ENCLOSURE 2

U.S. NUCLEAR REGULATORY COMMISSION
REGION IV

NRC Inspection Report: 50-482/95-24

Operating License: NPF-42

Docket: 50-482

Licensee: Wolf Creek Nuclear Operating Corporation
P. O. Box 411
Burlington, Kansas 66839

Facility Name: Wolf Creek Generating Station

Inspection At: Coffey County, Burlington, Kansas

Inspection Conducted: October 8 through November 18, 1995

Inspectors: J. F. Ringwald, Senior Resident Inspector
J. L. Dixon-Herrity, Resident Inspector
D. G. Passehl, Senior Resident Inspector, Callaway

Approved: W. D. Johnson, Chief, Project Branch B — 11/28/95 Date

Inspection Summary

Areas Inspected: Routine, unannounced inspection including plant status, operational safety verification, maintenance observations, surveillance observations, onsite engineering, plant support activities, followup-operations, and followup-engineering.

Results:

Plant Operations

- A noncited violation occurred when an operator failed to follow a surveillance procedure resulting in the inadvertent opening of a pressurizer power operated relief valve (Section 2.1).

- Operators responded appropriately to a partial loss of offsite power. The inspector identified that operators' immediate corrective actions failed to ensure that a similar event would not occur on the opposite train (Section 2.2).

- Operators responded appropriately to a component cooling water containment isolation valve failure (Section 4.1).

- The inspector identified inattention to detail on the part of a nuclear station operator who failed to recognize several material deficiencies while operating the component cooling water system (Section 4.2).

- Operators failed to inform health physics personnel when they placed the boron thermal regeneration system in service so that health physics technicians could verify postings (Section 6.2).

Maintenance

- An electrician failed to recognize that planned troubleshooting was not permitted by the limited work control process being used. The shift supervisor appropriately stopped the work (Section 3.1).

- The inspector identified two examples where work planning was deficient. Associated with one example, the combination of work package instructions, referenced procedure instructions, and skill of the craft was insufficient to ensure that workers performed the work properly the first time (Section 3.2).

Engineering

- The inspector identified an erroneous statement in an operability determination. This demonstrated inattention to detail on the part of the engineer and several reviewers (Section 5.2).

- The inspector's questions prompted an engineer to identify missing pages in the environmental qualification report for the turbine-driven auxiliary feedwater pump. The failure of the engineer to identify these missing pages during two previous opportunities represented a lack of a thorough engineering evaluation (Section 5.3).

- A management initiative to begin joint system engineer system walkdowns at both Wolf Creek and Callaway has the potential for improving safety at both sites.

Plant Support

- During followup of a resin spill during a resin transfer, the inspector identified a violation of a radiation protection procedure. The radiation work permit failed to properly state expected radiological conditions and health physics coverage requirements for a health physics technician performing the sampling (Section 6.1).

Summary of Inspection Findings:

- One Violation 482/9524-01 was opened (Section 6.1).
- One Inspection Followup Item 482/9524-02 was opened (Section 5.1)
- One noncited violation was identified (Section 2.1).
- Violation 482/9513-01 was closed (Section 7.1).
- Inspection Followup Item 482/9410-02 was closed (Section 7.2).
- Deviation 482/9517-01 was closed (Section 8).

Attachment:

- Persons Contacted and Exit Meeting

DETAILS

1 PLANT STATUS (71707)

The plant operated at essentially 100 percent power throughout the inspection period.

2 OPERATIONAL SAFETY VERIFICATION (71707)

The inspectors performed this inspection to ensure that the licensee operated the facility safely and in conformance with license and regulatory requirements. The methods used to perform this inspection included direct observation of activities and equipment, observation of control room operations, tours of the facility, interviews and discussions with licensee personnel, independent verification of safety system status and Technical Specifications limiting conditions for operation, verification of corrective actions, and review of facility records.

