APPENDIX B

U.S. NUCLEAR REGULATORY COMMISSION
REGION IV

Inspection Report: 50-298/92-22 Operating License: DPR-46

Licensee: Nebraska Public Power District
P.O. Box 499
Columbus, Nebraska 68602-0499

Facility Name: Cooper Nuclear Station

Inspection At: Brownville, Nebraska

Inspection Conducted: October 4 through November 14, 1992

Inspectors: R. A. Kopriva, Senior Resident Inspector
W. C. Walker, Resident Inspector
J. M. Keeton, Operator Licensing

Approv [signature] for 12/14/92
J. E. Gagliardo, Chief, Projects Section C Date

Inspection Summary

Areas Inspected: Routine, unannounced inspection of onsite response to events, operational safety verification, surveillance observations, followup, and onsite review of licensee event reports.

Results:

- Overall, the licensee operated the facility safety (paragraphs 2 and 3.5).
- The licensee's evaluation and corrective actions to address the water hammer event in Residual Heat Removal System B on October 22, 1992, were prompt and appeared to be good (paragraph 2).
- Housekeeping was improving. Licensee management was addressing this issue (paragraph 3.2).
- A compressed gas cylinder was not properly controlled on the refueling floor for an extended period of time. This is a violation (paragraph 3.2).
- One example of improper control of visitors was identified. This is a violation (paragraph 3.4).
- Surveillance tests were performed well. The licensee personnel involved were knowledgeable of the tasks required and their actions were good (paragraph 4.3).

- The maintenance activity to repair and inspect the faulty diesel generator fuse holders was good (paragraph 5.1).

- The licensee appropriately addressed, from a safety perspective, the use of a process can in the spent fuel pool (paragraph 6.3).

- Licensed operator training weaknesses were observed in command, control, and communications; however, the licensee was aware of the problems and was actively pursuing their corrective actions program. The simulator evaluators were very professional and exhibited good evaluation skills. Examination material was very good and in accordance with the standard. The licensed operators appeared to be safety-conscious and competent (paragraph 6.5).

Summary of Inspection Findings:

- Violation 298/9222-01 was opened (paragraph 3.2).

- Violation 298/9222-02 was opened (paragraph 3.4).

- Inspection Followup Item 298/9034-02 was closed (paragraph 6.1).

- Unresolved Item 298/9219-01 was closed (paragraph 6.2).

- Unresolved Item 298/9219-02 was closed (paragraph 6.3).

- Licensee Event Reports 92-008, 92-012, and 92-013 were closed (paragraph 7).

Attachments (and/or Enclosures):

- Attachment 1 - Persons Contacted and Exit Meeting

DETAILS

1 PLANT STATUS

At the beginning of this inspection period, the plant was operating at 53 percent power and in single-loop operation. On October 1, 1992, Reactor Recirculation Motor-Generator Set B had tripped due to a faulty resistor and two faulty diodes. The components were replaced and the motor-generator set was restarted. The unit returned to full power on October 5. At the end of this inspection, the plant was operating at 100 percent power.

2 ONSITE RESPONSE TO EVENT (93702)

Residual Heat Removal System B Inoperable

On October 22, 1992, Residual Heat Removal System B was declared inoperable during performance of Surveillance Procedure 6.3.5.1, "RHR Test Mode Surveillance Operation Quarterly Inservice Test," Revision 35.
During the surveillance, Residual Heat Removal Pump B was run, determined to be acceptable, and shut down. Pump D was then aligned according to the procedure, which took approximately 5 minutes. Upon the starting of Pump D, a loud noise was heard. The licensee investigated the source of the noise and located a leak on the 958 foot elevation of the reactor building, at the flange for Pressure Maintenance System Check Valve 19. The check valve was located in a 4-inch line which is part of the auxiliary condensate system, which provides pressure maintenance for the residual heat removal system. Approximately 50 gallons of water had leaked out of the system into the reactor building. Licensee employees observed that the bonnet gasket on Check Valve 19 was unseated. They proceeded to walk down the remainder of the pressure maintenance system and observed two pipe supports which had been deformed from the event and also several pipe hangers which were misaligned. The licensee determined that the gasket failure and pipe damage were caused by a water hammer.

