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NUCLEAR REGULATORY COMMISSION
REGION II
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May 1, 2000

Virginia Electric and Power Company
ATTN: Mr. D. A. Christian
Senior Vice President - Nuclear
Innsbrook Technical Center
5000 Dominion Boulevard
Glen Allen, VA 23060

SUBJECT: NRC INTEGRATED INSPECTION REPORT NOS. 50-338/00-02, 50-339/00-02

Dear Mr. Christian:

On April 1, 2000, the NRC completed an inspection at your North Anna Power Station Units 1 and 2. The enclosed report presents the results of that inspection.

During the seven weeks covered by this inspection period, your conduct of activities at the North Anna Power Station was generally characterized by good plant operations, maintenance and plant support work practices.

Based on the results of this inspection, the NRC has determined that two violations of NRC requirements occurred. These violations are being treated as non-cited violations (NCVs), consistent with Section VII.B.1.a of the NRC Enforcement Policy. These NCVs are described in the subject inspection report. If you contest the violation 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 Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555-0001, with copies to the Regional Administrator, Region II, the Resident Inspector at your facility and the Director, Office of Enforcement, United States Nuclear Regulatory Commission, Washington, DC 20555-0001.

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

Sincerely,

/RA/

Robert C. Haag, Chief
Reactor Projects Branch 5
Division of Reactor Projects

Docket Nos.: 50-338, 50-339
License Nos.: NPF-4, NPF-7

Enclosure: NRC Integrated Inspection Report

cc w/enclosure: See page 2
J. H. McCarthy, Manager

VEPCO

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U.S. NUCLEAR REGULATORY COMMISSION

REGION II

Docket Nos.: 50-338, 50-339
License Nos.: NPF-4, NPF-7

Report Nos.: 50-338/00-02, 50-339/00-02

Licensee: Virginia Electric and Power Company (VEPCO)

Facility: North Anna Power Station, Units 1 & 2

Location: 1022 Haley Drive
Mineral, Virginia 23117

Dates: February 13 through April 1, 2000

Inspectors: M. Morgan, Senior Resident Inspector
J. Canady, Resident Inspector
T. Morrissey, Project Engineer (Sections M8.1 and E8.1)
S. Vias, Reactor Inspector (Sections M1.2 and M7.1)

Approved by: R. Haag, Chief, Reactor Projects Branch 5
Division of Reactor Projects

Enclosure

EXECUTIVE SUMMARY

North Anna Power Station, Units 1 & 2 NRC Integrated Inspection Report Nos. 50-338/00-02, 50-339/00-02

This integrated inspection included aspects of licensee operations, engineering, maintenance, and plant support. The report covers a seven-week period of resident inspection. In addition, it includes the results of announced inspections by a regional reactor inspector and a regional project engineer.

Operations

- Activities observed during the Unit 1 shutdown for a refueling outage were performed in accordance with plant procedures and in a controlled manner. The inspectors also noted that operations personnel had received special shutdown training and were adequately prepared for the unit shutdown (Section O1.2).
- The inspectors concluded that fuel movement activities in the Unit 1 containment were performed safely and in accordance with the fuel movement sheet guidance. Foreign material exclusion practices were appropriate for the activity (Section O1.3).

Maintenance

- Observed maintenance activities associated with the replacement of control rod drive mechanism dampers with back draft type dampers, installation of an undervoltage/degraded voltage circuitry test switch, and repair of a pressurizer power-operated relief valve were properly performed. Personnel performing the repairs were knowledgeable and followed the specific work packages (Section M1.1).
- Inservice examination activities observed were performed using approved procedures by certified skilled examiners. The inspection results were properly recorded and evaluated in accordance with the appropriate test procedures (Section M1.2).
- A non-cited violation was identified for the failure to have battery 1-III and 2-III chargers properly sized. This condition is a violation of 10 CFR 50, Criterion III, "Design Control" (Section M8.1).

Engineering

- The design change package for the addition of test switches to Unit 1 emergency buses degraded/undervoltage relay circuits was adequately justified and had a proper 10 CFR 50.59 safety evaluation (Section E1.1).
- A non-cited violation was identified for failing to ensure the feedwater (FW) isolation configuration met the design requirement that the FW pump discharge valves close on a safety injection signal. This condition is a violation of 10 CFR 50, Criterion III, "Design Control" (Section E8.1).

Plant Support

- The inspectors concluded that the use of transient combustibles, including non-fire retardant wood, in the containment was in accordance with the licensee's fire protection program (Section F1.1).

