

APPENDIX

U.S. NUCLEAR REGULATORY COMMISSION
REGION IV

NRC Inspection Report: 50-482/87-21

License: NPF-42

Docket: 50-482

Licensee: Wolf Creek Nuclear Operating Corporation
P.O. Box 411
Burlington, Kansas 66839

Facility Name: Wolf Creek Generating Station

Inspection At: Wolf Creek Site, Burlington, Kansas

Inspection Conducted: August 31 through September 4, 1987

Inspector: *for* William L. Fisher
C. A. Hackney, Emergency Preparedness Analyst

9/18/87
Date

Accompanying
Personnel:

R. Vickrey, Region IV, NRC
E. Podolak, NRR, NRC Headquarters
D. Schultz, Comex Corporation

Approved: William L. Fisher
W. L. Fisher, Chief, Nuclear Materials and
Emergency Preparedness Branch

9/18/87
Date

Inspection Summary

Inspection Conducted August 31 through September 4, 1987 (Report 50-482/87-21)

Areas Inspected: Routine, announced inspection of the licensee's performance and capabilities during an annual exercise of the emergency plan and procedures.

Results: Within the areas inspected, no violations or deviations were identified. One deficiency was identified by NRC inspector (paragraph 4).

DETAILS1. Persons ContactedPrincipal Licensee Personnel

- *B. Withers, President and Chief Executive Officer
- *F. Rhodes, Vice President, Nuclear Operations
- *J. Bailey, Vice President, Engineering and Technical Services
- *G. Boyer, Plant Manager
- *R. Hagan, Manager, Nuclear Services
- *K. Moles, Manager, Emergency Planning
- *O. Maynard, Manager, Licensing
- *R. Andrews, Emergency Planning Administrator
- *M. Nichols, Superintendent, Plant Support
- *J. Zell, Manager, Nuclear Training
- *J. Goode, Licensing Engineer
- *J. Dagenette, Instructor Coordinator

NRC

- *J. Cummins, Senior Resident Inspector
- *B. Bartlett, Resident Inspector

Federal Emergency Management Agency (FEMA)

- R. Leonard, Program Manager
- R. Bissell, Technological Hazards Specialist

The NRC inspector also held discussions with other station and corporate personnel in the areas of security, health physics, operations, training, and emergency response organization.

*Denotes those present at the exit interview.

2. Followup on Previously Identified Items

(Closed) Deficiency (482/8704-01): The primary offsite dose calculation method used by the licensee was essentially a manual method, involving data entry into a matrix and operating in it with a handheld calculator. Although the method was reasonably timely, it had a high potential for error (due to numerous arithmetic operations) and only addressed simple, straight-line Gaussian dispersion conditions.

The NRC inspector observed dose assessment personnel performing dose calculations utilizing the dose assessment computer.

(Closed) Deficiency (482/8704-03): The access code number for placing telephone calls to state and local agencies was not initially available to

the Technical Support Center (TSC) communicator, thus causing confusion and a slight delay in making the required initial notification from the TSC.

The licensee had established a facility telephone directory. The telephone directory contained access codes for each facility and other appropriate information.

(Closed) Deficiency (482/8704-04): The Duty Emergency Manager (DEM) delayed making protective action recommendations after plant conditions (e.g., clad failure and core uncovering at 9:59 a.m.; 3.5 percent concentration of hydrogen in the containment at 10:30 a.m.; continuous pressure buildup in the containment building; large LOCA and loss of coolant inventory) warranted it. The DEM postponed making protective action recommendations for the public at risk, even after the NRC emergency response team informed him that in their opinion general emergency conditions were present (10:23 a.m.). The decision for sheltering personnel within the center zone was not recommended by the DEM until 11:10 a.m. At that time, the county decided for evacuation of human populations at the center zone.

The DEM made a timely classification at the general emergency. The accompanying protective action recommendations to the state and county were timely.

(Closed) Deficiency (482/8704-05): During the exercise, the EOF experienced a temporary loss of the telephone system. Communicators in the EOF had not received hands-on training in the use of the radio. That lack of hands-on radio training prevented the communicators from using the backup radio communications for making offsite notifications to the state. The telephone service was restored in a matter of minutes and the offsite notifications were made within the 15-minute requirement. If the event had been a lasting telephone system failure, notifications could have been substantially delayed.

The NRC inspector observed during the exercise that EOF communicators did establish radio contact with the county. The communicators demonstrated the capability to properly use the radio communication system. A review of training records revealed that personnel were given hands-on training in the use of the radios.

No violations or deviations were identified.

3. Program Areas Inspected

The following program areas were inspected. Unless otherwise noted, the inspection was completed and revealed no violations, deviations, deficiencies, unresolved items, or open items. The inspection included interviews with cognizant individuals, observations of activities, and record reviews. The depth and scope of these activities were consistent with past findings and with the current status of the facility. Notations

after a specific inspection item are used to identify the following:
 I = item not inspected or only partially inspected; V = violation;
 D = deviation; H = deficiency; U = unresolved item; O = open item.

