ENCLOSURE

U.S. NUCLEAR REGULATORY COMMISSION
REGION IV

Inspection Report: 50-285/95-18

License: DPR-40

Licensee: Omaha Public Power District
Fort Calhoun Station FC-2-4 Adm.
P.O. Box 399, Hwy. 75 - North of Fort Calhoun
Fort Calhoun, Nebraska

Facility Name: Fort Calhoun Station

Inspection At: Blair, Nebraska

Inspection Conducted: October 23 through November 27, 1995

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ATTACHMENTS:

EXECUTIVE SUMMARY

This inspection was conducted using Inspection Procedure 93808, "Integrated Performance Assessment Process." The inspection began with an in-office period which involved a documentation review and assessment of performance by the team. The results of this in-office assessment were contained in an NRC letter dated September 29, 1995. This in-office assessment formed the basis for preliminary conclusions regarding inspection recommendations using a performance assessment/inspection planning tree (Attachment 2). Following the in-office inspection period, the team conducted an inspection on site. After this on-site inspection period, the team finalized the inspection recommendations and the planning tree (Attachment 3). The inspection recommendations are contained in the body of the report.

Overall, the team found that the licensee had been effective in identifying problems and was usually effective in resolving problems. A strong oversight capability from the plant review committee, nuclear safety review group and the safety audit and review group was present. The licensee had recently implemented a new corrective action process.

Operations

The licensee demonstrated an appropriate safety focus regarding equipment problems and plant operations. Appropriate management involvement in decision making was present. Problem identification was consistently good. In contrast, problem resolution, while considered improving in some cases, had been protracted or ineffective. The apparent tolerance for numerous and long-standing deficiencies indicated that the control room staff was somewhat passive toward correcting these deficiencies. The quality of operations was generally good during normal operations with occasional inconsistencies or errors. The licensee's programs were good although minimal resources had been assigned to the procedure upgrades and equipment labeling projects.

Engineering

Overall, engineering demonstrated a strong safety perspective. System engineers were noted to be effectively involved with maintenance work activities. Engineering work products showed a strong technical capability and were of high quality. Design, systems, and special services engineering were found to be relatively effective in identifying problems. Exceptions to this included the failure to write a timely incident report for a design deficiency in the control room air conditioning system and the failure to communicate in a timely manner the revised lower ambient air temperature limits for emergency diesel generator operability. The team considered the system engineering report cards to be a strength. Once identified, the licensee usually effectively addressed equipment problems; however, some known performance issues and long-standing equipment problems were not resolved in a timely manner or had been ineffectively addressed. Also in some cases, the

engineering assistance request program had not resulted in timely resolution of problems. An example of this was the untimely resolution of an emergency diesel generator governor problem. This problem was identified in an engineering assistance request, however, the failure to resolve this problem in a timely manner resulted in the emergency diesel generator again being in a degraded condition.

Maintenance

The material condition of the plant was very good. Maintenance supervisors demonstrated good safety focus and were actively involved in evaluating emergent work and establishing priorities for maintenance efforts. Management attention to the maintenance backlog was evidenced by the increased performance in maintenance schedule adherence and the reduction in open corrective maintenance work documents. The team observed a high level of supervisory involvement in maintenance work. Problem identification and resolution by maintenance were very good. While there was evidence that personnel work practices exceeded the scope of the work documents and that there were instances of a lack of attention to details, the quality of maintenance work was considered to be good. The team noted that maintenance work packages were weak and that processes to correct these weaknesses were not timely or consistent. As a result, the licensee relied heavily on skill of the craft to compensate for these process implementation weaknesses.

Plant Support

- Security

The team found program strengths in security training and qualifications, maintenance support to security equipment and systems, security program audits, and protected area detection aids. The team observed some inconsistencies between licensee regulatory documents and regulatory requirements.

- Radiological Controls

The team found that the radiological protection representatives were aware of planned work and had sufficient time to review proposed work packages to implement radiation dose saving techniques. Management oversight was good, as evidenced by the radiological status and housekeeping of the facility and the correct performance of radiological protection activities. Radiological occurrence reports and incident reports were used appropriately to identify problems in the radiological protection area. Hot spots brought about by fuel problems added to plant radiation dose rates. Nevertheless, the licensee's ALARA program results were very good when measured by industry-wide standards.

- Emergency Preparedness

At the time of the on-site assessment, the inspection program had not yet been completed. The team performed only limited additional assessment in this area while on site. The team's final recommendations were based primarily on the assessments performed during the in-office review.

DETAILS

1 SAFETY ASSESSMENT/CORRECTIVE ACTION

1.1 Problem Identification

The team conducted an in-office review and assessment of both NRC and licensee documents relevant to the licensee's problem identification performance in the areas of operations, engineering, maintenance, and plant support. The team preliminarily concluded that the licensee was self-critical in its identification of problems. The quarterly trend report identified trends at a low threshold. The licensee's oversight organizations, including quality assurance, the plant review committee, the nuclear safety review group, and the safety audit and review committee, were effective at identifying plant problems. In some instances, the licensee had not documented plant problems in the incident report process. The team preliminarily concluded that problem identification warranted normal inspection effort.

During the on-site inspection, the team reviewed the implementation of the licensee's corrective action process, observed daily site meetings, reviewed quality assurance audits, and reviewed nuclear safety review group assessments. In each functional area, the team reviewed problems that had been identified and interviewed personnel.

The team found that the licensee continued to demonstrate a good capability to identify problems. Quality assurance audits and surveillances were critical. Nuclear safety review group assessments were challenging and critical.

The team found that the licensee had initiated a new corrective action process. While the team was not able to assess the effectiveness of this process, since it had been recently initiated, the team did consider that the daily review of condition reports by the condition review group and the documentation of conditions as opposed to problems were positive attributes of the system. The team noted that the rate of initiation of conditions in the new condition report system was about twice that of the replaced incident report system. Interviews with site personnel showed that they were familiar with the process.

The team found that the licensee's line self-assessment activities consisted primarily of the performance enhancement process. These efforts provided input to the quarterly trend report and identified trends at a low threshold. Self-assessments performed by radiological protection and security and were found to be good. The team noted that the identification of some performance weaknesses relied on third party evaluations. Examples included nonlicensed operator and shift technical advisor training weaknesses, operator work arounds and control room deficiencies, and emergency preparedness weaknesses. Licensee personnel informed the team that they planned to initiate a more structured self-assessment process.

Based on this inspection, the team recommends normal inspection effort for this area.

1.2 Problem Analysis and Evaluation

The team conducted an in-office review and assessment of both NRC and licensee documents relevant to the licensee's problem analysis and evaluation in the areas of operations, engineering, maintenance and plant support. The quarterly trend report was effective at developing performance trends at a low threshold. The system report cards provided a good summary of system performance, system problems and system repair backlog. Equipment failure rates and equipment history were well documented. The team noted that the safety audit and review committee had questioned the effectiveness of the root-cause analysis program. The team preliminarily concluded that problem analysis and evaluation warranted normal inspection effort.

During the on-site inspection, the team reviewed root-cause analyses and found them to be very good. However, the team determined from interviews that the consistency of the analyses could be improved. The licensee planned t enhance their root-cause analysis procedure by separating the evaluatic the root cause from the determination of corrective actions.

The team observed the performance of condition report reviews by the condition review group and found that the group critically reviewed the issues. The new corrective action process provided features for trending site problems that had not existed under the previous system. Historically, the trending of incident reports was not formally performed.

