U. S. NUCLEAR REGULATORY COMMISSION

REGION III

Reports No. 50-282/91024(DRP); 50-306/91024(DRP)

Docket Nos. 50-282; 50-306 License Nos. DPR-42; DPR-60

Licensee: Northern States Power Company
414 Nicollet Mall
Minneapolis, MN 55401

Facility Name: Prairie Island Nuclear Generating Plant

Inspection At: Prairie Island Site, Red Wing, MN

Inspection Conducted: October 30 through December 23, 1991

Inspectors: P. L. Hartmann R. L. Bywater

D. C. Kosloff M. Dapas

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

1-8-91
Date

Inspection Summary

Inspection on October 30 through December 23, 1991 (Reports No. 50-282/91024(DRP); 50-306/91024(DRP))
Areas Inspected: Routine unannounced inspection by resident inspectors of plant operational safety, licensee action on previous inspection items, maintenance, surveillance, engineering and technical support, decay heat removal reliability, licensee event reports, safety assessment and quality verification, and cold weather preparation.
Results:
No violations of NRC requirements were identified in any of the nine areas inspected.

Operations

No new strengths c weaknesses were identified. Operator knowledge and coordination were excellent in response to operating transients (paragraph 3.b). Operational control of plant activities was generally good, however a fire protection zone was bypassed without operator knowledge (paragraph 3.b).

Maintenance and Surveillance

No new strengths or weaknesses were identified. Personnel conducting a surveillance test erroneously left a switch in bypass (paragraph 5).

Engineering and Technical Support

No new strengths were identified. A weakness was identified in engineering control of activities in the plant (paragraphs 7.a and 7.d). Response to identified issues was excellent (paragraph 7).

Emergency Preparedness

No new strengths or weaknesses were identified. The licensee began upgrades of the Operations Support Center and the Emergency Operations Facility.

Safety Assessment/Quality Verification

No new strengths were identified. A weakness was identified in the licensee's control of plant engineering activities (paragraph 9). Management response to the weakness appears adequate. Management response was excellent relative to feedwater flow control system failures, a cooling water leak, and cracking observed in a foreign reactor vessel head penetration.

DETAILS

1. Persons Contacted

Northern States Power Company

*L. Eliason, Vice President, Nuclear Generation
*E. Watzl, General Manager, Prairie Island
#*M. Sellman, Plant Manager
*R. Fraser, Superintendent, Systems Engineering-Mechanical
*G. Goering, Manager, Nuclear Projects Department (NPD)
*B. Stephens, Superintendent, Design Standards
M. Klee, Superintendent, Quality Services
#M. Wadley, General Superintendent, Operations
#G. Lenertz, General Superintendent, Maintenance
#K. Albrecht, General Superintendent, Engineering
#G. Rolfson, General Superintendent, Engineering-NPD
#R. Lindsey, Assistant to the Plant Manager
D. Schuelke, Superintendent, Radiation Protection
G. Miller, Superintendent, Operations Engineering
#M. Reddemann, Superintendent, Technical Engineering
D. Mendele, Superintendent, Quality Engineering
#E. Eckholt, Nuclear Support Services
J. Leveille, Nuclear Support Services
#L. Ganser, Power Supply Quality Assurance (QA) - QA Specialist
#D. Silvers, Quality Services
A. Hunstad, Staff Engineer
*J. Sorensen, Shift Manager
*M. Madson, Project Engineer
*L. McCarten, Project Engineer

Nuclear Regulatory Commission

*A. Davis, Regional Administrator
*C. Paperiello, Deputy Regional Administrator
*W. Forney, Deputy Director, Division of Reactor Projects (DRP)
*T. Martin, Deputy Director, Division of Reactor Safety (DRS)
*W. Axelson, Deputy Director, Division of Radiation Safety and Safeguards (DRSS)
*W. Shafer, Chief, DRP Branch 2
*L. Greger, Chief, DRSS Reactor Programs Branch
*E. Schweibinz, Senior Project Engineer
*A. Masciantonio, NRR Project Manager
*T. Kozak, Radiation Specialist
*J. Neisler, Reactor Inspector
*G. Pirtle, Plant Protection Analyst
*J. Shapker, Reactor Inspector
*C. Orsini, Reactor Engineer (Intern)
*W. Pegg, Technical Intern
*D. Roth, Reactor Engineer (Intern)
#D. Kosloff, Resident Inspector

#Denotes those present at the management interview of December 27, 1991.

