UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
101 MARIETTA STREET, N.W., SUITE 2900
ATLANTA, GEORGIA 30323-0199

Report Nos.: 50-413/95-18 and 50-414/95-18

Licensee: Duke Power Company
422 South Church Street
Charlotte, NC 28242

Docket Nos.: 50-413 and 50-414 License Nos.: NPF-35 and NPF-52

Facility Name: Catawba Nuclear Station Units 1 and 2

Inspection Conducted: July 7, 1995 - August 5, 1995

Inspectors: _____ 8/30/95
R. J. Freudenberger, Senior Resident Inspector Date Signed

P. A. Balmain, Resident Inspector
R. Watkins, Resident Inspector
J. Zeiler, Resident Inspector

Approved by: _____ 8/31/95
R. V. Crlenjak, Chief Date Signed
Projects Branch 3
Division of Reactor Projects

SUMMARY

Scope: This resident inspection was conducted in the areas of plant operations, maintenance, engineering and plant support. As part of this effort, backshift inspections were conducted.

Results: In the plant operations area, additional temperature monitoring and manipulations of the nuclear service water system configuration were an added burden to the operators and complicated plant operation. Had a more thorough evaluation of the Technical Specification change been performed, these complications may have been prevented (paragraph 3.a).

In the maintenance area, a Non-Cited Violation was identified for inadequate procedures for calibrating containment pressure instruments (paragraph 4.c). An operability evaluation for Unit 1 steam generator secondary manway leakage included maximum allowable leakage limits that were appropriate (paragraph 4.b).

In the engineering area, the root cause evaluation of several equipment related problems using the Failure Investigation Process was rigorous and systematic (paragraph 5.a).

Enclosure 2

In the plant support area, a deviation was identified involving the Control Room Habitability System (paragraph 6.a). Staffing of the Fire Brigade exceeded regulatory requirements (paragraph 6.b). Security personnel response to a civil disturbance by non-licensee individuals on the licensee's owner controlled property was timely and efficient (paragraph 6.d).

REPORT DETAILS

1. **PERSONS CONTACTED**

Licensee Employees

B. Addis, Training Manager
S. Co', Radiation Protection Manager
* J. Forbes, Engineering Manager
W. Funderburk, Work Control Superintendent
T. Harrall, IAE Superintendent
D. Kimball, Safety Review Group Manager
* W. McCollum, Catawba Site Vice-President
W. Miller, Operations Superintendent
* K. Nicholson, Compliance Specialist
* M. Patrick, Safety Assurance Manager
* G. Peterson, Station Manager
R. Propst, Chemistry Manager
D. Rogers, Mechanical Superintendent
* Z. Taylor, Regulatory Compliance Manager
* D. Tower, Regulatory Compliance Engineer

* Attended exit interview.

Other licensee employees contacted included technicians, operators, mechanics, security force members, and office personnel.

Acronyms and abbreviations used throughout this report are listed in the last paragraph.

2. **PLANT STATUS**

a. Operational Status

Both units operated at essentially full power for the entire report period.

b. Inspections and Activities of Interest

Inspections conducted by specialist inspectors from the NRC Region II office were as follows:

Report	Dates	Subject	Lead Inspector
95-300	7/19-21	Licensed Operator Examination	R. Baldwin, DRS

On August 1, 1995, NRC personnel attended a Catawba self-assessment meeting at the site. See NRC Meeting Summary dated August 11, 1995, for additional information.

On July 17, it was announced that Mr. David Rehn was leaving his position of Site Vice President to assume the position of President, Duke Engineering and Services - Hanford, effective immediately. On July 24, Mr. William McCollum, previously the Catawba Station Manager, was designated the new Site Vice President. Mr. Gary Peterson, formerly the Manager of Nuclear Assessment and Issues, replaced Mr. McCollum as the Station Manager. The Manager of Nuclear Assessment and Issues position remained vacant. The inspectors reviewed Technical Specification (TS) 6.3.1, which references ANSI N18.1-1971, and verified compliance with qualification requirements for applicable positions.

