U. S. NUCLEAR REGULATORY COMMISSION

REGION III

Report No. 50-255/90039(DRP)

Docket No. 50-255 License No. DPR-20

Licensee: Consumers Power Company
212 West Michigan Avenue
Jackson, MI 49201

Facility Name: Palisades Nuclear Generating Plant

Inspection At: Palisades Site, Covert, MI

Inspection Conducted: November 28, 1990 through January 11, 1991

Inspectors: J. K. Heller

J. A. Hopkins

T. J. Kobetz

Approved By: B. L. Jorgensen, Chief
Reactor Projects Section 2A

1-23-91
DATE

Inspection Summary
Inspection on November 28, 1990 through January 11, 1991 (Report No. 50-255/90039(DRP))
Areas Inspected: Routine unannounced inspection by the resident inspectors of actions on previously identified items, plant operations, maintenance, surveillance, reportable events, security, steam generator replacement, training, allegations, refueling activities, cold weather preparations, and NRC Region III requests.
Results: Of the 12 areas inspected, no violations or deviations were identified.

The strengths, weaknesses and Open Items are discussed in paragraph 15, "Management Interview."

DETAILS

1. Persons Contacted

Consumers Power Company

D. P. Hoffman, Vice President, Nuclear Operations
+D. W. Joos, Vice President, Energy Supply
+G. B. Slade, Plant General Manager
* R. M. Rice, Plant Operations Manager
*+D. J. VandeWalle, Safety/Licensing Director
+R. D. Orosz, Engineering and Maintenance Manager
*+T. J. Palmisano, Administrative and Planning Manager
* K. M. Haas, Radiological Services Manager
J. L. Hanson, Operations Superintendent
R. B. Kasper, Mechanical Maintenance Superintendent
* K. E. Osborne, System Engineering Superintendent
L. J. Kenaga, Health Physics Superintendent
C. S. Kozup, Technical Engineer
J. R. Brunet, Licensing Analyst
* W. L. Roberts, Senior Licensing Analyst
+K. A. Toner, Plant Projects Superintendent
* J. C. Petro, Quality Assurance
* R. E. McCaleb, Quality Assurance Director

Nuclear Regulatory Commission (NRC)

+A. B. Davis, Regional Administrator
+H. J. Miller, Director, DRP
+M. P. Phillips, Chief, Operation Programs Section 2
+H. B. Clayton, Chief, Reactor Projects Branch 2
*+B. L. Jorgensen, Chief, Projects Section 2A
+W. G. Snell, Chief EP & Effluents Section
+R. N. Gardner, Chief, Plant Systems Section
*+J. K. Heller, Senior Resident Inspector
* J. A. Hopkins, Resident Inspector
+I. S. Yin, Reactor Inspector

+ Denotes some of those present at the Management Meeting on November 28, 1990

* Denotes some of those present at the Exit Interview on January 11, 1991

Other members of the Plant staff, and several members of the Contract Security Force, were also contacted during the inspection period.

2. Actions on Previously Identified Items (92701, 92702)

a. (Closed) Open Item 255/89038-04(DRP): Use of generic specification change to replace carbon steel studs with stainless steel studs. A number of problems (concerning print updates and old versus new

material compatibility) were identified. The generic specification change has been closed and all work done per the specification change has been reviewed. Future changeout will be handled by individual specification change. The licensee evaluation is documented on commitment tracking log 89-068.

b. (Closed) Bulletins 255/85003 and 255/87001: "Motor Operated Valve Common Mode Failures During Plant Transients Due to Improper Switch Settings" and "Thinning of Carbon Steel Piping in LWRs". NRC Region III Management has reviewed the existing open items and determined these bulletins will be closed administratively due to their safety significance relative to emerging priority issues and to the age of the items. The licensee is reminded that commitments directly relating to these bulletins are the responsibility of the licensee and should be met as committed.

