

U.S. NUCLEAR REGULATORY COMMISSION

REGION III

REPORT NO. 50-282/95011; 50-306/95011(DRP)

FACILITY

Prairie Island Nuclear Generating Plant, Units 1 and 2

License Nos. DPR-42; DPR-60

LICENSEE

Northern States Power Co.
414 Nicollet Mall
Minneapolis, MN 55401

DATES

July 4 through August 21, 1995

INSPECTORS

M. Dapas, Senior Resident Inspector
R. Bywater, Resident Inspector
P. Loudon, Radiation Specialist
G. Pirtle, Physical Security Inspector
F. Ehrhardt, Reactor Operations Assessment
Representative
J.D. Smith, Reactor Inspector
P. Loughheed, Reactor Inspector

APPROVED BY

W. J. Kropp
for W. J. Kropp, Chief
Reactor Projects Section 2A

9-15-95
Date

AREAS INSPECTED

A routine, unannounced inspection of operations, engineering, maintenance, and plant support was performed. Safety assessment and quality verification activities were routinely evaluated. Follow-up inspection was performed for non-routine events and for certain previously identified items. Special inspection was performed in the area of implementation of 10 CFR Part 20. Temporary Instruction TI 2515/123 was closed based on the results of this inspection.

RESULTS

Assessment of Performance

Performance within the area of OPERATIONS was mixed - see Section 1.0. Examples of weak performance were identified with respect to the performance of emergency diesel generator surveillance testing and followup review of unsatisfactory test results. Also, an untimely report was made to the NRC following an apparent actuation of an engineered safety feature. However, no violations were identified in this area.

Performance within the area of MAINTENANCE was good - see Section 2.0. No violations, deviations, or significant problems were found.

Performance within the area of ENGINEERING was good - see Section 3.0. No violations, deviations, or significant problems were found. Preparation for the service water system operational performance inspection was excellent.

Performance within the area of PLANT SUPPORT was good - see Section 4.0. However, a violation was identified for inoperability of a continuous air monitor; the violation is not being cited because criteria of the NRC Enforcement Policy were met. The requirements of the revised 10 CFR 20 regulations have been effectively implemented. Overall performance of personnel in the radiation protection and security staffs was a strength and excellent examples of self assessments and quality department audits were identified in each of these areas.

Summary of Open Items

Violations: not identified in this report

Unresolved Items: one identified in Section 4.3

Inspection Follow-up Items: three identified in Section 4.3

Non-cited Violations: one identified in Section 4.2

INSPECTION DETAILS

1.0 OPERATIONS:

NRC Inspection Procedure 71707 was used in the performance of an inspection of ongoing plant operations. Some examples of weak performance were identified.

1.1 Performance of Operations at Power.

Inoperable Emergency Diesel Generator (EDG)

On July 9, 1995, the licensee conducted surveillance procedure (SP) 2295, "D5 Diesel Generator Fast Start Test" to verify that the D5 EDG would start and accelerate to synchronous speed within 10 seconds of the initiation of a start signal. Steps 7.28 through 7.30 of SP 2295 require the operator to shut the diesel output breaker and within 60 seconds to increase load to 5100-5300 KW using the diesel generator governor control switch. While performing these steps of the procedure, the control room operator used the control room clock to determine the time required to load the D5 EDG to at least 5100 KW. Based on the clock indication, it took the operator longer than one minute to reach the desired load.

Operations shift management contacted the responsible system engineer about the apparent test discrepancy. Following discussion with the system engineer, shift management concluded that the operator had not performed the test correctly. Apparently, the operator had increased generator load gradually by repeatedly placing the governor control switch in the "raise" position for a few seconds and then releasing the switch to monitor the indicated load change. This was consistent with the method used to increase generator load during a slow start test. However, for the fast start test, the governor control switch must be held in the full "raise" position immediately upon closure of the diesel output breaker to achieve a load of at least 5100 KW within the required 60 seconds. Shift management therefore concluded that because the operator did not perform step 7.30, which states, "Over a period of <60 seconds, increase D5 load to 5100-5300 KW using CS-46947, D5 DSL GEN GOVERNOR CONTROL," correctly, the test results were invalid. Since completion of the remaining portions of SP 2295 satisfied the monthly slow start test requirements, shift management concluded that the D5 EDG was operable.