3. **PLANT OPERATIONS** (NRC Inspection Procedures 40500, 71707 and 92901)

Throughout the inspection period, control room observations and facility tours were conducted to observe operations activities in progress. During these inspections, discussions were held with operators, supervisors, and plant management. Some operations activity observations were conducted during backshifts. Licensee meetings were attended by the inspector to observe planning and management activities. The inspections evaluated whether the facility was being operated safely and in conformance with license and regulatory requirements. In addition, the inspection assessed the effectiveness of licensee controls and self-assessment programs in achieving continued safe operation of the facility.

The following items were reviewed in detail:

a. Standby Nuclear Service Water Pond Temperature Increase

During the report period, unusually high outside temperatures resulted in unexpected high surface water temperatures in the SNSWP. Beginning July 15, and almost daily afterwards, the Operator Aid Computer indication of SNSWP temperature began reaching its alarm setpoint of 88.5°F. One of the required operator actions for the alarm is to measure the water temperature locally to ensure that the TS allowable setpoint was not exceeded.

In order to cool the SNSWP to prevent exceeding the TS temperature limit, an additional RN pump was started and the discharge of both pumps was realigned from the lake, which is the normal discharge flowpath, to the SNSWP. However, during the course of the month, this became less effective due to the increasing temperature of Lake Wylie. On July 22, a procedure change was implemented to align the discharge of the RN train B pumps to the SNSWP while bypassing the normal plant heat loads. As part of this configuration, RN train A remained in its normal alignment removing the normal plant heat loads. This new alignment provided additional cooling margin since the plant heat loads were not

added to the water temperature being discharged to SNSWP.

TS 3.7.5.b states that the SNSWP shall be operable with an average temperature of 91.5°F measured at elevation 568 feet. A single temperature probe, located 4 feet below the normal water surface at elevation 568 feet, is used for this measurement. As a result of the probe being located close to the water surface, temperature cycled up to 4°F between day and night due to solar effects. The inspector noted that the location of the temperature probe changed from the RN pipe suction intake level (540 feet) to its present elevation as part of Licensee Amendment Nos. 108/102. In order to support the TS change, the licensee reportedly used SNSWP temperature data obtained during morning hours. As a result, the potential impact of solar heat from the day was not adequately considered in the decision to change the TS temperature measurements. The inspector considered the additional temperature monitoring and manipulations of the RN system configuration to be an added burden to the operators and complicated plant operation. Had a more thorough evaluation of the TS change been performed these complications may have been prevented.

The licensee is developing several long-term actions to mitigate the operational impact of SNSWP surface temperature increase during the summer months. These include adding additional temperature probes at either the same elevation or different elevations for a more representative temperature profile of the actual bulk water temperature of the SNSWP. Another option discussed was raising the minimum temperature limit of the SNSWP. Each of these options would require either a change to the existing TS governing the SNSWP temperature or reanalysis of the SNSWP analytical model. The licensee plans to implement one or more of these options prior to next summer in order to avoid similar temperature problems.

b. (Closed) VIO 50-413,414/93-26-02: Failure to Submit LER on TS 6.8.4 Violation and ESF Actuation

This issue involved the failure to submit LERs for two issues involving: (1) a violation of TS 6.8.4.a for failure to conduct outside containment leakage testing at the required frequency, and (2) an ESF actuation involving the opening of the ice condenser doors during a pipe break inside containment.

The licensee responded to this violation by letter dated November 29, 1993, and a supplemental response dated January 4, 1994. On December 22, 1993, the licensee submitted LER 413/93-10 for the TS 6.8.4.a violation. Licensee corrective actions for the first issue included revising the computer program for properly scheduling outside containment leakage tests. The inspector previously reviewed these changes during closeout of URI 50-413,

414/93-26-03, as documented in NRC Inspection Report 50-413, 414/95-10.

