UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION IV
1600 E. LAMAR BLVD.
ARLINGTON, TX 76011-4511

December 8, 2015

EA-15-139

Mr. Adam C. Heflin
President and Chief Executive Officer
Wolf Creek Nuclear Operating Corporation
P.O. Box 411
Burlington, KS 66839

SUBJECT: WOLF CREEK GENERATING STATION – NRC INSPECTION REPORT 05000482/2015009

Dear Mr. Heflin:

On June 19, 2015, the U.S. Nuclear Regulatory Commission (NRC) completed an inspection at your Wolf Creek Generating Station. Further inspection efforts continued onsite and in the Region IV offices through November 24, 2015. On November 24, 2015, the NRC inspectors discussed the results of this inspection with Mr. C. Reasoner, Site Vice President, and other members of your staff. Inspectors documented the results of this inspection in the enclosed inspection report.

NRC inspectors documented two findings of very low safety significance (Green) in this report. Both of these findings involved violations of NRC requirements. The NRC is treating these violations as non-cited violations (NCVs) consistent with Section 2.3.2.a of the NRC Enforcement Policy.

If you contest the violations or significance of these NCVs, you should provide a response within 30 days of the date of this inspection report, with the basis for your denial, to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555-0001; with copies to the Regional Administrator, Region IV; the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001; and the NRC resident inspector at the Wolf Creek Generating Station.

If you disagree with a cross-cutting aspect assignment in this report, you should provide a response within 30 days of the date of this inspection report, with the basis for your disagreement, to the Regional Administrator, Region IV; and the NRC resident inspector at the Wolf Creek Generating Station.

In accordance with Title 10 of the *Code of Federal Regulations* (10 CFR) 2.390, "Public Inspections, Exemptions, Requests for Withholding," a copy of this letter, its enclosure, and your response (if any) will be available electronically for public inspection in the NRC's Public Document Room or from the Publicly Available Records (PARS) component of the NRC's Agencywide Documents Access and Management System (ADAMS). ADAMS is accessible from the NRC Web site at http://www.nrc.gov/reading-rm/adams.html (the Public Electronic Reading Room).

Sincerely,

/RA/

Nicholas H. Taylor, Branch Chief
Project Branch B
Division of Reactor Projects

Docket Nos. 50-482
License Nos. NPF-42

Enclosure: Inspection Report 05000482/2015009
w/ Attachment: Supplemental Information

cc w/ encl: Electronic Distribution

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ML15342A317

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Letter to Adam C. Heflin from Nicholas H. Taylor dated December 8, 2015

SUBJECT: WOLF CREEK GENERATING STATION – NRC INSPECTION REPORT 05000482/2015009

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U.S. NUCLEAR REGULATORY COMMISSION

REGION IV

Docket:	05000482
License:	NPF-42
Report:	05000482/2015009
Licensee:	Wolf Creek Nuclear Operating Corporation
Facility:	Wolf Creek Generating Station
Location:	1550 Oxen Lane NE Burlington, Kansas
Dates:	June 13 through November 24, 2015
Inspectors:	C. Speer, Acting Senior Resident Inspector R. Stroble, Resident Inspector
Approved By:	Nicholas H. Taylor, Chief, Project Branch B Division of Reactor Projects

SUMMARY

IR 05000482/2015009; 06/13/2015 – 11/24/2015; Wolf Creek Generating Station; Other Activities

The inspection activities described in this report were performed between June 13 and November 24, 2015, by the resident inspectors at Wolf Creek Generating Station and inspectors from the NRC's Region IV office. Two findings of very low safety significance (Green) are documented in this report. Both of these findings involved violations of NRC requirements. The significance of inspection findings is indicated by their color (Green, White, Yellow, or Red), which is determined using Inspection Manual Chapter 0609, "Significance Determination Process," dated April 29, 2015. Their cross-cutting aspects are determined using Inspection Manual Chapter 0310, "Aspects within the Cross-Cutting Areas," dated December 4, 2014. Violations of NRC requirements are dispositioned in accordance with the NRC Enforcement Policy. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process," dated February 2014.

Cornerstone: Initiating Events

- Green. The inspectors reviewed a self-revealing Green non-cited violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," because the licensee did not assure the procedures for reactor startup were appropriate to the circumstances. Specifically, prior to May 3, 2015, the licensee failed to include adequate instructions for transferring feedwater flow from the main feedwater regulating valve bypass valves to the main feedwater regulating valves in Procedure GEN 00-003, "Hot Standby to Minimum Load." As a result, operations personnel did not properly control feedwater flow during a reactor startup, which led to a plant trip on May 3, 2015. The licensee entered this condition into their corrective action program as Condition Reports 96064 and 100583. The corrective action taken to restore compliance was to revise Procedure GEN 00-003 to update the process for transferring main feedwater control from the main feedwater regulating valve bypass valves to the main feedwater regulating valves, including the monitoring of necessary parameters steam flow and feedwater flow.

