



**UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION IV
611 RYAN PLAZA DRIVE, SUITE 400
ARLINGTON, TEXAS 76011-8064**

March 7, 2000

EA 99-267

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

**SUBJECT: NRC INSPECTION REPORT NO. 50-482/00-01
(NRC INVESTIGATION REPORT NO. A4-1999-020)**

Dear Mr. Maynard:

This refers to the inspection conducted on January 9 through February 19, 2000, at the Wolf Creek Generating Station facility and to the followup telephone exit with representatives of your staff on February 24, 2000, to present the details of two violations in the plant support area. The enclosed report presents the results of this inspection.

Based on the results of this inspection, the NRC has determined that six Severity Level IV violations of NRC requirements occurred. Two of these violations involved willfulness, but met the criteria contained in Section VII.B.1.a.4 of the Enforcement Policy. As a result, all six violations are being treated as noncited violations (NCVs), consistent with Section VII.B.1.a of the Enforcement Policy. These NCVs are described in the subject inspection report. If you contest the violations or severity level 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, U.S. Nuclear Regulatory Commission, Region IV, 611 Ryan Plaza Drive, Suite 400, Arlington, Texas 76011; 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 facility.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your response, if requested, will be placed in the NRC Public Document Room.

Wolf Creek Nuclear Operating Corporation -2-

Should you have any questions concerning this inspection, we will be pleased to discuss them with you.

Sincerely,

/RA/

William D. Johnson, Chief
Project Branch B
Division of Reactor Projects

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

Enclosure:
NRC Inspection Report No.
50-482/00-01

cc w/enclosure:
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ENCLOSURE

U.S. NUCLEAR REGULATORY COMMISSION
REGION IV

Docket No.: 50-482
License No.: NPF-42
Report No.: 50-482/00-01
Licensee: Wolf Creek Nuclear Operating Corporation
Facility: Wolf Creek Generating Station
Location: 1550 Oxen Lane, NE
Burlington, Kansas
Dates: January 9 through February 19, 2000
Inspectors: F. L. Brush, Senior Resident Inspector
R. A. Kopriva, Senior Project Engineer
J. B. Nicholas, Ph.D., Senior Radiation Specialist, Plant Support Branch
Approved By: W. D. Johnson, Chief, Project Branch B
Attachment: Supplemental Information

EXECUTIVE SUMMARY

Wolf Creek Generating Station NRC Inspection Report No. 50-482/00-01

Maintenance

- On December 14, 1999, licensee personnel identified that on February 11, 1999, both centrifugal charging pumps were inoperable for approximately 8 minutes. This rendered both emergency core cooling system trains inoperable. This was a violation of Technical Specification 3.5.2. This Severity Level IV violation is being treated as a noncited violation, consistent with Section VII.B.1.a of the NRC Enforcement Policy. This violation is in the licensee's corrective action program as Performance Improvement Request 99-3942 (Section M8.1).
- On December 23, 1999, licensee personnel identified that both safety-injection pumps were inoperable earlier in 1999 for a short time. This rendered both emergency core cooling system trains inoperable. This was a violation of Technical Specification 3.5.2. This Severity Level IV violation is being treated as a noncited violation, consistent with Section VII.B.1.a of the NRC Enforcement Policy. This violation is in the licensee's corrective action program as Performance Improvement Request 99-4044 (Section M8.2).

Engineering

- In 1991, the licensee failed to properly implement the containment sump leak rate calculation on the new plant computer system. The Updated Safety Analysis Report design basis was not met since the containment leak rate calculation could not always detect a one gallon per minute leak rate within 1 hour. This was a violation of 10 CFR Part 50, Appendix B, Criterion III. This Severity Level IV violation is being treated as a noncited violation, consistent with Section VII.B.1.a of the NRC Enforcement Policy. This violation is in the licensee's corrective action program as Performance Improvement Request 99-3865 (Section E8.1).

Plant Support

- A violation of Technical Specification 5.4.1.a was identified for the willful failure to comply with the protective clothing requirement and provide continuous health physics coverage during the decontamination of the steam generator platform as required by the radiation work permit. Based on the NRC's investigation (OI A4-1999-020) and the NRC's review of the circumstances associated with this issue (EA 99-267), the NRC has concluded that the violation was committed willfully. Although willfulness was involved, the NRC has also concluded that the criteria in Section VII.B.1.a.4 was met. Therefore, this Severity Level IV violation is being treated as a noncited violation, consistent with Section VII.B.1.a of the NRC Enforcement Policy. This issue is in the licensee's corrective action program as Performance Improvement Request 99-1357 (Section R4.1).

