

ENCLOSURE 2

U.S. NUCLEAR REGULATORY COMMISSION
REGION IV

Docket Nos.: 50-275
50-323

License Nos.: DPR-80
DPR-82

Report No.: 50-275/97-01
50-323/97-01

Licensee: Pacific Gas and Electric Company

Facility: Diablo Canyon Nuclear Power Plant, Units 1 and 2

Location: 7 1/2 miles NW of Avila Beach
Avila Beach, California

Dates: April 14 through May 2, 1997

Inspectors: T. O. McKernon, Lead Inspector, Operations Branch
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Approved By: J. L. Pellet, Chief, Operations Branch

ATTACHMENTS:

Attachment 1: Supplemental Information

Attachment 2: Simulator Facility Report



EXECUTIVE SUMMARY

Diablo Canyon Nuclear Power Plant, Units 1 and 2
NRC Inspection Report 50-275/97-01; 50-323/97-01

This multi-focused inspection included a review of the licensed operator requalification program, a review of a submitted draft initial licensed operator examination, a followup to open items, and sustained observations of control room activities, and Unit 1 outage control activities. The inspection covered the period from April 14 through May 2, 1997.

Operations

- Inspectors observed good control room coordination between the shift foreman and the other shift crew members. Good linkage between the shift foreman and the senior control operator was observed during abnormal condition response (Section O1.4).
- Inconsistent linkage between the shift foreman and the senior control operator was observed during some requalification examinations, contrary to the performance observed in the control room. This remains an issue warranting licensee management attention. This issue, also identified by licensee evaluators resulted in crew and individual failures of the requalification examination and remediation (Section O4.1).
- Although not firmly established, the control room staff practiced three-way communications (Section O1.4).
- Inspectors observed some inconsistent oversight of the shift crews by the shift supervisors (Section O1.4).
- Overall, the licensed operator requalification program was acceptable (Section O4.1).
- Licensed operator requalification examinations were well constructed, challenging, and discriminated at the appropriate knowledge levels (Section O5.2).
- Inspectors observed professional and consistent performance on the part of licensed operator requalification evaluators. Evaluators conducted good critiques of the crews and individual strengths and weaknesses were effectively identified. (Section O5.3).
- The remedial training program was adequate (Section O5.4)
- An apparent violation of Technical Specification with two examples related to the respiratory protection program was identified (Section O5.5).



- A submitted draft initial licensed operator examination was considered inadequate for administration, in that, portions of the operating test were narrower in scope than the guidance provided in NUREG-1021 (Section O5.1).



Report Details

Summary of Plant Status

Unit 1 entered Refueling Outage 1R8. Major work activities included valve repairs on the residual heat removal system, Diesel Generator 1-3 maintenance, testing, and replacement of the station batteries, Charging Pump 1-1 maintenance and replacement, and others.

Unit 2 remained at 100 percent power during this inspection period. No major equipment problems or transients were experienced.

I. Operations

O1 Conduct of Operations

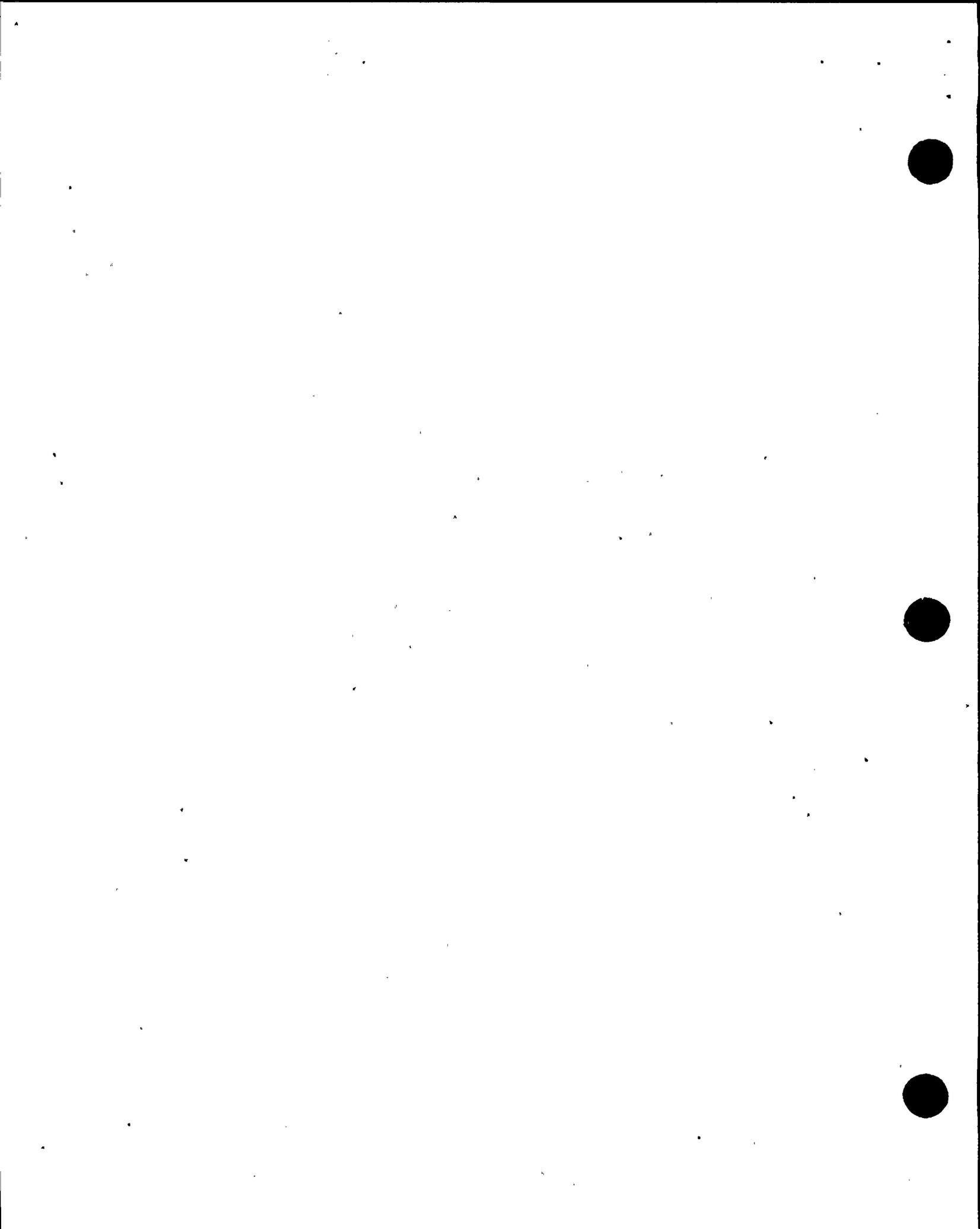
O1.4 Conduct of Operations - Extended Control Room Observations

