

ENCLOSURE 2

U.S. NUCLEAR REGULATORY COMMISSION
REGION IV

NRC Inspection Report: 50-285/95-21

Operating 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: November 5 through December 16, 1995

Inspectors: W. Walker, Senior Resident Inspector
V. Gaddy, Resident Inspector

Approved:

John L. Pellet

John L. Pellet, Acting Chief, Project Branch A

1-11-96

Date

Inspection Summary

Areas Inspected: Routine, unannounced inspection of onsite response to events, operational safety verification, plant support activities, maintenance and surveillance observations, onsite engineering, followup operations, and followup maintenance.

Results:

Plant Operations

- The licensee's initial assessment of the RMS-9 breaker trip units was narrowly focused, resulting in a delay in performance of a revised operability determination (Section 2.1).
- The inspectors conducted a tour of the cable spreading room and one housekeeping item was noted, which involved the storage of two step ladders in the cable spreading room. The licensee immediately took action to remove the ladders and properly store them (Section 3.3).
- The inspectors identified one example where the licensee's condition reporting system did not ensure a root cause evaluation was performed when appropriate (Section 3.6).

Maintenance

- The inspectors noted that all observed maintenance tasks were performed in a good manner, with good communication and coordination exhibited among the crafts (Section 5.1).

Engineering

- The adequacy of the amount of trisodium phosphate available for postaccident containment sump pH control and the past effect on the plant's operation within its design basis was unresolved (Section 2.2).
- The licensee's evaluation of Static Inverter B failure was good. System engineering and design engineering performed a thorough review to ensure that the inverter could still perform its intended safety function (Section 7.1).
- Licensee response to a structural crack in the raw water pump room floor was good. The licensee's decision to have an independent assessment performed on the structural crack was good. This issue will be tracked as an unresolved item pending further NRC review (Section 7.2).

Plant Support

- A poor practice was observed by the inspectors in that a full 55 gallon drum of diesel generator lubricating oil was observed left unattended near a generator electrical breaker. This was identified by the NRC inspectors as a violation (Section 3.4).
- Radiological protection personnel performed their responsibilities properly, in an effective manner. The security department continued to implement the program effectively, maintaining the protected area perimeter excellently throughout this inspection period (Section 4).

Summary of Inspection Findings:

- Unresolved Item 285/9521-01 was opened (Section 2.2).
- Unresolved Item 285/9521-03 was opened (Section 7.2).
- Violation 285/9521-02 was opened (Section 3.4).
- Violation 285/9424-01 was closed (Section 8.1).
- Violation 285/9424-02 was closed (Section 8.2).
- Violation 285/9514-01 was closed (Section 8.3).
- Violation 285/9514-01 was closed (Section 9.1).

Attachment:

- Persons Contacted and Exit Meeting

DETAILS

1 PLANT STATUS

The plant operated at 100 percent power throughout this inspection period.

2 ONSITE RESPONSE TO EVENTS (93702)

2.1 Spurious Tripping of Circuit Breakers With General Electric RMS-9 Trip Units

On November 8, 1995, the licensee issued a 1-hour report as a result of Operability Evaluation NOD-QP-31-199500195. The basis of the reportability was that the electrical system was determined to be outside its design basis in that a single event could have rendered multiple redundant motor control centers inoperable. Also, this event was not covered by the plant's operating and emergency procedures. Specifically, the licensee determined that the General Electric RMS-9 breaker trip units were subject to spurious tripping. Breaker tripping is a result of the trip units' apparent over sensitivity to short duration current spikes on the order of 100 microseconds. The noise spikes were being interpreted by the RMS-9s as overcurrent conditions that require a breaker trip. The RMS-9 units were installed in 1991 - 1993. The RMS-9 trip units were installed in 480V AK type circuit breakers which supply both safety grade and nonsafety grade assorted loads.

The licensee determined that grounds on the 480V system were possible from equipment located in containment or in Room 81, which is where the main steam lines are located. These two areas were determined to contain equipment which was not environmentally qualified, was not normally off, or that is not load shed in a design basis accident. These loads could act as the potential source or propagator of a 480V system ground.

