APPENDIX

U.S. NUCLEAR REGULATORY COMMISSION
REGION IV

Inspection Report: 50-285/94-12

License: DPR-40

Licensee: Omaha Public Power District
Fort Calhoun Station FC-2-4 Adm.
P.O. Box 399, Hwy. 75 - North of Fort Calhoun
Fort Calhoun, Nebraska

Facility Name: Fort Calhoun Station

Inspection At: Blair, Nebraska

Inspection Conducted: March 27 through May 7, 1994

Inspectors: R. Mullikin, Senior Resident Inspector
R. Azua, Resident Inspector

Approved: W D Johnson
William D. Johnson, Chief, Project Branch A

6/9/94
Date

Inspection Summary

Areas Inspected: Routine, unannounced inspection of onsite events, operational safety verification, maintenance and surveillance observations, followup on corrective actions for a violation, followup on post-TMI open item, and onsite review of licensee event reports.

Results:

- Plant Operations

An inadequate revision to an operating instruction and a lack of attention to detail and a nonquestioning attitude by operations personnel resulted in the overheating of Monitor Pump WD-23A (Section 2.2).

An enhancement to the equipment tagging program should provide assurance that known deficient components will not be included as a tagout boundary (Section 3.6).

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- Maintenance

Maintenance and surveillance activities were perform in a manner consistent with managements expectations. Appropriate measures were taken to ensure the work activities were within the skill of the craft. (Sections 4 and 5).

- Engineering

The licensee's response to Information Notice 90-41 was weak. The number of breaker cycles was not identified at the time, and they were not trended to determine if the prop springs needed to be replaced prior to scheduled refurbishment (Section 2.1).

- Plant Support

Radiological protection and security personnel performed their duties in a proper manner. Health physics personnel coverage of maintenance activities was found to be excellent (Sections 3.3 and 3.4).

Summary of Inspection Findings:

- Inspection Followup Item 285/9412-01 was opened (Section 2.1).
- Violation 285/9306-01 was closed (Section 5).
- Licensee Event Reports 93-02 and 93-13 were closed (Section 7).
- TMI Item II.B.3.4 was closed (Section 6).

Attachments:

- Persons Contacted and Exit Meeting

DETAILS

1 PLANT STATUS

The Fort Calhoun Station operated at 100 percent power throughout the inspection period.

2 ONSITE RESPONSE TO EVENTS (93702)

2.1 Failure of General Electric (GE) Magne-Blast Circuit Breaker Prop Spring

On April 6, 1994, the Raw Water Pump AC-10C breaker tripped after the breaker was closed for daily pump rotation. The licensee's troubleshooting activities discovered a broken prop spring in the GE Magne-Blast 4160-volt circuit breaker. The prop spring is used to latch the breaker in the closed position until the breaker is required to open. Failure of the spring prevents the latching action and maintains the breaker in an open position. The licensee replaced the spring with a spare.

The subject of broken breaker prop springs was discussed in NRC Information Notice 90-41. The information notice documented examples of prop spring breakage and stated that one plant was replacing prop springs every 2000 cycles. The licensee discussed the issue with GE and it was recommended that replacement be done after every 2000 cycles. The inspectors reviewed the licensee's evaluation of the notice and noted that the licensee had proposed to replace the breaker springs during scheduled refurbishment by GE. This was scheduled to be completed by 1996.

GE issued a service advice letter on December 7, 1990, recommending replacing the prop springs after every 2000 cycles. In addition, GE recommended that all safety-related breakers be inspected as soon as possible to check that the prop spring was still functioning. The inspectors did not locate this GE letter in the licensee's information notice closeout package. The licensee informed the inspectors that the service advice letter was not received by them in 1990, but was only obtained after the recent event. The inspectors determined that the licensee had not previously performed an inspection of the springs nor had they determined the current number of operating cycles on the installed springs. Thus, they did not know if any breakers were near or had exceeded 2000 operating cycles. The GE service advice letter also stated that the observed failures were in a spring style produced prior to 1971. An intermediate style was produced between 1971 and 1989, which had seen infrequent failures. A newer spring style was produced in 1990 which GE stated had a life expectancy of 10,000 cycles.

