APPENDIX

U.S. NUCLEAR REGULATORY COMMISSION
REGION IV

Inspection Report: 50-397/94-32

License: NPF-21

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

Facility Name: Washington Nuclear Project-2

Inspection At: WNP-2 site near Richland, Washington

Inspection Conducted: October 30 through December 10, 1994

Inspectors: R. C. Barr, Senior Resident Inspector
D. L. Proulx, Resident Inspector
G. W. Johnston, Senior Project Inspector

Approved: D. F. Kirsch, Chief, Reactor Project Branch E — 23 DECEMBER, 94 Date

Inspection Summary

Areas Inspected: Routine, announced inspection of resident and region-based inspectors of control room operations, licensee action on previous inspection findings, operational safety verification, surveillance program, maintenance program, licensee event reports, special inspection topics, and procedural adherence. During this inspection, Inspection Procedures 37551, 61726, 62703, 71707, 71750, 92700, 92901, 92903, 92904, and 93702 were used.

Results:

Operations

Control room professionalism has shown an improving trend over the past six months. Deficiencies were noted in the maintenance of the Technical Specification Inoperable Equipment Log/Limiting Condition for Operations status book, planning of minor maintenance activities and assessing the potential impact on safety, and control of control rod manipulations.

Maintenance

Surveillance Procedure PPM 7.4.7.2.8, for the control room ventilation system, included weaknesses, one of which allowed adjustments of dampers without recording as-found data.

Engineering

The modification associated with bypass of automatic isolation of the main steam isolation valves, PMR 92-0158-04, was an example of good engineering work.

Plant Support

Quality Assurance audit thoroughness and effectiveness have improved significantly. Licensee evaluation of two self-disclosing events was thorough. The engineering associated with identifying a deficiency in the analysis for the design basis control room fire was good. A weakness was identified with craftsmen adhering to a radiation work permit.

Summary of Inspection Finding:

- Inspection Followup Item 397/9432-01 (Section 7) was identified.
- Noncited Violation 397/9432-02 (Section 8.1) was identified.
- Licensee Event Report 397/94-17 (Section 9) was reviewed and closed.
- Violation 397/9350-06 (Section 10.1) was closed.
- Inspection Followup Item 397/9124-02 (Section 10.2) was reviewed and closed.

Attachment:

- Persons Contacted and Exit Meeting

DETAILS

1 PLANT STATUS

At the start of the inspection period, the reactor was operating at 100 percent power. Reactor power was reduced to 80 percent on November 18 to repair steam leaks in the turbine building. The reactor was operating at 100 percent power at the end of the inspection period.

2 ONSITE FOLLOWUP TO EVENTS (93702)

2.1 Scram Discharge Volume Switch CRD-LS-13E

During the 1994 Refueling Outage (R9) the licensee replaced the Channel A SDV high water level control rod block level switch. General Electric (GE) supplied the licensee with the switch and Magnetrol manufactured the switch. GE indicated to the licensee that the switch was equivalent to the switch that had been previously installed. In their substitution evaluation, the Supply System, largely based on the verbal information provided by GE, concluded that the replacement switch was a direct substitute. Licensee craftsmen calibrated and tested the switch, and operators declared the switch operable on June 30, 1994. On October 11, 1994, the switch failed a channel functional test, craftsmen recalibrated the switch and returned the switch to service. On October 27, 1994, a calibration check of the switch found the switch to be within calibration tolerances. On November 9, 1994, the switch again failed calibration and operators declared the switch inoperable. The following paragraphs document the licensee's findings associated with this switch's failures and the NRC's assessment of the licensee's evaluation.

The licensee generated Problem Evaluation Request (PER) 94-0975 to document the failure of the switch. In the PER the licensee had the following findings: the replaced switch had different operating characteristics than the original switch; GE had not provided the Supply System with operating and maintenance instructions for the switches; the replacement switch consisted of different switch types than the original switch; during licensee calibration, craftsmen had removed (modified) the upper (unused) switch without proper concurrence or documentation; and the lower switch had been set approximately one-third of an inch higher than the value designated by Magnetrol. In the PER, the licensee concluded the causes of the switch failure were a combination of installation, application, and adjustment errors. For interim disposition, the licensee had identified five actions to correct the deficiencies revealed by their assessment.

