



UNITED STATES
 NUCLEAR REGULATORY COMMISSION
 REGION II
 101 MARIETTA STREET, N.W.
 ATLANTA, GEORGIA 30323

Report Nos: 50-269/88-01, 50-270/88-01 and 50-287/88-01

Licensee: Duke Power Company
 422 South Church Street
 Charlotte, N.C. 28242

Docket Nos.: 50-269, 50-270, 50-287 License Nos. DPR-38, DPR-47, DPR-55

Facility Name: Oconee Nuclear Station

Inspection Conducted: January 16 - February 16, 1988

Inspectors:	<u><i>P. H. Skinner for</i></u>	<u>2/25/88</u>
	P. H. Skinner, Senior Resident Inspector	Date Signed
	<u><i>L. D. Wert for</i></u>	<u>2/25/88</u>
	L. D. Wert, Resident Inspector	Date Signed
Approved by:	<u><i>T.A. Peebles for</i></u>	<u>2/25/88</u>
	T.A. Peebles, Section Chief	Date Signed
	Division of Reactor Projects	

SUMMARY

Scope: This routine, announced inspection involved resident inspection on-site in the areas of operations, surveillance, maintenance, physical security, engineered safeguards features lineups, review of Safety System Functional Inspection items and meeting with public officials.

Results: Of the seven areas inspected, no violations were identified.

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REPORT DETAILS

1. Persons Contacted

Licensee Employees

- *M. Tuckman, Station Manager
- J. Davis, Technical Services Superintendent
- W. Foster, Maintenance Superintendent
- T. Glenn, Instrument and Electrical Support Engineer
- *C. Harlin, Compliance Engineer
- J. McIntosh, Administrative Services Superintendent
- *F. Owens, Assistant Engineer, Compliance
- *R. Sweigart, Operations Superintendent
- L. Wilkie, Integrated Scheduling Superintendent

Other licensee employees contacted included technicians, operators, mechanics, security force members, and staff engineers.

NRC Resident Inspectors:

- *P.H. Skinner
- *L.D. Wert

*Attended exit interview.

2. Exit Interview

The inspection scope and findings were summarized on February 16, 1988, with those persons indicated in paragraph 1 above.

The inspectors described the areas inspected and discussed in detail the inspection findings listed below. Dissenting comments were not received from the licensee. Proprietary information is not contained in this report.

<u>Item Number</u>	<u>Status</u>	<u>Description/Reference Paragraph</u>
287/83-11-01	Closed	Violation of Containment Integrity Unit 3
269,287/83-11-02	Closed	Failure to Provide Procedures to Assure the Correct Performance of Operating Activities
269/88-01-01	Open	Licensee Identified Violation: Containment Isolation Valve 1N-106 Found Open

269/87-48-02	Closed	Inspector Followup Item Associated With containment Isolation Valve 1N-106 Being Found Open
269,270,287/86-16-02	Closed	Open item on SSFI report associated with adequacy of the design of safety related inverters
269,270,287/86-16-04	Closed	Open item on SSFI report associated with battery design basis

3. Licensee Action on Previous Enforcement Matters

- a. (Closed) Violation 50-287/83-11-01: Violation of Containment Integrity, Unit 3. This violation was the subject of escalated enforcement as discussed in correspondence dated June 2, 1983. The licensee responded to this action in correspondence dated July 1, 1983. A subsequent letter from NRC dated December 20, 1983, reduced this violation from a Severity Level III category with a civil penalty to a Severity Level IV without a civil penalty. This problem was also addressed in LER RO-287/83-04 and additional documentation from the licensee dated April 29, 1983. The actions taken by the licensee have been reviewed by the inspectors and based on the completed action this item is closed.
- b. (Closed) Violation 50-269,287/83-11-02: Failure To Provide Procedures To Assure The Correct Performance of Operating Activities. This violation is discussed in detail in the same correspondence identified in the closing of Violation 50-287/83-11-01 discussed above.