Report Details

Summary of Plant Status

Unit 1 began the inspection period in a coastdown condition at 83 percent power. On March 12, the unit was shutdown for a scheduled refueling outage (RFO). The inspection period ended with Unit 1 outage activities in progress.

Unit 2 operated at or near 100 percent power for the entire inspection period.

I. Operations

O1 Conduct of Operations

O1.1 Daily Plant Status Reviews (71707)

The inspectors conducted frequent control room tours to verify proper staffing, operator attentiveness, and adherence to procedures. The inspectors also attended plant status meetings to maintain awareness of facility operations and reviewed operator logs to verify operational safety and compliance with Technical Specifications (TSs). Instrumentation and safety system line-ups were periodically reviewed to assess operability. Frequent plant tours were conducted to observe equipment status and housekeeping conditions. Licensee plant issue (PI) reports were reviewed to ensure that potential safety concerns were properly reported and resolved. The inspectors witnessed daily plant operations and determined that these operations were conducted in accordance with regulatory requirements.

O1.2 Unit 1 Shutdown for Refueling (71707)

On March 12, Unit 1 was shutdown for a scheduled RFO. During the coastdown and prior to entering the RFO, operations experienced minor problems in their attempts to place the turbine governor valve control in manual. On three occasions, placing the governor valve control in manual resulted in a peak reactor power greater than 100 percent. In no case did reactor power exceed 100.3 percent. In each instance, turbine governor valve control was placed back in automatic and reactor power decreased to less than 100 percent. The inspectors concluded that the observed power fluctuations were insignificant and were within NRC regulatory guidance. During the actual March 12 shutdown, the inspectors observed numerous operational activities throughout the power reduction from 40% to less than 10% power, the opening of the main generator output breakers, and operation of the steam dumps. These activities were performed in accordance with plant procedures. All observed shutdown activities were performed in a controlled manner. The inspectors also noted that operations personnel had received special shutdown training and were adequately prepared for the unit shutdown.

O1.3 Fuel Movement Observations During Unit 1 Containment Tours (71707)

The inspectors performed tours of the Unit 1 containment during the RFO. Activities observed included the movement of fuel assemblies during core off-load and reload. The inspectors accompanied the operators of the manipulator crane during a portion of

the fuel assembly reload activity. The inspectors observed that the manipulator crane operator was continuously cognizant of the loading on the crane and position indications during movement of the assemblies. The inspectors also noted that continuous communication was in effect with the main control room and that fuel movements were being performed in accordance with guidance contained in the fuel movement sheets.

The inspectors observed that a foreign material exclusion (FME) log was maintained by an attendant at the entry to the vessel cavity area. The attendant prohibited entry of unauthorized FME items into the area. The inspectors noted that the wearing of a life vest in the cavity area was required for all personnel.

The inspectors concluded that fuel movement activities in the Unit 1 containment were performed safely and in accordance with the fuel movement sheet guidance. FME practices were appropriate for the activity.

O8 Miscellaneous Operations Issues (92700)

- O8.1 (Closed) Licensee Event Report (LER) 50-338/99006-00: potential for safeguards exhaust flow to bypass charcoal filter due to degraded damper. On September 2, 1999, periodic testing on the B-train safeguards ventilation system determined the system flow rate to be 5300 scfm. The TS 4.7.8.1.b.1 requirement is 6300 ± 10 percent scfm. The licensee immediately declared the B-train of safeguards ventilation inoperable, issued a PI report and entered the seven-day action statement of TS 3.7.8.1. On September 4, 1999, during troubleshooting, the licensee determined that a system damper was degraded due to missing damper seals. The degraded damper caused a portion of the exhaust flow to bypass the auxiliary building high efficiency charcoal filter prior to release of the air to the surrounding environment. While the bypass flow and subsequent release would have been monitored, fulfillment of the ventilation system's accident function would have been adversely affected. The cause of the event was a long-term and gradual degradation of the damper's seals. The inspectors reviewed safeguards ventilation system periodic testing data dating back to 1996 and did not observe a trend that would have predicted degraded damper performance.