- A violation of 10 CFR 20.1501(a) was identified for the willful failure to perform a radiation survey of the steam generator platform work area prior to sending radiation workers into the area. Based on the NRC's investigation (OI A4-1999-020) and the NRC's review of the circumstances associated with this issue (EA 99-267), the NRC has concluded that the violation was committed willfully. Although willfulness was involved, the NRC has also concluded that the criteria in Section VII.B.1.a.4 was met. Therefore, this Severity Level IV violation is being treated as a noncited violation, consistent with Section VII.B.1.a of the NRC Enforcement Policy. This issue is in the licensee's corrective action program as Performance Improvement Request 99-1357 (Section R4.1).
- On November 16, 1999, the licensee discovered that the accumulator boron concentration on all four accumulators had not been verified since August 26, 1999. This is a violation of Technical Specification 4.5.1.1.b. This Severity Level IV violation is being treated as a noncited violation, consistent with Section VII.B.1.a of the NRC Enforcement Policy. This violation is in the licensee's corrective action program as Performance Improvement Request 99-3666 (Section R8.2).

Report Details

Summary of Plant Status

The plant operated at essentially 100 percent power the entire report period with the following exceptions. On February 2, 2000, the licensee reduced plant power to 97 percent for approximately 5 hours to allow repair of Heater Drain Pump A upper bearing cooling water supply piping. On February 13, 2000, the licensee reduced plant power to 88 percent to repair a tube leak on Feedwater Heater 1B. The licensee returned the plant to 100 percent power the following day.

I. Operations

O1 Conduct of Operations

O1.1 General Comments (71707)

The inspectors conducted frequent reviews of ongoing plant operations. In general, the conduct of operations was professional and safety conscious. Plant status, operating problems, and work plans were appropriately addressed during daily turnover and plan-of-the-day meetings. Plant testing and maintenance requiring control room coordination were properly controlled. The inspectors observed several shift turnovers and noted no problems.

O2 Operational Status of Facilities and Equipment

O2.1 Engineered Safety Feature System Walkdowns (71707)

The inspectors walked down accessible portions of the following engineered safety features and vital systems:

- Emergency Diesel Generators A and B
- Essential Service Water Trains A and B

Additionally, the inspectors performed a detailed walkdown of the auxiliary feedwater system. The inspectors did not observe any problems with equipment operability, material condition, or housekeeping.

II. Maintenance

M1 Conduct of Maintenance

M1.1 General Comments - Maintenance

a. Inspection Scope (62707)

The inspectors observed or reviewed portions of the following work activities:

- Work Order 00-215961-001, "Replace Relay K232 in Protection System Cabinet SB029A"

b. Observations and Findings

All work observed was performed with the work package present and in active use. The inspectors frequently observed supervisors and system engineers monitoring job progress, and quality control personnel were present, when required.

M1.2 General Comments - Surveillance

a. Inspection Scope (61726)

The inspectors observed or reviewed all or portions of the following test activities:

- Test Procedure STS IC-623A, "Slave Relay Test K623 Train A Containment Isolation Phase A," Revision 7
- Test Procedure STS IC-629A, "Slave Relay Test K629 Train A Containment Isolation Phase A," Revision 10

b. Observations and Findings

The surveillance testing was conducted satisfactorily in accordance with the licensee's approved programs and Technical Specifications.

M8 Miscellaneous Maintenance Issues (92902)

M8.1 (Closed) Licensee Event Report 50-482/99-015-00: failure to comply with the requirements of Technical Specification Limiting Condition for Operation 3.5.2 because of the inadequate verification. On December 14, 1999, licensee personnel identified that on February 11, 1999, both centrifugal charging pumps were inoperable, which rendered both emergency core cooling system trains inoperable.

The residual heat removal pumps supply water to the centrifugal charging pumps during hot leg recirculation following a loss-of-coolant accident. On February 11, 1999, Residual Heat Removal Pump A was inoperable during a planned maintenance activity

on emergency core cooling system Train A equipment. An operable flow path from Residual Heat Removal Pump B to the centrifugal charging pumps was required to meet Technical Specification 3.5.2.