The team found that the licensee had a good oversight capability. The safety audit and review committee was very active and had been critical and challenging. Examples of performance problems identified included continuing emergency preparedness communications problems and the unclear designation of personnel roles. The team reviewed the licensee's post-trip reviews for the three most recent trips and found that the reviews were effective in identifying plant equipment and procedure problems.

The plant review committee performed critical reviews of issues and was actively involved in assessing plant readiness for restart. The team found one item that involved the reactor coolant pump seal thermal barrier cooler, that was reviewed by the plant review committee before plant startup, where the plant review committee directed that an operability evaluation be performed. This evaluation was not completed until after plant startup. The reason given for the apparent delay in timing was that this evaluation was only to provide documentation of the plant review committee evaluation of the condition. This appeared to be an isolated case, however, use of this evaluation process only for documentation as opposed to being used to determine operability did not appear to be appropriate.

The team considered that the system report cards and report card summaries were very good. These report cards provided system performance information and a maintenance backlog status. Significant performance issues were assessed and identified to plant management for action.

Based on this inspection, the team recommends normal inspection effort for this area.

1.3 Problem Resolution

The team conducted an in-office review and assessment of NRC documents relevant to the licensee's resolution of problems in the areas of operations, engineering, maintenance and plant support. Licensee actions to correct problems had not always been timely or effective. Examples included protracted implementation of corrective actions to improve problem reporting processes, lingering human performance issues, and lack of aggressive resolution of some plant equipment problems. Equipment problems have resulted in reduced plant safety (diesel generator governor problem) and multiple plant trips (reactor coolant pump motor lube oil coolers). Other lingering equipment problems of concern included the long-standing raw water and component cooling water interface valve and sand problems, the reactor coolant pump motor internal oil leak, the high vibration problems of Auxiliary Feedwater Pump FW-54, and the degrading bearing in one low pressure safety injection pump motor. The team preliminarily concluded that problem resolution warranted increased inspection effort.

During the on-site inspection, the team assessed the licensee's resolution of plant equipment problems and found that the licensee had effectively resolved a number of them. The team reviewed the licensee's evaluation of and corrective actions for continuing equipment problems, including the degraded low pressure safety injection pump motor bearing, the reactor coolant pump motor oil leak, the sand found in the closed cooling water system, and the tendency to have sand build up in the dead legs of the raw water system. For these items, the team considered that they were properly evaluated and were being pursued. For the Auxiliary Feedwater Pump FW-54 vibration problems, the licensee was nearing the end of its evaluation. Overall, the team concluded that the licensee was effectively addressing and resolving plant equipment problems.

In some cases, the licensee's resolution of problems had not been timely or effective. Examples included 10 CFR 50.59 screening weaknesses, raw water pump trips, and correction of operator work arounds and control room deficiencies. For the raw water pump trips, the licensee had experienced another trip in April 1995 and had implemented additional corrective actions to address this long-standing plant problem. Also, the team found that emergency preparedness performance weaknesses identified by a safety audit and review committee review were not being addressed in a comprehensive manner. The team noted initiatives and plans to correct performance weaknesses in the root-cause analysis process and the 50.59 screening and evaluation process.

Corrective actions assigned from root-cause analyses were entered into the licensee's tracking system. Also, recommendations from the nuclear safety review group, the safety audit and review group, and plant review committee were entered into the tracking system. The team found that due dates were given a high priority and were either met or appropriately extended.

For performance enhancement process items, the team found that licensee actions to address performance had been of value. For areas needing improvement, action plans were formulated and entered into the licensee's tracking system.

Based on this inspection, the team recommends normal inspection effort for this area.

1.4 Conclusions and Recommendations

The team concluded that a good capability existed for identifying problems and that problems, once identified, were usually effectively addressed. Some examples of untimely problem identification and resolution have occurred. The licensee was in the process of implementing a new corrective action process to improve condition identification and resolution. Good management involvement in problem identification and resolution existed. The licensee was establishing an atmosphere that encouraged the identification of potential problems.

The team recommends normal inspection efforts for the area of safety assessment and corrective action, in the aggregate, but that inspection efforts focus on the implementation of the new condition reporting process and problem resolution.

2 OPERATIONS

2.1 Safety Focus

The team conducted an in-office review and assessment of NRC and licensee documents relevant to the licensee's safety focus in the area of operations. Based on this review, the licensee demonstrated a mixed safety perspective. Outage planning and the consideration of shutdown risk appeared good; however, certain activities indicated weaknesses with safety focus during normal operation. These were awareness of Technical Specification requirements, system configuration control following maintenance, and resolution of long-standing design deficiencies. The team preliminarily concluded that safety focus warranted normal inspection effort.

During the on-site inspection, the team reviewed the level of management involvement and found that it was extensive. The daily morning meetings focusing on emergent work, operations priorities (plan-of-the-day meeting), and review of new condition reports by the condition review group were effectively used by management to keep themselves informed of developing issues, to track key indicators that affected operations, and to communicate priorities and expectations. Key indicators tracked at these meetings included emergent and pre-planned maintenance, equipment and design deficiencies, modifications, surveillance testing, Technical Specification limiting conditions for operations, fire barrier impairments, specific management priorities, and condition reports written within the last 24 hours. The communication of priorities and expectations was evident throughout these meetings.

Management expectations and priorities were effectively communicated and reinforced to operators and other plant departments. However, operation managers remarked that they had difficulty in bringing about changes in operator attitudes and in attaining operator's commitment to implementing the changes needed to achieve management's performance goals. Operators regularly stated that initiatives and communications within operations were generally top-down with little opportunity for response or feedback.

The team found that probabilistic risk analysis was applied to on-line maintenance and other activities that had the potential to reduce the safety margin or increase risk. The licensee had developed a matrix to assist operations and maintenance in determining when to conduct on-line maintenance. Operators exhibited an appropriate sensitivity to risk as it applied to routine operations and evolutions.

Overall, the licensee demonstrated appropriate safety focus regarding equipment problems, normal operations, and had appropriate management involvement in establishing daily priorities and in participating in decision making.

Based on this inspection, the team recommends normal inspection effort for this area.

2.2 Problem Identification and Resolution

The team conducted an in-office review of NRC and licensee documents relevant to operations problem identification and resolution. Based on this review, the team noted very good problem identification through licensee audits and self-assessments. However, the team was concerned that the licensee often had been ineffective or untimely in correcting identified deficiencies. The in-office review identified concerns with the resolution of deficiencies that had created operator work arounds. Several deficiencies appeared to be long-standing conditions and the operator work arounds had potential risk impact since they placed additional requirements on operators during abnormal and emergency plant conditions. The team preliminarily concluded that problem identification warranted normal inspection effort while problem resolution warranted increased inspection effort.

On-site inspection activities included reviews of equipment and design deficiencies that created the need for operator work arounds, reviews of the abnormal and emergency operating procedure revision packages that incorporated operator actions to compensate for deficiencies, and interviews with operators regarding work arounds and control room and plant deficiencies. The objectives were to assess the effectiveness of problem resolution, including the appropriateness of the priority assigned, and corrective actions.