The inspector concluded that the licensee's investigation of the second occurrence of the malfunction of the level switch was thorough and probing. In their evaluation, the licensee identified that they had missed several opportunities to identify that the replacement switch was not a like-for-like substitution prior to the calibration failures. The inspector noted that the licensee identified weaknesses with the GE's and the Supply System's

substitution evaluation process, that licensee craftsmen had inappropriately modified the switch, and that the switch had not been installed at the correct elevation. Because the switch provides no safety functions and the licensee thoroughly assessed this event, no further NRC action or followup is required.

3 PLANT OPERATIONS (71707, 92901)

3.1 Plant Tours

The inspector toured the following plant areas:

- Reactor Building
- Primary Containment
- Control Room
- Diesel Generator Building
- Radwaste Building
- Service Water Buildings
- Technical Support Center
- Turbine Generator Building
- Yard Area and Perimeter

3.2 Observations

The inspector observed the following items during the tours.

3.2.1 Operating Logs and Records

The inspector reviewed operating logs and records against Technical Specification (TS) and administrative control procedure requirements. Log keeping was generally satisfactory. However, the following paragraph identifies a weakness in the Limiting Conditions for Operation (LCO) log.

3.2.1.1 Entry into Wrong TS Action Statement

On November 2, 1994, during a review of the TS Inoperable Equipment/LCO/ODCM status book, the inspector identified an error in implementing the TS. On November 1, 1994, control room Fan WMA-FN-51B was declared inoperable and tagged out for maintenance. This action rendered one train of the control room emergency filtration system inoperable in accordance with TS Action Statement 3.7.2.a. The action statement required the plant was to be placed in hot shutdown within the next 12 hours if the one train of the control room emergency filtration system was inoperable for 7 days. However, the control room supervisor incorrectly documented in the TS Inoperable Equipment Log that the applicable action requirement was the action of TS 3.7.2.b.

Further, the inspector identified the error and found that the error existed for three shifts prior to correction. Licensee procedures require the shift managers and the CRSs to review the TS Inoperable Equipment status book as part of each shift turnover. The inspector reviewed the shift turnover

checklists for November 1-2 and noted that the operators reviewed the TS Inoperable Equipment status book, but did not identify the entry error in implementing TS 3.7.2.a. The inspector concluded that the licensee's shift turnovers required improvement, in particular, the critical assessment of the meaning of log entries requires improvement.

Upon discovery, the inspector notified the shift manager, who corrected the error and initiated PER 294-0963. The licensee completed work on WMA-FN-51B in 2 days, compared to the 7 days allowed by the TS action statement. The inspector noted that, because the work was completed in time, this issue was of low safety significance.

The inspector discussed the above observations and conclusions with the plant manager. The plant manager agreed with the inspector's findings and conclusions. He stated that the Supply System will continue to emphasize and monitor operator improvement in attention to detail.

3.2.2 Monitoring Instrumentation

The inspector observed process instruments for correlation between channels and for conformance with TS requirements.

3.2.3 Shift Manning

The inspector observed control room and shift manning for conformance with 10 CFR 50.54 (k), TS, and administrative procedures. The inspector also observed the attentiveness of the operators in the execution of their duties, and the control room was observed to be free of distractions such as nonwork-related radios and reading materials. The inspector recognized an overall improvement in control room operator professionalism over the past 6 months. Operators appeared to more frequently walk down panels and interruptions appeared less frequent.

3.2.4 Equipment Lineups

The inspector verified that valves and electrical breakers were in the position or condition required by TS and administrative procedures for the applicable plant mode. This verification included routine control board indication reviews and conduct of partial system lineups. TS LCO were verified by direct observation.