The licensee also performed preventive maintenance on Valve EMHV8923A during the time Residual Heat Removal Pump A was inoperable. The valve was closed for approximately 8 minutes. The licensee identified that, even though Valve EMHV8923A was a Train A valve, it affected the flow path from Residual Heat Removal Pump B to the charging pumps. When Valve EMHV8923A was closed, the flow path to the centrifugal charging pumps from Residual Heat Removal Pump B was isolated. The licensee identified that the plant was in Technical Specification Limiting Conditions for Operation 3.0.3 for the 8 minutes that the valve was closed.

The licensee identified that the root cause of the error was inadequate identification of components capable of affecting the operability of multiple emergency core cooling system trains because of an inadequate maintenance procedure. The licensee's corrective actions included:

- Revising various procedures to restrict maintenance testing on Valve EMHV8923A while Residual Heat Removal Train A is inoperable;
- Issuing essential reading for various operations personnel and required reading for maintenance planning, operations support, and work week managers; and
- Evaluating whether any other emergency core cooling system components could have similar effects on system operability.

Technical Specification 3.5.2 requires that two independent emergency core cooling systems be operable. On December 14, 1999, licensee personnel identified that on February 11, 1999, both centrifugal charging pumps were inoperable for approximately 8 minutes. This rendered both emergency core cooling system trains inoperable. This was a violation of Technical Specification 3.5.2. This Severity Level IV violation is being treated as a noncited violation, consistent with Section VII.B.1.a of the NRC Enforcement Policy. This violation is in the licensee's corrective action program as Performance Improvement Request 99-3942 (50-482/0001-01).

M8.2 (Closed) Licensee Event Report 50-482/99-016-00: potential for both trains of safety injection to be inoperable due to erroneous valve test procedure line up. On December 23, 1999, the licensee discovered that, with one safety injection pump inoperable, the other pump could be rendered inoperable during in-service valve testing.

The licensee stroked the hot leg injection valve on a safety injection train with the associated pump inoperable for maintenance. With the safety injection system in normal lineup, the operable pump could have exceeded the flow runout value. The operable pump was lined up for cold leg injection as well as for hot leg injection. This would have rendered both safety injection pumps inoperable because of potential runout of the operable pump. The licensee determined that this condition had existed since 1984 at various times during safety injection pump planned outages.

The licensee could not determine a root cause of the problem since the procedures for valve testing were written in 1984. The licensee corrected the surveillance procedures to prevent recurrence.

Technical Specification 3.5.2 requires that two independent emergency core cooling systems be operable. On December 23, 1999, licensee personnel identified that both safety injection pumps were inoperable earlier in 1999 for a short time during valve testing. This rendered both emergency core cooling system trains inoperable. This condition had existed since 1984 when the surveillance procedures for testing safety injection valves were written. This was a violation of Technical Specification 3.5.2. This Severity Level IV violation is being treated as a noncited violation, consistent with Section VII.B.1.a of the NRC Enforcement Policy. This violation is in the licensee's corrective action program as Performance Improvement Request 99-4044 (50-482/0001-02).

III. Engineering

E8.1 Miscellaneous Engineering Issues (92903)

E8.1 (Closed) Licensee Event Report 50-482/99-014-00: computer leak rate calculation for containment sump leakage calculation does not meet design. On December 9, 1999, the licensee discovered that the computer leak rate calculation would not always detect a one gallon per minute leak within 1 hour. The licensee determined that the condition had existed since 1991 when the original plant computer system was replaced.

The Updated Safety Analysis Report design basis was not met since the containment leak rate calculation could not always detect a one gallon per minute leak rate within 1 hour. The licensee determined that, when the plant computer was replaced, the computer software was not correctly written and adequately tested to ensure the leak rate function was operable. The licensee determined that the following four factors contributed to the error:

- The software timer was not designed to reset properly;
- Factory software testing by the vendor was not conducted over a long enough period of time to validate the leak rate calculation;
- The site acceptance testing by licensee personnel did not identify the deficiency; and
- There was a problem with the validation, verification, classification, and grading of computer software at the time of the computer replacement.

The licensee changed the computer software to correct the calculation problem.

10 CFR Part 50, Appendix B, Criterion III, requires that measures be established to assure that design basis requirements are correctly translated into specifications, drawings, procedures, and instructions. In 1991, the licensee failed to properly

implement the containment sump leak rate calculation on the new plant computer system. The Updated Safety Analysis Report design basis was not met since the containment leak rate calculation could not always detect a one gallon per minute leak rate within 1 hour. This was a violation of 10 CFR Part 50, Appendix B, Criterion III. This Severity Level IV violation is being treated as a noncited violation, consistent with Section VII.B.1.a of the NRC Enforcement Policy. This violation is in the licensee's corrective action program as Performance Improvement Request 99-3865 (50-482/0001-03).