After the broken prop spring was discovered, the licensee performed an inspection of all similar circuit breakers to obtain baseline data on the number of operating cycles. The inspection determined that there were 43 of the subject breakers installed at the plant, which included both safety-related and nonsafety-related applications. The licensee found that

the breaker for Fire Pump FP-1A had the most cycles (1877) utilizing a pre-1971 style spring. This breaker prop spring was replaced on April 12. The breaker for Auxiliary Feedwater Pump FW-6 was the only other pre-1971 style spring with greater than 1000 operating cycles (1180). This prop spring was replaced on April 18. The licensee then proceeded to schedule the replacement of all safety-related breaker prop springs with a newer style spring. Some of the springs replaced were the older style (pre-1971) and the intermediate style (prior to 1990). The spring replacements were still in progress at the end of the inspection period for those that could be replaced on line. Completion of this group was scheduled to be completed by June 10, 1994. Six breakers supplying power to safety-related 480-volt busses were determined to require an outage for replacement. However, the largest number of cycles on these breakers was 383. The nonsafety-related breakers will have their springs replaced during the next outage.

The inspectors concluded that the licensee's review of Information Notice 90-41 was not thorough. Although the licensee did not have knowledge of the GE service advice letter in 1990, during this same period, communications with GE revealed the 2000-cycle replacement recommendation. The failure to perform an inspection of each breaker to determine the number of existing operating cycles in 1990 resulted in corrective actions not being taken until the safety-related breaker failed.

The licensee was performing a root cause analysis of this event at the end of the inspection period. The inspectors will review the results of this analysis when completed. This is an inspection followup item (285/9412-01).

The inspectors selected nine NRC information notices to determine the adequacy of the licensee's actions in regard to the information described. The review was performed on Information Notices 91-55, 91-55, 92-03, 92-05, 92-27, 92-51, 92-53, 93-26, and 93-64. The inspectors determined the licensee's actions in response to these information notices to be proper and timely.

2.2 Monitor Tank Pump Overheating

On April 28, 1994, the auxiliary building operator responded to an auxiliary building alarm for a problem with Monitor Tank Pump WD-23A. He noted that the pump overload circuit had tripped. A visual inspection of the pump did not result in any observed abnormality. The operator restarted the pump and observed smoke coming from the motor. He immediately tripped the supply breaker and used a fire extinguisher to extinguish any fire within the motor. At the time of the event, the pump was being used to recirculate Monitor Tank WD-22A prior to sampling. Although the monitor tanks and associated pumps are nonsafety-related equipment, the auxiliary building operator's responsibilities for overseeing and operating plant equipment were similar for both safety and nonsafety-related equipment

The Fort Calhoun Station has two 6,770 gallon monitor tanks, which collect processed liquid wastes from various sources in the plant. The tanks' contents are sampled prior to release to the circulating water discharge

canal. The two associated pumps serve to recirculate the tanks prior to sampling and to discharge the contents. A discharge radiation monitor will trip the pumps if a high radiation signal is received.

On the prior day, Monitor Tank WD-22B was released to the circulating water discharge canal. The procedure utilized for this release was Operating Instruction OI-WDL-3, "Liquid Waste Disposal Release." The procedure required that the outlet valve for the monitor tank that is not being released must be closed prior to tank release. However, there was no step in the procedure to reopen this valve. It was also identified that Operating Instruction OI-WDL-1, "Collection and Transfer of Liquid Waste," had not required the verification of the outlet valve position prior to recirculation.

The inspectors interviewed licensee personnel and determined that, during the last refueling outage, a change to Operating Instruction OI-WDL-3 was made to close the outlet valve of the monitor tank that was not being released. This change was made in order to prevent the possibility of releasing contents of a monitor tank that had not been sampled. Previously, only the cross-connect valve (WD-652) was closed during the release. The procedure change was made to provide an extra isolation valve in case Valve WD-652 leaked by during release. However, the revised procedure did not require reopening of the monitor tank outlet valve after the release was completed.

