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

AUG 19 1992

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

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

Gentlemen:

SUBJECT: NRC INSPECTION REPORT NO. 50-482/92-08

Thank you for your letter of July 30, 1992, in response to our letter and Notice of Violation (482/9208-01 and -02) dated June 30, 1992. We have reviewed your reply and find it responsive to the concerns raised in our Notice of Violation. We will review the implementation of your corrective actions during a future inspection to determine that full compliance has been achieved and will be maintained.

Sincerely,

A. Bill Beach, Director
Division of Reactor Projects

cc:
Wolf Creek Nuclear Operating Corp.
ATTN: Otto Maynard, Director
Plant Operations
P.O. Box 411
Burlington, Kansas 66839

Shaw, Pittman, Potts & Trowbridge
ATTN: Jay Silberg, Esq.
2300 M Street, NW
Washington, D.C. 20037

Public Service Commission
ATTN: C. John Renken
Policy & Federal Department
P.O. Box 360
Jeffer. .n City, Missouri 65102

U.S. Nuclear Regulatory Commission
ATTN: Regional Administrator, Region III
799 Roosevelt Road
Glen Ellyn, Illinois 60137

Wolf Creek Nuclear Operating Corp.
ATTN: Steven G. Wideman
Supervisor Licensing
P.O. Box 411
Burlington, Kansas 66839

Kansas Corporation Commission
ATTN: Robert Elliot, Chief Engineer
Utilities Division
1500 SW Arrowhead Rd.
Topeka, Kansas 66604-4027

Office of the Governor
State of Kansas
Topeka, Kansas 66612

Attorney General
1st Floor - The Statehouse
Topeka, Kansas 66612

Chairman, Coffey County Commission
Coffey County Courthouse
Burlington, Kansas 66839-1798

Kansas Department of Health
and Environment
Bureau of Air Quality & Radiation
Control
ATTN: Gerald Allen, Public
Health Physicist
Division of Environment
Forbes Field Building 321
Topeka, Kansas 66620

Kansas Department of Health and Environment
ATTN: Robert Eye, General Counsel
LSOB, 9th Floor
900 SW Jackson
Topeka, Kansas 66612

bcc to DMB (IE01)

bcc distrib. by RIV:

J. L. Milhoan
Section Chief (DRP/D)
DRSS-FIPS
RIV File
MIS System
Project Engineer (DRP/D)
DRS
Resident Inspector
DRP
Section Chief (RIII, DRP/3C)
SRI, Callaway, RIII
RSTS Operator
Lisa Shea, RM/ALF, MS: MNBB 4503
Chief, Technical Support Section

250060

bcc to DMB (IE01)

bcc distrib. by RIV:

J. L. Milhoan	Resident Inspector
Section Chief (DRP/D)	DRP
DRSS-FIPS	Section Chief (RIII, DRP/3C)
RIV File	SRI, Callaway, RIII
MIS System	RSTS Operator
Project Engineer (DRP/D)	Lisa Shea, RM/ALF, MS: MNBB 4503
DRS	Chief, Technical Support Section

RIV:AC:DRP/D	D:DRP			
MASatorius;df	ABBeach			
8/19/92	8/19/92			

WOLF CREEK
NUCLEAR OPERATING CORPORATION

Bart D. Withers
President and
Chief Executive Officer

July 30, 1992

WM 92-0127

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

Reference: Letter dated June 30, 1992 from A. B. Beach, NRC to B. D. Withers, WCNOC
Subject: Docket No. 50-482: Response to Violation 482/9208-01 and 9208-02

Gentlemen:

Attached is Wolf Creek Nuclear Operating Corporation's (WCNOC) response to Violations 482/9208-01 and 9208-02 concerning a failure to have appropriate procedures and failing to follow procedures, respectively.

If you have any questions concerning this matter, please contact me or Mr. S. G. Wideman of my staff.

