



UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION IV
1600 EAST LAMAR BLVD
ARLINGTON, TEXAS 76011-4511

September 12, 2013

EA-12-152

Matthew Sunseri, President and
Chief Executive Officer
Wolf Creek Nuclear Operating Corporation
P.O. Box 411
Burlington, KS 66839

Subject: ERRATA FOR WOLF CREEK GENERATING STATION – NRC INSPECTION
PROCEDURE 95002 SUPPLEMENTAL INSPECTION REPORT
05000482/2013010 AND ASSESSMENT FOLLOW-UP LETTER

Dear Mr. Sunseri:

Please remove page 1 of the cover letter and pages 2, 4 and A1-2 from the Wolf Creek Generating Station - NRC Inspection Procedure 95002 Supplemental Inspection Report 05000482/2012002 and Assessment Follow-up Letter (ADAMS ML#13203A329), and replace them with the pages enclosed with this letter. The purpose of this change is to add the Enforcement Action (EA) number associated with the Yellow finding.

In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your response, if you choose to provide one for cases where a response is not required, will be made available electronically for public inspection in the NRC Public Document Room or from the NRC's document system (ADAMS), accessible from the NRC Web site at <http://www.nrc.gov/reading-rm/adams.html>. To the extent possible, your response should not include any personal privacy or proprietary, information so that it can be made available to the Public without redaction.

Sincerely,

/RA/ M. Bloodgood for

Neil O'Keefe, Chief
Project Branch B
Division of Reactor Projects

Docket No. 50-482
License No. NPF-42

Enclosures: 1.ERRATA - WC NRC Inspection Report 05000482/2013010, Pages 1, 2, 4, A1-2

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SUNSI Rev Compl.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	ADAMS	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Reviewer Initials	MRB
Publicly Available	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Sensitive	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Sens. Type Initials	MRB
SPE:DRP/B	DRP:TL	C:ACES	C:DRP/B		
MBloodgood	CYoung	HGepford	NOKeefe		
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UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION IV
1600 EAST LAMAR BLVD
ARLINGTON, TEXAS 76011-4511

July 22, 2013

EA-12-152

Matthew W. Sunseri, President and
Chief Executive Officer
Wolf Creek Nuclear Operating Corporation
P.O. Box 411
Burlington, KS 66839

SUBJECT: WOLF CREEK GENERATING STATION – NRC INSPECTION PROCEDURE 95002
SUPPLEMENTAL INSPECTION REPORT 05000482/2013010 AND ASSESSMENT
FOLLOW-UP LETTER

Dear Mr. Sunseri:

On June 7, 2013, the U.S. Nuclear Regulatory Commission (NRC) completed a supplemental inspection pursuant to Inspection Procedure 95002, "Supplemental Inspection for One Degraded Cornerstone or Any Three White Inputs in a Strategic Performance Area," at your Wolf Creek Generating Station facility. This inspection included an assessment of your actions to address each of four open substantive cross-cutting issues. The team also performed a limited scope independent safety culture assessment follow-up in accordance with Inspection Procedure 40100, "Independent Safety Culture Assessment Follow up." The enclosed inspection report documents the inspection results, which were discussed during the exit meeting on June 7, 2013, with you and members of your staff.

In accordance with the NRC Reactor Oversight Process Action Matrix, this supplemental inspection was performed to address a Yellow finding (EA 12-152) with substantial safety significance in the Initiating Events cornerstone which was issued in the third quarter of 2012. This finding resulted in the station being placed in Degraded Cornerstone column of the Action Matrix. This issue was previously documented and assessed in NRC Inspection Reports 05000482/2012009 and 05000482/2012010. The NRC was informed on April 30, 2013, of your staff's readiness for this inspection.

The objectives of this supplemental inspection were to provide assurance that: (1) the root causes and the contributing causes for the risk-significant issues were understood; (2) the extent of condition and extent of cause of the issues were identified; and (3) corrective actions were or will be sufficient to address and preclude repetition of the root and contributing causes. This inspection also included an independent NRC review of the extent of condition and extent of cause for the Yellow finding and an assessment of whether any safety culture component caused or significantly contributed to the performance issue. The objectives of the independent safety culture assessment follow-up were: (1) to provide assurance that the licensee recognizes the safety culture cross-cutting component deficiencies that caused or significantly contributed to risk-significant performance issues and repetitive substantive cross-cutting issues; and (2) to assess whether completed and proposed corrective actions should be

SUMMARY OF FINDINGS

IR 05000482/2013010, 06/03/2013 - 06/07/2013, Wolf Creek Generating Station, Supplemental Inspection (IP 95002); Independent Safety Culture Assessment Follow-up (IP 40100); Substantive Cross-Cutting Issue Follow-up.

This supplemental inspection was conducted by four region-based inspectors and a senior resident inspector. No findings were identified. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process," Revision 4, dated December 2006.