a. Inspection Scope (71715)

During the period of April 28 to May 1, 1997, independent observations of control room activities were conducted with a focus on the Unit 1 outage activities. The objective of the observations was to evaluate control room performance by the operators, crew command and control, communication practices, work control, and procedure usage. The inspectors observed a number of outage management meetings, control room shift briefings, prejob briefings, shift turnover briefings, annunciator acknowledgments and responses, surveillance tests, and conducted interviews with selected key personnel.

b. Observations and Findings

Overall, communications were effective, but the application of formal three-way communications was inconsistent. Three-way formal communications was a recent management expectation and it was apparent that its use was not yet firmly established in the control room staff. Quite often, the receiver of the instructions had to be prompted to repeat them back and, in other instances, the communication lapsed into informal practices. For example, during initial fuel assembly removal, the operator in the control room and the communicator on the refueling floor in the containment had difficulty communicating the requirement for the fuel upender machine to be secured prior to the fuel handlers on the refuel bridge grappling another fuel assembly. This confusion appeared, in part, due to not completing the third leg of the three-way communications. At other times, the control room staff



did utilize three-way communications effectively when giving task instructions to plant personnel and reporting critical information. The inspectors also heard plant operators employ proper three-way communications on the plant radios. Despite the lapses in communication practices, communications by the licensed operators was improved over that observed during the prior year's requalification program inspection.

Shift management oversight of activities in the control room was effective. There was good linkage between the shift foreman, other members of the shift crew, and responsible test engineers. The senior control operator and shift foreman demonstrated good linkage during observed abnormal situations. For example, at one point during fuel movement a containment evacuation alarm annunciated at the same time an area high radiation alarm and a smoke detector alarm annunciated. The operators responded promptly to the alarms under the direction of the shift foreman. The reasons for the alarms were promptly identified and plant announcements made. Additionally, during a medical emergency in containment and a flooding event in the auxiliary saltwater intake structure caused by leaking check valves, the situations were properly evaluated by control room personnel and appropriate instructions were provided to field personnel. Proper public address announcements were made to alert plant personnel to the events in progress.

Appropriate briefings between control room personnel and technicians were conducted prior to commencing plant work activities, which could impact plant safety. The inspectors witnessed a briefing conducted by the shift foreman, which related to manipulating relays in energized 13.8 kV breaker enclosures. The work activity and potential effects on plant electrical distribution, as it related to the outage safety plan, were discussed in detail. Briefings on other important work activities, which were not expected to have a direct effect on plant safety, were appropriately conducted by the assistant shift foreman.

Routine work activities for plant operators were effectively controlled. The inspectors witnessed assignment of an activity involving cross-tying emergency diesel generator air compressors. The sequence of the work activities and the appropriate procedure steps were properly specified. The performer demonstrated his understanding of the task by repeating the instructions.

For the outage unit, shift turnover began an hour prior to shift change. The inspectors observed that logs and turnover checklists were properly reviewed and a comprehensive control board walkdown was performed by the oncoming operator accompanied by the offgoing operator. Prior to assuming the watch, the oncoming crew conducted an all hands meeting. Crew members summarized the status of equipment under their jurisdiction and expected work activities. The operations liaison to the outage control center also provided an overview of outage work status and expected outage work for the upcoming shift. The overall information exchange was effective and all crew members were cognizant of their responsibilities.