In addition to the repair of the above mentioned damper, the inspectors noted completion of the following corrective actions:

- Identification and repair of other degraded safeguards ventilation system dampers.
- New procedures were written to ensure that all unnecessary fans/dampers are secured as part of the operations group's post-accident activities to prevent charcoal filter bypass flow.
- New preventative maintenance schedules were produced to ensure that a visual inspection of the auxiliary building ventilation system dampers is performed.
- The issue has been addressed by the licensee's maintenance rule (MR) department. This specific degradation issue, as well as other previously

identified auxiliary building ventilation system deficiencies, are now listed as a(1) items in the licensee's MR program.

The inspectors considered the corrective actions to be comprehensive and appropriate.

- O8.2 (Closed) LER 50-339/99003-00: failure to lock containment isolation valve due to personnel error. On November 2, 1999, while Unit 2 was in mode 1, the licensee discovered that the Unit 2 safety injection accumulator makeup manual isolation valve, 2-SI-47, was closed but not properly locked. A chain had been secured around the handwheel of the valve and the lock hasp had been installed through the chain; however, the lock hasp had not been fully engaged within the locking mechanism. The inspectors independently verified that the valve in its as-found condition could not have been opened without the removal of the chain. TS 3.6.3.1 requires that each containment isolation valve shall be operable. Since 2-SI-47 was not properly locked closed, the TS conditions for containment isolation were not fully met. Upon initial discovery of the problem, 2-SI-47 was verified to be in the required closed position, the hasp was fully engaged into its locking mechanism, and the valve was independently verified as being properly locked. The cause of the condition was personnel error. As part of the corrective actions, the licensee briefed all the crews and incorporated the event description into the operations group's required reading. The inspectors considered the above actions to be comprehensive and appropriate. Since the valve was in the correct position, this event had minimal safety significance. The failure to have the safety injection accumulator makeup manual isolation locked is a violation of TS 3.6.3.1 which constitutes a violation of minor significance and is not subject to formal enforcement action.

II. Maintenance

M1 Conduct of Maintenance

M1.1 Observation of Preplanned Maintenance Activities

a. Inspection Scope (37551, 62707)

The inspectors observed the performance of all or portions of the following work orders (WOs):

- 353362-01 Replacement of existing control rod drive mechanism (CRDM) ventilation dampers with new back draft type dampers in accordance with Design Change Package (DCP) 99-108
- 405548-02 Repair/replace molded case circuit breaker to 1-III inverter
- 401207-01 Rotation of cavity bellows/vacuum fill to preclude air intrusion in accordance with DCP 00-101
- 421410-01 Inspection/refurbishment of pressurizer power operated relief valve (PORV) 1455C

- 399336-01 Repair of pressurizer PORV 1456 operator
- 417362-01 Installation of undervoltage/degraded voltage circuitry test switch in accordance with DCP 99-157

b. Observations and Findings

All observed work was properly approved by the operations department and included on the plan of the day and the outage scope. The inspectors found that work performed under these activities was professional and thorough. Work was performed with the work package present and in use. Accompanying documents such as supplemental instructions, the DCP, and technical manual information were properly followed and documentation of performed work activities was complete and contained appropriate details. The inspectors noted that craft personnel were knowledgeable of their assignments and that craft supervisors periodically monitored the work.

The components described in WOs 353362-01, 405548-02, 421410-01, and 399336-01 were listed as a(1) in the licensee's MR program in accordance with 10 CFR 50.65. The licensee will monitor future performance of these components to determine whether the components can be placed into an a(2) status.

c. Conclusions

Unit 1 maintenance activities associated with the replacement of control rod drive mechanism ventilation dampers with back draft type dampers, installation of an undervoltage/degraded voltage circuitry test switch, and repair of a pressurizer power operated relief valve were properly performed. Personnel performing the repairs were knowledgeable and followed the specific work packages.

M1.2 Inservice Inspection (ISI) - Observation of Work Activities

a. Inspection Scope (73753)

The inspectors observed two manual ultrasonic weld examinations, observed automated ultrasonic examinations of the 10-year reactor core vessel ISI, reviewed radiographs for six Unit 2 welds, observed eddy current acquisition and analyses activities for the 1B steam generator, reviewed ISI program requirements for Class 2 pressure retaining piping, and reviewed documentation which included outage plans, examination procedures, and examiner certification documentation. These observations were performed to determine whether the ISI, repair, and replacement of Class 1, 2, & 3 pressure retaining components were performed in accordance with TSs, the American Society of Mechanical Engineers (ASME) Code, Section XI 1983 Edition, Summer addenda (vessel exam) and Section XI 1989 Edition, no addenda (other examinations), and correspondence between NRC staff and the licensee.

