ENCLOSURE

U.S. NUCLEAR REGULATORY COMMISSION
REGION IV

Inspection Report: 50-528/95-18
50-529/95-18
50-530/95-18

Licenses: NPF-41
NPF-51
NPF-74

Licensee: Arizona Public Service Company
P.O. Box 53999
Phoenix, Arizona

Facility Name: Palo Verde Nuclear Generating Station, Units 1, 2, and 3

Inspection At: Maricopa County, Arizona

Inspection Conducted: September 24 through November 4, 1995

Inspectors: K. Johnston, Senior Resident Inspector
J. Kramer, Resident Inspector
D. Garcia, Resident Inspector
D. Acker, Senior Project Engineer

Approved: F. R. Huey, Acting Chief, Reactor Projects Branch F 11/22/95 Date

Inspection Summary

Areas Inspected (Units 1, 2, and 3): Routine, announced inspection of onsite response to plant events, operational safety, maintenance and surveillance activities, onsite engineering, refueling activities and licensee event report review.

Results (Units 1, 2, and 3):

Operations

- A control room supervisor in Unit 3 reviewed the wrong section of the steam generator blowdown system procedure, which led to exceeding licensed thermal power. A non-cited violation was identified (Section 2.1).

- A control room supervisor demonstrated excellent command and control during the planned shutdown in Unit 3 (Section 2.2).

- An auxiliary operator in Unit 3 displayed good attention to detail for identifying non-seismic qualified scaffolding in safety-related equipment rooms. The use of improperly qualified scaffolding was identified as a non-cited violation (Section 2.3).

- A work control senior reactor operator in Unit 3 failed to properly review a work order clearance, resulting in a loss of reactor coolant system inventory. A non-cited violation was identified (Section 2.4).

- Two auxiliary operators in Unit 3 failed to properly align and independently verify a valve required for reactor coolant system draindown. A non-cited violation was identified (Section 2.5).

- A reactor engineer in Unit 3 displayed a lack of attention to detail resulting in a mispositioned fuel assembly in the spent fuel pool. Also, refueling personnel exhibited insensitivity towards a reactivity management issue. A non-cited violation was identified (Section 6.1).

- Refueling machine personnel were knowledgeable about refueling equipment and procedures (Section 6.2).

Maintenance/Surveillance

- Electrical maintenance personnel responded appropriately to a failure of the Unit 2, Train B diesel generator (Section 3.1).

- Mechanical maintenance personnel displayed good judgement during troubleshooting efforts on the Unit 2, Train A auxiliary feedwater pump (Section 3.2).

Engineering and Technical Support

- Maintenance engineering displayed a questioning attitude and good knowledge of Technical Specifications when evaluating a high pressure safety injection pump relief valve lifting (Section 5.1).

Summary of Inspection Findings:

- A non-cited violation was identified for failure to follow a steam generator blowdown procedure (Section 2.1).

- A non-cited violation was identified for failure to follow a procedure for installing seismically qualified scaffolding (Section 2.3).

- A non-cited violation was identified for failure to follow a clearance generation procedure (Section 2.4).

- A non-cited violation was identified for failure to follow a valve position verification procedure (Section 2.5).
- A non-cited violation was identified associated with mispositioning of a fuel assembly in the spent fuel pool (Section 6.1).
- One licensee event report was reviewed and closed (Section 7).

Attachments:

1. Persons Contacted and Exit Meeting
2. List of Acronyms

1 PLANT STATUS

Units 1 and 2 operated throughout the inspection period at full power with no significant events.

Unit 3 began the inspection period at 100 percent power. On October 14, the unit was taken off-line in preparation for a refueling outage. On October 18, the unit entered Mode 6 and began a core offload on October 20. The unit ended the inspection period with the core offloaded to the spent fuel pool.