The operator work-around list was the primary means used by the licensee to indicate the priority and to track the status of the resolution of deficiencies related to work arounds. Since the activity began in late 1994, the licensee had identified a total of 72 deficiencies that led to operator work arounds. At the time of the inspection, 44 had been resolved, mostly through equipment repairs or modifications. Over 90 percent of the corrective

actions for the completed items were accomplished in less than a year from the time of the deficiency identification. However, 22 of the 28 open items represented deficient conditions that had existed for well over a year. As recently as July 1995, no resolution mechanisms or dates had been established for most of those 22 items. Many of the items had come to be viewed by operations and engineering as enhancements rather than deficiencies that needed to be addressed and resolved. While adequate focus and priority setting was occurring at the time of the inspection on a number of items, a level of tolerance was still evident in that the bulk of the open design deficiencies represented long-standing conditions on which no specific action had begun until recently.

Similarly, control room operators had become accustomed to the presence of a significant number of deficiency tags on controls and indications. Some of the deficiencies identified with tags in the control room did not represent deficiencies in equipment in the control room, but instead related to deficiencies involving in-plant equipment which might affect operation from the control room. During interviews, operators expressed little or no concern for the number of deficiency tags in the control room. Some expressed that they had a better understanding of equipment conditions as a result of the tags. An evaluation performed by the nuclear safety review group in July 1995 identified the same concerns regarding the number of deficiency tags in the control room and operator indifference or acceptance. The evaluation concluded that the operational impact of the existing deficiencies was minimal. While the team agreed with that conclusion, they retained some concern that operator tolerance of control room deficiencies might impair objective assessment of their impact.

Several weaknesses in operations training programs had been identified by a third party assessment and in a followup licensee self-assessment of operations training activities. The team reviewed the licensee's corrective actions and interviewed operators to assess the effectiveness of the corrective actions. The licensee had implemented a number of changes, which the team evaluated as significant improvements. The more significant improvements included the integration of large portions of licensed and nonlicensed operator training, development of evaluation standards for shift technical advisors, and increased emphasis on operations management involvement in operator training and evaluation. Operations managers or supervisors regularly audited operator training and participated in all graded evaluations operators.

The licensee had been unsuccessful in bringing about sustained improvement in two operator performance areas. Operator self-checking and attention to detail and control room communication discipline had been long-standing concerns in the licensee's attempts to enhance operational performance. As recently as August 1995, the plant had experienced a reactor trip as a direct result of operator error attributable to poor self-checking or attention to detail. The licensee's assessment of the event concluded that the existing guidance regarding self-checking at the time of the event was adequate and should have prevented the operator error. As a result of the event, however, the licensee instituted a peer check program. The program was intended to preclude major plant transients as a direct result of operator error by

requiring that operation of certain equipment or controls be observed by a second qualified operator. The effectiveness of the peer check program had yet to be assessed due to the short time since its implementation and the lack of specific examples where the process deterred operator error.

The September 1995 licensee assessment of the effectiveness of the operations performance enhancement program reported inconsistent adherence to the communication standards required of control room and plant operators. Additionally, the team observed several instances of improper communication discipline during control room observations. Through interviews, the team determined that a dual standard was applied to control room communications. During normal or expected evolutions, the standard only required a two part communication - initiation and repeat-back. During abnormal or unexpected events, the standard required a three part communication - initiation, repeat back, and verification. However, the only time the higher standard was being regularly applied and reinforced was during training once every 6 weeks, and then only if abnormal or emergency events were being run in the simulator. The lower standard applied to virtually all frequent communications in the control room. The senior licensed operators on shift were held responsible to enforce the standard applicable to the specific situation; however, there was little or no effort to use personnel outside of the shift crew to frequently assess and reinforce communication standards. It appeared that the higher standard of communication would be difficult to assure in a real event since daily communication habits would greatly out weigh the effects of infrequent reinforcement of the higher standard.

Overall, the licensee continued to exhibit good problem identification capability. Licensee problem resolution showed some improvement in its effectiveness, as exemplified by the resolution of the majority of equipment or design deficiencies that created operator work arounds and the changes in the operator training programs. However, the protracted approach to the resolution of several long-standing deficiencies related to operator work arounds and to the reduction of the number of control room deficiencies had contributed to an environment that tolerates deficiencies and reduces sensitivity to new deficiencies. Further, the licensee had been ineffective in sustaining improvements in operator self-checking and communications discipline.

Based on this inspection, the team recommends normal inspection effort for the problem identification and resolution area, with focus on problem resolution.

2.3 Quality of Operations

The team conducted an in-office review of NRC and licensee documents relevant to the licensee's quality of operations. Based on this review, the team concluded that overall performance in operations was good, but had concerns that negative trends may have developed in certain areas. The team identified a number of examples of performance problems during normal operation and, to a lesser degree, during shutdown conditions. Significant weaknesses had beer identified in the training programs for nuclear equipment operators and shift

technical advisors. Finally, operators appeared to be tolerant of long-standing control room deficiencies and deficiencies that created operator work arounds. The team preliminarily concluded that the quality of operations warranted increased inspection effort.

On-site inspection activities included monitoring of control room and plant activities and observing shift turnovers, pre-activity briefs, and surveillance activities. The objectives were to assess operator performance, communications, self-checking, and tolerance of deficiencies.

The team noted that operator performance during routine plant operations was satisfactory. The operators used procedures appropriately, as evidenced by their verification of the correct procedure, proper adherence to procedural requirements, and good self-checking while performing the system lineup for the diesel driven Auxiliary Feedwater Pump FW-54 and the post-maintenance testing of Valve HCV-490A. The operators demonstrated appropriate control and understanding of plant activities and deficiencies.

The team observed an experienced nuclear equipment operator align the diesel driven auxiliary feedwater pump for a prolonged run to assess reliability. During the system lineup, the operator exhibited proper self-checking behavior, but had to call on the system engineer on three occasions to locate or identify components specified in the lineup procedure. After the lineup was complete, the operator stated that this was the first time that he had performed that specific lineup. Additionally, the operator identified that the diesel mounted emergency shutdown push button was not labelled. The deficiency was reported to the labeling coordinator via the system engineer and a temporary label was installed by the next day while a permanent label was ordered.

The team observed several instances of improper communication discipline during control room observations. The instances involved a failure to announce an expected alarm and multiple instances of improper/no repeat back. Communication errors were committed by a licensed senior operator, a licensed operator, and a nuclear equipment operator. As previously noted, the licensee had been attempting to improve communication discipline for an extended period of time. In other respects, communication activity was effectively demonstrated by the adequate transfer of information during shift turnover and the frequent communications between the control room and the operations control center.

The operations control center had been established to relieve the control room operators of most of the daily administrative work necessary to conduct routine maintenance and testing. The operations control center was co-located in the maintenance craft spaces and provided ready access to the crafts to obtain clearance to begin maintenance and testing. A senior licensed operator was in charge of the operations control center and was authorized to initiate planned maintenance and testing without a review by control room operators. The operator in charge of the operations control center frequently communicated with the control room to ensure that conflicts did not arise with regard to actual plant conditions and scheduled maintenance and testing. The effectiveness of the operations control center was demonstrated by the very

low level of traffic and distractions in the control room, the frequent presence of the shift supervisor in the controls area, and the thorough awareness of shift supervision of on-going activities in the plant.

As previously noted, the operations training organization had responded well to identified weaknesses. Operators and managers at all levels conveyed very high satisfaction with the quality of operator training. In addition to good response to assessment findings, the operations training group had been pro-active in the application of probabilistic risk analysis in the review and assessment of training needs. Several new scenario events and task evaluations were developed as a result of probabilistic risk analysis review of training activities. Additionally, the operations training staff was effective in using probabilistic risk analysis to demonstrate the cost-risk benefit of a hardware modification over procedure changes and increased operator training.