The licensee issued LER 414/93-04, dated October 25, 1993, for the ESF actuation involving the ice condenser door opening. The root cause for not reporting the ice condenser door opening as an ESF actuation was that the licensee's procedure/policy for reporting requirements was not well defined or understood. Licensee corrective actions included revising Nuclear System Directive 202, 10 CFR 50.72 Reports, to include information on the actuation of passive safety systems, such as the ice condenser door opening, as examples of ESF actuations. Similar guidance was incorporated into procedure RP/0/A/5000/13, NRC Notification Requirements, which provides guidance for plant conditions requiring NRC notification. The inspector verified that these corrective actions were properly implemented. This violation is closed.

4. **MAINTENANCE** (NRC Inspection Procedures 62703, 61726 and 92902)

Throughout the inspection period, maintenance and surveillance testing activities were observed and reviewed. During these inspections, discussions were held with operators, maintenance technicians, supervisors, engineers and plant management. Some maintenance and surveillance observations were conducted during backshifts. The inspections evaluated whether maintenance and surveillance testing activities were conducted in a manner which resulted in reliable, safe operation of the facility and in conformance with license and regulatory requirements.

The following items were reviewed in detail:

a. Unit 1 Steam Generator Replacement Modifications

During this inspection period, the licensee performed several minor modifications inside the Unit 1 upper containment in preparation for the upcoming steam generator outage scheduled for June 1996. The minor modifications involved structural modifications to the polar crane and the installation of attachment beams and anchor locations in the upper containment to support the installation of temporary equipment and structures during the outage. The licensee performed these modifications with Unit 1 on line in order to reduce critical path time during the 1996 replacement outage. The inspector reviewed the modifications and the installation activities to determine if an adverse safety impact on Unit 1 operations was created by performing this work with the unit on line.

The inspector reviewed 10 CFR 50.59 safety evaluations for the minor modifications (CE-61003, 7, 8 and 10) and verified that the licensee considered the effect of installed materials during post

accident conditions, safe load paths for the movement of the polar crane, and structural integrity of divider barriers between upper and lower containment. The inspector verified that the licensee's implementation procedure (TN/O/B/1007/CE/01A) provided controls for materials used inside containment. The inspector also attended a prejob briefing for craft personnel and observed that the craft were instructed on the importance of maintaining containment cleanliness and material control. The inspector performed a tour of upper containment during work activities and observed that the licensee secured all loose tools and equipment, as well as controlled material properly. Following the modification work, the inspector toured containment again with the craft supervisor, implementation accountable supervisor and modification engineer. The upper containment was verified to be free of loose debris and materials. Subsequent to the modification, the inspector reviewed upper containment access logs and observed that craft and steam generator replacement group supervision made several entries into containment. The inspector also observed that operations supervisors did not make any entries into upper containment during this time.

Based on this review, the inspector concluded that the licensee effectively controlled containment cleanliness and housekeeping during the steam generator replacement modification work. The inspector observed that the scope of work was limited and did not have an adverse impact on Unit 1 operations. The inspector observed from containment entry logs that there was a lack of direct operations oversight during implementation of the work.

b. Unit 1 Steam Generator Manway Operability Evaluation

On July 12, the licensee completed an operability evaluation associated with a leaking Unit 1 Steam Generator secondary side manway to determine the acceptability of operating with the leakage. The leak (from a cocked 1B secondary manway) was initially identified in March following the most recent Unit 1 refueling outage and was leak repaired successfully. The manway began leaking again in May following a power reduction. Subsequent leak repair attempts were unsuccessful. The current secondary leakage from the manway is approximately 1 gallon per minute measured from VUCDT inleakage. Based on visual observation, the licensee characterized the leak as steam jets from several points around the manway. The leaks have resulted in increased temperature and humidity levels inside the steam generator compartment and increased input into the VUCDT.

The inspector observed a special PORC meeting which reviewed the operability evaluation. The evaluation considered eight operability concerns which included steam generator integrity,

containment integrity, Containment Ventilation heat and moisture removal capability, Reactor Coolant Leakage Detection, Post accident consequences and equipment qualification. The results of the evaluation determined that operation with the current manway leakage is acceptable. Several limiting parameters were identified which would require the licensee to reevaluate current operability. The limiting parameters include a maximum of 2.7 gpm inleakage into the VUCDT and high 1B Steam Generator Compartment temperatures. The inspector reviewed guidance available to operators for monitoring these parameters and verified that revisions to the plant computer alarm response manual was initiated for these parameters.

