



UNITED STATES
NUCLEAR REGULATORY COMMISSION

REGION IV

611 RYAN PLAZA DRIVE, SUITE 400
ARLINGTON, TEXAS 76011-8064

June 11, 1997

Otto L. Maynard, President and
Chief Executive Officer
Wolf Creek Nuclear Operating Corporation
P.O. Box 411
Burlington, Kansas 66839

SUBJECT: NRC INSPECTION REPORT 50-482/97-08

Dear Mr. Maynard:

Thank you for your letter of May 23, 1997, in response to our letter and Notice of Violation dated April 25, 1997. 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,

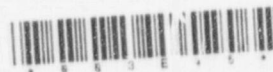
Ken E. Brockman for

Thomas P. Gwynn, Director
Division of Reactor Projects

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

cc w/enclosure:
Chief Operating Officer
Wolf Creek Nuclear Operating Corp.
P.O. Box 411
Burlington, Kansas 66839

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



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PDR ADOCK 05000482
G PDR

Wolf Creek Nuclear
Operating Corporation

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Supervisor Licensing
Wolf Creek Nuclear Operating Corp.
P.O. Box 411
Burlington, Kansas 66839

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

Office of the Governor
State of Kansas
Topeka, Kansas 66612

Attorney General
Judicial Center
301 S.W. 10th
2nd Floor
Topeka, Kansas 66612-1597

County Clerk
Coffey County Courthouse
Burlington, Kansas 66839-1798

Vick L. Cooper, Chief
Radiation Control Program
Kansas Department of Health
and Environment
Bureau of Air and Radiation
Forbes Field Building 283
Topeka, Kansas 66620

Mr. Frank Moussa
Division of Emergency Preparedness
2800 SW Topeka Blvd
Topeka, Kansas 66611-1287

Wolf Creek Nuclear
Operating Corporation

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JUN 11 1997

bcc to DCD (IE01)

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WOLF CREEK

NUCLEAR OPERATING CORPORATION

Otto L. Maynard
President and
Chief Executive Officer

May 23, 1997

WM 97-0064

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

Reference: Letter dated April 25, 1997, from
Thomas P. Gwynn, NRC, to Otto L. Maynard, WCNOG

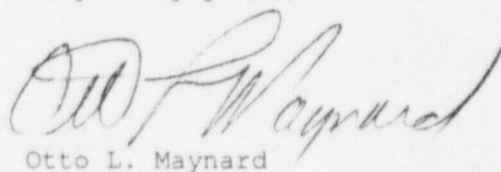
Subject: Docket No. 50-482: Response to Notice of
Violations 50-482/9708-01 (EA 97-108), -02, -03, and -05

Gentlemen:

This letter transmits Wolf Creek Nuclear Operating Corporation's (WCNOG) response to Notice of Violations 50-482/9708-01, -02, -03, and -05. Violations 9708-01 and -02 involve failure to follow procedures. Violation 9708-03 discusses a violation of Technical Specifications, and violation 9708-05 discusses failure to update the Updated Safety Analysis Report with the latest material developed.

WCNOG's response to these violations is provided in the attachment. If you have any questions regarding this response, please contact me at (316) 364-8831, extension 4000, or Mr. Richard D. Flannigan at extension 4500.

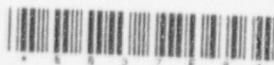
Very truly yours,


Otto L. Maynard

OLM/jad

Attachment

cc: W. D. Johnson (NRC), w/a
E. W. Merschhoff (NRC), w/a
J. F. Ringwald (NRC), w/a
J. C. Stone (NRC), w/a



Reply to Notice of Violations 50-482/9708-01, -02, -03, and -05

Violation 50-482/9708-01 (EA 97-108):

- "A. Technical Specification 6.8.1 states, in part, that procedures be established, implemented, and maintained covering the activities reference in Regulatory Guide 1.33, Revision 2, February 1978. Appendix A Section 7 (a), requires procedures for the liquid radioactive waste system.