Overall, the team concluded that the quality of operations was generally good with occasional inconsistencies or errors during routine operations. Based on this inspection, the team recommends normal inspection effort for this area.

2.4 Programs and Procedures

The team conducted an in-office review of NRC and licensee documents relevant to the licensee's programs and procedures in the area of operations. Based on this review, the team concluded that procedural deficiencies had contributed to several errors that had operational impact and, therefore, that on-going procedure upgrade efforts may have been ineffective. The team further concluded that the licensee's equipment labeling program was slow in implementation and not thorough in identifying labeling deficiencies. The team preliminarily concluded that operational programs and procedures warranted increased inspection effort.

On-site inspection activities included the review of emergency operating procedures, the procedure upgrade program, and the equipment labeling program. The objectives were to assess the adequacy of the emergency operating procedures in a specific area, and the effectiveness of the procedure upgrade and equipment labeling programs.

During a post reactor trip review in May 1995, the licensee identified that Procedure EOP-01, "Reactor Trip Recovery" did not contain explicit guidance to the operator for transitioning to another operating procedure once the conditions and requirements of Procedure EOP-01 had been satisfied. The team reviewed Procedure EOP-01 and observed that it had been revised soon after the identification of the deficiency to provide specific guidance for transitioning to another operating procedure. The team reviewed the remainder of the emergency operating procedures for similar transition guidance. All the remaining emergency operating procedures had clear exit criteria and appropriate guidance for transitioning to an applicable operating procedure.

The team reviewed the procedure upgrade program and determined that it addressed operating instructions and operating procedures. The licensee had begun the upgrade as an initiative from the performance enhancement program

for operations. The upgrade program's intent was to reformat the procedures and incorporate some human factors enhancements to make the procedures easier to use. The upgrade program was not intended to be a review for technical adequacy. However, the governing procedures (SO-G-73, "Fort Calhoun Station Writer's Guide," and SO-G-73A, "Operating Procedure/ Operating Instructions Writer's Guide,") required a technical review as a part of the verification and validation processes. Through interviews, the team concluded that technical reviews were being performed during the verification and validation processes. The upgrade program generated a schedule that had a target completion date of early 1997. At the time of the inspection, only 8 of 60 procedures scheduled for upgrade in 1995 had been completed and the bulk of the remaining procedures were still in the first of many stages of the process. Personnel involved with the upgrade program admitted that the target date would not be achieved at the then current pace of revision. Only one licensed operator with the part-time support of one document control clerk was assigned to the task of initial review, revision, and verification. When the procedures were in document control for reformatting or incorporating revisions, they were given the lowest priority with regard to other emergent demands for procedure revisions. The team concluded that the licensee had assigned a low priority to achieving the established goal for procedure upgrade, as evidenced by the minimal resources and low priority applied to the effort.

The team determined that the licensee's equipment labeling program was primarily intended to ensure the proper labeling of equipment installed or reconfigured as a result of plant modifications. The program did not have a specific charter to seek out labeling deficiencies in the plant; however, it was the means by which identified labeling deficiencies were corrected. During an initial tour of the plant, the team observed a large number of temporary equipment labels. The licensee explained that the large number of temporary labels was due to a backlog that had been created by the number of modifications completed during the most recent outage. During review of this program, the team found that minimal resources and low priority were assigned to the labeling program. The licensee's position was that once the present backlog was cleared (projected to be completed by about April 1996) the assigned resources would be adequate to keep up with emergent labeling demands. The team concluded that while some labeling deficiencies had been identified by operators and inspectors over the last year, the actual number was low and the operational significance was minimal. Further, the team concluded that while there had often been lengthy delays in installing permanent labels, the temporary labels were acceptable during the interval.

Overall, operational programs were generally good and effective, which was an improvement over the team's preliminary assessment.

Based on this inspection, the team recommends normal inspection effort for this area.

2.5 Conclusions and Recommendations

The team concluded that the licensee demonstrated appropriate safety focus and adequate management involvement in day-to-day operations. The licensee's problem identification ability was consistently good; however, problem resolution, while assessed as improving, often had been protracted or ineffective in multiple areas. The quality of operations was generally good performance during normal operations. There were occasional inconsistencies or errors during routine operations and a tolerance for numerous and long-standing deficiencies. The licensee's programs were adequate, although minimal resources and priority were assigned to procedure upgrades and equipment labeling.

The team recommends normal inspection efforts, in the aggregate, for the area of operations, but recommends inspection focus on problem resolution.

3 ENGINEERING

3.1 Safety Focus

The team conducted in-office review and assessment of both NRC and licensee documents relevant to engineering safety focus. This review indicated that engineering was providing good support to the plant, that surveillance tests were adequate, and that Technical Specification requirements were met. A sample of licensee quality assurance audits in the engineering area found no safety significant issues. The system engineers provided a high-quality safety contribution, but the corresponding level of design engineering safety focus was not clear. The team preliminarily concluded that engineering safety focus warranted normal inspection effort.

During the on-site inspection, the team conducted tours of the plant to observe examples of completed plant modifications and actual equipment condition. The plant modifications observed were discussed with the engineers and managers involved with the tasks to determine the basis for the projects, the original problem, the scope of the implemented correction action, the relation to the plant design basis, and the relation to plant operability. The team interviewed engineering personnel and reviewed operability evaluations, actions to minimize shutdown risk, management's efforts to reduce the engineering backlog, and management initiatives in the engineering area.

The team found that the backlog of engineering work was steady and that the licensee had appropriately prioritized work. The team reviewed incident reports and condition reports assigned to engineering and determined that the licensee had performed adequate operability determinations for the problems identified in these reports. The engineering staff was active in nuclear industry committees and working groups, providing the site with engineering input from the industry. Engineering safety focus and coordination with other plant departments was evident from the team's review of the minutes of the station modification acceptance and review team meetings. These teams were chaired by design engineering and included other plant department involvement (e.g., operations) in problem resolution for plant modifications.

The team found that the plant had 20 open temporary modifications. The licensee's goals for open temporary modifications were to have none open past one fuel cycle and to close those that can be worked on-line within 6 months of initiation. The team noted that 4 of these temporary modifications exceeded the goals and that work had been scheduled for 3 of these. The 4th, a means to provide independent local level indication of the boric acid storage tanks, was submitted to NRC for approval. As the result of the team's review of the September 1995 monthly status report, it was noted that this status report identified the department holding or working the temporary modification and provided plans for closure or the basis for delay. The team considered the control of temporary modifications to be acceptable.

Design engineering had demonstrated involvement in site activities. Examples included input for the path traversed during planned crane lifts, fuel loading and movement, and resolution of reactor trips due to water in reactor coolant pump motor lubrication oil. While the snubber testing process was an area normally covered by the special services engineering group, the team noted that design engineering provided input when design changes were needed.

The team found that design engineering involvement in the development and tracking of plant modifications assisted in improving the material condition of plant safety systems. In general, engineering related work products were found to be of high quality and supportive of plant operations.

Overall, engineering demonstrated a good safety perspective. Based on this inspection, the team recommends normal inspection effort in this area.

