UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION IV
611 RYAN PLAZA DRIVE, SUITE 400
ARLINGTON, TEXAS 76011-8064

FEB 20 19

Docket No. STN 50-482
License No. NPF-42
EA 91-161

Wolf Creek Nuclear Operating Corporation
ATTN: Bart D. Withers
President and Chief Executive Officer
P.O. Box 411
Burlington, Kansas 66839

Gentlemen:

SUBJECT: NOTICE OF VIOLATION & PROPOSED IMPOSITION OF CIVIL PENALTY - $150,000
(NRC INSPECTION REPORT 50-482/91-34)

This is in reference to NRC's November 4-8, 1991, inspection at the Wolf Creek Nuclear Generating Station (Wolf Creek). This inspection, which was discussed in exit meetings with Wolf Creek Nuclear Operating Corporation (WCNOC) officials on November 8 and November 15, 1991, disclosed several instances in which WCNOC failed to take either prompt or adequate corrective action for possible deficiencies related to motor-operated valves (MOVs) in safety-related systems at the Wolf Creek facility, and one instance in which WCNOC failed to take prompt corrective action in response to weaknesses in its MOV testing program that had been identified by a contractor.

On November 22, 1991, NRC issued an inspection report which described these apparent failures and other findings related to WCNOC's safety-related MOV testing and surveillance program. These failures, which indicated potentially significant violations of the requirements of 10 CFR Part 50, Appendix B, Criterion XVI, were again discussed at an enforcement conference with you and other WCNOC representatives on December 6, 1991, in NRC's Arlington, Texas office. In accordance with previous commitments, the results of WCNOC's analyses of the safety significance of these issues were provided to the NRC during a telephone conference on February 3, 1992.

Criterion XVI of 10 CFR Part 50, Appendix B, requires, in part, that WCNOC and other power reactor licensees assure that significant conditions adverse to quality are promptly identified and corrected, that the cause of the condition is determined and that corrective action is taken to preclude repetition of the condition. This regulation also requires that the identification of the condition, the cause of the condition and the corrective action be documented and reported to appropriate levels of management.

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NRC has concluded that in four of the five instances described in the inspection report, WCNOC failed to meet the above referenced requirement. In brief, these involved:

1) A failure in February 1991 to take prompt corrective action to resolve apparent deficiencies identified by WCNOC personnel with respect to five MOVs. Despite thrust calculations which indicated that the valve motor operators may be undersized, WCNOC did not take prompt action to assess the validity or significance of these calculations. By November 1991, four of the five motor operators were found incapable of producing the necessary thrust to operate their associated valves under design basis conditions and the motor operators were replaced;

2) A failure in May 1991 to take any corrective action to resolve a number of deficiencies identified through a contractor-performed audit of WCNOC's safety-related MOV testing and surveillance program. The audit identified 17 "required enhancements," including: the need to establish acceptance criteria for the diagnostic testing being performed on MOVs; the need to establish how deficiencies would be identified, documented, and resolved with a root cause analysis; and the need to establish methods to prove and justify the operability of MOVs. In November 1991, NRC's review of the same program found that the deficiencies had not been addressed;

3) A failure in October 1991 to take corrective action to assure that a significant condition adverse to quality did not exist with respect to an MOV that had been subjected to several times its maximum allowable thrust. Until prompted by NRC in November 1991, WCNOC took no action to assure that no damage had occurred; and

4) A failure in November 1991 to take corrective action to determine the cause of an apparent failure of an MOV to close completely when remotely operated. Until prompted by NRC later in November 1991, WCNOC took no action to examine the MOV.

In the telephone conference call on February 3, 1992, WCNOC informed NRC of the results of its analyses of the MOVs involved in the first example above. WCNOC's conclusion is that the valves in question would not have functioned as required under certain accident conditions due to incorrect torque switch settings and possible motor degradation. WCNOC also concludes that this condition would have had a minimal effect on the consequences of postulated accidents.

Nonetheless, NRC views WCNOC's corrective action failures as significant violations of regulatory requirements. In the first instance, WCNOC's failure to take adequate corrective action compromised the safety of the plant, in that the plant was operated with valves associated with the coolant charging/ safety injection system that would not have functioned under all design basis conditions. In the second instance, WCNOC's failure to take corrective action

in response to the audit findings cast a cloud of uncertainty over WCNOC's previous efforts to determine the adequacy of numerous safety-related MOV's in the plant.

In the remaining two instances, WCNOC's failure to take adequate corrective action in response to possible and known deficiencies created the potential to compromise plant safety, in that the operation of the valves in question in various safety-related systems could have been affected. In regard to the fifth example concerning apparent deficiencies with sizing of spring packs in two MOVs, no violation is being cited as subsequent licensee analysis has shown that the correct spring packs were installed.