On July 10, the licensee conducted SP 2307, "D6 Diesel Generator Fast Start Test." During the performance of this test, control room operators used two stop watches to record the time required to complete step 7.30. The licensee observed that the time to load D6 EDG to 5100 KW was 63 and 64 seconds as indicated on the respective stop watches. The responsible system engineer was again contacted and based on discussion with the engineer, operations shift management concluded that because the ramp rate circuit, which is used during manual loading of

the diesel generator, would be bypassed during an actual engineered safety features (ESF) actuation, then D6 was operable.

The inspectors attended the plant status briefing on Tuesday morning, July 11 during which the diesel events of July 9 and 10 were discussed. At that meeting, the licensee decided to convene an Operations Committee (OC) meeting (onsite safety review) to further discuss the status of D5 and D6. The inspectors attended the OC meeting and noted that the licensee concluded that the D5 EDG was operable and that the D6 EDG was operable but degraded. The operability decision for D6 was based on the fact that the ramp rate circuit is bypassed during an ESF actuation and therefore the performance of step 7.30 of SP 2307 does not provide any indication of diesel functionality.

The inspectors had several concerns with the basis for the licensee's operability determination. The inspectors noted that step 7.30 was denoted with an asterisk and that the "Purpose and General Discussion" section of SP 2307 contained the statement that, "Steps denoted by an asterisk (*) must be completed satisfactorily in order for the test to be acceptable." Thus, step 7.30 contained test acceptance criteria. In addition, the inspectors noted that Technical Specification (TS) 4.6.A.2 required that D5 and D6 EDGs be manually synchronized to the grid and loaded to at least 5100 KW in less than or equal to 60 seconds and then operated for at least one hour. The licensing basis for this TS was not discussed during the OC meeting. In addition, the inspectors noted that TS 4.0, "Surveillance Requirements," contained the statement, "Failure to perform a Surveillance Requirement within the allowed surveillance interval ... shall constitute noncompliance with the OPERABILITY requirements for a Limiting Condition for Operation." The "Definitions" section of the Technical Specifications contained the statement, "The OPERABILITY of a system or component shall be considered to be established when ... it has been tested periodically in accordance with Specification 4.0 and has met its performance requirements" The inspectors determined that D6 EDG should have been declared inoperable by the licensee when the test acceptance criterion contained in step 7.30 of SP 2307 was not satisfied.

The licensee convened a second OC meeting during the morning of July 11. At that meeting the licensee decided that D6 EDG had been inoperable since 10:43 p.m. on July 10 when the failure to satisfy specific test acceptance criteria contained in step 7.30 of SP 2307 was identified. This placed the D6 EDG in a 7-day LCO. The licensee initiated a work order to investigate an apparent problem with the ramp rate circuit.

Per TS 3.7.B.1 the licensee was required to verify the operability of the unaffected EDG, D5, within 24 hours of declaring D6 inoperable to confirm that there was not a common mode failure concern. The licensee initiated a conference call with the inspectors and with NRR technical and projects staff to discuss the licensee's plan of action. The licensee elected to perform SP 2295 with the exception of the one hour test run, to verify the operability of D5 EDG. The inspectors observed the test and noted that the operator was able to load D5 to 5100 KW in

less than 60 seconds following the closure of the diesel output breaker. This supported the licensee's original contention that the failure to satisfy step 7.30 of SP 2295 on July 9 was the result of how the operator manually loaded D5. Following an adjustment to the ramp rate circuit for the D6 EDG, the licensee successfully performed SP 2307 and declared D6 operable.

The inspectors identified several concerns with the licensee's response to these events. Operations shift management should have declared the D6 EDG inoperable based upon a failure to satisfy a previously established surveillance test acceptance criterion. Deciding that this established test criterion did not relate to operability of the EDG without knowledge of the licensing basis of TS 4.6.A.2 was inappropriate. The initial OC conclusion that the D6 EDG was operable but degraded was not adequately justified. The inspectors concluded that the licensee did not exhibit a conservative operating philosophy in responding to the subject surveillance testing discrepancies.

