

U. S. NUCLEAR REGULATORY COMMISSION
REGION III

Report No. 50-255/91024(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 5 through December 16, 1991

Inspectors: J. K. Heller
J. R. Roton

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

12/27/91
DATE

Inspection Summary

Inspection from November 5 through December 16, 1991 (Report No. 50-255/91024(DRP))

Areas Inspected: Routine unannounced safety inspection by resident inspectors of actions on previously identified items, operational safety verification, reactor trips, maintenance, outages, and quality program activities. No Safety Issues Management System (SIMS) items were reviewed.

Results: Of the six areas inspected, no violations or deviations were identified in five areas. One violation was identified (failure to document bases that an unreviewed environmental question does not exist - Paragraph 7) in the remaining area.

Strengths, weaknesses and open items are discussed in paragraph 9, "Management Interview." In summary, strengths were identified in a conservative operating philosophy, in open communications, in strong technical documentation to support resolution of an engineering problem, in control room leadership, in well planned maintenance activities, and in outage preparations. Weaknesses were noted in the lack of a complete response to a Notice of Violation, in plant reliance on an offsite group to determine Technical Specification applicability, in component identifiers not matching checklist description, in the lack of a screening mechanism for maintenance activities which could expand the cold-weather protection envelope, and in poor coordination of the emergency down-power event that occurred on December 9, 1991.

DETAILS

1. Persons Contacted

Consumers Power Company

- *G. B. Slade, Plant General Manager
- *R. M. Rice, Plant Operations Manager
- *P. M. Donnelly, Safety & Licensing Director
- *K. M. Haas, Radiological Services Manager
 - J. L. Hanson, Operations Superintendent
 - R. B. Kasper, Maintenance Superintendent
- *K. E. Osborne, System Engineering Superintendent
- *J. L. Kuemin, Licensing Administrator
- *R. D. Orosz, Engineering and Construction Manager
- *L. Morse, Licensing Clerk
 - D. D. Hice, Chemistry Superintendent
 - C. S. Kozup, Technical Engineer
 - W. L. Roberts, Senior Licensing Analyst
 - R. W. Smedley, Staff Licensing Engineer
 - K. A. Toner, Electrical/I&C/Computer Engineering Manager
- *T. J. Palmisano, Administrative & Planning Manager

Nuclear Regulatory Commission (NRC)

- W. D. Shafer, Chief, Reactor Projects Branch 2
- B. L. Jorgensen, Chief, Reactor Projects Section 2A
- *J. K. Heller, Senior Resident Inspector
- *J. R. Roton, Resident Inspector

* Denotes some of those present at the Management Interview on December 18, 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)

(Open) Violation 255/91017-1(DRP): Inoperability of Containment Spray Pump.

The licensee response of December 9, 1991, did not provide the information requested by the Notice of Violation. For example, the letter did not admit or deny the violation, the cover letter did not state "Reply to a Notice of Violation", it was not addressed to the correct person, and the response pertaining to testing components after installation of a breaker and fuse was not consistent with the information provided at the enforcement conference and to the inspector during the inspection. These discrepancies were verbally

provided to the licensee on December 12. The licensee submitted a revised response dated December 14.

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

3. Operational Safety Verification (71707, 71710, 71714, 42700)

Routine facility operating activities were observed as conducted in the plant and from the main control room. Plant startup, steady power operation, plant shutdown, and system lineup and operation were observed as applicable.

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, the degree of professionalism of control room activities, and performance during a plant transient.

a. General

The plant began the inspection period at essentially full power. During the reporting period the unit was derated to approximately 35 percent power from November 5 through 9, to resolve condenser tube leakage. The unit was offline from December 9 through 14, to resolve problems with the turbine-generator seal oil system. The plant ended the reporting period at essentially full power.

b. Turbine Driven Auxiliary Feedwater Pump Inoperable

On November 13, CV-0521, "Alternate Steam Supply to the Turbine Driven Auxiliary Feedwater (TDAFW) Pump," failed to stroke open during a surveillance test. The valve and the TDAFW pump were declared inoperable. Subsequent attempts to open the valve by normal means were successful. The valve stem was lubricated and an internal corrective action document (D-PAL-91-187) was written to evaluate the problem. The preliminary evaluation of D-PAL-91-187 determined that the valve was operable based on the maintenance performed and successful stroking of the valve. This evaluation reviewed historical valve performance, which did not identify any negative trends. The evaluation did raise the question of valve reliability. To address this question, the valve was placed on increased stroking frequency (daily and weekly) until root cause analysis was completed.