*Denotes those present at management meeting of December 16, 1991.

2. Licensee Action on Previous Inspection Findings (92701, 92702)

a. (Closed) Violations 50-282/89014-01: Surveillance Performed Late

50-282/90012-03; 50-306/90012-03: Surveillances Performed Late

The above violations involved technical specification surveillances which were not performed with the time frame required due to personnel error. The events were reported by the licensee as required. Common corrective action for the violations addressed a lack of timely review of completed surveillances. The licensee improved the review process and increased the resources dedicated to the process to ensure surveillances were completed, as required, on a daily basis. The review of this corrective action was documented in the recent Inspection Report 50-282/91022(DRP); 50-306/91022(DRP). The inspector now regularly reviews the daily surveillance checklist which is maintained by the shift supervisors in the control room. These violations are closed.

b. (Closed) Violation (50-306/89023-01(DRP)): Failure to Establish a Fire Watch in Accordance with Technical Specification 3.14.A.2.a.

The licensee corrective action was reviewed by an inspector and the Unit 1 violation was closed in Inspection Report 50-282/91015; 50-306/91015 at paragraph 2.e. The Unit 2 violation common to this event was not closed due to administrative error. This matter is closed, referencing the previous inspection and its documentation.

c. (Closed) 50-306/79002-2B; Bulletin 79-02, Rev. 1, Suppl. 1: Pipe Support Base Plate Designs Using Concrete Expansion Anchor Bolts

Following a review by Division of Reactor Safety Management, it was determined that this item should have been closed with the identical Unit 1 issue (50-282/90019(DRP); 306/90020(DRP)). No concerns are present for this issue at Prairie Island.

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

3. Operational Safety Verification (71707, 93702, 92701)

a. Operational Safety Verification (71707)

Unit 1 operated at full power except as discussed below. Unit 2 operated at full power the entire inspection period. On November 16, 1991, Unit 1 power was reduced to about 15 percent to allow replacement of a feedwater flow control system transducer and to perform other maintenance and testing. The unit was returned to full power the same day.

The inspector observed control room operations, reviewed applicable logs, conducted discussions with control room operators and observed shift turnovers. The inspector verified operability of selected emergency systems, reviewed equipment control records, and verified the proper return to service of affected components, conducted tours of the auxiliary building, turbine building, screenhouse and external areas of the plant to observe plant equipment conditions, including potential fire hazards, and to verify that maintenance work requests had been initiated for the equipment in need of repairs. Plant material condition was excellent.

b. Onsite Followup of Events (93702, 92701)

On November 14, 1991, the Unit 1 operators observed loop B steam generator (SG) level slowly changing for no apparent reason. The operators were unsuccessful in their attempt to control the loop B feedwater regulating valve (FRV) manually from the control room. An operator dispatched to the FRV was able to manually control the valve locally. It was later discovered that the air valve motor in the electropneumatic transducer for the FRV control system had failed (see paragraph 7.b. for more information). Operator response to this event was excellent.

On December 2, 1991, at 4:49 p.m., an instrument and control (I&C) technician observed that the toggle switch for Fire Protection Zone 29 on panel 122 was in bypass, rendering it inoperable. He notified the control room operators and the zone was immediately returned to normal. During a fire detection panel check at about 3:30 p.m., a control room operator had observed all toggle switches on panel 122 in the normal position.

Fire Zone 29 covers the 733 foot level of the Unit 1 Reactor Building. Fire Zones 10 (715 foot Unit 1 Reactor Building) and 32 (755 foot Unit 1 Reactor Building) were in the normal position, and should have alarmed if a fire occurred in the Reactor Building while Zone 29 was inoperable. Technical Specification (TS) 3.14 addresses fire detection systems. TS LCO 3.14.A.2.b was entered for the time that Zone 29 was inoperable. The fire zones in the reactor building are exempt from fire watch requirements whenever containment integrity is required. Containment integrity was required while Zone 29 was inoperable

The licensee was unable to determine how the switch was moved to the "bypass" position. It may have been accidentally bumped by I&C technicians working on an adjacent panel, or it may have been inadvertently bumped to the "bypass" position by another person. The licensee considered the possibility of tampering and determined it not to be credible.

