliance.

C. Maintenance

Recommended Licensee Actions

The licensee should follow through and assess the effectiveness of their corrective actions. The licensee should continue the increased emphasis on procedural compliance.

Response to Recommended Licensee Actions

The outage problems associated with the Maintenance organization included several examples of procedural noncompliance. It became apparent, however, that more was needed than a strong re-emphasis of procedural compliance philosophies. As a result, WCNOG undertook a major restructuring of the Maintenance organization to ensure strong supervisory support for not only procedural compliance, but for correction of other weaknesses as well.

As recognized in the SALP report, the organizational changes made during and since the outage have significantly strengthened the Maintenance organization. The current management team has emphasized procedural adherence, pre-job briefings, and identification of areas in need of improvement. This has resulted in improvement actions in the following areas:

- Staffing has been provided to address needed procedure improvements.
- Easier-to-use work packages with additional detail in the work instructions have been developed by using an enhanced desk-top publishing system.
- Regular meetings of supervisors, schedulers, and work groups are scheduled to improve communication and coordination of all involved personnel.

- Improvements in trending of maintenance indicators have been made.
- Administrative steps have been implemented to more effectively hold personnel accountable for their actions.

WCNOC will continue to emphasize management attention and support in the Maintenance and Modifications areas. Problems that are identified will receive prompt attention and corrective actions will continue to be assessed to verify effectiveness.

D. Surveillance

Recommended Licensee Actions

The licensee is encouraged to perform an in-depth review of the Technical Specification surveillance requirements and ensure that the surveillance procedures address these requirements. Also, additional management involvement with the surveillance activities is encouraged.

Response to Recommended Licensee Actions

As noted in the SALP report, WCNOC had several Licensee Event Reports associated with surveillance procedures. Those instances have been addressed through a number of mechanisms including:

- procedure revision
- review of infrequently performed surveillances
- review of Technical Specification bases and procedures to ensure consistency
- enhancement of programmatic controls of surveillance procedure revisions

While each of these resulted in some improvement in the program, the NRC has encouraged WCNOC to undertake an in-depth review of the entire Technical Specification surveillance requirements to ensure that they are procedurally addressed. WCNOC has recently initiated that effort through the Operations organization. This effort and the ongoing performance of the surveillance program will receive close management attention to ensure the correction of identified weaknesses.

E. Fire Protection

Recommended Licensee Actions

The licensee should assure that the recent organizational changes that have the fire protection engineer reporting to a different group and at a lower management level does not result in a reduction of management support.

Response to Recommended Licensee Actions

The recent organizational changes are anticipated to improve communication and coordination between the fire protection specialist and Operations organizations. This will enhance the response of the Operations department to the Fire Protection Specialist's input regarding housekeeping and surveillances. Management support for the fire protection program remains strong.

F. Emergency Preparedness

Recommended Licensee Actions

The level of management attention to the implementation of the emergency preparedness program should be increased to ensure proper response to NRC identified concerns relating to call-out drill response and shift augmentation response times. The licensee should expedite correction of the call-out drill response and shift augmentation concern. Management should review the distribution of on-site and off-site emergency program areas of authority and responsibilities.

Response to Recommended Licensee Actions

WCNOC has taken and is taking actions regarding the NRC's recommendations to provide a Radiological Emergency Response Plan and an Emergency Response Organization which are both effective and responsive to NRC concerns. In regard to call-out drill response and shift augmentation response times WCNOC has significantly revised the call-out procedures and methodology. As a result of these changes, WCNOC has successfully completed the last two quarterly call-out drills. However, the different methodologies are being continually assessed to improve the call-out response times.

In regard to shift augmentation, health physics training of additional project personnel is being conducted to increase the number of qualified personnel to respond to the call-out.

The distribution of authority and responsibilities between the on-site and off-site portions of the emergency response plan are currently under review. WCNOC has recognized that there may not be a clear understanding of the responsibilities of the Emergency Planning Coordinator and the Emergency Planning Administrator by all project personnel, although the division of responsibility and authority are defined in the Emergency Plan Implementing Procedures.

In an effort to improve accountability for the actions of the Emergency Planning Administrator in the performance of his duties, he now reports to a line manager in order to assure that his actions are monitored more closely and additional guidance and attention to detail is provided by management.