2 OPERATIONAL SAFETY VERIFICATION (71707)

2.1 Misalignment in the Steam Generator Blowdown System - Unit 3

On September 23, operators placed the steam generator blowdown system in a configuration that was not consistent with that assumed for the secondary calorimetric calculation performed by the core operating limits supervisory system (COLSS). As a result, for a period of approximately nine hours, COLSS underestimated actual power by approximately 0.11 percent power. The secondary calorimetric provided by COLSS was the primary indication of power used by operators and as a result, the plant was operated slightly above 100 percent power for approximately 12 hours.

The steam generator blowdown system has three modes of operation; normal, abnormal, and high rate. On September 23, chemistry personnel requested that operators return the system to normal rate from the abnormal rate. The control room supervisor had both the abnormal blowdown flow control valve and the isolation valves closed.

At the following shift turnover, the night shift control room supervisor informed the oncoming day shift control room supervisor that the abnormal blowdown isolation valves were isolated. The day shift control room supervisor determined that the isolation valves should have been open and directed an auxiliary operator to reopen the valves.

The day shift control room supervisor recognized that the abnormal blowdown lineup was not consistent with the lineup established for the test used to develop the blowdown flow constant that is entered into the COLSS for the secondary calorimetric calculation. The test was performed with the abnormal blowdown isolation valves in the open position and the flow control valves in the closed position. The flow control valves are not designed to be leak tight in the closed position, and an assumed leakage rate was incorporated into the blowdown constant test.

The inspector noted that in COLSS, the steam flow equals feed flow minus blowdown flow. With the abnormal blowdown isolated, actual blowdown flow was less than the constant inserted into COLSS. Therefore, actual steam flow was greater than COLSS calculated steam flow. Since secondary power was directly related to steam flow, actual power was greater than indicated power.

The licensee subsequently determined that licensed thermal power had been exceeded. The operators reduced reactor power from 100 percent to 98.8 percent for an hour to ensure that the 12 hour average power was less than 100 percent. The licensee calculated that the highest hourly power was 100.14 percent and the highest 12 hour rolling average power was 100.07 percent.

The licensee initiated a condition report/disposition request (CRDR) to evaluate the event. They found that the control room supervisor had reviewed the wrong section of the blowdown system operating procedure, and noted that the control room supervisor had performed the actions to isolate the blowdown isolation valves without including the rest of the control room team in the decision. Additionally, the licensee found that the precaution and limitations steps provided misleading information and noted other causal factors that may have contributed to the event. Also, the licensee noted that the change in operating philosophy to leave the blowdown isolation valves to the blowdown flash tank open was communicated to Units 1 and 2, but there was no documented evidence that this change was effectively communicated to Unit 3.

The licensee performed the following corrective actions:

- Issued a night order to all three units describing the event and the procedure weaknesses.
- Initiated a procedure change to eliminate the inaccurate precaution and limitation step and subsequently issued a new revision to the procedure.
- Counseled the control room supervisor on the event.
- Issued a letter to the shift supervisors and control room supervisors detailing operation teamwork issues and expectations.
- Issued an operations news flash on the procedure change process and the necessity of informing operators of procedure changes.
- Planned to discuss the event in licensed operator training.

The inspector reviewed the CRDR and the corrective actions. Additionally, the inspector reviewed a Licensee Event Report (50-530/95-02). The inspector noted that the event was bounded by the assumptions in the Updated Final Safety Analysis Report for thermal power of 102 percent. This licensee identified and corrected violation is being treated as a non-cited violation, consistent with Section VII of the NRC Enforcement Policy.

2.2 Plant Shutdown - Unit 3

On October 14, 1995, during a night shift tour, the inspector observed operations personnel commence a planned reactor shutdown in preparation of the fifth refueling outage for Unit 3. The operations staff began the decrease in

reactor power at approximately 10:24 p.m. The inspector observed the reactor operator manually trip the reactor at 27 percent reactor power.

