



UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION IV
611 RYAN PLAZA DRIVE, SUITE 400
ARLINGTON, TEXAS 76011-4005

January 12, 2006

Rick A. Muench, President and
Chief Executive Officer
Wolf Creek Nuclear Operating Corporation
P.O. Box 411
Burlington, KS 66839 Wolf Creek Nuclear Operating Corporation

SUBJECT: NRC INSPECTION REPORT 05000482/2005004

Dear Mr. Muench:

Because of an error in documenting the completed inspection scope for the ALARA inspection conducted June 27 - July 1, 2005, insert the enclosure to this letter as replacements for pages 13 - 15 of NRC Inspection Report 05000482/2005004.

Please accept my apology for any inconvenience these actions may have caused.

Sincerely,

//RA//

Michael P. Shannon, Chief
Plant Support Branch
Division of Reactor Safety

Docket: 50-482
License: NPF-42

Enclosure:
Pages 13 - 15 of NRC Inspection Report 05000482/2005004

cc w/enclosure:

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Only inspection reports to the following:

DRS STA (**DAP**)
 J. Dixon-Herrity, OEDO RIV Coordinator (**JLD**)
ROPreports
 WC Site Secretary (**SLA2**)

SUNSI Review Completed: Yes ADAMS: / Yes No Initials: GLG____
 / Publicly Available Non-Publicly Available Sensitive / Non-Sensitive

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RIV: DRS/PSB/HPI	C:PSB			
GLGuerra	MPShannon			
/RA/	/RA/			
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- Self-assessments, audits, and special reports related to the ALARA program since the last inspection
- Effectiveness of self-assessment activities with respect to identifying and addressing repetitive deficiencies or significant individual deficiencies
- Radiation worker and radiation protection technician performance during work activities in radiation areas, airborne radioactivity areas, or high radiation areas

The inspector completed 7 of the required 15 samples and 7 of the optional samples.

b. Findings

No findings of significance were identified.

4. **OTHER ACTIVITIES**

4OA2 Identification and Resolution of Problems

Resident Inspector Annual Sample Review

a. Inspection Scope

The inspectors evaluated the effectiveness of WCNOC's corrective action program as applied to corrective action document PIR 2005-2142. This document was initiated to address the conditions and events that led to the inoperability of both site fire protection pumps. Attributes considered during this review included the following:

- Completeness, accuracy, and timeliness of problem identification
- Operability and reportability evaluation
- Extent of condition evaluation
- Apparent cause evaluation
- Prioritization
- Corrective action effectiveness

The inspectors completed one sample.

b. Findings

Failure to Follow the Clearance Order Procedure

Introduction: An apparent violation (AV) of Technical Specification 5.4.1a occurred when station personnel failed to follow Procedure AP 21E-001, "Clearance Orders," and manipulated a component inside a fire protection piping clearance boundary without instructions and authorization. The starting of a temporary fire pump resulted in water

spraying on the controller of the operable diesel-driven fire pump through an open vent valve, which rendered the pump inoperable.

Description: On June 30, 2005, the motor of the electric fire pump experienced a short in its winding which led to a fire at the motor. The plant took the appropriate compensatory measures and started parallel paths to restore the fire suppression water system within the allotted 14 days. One path involved a temporary modification to the fire protection system that installed a temporary motor-driven fire pump, which was accomplished on July 11, 2005. The temporary fire pump was tested on July 12, 2005, to verify it would provide the required flow of water suppression; however, the pump failed this test.

Station fire protection personnel requested a clearance order to isolate the temporary fire pump from the fire protection piping but failed to make station operations personnel aware of the desire to run the temporary fire pump following repairs. Once repairs to the pump were completed, the vendor under the direction of station fire protection personnel started the pump believing they had authorization to operate the temporary fire pump. This resulted in water issuing from an open vent valve which sprayed the controller of the diesel-driven fire pump. Station fire protection personnel discovered the wet controller and notified the control room. Control room personnel declared the diesel-driven fire pump inoperable. The diesel-driven fire pump was returned to service in approximately 4 hours.

The inspectors reviewed Procedure AP-10-103, Fire Protection Impairment Control, Revision 19, which identified the compensatory measures for the loss of fire suppression water systems. With the motor driven and the diesel driven fire pump inoperable (approximately 4 hours) the impairment control procedure required that a backup fire pump be provided within 24 hours. In this case, both the motor driven and the diesel driven fire pumps were restored within approximately 18 hours. This issue involved human performance crosscutting aspects associated with station personnel not following a station procedure.

Analysis: The failure to follow station procedures is a performance deficiency. The finding was determined to be more than minor because it affected the mitigating systems cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Using the Phase 1 worksheets in Manual Chapter 0609, "Significance Determination Process," the finding was determined to degrade the fire protection system suppression and was evaluated using Appendix F, Fire Protection Significance Determination Process. This finding requires a Phase 3 analysis and is currently under evaluation. Wolf Creek Nuclear Operating Corporation entered this finding into their corrective action program as PIR 2005-2142

Enforcement: Technical Specification 5.4.1a requires procedures be implemented in accordance with Regulatory Guide 1.33, Revision 2, Appendix A. Regulatory Guide 1.33, Appendix A, Section 9, requires procedures for the performance of station maintenance. Contrary to the above, on July 13, 2005, station personnel operated

Enclosure

components inside an established fire protection piping clearance boundary without work instructions or control room authorization as required by Station Procedure AP 21E-001, "Clearance Orders," Section 6.6.8. This resulted in an adjacent diesel-driven fire pump becoming inoperable. Pending determination of the final safety significance of this issue, this violation is being treated as an AV consistent with Section VI.A of the NRC Enforcement Policy: AV 05000482/0500404, manipulation of plant component without proper authorization results in inoperable fire protection pumps.

Corrective Action Effectiveness

There were no findings identified that were associated with the corrective actions for this event. However, the inspectors made the following observations from their review of the apparent cause evaluation and the associated corrective actions: The apparent cause evaluation states that some fire protection personnel are unfamiliar with the clearance order program because, for them, clearance orders are infrequently performed evolutions. Additionally, the evaluation states that some "groups" mistakenly believed it was acceptable to work on vendor equipment inside clearance order boundaries without proper authorization or an approved procedure. These evaluation results suggest a clearance order program knowledge deficiency within the fire protection group. Yet, the corrective action for these contributing causes was counseling only the one individual involved with this event.

.2 Cross-References to Problem Identification & Resolution Findings Documented Elsewhere

Section 1R15 documents a condition where station personnel did not properly evaluate a condition adverse to quality regarding debris in the auxiliary feedwater flow transmitters.

.3 Access Control to Radiologically Significant Areas and ALARA Inspections

Section 2OS1 evaluated the effectiveness of WCNOG's problem identification and resolution processes regarding access controls to radiologically significant areas and radiation worker practices. The inspectors reviewed corrective action documents for root cause/apparent cause analysis against WCNOG's PI&R process. No findings of significance were identified.

Section 2OS2 evaluated the effectiveness of WCNOG's PI&R processes regarding exposure tracking, higher than planned exposure levels, and radiation worker practices. The inspector reviewed the corrective action documents listed in the attachment against WCNOG's PI&R program requirements. No findings of significance were identified.