The licensee completed a week of daily stroke timing on the valve and had reduced to weekly stroke testing when the valve failed to stroke a second time. The valve and TDAFW pump were declared inoperable. While the maintenance department attempted to open the valve, the Plant Review Committee (PRC) evaluated

the problem and considered the available options. The maintenance department was able to open the valve by lightly tapping the top of the stem. The valve was successfully stroked, the actuating air pressure increased and the valve placed on a daily stroking frequency until the next outage. The licensee has not been able to determine the root cause and it is not likely that the root cause will be determined prior to the outage.

The inspector discussed the following items with members of the plant staff.

- (1) The inoperability of the TDAFW pump was discussed with the Operations Superintendent and the Director of Safety and Licensing. The inspector concluded that the decision to declare the TDAFW pump inoperable demonstrated a conservative operating philosophy. This conclusion was based on these facts: the other steam supply valve (CV-0522B) receives the auto-open signal and was operable; the operation of CV-0521 was not directly discussed in the FSAR; no credit was taken in an accident analysis; and the Technical Specification does not directly discuss operability of CV-0521.
- (2) The use of mechanical force to open the valve was discussed with the Maintenance Superintendent and the Safeguards System Engineering Section Supervisor. Both stated that the mechanical force was minimal and use of mechanical force to assist component operation in lieu of corrective maintenance was not a tolerated practice. The use and type of force was documented on the work order and freely communicated to plant management. In addition, the applicable Work Order (WO 24105346) clearly identified the need to use force to open the valve.

The general topic of applying force to assist component operation and lessons learned at other plants was discussed at the Management Interview.

- (3) The corrective actions taken, which consisted of increasing the actuating air pressure and increasing the valve stroking frequency, were discussed with members of the plant staff. All stated that these were interim corrective measures until the plant was placed in a mode that permitted repair of CV-0521.

The inspector considered enforcement action for failure to take appropriate corrective action when the valve failed to stroke the first time. The inspector does not consider enforcement action appropriate at this time based on the detailed documentation contained in D-PAL-91-187. The documentation

included a fault tree analysis of the potential fault paths and a reason for not considering a fault path.

c. Control Room Observations

On December 14, the inspector observed control room personnel taking the reactor critical through the point of adding heat. The shift supervisor displayed a strong command presence and a high degree of professionalism. The inspector noted that although the Operations Superintendent and the Operations Manager were present throughout the evolution, they remained in the background allowing the Shift Supervisor uninhibited control and direction of the evolution. In addition, the inspector observed the performance of a recently licensed operator performing the rod withdrawal steps. The manner in which other members of the shift provided insights and recommendations, based on their experience, was noteworthy.

d. 50.72 Notifications

During power escalation on December 15, the licensee added additional non-safety related loads to non-safety related bus "1E" which caused undervoltage relays to activate on the "1C" and "1D" safety related busses. The non-safety related bus and the safety related busses are fed from a common safeguards bus. The undervoltage was sensed by both safety related busses and subsequently caused the auto-start of both diesel generators. This undervoltage condition was not of sufficient duration to activate the load shed sequencers. The licensee secured the diesel generators and continued with the power escalation. The system was designed such that undervoltage sensed on either safety related bus would cause an auto start of both diesel generators.

Initial reports indicated that the plant electrical loads may have been lined-up in an unusual condition. Subsequent reviews determined that while the safety related busses were unevenly loaded, the electrical lineup was not unusual.

The inspector had no additional questions concerning this event. Additional reviews will be performed when the LER is issued. In addition, the licensee was informed that Region III Division of Reactor Safety inspection specialists are reviewing this item.

e. System Walkdowns

The inspector verified operability of the systems listed below by using the applicable checklist and confirming that major flowpath valves were in their correct position. No items were found that degraded the systems.