IV. Plant Support

R1 Radiological Protection and Chemistry Controls

R1.1 General Comments (71750)

The inspectors observed health physics personnel, including supervisors, routinely touring the radiologically controlled areas. Licensee personnel working in radiologically controlled areas exhibited good radiation worker practices.

Contaminated areas and high radiation areas were properly posted. Area surveys posted outside the rooms in the auxiliary building were current. The inspectors checked a sample of doors, required to be locked for the purpose of radiation protection, and found no problems.

R4 Staff Knowledge and Performance

R4.1 Violations of Radiation Work Permit and Radiation Survey Requirements

a. Inspection Scope (71750)

The inspectors reviewed the circumstances surrounding a radiation worker entering a potential hot particle area without the required protective clothing and directing radiation workers to enter a locked high radiation and potential hot particle area to remove the herculite covering the steam generator platform and decontaminate the steam generator platform area prior to the performance of a radiation survey of the area. The inspectors also reviewed the following documents:

- Radiation Work Permit 99-3202, Revision 0
- Procedure RPP 02-105, "Radiation Work Permit," Revision 14
- Procedure AP 25B-100, "Radiation Worker Guidelines," Revision 11

b. Observations and Findings

On April 16, 1999, the inspectors observed the work associated with the nozzle dam installation on the platforms for Steam Generators B and C from video displays at the health physics remote coverage location at access control. While the nozzle dam installation was in progress for Steam Generator C, the covering health physics technician and the inspectors noted that a maintenance worker entered the steam

generator platform access area on the 2000 foot level of the containment building. The inspectors observed that the worker did not appear to be wearing the required protective clothing.

On April 17, 1999, the licensee informed the inspectors that they were investigating the circumstances associated with the incident. On April 19, 1999, the licensee provided the inspectors with the following results of their investigation:

- The licensee determined that the maintenance worker who entered the steam generator platform work area without the required protective clothing was directed to do so by a senior health physics technician located at the work access area. The worker was directed to enter the potential hot particle area to accomplish a short duration task without the required protective clothing specified by the radiation work permit.
- The radiation workers were allowed to enter a hot particle and contaminated area and continuous health physics technician coverage was not provided as required by the radiation work permit.

Procedure AP 25B-100, "Radiation Worker Guidelines," Revision 11, established the implementing requirements for radiation worker use of radiation work permits. Section 9.3 of Procedure RPP 02-105, "Radiation Work Permit," Revision 14, provides guidance for minimum protective clothing requirements. Section 9.5.2 of Procedure RPP 02-105 states specific instruction for continuous health physics coverage for personnel to access/work in locked high radiation and hot particle areas. Technical Specification 5.4.1.a requires, in part, that written procedures be established, implemented, and maintained covering the activities recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978. Section 7.e(1) of Appendix A of this Regulatory Guide includes procedures for the access control to radiation areas, including a radiation work permit system.

Radiation Work Permit 99-3202 required workers to wear a full set of protective clothing, including an extra pair of paper coveralls, extra pair of rubber gloves, extra pair of plastic booties, extra hood, and a face shield. Specifically, instead of wearing paper coveralls outside his first set of protective clothing, the radiation worker was wearing two sets of cloth coveralls, no extra plastic shoe covers, and no face shield. Radiation Work Permit 99-3202 also required continuous health physics technician coverage of the radiation workers during the decontamination of the steam generator platform. According to the results of the licensee's investigation stated above, the senior health physics technician allowed a radiation worker to enter a controlled area without the proper protective clothing and failed to provide continuous coverage of the radiation workers once inside the controlled area during the decontamination of the steam generator platform. The failure to comply with the protective clothing requirement and provide continuous health physics coverage during the decontamination of the steam generator platform as required by the radiation work permit was a violation of Technical Specification 5.4.1. Based on the NRC's investigation (OI A4-1999-020) and the NRC's review of the circumstances associated with this issue (EA 99-267), the NRC has concluded that the violation was committed willfully. Although willfulness was involved,

the NRC has also concluded that the criteria in Section VII.B.1.a.4 was met. Therefore, this Severity Level IV violation is being treated as a noncited violation, consistent with Section VII.B.1.a of the NRC Enforcement Policy. On April 16, 1999, the licensee documented this issue in Performance Improvement Request 99-1357 (50-482/0001-04).