4. Plant Operations (71707)

- a. The inspectors reviewed plant operations throughout the reporting period to verify conformance with regulatory requirements, technical specifications (TS), and administrative controls. Control room logs, shift turnover records, and equipment removal and restoration records were reviewed routinely. Discussions were conducted with plant operations, maintenance, chemistry, health physics, Instrument & Electrical (I&E), and performance personnel.

Activities within the control rooms were monitored on an almost daily basis. Inspections were conducted on day and on night shifts, during week days and on weekends. Some inspections were made during shift change in order to evaluate shift turnover performance. Actions observed were conducted as required by the Licensee's Administrative Procedures. The complement of licensed personnel on each shift inspected met or exceeded the requirements of TS. Operators were responsive to plant annunciator alarms and were cognizant of plant conditions.

Plant tours were taken throughout the reporting period on a routine basis. The areas toured included the following:

- Turbine Building
- Auxiliary Building
- Units 1, 2, and 3 Electrical Equipment Rooms
- Units 1, 2, and 3 Cable Spreading Rooms
- Station Yard Zone within the Protected Area
- Standby Shutdown Facility
- Units 1, 2, and 3 Penetration Rooms

During the plant tours, ongoing activities, housekeeping, security, equipment status, and radiation control practices were observed.

Unit 1 operated at 100% power for the entire report period.

Unit 2 operated at approximately 85% until shutting down for scheduled refueling outage on February 3.

Unit 3 operated at 100% power for the report period. As of February 16, Unit 3 has operated for 289 continuous days.

b. Containment Isolation Valve 1N-106 Found Open

As stated in Inspection Report 269,270,287/87-48, a low pressure nitrogen system containment isolation valve (1N-106) was discovered open on December 19, 1987. TS 3.6.1 states that containment integrity is required to be maintained whenever reactor coolant pressure is 300 psig or greater, reactor coolant temperature is 200 degrees F or higher, and fuel is in the core. Investigation of the incident disclosed that valve 1N-106 had been incorrectly open from November 19, 1987 until December 19, 1987 due primarily to a personnel error. Unit 1 was at 100% power throughout this period. Details of the incident were reported in Licensee Event Report (LER) 269/87-13.

The licensee classified the root cause of the incident as personnel error because the Senior Reactor Operator (SRO), during the assignment of the restoration portion of OP/O/A/1102/06, Removal and Restoration of Station Equipment, involving 1N-106, failed to adequately review the procedure. Additionally, the SRO failed to give appropriate or adequate guidance to the Nuclear Equipment Operator (NEO) before he assigned the restoration procedure.

The inspector discussed the incident at length with personnel who had conducted the investigation and also with several of the operators involved. The inspector concurred with the root cause as stated and the proposed corrective actions. The fact that the Removal and Restoration procedure had not been identified as TS related (step 1.3 of OP/O/A/1102/06 was documented as not applicable) contributed significantly to this event. Removal and Restoration procedures

documented as related to TS equipment are maintained separately and labeled as such. Apparently this misclassification occurred due to existing plant conditions (Unit 1 was shutdown and less than 200 degrees F) when the Removal and Restoration was initiated on September 4, 1987. This error in conjunction with the inadequate review by the SRO, caused the Removal and Restoration procedure to be handled with less detailed attention than is required to be given to a Removal and Restoration procedure involving containment isolation valves. The licensee's proposed corrective actions should correct these types of problems.

The inspectors discussed with station management two additional concerns that were noted during followup of this incident. Station procedures require that all Removal and Restoration procedures currently in effect on a unit are to be reviewed by two different licensed operators once per shift. Despite this review, 1N-106 remained incorrectly positioned for thirty days. Additionally step 1.4 of Enclosure 3.2 (Restoration portion) of OP/O/A/1102/06 requires that certain types of equipment are to be independently verified prior to being returned to service. While the low pressure nitrogen system as a whole does not fit into any of these equipment types, portions of the system (including 1N-106) clearly fit at least one of the types listed as requiring independent verification, (Safety Related equipment, equipment which if aligned improperly can result in the release of radioactive fluid). None of these categories were checked as applicable and consequently independent verification was not performed. An independent verification by a second operator may have prevented the opening of a normally shut containment isolation valve. The licensee stated that both of these issues are primarily consequences of the misclassification of the procedure as not required by TS and the inadequate review by the SRO. It was concluded after review of the involved procedures that existing procedural guidance (if adhered to) is adequate to prevent recurrence.