Based on the licensee's operability evaluation, Operations Memorandum 95-16 was issued describing actions required following any reactor trip. Reactor operators are required to take the following actions upon determining that either a loss of coolant accident or an uncontrolled heat extraction is occurring in containment. The operations memo requires the operators to immediately place the control switch for each reactor coolant pump oil lift pump in the pull-to-lock position. This action is required because the engineering analysis identified that a ground potentially could be induced by the reactor coolant pump oil lift pumps. This could cause a spurious signal to trip the breakers to the motor control centers that power the control room air conditioning units and the containment emergency sump valves, which would be required to open upon a recirculation actuation signal. The operations memo requires that these compensatory measures remain in place until the trip units are replaced, which currently is scheduled for the March 1996 outage. In addition, an operations note was located on the control boards near the reactor coolant pump oil lift pumps to remind the operators of the above requirements.

The inspectors reviewed the operability evaluation, the operations memorandum, and the operations aids placed on the control panels and found them to be appropriate.

The inspectors discussed with the system engineer the chronology of events which led to the November 8 reportability. The system engineer provided the inspectors with information dating back to 1992 involving spurious tripping of RMS-9 trip units. The inspectors discussed with the system engineer the responses to several industry notifications of problems with the RMS-9 trip units. In addition, Information Notice 93-75 was issued on September 17, 1993, which also discussed spurious tripping of low voltage power circuit breakers with GE RMS-9 digital trip units. The licensee addressed this information notice by referring to particular events at other plants which had occurred and appeared to have looked narrowly at the tripping of the RMS-9 trip units. Several more instances of RMS-9 trips occurred at the Fort Calhoun Station in October and December of 1993 and in March of 1994. During this time, the licensee continued to contact the RMS-9 vendor for additional information regarding potential corrective actions to resolve the spurious tripping of the RMS-9 units.

Based on the inspectors' review, it appeared that the licensee should have performed a new or revised operability evaluation incorporating the additional information received from the vendor in May 1995 concerning more failures of RMS-9 trip units. Also, it appeared from the review that communication problems existed between the licensee and the vendor concerning the number of failures which had been experienced at Fort Calhoun Station. Finally, in November 1995, the production engineering division requested that an accelerated modification schedule for the RMS-9 trip units be pursued and that an additional detailed reevaluation of the operability determination be performed. Based on this reevaluation of the initial operability evaluation, Licensee Event Report 95-007 was instituted and a 1-hour report made to the NRC.

2.2 Evaluation of Trisodium Phosphate Inside Containment

On December 4, 1995, the licensee reported a plant condition outside the design basis. Specifically, it was identified that the quantity of trisodium phosphate in the containment sump which is necessary to neutralize the boric acid from the containment spray and safety injection systems after a loss of coolant accident was less than required. The trisodium phosphate is necessary to neutralize the potential for chloride induced stress corrosion cracking in stainless steel materials. This has been an ongoing issue, which the licensee has been pursuing, and on November 28 the licensee obtained a new calculation utilizing a conservative methodology from the nuclear steam system supply vendor. Based on the licensee's review and evaluation of the significance of this updated calculation, the licensee concluded that the quantity of trisodium phosphate at times has failed to be sufficient to neutralize sump water to a pH greater than 7, as specified by Technical Specification 3.6.2(d), which provides the requirements for trisodium phosphate. At the time, the licensee lacked controls on the allowable boron

concentration in the boric acid storage tank, safety injection refueling water tank, and safety injection tanks that would prevent dropping below a postaccident pH of 7 with the existing trisodium phosphate. Based on further analysis, the licensee concluded that at no time in the past would the worst case postaccident containment sump pH have been less than 6.5. The licensee also concluded, from separate analysis, that a postaccident sump pH of at least 6.5 would have been acceptable. This issue is unresolved pending NRC review of the design basis consequences presented in licensee Letter LIC-95-9234, dated January 4, 1996 (Unresolved Item 285/9521-01). The licensee has taken actions which ensure the pH remains greater than 7 in that they have prohibited increases in boron concentration in the boric acid storage tank, safety injection refueling water tank, and safety injection tanks by issuing notes in the shift supervisors' and control room log. In addition, the licensee completed an operability determination for the current conditions and has verified that a pH of 7 would be maintained during an accident under current conditions. Long-term actions planned will include a procedure change to limit boron concentrations when additional calculations are completed and the licensee will be reviewing what additional trisodium phosphate will need to be added to containment to ensure a pH of 7 can be maintained.

The inspectors reviewed the licensee controls for ensuring the postaccident pH remains at 7 or above inside containment. The inspectors will continue to monitor the licensee actions concerning amounts of trisodium phosphate needed inside containment to maintain a postaccident pH of 7.