Following the reactor trip, the control room operators implemented the standard post trip procedures. The inspector observed control room operators respond to plant anomalies and various alarms. The inspector noted good procedure usage and communications. The inspector concluded that the control room supervisor displayed excellent command and control, the operators were attentive and responded appropriately to various alarms.

2.3 Non-seismically Qualified Scaffolding Installed - Unit 3

On October 16, 1995, during routine area rounds, an auxiliary operator identified non-seismic scaffolding installed in both trains of the essential cooling water heat exchanger rooms. The auxiliary operator notified the shift supervisor and discussed the operability concern for the essential cooling water heat exchanger. The backshift scaffolding supervisor, site shift manager, and the outage control manager were also informed of the event.

The scaffolding supervisor determined that the scaffolding was not built to the required seismic qualifications and directed a scaffolding crew to rebuild the scaffolding in accordance with seismic qualifications stated in Procedure 30DP-9WP11, Revision 5, "Scaffolding Instructions." A previous example of non-seismic scaffolding installed in areas with safety-related equipment was identified by the NRC and documented in Inspection Report 95-12. The licensee initiated an operability determination and a CRDR. Licensee management initiated a stop work for all scaffolding installation, briefed the scaffolding crews on the event, and performed a walkdown of all installed scaffolding in Unit 3.

The scaffolding crew installed the scaffolding on October 14 using Procedure 30DP-9WP11, Revision 4. Revision 4 allowed the scaffolding crew foreman the flexibility to determine whether or not scaffolding would be installed to seismic qualifications. The previous day, Revision 5 to the procedure became effective as part of the corrective actions for the inspector's previous concerns. In addition to other enhancements to the procedure, Revision 5 did not allow the foreman the flexibility to determine whether or not scaffolding would be installed to seismic qualifications. The licensee had briefed 7 of the 9 scaffolding crews on Revision 5 to the procedure. The other two crews had been on their scheduled days off. The scaffolding crew in question had not been aware of the new procedure revision. The two crews were briefed after the scaffolding had been installed incorrectly. However, the scaffolding crew did not question the adequacy of the installed scaffolding.

The inspector noted that the scaffolding crew failed to construct the scaffolding in accordance with Revision 4 of the procedure. In addition, the scaffolding foreman responsible for the October 14 job had also been involved with the previous events documented in Inspection Report 95-12. The inspector noted the inadequacy of communications and the improper verification of the most current procedure revision.

The non-seismic scaffolding was identified by the auxiliary operator when the unit was in Mode 5. Technical Specifications do not require the essential cooling water heat exchangers to be operable in Mode 5. However, the scaffolding had been installed on October 14, when the plant was in Mode 4 when both trains of essential cooling water heat exchangers were required to be operable.

Design engineering performed an evaluation which determined that the as-found conditions of the scaffolding would not have damaged the essential cooling water heat exchangers during a seismic event. Therefore, the non-seismic scaffolding had no impact on the operability of the essential cooling water heat exchanger. The inspector discussed this determination with the design engineer and agreed with the licensee's conclusion.

The licensee counselled and disciplined the foreman who was involved in both events and provided additional training to the scaffolding crews. The licensee issued a night order to all operators describing the event. The night order indicated that operations personnel will make the decision for the approval of non-seismic scaffolding in seismic areas. The normal expectation is to have seismic scaffolding always erected around safety-related components. This licensee identified and corrected violation is being treated as a non-cited violation, consistent with Section VII of the NRC Enforcement Policy.

2.4 Improperly Authorized Clearance Causes a Loss of Reactor Coolant System Inventory - Unit 3

On October 16, three days into the Unit 3 refueling outage, the work control senior reactor operator authorized a clearance without first ensuring that the required plant configuration had been established. Approximately 15 minutes after the clearance was hung, a reactor operator identified an increasing level in the reactor drain tank and that leakage was coming from the reactor coolant system. The control room staff evaluated the activities in progress and determined that a recently issued clearance drained the reactor coolant system through the reactor coolant pumps. The licensee suspended the clearance, and stopped the loss of reactor coolant system inventory. The licensee calculated that a 6 gpm reactor coolant system leak occurred for total of 51 minutes.

