

Wolf Creek 1

3Q/2010 Plant Inspection Findings

Initiating Events

Significance:  Dec 31, 2009

Identified By: NRC

Item Type: VIO Violation

Failure to Correct Vessel Head Vent Path

The inspectors identified a cited violation of 10 CFR Part 50, Appendix B, Criterion III, “Design Control,” due to an inadequate vent path for the reactor vessel head. The inadequate vent path resulted in the formation of voids in the reactor vessel head during Refueling Outage 17. Failure to ensure an adequate vent path in the reactor vessel head was the subject of a noncited violation in NRC Inspection Report 05000482/2008004. During and after Refueling Outage 16, Wolf Creek initiated a root cause evaluation and corrective actions to prevent occurrence. When one of the possible root causes was disproven in Refueling Outage 17, no additional action was taken to determine the cause of the vessel head vent blockage. However, the licensee could not exclude blockage in the piping. This issue was entered into the corrective action program and the licensee plans to conduct a more thorough inspection of the piping during the next refueling outage. This issue is being tracked by the licensee as Condition Report 22501.

The inspectors determined that the failure to provide adequate vessel head vent path to prevent gas accumulation in the reactor vessel during depressurized plant operations was a performance deficiency. The inspectors determined that this finding, which was associated with the Initiating Events Cornerstone, was more than minor because if left uncorrected, it would have become a more significant safety concern. Specifically, without an adequate vent path the reactor vessel does not have an effective means of relieving noncondensable gases to prevent a loss of reactor coolant system inventory. The inspectors evaluated this finding using Inspection Manual Chapter 0609, Appendix G, Attachment 1, and determined it be of very low safety significance based upon the demonstrated availability of mitigating systems and the flooded reactor cavity inventory. The inspectors determined the cause of the finding had a problem identification and resolution aspect in the corrective action program. Specifically, Wolf Creek’s corrective actions were not successful to address the vent path blockage in a timely manner [P.1(d)].

Inspection Report# : [2009005](#) (*pdf*)

Significance:  Dec 22, 2009

Identified By: NRC

Item Type: FIN Finding

Failure to Enter Adverse Conditions into the Corrective Action Program

The team identified a finding associated with the licensee’s failure to recognize the adverse conditions related to their offsite power system as prescribed by Procedure AP 28A-100, “Condition Reports.” Specifically, the licensee failed to enter pertinent switchyard operating experience and six occurrences of offsite power line losses as adverse conditions in their corrective action program as of August 2009. The licensee entered these deficiencies in their corrective action program as Wolf Creek Condition Reports 00022242 and 00022241.

This finding is greater than minor because, if left uncorrected, the failure to fully utilize the corrective action program could become a more significant safety concern. The inspectors determined that this finding impacted the Initiating Events Cornerstone equipment maintenance attribute and affected the cornerstone objective to limit events that upset plant stability and challenge critical safety functions during power operations. Using Manual Chapter 0609.04, “Phase 1 – Initial Screening and Characterization of Findings,” the issue screened as having very low safety significance because it did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions would not be available.

Inspection Report# : [2009007](#) (*pdf*)

Significance:  Dec 22, 2009

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Adequately Control Steam Generator Water Levels

The team identified a self-revealing noncited violation of Technical Specification 5.4.1.a, “Procedures,” after operator’s failure to monitor and maintain steam generator water levels resulted in an unanticipated turbine trip signal and feedwater isolation. On August 21, 2009, while in Mode 3, Wolf Creek operators, using an intermittent method of feeding steam generators over shift turnover, lost control of the level in steam generator A. This resulted in increased levels above the P-14 feedwater isolation actuation setpoint. Contributing to the loss of level control was the disabling of a previously established operator selectable alarm for the steam generator level. The licensee entered this deficiency in their corrective action program as Wolf Creek Condition Report 00019295.

This finding is greater than minor because it impacted the Initiating Events Cornerstone human performance attribute and affected the cornerstone objective to limit events that upset plant stability and challenge critical safety functions during power operations. Using Manual Chapter 0609.04, “Phase 1 – Initial Screening and Characterization of Findings,” the issue screened as having very low safety significance because it did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions would not be available and it did not increase the likelihood of a fire or internal/external flooding. This finding has a crosscutting aspect in the area of human performance associated with the decision making component because licensee personnel failed to make safety-significant or risk-significant decisions using a systematic process especially when faced with uncertain or unexpected plant conditions to ensure that safety is maintained [H.1(a)].

Inspection Report# : [2009007](#) (*pdf*)

Significance:  Dec 22, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Operator Actions Disable Circuit Breaker Coordination and Could Initiate Secondary Fires

The inspectors identified a noncited violation of License Condition 2.C.(5), “Fire Protection,” for the failure to implement and maintain the approved fire protection program. Specifically, the licensee prescribed mitigating actions in response to certain fire scenarios that would result in a loss of circuit breaker coordination and could initiate secondary fires in plant locations outside of the initial fire area. The licensee entered this issue into their corrective action program as Condition Report 2008-005210.

This finding was more than minor because it was associated with the Protection Against External Factors attribute of the Initiating Events Cornerstone and adversely affected the cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. The risk significance of this finding was determined using Manual Chapter 0609, Appendix F, “Fire Protection Significance Determination Process.” The finding was determined to be of very low safety significance using a Phase 2 evaluation. This finding was not assigned a crosscutting aspect because the cause was not representative of current performance.

Inspection Report# : [2009005](#) (*pdf*)

Significance:  Dec 16, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Obtain Vendor Data Necessary for Plant Modification

On December 16, 2009, inspectors identified a noncited violation of 10 CFR Part 50, Appendix B, Criterion III, “Design Control,” involving failure to obtain vendor design data for a modification. In August 2009, a component cooling water modification was made to the reactor coolant pump thermal barrier heat exchangers’ flow rates as a corrective action to VIO 05000482/2009002 07 (EA-09-110). A flow rate above the previous design value was justified by an internal memo of a vendor opinion from a telephone conversation in 1992. The inspectors found this to be contrary to Procedure AP 05-005, for obtaining data from vendors. The notice of violation will remain open until

full compliance has been restored. Wolf Creek consulted with Westinghouse, confirmed the acceptability of the increased flow rate, and requested a formal calculation. This issue is captured in Condition Report 22824.