The attention to detail of another NEO investigating an unrelated problem in the area of 1N-106 permitted the open valve to be discovered and is noteworthy. The safety significance of the mispositioned valve was small in that an upstream check valve (1N-246, inside the Reactor Building) was verified closed and capped off both during the previous unit startup and immediately after the open valve was discovered. 1N-246 had been leak tested with results well within acceptance limits on September 24, 1987. Any leakage would be reduced at the seat of 1N-106 to a rate much less than that assumed in the Dconeé FSAR analysis of ESF system leakage for the maximum hypothetical accident.

Although this problem is a violation of TS, it will not be cited as such since it meets the conditions as stated in 10 CFR 2, Appendix C, in that:

- (1) The problem was identified by the licensee.
- (2) The problem fits into a Severity Level IV.
- (3) The problem was promptly corrected upon discovery and measures are being taken to prevent recurrence.
- (4) It was reported as required.
- (5) It was not a violation that could reasonably be expected to have been prevented by corrective action taken on a previous violation.

This item is identified as Licensee Identified Violation (LIV) 269/88-01-01: Containment Isolation Valve 1N-106 Found Open. This item will remain open until the resident inspectors have reviewed and verified completion of all corrective actions. The licensee has committed to completing such action by June 30, 1988. (The lengthy time period is primarily required to provide training to operations personnel temporarily assigned offsite).

c. Turbine Driven Emergency Feedwater Pump, Operability from Auxiliary Steam

During a control room tour, the inspector noted that a Removal and Restoration Procedure (OP/O/A/1102/06) was in effect for 3MS-86, the main steam supply valve for the Unit Three turbine driven emergency feedwater pump (TDEFWP) turbine. The Removal and Restoration was not identified as related to TS required equipment and the TDEFWP was not logged as out of service. Operators informed the inspector that this was the case since the auxiliary steam system was operable and could provide required steam flow to the TDEFWP turbine. The inspector followed up on this situation since some of the auxiliary steam system is not seismic rated.

After review of the Safety Evaluation Report (SER) of Jan. 14, 1987, concerning the seismic qualification of Oconee's EFW System (in regards to Generic Letter 81-14) the inspector concluded that the TDEFWP was in fact fully operable during this time period. However, the inspector pointed out to licensee management that the Removal and Restoration procedure should have been identified as involving TS related equipment. TS related Removal and Restoration procedures are maintained separately from other Removal and Restoration procedures and receive closer operator attention. This could possibly prevent inadvertent isolation of auxiliary steam to the TDEFWP turbine at some later time by an operator that was not aware that TDEFWP operability depended on auxiliary steam. Station management concurred with this position and stated that the problem of inappropriate identification of Removal and Restoration procedures will be addressed as part of the corrective actions for LIV 269/88-01-01 discussed in paragraph b above.

d. Procedural Reviews

The inspectors reviewed numerous procedures which contained steps which had been labeled as "not applicable" by the job supervisor or some other supervisor. These steps were not conditional steps or lists of alternative steps but rather specific directive steps to be performed. The supervisor, acting as permitted by Oconee Nuclear Station Directive 2.2.1, apparently designated steps "not applicable" as required to accomplish a task by a different method other than that described in the procedure. This matter was brought to the attention of station management. The inspectors feel that supervisors that are performing this action may not be aware of all considerations that were utilized in the development of the procedure and thus they could omit a necessary or required step thereby having a significant impact on the procedure. Station management is currently reviewing this practice to evaluate compliance with requirements and intent of ANSI 18.7 and the Administration Policy Manual. The resident inspectors are closely following licensee action on this issue.