G. Security

Recommended Licensee Actions

The licensee should continue to probe the causative factors of security events for broader implications and adjust programs, training, disciplinary actions, maintenance, and engineering responses appropriately. The organizational adjustments made in the QA area should be closely monitored to ensure that the high quality of the security oversight program continues.

Response to Recommended Licensee Actions

WCNOC will continue in-depth evaluation of security events to determine causative factors and to identify broader implications which require changes to programs, training, disciplinary actions, maintenance, and engineering responses, as suggested.

It is important to note that the Quality Department was reorganized in February, 1988. The objective of this change was to more effectively group functional responsibilities. No changes were made with regard to the personnel or methods previously used to perform security program evaluations. The auditors who had been previously involved are still involved in the performance of QA audits and surveillances of security.

Additional Response

Two security related issues discussed in the SALP report deserve some additional discussion from WCNOC's perspective. These two issues are Control Room access and the closed circuit television (CCTV) system.

The Control Room access issue is still open pending the issuance of an NRC position on two items. A meeting was held between WCNOC (then KG&E) personnel and NRC Region IV personnel in Arlington, Texas on October 27, 1986. In that meeting Region IV agreed to obtain and relay to Wolf Creek the NRC's position on the two items. It was understood that Wolf Creek would make no significant changes until Region IV provided the NRC's position on these two items. Although recent discussions indicate that this information is forthcoming, it had not been received at the time of the issuance of the SALP report. Therefore, WCNOC believes it was inappropriate and incorrect to identify this as a long standing regulatory issue attributable to the Licensee.

The second issue that was identified as a long standing regulatory issue attributable to the Licensee was relative to the CCTV system. When the inspector identified this as a potential violation in his exit meeting, he stated that his concerns were with both the design and maintenance of

the system. WCNOG's initial response challenged the design concerns and acknowledge the maintenance concerns. After several discussions it was discovered that the NRC was not challenging the design. Therefore, WCNOG completed the maintenance enhancements needed to keep the CCTV system in good working condition. The time between the receipt of the violation and completion of the enhancements was less than six months. Again, WCNOG believes it is inappropriate to identify this as a long standing regulatory issue attributable to the Licensee.

H. Outage

Recommended Licensee Actions

The licensee should ensure that lessons learned from the previous outages are identified and reviewed for program improvements. The results of this review should be incorporated into outage planning and control.

Response to Recommended Licensee Actions

In general WCNOG agrees with the evaluation and Recommended Licensee Actions, recognizing that the events do not lend themselves to grouping. For example, the Maintenance area, the Operations area and the Outage area all have interconnecting concerns as a result of the events of last fall. There was a major "lesson learned" in this outage. A traumatic event such as a death manifests itself throughout the organization, causing a preoccupation with the event and a potential to lose track of plant and job status. The loss of effective management oversight of the outage activities was one of the more obvious effects, and necessitated a self initiated work halt to regain control of the project activities.

In order to ensure that events such as these do not repeat themselves, WCNOG looked at organizational relationships and at personnel assignments. WCNOG recognized that accountability of personnel for their actions during the outage was not adequate. WCNOG also recognized that the Outage organization's activities in controlling the outage were not totally effective. Also, the Outage organization was not perceived by the line organizations to be an accountable function.

During the outage, a Shift Supervisor was temporarily added to the Outage group for the remaining part of the outage. This provided operational knowledge to the group and contributed to the outage recovery. As a permanent change, two senior supervisors have been added to the group as permanent members of the Outage organization, one Maintenance Superintendent and one Shift Supervisor. To give the group the accountability they require, the Outage group was transferred to the Plant Manager's organization, with the Outage Manager now reporting to the Plant Manager. In addition the scheduling personnel now get their direction directly from the outage group.

The Outage Group is strengthened during a major outage also, by adding Containment Outage Coordinators to the group. In this manner, there will be an Outage group representative on each shift working in containment during a major outage period.

WCNOC has also strengthened the cooperation between organizations by structuring a periodic meeting, chaired by the Outage Manager, to develop minor and major outage plans. All affected working groups attend these meetings including Engineering, Procurement, and Operations.