The inspectors determined that this finding was more than minor because this issue aligned with Inspection Manual Chapter 0612, Appendix E, example 2.f, in that the modification relied on verbal statements to raise the allowable flow through the heat exchanger. This is a significant deficiency in the modification package. The inspectors determined this finding was associated with the design control attribute of the Initiating Events Cornerstone and affected the cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions. The inspectors evaluated the significance of this finding using Phase 1 of Inspection Manual Chapter 0609.04 and determined that the finding was of very low safety significance because assuming worst case degradation, the finding would not result in exceeding the technical specification limit for identified reactor coolant system leakage and would not have likely affected other mitigation systems resulting in a total loss of their safety function because seal injection was available. This finding has a crosscutting aspect in the area of human performance associated with work practices in that management was unsuccessful in communicating expectations on procedure use and adherence in engineering [H.4(b)].

Inspection Report# : [2009005](#) (pdf)

Significance:  Oct 23, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Identify Sources of Boron Leakage

The inspectors identified a noncited violation of 10 CFR Part 50, Appendix B, Criterion V, “Instructions, Procedures, and Drawings,” involving the licensee’s failure to identify sources of boron leakage and document them in a corrective action document. Specifically, prior to October 23, 2009, the licensee failed to accomplish the requirements of Procedure AP 16F-001, “Boric Acid Corrosion Control Program,” Revision 5, step 6.4.1, which states, in part, “Sources of boron seepage/leakage shall be identified/verified and documented in the applicable corrective action document.” During a boric acid walkdown, the inspectors identified 11 sources of boron leakage which had not been previously identified and documented by the licensee. The licensee entered this finding into their corrective action system as Condition Report 00021274.

The finding was determined to be more than minor because it was associated with the Initiating Events Cornerstone attribute of human performance and affected the cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. The inspectors used Inspection Manual Chapter 0609, “Significance Determination Process, Attachment 4, Phase 1 – Initial Screening and Characterization of Findings,” and determined the finding was of very low safety significance (Green) because the issue would not result in exceeding the technical specification limit for identified reactor coolant system leakage or affect other mitigating systems resulting in a total loss of their safety function. The inspectors also determined that the finding had a crosscutting aspect in the area of problem identification and resolution, operating experience, where the licensee did not institutionalize operating experience through changes to station processes, procedures, equipment, and training programs [P.2(b)].

Inspection Report# : [2009005](#) (pdf)

Significance:  Mar 31, 2009

Identified By: NRC

Item Type: VIO Violation

Failure to correct component cooling water valve closures

The inspectors identified a cited violation of 10 CFR Part 50, Appendix B, Criterion XVI, “Corrective Action,” involving Wolf Creek’s failure to correct the cause of the reactor coolant pump thermal barrier component cooling water heat exchanger outlet valves stroking closed on high flow. Specifically, between 2001 and 2009, Wolf Creek experienced repeated cases of the reactor coolant pump thermal barrier component cooling water heat exchanger outlet valves stroking closed during component cooling water pump swaps and during isolations of the radioactive waste evaporators. Wolf Creek reinitiated evaluation of the issue after the inspector’s questions but did not review the impact on the operators’ ability to open the valves given the valves’ circuit breakers opening. Repeated throttle valve adjustments have not been successful in stopping the valve closures. This issue and the corrective actions are being

tracked by the licensee in Condition Report 2007 002074 and has corrective action pending to modify valve circuitry but it has not been implemented.

The failure to correct a condition adverse to quality of ensuring reactor coolant pump seal cooling as described in the Updated Safety Analysis Report is a performance deficiency. The finding is more than minor because it is associated with the equipment performance attribute for the Initiating Events Cornerstone; and, it affected the cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. The finding was determined to be of very low safety significance because the finding would not result in exceeding the Technical Specification limit for identified reactor coolant system leakage and would not have affected other mitigation systems resulting in a total loss of the seal cooling safety function. This finding is being cited because the licensee failed to establish measures to assure this condition adverse to quality was promptly identified and corrected. This finding has a crosscutting aspect in the area of human performance associated with the decision making component because, even though numerous instances of valve closures occurred since the first noncited violation, Wolf Creek downgraded the condition report. Using nonconservative assumptions, the licensee consistently viewed this issue as not having a risk impact because seal injection was not simultaneously lost. [H.1.b]

Inspection Report# : [2009002](#) (pdf)

Inspection Report# : [2009005](#) (pdf)

Mitigating Systems

Significance:  Jun 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Maintain an Adequate Flooding Analysis for Auxiliary Feedwater Trains

The inspectors identified a green noncited violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," after Wolf Creek failed to provide adequate design control measures for verifying the adequacy of the flooding analysis for the auxiliary feedwater pipe rooms 1206 and 1207. Wolf Creek failed to identify piping that was seismically unqualified and that if ruptured could potentially overwhelm the floor drains. Wolf Creek re-analyzed the piping and determined it would not rupture during an earthquake. Flooding of the room could have caused all three of the auxiliary feedwater pump suction pressure transmitters to fail and inhibit automatic swap to essential service water. The licensee placed this issue in their corrective action program as Condition Report 26050.

The inspectors determined that the incorrect calculation assumption in the flooding analysis of record was the performance deficiency. This finding was determined to be more than minor because it impacted the Mitigating Systems Cornerstone attribute of the design control and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Using Manual Chapter 0609.04, "Phase 1 – Initial Screening and Characterization of Findings," the finding was determined to have very low safety significance because the deficiency was confirmed not to result in loss of operability or functionality. This finding has a crosscutting aspect in the area of problem identification and resolution associated with the corrective action program because the licensee's evaluation focused on the probability of equipment failure leading to a flooding event rather than the stated design basis of the facility [P.1(c)].