2.1 Operator Error

On November 3, 1995, while performing Surveillance Procedure STS BB-004, the reactor operator inadvertently opened Valve BB PCV0456, pressurizer power operated relief valve. The operator attempted to perform Step 8.19.4, which directed the operator to open Valves HB HV7176 and HB HV7136, reactor coolant drain tank pump discharge header containment isolation valves, to unisolate the reactor coolant drain tank. The operator attempted to open Valve HB HV7136, but depressed the open switch on the control for Valve BB PCV0456 instead. This action immediately caused Annunciators 34E, pressurizer relief tank pressure high; 35B, relief valve open; and 35D, pressurizer relief valve discharge temperature high, to alarm. The reactor operator immediately recognized the error and closed Valve BB PCV0456. This closed Valve BB PCV0456 prior to it reaching the full-open position. Reactor coolant pressure dropped from the normal pressure of 2235 psig to 2214 psig, and was restored when operators manually energized the pressurizer backup heaters. Operators entered Technical Specifications Limiting Conditions for Operation 3.2.5, Action a, for approximately 3 minutes while pressure was below 2220 psig. Operators also performed all the required actions of the alarm response procedures for the alarms mentioned above.

Operations supervision immediately disciplined the operator involved, and initiated Performance Improvement Request (PIR) 95-2658 to track the investigation and corrective action. The control switch for Valve BB PCV0456 was on the Main Control Board RL021 near the control switch for Valve HB HV7136. The cold overpressure protection block/arm control switch was located between the control switches for Valves BB PCV0456 and HB HV7136, and Valves HB HV7136 and HB HV7176 were demarcated with black tape to separate the control group for the reactor drain tank from the other control switches on that section of the control board. During the subsequent followup, the inspector noted that Procedure STS BB-004, Step 8.19.4, required the operators

to open Valve HB HV7176 prior to opening Valve HB HV7136. The operator stated that Valve BB PCV0456 had been inadvertently opened while attempting to open Valve HB HV7136, with Valve HB HV7176 still shut, indicating that the operator attempted to open a valve out of sequence with the procedure. The inspector concluded that there was no safety significance to the operator's attempt to open the valves out of sequence with the procedure. The inspector concluded that the operator failed to follow the procedure. This self-revealing event is being handled as a licensee-identified and corrected violation, and is being treated as a noncited violation, consistent with Section VII of the NRC Enforcement Policy.

2.2 Partial Loss of Offsite Power

On November 10, 1995, operators experienced a partial loss of offsite power during a snow storm when the startup transformer lost power, deenergizing the Train B engineered safety features transformer and the Train B Class 1E 4160 volt bus. Coincidentally, the west bus of the site switchyard, one of the offsite power sources, also deenergized. This started the Train B emergency diesel generator, actuated the shutdown sequencer, and started the turbine-driven auxiliary feedwater pump. Operators verified that all equipment actuated per plant design, and that the plant condition did not require an activation of the emergency plan. The licensee reported this event per 10 CFR 50.72 at 11:13 p.m. System operations personnel inspected the switchyard and found a bad gasket on the control box for Air Break Switch 345-163, the switch feeding the startup transformer from the west bus. Moisture entered the control box, shorted out contacts, and energized the motor which opened the switch. This switch had not been designed to be opened under load, and was not designed with protective features. After further inspection, technicians found no additional damage. Operators restored the plant to a normal full-power lineup, and exited all action statements associated with this event on November 11, 1995. Further corrective action included opening the circuit breakers for air break switch motor operators associated with the startup transformer and the main generator output breaker. The inspector questioned whether the air break switch motor operators associated with the switchyard power feed to the Train A Class 1E 4160 volt bus should also be deenergized. The shift supervisor agreed and promptly directed workers to deenergize the appropriate air break switch motor operators. The licensee initiated PIR 95-2716 to address the event and any lessons learned that may result. The inspector concluded that operator actions were prompt and effective at mitigating the transient, and that except for the identified omission, licensee immediate corrective actions were appropriate.