3.2.5 Equipment Tagging

The inspector observed selected equipment, for which tagging requests had been initiated, to verify that tags were in place and the equipment was in the condition specified. The inspector did not identify any deficiencies in observing clearance orders.

3.2.6 General Plant Equipment Conditions

The inspector observed plant equipment for indications of system leakage, improper lubrication, or other conditions that would prevent the system from fulfilling its functional requirements. Annunciators were observed to ascertain their status and operability.

3.2.7 Plant Chemistry

The inspector reviewed chemical analyses and trend results for conformance with TS and administrative control procedures.

3.3 Engineered Safety Features Walkdown

The inspector walked down selected engineered safety features (and systems important to safety) to confirm that the systems were aligned in accordance with plant procedures. During the walkdown of the systems, items such as hangers, supports, electrical power supplies, cabinets, and cables were inspected to determine that they were operable and in a condition to perform their required functions. Proper lubrication and cooling of major components were also observed for adequacy. The inspector also verified that certain system valves were in the required position by both local and remote position indication, as applicable.

The inspector walked down accessible portions of the following systems on the indicated dates.

System	Dates
Automatic Depressurization System	November 1
Diesel Generator Systems, Divisions 1, 2, and 3.	November 15-17
Low Pressure Coolant Injection Trains A, B, and C	November 1, 16
Low Pressure Core Spray	November 1, 16
High Pressure Core Spray	November 1, 16
Reactor Core Isolation Cooling (RCIC)	November 1, 16
Residual Heat Removal (RHR) Trains A and B	November 1, 16
Standby Gas Treatment (SGT)	November 10, December 4
Standby Liquid Control	November 10, December 4

125V DC Electrical Distribution, Divisions 1 and 2	November 10
250V DC Electrical Distribution	November 10

The inspector determined that routine plant operations appeared to be adequate during this inspection period. In addition, the inspector determined that, overall, the engineered safety feature systems were in good order and aligned in accordance with plant procedures.

3.3.1 Painting in the RHR Train C Pump Room

On November 16, 1994, during a tour of the RHR C pump room, the inspector noted that the licensee was painting the upper mezzanine level of the room. To support this evolution, the licensee placed herculite covering over the entire decking of the upper mezzanine area. The only area available for air flow was through the access ladder. This effectively isolated the emergency core cooling system (ECCS) room cooler from the RHR C pump. Section 9.4 of the Final Safety Analysis Report (FSAR) states that each of the ECCS pump room coolers provides approximately 5200 cubic feet per minute (CFM) of cooling to its associated pump. The inspector concluded that, with the air flow restricted by the floor covering, the ECCS room cooler for RHR pump C would likely not achieve the 5500 CFM air flow.

The inspector notified the shift manager, who initiated PER 294-0989 and immediately directed the painters to remove the herculite from directly above the RHR C pump. The licensee subsequently performed an operability assessment and determined that approximately 1500 CFM of cooling flow could reach the RHR C pump and that 1500 CFM was adequate to ensure operability.

The inspector discussed this issue with the plant manager. The inspector noted that, in this case, work planning did not take into consideration the possibility that painting activities would result in a potentially degraded condition of a safety system. The plant manager agreed with the inspector's findings and conclusions and stated that he would continue to focus on improving assessments of the impact of minor maintenance activities on safety.

3.4 Conclusions

The inspector noted an overall improving trend in control room professionalism. Deficiencies were noted in the maintenance of the TS Inoperable Equipment Log/LCO status book, planning of minor maintenance activities and assessing the potential impact on safety, and control of control rod manipulations (Section 8.1).

4 ONSITE ENGINEERING (37551)

The inspector performed inspection of the following engineering related activities during this inspection period.