Inspection Report# : [2010003](#) (pdf)

Significance:  Jun 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Lack of Acceptance Criteria Allows Degraded EDG Power Supply to Remain in Service

The inspectors identified a violation of Technical Specification 5.4.1.a, "Procedures," for the failure of maintenance personnel to provide an adequate work order that included critical acceptance criteria for the emergency diesel generator B. On October 22, 2010, emergency diesel generator A failed because excessive power supply voltage ripple caused its speed switch to actuate while in standby. Emergency diesel generator B also failed voltage ripple

tests on October 27, 2009. On October 27, 2009, voltage ripple was at 2,015 mV, but no acceptance criteria were specified in Work Order 09-321599-000. Corrective action was not taken until March 2010 and subsequent evaluation of the issue did not identify the lack of acceptance criteria in the work order. The licensee placed this issue into the corrective action program as Condition Report 26651.

The inspectors determined that the failure to replace a power supply that was degraded below its acceptance criteria was the performance deficiency. This finding is more than minor because it affected the Mitigating Systems Cornerstone attribute of availability and reliability and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Using Manual Chapter 0609.04, "Phase 1 – Initial Screening and Characterization of Findings," the finding was determined to have very low safety significance because the deficiency was confirmed not to result in loss of operability or functionality. This finding has a crosscutting aspect in the area of problem identification and resolution associated with the corrective action program because several work groups failed to question the March 17, 2010, results and initiate a condition report [P.1(a)].

Inspection Report# : [2010003](#) (pdf)

Significance:  Jun 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Nonsafety Power Supply Causes Failure of Emergency Diesel Generator A

The inspectors identified a Green noncited violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," for the failure of the licensee to ensure the design of the emergency diesel local annunciator power supply circuit such that its failure would not cause failure of the associated emergency diesel generator. On October 22, 2009, Wolf Creek was defueled when the control room received annunciators for emergency diesel generator A. The power supply for the local annunciators had input enough noise or voltage spikes on to the safety related power wires to cause the speed switch to actuate while the engine was in standby. This inhibited engine start. The power supply was replaced and emergency diesel generator A was returned to service on October 23, 2009. Condition Report 21039 examined this failure but failed to identify that the vendor's circuit analysis did not consider voltage ripple as a failure mode and that the requirements of IEEE 384-1974 were not met. The nonsafety related power supply was not supposed to be able to cause the failure of the safety related emergency diesel generator. The licensee placed this issue into the corrective action program as Condition Reports 25663, 24867, and 25479.

The inspectors determined the failure to ensure that the licensing basis for the emergency diesel generators was being met to be the performance deficiency. This finding was more than minor because it was associated with the Mitigating Systems Cornerstone attribute of human performance and it affected the objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Using Inspection Manual Chapter 0609.04, "Phase 1 - Initial Screening and Characterization of Findings," the finding was determined to have very low safety significance because emergency diesel generator A was out of service for less than 24 hours. This finding has a crosscutting aspect in the area of problem identification and resolution associated with the corrective action program because the licensee failed to evaluate this failure mode against the vendor's circuit analysis [P.1(c)].

Inspection Report# : [2010003](#) (pdf)

Significance:  Mar 31, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Follow Procedure for a Main Feed Pump Trip

The inspectors identified a Green noncited violation of Technical Specification 5.4.1.a, "Procedures," for the failure of Wolf Creek control room personnel to follow procedures for a main feedwater pump trip. During a review of the posttrip data and operator statements, the inspectors noted that control room operators took manual control and reset main feedwater Pump A, which was not in accordance with station procedures. This issue was entered into the licensee's corrective action program as Condition Report 24011.

This finding was greater than minor because it was associated with the Mitigating Systems Cornerstone attribute of

human performance and it affected the objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). The inspectors evaluated the significance of this finding using Inspection Manual Chapter 0609.04, "Phase 1 - Initial Screening and Characterization of Findings," and screened the finding to Phase 2 because the finding represents a loss of auxiliary feedwater actuation system safety Function g. The finding screened to Phase 3 because of the failure to start of both motor-driven auxiliary feedwater pumps. The senior reactor analyst performed a Phase 3 analysis and concluded that the finding was Green because the probability of an initiator occurring within any 10-second exposure time is approximately $3E-7$. Additionally, auxiliary feedwater pumps would have been automatically started on lo-lo steam generator level if required. The inspectors also determined that the cause of the finding has a crosscutting aspect in the area of problem identification and resolution associated with operating experience because Wolf Creek failed to communicate relevant operating experience to affected internal stakeholders [P.2(a)].
Inspection Report# : [2010002](#) (pdf)

Significance:  Mar 10, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Establish goals and Monitor for a(1) Offgas Radiation Monitor GERE0092

The inspectors identified a noncited violation of 10 CFR 50.65 for failure to establish goals per paragraph (a)(1) to monitor the performance of the main condenser offgas radiation Monitor GERE0092. Multiple failures occurred which exceeded the monitoring goals and the function was not moved to 50.65(a)(1) status for corrective action and goal setting. Wolf Creek engineering subsequently evaluated the issues and determined that the function should have been moved to a(1) for goal setting. The licensee entered this issue in their corrective action program as Condition Report 24423.

This finding is more than minor because it is associated with the equipment performance attribute of the Mitigating Systems Cornerstone and affects the cornerstone objective to ensure the availability, reliability and capability of systems that respond to initiating events. The inspectors evaluated the significance of this finding using Inspection Manual Chapter 0609.04, "Phase 1 – Initial Screening and Characterization of Findings," and determined that this finding is of very low safety significance, Green. Specifically, the associated function (SP-04) to detect primary to secondary leakage and then isolate the steam generator blowdown flow path does not result in a loss of any safety function. The inspectors determined that this finding has a crosscutting aspect in the problem identification and resolution area associated with corrective action program because Wolf Creek failed to take appropriate corrective actions to address the system reliability issue and adverse radiation monitor performance trends in a timely manner, commensurate with safety significance and complexity [P.1(d)].