2.3 Review of INPO Evaluations

The inspector reviewed the INPO Evaluation Report dated June 1995, and the Accreditation Evaluation Report for Nonlicensed Operator, Licensed Operator, and Shift Technical Advisor training programs dated November 17, 1994. The inspector did not identify the need for additional NRC followup as a result of these reviews.

3 MAINTENANCE OBSERVATIONS (62703)

During this inspection period, the inspectors observed and reviewed the selected maintenance activities to verify that personnel complied with regulatory requirements including: (1) receiving permission to start; (2) requiring quality control department involvement; (3) proper use of safety tags; (4) proper equipment alignment; (5) use of jumpers, appropriate radiation worker practices; (6) use of calibrated tools and test equipment; (7) documenting the work performed; and (8) proper postmaintenance testing. Specifically, the inspectors witnessed portions of the following work packages:

- WP 104838T1 — Oil Change On Emergency Diesel Generator Air Start Compressor
- WP 104842T1 — Cleaning and Lubrication of Emergency Diesel Generator Air Start Compressor Automatic Condensate Drain Valve
- WP 106620T1 — Adjust Turbine-Driven Auxiliary Feedwater Pump Turbine Oil Pressure Regulating Valve
- WP 106420T1 — Troubleshooting Test to Verify Proper Limit Switch Operation on Turbine-Driven Auxiliary Feedwater Pump Trip Throttle Valve
- WP 106944T1 — Troubleshooting Inservice Test Failure on Valve EG HV0061
- WP 106983T1 — Radiography of Valve EG HV0061
- WP 105122T1 — Perform Procedure MPE E009Q-02, Inspection and Testing of 13.8 kV and 4.16 kV Circuit Breakers for Centrifugal Charging Pump B Breaker
- WP 105123T1 — Perform Procedure MPE E009Q-02, Inspection and Testing of 13.8 kV and 4.16 kV Circuit Breakers for Residual Heat Removal B Breaker
- WP 103320T1 — Install PMR 05810 on Centrifugal Charging Pump B Breaker
- WP 103320T4 — Install PMR 05810 on Residual Heat Removal B Breaker
- WP 105098T1 — Oil Sample and Change on Residual Heat Removal B Motor
- WP 103731T1 — Troubleshoot Nuclear Plant Information System Computer Point on Essential Service Water Traveling Screen B
- WP 105804T1 — Replace Auxiliary Building Security Door

Selected observations from the activities witnessed are discussed below.

3.1 Troubleshooting Work Control

On October 31, 1995, the inspector observed an electrician obtain permission to perform troubleshooting on Valve FC HV0312, turbine-driven auxiliary feedwater pump trip-throttle valve, using Limited Work Package Task WP 106420 per Procedure AP 16C-002, "Work Controls," Revision 1, Appendix C, paragraph C.2.1. Subsequent to obtaining permission, the electrician requested a clearance order deenergizing the valve to facilitate removal of the Limitorque actuator cover. Procedure AP 16C-002, Step C.2.1.1, permitted troubleshooting using a limited work package task provided that these activities were limited to actions that were relatively insignificant to plant operations. The shift supervisor recognized that establishing a clearance order for Valve FC HV0312 would render the turbine-driven auxiliary feedwater pump inoperable. The shift supervisor subsequently retracted permission for the electrician to perform the work specified in Work Package 106420. The inspector concluded that the electrician proposed troubleshooting work which was not permitted under a limited work package task, and therefore failed to recognize that the planned work was inappropriate for the work control process being used. The inspector further concluded that the shift supervisor appropriately stopped the work. The central work authority superintendent initiated PIR 95-2627 to evaluate this issue.

3.2 Work Planning Deficiencies

The inspector identified work planning deficiencies in two safety-related work packages. Ultimately, workers performed the work on plant equipment properly; however, the potential existed for worker confusion and improper maintenance.