<u>Procedure</u>	<u>Program Area and Inspection Requirements</u>
82201	<u>Emergency Detection and Classification</u> <ul style="list-style-type: none"> 021 - Adequacy of EALs in site emergency plan and procedures. (I) 022 - Initial offsite notification procedures based on EALs. Procedures for recommending protective actions for onsite nonessential personnel. 023 - State and local agency agreement with EALs. (I) 024 - Emergency event classification. 025 - Use of post-TMI indicators for core and containment status. (I) 026 - One individual onsite at all times understands authority and responsibility to classify events and initiate emergency actions. 027 - Emergency Operating, Alarm, or Abnormal Occurrence Procedures direct the user to classify emergencies. (I) 028 - EALs consistent with appropriate control room instrumentation. Decisional aids readily available and consistent with EALs. 029 - Shift supervisors and other responsible personnel promptly and correctly classify events. (I)
02202	<u>Protection Action and Decision Making</u> <ul style="list-style-type: none"> 021 - Authority and responsibility clearly and unambiguously assigned. 022 - Authority and responsibility for making protective action decisions are in procedures and understood by licensee personnel. 023 - Emergency response facilities can implement onsite and offsite protective measures. 024 - Understanding of relationships between plant conditions, offsite consequences, and effectiveness of protective measures. 025 - Offsite officials have the capability to make prompt public notifications and protective action decisions in 15 minutes. (I)
82301	<u>Evaluation of Exercises for Power Reactors</u> <ul style="list-style-type: none"> (1) Control Room (D) (2) Technical Support Center (3) Emergency Operations Facility

- (4) Operational Support Center
- (5) Corporate Command Center (HOEC) (I)
- (6) Offsite Monitoring Team (I)
- (7) Corrective Action/Rescue Team
- (8) Security/Accountability Team
- (9) Press Center (I)
- (10) Medical Team (I)
- (11) Postaccident Sampling (I)

4. Control Room (Emergency Classification) 82301 (1)

The NRC inspector noted that several EALs relating to fuel breach were exceeded, but the control room staff classified the event as an unusual event. EALs exceeded included:

- ° CVCS letdown radiation monitor off scale high,
- ° containment air monitor(s) increased significantly,
- ° area radiation monitors increased significantly, and
- ° sampling data verified existence of failed fuel (five times Technical Specification limits).

Based on the observation above, the following is considered to be an emergency preparedness deficiency:

Classification of the emergency was incorrect, considering the plant parameters and radiological conditions given to the operators.
(482/8721-01)

5. Exercise Critique

The NRC inspector attended the post-exercise critique by the licensee staff on September 3, 1987, to evaluate the licensee's identification of deficiencies and weaknesses as required by 10 CFR 50.54(q), 10 CFR 50.47(b)(14), and 10 CFR Part 50, Appendix E, paragraph IV.F.5. The licensee staff identified the deficiencies listed below.

No violations or deviations were identified.

Licensee Identified Deficiencies

- ° Reliability of dose assessment computer needs to be increased.
- ° Media representatives need additional training.
- ° Review news release information flow from Wichita to Topeka, especially for fast occurring events.
- ° Review core damage methodology, need additional method.

- ° Correct cause of telecopier problems in Wichita and the plant.

Corrective action for identified deficiencies and weaknesses will be examined during a future NRC inspection.

No violations or deviations were identified.

6. Exit Interview

The NRC inspector met with licensee representatives (denoted in paragraph 1) at the conclusion of the inspection on September 4, 1987.

The inspectors summarized the purpose and the scope of the inspection and the findings. The NRC team leader reviewed the deficiency with Mr. B. D. Withers and staff and stated that the findings would be reviewed by NRC Region IV management. Any substantive changes to the findings would be brought to the attention of appropriate licensee representatives.

The licensee's actions during the exercise were found to be acceptable to protect the health and safety of the public.

No violations or deviations were identified.

UPDATE FORM

FACILITY: Wolf Creek
DOCKET: SD 482

ORIGINATORS NAME: [] [] [] [] [] [] [] [] [] [] [] [] [] [] [] [] [] [] []

TYPE: H

ITEM NO.: 8721-01

REPORT: 8 7 2 1

PARAGRAPH:

[illegible]

DESCRIPTION: IncorrectEmergency

Classification

[illegible]STATUS CODE: ☐

UPDATE/CLOSE:
REPORT

RESPONSIBLE SECTION SPESPS

Charles

ACTIVE FILE 1986
Wolf Creek

Inspector Name	Type	Item No.	Report Paragraph	Functional Area	Description	Resp. Sect.	(Update)/(Close) Report	SI
Hackney, C.	H	8425-062	84-25 5.4.2	Emergency Prep.	Install & verify SPDS	NM&EPB		0
Hackney, C.	H	8425-092	84-25 7.2	Emergency Prep.	Initiating conditions to be added to EPP 01-2.1	NM&EPB		0
Hackney, C.	<i>Closed</i> H	8704-001	87-04 5	Emergency Prep.	Dose Assessment Manual Method Errors	NM&EPB		0
Hackney, C.	<i>Remains open</i> H	8704-002	87-04 5	Emergency Prep.	Could Not Measure Radioiodine	NM&EPB		0
Hackney, C.	<i>Closed</i> H	8704-003	87-04 5	Emergency Prep.	Access Codes for Communicators	NM&EPB		C
Hackney, C.	<i>Closed</i> H	8704-004	87-04	Emergency Prep.	Dem Delayed Mating Pag	NM&EPB		0
Hackney, C.	<i>Closed</i> H	8704-005	87-04	Emergency Prep.	Communicators No Hands-On Radio Training	NM&EPB		C
Hackney, C.	V	8714-001	87-14 4	Emergency Prep.	Failure to Document Communication Test	NM&EPB		0
Hackney, C.	V	8714-002	87-14 5	Emergency Prep.	Shift Staffing and Augmentation	NM&EPB		0

Updated: August 20, 1987

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