Cornerstone: Initiating Events

The NRC staff performed this supplemental inspection in accordance with Inspection Procedure 95002, "Supplemental Inspection for One Degraded Cornerstone or Any Three White Inputs in a Strategic Performance Area," to assess the licensee's evaluation associated with the failure of a startup transformer due to a failure to follow maintenance procedures, which resulted in a loss of offsite power event at the station in January 2012. The NRC staff previously characterized this issue as having substantial safety significance (Yellow), as documented in NRC Inspection Reports 05000482/2012009 and 05000482/2012010 (EA 12-152). A follow-up assessment letter dated September 21, 2012, transitioned Wolf Creek to the Degraded Cornerstone Column beginning August 6, 2012, due to one Yellow input in the Initiating Events Cornerstone, and identified the intention to perform Inspection Procedure 95002.

The inspectors determined that the licensee performed a comprehensive evaluation of the issues related to the Yellow finding, which appropriately identified the root cause of the issue to be the failure to recognize the risk/consequence of having a vendor perform work, in accordance with vendor procedures and processes, without an established verification method for ensuring work quality, resulting in an undetected human performance error. The failure to follow maintenance procedures during a maintenance activity in April 2011, resulted in a subsequent failure of the startup transformer and a loss of offsite power during an event on January 13, 2012. The inspectors determined that the licensee identified appropriate corrective actions to enhance the oversight of supplemental workers performing work activities, which appear to be adequate to address the identified performance issue.

In addition to assessing the licensee's evaluations, the inspection team performed an independent extent of condition and extent of cause review and a focused inspection of the site safety culture as it related to the root cause evaluation. The team concluded that the licensee's root cause evaluation and corrective actions, both completed and planned, adequately addressed the extent of condition and extent of cause, and were adequate to address the cause and prevent recurrence. Based on independent inspection, the team also determined that the licensee's assessment of site safety culture contribution to the issue was adequate.

REPORT DETAILS

4. OTHER ACTIVITIES

4OA4 Supplemental Inspection (95002)

.01 Inspection Scope

The NRC staff performed this supplemental inspection in accordance with Inspection Procedure 95002, "Inspection for One Degraded Cornerstone or Any Three White Inputs in a Strategic Performance Area," to assess the licensee's evaluation of a Yellow finding, which affected the initiating events cornerstone in the reactor safety strategic performance area. The inspection objectives were to:

- provide assurance that the root and contributing causes of risk-significant issues were understood
- provide assurance that the extent of condition and extent of cause of risk-significant issues were identified and to independently assess the extent of condition and extent of cause of individual and collective risk-significant issues
- independently determine if safety culture components caused or significantly contributed to the risk significant issues
- provide assurance that the licensee's corrective actions for risk-significant issues were or will be sufficient to address the root and contributing causes and to preclude repetition

The licensee entered the Degraded Cornerstone Column of the NRC's Action Matrix in the third quarter of 2012 as a result of one inspection finding of substantial safety significance (Yellow). The finding was associated with the failure of a startup transformer during a power transient which occurred on January 13, 2012, resulting in a loss of offsite power event at the station. The startup transformer failure was the result of an inadequately performed maintenance activity conducted by contracted workers in April 2011, in which maintenance procedure requirements were not adequately followed. The finding was characterized as having Yellow safety significance, as discussed in NRC Inspection Reports 05000482/2012009 and 05000482/2012010. (EA-12-152)

The licensee staff informed the NRC on April 30, 2013, that Wolf Creek was ready for the supplemental inspection. In preparation for the inspection, the licensee performed a root cause evaluation (RCE) to identify weaknesses that existed, which allowed for a risk-significant finding and Degraded Cornerstone, and to determine the organizational attributes that resulted in the Yellow finding. The licensee also conducted assessments to determine whether safety culture aspects contributed to the performance issues that led to the Yellow finding.

LIST OF ITEMS OPENED, CLOSED, AND DISCUSSED

Open
None

Closed

05000482/2012009-01 NOV Failure to Provide Adequate Oversight of Contractors During Maintenance on the Startup Transformer (EA-12-152) (Section 40A4)

Discussed

05000482/2012007-03 NOV Failure to Take Timely Corrective Action to Preclude Repetition (Section 40A4)

LIST OF DOCUMENTS REVIEWED

PROCEDURES

<u>NUMBER</u>	<u>TITLE</u>	<u>REVISION</u>
AP 15C-001	Procedure Writers Guide	26
AP 15C-002	Procedure Use and Adherence	
AP 22C-004	Operability Determination and Functionality Assessment	27
AP 27-007	Nonconforming and Degraded Conditions	9
AI 28A-018	Corrective Action Review Board	0
AI 22C-010	Operation Work Control	16
AI 22C-012	Quality Review Team (QRT) for Maintenance Work Planning	3
AP 09F-001	Business Planning	Draft
GEN 00-003	Hot Standby to Minimum Load	91
AI 28A-018	Corrective Action Review Board	0
AI 36-001	Nuclear Safety Culture Monitoring	1 (with OTSC 13-0022)
AP 36-001	Nuclear Safety Culture	3
AP 20B-001	Plant Safety Review Committee	12
AI 13E-015	Wolf Creek Leadership and Accountability Model	5A
AI 13E-015	Wolf Creek Leadership and Accountability Model	0
AI 34-010	Human Performance Tools	0
AP 28A-100	Condition Reports	20A
AI 28A-100	Cause Analysis	4
AI 28A-010	Screening Condition Reports	15