The first example involved an oil change on the Residual Heat Removal Pump B motor on November 13, 1995. Workers attempted to remove oil from the lower motor bearing using the sightglass, but only removed a few ounces of oil. After discussing the job with other workers in the shop, the workers learned that the lower oil bearing reservoir had a drain plug accessible from the pump packing gland area. After learning of their error, the workers returned to the field and properly changed the oil in the lower bearing. Work Package 105098T1 referenced Procedure MPM OS-001, "Preventive Maintenance Lubricant Sampling and Replenishment," Revision 9; however, the inspector concluded that the combination of the work package instructions, the referenced procedure instructions, and the skill of the craft failed to result in workers understanding how to properly perform the oil change task the first time. During the work package review, the inspector also identified several other less significant issues associated with this work package. The system engineer initiated PIR 95-2719 to document and track these issues.

The second example involved replacement of the auxiliary building security door under Work Package 105804T1. The inspector identified that Revision 3 duplicated work instruction steps in Revision 2, yet the planner failed to mark the duplicate steps in Revision 2 as no longer applicable. Therefore,

the package contained work steps in Revision 3 that workers signed as complete, and duplicate work steps in Revision 2 that appeared to be not complete. In addition, the inspector noted one work step that had been completed but had not been signed off as complete, and another that had not been completed but had been signed off as complete. In this example, the inspector concluded that there was no safety significance associated with the potential confusion in this work package, but noted that in other circumstances, weak documentation of work status has the potential to result in improperly performed work. The maintenance supervisor initiated PIR 95-2677 to document and track these issues.

4 SURVEILLANCE OBSERVATIONS (61726)

The inspectors sampled selected surveillance tests required by Technical Specifications to verify that personnel performed the tests in accordance with Technical Specifications, used technically adequate procedures and appropriate test equipment, and properly dispositioned any tests results which failed to meet the acceptance criteria. Specifically, the inspectors witnessed the following surveillance tests.

- STS AL 103 — Turbine-Driven Auxiliary Feedwater Pump In Service Pump Test
- STS IC 208 — 4 kV Loss of Voltage and Loss of Offsite Power TADOT [Trip Actuation Device Operational Test]
- STS EG 100B — Component Cooling Water Pumps B/D Inservice Test
- STS EG 201A — Component Cooling Water System Train A Inservice Valve Test
- STS FC 201 — Auxiliary Feedwater System Inservice Valve Test

The inspectors concluded that the surveillance tests were performed as required.

4.1 Component Cooling Water Valve Surveillance Failure

On November 2, 1995, during Surveillance Test STS EG-201A, "Component Cooling Water System Train A Inservice Valve Test," Revision 0, Valve EG HV0061, component cooling water from reactor coolant pump thermal barriers outer containment isolation valve, failed to close within 30 seconds as required by Technical Specifications 3.6.3. Operators declared the valve inoperable. When troubleshooting efforts failed to identify the cause of the problem within 4 hours, operators entered Action d of Technical Specifications 3.6.3 which required operators to be in hot standby within 6 hours and cold shutdown within the following 30 hours. Four hours and 7 minutes after Valve EH HV0061 failed, operators shut and deenergized the valve, exiting Action d and entering Action b of Technical Specifications 3.6.3. While this isolated

thermal barrier cooling to the reactor coolant pumps, according to the system engineer, this was consistent with guidance in the vendor manual and with off normal procedures. The system engineer also telephoned the vendor and confirmed that the vendor supported this action.

Since operators entered Action d of Technical Specifications 3.6.3, the licensee initiated PIR 95-2649 to document and track corrective actions, and Reportability Evaluation Request 95-037 to evaluate reportability. The licensee concluded that this was not reportable because the entire limiting condition for operation action statement time had not been exceeded.