e. Spill during Maintenance on a High Pressure Injection System Instrument Valve

On February 11, 1988 at approximately 1:45 PM a 500-1000 gallon spill of primary coolant occurred as a result of operator error during maintenance on a High Pressure Injection (HPI) system valve. Maintenance personnel authorized to perform work on a Unit 2 valve in error loosened the packing on an Unit One HPI instrument root valve (to HPI train 'A' flow gauge). Unit One was operating at 100% power and when the packing was loosened it blew out under HPI system pressure and resulted in a leak of approximately 40 gpm. Control Room operators received HPI flow annunciator alarms and indications along with calls from personnel informing them of the spill. Pressure was relieved on the instrument valve by shutting several HPI valves and the leaking valve was first backseated and subsequently shut to stop the leak. Four persons were exposed to the water as a result of the spill, two had external contamination which was removed by showering. There were no injured personnel. The resident inspectors observed both the initial isolation actions and recovery actions. The valve was repacked and the system was restored to normal by 10 p.m. The licensee issued a press release concerning the incident and called the NRC Incident Response Center as required. Initial investigation indicated that the primary cause was that an orange tag used to identify equipment needing maintenance by work request number had been hung on the wrong valve. The licensee's investigation is continuing. A contributing factor in this event was that the instrument root valve was not labeled (most instrument valves at Oconee are not labeled). The inspectors feel that unlabeled instrument valves are a significant weakness. Discussions with the licensee disclosed that the licensee has been reviewing this aspect. The resident inspectors will followup on the results of this

review and the corrective actions taken as a result of the licensee investigation.

5. Surveillance Testing (61726)

Surveillance tests were reviewed by the inspectors to verify procedural and performance adequacy. The completed tests reviewed were examined for necessary test prerequisites, instructions, acceptance criteria, technical content, authorization to begin work, data collection, independent verification where required, handling of deficiencies noted, and review of completed work. The tests witnessed, in whole or in part, were inspected to determine that approved procedures were available, test equipment was calibrated, prerequisites were met, tests were conducted according to procedure, test results were acceptable and systems restoration was completed.

Surveillances reviewed or witnessed in whole or in part:

TT/2/A/0911/09	End of Cycle APSR Withdrawal (Unit 2)
PT/2/A/600/10	Reactor Coolant System Leakage (Unit 2)
PT/2/A/113/15	Shutdown Margin Calculation (during unit shutdown)
MP/0/A/1100/15	Cooler - LPI (Decay Heat Removal) - Chemical Flush
IP/0/A/3000/03	125 VDC Instrument and Control Battery Service Test
IP/0/A/0275/6A&6B	Emergency Feedwater System Emergency Feedwater Flow Channel "A" Indication Calibration and Test
PT/0/A/0170/03	Control Room Filtering System Operational Test

No violations or deviations were identified.

6. Maintenance Activities (62703)

- a. Maintenance activities were observed and/or reviewed during the reporting period to verify that work was performed by qualified personnel and that approved procedures in use adequately described work that was not within the skill of the trade. Activities, procedures and work requests were examined to verify proper authorization to begin work, provisions for fire, cleanliness, and exposure control, proper return of equipment to service, and that limiting conditions for operation were met.

Maintenance reviewed or witnessed in whole or in part:

WR 57410E	Cleaning of LPSW Side LPI Cooler
WR 12796C	Repairs to 1LPSW-516

No violations or deviations were identified.

7. Resident Inspector Safeguards Inspection (71881)

In the course of the monthly activities, the Resident Inspectors included review of portions of the licensee's physical security activities. The performance of various shifts of the security force was observed in the conduct of daily activities which included; protected and vital areas access controls, searching of personnel, packages and vehicles, badge issuance and retrieval, escorting of visitors, patrols and compensatory posts. In addition, the inspectors observed protected area lighting and protected and vital areas barrier integrity, and verified interfaces between the security organization and operations or maintenance.