The licensee is considering the use of a mechanical device which could be mounted over the toggle switch to maintain it in the "normal" position. The inspector will review the licensee's progress on this issue in a future inspection.

On December 10, 1991, the high/low sample flow alarm bypass switch for 1-R-22, Unit 1 Shield Building Vent Stack Monitor, was placed in

bypass during testing (SP 1296, see paragraph 5 for more information). The switch was not returned to normal because of a personnel error during the test. The test was completed at 5:49 p.m. The high/low flow sample alarm is provided to alert the operators to a malfunction of the sample pump or its associated piping. The operator performing the daily radiation monitor check [illegible] the procedure, early the next morning did not notice that the sw[illegible] was in the bypass position. The procedure did not specifically address the bypass switch. At 10:23 on December 11, 1991, an operator observed the switch in the bypass position and returned it to normal. At the time it was noted that the sample pump was operating normally with normal flow and there was no reason to believe that 1-R-22 had not been operating normally while the switch was in bypass. The licensee's Error Reduction Task Force is evaluating this event. The inspector will review the licensee's evaluation when it is complete.

On December 18, 1991, the Unit 2 operators observed loop A SG level slowly changing for no apparent reason. The operators were unsuccessful in their attempt to control the loop A FRV manually from the control room. An operator dispatched to the FRV was able to manually control the valve locally. It was later discovered that a limit switch in the electropneumatic transducer for the FRV control system had failed (see paragraph 7.b. for more information). Operator response to this event was excellent.

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

4. Maintenance Observation (71707, 37700, 62703)

Routine, preventive, and corrective maintenance activities were observed to ascertain that they were conducted in accordance with approved procedures, regulatory guides, industry codes or standards, and in conformance with Technical Specifications. The following items were considered during this review: adherence to Limiting Conditions for Operation while components or systems were removed from service, approvals were obtained prior to initiating the work, activities were accomplished using approved procedures and were inspected as applicable, functional testing and/or calibrations were performed prior to returning components or systems to service, quality control records were maintained, activities were accomplished by qualified personnel, radiological controls were implemented, and fire prevention controls were implemented.

Portions of the following maintenance activities were observed during the inspection period:

- Unit 1 Loop B Feedwater Regulating Valve (FRV) Electropneumatic (M/P) Transducer Replacement. This transducer was replaced due to an internal DC motor failure (see paragraph 7.b. for more information).

- Troubleshooting and Repair of 14 Inverter. The inspector observed a fine white powder inside some of the inverter relays. The

performance of the inverter and an engineering review by the licensee indicated that the performance of the relays has not been affected. The licersee plans to replace the inverter relays periodically. The inspector will review this issue further in a future inspection.

- Battery Room Heatup Test. This special test was performed because the battery rooms do not have a safety-related ventilation system (see paragraph 7.d. for more information.).

- Inspection of Discharge Check Valve for Residual Heat Removal Pump #21. The licensee observed that two hinge pin bushings had never been installed in the valve. The licensee notified the manufacturer and verified that the absence of the bushings had not affected the performance of the check valve. The licensee installed the bushings.

- Unit 2 Loop A FRV M/P Transducer Troubleshooting. The licensee identified a failed limit switch and bypassed it. The transducer then functioned normally (see paragraph 7.b. for more information).

- Replacement of cooling water system piping spoolpiece for emergency diesel generators (EDG) D1 and D2.

- Replacement of exhaust manifolds and piping on EDG D2.

  Preventive maintenance of EDG D2.

- Rerouting of Steam Trap Drain Piping for Auxiliary Feedwater Pump Turbine Steam Supply Piping. When the isolation for this work was completed the operators noted that "Safeguards Hold" tags had been removed to complete the isolation. The operators stopped the job to determine if repositioning of valves controlled by the Safeguards Hold tags had affected operability of safety-related equipment. The tags were used to help assure reliability of the auxiliary feedwater pumps. The isolation request was rewritten to provide more specific guidance on the operation of the valves controlled by the tags. The licensee is evaluating this event to see if the isolation process can be improved. The inspector will review the licensee's evaluation in a future inspection.

- Operations Support Center Upgrade.

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

5. Surveillance (61726, 71707)

The inspector reviewed Technical Specifications required surveillance testing as described below and verified that testing was performed in accordance with adequate procedures. Additionally, test instrumentation was calibrated, Limiting Conditions for Operation were met, removal and restoration of the affected components were properly accomplished, and test results conformed with Technical Specifications and procedure

requirements. The results 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.