- (1) Diesel Generators, CL No. 22.1
- (2) Feedwater System, CL No. 12.1.

The inspector found this checklist to be difficult to utilize. Valve designators had been changed without revising the checklist. The checklist was last reviewed on May 27, 1988, and is not due for its next periodic review until May 1993. Due to the seemingly large number of system designator changes, the inspector indicated that an earlier review may be prudent.

- (3) Main Turbine Electro-Hydraulic Oil System, CL No. 8.1
- (4) Engineered Safeguards System Iodine Removal Instrumentation, CL No. 3.7

f. Cold Weather Preparations

The inspector reviewed the licensee cold weather protective measures program. The program consisted of two operating checklists - CL-CWCL-1, "Cold Weather Checklist," and CL-CWCL-2, "Cold Weather Checklist (Electrical)" - which are scheduled annually. Each checklist has a thirty day completion window. The inspector conducted walkdowns of CL-CWCL-1 and CL-CWCL-2. There were no significant problems identified; however, there was no formal feedback mechanism to ensure that systems which have been subjected to maintenance and/or modification during the past year are considered for cold weather preparations. This was discussed at the Management Interview.

g. Tours

During tours of the auxiliary building with two members of NRC Region III Management, the number and method of control of the yellow plastic catches used to control the flowpath of potentially contaminated liquid was discussed with the Radiation Protection staff. It was determined that the number of catches was small and an informal method of control was appropriate for now. The staff was able to identify those that were in-place for contamination control because a piece of equipment was leaking and scheduled for repair; and those that were in-place because boric acid had been cleared from the component and an evaluation was underway to determine if leaking was present and a repair was necessary. There were a couple of catches in-place to control the condensation from room coolers. It is appropriate to control the condensation in this manner, however, if this is a long term problem then a permanently installed drip pan may be more appropriate. This was discussed at the Management Interview.

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

4. Reactor Trip (93702)

The unit was removed from service at 5:22 p.m. on December 9, 1991, when the air side turbine-generator seal oil system failed resulting in a reduction of generator hydrogen pressure.

a. Power Reduction

At approximately 4:30 p.m. an Auxiliary Operator noted that turbine-generator seal oil pressure was decreasing. Automatic attempts by the backup seal oil system and manual intervention by the Auxiliary Operator, as directed by the Shift Supervisor, failed to stabilize the decreasing pressure. The Shift Supervisor ordered an emergency power reduction at 5:14 p.m. The power reduction was successful, in that power was reduced from 100 percent to approximately 20 percent in 10 minutes without the activation of any automatic trips. However, as evidenced by the mismatch between turbine and reactor power - which resulted in two reductions of the Primary Coolant System Temperature below the minimum temperature for criticality - the evolution was not well coordinated. Additionally, the power reduction was hampered by slow movement of control rod drive number 36. This drive lagged the other control rods in the group resulting in additional manipulations by the operator.

At approximately 5:25 p.m., the operators observed and confirmed that the water level for the "B" Steam Generator was above the auto isolation setpoint for main feedwater and approaching the manual trip setpoint; the operators initiated a reactor and turbine trip. The turbine trip was activated before the reactor trip, resulting in an automatic reactor trip due to loss-of-load with the reactor above the loss-of-load setpoint.

b. Unusual Event

At approximately 5:35 p.m., the Shift Supervisor declared an Unusual Event because of the potential for explosive quantities of hydrogen gas in the turbine building. The Unusual Event was secured at 12:50 a.m. on December 10, after the generator had been purged with carbon dioxide. During the Unusual Event, the turbine building was checked for explosive concentrations of hydrogen; none were found. In addition, turbine building ventilation was increased to minimize the risk of explosion due to hydrogen buildup.

