U. S. NUCLEAR REGULATORY COMMISSION

REGION III

REPORT NO. 50-346/95008

FACILITY
Davis-Besse Nuclear Power Station
License No. NPF-3

LICENSEE
Toledo Edison Company
300 Madison Avenue
Toledo, OH 43652

DATES
August 23, 1995 through October 11, 1995

INSPECTORS
S. Stasek, Senior Resident Inspector
K. Zellers, Resident Inspector
R. Jickling, EP Analyst, Lead Inspector
J. Foster, Senior EP Analyst
T. Essig, Chief EP & Environmental HP Section, NRR
J. Neisler, Reactor Engineer
J. Creed, Chief, Plant Support Branch 1

APPROVED BY

R. D. Lanksbury, Chief
Projects Branch 2

11/21/95
Date

AREAS INSPECTED

A routine inspection of operations, maintenance, engineering, plant support and preparations for dry cask storage of spent fuel 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.

RESULTS

Assessment of Performance

OPERATIONS: Control room activities were performed well. Operator response to a letdown and purification system divert valve failure was very good (Section 1.2). However, Reactor Operator shift turnovers were not conducted in accordance with established procedural requirements (Section 1.5) and the Inoperable Equipment Tracking Log was not effectively used to assure proper follow-up of a degraded fire/high energy linebreak/flood/negative pressure barrier (Section 1.4).

MAINTENANCE: Observed surveillance and corrective maintenance activities were conducted in an excellent manner. However, several material condition concerns were identified by the inspectors during routine walkdowns of the plant. Two of these, spring can degradation (Section 2.3.1) and mixed compression fitting issues (Section 2.3.2), merit further NRC follow-up because of possibly more generic implications and will be tracked as inspection follow-up items pending their resolution.

ENGINEERING: Overall, engineering personnel vigorously supported the day-to-day operation of the plant. Plant engineers were noted to be involved in preparations for, and the conduct of, testing and maintenance activities for their assigned systems. Identification that the Ultimate Heat Sink (forebay) temperature detector, used to ensure compliance with technical specification requirements, was not functioning properly and was not in the calibration program did not occur until prompted by the NRC despite earlier opportunities, including questioning by NRC inspectors. Once problems associated with the Ultimate Heat Sink temperature instrumentation were identified, a thorough engineering investigation and corrective action plan were quickly devised and implemented. Additionally the root cause and extent of condition evaluation were thorough and contributed to the identification of two additional temperature monitors that were not included in the licensee's calibration program (Section 3.1).

PLANT SUPPORT: Personnel adherence to the radiation protection and security programs continued to be excellent. The emergency organization's performance during the graded exercise was also excellent (Section 4.1). Radiation Protection (RP) personnel responded well to a failure of a letdown and purification system divert valve (Section 4.2). Security personnel were alert and conducted their activities in a professional manner (Section 4.3).

SAFETY ASSESSMENT/QUALITY VERIFICATION: The licensee provided quality oversight of the design, fabrication, and installation of the dry cask storage horizontal storage modules (Section 5.2). The Potential Condition Adverse to Quality Reporting (PCAQR) program was well utilized during root cause and extent of condition determinations for various potential plant problems (Section 3.1). Plant personnel from all disciplines actively utilized this program to document potential concerns.

Summary of Open Items
Violations: Section 3.1
Unresolved Items: Section 1.5
Inspector Follow-up Items: Sections 2.3.1, 2.3.2, and 4.1
Non-cited Violations: Section 1.4

INSPECTION DETAILS

1.0 OPERATIONS

NRC Inspection Procedure 71707 was used in the performance of an inspection of ongoing plant operations. No violations or deviations were identified. However, a non-cited violation was documented for inadequate follow-up of a degraded room penetration. Also, reactor operator shift turnovers were not conducted in accordance with plant procedural requirements.

1.1 Control Room Activities were Performed Well Control room activities and plant evolutions were performed in a conservative and controlled manner. Alarms were properly responded to, operating parameters were adequately monitored, and watchstander knowledge of plant status and evolutions in progress was up to date.

Plant management was kept informed of plant and equipment status. They were visible in the control room and in the equipment spaces during the inspection period.

1.2 Good Operator Response to MU-11 Failure On September 30, 1995, MU-11, a three way, motor operated, level divert valve in the letdown and purification system failed. MU-11 failed to an intermediate position, diverting letdown flow from the Make-Up tank (MUT) to the Clean Waste Receiver Tank (CWRT).