The licensee determined that the work control senior reactor operator was busy at the beginning of the shift and numerous clearances required authorization prior to issuance. An outage coordinator placed several reactor coolant pump clearances in the work control senior reactor operator's basket for review and authorization. One of the clearances required plant conditions to be at half-pipe, whereas actual plant condition was approximately 50 percent pressurizer level. The licensee defined half-pipe as a midloop condition with the core offloaded. The work control senior reactor operator performed an abbreviated review of the clearances and authorized implementation. The work control senior reactor operator indicated he recognized the scope of the work on the reactor coolant pump clearance, but did not consider the clearance scope in

conjunction with the plant conditions present at that time.

The licensee reinforced the procedure requirement of 40DP-90P29, "Clearance Generation," which requires that special instructions be placed on the clearance cover sheet that explain the required plant conditions to hang the clearance. The licensee reviewed all the clearances and added special instructions to the clearances when necessary. The licensee initiated a clearance process review as a result of this and previous clearance problems. In addition, the licensee planned to ensure that sufficient additional work control manpower is available during periods of increased outage activity.

The inspector reviewed the licensee evaluation, discussed the corrective actions with operations management, and concluded that the corrective actions were appropriate. Although the licensee failed to follow the procedure for clearance generation, this licensee identified and corrected violation is being treated as a non-cited violation, consistent with Section VII of the NRC Enforcement Policy.

2.5 Improper Valve Lineup During Reactor Coolant System Draindown - Unit 3

On October 17, operations personnel attempted to lower reactor coolant system level by performing a draindown to the refueling water tank. The operators reviewed a previously performed valve lineup and discovered that a required open valve, CH-495, was closed. The control room staff directed an auxiliary operator to reposition the valve, and the draindown continued as expected.

The licensee identified that an auxiliary operator had failed to properly position valve CH-495 when performing the valve lineup prior to the draindown, and another auxiliary operator had failed to properly perform an independent verification that the valve was open. During the performance of the initial positioning and independent verification, the licensee noted that both auxiliary operators were in the same room during the valve manipulation. The inspector noted that, while the licensee procedure does not require physical separation during verification activities, it recommends physical separation to avoid errors.

The licensee issued a night order and operations news flash describing the event and the expectations for proper independent review. The licensee initiated a CRDR to evaluate the event and identify further corrective actions. The inspector concluded that the initial corrective actions were adequate. The inspector will continue to monitor auxiliary operator performance.

At the exit meeting, the inspector noted the weaknesses in auxiliary operator performance which were identified in the previous inspection period (NRC Inspection Report 50-528/95-16; 529/95-16; 530/95-16), and expressed concern for the recent auxiliary operator performance problems. Licensee management acknowledged the recent operations performance problems, and described current actions to address human performance errors and weaknesses in the implementation of the equipment clearance program. The inspector noted that

the licensee's reviews in these areas were appropriate and plans to assess these areas in a future inspection. This licensee identified and corrected violation is being treated as a non-cited violation, consistent with Section VII of the NRC Enforcement Policy.

3 MAINTENANCE OBSERVATIONS (62703)

3.1 Overspeed Trips on Diesel Generator During Testing - Unit 2

During the month of October 1995, the Unit 2 Train B diesel generator experienced three non-emergency trips during operability surveillance testing. None of the involved trips would have affected the ability of the diesel generator to properly function during an actual emergency start condition. Electrical maintenance engineering provided action plans for troubleshooting and correcting the problems. The inspector observed partial troubleshooting efforts by the electrical maintenance technicians. The inspector concluded that the maintenance activities were performed appropriately and these trips did not impact the safety function of the diesel generator.

