

APPENDIX B

U.S. NUCLEAR REGULATORY COMMISSION  
REGION IV

Inspection Report: 50-397/94-28

License: NPF-21

Licensee: Washington Public Power Supply System  
3000 George Washington Way  
P.O. Box 968, MD 1023  
Richland, Washington 99352

Facility Name: Washington Nuclear Project-2

Inspection At: Richland, Washington

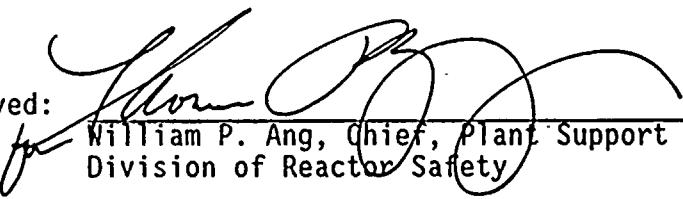
Inspection Conducted: September 26 through October 7, 1994

Inspectors: Phillip Qualls, Reactor Inspector, Plant Support Branch  
Division of Reactor Safety

Clifford Clark, Reactor Inspector, Plant Support Branch  
Division of Reactor Safety

Accompanying Personnel: Amarjit Singh, Reactor Systems Engineer, Plant  
Support Branch, Office of Nuclear Reactor  
Regulation

Approved:

  
William P. Ang, Chief, Plant Support Branch  
Division of Reactor Safety

11/7/94  
Date

Inspection Summary

Areas Inspected: Routine, announced triennial inspection of postfire safe shutdown capability and followup inspection of previously identified NRC items. NRC Inspection Manual Procedures 64150, 64704, and 92904 were used.

Results:

- The licensee had initiated an extensive corrective action program to identify and correct problems with fire barrier penetration seals.
- The implementation of the licensee's interim measures for a control room fire were adequate.

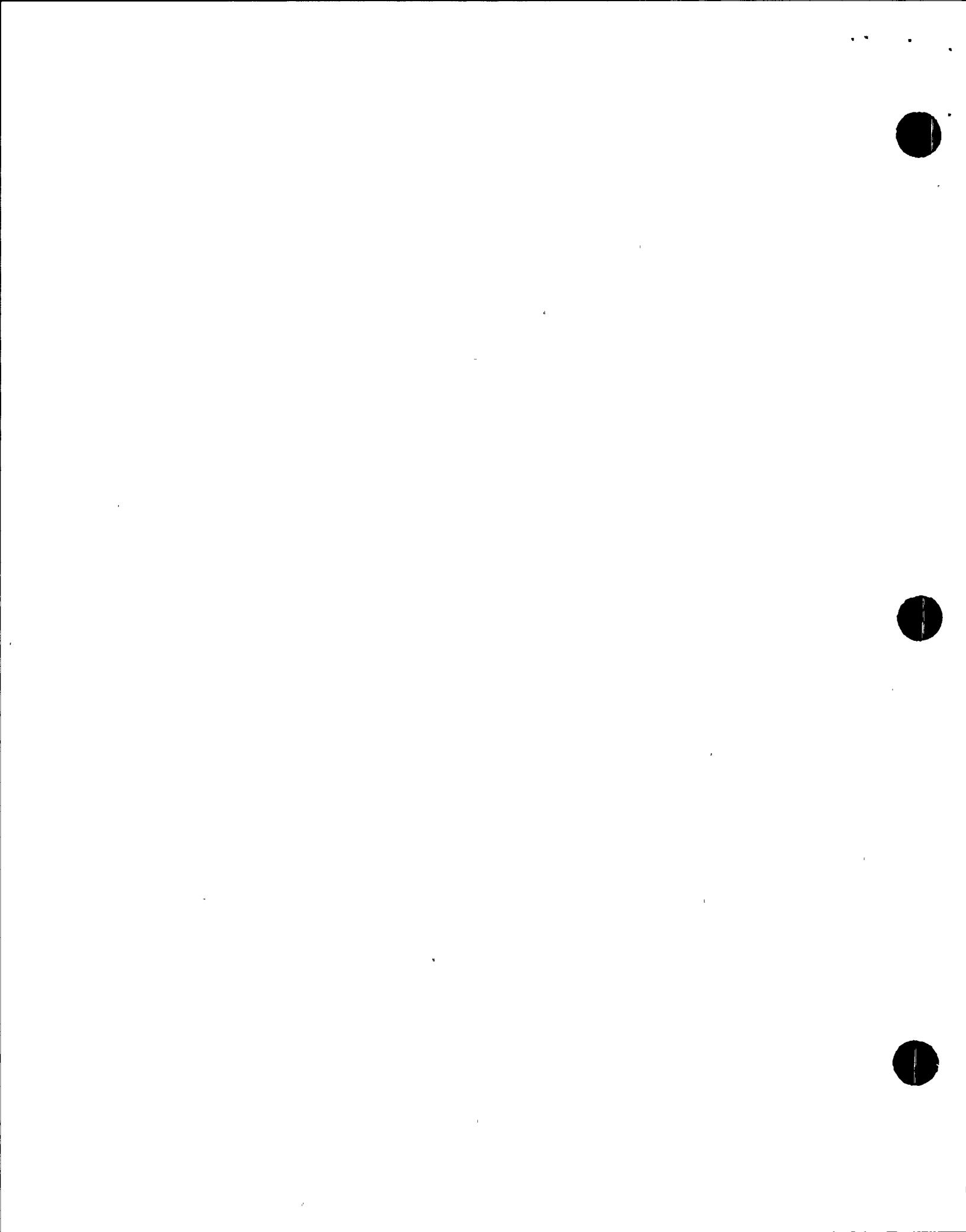
- A violation was identified concerning two examples of failure of the licensee to take prompt corrective actions for fire protection deficiencies (see paragraph 3.3 and 3.4).