The licensee reviewed past water hammer events that have occurred in boiling water reactors, conducted system walkdowns, and assessed the impact the water hammer had on the residual heat removal system. The licensee repaired the pipe supports that were damaged and the check valve which was found to be leaking due to the event. The check valve was functionally tested and found to be satisfactory. Documentation was provided which showed that the event had not compromised the system pressure boundary integrity in its repaired configuration.

The licensee determined that the event was caused by valving out the pressure maintenance system when switching over from Pump B to Pump D during the surveillance test. A procedure change had been made which requires that the pressure maintenance system remain in service during pump changeover. The inspectors reviewed the licensee's corrective actions and found them appropriate.

Conclusions

The licensee's evaluation and corrective actions were prompt and appeared to be good.

3 OPERATIONAL SAFETY VERIFICATION (71707)

3.1 Control Room Observations

The inspectors observed operational activities throughout this inspection period to verify that proper control room staffing and control room professionalism were maintained. Control room shift supervisor log book, tag out log book, and control room balance-of-plant log book entries were reviewed to verify that appropriate entries were made. The licensee's control of these activities was good.

3.2 Plant Tours

The inspectors toured various areas of the plant to verify that proper housekeeping was being maintained. Housekeeping was found to be improving, but some areas remained where additional improvement was needed. The licensee's increased efforts for improving housekeeping were evident and management was continuing to review this activity.

On October 5, the inspectors found an unsecured, wheeled fire extinguisher in the reactor building on the 958-foot elevation and questioned the licensee as to what effect a seismic event would have on the unsecured fire extinguisher. Approximately 15 feet separated the fire extinguisher cart from Fuel Pool Cooling Instrument Rack 25-16 containing essential equipment. The licensee performed a seismic analysis to determine whether the subject fire extinguisher could have interacted with essential equipment. The analysis concluded that it would be unlikely that the extinguisher would topple during a seismic event. However, if it did tip over, there was no essential equipment located where it could interact with the extinguisher.

As a conservative measure, the licensee secured the extinguisher. In addition, the licensee reviewed six other wheeled fire extinguisher locations within the plant to determine possible interaction of those extinguishers with essential equipment. The licensee concluded that no concerns existed with the six other wheeled fire extinguishers. The inspectors reviewed the licensee's actions and considered them to be appropriate.

On October 6, 1992, during a walkdown of the reactor building, the inspector identified a gas cylinder in the northwest quadrant of the refueling floor which was roped to the two-wheel cart used for transporting the gas cylinder. The gas cylinder was not secured to a fixed restraint, the cart was not a wheeled cart of approved design for storage or use, and the wheels of the cart were not blocked or locked. At the time of discovery the inspector could not identify a use for the cylinder or the status of the cylinder (i.e., whether

it was full or empty). Under certain conditions, the cylinder could become a missile and damage equipment or personnel on the refueling floor or equipment in the fuel pool.

The licensee determined that the gas cylinder was helium and that it had been used on April 11 to leak test the reactor pressure vessel surveillance specimen shipping cask in accordance with Special Procedure 92-022. The special procedure did not include specific precautions or instructions for handling, storage, or removal of the gas cylinder. The licensee removed the gas cylinder from the refueling floor. The protective cap was in place on the cylinder and it was partially, if not completely, depressurized.

Title 10 CFR Part 50, Appendix B, Criterion V, states that activities affecting quality shall be prescribed by documented instruction, procedures, or drawings of a type appropriate to the circumstances and shall be accomplished in accordance with these instructions, procedures, or drawings. Procedure 0.7, Revision 8, "Flammable, Combustible, and Chemical Material Control," paragraph 8.3.2.2.C, states that, during storage and use, gas cylinders shall be individually secured to a fixed support by a restraint, and paragraph 8.3.2.3 states that use of wheel-mounted carts of approved design are permitted for certain uses of gas cylinders. The helium gas cylinder had been on the refueling floor since approximately April 11 and on October 6 was not secured to a fixed support and was not on a wheel-mounted cart of approved design. This is a violation (298/9222-01).