Very truly yours,

BDWithers

Bart D. Withers
President and
Chief Executive Officer

BDW/aem

Attachment

cc: A. T. Howell (NRC), w/a
J. L. Milhoan (NRC), w/a
G. A. Pick (NRC), w/a
W. D. Reckley (NRC), w/a

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P.O. Box 411 · Burlington, KS 66839 · Phone: (316) 364-8831

REPLY TO A NOTICE OF VIOLATION

Violation 482/9208-01: Failure To Have Appropriate Procedures

Finding:

TS 6.8.1.a requires that written procedures shall be established, implemented, and maintained covering the applicable procedures recommended in Appendix A of RG 1.33, Revision 2, February 1978. 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," requires, in part, that activities affecting quality shall be prescribed by procedures of a type appropriate to the circumstances. One example of violating this requirement is stated below:

RG 1.33, Appendix A, Item 7.c.(1), requires procedures for the collection, storage, and discharge of gaseous waste. This is accomplished, in part, by Procedure SYS HA-200, Revision 10, "Waste Gas System Startup and Shutdown."

Contrary to the above, on April 23, 1992, SYS HA-200 was determined to have been inappropriate to the circumstances because it did not provide adequate guidance for placing the waste gas decay tank in service. As a result, an inadvertent radioactive release of gaseous waste occurred in the radwaste building.

Reason For Violation:

At 0300 hours on April 23, 1992, a "Process Radiation High" alarm was received in the Control Room. It was subsequently determined that a one pound per square inch (psi) decrease in Waste Gas Decay Tank (WCDT) #4 had occurred when the Radwaste Operator placed the tank in recirculation mode.

It was determined that all controls and equipment were in the proper configuration as the Radwaste Operator was preparing to start the waste gas compressor; however, while reviewing the next few steps of the startup procedure, the high pressure WGDT that was in service began pressurizing the hydrogen recombiner past the relief setpoints. The sample lines from the recombiner have relief valves that lift at 50 psi and discharge to the room ventilation system when in the standby mode (the mode the system was in at the time).

This event occurred as a result of the inlet pressure control valve being in the manual position as required by system procedure SYS HA-200, "Waste Gas System Startup and Shutdown," which allowed immediate pressurization of the recombiner. It was necessary in the past for the valve to be in manual because of the poor discharge pressure from the compressors. New compressor internals are now present which can allow operators to start the system with the valve in the automatic position. It was not identified until this event had occurred that the procedure should be changed because the procedure was as written for operation of the system in the manual position. An additional factor in the system relief valves lifting was that the recombiner sample isolation valves were in an open position, as specified by system procedure SYS HA-205, "Gaseous Radwaste System Gas Analyzer Racks (HA-161/HA-162) and Catalytic Hydrogen Recombiners (SHA01A/SHA01B Operations," while the hydrogen analyzers were in the standby mode.

Corrective Action That Has Been Taken And Results Achieved:

Effluent radiation levels immediately returned to normal following the initial spike. Control Room Operators cleared the process radiation alarm, reset the radiation monitor and notified Chemistry personnel of a possible radioactive gas release. The dose rates of the release were subsequently calculated and determined to be significantly below the regulatory limits.

Corrective Action That Will Be Taken To Avoid Further Violations:

System Procedure SYS HA-200 has been revised to ensure that Hydrogen Recombiner Inlet Pressure Control Valve PCV 1103 is in the automatic position and initially set to control at 20 psi to prevent rapid pressurization. Additionally, system procedure SYS HA-205 has been revised to ensure the analyzer rack instrument sample isolation valves are closed until the system is recirculating and all parameters are stable. These actions should be sufficient to prevent overpressurizations during startup transients.

Date When Full Compliance Will Be Achieved:

Full compliance has been achieved.

Additional Information:

A similar waste gas release had occurred on March 3, 1992 during placement of a high pressure waste gas decay tank in recirculation while the system was in the low pressure mode (an example of violation 482/9202-02, "Failure To Have Appropriate Procedures"). The root cause of the March 3 event was determined to be a failure of system procedure SYS HA-200 to state that prior to switching waste gas decay tanks, ensure the system is in the proper operational line-up for the pressures contained in the oncoming waste gas decay tank.

The event discussed in this response may have resulted in a similar outcome; however, the operator was in the proper pressure mode. This procedural inadequacy is unrelated and therefore the investigation into the March 3 event would not have identified the procedural inadequacy discussed in this response.