The inspectors attended outage control center critical activities and shift turnover meetings. The operations liaison provided appropriate input on plant operational considerations as they affected scheduled work. All participants demonstrated appropriate concern for plant operational and safety considerations.

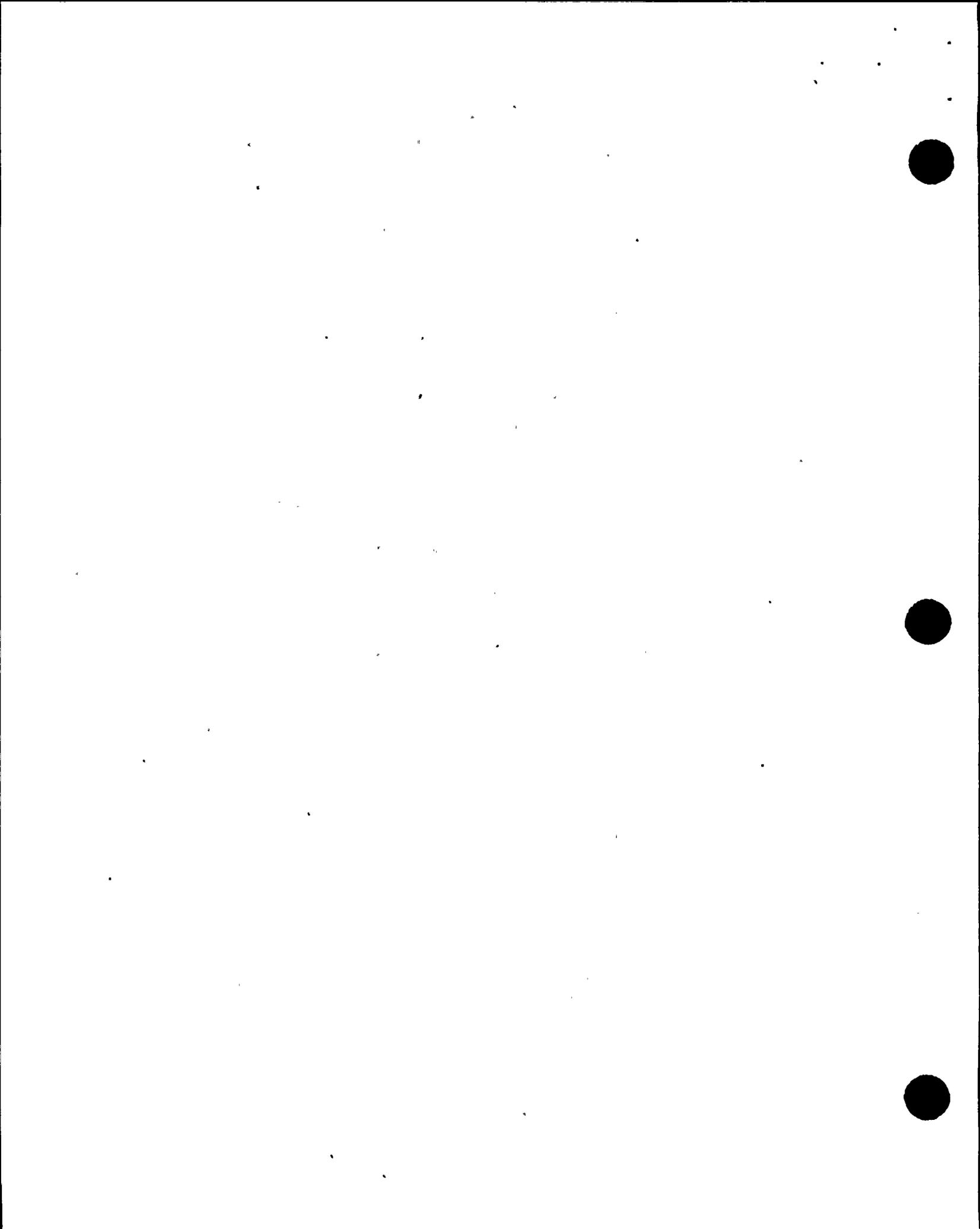
Operations personnel exhibited heightened sensitivity to previous problems with ground buggy installation on major electrical equipment. The inspectors observed restoration of Engineered Safety Feature Bus F. An operator and the shift technical advisor performed a deliberate walkdown prior to energizing the bus where they checked for proper fuse alignment, ground buggy installation and door bolting. The inspectors discussed the transformer explosion from the previous outage with several operators and the shift foreman. All were well aware of the causes and how improper ground buggy installation contributed to the event.

Peer checking was used on control panel manipulations. The inspectors observed the unloading portion of the overspeed test on Emergency Diesel Generator 1-3. This was performed in accordance with Procedure STP M-9B, "Overspeed Trip Test of Diesel Generators," Revision 17. During the evolution, control room operators self-checked and peer-checked each step of the procedure as it was performed. The peer-checker read the procedure and verified the operator was performing the steps on the proper equipment.

Prejob briefings were conducted in a thorough and formal manner. Prior to restoring Engineered Safety Feature Bus F to service the shift foreman specifically warned operators how ground buggies should be installed. Prior to performing the overspeed test on Emergency Diesel Generator 1-3 the shift foreman emphasized to operations and test personnel involved the precautions and limitations in the procedure, specifically the maximum speed on the diesel.