3.2 Problem Identification and Problem Resolution

3.2.1 Problem Identification

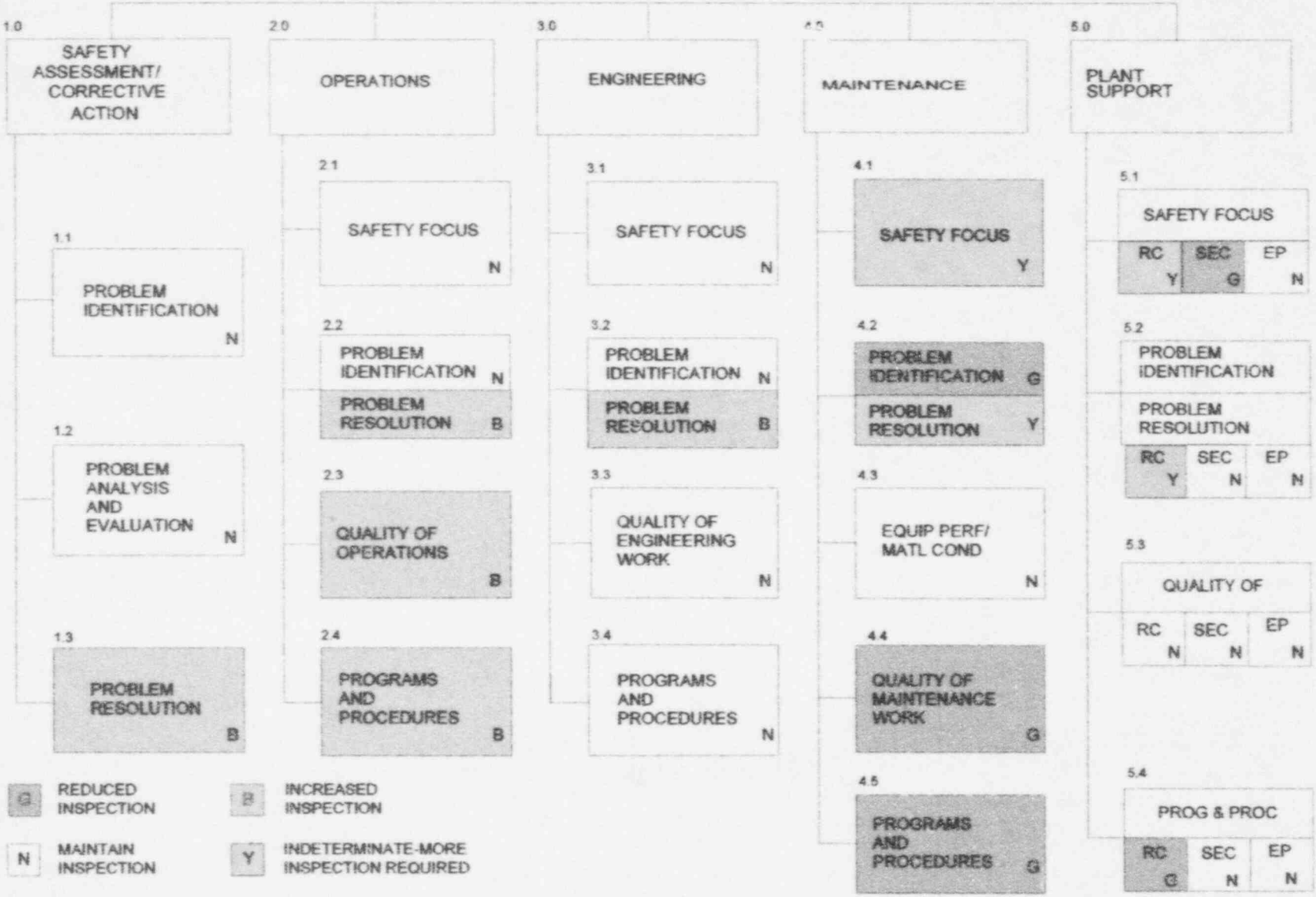
The team conducted an in-office review and assessment of both NRC and licensee documents relevant to engineering problem identification. This review found that engineering had been effective in identifying problems. The licensee conducted a service water system self-assessment and, as a result, identified new and pre-existing issues with the system. This effort showed a good self-assessment capability. There were some examples, however, that while engineering became aware of problems, they did not initiate timely corrective actions. Knowledge of system status by the system engineers was considered to be a strength. The system engineers exhibited ownership for their systems, which was reflected in detailed system report cards. The team preliminarily recommended that the NRC maintain a normal inspection effort in the problem identification area.

During the on-site inspection, the team assessed engineering effectiveness in identifying, resolving, and preventing problems by reviewing corrective actions, root-cause analyses, self-assessments, and resolutions of technical issues. The processes to identify problems and provide for their resolution, including the applicable procedures and resulting documentation, were examined. Examples of problem identification and resolution were discussed with the engineering staff.