Inspection Report# : [2010002](#) (pdf)

Significance:  Mar 03, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Degraded Fire Barriers for Auxiliary Feedwater

The inspectors identified a noncited violation of License Condition 2.C(5)(a) for degraded fire seals that separated redundant safe shutdown equipment. Specifically, silicone foam and ceramic fiber board seals separating the auxiliary feedwater trains from the turbine building and the condensate storage tank valve house were degraded so that they no longer provided a 3-hour rated fire barrier. The licensee entered the finding into the corrective action program as Condition Report 23828.

The finding was more than minor because it was associated with the Mitigating Systems Cornerstone attribute of protection against external events and affected the cornerstone objective to ensure the reliability of systems that respond to initiating events to prevent undesirable consequences. Using Inspection Manual Chapter 0609, Appendix F, Attachment 2, "Degradation Rating Guidance Specific to Various Fire Protection Program Elements," under Fire Barrier Degradation, Table A2.2, the finding was associated with Moderate B degradation due to the seal not being in a tested or evaluated condition. Using Inspection Manual Chapter 0609, Appendix F, "Fire Protection Significance Determination Process," in supplemental screening for fire confinement findings, the finding screens as Green due to exposing Fire Area A33 featuring an automatic full area water-based suppression system. No crosscutting aspect was assigned as this condition was not reflective of current licensee performance.

Significance:  Mar 03, 2010

Identified By: NRC

Item Type: FIN Finding

Failure to Perform Adequate Posttrip Review

The inspectors identified a Green finding for the failure to adequately implement the posttrip review procedure following a reactor trip caused by low steam generator water levels on March 2, 2010. Specifically, Wolf Creek's posttrip evaluation was not adequate because it failed to identify or evaluate anomalous equipment performance associated with the main feedwater pump that caused the trip. Additionally, the inspectors determined that the Wolf Creek's posttrip review failed to identify that some aspects of operator response to the trip of the main feedwater pump were not in accordance with station procedures. Wolf Creek evaluated the individual issues and deficiencies listed above and entered them into the corrective action program as Condition Reports 23932, 23966, 24043, 23982, and 23981.

This finding was greater than minor because the information omitted from the posttrip review was associated with the human performance attribute of the mitigating systems cornerstone and affected the cornerstone objective to ensure the availability, reliability and capability of systems that respond to initiating events. Using Manual Chapter 0609.04, "Phase 1 - Initial Screening and Characterization of Findings," this finding was determined to be of very low safety significance since the finding does not represent a loss of system safety function, nor does the finding represent actual loss of safety function for single train for a greater time than permitted by technical specifications. This finding had a crosscutting aspect in the area of problem identification and resolution associated with the corrective action program component because Wolf Creek failed to fully evaluate plant computer data and operator statements associated with the March 2, 2010, reactor trip [P.1(c)].

Inspection Report# : [2010002](#) (pdf)

Significance:  Dec 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Follow Procedure Results in Draining of Emergency Core Cooling System Pump Oil

On November 23, 2009, a self-revealing violation of Technical Specification 5.4.1.a was identified when a technician failed to follow procedure and emptied 45 gallons of oil from centrifugal charging Pump A. The technician was supposed to remove the temperature indicator for calibration but instead removed the thermowell which breached the lube oil subsystem of centrifugal charging Pump A. An unplanned entry into Technical Specification 3.5.2, Condition A, was made for approximately 10 hours. The licensee entered this issue in their corrective action program as Condition Report 21993.

The failure to follow station procedures and correctly remove the detector was a performance deficiency. The finding was more than minor because it was associated with the equipment performance attribute of the Mitigating Systems Cornerstone and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The inspectors evaluated the significance of this finding using Phase 1 of Inspection Manual Chapter 0609.04, and determined that the finding was of very low safety significance (Green) because the pump was inoperable for less than 24 hours. Also, the finding did not screen as potentially risk significant due to a seismic, flooding, or severe weather initiating event. The inspectors identified a human performance crosscutting in the area of work practices because self-checking and communication with the supervisor failed to prevent the event [H.4(a)].

Inspection Report# : [2009005](#) (pdf)

Significance:  Dec 22, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Perform an Operability Evaluation

The team identified a noncited violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and

Drawings,” regarding the licensee’s failure to follow the requirements of Procedure AP 26C-004, “Technical Specification Operability.” Specifically, licensee personnel failed to perform an operability evaluation for the impact of the 2009 water hammer and internal corrosion on the entire essential service water system. The Wolf Creek essential service water system was degraded by a significant water hammer on August 19, 2009. Also in 2009 widespread internal corrosion resulted in at least three through wall leaks. Discovery of these conditions had been documented in the corrective action program but had not resulted in performance of an operability evaluation of the current and potentially future impact on the system as a whole. The licensee entered this deficiency in their corrective action program as Wolf Creek Condition Report 00022240.

This finding is greater than minor because it is associated with the Mitigating Systems Cornerstone attribute of equipment performance and adversely affected the objective to ensure equipment availability and reliability. Using Manual Chapter 0609.04, “Phase 1 – Initial Screening and Characterization of Findings,” the issue screened as having very low safety significance because it was not a design or qualification deficiency that resulted in a loss of operability or functionality, did not create a loss of system safety function of a single train for greater than the technical specification allowed outage times, and did not affect seismic, flooding, or severe weather initiating events. This finding has a crosscutting aspect in the area of problem identification and resolution associated with the corrective action program because licensee personnel failed to thoroughly evaluate problems such that the resolutions address causes and extent of conditions [P.1(c)].