3.1.1 First Trip

On October 3, the diesel generator experienced a trip. The local panel indicated an "overspeed trip" alarm, but the overspeed butterfly valve did not shut, confirming that an actual overspeed trip had not occurred. During an actual overspeed condition, the mechanical overspeed governor would trip the butterfly valve in the turbocharger air inlet. Operations personnel notified the electrical maintenance engineers and initiated a CRDR.

The electrical maintenance technician identified a loose wire connection in a junction box from one of the overspeed butterfly valve limit switches. There are two limit switches on the butterfly valve which provide overspeed trip signals in both the emergency and test mode. The loose connection made up the one out of two logic signals required for a non-emergency mode trip. The licensee tightened the wire and initiated a work request to inspect the junction boxes for loose connections on the remaining diesel generators. The inspection of the other junction boxes did not identify other loose wire connections. After a satisfactory test run, the Train B diesel generator was returned to operable status.

3.1.2 Second Trip

On October 18, the diesel generator experienced another indicated overspeed trip during a surveillance test. The indications were similar to the previous overspeed trip that occurred on October 3. After extensive troubleshooting, electrical maintenance engineers identified a problem with a fiber optic receiver board. The technicians replaced the fiber optic receiver board and other circuitry boards and relays. The trip circuitry and power supplies had been checked. The limit switches mounted on the diesel were checked for continuity, however the inside of the limit switches could not be tested without taking them apart. The diesel generator was tested and returned to

service.

The electrical maintenance engineer suspected that both trips could have been induced by vibration since both trips occurred after the diesel generator had been started and loaded. The trip circuitry remains energized at all times and there were no indications of a non-emergency trip while the diesel was in stand-by mode. The electrical maintenance department leader, site shift manager, and shift supervisor conferred and decided to replace the two overspeed limit switches.

3.1.3 Third Trip

On October 21, after the replacement of the limit switches, the diesel generator was tested and tripped at full load on "Incomplete Sequence," another non-emergency trip. If the diesel engine does not attain the first speed point before the timer times out, an incomplete sequence is initiated and the unit shuts down.

The diesel was quarantined and electrical technicians began troubleshooting. An electrical maintenance technician identified another bad fiber optic relay board. The inspector questioned the electrical maintenance engineer about the previous board replacement and whether or not this board should have been replaced. The engineer stated that this board was not related to the previous maintenance activities or the overspeed trips. The electrical maintenance department leader, engineers, technicians, and the site shift manager had a conference call with the inspectors and regional management to discuss the plan of action. The electrical maintenance engineer stated that no other malfunctions were identified, and that the fiber optic board was replaced and the diesel generator was satisfactorily retested. Operations returned the Train B diesel generator to service.

3.1.4 Conclusions

A multi-discipline diesel generator task force team was established to determine the root cause of failure of the recent trips and to provide an assessment of the trips and control problems. The team planned to assess all trips since 1993 and major events relevant to the Train B diesel generator for common mode failures and adverse trends. The corrective actions will also be evaluated by the team for effectiveness.

The inspector concluded that appropriate actions were being taken for the recent trips to the diesel and the initiation of the task force team was noted as a good effort by management.

3.2 <u>Auxiliary Feedwater Pump High Vibrations - Unit 2</u>

On October 23, 1995, during the performance of a surveillance test, the Unit 2 steam driven auxiliary feedwater pump failed to meet the acceptance criteria for pump bearing vibration, and the pump was subsequently declared inoperable. Mechanical maintenance engineers were notified and a CRDR was initiated.

The mechanical maintenance engineer developed an action plan to determine the cause of the vibration. The inspector attended meetings with mechanical maintenance engineers and vibration experts to discuss possible causes. Oil samples were taken, and the licensee concluded that bearing damage was not the cause. Vibration analysts determined that the vibration data and maintenance history indicated that a coupling misalignment may have been the cause.