Systems Procedure SYS HB-135, "Liquid Radwaste Demin Floor Drain and Waste Holdup Tanks Processing," Revision 0, Precaution Step 4.12, states, "Do not exceed Water Monitor Tanks A or B (THB07A or THB07B) level of 90 percent to prevent an inadvertent overflow."

Alarm Response Procedure ALR 702, "Liquid Process Control Panel HB-115," Revision 2, Attachment S, "702-08A, Waste Monitor Tank 1 HI-LO Level," requires that liquid transfers to Waste Monitor Tank 1 (WMT B) be stopped if the level is greater than 90 percent.

Contrary to the above, on February 27, 1996, radwaste operators did not follow the above procedural guidance and disregarded the panel alarm when they were instructed by their supervisor to exceed the precautionary 90 percent fill limit and fill the waste monitor tank to the 95-97 percent level.

This is a Severity Level IV violation (Supplement IV) (482/9708-01) (EA 97-108).

Admission of Violation:

Wolf Creek acknowledges that a violation of Technical Specification 6.8.1 occurred when procedures were not followed.

Reason for Violation:

On February 27, 1996, instructions to fill the Waste Monitor Tank (WMT) to greater than 90 percent capacity were given by the Radwaste Supervisor to the day shift radwaste operator and then transferred to the night shift radwaste operator. The supervisor was focused on maximizing storage capability by conserving radwaste hold-up volume due to the inability to discharge effluents at the time. Procedure SYS HB-135, "Liquid Radwaste Demin Floor Drain and Waste Holdup Tanks Processing," was open and in use during the processing evolution and contained a precaution step to limit the level to 90 percent full. This precaution was not followed by the operators.

The operators did not use alarm response procedure, ALR 702, "Liquid Process Control Panel HB-115," because they knew the Radwaste Supervisor's instructions would cause an alarm and they were expecting it. They believed that they did not need the ALR to troubleshoot as this was an expected alarm. The operators did not question that the Radwaste Supervisor's direction was contrary to procedures.

The Radwaste Supervisor failed to follow administrative requirements for use and adherence to procedures. Additionally, the Radwaste Supervisor did not make changes to procedures when required and continued to give instructions that were contrary to procedures.

Corrective Steps Taken and Results Achieved:

The Radwaste Supervisor received appropriate disciplinary actions in accordance with WCNOC policy.

To increase oversight and provide full-time supervision, the Radwaste and Water Treatment operators have been integrated into the Operating Crews.

On January 14, 1997, the radwaste and water treatment operators were coached and counseled about:

- the importance of maintaining a questioning attitude and their right to call for a "time out"
- not placing themselves in a posture of blind compliance to procedures or supervisory authority
- reviewing procedures when making decisions to ensure that decisions are compatible with requirements.

WCNOC Senior Management held a site-wide stand-down meeting on February 28, 1997, to ensure that all WCNOC personnel understand their expectations for literal compliance with procedures.

Date When Full Compliance Will Be Achieved:

All of the above listed corrective actions are complete and full compliance has been achieved.

Violation 50-482/9708-03:

- "B. With one required diesel generator inoperable, Technical Specification 3.8.1.1, Action b, requires the performance of surveillance testing to demonstrate the operability of offsite alternating current sources by performing Technical Specification Surveillance 4.8.1.1 within 1 hour.

Contrary to the above, on May 16, 1996, maintenance personnel inadvertently rendered Emergency Diesel Generator A inoperable, and the licensee failed to perform Technical Specification Surveillance 4.8.1.1 within 1 hour.

This is a Severity Level IV violation (Supplement 1) (482/9708-03)."

Admission of Violation:

Wolf Creek acknowledges that a violation of Technical Specification (TS) occurred when Technical Specification Surveillance 4.8.1.1.1 was not completed within one hour after one diesel generator was rendered inoperable. This TS violation was reported in Licensee Event Report (LER) 96-008-00. During the closure of LER 96-008-00 the Senior Resident Inspector determined that the stated corrective actions would not prevent recurrence and were inadequate and the LER closed with a cited violation.