Summary of Inspection Findings:

- Violation 397/9313-01 was closed (Section 3.1).
- Inspection Followup Item 397/9343-01 was closed (Section 3.2).
- Inspection Followup Item 397/9345-03 was closed (Section 3.5).
- Unresolved Item 397/9351-01 was closed (Section 3.3).
- Unresolved Item 397/9351-02 was closed (Section 3.3).
- Unresolved Item 397/9408-01 was closed (Section 3.3).
- Unresolved Item 397/9421-01 was closed (Section 3.4).
- Licensee Event Report 94-002-01 was closed (Section 3.3).
- Licensee Event Report 94-010 was closed (Section 3.3).
- Violation 397/9428-01 was opened (Section 3.3 and 3.4).

Attachment:

- Attachment - Persons Contacted and Exit Meeting



## DETAILS

### 1 INTRODUCTION

A triennial postfire safe shutdown capability reverification inspection was initiated June 20 through July 19, 1994, to verify that the licensee had properly maintained the plants postfire safe shutdown capability. The results of that inspection were documented in NRC Inspection Report 50-397/94-21. An additional inspection was performed on September 26 through October 7, 1994, to complete the reverification inspection and to resolve issues left open during the previous inspection. In addition, an inspection was also performed to review licensee action for open and unresolved items from other previous NRC inspections.

### 2 TRIENNIAL POSTFIRE SAFE SHUTDOWN CAPABILITY REVERIFICATION (64150)

#### 2.1 Washington Nuclear Project-2 (WNP-2) Fire Protection Requirements

Washington Public Power Supply System Facility Operating License, Amendment No. 6, dated May 25, 1989, paragraph 2.C.(14), "Fire Protection Program (Generic Letter 86-10)," requires, in part, that the licensee shall implement and maintain in effect all provisions of the approved fire protection program as described in Section 9.5.1 and Appendix F of the final safety analysis report. Section 9.5.1 and Appendix F of the final safety analysis report contain the licensee's commitments for WNP-2 fire protection systems and fire protection program.

#### 2.2 Inspector Review of Compliance with Fire Protection Requirements

The inspectors reviewed and discussed with licensee personnel the licensing basis documents for the fire protection program at WNP-2 during the inspection period. The documents were reviewed to ascertain the licensing basis for the licensee's fire protection program and to confirm the adequacy of the existing fire protection program.

#### 2.3 Plant Tour

The inspectors performed a visual inspection of various areas in the reactor building, the radwaste building, the diesel generator building, and the standby service water building to visually assess any obvious fire impairments that could invalidate safe shutdown assumptions, to inspect the material condition of the fire protection equipment and emergency lighting, to observe licensee control of transient combustible materials, to interview licensee personnel concerning fire protection program requirements, and to observe the licensee's hourly fire watch.

The inspectors did not identify any major modifications to the plant which could affect fire-related safe shutdown. The material condition of the fire protection equipment was good, emergency lighting appeared adequate, and no excessive concentration of transient combustible materials was observed.

Licensee personnel interviewed appeared knowledgeable about the fire protection program, and the fire watch appeared to be adequately implementing requirements.

#### 2.4 Modification Review

The inspectors reviewed selected plant modification packages from a list of plant modifications implemented since 1989 to determine whether the licensee had a functioning configuration management program with respect to postfire shutdown capability.

The licensee review of plant modifications was performed in accordance with Engineering Instructions 2.8, "Generating Facility Design Change Process," Revision 11, and 2.20, "Special Design Verification Analyses," Revision 2.