The written statement from the Auxiliary Operator in the safeguards room, at the time the Unusual Event was announced, indicated that he did not hear the announcement and was unaware

that an Unusual Event was declared. Communication problems due to high noise level were the subject of IEB 79-18. Discussion with the NRC Region III Emergency Preparedness Staff identified the need for an Open Item for a Region III Emergency Preparedness specialist to review the licensee program for in-plant communication (Open Item 255/91024-01(DRSS)).

c. Post Trip Review

- (1) The post trip review indicated that a number of equipment problems occurred during the trip. None hindered the plant response or the operators' ability to recover from the trip. However, they did raise the frustration level in the control room which could have an indirect effect on the operators' ability to respond. In addition to the problems already discussed, the control room annunciator chime malfunctioned, the offsite communicator auto-dialer malfunctioned, and the telephone number to the power controller resulted in a recording providing additional numbers to call.
- (2) The post trip review identified that the two backup trip breakers failed to open when the associated trip push button was pushed. The primary trip contactors did open when activated by the reactor protective system. Pushing the backup trip breaker push button is a post trip checklist requirement. Performance of this step was documented. Later, because of the sequencing of a startup surveillance test, the final step of the post trip checklist (which verified the status of the trip breakers) was not performed but was marked "N/A". The surveillance procedure that was in progress required reset of the reactor protective system. In this case, the checklist step was marked "N/A" because the breakers were closed to perform the test. During a subsequent test, which concluded by opening the backup trip breakers, it was discovered that one of the breakers did not open when the push button was pressed. Based on this information and interviews conducted with the operators onshift during the trip, the licensee concluded that both of the trip breakers did not open. This conclusion was based on information obtained from the operator who stated he reset the reactor protective system to perform the first surveillance test without resetting the backup trip breakers. The licensee's investigation traced the problem to the push button, which required a steady push to assure proper make up of the internal contacts. This information was provided, as part of the shift turnover, to oncoming operators prior to assuming the watch. In addition, the licensee placed an operator aid on the control panel next to the switch.

d. Seal Oil

The licensee investigation of the air-side generator hydrogen seal-oil system determined that an in-line seal-oil filter became clogged and resulted in a reduction in seal-oil pressure. This conclusion was based on the fact that the backup system functioned properly and attempts to rotate the filter, after the trip, were unsuccessful. This type of filter is manually rotated once a shift to clean the internal filter surface. In addition, the licensee performed an air test of the generator shaft seal to confirm its integrity.

e. CRDM 36

During the power reduction, the movement of CRDM 36 was slow, resulting in manual operation by the control room operator, to keep the rod within the group. The problem was attributed to the drive package and it was replaced. The required trip time of the rod was subsequently verified and found to be satisfactory.

The inspector has reviewed the post trip information and verified that the problems were resolved prior to returning the plant to service. The inspectors have no additional questions at this time. Additional reviews will be performed when the 10 CFR 50.73, "Licensee Event Report" is issued.

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

5. 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 Inspector verified that 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 work order (WO) activities were observed:

- a. WO 24100421: Diesel Generator K-6B Fuel Oil Pressure Switch.
- b. WO 24104033: K-6B Starting Air Pressure Switch Incorrectly Piped.
- c. WO 24104034: K-6B Starting Air Pressure Switch Incorrectly

Piped.

- d. WO 24104056: Replace 18 Fuel Pump Cover Gaskets on Diesel Generator 1-2.
- e. WO 24104462: Swap Fuel Pumps, Cylinder 7L with 2R, on Diesel Generator 1-2.
- f. WO 24103212: Preventive Maintenance on Diesel Generator 1-2 Air Compressor.
- g. WO 24102666: Preventive Maintenance on Diesel Generator 1-2 A/C Backup Gasoline Engine.
- h. WO 24102096: Replace Band Clamp on Air Inlet Pipe/Turbo Charger on Diesel Generator 1-2.
- i. WO 24104114: Multi-009 Group, K-6B Air Start Motor Starting Air Instrumentation.

For several of the WOs listed above, the inspector noted that the mechanics or technicians involved in the repair or maintenance activity demonstrated a thorough understanding of the procedure. The procedures were clear and concise as to the work to be performed. Tools and other documentation required to complete the task appeared to be staged at the job site indicating a detailed pre-job review of the work order was performed prior to starting the job.

- j. WO 24105743 and Specification Change 91-77: E-50A Upper East Handhole Leak.