Reason for Violation:

The excerpt below from LER 96-008-00 is provided for background information.

On May 16, 1996, troubleshooting Work Package (WP) 112603 was initiated on the computer point for the "A" Train Essential Service Water (ESW) room temperature indicator. The Control Room reviewed and approved the work package to be worked. At approximately 1035 on May 16, 1996, as part of WP 112603, surveillance procedure STN IC-465, "Channel Calibration ESW Pump Room Temperature Control Loop," was commenced on the "A" Train ESW supply fan; this procedure lifted lead RP053AC for the fan, keeping the fan from starting on any signals, thus causing the ESW train "A" to be inoperable. It was not recognized that this procedure affected the operability of the ESW fan. Technical Specification 3.7.4 should have been entered; additionally, Technical Specification surveillance 3.8.1.1 should have been performed when the ESW train was inoperable for greater than one hour. The Diesel Generator Technical Specification 3.8.1.1 for the "A" Train should have been entered.

On May 17, 1996, the troubleshooting activities on the computer point were continued, with the lifting of lead RP053AC. This again made the ESW "A" supply fan inoperable. Coinciding with these events, an oil line broke on the Control Building Air Conditioner unit, SGK04B, which caused the "3" train Control Room Emergency Ventilation System (CREVS) to be inoperable. Therefore, both "A" and "B" trains of CREVS were inoperable for ten to fifteen minutes, contrary to Technical Specification 3.7.6, and Technical Specification 3.0.3 should have been entered.

The LER corrective actions were stated as follows:

Immediate:

1. STN IC-465 was revised to include cautions that during the performance of this procedure, the supply fan will be inoperable.
2. The importance of clear communications with the shift supervisor, and the importance of understanding the effects of the work they perform on equipment operability have been emphasized during I&C group meetings.

Long-term:

1. All I&C STNs will be reviewed for potential impact to equipment operability, prior to any use. This review will be completed entirely by September 20, 1996.
2. A checklist of questions and considerations will be generated that the shift supervisor and Work Control Center should ask when a troubleshooting request, or a request to perform a procedure, is received to help ensure complete communication takes place, and to address operability questions. This checklist will be utilized until such time as WCNOC determines that this interim measure is no longer of value. The checklist will be completed by September 16, 1996.

Inspection Report 97-08 documented three deficiencies with the above corrective actions.

- 1) The checklist to ensure complete communication between the shift supervisor or the work control center and the maintenance personnel did not directly question whether the proposed work affected the operability of safety related work.

As stated in LER 96-008-00, the checklist questions should be asked when a troubleshooting request or a request to perform a procedure is received, to ensure that complete communications take place, and to address operability questions. It was never intended for the checklist to prompt the Shift Supervisor (SS) or Supervising Operator (SO) to ask Maintenance personnel if they considered the work to effect operability. At WCNOC, operability can only be determined by the SS. The checklist does state under the preparation section to "Review equipment status and system operability including any pre-planning checklists that apply." The checklist questions were intentionally written to be open-ended in order to prompt further thought, discussion and investigation.

- 2) LER 96-008-00 stated that the checklist would be utilized until such time as WCNOC determined that the interim measure was no longer of value. On March 31, 1997, the inspector noted that Work Control Center personnel had stopped using the checklist, although the Manager Operations believed that the checklist was still being used.

The checklists were made into laminated cards and distributed to Operations personnel, however, no clear communication or direction concerning their usage was provided. Interviews with Operations personnel determined that most personnel found the cards useful, however, it was not understood to be a regulatory commitment, and was not consistently used. An evaluation to determine if the checklist was of value was not performed because it was not desired to discontinue its use. Inconsistent checklist implementation was caused by inadequate communication among the groups involved and lack of management expectations regarding use of the card.

- 3) The corrective actions associated with reviewing procedures for inadequacy and the shop meeting discussions were not performed for the electrical or mechanical maintenance groups.