In some instances, inconsistent shift supervisor to shift crew interaction and oversight was observed. While one shift supervisor involved himself in oversight of unanticipated annunciator responses and prebriefings, as well as, shift turnover briefings, another shift supervisor limited his involvement to shift turnover and a few status briefings by the shift foreman. The inspectors noted that the licensee's expectations for shift supervisor shift crew involvement was not specifically delineated. Procedure OP1.DC10, Revision 3, stated that the shift supervisor responsibility was for direction of the shift foreman and for providing overall coordination of all plant activities. The procedure did not set forth management's expectation as to the amount of shift supervisor to crew involvement. The licensee management representative acknowledged the observation and stated that more consistent involvement in interactions was an area for improvement.

The inspectors observed one instance in which there appeared to be a lapse in communication between the clearance coordinator and the shift foreman, which related to the status of control board clearance tags. During the preparation for re-energization of the 4 kV Bus F, the shift foreman noted a control board



information tag on the 480 volt Bus F. Prior to re-energizing the 4 kV bus the shift foreman had personnel physically verify no grounding straps were installed on the 480 volt bus and verified all work activities on the 480 volt bus had been reported complete and ready for testing. The inspectors noted that Procedure OP2.ID1, Revision 7, required the clearance coordinator to inform the shift foreman when it was appropriate to have the operators remove control board information tags. This example represented good oversight by the shift foreman and cautious actions taken prior to re-energizing the 4 kV bus. No safety concern or personnel hazard existed. The licensee initiated an event trending record to track the administrative error. Because of this example, the inspectors reviewed training provided on the clearance request process prior to entering the 1R8 Refueling Outage. The inspectors verified that clearance training had been provided to both licensed and non-licensed operators between February 10 and March 14, 1997. The training, a 2-hour class, included familiarization with the clearance procedure, how to manipulate clearances, and a practical exercise in making a master clearance and subclearances. The inspectors considered the training appropriate and comprehensive.

c. Conclusions

Control room communications, command, and control were effective. Although it was not a uniformly implemented practice, the control room staff normally practiced formal three-way communications when providing instructions and reporting critical information. Prejob briefings and peer-checking were used properly. Shift turnover was effective and crew members demonstrated a good understanding of plant status and work activities. Communications and coordination of work between the control room and the outage control center was effective. Some variance in shift supervisor to shift crew interaction was observed.

There was good linkage between the shift foreman and the operating crew members during responses to abnormal conditions.

O4 **Operator Knowledge and Performance**

O4.1 Operator Performance on Annual Requalification Examinations

a. Inspection Scope (71001)

The inspectors observed the performance of two shift crew groups and one staff crew group during their annual requalification evaluations. Each shift crew group was composed of five active licensed operators and one shift technical advisor. The staff crew group was a composite group of licensed shift operators, inactive licenses, a certified trainer, and one shift technical advisor. The 2-year licensed operator requalification cycle began with Session 95-1 on June 19, 1995, and



ended for licensed operators with Session 96-7 on April 18, 1997, for a total of 14 sessions. The cycle included two annual operating examinations during Sessions 95-8 (May 21 through June 21, 1996) and 96-7 (March 15 through April 18, 1997). These operating tests included simulator dynamic performance evaluations and five job performance measures for each licensed operator. Also included was a written examination during Session 96-7 for each operator consisting of an open reference examination.

b. Observations and Findings

The inspectors observed a portion of Session 96-7 biennial examination during the week of April 14, 1997. All three crew groups observed passed all portions of their evaluations. However, one individual on the staff (composite) crew group failed the dynamic simulator evaluation. Additionally, a shift crew failed the dynamic simulator evaluation during the first week of requalification examinations administered prior to this inspection period.

The cause for the failures was primarily performance deficiencies in crew oversight, communication, and procedure usage skills. The licensee's practice was that the senior control operator serve as a procedure reader during abnormal and emergency evolutions, allowing the shift foreman to focus attention on plant conditions and procedure entry conditions and transitions. The inspectors observed inconsistent linkage between the senior control operator, a licensed reactor operator, the shift foreman, and a licensed senior reactor operator. The inspectors were concerned because there were times when the shift foreman was not aware of changing plant conditions and responses directed by the senior control operator and was unaware that errors in procedure usage occurred, such that the incorrect emergency operating procedures were being implemented.

In one instance, the shift foreman failed to conduct tailboards prior to transitioning between emergency procedures and failed to inform the shift supervisor of the transition. In another instance, the shift foreman was unaware that the primary operator had been directed to secure the residual heat removal pumps during cold-leg recirculation swapover and had performed the actions. During such instances, the senior control operator appeared to direct other reactor operators during emergency scenario conditions, while reading the emergency procedures. While the senior control operator's actions were not considered sufficient to justify a failure, the importance of the senior control operator informing and getting the concurrence of the shift foreman of actions was reinforced by the licensee evaluations during the crew critiques.