No violations or deviations were identified.

8. Inspection of Open Items (92701)

The following open items are being closed based on review of licensee reports, inspection, record review, and discussions with licensee personnel, as appropriate:

(Closed) LER 269/87-07: Misclassification of Low Pressure Service Water System Piping. This report described a design error associated with documentation associated with the Low Pressure Service Water System Piping. The appropriate design documents will be corrected along with the FSAR. Based on this action this item is closed.

(Closed) LER 269/87-08: A Direct Pathway From Containment To The Environment During Fuel Movement Resulting In A Violation of Technical Specifications. This occurrence is addressed by Violation 269,270,287/87-49-01: Failure to Maintain Containment Integrity During Refueling Operations. This item is closed since the corrective actions will be reviewed during followup of the violation.

(Closed) LER 269/87-10: Manual Reactor Trip Due to a Component Failure During Startup Physics Testing. This trip occurred due to a failed component in the control rod actuation circuits. The malfunction was identified, corrected and the unit returned to power operation. The licensee performed required post trip reviews and analysis. Based on this action, this item is closed.

(Closed) LER 287/87-05: Reactor Coolant System Cooldown In Excess of Technical Specification Limits. The details of this event are addressed in LER 287/87-05 dated June 2, 1987. The inspectors reviewed this event in detail and reviewed the corrective action taken by the licensee. Based on this review, this item is closed.

(Closed) Inspection Followup Item (50-269/87-48-02): Containment Isolation Valve 1N-106 Open. As discussed in Inspection Report 87-48, this item remained open pending further investigation. The licensee has completed its investigation and the resident inspectors have reviewed the

investigation and corrective action in detail. This item is discussed further in section 4 of this report.

9. Safety System Functional Inspection Report (92701)

Items left open on the referenced inspection report (50-269,270,287/86-16) were reviewed to determine current status, as follows:

- a. (Closed) Open Item (50-269,270,287/86-16-02): Adequacy of the Design of Safety Related Inverters. This item concerned the potential to operate Unit 3 safety-related inverters below their design input voltage when being supplied power from Unit 1. A calculation was performed on June 12, 1986, as detailed in DPC document OSC-2176 indicated that the inverter terminal voltages in the lineup specified above were below the equipment operating voltages. Subsequent to this calculation a test was performed TI/O/B/3001/010, Spare Exide Inverter Half Load, Low Voltage Test, in July of 1976 which determined the lowest input voltage at which an inverter will still function with an output load one-half of the rated inverter output. Based on the test results, the inverter operation was determined to be acceptable in an alignment which would produce the worst voltage drop conditions expected during potential operating conditions. Based on this review this item is closed.
- b. (Closed) Open Item (50-269,270,287/86-16-04): Battery Design Basis. This item was concerned with questions on whether the design basis for any one unit's battery was that the battery could carry the load of one entire unit (4 panelboards total) as specified in TS bases or one batteries own load plus one additional panelboard (3 panelboards total). Discussions with design engineering and plant personnel indicate that the plant original design basis, as determined by calculations, was that a battery would carry its own load plus an additional panelboard. Subsequent calculations and battery load shed testing have shown that each battery is capable of carrying the load for one entire unit as discussed in TS section 3.7 bases. The licensee has completed its review of this area and determined that a change to the TS is not required. Based on this information and review by the inspector, this item is closed.

10. Meeting with Public Officials (94600)

On February 2 at 7:00 p.m., the inspectors met with local officials from Oconee County. The residents made a presentation that introduced the inspectors, discussed the NRC responsibilities both in Washington and in Region II, provided local officials with names of NRC supervisory personnel and phone numbers locally and in Atlanta, and answered questions of concerns that were raised. Prior to the meeting, the inspector visited the satellite public document room (PDR) at Cooper Library on the Clemson University campus. The PDR was not up to date and not being maintained as a PDR. Discussions with the custodian indicated that the facility had not been used for several years. Based on the review of the PDR, the

inspector recommended to Region II and to the Document Control Branch that this PDR be discontinued.

