

ENCLOSURE 2

U.S. NUCLEAR REGULATORY COMMISSION  
REGION IV

NRC Inspection Report: 50-285/96-01

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: January 28 through March 9, 1996

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

Approved:

  
John L. Pellet, Acting Chief, Project Branch A

4/5/96  
Date

Inspection Summary

Areas Inspected: Routine, announced inspection of operational safety verification, plant support activities, maintenance and surveillance observations, onsite engineering, and open item followup.

Results:

Plant Operations

- The scope of a hydrazine spill drill was limited in that it addressed a spill on one floor elevation only and did not consider all the possible locations for hydrazine to flow. This was of concern to the inspector because the actual hydrazine spill in January 1996 extended to more than one floor elevation (Section 2.3).
- During a walkdown of the safety injection system, the inspector noted a difference between the procedure and the equipment tag. The licensee initiated a procedure change to correct the difference (Section 2.4).
- The operations department failed to initiate a condition report as required by the corrective action program standing order to document the failure of and entry into a Technical Specification limiting condition

for operation for a control room toxic gas monitor. This was a violation for failure to properly implement the corrective action program (285/9601-01) (Section 2.5).

#### Maintenance

- Several personnel errors during maintenance on a condensate cooler resulted in a near miss that could have potentially injured plant personnel and damaged plant equipment (Section 4.2).
- The inspector observed an instrument and controls technician manipulate the wrong valve during a surveillance of check valves in the raw water system. This was the first example of a cited violation for failure to follow procedures (285/9601-02) (Section 5.1.1).
- The dedicated operator assigned to perform the diesel generator surveillance was interrupted to review paperwork on a completed maintenance activity. This did not appear to affect the completion of the surveillance (Section 5.1.2).
- A lack of attention to detail resulted in the quarterly battery surveillances being performed using the wrong procedure. This was the second example of a violation for failure to follow procedures (285/9601-2) (Section 5.1.3).

#### Engineering

- The licensee determined that solenoid-operated valves in safety-related application were being protected by nonqualified pressure regulators. The licensee's operability determination provided adequate justification for continued operation (Section 7.1).
- The licensee experienced 14 incore detector failures during this inspection period and 22 failures since the start of the current fuel cycle. Neither the licensee nor the incore detector vendor has identified the cause of the failures. This item will be tracked as an inspection followup item (Section 7.2).

#### Plant Support

- The number of contaminated areas in the auxiliary building have been substantially reduced (Section 3.1).
- The licensee's response to the presence of unexpected noble gas during the reactor coolant system purification filter change out was good. This was based on the response by radiation protection personnel and the strong procedural controls implemented which precluded any personnel contamination (Section 3.2).

- Housekeeping and plant material condition in certain areas of the plant had declined since the last report period. Dirt, trash, and boric acid buildup were identified within the plant (Section 3.4).

Summary of Inspection Findings:

- Violation 285/9601-01 was opened (Section 2.5).
- Violation 285/9601-02 was opened (Sections 5.1.1 and 5.1.3).
- Violation 285/9521-01 was closed (Section 6).
- Inspection Followup Item 285/9601-03 was opened (Section 7.2).

Attachment:

- Persons Contacted and Exit Meeting

## DETAILS

### 1 PLANT STATUS

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

### 2 OPERATIONAL SAFETY VERIFICATION (71707)

#### 2.1 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. Expected annunciators were acknowledged and unexpected annunciators were thoroughly investigated. Control room indications of various valve and breaker lineups were verified for current plant status. The inspectors also verified that operations management made daily visits to the control room.

#### 2.2 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.

#### 2.3 Hydrazine Spill Drill

On February 13, 1996, the licensee conducted a drill simulating a hydrazine spill. The licensee had an actual hydrazine spill on January 24, 1996, in which 50 gallons of hydrazine was spilled on several floors in the turbine building. The licensee response during this spill was good.