The inspectors questioned operations personnel on why this problem had not occurred on previous occasions, since Operating Instruction OI-WDL-3 had been deficient since the last refueling outage. The response was that operators had recognized the fact that the tank outlet valve must be reopened after the tank release.

The licensee's immediate corrective action was to institute an on-the-spot procedure change. In addition, the Assistant Plant Manager - Operations issued a memorandum to all operations personnel detailing this event and the need to verify correct valve lineups, along with following the procedure.

The inspectors concluded that this event was caused by a combination of items. The inadequacy of the revision to Operating Instruction OI-WDL-3 was a significant contributor to this event. However, the failure by operators to initiate a procedure change when they recognized the need to realign the monitor tank outlet valve, after performing this procedure, also contributed to this event occurring. Finally, there was inattention to detail by the operator failing to recognize an improper valve lineup prior to monitor tank recirculation and subsequent motor overheating. This event demonstrates that the performance enhancement plan and the corrective actions which resulted from the events identified in Escalated Action 94-026 have not been fully effective.

The inspectors will continue to review the effectiveness of the licensee's corrective actions and any revision that results from this event.

2.3 Conclusions

Licensee response to Information Notice 90-41 was weak because it did not address the most significant portion of the information notice regarding failures in relation to the number of breaker cycles. In addition, the licensee failed to obtain pertinent vendor information. The failure to reopen a liquid monitor tank outlet valve resulted from an inadequate procedure, a willingness to work around the procedure deficiency, a nonquestioning attitude, and inattention to detail by operations personnel performing the procedure.

3 OPERATIONAL SAFETY VERIFICATION (71707)

3.1 Routine Control Room Observations

The inspectors observed activities throughout this inspection period to verify that proper control room staffing and control room professionalism were maintained. Shift turnover meetings were conducted in a manner that provided for proper communication of plant status from one shift to the other. Discussions with operators indicated that they were aware of plant and equipment status and reasons for lit annunciators. The inspectors observed that Technical Specification limiting conditions for operation were properly documented and tracked. The inspectors noted that operators were consistently declaring equipment inoperable during surveillance testing. Control room traffic was observed to be effectively limited to personnel requiring access to conduct related work activities.

3.2 Plant Tours

The inspectors routinely toured various areas of the plant to assess the safety conditions and adequacy of plant equipment.

- The inspectors verified that various valve and switch positions were correct for the current plant conditions. Personnel were observed obeying rules for personnel safety and rules for escorts, visitors, and entry and exits into and out of vital areas.

- Housekeeping was observed to be very good throughout the plant. However, tools normally stored within one area of the auxiliary building were stored throughout various areas in the corridors. This was due to the tool storage area being temporarily used to store new spent fuel racks. The tools were stored generally in locked boxes maintained by the various crafts responsible for them. A few tools were stored on the floor. Although this presented an appearance problem, the inspectors concluded that it was an acceptable practice until the tools could be stored in a central location after the spent fuel reracking project is completed in August 1994.

- During tours of the auxiliary building, the inspectors reviewed the piping and instrumentation drawings posted in each of the operating workspaces. The purpose of this effort was to verify that the drawings in question represented the system and equipment located in these spaces, and to determine if they were the most recent revision. No problems were noted.

- In the auxiliary building on April 7, 1994, the inspectors noted two hydraulic seismic restraints which were at questionable angles (in the vertical plane) to the horizontally installed clevises to which they were attached. The restraints in question were SIS-8C and SIS-185, which were located in the east and west safety injection pump rooms. The restraints were found to have angles which exceeded the 10 degree (plus or minus) recommendation described in Mechanical Engineering Guidance Procedure MEI-6, "Current Practice for Load Case Analysis and Component Qualification for B31.7 Class II/III Systems." Per the guidance procedure, the inspectors found that the licensee had previously performed an out-of-tolerance evaluation (Engineering Calculation FC-28-26) for these two restraints. It was determined, based on the calculations, that the excess angles identified did not affect the restraints' capabilities to perform their function. The inspectors reviewed the engineering calculations and the associated reference drawings. No problems were noted.