After isolating the penetration, additional troubleshooting included pre- and postmaintenance local leak rate determinations; Valve Operation Test and Evaluation System (VOTES) tests; inspection and relubrication of the Limitorque actuator limit switch, torque switch, spring pack, and worm gear; cleaning and relubrication of the valve stem; radiography of the valve; and an overall visual inspection. The VOTES traces prior to the premaintenance local leak rate test and the actuator and stem inspection and relubrication, showed normal running thrust for all but the last approximately 1/4 inch of valve travel. During the last 1/4 inch of valve travel, the thrust increased sufficiently to open the torque switch. Subsequent to this maintenance, the VOTES trace showed normal running thrust until the actuator limit switch stopped the valve movement per design. No single maintenance action clearly repaired the valve, and at the end of the inspection period engineering continued to evaluate the data under PIR 95-2694 to identify a root cause of failure.

The inspector observed the radiography activities and concluded that the technician was very knowledgeable and proficient. Appropriate radiological controls were utilized to ensure that the radiography did not pose a hazard to other radiation workers in the vicinity. Health physics personnel provided appropriate coverage, including special surveys in areas adjacent to the radiography source.

The inspector concluded that operators and other licensee personnel responded appropriately and conservatively to this surveillance failure.

4.2 Equipment Material Condition Issues

On October 31, 1995, during the performance of STS EG-100B, the inspector observed several material condition issues. One of these issues was identified by the nuclear station operator. The remaining issues were not noted by the nuclear station operator until they were identified by the inspector. The nuclear station operator identified a packing leak on Valve EG V0013, component cooling water Pump D discharge isolation valve, and wrote an action request to initiate corrective action. The inspector identified grease leaking from the manual actuator for Valve EG V0017, component cooling water Pump D discharge isolation valve, oil leaking from the coupling between the motor and pump for component cooling water Pumps B and D, and oil leaking from the component cooling water Pump D outboard bearing. The

inspector concluded that this represented inattention to detail on the part of the nuclear station operator and other individuals participating in the test. The licensee responded by coaching the nuclear station operator regarding attention to detail while operating plant equipment.

The inspector discussed the material deficiencies with the system engineer, who stated that similar deficiencies had also been identified during joint component cooling water system engineer walkdowns at the Callaway Plant. The system engineer described joint efforts to develop corrective actions for these material condition issues at both sites. During discussions with system engineering management, the inspector learned that all system engineers were directed to engage in similar joint system walkdowns at Wolf Creek and Callaway. The inspector concluded that the joint effort was a very positive initiative with the potential for improving safety at both sites.

5 ONSITE ENGINEERING (37551)

The inspectors reviewed and evaluated engineering performance as discussed below.

5.1 Spurious Overcurrent Trip of a Safety-Related Breaker

On November 9, 1995, during routine surveillance testing of STS EJ-100B on Residual Heat Removal Pump B, the associated room cooler failed to start per design. Plant operators declared the residual heat removal pump inoperable, entered Technical Specifications Limiting Conditions for Operation 3.5.2, and commenced troubleshooting.

The plant staff determined that the room cooler failed to start because the associated circuit breaker that supplies power to the room cooler fan motor tripped on instantaneous overcurrent. The system engineer later determined that the instantaneous overcurrent trip setting was too low, causing the failure of the cooler to start.

In May 1995, the breaker to the fan motor was changed from a Gould Model FSGL10B to a Westinghouse Type HMCP molded case circuit breaker as part of a larger modification to replace all Gould breakers with Westinghouse breakers. The breaker replacement was not straightforward because the Westinghouse breakers did not have instantaneous overcurrent settings comparable to the Gould breaker setting. The original Gould breakers had the instantaneous overcurrent setting at 470 amps. The new Westinghouse breakers came with a choice of either 420 or 490 amps. Plant engineers had recognized this and provided instructions to the technicians installing the new breakers to set the instantaneous overcurrent trip setpoint on the Westinghouse breaker to 420 amps.