During the exercise, water simulating hydrazine was spilled in the truck bay of the turbine building. The licensee did a good job containing and controlling the water in the truck bay. Near the conclusion of the drill, the inspectors were touring Room 87 (Diesel Driven Auxiliary Feedwater Pump FW-54) and noted that water was flowing from the ceiling of the room down onto the floor. Room 87 was located beneath the truck bay. The inspectors asked if this room had been included as part of the drill scenario. The licensee indicated that the room had not been included in the drill scenario because they were not aware of the crack in the truck bay floor that allowed the water to flow into Room 87. The licensee also indicated that the scenario was a one

floor elevation scenario, was written only to assess efforts in cleaning up the truck bay, and was therefore limited to that area. The licensee wrote a maintenance work request to repair the crack in the floor.

The inspectors concluded that the scope of the drill was limited because it did not consider all the possible locations for hydrazine to flow. The licensee indicated that the drill had been planned in advance and was practiced at routine intervals. The licensee is currently considering expanding the scope of the drill to include multiple elevations.

#### 2.4 Safety System Walkdown

During the inspection period the inspectors performed walkdowns of portions of the following safety-related systems:

- OI-RW-01, "Raw Water System Normal Operation"

The inspectors verified the valve lineup of Raw Water Pumps AC-10A and AC-10B in accordance with Checklist OI-RW-1-CL-A, "Raw Water System." The pumps were located in the intake structure.

- OI-SI-1, "Safety Injection Normal Operation"

The inspectors verified the valve lineup of the low pressure safety injection system located in Rooms 21 and 22 (West and East Safety Injection Pump Room, respectively) in accordance with Checklist OI-SI-1-CL-B, "LP Safety Injection System."

The portion of the systems walked down were found to be in accordance with the procedures. The physical appearance of the systems and plant labeling was good. Seismic restraints and supports were properly secured and in good condition.

During the walkdown of the safety injection system, the inspectors did note that the procedural description for Valve SI-227 did not match the description on the equipment tag. The procedure indicated that the valve was the "LPSI Pump IA PI Isolation Valve." The equipment tag indicated that the valve was "Discharge Pressure Gauge P1-302A Root Valve." The inspector informed the licensee of the difference. The licensee indicated that the equipment tag had been recently changed to accurately reflect the valve but that the procedure had not been changed. In response, the licensee initiated a request to change the procedure. Also the licensee is continuing to resolve any potential discrepancies through the implementation of their procedural upgrade program.

#### 2.5 Toxic Gas Monitors

On February 13, 1996, Toxic Gas Monitor YIT-6286B alarmed and properly secured the control room ventilation. The monitor detects sulfuric and hydrochloric acid. The shift chemist responded to the control room and verified through

air samples that no acid was present. The monitor was declared inoperable, a Technical Specification Limiting Condition for Operation was entered, and a maintenance work request was written; however, a condition report was not written. The inspectors reviewed the licensee's condition reporting standing order, Standing Order SO-R-2, "Condition Reporting and Corrective Action," and determined that the licensee should have initiated a condition report based on the failure of the monitor. Instrumentation and control technicians later performed troubleshooting and did not detect any problem with the monitor. The monitor was declared operable on February 15.

On February 16, the monitor again alarmed and secured the control room ventilation. In this instance, operators overrode the alarm and restarted the control room ventilation. The inspectors asked if a condition report should have been initiated. The licensee stated that a condition report did not have to be initiated because when the monitor was inspected by the operating crew it was reading normal. Based on the normal reading, operators reset the alarm and restarted the ventilation system. Approximately 8 hours later, the operations manager made the decision to voluntarily declare the monitor inoperable for troubleshooting due to its recent failure history. Troubleshooting attributed the failure to a loose optic lamp and the monitor was declared operable. This appeared to not have been the root cause due to the fact that the monitor had alarmed on several other occasions during the inspection period. The licensee is currently monitoring the toxic gas monitors and performing troubleshooting as needed.

On February 17, the monitor again alarmed and secured the control room ventilation. Following the event, the licensee initiated Condition Report 196600201 on February 20.

The inspectors concluded that the licensee did not initiate a condition report as required by their standing order to document the February 13, 1996, failure of Technical Specification instrumentation. This was not in compliance with Standing Order SO-R-2, Revision 0, Step 2.2.13, which is a violation of Technical Specification 5.8.1 (285/9601-01).