3 OPERATIONAL SAFETY VERIFICATION (71707)

3.1 Routine Control Room Observations

The inspectors observed operational activities throughout this inspection period to verify that adequate control room staffing and control room professionalism were maintained. Shift turnover meetings were conducted in a manner that provided for proper communication of plant status from one shift to the other. Discussions with operators indicated that they were aware of plant status, equipment status, and reasons for lit annunciators. Control room indications of various valve and breaker lineups were verified to be consistent with current plant status.

3.2 Plant Tours

The inspectors routinely toured various areas of the plant to assess the safety conditions and adequacy of plant equipment. The inspectors verified that various valve and switch positions were correct for the current plant conditions. Piping and instrumentation drawings and operating instructions posted in vital areas were inspected and found to be current. Personnel were observed obeying rules for escorts, visitors, and entry and exits of vital areas.

During plant tours, the inspectors noted that plant housekeeping was good. Plant material condition was also good.

3.3 Cable Spreading Room Tour

During a tour of the cable spreading room on November 16, 1995, the inspectors observed two step ladders located on the floor. The inspectors noted that one of the ladders was marked Emergency Operating Procedures/Abnormal Operating Procedures (EOP/AOP). The inspectors questioned the licensee concerning the ladder marked EOP/AOP to determine whether this ladder should have been placed in a specific location.

The licensee informed the inspectors that this ladder was no longer part of the EOP/AOP program and that all such ladders were located in a locked room on the lower level of the turbine building. This particular ladder that was labeled EOP/AOP should have been painted over and was no longer part of the EOP/AOP program. The licensee removed both ladders from the cable spreading room and properly stored them and informed the inspectors that the EOP/AOP indication would be painted over. No other anomalies were noted.

3.4 Control of Combustibles

On November 9, 1995, during a tour of Room 56 (East Switchgear Room), the inspectors observed that a 55 gallon drum filled with lubricating oil had been stored inside the target zone next to Breaker Unit 1A3-20 (Incoming Breaker 1AD1 feed from Diesel Generator 1 to 1A3) located inside the auxiliary building. Bus 1A3 provided a source of emergency power from the diesel generator. The inspectors notified the control room of the observation and corrective action was taken by removing the 55 gallon drum. The inspectors later were informed that the drum of lubricating oil had been stored in the area while oil was being added to Diesel Generator 1 following the monthly surveillance run. The drum was left inside a target zone while maintenance personnel went on break.

Storing the 55 gallon drum filled with lubricating oil inside the switchgear room was a violation of Section 6.2.1.A of Standing Order Procedure SO-G-91, "Control and Transportation of Combustible Material," that requires, in part, that combustibles temporarily retained to support an ongoing work activity be minimized and that they should be limited to 5 gallons of Class B material (oil). The licensee's failure to adhere to this procedure is a violation of Criterion V of Appendix B of 10 CFR Part 50 (Violation 285/9521-02).

3.5 Operator Aids

On December 7, 1995, the inspectors observed what appeared to be an operator aid on Toxic Gas Monitor YIT-6286A and YIT-6286B cabinets located inside the control room. The charts attached to the monitors provided information on determining the levels of sulfuric acid and hydrogen chloride based on the hydrogen chloride meter reading. The inspectors reviewed Standing Order O-41 entitled "Control of Operator Aids in Emergency Equipment," Revision 60. This procedure lists all locations for operator aids. The particular charts observed on the toxic gas monitor were not contained in this procedure. The licensee informed the inspectors that this correlation chart was developed

when the monitors were first installed and that these charts were probably placed on the cabinets at that time. In addition, the toxic gas system engineer informed the inspectors that the correlation chart is also located in Operations Instruction PAP-12, "Toxic Gas Accidents," Revision 9. The toxic gas system engineer, the operations supervisor, and the shift supervisor discussed the need for the correlation charts on the monitor cabinets and a decision was made that the charts were not required. This decision was based on the fact that the chart is located in Operations Instruction PAP-12. The operations supervisor informed the inspectors that operations and maintenance do not routinely use the correlation chart for operation or calibration of the monitors. Based on this information, the inspector considered that the licensee's removal of the charts was the appropriate response.