The inspector did not identify any discrepancies with the operability analysis and determined that maximum allowable leakages limits were appropriate.

c. (Closed) LER 414/95-02: Technical Specification 3.6.1.1 Violation Due to Written Communication

On April 20, the licensee determined that containment integrity was not being maintained in accordance with TS 3.6.1.1 during calibrations involving containment pressure sensing transmitters. When these calibrations were performed, an open path was aligned from the containment to the auxiliary building for short durations. In addition, the pressure transmitter manual isolation valves, which were utilized for containment boundary isolation during the calibration process, had not been Type C leak rate tested.

Each of the four containment pressure instrument penetrations for each unit are provided with a solenoid valve located close to the outside containment vessel wall. These solenoid valves are for containment isolation and are Type C leak rate tested every outage. There are four pressure transmitters associated with each penetration and each have manual isolation valves whereby the transmitters can be individually isolated from the penetration.

The inspector reviewed the procedures used to conduct the pressure transmitter calibrations. The procedures had the technicians valve out the transmitter being calibrated using the manual isolation valve. Calibration was performed by removing a test tee plug on the high side of the transmitter and installing the pressure test instrument. In this alignment, the penetration solenoid valve was still open; therefore, containment integrity was not maintained since the manual isolation valve had not been Type C leak rate tested. Once the calibration was completed, the procedure had the technician open the manual isolation valve and observe whether the pressure reading on the transmitter was zero. The isolation valve was then re-closed. With both the solenoid

and isolation valve open at the same time, a direct path from the containment existed since the test plug was still removed.

The inspector reviewed the licensee's corrective actions for this issue. A procedure was developed for Type C leak rate testing the manual transmitter isolation valves so tnat they could be qualified for containment isolation during pressure transmitter calibrations and testing. On August 3 and 4, the manual transmitter isolation valves associated with two of the four Unit 2 penetrations were leak rate tested. The "as-found" leakage results were found to be within acceptable limits. The inspector noted that the test procedure was detailed and the activities were well coordinated and controlled. The licensee planned to leak rate test the remaining isolation valves prior to calibrating the other pressure transmitters. In addition to this, the licensee planned to revise each of the procedures for calibrating the pressure transmitters to ensure that the transmitter test tee was reinstalled and leak rate tested prior to opening the manual isolation valve upon completion of the calibration. The inspector verified that these procedure revisions were completed for pressure transmitters that were due to be calibrated prior to the outage. The inspector determined that the licensee's corrective actions were adequate.

The inspector concluded that the original procedures for calibrating the pressure transmitter were inadequate in that they failed to ensure that containment integrity was maintained during their performance. This constitutes a violation TS 6.8.1 for inadequate procedures. This licensee identified and corrected violation is being treated as a Non-Cited Violation, consistent with Section VII of the NRC Enforcement Policy. This item is identified as NCV 50-413,414/95-18-01: Inadequate Procedures for Calibrating Containment Pressure Instrumentation.

5. **ENGINEERING** (NRC Inspection Procedure 37551)

Throughout the inspection period, the inspectors reviewed engineering evaluations, root cause determinations, and modifications. During these inspections, discussions were held with operators, engineers, and plant management. The inspection evaluated the effectiveness of licensee controls in identifying and appropriately documenting problems, as well as implementing corrective actions.

The following items were reviewed in detail:

a. Review of Failure Investigation Process Items

During this report period, the licensee initiated FIP teams for several equipment related problems that occurred. The FIP is an engineering program initiative for conducting formal root cause determinations. While the program has yet to be fully implemented, it has been utilized for conducting root cause evaluations for several equipment related problems over the recent months. The inspector monitored the FIP investigations for the issues discussed below.

