

Wolf Creek 1

3Q/2005 Plant Inspection Findings

Initiating Events

Mitigating Systems

G**Significance:** Jul 12, 2005

Identified By: Self-Revealing

Item Type: AV Apparent Violation

Manipulation of Plant Component Without Proper Authorization Results in Inoperable

A self-revealing noncited violation of a Technical Specification 5.4.1a occurred when station personnel failed to follow Procedure AP 21E-001, "Clearance Orders," and manipulated a component inside the clearance boundary without instructions and authorization. Specifically, station personnel started a temporary fire pump physically attached to the station's fire protection system causing water to spray from a tagged open vent valve. The water spray resulted in the only remaining station fire pump becoming inoperable due to wetting of the pump's controller. This issue involved human performance crosscutting aspects associated with station personnel not following a station procedure.

The failure to follow station procedures is a performance deficiency. The finding was determined to be more than minor because it affected the mitigating systems cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Using the Phase 1 worksheets in Manual Chapter 0609, "Significance Determination Process," the finding was determined to have very low safety significance because the finding did not represent a complete loss of a safety function or a train of safety function and is not potentially risk significant due to external events. The licensee entered this finding into their corrective action program as PIR 2005-2142.

Inspection Report# : [2005004\(pdf\)](#)**G****Significance:** Jul 11, 2005

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Inadequate Corrective Actions Fail to Prevent Subsequent Failure of Auxiliary Feedwater Flow Transmitters

The inspectors documented a self-revealing, noncited violation of 10 CFR Part 50, Appendix B, Criterion XVI, because the licensee failed to assure corrective actions taken in response to a significant condition adverse to quality preclude repetition of the condition. On May 5, 2005, auxiliary feedwater flow Transmitter ALFT-0011 indicated flow without existing flow in the auxiliary feedwater system due to the buildup of debris from steam generator chemical cleaning. Following the May 5, 2005, event, the licensee flushed all auxiliary feedwater flow transmitters and the level transmitters for the steam generators. On July 11, 2005, another auxiliary feedwater flow Transmitter ALFT-0003 indicated flow without existing flow in the auxiliary feedwater system. This transmitter was flushed and the conditions found on May 5, 2005, existed in this transmitter. This issue involved problem identification and resolution crosscutting aspects, in that, station personnel did not properly evaluate a condition adverse to quality regarding debris in the auxiliary feedwater flow transmitters.

The failure to take appropriate corrective measures to address a significant condition adverse to quality is a performance deficiency. This finding was determined to be more than minor because it affected the mitigating systems cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Using the Phase 1 worksheets in Manual Chapter 0609, "Significance Determination Process," the finding was determined to have very low safety significance because the finding did not represent a complete loss of a safety function or a train of safety function and is not potentially risk significant due to external events. The licensee entered this finding into their corrective action program as PIR 2005-2149.

Inspection Report# : [2005004\(pdf\)](#)**G****Significance:** Jun 28, 2005

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Follow Station Procedures Results in Transfer of Water From VCT to RWST

The inspectors documented a self-revealing, noncited violation of 10 CFR Part 50, Appendix B, Criterion XVI, because the licensee failed to assure corrective actions taken in response to a significant condition adverse to quality preclude repetition of the condition. On June 28, 2005, planned motor-operated valve actuator work on an isolation valve in the safety injection system lead to the unplanned transfer of water from the

volume control tank (VCT) to the refueling water storage tank (RWST). The same event occurred in 1995. This issue involved human performance crosscutting aspects associated with station personnel not following a station procedure.

The failure to take appropriate corrective measures to address a significant condition adverse to quality is a performance deficiency. This finding was determined to be more than minor because it affected the mitigating systems cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Using the Phase 1 worksheets in Manual Chapter 0609, "Significance Determination Process," the finding was determined to have very low safety significance because the finding did not represent a complete loss of a safety function or a train of safety function and is not potentially risk significant due to external events. The licensee entered this finding into their corrective action program as PIR 2005-2004.

Inspection Report# : [2005004\(pdf\)](#)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

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Significance: Jul 01, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Perform an Exit Whole Body Count

The inspector identified a noncited violation of a Technical Specification 5.4.1a which requires procedures for radiation protection and personnel monitoring. Specifically, on September 22, 2003, the licensee failed to perform an exit whole body count for a radiation worker that had entered the radiologically controlled area and terminated their employment with the licensee.

The failure to perform an exit whole body count was a performance deficiency. The finding was determined to be more than minor because it was associated with the Occupational Radiation Safety cornerstone attribute of Programs and Process and affected the cornerstone objective to ensure the adequate protection of worker health and safety from exposure to radiation and radioactive materials. Because the occurrence involved conditions that were contrary to licensee procedures related to measuring worker dose, this finding was processed through the Occupational Radiation Safety Significance Determination Process. The finding was determined to be of very low safety significance (Green) because it did not involve: (1) as low as is reasonably achievable planning and work controls, (2) an overexposure, (3) a substantial potential for an overexposure, or (4) an impaired ability to assess dose. The finding was entered into the licensee's corrective action program as PIR 2005-1653.

Inspection Report# : [2005004\(pdf\)](#)

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Significance: Apr 15, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Perform an Adequate Survey to Identify a Radiation Area

The inspectors identified a non-cited violation of 10 CFR 20.1501(a) for failure to perform a survey to identify a radiation area. Specifically, on April 14, 2005, the inspectors identified, by direct survey, an unposted radiation area directly above the resin loading flange of the "A" Recycle Evaporator Feed Demineralizer on the 2051-foot elevation of the radioactive waste building. The licensee performed a confirmatory survey that indicated a contact dose rate of 20 millirem per hour and 10 millirem per hour at 30 centimeters.

The finding is greater than minor because it was associated with a cornerstone attribute (Human Performance) and affected the associated cornerstone objective because the failure to perform an adequate radiation survey effects the adequate protection of worker health and safety from exposure to radiation. Using the Occupational Radiation Safety Significance Determination Process, the inspectors determined that the finding was of very low safety significance because it did not involve (1) ALARA planning and controls, (2) an overexposure, (3) a substantial potential for overexposure, or (4) an impaired ability to assess dose. This finding also had a crosscutting aspect associated with human performance because radiation protection personnel directly contributed to the finding by not performing an adequate survey. The finding was placed in the licensee's corrective action program as performance improvement request PIR 2005-1046.

Inspection Report# : [2005003\(pdf\)](#)

Public Radiation Safety

Physical Protection

[Physical Protection](#) information not publicly available.

Miscellaneous

Last modified : November 30, 2005