Portions of the following test activities were observed or reviewed:

- SP 1003 Analog Protection System Monthly Test

- SP 1093 D1 Diesel Generator Slow Start and Train A Auto Load Sequencer Test. During this test the licensee observed a small cooling water leak in a short carbon steel spoolpiece between valve CV-31505 and the air to water heat exchanger. The licensee declared D1 inoperable because the structural capability of the leaking cooling water spoolpiece could not be analytically verified with through-wall corrosion present. The licensee replaced the spoolpiece with a new stainless steel and carbon steel spoolpiece. After the new spoolpiece was installed and no leakage was observed, D1 was declared operable. A similar spoolpiece was installed for D2 (see paragraph 7.b. for more information).

- SP 1296 Radiation Monitor Flow Totalizer Replacement and Calibration. A flow alarm was bypassed during this test and not returned to normal (see paragraph 3.b. for more information).

- SP 2035A Reactor Protection Logic Test at Power. During this monthly test bypass reactor trip breaker BYB opened immediately after it was closed. The breaker then operated normally and the licensee could not duplicate the condition. During the next monthly test the breaker operated normally. The licensee plans to install troubleshooting instrumentation on the breaker during the next monthly test. The inspector will continue to monitor licensee activities related to trip breaker operation.

- SP 2093 D2 Diesel Generator Slow Start and Train B Auto Load Sequencer Test

- SP 2102 22 Turbine Driven Auxiliary Feedwater Pump Test

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

6. Licensee Event Report Followup (92700)

(Closed) LERs 50-282/89014-LL: Surveillance Performed Late
50-282/89017-LL: Surveillance Performed Late
50-282/90004-LL: Surveillance Performed Late
50-282/90010-LL: Surveillance Performed Late
50-306/90004-LL: Surveillance Performed Late

The above LERs involved technical specification surveillances which were not performed within the time frame required due to personnel error. The common corrective action for these events addressed the lack of timely review of completed surveillances. The licensee improved the review process and increased the resources dedicated to the process to ensure surveillances were completed as required. The inspector now reviews the daily surveillance completion lists. This corrective action was reviewed by an inspector in the recent Inspection Report 50-282/91022(DRP); 50-306/91022(DRP), paragraph 3.1.

7. Engineering and Technical Support

a. Scaffolds

During a facility tour which included the 4kV switchgear rooms for both units, the inspector observed that extensive scaffold had been constructed in all four rooms. This scaffold was present to provide access to the room overhead for cable tray installation and cable pulling. Many new cables were being installed as part of the plant modification to meet Station Blackout (SBO) requirements.

The inspector questioned certain characteristics of the observed scaffolds. Some appeared to be rigidly braced against all four walls while others did not. Wood was used extensively on some. All four safety-related 4kV buses had scaffold structures in very close proximity (a few inches) to 120V control power conduit mounted atop the cabinets. Some emergency lighting was partially to substantially blocked by scaffold decking, and flashlights had been staged - apparently in compensation - on lanyards attached to the scaffold frames.

The licensee's administrative control procedure for use of scaffold was reviewed. It appeared to provide a reasonable set of controls for review and approval prior to scaffold erection. A post-construction checklist was also present. Criteria involving compliance to OSHA guidelines, avoiding interference with (or access to) plant operating equipment, and seismic adequacy were all present. The inspector asked the licensee to reexamine the scaffold in the four 4kV switchgear rooms.

The licensee performed the reexamination as requested. Some of the scaffolds in question were found not to conform to applicable criteria in several respects, including wall bracing, use of wood, and obstruction of or proximity to installed plant equipment. These problems were immediately corrected (in some cases scaffolds were completely disassembled) and a broader review was undertaken. The broader review included inspection of all SBO project scaffold throughout the plant, and an investigation of how the questionable conditions developed. In general, scaffold elsewhere throughout the plant was found to conform to applicable criteria.

The review of the situation in the 4kV rooms determined that the scaffold was not as originally built some weeks earlier. It had been modified at the request of the electricians using it, but the

modifications had not received the scrutiny normally applied to new installations. The carpenters made the scaffold changes for the purpose of making the electrician's work easier. The changes were recent, not having been observed in a periodic check a week or two earlier.