The inspectors were concerned with the shift foreman and senior control operator linkage issue because only a senior operator is licensed by 10 CFR 55 to direct reactor operators. This issue had been previously identified during NRC inspections (e.g., 50-275;-323/95-04 performed in June 1995). The inspectors pointed out to the licensee staff that the policy to allow the senior control operator to read the emergency and abnormal procedures was vulnerable because it could, at times, result in a violation of regulations when a breakdown of the shift foreman to senior control operator linkage occurred.

The licensee's staff acknowledged this vulnerability and agreed to reevaluate the policy and also strengthen the linkage between the senior control operator and shift foreman through their training feedback system.

Except for the examples discussed above, operator performance in the simulator was consistent with that observed in the control room. Inspectors did not observe a similar shift foreman to senior control operator linkage problem in the control room during abnormal conditions response. During stressful simulator scenario conditions, formal three-leg communications broke down at times and lapsed into informal communications. This weakness was most obvious in the crew group discussed above, but also apparent, to a lesser degree, in the other two groups evaluated during this session. The inspectors also observed that the shift technical advisors demonstrated more involvement in assisting the crews than in previous inspections. This was evidenced by shift technical advisors making helpful observations on required component settings and monitoring vital components.

The licensee's staff acknowledged that crew communications weaknesses had been identified and improvements incorporated into the training program through the feedback process.

c. Conclusions

The inspectors concluded that, with the exception of the one crew failure and an individual failure in the dynamic simulator portion of the requalification examination, which were primarily caused by performance deficiencies in crew oversight, communication, and procedure usage, the licensed operators exhibited good knowledge and ability during the requalification examinations.

The inspectors concluded the licensee requalification program was acceptable.

Shift management issues related to inconsistent linkage between the shift foreman and the senior control operator remains an issue warranting licensee management attention.



O5 Operator Training and Qualification

O5.1 Initial Licensing Examination Development

The facility licensee developed an initial licensing examination in accordance with guidance provided in Generic Letter 95-06, "Changes in the Operator Licensing Program." However, prior to administration the licensee decided to withdraw the application. As such, the planned licensed operator examination was cancelled. The following provides observations as to the licensee developed draft examination.

O5.1.1 Examination Outline

a. Scope

The licensee submitted the initial examination outlines on February 14, 1997. The chief examiner reviewed the submittals against the requirements of NUREG-1021, "Licensed Operator Examiner Standards," Revision 7, Supplement 1, and NUREG/BR-0122, "Examiner's Handbook for Developing Operator Licensing Written Examinations," Revision 5.

b. Observations and Findings

The chief examiner determined that the initial examination outlines satisfied the above requirements. However, minor changes to the written examination were made so that a more evenly weighted distribution would be achieved in Group III of plant systems. The chief examiner also noted that the job performance measures outline did not meet the requirements of NUREG-1021/ES-201 in that there was direct overlap between Job Performance Measure 7 and Event 5 of Scenario 2. Other observations by the examiner were minor. The comments on the outline were discussed with the licensee author and revisions were made and submitted along with the draft examination.

c. Conclusion

With the exception of the inadequate job performance measure outline, the licensee submitted generally good examination outlines.

O5.1.2 Draft Initial Examination Package

a. Scope

On March 10, 1997, the licensee submitted a draft initial reactor operator examination developed under the guidance of the pilot examination program. The chief examiner reviewed the draft examination and provided comments to the licensee author and supervisor on April 14, 1997.



b. Observations and Findings

The chief examiner reviewed the draft initial examination and determined that with the exception of the operating portion of the test, the examination was adequate. The written examination and the scenarios needed only minor enhancements. However, the administrative and walkthrough portions of the operating test were not adequate for examination administration. Several of the administrative and job performance measure followup questions were considered direct lookups. Some job performance measure followup questions were constructed such that multiple answers were required. In another instance, a job performance measure was considered overly simplistic in that it contained only one active step and was considered to discriminate poorly. The walkthrough portion of the operating test failed to meet the quality assurance checklist, "Examiner Standard 301-?", items 3a, b, and d of NUREG 1021, Revision 7, Supplement 1.

c. Conclusion

The chief examiner concluded that the draft initial examination was not adequate for administration in that portions of the operating test were narrower in scope than the guidance provided in the examination standard, NUREG-1021.

O5.2 Review of Requalification Examinations

a. Inspection Scope (71001)

The inspectors performed a review of the annual requalification examinations, including operating tests and biennial written examination, to evaluate general quality, construction, and difficulty level. The inspectors also reviewed the methodology for developing the requalification examinations.

b. Observations and Findings

The operating examinations consisted of job performance measures and dynamic simulator scenarios. The scenarios followed the guidelines of NUREG 1021, "Operator Licensing Examiner Standards," Revision 7, Supplement 1, in complexity and quantitative event requirements. The scenarios were written with clear objectives, expected operator actions, and critical task identification and evaluation criteria. The job performance measures were adequate in scope and depth, and covered a broad range of topics as required by the training program and the regulations. Critical steps in the job tasks were appropriately identified.

The inspectors determined that the written examinations were of the appropriate breadth of coverage and depth of knowledge, and of particularly effective discriminating value.



c. Conclusions

The inspectors concluded that the requalification examinations were well constructed, challenging, and discriminated at the appropriate knowledge level.