Unexpected Closure of Containment Isolation Valves

On August 21, 1995, the outside-of-containment supply and return isolation valves for the Unit 2 containment gas and particulate radiation monitoring system closed for no apparent reason. An investigation was promptly initiated to identify the cause for the closure of the valves; however, the control room operators overlooked the possibility that this event may be reportable as a 4-hour non-emergency event per 10 CFR 50.72 as an actuation of an engineered safety feature (ESF). Notification to the NRC was not made until after 4 hours of the event's occurrence. At the conclusion of the report period, the licensee was still reviewing the reportability for this event. However, the inspectors concluded that given the information available to the control room operators at the time of occurrence, the event should have promptly been considered an actuation of an ESF and reported per the licensee's administrative procedure requirements and 10 CFR 50.72.

Reactor Operations Assessment Representative Observations

The inspector reviewed documentation and records associated with Unit 2, cycle 17 physics testing including procedure D30, "Post Refueling Startup Testing." During performance of step 7.3.3, the licensee noted that the hot zero power boron concentration for the all rods out condition was 57 ppm higher than predicted. This value exceeded the procedure review criterion by 7 ppm. The review criterion specified that the measured boron concentration must be within 50 ppm of the predicted boron concentration. Step 8.5.1 of D30 directed the licensee to initiate an examination of historical physics testing trends, contact the Nuclear Analysis Department (NAD) to review the safety significance of the deviation, and have the OC review the results of this investigation if the review criteria were not met.

The licensee documented the results of the NAD review in a letter dated June 24, 1995. A draft of the meeting minutes from the June 26, 1995, OC meeting referenced the NAD letter but did not mention the results of the historical physics testing trends. When asked by the inspector whether this examination had been performed, the licensee stated that it had and that the results had been discussed at the OC meeting. The inspectors asked for the results of the examination of physics testing data and were informed by the licensee that the results and conclusions of this review had not been documented. This was considered a weakness of documentation and a weakness of what the purpose and expectation was for the historical review.

The inspector observed routine control room shift operations. Operators maintained a professional decorum in the control room. They were relaxed, but maintained clear communications and responded promptly to annunciators. The shift turnover was informative and included a discussion of present plant status as well as upcoming work. The inspector did not observe any distractions to safe plant operations in the control room.

The inspector accompanied a licensed plant equipment operator during a tour of the turbine building. The operator was thorough in his rounds and his logs were accurate and up-to-date.

- 1.2 Follow-up on Non-Routine Events NRC Inspection Procedures 90712 and 92700 were used to perform a review of written reports of non-routine events. For items which are "Closed" on the basis of this inspection, the Inspection Procedures were satisfied as regards verification of appropriate licensee corrective and preventive actions.

(Closed) LER 50-282/95007: A containment airlock surveillance test required by Technical Specifications had been missed. Note: this event was the subject of a separate enforcement action (Inspection Report No. 50-282/95009; 50-306/95009).

(Closed) LER 50-306/95002: Reactor trip while subcritical caused by personnel error. Following a shift change, oncoming control room operators did not initiate auxiliary feedwater soon enough during preparations for Unit 2 startup. The procedure interface problem between the unit startup procedure and steam generator crevice flushing procedure that was identified will be corrected. Also, the licensee's error reduction task force performed a thorough review of the event and identified several problems with verbal communications among control room operators and turnover to the next shift. The operations department was tasked to develop corrective actions in this area.

- 1.3 Follow-up on Previously Opened Items A review of previously opened items (violations, unresolved items, and inspection follow-up items) was performed per NRC Inspection Procedure 92901.

(Closed) Violation 50-282/94003-01; 50-306/94003-01(DRP): Failure to take adequate actions to correct conditions adverse to quality.

This 10 CFR Part 50 Appendix B violation pertained to inadequate corrective action in response to a previously issued violation for removing safeguards heat removal equipment from service without addressing the operability of the parent system. One of the licensee's actions in response to the original violation was the issuance of an Operations Department daily order that contained a list of equipment heat removal systems and the associated Technical Specification (TS) limiting condition for operations (LCOs) that applied if specific systems were removed from service. Contrary to the guidance in the subject daily order, the licensee removed bus room No. 120 Train A unit cooler from service without declaring the 480 Volt bus inoperable and applying the action requirements of TS 3.7.B.6 which allowed bus No. 120 to be inoperable for 8 hours.

As stated in the licensee's violation response, the primary reason for this violation was that the importance of essential support equipment and its impact on the operability of parent components had not been adequately communicated to plant personnel. In evaluating the root causes for this event, the licensee identified that improvement was needed in the mechanism for transmitting new information and requirements to the staff and for ensuring that requirements were properly implemented.