3.3 Radiological Protection Observations

The inspectors verified that selected radiological protection activities were in conformance with facility policies, procedures, and regulatory requirements. Radiation and/or contaminated areas were properly posted and controlled.

3.4 Security Program Observations

On October 5, the inspectors observed a repairman, with a visitor's badge, on the first floor of the administration building, in a room with two separate access points, and he was not within the line of sight of his escort. One access point would have allowed the repairman to leave the work area unseen by the escort and obtain access to other areas within the protected area. The inspectors asked the repairman about his escort. The repairman thought he could identify his escort, but was uncertain where the escort was. The inspectors located the escort. The escort had assumed that the access door leading from the work room to other areas within the plant was closed. After being questioned by the inspectors, the door was closed. However, there was no way to lock this door which would prevent the repairman from exiting unobserved. The inspectors promptly reported the situation to station security and a security officer was dispatched to review the situation.

The inspectors reviewed the licensee's escort training and training documentation. The escort training lesson plan and Visitor/Tour Station

Access Procedure 1.15 provided instructions to escorts to maintain positive control of visitors. The individual responsible for escorting the repairman had received the training. The licensee counseled the individual responsible for escorting the visitor to ensure understanding of proper escort procedures.

On October 5, Security Event Report 92-224 was completed, which outlined the event details. Immediate corrective actions included providing an escort for the repairman and sending a security guard to the incident location to review the situation. The licensee also counselled the individual, emphasizing instructions regarding visitor control requirements. The licensee was reviewing the procedures to determine their adequacy, and long-term corrective actions had not been established at the end of this report period.

Title 10 CFR 50.34(c) requires that each application for a license to operate a production or utilization facility shall include a physical security plan. The Cooper Nuclear Station Physical Security Plan, Section 1.5.2, requires that escorts exercise and maintain control of their visitors at all times. Cooper Nuclear Station Operations Manual, Plant Services Procedure 1.15, "Visitor/Tour Station Access," Revision 8, Section 4.2.1, states that an escort is responsible to exercise and maintain control of the visitor at all times. The failure to exercise and maintain control of a visitor (i.e., an individual not authorized by the licensee to enter protected areas without an escort) while the visitor was working within the protected area on October 5, 1992, is a violation of NRC requirements (298/9222-02).

3.5 Conclusions

- Overall, the licensee operated the facility safely.
- Housekeeping was improving. Licensee management was addressing this issue.
- A compressed gas cylinder was not properly controlled on the refueling floor for an extended period of time. This is a violation.
- One example of improper control of visitors was identified. This is a violation.

4 SURVEILLANCE OBSERVATIONS (61726)

4.1 Undervoltage Relays and Relay Timers Functional Test

On October 16, 1992, the inspector observed the performance of Surveillance Procedure 6.2.2.1.10, "4160V Buses 1F and 1G Undervoltage Relays and Relay Timers Functional Test," Revision 18.

Operators appeared to be following the surveillance procedure both locally and in the control room. Good communications were noted between the control room operators and individuals performing the surveillance. In reviewing the

procedures the inspector noted that proper signatures and approvals were evident. During the surveillance the inspector observed that the conditions inside the 4160V breaker cabinets were clean.

4.2 Reactor Core Isolation Cooling Steam Line High Flow Calibration and Functional Test

On October 28 the inspectors observed performance of Surveillance Procedure 6.2.2.6.1 "Reactor Core Isolation Cooling Steam Line High Flow Calibration and Functional Test," Revision 21. The inspector observed an instrument mechanic performing the calibration of the differential pressure switches which are used to monitor reactor core isolation cooling steam line flow. The instrument mechanic was adhering to the procedure and maintained good communications with the control room operators throughout the surveillance. The instrument mechanic was conscientious in complying with good radiological practice as he routinely changed protective gloves during his manipulation of the valves associated with the differential pressure switches. The surveillance was completed satisfactorily with no anomalies encountered.