4.1 Modification of Main Steam Isolation Valve (MSIV) Isolation Bypass

The inspector reviewed Plant Modification Record PMR 92-0158-04, which modified the isolation logic for the MSIVs such that the operators could use keylocked switches to bypass automatic isolation of the MSIVs when implementing the emergency operating procedures. The inspector reviewed the 50.59 evaluation, revised procedures, updated drawings, and walked down the hardware in the field. The inspector determined that PMR 92-0158-04 was completed in a thorough manner and was an example of good engineering work.

5 PLANT SUPPORT ACTIVITIES (71750)

The inspector evaluated plant support activities based on observation of work activities, review of records, and facility tours. The inspector noted the following during this evaluation.

5.1 Fire Protection

The inspector observed firefighting equipment and controls for conformance with administrative procedures. The inspector determined that fire protection activities were satisfactory during this inspection period. The licensee identified the following concern in the fire protection area.

5.1.1 Hot Short Affecting Safe Shutdown Capability

On November 11, 1994, when reviewing safe shutdown designs for fire protection, the licensee found that during the design basis fire a "hot short" in the control room would affect instrumentation for Valve CIA-V-20 causing it to close. This valve supplies nitrogen to the inboard MSIVs and the nonautomatic depressurization system (ADS) safety relief valves (SRVs).

PPM 4.12.1.1, "Control Room Evacuation and Remote Cooldown," credits using six SRVs for safe shutdown, which include the three nonADS SRVs supplied by Valve CIA-V-20. The scenario postulated that due to Valve CIA-V-20 going closed, the MSIVs would shut and the three nonADS SRVs would cycle three times and deplete the nitrogen necessary for further valve operation. At this point, the reactor vessel could not be depressurized in the time frame described in the licensee's fire protection analysis.

The licensee initiated PER 294-0980 to document this finding, to propose compensatory actions until the problem is corrected, and to provide for long-term corrective actions. The inspector concluded that identifying this deficiency was an example of good engineering work. The inspector will assess the licensee's followup actions upon receipt of the Licensee Event Report (LER).

5.2 Radiation Protection Controls

The inspector periodically observed radiological protection practices to determine whether the licensee's program was being implemented in conformance

with facility policies and procedures and in compliance with regulatory requirements. The inspector also observed compliance with radiation work permits, proper wearing of protective equipment and personnel monitoring devices, and personnel frisking practices. Radiation monitoring equipment was frequently monitored to verify operability and adherence to calibration frequency.

5.2.1 Maintenance Craft Removing Dosimetry

On November 15, 1994, while witnessing maintenance on DSA-SPV-5C1 (per work order MK3701), the inspector noted that maintenance personnel removed their dosimetry during work. The individuals removed and set their dosimetry on the diesel generator and then proceeded to work underneath nearby deck grating. The inspector verified that the workers had not contacted Health Physics prior to removing their dosimetry. The dosimetry was approximately 3 feet from the workers.

This action was contrary to the Radiation Work Permit for MK3701 which specified a thermoluminescent dosimeter and dosimeter for the work to be worn at the chest area. The inspector related his concerns to the craft supervisor. The supervisor directed the individuals to properly wear their dosimetry, contacted Health Physics, and initiated PER 294-0984.

The inspector noted that this issue had no radiological significance because the work occurred in the high pressure core spray (HPCS) diesel generator room, which is within the radiologically controlled area but is not in a radiation area. The inspector noted that this issue emphasized the need for attention to detail and adherence to radwaste work permits.

5.3 Plant Housekeeping

The inspector observed plant conditions and material/equipment storage to determine the general state of cleanliness and housekeeping. Housekeeping in the radiologically controlled area was evaluated with respect to controlling the spread of surface and airborne contamination. Housekeeping was observed to be generally good in all plant areas.

5.4 Security

The inspector periodically observed security practices to ascertain that the licensee's implementation of the security plan was in accordance with site procedures, that the search equipment at the access control points was operational, that the vital area portals were kept locked and alarmed, and that personnel allowed access to the protected area were badged and monitored and the monitoring equipment was functional.