### **3 PLANT SUPPORT ACTIVITIES (71750)**

#### **3.1 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.

On February 6, 1996, during a routine tour of the radiological controlled area, the inspectors observed that the number of contaminated areas within the auxiliary building had been substantially reduced during this inspection

period. Especially notable was the clean up of the safety injection pump rooms allowing for easier access to plant equipment.

The inspectors discussed with radiation protection staff whether additional efforts were planned to remove the number of hot spots within the radiological controlled area. The inspectors were informed that an effort to clean up radiological hot spots will be implemented during the mini-outage scheduled to begin March 16.

### 3.2 Reactor Coolant System Purification Filter Replacement

While replacing the reactor coolant system purification filter, CH-17B, in Room 11 (Purification/Waste Filter Room) on February 13, 1996, the particulate, iodine, noble gas monitor (PING) outside of Room 6 (charging pump room) unexpectedly alarmed due to high levels of noble gas. The alarm occurred when the housing of the filter was unbolted. The PING spiked to approximately 500 counts per minute and dropped to approximately 250 counts per minute. Since the PING alarm was unexpected, an air sampler was started to monitor the air for noble gases. Approximately 10 minutes later, the PING outside of Room 6 alarmed again and spiked to 5000 counts per minute. The PING returned to normal over a 10-minute period. This second alarm coincided with the removal of the interior filter housing.

Prior to the event, radiation protection staff was aware that the filter had been in service prior to the 1995 refueling outage. However radiation protection staff did not know for sure how long the filter had been in service. After the event, radiation protection staff determined that the filter had been in service for 46 days in early 1995. Since the filter had been out of service for approximately a year, the noble gas was not expected. Subsequent half-life calculations indicated that the noble gases should not have been present.

In addition, the filter measured approximately 6 R/hour on contact. This was also not expected. The licensee staff believed a maintenance isolation valve in the system was leaking by. This would account for the unexpected activity and noble gas. The licensee is currently evaluating the replacement of the isolation valve.

The inspectors concluded that radiation protection's performance during the event was good. No overexposures or uptakes occurred. The procedural controls already established prevented any contaminations or overexposures.

### 3.3 Security Program Observations

The inspectors observed various aspects of the licensee's security program. Security personnel were found to perform their duties in a thorough, attentive 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 well maintained. Proper compensatory measures were observed when a security barrier was inoperable.

### 3.4 Housekeeping

During a tour of Room 69, the inspectors noted that housekeeping in the vicinity of the raw water/component cooling water interface piping was poor because there were dirt and trash throughout the area. The inspectors notified the licensee of the observation and the area was immediately cleaned.

Throughout the inspection period, the inspectors noted that there were lube oil leaks around the diesel generators. The inspectors asked if the lube oil leaks posed a fire hazard while the diesels were operating. The system engineer informed the inspectors that the hottest diesel generator piping was approximately 150°F lower than the flash point of the lube oil, and a fire resulting from the lube oil was not likely.

The inspectors also noted boric acid buildup on the containment spray and low pressure safety injection pumps in both safety injection rooms. These buildups were indicative of packing leaks on the pumps. This observations was provided to the licensee for resolution.

## 4 MAINTENANCE OBSERVATIONS (62703)

The maintenance activities listed below were observed and documentation reviewed to verify that the activities were conducted in a manner which resulted in reliable safe plant operation.

### 4.1 Maintenance Observations

The following maintenance activities were observed:

- MWD 952967 "Containment Cooling Coil Backup Raw Water Outlet Valve"
- MWD 953207, "Pinhole Leak in Separator of Air Compressor CA-1A"
- MWD 960512, "Condensate Pump FW-2A Rebuild"

No problems were identified during these observations. Issues stemming from the review of other maintenance activities are noted below.

### 4.2 Condensate Cooler

On March 1, 1996, Condensate Cooler FW-3 was isolated and taken out of service for cleaning and eddy current testing. The work was being conducted in accordance with Maintenance Work Document 952890. In preparation for work on the cooler, a steam fitter mechanic opened Drain Valve CW-289 to verify the cooler was completely drained. Minimal water drained from the cooler. Since minimal water was drained from the cooler, the steam fitter mechanic assumed



the cooler was thoroughly drained. In addition, a senior crew leader and a senior craftperson were also present at the work location.