After diverting approximately 220 gallons of letdown from the letdown system to the CWRT the primary Reactor Operator noticed a decreasing MUT level. He observed that MU-11 had no indicating lights, notified shift personnel of the issue, and proceeded to batch add to the MUT via the primary water transfer and boric acid pumps. Zone operators were dispatched to MU-11, located in a locked high radiation room, and discovered that the valve stem had separated from the motor operator stem. Shift personnel determined that water was being diverted inappropriately to the CWRT as confirmed by CWRT flow indication, and stopped the inventory loss by shutting a CWRT isolation valve. Operators opened the breaker to MU-11's motor operator, reattached the valve stem to the operator stem and manually positioned the valve to its normal (open to the MUT) position. Appropriate plant personnel were then notified to provide additional engineering and maintenance support.

The inspector was on site during the malfunction and observed control room activities during efforts to restore letdown and purification to a normal configuration. Control Room personnel properly identified a degrading condition in the plant, responded to the malfunction in a controlled, conservative manner, returned the letdown and purification system to a normal condition in a timely manner and notified maintenance and engineering for additional support. Overall good response was noted.

1.3 Notice of Enforcement Discretion (NOED) Request On August 17, 1995, with Ultimate Heat Sink (UHS) water temperature increasing and approaching the Technical Specification limit of 85°F, the licensee submitted a Request for Enforcement Discretion regarding Technical Specification 3/4.7.5.1, Ultimate Heat Sink, to allow the plant to operate at UHS temperatures up to 90°F. Additionally a request for a permanent change to Technical Specification 3/4.7.5.1., Ultimate Heat Sink, was submitted shortly thereafter. Since making the submittal and during this inspection period, UHS temperatures gradually declined without reaching the UHS 85°F limit, and the NOED request and Technical Specification change request were withdrawn on September 12, 1995.

1.4 Untimely Evaluation of a Degraded Penetration On August 29, 1995, the inspector noted that the inoperable equipment tracking log included an entry that indicated that penetration 209-F2-004/105-C-034 (ceiling penetration to #1 ECCS pump room) was degraded. Leakage past this penetration was identified during normal work activities on July 13, 1995, and operations had deemed that further evaluation by engineering relating to high energy line break (HELB), flood protection, fire protection, and negative pressure boundary integrity was required to determine if the degradation caused any operability concerns. Per operations administrative procedure DB-OP-00018, Inoperable Equipment Tracking Log, such an evaluation was required to be completed within 72 hours. However, it was determined that the degraded penetration was identified on July 13, 1995, and engineering actions had not been initiated until questioned by the inspector. This occurred despite the fact that operators reviewed the inoperable equipment tracking log as part of every shift turnover. PCAQR 95-0587 was initiated to track resolution of this issue.

Since the engineering evaluation was not accomplished in accordance with operations administrative procedure DB-OP-00018, this is considered a violation of 10 CFR Part 50, Appendix B, Criterion V. However based in part upon the subsequent engineering determination that no operability concerns were involved, this violation was determined to be of minor significance and is being treated as a non-cited violation, consistent with Section VII of the NRC Enforcement Policy.

1.5 Inadequate Shift Turnover On September 5, 1995, the inspector observed that reactor operator (RO) shift turnovers were not being conducted in accordance with established plant procedures. Specifically, as required by operations procedure DB-OP-00100, Shift Turnover, the critical parameters checklist was not completed prior to the offgoing shift leaving the control room on September 5, 1995. It was also noted by the inspector that the entire shift turnover, the period of time that it took for both oncoming ROs to enter the Control Room and relieve the offgoing ROs, took a total of about 8 minutes. However, additional review of control room security door transaction records for the previous week as well as for a period in June 1995 indicated several instances of much shorter shift turnover times.

Although this condition apparently existed for an extended period of time, the licensee did not identify the condition even though several opportunities presented themselves. Shift Supervisors and Assistant Shift Supervisors did not identify the issue even though they were responsible for and directly supervised ROs. Operations management did not identify the issue although they periodically observed the shift turnover process. QA also did not identify the condition even though they were in process of performing an audit of control room activities during the period August 21 to September 1, 1995.

Once this issue was identified to operations management, discussions were held with all ROs to reinforce shift turnover procedural requirements. Subsequently, no further concerns with RO shift turnover were noted during the inspection period.

Pending completion of NRC review of this matter, this is considered an **Unresolved Item (50-346/95003-01(DRP))**.

1.6 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.