ATTACHMENT 2

FORT CALHOUN STATION

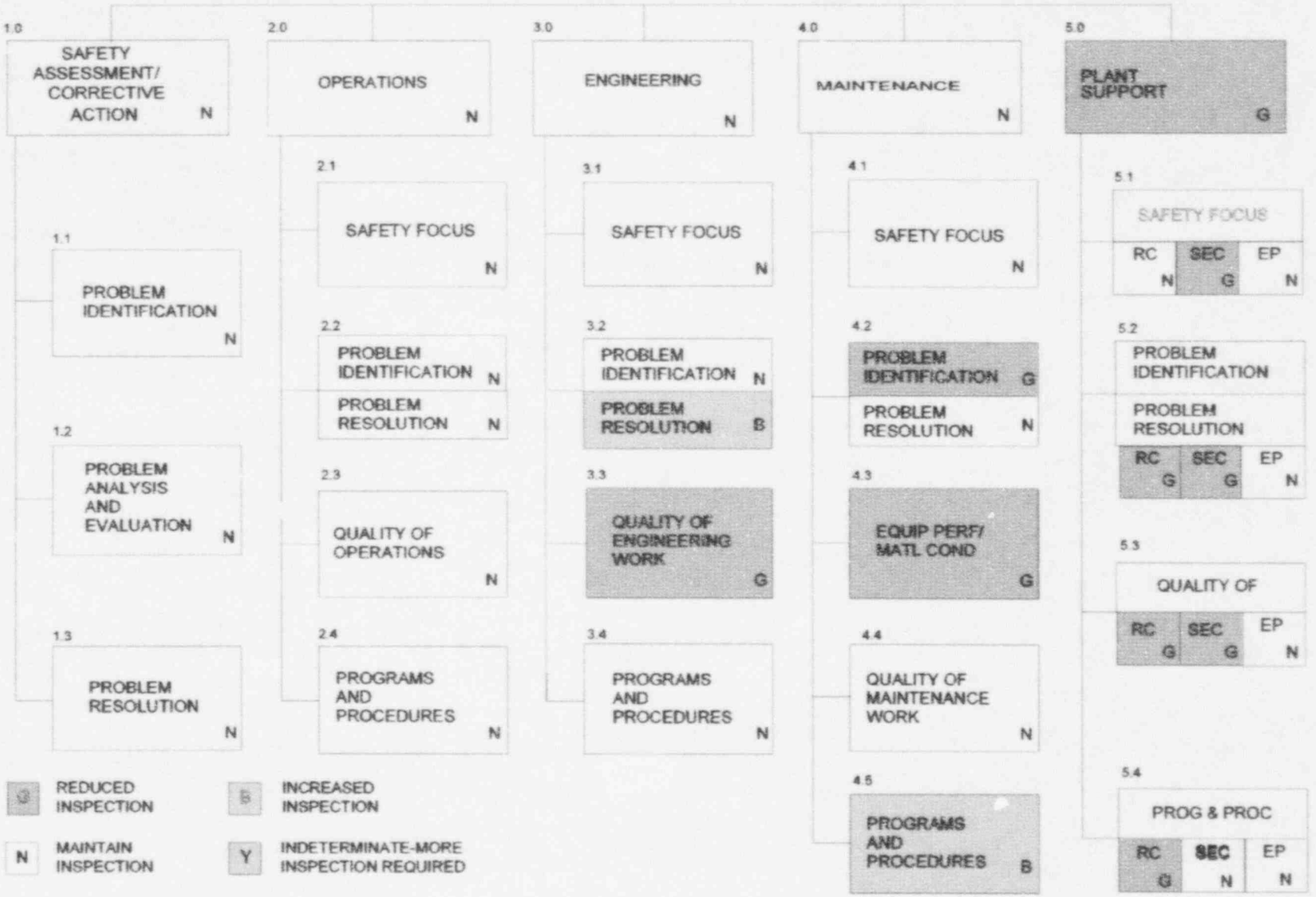
IN-OFFICE REVIEW RESULTS OF LICENSEE PERFORMANCE



ATTACHMENT 3

FORT CALHOUN STATION

FINAL ASSESSMENT OF LICENSEE PERFORMANCE



ATTACHMENT 4

INSPECTION FINDING INDEX

Violation 285/9503-01 was closed (Section 5.4.2).

Inspection Followup Item 285/9503-02 was closed (Section 5.4.2).

ATTACHMENT 5

LIST OF DOCUMENTS REVIEWED

PROCEDURES

- Emergency Operating Procedure EOP-00, Standard Post Trip Actions, Revision 8A
- Emergency Operating Procedure EOP-01, Reactor Trip Recovery, Revision 4.1
- Emergency Operating Procedure EOP-02, Loss of Off-site Power/Loss of Forced Circulation, Revision 6.1
- Emergency Operating Procedure EOP-03, Loss of Coolant Accident, Revision 8.2
- Emergency Operating Procedure EOP-04, Steam Generator Tube Rupture, Revision 8.2
- Emergency Operating Procedure EOP-05, Uncontrolled Heat Extraction, Revision 7.2
- Emergency Operating Procedure EOP-06, Loss of All Feedwater, Revision 6.1A
- Emergency Operating Procedure EOP-07, Station Blackout, Revision 4.2
- Emergency Operating Procedure EOP-20, Functional Recovery Procedure, Revision 2.3C
- General Engineering Instruction GEI-17, Heavy Loads Review
- Maintenance Department Administrative Procedure MD-AD-0002, Maintenance Work Request Creation, Disposition and Closure, Revision 0
- Maintenance Department Administrative Procedure MD-AD-0003, Preparation of Maintenance Work Documents, Revision 0
- Maintenance Department Administrative Procedure MD-AD-0004, Detailed Work Instructions Writers Guide for Maintenance Work Documents, Revision 0
- Maintenance Department Administrative Procedure MD-AD-0005, On-Line Maintenance Scheduling, draft
- Maintenance Department Instruction MDI - 11, Scheduling Coordinator Duties, Revision 8

- Preventive Maintenance Procedure EM-PM-MX-1000, Vibration Monitoring of Rotating Equipment
- Maintenance Procedure EM-RR-EX-0200, Repair/Replacement of Switches, Revision 1
- Calibration Procedure IC-CP-07-0001, Calibration of Pressure Gages, Revision 6
- Maintenance Procedure MM-RR-FW-0020, Inspection and Repair of Heater Drain Pumps, Revision 3
- Preventive Maintenance Procedure PE-PM-VX-3001, CQE Relief Valve Setpoint and Leakage Test, Revision 10
- Surveillance Test Procedure PE-ST-VX-3010, ASME Section XI Code Relief Valve Test for the Hydrogen Purge Ventilation System, Revision 0
- Operating Instruction GM-OI-HE-1, Polar Crane Normal Operation
- Radiation Protection Procedure RP-201, Radiation Work Permits, Revision 11
- Radiation Protection Procedure RP-202, Radiological Surveys, Revision 6
- Radiation Protection Procedure RP-213, Operational Containment Entry, Revision 4
- Radiation Protection Procedure RP-214, Access Control Radiological Controlled Area, Revision 6
- Radiation Protection Procedure RP-303, ALARA Cost-Benefit Analysis, Revision 0
- Standing Order SO-G-21, Modification Control, Revision 58
- Standing Order SO-G-23, Surveillance Test Program, Revision 44
- Standing Order SO-G-30, Procedure Changes and Generation, Revision 65
- Standing Order SO-G-73, Fort Calhoun Station Writer's Guide, Revision 16
- Standing Order SO-G-73A, Operating Procedure/Operating Instructions Writer's Guide, Revision 1
- Standing Order SO-G-78, Observation Program, Revision 10
- Standing Order SO-G-96, Planned LCO Entry Criteria & Equipment Reliability Control, Revision 1
- Standing Order SO-G-101, Radiation Worker Practices, Revision 3

- Standing Order SO-M-10, Foreign Material Exclusion, Revision 14
- Standing Order SO-M-101, Maintenance Work Control, Revision 34
- Standing Order SO-M-103, System Cleanliness, Revision 2
- Standing Order SO-R-002, Condition Reporting and Corrective Action, Revision 0
- FCS Training Program Master Plan for Engineering, R0, 10/25/95
- Procedure NOD-QP-31, Operability and Reportability Determinations
- Quality Procedure QP-19, Evaluation of Potentially Reportable Conditions
- Standing Order SO-R-3, Reportable Occurrences
- Standing Order SO-R-11, Notification of Significant Events
- Engineering Procedure EEI-3, Instrument Loop Uncertainty Setpoint/ Tolerance Calculation Methodology, R1
- Nuclear Program Planning Manual, Section 5, Prioritization, R5
- Quality Procedure QP-27, Repair/Replacement Program
- General Engineering Instruction GEI-55, Instructions for ASME Section XI Repair/Replacement Plan
- General Engineering Procedure PED-GEI-03, Preparation of Design Change Packages, R15
- Engineering Quality Procedure PED-QP-2, Configuration Change Control, R18
- Quality Procedure QP-01, Engineering Assistance Requests, R5
- General Engineering Instruction GEI-29, Facility Change Evaluation, R3

MAINTENANCE WORK DOCUMENTS

- Maintenance Work Order (MWO) 953518, Heater Drain Pump FW-5A has a face to face seal leak
- MWO 950701, AC-165 intermittently leaking by
- MWO 953402, VA-287 failed its setpoint due to excessive seat leakage. Refurbish VA-287 per PE-RR-VX-0439S.
- MWO 953511, The On-Auto light for SI-2C on sequencer panel AI-30A-S1-1 will not light

- MWO 953581, Troubleshoot breaker unit: feeder for fire pump FP-1A
- Preventive Maintenance Order (PMO) 9507531, Perform vibration analysis on FP-1A and FP-1A-M, electric fire pump
- PMO 9508029, Calibrate FI-1113, 3rd Aux FW Pump cooling water flow pressure indicator
- PMO 9508028, Calibrate FI-1114, 3rd Aux FW Pump recirculation line flow element differential pressure indicator
- Construction Work Order 95-106, Replacement and pre-operation testing of 1200 amp feeder breaker 1A1-0, (service - Fire Pump, FP-1A)