These changes, plus the changes in the plant organization combining Maintenance with the Modifications Group provide a vertical integration of the work function with proper line authority for direction and approval of outage activities. These changes are strong improvements to the total organization.

In the overall improvement area WCNOC has looked closely at five specific items, Management Effectiveness, Communications Problems, Work Planning, Procedure Problems and Quality Problems. In each of these, the concerns were identified, the corrective action identified and the individual responsible recognized.

In a similar manner the concerns and the areas for improvement resulting from a review of Refueling Outage II were examined and specific assignments made to ensure the identified areas of concern were not overlooked in any future outage.

I. Quality Programs and Administrative Controls Affecting Quality

Recommended Licensee Actions

Increased corporate management involvement in site activities is recommended. In particular, additional corporate management involvement is needed to ensure that proper engineering and involvement is maintained in all activities.

Response to Recommended Licensee Actions

Although the activities in this area are very much interrelated, this section of the report is divided into three functional areas which are discussed below.

a) Engineering

Cooperation and coordination between the plant staff and various technical support groups such as Engineering, Quality and Safety Engineering Group have become a major priority at Wolf Creek. Experiences like those cited in the SALP report have taught the importance of improving communications between the plant operating staff and technical support organizations. Engineering and Operations Department management have assessed their current means of communication, and are implementing major improvements which are discussed below.

In the Operations group, plant management has been instructed to maintain daily contact with Engineering and Quality to ensure the plant issues are promptly addressed with consideration to design conformity, and quality program compliance as well as operability.

The Engineering organizations normally communicate limiting conditions and required operator actions to the plant staff through their disposition/safety evaluation packages. To ensure that the requirements of engineering dispositions are more visible to all organizations within Operations, engineering personnel have been instructed to discuss any special requirements of dispositions during the daily management meeting. In addition, engineering procedures used for the disposition of nonconforming conditions have been revised to require the engineers to describe the affected design basis in addition to their technical resolution when resolving problems. This change will improve communication of design basis information to the plant staff so that design considerations can routinely be factored into plant operating decisions.

Much of the communication between the Operating staff and Engineering is formalized in written work documents. WCNOG understands the need for formal documentation of technical requirements and design changes. However, WCNOG also recognizes that formal work document processes sometimes tend to inhibit interaction between departments because of the various approvals required before these documents can be transmitted across organizational lines and simply because of the time inherent in preparation of formal documents. The Engineering and Operations departments are committed to a new policy of openness whereby all groups verbally exchange preliminary information and actively participate in the resolution of problems. Of course those technical issues which have safety significance will continue to be documented through the formal methods; but face to face coordination prior to initiation of the documents will expedite needed information exchange. For nonsafety-related activities, engineering will document this technical information through memos to operating personnel, with a copy to the Control Room. This will provide an expedited means to convey design information to the Operating staff.

These measures will enhance Engineering's input, Operation's responsiveness, and improve cooperation and coordination between all organizations.

WCNOC has assembled an experienced engineering staff with technical expertise, however, partially as a result of the NRC's Safety Systems Outage Modification Inspection (SSOMI) at Wolf Creek last fall, WCNOC has become aware that the engineering organizations do not consistently evaluate the effects of modifications on original design. The need to ensure that the engineering staff firmly understands the Wolf Creek - specific design basis is being stressed. Two major projects have been undertaken to address this, a design transition training program and a design basis turnover project.

A design transition training plan was developed for technical personnel in the Nuclear Plant Engineering Division. This training is taught by experienced engineers from the original design A/E firm and consists of twenty-eight (28) courses - each 8 to 16 hours in length for the civil, electrical, instrument/control, and mechanical engineering disciplines. In addition to Engineering, members of the plant staff from Maintenance, I&C, and Results Engineering also attend. The planned objectives for each course include training in the requirements and intent of the original Wolf Creek design, an understanding of the analytical methods employed for the original Wolf Creek design, and a familiarization with the design input documents which define the original design. The design-transition training program began in mid-1987 and will be complete by Spring, 1988.

In addition to this transition training, Engineering has methods in place to systematically evaluate the experience of individual engineers to determine developmental needs and to provide proficiency training in specific technical areas.