b. Observations and Findings

The inspectors observed the manual ultrasonic examinations of two 16" feedwater welds using Procedure NDE-UT-701, Ultrasonic Examination of Piping Welds, R/0. No

defects were observed during these examinations. Automated ultrasonic examinations and review of examination data for the reactor vessel were also observed by the inspectors. Review of radiographic film for six Unit 2 welds revealed that radiographic film quality and weld quality were satisfactory. Eddy current acquisition activities and analyses of the data were observed for the 1B steam generator. The eddy current testing included 50% BOBBIN Probe inspection and 20% using the Rotating Pancake Coil (RPC). Due to indications observed using the RPC in Row 1, the licensee performed the analysis again using a Plus Point probe and were able to determine that there were no indications of significance. No significant erosion wear was identified during the activities observed.

The inspectors held discussions with the ISI program engineer, reviewed drawings, and documentation of the ISI program to determine if ISI program requirements for class 2 piping above 3/8 inch in thickness had been implemented in accordance with the 1989 ASME Code. The inspectors found that the licensee had properly implemented the Code.

c. Conclusions

Inservice examination activities observed were performed using approved procedures by certified skilled examiners. The inspection results were properly recorded and evaluated in accordance with the appropriate test procedures.

M7 Quality Assurance in Maintenance Activities

M7.1 Licensee Assessments of ISI Activities (73753)

The inspectors evaluated the effectiveness of licensee's controls for identifying, resolving and preventing problems in ISI by reviewing a Category 3 Root Cause Evaluation. The investigated concern the identification of missed re-examinations (VT2 visual examination) for the next inspection periods.

After examination of the identified problem, the inspectors concluded that the licensee's controls were effective in identifying and resolving issues within the corrective action program.

M8 Miscellaneous Maintenance Issues (92700)

M8.1 (Closed) LER 50-338, 339/99007-00: battery chargers not sized for design capability due to incorrect calculations. On June 28, 1999, the North Anna emergency power integrated review team identified a concern with the calculations associated with the battery chargers for the station's 125-volt battery banks for Units 1 and 2. As a result of this concern, Engineering Transmittal (ET) CEE 99-0014, "Station Battery Charger Sizing Evaluation North Anna Power Station, Units 1 and 2," Revision 0, was written to evaluate the charger sizing. The licensee determined that the chargers associated with station battery 1-III (charger 1-III and swing charger 1C-II) and station battery 2-III, (charger 2-III and swing charger 2C-II) could not provide adequate recharge capability of the associated battery within 24 hours following a design basis accident as required

by Updated Final Safety Analysis Report (UFSAR) Section 8.3.2.2.3. In addition, the licensee determined that TS surveillance requirement 4.8.2.3.2.c.3 which verifies the chargers will supply at least 200 amperes (amps) at 125 volts for at least four hours is non-conservative.

In 1990, the licensee recognized that the station battery chargers were marginally sized. Calculation EE-0057, "DC system equipment sizing," was changed to assume actual inverter loading vice design load to obtain more margin for the chargers. In 1991 (Unit 1) and in 1992 (Unit 2), the P250 computer 9 kVA inverters were removed from batteries 1-IV and 2-IV and replaced by 10kVA inverters supplied by batteries 1-III and 2-III. Calculation EE-057 was not updated since the licensee incorrectly determined that there was no effect on charger loading.

To resolve the recharge deficiencies the operating procedures associated with the four chargers were changed to reduce the load on batteries 1-III and 2-III whenever power is lost to the associated battery charger for more than 30 minutes. Specifically, each units P250 computer would be placed on its alternate power source. No load reduction would be required if power was lost for less than 30 minutes. The inspectors verified that the operating procedures were changed. The inspectors reviewed ET CEE 99-0014 and the associated calculations and determined that the battery chargers are capable of supplying normal and emergency loads. The inspectors determined that changes to the operating procedures would enable all the station chargers associated with the 125-volt batteries to recharge the batteries within 24 hours. Additionally, the 18-month periodic tests (PTs) associated with the batteries/chargers were verified to be changed to evaluate battery/charger performance if the chargers failed to supply at least 270 amps for four hours during the PTs. The Unit 1 and Unit 2 battery chargers have been tested at this higher amperage. The licensee initiated a TS change to test the chargers to 270 amps.

The failure to have the four battery chargers correctly sized only had an effect on the recharge capability of batteries 1-III and 2-III if power was lost to the chargers for greater than 30 minutes. Both batteries would have been available to supply power to the normal and emergency loads associated with a design basis accident or station blackout for the time specified in the UFSAR with or without shedding both P250 computer loads. The safety significance of this event is low.