The items below (c - f) were identified by a team inspection lead by Region III, with support provided by the NRC office of Nuclear Reactor Regulation (NRR). The inspection report requested a written response for each of the items identified. The licensee response, dated September 20, 1990, was reviewed by NRR and a safety evaluation was issued on November 20, 1990. This safety evaluation discussed and closed each of the four open items.

c. (Closed) Open Item 255/90019-01(DRS): Facility Change 915 "Component Cooling Water Surge Tank Room Modifications" did not address the potential for airborne release, damage to equipment in the room, and heat loads in the system.

d. (Closed) Open Item 255/90019-02(DRS): A number of questions were raised during the review of Facility Change 914 "Containment Construction Opening".

e. (Closed) Open Item 255/90019-03(DRS): Facility Change 904 "Auxiliary Building Modification for Containment Access" did not address the potential for radioactive release.

f. (Closed) Open Item 255/90019-04(DRS): Facility Change 909 "Steam Generator Replacement" concluded that some technical specifications were not required prior to startup. The reviewers disagreed and requested that a new schedule be implemented.

No violations, deviations, unresolved or open items were identified.

3. Operational Safety Verification (71707, 71710, 42700)

Routine facility operating activities were observed as conducted in the plant and from the main control room.

The performance of Reactor Operators and Senior Reactor Operators, Shift Engineers, and Auxiliary Equipment Operators was observed and evaluated. Included in the review were procedure use and adherence, records and logs, communications, shift/duty turnover, and the degree of professionalism of control room activities.

Observations of the control room monitors, indicators, and recorders were made to verify the operability of emergency systems, radiation monitoring systems, and nuclear reactor protection systems. Reviews of surveillance, equipment condition, and tagout logs were conducted. Proper return to service of selected components was verified.

a. General

The plant began this reporting period in a refueling shutdown condition with the vessel defueled and all fuel in the spent fuel pool. The inspector verified by observation, discussion with the control room operators, and review of checksheets that the spent fuel pool cooling system was operable. This included verification that the fuel pool temperature was maintained, spent fuel ventilation was operable during spent fuel pool activities, cooling water was available to the spent fuel pool heat exchangers, and emergency power was available.

b. Contaminated Water Spill In West Safeguards Room

At approximately 8:00 p.m., on December 10, 1990, while attempting to place the safety injection and refueling water storage (SIRW) tank on "fast recirculation," the licensee inadvertently transferred contaminated water to the spent fuel pool (SFP) and the engineering safeguards piping. The water introduced to the safeguards piping resulted in a spill of approximately 2000 gallons to the west safeguards room located in the auxiliary building basement. The addition of water to the SFP had little effect.

The inspectors investigation determined that the procedure used to place the SIRW tank on fast recirculation was apparently not appropriately implemented. The plant operating procedure used was modified to account for various interfacing system being out-of-service for maintenance due to the ongoing refueling outage. By reconfirming valve lineups, the licensee was able to secure the addition of water to the safeguards piping and the SFP and place the SIRW tank on fast recirculation.

The licensee determined that poor communication between the Shift Supervisor (senior licensed operator on shift) and the Auxiliary Operators was the cause of the event. To prevent recurrence, the Operations Superintendent reviewed the event with all of the shift supervisors and intensified the operators' classroom and simulator communications training. The inspector has no additional concerns at this time.

c. Tours

(1) On November 16, 1990, during a routine containment tour, a fire watch informed the inspector that he was standing in an elevated dose area. The area was near the north stair well on the 625 elevation. There were no signs or postings identifying this as an elevated dose area. A Health Physics (HP) technician measured the dose in the approximate 1 square foot area and

observed approximately 50 mr/hr on the floor and 20 mr/hr at 18 inches. The HP technician stated that the concern would be reported to the HP containment supervisor.

On November 27, 1990, the inspector observed two people working in the area who were unaware of the elevated dose. HP technicians again confirmed the dose rates and indicated that the HP containment supervisor would be informed.

On December 1, 1990, the inspector observed that the area was not identified as an elevated dose area and notified the Outage Manager and the duty HP Supervisor. The inspector described the events listed above and discussed his concern that personnel may be loitering in the area.

The HP Superintendent stated that there were no requirements to specifically post the area because it falls below the posting threshold. However, the area was posted as an elevated dose area and both licensee and outage contract HP technician were briefed to be more sensitive to posting areas of elevated dose which are below the high radiation or "hot spot" threshold. The HP Superintendent stated that poor communication between contractor and licensee HP organizations was the probable cause for this concern not being resolved in a more timely manner. The inspector verified that the area was posted during a containment tour.