5.5 Emergency Planning

The inspector toured the Emergency Operations Facility, the Operations Support Center, and the Technical Support Center and ensured that these emergency

facilities were in a state of readiness. Housekeeping was noted to be good and all necessary equipment appeared to be functional.

5.6 Quality Assurance (QA) Audits

The inspector assessed the audits and the audit plans of QA audits 294-058, "Fitness for Duty," and 294-073, "Fire Protection Program." The inspector found that the audit plans were well-developed. The audit plans were based on current industry information and standards, and thoroughly evaluated previously observed weaknesses at WNP-2. The auditors, which included experts from outside the licensee's organization, were well-qualified. The inspector found that the audits appeared thorough and probing, identifying a number of strengths and areas for improvement. The line organizations appeared to accept the audit findings and take appropriate immediate corrective actions.

The inspector concluded that the quality of these audits represented a substantial improvement over audits performed approximately two years ago.

5.7 Conclusions

The inspector noted improvements in QA audit thoroughness and effectiveness, and good engineering work associated with identifying a deficiency in the analysis for the design basis control room fire. A weakness was identified with craftsmen adhering to a radiation work permit.

6 SURVEILLANCE TESTING (61726)

The inspector reviewed surveillance tests required to be performed by the TS on a sampling basis to verify that: (1) a technically adequate procedure existed for performance of the surveillance tests; (2) the surveillance tests had been performed at the frequency specified in the TS and in accordance with the TS surveillance requirements; and (3) test results satisfied acceptance criteria or were properly dispositioned.

The inspector observed the following surveillance on the dates shown:

Procedure	Description	Dates Performed
7.4.1.3.5.1	Control Rod Scram Accumulator Operability	December 7
7.4.7.2.8	Control Room Ventilation Pressurization Flow Test	November 21 and 23

The inspector observed that these surveillances were performed properly during this inspection; however, the following procedure and performance weaknesses were identified with PPM 7.4.7.2.8:

- Access to the control room is not restricted during this surveillance test which evaluates the integrity of the control room boundary. Because the access is not restricted, each control room entry results in a significant pressure and flow perturbation that has the potential to result in inaccurate data collection. As a minimum, not restricting control room access results in a significant extension of the time required to perform the surveillance.

- Some 'notes' within the procedure contain action statements directing operators to manipulate components. This is contrary to recommendations of Supply System administrative procedures. Specifically, the 'note' states it may be necessary to throttle the volume damper to achieve the acceptance criteria flow value. The procedure does not direct the damper be changed, even though while performing the surveillance to attain the desired flow value the damper position may have to be repositioned.

- A precaution in the procedure states that during the performance of the surveillance it should be noted that all steps preceded by # denote a TS requirement and that failure to meet the acceptance criteria on these steps requires immediate referral to the respective TS action requirement. Step 13 of the procedure, which is denoted by a #, is not consistent with applicable TS requirements and states to verify the control room outside air flow is 1000 (+,-100) actual cfm; however, the TS requirement is less than or equal to 1000 cfm.

- The procedure requires the recording of as-found flow rate data, but does not require recording as-left flow rate data. This has caused confusion and, at least on one occasion (1992), resulted in recording the as-left data and not the as-found data. In this example, the actual flow rate could have been out of TS requirements without having been identified as such.

The inspector shared these procedure weaknesses with the plant manager. The plant manager acknowledged the inspector's findings and committed to have the procedure revised to address these weaknesses.

7 MAINTENANCE OBSERVATIONS (62703)

During the inspection period, the inspector observed and reviewed documentation associated with maintenance and problem investigation activities to verify compliance with regulatory requirements and with administrative and maintenance procedures, required QA/QC involvement, proper use of clearance tags, proper equipment alignment and use of jumpers, personnel qualifications, and proper retesting. The inspector verified that reportability for these maintenance activities was correct.

The inspector witnessed the following maintenance activities.

