

WOLF CREEK

NUCLEAR OPERATING CORPORATION

John A. Bailey
Vice President
Operations

December 2, 1991

NO 91-0337

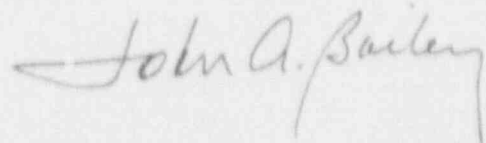
U. S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Mail Station P1-137
Washington, D. C. 20555

Subject: Docket No. 50-482: Licensee Event Report 91-024-00

Gentlemen:

The attached Licensee Event Report (LER) is being submitted pursuant to 10 CFR 50.73 (a)(2)(v) concerning a condition that could have prevented the function of systems needed to mitigate the consequences of an accident.

Very truly yours,



John A. Bailey
Vice President
Operations

JAB/aem

Attachment

cc: A. T. Howell (NRC), w/a
R. D. Martin (NRC), w/a
G. A. Pick (NRC), w/a
W. D. Reckley (NRC), w/a

Handwritten initials/signature

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) **Wolf Creek Generating Station** DOCKET NUMBER (2) **0 5 1 0 0 0 4 8 2 1** or **0 1 3** PAGE (3)

TITLE (4) **Deficiencies Discovered In Motor-Operated Valve Testing Program Which Caused Potential Inoperability of Safety Related Valves**

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)		
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	DOCKET NUMBER (9)		
11	02	91	91	024	00	12	02	91	0 5 1 0 0 0		
									0 5 1 0 0 0		

OPERATING MODE (9) **6** THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR (Check one or more of the following) (11)

20.402(b)	20.405(c)	50.75(a)(2)(iv)	73.71(b)
20.405(a)(1)(i)	50.36(c)(1)	<input checked="" type="checkbox"/> 50.75(a)(1)(v)	73.71(c)
20.405(a)(1)(ii)	50.36(c)(2)	50.75(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 388A)
20.405(a)(1)(iii)	50.75(a)(2)(i)	50.75(a)(2)(viii)(A)	
20.405(a)(1)(iv)	50.75(a)(2)(ii)	50.75(a)(2)(v)(b)	
20.405(a)(1)(v)	50.75(a)(2)(iii)	50.75(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
Merlin G. Williams - Manager Plant Support	AREA CODE: 3 1 6 NUMBER: 3 6 4 - 8 8 3 1

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC

SUPPLEMENTAL REPORT EXPECTED (14)

<input checked="" type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE)	<input type="checkbox"/> NO	EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
			01	31	92

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

In October and November of 1991, with the unit in Mode 6, Refueling, deficiencies were discovered in Wolf Creek Nuclear Operating Corporation's program for implementing commitments to the provisions of Generic Letter 89-10, "Safety Related Motor-Operated Valve Testing and Surveillance". In response to these deficiencies a task force effort was initiated to provide a detailed engineering evaluation and determine the operability of valves EN HV15, EN HV16, EM HV8807A, EM HV8807B, BB HV8351A, B, C, D, BB HV8000B, BG HV8111, EJ HV8716A, EJ HV8716B and other motor-operated valves identified by the task force. Operability of all valves identified to have deficiencies will be assured prior to startup.

It is not possible to determine the root cause and corrective actions for this event until further information is obtained from engineering evaluations. Therefore, a supplement to this report will be submitted upon completion of the engineering evaluation by January 31, 1992.

**LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION**

FACILITY NAME (1)	DOCKET NUMBER (2)	YEAR	LER NUMBER (3) SEQUENTIAL NUMBER	REVISION NUMBER	PAGE (5)
Wolf Creek Generating Station	0 5 0 0 0 4 8 2 9 1	-	0 2 4	-	0 0 0 2 of 0 3

TEXT (If more space is required, use additional NRC Form 306A's) (17)

INTRODUCTION

In October and November of 1991, deficiencies were discovered in Wolf Creek Nuclear Operating Corporation's program for implementing commitments to the provisions of Generic Letter 89-10, "Safety Related Motor-Operated Valve Testing and Surveillance". In response to these deficiencies a task force effort was initiated to determine the operability of safety related motor-operated valves (MOV) in the MOV testing program. Until a detailed engineering evaluation can be conducted, this condition is being reported pursuant to 10 CFR 50.73(a)(2)(v) as a condition that alone could have prevented fulfillment of a safety function that is needed to mitigate the consequences of an accident.