(2) When exiting containment through the personnel air lock, the inspector observed several people not following the licensee method for removing anti-contamination protective clothing. Additionally, due to the layout of the change out area, people had to throw some of their used protective clothing into a basket when standing on the "clean" side of the step-off pad. After continued observation with licensee HP personnel present, the layout of the air lock change area was modified to prevent throwing protective clothing.

(3) During a routine tour, the inspector observed a security guard hurrying to respond to a security door alarm in the radiologically controlled area (RCA) of the auxiliary building. The guard attempted to "log in" using the Management Information System (MIS) computer but was denied access to the RCA. (The inspector did not observe the specific reason). Since MIS denied access, the guard was issued a self reading dosimeter (SRD) vice the MIS controlled electronic dosimeter (EMD) and proceeded to respond to the door alarm. (Note: the guard was authorized under the appropriate Radiation Work Permit (RWP)).

The inspector asked the licensee HP staff how the guard's SRD dose was incorporated into the MIS data base. The MIS tracks each RCA entry, RWP used, individual dose received on EMD and dose accumulated against the RWP. HP stated that SRD dose is normally recorded when the individual exits the RCA and MIS is

updated within 24 hours. Normally, the log is then discarded. The licensee was unable to find any record of the guard's RCA entry. The licensee performed a dose assessment for the entry based on security door card reader history and entered the "best estimate" dose received into the MIS. (The guard's film badge captured all dose received for the quarter.)

This appeared to be an isolated case and the inspector had no additional concerns.

(4) During a routine turbine building tour, contract employees working on the main condenser replacement project expressed concerns about the differences between the licensee's and contractor's confined space entry requirements. The inspector forwarded the concern to the licensee's Safety Coordinator. The Safety Coordinator determined that although the licensee's and the contractor's entry requirements differ, both meet Michigan Occupational Health and Safety Administration standards and are being correctly implemented. The Safety Coordinator forwarded the concern and the results of the investigation to the contractor, who then informed the individual work groups.

d. During a review of the outage manager's logbook, the inspector noted that the outage manager had approved a deviation from the plant overtime limitations. The administrative procedures permitted deviations from the overtime limitations and specified, by title, who could authorize a deviation. The list was comprised of senior plant managers. The outage manager who approved the deviations was not included on the list. The licensee reviewed the inspector's observation and determined that the unauthorized approval did not affect quality, however, the licensee determined that the list would not be expanded to include the outage manager. In addition, the outage manager was reminded of this requirement and a log entry was made in the outage manager logbook reflecting plant managements' expectations. The inspector had no additional concerns.

No violations, deviations, unresolved or open items were identified.

4. Maintenance (62703, 42700)

Maintenance activities in the plant were routinely inspected, including both corrective maintenance (repairs) and preventive maintenance. Mechanical, electrical, and instrument and control group maintenance activities were included as available.

The focus of the inspection was to ensure that the maintenance activities reviewed were conducted in accordance with approved procedures, regulatory guides, industry codes or standards, and were in conformance with Technical Specifications. The following items were considered during this review: Limiting Conditions for Operation were met while components or systems were removed from service, approvals were obtained prior to initiating the work, activities were accomplished using approved procedures, and post maintenance testing was performed as applicable.

The following activities were inspected:

a. Install Flow and Pressure Indicators on Component Cooling Water Pump, P-52A (Work Order (WO) 24904125).

b. SPS-016 ED-01 Battery Cleaning.

c. RM-63-1 Diesel Generator (DG) 1-1 Periodic Diesel Engine Inspection (Refueling Outage).

During the engine inspection, two defects were identified on the crankshaft vibration damper. The licensee evaluated the damage with technical assistance from the diesel manufacturer, ALCO Power Incorporated, and determined that the defects would not effect DG operability. The ALCO representative concluded that the damage occurred during factory assembly or testing. The only two previous inspections (RM-63-1 was a relatively new inspection) would not necessarily have discovered the defects because of their location. The licensee determined that a special inspection of DG 1-2 was not warranted due to the lack of similar indications found during the inspection earlier in the refueling outage, the negligible impact the defects had on DG 1-1 operability, and the scope of engine disassembly required to perform additional inspections. The inspector had no additional concerns.

d. Emergency Diesel Generator (EDG) 1-2, Cylinder 2L Fuel Oil Leak (WO 24006908).