  The failure to assure the procedures for reactor startup were appropriate to the circumstances was a performance deficiency. The performance deficiency was more than minor, and therefore a finding, because it adversely affected the human performance attribute of the initiating events cornerstone objective of limiting the likelihood of events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. Specifically, prior to May 4, 2015, the licensee did not provide adequate guidance for the control of feedwater flow during plant startup, resulting in a plant trip on May 3, 2015. Using NRC Inspection Manual Chapter 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," issued June 19, 2012, the inspectors determined that the finding was of very low safety significance (Green) because the finding did not cause a trip and the loss of mitigation equipment relied upon to transition the plant from the onset of the trip to a stable shutdown condition. Specifically, following the plant trip, all mitigation equipment responded as designed.

  The inspectors concluded that the finding reflected current licensee performance and had a cross-cutting aspect in the area of human performance, avoid complacency, in that the licensee did not recognize and plan for the possibility of mistakes, latent issues, and inherent risk even while expecting successful outcomes. Specifically, the licensee did not

recognize and plan for potential of mistakes when using a procedure that did not contain adequate guidance for minimizing mismatches in steam flow and feedwater flow [H.12] (Section 4OA3).

- Green. The inspectors reviewed a self-revealing Green non-cited violation of 10 CFR 55.46(c)(1), "Plant-referenced Simulators," due to the licensee's failure to maintain a plant-referenced simulator used for the administration of the operating test such that it would demonstrate expected plant response to operator input and to normal, transient, and accident conditions to which the simulator has been designed to respond. Specifically, until June 13, 2015, the licensee failed to maintain the simulator consistent with actual plant response when using the main feed regulating valves in manual control. The licensee entered this condition into their corrective action program as Condition Report 96252. The corrective action taken to restore compliance was to change the simulator modeling of the main feedwater regulating valve controller to match the installed plant controllers.

  The failure to maintain the plant-referenced simulator such that it would accurately reproduce the operating characteristics of the facility was a performance deficiency. The performance deficiency is more than minor because it adversely affected the human performance attribute of the initiating events cornerstone objective of limiting the likelihood of events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. Specifically, prior to June 13, 2015, the licensee failed to maintain the simulator consistent with actual plant response when using the main feed regulating valves in manual control, which impacted operator control of the plant during power operations. Using NRC Inspection Manual Chapter 0609, Appendix I, "Licensed Operator Requalification Significance Determination Process (SDP)," issued December 6, 2011, the inspectors determined that the finding was of very low safety significance (Green) because the deficient simulator performance did not negatively impact operator personnel performance in the actual plant during a reportable event. Specifically, after the trip occurred the operators took all appropriate required actions.

  The inspectors concluded that the finding did not have a cross-cutting aspect because the finding was not indicative of current performance. The configuration change that introduced the error occurred more than three years before the event. Specifically, the discrepancy between the simulator and the plant manual controller rates had existed since simulator use began in 1985 (Section 4OA3).

REPORT DETAILS

4. OTHER ACTIVITIES

Cornerstones: Initiating Events, Mitigating Systems, Barrier Integrity, Emergency Preparedness, Public Radiation Safety, Occupational Radiation Safety, and Security

4OA3 Follow-up of Events and Notices of Enforcement Discretion (71153)

(Closed) Licensee Event Report 05000482/2015-003-00, "Manual Reactor Trip due to High Steam Generator Level Transient at Low Power"

a. Inspection Scope

On May 3, 2015, the licensee performed a startup of the reactor following the completion of a refueling outage. At approximately 25 percent reactor power, the licensee initiated the transfer of main feedwater flow control from the main feedwater regulating valve bypass valves to the main feedwater regulating valves. While transferring to the C main feedwater regulating valve in manual control, main feedwater flow increased at higher rate than expected. The control room received a main feedwater isolation alarm due to the C steam generator level exceeding 78 percent. The main turbine subsequently tripped due to the high level in the C steam generator. Operators manually tripped the reactor due to the automatic trip of the main turbine. All safety systems responded as expected during and following the plant trip. In reviewing the event, the inspectors documented two findings found below. This licensee event report is closed.