DESCRIPTION OF EVENT

On October 28, 1991, it was discovered that incorrect spring packs may have been installed in the actuators for Spray Additive Tank Outlet to Containment Spray "A" Isolation Valve EN HV15 [BE-ISV] and Spray Additive Tank Outlet to Containment Spray "B" Isolation Valve EN HV16 [BE-ISV]. A preliminary engineering evaluation indicated that the subject valves were capable of meeting design requirements.

On November 2, 1991, during performance of diagnostic testing on Residual Heat Removal Heat Exchanger "A"/Chemical and Volume Control System to Safety Injection Pump "A" Downstream Isolation Valves EM HV8807A and EM HV8807B [CB-ISV], it was discovered that the required design stem thrust could not be obtained. Following the discovery, a preliminary engineering evaluation determined that the actuators for these valves may be undersized and unable to meet design requirements.

During a Nuclear Regulatory Commission inspection conducted on November 4 through 8, 1991, deficiencies were discovered in Wolf Creek Nuclear Operating Corporation's program for implementing commitments to the provisions of Generic Letter 89-10. In order to resolve these deficiencies a task force was initiated to examine all safety related MOVs which have been previously tested and other specific MOVs in the MOV testing program. This task force was to determine if the MOVs would be able to perform their safety related functions under design basis conditions.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
Wolf Creek Generating Station	0 5 0 0 0 4 8 2	9 1	- 0 2 4	- 0 0	0 3	of 0 3

TEXT (If more space is required, use additional NRC Form 360A's) (17)

On November 6, 1991, during testing of Pressurizer Power Operated Relief Valve BB HV8000B [AB-RV], the valve was subject to an overthrust condition of 30000 pounds by the motor operator. A preliminary engineering evaluation indicated that the valve was capable of withstanding 5 overthrust cycles of this magnitude therefore it was acceptable for use-as-is.

On November 22, 1991, during an investigation by the MOV task force, it was discovered that Reactor Coolant Pump Seal Water Supply Isolation Valves BE HV8351A, B, C, D [CB-ISV] and the Centrifugal Charging Pumps Minimum Flow Valve BG HV8111 [CB-ISV] could not be declutched to be opened manually from the closed position. These valves are required to be manually opened after a Control Room evacuation due to a fire in order to maintain Reactor Coolant Pump Seal integrity if a spurious signal closes the valves.

On November 27, 1991, it was discovered that incorrect spring packs were installed in the actuators for Residual Heat Removal to Safety Injection Hot Leg Recirculation Loops 2 and 3 Isolation Valves EJ HV8716A and EJ HV8716B [BP-ISV]. It was determined that with the incorrect spring packs installed the required design thrust could not be obtained.

At the time of this report a detailed engineering evaluation from the MOV task force for the identified MOVs had not been completed. However, the MOV task force has found potential deficiencies in 69 of the 153 safety related MOVs which are covered under the scope of Generic Letter 89-10. A supplement to this report will be submitted to address deficiencies related to valves EN HV15, EN HV16, EM HV8807A, EM HV8807B, BB HV8351A, B, C, D, BB HV8000B, BG HV8111, EJ HV8716A, EJ HV8716B, and other MOVs identified by the task force.

ROOT CAUSE AND CORRECTIVE ACTIONS

It is not possible to determine the root cause and corrective actions for this event until further information is obtained from the engineering evaluations. However, the program for evaluating the design requirements of the MOVs has been upgraded to meet Generic Letter 89-10 requirements and operability of all valves identified by the task force will be assured prior to startup. A supplement to this report will be submitted upon completion of the engineering evaluations by January 31, 1992.

ADDITIONAL INFORMATION

Licensee Event Report 86-043-00 discusses an event in which discrepancies in the internal wiring and terminal blocks in safety related MOV actuators were identified. The corrective actions taken in that event addressed specific circumstances and had no correlation with this event.