Inspection Report# : [2009007](#) (pdf)

Significance:  Dec 22, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Correctly Screen Essential Service Water Piping Leaks for Significance

The team identified a noncited violation of 10 CFR Part 50, Appendix B, Criterion V, “Instructions, Procedures, and Drawings,” regarding the licensee’s failure to follow the requirements of Procedure AI 28A-010, “Screening Condition Reports.” Specifically, licensee personnel failed to properly screen condition reports for the essential service water system adverse conditions of internal corrosion and loss of offsite power induced water hammer since April 2008. The adverse conditions met the procedure’s ‘marginal’ consequence and probable frequency definitions which should have, but did not, result in a requirement to perform a root cause analysis prior to September 2009. The licensee entered this deficiency in their corrective action program as Wolf Creek Condition Report 00022239.

This finding is greater than minor because, if left uncorrected, the failure to fully utilize the corrective action program could become a more significant safety concern. The inspectors determined that this finding impacted the Mitigating Systems Cornerstone. Using Manual Chapter 0609.04, “Phase 1 – Initial Screening and Characterization of Findings,” the issue screened as having very low safety significance because it was not a design or qualification deficiency that resulted in a loss of operability or functionality, did not create a loss of system safety function of a single train for greater than the technical specification allowed outage times, and did not affect seismic, flooding, or severe weather initiating events. This finding has a crosscutting aspect in the area of problem identification and resolution associated with the corrective action program because licensee personnel failed to thoroughly evaluate problems such that the resolutions address causes and extent of conditions [P.1(c)].

Inspection Report# : [2009007](#) (pdf)

Significance:  Dec 22, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Ensure Adequate Acceptance Criteria and Extent of Condition Guidance in Lake Water and Corrective Action Program Procedures

The team identified a noncited violation of 10 CFR Part 50, Appendix B, Criterion V, “Instructions, Procedures, and Drawings,” regarding the licensee’s failure to provide adequate guidance to identify and address pitting, corrosion, and surface indications in the essential service water system. A 2007 licensee self-assessment on lake water corrosion issues recommended improvements in lake water chemistry control procedures to establish a pit monitoring program. In September 2009 NRC inspectors noted that the lake water monitoring and chemistry control procedures did not

contain quality standards or acceptance criteria for newly discovered flaws or abnormal gross degradation due to erosion, pitting, or corrosion. Not having such procedural quality standards resulted in allowing repairs to not be performed until such degradations (pitting) had become through-wall leaks. Several instances of internally identified corrosion were not entered into the corrective action program until essential service water piping had thinned to below the minimum ASME code allowed wall thickness. The licensee entered this deficiency in their corrective action program as Wolf Creek Condition Report 00022243.

This finding is greater than minor because it is associated with the Mitigating Systems Cornerstone attribute of procedure quality and adversely affected the objective to ensure equipment availability and reliability. Using Manual Chapter 0609.04, "Phase 1 – Initial Screening and Characterization of Findings," the issue screened as having very low safety significance because it was not a design or qualification deficiency that resulted in a loss of operability or functionality, did not create a loss of system safety function of a single train for greater than the technical specification allowed outage times, and did not affect seismic, flooding, or severe weather initiating events. This finding has a crosscutting aspect in the area of problem identification and resolution associated with the corrective action program because licensee personnel failed to take appropriate corrective actions to address safety issues and adverse trends in a timely manner [P.1(d)].

Inspection Report# : [2009007](#) (pdf)

Significance:  Dec 22, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Procedure Resulted in Failure to Discover Essential Service Water System Leakage Following a Water Hammer Event

The team identified a noncited violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," regarding the licensee's failure to provide adequate guidance to address the impact of a loss of offsite power event on the essential service water system. On August 19, 2009, seven hours following a loss of offsite power induced water hammer of the essential service water system, the NRC senior resident identified that the licensee was unaware of significant leakage from the piping on the 1988' elevation of the auxiliary building. Wolf Creek Procedure STN PE-040G, "Transient Event Walkdown," required that systems subject to expected transient dynamic forces following a reactor trip to have a post-trip walkdown to identify any structural damage. This procedure did not include the essential service water system as a vulnerable system. The procedure only specifically identified portions of systems inside containment. As a result, no walkdown was performed for the essential service water system on August 19, 2009. The licensee entered this deficiency in their corrective action program as Wolf Creek Condition Report 00022265.

This finding is greater than minor because it is associated with the Mitigating Systems Cornerstone attribute of procedure quality and adversely affected the objective to ensure equipment availability and reliability. Using Manual Chapter 0609.04, "Phase 1 – Initial Screening and Characterization of Findings," the issue screened as having very low safety significance because it was not a design or qualification deficiency that resulted in a loss of operability or functionality, did not create a loss of system safety function of a single train for greater than the technical specification allowed outage times, and did not affect seismic, flooding, or severe weather initiating events. This finding has a crosscutting aspect in the area of problem identification and resolution associated with the operating experience component because the licensee failed to institutionalize lessons learned through changes to station walkdown procedures [P.2(b)].

Inspection Report# : [2009007](#) (pdf)

Significance:  Dec 22, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Initiate Timely Fire Protection Impairment Control Permit and Implement Compensatory Measures

The team identified a noncited violation of License Condition 2.C.(5), "Fire Protection," for the failure to establish a compensatory fire watch in a timely manner per the station fire protection program. On August 19, 2009, a complete

loss of offsite power resulted in fire protection trouble alarms on fire protection panel KC-008. The control room supervisor acknowledged the alarms. Procedure ALR KC-888, "Fire Protection Panel KC-008 Alarm Response," required an impairment and compensatory measures for the affected smoke detectors. The following day it was noticed that impairments and fire watches for the 13 affected fire zones on KC-008 had not been initiated. The licensee entered this deficiency in their corrective action program as Wolf Creek Condition Report 00019320.

