

Wolf Creek 1

4Q/2013 Plant Inspection Findings

Initiating Events

Significance:  Dec 31, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Assess Risk Prior to Performing Online Maintenance to an Offsite Power Circuit Component

The inspectors identified a Green non-cited violation of 10 CFR 50.65(a)(4) for the failure to assess risk associated with an emergent maintenance activity performed on one of the offsite power circuit components inside the Wolf Creek switchyard. Specifically, Wolf Creek arranged for the transmission system maintenance companies to recharge SF6 gas in a 13.8kV breaker actively feeding the train A Class 1E distribution system without performing a risk assessment or management actions to verify the readiness of onsite power sources. The inspectors walked down the task and determined that problems during the task could cause the loss of SF6 pressure, which would have caused this breaker to automatically open. Inspectors determined that operators failed to recognize this potential risk impact, and had incorrectly assumed that being classified as routine maintenance meant that the risk had been pre-determined to be low when no risk evaluation existed.

The inspectors determined that failure to assess risk associated with an emergent maintenance activity in accordance with station procedure AP 22C-003, "Online Nuclear Safety and Generation Risk Assessment," was a performance deficiency. The performance deficiency was more than minor because it affects the switchyard activities area of the protection against external factors attribute of the Initiating Events Cornerstone. Using the Inspection Manual Chapter 0609, Appendix K, "Maintenance Risk Assessment and Risk Management Significance Determination Process," the inspectors determined that the finding was of very low safety significance (Green) because the risk deficit was small and the duration of the maintenance was brief. The inspectors determined that the finding did not have a cross-cutting aspect because the performance deficiency was caused by an inadequate procedure change that was made in 1998, and did not represent current performance.

Inspection Report# : [2013005](#) (*pdf*)

Significance:  Oct 28, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Ensure that Degraded Voltage Relay Minimum Allowable Time Delay Value is Bounded by Analyzed Value

The team identified a Green, non-cited violation of 10 CFR 50, Appendix B, Criterion III, "Design Control," which states, in part, "Measures shall be established to assure that applicable regulatory requirements and the design basis are correctly translated into specifications, drawings, procedures, and instructions. The design control measures shall provide for verifying or checking the adequacy of design, such as by the performance of design reviews, by the use of alternate or simplified calculational methods, or by the performance of a suitable testing program." Specifically, on May 9, 2003, Calculation XX-E-009, "System NB, NG, PG Undervoltage/Degraded Voltage Relay Setpoints," Revision 1, identified that the degraded voltage relays minimum time delay was 7.5 seconds, and the maximum time delay was 8.5 seconds. During testing of the degraded voltage relays, the calculation states, "In all cases the steady state voltage on NB01 and NB02 recovered within the 7.5 seconds accident criteria. However in some cases the

recovery time is marginal.” This requirement was not correctly translated into Surveillance Test Procedures STS IC-805A and STS IC-805B which allow a minimum time delay of 7.0 seconds, and a maximum time delay of 9.0 seconds for the degraded voltage relays timeout period during accident conditions. The licensee has entered this issue into their corrective action program as Condition Report CR-72496.

The team determined that the licensee’s failure to ensure that the analyzed minimum allowable degraded voltage relay time delay of 7.5 seconds and maximum allowable degraded voltage relay time delay of 8.5 seconds, was incorporated into acceptance criteria for surveillance testing procedures was a performance deficiency. This finding was more than minor because it was associated with the Procedure Quality attribute of the Reactor Safety Initiating Events Cornerstone and adversely affected the cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. Specifically, it was indeterminate whether the design requirement to prevent spurious actuation of the degraded voltage relays and consequential loss of offsite power would have been met if the time delay had been set at less than 7.5 seconds or greater than 8.5 seconds. In accordance with NRC Inspection Manual Chapter 0609, Appendix A, Exhibit 1, “Initiating Events Screening Questions,” the finding was determined to have very low safety significance (Green), because it did not cause a reactor trip and loss of mitigation equipment. This finding did not have a cross-cutting aspect because the most significant contributor to the performance deficiency did not reflect current licensee performance.

Inspection Report# : [2013008](#) (pdf)

Significance:  Jul 24, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Analyze Erected Scaffolding for Fire Impairment and Transient Combustible Loading

The inspectors identified a non-cited violation of Technical Specification 5.4.1.d “Fire Protection Program Procedures” for the failure to analyze scaffolding for fire protection impairments and transient combustible loading. The cause of the finding was a procedure change that allowed for a grace period of one working day to complete a fire protection review of newly erected scaffolding. As a result, there was no longer a direct interface with the scaffold builders and fire protection engineers, which complicated scoping and tracking the required inspections.

Failure to analyze scaffolding for fire impairment and transient combustible loading is a performance deficiency. The performance deficiency is more than minor because it affects the protection against external factors attribute of the Initiating Events Cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. The inspectors evaluated the finding using Inspection Manual Chapter 0609, Appendix A, “Significance Determination for Findings at Power”, Exhibit 1, “Initiating Events Screening Questions”, Section E, “External Event Initiators”, and determined that the finding was of very low safety significance (Green) because the finding did not impact the frequency of a fire initiating event. The inspectors determined that this finding had a cross-cutting aspect in the human performance area of work control, because the licensee failed to appropriately coordinate work activities by incorporating the need for planned compensatory actions. Specifically, Wolf Creek did not ensure that a fire protection assessment of scaffold 13-S100 and 13-S134 was performed in a timely manner which resulted in compensatory measures for the impaired sprinkler heads and transient combustible material not being established.

Inspection Report# : [2013004](#) (pdf)

Significance:  Jun 30, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Follow Station Procedures

The inspectors identified a Green non-cited violation of 10 CFR Part 50, Appendix B, Criterion V, “Instructions,

Procedures, and Drawings,” which states, in part, “activities affecting quality shall be prescribed by procedures of a type appropriate to the circumstance and accomplished in accordance with these procedures.” Contrary to the above, the licensee failed to ensure procedures related to the boric acid corrosion control program were adequate and properly implemented. Specifically, prior to February 19, 2013, the licensee failed to: (1) resolve discrepancies within the boric acid corrosion control program procedure; (2) resolve discrepancies between the boric acid corrosion control program procedure and the boric acid leak management procedure; and (3) failed to track and resolve leakage for locations where health physics had installed drip catch containments, to review the Health Physics Drip Bag Log as part of the quarterly outside containment walkdown, and to add component locations to the program. Further, the licensee failed to periodically assess the effectiveness of the program on a refueling frequency. The violation was entered into the licensee’s corrective action program as Condition Report 65212.