During the visual inspection of EDG 1-2 prior to performing MO-7A-2, EDG 1-2 Monthly Test, a fuel oil leak in cylinder 2L was identified. The copper washer on the fuel inlet to the injector pump was not seated properly and was repaired under Work Order No. 24006908. After EDG startup, the local operator identified a low temperature on cylinder 2L (100 degrees F - nominal is 800 F degrees). Initial investigation revealed that the control rack latch (a device which holds the reciprocating fuel oil control valve shut) was engaged. The local operator disengaged the latch and the cylinder temperature returned to normal operating conditions.

The inspector's investigation determined that the job supervisor, who was also the work planner and was experienced with diesel engine maintenance, believed that the correct position for the latch was "engaged."

To prevent recurrence, the licensee will add this event to the mechanical maintenance training program and has posted caution signs in the EDG rooms to remind maintenance personnel that Operations Department permission is required to change the positions of the fuel oil control rack latch. The inspector had no additional concerns.

e. Low Pressure Safety Injection (LPSI) Pump, P-67A, Shaft Seal Leak (WO 24901897).

LPSI Pump P-67A was taken out of service to repair a pump shaft sleeve leak and to investigate the cause of increased vibration level readings on the pump inboard bearing. Investigation revealed that the pump impeller jam nuts were loose, and the stuffing box bushing was galled onto and rotating freely with the impeller. Additionally, the thrust bearing had visible signs of wear and the shaft was out of round in two places. The root cause of the impeller galling appears to be the loose jam nuts.

The pump bearings and shaft seal were repaired/replaced and the shaft was machined to specifications. The impeller jam nuts were torqued to their proper values. Note: The last time P-67A was disassembled (1984) there was no required torque value in the procedure. The maintenance procedure has been revised since then. Additionally, P-67B was last disassembled in January 1990 and the impeller jam nuts were properly torqued. Post maintenance testing was completed satisfactorily.

f. Service Water Pump Brace Modification to Reduce Vibrations, Facility Change No. 865.

Braces were added to the three service water pumps to control vibrations during normal operation. Post modification evaluation of pump vibrations indicates a 60-80 percent overall reduction.

g. CC5-010 Clean and Inspect Component Cooling Water (CCW) Heat Exchanger (HX) Tubes.

CCW HX E-54A tubes (service water side) were cleaned and inspected using eddy current testing. There were no indications of marine fouling in the tubes. Only two tubes required plugging. A total of 98 out of 2020 tubes are currently plugged.

No violations, deviations, unresolved or open items were identified.

5. Surveillance (61726, 42700)

The inspector reviewed Technical Specifications required surveillance testing as described below and verified that testing was performed in accordance with adequate procedures, test instrumentation was calibrated, Limiting Conditions for Operation were met, removal and restoration of the affected components were properly accomplished, test results conformed with Technical Specifications and procedure requirements and were reviewed by personnel other than the individual directing the test, and deficiencies identified during the testing were properly reviewed and resolved by appropriate management personnel.

The following activities were inspected:

a. MO-7A-1 Emergency Diesel Generator 1-1 Monthly Test
MO-7A-2 Emergency Diesel Generator 1-2 Monthly Test

Both tests required that one of the two air start motors associated with each diesel be removed from service prior to the start of the

test. If the diesel starts in less than 10 seconds then the test continues. If the diesel does not start or the start time exceeds 10 seconds, the second air start motor is returned to service and another start test is performed. If the diesel starts in 10 seconds or less the test continues. This test methodology verifies the redundancy of the individual diesel generator air start systems and permits trending of individual air start motors. However the diesels are not tested in the as found condition (both air start motors in service). The potential exists that a slow or incomplete start may warm the system up such that the diesel will start within 10 seconds during the next start if the second air start is in service or not. This warm-up may mask or hide a problem with the air start system.