(Open) Unresolved Item (50-346/95007-01(DRP)): Electrical equipment operating at high voltage conditions. Licensee Design Engineering did a downstream load evaluation on busses YAU and YBU and determined that the appropriate operating voltage range, considering minimum load voltage requirements and voltage drops from the bus to the load, to be 120-126 VAC (reference PCAQR No. 95-0843). This voltage range was more restrictive than that of Request for Action (RFA) 88-1042 voltage range of 108-126 VAC for 120 volt busses. This item remains open pending further NRC and licensee review.

2.0 MAINTENANCE

NRC Inspection Procedures 62703 and 61726 were used to perform an inspection of maintenance and testing activities. No violations or deviations were identified. Several equipment material condition related concerns were noted however. None of the examples directly affected equipment operability, but did require follow-up actions by the licensee.

2.1 Surveillance Activities were Conducted in an Excellent Manner The inspector observed several surveillance activities during this inspection period. They included: EDG #1 monthly, AFW #1 monthly, and Reactor Trip Breaker testing.

All of the activities observed were conducted in accordance with procedures and in a controlled, professional manner. The equipment performed as designed with no substantive deficiencies noted in equipment performance.

2.2 Corrective Maintenance was Conducted in an Excellent Manner The inspector observed the following corrective maintenance activities by plant maintenance personnel: Service Water strainer blowdown valve repairs, Service Water pump suction cavity cleaning, and Containment Radiation Monitor RE-2005 maintenance activities.

Maintenance activities, in general, were well planned and conducted by appropriately qualified personnel using adequate procedures. Supervision of work activities was visible, appropriate, and effective. Safety consciousness was high and professionalism was evident.

2.3 Plant Material Condition

Several plant equipment material condition and housekeeping problems were identified during the inspection period. The individual problems were not significant and none adversely affected equipment operability. However, additional licensee attention was warranted and in several instances, PCAQRs were initiated to track their resolution.

2.3.1 Spring Can Degradation

- During plant walkdowns the inspectors noted that certain piping support spring cans were becoming degraded in that the position indicating tabs had gouged recesses into the can housings, thereby somewhat limiting can movement. The gouging action appeared to be a result of piping vibration transmitted to the particular spring cans. A PCAQR was subsequently initiated to track the resolution of this issue with the corrective action/follow-up response being in process at the end of the inspection period. Long-term follow-up actions were specifically to be addressed. Civil engineering had determined that the particular examples identified did not result in any overstressed piping conditions.

  In addition, the licensee was implementing an inspection program for ASME Class 1, 2 and 3 supports (including spring cans) on a periodic sampling basis that would identify spring can degradation similar to those identified. Because of this, no spring can degradation would be anticipated for those spring cans covered under that program. Pending follow-up of the licensee's corrective actions on this matter, this is considered an **Inspection Follow-up Item (50-346/95008-02(DRP))**.

2.3.2 Mixed Compression Fittings

- During a plant walkdown on August 30, 1995, the inspectors noted mixed compression fittings on the cyclone separator piping on the No. 1 high pressure injection (HPI) pump. Specifically, the subject compression fittings were comprised of a swagelok type mated with a Yoke type in each case. This matter was communicated to plant engineering to determine the acceptability of using mixed fittings of the type(s) noted. Operability of the HPI pump was not of concern since no leakage from the fittings or piping was

noted. However, extent of condition may be a longer standing issue in need of resolution. Pending review of the licensee's follow-up actions on this matter, this is considered an **Inspection Follow-up Item (50-346/95008-03(DRP))**.

2.3.3 Emergency Diesel Generator (EDG) No. 1

- Fuel oil filters for #1 EDG were potentially overtorqued as exhibited by slightly bowed flanges. The system engineer indicated that the oil filter systems were habitual leakers that would cause personnel to torque the hold down bolts to maximum values to stop fuel oil leakage. The fuel oil filters were scheduled at the time to be replaced with a better design.

- A missing nut was identified on a bracket that fastened a conduit to the EDG.

2.3.4 Auxiliary Feedwater System Train 1

- A pair of pliers was noted in a floor drain.

- An instrument line isolation valve handwheel was found loose.

2.3.5 Service Water Pipe Support

- A saddle type support was noted not properly fastened to its bedplate (i.e., washers/nuts either loose or missing). Subsequent engineering review determined that the support was not required to adequately support the subject run of piping. However, the support was not documented on any controlled design or installation document. The licensee postulated it was a temporary type support installed during original construction that had not been removed following final pipe installation. Subsequently actions were initiated to incorporate the support into the appropriate engineering documents/drawings as abandoned in place.