The following local county representatives were present at the meeting.

Mr. Norman Crain, Oconee County Supervisor, Chairman
Mr. Larry Butts, District 4 Supervisor
Mr. Jerry Dyar, District 2 Supervisor
Dr. Julius Earle, District 1 Supervisor
Mr. Mike Harper, District 3 Supervisor
Mr. Alton Williams, District 5 Supervisor
Mayor Gladys D. Pepper of Walhalla

The attached outline was provided each of the interested personnel present.



0217/BB 12:05
2 P

UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
101 MARIETTA ST., N.W., SUITE 3100
ATLANTA, GEORGIA 30303

NUCLEAR REGULATORY COMMISSION
MEETING WITH LOCAL OFFICIALS

FROM NRC Ocone
Jan. 88

I. Purpose of Meeting:

- A. Introduce local NRC people.
- B. Provide an overview of the NRC.
- C. Provide phone numbers of NRC offices.
- D. Answer questions.

II. NRC Overview:

A. Background;

1. Atomic Energy Act of 1954 (AEC)
2. Energy Reorganization Act of 1974 (NRC/ERDA)

B. Organization;

1. Commission (Lando Zech Chairman, Kenneth Carr, Frederick Bernthal, Thomas Roberts, and Kenneth Rogers)
 - a. Licensing Boards.
 - b. Scientific Advisory Committees.
 - c. Various Program Offices.
 - d. NRC Regional Offices.
2. Region II, Atlanta: (10 Southeastern states plus Puerto Rico and Virgin Islands.)

C. Functions;

1. Support of international agencies.
2. Control of import and export of nuclear materials.
3. Safety research and standards development.
4. Regulation of nuclear waste.
5. Regulation of nuclear materials.
6. Regulate uranium mining and the fuel process.
7. Regulation, including licensing and inspection of nuclear power plants.
8. Public information source (PDR Ocone County Library at Walhalla and Robert M. Cooper Library at Clemson Univ.)

D. Inspection programs;

1. Regional.
2. Resident-two full-time inspectors at Ocone.
 - a. Increased inspection (more inspection per dollar).
 - b. Immediate availability.
 - c. Better able to assess licensee performance.
 - d. Availability to local people.



**UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
101 MARIETTA ST., N.W., SUITE 3100
ATLANTA, GEORGIA 30303**

3. Authority-\$100,000/Violation/day statutory limit.
4. NRC serves as a center for reporting of problems.

Nuclear Power Plants in the United States



Key
 ● Reactors With Operating Licenses
 ○ Reactors With Construction Permit
 △ Reactors On Order

91 Reactors operable	76,679 MWe
36 Reactors with construction permits	39,842 MWe
2 Reactors on order	2,240 MWe
129 Total	118,761 MWe

January 1, 1985

Atomic Industrial Forum, Inc.

*Also shown on the map are two reactors with operating licenses but shut down indefinitely: Three Mile Island 1 - 819 MWe; Three Mile Island 2 - 819 MWe