The licensee was asked if a diesel generator start with both air start motors valved in should be included as one of the rotation sequences for starting the diesel generators. The system engineer agreed to review the starting methodology and implement appropriate changes. This is an open item pending the system engineer's review. (Open Item 255/90039-01(DRP).

b. MO-7B Fire Water Pumps: P-9A, P-9B and P-41 (Monthly Operability Verification)

c. MO-37 Fuel Handling Auxiliary Ventilation System (Operability Verification).

d. Special Test T-223 Component Cooling Water Flow Verification (Design Basis Accident Flow Balance).

e. MO-33 Control Room Ventilation Emergency Operation (Monthly Operability Verification)

On December 2-3, 1990, the A-Train of the control room ventilation system successfully completed MO-33. On December 3, 1990, the B-Train surveillance was interrupted because VC-10, the refrigeration condensing unit chiller, tripped on low oil pressure. Repairs were completed under Work Order 24006694 and MO-33 was successfully completed on December 9, 1990.

One open item and no violations, deviations or unresolved items were identified.

6. Steam Generator Replacement Project (37701)

a. The inspector observed the containment construction opening cement pour on December 8, 1990. Observations made at the batch plant and at the construction opening were as follows:

(1) At the batch plant, the inspector verified that the moisture content of the aggregates was considered when making adjustments to the batch weight, the calibration of the batching equipment had been performed, special security measures were implemented to minimize delays and to safeguard the delivery trucks, and the drivers were cautioned not to add water once the batch was in the truck.

(2) At the construction opening, the inspector witnessed the air content test, unit weight test, and "slump" test on the first batch of cement used for the pour. The equipment used for these tests was all recently calibrated. All test data was recorded on a "Construction Material Testing Document" developed by the contractor performing the tests. As a minor note, the inspector observed that the acceptance criteria was not written on the "Construction Material Testing Document." However, the test contractor's and Bechtel Quality Control (QC) inspectors were familiar with the requirements. Bechtel QC inspectors were observing the contractor testing and cement pour at both the batch plant and the containment opening. The cement pour started at approximately 1:00 p.m. and was completed at about midnight.

(3) Before and during the cement pour, the tendon guides were inspected for blockage by inserting a "rabbit" wire through the guide tubes. There was no apparent blockage of the tendon guide tubes.

b. For most of the report period, welding the steam generator (SG) nozzles to the primary coolant system (PCS) was ahead of schedule. Narrow gap welding of the hot leg piping to the SG nozzles proceeded without incident. This welding process was developed by the German company Kraftwerk Union. Minor repairs were required on one of the hot leg welds due to weld porosity near the outside diameter of the joint. Cold leg welds required extensive repair on six of the eight joints due to unacceptable porosity scattered throughout the weld and lack of fusion (primarily in the stainless steel cladding). The narrow gap weld defects were removed and the piping was rewelded by conventional means.

A more detailed explanation of the welding process and problems will be in Inspection Report No. 50-255/90025(DRS).

c. On December 7, 1990, a contractor-employed level III quality control (QC) inspector, who was reviewing the radiographic film for the construction opening liner plate welds, resigned. After discussion between the licensee and Region III personnel, the licensee interviewed the QC inspector (by telephone) to confirm that there were no safety concerns. The record of the telephone interview documented that the QC inspector had no safety concerns and his departure was mainly due to treatment by management and the excessive hours that he was working. He stated he was exhausted and chose to resign because he was on 24 hour call and occasionally worked between 18 and 20 hours per day.

The inspector reviewed Palisades Administrative Procedure Number 1.00 "Plant Organization and Responsibilities", and found that this procedure provided overtime limitations that apply to both plant and contractor personnel. The procedure also provided a mechanism to

deviate from these limitations. The inspector reviewed the approved deviation and found what appeared to be a "blanket authorization" for the SG replacement project, permitting the contractor to control overtime. This appeared to meet the requirements to permit a deviation, however this may be a case where the spirit of the administrative requirement was not met. Because of delays in the project this may not be the only example. The licensee was asked to review this and determine if the contractor was controlling overtime in the manner that was intended by Palisades Administrative Procedure Number 1.00.

After a new level III QC inspector was certified, the film of the liner plate welds was reviewed and no concerns were identified. A Region III specialist reviewed a sample of the film without any findings. Based on the above, it appears the quality of the liner plate welds was not compromised.

No violations, deviations, unresolved or open items were identified.