The inspectors reviewed a sample of four modifications implemented for safe shutdown components to verify that previous analyses, separation, and protection requirements for postfire safe shutdown were maintained. The inspectors reviewed the following plant modifications:

- 89-0132-1C, "Reactor Feedwater Pump and Turbine Vibration Monitor," February 10, 1992;
- 89-0435-0A, "Relocate Rod 22-35, 39-19 and 58-23 Position Cables to Spare Penetration," December 21, 1989;
- 89-0435-0B, "Relocate Rod 38-19 Position Cables," February 9, 1990; and
- 94-0048-0A, "Replacement of Containment Penetration X101B Modules," April 13, 1994.

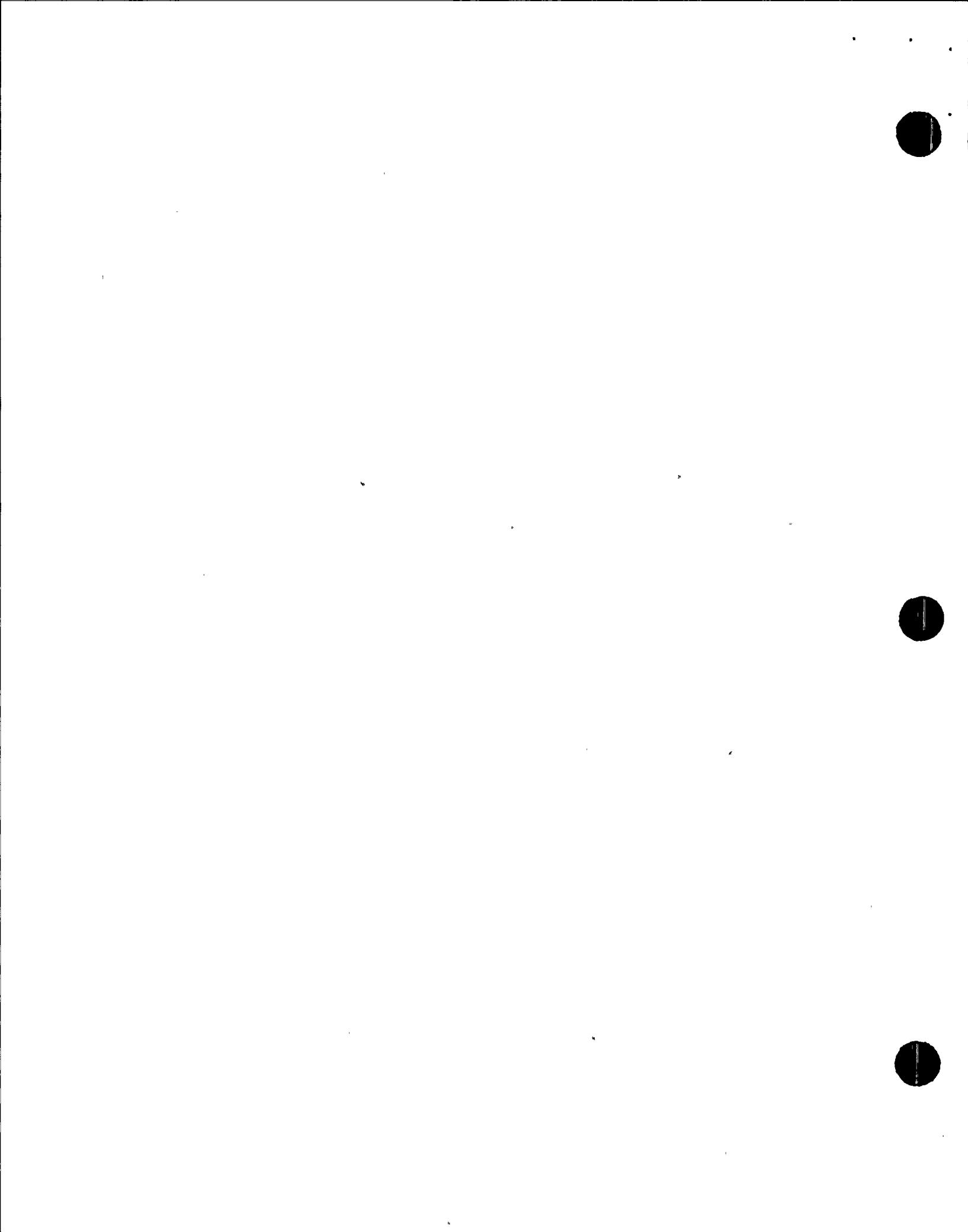
No significant safety concerns were identified during review of the above design changes and associated documentation. The inspectors concluded that the licensee configuration management program for design modifications maintained WNP-2's postfire safe shutdown capability.