3.0 ENGINEERING

NRC Inspection Procedure 37551 was used to perform an onsite inspection of the engineering function. Overall, engineering personnel vigorously supported the day-to-day operation of the plant during the inspection period. Plant engineers were noted to be involved in preparations for, and the conduct of, testing and mainteance activities for their assigned systems. However, one violation was identified where instrumentation used to monitor for Technical Specification compliance was not properly maintained.

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).

(Closed) Violation (50-346/94012-01(DRS)): Davis-Besse did not adequately evaluate increased diagnostic equipment inaccuracies described in an ITI-MOVATS 10 CFR Part 21 notification dated February 28, 1992. In November 1994, initial Valve Operation Testing Evaluation System (VOTES) testing for all Generic Letter 89-10 MOVs was completed and confirmed that the 10 CFR Part 21 affected MOVs were operable. This item is closed.

(Closed) Violation (50-346/94012-02(DRS)): Procedure DB-PF-04167, "Periodic Test Procedure Motor Operated Valve Differential Pressure and Flow Test," Revision 1, did not include appropriate quantitative acceptance criteria. Toledo Edison added qualitative acceptance criteria such as comparison of maximum closing thrust or torque to actuator closing and structural limits; a comparison of actuator capability to the closing thrust limits for limit seated valves; an adjustment of control switch trip values for diagnostic extrapolation error; and the margin required prior to returning valves to service. This item is closed.

(Closed) Unresolved Item (50-346/95007-04(DRP)): Service Water System Intake Forebay Temperature Monitoring Problems. In July 1995, when the midwest was experiencing a heat wave, the inspectors conducted a review of equipment that might potentially be affected by the high temperatures. The inspectors discovered a 2-4°F difference between locally indicated Service Water (SW) supply header temperatures and Ultimate Heat Sink (forebay) temperature detector T413. The two SW supply header temperatures agreed within 0.25°F of each other. This discrepancy was then discussed at the time with Engineering personnel who began evaluation of the discrepancy.

On August 17, 1995, the licensee eventually determined that T413 was not being maintained properly. Specifically: 1) T413 was not in the licensee's calibration program, 2) the detector was located in a closed well that had been partially insulated with a layer of silt and 3) Instrument and Control personnel had difficulties in calibrating the detector because of associated equipment problems.

The licensee then restored T413 to an operable status and once again relied on it to provide Technical Specification UHS temperature indications. The T413 detector well was sawed off on the bottom end to allow silt to escape the well. Repairs were made to the instrument string, and it was re-calibrated and placed into the calibration program. T413 and the local SW header were found to be within 0.7°F of each other, which was within the tolerance of these instruments.

A material history review determined that T413 was not originally the temperature monitor relied upon for Technical Specification UHS temperature monitoring. The previous temperature monitor was unreliable so a switch was made to T413 in 1990. However, a verification that T413 was included in the calibration program was not done.

Several opportunities had existed for the licensee to discover that T413 was not in the calibration program:

- A bias in the computer acquisition card that was discovered the previous year could potentially have led to the discovery that T413 was not in the calibration program;

- Follow-up of the 2-4°F differential temperature between T413 and the two SW Supply header associated temperature instruments would have involved review of calibration records (which did not exist); and

- A systematic audit of Technical Specifications conducted in 1993 to assure associated instruments were properly identified failed to determine the calibration status of T413 because the monitoring of T413 was being performed as part of a daily/shiftly surveillance. Daily/shiftly surveillances were not checked as part of the audit.

Since the discovery that T413 was not in the calibration program, a review was performed by the licensee under its PCAQR program to determine the extent of condition. Two additional instruments were found not to be in the calibration program as required by the licensee. One was a control room temperature monitor and the other was a backup UHS temperature monitor located on a SW supply header.

Although the licensee initially had to be prompted to review the condition of T413, aggressive corrective action was subsequently taken to provide adequate monitoring of UHS temperatures, repair and calibrate the instrument string, modify the detector well to prevent future silt buildup, and to place T413 into the calibration program. Additionally, an excellent investigation was performed to determine the root cause and extent of condition. This investigation led to the discovery of two other temperature instruments not in the calibration program, one being one of the local SW supply header temperature indicators which was a back up indication for UHS temperature monitoring and the other being a temperature monitor associated with the Control Room Emergency Ventilation System (CREVS) which was used to determine if a Technical Specification limit of 120°F in the control room had been exceeded. Questioning of control room personnel about the CREVS and knowledge of plant conditions determined with reasonable assurance that no Technical Specification limit had been exceeded.