These activities constitute completion of one event follow-up sample, as defined in Inspection Procedure 71153.

b. Findings

1. Failure to Provide Adequate Instructions for Control of Feedwater Flow in Startup Procedures

Introduction. The inspectors reviewed a Green self-revealing, non-cited violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," because the licensee did not assure the procedures for reactor startup were appropriate to the circumstances. Specifically, prior to May 3, 2015, the licensee failed to include adequate instructions for transferring feedwater flow from the main feedwater regulating valve (MFRV) bypass valves to the MFRVs in Procedure GEN 00-003, "Hot Standby to Minimum Load." As a result, operations personnel did not properly control feedwater flow during a reactor startup, which led to a plant trip on May 3, 2015.

Description. On May 3, 2015, the licensee performed a startup of the reactor following a refueling outage. At approximately 25 percent reactor power, the licensee initiated the transfer of main feedwater control from the MFRV bypass valves to the MFRVs in accordance with Procedure GEN 00-003, "Hot Standby to Minimum Load," Revision 96B. While transferring to the C MFRV in manual control, main feedwater flow increased at higher rate than expected. The control room subsequently received a main feedwater isolation alarm due to the C steam generator level exceeding 78 percent. The main turbine also tripped due to the high level in the C steam generator. Operators

manually tripped the reactor due to the automatic trip of the main turbine. All safety systems responded as expected during and following the plant trip.

In reviewing the event, the licensee found that large mismatches of several hundred lbm/hr existed between steam generator steam flows and feedwater flows while transferring main feedwater flow control from the MFRV bypass valves to the MFRVs. These large deviations resulted in unstable steam generator behavior, which led to high levels in the C steam generator and the resulting reactor trip.

Prior to performing the reactor startup, the operating crews received training on methods to reduce errors and transients during the startup. Included in the training prior to the May 3, 2015, startup was guidance to minimize mismatches in steam flow and feedwater flow to the steam generators in order to enhance steam generator water level control. However, Procedure GEN 00-003 did not reflect the guidance provided in the operator's startup training for minimizing mismatches in steam flow and feedwater flow. Additionally, it provided operators with no direction how to monitor steam flows and feedwater flows or the expected manner in which the transfer would occur. The operator who was responsible for the transfer of feedwater flow control on the C steam generator focused on steam generator level and did not recognize the large feed-steam flow mismatch that existed for almost a full minute before the turbine trip occurred.

In the subsequent reactor startup on May 4, 2015, the licensee took interim actions to better control the MRFV transfer evolution, including more gradual manipulation of the MFRVs and focus on critical plant parameters and using an additional operator to monitor the steam flow and feedwater flow indications while placing the MFRVs into service. The long-term corrective actions included revising Procedure GEN 00-003 to update the process for transferring main feedwater control from the MFRV bypass valves to the MFRVs.

In reviewing operator training, the licensee found that emphasis was placed on performing the transfer of main feedwater flow control from the MFRV bypass valves to the MFRVs quickly. The emphasis for reducing the time period of the transfer was due to instability of steam generator level control at low power operations. This emphasis was shared by operations management and licensed operators. Additionally, the licensee found that different operating crews implemented the procedure in different ways. The differences included the number of MFRVs operated simultaneously, using large or small valve movements, and the overall time taken to complete the transfer. These differences were all compliant with the version of Procedure GEN 00-003 in place at the time. The inspectors concluded that the licensee did not recognize or plan for the potential for mistakes related to this emphasis. Had that occurred, the licensee would likely have recognized the operating difference resulting from the inadequate guidance contained in Procedure GEN 00-003.

Analysis. The failure to assure the procedures for reactor startup were appropriate to the circumstances was a performance deficiency. The performance deficiency was more than minor, and therefore a finding, because it adversely affected the human performance attribute of the initiating events cornerstone objective of limiting the likelihood of events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. Specifically, prior to May 4, 2015, the licensee did not provide adequate guidance for the control of feedwater flow during plant startup, resulting in a plant trip on May 3, 2015.

The inspectors performed an initial screening of the finding in accordance with NRC Inspection Manual Chapter (IMC) 0609, "Significance Determination Process," issued April 29, 2015. Using IMC 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," issued June 19, 2012, the inspectors determined that the finding was of very low significance (Green) because the finding did not cause a trip and the loss of mitigation equipment relied upon to transition the plant from the onset of the trip to a stable shutdown condition. Specifically, following the plant trip, all mitigation equipment responded as designed.

The inspectors concluded that the finding reflected current licensee performance and had a cross-cutting aspect in the area of human performance, avoid complacency, in that the licensee did not recognize and plan for the possibility of mistakes, latent issues, and inherent risk even while expecting successful outcomes. Specifically, the licensee did not recognize and plan for possibility of mistakes when using a procedure that did not contain adequate guidance for minimizing mismatches in steam flow and feedwater flow [H.12].