INCIDENT REPORTS (IRs)

- 930145 Tool dropped into spent fuel pool due to failure of lanyard hook
- 930291 Metal piece on top of core
- 940019 Failure to initiate GEI-55 forms for work on HCV-317 and HCV-315
- 940381 Work on HCV-400C-0 outside scope of MWO
- 940382 Check valve installation in charging pump with flow bypass, repeat of IR 930126
- 940401 Failure to follow detailed work instructions during performance of MWO 943300
- 940417 Inadequate work package and work outside scope of MWO 940218
- 940435 Crowbar dropped into cell of CW-2D travelling screen
- 950013 Failure to follow MWOs 941098 and 941099
- 950018 Loose debris identified on top of refueling area crane HE-2
- 950054 Post maintenance test and GEI-55.7 were not performed for work on CH-190
- 950057 Glove found on top of final stage of condensate pump FW-2A discharge impeller
- 950084 Inadequate work documents for work on PS-923
- 950101 GEI-55.7 was not completed for work on CH-1C
- 950114 Steam Generator manway removed
- 950236 Inadequate procedure and several procedural non-compliances during troubleshooting under MWO 950676

- 950262 Power Operated Relief Valves not operable when steam generator manway installed. Low Temperature Over Pressure protection lost
- 950273 Rag found in reactor coolant pump motor RC-3A-M oil cooler
- 950297 Charging pump flows low
- 950319 Procedures not updated after modifications/Engineering Change Notices
- 950343 PT not performed per GEI-55.7 on FW-10
- 950344 ANII did not witness VT-2 leak tests for work on HCV-2877A and HCV-2882B as required in GEI-55 repair/replacement plans
- 950347 GEI-55 documentation not performed for work on HCV-347
- 950356 Wrong studs/nuts installed on HCV-383-3 (GEI-55)
- 950382 GEI-55 issues associated with work on containment sump outlet Valve HCV-383-4
- 950392 VT-2 inspection not performed on steam generator A and B hand holes (GEI-55)
- 950395 Procedural non-compliance during the performance of PMO 9502637 / foreign material inside condensate cooler FW-3
- 950405 Invalid purchase order listed in GEI-55 documents for parts used in CH-128 (typographical error)
- 950409 Instrument Uncertainty for ECS subcooling
- 950410 Instrument Uncertainty for inconsistent pressurizer/system design
- 950413 EFWST level instruments
- 950428 No GEI-55 documentation in MWO 942316 and ECN 94-351 for work on Support RWH-4
- 950430 No GEI-55 documentation for MWO 942054 for work on component cooling heat exchanger AC-1D
- 950439 GEI-55 documentation for work on auxiliary feedwater pump FW-10 closed out without appropriate reviews
- 950440 GEI-55 problems concerning work on HCV-1387
- 950443 VT-2 leak checks not performed and values for pressure test not recorded on GEI-55 for MWOs 940731 and 943165 and PMO 9505396
- 950446 GEI-55 discrepancies in work on AC-366

- 950449 GEI-55 documentation discrepancy for work on MS-279
- 950451 VT-2 not performed following maintenance on HCV-1041A
- 950452 Documentation discrepancies for work on RC-3A
- 950461 Several IRs have been generated concerning ASME Section XI and GEI-55
- 950462 ASME III bolting
- 950517 Problems with foreign material exclusion logs

ENGINEERING ASSISTANCE REQUESTS

- Engineering Assistance Request 91-118, Toxic Gas Hazards Analysis Update
- Engineering Assistance Request 93-150, Safety Injection Pump Motor to Pump Alignment
- Engineering Assistance Request 93-163, Evaluation of Stroke Time for Valve HCV-2506B/2507A/B
- Engineering Assistance Request 93-182, Evaluation of A193 B8 Bolting for Boric Acid Safety Relief Valve
- Engineering Assistance Request 94-024, Raw Water Pump Performance
- Engineering Assistance Request 94-093, Flooding Consequences on Raw Water Pump Motors
- Engineering Assistance Request 95-033, Diesel Generator Temperature Control Valve JW-106
- Engineering Assistance Request 95-063, Clarification of Design Basis for HCV-1103/04
- Engineering Assistance Request 95-086, Evaluation of RCP-3D Lubrication Oil Usage
- Engineering Assistance Request 95-088, Lack of Wide Range RCS Temperature Indication at AI-185
- Engineering Assistance Request 95-090, PASS Containment Sump Sample
- Engineering Assistance Request 95-091, Appendix J Testing (LLRT) for Penetration M-3
- Engineering Assistance Request 95-093, SIAS Signal to FCV-269X and FCV-269Y

- Engineering Assistance Request 95-094, Containment Spray Pump Suction Piping
- Engineering Assistance Request 95-105, Smart Fire Protection for HCV-308, 1384, 329, 315
- Engineering Assistance Request 95-106, OPLS Actuation During Pump Restart
- Engineering Assistance Request 95-109 Sand/Rock Accumulation in FW-3 and CW-6A/B
- Engineering Assistance Request 95-108, MS-291, MS-292, HCV-1107B, HCV-1108B Accumulators
- Engineering Assistance Request 95-110, Post CIAS Sampling of RCS
- Engineering Assistance Request 95-111, Containment Spray Pump Recirculation Valves

ENGINEERING CHANGE NOTICES (ECNs)

- Engineering Change Notice 92-006, Feedwater Regulating System Transmitters
- Engineering Change Notice 93-322, Replace Body To Bonnet Fasteners in LCV 218-3
- Engineering Change Notice 93-456, Replacement of RC-Pump Delta Pressure Loop DP-1242
- Engineering Change Notice 93-569, RCS-65 snubber bracket reduction
- Engineering Change Notice 93-592, Substitute Replacement Item For PCV-1295A-20, PCV-1295B-20, PCV-1295C-20
- Engineering Change Notice 94-048, Sizing of RW/CCW Heat Exchanger Orifice Plates
- Engineering Change Notice 94-276, Update Bolting Specifications For Steam Generator and Pressurizer
- Engineering Change Notice 94-404, Diesel Generator Engine Heater Contactor Replacement
- Engineering Change Notice 94-572, Replace Boric Acid Pumps CH-4A and CH-4B
- Engineering Change Notice 95-210, Replacement of Lubrication Oil Coolers Reactor Coolant Pump Motors

OTHER DOCUMENTS

- History of Pump Cell Inspections and Sand Buildup Incidents
- Position Paper on RC-3C Thermal Barrier Heat Exchanger
- Position Paper on Sand in the Raw Water Backup Supply/Discharge Piping
- Task Basis and Content Development for the Preventive Maintenance Program
- PED-SSE-94-0324, Memorandum from M.T. Frans, Inadequate Preventive or Predictive Maintenance, September 22, 1994
- PED-SSE-94-0425, Memorandum from M.T. Frans, Repeat Failures, December 12, 1994
- PED-SYE-95-0290, Memorandum from K.S. Dowdy, July 1995 Semi-Annual Component Failure Analysis Report, July 31, 1995
- September 1995 Fort Calhoun Station Performance Indicators
- Maintenance Department 1995 Objectives to Support Safe Operations, Performance, and Cost
- Maintenance Department 1996 Objectives to Support Safe Operations, Performance and Cost
- PED-SYE-95-0281, System Report Cards for the Period January 1 Through June 30, 1995
- Major Equipment Performance/Reliability Problems, August 29, 1995
- 95-NSD-006, Memorandum from R.L. Andrews, Response to Equipment PEP Recommendations, February 14, 1995
- FC-0345-94, Memorandum from H.J. Faulhaber, Maintenance Functional Area Process Enhancement Program, April 28, 1994
- Maintenance Functional Area Process Enhancement Program (PEP) (Revised September 25, 1995)
- Maintenance PEP Action Item List, September 20, 1995, Open and Closed Items
- Maintenance Department Training Weaknesses and Areas for Improvement, September 1, 1995
- Fort Calhoun Station Operator Work Around List, October, 1995, Revision 1
- Quarterly Maintenance Schedule, October 24, 1995