This finding was more than minor since it was associated with the protection against external factors attribute of the Mitigating Systems Cornerstone and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Using Manual Chapter 0609, Appendix F, "Fire Protection Significance Determination Process," the inspectors determined that the finding had an adverse affect on the fixed fire protection systems element of fixed fire detection systems. This finding was ultimately determined, by a senior reactor analyst, to be of very low safety significance because of a low exposure time of the uncompensated deficiency. This finding has a crosscutting aspect in the area of human performance associated with the work practices component because the licensee failed to ensure supervisory oversight of work activities such that nuclear safety is supported [H.4(c)].

Inspection Report# : [2009007](#) (pdf)

Significance:  Nov 12, 2009

Identified By: NRC

Item Type: VIO Violation

Failure to Correct Discolored Boric Acid Deposits

The inspectors identified a cited violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," for failure to take action to stop leakage from the base of the refueling water storage tank or evaluate the leakage and wastage for acceptability. Specifically, the licensee did not take actions to prevent recurring discolored boric acid deposits for approximately 11 years. Failure to correct leakage from the refueling water storage tank base was the subject of a noncited violation in NRC Inspection Report 05000482/2007006. This issue was entered into the licensee's corrective action program as Condition Report 22866.

The failure to implement corrective actions for the refueling water storage tank leakage was a performance deficiency. The inspectors determined this issue impacted the Mitigating Systems Cornerstone and was greater than minor because if left uncorrected, the failure to correct the presence of boric acid leakage could become a more significant safety concern in that continued wastage could impact tank operability. Using the Phase 1 worksheets in Inspection Manual Chapter 0609.04, "Significance Determination Process," the finding was determined to have very low safety significance because it did not result in a system or component being inoperable and it did not screen as potentially risk significant due to a seismic, flooding, or severe weather initiating event. The inspectors identified a crosscutting aspect in the area of human performance associated with resources. Specifically, Wolf Creek did not maintain long term plant safety minimizing corrective maintenance deferrals and this long standing equipment issue [H.2(c)].

Inspection Report# : [2009005](#) (pdf)

Significance:  Nov 05, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Operability Evaluation of Essential Service Water Pumps

On November 5, 2009, inspectors identified a noncited violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," for the failure to perform an adequate operability evaluation required by procedure. The inspectors identified that Operability Evaluation EF 09-010, Revisions 0 and 1, did not demonstrate that the essential service water pumps could withstand a safe shutdown earthquake. Revision 2 of the operability evaluation included calculations to demonstrate acceptable stresses and included pump impeller clearances. This issue is captured in the corrective action program as condition reports 22798 and 21572.

The failure to perform an adequate operability evaluation per Procedures AP 28-001 and AP 26C-004 was a performance deficiency. The inspectors determined that this finding was more than minor because it is associated with the equipment performance attribute of the Mitigating Systems Cornerstone, and it affected the cornerstone objective

to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, this issue relates to the availability and reliability examples of the equipment performance attribute because a latent common mode failure mechanism was not correctly evaluated. The inspectors evaluated the significance of this finding using Phase 1 of Inspection Manual Chapter 0609, Appendix A, and determined that the finding was of very low safety significance (Green) because the issue was not a design or qualification deficiency confirmed to result in loss of operability or functionality, did not represent a loss of system safety function, an actual loss of safety function of a single train for greater than its technical specification allowed outage time, an actual loss of safety function of a nontechnical specification risk-significant equipment train, and did not screen as potentially risk significant due to a seismic, flooding, or severe weather initiating event. The cause of the finding has a problem identification and resolution crosscutting aspect associated with the corrective action program because Wolf Creek failed to thoroughly evaluate the failure mechanism such that the resolutions address the causes and extent of conditions, as necessary [P.1(c)].

Inspection Report# : [2009005](#) (pdf)

Significance:  Oct 21, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Control of Transient Ignition Sources

The inspectors identified a noncited violation of Technical Specification 5.4.1.a, for an inadequate Procedure AP-10-101, "Control of Transient Ignition Sources." On October 21, 2009, the inspectors observed maintenance personnel performing weld preparation work on essential service water piping to containment cooler B using a flapper wheel. The inspectors observed that the ignition control barriers for the hot work were insufficient in that the sparks from the preparation work extended four to five feet from the job site and there was no fire watch posted. On December 4, 2003, a procedure revision inappropriately incorporated a change to the procedure where a fire watch did not have to be posted when using "wire brushes, flapper wheels, polishing devices, or Rol-Lok type buffing pads mounted on power grinder motor drives or air tools." The maintenance supervisor stopped the work until a fire watch was posted. The licensee entered this into their corrective action system as Condition Report 20993.

This finding is more than minor because it affected the Mitigating Systems Cornerstone attribute of "Protection Against External Factors - Fires," and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The lack of a posted fire watch could adversely affect the ability to achieve and maintain safe shutdown in the event of a severe fire in the affected area. Inspection Manual Chapter 0609, Appendix F, "Fire Protection Significance Determination Process," could not be used to effectively evaluate the finding and defense-in-depth strategies because the 2003 changes to the fire watch program affected multiple fire areas and conditions. Therefore, in accordance with Inspection Manual Chapter 0609, Appendix M, the safety significance was determined by regional management review who concluded that the finding was of very low safety significance (Green). This finding was reviewed for crosscutting aspects and none were identified. The original change occurred in 2003 and was not indicative of current performance.

Inspection Report# : [2009005](#) (pdf)

Significance:  Oct 21, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Incorporate Requirements of Regulatory Guide 1.182 into Shutdown Risk

The inspectors identified a noncited violation of 10 CFR 50.65(a)(4) involving the failure to adequately perform shutdown risk assessments during Refueling Outage 17. Between October 10 and November 17, 2009, Wolf Creek did not appropriately consider electrical power, decay heat removal, and containment when assessing shutdown risk. This changed the outcome or color of the qualitative calculation on several occasions. The licensee entered this issue in their corrective action program as Condition Reports 22295 and 22296.