Enforcement. Title 10 of the *Code of Federal Regulations*, Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," requires, in part, that activities affecting quality shall be prescribed by documented instructions, procedures, or drawings, of a type appropriate to the circumstances. Contrary to the above, prior to May 4, 2015, the licensee's procedure for control of feedwater flow during reactor startup was not appropriate to the circumstance. Specifically, Licensee Procedure GEN 00-003, "Hot Standby to Minimum Load," Revision 96B, did not contain adequate instructions for the control of feedwater flow during plant startups, resulting in overfeeding of a steam generator and a reactor trip. The licensee entered this condition into their corrective action program as Condition Reports 96064 and 100583. The corrective action taken to restore compliance was to revise Procedure GEN 00-003 to update the process for transferring main feedwater control from the main feedwater regulating valve bypass valves to the main feedwater regulating valves, including the monitoring of necessary parameters steam flow and feedwater flow. Because this violation was of very low safety significance and the licensee entered the issue into their corrective action program, this violation was treated as an NCV, consistent with Section 2.3.2 of the NRC Enforcement Policy: NCV 05000482/2015009-01, "Failure to Provide Adequate Instructions for Control of Feedwater Flow in Startup Procedures."

2. Failure of the Plant Referenced Simulator to Demonstrate Expected Plant Response

Introduction. The inspectors reviewed a Green self-revealing non-cited violation of 10 CFR 55.46(c)(1), "Plant-referenced Simulators," due to the licensee's failure to maintain a plant-referenced simulator used for the administration of the operating test such that it would demonstrate expected plant response to operator input and to normal, transient, and accident conditions to which the simulator has been designed to respond. Specifically, until June 13, 2015, the licensee failed to maintain the simulator consistent with actual plant response when using the main feed regulating valves in manual control.

Description. On May 3, 2015, the licensee performed a startup of the reactor following a refueling outage. At approximately 25 percent reactor power, the licensee initiated the transfer of main feedwater control from the main feedwater regulating valve (MFRV) bypass valves to the MFRVs in accordance with Procedure GEN 00-003, "Hot Standby

to Minimum Load," Revision 96B. While transferring to the C MFRV in manual control, main feedwater flow increased at higher rate than expected. The control room subsequently received a main feedwater isolation alarm due to the C steam generator level exceeding 78 percent. The main turbine also tripped due to the high level in the C steam generator. Operators manually tripped the reactor due to the automatic trip of the main turbine. All safety systems responded as expected during and subsequent to the plant trip.

As part of the cause investigation for the plant trip, the licensee found that the controllers for the MFRVs had a controller time-constant for manual control of the output of 8 seconds in an exponential fashion. With this setting, the valves would reach fully-open in 8 seconds, moving slower at the beginning of the stroke and accelerating through the end of the stroke. The licensee found that the MFRV controllers modeled in the simulator had this time-constant set at 30 seconds. Operators were not made aware the discrepancy between the simulator and plant MFRV controllers.

The NRC staff performed an inspection in the plant reference simulator on September 1, 2015, to gain an understanding of the importance of this simulator configuration error. The simulator staff replicated the plant conditions prior to the plant trip on May 3, 2015, and replicated the exact valve movements made by the operator during the event. This evolution was conducted twice: once with the MFRV controller time constant set at 8 seconds (as installed in the plant), and once with the MFRV controller time constant set at 30 seconds (as modeled in the simulator before the event). The inspectors noted that the result in the simulator in both scenarios was the same, in that the C steam generator narrow range level peaked at 78 percent regardless of the time constant. The inspectors did note that this result was received more quickly with the shorter time constant in the plant, but that the impact on the plant and required response by the control room staff was unaffected.

The discrepancy between the simulator and the plant manual controller rates has existed since simulator use began in 1985. The discrepancy was not discovered previously because, under most circumstances, operators are trained to use small movements when taking manual control of valves. The exponential setup of the MFRV controllers causes the valves to open faster the longer the manual pushbutton is pressed. When using small movements, as is done during most normal operations, the difference between the plant and simulator outputs is small. However, when using large movements, as was done during plant startup, the plant valves open much faster than the valves modeled in the simulator.

Analysis. The failure to maintain the plant-referenced simulator such that it would accurately reproduce the operating characteristics of the facility was a performance deficiency. The performance deficiency is more than minor, and therefore a finding, because it adversely affected the human performance attribute of the initiating events cornerstone objective of limiting the likelihood of events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. Specifically, prior to June 13, 2015, the licensee failed to maintain the simulator consistent with actual plant response when using the main feed regulating valves in manual control.