Since the installation of the Westinghouse breaker, the residual heat removal pump room cooler breaker operated properly during routine operational and surveillance testing between May 1995 and the test failure on November 9, 1995. Following this test failure, system engineering initiated Plant

Modification Request 03907 to change the instantaneous overcurrent setting to 490 amps. After implementing the plant modification, subsequent testing demonstrated satisfactorily equipment performance.

The inspector raised additional questions related to the technical basis for selecting 420 amps as the instantaneous overcurrent setting on the new breakers. The cognizant personnel knowledgeable of the breaker modification were unavailable at the close of this inspection report period. The inspector will review the modification package and discuss these issues with cognizant engineers, during a future inspection. This will be tracked as Inspection Followup Item 482/9524-02.

The associated breaker for the opposite residual heat removal train (Train A) had a new Westinghouse breaker with an instantaneous overcurrent setting of 420 amps. The inspector reviewed the basis for operability of this train and found a shift supervisor log entry documenting engineering's position that since the new breaker has never exhibited any problems, there were no operability concerns. The lack of a documented technical basis for operability determination was identified as a weakness in NRC Inspection Report 50-482/95-02, paragraph 5.3, in 1992. The inspector will address this issue with the inspection followup item noted above.

5.2 Containment Equipment Hatch Missile Shield

On October 13, 1995, a system engineer discovered that two restrairts on the containment equipment hatch missile shield had never been installed per the design. These two restraints limited the outward travel of the bottom of the missile shield during a seismic event. The shift supervisor reported the discovery per 10 CFR 50.72(b)(1)(ii)(B), and requested an operability evaluation per Procedure AP 28-001, "Evaluation of Nonconforming Conditions of Installed Plant Equipment," Revision 1. The system engineer prepared an evaluation concluding that the missing restraints had no effect on the operability of the equipment hatch. After engineering later determined that the missing restraints did not actually place the plant outside the design basis, the shift supervisor withdrew the 10 CFR 50.72(b)(1)(ii)(B) report. The inspector noted that the operability evaluation contained an inaccurate statement. While the inaccurate statement did not affect the conclusion, the inspector concluded that the inaccuracy represented inattention to detail on the part of the system engineer, the peer reviewer, the engineering supervisor, and the shift supervisor. The system engineering manager acknowledged the inspector's comment and stated that several measures were being considered to improve the accuracy of documents written by engineering.

5.3 Engineering Evaluation Not Thorough

During the turbine-driven auxiliary feedwater pump surveillance test on October 25, 1995, the nuclear station operator noted damage to conduits on the turbine. One of the damaged conduits provided a turbine speed signal and the other provided a status of the mechanical overspeed trip. The system engineer immediately believed that the conduit damage invalidated the equipment

qualification of the turbine and recommended that the pump remain inoperable. The shift supervisor immediately initiated an action request to repair the pump. Maintenance personnel recalled that this conduit had been damaged approximately 1 year earlier, and a document search identified Work Request 05896-94. An engineering evaluation documented on this work request stated that the damage to the conduit did not affect the environmental qualification of the cables. The engineer who provided the engineering disposition for Work Request 05896-94 determined that disposition continued to apply to the October 25, 1995, discovery. Based on this determination, the shift supervisor declared the pump operable.

The inspector reviewed the engineering disposition and determined that the engineer relied on a paragraph in the environmental qualification report which asserted the qualification of the cables and connectors without reference to the conduit. The engineer, therefore, concluded that since the environmental qualification report did not rely on the conduit, damage to the conduit sheath had no impact on the environmental qualification of the cable. The applicable paragraph in the environmental qualification report referenced a manufacturer's part number which differed from the part numbers of the damaged cables. The inspector asked how the referenced paragraph applied to the damaged cables. After additional research, the engineer discovered that some pages in the environmental qualification report had been missing. The engineer contacted personnel at the Callaway Plant who provided the missing pages. These missing pages provided a cross reference which demonstrated that the referenced paragraph also applied to the damaged cables. The inspector concluded that this represented a lack of a thorough engineering evaluation. The engineer was counselled and the licensee initiated PIR 95-2584 to track the document control issue.