### 3 FOLLOWUP OF CORRECTIVE ACTIONS FOR NRC OPEN ITEMS IDENTIFIED IN THE PLANT SUPPORT AREA (92904)

#### 3.1 (Closed) Violation 397/9313-01: Failure to Maintain Drawings Current for Thermolag Installations

##### 3.1.1 Original Violation

This violation involved a failure of the licensee to maintain drawings current for Thermolag installations. During a tour of a standby service water pump house on April 16, 1993, inspectors found that several of the cable trays and



safety-related conduits were protected by Thermolag System 330 fire retardant material. These Thermolag installations were not shown on applicable drawings. The licensee was unaware that Thermolag was installed in those areas.

Inspectors also determined that, because they were previously unaware of the installation of Thermolag in those locations, the licensee would not have performed cable ampacity derating calculations that they had committed to in their response to NCR Generic Letter 92-08.

In the licensee's research of this issue, several other plant areas were identified where Thermolag was installed, but not reflected on the drawings.

### 3.1.2 Licensee Action in Response

The licensee's response to this violation, dated July 9, 1993, acknowledged the validity of this violation and stated the following:

- Thermolag was applied in many places for electrical separation. Later reviews showed that these Thermolag installations were not required for electrical separation. The electrical cables were still in use, but no 10 CFR 50, Appendix R credit was taken for the Thermolag. Non-Appendix R (noncredited) Thermolag applications were not consistently incorporated into the design documentation database or design drawings as there were no requirements to include field installed fire barriers in design documents.
- The root cause of this violation was the lack of procedural requirements. This resulted in a condition where documentation was not available to assure that power cable ampacity derating calculations were performed in all cases where required.
- Certain Thermolag installation configurations could cause elevated internal temperatures of the enclosed electrical power cables. This could cause premature aging of power cables supplying safety-related equipment. In Licensing Event Report 86-033-02, the supply system committed to perform a power cable ampacity derating evaluation on all electrical cabling protected by Thermolag. Based on this evaluation, the Supply System identified that calculations would be performed on scheduled raceway continuous power cables enclosed in Thermolag barrier installations that met certain configuration criteria.
- None of the Thermolag installations found in the 1993 standby service water pump house inspections met the evaluation criteria for continuous power cable ampacity derating calculations.
- Problem Evaluation Request 293-428 was initiated on April 23, 1993, to address the apparent inadequate power cable ampacity derating evaluation performed in response to NRC Generic Letter 92-08.

- A request for technical services (93-03-066) was initiated on March 16, 1993, to update drawings to reflect as-built Thermolag tray installations in the applicable standby service water pump house.
- A revised response to NRC Generic Letter 92-08 was submitted on June 23, 1993, to include corrective actions to identify Thermolag installations not previously identified on design drawings.
- Walkdown criteria for Thermolag inspection was scheduled to be developed by July 31, 1993. These walkdown inspections to identify noncredited Thermolag installations on power cables were scheduled to be completed by January 31, 1994. Power cable ampacity derating calculations were scheduled to be completed by June 30, 1994.
- No generic design documentation control corrective actions were identified as necessary. Original plant documentation controls failed to fully incorporate Thermolag applications that were not originally required. The importance of documenting these applications apparently was not clearly understood. Documentation controls were in place to adequately maintain design documents current and prevent recurrence of this deficiency.
- Full compliance would be achieved on June 30, 1994, when electrical design documents would reflect the current Thermolag installation configurations that could impact power cable ampacity calculations.

### 3.1.3 Activity During this Inspection

The inspectors performed an onsite review of the licensee's documentation associated with this violation to verify appropriate actions were taken. The inspectors noted the following:

- The "Walkdown Criteria for Thermolag inspection" was provided as an attachment to a July 16, 1993, interoffice memorandum (SS2-PE-93-0553).
- The walkdown of noncredited Thermolag had been completed and completion was documented in an interoffice memorandum dated June 24, 1994.
- A calculation modification record (CMR-94-0654) dated July 6, 1994, documented the recalculation of the ampacity of approximately 578 cables in approximately 200 trays not previously identified as covered or Thermolaged raceways. This CMR noted that after incorporation of the CMR, the cables affected by the CMR had adequate ampacity to supply their loads without a reduction in cable life. It was also noted that additional Thermolag had been incorporated into Ampacity Calculation 2.06.20 by CMR-93-0554.

- Work was underway to consolidate all available cable tray information into a computerized database which would be linked to the computerized cable schedule database. This work was scheduled to be completed by December 31, 1994.

No additional undocumented Thermolag installations were identified during NRC inspector walkdowns of the plant.

### 3.1.4 Conclusion

The inspectors found the licensee actions to be adequate. This item is closed.