The inspectors determined that the failure to recognize discrepancies between boric acid control procedures and the failure to follow boric acid program procedures was a performance deficiency. The performance deficiency was more than minor because it affected the Initiating Events Cornerstone attribute of procedure quality and affected the cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations, and if left uncorrected, the performance deficiency had the potential to lead to a more significant safety concern. Specifically, failure to resolve discrepancies within procedures or track and resolve leak locations where health physics had installed drip catch containments had the potential to mischaracterize leaks or allow leaks to corrode safety related systems. Using Inspection Manual Chapter 0609, Appendix A, “The Significance Determination Process for Findings At-Power,” the finding was determined to be of very low safety significance (Green), because the finding was a procedure quality problem that did not represent a loss of system safety function, and did not screen as potentially risk significant due to a seismic, flooding, or severe weather initiating event. The finding had a cross-cutting aspect in the area of human performance associated with the work practices component because the licensee failed to ensure supervisory and management oversight of work activities, including procedure appropriateness and compliance, such that nuclear safety is supported [H.4(c)].

Inspection Report# : [2013003](#) (*pdf*)

Significance:  Jun 30, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Identify Leakage at Refueling Pool Cavity

The inspectors identified a Green non-cited violation of 10 CFR Part 50, Appendix B, Criterion XVI, “Corrective Action,” which states, in part, “Measures shall be established to assure that conditions adverse to quality are promptly identified and corrected.” Contrary to the above, the licensee failed to identify and correct a condition adverse to quality in a timely manner. Specifically, prior to February 19, 2013, the licensee failed to document the large area of boric acid leakage and corroded steel plates on the south primary shield wall of the containment refueling pool. The violation was entered into the licensee’s corrective action program as Condition Report 64213.

The inspectors determined that the failure to promptly identify and evaluate a condition adverse to quality was a performance deficiency. The performance deficiency was more than minor because it affected the Initiating Events Cornerstone attribute of human performance and affected the cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations, and if left uncorrected, the performance deficiency had the potential to lead to a more significant safety concern. Specifically, failure to implement corrective actions could result in increased leakage and further degradation of the safety system. Using Manual Chapter 0609.04, “Phase 1 – Initial Screening and Characterization of Findings,” the inspectors determined that this finding was of very low safety significance (Green), because it was not a design or qualification deficiency, did not represent a loss of system safety function, and did not screen as potentially risk significant due to a seismic, flooding, or severe weather initiating event. The finding had a cross-cutting aspect in the area of human performance associated with the work practices component because the licensee failed to define and

effectively communicate expectations regarding procedural compliance and that personnel follow procedures [H.4(b)].
Inspection Report# : [2013003](#) (*pdf*)

Significance:  Jun 30, 2013

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Update Station Procedures and Train Operators Regarding the Effects of Implemented Design Changes to the Turbine Control System

A Green self-revealing non-cited violation of Technical Specification 5.4.1.a was identified for failure to properly update operating procedures and train operators on the effects of a recently installed modification. Specifically, procedures were not adequately revised to provide guidance for operating the new Westinghouse Ovation digital turbine controls. As a result, operators shifted operating modes at a power level that caused an 11 percent power increase due to the combined characteristics of the steam control valves and the turbine control unit. Additionally, operators were trained to shift control modes at low power levels, where minor transients occurred, but were not restricted from performing the shift at high power levels, where the transient could be more significant. This issue was entered into the licensee's corrective action program under Condition Report 68711.

Failure to update station operating procedures to provide adequate guidance for design changes, and failure to adequately train operators on those implemented design changes is a performance deficiency. The performance deficiency is more than minor because it affected the design control, procedure quality, and human performance attributes of the Initiating Events cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. Using Inspection Manual Chapter 0609, Appendix A, Checklist 1, "Initiating Events Screening Questions," and the inspectors determined that the finding was of very low safety significance (Green) because the finding did not result in a reactor trip coincident with the loss of mitigation equipment. The inspectors determined that this finding had a cross-cutting aspect in the area of human performance area of work control, because the licensee did not appropriately communicate and coordinate during activities in which interdepartmental coordination was necessary to assure plant and human performance. Specifically, Wolf Creek did not communicate and coordinate to ensure that procedure guidance and operator training adequately conveyed the operational impacts of shifting turbine control modes at different power levels. [H.3(b)](

Inspection Report# : [2013003](#) (*pdf*)

Significance:  Jun 30, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Properly Manage Reactivity Changes when Swapping Turbine Steam Admission Modes from Full to Partial Arc

Inspectors identified a Green non-cited violation of Technical Specification 5.4.1.a for the failure to follow Conduct of Operations and Reactivity Management procedures. The inspectors reviewed an unplanned 11 percent power increase during a shift in turbine control modes, and identified that pre-job briefings did not adequately discuss expected plant response, operators did not take action to limit the power increase when an unexpected response was observed, and management was not adequately involved in decision making prior to continuing power ascension before the details of an apparent turbine control malfunction were fully understood. This issue was entered into the licensee's corrective action program under Condition Report 68711.

Failure to provide contingency actions for a greater than anticipated reactor transient in the pre-job reactivity brief, and continuing with power ascension without understanding the cause of the unexpected turbine control system behavior is a performance deficiency. The performance deficiency is more than minor because it affected the human performance attributes of the Initiating Events cornerstone objective to limit the likelihood of events that upset plant

stability and challenge critical safety functions during shutdown as well as power operations. Using Inspection Manual Chapter 0609 Appendix A, Checklist 1, "Initiating Events Screening Questions," and the inspectors determined that the finding was of very low safety significance (Green) because the finding did not result in a reactor trip coincident with the loss of mitigation equipment. The inspectors determined that this finding had a cross-cutting aspect in the area of human performance area of work practices because the licensee failed to communicate human error prevention techniques, such as holding pre-job briefings, self and peer checking, and proper documentation of activities such that work activities were performed safely. In addition, personnel proceeded in the face of uncertainty or unexpected circumstances. Specifically, in the first example control room operators pre-job reactivity brief was not appropriate commensurate with the risk of the assigned task; in the second example station personnel proceeded in the face of uncertainty. [H.4(a)]