On April 16, 1999, after the steam generator nozzle dams were installed, the radiological conditions on the steam generator platform work area were significantly changed. The work area was known to be contaminated and hot particles were expected to be present. A health physics supervisor requested that the senior health physics technician covering the steam generator work perform a radiation survey of the work area before permitting radiation workers to enter, remove the herculite covering the steam generator platform work area, and decontaminate the area. Radiation workers were allowed to enter the steam generator platform work area prior to a radiation survey being performed. The radiological conditions of the steam generator platform area were unknown at this time, since the area had been occupied by personnel who had been inside the primary side of two steam generators.

In part, 10 CFR 20.1501(a) states that each licensee shall make, or cause to be made, surveys that are reasonable under circumstances to evaluate radiation levels, concentrations or quantities of radioactive materials, and the potential radiological hazard that could be present. The failure to perform a radiation survey of the steam generator work area prior to sending radiation workers into the area was a violation of 10 CFR 20.1501(a). Based on the NRC's investigation (OI A4-1999-020) and the NRC's review of the circumstances associated with this issue (EA 99-267), the NRC has concluded that the violation was committed willfully. Although willfulness was involved, the NRC has also concluded that the criteria in Section VII.B.1.a.4 was met. Therefore, this Severity Level IV violation is being treated as a noncited violation, consistent with Section VII.B.1.a of the NRC Enforcement Policy. On April 16, 1999, the licensee documented this issue in Performance Improvement Request 99-1357 (50-482/0001-05).

c. Conclusions

A violation of Technical Specification 5.4.1.a was identified for the willful failure to comply with the protective clothing requirement and provide continuous health physics coverage during the decontamination of the steam generator platform as required by the radiation work permit. Based on the NRC's investigation (OI A4-1999-020) and the NRC's review of the circumstances associated with this issue (EA 99-267), the NRC has concluded that the violation was committed willfully. Although willfulness was involved, the NRC has also concluded that the criteria in Section VII.B.1.a.4 was met. Therefore, this Severity Level IV violation is being treated as a noncited violation, consistent with Section VII.B.1.a of the NRC Enforcement Policy. On April 16, 1999, this issue was documented in the licensee's corrective action program as Performance Improvement Request 99-1357.

A violation of 10 CFR 20.1501(a) was identified for the willful failure to perform a radiation survey of the steam generator platform work area prior to sending radiation

workers into the area. Based on the NRC's investigation (OI A4-1999-020) and the NRC's review of the circumstances associated with this issue (EA 99-267), the NRC has concluded that the violation was committed willfully. Although willfulness was involved, the NRC has also concluded that the criteria in Section VII.B.1.a.4 was met. Therefore, this Severity Level IV violation is being treated as a noncited violation, consistent with Section VII.B.1.a of the NRC Enforcement Policy. On April 16, 1999, this issue was documented in the licensee's corrective action program as Performance Improvement Request 99-1357.

R8 Miscellaneous Radiological Protection and Chemistry Issues (92904)

R8.1 (Closed) Unresolved Item 50-482/9903-04: radiation worker entered a hot particle zone without wearing appropriate protective clothing. As a result of the licensee's and NRC's investigation of the circumstances identified in the unresolved item, two noncited violations are being issued for failure to comply with protective clothing requirements of a radiation work permit and failure to perform a radiation survey of the work area prior to sending radiation workers into the area. For reference purposes, these violations are 50-482/0001-04 and 50-482/0001-05, respectively.

R8.2 (Closed) Licensee Event Report 50-482/99-013-00: missed surveillance (Technical Specification 4.5.1.1.b) on accumulator boron concentration verification due to inadequate tracking mechanism. On November 16, 1999, the licensee discovered that the accumulator boron concentration on all four accumulators had not been verified since August 26, 1999. Technical Specification 4.5.1.1.b required that the boron concentration in the accumulators be verified at least once per 31 days.

The licensee determined that the root cause of the event was an inadequate tracking mechanism when the new chemistry data management system was implemented in August 1999. The surveillance was missed when the system did not function as expected. The licensee determined that there was not an adequate backup/manual tracking method to ensure the surveillances were performed as required. The licensee terminated the manual tracking method prior to adequately testing the chemistry data management system software.

The licensee's corrective actions included:

- Performing additional troubleshooting on the new management system software,
- Continuing to use a manual tracking system until the software is corrected, and
- Incorporating the accumulator chemistry surveillances into the surveillance test master cross-reference database.

The licensee planned to complete the corrective actions by March 14, 2000.