3.6 Condition Reporting

On December 4, 1995, the inspectors observed the corrective action group meeting where condition reports are routinely discussed and recommendations for resolution priority are determined. Condition Report 199500329 concerning Hydrogen Purge Blower VA-80B, which is used to remove hydrogen from containment during postaccident conditions, was reviewed. While performing an inspection on a 480V motor control center, electrical technicians discovered that Compression Lugs T1 and T2 on the load side of the cubical for the field wires of the motor were not tightened down. Further investigation by the electricians determined that Lugs T1 and T2 were stripped. During corrective action group discussions of this particular condition report, the inspectors observed that the licensee was focused on whether the 480V motor and, subsequently, the hydrogen purge blower system had been operable. The determination was made during discussions that the previous surveillance performed on the hydrogen purge blower was successful, therefore, there was no operability concern. However, the inspectors were concerned that the priority assigned to the condition report did not require or indicate that a root cause would be determined from the standpoint of why the lugs were stripped. They discussed their concern with licensee management. The licensee concluded that it was a good observation and that a root cause determination should and would be included in the condition report review. The inspectors considered this to be an example in which the condition reporting system did not ensure that a root cause would be determined when appropriate.

4 PLANT SUPPORT ACTIVITIES (71750)

4.1 Radiological Protection Program Observations

During this inspection period, the inspectors verified that selected activities of the licensee's radiological protection program were properly implemented. Health physics personnel were observed routinely touring the radiologically controlled areas. Contaminated areas and high radiation areas were properly posted, and restricted high radiation areas were found to be locked, as required. Area surveys, posted outside each room in the auxiliary building, were found to be current.

4.2 Security Program Observations

The inspectors observed various aspects of the licensee's security program. Security personnel were found to perform their duties in a professional manner. Vehicles were properly controlled or escorted within the protected area. Designated vehicles parked and unattended within the protected area were found to be locked and the keys removed. The inspectors routinely toured the protected area perimeter and found it maintained at an excellent level. Proper compensatory measures were observed when a security barrier was inoperable.

5 MAINTENANCE OBSERVATIONS (62703)

During the inspection period, the inspectors observed and reviewed selected documentation associated with the maintenance and problem investigation activities listed below: verifying compliance with regulatory requirements, compliance with administrative and maintenance procedures, quality control department involvement, proper use of safety tags, proper equipment alignment and use of jumpers, personnel qualifications and proper testing. Specifically, the inspectors reviewed the work documentation or witnessed portions of the following maintenance activities.

5.1 Maintenance Observations

The following maintenance activities were observed:

- Calibration of the wide-range logarithmic Channel D at Alternate Shutdown Panel AI-212
- Replacement of Diesel Generator 1 carbon steel tubing with stainless steel tubing
- Replacement of the aftercooler inlet temperature indicator on Diesel Generator 2
- Modification to the Diesel Generator 1 governor runback indication
- Cleaning and eddy current testing of Raw Water Component Cooling Water Heat Exchanger AC-1A
- Replacement and rebuilding of Raw Water Pump Motor AC-10C

The maintenance tasks observed by the inspectors were performed in a good manner. Good communication and coordination was exhibited among the craft personnel. For each maintenance activity, proper equipment boundaries had been established. All equipment examined by the inspectors was calibrated. All maintenance personnel were trained appropriately for the work activity being performed. For the activities observed, the work packages were correct and properly implemented by the craft personnel.

6 SURVEILLANCE OBSERVATIONS (61726)

The inspectors observed the surveillance testing listed below to verify that the activities were performed in accordance with the licensee's approved programs and the Technical Specifications.

6.1 Surveillance Observations

The following surveillance activities were observed:

- IC-ST-VA-0023, "Quarterly Functional Test of Containment High Pressure Switches PC-765 and Trip Units TU-11," Revision 2
- IC-ST-RPS-0042, "Quarterly Functional Test of RPS Trip Logic," Revision 8

6.1.1 Functional Test of RPS Trip Logic

During performance of the latter test, operators in training were in the control room. The shift supervisor asked them to leave and return when the surveillance was completed. The inspectors considered this to be good due to the sensitivity of the surveillance activities in progress.

The inspectors noted that the performance of the test was orderly and controlled.

7 ONSITE ENGINEERING (37551)

7.1 Static Inverter B

On November 26, 1995, the 125 VDC/120 VAC Static Inverter B failed and the licensee entered an 8-hour limiting condition for operation. The licensee initiated emergency Maintenance Work Document 957003 and began troubleshooting to determine the cause of the failure. The failure was attributed to a static switch board and the component was replaced.