The failure to meet shutdown risk assessment requirements in the daily shutdown risk assessment process is a performance deficiency. The inspectors determined this finding was associated with the Mitigating Systems

Cornerstone and was more than minor because it involved incorrect risk assessment assumptions by omitting requirements specified in committed guidance without providing justification for that omission. Such errors of omission have the potential to change the outcome of the licensee's maintenance risk assessment as described above. Per Inspection Manual Chapter 0609, Appendix K, "Maintenance Risk Assessment and Risk Management Significance Determination Process," licensees who only perform qualitative analyses of plant configuration risk due to maintenance activities, the significance of the deficiencies must be determined by an internal NRC management review using risk insights where possible in accordance with Inspection Manual Chapter 612, "Power Reactor Inspection Reports." The NRC management review concluded that this finding was of Green safety significance because missing risk management actions did not result in loss of key shutdown risk functions. Additionally, the cause of the finding has a human performance crosscutting aspect in the area associated with the resources. Specifically, Wolf Creek did not ensure that Procedure APF 22B-001-02 was complete, accurate, and up-to-date [H.2(c)].

Inspection Report# : [2009005](#) (pdf)

Significance:  Oct 15, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Follow Corrective Action Procedure

On October 15, 2009, the inspectors identified a noncited violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," for failure to follow Procedure AP 28A-100, "Condition Reports." Wolf Creek failed to initiate a condition report for evaluation of corrosion on containment cooler A piping. After inspector challenging, Wolf Creek initiated condition reports, performed nondestructive testing, replaced corroded studs, and evaluated the cause of the corrosion.

The inspectors determined that the failure to follow AP 28A-100, Appendix C, was a performance deficiency. This issue was more than minor because it was associated with the equipment performance attribute of the Mitigating Systems Cornerstone and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Using Inspection Manual Chapter 0609.04, the issue screened to Green because there was not a loss of operability and the finding did not screen as potentially risk significant due to a seismic, flooding, or severe weather initiating event. A crosscutting aspect was identified in the problem identification and resolution area of the corrective action program. Specifically, Wolf Creek failed to implement a corrective action program with a low threshold for identifying issues [P.1(a)].

Inspection Report# : [2009005](#) (pdf)

Significance:  Oct 15, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Unevaluated Scaffold Against Component Cooling Water Piping

The inspectors identified a noncited violation of Technical Specification 5.4.1.a for failure to properly implement Procedure AP 14A-003, "Scaffold Construction and Use," when scaffolding was erected against operable safety-related equipment. On October 15, 2009, the inspectors walked down containment and identified scaffolding in contact with component cooling water piping. The tag on the scaffold explicitly stated that it was not seismically qualified. At the time, both steam generators were inoperable and both trains of residual heat removal were required to be operable. The inspectors reviewed the bases for Technical Specification 3.4.7, "RCS Loops - Mode 5, Loops Filled," which required an operable heat sink path from residual heat removal to component cooling water to essential service water. This issue was entered into the corrective action program as Condition Report 22464.

The construction of an unqualified scaffold against operable component cooling water piping was a performance deficiency. The inspectors determined that this finding was more than minor because it is associated with the equipment performance attribute for the Mitigating Systems Cornerstone and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, this issue relates to the availability and reliability examples of the equipment performance attribute because a latent failure mechanism was not evaluated. The inspectors evaluated the significance of this finding using Inspection Manual Chapter 0609, Appendix G, Attachment 1, "Shutdown

Operations Significance Determination Process Phase 1 Operational Checklists for Both PWRs and BWRs.” The inspectors determined that Checklist 3 was applicable because the unit was in cold shutdown with the refueling cavity level less than 23 feet. Using Appendix G, Attachment 1, Checklist 3, Phase 2 analysis was not needed and the finding was of very low safety significance (Green) because the licensee was able to demonstrate that the seismically unqualified scaffolding would not have resulted in a loss of safety function. The inspectors determined the cause of the finding had a human performance aspect in the area of resources. Specifically, Procedure AP 14A-003 was inadequate because it had conflicting guidance that allowed seismically unqualified scaffolds in Modes 5 and 6 [H.2 (c)].

Inspection Report# : [2009005](#) (pdf)

Barrier Integrity

Significance:  Mar 03, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Inoperable Containment Cooler Condensate Monitoring System

The inspectors identified a noncited violation of 10 CFR Part 50, Appendix B, Criterion III, due to all containment cooler drip pans being degraded such that the containment cooler condensate monitoring system could not perform its design basis safety function to quantify reactor coolant system leakage into the containment atmosphere. Wolf Creek initiated Condition Report 24005 and Work Order 10-325741-000 to clean and repair the drip pans.

This issue is more than minor because it was associated with the equipment performance aspect of the Barrier Integrity Cornerstone and impacted the cornerstone objective to provide reasonable assurance that physical design barriers protect the public from radionuclide releases caused by accidents or events. Specifically, it affected the licensee’s ability to detect a reactor coolant system leak. The inspectors used Inspection Manual Chapter 0609.04, “Phase 1 - Initial Screening and Characterization of Findings,” to analyze the significance of this finding. The inspectors concluded the finding is of very low safety significance because the condition was not related to pressurized thermal shock. The inspectors also determined that the cause of the finding has a crosscutting aspect in the area of problem identification and resolution associated with the corrective action program because Wolf Creek failed to identify adverse postwork conditions after the coolers received maintenance in the 2009 refueling outage [P.1(a)].

Inspection Report# : [2010002](#) (pdf)

Significance:  Dec 30, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Identify Inoperable P-6 Interlock and Intermediate Range Detector

On December 30, 2009, the inspectors identified a noncited violation of Technical Specification Table 3.3.1-1, Function 18.a, when Wolf Creek restarted on May 18, 2005. During a reactor shutdown on October 7, 2006, intermediate range neutron detector Nuclear Instrument 36 did not decrease below 6E -11 amps and energize source range detector Nuclear Instrument 32. The detector was not replaced until Refueling Outage 16 in March 2008. The licensee entered this issue in their corrective action program as Condition Report 22450.