FIGURE 2

SOUTH EAST

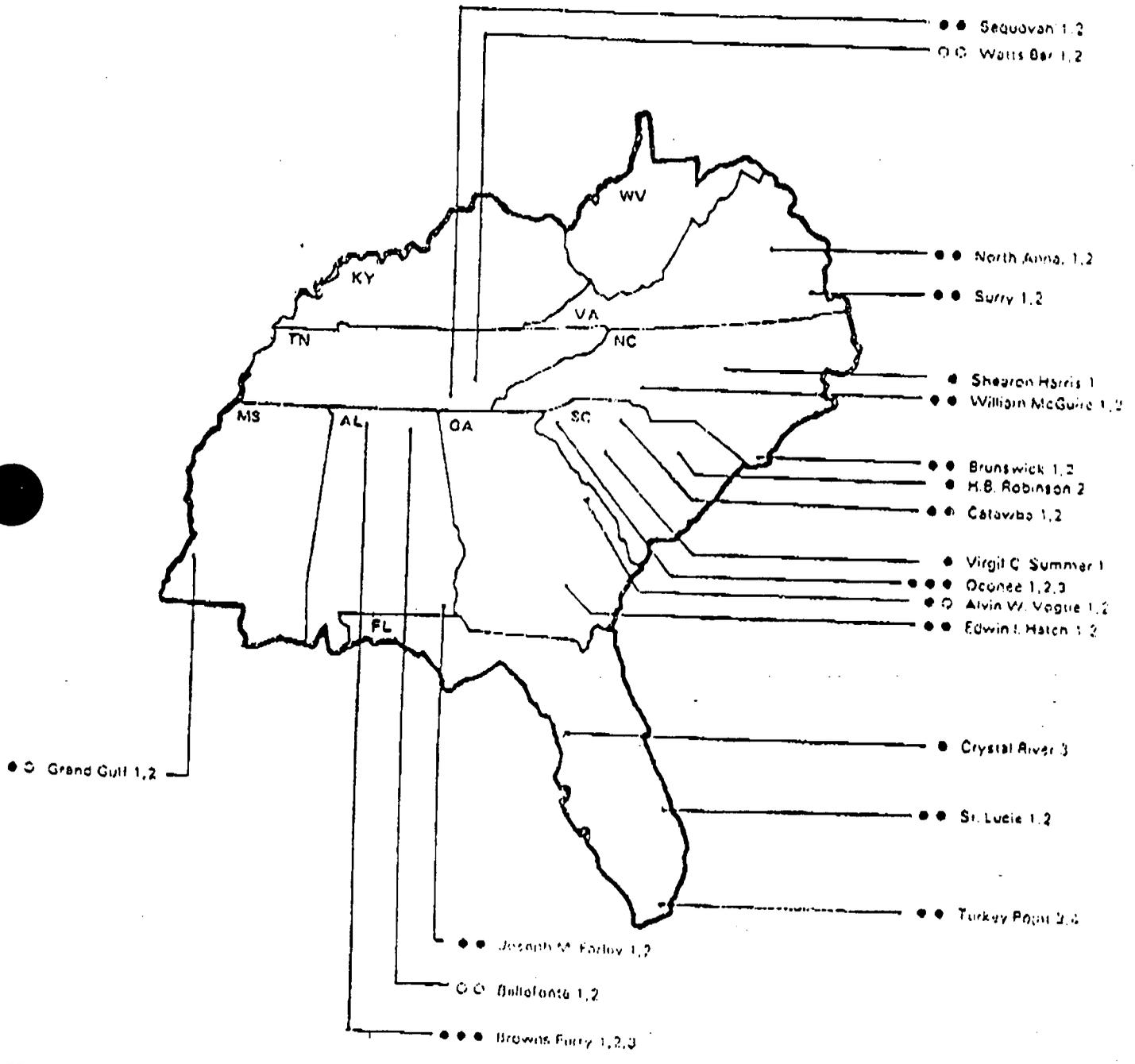


FIGURE 3

ORGANIZATION CHART

U.S. NUCLEAR REGULATORY COMMISSION

NRC ACCEPTS COLLECT CALLS AT
OCONEE NUCLEAR STATION AND AT
ATLANTA OFFICE AT
404-331-4503

REGION 11
Executes established NRC policies and assigned programs relating to inspection, licensing, enforcement and governmental liaison within Regional boundaries.
Administrator J. Nelson Grace
Deputy Administrator Malcolm L. Ernst \$5500

Public Affairs Staff
Implements the NRC policies and programs for Public Affairs in the Region.
Director Kenneth H. Clark
\$5503

Regional Counsel
Advises the Regional Administrator on legal issues.
Regional Counsel Richard J. Goddard