Proficiency training is normally provided through university continuing education, industry-sponsored programs, on-the-job training with more experienced engineering personnel, and through contracted, on-site course work.

WCNOC is confident that these training programs will channel efforts to improve the depth of engineering expertise relative to the Wolf Creek specific design basis. This increased expertise will strengthen WCNOC's engineers' consideration of the original design basis for safety evaluations and modifications. It will also promote more timely technical support of the operating staff.

In addition to the engineering transition training mentioned previously, WCNOC management has initiated a design basis turnover project. This project will result in the incorporation of the Wolf Creek design basis into our configuration control program and will provide more expedient retrieval of technical information by engineering and operations personnel.

This project will involve turnover of remaining design basis documents from the original A/E. Phase I of this project began in January, 1988 and is scheduled to be completed in December, 1988. This project will result in a clearly defined methodology for engineers to assemble pertinent design basis requirements during the design change process and will improve the ability to retrieve design intent information quickly. WCNOC is confident that this project will strengthen the Engineering staff's understanding of the original design basis.

Senior management in both the Engineering and Operations Departments recognize that they need to focus more attention on job prioritization so that significant safety work is completed in a timely manner. Each department has been directed to implement methods to screen work activities as needs are recognized. Safety significant work is assigned a high priority, then scheduled and monitored by upper management through completion. Operations and Engineering departments routinely meet to assess work load and coordinate shared work scopes to ensure compatibility. This will allow management to focus attention on completing significant safety work so that follow-up actions, like those mentioned in the SALP report, are identified and monitored through timely completion.

Improved coordination of significant jobs between the Engineering and the Operating staff is also paramount. WCNOC is currently in the process of completing an extensive project which will result in a more structured planning process for major modifications. At the start of each major modification, a formal scoping session is held to develop a modification plan for all phases of the job. The scoping session includes a field walkdown and results in a clear definition of the problem, cause of the problem, scope of work, assigned organizational responsibilities, relative priority and schedule. These sessions are attended by "worker" level personnel from the appropriate organizations in Engineering and Operations who have detailed hands-on knowledge of the problems, operational considerations, and design requirements. Proposed modification plans are reviewed and approved by all levels including senior management in the Engineering, Operations, and Quality departments. This modification

planning process is supported by a performance monitoring program which allows our management to ensure that significant jobs proceed according to plan and remain well coordinated. Development of this refined planning process began in 1987 and will be fully functional by December, 1988. When this process is fully functional, it will provide a mechanism to focus Engineering's and Operation's talent on specific problem areas in the plant and will improve the sharing of information between both departments.

b) Quality Assurance

The Quality Department has been reorganized to more effectively group similar functions. These changes included the consolidation of all QA activities relating to suppliers, procurement and materials into one division to ensure effective management oversight. This change improved communications and resulted in the ability to better coordinate vendor specific quality requirements with the Purchasing department. This can decrease the probability of problems such as the noncode part being procured for use as a code boundary. It also provided for direct involvement and supervision by senior Quality staff members in the receiving and inspection process. This will reduce problems such as the improperly documented receipt inspection of the reactor vessel O-ring seals.

Quality Department procedures have been reviewed and revised where necessary to ensure they clearly communicate specific performance methods and criteria to the people doing the job. Personnel are receiving training on these procedures. Specific job details are reviewed prior to the start of activities to ensure all requirements are understood. This will help eliminate problems such as the incomplete inspection performed at the installation of the reactor vessel O-rings and the problems identified with weld control inspections during the outage.

WCNOC recognizes the importance of "performance-based" assessments and had previously arranged for training of our QA audit and surveillance personnel. This training was conducted July 19-21, 1988. WCNOC is confident that this performance-based approach will result in QA audits and surveillances that focus on plant safety and reliability rather than procedure and record reviews.

The Quality Department is currently performing research to develop a corporate program for root cause analysis (RCA). RCA programs have been requested from several other utilities and consulting firms. After careful review of these programs a corporate policy will be issued. This RCA program will be factored into the procedures used to resolve nonconforming hardware conditions. These procedures will also consider the need to evaluate the cause of the nonconformance for potential generic implications, as well as methods to implement and track generic corrective actions for hardware nonconformances. This program will ensure that problems like the generic implications in the pipe wall thinning issue are

eliminated in the future. Training in RCA methods will be provided to user groups. This program will ensure that root cause analysis is comprehensive and consistent throughout the company.