- On May 3, 1994, the inspectors selected a number of pipes associated with the safety injection system, located in the auxiliary building, which lay on pipe supports but did not have any visible pipe restraints. The inspectors reviewed the appropriate isometric and reference drawings for these pipes and pipe supports. Both sets of drawings supported the actual conditions identified in the plant.

- Throughout this inspection period, operations and plant management personnel were observed touring the operating spaces of the plant.

3.3 Radiological Protection Program Observations

The inspectors verified that selected activities of the licensee's radiological protection program were properly implemented. Health physics personnel were observed routinely touring the controlled area. Contaminated areas and high radiation area were properly posted, and restricted high radiation areas doors were found to be locked, as required. Plant personnel were observed to be following procedures for entry and exit of contaminated areas. Area surveys posted outside each room in the auxiliary building were found to be current. These survey readings were found to be similar with readings obtained by the inspectors with the use of the NRC's survey meter. Also, with the use of the NRC's survey meter, the inspectors verified the relative accuracy of listed readings on bags containing contaminated trash and/or equipment.

During the review of maintenance and surveillance activities, the inspectors noted that the health physics technicians had provided excellent coverage. The technicians periodically surveyed the work areas and appropriately identified the best places to stand so as to minimize radiation exposure. This was most notable during the spent fuel pool reracking effort, in which health physics technicians monitored the removal of equipment from the spent fuel pool (old fuel racks, submerged filters, and other pieces of equipment). They also monitored diving personnel in and out of the pool (with the use of remote dose monitoring equipment and submerged detectors) and monitored other contract personnel and equipment during different activities being performed around the spent fuel pool.

3.4 Security Program Observations

Security personnel were observed performing their duties in a professional manner. Vehicles were properly controlled or escorted within the protected area. Designated vehicles parked and unattended within the protected area were found to be locked with the keys removed. The inspectors routinely toured the protected area perimeter and found it maintained at an excellent level. Proper compensatory measures were taken when a security barrier was inoperable. Plant personnel who were assigned escort responsibilities appropriately maintained control of their assigned personnel.

The inspectors toured the central alarm station and the secondary alarm station. The security personnel stationed at these locations were observed for a period while they performed their duties. The overall assessment of their duties was very good. The inspectors then observed as the security personnel performed a shift turnover. Proper communication of security status from one shift to the other was noted. The security personnel interviewed were knowledgeable of their responsibilities and of the present condition of the security system.

3.5 Installation of Sparger in Intake Cell "B"

In April 1994, the licensee installed a water sparging system in Intake Cell B to alleviate sand buildup that has degraded the raw water pumps. The Fort Calhoun Station has three intake cells, with Cell B providing the suction for Raw Water Pumps AC-10B and AC-10C. Cells A and C each provides suction for one raw water and one fire pump. The decision to only install the sparging system in Cell B was made from input from the system engineer. He had determined from recent historical data that Raw Water Pumps AC-10B and AC-10C were the only pumps with a sand accumulation problem. The licensee determined that the problem occurs when sand accumulates around the pump suction bell. Sand enters the pump when started, causing seizure or dragging of the pump. The sparging system was designed to keep the sand in suspension.

The licensee chose the nonsafety-related screen wash system as the supply of sparging water. This modification was performed under Engineering Change Notice 93-431. The inspectors reviewed the engineering change notice and found it to be very detailed. The inspectors concluded that this modification

could improve the sand intrusion problem concerning the raw water pumps. However, it is not certain that the introduction of additional suspended sand in the raw water system will not result in sand collecting elsewhere and causing other problems. The inspectors will monitor the results of this plant modification.