On November 16, 1999, the licensee discovered that the accumulator boron concentration on all four accumulators had not been verified since August 26, 1999. This is a violation of Technical Specification 4.5.1.1.b. This Severity Level IV violation is

being treated as a noncited violation, consistent with Section VII.B.1 of the NRC Enforcement Policy. This violation is in the licensee's corrective action program as Performance Improvement Request 99-3666 (50-482/0001-06).

V. Management Meetings

X1 Exit Meeting Summary

The exit meeting was conducted on February 18, 2000. The licensee did not express a position on any of the findings in the report. The inspectors asked the licensee whether any materials examined during the inspection should be considered proprietary. No proprietary information was identified.

The inspectors conducted a followup telephone exit with licensee representatives on February 24, 2000, to present the details of two violations in the plant support area.

ATTACHMENT

SUPPLEMENTAL INFORMATION

PARTIAL LIST OF PERSONS CONTACTED

Licensee

M. J. Angus, Manager, Licensing and Corrective Action
J. W. Johnson, Manager, Resource Protection
O. L. Maynard, President and Chief Executive Officer
B. T. McKinney, Vice President Plant Operations and Plant Manager
R. Muench, Vice President Engineering and Information Services
S. R. Koenig, Manager, Performance Improvement and Assessment
C. C. Warren, Vice President Operations Support

INSPECTION PROCEDURES USED

IP 37551	Onsite Engineering
IP 61726	Surveillance Observations
IP 62707	Maintenance Observations
IP 71707	Plant Operations
IP 71750	Plant Support Activities
IP 92700	Onsite Follow-Up of Written Reports of Nonroutine Events at Power Reactor Facilities
IP 92901	Followup - Operations
IP 92902	Followup - Maintenance
IP 92903	Followup - Engineering
IP 92904	Followup - Plant Support

ITEMS OPENED AND CLOSED

Opened

50-482/0001-01	NCV	Failure to comply with the requirements of Technical Specification Limiting Conditions of Operation 3.5.2 (Section M8.1)
50-482/0001-02	NCV	Potential for both trains of safety injection to be inoperable due to erroneous valve test procedure line up (Section M8.2)
50-482/0001-03	NCV	Computer leak rate calculation for containment sump leakage calculation does not meet design (Section E8.1)
50-482/0001-04	NCV	Failure to comply with the protective clothing requirement and provide continuous health physics coverage during the decontamination of the steam generator platform as required by the radiation work permit (Section R4.1)

50-482/0001-05	NCV	Failure to perform a radiation survey of the steam generator platform work area prior to sending radiation workers into the area (Section R4.1)
50-482/0001-06	NCV	Missed surveillance (Technical Specification 4.5.1.1.b) on accumulator boron concentration verification due to inadequate tracking mechanism (Section R8.2)

Closed

50-482/9903-05	URI	Radiation worker entered a hot particle zone without wearing appropriate protective clothing (Section R8.1)
50-482/99-013-00	LER	Missed surveillance (Technical Specification 4.5.1.1.b) on accumulator boron concentration verification due to inadequate tracking mechanism (Section R8.2)
50/482/99-014-00	LER	Computer leak rate calculation for containment sump leakage calculation does not meet design (Section E8.1)
50-482/99-015-00	LER	Failure to comply with the requirements of Technical Specification Limiting Conditions of Operation 3.5.2 because the inadequate verification (Section M8.1)
50-482/99-016-00	LER	Potential for both trains of safety injection to be inoperable due to erroneous valve test procedure line up (Section M8.2)
50-482/0001-01	NCV	Failure to comply with the requirements of Technical Specification Limiting Conditions of Operation 3.5.2 (Section M8.1)
50-482/0001-02	NCV	Potential for both trains of safety injection to be inoperable due to erroneous valve test procedure line up (Section M8.2)
50-482/0001-03	NCV	Computer leak rate calculation for containment sump leakage calculation does not meet design (Section E8.1)
50-482/0001-04	NCV	Failure to comply with the protective clothing requirement and provide continuous health physics coverage during the decontamination of the steam generator platform as required by the radiation work permit (Section R4.1)
50-482/0001-05	NCV	Failure to perform a radiation survey of the steam generator platform work area prior to sending radiation workers into the area (Section R4.1)

50-482/0001-06	NCV	Missed surveillance (Technical Specification 4.5.1.1.b) on accumulator boron concentration verification due to inadequate tracking mechanism (Section R8.2)
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