Mechanical maintenance technicians removed the pump half of the coupling and found that the coupling did not have a proper interference fit with the shaft. After the licensee discussed this problem with the vendor, the licensee determined that the coupling misalignment would be a contributor to outboard bearing vibration. The technicians replaced the pump half of the coupling with a new coupling that had been field balanced.

The licensee performed a postmaintenance test and collected vibration data. The vibrations were below the action level range, and engineering recommended that operations perform the operability surveillance test. The surveillance test was performed satisfactorily and the pump was returned to service. An additional test was performed the next day for trending purposes to ensure that the pump coupling replacement had reduced outboard bearing vibrations. The inspector observed the vibration technician obtain data. The vibration data obtained was within the acceptance criteria.

The last surveillance test performed prior to the October 23 test was satisfactory, however, because this pump showed an increasing trend in vibrations, the decision was made by mechanical maintenance engineering to place the pump on increased frequency testing until the next refueling outage. The inspector concluded that the actions taken were appropriate and will continue to assess the licensee's evaluations of pump performance.

3.3 Other Maintenance Observations

The inspectors observed the following maintenance activities and determined that they were performed acceptably:

- Charging Pump "A" Drain Line Cleaning - Unit 3
- Ground Fault Relay Replacement on LPSI Injection Valve - Unit 2

4 SURVEILLANCE OBSERVATION (61726)

The inspectors observed the following surveillance activities and determined that they were performed acceptably:

- Reactor Protection System Functional Matrix Testing - Unit 1
- Integrated Safeguards Testing - Unit 3
- Battery Charger 18 Month Load Test - Unit 3

5 ONSITE ENGINEERING (37551)

5.1 High Pressure Safety Injection Pump Relief Valve Lifted During Surveillance - Unit 2

On October 18, during a surveillance test of the train B high pressure safety injection pump, relief valve PSV409 lifted. The name plate rating of PSV409 was 10 gpm. The onshift crew noted that the relief fully opened and calculated the leakage at 15 gpm. The high pressure safety injection pump passed the surveillance test acceptance criteria of pump response time, differential pressure, pump vibration, and miniflow flow rate. The onshift crew performed an operability determination and concluded that the pump was operable. The licensee initiated a CRDR to further evaluate the problem.

On October 20, maintenance engineering received the CRDR and questioned the operability of the system to meet Technical Specification Surveillance Requirement 4.5.2.e.4, due to the relief valve lifting early. The surveillance requirement stated, in part, that all emergency core cooling system piping outside of containment have a total leakage less than one gpm when pressurized to 40 psi. The train B high pressure safety injection pump had a leakage of greater than 10 gpm at 1877 psi. The licensee replaced the relief valve and initiated the evaluation of the cause of failure. The inspector concluded that the maintenance engineer displayed a good knowledge of Technical Specifications and a strong questioning attitude.

The licensee tested the relief valve to determine the actual relief setpoint. The relief valve lifted at a pressure of 2053 psi, with a required setpoint of 2050 psi. The licensee planned to continue to evaluate the events and plant conditions that caused the initial failure mechanism of the relief valve since the pop test was not conclusive.

The inspector discussed the October 18 high pressure safety injection pump operability determination with the site shift manager. The inspector concluded that the assumption used by operations personnel that the relief valve would be seated at 40 psi was appropriate. The inspector will continue to monitor engineering's evaluation of the relief valve failure as part of future routine inspection.

6 REFUELING ACTIVITIES (60705 AND 60710)

6.1 Mispositioned Fuel Assembly in Spent Fuel Pool - Unit 3

On October 22, the licensee mispositioned a fuel assembly in the spent fuel pool. The licensee moved the fuel assembly to the correct location upon discovery of the error. The inspector noted that the cause of the event was that the reactor engineer, located in the control room, directed the spent fuel handling machine operator to place the fuel assembly into the wrong location. The inspector noted that the safety significance of mispositioning the fuel assembly was minimal due to the high boron concentration of the spent fuel pool.