3.6 Deficiency Tags

In January 1994, the inspectors had discussed with the licensee the possibility that an equipment tagout could include a boundary valve which is known to leak. The concern was that personnel performing maintenance could be injured due to an inadequate tagout boundary. Deficiency tags attached to the deficient component should alert the operator to a leaking valve when the danger tag is placed and the valve is put in the required position. However, the inspectors raised the concern that the deficiency tag could be lost and there was no program to periodically verify that the tags were still installed. In addition, the tagging coordinator did not utilize maintenance work order information when creating tagouts. The inspectors identified this as a weakness in the tagout program.

The licensee subsequently determined that a revision to Standing Order SO-G-20A, "Equipment Tagging Procedure," would enhance their tagging program with regard to component deficiencies. A revision to the standing order has been approved and is awaiting training before issue. The revision will require that the shift supervisor perform an investigation to determine boundary integrity. This may be done by either using information from the deficiency tag or reference maintenance work request/order data from the computer. As an added precaution, the operator hanging the equipment tag will be required to not hang a tag on a component with a deficiency tag unless an investigation has been performed.

The inspectors performed a walkdown of selected areas of the plant to determine whether all deficiency tags were adequately placed. The source of data was a computerized list, sorted by room number, which showed all open maintenance work requests/orders and the associated deficiency tag. The inspectors could not locate seven deficiency tags that were on the computerized list. These observations were turned over to the licensee for their review. The licensee's response was that all seven tags that were apparently missing had been on components where the work was completed. However, the computerized list does not close out the item until all paperwork is completed. This explained the inability to locate the tags in the plant. The inspectors determined that the removal of the deficiency tag upon completion of the work is consistent with the requirement in Standing Order SO-M-101, "Maintenance Work Control."

The inspectors concluded that the probability is low that a deficiency tag would be removed in the field. However, the proposed changes to the tagging procedure should provide assurance that a known component deficiency would not go undetected when establishing an equipment tagout boundary.

3.7 Conclusions

Operations, radiological protection, and security personnel performed their duties in a proper manner. Health physics personnel coverage of maintenance activities was found to be excellent. Plant housekeeping was found to be very good even though an increase of tools in the work spaces had been noted. The revision to the equipment tagging procedure should enhance the tagging program.

4 MAINTENANCE OBSERVATIONS (62703)

The following maintenance activities were observed:

- Maintenance Work Order 941002, "Electric Fire Pump FP-1A 4160-Volt Prop/Reset Spring Replacement"
- Maintenance Work Order 941042, "Raw Water Pump AC-10B 4160-Volt Prop/Reset Spring Replacement"
- Construction Work Order 94-016, "Spent Fuel Pool Rerack Effort"
- Maintenance Work Order 941198, "Adjust Seismic Restraint"

The inspectors concluded that maintenance activities were properly performed. The inspectors noted that for Maintenance Work Orders 941002 and 941042, maintenance personnel utilized an old breaker to practice the spring replacements prior to performing the field work. The inspectors determined that the work was within the skill of the craft.

For Construction Work Order 94-016, the inspectors noted that job prebriefings and ALARA briefings were excellent. They provided a very good forum for raising questions. Many questions were raised throughout this effort by the contract personnel involved. The inspectors observed that licensee and contractors did not raise loads over areas that contained stored fuel bundles. The diving effort was observed to be well coordinated. Licensee efforts to reduce the divers' exposure rates, such as moving stored fuel from one side of the pool to the other, were excellent. Foreign material exclusion efforts to control material in the area surrounding the spent fuel pool were good. Personnel were knowledgeable of their responsibilities. Licensee control of contract personnel during this effort was very good. In the area of personnel safety, some of the personnel had to be reminded to hook their harness sling onto an anchor while climbing around the top of the fuel racks.