- Report #11B, Open On-Line Maintenance Work Documents by Class / Target Date, November 2, 1995
- Program Basis Document Relief Valve, Revision 4
- Accreditation Probation Addendum, dated September 20, 1995
- Comparison of Job Performance Measures (JPMs) with Risk-significant Operator Actions, dated August 15, 1995
- Control Room Deficiencies List, September 19, 1995
- Emergency Preparedness Enhancement Plan draft dated August 14, 1995
- Emergency Planning Department Proposals to Enhance Fort Calhoun Emergency Response Functions, May 18, 1995
- Fort Calhoun Station Operator Work Around List, July 13,1995
- Fort Calhoun Station Operator Work Around List, September 1995
- Fort Calhoun Station Operator Work Around List, October 1995
- Maintenance and Technical Programs Weaknesses and Areas for Improvement Preliminary Action Plans
- Memorandum FC-OPS-194-95, "Assessment of Operations Performance Enhancement Program Effectiveness," September 1, 1995
- Memorandum 95-SRG-096, "Evaluation of Control Room Deficiencies and Operator Work Arounds," July 12, 1995
- Memorandum FC-OPS-128-95, "CID 950227/04 PRC "B" Action Item Response, July 6, 1995
- Memorandum PED-DEN-95-593, "Comparison of JPMs with Risk-significant Operator Actions," August 15, 1995
- Memorandum PED-FC-94-1159, "Probably Risk Analysis (PRA) Insights for Operator Training," September 21, 1994
- Memorandum FC-T-361-94, "PRA Insights for Operator Training," August 17, 1994
- Memorandum LIM-94-169, "Assessment of Operation Performance Enhancement Program Effectiveness," September 2, 1994
- Memorandum FC-T-222-94, "Assessment of Operation Performance Enhancement Program Effectiveness," May 23, 1994
- NLO Accreditation Renewal Plan

- Nuclear Safety Review Group Follow-up Assessment of Operator Work Arounds, SRG-95-036, Revision 0
- Nuclear Safety Review Group Special Review of the Operations Performance Enhancement Program, Revision 7, issued December 7, 1994, SRG-95-103, September 27, 1995
- Operating Instruction and Normal Operating Procedure upgrade plan and schedule
- Operations Performance Enhancement Program, Revision 0
- Operations Performance Enhancement Program OPD-4-14, Revision 7
- PRA Assessment of Fort Calhoun Station Operator Work Arounds, Draft, October 31, 1995
- PRA Insights for Operator Training Memorandum, dated September 21, 1994
- Problem Analysis and Action Plan Based on Accreditation Team Visit Exit of December 9, 1994
- Procedure Revision Packages (Related to Operator Work-Arounds) for the following:
    - Abnormal Operating Procedure AOP-03, Emergency Boration
    - Abnormal Operating Procedure AOP-06, Fire Emergency
    - Abnormal Operating Procedure AOP-11, Loss of Component Cooling Water
    - Abnormal Operating Procedure AOP-22, Reactor Coolant Leak
    - Abnormal Operating Procedure AOP-24, Steam Generator Tube Rupture
    - Abnormal Operating Procedure AOP-28, Auxiliary Feedwater System Malfunctions
    - Emergency Operating Procedure EOP-00, Standard Post Trip Actions
    - Emergency Operating Procedure EOP-02, Loss of Off-site Power/Loss of Forced Circulation
    - Emergency Operating Procedure EOP-03, Loss of Coolant Accident
    - Emergency Operating Procedure EOP-04, Steam Generator Tube Rupture
    - Emergency Operating Procedure EOP-05, Uncontrolled Heat Extraction
    - Emergency Operating Procedure EOP-06, Loss of All Feedwater
    - Emergency Operating Procedure EOP-20, Functional Recovery Procedure
- Quality Assurance Audit No. 70, dated February 24, 1995, Fitness-for-Duty
- Quality Assurance Surveillance No. S1-95-1, dated March 3, 1995, Security Operations and Access Control
- Quality Assurance Audit No. 95-001, dated March 9, 1995, Clinical Reference (FFD) Laboratory

- Quality Assurance Surveillance No. S7-95-1, dated march 10, 1995, Security System, Equipment Testing and Access Control
- Quality Assurance (SARC) Audit No. 6, dated August 11, 1995, Site Security and Contingency Plan
- Quarterly Safeguards Event Logs: January 1 through September 30, 1995
- Resolved Operator Work Arounds list, October 27, 1995
- Modification Request for Raw Water Pump Seal Water Supply Upgrade MR-FC-94-019
- Listing of Engineering Assistance Requests (EARs) Completed September 1993 to October 1993
- Listing of EARS in Design Engineering Nuclear (DEN) awaiting response as of October 27, 1995
- Listing of Facility Change and Substitute Replacement Item ECNs closed September 1993 to October 1995
- Listing of Engineering Change Notices (ECNs) in DEN awaiting response as of October 27, 1995
- Listing of Facility Change and Substitute Replacement Item ECNs completed by DEN September 1993 to October 1995
- Production Engineering Design Quality Performance Self Assessment Data Base, '93-'95
- Listing of DEN Staff Loaned to 1993 and '95 Outage
- Summary of DEN staff plant organization experience
- ISI Program Plan for the third 10-year interval
- FCS Plan of the Day for October 25, 1995
- Incident Report Update for October 25, 1995
- Root-cause Analysis for IR 950259, Deficiency in procedures for heavy load movement over Rx vessel, LER 95-002
- Intake structure, Heavy Load Drop Analysis, EA-FC-95-001
- ECNs and EAR status graphs for September, October 1995
- Failure Analysis, RC-3 Lube Oil Cooler Heat Exchangers

- Root Cause and Generic Implications report, Water intrusion from the CCW system into the RC-3D Lube Oil Cooler Heat Exchangers, R0 dated July 17, 1995
- Modification MR-FC-94-008, 4160 volt AC breaker replacements
- LER 94-007, RW Pump Seal water out of design basis
- Root Cause and Generic Implications analysis report, Raw Water Pump Seal Water, dated November 3, 1994
- Memo PED-FC-95-33 on the 10 CFR 50.59 Improvement Program
- Memo PED-SYE-95-0371, Temporary Modification Status for September 1995
- FCS Core Follow Report for July-September 1995, Cycle 16
- Engineering Process Enhancement Plan, dated June 29, 1994
- Quarterly Trend Report for Second Quarter 1995
- FCS Performance Indicators Report for September 1995

REVIEW COMMITTEE DOCUMENTS

- Plant Review Committee minutes for meeting 95-032
- Nuclear Projects Review Committee Meeting agenda for October 26, 1995
- Station Modification Acceptance and Review Team Meeting Minutes for MR-FC-94-020, control room ac
- Station Modification Acceptance and Review Team review of completed modifications MR-FC-94-002, 005,007, 010, 019, 021, 024, 032