The inspectors performed an initial screening of the finding in accordance with IMC 0609, "Significance Determination Process," issued April 29, 2015. Using IMC 0609,

Attachment 4, Table 3, "SDP Appendix Router," issued June 19, 2012, the inspectors determined that the finding involved simulator fidelity. As a result, the inspectors used IMC 0609, Appendix I, "Licensed Operator Requalification Significance Determination Process (SDP)," issued December 6, 2011, and determined that the finding was of very low safety significance (Green) because the deficient simulator performance did not negatively impact operator personnel performance in the actual plant during a reportable event. Specifically, after the trip occurred the operators took all appropriate required actions.

The inspectors concluded that the finding did not have a cross-cutting aspect because the finding was not indicative of current performance. The configuration change that introduced the error occurred more than three years before the event. Specifically, the discrepancy between the simulator and the plant manual controller rates had existed since simulator use began in 1985.

Enforcement. Title 10 of the *Code of Federal Regulations*, Section 55.46(c)(1), "Plant-referenced Simulators," requires, in part, that a plant-referenced simulator used for the administration of the operating test must demonstrate expected plant response to operator input and to normal, transient, and accident conditions to which the simulator has been designed to respond. Contrary to the above, until June 13, 2015, the licensee failed to assure that the plant-referenced simulator used for the administration of the operating test demonstrated expected plant response to operator input for which the simulator has been designed to respond. Specifically, the Wolf Creek simulator failed to model the response of the main feedwater regulating valves to manual operator input during startup operations, a condition to which the simulator has been designed to respond. The licensee entered this condition into their corrective action program as Condition Report 96252. The corrective action taken to restore compliance was to change the simulator modeling of the main feedwater regulating valve controller to match the installed plant controllers. Because this violation was of very low safety significance and the licensee entered the issue into their corrective action program, this violation was treated as an NCV, consistent with Section 2.3.2 of the NRC Enforcement Policy: NCV 05000482/2015009-02, "Failure of the Plant Referenced Simulator to Demonstrate Expected Plant Response."

4OA6 Meetings, Including Exit

Exit Meeting Summary

On November 24, 2015, the inspectors presented the inspection results to Mr. C. Reasoner, Site Vice President, and other members of the licensee staff. The licensee acknowledged the issues presented. The licensee confirmed that any proprietary information reviewed by the inspectors had been returned or destroyed.

SUPPLEMENTAL INFORMATION

KEY POINTS OF CONTACT

Licensee Personnel

T. Damashek, Simulator Fidelity Coordinator
J. Edwards, Manager, Operations
R. Hobby, Licensing
J. Knapp, Superintendent Operations Training
B. Lee, Licensed Supervising Instructor
B. Meyer, Simulator and Exam Group Supervisor
W. Muilenburg, Supervisor, Licensing
G. Olmstead, Contract Operations Training Instructor
C. Reasoner, Site Vice President
T. Slenker, Operations
J. Starr, Lead Simulator Software Specialist

NRC Personnel

D. Dodson, Senior Resident Inspector
A. Rosebrook, Acting Branch Chief

LIST OF ITEMS OPENED, CLOSED, AND DISCUSSED

Opened and Closed

05000482/2015009-01	NCV	Failure to Provide Adequate Instructions for Control of Feedwater Flow in Startup Procedures (Section 4OA3)
05000482/2015009-02	NCV	Failure of the Plant Referenced Simulator to Demonstrate Expected Plant Response (Section 4OA3)

Closed

05000482/2015-003-00	LER	Manual Reactor Trip due to High Steam Generator Level Transient at Low Power (Section 4OA3)

LIST OF DOCUMENTS REVIEWED

Section 4OA3: Follow-up of Events and Notices of Enforcement Discretion

Procedures

Number	Title	Revision
AI 30C-001	Continued Assurance of Simulator Fidelity	16
ALR 00-108B	SG A Lev Dev	9
AP 21-001	Conduct of Operations	72
GEN 00-003	Hot Standby to Minimum Load	96B

Procedures

Number	Title	Revision
GEN 00-003	Hot Standby to Minimum Load	97
GEN 00-003	Hot Standby to Minimum Load	97C
K02-023	Post-Trip/Event Review Data Package	0
OFN SB-008	Instrument Malfunctions	43
SYS AE-200	Feedwater Preheating During Plant Startup and Shutdown	38

Condition Reports (CRs)

96064	96252	100583