Inspection Report# : [2013003](#) (*pdf*)

Significance:  Mar 30, 2013

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Promptly Identify and Correct Reactor Coolant System Pressure Boundary Leakage

The inspectors reviewed a self-revealing non-cited violation (NCV) of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Actions," for the failure to promptly identify and correct the source of a reactor coolant system pressure boundary leak from about August, 2012, through February 5, 2013. On February 4, 2013, Wolf Creek was performing a routine boric acid walkdown of containment as part of Refueling Outage 19. A cracked weld spraying reactor coolant pump seal water was observed on the upstream side of valve BBV130, reactor coolant pump A seal water supply line drain valve. The licensee had attributed increased leakage in July to reactor coolant system leakage identified in early June 2012, past emergency core cooling system check valves, without conducting inspections to rule out pressure boundary leakage.

Wolf Creek's failure to promptly identify and correct the cause of reactor coolant system pressure boundary leakage is a performance deficiency. The issue is more than minor because, if left uncorrected, it could lead to a more significant safety concern in that leakage could increase over time. The inspectors assessed the significance of the issue using IMC 609, Appendix A, "Significance Determination Process for Findings at Power," Exhibit 1, "Initiating Events Screening Questions," Section A, "LOCA Initiators." The inspectors determined that the finding was of very low safety significance (Green) because after a reasonable assessment of degradation, the finding could not result in exceeding the reactor coolant system leak rate for a small loss of coolant accident and the finding would not have affected other systems used to mitigate a loss of coolant accident resulting in a total loss of their function (e.g., Interfacing System LOCA). The inspectors determined that this issue had a cross-cutting aspect in the human performance cross-cutting area; Wolf Creek did not maintain long term plant safety by minimization of long-standing equipment issues to support safety. Specifically, the pressure boundary leakage was more difficult to identify because of concurrent check valve leakage into emergency core cooling systems, an intermittent but long-standing issue [H.2 (a)] (Section 40A3).

Inspection Report# : [2013002](#) (*pdf*)

Mitigating Systems

Significance:  Dec 31, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Preclude Repetition of a Significant Condition Adverse to Quality Affecting Class 1E Air Conditioning Unit

A Green self-revealing non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Actions," was identified for failure to identify the underlying causes of the train A Class 1E air conditioner slug flow in the refrigerant prior to a recurrent failure.

Failure to correctly identify the causal links between a known direct cause and the underlying root cause in order to preclude repetition is a performance deficiency, specifically when considering that the condition adverse to quality was identified as a significant condition adverse to quality because its repetition would have a serious effect on operability of technical specification systems, structures, and components, by the screening review team per station procedure AI 28A-010, "Screening Condition Reports," Step 6.3.5. The performance deficiency is more than minor because it affected the equipment performance attribute of the Mitigating Systems Cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically the leftover debris in the system resulted in a subsequent maintenance outage to replace rapidly degrading components. Using the Inspection Manual Chapter 0609, Appendix A, Exhibit 2, "Mitigating Systems Screening Questions," the inspectors determined the finding was of very low safety significance (Green) because the finding did not represent an actual loss of function of at least a single train for greater than its technical specification allowed outage time and the finding did not represent an actual loss of function of one or more non-technical specification trains of equipment designated as high safety-significant in accordance with the licensee's maintenance rule program for greater than 24 hours. The inspectors determined that the cause of the finding had a cross cutting aspect in the area of problem identification and resolution. The licensee did not thoroughly evaluate problems such that the resolutions address causes and extent of conditions, as necessary. This includes properly classifying, prioritizing, and evaluating for operability and reportability conditions adverse to quality. Specifically, the licensee framed the cause evaluation within the scope of the Notice of Enforcement Discretion (NOED) request and repair plan, and therefore overly focused attention on the compressor itself, and did not consider system components outside the compressor until after the second failure in September.

Inspection Report# : [2013005](#) (pdf)

Significance: G Dec 31, 2013

Identified By: NRC

Item Type: FIN Finding

Failure Rates Exceed Twenty Percent for Annual Requalification Operating Tests

The inspector reviewed a self-revealing finding associated with licensed operator performance on the annual requalification operating tests. Specifically, 2 of 8 crews (25 percent) failed the simulator scenario portion of the operating test; and 11 of 46 licensed operators (23 percent) either failed the scenario or failed the job performance measure portions of the operating tests. The licensee remediated and retested the staff prior to returning them to licensed duties. Wolf Creek entered this finding into their corrective action program as Condition Report 75336.

In accordance with Inspection Procedure 71111.11, each of the following was a performance deficiency against expected licensed operator knowledge and abilities: 1) Greater than 20 percent of the crews failing their scenarios; and 2) greater than 20 percent of the licensed operator staff failing their operating tests. Using Manual Chapter 0612, "Power Reactor Inspection Reports," Appendix B, "Issue Screening," the inspector determined that the finding was more than minor because the performance deficiency was associated with the Mitigating Systems Cornerstone attribute of human performance, and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The inspector determined that this finding could be evaluated using Inspection Manual Chapter 0609, "Significance Determination Process," Appendix I, "Licensed Operator Requalification Significance Determination Process." This finding was of very low safety significance (Green) because the finding was related to the requalification exam results, did not result in a

failure rate of greater than 40 percent, and the licensed operators were remediated prior to returning to shift. This finding has a cross-cutting aspect in the area of human performance associated with resources, because the licensee failed to ensure that personnel were adequately trained to assure nuclear safety.

Inspection Report# : [2013005](#) (*pdf*)

Significance:  Oct 28, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Follow Procedure When Making Changes to Off-Normal Operating Procedure OFN NB-042

The team identified a Green, non-cited violation of 10 CFR 50, Appendix B, Criterion V, “Instructions, Procedures, and Drawings,” which states, in part, “Activities affecting quality shall be prescribed by documented instructions, procedures, or drawings, of a type appropriate to the circumstances and shall be accomplished in accordance with these instructions, procedures, or drawings.” Specifically, in 2007 the licensee failed to follow Procedure AP 15C-004, “Preparation, Review and Approval of Procedures, Instructions and Forms,” when making changes to safety-related emergency diesel generator surveillance testing Procedure OFN NB-042. The technical reviewer failed to identify that the power supply for the communication equipment for the dedicated operator was from non-essential power and would be lost during a loss of offsite power event, losing the communications between the control room and the operator. The licensee has entered this issue into their corrective action program as Condition Report CR-72711.