4.3 Conclusions

The surveillances observed were performed well. The licensee personnel involved were knowledgeable of the tasks required and executed these tasks sufficiently to comply with the procedures. The inspectors found the licensee actions, as they pertained to these surveillances, to be good.

5 MAINTENANCE OBSERVATION (62703)

On November 10, 1992, during a routine surveillance run of Emergency Diesel Generator 1, it was noted that the air start solenoid to one bank of air cylinders had not actuated. Upon further investigation, the licensee found the fuse holder for that solenoid to be loose.

The inspectors observed the corrective maintenance activity to repair the fuse holder and the panel inspections to check other fuse holders that may have experienced similar problems. The licensee did not identify any addition examples of this deficiency. The inspectors verified that the workers obtained proper authorization to perform the work, that control room operators were cognizant of the maintenance activity, that workers followed the maintenance instructions, and that appropriate safety precautions were taken for work in energized panels. The inspector observed the postmaintenance functional check of the solenoid and verified proper operation. The inspectors noted that the electrical cabinets were clean. No unacceptable conditions were identified.

5.1 Conclusion

The maintenance activity to repair and inspect fuse holders was good.

6 FOLLOWUP (92701)

6.1 (Closed) Inspection Followup Item 298/9034-02: Entry into a Technical Specification Limiting Condition for Operation During the Performance of Surveillance Testing

The resident inspectors reviewed a licensee memorandum dated April 17, 1991, which outlined proposed technical guidance and reflected existing policy on the subject of entering Technical Specification action statements during the performance of surveillance testing. The licensee had identified several cases where procedures could disable a safety function during the performance of a routine test. As a result, several procedures were revised. Certain Technical Specification surveillance requirements have been amended to change the test frequency to allow the performance of the surveillance procedures during refueling shutdowns instead of performing these at power. Also, a Technical Specification amendment eliminated the testing of certain systems and components following the failure of a redundant system or component, a practice which could result in the removal from service of the only operable system or component. The licensee has taken further action to address the issue of operability during the performance of surveillance procedures by organizing a task force to identify additional required changes in the surveillance program and Technical Specifications.

6.2 (Closed) Unresolved Item 298/9219-01: Implementing Organizational Change without Having Amended the Technical Specifications

The licensee implemented a site reorganization on July 20, 1992, and had not revised their Technical Specifications to reflect the changes in the reorganization. On October 8, the licensee submitted their Technical Specification amendment to the Commission. Inspectors reviewed, for the time between reorganization and submittal of the amendment, the person assigned full time responsibility for the operation of the facility as specified in Technical Specification 6.1.1. The inspectors concluded that the licensee met Technical Specification 6.1.1 during this time period.

6.3 (Closed) Unresolved Item 298/9219-02: Potential Failure to Perform a 10 CFR 50.59 Review for Equipment Placed on Top of Empty Spent Fuel Racks

On September 25, 1992, during a plant walkdown, the inspector identified a process can located on top of empty spent fuel racks. The process can was used as part of the licensee's spent fuel pool cleanup project. The inspectors questioned whether a 10 CFR 50.59 evaluation for the process can pertaining to its location on the spent fuel racks had been performed.

The process can was 2 feet in diameter by 4 feet long with a fully loaded weight of approximately 800 pounds. An engineering evaluation had been performed prior to placement of the can on the spent fuel racks, to ensure that the racks would handle the fully loaded weight of the can. Also, the licensee considered the possibility of damaging fuel assemblies should a seismic event or industrial accident happen. Interaction between the can and

spent fuel assemblies was not deemed to be credible because of the 20-foot distance between the can and the storage racks containing spent fuel.