## 3.2 (Closed) Inspection Followup Item 397/9343-01: Training of Quality Control Personnel Inadequate to Assure Compliance with Inspection and Enforcement Bulletin (IEB) 79-19

### 3.2.1 Original Item

In October of 1993, an inspector reviewed training records and lesson plans to determine if the licensee's training program for radwaste workers responsible for performing quality control functions were consistent with the recommendations and requirements prescribed in IEB 79-19, "Packaging of Low-Level Radioactive Waste for Transportation and Burial."

A problem with the licensee's capability to retrieve training records in a timely manner and the ability to verify that radwaste workers were qualified pursuant to IEB 79-19 were identified during the inspection. The licensee's staff determined that the difficulty in retrieving the records was because they had not developed a matrix defining the training and qualification requirements for the different categories of radwaste workers (e.g., radwaste laborer, health physics technician, quality control inspectors, radwaste supervisor, etc.).

Additional licensee review determined that training provided to the licensee's staff involved in the performance of quality control functions associated with transportation of radioactive materials was not clearly defined. Surveillance Report No. 2-91-075 concluded that training provided to quality control personnel was inadequate to assure compliance with IEB 79-19. This surveillance report was closed on July 15, 1993. During review of the licensee's verification of corrective actions taken for this item, the inspectors was unable to determine how the surveillance findings were resolved. The corrective actions identified for the surveillance findings did not establish the training requirements for the quality control staff. Discussions held with the training staff disclosed that then quality control staff had not attended the training course that was routinely provided to all other licensee personnel involved in the transfer, packaging, and

transportation of radioactive material. The licensee staff was not able to explain how the surveillance findings were resolved. The inspectors informed the licensee that resolution of this item would be reviewed during a subsequent inspection.

### 3.2.2 Licensee Action in Response

The licensee provided the required training to the applicable quality control staff.

### 3.2.3 Activity During this Inspection

The inspectors reviewed the licensee's documentation associated with this concern to verify the appropriate actions were taken. The inspectors noted the following:

- Selected members of the quality control staff involved in the transfer, packaging, and transportation of radioactive material were provided the required training during two day training sessions provided in January and March of 1994. The inspectors reviewed copies of training records and noted completion of this training was documented in a licensee interoffice memorandum dated March 23, 1994.
- The latest training information contained in Lesson Plan 82-RWD-2900-LP, "Packaging and Transportation of Radioactive Waste and Material," Revision 1, was reviewed by the inspectors.

### 3.2.4 Conclusion

The inspectors concluded that the license had implemented appropriate corrective actions to address this concern. This item is closed.

## 3.3 Unresolved Items 397/9351-01, 397/9351-02, 397/9408-01 and Licensee Event Report 94-02-01: Fire Barrier Penetration Seals

### 3.3.1 Original Unresolved Items

In response to an employee concern on September 1, 1993, about the adequacy of fire barrier penetration seal inspections, the supply system initiated an investigation of issues related to the seal inspection program in December 1993. A licensee reinspection of one suspect seal found that the seal did not meet the inspection procedure acceptance criteria of Plant Procedure Manual 15.4.6, "Fire Rated Assembly/Inspection and Operational Verification." The licensee inspected previously repaired seals and determined that the repairs did not correct the deficient condition. An examination of selected seals found an additional 15 that could not be considered operable. Deficiencies identified by the licensee included original installation practices, periodic inspection practices and criteria, and seal repair practices and documentation.

The licensee's investigation concluded that all personnel that were involved in the fire barrier penetration seal program since startup assumed that the initial installation of the fire seals was adequate. Personnel assumed that the installed configurations were supported by fire tests, and the existing penetration seal tracking system reflected those configurations. Licensee evaluations performed on identified deficiencies showed an acceptance of initially installed configurations that did not meet existing acceptance criteria. These evaluations also determined that the seal configurations that were initially installed did not reflect the design drawings. The actual depth of seal in some penetrations could not be verified because removal of seal material was not reflected in the initial installation records. Initial work practices were not in accordance with the original installation procedures.

The licensee's investigation report also concluded that there were several contributing causes for the penetration seal deficiencies at WNP-2. The report identified, specifically, five major areas: (1) original construction less than adequate, (2) managerial methods less than adequate, (3) design configuration and analysis less than adequate, (4) work practices less than adequate, and (5) training less than adequate. Subsequently, the licensee declared all the penetration seals at WNP-2 inoperable and fire watches were established as compensatory action.

### 3.3.2 Licensee Action in Response

The licensee initiated a penetration seal upgrade project to correct the deficiencies identified above. The licensee declared all seals inoperable and instituted hourly fire watch tours. With all seals inoperable, the licensee voided the surveillance procedure and is developing a new inspection procedure for fire barrier seals.