The team determined that the failure to follow Procedure AP 15C-004 when making changes to off normal operating Procedure OFN NB-042 was a performance deficiency. This finding was more than minor because it was associated with the Equipment Performance attribute of the Reactor Safety, Mitigating Systems Cornerstone, and adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the licensee failed to perform a technical walk-down of the procedure steps to verify the power supply for the communication equipment would not be lost during a loss of power event. In accordance with NRC Inspection Manual Chapter 0609, Appendix A, Exhibit 2, the inspectors determined the finding was of very low safety significance (Green), because the finding was not a design deficiency and did not result in the loss of operability or functionality. This finding did not have a cross-cutting aspect because the most significant contributor to the performance deficiency did not reflect current licensee performance.

Inspection Report# : [2013008](#) (*pdf*)

Significance:  Oct 28, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Verify or Check the Adequacy of Design Calculations

The team identified a Green, non-cited violation, with three examples, of 10 CFR 50, Appendix B, Criterion III, “Design Control,” which states, in part, “Measures shall be established to assure that applicable regulatory requirements and the design basis are correctly translated into specifications, drawings, procedures, and instructions. The design control measures shall provide for verifying or checking the adequacy of design, such as by the performance of design reviews, by the use of alternate or simplified calculational methods, or by the performance of a suitable testing program.” Specifically, on September 12, 2011, the licensee failed to verify or check the adequacy of design Calculation XX-E-006, “AC System Analysis,” Revision 6, by 1) not recognizing that the actual switchyard voltage could be lower than the calculated minimum voltage due to loop uncertainties of the switchyard voltmeters, 2) failing to provide a comparison between postulated loading levels and equipment ratings for distribution equipment, in order to verify that overloading conditions would not occur, and 3) not placing limits on the voltages on the Class 1E 480 Vac system which could exceed the allowable maximum equipment voltage rating of 506 Vac. The licensee has entered these issues into their corrective action program as Condition Reports CR-73244, CR-73240, and CR-73206.

The team determined that the licensee's failure to verify or check the adequacy of design Calculation XX E 006, "AC System Analysis," Revision 6, was a performance deficiency. This finding was more than minor because it was associated with the Design Control attribute of the Reactor Safety, Mitigating Systems Cornerstone, and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the licensee failed to verify or check the adequacy of design Calculation XX-E-006, "AC System Analysis," Revision 6, regarding loop uncertainties of the switchyard voltmeters, equipment loading, and maximum allowed Class 1E 480 voltage. In accordance with NRC Inspection Manual Chapter 0609, Appendix A, Exhibit 2, the inspectors determined the finding was of very low safety significance (Green), because the finding was not a design deficiency and did not result in the loss of operability or functionality. This finding had a cross-cutting aspect in the area of Human Performance, associated with the Resources component because the licensee failed to ensure that personnel, equipment, procedures, and other resources are adequate to assure nuclear safety by maintaining long term plant safety by maintenance of design margins.

Inspection Report# : [2013008](#) (*pdf*)

Significance: G Oct 28, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Prevent Over Voltages on the 480 Vac System During Emergency Diesel Generator Training

The team identified a Green, non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," which states, in part, "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." Specifically, in 2006, the licensee implemented corrective actions per Condition Report 2006-2062, to monitor the voltages for the 480 Vac system to ensure that over-voltages would not occur during emergency diesel generator testing. The licensee implemented voltage monitoring for the "B" Train 480 Vac system, but failed to monitor voltages of "A" Train, which had the same vulnerability. The licensee has entered this issue into their corrective action program as Condition Report CR-73209.

The team determined that the licensee's failure to implement corrective actions into diesel testing Procedure STS KJ-001A was a performance deficiency. This finding was more than minor because it was associated with the Equipment Performance attribute of the Reactor Safety, Mitigating Systems Cornerstone and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the licensee failed to ensure that over-voltages would not occur during the testing of the "A" train emergency diesel generator. In accordance with NRC Inspection Manual Chapter 0609, Appendix A, Exhibit 2, the inspectors determined the finding was of very low safety significance (Green), because the finding was not a design deficiency and did not result in the loss of operability or functionality. This finding did not have a cross-cutting aspect because the most significant contributor to the performance deficiency did not reflect current licensee performance.

Inspection Report# : [2013008](#) (*pdf*)

Significance: G Oct 28, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Ensure Motors are Operated Within Their Thermal Limits

The team identified a Green, non-cited violation of 10 CFR 50, Appendix B, Criterion III, "Design Control," which states, in part, "Measures shall be established to assure that applicable regulatory requirements and the design basis are correctly translated into specifications, drawings, procedures, and instructions. The design control measures shall provide for verifying or checking the adequacy of design, such as by the performance of design reviews, by the use of alternate or simplified calculational methods, or by the performance of a suitable testing program." Specifically, on June 26, 2013, the licensee issued drawing E-11005, "List of Loads Supplied by Emergency Diesel Generator,"

Revision 39, that identified certain motors with load brake horsepower in excess of the motor nameplate ratings, but failed to verify that the excess horsepower would not result in the motors exceeding their thermal design limits. Additionally, the brake horsepower values on the referenced drawing do not reflect the worst-case condition, which would occur when the diesel generator is operating at maximum allowable frequency and powering the motors. The licensee has entered this issue into their corrective action program as Condition Report CR-72945.

The team determined that the licensee's failure to evaluate motor loading to confirm margin exists to prevent overheating of the motors was a performance deficiency. This finding was more than minor because it was associated with the Design Control attribute of the Reactor Safety, Mitigating Systems Cornerstone and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, motors serving loads with demands in excess of the motor horsepower ratings were not analyzed to ensure that overheating would not occur. In accordance with Inspection Manual Chapter 0609 Appendix A, Exhibit 2, the inspectors determined the finding was of very low safety significance (Green), because the finding was not a design deficiency and did not result in the loss of operability or functionality. This finding had a cross-cutting aspect in the area of Human Performance, associated with the Resources component, because the licensee failed to ensure that personnel, equipment, procedures, and other resources are adequate to assure nuclear safety by maintaining long term plant safety by maintenance of design margins.