O5.3 Requalification Examination Administration

a. Inspection Scope (71001)

The inspectors observed the administration of all aspects of the requalification examinations to determine the evaluators' abilities to administer an examination and assess adequate performance through measurable criteria. The inspectors also observed the plant simulator to support training and examination administration. Five licensed operator requalification training evaluators and one operations management evaluator were observed participating in one or more aspects of administering the examinations, including pre-examination briefings, observations of operator performance, individual and group evaluations of observations, techniques for job performance measure cuing, and final evaluation documentation. Additionally, the feedback system for entering training information and modifying the requalification training was reviewed.

b. Observations and Findings

The evaluators conducted the examinations professionally, and thoroughly documented observations for later evaluation. Job performance measure cues were provided appropriately as needed, with no inadvertent cuing observed.

A formal evaluation method was used that reviewed crew and individual critical tasks following the scenario observations, and then competencies for the crew and for individuals when appropriate. During the simulator evaluations, the inspectors noted that the evaluator staff was particularly effective in identifying and properly categorizing operator performance deficiencies and weaknesses. The inspectors also observed strong operations staff participation. A representative from the operations department performed the crew evaluation in the simulator and was involved with making the pass/fail decision for the crew. The post-scenario examination evaluation caucuses were well organized and efficient with the evaluation team reaching an accurate consensus on performance results. This evaluation method minimized overall crew stress. The inspectors observed that the crews held independent self-critical caucuses, led by their shift supervisors, who were also involved with developing remediation plans, when necessary. The inspectors also observed that shift supervisor ownership for crew and individual performance was a management expectation and was apparent in most cases.

The inspectors observed that the performance of the simulator in supporting the examination process was good. Simulator issues were not observed during the examination (see Attachment 2).



The inspectors also reviewed operator classroom and simulator critiques for the month of January 1997. Also reviewed were training steering committee meeting minutes and event trend report information input into operator training. Overall, the training department appeared responsive to operator feedback and had recently started providing a direct response to comments using the licensee's e-mail system. The training department also presented the disposition of operator training feedback comments to the training steering committee. This appeared to be a proactive initiative and provided a mechanism for establishing direct accountability of the training department to operations. Event trend records which are utilized to document lower threshold problems that do not require specific corrective actions were also tracked and trended. The summaries of the records were also presented to the training steering committee to determine whether specific training was required for any specific area of operator performance.

c. Conclusions

The facility evaluators administered the examinations professionally and consistently. The facility evaluators effectively identified strengths and weaknesses in crew and individual performance and conducted good critiques. Training needs were being fed back into the training program.

05.4 Remedial Training Program Review

a. Inspection Scope (71001)

The inspectors assessed the adequacy of the effectiveness of the remedial training conducted during this requalification cycle and the training planned for the next cycle to ensure that it addressed operator or crew performance weaknesses. The inspectors also reviewed simulator documentation records for requalification examinations administered during 1995 and 1996 to ascertain whether evaluations were consistent between crews, and individuals. Records associated with remediation were additionally reviewed to determine if the planned remediation was appropriate and timely.

b. Observations and Findings

The inspectors reviewed the observed failed crew groups' short-term remedial training documentation process and the documentation for other crew and individual failures that had occurred throughout the requalification cycle. The inspectors determined that the short-term remedial training was effective. The inspectors determined that of the 12 previous requalification training sessions and two evaluation sessions, each session consisted of approximately 15 crew groups of 5 licensed operators and 1 shift technical advisor. During this requalification cycle



examination, 1 of the crew groups and 5 individuals failed in the simulator, no individuals failed the written, and two individuals failed the job performance measures portion of the operating test. The inspectors assessed that these failure rates were not excessive and were consistent with other industry licensed operator requalification training programs.

In addition to the above, a review of past requalification results documentation indicated that the bases used by evaluators for determining pass/fail grades were consistently applied. For those individuals, which required remediation, the remediation plans were well documented and the remediation was timely. For example, during the 1996 licensed operator requalification examination simulator scenarios utilizing Functional Recovery Procedure FR-S.1, "Response to Nuclear Power Generation/ATWS," was used in scenarios for 5 of 17 total groups. Of the 5 groups, 3 individuals failed the simulator scenarios. In all three of these cases, evaluations were consistently applied as related to six performance competency areas, individual remediation plans were well documented, and implementation of the remediation was timely.

c. Conclusions

The remedial training program was adequate. Short-term remedial training was effective. Evaluations by the training department staff and representatives of the operations department were consistently applied. Remediation was well documented and quickly implemented.