Wolf Creek management has become more aware of the need for management involvement in the corrective action process. On July 6, 1988, an escalation policy was issued by the President/CEO which will ensure senior management involvement in corrective actions which are untimely or inadequate. In addition, every effort is being made to ensure that open communications are maintained between line organizations such as Operations, Engineering and the Quality department. Several groups in our Quality department are physically located with their line counterparts to promote ongoing communication. The office of the QA Manager is located adjacent to the Plant Manager's office to ensure there is an open and ongoing exchange of information on issues regarding plant safety and reliability.

These actions are fully supported by the corporate commitment to excellence. WCNOG is confident that these collective actions will serve to strengthen the Quality program.

c) Management and Administrative Controls

WCNOG agrees that the response to the safety-related pipe wall thinning issue was not timely and lacked consideration for long-term design integrity and ASME Code compliance. Our plant management failed to solicit and consider Engineering input in the early stages, including the possibility of generic implications.

One of the most effective changes in improving teamwork and cooperation has been the significant restructuring of the daily management meeting. The attendance of key management personnel from the plant staff, Engineering, Quality and other support groups is now required. This meeting is also routinely attended by the NRC resident inspectors. The meeting includes a review of current plant conditions, new work requests and current work schedule. At this meeting, there is an emphasis on a thorough airing of issues in a non-threatening environment. Opportunities are available to express design concerns and present any problems that might relate to compliance with the Quality program.

The problems with the chlorine monitors started in April of 1985 and have resulted in numerous Licensee Event Reports (LERs). It became obvious early that there may be inherent design flaws in these instruments. WCNOG is in the process of qualifying different type of monitor and will be installing them during the next refueling outage.

The end result here is the acknowledgment by WCNOG management that the resolution of these problems was not timely. WCNOG has learned its lessons and problems like the ESW pipe issue and the chlorine monitors will be pursued aggressively. Primarily, this improvement will be a result of teamwork, with all departments involved in plant activities.

The emphasis is now on teamwork to ensure effective cooperation and coordination. The ability to get to the bottom line and permanently resolve problems through a comprehensive corporate approach to root cause analysis is being required. The goal at Wolf Creek is aggressive management involvement to ensure that issues are resolved correctly and in a timely manner and to ensure that all necessary resources are brought to bear in the operation of Wolf Creek Generating Station.

J. Licensing

Recommended Licensee Actions

The licensee should improve the quality of the safety evaluation summaries submitted pursuant to 10 CFR 50.59 and should improve the content of licensing submittals to preclude the need for staff requests for additional information that could have been foreseen by the licensee.

Response to Recommended Licensee Actions

The SALP evaluation of the Licensing area has been reviewed and while WCNOG has a slightly different perspective than the NRC on three of the items discussed in the report, actions are being taken to implement the "Recommended Licensee Actions."

WCNOG is obtaining examples of what the NRC Project Manager considered acceptable 50.59 annual reports. These will be evaluated and the necessary adjustments made in the next annual report so that the requested level of detail can be provided.

Although these actions are being taken, WCNOG is somewhat disappointed that this issue was cited in the SALP report. The regulations require a summary and do not provide guidance on the level of detail. A number of annual reports have been reviewed which revealed a wide variety of depth of information in the reports. For several of these reports that WCNOG considers similar to WCNOG's annual report, nothing was found in their SALP reports or the inspection reports of those utilities to indicate that the level of detail was insufficient. When the NRC Project Manager first questioned WCNOG's annual report, WCNOG requested the NRC's guidance relative to this item that was applicable to all plants. The Licensing division was informed that the guidance did not exist. WCNOG believes it is inappropriate to cite this issue in the SALP report since WCNOG was attempting to get generic NRC guidance on the acceptable level of detail and since there appears to be a large variance in what NRC Project Managers find acceptable.