Inspection Report# : [2013008](#) (pdf)

Significance: G Oct 28, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Fully Implement Electrical Protection Criteria for Containment Penetrations

The team identified a Green, non-cited violation of 10 CFR 50, Appendix B, Criterion III, "Design Control," which states, in part, "Measures shall be established to assure that applicable regulatory requirements and the design basis are correctly translated into specifications, drawings, procedures, and instructions. The design control measures shall provide for verifying or checking the adequacy of design, such as by the performance of design reviews, by the use of alternate or simplified calculational methods, or by the performance of a suitable testing program." Specifically, on June 23, 2010, the licensee failed to verify that Calculation A-06-W meet all of the criteria identified in the Updated Safety Analysis Report, Section 8.1.4.3. The team determined that the criteria identified in the Updated Safety Analysis Report was not met for several circuits, where the vertical intercept of the magnetic only circuit breaker time-current curve overlaps the penetration conductor damage curve. This indicates that, for a sustained short circuit of a certain magnitude, the thermal limit of the conductor passing through a penetration could be exceeded without tripping of the magnetic-only circuit breaker. The licensee has entered this issue into their corrective action program as Condition Report CR-73124.

The team determined that the licensee's failure to ensure that containment penetrations are properly sized to meet the Updated Safety Analysis Report, Section 8.1.4.3, requirements was a performance deficiency. This finding was more than minor because it was associated with the Configuration Control attribute of the Reactor Safety, Barrier Integrity Cornerstone and adversely affected the cornerstone objective to ensure that physical design barriers protect the public from radionuclide releases caused by accidents or events. Specifically, the thermal limit of the penetration conductor could be exceeded without tripping the magnetic-only circuit breaker, jeopardizing the integrity of the electrical penetration. In accordance with NRC Inspection Manual Chapter 0609, Appendix A, Exhibit 3, "Barrier Integrity Screening Questions," the finding was determined to have very low safety significance (Green), because it did not result in an actual open pathway in containment and did not involve hydrogen igniters. This finding did not have a cross-cutting aspect because the most significant contributor to the performance deficiency did not reflect current licensee performance.

Inspection Report# : [2013008](#) (pdf)

Significance:  Oct 28, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Account for Flow Measurement Uncertainty when Operating the Residual Heat Removal Pumps in the Low Flow Regime

The team identified a Green, non-cited violation of 10 CFR 50, Appendix B, Criterion III, “Design Control,” which states, in part, “Measures shall be established to assure that applicable regulatory requirements and the design basis are correctly translated into specifications, drawings, procedures, and instructions. The design control measures shall provide for verifying or checking the adequacy of design, such as by the performance of design reviews, by the use of alternate or simplified calculational methods, or by the performance of a suitable testing program.” Specifically, on August 27, 2013, the team identified that the licensee had failed to account for flow measurement uncertainties of the Residual Heat Removal System. Technical Specifications require that when operating in Mode 6, the circulating residual heat removal flow is required to be greater than or equal to 1000 gpm for adequate heat removal and to prevent stratification, and Alarm Response Procedure ALR 00-049C, “RHR LOOP 1 FLOW LOW,” requires that when operating the residual heat removal pumps at low flows that the flow must be at or above 1700 gpm for pump protection. The failure to account for flow measurement uncertainties could allow flow to actually be below the required technical specification and alarm response limits, without the operator’s knowledge. The licensee has entered this issue into their corrective action program as Condition Reports CR-73071 and CR-73231.

The team determined that the failure to account for flow measurement uncertainties when operating Residual Heat Removal pumps at low flows was a performance deficiency. This finding was more than minor because it was associated with the Procedure Quality attribute of the Reactor Safety, Mitigating Systems Cornerstone and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the failure to account for flow measurement uncertainties in the residual heat removal system could allow operation below technical specification and alarm response limits and potentially damage the residual heat removal pumps. In accordance with NRC Inspection Manual Chapter 0609, Appendix G, “Shutdown Operations Significance Determination Process,” the finding was determined to have very low safety significance (Green), because the finding did not require a quantitative assessment because adequate mitigating equipment remained available and the finding did not constitute a loss of control as defined in Appendix G. This finding did not have a cross-cutting aspect because the most significant contributor to the performance deficiency did not reflect current licensee performance.

Inspection Report# : [2013008](#) (*pdf*)

Significance:  Oct 28, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Properly Assess Problems with Component Cooling Water Valve EGHV102

The team identified a Green, non-cited violation of 10 CFR Part 50, Appendix B, Criterion XVI, “Corrective Action,” which states, in part, “Measures shall be established to assure that conditions adverse to quality, such as failures, malfunctions, deficiencies, defective materials and equipment, and nonconformance are promptly identified and corrected.” Specifically, in April 2011 and November, 2012, the licensee failed to properly categorize Condition Reports CR-37825 and CR-60298 correctly, which resulted in the condition reports not getting an Apparent Cause Evaluation, to promptly identify and correct the cause of the Component Cooling Water Butterfly Valve EGHV0102 loose disc to shaft, failure of the groove pin in the valve, and to investigate the extent of condition for similar valves currently installed in the plant. The licensee has entered this issue into their corrective action program as Condition Report CR-73227.

The team determined the licensee’s failure to follow the Corrective Action Procedure AI 28A-010, “Screening Condition Reports,” which improperly categorized Condition Reports CR-37825 and CR-60298, which should have

had apparent cause evaluations performed, was a performance deficiency. This finding was more than minor because it adversely affected the Equipment Performance attribute of the Mitigating Systems Cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the failure to perform an apparent cause evaluation resulted in the licensee not identifying a root cause for the valve leakage, preventing reoccurrence, or investigating the extent of condition for other similar valves installed in the plant. In accordance with NRC Inspection Manual Chapter 0609, Appendix A, Exhibit 2, the inspectors determined the finding was of very low safety significance (Green), because the finding was not a design deficiency and did not result in the loss of operability or functionality. This finding had a cross-cutting aspect in the area of Human Performance, associated with Work Practices. Specifically the licensee defines and effectively communicates expectations regarding procedural compliance and personnel follow procedures.
Inspection Report# : [2013008](#) (*pdf*)