The licensee implemented several corrective actions. The licensee conducted heatup analyses for rooms that contained safeguards equipment and incorporated the results of these analyses into Operating Procedure C18.1, "Engineered Safeguards Essential Support Equipment," which identified required actions for inoperable heat removal equipment. Unit coolers considered essential support equipment for parent components were appropriately labeled. The licensee also added two positions to the Operations Committee (onsite safety review), the Work Request Authorization Coordinator - Electrical (WRAC-E) and the Work Request Authorization Coordinator - Mechanical (WRAC-M). These two experienced engineering superintendents were responsible for reviewing and authorizing work on critical structures, systems, and components. In addition, the licensee conducted training on essential support equipment operability with engineering and operations personnel.

(Closed) Violation 50-306/94015-03(DRP): Essential support equipment removed from service without prior authorization.

This violation pertained to the removal of the D6 safeguards ventilation system, an essential support system for Unit 2 Train B safeguards busses, from service on two separate occasions without first obtaining authorization to enter the appropriate LCO. As discussed in NRC Inspection Report 94015, the first event involved poor communications between maintenance and operations personnel, and reflected an inadequate understanding of the design function of the safeguards ventilation system. The second event involved inadequate review of

electrical drawings during the preparation of a work request isolation, and misleading nomenclature on electrical drawings. These two events indicated that the licensee's corrective actions for two previous violations regarding the operation of essential support equipment and the impact of that equipment on parent system operability, were not broad and comprehensive enough to prevent recurrence of a similar violation.

The licensee implemented several corrective actions to address both the root cause of the subject violation and the inspectors previously identified concerns with how the licensee defined and treated essential support equipment in general, and how the licensee ensured that interim corrective actions were broad enough to prevent recurrence while long-term corrective actions were being developed and implemented. These included:

- A project to identify all essential support equipment required for the operability of TS related systems and components, the incorporation of this information into an "Essential Support Equipment Matrix" for plant staff use, and the revision of C18.1 as the matrix was developed.
- Additional staff training on the contents of C18.1 and operation of the D5/D6 safeguards ventilation system.
- The issuance of a letter by the plant manager emphasizing that permission must be obtained from the control room before non-operations personnel can manipulate any equipment or controls, except as specified in a procedure that has been authorized for work.
- Plant management emphasis of the importance of performing thorough and complete reviews using all applicable electrical schematics, drawings, flow diagrams, etc., with engineering department personnel responsible for writing or reviewing procedures and work packages.
- Consultation with INPO for information regarding the best practices for communicating new operating requirements to plant personnel.

(Closed) Violation 50-282/94018-01; 50-306/94018-01(DRP): Failure to enter the appropriate LCO while performing a surveillance test.

This violation pertained to the failure to enter the appropriate residual heat removal (RHR) system LCO while performing a surveillance test on the control room chilled water pumps. The control room chilled water system was an essential support system for the RHR pumps. As documented in NRC Inspection Report 94018, this event involved an inadequate understanding of the operability status of No. 121 motor-driven cooling water pump by operations shift management. Shift management did not recognize that with two of three safety-related cooling water pumps inoperable, the removal of Train A of the control room chilled water system from service for a surveillance test resulted in Train A of the RHR system for each unit being considered inoperable per procedure. This was a condition prohibited by TS 3.3.D.2.a which

required that the engineered safety features associated with the remaining operable cooling water pump (Train A) also be operable.

Although the violation had minimal safety significance, the inspectors were concerned that this was the third violation issued in the past 12 months that pertained to problems with essential support equipment during maintenance and surveillance activities.

In response to the violation, the licensee revised surveillance procedure (SP) 1161, "Control Room Chilled Water Pump Test" to address the requirements of C18.1. The licensee also reviewed other preventive maintenance and surveillance procedures and revised them as necessary to incorporate the LCO requirements of C18.1. The output from the weekly work planning and scheduling meeting was revised to provide operators with only one schedule instead of a daily work schedule and a surveillance schedule. The licensee is also in the process of translating information from the "Essential Support Equipment Matrix" into procedures for use by the engineering and operations staff.