05.5 Review of Conformance with Operator License Conditions:

a. Inspection Scope (71001)

The inspectors evaluated the adequacy of the requalification program's compliance with Subpart C, Medical Requirements and 10 CFR 55.53, "License Conditions." The inspectors interviewed operators and training management, and examined the licensee's records to determine compliance for conditions to maintain an active operator license, reactivation of licenses, and medical fitness.

b. Observations and Findings

Operator license conditions were being accurately identified and tracked. However, it was determined that a number of licensed operators (approximately 26) with corrective lenses as a condition of license did not have special frames and lens for their self-contained breathing apparatuses used in the control room. The inspectors observed that the licensee's Final Safety Analysis Report, Sections 9.5B-24, 9.5B-36 and 6.4-3, indicated that self-contained breathing apparatuses are provided for fire brigade and control room personnel use, which requires that control room personnel be self-contained breathing apparatus qualified. As such, the inspectors considered the use of self-contained breathing apparatuses as design bases



contingency measure. It was also noted that Procedure RP1.ID3, "Respiratory Protection Program," requires that only special spectacle kits specified by the manufacturer of the respirator be used. Further, Procedure OM14.ID2, "Medical Examinations" required individuals with prescription eyeglasses who are required to wear a full-face respirator shall use special frames for their glasses that do not interfere with the face-piece seal. The inspectors also noted that operators would be required to wear self-contained breathing apparatus for performance of procedures under abnormal environmental conditions, (e.g., Procedure AP-8B, "Control Room Inaccessibility - Hot Shutdown to Cold Shutdown." This was an example of an apparent violation of Technical Specification 6.8.1a for a failure to follow procedures, (50-275;-323/9701-01).

Further, as a result of the inspector's questions with regard to licensed operator usage of self-contained breathing apparatuses, the licensee performed data base searches of the plant information management system and licensed operator qualifications. The licensee determined that approximately 75 percent of the licensed watchstanders had not completed the annual refresher training for self-contained breathing apparatus. Procedure OD1.DC37, Attachment 6.4, specifies that, ". . . operators fulfilling a minimum shift crew position must be a qualified respirator user." Since the only available respirators in the control room for operator use are self-contained breathing apparatuses, licensed operators onshift in the control room are required to be self-contained breathing apparatuses qualified. The Respirator Training Procedure, TQ1.DC20, steps 2.1-2.3, describes the respirator training program as a two-part training program consisting of initial training and an annual followup refresher training course. The followup annual refresher training course is designed to provide training on new equipment or procedures and work practices, as well as, check proficiency in the initial cognitive objectives which include proper actions for abnormal or emergency situations. However, it was this annual refresher with which many of the licensed operators standing watch were not current. This was a second example of a failure to follow procedures and an apparent violation of Technical Specification 6.8.1a (50-275;-323/9701-01).

As corrective actions, the licensee conducted "Just in Time" training for individuals coming onto the watch bill to assure watchstanders were current in annual self-contained breathing apparatuses training. The licensee also initiated Action Request A0429503 to ensure licensed operators are provided with the required frames.



c. Conclusions

The inspectors concluded that the licensee accurately tracked, maintained, and controlled the conditions of operator licenses and reactivation of inactive licenses in accordance with Subpart C, "Medical Requirements," and 10 CFR 55.53, "License Conditions." However, the issues related to licensed operators with conditioned licenses not having the special frames for self-contained breathing apparatus and not satisfying the required annual self-contained breathing apparatus refresher training were considered examples of a procedural violation.

O8 Miscellaneous Operations Issues (92900)

O8.1 (Closed) Licensee Event Report 50-323/95004: Technical Specification 3.0.4 Not Met Due to Personnel Error

This licensee event report involved the failure to have hydrogen analyzer cell 82 operable during entry into Mode 1 and 2 while in Action A of Technical Specification 3.6.4.1. The hydrogen analyzer was determined to be inoperable due to its isolation valves being closed.

During this inspection, the inspectors verified that long-term corrective actions were taken by reviewing the event with the appropriate personnel during technical maintenance continuing training. The training was incorporated into configuration control continuing training. Lessons plans and attendance records were reviewed to verify subject matter coverage and personnel attendance.

This licensee-identified and corrected violation is being treated as a noncited violation, consistent with Section VII.B.1 of the NRC Enforcement Policy (50-275;-323/9701-02).

O8.2 (Closed) Licensee Event Report 50-323/96005: Manual Reactor Trip Upon Discovery of Digital Rod Position Indicator System Inoperability Due to Personnel Error

This licensee event report was submitted to report the inoperability of the digital rod position indicator system due to a switch being left in the test position after completion of periodic testing.

During the inspection, the inspectors verified that the applicable Procedures MP I-1.6-1, Revision 2, and MP I-1.10-1 were revised to add verification steps to ensure the S7 test switches on the data input/output cards are left in the correct position following testing.

This licensee-identified and corrected violation is being treated as a noncited violation, consistent with Section VII.B.1 of the NRC Enforcement Policy (50-275;-323/9701-03).



08.3 (Closed) Violation 50-275/9602-03;50-323/9602-03: Failure to Complete Proficiency Training Required by Procedure TQ1.DC12 and the Updated Final Safety Analysis Report for Individuals Assigned to the Fire Brigade

This violation involved the failure to adequately train fire brigade members in that onshift watchstanders did not complete biennial training requirements.

During this inspection, the inspector verified that long-term corrective actions were implemented to resolve the cited violation. The licensee had revised controlling procedures to provide the additional guidance necessary for the individual making up the fire brigade list for the applicable shift have the fire brigade leader and members status and qualifications listing available to him in the plant information management system. A watch bill listing along with a fire brigade member report were verified for April 22, 1997. No discrepancies were identified.