Significance:  Oct 28, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Provide Procedure Instructions to Remove Thermal Overload Bypass Jumpers

The team identified a Green, non-cited violation of 10 CFR 50, Appendix B, Criterion III, "Design Control," which states, in part, "Measures shall be established to assure that applicable regulatory requirements and the design basis are correctly translated into specifications, drawings, procedures, and instructions. The design control measures shall provide for verifying or checking the adequacy of design, such as by the performance of design reviews, by the use of alternate or simplified calculational methods, or by the performance of a suitable testing program." Specifically, in 1994, the licensee was committed to the requirements specified in Regulatory Guide 1.106, "Thermal Overload Protection for Electric Motors on Motor-Operated Valves," Revision 1, to remove the thermal overload bypass jumpers during maintenance and testing. The licensee failed to translate the requirements into Procedure MGE LT-099, "MOV Diagnostic Testing," and failed to include procedural guidance to remove the thermal overload bypass jumpers when performing maintenance testing that strokes the valve from the control room. Also, the Wolf Creek Updated Safety Analysis Report, Section 8.3.1.1.2, has incomplete information which does not support Regulatory Guide 1.106, in that it does not state that the thermal overload bypass jumpers should be removed when performing maintenance testing that strokes the valve. The licensee has entered this issue into their corrective action program as Condition Reports CR-73120 and CR-73219.

The team determined that the licensee's failure to provide procedure instructions to remove the thermal over-load bypass jumpers during motor-operated valve diagnostic testing as committed to in Regulatory Guide 1.106, Revision 1, was a performance deficiency. This finding was more than minor because it was associated with the Procedure Quality attribute of the Reactor Safety, Mitigating Systems Cornerstone and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the licensee failed to include procedural guidance to remove the thermal overload bypass jumpers when performing maintenance testing that strokes the valve from the control room, and to include the requirements of Regulator Guide 1.106 in the Updated Safety Analysis Report, Section 8.3.1.1.2, that the bypass jumpers will be removed during testing of the motor-operated valves. In accordance with NRC Inspection Manual Chapter 0609, Appendix A, Exhibit 2, the inspectors determined the finding was of very low safety significance (Green), because the finding was not a design deficiency and did not result in the loss of operability or functionality. This finding did not have a cross-cutting aspect because the most significant contributor to the performance deficiency did not reflect current licensee performance.

Inspection Report# : [2013008](#) (*pdf*)

Significance:  Oct 28, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Verify Adequacy of Electrical Protective Devices to Isolate Fire-Damaged Associated Circuits

The team identified a Green, non-cited violation of 10 CFR 50, Appendix B, Criterion III, "Design Control," which states, in part, "Measures shall be established to assure that applicable regulatory requirements and the design basis are correctly translated into specifications, drawings, procedures, and instructions. The design control measures shall provide for verifying or checking the adequacy of design, such as by the performance of design reviews, by the use of alternate or simplified calculational methods, or by the performance of a suitable testing program." Specifically, as of September 2011, Wolf Creek Updated Safety Analysis Report, Appendix 9.5 E, required isolation between safe shutdown circuits and non-safe shutdown (associated) circuits, such that "hot shorts, open circuits, or shorts to ground in the associated circuits will not prevent operation of the safe shutdown equipment." On September 29, 2011, the licensee completed study WCNO-171, "Post-Fire Safe Shutdown Associated Circuits Study," Revision 0, but failed to provide documented verification of the adequacy of electrical protective devices for associated shutdown circuits such that hot shorts or shorts to ground will not prevent operation of the safe shutdown equipment. The licensee has entered this issue into their corrective action program as Condition Report CR-73242.

The team determined that the licensee's failure to provide a documented comparison of upstream and downstream electrical protective devices with maximum short circuit levels, in order to verify the required coordination, was a performance deficiency. This finding was more than minor because it was associated with the Design Control attribute of the Reactor Safety, Mitigating Systems Cornerstone, and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the licensee was unable to provide an analysis to demonstrate that associated shutdown circuits would be isolated from the safe shutdown circuits during fire events. In accordance with NRC Inspection Manual Chapter 0609, Appendix A, Exhibit 2, the inspectors determined the finding was of very low safety significance (Green), because the finding was not a design deficiency and did not result in the loss of operability or functionality. The finding had a cross-cutting aspect in the area of Human Performance, Resources attribute, because the licensee failed to ensure that personnel, equipment, procedures, and other resources are adequate to assure nuclear safety by maintaining long-term plant safety by maintenance of design margins.

Inspection Report# : [2013008](#) (pdf)

Significance:  Oct 28, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Translate Design Basis Performance Requirements into Pump Surveillance Tests

The team identified a Green, non-cited violation of 10 CFR 50, Appendix B, Criterion XI, "Test Control," which states, in part, "A test program shall be established to assure that all testing required to demonstrate that structures, systems, and components will perform satisfactorily in service is identified and performed in accordance with written test procedures which incorporate the requirements and acceptance limits contained in applicable design document." Specifically, on August 28, 2013, the team identified that the licensee failed to incorporate minimum pump performance requirements into the corresponding pump surveillances for the Containment Spray and Residual Heat Removal pumps. The acceptance criteria did not adequately overlap with the pump design performance requirements. Further, instrument uncertainty was not adequately evaluated, nor incorporated into the tests. The licensee has entered this issue into their corrective action program as Condition Reports CR-73149 and CR-73070.

The team determined that the failure to establish and incorporate adequate acceptance criteria into the Containment Spray and Residual Heat Removal pump comprehensive surveillance tests was a performance deficiency. This finding was more than minor because it was associated with the Procedure Quality attribute of the Reactor Safety, Mitigating Systems Cornerstone and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the failure to incorporate adequate acceptance criteria and instrument uncertainties into the safety related surveillances could cause unacceptable pump performance conditions to go undetected. In accordance with NRC Inspection Manual Chapter 0609, Appendix A, Exhibit 2, the inspectors determined the finding was of very low safety significance (Green),

because the finding was not a design deficiency and did not result in the loss of operability or functionality. This finding did not have a cross-cutting aspect because the most significant contributor to the performance deficiency did not reflect current licensee performance.