The inspectors concluded that the licensee's corrective actions to address these three violations involving essential support equipment were adequate to prevent recurrence. The inspectors will continue to evaluate the licensee's efforts to address change management issues during future inspections.

2.0 MAINTENANCE

NRC Inspection Procedures 62703 and 61726 were used to perform an inspection of maintenance and testing activities. No violations or deficiencies were identified and overall performance in this area was considered good.

2.1 Follow-up on Non-Routine Events NRC Inspection Procedures 90712 and 92700 were used to perform a review of written reports of non-routine events. Items which were "Closed" as a result of the inspection satisfied the criteria established in the Inspection Procedures.

(Closed) LER 282/95005: Incorrect calibration tolerances for vibration equipment. Calibration cards for the affected instrumentation were corrected to address the identified issues.

(Closed) LER 306/95003: Unplanned auto-start of an auxiliary feedwater pump due to faulty adjustment of a circuit breaker cell switch. This event was discussed in detail in Inspection Report 50-282/95009; 50-306/95009. The licensee identified the need to remove the auxiliary switch cover and perform a visual inspection of contact wipe following breaker maintenance. The maintenance procedures were to be revised to include this inspection.

3.0 ENGINEERING

NRC Inspection Procedure 37551 was used to perform an onsite inspection of the engineering function. No violations or deficiencies were identified and overall performance in this area was considered good.

3.1 Follow-up on Previously Opened Items NRC Inspection Procedure 92903 was used to perform a review of previously opened items (violations, unresolved items, and inspection follow-up items). The following item was closed:

(Closed) Unresolved Item: 50-282/94014-04; 50-306/94014-04: Plan to re-evaluate the cooling water system design basis. The licensee had undertaken a project to prepare for a service water system operational performance inspection (SWSOPI). Issues such as those discussed in Inspection Report 50-282/94014; 50-306/94014 (impact of non-safeguards cooling water system loads on accident mitigation capability) are included in this project. At the conclusion of the report period the licensee was completing a SWSOPI self assessment with audit by NRC inspectors. Performance of this self assessment and issues identified will be discussed in a future NRC inspection report. The inspectors made a preliminary conclusion that the licensee had exhibited excellent performance in preparing for the SWSOPI.

4.0 PLANT SUPPORT

NRC Inspection Procedures 71750 and 83750 were used to perform an inspection of Plant Support Activities. Also, a review of the licensee's implementation of 10 CFR Part 20 was performed per NRC Inspection Manual Temporary Instruction 2515/123. Overall performance in this area was good.

4.1 Radiological Controls

A. Implementation of Revised 10 CFR 20 (Temporary Instruction (TI) 2515/123)

The inspectors reviewed the licensee's implementing procedures and programmatic practices with respect to the January 1, 1994 changes in the 10 CFR 20 regulations. Specific program areas reviewed included control of high and very high radiation areas (HRAs and VHRAs), planned special exposures (PSEs), declared pregnant workers (DPWs), and maintaining total effective dose equivalent as low as reasonably achievable (TEDE ALARA).

1. High and Very High Radiation Area Controls

HRA and VHRA controls are detailed in Radiation Protection Implementing Procedure 1001, "Radiation Protection Program," Rev.1. Keys for required locked HRAs are controlled by the Radiation Protection Department and are inventoried on a daily basis. Certain individuals in the Operations department also have keys which access HRAs and no problems

were identified with the key control program. Two VHRA's are identified within the plant, the fuel transfer tube (during fuel moves) and the incore thimble chase (sump C) area within containment when the incore thimbles are retracted. These areas are controlled with unique keys/locks which are controlled by the Shift Supervisor in the Control Room. Authorization from the Plant Manager is required for access into such areas. Overall the inspectors found the program for HRA and VHRA control to be well implemented.

2. Planned Special Exposures

Planned Special Exposures (PSEs) are discussed in the aforementioned Radiation Protection Program procedure and are not anticipated to be needed at the station. However, the procedure provides for a provision, that in the unlikely event that a PSE must be undergone, authorization for such an activity must be received from the Vice President of Nuclear Generation and a task specific procedure will be developed at that time.