5 SURVEILLANCE OBSERVATIONS (61726)

The following surveillance activities were observed:

- Surveillance Test CH-SMP-RE-0018, "Laboratory and Radioactive Waste Processing Building Exhaust Stack Sampling"

- Surveillance Test SS-ST-RW-3003, "Raw Water System 10-Year Hydrostatic Test"

During review of these surveillance activities, the inspectors concluded that these tests were performed properly. A good job prebriefing was noted with regard to the 10-year raw water hydrostatic test. However, some instances were noted where equipment (i.e., pump discharge pressure gauges) had not been properly staged prior to the hydrostatic test.

6 FOLLOWUP - ENGINEERING (92903)

6.1 (Closed) Severity Level IV Violation 285/9306-01: Failure to Submit Temporary Modification Red-Lined Drawings to the Document Control Center

This violation resulted when the inspectors identified that three red-lined drawings associated with Temporary Modification TM-93-016 were not included in either the document control center drawing file or the drawing data base file. This was contrary to the requirements set forth in Standing Order SO-O-25, "Temporary Modification Control."

The licensee determined that this failure to follow the standing order resulted from a lack of attention to detail by the personnel involved, since the standing order clearly stated the requirements. In addition, the licensee believed that a contributing factor to this failure to follow procedure was a procedure change that was made to Standing Order SO-O-25 in 1990. This procedure change was made in response to a corrective action report which was issued to improve deficiencies in the drawing control program at the Fort Calhoun Station. This change added a step to the body of the standing order requiring that all red-line drawings associated with temporary modifications be provided to the document control center. The personnel involved in making the changes to the standing order failed to make appropriate changes to a supporting Form FC-66, "Temporary Modification Control Form." Since the use of the form is required to ensure that the requirements of the standing order are met, personnel placed an over reliance on the use of the Form FC-66 checklist.

In response to this violation, the licensee conducted a 100 percent review of the open temporary modifications. Of the 29 that were open on May 17, 1993, four other temporary modification packages were found to have red-lined drawings which were not submitted to the document control center.

Form FC-66 was revised to include a sign-off for submitting red-lined drawings to the document control center. Additionally, a memo was issued to remind personnel who use Standing Order SO-O-25 of the change to Form FC-66.

The licensee made changes to the procedure change process by revising Standing Order SO-G-5, "Fort Calhoun Station Plant Review Committee," and Standing Order SO-G-95, "Qualified Review Process." These changes were made to ensure

that forms associated with operating procedure changes are reviewed and revised as necessary.

Finally, a change to Standing Order SO-O-25 was made to ensure that system engineering personnel compare the document control center drawings with the control room temporary modification log book as part of their monthly temporary modification review process. This was done to ensure that the document control center receives the red-lined drawings as a result of the temporary modifications.

The inspectors reviewed documentation for the completion of the corrective actions taken by the licensee. Based on this review it was determined that the licensee had taken appropriate action to preclude repetition of this event.

7 FOLLOWUP - PLANT SUPPORT (92904)

7.1 (Closed) TMI (NUREG-0737) Item II.B.3.4, "Postaccident Sampling Modification"

This item remained open until the licensee resolved the issue of sampling for total dissolved gases in the reactor coolant system. In a letter dated September 24, 1993, the licensee submitted to the Office of Nuclear Reactor Regulation several revisions and clarifications to the licensing bases for the postaccident sampling system at the Fort Calhoun Station. On February 17, 1994, the Office of Nuclear Reactor Regulation concluded that the licensee's proposed revisions and clarifications would not depart from the requirements specified in NUREG-0737, Item II.B.3.4.

8 ONSITE REVIEW OF LICENSEE EVENT REPORTS (92700)

8.1 (Closed) Licensee Event Report 93-002: Inappropriate Steam Generator Low Pressure Signal Block Reset Values

This report described an event in which the licensee, following a review of calibration procedures for the steam generator pressure loops, identified that the steam generator low pressure signal block reset values, for all four channels of both steam generators, were greater than that allowed by Technical Specification 2.14, Table 2-1.