To prevent a recurrence of questionable conditions such as those found in the 4kV switchgear rooms, the licensee undertook a series of actions. These were generally specific to scaffold erected to support SBO project activities. They included:

(1) carpenter retraining in procedural controls;

(2) daily carpenter foreman scaffold inspection;

(3) weekly engineer-oriented scaffold inspection (previous practice permitted "periodic" inspection - as infrequently as each six weeks or so); and,

(4) mandatory post-construction inspection by operations staff (previously, scaffold built with no deviations from operations guidance was sometimes not given a followup inspection).

The inspector verified that the above activities were documented at various scaffolds throughout the plant while inspecting the scaffolds. The licensee's actions appeared appropriate to address the concerns which the inspector had raised.

The licensee did not commit to avoiding the simultaneous utilization of scaffold in rooms containing opposite-train equipment. Its position is that scaffold properly constructed to its criteria (and not modified thereafter) qualifies as a "rigid structure" and has ample safety margin such that it would not fail during an earthquake and damage plant safety equipment in the vicinity. The inspector had no further questions concerning these matters.

b. Feedwater Flow Control

On November 14, 1991, the Unit 1 operators observed loop B steam generator (SG) level slowly changing for no apparent reason. It was later discovered that the air valve motor in the electropneumatic transducer for the feedwater (FW) regulating valve had failed. Upon replacing the electropneumatic transducer the licensee observed that the new transducer was not operating properly, so a third transducer was installed and successfully tested. Preliminary analysis of the first failed transducer revealed that the DC motor that operates the air valve had worn out. Since the transducer, part of the advanced digital FW control system, had only been in service for about three years, this was an unexpected failure. The second (new) transducer failed due to a bad internal solder joint. The licensee developed a comprehensive action plan to investigate the observed failures, other possible failure modes, possible system modifications, and the use of an air operated valve diagnostic system. The inspector will observe progress on this action plan during future inspections. A

third transducer malfunction on December 18, 1991, was caused by a limit switch failure. The limit switch was bypassed. The inspector will review the analysis of this failure during a future inspection. The inspector verified that the licensee issued Abnormal Operating Procedure C28 AOP1, "Feedwater Regulating Valve Control Failure," to provide the operators with a symptom-based procedure for FW control system malfunctions. Engineering support of troubleshooting and repair activities was excellent.

c. Cooling Water Piping Corrosion

During a surveillance test of EDG D1 the licensee observed a small cooling water leak in a short carbon steel spoolpiece between valve CV-31505 and the air to water heat exchanger. When the spoolpiece was removed the licensee saw that the leak had been caused by through-wall microbiologically induced corrosion (MIC). The spoolpiece was not classified by the licensee as ASME Code Class 3 piping. The piping upstream of CV-31505 is classified as ASME Code Class 3 piping. CV-31505 is normally closed so there is normally flow in the spoolpiece only when D1 is operating. The spoolpiece was made with schedule 10 pipe. The licensee had previously observed MIC in the cooling water system with through-wall corrosion of piping at one location. However, the licensee did not inspect the spoolpieces for MIC. The licensee decided to replace the spoolpiece because it could not analytically verify the structural capability of the leaking cooling water spoolpiece using the methodology of NRC Generic Letter 90-05, "Guidance for Performing Temporary Non-Code Repairs on ASME Code Class 1,2, and 3 Piping."

The licensee replaced the spoolpiece with a new, thicker stainless steel and carbon steel spoolpiece. A similar spoolpiece was installed on D2.

d. Non-safety-related Ventilation Systems

As discussed in Inspection Report 50-282/91020(DRP); 50-306/91020(DRP), the licensee had been unable to verify that the safety-related battery rooms have adequate ventilation during all postulated accidents. The cooling system for the battery rooms is not safety-related and the licensee could not find records of analyses that supported the pre-operational decision to eliminate a planned safety-related cooling system. The licensee performed a special test to validate recent analytical heat up rate predictions. The special test showed that the analytical method was relatively accurate. The analysis showed that, with high ambient temperatures, if a loss of the non-safety-related cooling system occurred, room temperatures would probably exceed the maximum temperature allowed for continuous operation of the battery chargers. The inspector reviewed the licensee's safety evaluation (No. 319) of the current plant conditions and concluded that there was no current safety concern. This conclusion was based on current ambient temperature conditions, procedural changes which increased the availability of non-safety-related ventilation systems and the high probability that the battery charger temperature limit is conservative. The licensee

is continuing its analysis of this condition to allow it to develop appropriate permanent corrective actions. This is an open item (50-282/91024-01; 50-306/91024-01) pending a review of the licensee's corrective actions.