Description	Dates Performed
MK3701, Repair DSA-SPV-5C1	November 15, 1994
PF5605, Replace DSA Piping	November 16-17, 1994
PY5305, Repair WMA-FN-51B	November 22, 1994

The inspector determined that these maintenance activities were performed and documented properly. However, the inspector noted that, during the performance of PY5305 on WMA-FN-51B, a degraded condition on WMA-FN-51B had existed since November 2, 1994. Specifically, a green equipment deficiency tag was attached to the access door of the unit. The tag indicated that the gasket was missing. The inspector was concerned that the reason for the failure of the control room to pressurize during performance of the air flow test on November 21, 1994, was due to the missing gasket. Therefore, the degraded condition appeared to have existed for at least 20 days. The inspector determined that this issue required further inspection (Inspection Followup Item 397/9432-01).

8 OPERATIONS FOLLOWUP (92901)

8.1 Mispositioning of Control Rod 34-47

On November 18, 1994, during control rod surveillance testing, WNP-2 licensed operators positioned Control Rod 34-47 out of the sequence prescribed by the control rod pull sheet. The licensee initiated PER 94-0997 following their identification of this error. NRC inspectors performed followup assessment of this event since errors associated with either mispositioning of control rods or mispositioning of components during refueling have frequently occurred at WNP-2. The assessment consisted of reviews of the PER and the Incident Review Board report and discussions with selected Supply System personnel.

The Supply System's investigation of this issue identified the following: due to insufficient self-checking and communication by the control room operator and the shift nuclear engineer, Control Rod 34-47 was moved instead of Control Rod 38-47; in response to the mispositioned control rod operators did not appropriately refer to the abnormal procedure, PPM 4.1.17A, which resulted in the late notification of operations management; and clarification of plant management involvement and concurrence prior to resumption of rod movement after a rod mispositioning was required. Management also concluded that expectations for the controls used during the manipulation of rods were not fully understood by operators. As immediate corrective action, the operators immediately established correct rod positioning. Some of the licensee's followup actions included: discussion of the event with all licensed operators and shift nuclear engineers; clarification of the differences between and independent verifier and simultaneous verifier for control rod

movement; and revising procedures that deal with control rod movement to reference Procedure Preparation Manual (PPM) 4.1.1.7A.

The inspector concluded that the licensee's evaluation of this issue was timely and thorough and that the corrective actions appeared adequate. Therefore, the failure to adhere to surveillance Procedure 7.4.1.3.2, "Control Rod Drive Scram Timing With Auto Scram Timer System," is a noncited violation (50-397/94-32-02).

9 ONSITE REVIEW OF LERs (92700)

The inspector reviewed the following LER, associated with an operating event, during this inspection period and closed the LER based on in-office review.

50-397/94-17	TS Limit Exceeded due to Improper Calibration of the Suppression Pool Narrow Range Level Transmitters

10 FOLLOWUP OF MAINTENANCE AND ENGINEERING OPEN ITEMS (92902 and 92903)

10.1 (Closed) Violation 397/9350-06: First Repair of Steam Leak in Valve MS-V-20

This violation involved the failure to document, by use of a PER, that an installation work plan had not been performed for the installation of Furmanite adapters on the valve bonnet packing chamber of Valve MS-V-20.

The licensee acknowledged the failure to issue a PER in their response dated April 12, 1994. Further, the response provided that the following corrective actions were accomplished:

- A PER, written on December 16, 1993, documents the work plan issue.
- Another PER written on February 3, 1994, documented the failure to write a PER on the work record discrepancy.
- The counseling of the engineer involved in the issue and a memorandum issued to WNP-2 employees covering the lessons learned from the issue.
- Revisions to Procedures PPM 1.3.7D, "Work Planning," and PPM 1.3.7I, "Work Closeout Activities," to emphasize review and closeout activities.

The inspector examined these corrective actions and concluded that they appear adequate to address the concerns of the NRC.