The battery chargers associated with station batteries 1-III and 2-III would not have met the design basis requirement for a 24-hour recharge if power was lost to the chargers for more than 30 minutes during a design basis accident. This condition is a violation of 10 CFR 50, Appendix B, Criterion III, "Design Control," which states in part, that measures shall be established to assure that the design basis is correctly implemented.

This Severity Level IV violation is being treated as a non-cited violation (NCV) consistent with Section VII.B.1.a of the NRC Enforcement Policy, and is identified as NCV 50-338, 339/00002-01. This item is in the licensee's corrective action program as PI N-99-2708 and PI N-99-2947.

III. Engineering

E1 Conduct of Engineering

E1.1 Review of Design Change Package (DCP) for the Addition of Test Switches to Unit 1 Emergency Buses Degraded/Undervoltage Relay Circuits (37551)

The inspectors noted from a review of the licensee's PI data base and discussions with engineering personnel that repeated removal and reinstallation of the 4 Kv emergency bus degraded/undervoltage relay circuit fuses during testing led to the fatigue of the fuse clips and loose fuses. To solve this problem, the licensee implemented DCP 99-157. This DCP installed safety-related, seismically qualified test switches in series with the relay fuses to allow the circuits to be isolated for testing without removing the fuses.

The inspectors reviewed the DCP and the associated 10 CFR 50.59 safety evaluation. The design package was logically organized and included vendor supplied, supporting documentation. The inspectors independently verified from a review of documentation referenced in the DCP that the addition of the test switches in series with the fuses did not alter the original design basis of the associated circuits. The referenced documents reviewed included the TSs, UFSAR, and a similar DCP previously implemented on Unit 2. Additionally, the inspectors verified that the applicable periodic test procedures and drawings were revised to reflect the implementation of the DCP.

The inspectors concluded that the DCP was adequately justified and had a proper 10 CFR 50.59 safety evaluation.

E8 Miscellaneous Engineering Issues (92700)

E8.1 (Closed) LER 50-338, 339/99005-00: potential for continued feed flow to faulted steam generator during main steam line break (MSLB). On June 16, 1999, the licensee's integrated review of the feedwater (FW) system identified that Units 1 and 2 may have previously been outside the plant design basis. During a MSLB inside containment with offsite power available, there was the potential for continued condensate pump flow to a faulted steam generator through a standby FW pump's open discharge isolation valve and a main FW regulating bypass valve (MFRBV) that fails to close. The licensee incorrectly assumed that the discharge valve for a standby pump would close on a safety injection signal that trips the operating FW pumps. In 1993, the licensee evaluated a concern with the possibility of continued feed flow to a faulted steam generator. Engineering failed to recognize the flow path through the standby FW pump.

The licensee issued standing order number 227 that required the operators to place the standby FW pump in pull-to-lock and close the associated discharge valve whenever operation of a MFRBV was required. This standing order was in effect until the circuitry could be modified. The licensee modified the circuitry for the Unit 1 and Unit 2 FW pump discharge valves to close on a Hi-Hi steam generator level or a safety injection during the Spring 2000 and Fall 1999 outages, respectively. The inspectors reviewed the modification package for Units 1 and 2 and found it to be complete and adequate to ensure the units remained within the design basis for FW system isolation.

The licensee's analysis for a MSLB inside containment assumes redundant isolation of the FW system, FW isolation within 60 seconds, and that the most reactive control rod assembly is stuck out of the core. The concern with continuing feed flow is twofold; over pressurizing the containment and a possible restart accident due to cool down of the reactor coolant system. The licensee's emergency procedures contain actions to verify FW is isolated following a reactor trip and safety injection signal. However, it is recognized that these actions would not be completed within the time frame specified in the analysis. The probability of continuing to feed a faulted steam generator is low. The MFRBV is not routinely operated and when it is used, a safety injection signal would close the valve. The concern is that flow through the MFRBV does not have a redundant isolation to secure flow should the MFRBV fail to close. Based on the low likelihood of a MSLB inside containment, the limited time that a MFRBV is open, and the low probability of an open MFRBV not closing, the safety significance of this event is low.