The steam fitter mechanic then directed that the studs be removed from the end bell of the cooler in preparation for removing the end bell. A hydraulic hoist was rigged to the end bell to provide support when all the studs were removed. Approximately 5 minutes after the last stud had been removed, the end bell popped off the cooler. Water under some pressure forced the end bell to fall into a water box that had been constructed to support the work. The weight of the end bell (approximately 1100 pounds) rocked the hoist. Approximately 300 gallons of water spilled onto the floor of the turbine building. Personnel present evacuated the area and contacted the operations control center to inform them of the problem. The water in the area did not affect any other plant equipment. The operations control center subsequently informed the control room.

In investigating the event, the licensee determined that the drain valves on the condensate coolers had a history of being clogged by sand and dirt. Licensee management indicated that the steam fitter mechanic, with their knowledge of the system and history of the condensate cooler, should have questioned whether the cooler had been completely drained. The licensee also determined that the individual should not have removed all the studs from the end bell. Licensee management indicated that, again, skill of the craft should have precluded this. The licensee also determined that the hoist used during the job was underrated. The end bell weighed approximately 1100 pounds. However, the hoist used to support the end bell was only rated up to 1000 pounds. Finally, the licensee determined that maintenance personnel involved in the event should have immediately notified the control room as directed by Standing Order M-100, "Conduct of Maintenance," instead of the operation control center.

The licensee began a root cause analysis of the event to identify all the factors that may have contributed to the event. Maintenance supervisors were also directed to meet with craft personnel to reenforce the procedural requirement that the control room be immediately notified during any unexpected event.

The inspectors concluded that a series of personnel errors resulted in a near miss that could have potentially injured plant personnel and damaged plant equipment.

## 5 SURVEILLANCE OBSERVATIONS (61726)

The inspectors observed the following surveillances during the inspection period. The inspectors observed portions of testing in the control room and also locally at plant equipment. The inspectors verified that the proper tagouts had been established and that test equipment used was properly calibrated. The inspectors also verified that each surveillance test met the objectives of the Technical Specification. In general, the surveillances were

completed in accordance with the procedure. Specific observations are also discussed below.

### 5.1 Surveillance Observations

Portions of the following surveillance activities were observed:

- OP-ST-AFW-0004, "Auxiliary Feedwater Pump Operability Test"
- OP-ST-DG-0001, "Diesel Generator 1 Check"
- IC-ST-IA-3003, "Raw Water Instrument Air Accumulator Check Valve"
- EE-ST-EM-0003, "Quarterly Surveillance Test For Station Battery #2 (EE-8B)"

#### 5.1.1 Raw Water Instrument Air Accumulator Operability Test

On February 8, 1996, the inspectors were observing a nonlicensed operator and an instrumentation and control technician perform Surveillance Test IC-ST-IA-3003, "Raw Water Instrument Air Accumulator Check Valve Operability Test," Revision 7. During the test, the nonlicensed operator was reading the steps to be performed to the instrumentation and control technician. Step 7.2.10 of the procedure instructed personnel to open Instrument Air Vent Valve IA-HCV-2851-T. However, the instrumentation and control technician opened Valve IA-HCV-2852-T (Instrument Air Supply Test Valve for Raw Water Pump AC-10C). This was not in compliance with Standing Order SO-G-23, Revision 44, Step 5.2.2, which is one example of a violation of Technical Specification 5.8.1 (285/9601-02).

Once the valve was opened, the technician realized the mistake and closed the valve. In this instance, opening the wrong valve did not affect the raw water pump. The inspectors concluded that inattention to detail caused the personnel error that resulted in an instrumentation and control technician opening the wrong valve in the raw water system.

#### 5.1.2 Diesel Generator Surveillance

While observing the Diesel Generator 1 surveillance from the control room, the inspectors noted that Surveillance Test IC-ST-RPS-0018, "Quarterly Functional Test of Steam Generator Low Pressure and Asymmetric Steam Generator Transient RPS Bistable Trip Units," was being conducted concurrently. The inspectors noted that the noise level in the control room was elevated at times. The inspectors also noted that there were more personnel in the control room than normal. Neither the extra personnel, nor the elevated noise levels appeared to affect the completion of the surveillances. The inspectors did note that the dedicated operator performing the diesel surveillance was interrupted to review paperwork on a maintenance activity that had been performed on the

diesel generator earlier in the day. This also did not affect the completion of the surveillance.