10.2 (Closed) Inspection Followup Item 397/9124-02: Diesel Starting Air Capacity

In NRC Inspection Report 50-397/91-24 the inspector identified a concern that the diesel generator start air receivers may not have adequate capacity for seven starts per bank. NRC Inspection Report 50-397/92-22 identified concerns about the HPCS diesel air capacity. The inspectors were concerned that the HPCS diesel would not have enough air to start the diesel engine following a failed start. The licensee agreed to provide a response to the inspector's concerns. NRC Inspection Report 50-397/93-18 further followed up on the licensee's efforts to resolve the issues about the air receivers capacities. During the exit meeting for that report period, the inspector noted that the licensee's resolution of the issue had been slow.

The inspector reviewed Calculation ME-02-94-44 dated August 16, 1994. The calculation involves assessing test results from the R-9 outage versus the requirements in the licensing basis for WNP-2. The licensing basis requires five consecutive starts for the Divisions 1 and 2 diesel generators. The licensing basis also requires three consecutive starts for the HPCS diesel generator. The start after a failed start for the HPCS diesel generator is not a requirement of the licensing basis.

The test results and calculations show that the Divisions 1 and 2 diesel generators will sustain five consecutive starts from each air receiver bank (two trains for each diesel engine). Further, the licensee showed the diesel generators will sustain a start after a failed start. The licensee also conducted a start test with both receivers in use for the Division 1 diesel generator that resulted in 17 consecutive starts.

The test results and calculations also show that the HPCS diesel generator will sustain three consecutive starts. The calculation further shows that the HPCS diesel generator will sustain a start after a failed start. The calculations involve conservative values and test results that reflect worst case situations. The calculation shows that, for the worst case conditions (final receiver air pressure of 150 psig), the volume of air available will always provide for two starts. Thus, there is assurance that a start can occur following a start failure.

The inspector concluded from the analysis that the Divisions 1 and 2 diesel generators will meet their licensing basis requirement for five consecutive starts. The HPCS diesel generator will meet the three consecutive start requirement and will start after a single failed start. The FSAR specifies that the Divisions 1 and 2 diesel generators will perform seven consecutive starts. The inspector noted that Receiver Bank 2A for Division 2 would only provide for six starts. The other banks would provide for seven to eight starts. The licensee has indicated that a proposed amendment to the FSAR will reflect the licensing basis.

ATTACHMENT

1 PERSONS CONTACTED

Washington Public Power Supply System

V. Parrish, Assistant Managing Director for Operations (AMDO)
*M. Flasch, Executive Assistant to AMDO
J. Burn, Engineering Director
J. Gearhart, Quality Assurance Director
*J. Swailes, Plant Manager
J. Baker, Technical Training Manager
*R. Webring, Support Services Manager
*G. Smith, Operations Division Manager
*R. Barbee, System Engineering Manager
*S. Kirkendall, Plant Support Engineering Manager
*J. Benjamin, Quality Assessments Manager
*M. Monopoli, Maintenance Division Manager
P. Bemis, Regulatory Programs Manager
J. Albers, Radiation Protection Manager
*C. Noyes, Engineering Programs Manager
*M. Mann, Assistant Operations Manager
*D. Swank, Licensing Manager
*J. Peters, Assistant to Plant Manager
*S. Washington, Operating Events Analysis and Resolution Manager
*W. Sawyer, Day Shift Manager
*W. Estes, Shift Manager
*C. Fricker, Quality Assurance Engineer
*J. Pedro, Licensing Engineer

Nuclear Regulatory Commission

*D. Kirsch, Chief, Project Branch E
*R. Barr, Senior Resident Inspector
*D. Proulx, Resident Inspector

The inspector also interviewed various control room operators, shift supervisors and shift managers, maintenance, engineering, quality assurance, and management personnel.

*Attended the exit meeting on December 15, 1994.

2 EXIT MEETING

An exit meeting was conducted on December 15, 1994. During this meeting, the inspectors reviewed the scope and findings of the report. The licensee did not identify as proprietary any of the information provided to, or reviewed by, the inspectors.