The licensee failed to ensure the FW isolation configuration met the design requirement that the FW pump discharge valves close on a safety injection signal. 10 CFR 50, Appendix B, Criterion III, "Design Control," states in part, that measures shall be established to assure that the design basis is correctly implemented. This Severity Level IV violation is being treated as a NCV consistent with Section VII.B.1.a of the NRC Enforcement Policy, and is identified as NCV 50-338, 339/00002-02. This violation is in the licensee's corrective action program as DR N-99-1415.

IV. Plant Support

R1 Radiological Protection and Chemistry (RP&C) Controls (71750)

On numerous occasions during the inspection period, the inspectors reviewed radiation protection (RP) practices including radiation control area entry and exit, survey results, and radiological area material conditions. Emphasis was placed upon Unit 1 refueling outage radiological control practices. No discrepancies were noted, and the inspectors determined that licensee RP practices were proper.

S1 Conduct of Security and Safeguards Activities (71750)

On numerous occasions during the inspection period, the inspectors performed walkdowns of the protected area perimeter to assess security and general barrier conditions. Emphasis was also placed upon Unit 1 refueling activities which had the potential to affect normal licensee security and safeguards practices. No deficiencies were noted. The inspectors concluded that security posts were properly manned, that the perimeter barrier's material condition was properly maintained, and that the Unit 1 refueling activity impacts upon routine plant security and safeguards were minimal.

F1 Control of Fire Protection Activities

F1.1 Use of Non-Fire Retardant Wood in Containment During Unit 1 Refueling Outage (71750)

The inspectors reviewed procedure VPAP 2401, "Fire Protection Program," Revision 13. This review was associated with the use of non-fire retardant wood that the inspectors observed in the containment building during the Unit 1 refueling outage. The non-fire retardant wood was used to support temporary radiation shielding required during the movement of the vessel upper internals to an underwater storage area.

The inspectors reviewed transient combustible permits and held discussions with licensee personnel. The inspectors concluded that the use of transient combustibles, including the non-fire retardant wood, in the containment was in accordance with the licensee's fire protection program.

V. Management Meetings

X1 Exit Meeting Summary

The inspectors presented the inspection results to members of licensee management at the conclusion of the inspection on April 13, 2000. The licensee acknowledged the findings presented.

The inspectors asked the licensee whether any materials examined during the inspection should be considered proprietary. No proprietary information was identified.

PARTIAL LIST OF PERSONS CONTACTED

Licensee

- D. Christian, Senior Vice President, Nuclear Operations
- B. Foster, Superintendent Station Engineering
- C. Funderburk, Manager, Station Operations and Maintenance
- D. Heacock, Site Vice President
- P. Kemp, Director, Nuclear Oversight
- L. Lane, Superintendent, Operations
- T. Maddy, Superintendent, Security
- W. Matthews, Vice President, Nuclear Operations
- H. Royal, Superintendent, Nuclear Training
- D. Schappell, Superintendent, Site Services
- R. Shears, Superintendent, Maintenance
- A. Stafford, Superintendent, Radiological Protection

INSPECTION PROCEDURES USED

IP 37551: Onsite Engineering
 IP 62707: Maintenance Observations
 IP 71707: Plant Operations
 IP 71750: Plant Support Activities
 IP 73753: Inservice Inspection
 IP 92700: Onsite Followup of Written Reports of Nonroutine Events at Power Reactor Facilities

ITEMS OPENED AND CLOSED

Opened

50-338, 339/00002-01	NCV	failure to have battery 1-III and 2-III chargers properly sized is a violation of 10 CFR 50, Appendix B, Criterion III (Section M8.1)
50-338, 339/00002-02	NCV	licensee failed to ensure the FW isolation configuration met the design requirement that the FW pump discharge valves close on a safety injection signal (Section E8.1)

Closed

50-338/99006-00	LER	potential for safeguards exhaust flow to bypass charcoal filter due to degraded damper (Section O8.1)
50-339/99003-00	LER	failure to lock containment isolation valve due to personnel error (Section O8.2)
50-338, 339/99007-00	LER	battery chargers not sized for design capability due to incorrect calculations (Section M8.1)
50-338, 339/00002-01	NCV	failure to have battery 1-III and 2-III chargers properly sized is a violation of 10 CFR 50, Appendix B, Criterion III (Section M8.1)
50-338, 339/00002-02	NCV	licensee failed to ensure the FW isolation configuration met the design requirement that the FW pump discharge valves close on a safety injection signal (Section E8.1)
50-338, 339/99005-00	LER	potential for continued feed flow to faulted steam generator during main steam line break (Section E8.1)