During the surveillance the inspectors noted that the diesel generator phase voltage meter was oscillating. The inspectors brought this to the attention of operators and a maintenance work request was initiated. The instrument was added to the list of control room deficiencies and will be tracked accordingly.

### 5.1.3 Station Battery Surveillance

On March 6, 1996, the inspectors observed two electrical maintenance technicians begin Surveillance Test EE-ST-EM-0003, "Quarterly Surveillance Test for Station Battery #1 (EE-8A)." The purpose of the surveillance was to obtain voltage, specific gravity, and temperature in each battery cell. The surveillance satisfied a quarterly Technical Specification requirement.

While reviewing a copy of the surveillance procedure, the inspectors determined that electrical maintenance had performed the surveillance on the wrong battery. The procedure indicated that the surveillance should have been performed on Station Battery 1, but electrical maintenance technicians had performed the surveillance on Station Battery 2. After the discovery, the inspectors notified the electrical maintenance crew leader.

The inspectors later determined that the surveillance tests for both batteries were conducted on March 6. The surveillance for Station Battery 1 had been conducted earlier in the day. To perform this surveillance, the electrical maintenance technicians used the procedure for Station Battery 2 (EE-ST-EM-0004). This was not in compliance with Standing Order SO-G-23, Revision 44, Step 5.2.2, which is the second example of a violation of Technical Specification 5.8.1 (285/9601-02).

The inspectors contacted the system engineer, who stated that the procedures used to perform the surveillances were the same and that the batteries were not affected by the use of the wrong procedure. The inspectors reviewed the procedure and determined that there were several steps in each procedure that should have alerted electrical maintenance personnel to the fact that they were performing the surveillance on the wrong battery.

## 6 FOLLOWUP - MAINTENANCE (92902)

### (Closed) Violation 285/9521-02: Failure to Adequately Control Transient Combustible Materials

This violation involved the failure of maintenance personnel to control transient combustible materials during a routine maintenance activity on Diesel Generator 1. Specifically, the inspector observed that, during a period of nonwork activity, maintenance personnel had not taken appropriate measures to ensure a 55 gallon drum of lubricating oil was properly stored.

As part of the immediate response to this violation, the licensee counseled the individuals involved in the event and presented training sessions to appropriate maintenance personnel to reinforce management expectations concerning Standing Order SO-G-91, "Control and Transportation of Combustible Materials." Specifics of the training included procedural compliance, expectations for maintenance crew leaders regarding the adequacy of maintenance work documents for the scope of work to be performed, and additional quality assurance observations of maintenance activities.

As part of the long-term corrective action, the licensee planned to reformat and rearrange portions of the procedure to make it easier to understand. This revision was scheduled for completion by April 1, 1996. In addition, training was to be provided to maintenance and operations personnel regarding proper control of combustible material. All training was scheduled to be completed by August 1996.

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

## **7 ONSITE ENGINEERING (37551)**

### **7.1 Nonqualified Instrument Air Pressure Regulators**

On February 9, 1996, the licensee determined that approximately 13 solenoid operated valves in safety-related applications were being protected by nonqualified pressure regulators. This discrepancy was documented in Condition Report 199600161. This discrepancy was discovered during the development of the solenoid-operated valve program in accordance with Generic Letter 91-15.

Instrument air normal supply pressure was approximately 100 psig. The pressure regulators in question were designed to regulate pressure to approximately 65 psig. The concern was that, if the pressure regulators failed, full instrument air pressure would be present at the solenoid valve, which would expose the valves to pressures greater than the rated maximum operating differential pressure. This could cause the valves to change position. The licensee determined that four of the valves would fail to indeterminate positions.