WCNOG will strive to provide the necessary information in all NRC submittals. Internally, WCNOG will be more critical in the review of draft NRC submittals and assure that the submittals provide the information necessary for a thorough regulatory review.

As for the comments relative to the IST program meeting and subsequent submittal of Rev. 6 of the IST program, WCNOG has a slightly different recollection of the agreements. WCNOG understood the individual reviewer's position relative to his interpretation of the code requirements. WCNOG believed at that time, as WCNOG still believes, that the proposed testing met the requirements. Therefore, WCNOG exercised its Regulatory rights and submitted the program the way WCNOG thought was best. The NRC exercised its authority and formally rejected the proposal. This was simply a case of exercising the regulatory process. Since the regulatory process was followed, WCNOG believes it is inappropriate to downgrade the WCNOG project in the SALP report for using the Regulatory process.

K. Training

Recommended Licensee Action

The licensee should further emphasize the need for oversight of operator requalification training and the need for the training staff to be more attentive to details in the performance of their activities. Licensee management should continue their oversight and support of the training of the nonlicensed staff.

Response to Recommended Licensee Actions

In training, WCNOG is committed to a positive program of dealing with the Training needs of the entire organization. Training is continuing, for example to emphasize advanced college programs for personnel through the involvement with Kansas State and Emporia State Universities. The successful program of obtaining college credit for selected training courses in the Training Programs by virtue of the academic accreditation program has given the programs a better acceptance by the individual trainees.

WCNOG does recognize the NRC's concerns for increased management attention to the proper level of detail and is striving to accomplish that.

Additional Response

While WCNOG basically agrees with and is implementing the NRC's recommendations, some of the items discussed in the evaluations deserve further discussion from WCNOG's perspective.

The SALP report for Training seemed to stem from one NRC inspection report (50-482/87-19). The overall effect is that the Training category rating at Wolf Creek was reduced even though there were significant positive accomplishments during the reporting period. These accomplishments include achievement of full corporation membership in the National Academy for Nuclear Training and a recommendation for credit equivalency of 90 hours of college and votech credit by the American Council on Education.

To address the NRC comment in the SALP report about an informal method of tracking licensed operator records, WCNOG has a slightly different interpretation of the event. A formal mechanism did exist to track required reactivity manipulations and is included in station records. The Training Coordinator was using prudent judgment by maintaining his own parallel tracking mechanism in a checklist format to ensure required performance. The checklist was for planning purposes and was not intended to replace our formal tracking mechanism. As was mentioned in the NRC inspection report, the instructors efforts were beneficial. The report does not state that the formal mechanism was either missing or insufficient. The correction of the cause of the missed manipulations was management emphasis that the Training Coordinator would have the personal responsibility to overview this activity. As verified by your inspector in the inspection report the emphasis appeared to be effective in accomplishing its desired results.

SECTION III

ADDITIONAL COMMENTS

This section list minor errors in the SALP report which have been identified by WCNOG. There is no discussion of these errors, only a clarification of the facts as reflected in WCNOG's records. The errors are identified by Page, Table or Section number in the SALP report.

Page 30

The last outage listed is not correct. WCNOG had 242.5 hours in January plus 379.5 hours in February for a total of 621.7 hours. No mention was made of the exciter/ generator out that followed.

Page 19

The Reactor vessel O-ring outage was followed by a generator/exciter outage which lasted a total of 10 days in January and 16 days in February for a total of 25 days, 21.7 hours. The report states 16 days.

Table 3 & Page 24

Correction

10 LERs
8 CRVIS
6 from Cl⁻ monitors

13 LERs
11 CRVIS
9 from Cl⁻ monitors

Table 1

I. Quality Programs

IV

Correction

9

7

Total

25

23

Table 2 page 4

The last three violations were actually one violation with three examples. Violation 50/482-8815.

Training page 27

License Exams - The reported statistics of 5/7 ROs and 6/7 SROs passing their examinations is in error. Wolf Creek statistics indicate that 4/6 ROs and 7/7 SROs passed their exams. It should be noted that one RO candidate was withdrawn from the examination process by Wolf Creek. Also, Wolf Creek presently has 34 SROs and 17 ROs versus the 36 SROs and 15 ROs mentioned in the SALP report.