Based on its review of the information developed during its inspection, the discussions that took place during the enforcement conference, and the information that WCNOC has since generated relative to the ability of safety-related MOVs to function under design conditions, NRC has concluded, relative to the first and second instances above, that these failures constitute a significant regulatory concern. Therefore, in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," (Enforcement Policy) 10 CFR Part 2, Appendix C (1991), the violations are classified in the aggregate as a Severity Level III problem.

These violations appear to have occurred for a number of reasons. WCNOC stated at the enforcement conference that a lack of management attention to the Wolf Creek MOV program was the fundamental cause, and that attitudes toward the MOV program -- particularly that it was a long-term program with a targeted completion date in 1994 -- contributed to a failure to properly focus on the safety significance of technical issues that were emerging through the implementation of the program.

However, historical weaknesses in WCNOC's corrective action program, which WCNOC had not previously acknowledged as significant, also played a role in causing these violations. NRC's concern about the current failures is heightened by the fact that problems and weaknesses in Wolf Creek's corrective action and self-assessment programs have been documented by NRC on several occasions, were the subject of a management meeting with WCNOC officials in April 1991, were the subject of violations issued to WCNOC in Inspection Reports 90-05, 90-31 and 90-34, and have been discussed in Systematic Assessment of Licensee Performance (SALP) reports issued by NRC. Many of these concerns were discussed in Inspection Report 91-01, issued on April 29, 1991. In the letter transmitting that report, NRC said ". . . our view is that the identified weaknesses and concerns reflect the need for substantially more management involvement and support to ensure a fully effective (corrective action) program . . ."

WCNOC must take steps to improve its response to deficiencies and, most importantly, to instill in the Wolf Creek staff a sense of responsibility and an attitude toward safety that results in initiating prompt and thorough corrective actions when significant deficiencies or potentially significant deficiencies are identified.

NRC recognizes that WCNOC, in accordance with commitments made to NRC, corrected all hardware-related MOV deficiencies prior to resuming plant operations in January 1992. In addition, NRC believes that WCNOC has responded appropriately to the current issues, and believes that the actions it has outlined to resolve problems in its MOV program and its corrective action program are capable of success if aggressively implemented. These actions include specific actions to address all aspects of the violations discussed above, commitments to significant enhancements to management involvement in overseeing safety-related programs and activities, and commitments to significant efforts to improve employee performance in the area of identifying, documenting and correcting safety problems.

To emphasize the need for WCNOC to appropriately respond to known or suspected MOV deficiencies, and the significance that NRC attaches to the violations that are the subject of this correspondence, I have been authorized, after consultation with the Director, Office of Enforcement, and the Deputy Executive Director for Nuclear Reactor Regulation, Regional Operations, and Research, to issue the enclosed Notice of Violation and Proposed Imposition of Civil Penalty (Notice) in the amount of $150,000 for the Severity Level III problem described above and in the Notice.

The base value of a civil penalty for a Severity Level III problem is $50,000. The escalation and mitigation factors in Section V.B. of the Enforcement Policy were considered and resulted in a net increase of $100,000. Since the NRC identified these violations, the base civil penalty was escalated 50 percent. Mitigation of 50 percent was warranted for the comprehensive corrective actions discussed above. However, the base civil penalty was escalated 100 percent based on WCNOC's poor past performance with its corrective action program, as previously discussed. An additional 100 percent escalation was applied for the added significance of the duration of Violations I.A and I.B. In the first case, WCNOC failed to take adequate corrective action for eight months after analyses indicated that five safety-related valves may be incapable of performing their safety function. In the second case, WCNOC failed to act on the findings of an internal audit for some five months until alerted by NRC. The remaining factors -- prior notice and multiple occurrences -- were considered but were not applied in determining the penalty amount.

The two remaining violations, which also indicate a failure to meet the requirements of 10 CFR Part 50, Appendix B, Criterion XVI, have been deemed less significant from a safety and regulatory perspective and are not being assessed a civil penalty. These violations appear in Section II of the Notice.

In addition to the violations identified during inspection 91-34, a number of deviations from WCNOC's commitments relative to the conduct of its MOV program also were identified. These deviations, which were discussed in detail in the inspection report, are described in a Notice of Deviation which is also enclosed with this letter.

WCNOC is required to respond to this letter and should follow the instructions specified in the enclosed Notices when preparing its response. In your

response, you should document the specific actions taken and any additional actions you plan to prevent recurrence of these violations and deviations. After reviewing your response to this Notice, including your proposed corrective actions and the results of future inspections, the NRC will determine whether further NRC enforcement action is necessary to ensure compliance with NRC regulatory requirements.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosures will be placed in the NRC Public Document Room.

The responses directed by this letter and the enclosed Notice are not subject to the clearance procedures of the Office of Management and Budget as required by the Paperwork Reduction Act of 1980, Pub. L. No. 96-511.

Sincerely,

John M. Montgomery for
Robert D. Martin
Regional Administrator

Enclosures:
1. Notice of Violation and Proposed Imposition of Civil Penalty
2. Notice of Deviation

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Wolf Creek Nuclear Operating Corporation

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