Non-Instrumentation and Controls (I&C) maintenance procedures and personnel were not included because all Electrical and Mechanical Maintenance surveillance procedures were thought to be performed after issuance of a clearance order isolating the equipment being tested. Further research concluded that there are some Electrical Maintenance procedures that are performed on on-line or energized equipment. The reason for this oversight was that the review of procedures was inadequate and did not uncover all applicable procedures and organizations.

Corrective Steps to Be Taken to Prevent Recurrence:

Integrated Plant Scheduling and Operations Management will proceduralize their expectations regarding the usage of the checklist card by June 27, 1997.

In order to broaden the scope of the corrective actions from LER 96-008-00, a review of all Maintenance surveillance procedures will be performed to ensure technical specifications are properly referenced. This review will be completed by June 27, 1997.

Date When Full Compliance Will Be Achieved:

All Corrective Actions will be completed by June 27, 1997.

Violation 50-482/9708-02:

- "C. Criterion V of Appendix B to 10 CFR Part 50 requires, in part, that activities affecting quality shall be prescribed by documented instructions, procedures, and drawings appropriate to the circumstances, and shall be accomplished in accordance with these instructions, procedures, or drawings.

Administrative Procedure AP 22C-003, "Operational Risk Assessment Program," Revision 1, requires the performance of operations risk assessments for equipment removed from service for maintenance activities.

Step 6.1.3 of Procedure AP 22C-003, requires any activities added to or slipped from the current weekly Revision 0 schedule be assessed and documented on the original operational risk assessment.

Contrary to the above, on April 2 and 3, 1997, the licensee added activities which had been slipped from the weekly Revision 0 schedule without documenting an assessment of risk on the operational risk assessment.

This is a Severity Level IV violation (Supplement 1)(482/9708-02)."

Admission of Violation:

Wolf Creek acknowledges that a violation of Criterion V of Appendix B occurred when personnel failed to update the operational risk assessment as required by procedure.

Reason for Violation:

Procedure AP 22C-003, "Operational Risk Assessment Program," step 6.1.3 requires any activities added to or slipped from the current weekly Revision 0 schedule be assessed and documented on the original operational risk assessment.

On March 31, 1997, an annotation on the operational risk assessment was made to indicate that the "A" train Component Cooling Water (CCW) was inoperable and that the planned work on the "B" train CCW would be put on hold until the "A" train was operable. On April 2 and 3, 1997, after the "A" train CCW was restored, WCNOC performed "B" train CCW activities. When these activities were performed the operational risk assessment was not updated.

The operational risk assessment was not updated because personnel interpreted AP 22C-003 to apply to activities removed from that week's operational risk assessment, and not to activities placed on hold. The definition of "slipped" from the schedule was unclear. The reason for this violation is that the instructions in AP 22C-003 were ambiguous and the procedure details were less than adequate.

Corrective Steps That Will Be Taken to Prevent Recurrence:

Procedure AP 22C-003 will be revised by May 27, 1997, to include detailed instructions for addressing slippage within the current week. Step 6.1.3 will be revised to clearly specify when and how adds, slips, and changes will be documented.

Required reading will be routed to Shift Supervisors and Supervising Operators, Work Week Managers, and the Central Work Authority by June 30, 1997, to inform them of the procedure changes.

Date When Full Compliance Will Be Achieved:

All corrective actions will be completed by June 30, 1997.

Violation 50-482/9708-05:

"D. 10 CFR50.71(e) requires that each person licensed to operate a nuclear power plant reactor update periodically the Final Safety Analysis Report to assure that the information included in the Final Safety Analysis Report contains the latest material developed. The Updated Safety Analysis Report is to include the effect of all changes made in the facility.