6 PLANT SUPPORT ACTIVITIES (71750)

The inspectors sampled selected activities in the different areas of plant support and verified that they were implemented in conformance with licensee procedures and regulatory requirements.

6.1 Resin Spill - Inadequate Radiation Work Permit

On November 13, 1995, while transferring resin from the primary spent resin tank to a high integrity container in the radwaste building, a health physics technician overflowed the sample bottle and splashed resin into a catch pan and onto the floor below. According to the technician, a slight resin blockage initially prevented water and resin flow into the sample bottle, then the blockage suddenly cleared causing the spill. The technician's only protective clothing included rubber gloves with surgeon's gloves outside. While the event did not contaminate the technician or any other person, the technician informed the inspector that a lab coat should have also been worn.

The technician had performed many resin sampling evolutions prior to this event. During each of the previous evolutions, the technician experienced no problems with resin blockage. The technician prestaged the catch pan and

sample bottle, removed the pipe cap below the sample valve prior to the resin transfer, and surveyed the sample valve work area with an extended probe survey meter prior to climbing the ladder near the sample valve. The health physics technicians immediately covered the spilled material, established and verified a boundary, and proceeded to decontaminate the area. The responsible health physics supervisor initiated PIR 95-2749 to document and evaluate the event and lessons learned.

The inspector noted that the technician performed the sampling under Radiation Work Permit 950019, Revision 23, which permitted sampling, but did not list sampling as a work activity. As a result, for the sampling evolution, the radiation work permit provided no estimate of radiological conditions, no specification of health physics technician coverage requirements, and no specification of protective clothing requirements. Procedure RPP 02-105, "RWP [Radiation Work Permit]," Revision 7, Step 9.2.5, required the radiation work permit preparer to specify radiological conditions for the immediate work area on the radiation work permit. The failure of personnel to specify radiological conditions for the sampling work area is an example of a violation of Technical Specifications 6.11. Procedure RPP 02-105, Step 9.5.6, required the radiation work permit preparer to specify health physics coverage requirements for system breach of contaminated systems. The failure of personnel to specify health physics coverage requirements for the sampling breach is an example of a violation of Technical Specifications 6.11 (482/9524-01).

6.2 Failure to Inform Health Physics

On October 26, 1995, after operators placed the boron thermal regeneration system in service, the inspector checked the radiation levels adjacent to the system to determine if the radiological conditions had increased enough to require a change in radiological postings. The inspector found that a change in postings was not necessary. When health physics personnel learned of the inspector's activities, they determined that operations had not informed them of the change in plant condition. The shift supervisor announced plans to place the boron thermal regeneration system in service that day during the 7:30 a.m. work planning meeting, but operators did not subsequently inform health physics personnel when they actually placed the system in service. The health physics supervisor initiated PIR 95-2580 to document this issue. At the exit meeting, the operations manager stated that a change to the operating procedure would be made to require operators to inform health physics personnel upon placing the system in service.

7 FOLLOWUP-OPERATIONS (92901)

7.1 (Closed) Violation 482/9513-01: Clearance Order Failure to Verify Open Molded Case Breaker

This item involved the failure of operators to ensure that electricians confirmed the opening of molded case breakers used as clearance order boundaries prior to permitting workers to sign onto the clearance as required

by procedure. The licensee initiated PIR 95-1724 to track corrective action. The operations manager wrote a letter to operations and central work authority personnel which outlined management's expectations, and reminded personnel to verify the completeness of the clearance prior to permitting workers to sign onto the clearance. The operations manager added a review of this event to licensed and nonlicensed operator requalification training. Work groups that accept clearances also received training on their duties and responsibilities regarding clearances. The inspector concluded that the licensee's actions appear to be adequate to prevent recurrence.