One open item was identified. No other violations, deviations, unresolved or open items were identified.

8. Reliable Decay Heat Removal During Outages (TI 2515/113)

The inspector attended the licensee's pre-outage meeting for the Unit 2 refueling outage scheduled for February and March of 1992. The inspector verified that planning included consideration of activities related to reliable decay heat removal and that plant management emphasized the importance of maintaining decay heat removal. The inspector, on a separate occasion, discussed events at other plants which involved crane interference with offsite electric power lines. The inspector will continue inspection of this issue in future inspections.

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

9. Safety Assessment and Quality Verification (40500, 92701)

Safety assessment and quality verification activities were generally excellent. In November, the licensee was notified that cracks had been found in a control rod drive mechanism penetration of a French reactor vessel (RV) head. The licensee's RV heads were manufactured in France. The licensee began an engineering review to determine if its RV heads need inspection. The licensee has contacted Westinghouse and a Japanese manufacturer for contract support. The inspector will evaluate the licensee's engineering review in a future inspection. The licensee's work on this issue was an example of excellent safety assessment. However, the inspector observed four isolated cases of minor weaknesses as follows:

The licensee did not control the use of scaffolding in accordance with management expectations and management did not identify this situation until it was questioned by the inspector (see paragraph 7.a.).

Preparations for the Battery Room Heat Up Special Test were generally thorough with appropriate reviews conducted. However, the inspector observed two significant errors in the procedure used to conduct the test. The errors existed after several levels of review, including an onsite safety review committee (Operations Committee) review. The inspector notified the licensee of the errors before the test was conducted.

Safety assessment of the condition of the cooling water spoolpieces for the EDGs was excellent once a leak revealed the condition. However, the licensee's quality verification programs did not identify that the licensee's program for piping inspections did not identify the spoolpieces as potential significant sites of microbiologically induced corrosion (see paragraph 7.c. for more information).

Due to concerns about the licensee's weld inspection program, the licensee began a quality assurance audit in October 1991. The licensee informed the inspector of the concerns and the audit. The audit reviewed safety-related and non-safety-related welding activities. The audit, completed on November 11, 1991, found weaknesses in engineering activities associated with weld control records. The weaknesses appeared to be a result of poor understanding of the licensee's weld control program which was not ideal for the normal conditions of use. The licensee did not identify any physical problems with welds. The licensee has completed some initial corrective actions; however, it has not completed its evaluation of the problem. The inspector will monitor licensee corrective actions as they are developed and implemented. Once this problem was identified safety assessment activities were excellent. The licensee recognized that its quality verification program should have identified these program deficiencies earlier.

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

10. Cold Weather Preparations (71714)

In conjunction with the requirements of NRC Inspection Procedure 71714, "Cold Weather Preparations," the inspector reviewed the licensee's surveillance procedure SP 1637, "Winter Plant Operation," Revision 9. The inspector also toured the plant during cold weather to determine the adequacy of the licensee's program. Tours of the turbine building, auxiliary building, radioactive waste buildings and screenhouse revealed temperatures well above freezing with safety-related fluid systems properly heat traced or contained within heated structures.

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

11. Meetings With Local Public Officials (94600)

Five Minnesota state legislators visited the plant on December 19, 1991. During their visit the inspector met with them, discussed NRC activities and answered questions they had about NRC activities.

12. Management Meeting (30702)

A management meeting, attended as indicated in paragraph 1, was conducted at the Region III office on December 16, 1991. The purpose of the meeting was to discuss the progress of and observations from various licensee initiatives and programs.

The topics presented by the licensee staff were:

a. Independent Spent Fuel Storage Installation Project
b. Station Blackout/Electrical Systems Upgrade Project
c. Outage Risk Management
d. Design Basis Documentation
e. Plant Material Improvement Program

13. 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 7.d.

14. Management Interview (71707)

The inspector met with the licensee representatives denoted in paragraph 1 at the conclusion of the report period on December 27, 1991. The inspector discussed the purpose and scope of the inspection and the findings. The inspector also discussed the likely information content of the inspection report with regard to documents or processes reviewed by the inspector during the inspection. The licensee did not identify any documents or processes as proprietary.