The licensee corrected the immediate concern of the mispositioned fuel assembly, however, the inspector expressed concern that operators continued to move fuel for approximately two hours before suspending fuel movement to evaluate the event and to take action to prevent reoccurrence. In addition, operators relied upon verbal direction from the reactor engineer to the spent fuel handling machine operator on placement of the fuel assembly. The spent fuel handling machine operator did not have an independent tracking sheet to verify proper fuel location.

The licensee briefed involved refueling personnel to describe the event and corrective actions. The licensee placed a tracking sheet on the spent fuel handling machine to provide an independent verification of the fuel assembly placement. The licensee issued a night order describing the event and initial corrective actions and initiated a CRDR to evaluate further corrective actions. The inspector concluded that after the licensee suspended fuel movement, the corrective actions were appropriate.

At the exit meeting, the inspector addressed the concern that refueling personnel appeared to be insensitive to reactivity management problems, and that by not having a tracking method for the fuel assemblies on the spent fuel handling machine they lacked defense in depth. Licensee management acknowledged the inspectors concerns. This licensee identified and corrected violation is being treated as a non-cited violation, consistent with Section VII of the NRC Enforcement Policy.

6.2 Observation of Core Offload - Unit 3

On October 21, the inspector observed portions of core offload activities from the control room and the refueling machine inside containment. The inspector noted that in the control room, personnel demonstrated good communications and professionalism.

The inspector noted that operators on the refueling machine were knowledgeable about the equipment and displayed good verification of the required coordinates set in the machine to retrieve the next assembly. The limited senior reactor operator displayed appropriate knowledge of the abnormal operating procedure for loss of refueling pool level. The inspector noted adequate foreign material exclusion controls. The inspector concluded that the performance of refueling machine personnel was good.

ATTACHMENT 1

1 PERSONS CONTACTED

1.1 Arizona Public Service Company

*J. Bailey, Vice President, Nuclear Engineering
*S. Burns, Department Leader, Design Engineering
*I. Chavez, Section Leader, Instrument and Controls Maintenance
*P. Crawley, Director, Nuclear Fuels Management
*B. Dayyo, Senior Representative, Strategic Communications
*R. Flood, Department Leader, System Engineering
*R. Hazelwood, Engineer, Nuclear Regulatory Affairs
*M. Hodge, Department Leader, Nuclear Engineering
*W. Ide, Director, Operations
*K. Jones, Section Leader, Maintenance Services
*A. Krainik, Department Leader, Nuclear Regulatory Affairs
J. Levine, Vice President, Nuclear Production
*R. Lucero, Department Leader, Electrical Maintenance
*D. Mauldin, Director, Maintenance
*G. Overbeck, Vice President, Nuclear Support
*C. Seaman, Director, Nuclear Assurance
*B. Thiele, Section Leader, Nuclear Fuels Management
*M. Winsor, Section Leader, Mechanical Maintenance Engineering

1.2 NRC Personnel

*R. Huey, Chief, Region IV Reactor Projects Branch F
*D. Garcia, Resident Inspector
*J. Kramer, Resident Inspector

1.3 Others

*F. Gowers, Site Representative, El Paso Electric
*R. Henry, Site Representative, Salt River Project

*Denotes those present at the exit interview meeting held on November 3, 1995.

The inspector also held discussions with and observed the actions of other members of the licensee's staff during the course of the inspection.

2 EXIT MEETING

An exit meeting was conducted on November 3, 1995. During this meeting, the inspectors summarized the scope and findings of the report. The licensee acknowledged the inspection findings documented in this report. The licensee did not identify as proprietary any information provided to, or reviewed by, the inspectors.

ATTACHMENT 2

LIST OF ACRONYMS

COLSS	core operating limits supervisory system
CRDR	condition report/disposition request