Inspection Report# : [2013008](#) (*pdf*)

Significance: G Oct 28, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Fully Establish Design Control Measures for Vital Essential Chillers SGK05 A/B Air Conditioning Units

The team identified a Green, non-cited violation of 10 CFR Part 50, Appendix B, Criterion XVI, “Corrective Action”, which states, in part, “Measures shall be established to assure that conditions adverse to quality, such as failures, malfunctions, deficiencies, defective materials and equipment, and nonconformances, are promptly identified and corrected.” Specifically, since May 2011, the licensee had numerous opportunities, but failed to correct calculation GK06W and to adequately assess compensatory actions identified to supplement weaknesses in the calculations for operation of one vital air conditioning unit to cool both trains of Class IE electrical equipment. The licensee has entered this issue into their corrective action program as Condition Report CR73410.

The team determined the failure to promptly identify and correct the errors in Calculation GK06W and to have adequate compensatory measures in place as required by the calculation was a performance deficiency. This finding was more than minor because it adversely affected the Equipment Performance attribute of the Mitigating Systems Cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, without having an adequate calculation and compensatory measures, the licensee would not be assured that one vital air conditioning unit would be capable of cooling both trains of Class IE electrical equipment. In accordance with NRC Inspection Manual Chapter 0609, Appendix A, Exhibit 2, the inspectors determined the finding was of very low safety significance (Green), because the finding was not a design deficiency and did not result in the loss of operability or functionality. The finding had a cross-cutting aspect in the area of Human Performance, Resources component, because the licensee failed to ensure that personnel, equipment, procedures, and other resources are available and adequate to assure nuclear safety. Specifically, those resources necessary to provide complete, accurate, and up-to-date design documentations, and equipment are available and adequate to assure nuclear safety.

Inspection Report# : [2013008](#) (*pdf*)

Significance: G Jun 30, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Diesel Generator Pressure Switch Failed Due to Instrument Line Pressure Oscillations

A self-revealing non-cited violation of 10 CFR 50 Appendix B, Criterion XVI, Corrective Action, was identified on March 13, 2013. Specifically, the licensee replaced a jacket water pressure transmitter ten times, but failed to correct pressure oscillations that caused a fatigue failure of a pressure switch diaphragm, which rendered emergency diesel generator B inoperable. The inspectors concluded that the licensee ineffectively focused on correcting the apparent source of the pressure oscillations, but failed to evaluate the effects of the pressure cycles on components exposed to the same oscillations. This issue was entered into the licensee’s corrective action program as Condition Report 65624 Failure to analyze the effects of pressure oscillations in the emergency diesel jacket water system on interfacing system components is a performance deficiency. The performance deficiency is more than minor because it affected the equipment performance attribute of the Mitigating Systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Using Inspection Manual Chapter 0609 Appendix A, “Significance Determination Process for Findings at Power”, and determined that the finding screens as very low safety significance (Green) because the finding does not meet any

criteria outlined in the Exhibit 2, Section A. Specifically the finding did not represent a loss of system safety function and did not exceed its technical specification allowed outage time of 72 hours. The inspectors determined that the finding had a cross-cutting aspect in the area of problem identification and resolution evaluations because the licensee failed to ensure that issues that potentially affect nuclear safety are fully evaluated and addressed in a timely manner. [P.1(c)]

Inspection Report# : [2013003](#) (*pdf*)

Significance: G Apr 29, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Identify the Cause and Take Corrective Action to Preclude Repetition of a Diesel Generator Functional Failure

The inspector identified a NCV of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," for failure to determine the cause of a significant condition adverse to quality and take corrective action to preclude repetition. On October 22, 2009, the plant received multiple alarms for the A EDG due to actuation of speed control relays while in a standby condition. This condition would have prevented an automatic start of the A EDG. The licensee's handling of this issue had the following problems: the failure was entered into the CAP, but the licensee failed to recognize that this was a significant condition adverse to quality; the initial evaluation failed to identify that the cause of the failure was a circuit design error, and therefore the licensee failed to implement appropriate action to prevent recurrence; the extent of condition review failed to identify that the Turbine Driven Auxiliary Feedwater Pump (TDAFWP) was also affected; prior indications of the failure mechanism had not been entered into the CAP; and multiple examples of failure to follow the corrective action process contributed to not finding the actual cause sooner. This was entered into the licensee's CAP as CR 65323. The failure to determine the cause of a significant condition adverse to quality and take corrective action to preclude repetition was a performance deficiency. The performance deficiency was more than minor because it was associated with the equipment performance attribute of the Mitigating Systems Cornerstone and affected the cornerstone objective. Specifically, the failure to determine the cause and take effective corrective action for electrical noise that impacted the EDG speed switches resulted in the degraded condition continuing to exist for over two years after the initial failure. The inspector determined that the finding was of very low safety significance (Green) because the finding was a deficiency affecting the design or qualification of a mitigating structure, system, or component (SSC), but the corrective actions that were implemented were sufficient to ensure that the SSC maintained its operability and functionality.

The NRC determined the finding had a cross cutting aspect in the human performance area associated with decision-making - systematic processes because the licensee did not make safety-significant or risk-significant decisions using a systematic process when they evaluated the cause of the diesel generator failure.

Inspection Report# : [2013009](#) (*pdf*)

Significance: G Mar 30, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Initiate a Condition Report and Determine Extent of Condition for Emergency Diesel Generator Head Stud Failure

The inspectors identified a Green, NCV of 10 CFR 50 Appendix B, Criterion XVI, "Corrective Actions." The licensee did not initiate a condition report (CR) for a hardware failure of an emergency diesel generator structural component identified in October 2006. On October 15, 2006, while performing planned maintenance on the emergency diesel generator B, a broken cylinder head stud was discovered while disassembling the number four cylinder. None of the other seven studs on that cylinder showed any visible damage, so maintenance and engineering personnel assumed a surface nick was the cause of the failure and simply replaced the bolt under Work Order WO 06-288926-000. No CR was generated, as such there was no formal cause evaluation, no hardware failure analysis to specify the mode of degradation, or any other consideration of extent of condition for potential common cause failures was implemented.

On January 7, 2013, a broken cylinder head stud was found during maintenance on emergency diesel generator B. An independent laboratory determined that the stud had failed due to high cycle fatigue. Subsequent analysis of the stud that failed in 2006 confirmed the same failure cause.