(1) Main Turbine Hydraulic Oil System Pressure Switch Actuation

On July 13, while swapping LH pumps during performance of the Unit 2 weekly main turbine trip test, a momentary alarm signal was received for low LH oil pressure. It was determined that one of the three pressure switches which provide a 2/3 logic turbine trip on low LH pressure had actuated. Since October 1993, two similar alarms had occurred on different pressure switches during this testing. An FIP team composed of engineering and operations personnel was initiated to determine the root cause for the actuation of the pressure switches. The results of the initial FIP evaluation indicated that excessive vibration had caused the inadvertent pressure switch actuation. The FIP evaluation was incomplete at the end of the report period.

(2) Letdown Heat Exchanger Outlet High Pressure Transient

On July 14 and 16, the Letdown Heat Exchanger Outlet High Pressure annunciator was received on Unit 1. The operators also noted momentary fluctuations in letdown flow. In response to the July 16 transient, the operators took manual control of the letdown pressure control valve (1NV148) and stabilized pressure at its normal value. The controller was then returned to auto without any further perturbations. An FIP was initiated to investigate the letdown pressure transient. The FIP team determined that the transient was initiated when 1NV148 closed slightly, causing letdown pressure to increase. This also resulted in the momentary lifting of the letdown relief valve which has a setpoint of 600 psig. The letdown pressure control loop associated with 1NV148 was tested and found to be in calibration. A chart recorder was also connected to the pressure control circuitry in order to monitor for any abnormal operation. The FIP evaluation was incomplete at the end of the report period.

(3) Residual Heat Removal System Sodium Intrusion

On February 21, following a Unit 2 trip, sodium levels increased significantly in the reactor coolant, chemical and volume control, and residual heat removal systems (PIP 2-C95-0494). The licensee determined that the most likely source of sodium was from the component cooling water system leaking into the residual heat removal system. In mid July, an FIP team, composed of engineering, operations and chemistry personnel was established to methodically review all potential sources of this leakage and to develop testing. The FIP team identified six possible failure modes and is currently in the testing phase to prove or eliminate each of the failure modes. Testing had not been completed at the end of the report period.

The inspector monitored the FIP investigations for the equipment problems discussed above and concluded that the teams were rigorously and systematically pursuing the root cause of these issues. The inspector concluded that when fully implemented, the FIP program should help improve the quality and consistency of the licensee's root cause determinations.

b. Review of 10 CFR Part 21 Report on Relief Valves

During this report period, the inspector became aware of a 10 CFR Part 21 Report that was submitted to the NRC by Anderson Greenwood and Company (AGCO). In the Part 21, AGCO indicated that there could be a considerable difference in setpoint if their Model 81P series relief valves were adjusted using air as opposed to water. These relief valves were designed for water applications and were factory set using water as the test media. Catawba uses these same series relief valves in the condensate, feedwater, and nuclear sampling systems.

The inspector verified the licensee had received information regarding the Part 21. On July 19, the licensee's Operating Experience Program group initiated PIP 0-G95-581 to address this issue. The inspector also reviewed procedure MP/0/A/7650/37, Relief Valve Set Pressure Testing and Adjustment, which provides the method of testing and adjusting the setpoint of relief valves. The inspector determined from review of this procedure and discussions with the responsible valve engineer that relief valves are tested with the same test medium as their process medium. Based on this, the inspector determined that this problem was not applicable to Catawba.

6. **PLANT SUPPORT** (NRC Inspection Procedures 71750 and 64704)

Throughout the inspection period, facility tours were conducted to observe activities in progress. Some tours were conducted during backshifts. The tours included entries into the protected areas and the radiologically controlled areas of the plant, including emergency response facilities. Observations included assessments of radiological postings and work practices. During these inspections, discussions were held with radiation protection and security personnel. The inspections evaluated the effectiveness of the programs to assess whether activities were performed safely and in conformance with license and regulatory requirements.

The following items were reviewed in detail:

a. Self Contained Breathing Apparatus Availability

During this inspection period the inspector reviewed the licensee's provisions for use of self contained breathing apparatus by control room personnel. This review was performed in response to an event at another nuclear facility where a toxic gas release onsite required control room operators to don self contained breathing apparatus.