The inspectors determined that the failure to ensure that the P-6 interlock was operable per the technical specification as defined in the bases was a performance deficiency. The finding was more than minor because it was associated with the configuration control (reactivity control) attribute of the Barrier Integrity Cornerstone, and it affected the cornerstone objective to provide reasonable assurance that physical design barriers (fuel cladding, reactor coolant system, and containment) protect the public from radionuclide releases caused by accidents or events. The inspectors evaluated the significance of this finding using Phase 1 of Inspection Manual Chapter 0609.04, and determined that the finding screened to Green because the P-6 interlock only affected the fuel barrier. This finding was not assigned a crosscutting aspect because the cause was not representative of current performance.

Inspection Report# : [2009005](#) (pdf)

Significance: G Dec 15, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequately Analyzed Emergency Operating Procedure Change

The NRC examiners identified a Green noncited violation of Technical Specification 5.4.1.b for failure to validate changes made to Emergency Operating Procedures. Specifically, the licensee failed to validate a change made to Emergency Operating Procedure E-0, Reactor Trip or Safety Injection. This unvalidated change to E-0 had the unintended consequence of changing the Emergency Operating Procedure mitigation strategy in the steam generator tube rupture procedure, E-3, in that it resulted in premature direction to close the main steam isolation valves which increases the likelihood and duration of a radioactive release during a tube rupture event. This was an undesirable effect that the licensee had not considered when it made the change to E-0. This was entered into the licensee's Corrective Action Program under AR22391, and the licensee removed the change that was made to E-0.

The finding was more than minor because it adversely affected the barrier integrity cornerstone attribute of "Procedure Quality" in that the change to the emergency operating procedure increased the likelihood of an offsite release during a steam generator tube rupture casualty. Manual Chapter 0609, Attachment 4, "Initial Screening and Characterization of Findings," was used to evaluate the finding. The finding is of very low safety significance because it did not represent a degradation of the radiological barrier function provided for the control room, auxiliary building, or spent fuel pool; it did not represent a degradation of the barrier function of the control room against smoke or a toxic atmosphere; it did not represent an actual open pathway in the physical integrity of reactor containment; and it did not involve an actual reduction in function of hydrogen ignitors in the reactor containment. The finding had a crosscutting aspect in the area of human performance associated with decision making because the licensee failed to conduct effectiveness reviews of safety-significant decisions to verify the validity of underlying assumptions and identify possible unintended consequences.

Inspection Report# : [2009302](#) (*pdf*)

Emergency Preparedness

Occupational Radiation Safety

Significance: G Nov 23, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Maintain Administrative Control of Keys to Locked High Radiation Areas

The inspector identified a noncited violation of Technical Specification 5.7.2.a.1 for failure to maintain administrative control of door and gate keys to high radiation areas with dose rates greater than 1 rem per hour but less than 500 rads per hour (referred to as locked high radiation areas). Specifically, as of October 21, 2009, the licensee did not have administrative controls over a single master key to locked high radiation areas. This issue was entered into the licensee's corrective action program as Condition Report 20973.

Failure to maintain administrative control of the master key to locked high radiation areas was a performance deficiency. This finding is greater than minor because if left uncorrected the finding has the potential to lead to a more significant safety concern in that an individual could receive unanticipated radiation dose by gaining access a locked high radiation area without the proper controls and briefing. This finding was evaluated using the occupational radiation safety significance determination process and determined to be of very low safety significance because it did not involve: (1) as low as is reasonably achievable planning or work control issue, (2) an overexposure, (3) a substantial potential for overexposure, or (4) an impaired ability to assess dose. Additionally, the violation has a crosscutting aspect in the area of human performance associated with the work practices component because the lack of peer and self-checking resulted in inadequate control of keys to locked high radiation areas [H.4(a)].

Public Radiation Safety

Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Significance: SL-IV Dec 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Report a Condition That Could Have Prevented Fulfillment of a Safety Function

The inspectors identified a Severity Level IV noncited violation of 10 CFR 50.73 in which the licensee failed to submit a licensee event report within 60 days following discovery of events or conditions meeting the reportability criteria. On December 31, 2009, the inspectors identified a licensee event report that was not timely. Licensee Event Report 2009-009-00 was not issued within 60 days for a condition prohibited by technical specifications, and the event report did not identify that the disabling of both trains of the P-4 interlock on August 22, 2009 was also reportable per 10 CFR 50.73(a)(2)(v). The P-4 interlock was required by Technical Specification 3.3.2, function 8.a, and is discussed in USAR, Section 7.3.8, "NSSS Engineered Safety Feature Actuation System." Wolf Creek licensee event report 2009-009 was correct in that the interlock is not credited in accident analysis. However, NUREG 1022, Section 3.2.6, specifies that inoperable systems required by the technical specifications be reported, even if there are other diverse operable means of accomplishing the safety function.

The inspectors reviewed this issue in accordance with Inspection Manual Chapter 0612 and the NRC Enforcement Manual. Through this review, the inspectors determined that traditional enforcement was applicable to this issue because the NRC's regulatory ability was affected. Specifically, the NRC relies on the licensee to identify and report conditions or events meeting the criteria specified in regulations in order to perform its regulatory function, and when this is not done, the regulatory function is impacted. The inspectors determined that this finding was not suitable for evaluation using the significance determination process, and as such, was evaluated in accordance with the NRC Enforcement Policy. The finding was reviewed by NRC management, and because the violation was determined to be of very low safety significance, was not repetitive or willful, and was entered into the corrective action program, this violation is being treated as a Severity Level IV noncited violation consistent with the NRC Enforcement Policy. This finding was determined to have a crosscutting aspect in the area of problem identification and resolution associated with the corrective action program in that the licensee failed to appropriately and thoroughly evaluate for reportability aspects all factors and time frames associated with the inoperability of the engineered safety features actuation system [P.1(c)].

Inspection Report# : [2009005](#) (pdf)

Last modified : November 29, 2010