During a containment tour on December 12, the licensee observed a steam leak at a secondary side handhole for the "A" steam generator. The leak was caused by improper installation of a handhole cover, resulting in a non-uniform gap between the cover and the flange. The steam leak was from the gasket and did not affect the integrity of the flange, cover, or fasteners. The attempted repair included retorquing the nuts and installation of an enclosure that was injected with a liquid sealant. The inspector concluded, after consultation with Region III and NRR, that this was an acceptable repair because the structural integrity of a pressure retaining boundary was not compromised or degraded. Because of the ambient temperature, the liquid sealant solidified prior to securing the steam leak. The licensee was able to reduce the leak by approximately one third before concluding that additional repair attempts were unnecessary. The specification change was provided to Region III specialists for additional review. The inspector has no additional questions at this time.

- k. WOs 24101783, 24102631, 24102603: Repair steam leaks on the

management of the forthcoming refueling outage. The inspector running vent lines for the E6A and E6B Feedwater Reheaters.

The WOs documented that through wall pipe leaks exist in the 3 inch running vent lines. The temporary repair consisted of enclosures which were injected with liquid sealant. This temporary form of repair was acceptable because the lines are non-ASME code class lines. The inspector questioned the use of this type of repair because of steam line problems at other plants. In addition, the NRC has not generally accepted this type repair. The licensee stated that the repairs were temporary and will be removed during the next outage. WOs 24101996, 24103059, and 24103068 were issued to make permanent repairs during the outage.

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

6. Outages (86700)

The inspector reviewed various activities associated with the project examined the management techniques and tools utilized to ensure that the outage was planned in a safe and risk-free manner. Several strengths were noted during this review. The licensee utilized "system windows" to sequence work at the system level. By overlaying these system level work schedules onto various plant requirements, such as shutdown cooling, the licensee can determine when a system can be released for work without impacting plant safety. Additionally, the licensee utilized the Artemis scheduling package and the precedence scheduling technique. The Artemis system is capable of handling large numbers of activities allowing the licensee to schedule below the work order level. This allows for better work load forecasting and resource loading. The precedence scheduling technique allows the licensee to develop schedules that reflect real time accomplishment. This allows for the maximum utilization of limited outage time and better development of controlling path work.

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

7. Quality Program Activities

Plant Procedure CH 3.42, "Betz Clam Trol 1 Treatment of Service Water System."

The intent of CH 3.42 was to provide for treatment against zebra mussel infestation and prevent blockage caused by their rampant growth. The inspector interviewed the author of the procedure and reviewed the non-radiological environmental evaluation, the unreviewed safety question evaluation, the safety review, the environmental impact review and the Environmental Protection Plan. The inspector's observations are discussed below.

- a. The licensee unsuccessfully treated the firewater system for zebra mussels. During the summer of 1991, the firewater system was used to facilitate soil compaction of the independent spent fuel storage installation foundation and support fire fighting activities at a nearby housing subdivision. These activities created the potential to contaminate the firewater system with zebra mussels. The firewater system is an alternate source of feedwater to the auxiliary feedwater pumps. The firewater system piping configuration to the auxiliary feedwater pumps includes a section of piping (approximately 3 feet) which is exposed to the elevated ambient temperature of the auxiliary feedwater pump room. If a colony of zebra mussels is established in this leg of piping, the colony may continue to grow during the winter months because the ambient room temperature may keep the piping and water above the zebra mussels' dormant temperature. This concern was expressed to the licensee.
- b. The safety evaluation implied that fouling of heat exchangers due to deceased zebra mussels will occur approximately one week after the treatment. Discussions with NRC inspectors at power plants that have dealt with zebra mussels, indicated that fouling due to deceased zebra mussels may occur three weeks after treatment. This information was provided to the licensee.
- c. The Environmental Impact Review sheet (part of the support documentation for CH 3.42) requires an evaluation to determine if the proposed procedure modification resulted in an unreviewed environmental question as defined in Section 3.1 of Appendix B, "Palisades Environmental Protection Plan (EPP) to the Palisades Facility Operating License." The response was "no". No review comments were provided to document the bases for this response.