### 3.3.3 Inspector Actions During the Present Inspection

The licensee had previously performed a limited inspection of about 125 penetration seals to obtain a preliminary assessment of the scope of the seal penetration problem. The licensee noted that many had defects during that inspection, such as gouges and cracks, but determined, based on fire loading, that all fire barrier penetration seals inspected at that time were functional.

The NRC inspectors performed visual inspections of fire barrier penetration seals. The inspectors visually inspected approximately 100 fire barrier seals. The inspectors noted that many had small cracks or a small space around the outer edges between the seal and the wall. However, the inspectors did not identify any fire barrier penetration seals that appeared to be nonfunctional.

The inspectors reviewed the licensee's fire barrier penetration seal upgrade project and noted their aggressive corrective action to resolve this issue.

The licensee's penetration seals upgrade project included: (1) a pre-walkdown engineering effort, (2) a critical parameter walkdown and seal work, and (3) configuration control and documentation closure. The major prewalkdown phase activities were in progress during this inspection. The first phase included the development of design acceptance criteria for all seals. This task consists of: (1) reviewing data from penetration seal fire test reports, (2) obtaining additional fire test reports which bound WNP-2 penetration designs, (3) obtaining needed physical property data from the vendor/manufacturer, and (4) performing calculations to document the acceptability of the seal limiting design parameters in accordance with license based documents. During this inspection, the licensee stated that WNP-2 had obtained over 30 fire test reports covering over 280 different fire tested assemblies. This data will be reviewed by the licensee to ensure that credited assemblies meet the committed fire test standards and the development of acceptance criteria for WNP-2. This acceptance criteria will be utilized in the project walkdown so that all penetration designs are bounded by representative fire testing. Additionally, the licensee stated that this acceptance criteria will also be added to new typical seal design details for future configuration control. The first phase of this project was scheduled to be completed in February 1995. At the completion of this project, the licensee's fire barrier seal program will include: seal calculations backed by fire tests, seal design guide, new typical seal details, barrier functional list, revised plant procedures/specifications which reference aforementioned documents, all seal impairments closed, Generic Letter 86-10 engineering evaluations for certain non-rated barriers, updated installation and surveillance procedures, trained seal installers and inspectors, and qualified operable penetration seals.

The licensee issued Significant Deficiency Report (SDR) 293-1413 to document a fire barrier penetration seal problem identified on December 14, 1993. Subsequently, several other fire barrier penetration seal problems were incorporated into the SDR. The inspectors reviewed the SDR and noted that Attachment 1 to the SDR provided a chronology of fire barrier seal installation, inspection, tests, and identified problems. The SDR attachment stated, in part, that in July of 1987, Supplement 1 to Licensee Event Report 87-04 provided commitments to correct identified fire barrier penetration seal deficiencies. However, the SDR attachment also stated that "This was the first significant opportunity to identify major concerns with the penetration seal program. The resolution focused on Technical Specification and Appendix R design criteria. The penetrations should have been sealed whether Technical Specification related or not. Deficiencies in initial installation and in the seal tracking system was not addressed and perhaps not considered."

### 3.3.4 Discussion and Conclusions

In addition to the fire barrier seal deficiencies noted in 1987, concerns about fire barrier seal deficiencies were again identified by licensee personnel to their management on September 1, 1993. The concerns were not investigated, documented, nor corrected at that time. License

Condition 2.C.14 requires that the licensee implement and maintain in effect all provisions of the approved fire protection program as described in Section 9:5.1 and Appendix F of the FSAR for the facility. Appendix F to the FSAR Table F.3.1.C.8 states that "Fire Protection systems are subject to the applicable portions of the WNP-2 Operating Quality Assurance Program and that plant procedures require that conditions adverse to fire protection, such as failures, malfunctions, deficiencies, deviations, defective components, uncontrolled combustible material, and non-conformances are promptly identified and corrected." The failure to promptly correct the fire barrier seal deficiencies is one of two examples of a corrective actions violation (397/9428-01). The inspectors noted that the safety significance of the seal deficiencies could not be completely assessed until completion of the licensee's walkdown of the seals and the condition of the remaining seals to be inspected had been determined. Review of the status of the evaluation and findings of the licensee will be performed as part of the followup for this violation.

3.4 (Closed) Unresolved Item 397/9421-01, Licensee Event Report 94-010:  
Adequacy of Safe Shutdown Procedures

3.4.1 Original Unresolved Item

The licensee performed Quality Assessment Audit 294-029, "Supply System 10 CFR Part 50, Appendix R Program," and documented the results by means of an audit report dated July 14, 1994. From June 20 through July 19, 1994, the licensee evaluated the deficiencies identified by the quality assurance audit. Subsequent NRC inspection noted three major concerns that had not been addressed: (1) potential residual heat removal (RHR) pump deadheading, (2) potential RHR system waterhammer, and (3) adequacy of safe shutdown procedures.