The licensee maintains a Control Room Habitability System in the main control room which consists of six large breathing air cylinders, a distribution manifold, and six breathing air ports mounted on a portable cart. Full face masks with pressure demand regulators and hoses are stored adjacent to the system. In the event control room operators need a breathing air supply, this apparatus would be rolled from its storage location in the rear of the control room to a location near the control room horseshoe area and placed in service. The system is sized to accommodate five people for up to six hours. Annunciator response procedures require use of this system under certain conditions when either high chlorine, radiation, or smoke concentrations are present in the control room outside air intakes.

During this review, the inspector identified several discrepancies with the Control Room Habitability System, including the following: (1) only one mask size was provided; (2) no formal provisions for maintaining eyeglass inserts available; (3) the design of the air distribution manifold was susceptible to single failure since air supplied to all ports passes through a single pressure regulator valve; (4) procedures do not specify staffing assignments for use of system; (5) TS minimum staffing requires six operators while the system is sized for five operators; and (6) untimely resolution of a previously identified calibration deficiency. The inspector did not have an immediate concern regarding the ability of the Control Room Habitability system to

supply breathing air to the TS minimum staff, since sizing calculations were conservative and additional SCBAs are stored near the main control room. The licensee corrected the outstanding calibration deficiency and initiated PIP 0-C95-1158 on August 2, 1995, to address the remaining concerns.

The inspector reviewed applicable FSAR requirements involving the Control Room Habitability System and toxic gas protection. FSAR section 1.7.1.1, Regulatory Guides, discusses the licensee's commitment to conform with the requirements of Regulatory Guide 1.95, Protection of Nuclear Plant Control Room Operators Against an Accidental Chlorine Release (Revision 1, 1/77). Regulatory Guide 1.95 paragraph C.4.c specifies the rehearsal of chlorine release emergency plan provisions to ensure donning of full face self-contained pressure demand type breathing apparatus on detection of high chlorine concentrations. Paragraph C.4.c specifies storage provisions and procedures for breathing apparatus such that operators can begin using the apparatus within two minutes after an alarm. Paragraph C.4.d specifies, in part, that air supply apparatus should meet the single failure criterion.

The inspector identified that rehearsals to ensure the donning of the Control Room Habitability system had not been conducted; storage provisions and procedures such that the operators can begin using the Control Room Habitability System within two minutes after an alarm were not implemented; and the Control Room Habitability system does not meet the single failure criterion. Based on this review, the inspector concluded that the licensee failed to meet FSAR commitments regarding the Control Room Habitability System which potentially impacted the ability to respond to an onsite toxic gas release. This issue is identified as Deviation 50-413,414/95-18-01, Control Room Habitability Discrepancies.

b. Fire Brigade Information

During this inspection period the inspector reviewed fire brigade composition, shift manning and fire drill activities. This review was performed in response to an event at another facility which involved a switchgear fire. Concerns were identified at the other facility relative to the delayed response to the fire by the fire brigade.

The inspector reviewed the composition and normal duties of fire brigade members and determined the licensee maintains a primary fire brigade of five members including a fire brigade leader. The primary fire brigade is normally composed of shift operations personnel. The fire brigade leader is an SRO and the fire brigade members are non-licensed operators. In addition to the primary

fire brigade, the licensee assigns five additional fire brigade members. The additional members are also shift personnel whose normal duties include maintenance support as part of the SPOC crew. The inspector verified that the normal staffing of the fire brigade exceeds the minimum required staffing and that no other duties would take priority for the five primary fire brigade members. The inspector determined that fire brigade drills are conducted on backshifts at least once per shift per year.

From discussions with the licensee's Emergency Planning/Fire Protection specialist, the inspector determined that the fire brigade would be activated at the first report of smoke. In addition, the inspector verified that the licensee's fire detection system provides an alarm which is part of the main annunciator system and would be audible and visible when other alarms would occur during a plant event. Fire brigade response to an electrical switchgear fire is to first attempt to extinguish the fire using carbon dioxide and then use water fog on deenergized switchgear if carbon dioxide is not effective. The inspector observed that off-site assistance is requested at the discretion of the fire brigade leader. The inspector also verified that requirements for declaring emergencies for events involving fires are provided in procedure RP/0/A/5000/01, Classification of Emergency.