However, the condition of T413 was not discovered despite several prior opportunities to do so, including through questioning by the NRC. Therefore, since T413 was not included in the calibration program, this is considered a **violation** of 10 CFR Part 50, Appendix B, Criterion V as implemented by licensee procedure DB-DP-00013, Surveillance and Periodic Test Program, and Nuclear Quality Assurance Manual section 11.4.1.8 **(50-346/95008-04(DRP))**.

4.0 PLANT SUPPORT

NRC inspection procedures 71750, 82301, 82302 and 83750 were used to perform an inspection of plant support activities. Personnel adherence to the radiation protection and security programs was excellent. The emergency preparedness (EP) exercise satisfactorily demonstrated implementation of the licensee's EP program.

4.1 Emergency Preparedness

General Observations

An announced, daytime exercise of the licensee's emergency plan was conducted on September 20, 1995. This exercise included the full participation of the State of Ohio, Lucas and Ottawa Counties, and partial participation of Erie County. The exercise demonstrated that the onsite emergency plan and procedures were satisfactory and the licensee was capable of implementing them.

The performances of State and local response organizations were evaluated by the Federal Emergency Management Agency (FEMA). NRC and FEMA representatives summarized their preliminary findings at a media briefing at the Ottawa County Courthouse in Port Clinton, Ohio, on September 22, 1995.

Specific Observations

Simulator Control Room Overall simulator control room (SCR) performance was excellent. The SCR crew was professional. Communications within the facility were strong. Command and control by the Shift Supervisor and Assistant Shift Supervisor was very good, and periodic briefings were well done and efficient. Notifications of offsite agencies were made in a timely manner. The crew proactively tracked plant conditions and followed Technical Specifications and emergency procedures. Good discussions and follow-up on routine and abnormal conditions by the operations crew were observed.

Technical Support Center Overall performance in the Technical Support Center (TSC) was excellent. The TSC was rapidly and efficiently activated. The Emergency Director (ED) demonstrated excellent awareness when he properly delayed assuming responsibilities until the overall situation was understood and TSC personnel were ready for facility activation.

The ED and Emergency Plant Manager (EPM) exercised good command and control of the facility. Communications between the SCR, TSC and Emergency Command Center (ECC) staff were excellent.

Engineering activities in the TSC were excellent. The staff displayed a comprehensive understanding of plant events, anticipated potential problems, and developed plans to mitigate plant problems.

However, the results obtained by emergency response teams dispatched from the Operations Support Center (OSC) were not formally tracked in the TSC. A good "ad hoc" board was utilized in the TSC to track inplant team activities and repair status, and provided important information to facility personnel. However, when teams returned, all information was erased and task data was lost in the facility. The licensee's actions to evaluate this process will be tracked as an **Inspection Follow-up Item (50-346/95008-05(DRS))**.

Operations Support Center and Inplant Teams Overall performance in the OSC was outstanding. The activation of the OSC was rapid and efficient. OSC staff members demonstrated excellent ability to work together in efficiently setting up the OSC and making it operational.

The OSC team tracking status boards were excellent. Status boards prominently displayed important information used to coordinate team activities in a very effective manner.

All exercise participants in the OSC conducted their activities in a professional manner, responding to the situation as if it was a real emergency.

Emergency Control Center Overall performance in the Emergency Control Center (ECC) was excellent. Staffing and activation of the ECC was effective and accomplished in a timely, professional manner.

Notifications of the transfer of responsibilities were rapidly communicated. Implementing procedures were referred to throughout the activation process. The facility staffing status board was effectively used for determining minimum staffing.

The ED demonstrated strong command and control. During briefings, the ED reminded the staff to ensure details were not overlooked. Communications in the facility, including the offsite agencies briefings, were excellent.

Accident assessments and classifications were timely and accurate. ECC staff continuously evaluated plant conditions and compared conditions to the emergency action levels, actively looking ahead to determine what conditions could drive them to the next higher classification. Offsite dose assessment was effective and resourceful. Prior to any release the licensee conducted several contingency projections in an attempt to characterize the potential release's magnitude.

Facility staff continuously assessed the status of the reactor core, reactor systems and containment, and recommended offsite protective actions within minutes of the General Emergency classification. Protective action recommendations were quickly and correctly revised as conditions continued to degrade during the release.