Failure to initiate a condition report, determine the cause and take actions to prevent recurrence for a broken emergency diesel generator cylinder head stud, a significant condition adverse to quality, is a performance deficiency. The performance deficiency is more than minor and therefore a finding because, if left uncorrected, it could lead to a more significant safety concern; specifically, because the failure to evaluate extent of condition was later confirmed to have left additional degraded or failed studs undetected for over six years. The inspectors screened the finding using Inspection Manual Chapter 0609, Appendix A, "Significance Determination Process for Findings at Power," Exhibit 2, "Mitigating Systems Screening Questions," Section A. The finding screened as Green because it was a design or qualification issue where affected system, structures, or components maintain their operability or functionality. No cross-cutting aspect was assigned associated with the 2006 events because the primary causes of this finding were not indicative of current licensee performance. Specifically the inspectors observed proactive decision making by engineering management in the 2013 bolt failure including condition reporting, hardware failure analyses, and extent of condition testing missing from the 2006 event were promptly carried out with no impetus from government or industry regulators (Section 4OA3).

Inspection Report# : [2013002](#) (*pdf*)

Significance: G May 26, 2012

Identified By: NRC

Item Type: VIO Violation

Failure to Take Timely corrective Action to Preclude Repetition

The inspectors identified a violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," for the licensee's failure to take corrective action to preclude repetition of system leaks due to water hammer events in the essential service water system. Extensive inadequately evaluated corrosion in the system has led to multiple water-hammer-induced leaks of essential service water piping. These leaks were the subject of two previous violations issued by the NRC. The licensee failed to take timely corrective action to restore compliance. The licensee entered this finding in its corrective action program as condition report 53443.

The failure to preclude recurrence of water hammer in the essential service water system and the failure to take adequate corrective action to control internal pitting corrosion in essential service water system piping was a performance deficiency. The deficiency was more than minor because it is associated with the equipment performance attribute of the mitigating systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. It is therefore a finding. Using Inspection Manual Chapter 0609.04, "Phase 1 - Initial Screening and Characterization of Findings," the team determined that the finding was of very low safety significance (Green) because the finding was a design or qualification deficiency that was confirmed not to result in loss of system operability or functionality. This finding has a cross-cutting aspect in the corrective action program component of the problem identification and resolution cross-cutting area because the licensee failed to take appropriate corrective actions to address safety issues and adverse trends in a timely manner, commensurate with their safety significance (P.1(d)). (Section 4OA2.5.c)

Inspection Report# : [2012007](#) (*pdf*)

Barrier Integrity

Significance: G Oct 28, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Account for Containment Temperature Measurement Uncertainty

The team identified a Green, non-cited violation of 10 CFR 50, Appendix B, Criterion III, “Design Control,” which states, in part, “Measures shall be established to assure that applicable regulatory requirements and the design basis are correctly translated into specifications, drawings, procedures, and instructions. The design control measures shall provide for verifying or checking the adequacy of design, such as by the performance of design reviews, by the use of alternate or simplified calculational methods, or by the performance of a suitable testing program.” Specifically, on August 28, 2013, the team identified that the licensee had failed to have adequate controls in place to ensure that the bulk average containment temperature would not exceed the Technical Specification limit and design basis limit of 120°F. The licensee did not have: 1) a calculation addressing containment temperature indication uncertainty, 2) there was a lack of temperature sensor and associated circuitry uncertainty, 3) and there was no calculation or justification addressing potential temperature stratification in containment. The licensee has entered these issues into their corrective action program as Condition Reports CR-72639, CR-73118, and CR-73152.

The team determined that the failure to account for instrument uncertainty on the containment bulk average temperature instrumentation used to determine containment operability was a performance deficiency. This finding was more than minor because it was associated with the Design Control attribute of the Reactor Safety, Barrier Integrity Cornerstone, and adversely affected the cornerstone objective to ensure that physical design barriers protect the public from radionuclide releases caused by accidents or events. Specifically, by not accounting for the temperature measurement accuracy and stratification, the containment temperature could unknowingly exceed the Technical Specification operability limit. In accordance with NRC Inspection Manual Chapter 0609, Appendix A, Exhibit 3, “Barrier Integrity Screening Questions,” the finding was determined to have a very low safety significance (Green), because it did not result in an actual open pathway in containment and did not involve hydrogen igniters. Operability Evaluation OE GN-13-006 evaluated the containment temperature concerns and concluded that the containment would be operable, but degraded or nonconforming. This finding did not have a cross-cutting aspect because the most significant contributor to the performance deficiency did not reflect current licensee performance. Inspection Report# : [2013008](#) (*pdf*)

Significance: N/A Jun 30, 2013

Identified By: NRC

Item Type: VIO Violation

Failure to Maintain Complete and Accurate Housekeeping Records

The inspectors identified a Severity Level IV violation of 10 CFR 50.9, “Completeness and Accuracy of Information,” for the Wolf Creek Nuclear Generating Station’s failure to maintain complete and accurate records required by a license condition. Title 10 CFR 50.9 requires, in part, that information required by statute, orders, or license conditions to be maintained by the licensee shall be complete and accurate in all material respects. Contrary to the above, between October and December 2008, the licensee failed to maintain records required by License Condition 2.C.5 that were complete and accurate in all material respects. Specifically, the Housekeeping Inspection Card for the spent fuel pool area indicated that the inspection had been completed when security access logs indicate that the individual that completed the record had not entered the area. The NRC investigation determined that the assigned individual did not walk down the assigned area, and did not assign a designee to do so. (EA-013-084)

The failure to maintain records required by License Condition that are complete and accurate in all material respects in accordance with 10 CFR 50.9 was a violation. Traditional enforcement applies because it involved a violation that impacted the regulatory process. In accordance with the Enforcement Manual, Section 2.11.F, since this violation was the result of a willful action, it is more than minor and is being treated as a Severity Level IV violation.

Inspection Report# : [2013003](#) (*pdf*)

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Security

Although the Security Cornerstone is included in the Reactor Oversight Process assessment program, the Commission has decided that specific information related to findings and performance indicators pertaining to the Security Cornerstone will not be publicly available to ensure that security information is not provided to a possible adversary. Other than the fact that a finding or performance indicator is Green or Greater-Than-Green, security related information will not be displayed on the public web page. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Last modified : April 03, 2014