3. Declared Pregnant Workers

The declared pregnant worker program is described in Plant Safety Procedure F2 "Radiation Safety," Rev. 12. The program allows for women to voluntarily declare their pregnancy and have special dose controls placed on their work activities. The station has established an administrative control of 20 mrem (0.2 mSv) per month and 200 mrem (2 mSv) for the duration of the pregnancy. To date, four workers have declared their pregnancy at the station. Modifications to the program were implemented based on comments from women on the program. Overall, the inspectors determined that the declared pregnant worker program was being effectively implemented.

4. Maintaining Total Effective Dose Equivalents ALARA

The TEDE ALARA program is discussed in the Radiation Protection Implementing Procedure 1121, "Radiation Work Permit Issue" Rev. 11. The procedure discusses approaches that should be taken to maintain total doses ALARA when considering the use of respiratory protection for work in airborne areas. A worksheet was developed (RP-273) to be used for evaluating worker doses with and without respirators and the effectiveness of engineering controls. The licensee references a 25% inefficiency factor for workers wearing a respirator. Feedback from workers has been positive with respect to respirator use reduction; however, a few individuals have demanded that they be given respirators and the station complied with the demands of

workers for these isolated cases. Overall, the TEDE ALARA program appeared to be effectively implemented.

B. 1995 Unit 2 Refueling Outage Summary

The licensee recorded 95 person-rem (0.95 person-Svs) for the recent Unit 2 refueling outage. Major exposure work included Steam Generator plugging, sleaving, and eddy current testing; Reactor Coolant Pump work; In-Service-Inspections (ISI); and Canopy Seal Repair. Personnel exposures for these activities are detailed below.

Steam Generator Work	- 27 person-rem (0.27 person-Svs)
Reactor Coolant Pump	- 8 person-rem (0.08 person-Svs)
ISI	- 4 person-rem (0.04 person-Svs)
Canopy Seal Assemblies	- 2 person-rem (0.02 person-Svs)

Overall, licensee performance during the outage was very good; however, one job involving work on the CV-31229 Pressurizer Spray Valve encountered several problems and is discussed in the section on Quality Assurance.

C. Self-Assessment and Quality Assurance (QA) Activities

Station QA personnel with the assistance of staff from the Monticello Plant performed frequent monitoring of jobs ongoing during the refueling outage. One observation involving problems associated with the repair of the CV-21229 Pressurizer Spray Valve detailed many problems which required attention from RP management. During the course of the repair evolution, several workers became externally contaminated and a few received minor intakes (worst being 26 mrem) of radioactive material as a result of inadequate controls and failure to follow RWP requirements. Work scope changes were not adequately communicated to RP supervision in order to affect any necessary changes to work control. All the observations of the auditors were communicated to the General Supervisor of RP and the department immediately initiated a non-conformance report to detail the program weaknesses and initiate corrective actions. In addition, the station Error Reduction Task Force will be performing a root cause analysis of the problems to identify global performance problems for incorporation into the final lessons learned. The inspectors noted that the observations of the auditors were thorough and the response by the RP department was good in identifying the various weaknesses associated with the job. The full effectiveness of the licensee's actions to prevent recurrence of these job control problems will be reviewed during future inspections.

The inspectors also reviewed a recently completed audit of the RP program. Audit "AG 95-12-15" was found to include detailed and thorough reviews of various elements of the RP program at the station with several findings documented. Most of the findings were of a documentation nature and the RP department had initiated corrective actions to address the findings. The inspectors determined that the audit was very good and effectively identified areas within the program in need of improvement.

- 4.2 Follow-up on Non-Routine Events NRC Inspection Procedures 90712 and 92700 were used to perform a review of written reports of non-routine events. Items which were "Closed" as a result of the inspection satisfied the criteria established in the Inspection Procedures.

(Closed) LER 282/95008: Inoperability of Continuous Air Monitor When Drive Belt Failed. At 1330 on June 17, 1995, an Auxiliary Building Operator on normal rounds noticed that the continuous air monitor (CAM) for the Spent Fuel Pit (CAM-5) was not operating due to the sample pump drive belt being broken. Backup sampling was initiated following notification of the CAM's failure and the CAM was returned to normal service on June 19, 1995. This event is similar to an event (LER 282/95002) which occurred earlier this year. Corrective actions for the previous event had not been fully implemented at the time of the second occurrence. However, based on performance history, the drive belt's life should have been longer than three months, and preventive maintenance changes were planned to be implemented around the time of the failure.