Contrary to the above, as of September 23, 1996, the licensee had not updated the Updated Safety Analysis Report Figure 9.3-8-03, "Piping and Instrumentation Diagram Chemical and Volume Control System," to reflect actual plant practices regarding Valve BG 8384A or Updated Safety Analysis Report Figure 6.2.4-1, "Containment Penetrations," to reflect the following changes:

- On Sheet 17, Valve EJ V167 was identified as a containment isolation valve, but was never installed in the plant. Valve EJ V124 was not shown in the same location as actually installed. Valves EJ V177 and -V178 are shown reversed from their actual orientation in the plant.
- On Sheet 23, Valve EJ V166 was not shown, but is installed in the plant
- On Sheet 36, Valves EM -V164, -V166, and -V168 were not shown in the proper orientation.
- On Sheet 38, Valve EJ -V116 was not shown in the correct location
- On Sheet 42b, Valve SJ -V114 was not identified on the diagram as a containment isolation valve.
- On Sheet 43, Valve EM HV200 was identified, but was never installed in the plant.
- On Sheet 53, Valves EG V397 and -V126 were shown in the wrong location.
- On Sheet 54, Valves EG V371, -V377, and -V369 were shown in the wrong location.
- On Sheet 56, Valve EJ V152 was identified, but was never installed in the plant.
- On Sheet 58, Valves EJ V171 and -V172 are shown reversed from the actual installation in the plant.
- On Sheet 64, Valve BB V1 is identified as BB V-051.
- On Sheet 66, Valve EM V0038 is shown open but it is maintained locked and closed in the plant.

This is a Severity Level IV violation (Supplement I) (482/9708-05).

Admission of Violation:

WCNOC acknowledges that a violation of 10 CFR50.71(e) occurred when the Updated Safety Analysis Report was not maintained with the latest material developed.

Reason for Violation:

The reason for the inaccuracies in the sheets associated with Updated Safety Analysis Report (USAR) Figure 6.2.4-1 and Figure 9.3-8-03 is personnel error. Updated Safety Analysis Report (USAR) Figure 6.2.4-1 contains 74 sheets, with each sheet showing a containment penetration figure. Except for one example, the errors in Figure 6.2.4-1 were made prior to Wolf Creek's operating license in 1985. The exception was made three years ago when the originator of a Plant Modification Request (PMR) revised the affected P&ID USAR Figure but apparently overlooked USAR Figure 6.2.4-1. All the errors involved design changes that resulted in the revision of the associated USAR P&ID figure, however, the USAR containment penetration Figure 6.2.4-1 was overlooked.

The purpose of USAR Figure 6.2.4-1 is to illustrate WCNOC's provisions for meeting 10CFR50 Appendix A, design criterion 54, 55, 56 & 57 including containment isolation configurations that have been demonstrated acceptable

based on "other defined bases". Performance Improvement Request (PIR) 96-2216 that documented the inaccuracies, found no errors that would invalidate or cause questions as to whether WCNOG meets these criteria or the criteria/guidance contained in Regulatory Guide 1.141 and ANSI N 271-76.

The inaccurate wording in Note 13 on Figure 9.3-8-03 regarding BG8384A was also made prior to the operating license. The operating procedure correctly implemented the intent of the note which is to ensure that at least one charging pump is aligned to support the Emergency Core Cooling System, however the error in the Note was not discovered.

Corrective Steps Taken and Result Achieved:

As part of PIR 96-2216, all 74 sheets of USAR Figure 6.2.4-1 were reviewed in detail and all discrepancies corrected inside the containment isolation envelope.

PIR 97-0711 was written to document and evaluate the discrepancy with drawing M-12BG03 Note 13. This evaluation determined that it is acceptable to have either valve BG8483A or valve BG8483C locked closed depending on which charging pump is aligned to support ECCS and that Note 13 needed to be clarified. WPT 118280-09 was initiated to revise M-12BG03 Note 13.

Corrective Steps to Be Taken to Prevent Recurrence:

A USAR change request will be initiated to revise Figure 9.3-8-03 (M-12BG03) Note 13 by August 1, 1997.

A review of all P&ID's notes for locked valve information for accuracy and appropriateness will be performed by August 1, 1997.

Procedure AP 21G-001, "Control of Locked Component Status," will be revised by September 1, 1997, to include a USAR reference when the components are described as being locked by the USAR.

Date When Full Compliance Will Be Achieved:

All corrective actions will be completed by September 1, 1997.