State and Governmental Affairs Staff
Provides State and Governmental liaison and conducts the Agreement States Program.
Director Robert E. Trojanowski
\$5597

Enforcement and Investigation Coordination Staff
Implements enforcement policy in the Region and coordinates allegation investigation activities.
Director George R. Perkins

DIVISION OF REACTOR PROJECTS
Implements and coordinates all project management activities related to the regulation of all non-NVA nuclear power and research reactor facilities under construction and/or operation.
Director Louis Reyes
Deputy Director William Heil
\$5179

DIVISION OF RADIATION SAFETY AND SAFEGUARDS
Performs inspections and evaluations in emergency planning, radiological safety, material control and accountability, physical security, and environmental monitoring. Administers materials licensing program and conducts independent measurements program. Prepares for regional response to licensee emergencies.
Director J. Phillip Storr

DIVISION OF RESOURCE MANAGEMENT AND ADMINISTRATION
Manages all administrative functions in the Region, including planning, coordinating, directing, and administering the financial, human, and property resources of the Region.
Director Richard J. Hale

DIVISION OF REACTOR SAFETY
Executes an inspection program in the functional areas of electrical, civil, chemical, mechanical, nuclear, and human engineering nuclear physics; management and QA systems; and facility operations for all reactor programs within the Region. Manages the Regional operator licensing program.
Director Albert F. Dill
Deputy Director

Reactor Projects Branch 1
Plans, directs, coordinates, and supervises the project management functions and the programs and activities of Reactor Project Sections.
Chief David M. Verrelli

Reactor Projects Branch 3
Plans, directs, coordinates, and supervises the project management functions and the programs and activities of Reactor Project Sections.
Chief Virg. L. Brownlee
\$5583

Technical Support Staff
Develops and maintains data and records on priorities, schedules, assignments, and the status of all non-NVA reactor projects and tasks. Also develops, coordinates, and issues abnormal occurrence reports, and oversees Regional SALP program.
Chief Kerry B. Landis

Emergency Preparedness and Radiological Protection Branch
Plans, directs, coordinates, and supervises the program and activities of the Facilities Radiological Protection, Radiological Effluents and Chemistry, and the Emergency Preparedness Sections.
Chief Douglas H. Collins

Nuclear Materials Safety and Safeguards Branch
Plans, directs, coordinates and supervises the programs and activities of the Nuclear Materials Safety, Material Control and Accountability, and Physical Security Sections.
Chief William E. Elme

SECTION CHIEF
THOMAS PEEBLES
\$4196

SR. RESIDENT INSPECTOR
PIERCE SKINNER
RESIDENT INSPECTOR
LEN WERT

Resource Management Branch
Performs budgeting, accounting, travel, contract administration, purchasing, procurement of goods and services, property management, and Regional imprest fund administration.
Chief Thomas M. Loy

Personnel Staff
Performs recruitment, training, position evaluation, appointment of consultants, labor relations, time and attendance reporting, and equal employment opportunity administration.
Personnel Officer Theresa D. Spearman

Administrative Management Branch
Performs records and files management, information and data processing, Freedom of Information Act functions, facility security program activities, space and license fee management, and telecommunications services.
Chief Jeffrey B. Lanford

Engineering Branch
Plans, directs, coordinates and supervises the programs and activities of the Materials and Mechanical, Test Programs and Plant Systems Sections.
Chief Alan J. Hertz

Operations Branch
Plans, directs, coordinates and supervises the programs and activities of the Operator Licensing, Quality Assurance Programs and Operational Programs Section.
Chief Caudle - Julia

ONS NRC OFFICE
882-6927 (RECORDER AVAILABLE)
SKINNER
882-1299 (HOME)
WERT
882-4822 (HOME)

* ALL PHONE NUMBER 1-404-331

FIGURE 1

FROM NRC OCONEE 02/17/88 12:09 P. 7 TOTAL P. 7