The licensee performed an evaluation to determine if any operability concerns existed. The operability evaluation concluded that the pressure regulators were operable. The licensee based this determination on the regulator's operating history and the fact that the regulators were essentially identical to the seismic qualified equivalent regulator model. Also, approximately 800 regulators were currently in operation. The regulators were replaced at 5-year intervals and, to date, no regulator had failed to regulate at or below the setpoint. The licensee also indicated that, although the pressure regulators were noncritical quality equipment, they met all functional requirements and were maintained and tested adequately to insure they

performed as expected during a design basis accident. The licensee determined that, based on this operating history and the functional requirements, the solenoid-operated valves were operable.

The licensee also determined that this condition was not reportable. The analysis concluded that, although the pressure regulators were noncritical quality equipment, the failure of a regulator would not automatically place the plant outside its design basis. This was based on the fact that the pressure regulators were maintained and tested to ensure they would perform their design basis accident function. The licensee has also issued engineering change notices to replace the solenoid-operated valves in question with solenoid-operated valves with a maximum operating design pressure greater than the instrument air supply pressure.

The inspectors reviewed the licensee's operability and reportability determinations and concluded that they appear to provide adequate justification for continued operation and the reportability decision.

## 7.2 Incore Detectors

During this inspection period, the licensee experienced failures of 14 incore instruments. During the current fuel cycle (Cycle 16), 22 incore detectors in 12 detector strings have failed. There are 28 incore detector strings in the vessel. Six detector strings have been declared inoperable. Each string consists of four rhodium detectors and one thermocouple. The licensee defined a failed string as having at least two failed rhodium detectors.

To date, the licensee has performed testing on detectors removed during past refueling outages but has yet to determine the cause of the failures. All 22 failed detectors were installed during the last refueling outage (March 1995) and were manufactured by the same vendor. The vendor has provided onsite technical support but also has not been able to determine why the detectors were failing. The licensee planned to perform additional testing on the incore detectors currently in the vessel during the mini-outage scheduled to begin March 16, 1996. The licensee believed the results of the testing would help to identify the cause of the detector failures.

The incore detectors are explicitly addressed in the Updated Safety Analysis Report. The licensee, in the Updated Safety Analysis Report, committed to having 21 incore detectors strings operable. After the fifth detector string was declared inoperable, the licensee completed a 10 CFR 50.59 evaluation to allow continued operation with as few as eight detectors, two per quadrant. This evaluation was completed and approved by the Plant Review Committee on March 1, 1996, and the licensee intends to incorporate the 10 CFR 50.59 evaluation results into the Updated Safety Analysis Report.

This item will remain open pending the licensee's determination of the source of the failures, the proposed corrective action, and the NRC's review of these results. This item will be tracked as an inspection followup item (285/9601-03).

## 8 REVIEW OF UFSAR COMMITMENTS

A recent discovery of a licensee operating their facility in a manner contrary to the Updated Final Safety Analysis Report (UFSAR) description highlighted the need for a special focused review that compares plant practices, procedures, and/or parameters to the UFSAR descriptions. While performing the inspections discussed in this report, the inspectors reviewed the applicable portions of the UFSAR that related to the areas inspected. The inspectors verified that the UFSAR wording was consistent with the observed plant practices, procedures, and/or parameters.

## ATTACHMENT

### 1 PERSONS CONTACTED

#### 1.1 Licensee Personnel

R. Andrews, Division Manager, Nuclear Services  
J. Bobba, Acting Manager, Nuclear Safety Review Group  
C. Brunnert, Manager, Quality Assurance and Quality Control  
J. Chase, Manager, Fort Calhoun Station  
R. Connor, Manager, Training  
G. Cook, Supervisor, Station Licensing  
M. Core, Manager, System Engineering  
H. Faulhaber, Manager, Maintenance  
S. Gambhir, Division Manager, Production Engineering  
W. Gates, Vice President, Nuclear  
S. Gebers, Manager, Radiation Protection  
R. Jaworski, Manager, Design Engineering, Nuclear  
D. Leiber, Supervisor, Security Support Services  
E. Matske, Station Licensing Engineer  
T. Patterson, Division Manager, Nuclear Operations  
R. Short, Manager, Operations  
D. Spires, Manager, Chemistry  
M. Tesar, Manager, Corrective Action Group  
J. Tills, Manager, Nuclear Licensing

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

### 2 EXIT MEETING

An exit meeting was conducted on March 12, 1996. 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.