7. Regional Request (71707)

Licensee Use of Overtime

Based on a NRC Region III memorandum, the inspector reviewed Palisades Administrative Procedure Number 1.00 (Proc. No. 1.00) "Plant Organization and Responsibilities", and Technical Specifications (TS) section 6 "Administrative Controls", to evaluate the licensee's practices and programs which control the use of overtime by departments other than Operations. The controls in place appeared to be adequate to control the use of excessive overtime by all CPCo and contractor personnel assigned to the Palisades Nuclear Power Plant. The details of the review were forwarded to Region III under separate correspondence.

Due to the inspector's increased sensitivity to overtime concerns and the apparent departure from the spirit of the procedures in place, the licensee was asked to perform a detailed review of the contractor's control of overtime. (See paragraph 6.c above.)

No violations, deviations, unresolved or open items were identified.

8. Training (41701)

The inspector observed a training session - on shift - for hardware/software modifications made to the fuel handling equipment. The seminar was for all operators and supervisors directly involved in the refueling process. The licensee's Training Department recorded the attendance and gave individual training to any personnel who missed the on shift sessions. The modifications are scheduled to be incorporated into the refresher training lesson plan prior to the next refueling outage.

The inspector contacted the Training Department to observe the methodology used to incorporate plant modifications, facility changes and other changes into the licensed operator initial and requalification training program. The process is outlined in Administrative Procedure 11.0, "Plant Training

Organization and Responsibilities." The modifications and other changes are evaluated by the Training Review Tracking Committee (TRTC) to determine their impact on operator knowledge/performance. The TRTC then assigns a specific technical group to develop the lesson plan details. The lesson plan is reviewed and then incorporated into the initial and/or requalification training cycle. The process outlined in Administrative Procedure 11.0, appears to be adequate to capture and incorporate facility changes into the training programs.

No violations, deviations, unresolved or open items were identified.

9. Refueling Activities (60705, 60710)

In preparation for the upcoming fuel load, the inspector reviewed procedures; interviewed Reactor Operators, Refueling System Engineers, and Training Instructors; and toured the fuel handling and storage systems. The inspector determined the following:

a. Weaknesses were identified in the implementation of the foreign material exclusion (FME) procedures. During a tour of the spent fuel pool, the inspector found a pen detached from its lanyard and lying on the bridge. This is in direct conflict with Palisades Nuclear Plant Permanent Maintenance Procedure MSM-M-47, step 5.2.1 which states "All materials used within a FMEA shall be made fail-safe or have other special precautions in place to prevent loss of control of foreign material." During interviews with operators, maintenance, and contract personnel - it became apparent that, in the past, formal FME training had not been adequately addressed for refueling activities. The licensee has begun to formally brief refueling contractor and maintenance personnel on FME. Reactor Operators will be briefed prior to fuel movement operations. The inspector will continue to observe the implementation of FME procedures during the upcoming fuel movement operations.

b. Management involvement in refueling preparations was very apparent. Operations, the Refueling Systems Engineers, and contractors were found to have worked closely together to design procedures which were easy to use and took all the new equipment modifications into account. Reactor Operators felt confident in using the procedures.

c. Around the clock coverage will be provided by contractor personnel during fuel movements to assist in any equipment problems. This will prevent lengthy time delays and enhance ALARA.

d. The inspector noted that the FSAR did not reflect the current refueling machine and spent fuel pool positioning modifications. The system engineer stated that the modifications will be incorporated during the next annual FSAR update.

No violations, deviations, unresolved or open items were identified.

10. Cold Weather Preparations (71714)

The inspector reviewed the licensee's Cold Weather Preparations Check List and interviewed Reactor Operators. It was determined that adequate measures had been taken to prevent freeze up of vital safety equipment. The licensee had reviewed the effects of the extended outage and taken actions necessary to ensure areas normally kept warm by plant operation were adequately protected. One instance of test equipment freeze up did occur. During the performance of QO-13, a test tee, located on the auxiliary building roof next to the SIRW tank, froze and caused blockage. The tee was heated using a hot air gun and heat tape. The test was then completed satisfactorily.

No violations, deviations, unresolved or open items were identified.