During troubleshooting, the licensee measured the total harmonic distortion of the inverter and noted that it was 6.2 percent. A manufacturer's specification listed in the licensee's design basis document specified a total harmonic distortion of no more than 5 percent as a measure of output quality.

During the troubleshooting, the licensee verified that, although the manufacturer's specification was not being met, the inverter would still perform its intended safety function. Since the safety function could still be performed, the licensee declared the inverter operable.

Although the inverter had been declared operable, operations personnel requested that engineering perform an operability evaluation on the inverter. The inspector reviewed the licensee's operability evaluation procedure

(NOD-QP-31). The procedure indicated that operation may continue while an operability evaluation was being conducted, as long as there was a reasonable expectation that the system was operable. The initial analysis conducted during troubleshooting supported the operability of the inverter. The inspectors concluded that the actions taken by the licensee were appropriate.

Since the manufacturer recommended a total harmonic distortion of 5 percent, the licensee initiated a maintenance work request to provide vendor support to lower the total harmonic distortion during the outage scheduled in March 1996.

7.2 Raw Water Pump Room Floor Crack

On November 4, 1995, the licensee discovered a hair line crack approximately 16 feet in length (less than 1/64 inch in width) in the intake structure on the floor slab of the raw water pump room. The raw water pump floor slab is 2 feet thick. Water from the Missouri River was seeping through the crack at a rate of 4 tablespoons per hour into Pump Room P2. The licensee initiated Condition Report 199500204 to document the crack. The concern was that a failure of the raw water pump room floor would render all raw water pumps inoperable. On November 9, 1995, the licensee conducted an operability evaluation to determine the effect the hair line crack might have on the raw water pumps.

The operability evaluation concluded that, because of the design and construction of the floor and the characteristics of the crack (hair line which was indicative of a nonstructural crack), the pump room floor was capable of preventing flooding in the room and withstanding the force of a design basis earthquake without any adverse effects. The licensee referenced a 1994 study performed by Oak Ridge National Laboratory (Repair Materials and Techniques for Concrete Structures in Nuclear Power Plants) as the basis for this conclusion. The study concluded that a crack of 1/64 inch width in the structure was acceptable. The evaluation also concluded that under a scenario beyond the design basis seismic event the structure was also still capable of performing its safety function.

In addition, the licensee observed the leak while raw water pumps were running and concluded that vibration produced while running the pumps did not cause any increase in water seepage through the crack.

On November 28, 1995, divers visually inspected the bottom of the floor slab. The inspection revealed that the crack was through-wall. Although the crack was through-wall, the licensee concluded that there was no slab deterioration or any concrete failure. The licensee concluded that the floor slab and its design criteria were not compromised as a result of the crack.

At the next opportunity, the licensee planned to apply an epoxy to the bottom of the floor slab to seal the crack to prevent moisture from penetrating the slab. The licensee also planned to have its analysis of the event reviewed by

a contractor to provide an independent assessment of its evaluation. The contractor that will perform the review was involved in the original design of the intake structure.

The inspectors concluded that the actions taken by the licensee were appropriate to characterize the crack and provided adequate immediate assurance that the floor would maintain its structural integrity. The issue is unresolved pending NRC review of the licensee's plans to demonstrate that the crack is stable and NRC review of the licensee's final assessment report (Unresolved Item 285/9521-03).

8 FOLLOWUP - PLANT OPERATIONS (92901)

8.1 (Closed) Violation 285/9424-01: Control Room Air Conditioning Design Modification Not in Accordance with Design Basis Specifications

This violation concerned a 1988 modification that installed a new control room air conditioning unit. The unit used component cooling water as a condensing medium. The licensee's design basis had an established maximum component cooling water temperature, after a high energy line break accident, of 120°F. However, the air conditioning units purchased would trip at a component cooling water temperature of 102°F.

The licensee's investigation revealed that component cooling water temperature could significantly exceed the 120°F design basis limit during accident conditions. Thus, the licensee purchased and installed a control room air conditioning condensing unit on the roof of the plant which would not require component cooling water. This was completed during the 1995 refueling outage.

The licensee determined that the causes of the design basis information not being incorporated in the modification were the inadequate design change process procedures and personnel error. The licensee stated that improvements to the design change process have occurred since 1988 that would reduce the possibility of recurrence. The inspectors have observed these changes and concluded that the current design change process should eliminate this concern.