The licensee concluded that the calculated design basis seismic force would overcome the friction between the process can and the spent fuel rack before tipping the can, therefore, the can would remain upright and horizontal movement would be limited because of the oscillating nature of a seismic event. The can was submerged in water which had a dampening effect on any movement of the can. If the process can were to slide or roll far enough to impact fuel bundles, damage to the fuel assemblies would not be expected. The fuel manufacturer estimated that it would take 250 foot-pounds of downward impact loading to damage one fuel rod. Further, the licensee's Refuel Accident Radiological Effects Calculation (No. NEDC 88-171), which assumes 111 rods to be broken, concludes that the resulting lifetime thyroid and whole body dose would be less than 1 percent of the NRC 10 CFR Part 100 reactor siting criteria. The relationship between a vertical drop loading and a side loading (assuming the process can moves horizontally) would not be one to one. The 800 pound process can would have to free-fall approximately 34 feet to damage 111 fuel rods. This amount of energy would not be attainable for the configuration and controls the licensee had in place for the process can. If the can were to move in a direction away from the spent fuel, it could possibly fall into the cask pad area of the fuel pool. This accident would be significantly less severe than the shipping cask drop accident analyzed in Burns & Roe Calculation 2520-02.

Concerns for loose parts (i.e., if the can were to topple over) falling into the spent fuel pool or even potentially being transported into the reactor have been addressed in bounding analysis previously completed for the site. The licensee concluded that, with the procedures being used, the location of the process can in the spent fuel pool, and the previous analysis performed, all safety questions/concerns pertaining to the process can had been addressed.

The inspectors concluded that the licensee's evaluation of the use of the process can was appropriate.

6.4 Licensed Operator Requalification Program Evaluation

On November 4 and 5, 1992, the resident inspector and a Region-based inspector observed some requalification examinations, interviewed on-shift supervisors, and reviewed training and testing material. Also, the licensed operators were observed during the simulator examinations to determine if they were conducting activities in a manner conducive to protection of the public health and safety.

The following previously identified weaknesses (from NRC Inspection Report 50-298/9102) were specifically addressed either by direct observation, interviews, or by reviewing training program records:

- Crew command, control, and communication
- Adequacy of simulator scenarios
- Operators' ability to establish shutdown cooling
- Operators' ability to diagnose conditions

Some communications weaknesses were seen during this inspection:

- During one scenario, the supervisor directing panel activities was not concise in his directives. A lack of uniformity in communication among crews was seen.

- During another scenario, a supervisor directed an operator to establish torus spray. The operator could not get torus spray started and did not inform the supervisor, who assumed that the torus was being sprayed.

The communications problems observed were compensated by actions of the operators such that safety problems did not develop and mitigation strategies were not degraded. The facility managers stated that initiatives were in progress to improve communications. This was primarily being done in the evaluation sessions during the requalification training. There was no formal classroom presentation geared to defining a communications policy.

Training Guide NTG 318, "Command and Control" and operations directive, "CNS Communications," were developed to address command and control. However, there did not appear to be a formal method to define their interrelationship. Command and control training had been incorporated into the evaluation sessions during requalification training, but there were no formal classroom presentations scheduled to address this area.

A review of the training and testing material used for this requalification cycle showed that the material was current and that mechanisms were in place to update the material. The simulator scenarios developed for this evaluation were in accordance with the guidelines stated in NUREG-1021, "Operator Licensing Examiner Standards," Revision 7. Critical task identification and task standard definitions were very good. A review of the graded written examinations indicated that they were developed based on the sample plan and that they discriminated at the proper level.

During the simulator scenarios and walkthroughs, conditions existed that required establishing shutdown cooling. The operators were able to perform all operations necessary to accomplish shutdown cooling. No errors were noted.

The licensed operators observed during the simulator and walkthrough examinations demonstrated the ability to diagnose events and conditions. No errors were observed.

The facility evaluators conducted the dynamic simulator and walkthrough examinations professionally and in accordance with the standards. The

evaluators were able to function autonomously without management interference or visible constraints. During simulator evaluation sessions that were observed, the lead examiner elicited full participation from all evaluators. Facility evaluations were consistent with their program guidance, and the licensee took appropriate measures to preserve examination integrity.