4.2 Radiological Controls The inspectors noted during plant walkdowns that adequate controls were being maintained to minimize exposure to personnel. Contaminated areas were clearly marked, posted and exclusion boundaries were properly roped off. Radiation areas were effectively surveyed and posted next to access points, and on-duty radiation protection personnel were aware of radiological conditions and evolutions. Additionally, during a failure of MU-11 (reference Section 1.2 of this report), on-watch radiation protection personnel responded well when they assisted operations personnel in gaining access to a locked high radiation room and provided surveys of radiation levels while immediate and supplemental corrective actions were conducted.

4.3 Security and Safeguards The inspectors observed that proper security measures were being implemented by the security organization during the inspection period. The inspectors observed random searches, vehicle searches prior to entering the protected area, and that frequent tours of the plant were made by the security force. The inspectors also observed midshift security guard rounds. Security rounds personnel remained alert and performed their duties in a professional manner.

5.0 DRY CASK STORAGE OF SPENT FUEL

Inspections of onsite activities conducted in preparation for dry cask storage of spent fuel were performed. Component installation activities were appropriately conducted and associated procedures reviewed during the inspection period that were prepared and/or revised to support dry cask storage were determined to be acceptable.

5.1 Component Installation Activities The inspectors examined the base and wall units and the roof slabs for the horizontal storage modules (HSM). The base and wall units were positioned in place on the southwest corner of the dry fuel storage pad. Unit positioning was in accordance with specifications for required spacing and leveling.

The inspectors observed the placement of dry shielded canister (DSC) support steel inside the four HSMs. Condition of the steel appeared acceptable. Coatings had been sandblasted and re-applied as a result of licensee quality organization rejection during receipt inspection. The inspectors also observed the installation of the roof slabs atop the HSM vertical walls. A sealing compound was applied to the top of the wall, the slab lowered into position and the hold down bolts installed. The bolts were to be grouted before the fuel canisters are placed in the HSM.

Overall, installation activities were well conducted and in accordance with accepted construction practices and standards.

5.2 Quality Assurance The inspectors reviewed the licensee's audit and surveillance reports demonstrating the level of licensee oversight of the HSM and DSC fabricators. Also, the reviews included some surveillances of the licensee's dry storage activities performed onsite.

The licensee's audit performed between July 2 and August 3, 1995, closed audit findings related to concrete discrepancies identified during the previous audit at the HSM fabricator's plant.

The inspector concluded that the licensee had a well-executed Quality Assurance program relative to the design, fabrication, and installation of the HSMs.

5.3 Review of Procedures During the inspection period the inspector reviewed the following licensee procedures issued or revised to address dry cask storage requirements.

- EN-DP-01201 Temporary Modifications and Temporary Drawing Change Notices
- NG-EN-00313 Control of Temporary Modifications
- DB-NE-00100 Fuel Handling Administration
- DB-OP-02530 Fuel Handling Accident
- NG-NP-00401 Project Management
- RA-EP-02861 Radiation Incidents
- RA-EP-01500 Emergency Classification
- DB-OP-02550 Dry Fuel Storage Abnormal Events
- RA-EP-02820 Earthquake
- DB-OP-00002 Operations Section Event/Incident Notifications and Actions
- NG-IM-00107 Document Control
- DB-DP-00022 Station Review Board
- DB-HP-04004 Area and Spiked TLD Checks

No substantive concerns were identified during the review.

6.0 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 October 11, 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.

*J. P. Stetz, Vice President, Nuclear
S. C. Jain, Director, Engineering and Services
*J. K. Wood, Plant Manager
T. J. Myers, Director, Nuclear Assurance
*J. L. Michaelis, Manager, Nuclear Support
*J. W. Rogers, Manager, Maintenance
B. Donnellon, Manager, Plant Engineering
*G. Skeel, Manager, Security
W. T. O'Connor, Manager, Regulatory Affairs
*R. Scott, Manager, Radiation Protection

*T. Bergner, Manager, Training
*J. Lash, Manager, Plant Operations
*L. Dohrmann, Manager, Quality Service
*N. Peterson, Senior Engineer, Licensing
*D. Eshelman, Superintendent, Operations
*E. C. Matranga, Supervisor, Mechanical Systems Engineering
*F. Swanger, Supervisor, Reactor Engineering
*K. Tyger, Supervisor-Audits
*W. Klippstein, Supervisor, Quality Engineering
*L. Myers, Shift Supervisor, Operations
*G. Melssen, Shift Manager, Operations
*M. L. Klein, Assistant Shift Supervisor, Operations