3.4.2 Licensee Action in Response

The licensee completed the safe shutdown analysis and calculations for a control room fire. The licensee completed procedure revisions and walkthroughs to ensure that interim corrective actions could be properly accomplished.

3.4.3 Inspector Actions During the Present Inspection

The inspectors reviewed the followup assessment of operability contained in Problem Evaluation Request 294-359, Calculations 94-0613, and the Control Room Evacuation and Remote Cooldown Procedure 4-12-1.1, Revision 22. The inspectors performed a walkdown of portions of the control room evacuation and remote cooldown procedure.

The licensee's quality assurance audit, conducted in April 1994, identified concerns associated with the analysis performed for fire-related safe shutdown at WNP-2. Specifically, the analyses documentation associated with fire generated spurious equipment actuators/failures in plant systems and the time available for the accomplishment of operator actions was questioned by the

inspectors. To address these concerns, the licensee performed analyses and calculations to reverify that the conclusions of the original analyses were both accurate and complete.. In the reverification process, the licensee determined that some actions were needed to be restructured to enhance the operator's ability to respond to the most limiting fire induced spurious actuations. As a result, the licensee revised Plant Procedure Manual 4.12.1.1, Revision 21, and 4.12.4.1, Revision 13, to include operator actions. Additionally, the licensee issued a new plant procedure manual to provide an interface between abnormal procedures related to fire and the emergency operating procedures.

The changes to the procedures included prestaged operators to take control of Valves RHR-V-24-A (B), 27A (B), and 64B at the remote and alternate shutdown panels and to trip reactor feedwater pumps locally in the plant. This prestaging of individuals at the onset of a control room fire was scheduled to be accomplished prior to the need to evacuate the control room, to ensure that actions could be taken in the plant locally, outside the influence of the effects of the fire. These prestaged actions would ensure proactive control over valves in the RHR A and B systems, and would assist in maintaining the system functions by preventing system damage. Also, these actions would place operators in position to perform confirmatory actions for verification of the trip of the feedwater pumps and closure of the main steam isolation valves. The changes to Plant Procedure Manual 4.12.4.1, 4.12.11, and the new 5.7.1 would ensure the performance of operator actions that were necessary to successfully achieve safe shutdown were accomplished in the proper sequence, location, and within the specified time constraints. The coordination and timing of operator actions were consistent with the calculations and the analyzed plant response.

These changes provided additional guidance to ensure that operator actions necessary for fire mitigation are accomplished during a control room evacuation. These changes involved transferring control of the 64B, 24A(B) and 27A(B) valves from the control room to the remote and alternate shutdown panels. The transferred functions included the RHR B minimum flow, wetwell, spray, and suppression pool cooling mode functions for RHR A and B loops. Control of these valves are transferred to preclude a fire in the control room from spuriously opening one of these valves and either causing loss of the system pump due to loss of minimum flow capability, or causing drain down of the piping system, which could lead to a waterhammer in the RHR system. The inspectors performed a walk down of these procedures and determined that there was sufficient time available to perform the above actions.

The inspectors reviewed the training records for the revised control room safe shutdown procedure. The training records indicated that all operators were extensively trained on the procedure revision. The inspectors interviewed operators in the unit concerning the adequacy of the training received. The inspectors concluded that the operators had been adequately trained to carry out all necessary actions to implement the procedure.

The inspectors noted that the prestaging of operators and implementation of manual actions to prevent spurious operations of the RHR system was an interim solution. The licensee was considering a long-term solution to this concern by modifying the circuits for the RHR system. The proposed modification would eliminate the need for operator prestaging prior to the control room evacuation. Therefore, the inspectors concluded that this unresolved item, with the three major concerns noted during the previous inspection: (1) potential RHR pump deadheading, (2) potential RHR system waterhammer, and (3) adequacy of safe shutdown procedure, is considered closed.

#### 3.4.4 Discussion and Conclusions

The deficiencies in the licensee's analysis were previously noted by the licensee in an interoffice memorandum on November 9, 1992, which was subsequently incorporated into NCR 292-1284 on December 2, 1992. Licensee documents concerning resolution of these issues contained in an interoffice memorandum, dated February 25, 1993, stated that no corrective action completion date was forecast. Actions to correct the deficiencies were not initiated until the concern was raised during the April 25, 1994, audit.