8.2 (Closed) Violation 285/9424-02: Failure to Initiate a Timely Incident Report

This violation concerned the licensee's failure to initiate an incident report, or to perform the required operability and reportability determinations on October 4, 1994, when a design basis deficiency was identified. On October 15, the licensee determined that the maximum component water temperature, after a high energy line break accident, exceeded the established design basis limit and the capability of the control room air conditioning unit. However, an incident report was not initiated until November 15, 1994.

The licensee determined that the main cause of this incident was an inadequate applicable engineering procedure which required an incident report to be generated only after the completion of the analysis and engineering management's review and approval. The licensee's immediate corrective actions were to revise the applicable engineering procedure and review other open engineering issues to assure compliance with the licensee's incident report requirements. In addition, the licensee initiated a corrective action program which incorporated all of the licensee's corrective action documents into a condition report. In addition, the corrective action program has its own manager. These actions should enhance the licensee's timely reporting of deficient conditions.

8.3 (Closed) Violation 285/9514-01: Failure to Follow Procedure For Diverse Scram System Actuation Relay Operability Resulting in a Plant Trip

This violation involved the failure of an operator to directly follow his procedure by manipulating the wrong switch during diverse system scram testing, which caused the reactor to trip. The root cause of this event was determined to be inadequate attention to detail which resulted in a human error that could have been prevented with additional self-checking. As part of the immediate response to this violation, the licensee required control room operators to verbalize pertinent label information as an additional self-checking technique prior to operating equipment from the control room. In addition, peer verification has been implemented for control room operators prior to operating equipment in the control room that can cause a significant plant transient. As part of the long-term corrective actions, the licensee planned to perform an evaluation of self-checking and peer verification during the next operations self-assessment, currently scheduled to be completed by March 31, 1996. Also, station management will conduct an evaluation of the operations performance enhancement program to determine its effectiveness and make any needed corrections to the program. This action is scheduled to be completed by December 31, 1995.

The inspectors reviewed the actions already completed by the licensee and proposed actions and found that the actions appropriately addressed this issue.

9 FOLLOWUP - MAINTENANCE (92902)

9.1 (Closed) Violation 285/9514-01: Failure to Properly Secure Ladder During Maintenance Activities

This violation involved the failure of maintenance personnel to properly secure a ladder during the installation of a junction box and associated conduit in the west switchgear room. Specifically, the inspector observed that, during performance of the work, maintenance personnel secured a ladder to a section of 1 inch conduit. Per the licensee's procedure, ladders are not to be secured to any conduit less than 2 inches in nominal diameter. As part of the immediate response to this violation, the licensee counseled the individuals involved in the event and presented training sessions to

appropriate contract maintenance personnel to reinforce management expectations concerning Standing Order G-107, "Storage of Transient Equipment and Material to Prevent Seismic Interactions," Revision 0. Specifics of the training included review of areas in the plant marked for transient equipment and materials for consistent compliance with requirements of transient equipment and material and ensuring management expectations on adhering to all requirements. In addition, the procedure was revised to be more user friendly and better define the program objectives.

The inspectors reviewed the actions completed by the licensee and found that the actions appropriately addressed this issue.

ATTACHMENT

1 PERSONS CONTACTED

Licensee Personnel

R. Andrews, Division Manager, Nuclear Services
J. Chase, Manager, Fort Calhoun Station
G. Cook, Supervisor, Station Licensing
J. Cook, Shift Supervisor, Operations
H. Faulhaber, Supervisor, Maintenance
W. Gates, Vice President, Nuclear
J. Herman, Supervisor, Outage Planning
R. Jaworski, Manager, Station Engineering
L. Kusek, Manager, Nuclear Safety Review Group
D. Leiber, Security Services
E. Matske, Licensing Engineer
W. Orr, Manager, Quality Assurance and Quality Control
T. Patterson, Division Manager, Nuclear Operations
J. Skiles, Acting Manager, Design Engineering
D. Spires, Acting Supervisor, Chemistry
M. Tesar, Manager, Corrective Action Group
J. Tills, Assistant Plant Manager, Operations
D. Trausch, Manager, Licensing and Industry Affairs

2 EXIT MEETING

An exit meeting was conducted on December 19, 1995. During this meeting, the inspectors reviewed the scope and findings of the report. The licensee did not express a position on the inspection findings documented in this report. The licensee did not identify as proprietary any information provided to, or reviewed by, the inspectors.