Violation 482/9208-02: Failure To Follow Procedures

Finding:

Technical Specification (TS) 6.8.1.a requires that written procedures shall be established, implemented, and maintained covering the applicable procedures recommended in Appendix A of Regulatory Guide (RG) 1.33, Revision 2, February 1978. RG 1.33, Appendix A, Item 9.a, requires that maintenance that can affect the performance of safety-related equipment should be properly preplanned and performed in accordance with written procedures, documented instructions, or drawings appropriate to the circumstances. This is accomplished, in part, by Procedure ADM 01-057, Revision 24, "Work Request."

Step 2.1 of Procedure ADM 01-057 requires that the work request will be used to document and control work on plant systems.

Contrary to the above, on May 21, 1992, licensee personnel performed maintenance on the reach-rod attachment for Valve BG V322 (boric acid filter drain valve) without a work request. The work was performed to remove interferences and allowed the valve to be positioned fully closed.

Reason For The Violation:

On May 21, 1992, following changeout of the Boric Acid Filter, the diaphragm and stem to Boric Acid Filter Drain Valve BG V322 was found to be damaged. The bonnet assembly was replaced in accordance with the work instructions for Work Request (WR) 02652-92. Valve BG V322 was opened and closed several times to ensure proper operation. The system was restored and post maintenance testing was performed to check the bonnet vent plug with the valve in service.

A short time later, the Boric Acid Tanks (BAT) were placed on recirculation. After approximately 1.5 hours, Control Room Operators identified a decrease in BAT levels of 7.5 percent each. The level decrease was determined to be the result of a bolt on the valve-to-reach rod attachment coming in contact with a support, thereby preventing full closure of valve BG V322. Mechanical Maintenance personnel adjusted a stud and nut on the reach rod to allow the valve to completely close.

It was subsequently identified that the stud and nut adjustment had been performed without the issuance of a WR. An investigation revealed that the Mechanical Maintenance personnel responsible for the adjustment were aware of the work performed on valve BG V322 during the previous shift but perceived the adjustment as a part of the retest on WR 02652-92. They were unable to locate WR 02652-92 that night, not knowing the work request had already been processed for closure. The work was noted in the daily work log used for turnover. Additionally, during review of the log the next morning, the supervisor also failed to identify that WR 02652-92 had already been processed for closure and also perceived the adjustment as continuing work on WR 02652-92.

This event is attributed to a personnel error in failing to follow administrative procedure ADM 01-057, "Work Request," which requires issuance of a WR to document and control work performed on plant systems. Also contributing to this event was a work program inadequacy where the program in place did not provide the worker an easy method to locate the WR paperwork. There was no method for personnel to determine if a package was to be worked or completed.

Additionally, it was determined that had the post maintenance testing, following the boric acid filter replacement, been effective, the problem with valve BG V322 not fully closing may have been discovered and the work completed under a revision to WR 02652-92 prior to its closure.

Corrective Action That Has Been Taken And Results Achieved:

Following adjustment of the valve and ensuring that there would be no leakage from the BAT, Control Room Operators transferred inventory from BAT "B" to BAT "A" and added boric acid to BAT "B" from the Boric Acid Batching Tank in accordance with system procedure SYS BG-206, "Boric Acid System Operation."

Following identification that a WR should have been used for the adjustments performed on valve BG V322, WR 03080-92 was written to document the activities.

Corrective Action That Will Be Taken To Avoid Further Violations:

A meeting was held with the involved senior, lead, and supervision personnel to review and understand the sequence of events. Also, although unrelated to this event, the Supervisor Mechanical Maintenance has been holding review sessions on the use of administrative procedure ADM 01-057 and the work request process. These sessions are conducted in small groups to encourage openness and feedback on the program and process. At the time of this event, the involved crews had not participated in the review session. Further corrective action is to complete a review session with the remaining Mechanical Maintenance personnel. Additionally, improvement has been made to assist Mechanical Maintenance personnel track the status and work package of items that had not been previously included on the seven day work schedule.

Since the occurrence of this event, the post maintenance testing requirements as specified in administrative procedure ADM 01-057 have been revised. The post maintenance test block on the WR form has been changed to require more specific information on the test, including: Test Description, Responsible Group, Acceptance Criteria, and Results. Maintenance management and supervision continue to monitor the effectiveness of post maintenance testing.

Date When Full Compliance Will Be Achieved:

Full compliance will be achieved by September 18, 1992, following completion of the review sessions with the remaining Mechanical Maintenance personnel who have not participated in the review sessions of administrative procedure ADM 01-057.