NRC Information Notice 91-50, "A Review of Water Hammer Events After 1985," stated that "cost-benefit considerations did not support new requirements to reduce the number of water hammer events" and that "new or additional requirements to reduce the number of water hammer events were not cost effective." As a result, the failure to adequately analyze for the potential water hammer event was not identified as a violation. Licensee Event Report 94-010 was issued because the licensee determined that a start of Residual Heat Removal Pump 2B and a fire induced failure to open of the minimum flow control valve (RHR-FCV-64B) could have resulted in damage to the pump. The licensee determined that the cause of this event was a lack of an adequate analysis of the potential fire impact on the minimum flow control valve circuitry. The licensee concluded that this event was deemed to have minimal safety significance.

License Condition 2.C.14 requires the licensee to implement and maintain in effect all provisions of the approved fire protection program as described in Section 9.5.1 and Appendix F of the FSAR for the facility. Section F.4.3 of Appendix F to the FSAR requires that deficiencies be promptly corrected. The failure to promptly correct the deficiencies in the associated circuit analysis is a second example of a corrective actions violation (50-397/9428-01).

#### 3.5 (Closed) Unresolved Item 397/9345-03: Plant Operations Committee

##### 3.5.1 Original Unresolved Item

The item concerned the licensee's use of "delegates" as primary members of the plant operations committee (POC) to satisfy quorum requirements.

### 3.5.2 Licensee Action in Response.

On July 1, 1994, the licensee revised Plant Procedure Manual 1.1.5, "Plant Operations Committee," Revision 16, dated July 1, 1994, to clarify POC quorum requirements to use the term "designated alternates" for various positions such that the term used in the procedure was consistent with the term used in Technical Specifications.

### 3.5.3 Activity During This Inspection

The inspectors reviewed the licensee's documentation associated with this concern to verify appropriate actions were taken. The inspectors noted the following:

- The procedure requirements effectively implemented Technical Specifications and the clarifications should be sufficient to assure that the requirements were met.
- The inspectors reviewed the minutes for ten POC meetings which were held subsequent to the procedure revision and noted that Technical Specification POC quorum requirements were met.

### 3.5.4 Conclusion

The inspectors concluded that the licensee had reviewed this item, and implemented appropriate corrective actions to address this concern. The inspectors did not find that inappropriate persons were included in the POC quorums, but that the term "delegate" was interchanged with the term "designated alternate" used in the Technical Specifications. This item is closed.

## 4 QUALITY ASSURANCE (64704)

### 4.1 Audits

The inspectors reviewed Quality Assessment Audit 294-029, "Supply System 10 CFR [Part] 50, Appendix R Program," which was issued on July 14, 1994. The licensee stated that this was a special audit performed to identify potential problems in the 10 CFR Part 50, Appendix R, Program. During the course of this audit, the licensee noted that corrective actions had not been initiated for the deficiencies identified in 1992. The inspectors reviewed the licensee's audit. The audit appeared to be an indepth, comprehensive audit performed by well qualified personnel.

#### 4.2 Corrective Action

As noted in paragraph 3.4.4, the deficiencies in the licensee's analysis were noted by the licensee on November 9, 1992, and actions to correct the deficiencies were not initiated until the concern was raised during the April 25, 1994, audit. The failure to take prompt corrective actions was identified as a violation with two examples as previously noted.

#### 4.3 Conclusion

The licensee conducted an extensive, well-planned audit.

ATTACHMENT

1 PERSONS CONTACTED

1.1 Licensee Personnel

\*P. Bemis, Manager, Regulatory Programs  
\*C. Edwards, Plant Quality Control Manager  
\*M. Flasch, Director, Engineering  
\*C. Foley, Principal Licensing Engineer  
\*J. Gearhart, Director, Quality Assurance  
\*J. Irish, Bonneville Power Association  
\*D. Kibus, Fire Protection Project Coordinator  
\*J. McDonald, Manager, Quality Assurance  
\*R. Matthews, Manager, Electrical and I&C  
\*T. Meade, Manager, Technical Services  
\*S. Mulkey, Supervisor, Technical Programs  
\*C. Noyes, Manager, Engineering Programs  
\*J. Parrish, Assistant Managing Director of Operations  
\*M. Reddemann, Manager, Technical Services  
\*C. Schwarz, Manager, Operations  
\*L. Sharp, Supervisor, Engineering  
\*J. Streeter, Executive Assistant to Managing Director  
\*J. Swailes, Plant Manager  
\*D. Swank, Manager, Compliance  
\*P. Taylor, Operations, Shift Manager  
\*R. Webring, Manager, Support Services

1.2 NRC Personnel

David Proulx, Resident Inspector

\*Denotes personnel that attended the exit meeting.

2 EXIT MEETING

An exit meeting was conducted on October 7, 1994. During this meeting, the inspectors reviewed the preliminary scope and findings of this report. The licensee indicated that they understood the inspection findings, but did not express a position on the inspection findings at that time. Proprietary material was reviewed during the inspection and returned to the licensee prior to the exit meeting. Proprietary information is not contained in this inspection report.