11. Security (71707)

Routine facility security measures - including control of access for vehicles, packages, and personnel - were observed. Performance of dedicated physical security equipment was verified during inspections in various plant areas. The activities of the professional security force in maintaining facility security protection were occasionally examined or reviewed, and interviews were occasionally conducted with security force members. Additionally, the inspector discussed the increased potential of threats to plant security based on the situation in the Persian Gulf.

During the week of November 26, 1990, a regional security specialist inspected the site security systems. The inspector's conclusions were detailed in Inspection Report No. 50-255/90037(DRSS).

During this report period, a contractor supervisor tested positive during random drug testing. The individual's access authorization was revoked and a telephone notification to the NRC was made pursuant to 10 CFR 26.73(a)2(ii). Any additional information pertaining to this subject will be discussed under separate correspondence.

No violations, deviations, unresolved or open items were identified.

12. Allegation (92705)

On December 12, 1990, the inspector received a telephone call alleging maintenance procedure violations and the fear of punitive measures if these concerns were brought to management's attention. This information was forwarded to Region III. Any additional information pertaining to this subject will be discussed under separate correspondence.

No violations, deviations, unresolved or open items were identified.

13. Reportable Events (92700, 92720)

The inspector reviewed the following Licensee Event Report (LER) by means of direct observation, discussions with licensee personnel, and review of records. The review addressed compliance to reporting requirements and, as applicable, that immediate corrective action and appropriate action to prevent recurrence had been accomplished.

(Closed) LER 255/90013: Overtime Limit Exceeded Due To Scheduling Oversight.

The event occurred due to personnel error by a licensed Shift Engineer and an Operations Scheduler for failing to recognize that Technical Specification overtime limits had been exceeded. Technical Specification overtime limitations are currently part of the Operations Training Program. To prevent recurrence, this event was added to the training as an example of unauthorized exceeding of overtime limits. The quality of the individual work was not affected by the additional hours on shift.

No violations, deviations, unresolved or open items were identified.

14. Quarterly Management Meeting

On November 28, 1990, a quarterly management meeting was held in the NRC Region III office - with the personnel indicated in Paragraph 1 in attendance - to discuss the steam generator replacement project, restart test plan, safety injection and refueling storage tank repairs, and status of engineering self-assessment. Questions were raised by Region III personnel that the licensee has agreed to evaluate. Particular items included in the discussion were as follows:

a. Should the startup test program include a requirement for natural circulation testing (Open Item 255/90039-02(DRP)).

b. Should the startup test program include a requirement for auxiliary feedwater hammer testing (Open Item 255/90039-03 (DRP)).

c. Should system measurements be made during the next cooldown to determine effect of the thermal cycle on the modifications (Open Item 255/90039-04(DRP)).

d. Does the Safety Injection and Refueling Water (SIRW) tank floor plate flexing induce stress on the pipe penetration welds that will affect the tank seismic certification (Open Item 255/90039-05(DRP)).

Four open items and no violations, deviations or unresolved items were identified.

15. Management Interview (30703)

The inspectors met with licensee representatives - denoted in Paragraph 1 - on January 11, 1990 to discuss the scope and findings of the inspection. In addition, the likely informational content of the inspection report with regard to documents or processes reviewed by the inspector during the inspection was also discussed. The licensee did not identify any such documents/processes as proprietary.

Highlights of the exit interview are discussed below:

a. Strengths noted:

(1) Trending of diesel generator start times using a single air start motor (paragraph 5.a).

(2) Special security measures taken to minimize delays for the cement delivery trucks' access to the protected area (paragraph 6.a (1)).

b. Weaknesses noted:

(1) Communications -

Improper valve line up resulting in contaminated water spill (paragraph 3.b).

Timely posting of elevated dose rate area in containment (paragraph 3.c (1)).

(2) Overtime Practices -

Outage Shift Manager unauthorized approval to exceed overtime limits (paragraph 3.d).

Apparent "blanket authorization" to exceed overtime limits (paragraph 6.c).

c. The five Open Items were discussed:

(1) Diesel generator (DG) surveillance in the "as found" condition (paragraph 5.a.). The licensee was asked to review the DG starting methodology to determine if problems with the air start system are being masked.

(2) The last four were questions raised during the November 28, 1990 Quarterly Management Meeting (paragraph 14).

d. The licensee acknowledged receipt of Region III allegation review board evaluation of the allegation (paragraph 12).