Based on this review, the inspector concluded that the concerns relative to delayed fire brigade response at the other facility do not apply to Catawba.

c. (Closed) IFI 413,414/93-07-01, Review Adequacy of Fire Brigade Staffing

This item identified a concern that the majority of personnel qualified as fire brigade members were working on the day shift. The inspector reviewed fire brigade staffing and determined that the licensee assigns a total of ten people to the fire brigade. The inspector verified by reviewing shift assignment documentation that full staffing is maintained on both the day shift and the night shift. Based on this review, this item is closed.

d. Security Response to Civil Disturbance in Owner Controlled Area

On July 13, plant security personnel responded to a civil disturbance between four non-licensee individuals at a park area located behind the plant. This park is on the licensee's owner controlled property. After a fight occurred between two of the individuals, they crossed a wooded area and entered the non-safety RL intake structure which is located outside the protected area fence. The other individuals left the park and drove to the RL intake structure. During the altercation, one of the individuals

jumped into the lake, swam to the RL intake, and could not be located for several minutes. The individual was later found, removed from the water, and taken into custody by the local law enforcement agency. Plant security personnel surveyed the RL intake area and found no evidence of damage or sabotage. While a news release was not issued, the licensee made a courtesy NRC Notification concerning the event due to the potential for media interest.

The inspector determined that the security staff responded in a timely and efficient manner to the disturbance. The inspector also reviewed the licensee's Security Plan and discussed the access controls for vehicles accessing the park and RL intake structure. While there are no requirements for controlling these areas, the licensee indicated that several access controls were being considered for implementation. Among these included monitoring of the plant entry points for unauthorized vehicles and construction of fences and gates to restrict entry to portions of the owner controlled area.

7. EXIT INTERVIEW

The inspection scope and findings were summarized on August 3, 1995, with those persons indicated in paragraph 1. The inspector described the areas inspected and discussed in detail the inspection findings listed below. No dissenting comments were received from the licensee. The licensee did not identify as proprietary any of the materials provided to or reviewed by the inspectors during this inspection.

Item Number	Status	Description and Reference
VIO 413,414/93-26-02	Closed	Failure to Submit LER on TS 6.8.4 Violation and ESF Actuation (paragraph 3.b).
LER 414/95-02	Closed	Technical Specification 3.6.1.1 Violation Due to Written Communication (paragraph 4.c).
NCV 413,414/95-18-01	Closed	Inadequate Procedures for Calibrating Containment Pressure Instrumentation (paragraph 4.c).
DEV 413,414/95-18-02	Open	Control Room Habitability System Discrepancies (paragraph 6.a).

IFI 413,414/93-07-01	Closed	Review Adequacy of Fire Brigade Staffing (paragraph 6.c).

8. **ACRONYMS AND ABBREVIATIONS**

AGCO	-	Anderson Greenwood and Company
ANSI	-	American National Standards Institute
CFR	-	Code of Federal Regulations
ESF	-	Engineered Safety Features
FIP	-	Failure Investigation Process
FSAR	-	Final Safety Analysis Report
gpm	-	gallons per minute
IAE	-	Instrument and Electrical
IFI	-	Inspector Followup Item
LER	-	Licensee Event Report
LH	-	Main Turbine Hydraulic Oil System
NCV	-	Non-Cited Violation
PIP	-	Problem Investigation Process
PORC	-	Plant Operations Review Committee
psig	-	pounds per square inch gauge
RL	-	Low Pressure Service Water System
RN	-	Nuclear Service Water System
R&R	-	Removal and Restoration (Tagging Order)
SCBA	-	Self Contained Breathing Apparatus
SNSWP	-	Standby Nuclear Service Water Pond
SPOC	-	Single Point of Contact
SRO	-	Senior Reactor Operator
TS	-	Technical Specifications
URI	-	Unresolved Item
VUCDT	-	Ventilation Unit Condensate Drain Tank
WO	-	Work Order