7.2 (Closed) Inspection Followup Item 482/9410-02: Engineering Evaluation of Temporary Conditions

In September 1994, the licensee began a program where short-term temporary conditions such as scaffolding and shielding near safety-related equipment would not be designed to full-seismic qualification based on a probabalistic risk assessment evaluation that concluded that the additional risks imposed would be minor. The inspector noted that the Office of Nuclear Reactor Regulation began reviewing an earlier similar proposal from Commonwealth Edison under Technical Assignment Control 89067, "LaSalle One: Reduced Seismic Criteria at CECo Facilities." The inspector reviewed the completed evaluation and informed the licensee that the Office of Nuclear Reactor Regulation determined that Title 10 CFR 50.59 still applied in these cases. As a result, the licensee determined that it was not appropriate to continue the program established in September 1994. The licensee initiated PIR 95-2499 to identify and track corrective actions. The licensee removed all nonseismically qualified scaffolding and temporary shielding from the plant, revised all affected procedures, and briefed affected personnel on the decision to no longer follow the program initiated in September 1994. The inspector concluded that the licensee's corrective actions were appropriate.

8 FOLLOWUP-ENGINEERING (92903)

(Closed) Deviation 482/9517-01: NK13 Battery Rack End to Cell Gap

This item involved the inspector's identification of an excessive gap between the end cell and the rack end on one bank of the NK13 safety-related battery. The licensee corrected the excessive gap the day it was discovered. The system engineer walked down all safety-related batteries and found no other cases where the gap exceeded the design specification. Procedure MCD BA-001, "Battery Assembly Connector Maintenance," was revised to incorporate a requirement for workers to verify and document correct battery-to-rack spacing. The licensee plans to replace all safety-related batteries with AT&T round cell batteries during the next refueling outage. The inspector concluded that these actions appear appropriate.

ATTACHMENT 1

1 PERSONS CONTACTED

M. A. Blow, Superintendent, Chemistry
G. D. Boyer, Manager, Training
N. S. Carns, President and Chief Executive Officer
T. A. Conley, Superintendent, Radiation Protection
T. D. Damashek, Supervisor, Regulatory Compliance
R. B. Flannigan, Manager, Nuclear Safety Engineering
T. J. Garrett, Manager, Design Engineering
D. E. Gerrelts, Superintendent, Instrumentation and Control
S. F. Hatch, Engineering Specialist, Regulatory Compliance
D. Jacobs, Assistant Manager, Maintenance
R. Johannes, Chief Administrative Officer
J. J. Johnson, Superintendent, Security
B. T. McKinney. Manager, Operations
R. W. Miller, Superintendent, Mechanical Maintenance
W. B. Norton, Manager, System Engineering
G. J. Pendergrass, Supervisor, Engineering-Performance
J. M. Pippin, Manager, Integrated Plant Scheduling
L. D. Ratzlaff, Supervisor, Engineering
C. C. Reekie, Technical Specialist III, Regulatory Compliance
K. L. Scherich, Supervisor, NSSS Systems
R. L. Sims, Supervisor, Operations Support
A. Smith, Superintendent, Electrical Maintenance
B. B. Smith, Superintendent, Maintenance Planning
J. D. Weeks, Manager, Emergency Planning
M. G. Williams, Manager, Plant Support
D. L. Williamson, Supervisor, Environmental Management
C. R. Younie, Superintendent, Operations

The above licensee personnel attended the exit meeting. In addition to the personnel listed above, the inspectors contacted other personnel during this inspection period.

2 EXIT MEETING

An exit meeting was conducted on November 17, 1995. During this meeting, the inspectors reviewed the scope and findings of the report. The licensee did not identify as proprietary any information provided to, or reviewed by, the inspectors.