The event was not determined to be significant with respect to plant safety. This was due to the fact that the reset value deficiency would not have affected the ability of the reactor protective system to perform its design function. In addition, for the amount of time the conditions in which the block reset value would be a concern (i.e., steam generator pressure range of 500-566 psia), the licensee also determined that there was a low probability that a main steam line break would occur at the same time. Finally, the licensee emergency operating procedures instruct the operators to ensure that the appropriate isolation valves are closed in the event the steam generator isolation signal was not present during an uncontrolled heat extraction event.

The root cause of this event was determined to be an inadequate design of the pressure indicator controllers. Also, a contributing factor to this event was an inadequate calibration procedure, which did not have provisions for verifying the block reset values. The licensee's corrective actions were as follows:

- Surveillance Tests IC-ST-MS-0026 through 0033 (procedures for calibration of steam generator pressure loops) were revised to specify a desired value and tolerance range for the block reset function.

- A Technical Specification amendment has been issued to allow higher values for the steam generator low signal permissive/block reset function.

The inspectors reviewed documentation for the completion of the corrective actions taken by the licensee. Based on the review performed by the inspectors, it was determined that the licensee had taken appropriate actions to preclude repetition of this event.

8.2 (Closed) Licensee Event Report 93-013: Pressurizer Safety Valve Outside Lift Setting Acceptance Criterion

This report described a condition which was discovered during the scheduled 1993 refueling outage. This referred to the "As-Found" lift pressure of Pressurizer Safety Valve RC-141, which was found to be outside of its specified lift setting acceptance criterion.

The event was not determined to be significant with respect to plant safety. It was determined that the "As-Found" lift pressure was well within the updated safety analysis report analysis.

The licensee determined that the root cause for this event was normal setpoint drift/scatter. This determination was made following visual inspections of the pressurizer safety valves, interviews performed with the testing lab personnel, and from reviewing the valve test results.

The licensee's corrective actions were as follows:

- Adjustments were made so that the "As-Left" lift setting was within the ± 1 percent range.

- Future pressurizer safety valves "As-Found" lift pressure test results will continue to be monitored and trended as a part of the relief valve program, for possible additional investigation and corrective actions.

The inspectors reviewed documentation for the completion of the corrective actions taken by the licensee. Based on the review performed by the inspectors, it was determined that the licensee had taken appropriate actions to preclude repetition of this event.

ATTACHMENT

1 PERSONS CONTACTED

1.1 Licensee Personnel

*R. Andrews, Division Manager, Nuclear Services
*K. Belek, Supervisor, Industry Affairs
J. Chase, Manager, Fort Calhoun Station
*R. Conner, Assistant Manager, Fort Calhoun Station
*G. Cook, Supervisor, Station Licensing
*J. Gasper, Manager, Training
*W. Gates, Vice President, Nuclear
*R. Jaworski, Manager, Station Engineering
*W. Jones, Senior Vice President
*L. Kusek, Manager, Nuclear Safety Review Group
*W. Orr, Manager, Quality Assurance and Quality Control
*T. Patterson, Division Manager, Nuclear Operations
*T. Reisdorff, Shift Supervisor, Fort Calhoun Station
*M. Sandhoefner, Shift Supervisor, Fort Calhoun Station
*J. Sefick, Manager, Security Services
*P. Sepcenko, Supervisor, Outage Projects
*J. Skiles, Acting Manager, Design Engineering
*F. Smith, Supervisor, Chemistry
*R. Short, Manager, Nuclear Licensing and Industry Affairs
*J. Tills, Operations Supervisor
*D. Trausch, Supervisor, Operations

*Denotes personnel that attended the exit meeting. In addition to the personnel listed above, the inspectors contacted other personnel during this inspection period.

2 EXIT MEETING

An exit meeting was conducted on May 11, 1994. During this meeting, the inspectors reviewed the scope and findings of the report. The licensee agreed with the inspection findings presented at the meeting. The licensee did not identify as proprietary any information provided to, or reviewed by, the inspectors.