Section 3.1 of the EPP requires an environmental review to determine if activities which may affect the environment could create an unreviewed environmental question. One of the areas to be considered pertained to activities that were not evaluated in the EPP and may have a sufficiently adverse environmental impact. The use of Betz Clam Trol was not previously evaluated in the EPP. Section 3.1 also requires that records shall include a written evaluation which provides the bases for determining why an activity does not create an unreviewed environmental question and does not constitute a decrease in the effectiveness of the EPP.

As stated above, the licensee determined that the activity did not involve an unreviewed environmental question. However, the licensee did not provide a written evaluation which provided the bases that the activity did not involve an unreviewed environmental question or decrease the effectiveness of the EPP.

Failure to include written bases is a violation of Section 3.1 of the EPP. Compliance to the EPP is a requirement of the Facility Operating License, paragraph 2.c.(2) (Violation 255/91024-02(DRP)).

During interviews with plant personnel, the inspector was informed that it was not past practice to provide bases when the test, change or modification was found not to constitute an unreviewed environmental question. Based on this information the inspector concluded the problem was programmatic.

- d. The inspector observed that a person or group that does not directly report to the plant was determining compliance to the license as it applied to the Environmental Protection Plan. This was discussed with the licensee.

One violation was identified. No deviations, unresolved or open items were identified.

8. Open Items

Open items are matters which have been discussed with the licensee, and will be reviewed further by the inspector. These involve some action on the part of the NRC or licensee or both. An open item identified during the inspection is discussed in Paragraph 4.b.

Management Interview

The inspectors met with licensee representatives - denoted in Paragraph 1 - on December 18, 1991, 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 inspectors during the inspection was also discussed. The licensee did not identify any such documents or processes as proprietary.

Highlights of the exit interview are discussed below:

a. Strengths noted:

- (1) The licensee demonstrated a conservative operating philosophy when dealing with the inoperable steam supply valve to the turbine driven auxiliary feedwater pump (paragraph 3.b.(1), "Operations -Turbine Driven Auxiliary Feedwater Pump Inoperable").
- (2) Open communication within the maintenance organization (paragraph 3.b.(2), "Operations - Turbine Driven Auxiliary Feedwater Pump Inoperable").
- (3) Strong documentation by system engineering when discussing

resolution of a problem (paragraph 3.b.(3), "Operations - Turbine Driven Auxiliary Feedwater Pump Inoperable").

- (4) Control room leadership (paragraph 3.c, "Operations - Control Room Observations").
- (5) Several examples were identified of well planned maintenance activities and thorough understanding of procedures and equipment by the workers (paragraph 5.i, "Maintenance").
- (6) Scheduling of outages (paragraph 6, "Outages").

b. Weaknesses noted:

- (1) The lack of completeness of a licensee response to a Notice of Violation. The inspector discussed the completeness and accuracy requirements of 10 CFR 50.9 (paragraph 2, "Actions on Previously Identified Items").
 - (2) The plant reliance on an offsite group to determine the plant compliance with a Technical Specification (paragraph 7.d, "Quality Program Activities").
 - (3) Component identifiers that do not match the checklist description (paragraph 3.e.(2), "Operations - System Walkdowns").
 - (4) Lack of a screening mechanism to assure that maintenance activities or modifications do not expand the cold weather preparations envelope (paragraph 3.f, "Operations - Cold Weather Preparations").
 - (5) Poor coordination of the emergency down power (paragraph 4.a, "Reactor Trip - Power Reduction").
- c. The inspector discussed the Notice of Violation (paragraph 7.c, "Quality Program Activities").
- d. The inspector discussed the potential of flow blockage of the emergency feedwater to the auxiliary feedwater pumps as the result of flow blockage from zebra mussels (paragraph 7.a, "Quality Program Activities").
- e. The 50.72 notification was discussed. The inspector will perform additional reviews when the associated LER is issued (paragraph 3.d, "Operations - 50.72 Notifications").
- f. The open item pertaining to inplant communication was discussed (paragraph 4.b, "Reactor Trip - Unusual Event").
- g. A topic that was not documented in the inspection report but was

discussed at the exit interview pertained to lessons learned at another plant. Apparently there was a return to criticality event during a plant cooldown. The event was not documented or communicated to plant management. The lesson learned pertained to the threshold for documentation and communication of problems.