The failure to continuously maintain CAM-5 operable is considered a violation of Technical Specifications 3.9 and 4.17. However, this violation will not be cited because the criteria set forth in Section VII of the NRC Enforcement Policy as published June 30, 1995, in the Federal Register (60 FR 34381) were met. In addition, the licensee has submitted a license amendment request to the NRC which would remove the air monitoring requirements from T.S. and include them in the Offsite Dose Assessment Manual (ODCM) which would change the reporting aspects of such failures.

(Closed) LER 306/94003: Auto-Start of One Train of Auxiliary Building Special Ventilation System on High Radiation During Restoration of a Seal Water Return Filter. The details of this event and corrective actions were detailed in Inspection Report 50-282/94017; 50-306/94017. The implementation of the procedural changes were pending at the time of the last report; therefore, this LER was left open until completion of the procedural changes. During this inspection period, the licensee had effectively implemented the procedural changes necessary to prevent recurrence of the original problem.

4.3 Security and Safeguards

An onsite security inspection between July 25-28, 1995. Observations are addressed below, including three inspection followup items and one unresolved item.

- a. Some alarm system penetration attempts at the Independent Spent Fuel Storage Installation (ISFSI) were not detected (Details of the test results and methodology are considered Safeguards Information and exempt from public disclosure). Adequate compensatory measures and corrective actions were immediately implemented. The system was retested after modifications were completed and the alarm system performed satisfactorily.

Alarm system testing and procedures will be reviewed during subsequent inspections (Inspection Followup Item 282/95011-01; 306/95011-01(DRSS)).

- b. The loggable security incidents attributed to the security force increased from four in 1994 to eight between June and July 1995. Most of the loggable security incidents were caused by supervisors. The increase in loggable security incidents caused by the security force has been over a short period of time and is currently being analyzed by the security staff. We will monitor the trend during future inspections (Inspection Followup Item 282/95011-02; 306/95011-02(DRSS)).

- c. A weakness in the conduct and control of entrance searches was observed when a large tour group entered the protected area. Only one security officer was assigned to the search area and the number of alarms generated by personnel unfamiliar with the search equipment and other functions performed by the officer contributed to this concern.

The security staff's immediate corrective actions was to develop a policy whereby an additional security officer will be within the search area if ten or more visitors are processed for tours. We will monitor ingress search activities during subsequent inspections (Inspection Followup Item 282/95011-03; 306/95011-03 (DRSS)).

- d. An unresolved item was noted pertaining to whether tamper seals are still required for special nuclear material accounting and control purposes based on the spent fuel cask design, and the level of protection provided for the ISFSI. If tamper seals are an acceptable option, the other issue will be what type of seals are acceptable. This unresolved item will be addressed by separate correspondence. (Unresolved Item 282/95011-04; 306/95011-04(DRSS)).
- e. The quality of the recent Quality Assurance security audit (No. AG95-11-OUT) was considered a strength. The audit was well

documented and thorough in scope and depth. The audit identified some findings that are being resolved by the security staff.

The observed performance of security force members was also considered a strength. The personnel observed were very familiar with procedural requirements and performed the work functions in accordance with the procedures. Supervisors provided an active oversight of important security functions being performed.

5.0 PERSONS CONTACTED AND MANAGEMENT MEETINGS

The inspectors contacted various licensee operations, maintenance, engineering, and plant support personnel throughout the inspection period. Senior personnel are listed below.

At the conclusion of the inspection on August 23, 1995, the inspectors met with licensee representatives (denoted by *) and summarized the scope and findings of the inspection activities. The licensee did not identify any of the documents or processes reviewed by the inspectors as proprietary.

- *M. Wadley, Plant Manager
- *K. Albrecht, General Superintendent, Engineering
- *G. Lenertz, General Superintendent, Maintenance
- *D. Schuelke, General Superintendent, Radiation Protection and Chemistry
- *J. Sorensen, General Superintendent, Plant Operations
- *J. Hill, Manager, Generation Quality Services
- *R. Fraser, Superintendent, Technical Programs Engineering
- *J. Maki, Superintendent, Electrical Systems Engineering
- C. Mundt, Superintendent, Instrumentation and Controls Systems Engineering
- B. Stephens, Superintendent, Mechanical Systems Engineering
- *A. Hunstad, Staff Engineer
- D. Baxa, Senior Production Engineer