IV. Plant Support

F8 Miscellaneous Fire Protection Issues

F8.1 General Comments

The inspectors observed general plant housekeeping incident to administration of the in-plant job performance section of the operating test. The facility was reasonably clean, well lighted, and the floors were clear and free from debris. The operators were conscientious to note discrepancies and inform the main control room.

V. Management Meetings

X1 Exit Meeting Summary

The inspectors presented the inspection results to members of the licensee management at the conclusion of the inspection on May 2, 1997. The licensee acknowledged the findings presented.

The licensee did not identify as proprietary any information or materials examined during the inspection.



ATTACHMENT 1

SUPPLEMENTAL INFORMATION
PARTIAL LIST OF PERSONS CONTACTED

Licensee

D. Adams, Nuclear Quality Services
J. Becker, Operations Director
C. Belmont, Nuclear Quality Services, Director
W. Crockett, Nuclear Quality Services
S. David, Operations Foreman
S. Fridley Operations Services Manager
S. Ketelsen, Regulatory Services
S. LaForce, Regulatory Services
R. Martin, Regulatory Services
J. Molden, Operations Manager
D. Oafley, Maintenance Manager
G. Rueger, Senior Vice President
B. Vatter, Learning Services

INSPECTION PROCEDURES USED

71001 Licensed Operator Requal Evaluation
71715 Extended Control Room Observations
92900 Followup

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

50-275;-323/ 9701-01	VIO	Failure to Follow Procedures Related to Respiratory Protection
50-275;-323/ 9602-03	VIO	Failure to Complete Proficiency Training Related to Fire Brigade Personnel
50-275;- 323/9701-02	NCV	Technical Specification 3.0.4 Not Met Due to Personnel Error
50-275;- 323/9701-03	NCV	Manual Reactor Trip Upon Discovery of Digital rod Position Indicator System Inoperability Due to Personnel Error

Closed

50-275;-323/ 2-95-004	LER	Technical Specification 3.0.4 Not Met Due to Personnel Error
50-275;-323/ 2-96-005	LER	Manual Reactor Trip Due to Digital Rod Position Indicator System Inoperability Due to Personnel Error



50-275;- 323/9701-02	NCV	Technical Specification 3.0.4 Not Met Due to Personnel Error
50-275;- 323/9701-03	NCV	Manual Reactor Trip Upon Discovery of Digital rod Position Indicator System Inoperability Due to Personnel Error

DOCUMENTS REVIEWED

Procedures Reviewed

TQ2.ID4, Training Program Implementation

TQ2.DC3, Licensed Operator, Non-Licensed Operator, and Shift Technical Advisor, Continuing Training Program.

OP L-6, "Refueling," Revision 26

STP-V-18A, "Full-Flow Accumulator Discharge Check Valve Test," Revision 7

STP-I-1A, "Routine Shifts Checks Required by Licenses," Revision 60

OP1.DC37, "Plant Logs," Revision 5B

OM14.ID2, "Medical Examinations," Revision 1A

Operations Policy Guidelines D-3, "Handling of Control Board Caution Tags and Instrument Stickers," Revision 2

OP2.ID1, "Clearances and Administrative Tag Outs," Revision 7,

Record of Reactor Operator Medical & License Summary, dated April 15, 1997

Operations Section Performance Trends for January and March 1997

1R8 Plan of the Day, April 30, 1997

STP M-9A, "DG Surveillance"

OPE 5:IV, "Auxiliary Saltwater- Changing over Pump & HX Trains," Revision 5

Equipment Control Guidelines, ECG 7.4, Revision 0, Table 7.4-1

TQ1.DC20, "Respirator Training Program," Revision 1

AP-8B, "Control Room Inaccessibility - Hot Standby to Cold Shutdown," Revision 8



Other Documents:

Session 96-7 Group 1 Master Exams (Written, Scenarios, and JPMs)

Session 96-7 Group 2&3 Master Exams (Written, Scenarios, and JPMs)

Sessions 95-8 and 96-7 Biennial examination remedial training records.

Operator Shift Watch List

Active License List

Operator Continuing Training, Session 96-6 Lesson Plans R966C3 & R966C4, "Clearance Training"

Simulator Documentation Records for LR 948SE1, 948SE2, R95-8, and other related documentation (e.g., remediation plans, remediation records, and others) for Licensed Requalification Examinations during 1995 and 1996.



ATTACHMENT 2

SIMULATION FACILITY REPORT

Facility Licensee: Pacific Gas and Electric Company

Facility Docket: 50-275, 50-323

Operating Examinations Administered at: Diablo Canyon Nuclear Plant,
San Luis Obispo, Ca.

Operating Examinations Administered on: April 15-17, 1997

These observations do not constitute audit or inspection findings and are not, without further verification and review, indicative of noncompliance with 10 CFR 55.45(b). These observations do not affect NRC certification or approval of the simulation facility, other than to provide information which may be used in future evaluations. No licensee action is required in response to these observations.

None.