Other observations made by the inspectors and communicated to the licensee include:

- Shift technical advisor rotation policy and involvement during requalification examinations was not fully understood by the shift crews.
- Simulator difficultly with P-1 printout has contributed to negative training. Rather than following up when a P-1 was not obtained, the crew assumed it was a simulator problem and simulated having a printout.
- At one point during a shift crew scenario, both reactor operators were behind the control panels at the same time.
- Based on inspectors' observations, the licensee has made progress to increase operations' sense of ownership in training.

Areas of strength that were identified include:

- Evaluators were very professional and exhibited good evaluation skills.
- Examination material was very good and in accordance with the standard.
- Licensed operators took a serious professional approach to the annual evaluation.

Although weaknesses were seen in command, control, and communications, the licensee was aware of the problems and was actively pursuing their corrective actions program. The licensed operators appeared to be safety-conscious and competent.

6.5 Conclusions

- The licensee appropriately addressed, from a safety perspective, the use of a process can in the spent fuel pool.
- Licensed operator training weaknesses were observed in command, control, and communications; however, the licensee was aware of the problems and was actively pursuing their corrective actions program. The simulator evaluators were very professional and exhibited good evaluation skills. Examination material was very good and in accordance with the standard. The licensed operators appeared to be safety-conscious and competent.

7 ONSITE REVIEW OF LICENSEE EVENT REPORTS (92700)

7.1 (Closed) Licensee Event Report 298/92-008: Inoperability of the High Pressure Coolant Injection System Due to Stem Nut Wear of a Motor-Operated Valve

This licensee event report documented the licensee's determination that the high pressure coolant injection valve, HPCI-MOV-58, which is the pump suction valve from the torus, was not stroking properly. During the running of Surveillance Procedure 6.2.2.3.4, "HPCI Suppression Chamber and Emergency Condensate Storage Tank Water Level Calibration and Functional/Functional Test and Water Initiation," Revision 25, both HPCI-MOV-58 and HPCI-MOV-17, the pump suction valve from the emergency condensate storage tank, could have been closed. The system logic for these two valves is such that one of them should always remain in an open position to provide suction for emergency core cooling through the high pressure coolant injection system.

The licensee concluded that, had the high pressure coolant injection system been required, it would have functioned as designed for as long as 10 minutes before tripping off on low suction pressure. The most limiting accident requiring operation of the high pressure coolant injection system is a small break loss-of-coolant accident and, for accident analysis purposes, high pressure coolant injection is considered inoperable. The response of the plant to the small break loss-of-coolant accident has been predicted in the latest accident analysis.

The licensee replaced the worn stem nut and reset the limit and torque switch settings. The licensee established acceptance criteria for stem nut thread inspection, but had not yet revised the maintenance procedure. The licensee committed to provide detailed instructions for performing stem nut inspections in the Limitorque maintenance procedures. Also, all Generic Letter 89-10 safety-related motor-operated valves with rising stems which have original stem nuts installed are being identified. Following the above activities, a representative sample of the motor-operated valves identified will have their stem nuts inspected to determine whether a potential motor-operated valve stem nut wear problem exists.

The inspector reviewed the documentation of the completed corrective actions and concluded that the licensee's actions were appropriate.

7.2 (Closed) Licensee Event Report 298/92-012: Inoperability of Reactor Core Isolation Cooling Motor-Operated Valve Due to Water Intrusion into the Motor Operator

This event involved the surveillance testing on the outboard steam supply isolation valve to the reactor core isolation cooling system. As part of the surveillance, the outboard isolation valve was closed but failed to reopen when required. Upon investigation, moisture was discovered in the limit switch box which caused the valve to not open. A hair-line crack was found in the flexible conduit installed to protect the wiring between the limit switch

compartment and the terminal box. This crack was near a steam packing leak which allowed moisture to enter the conduit line and travel into the limit switch box. The inboard and outboard isolation valves were both normally open. The inboard isolation valve was operable.

The licensee reduced power for ALARA purposes so that entry into the steam tunnel for repair of the valve could be made safely. The corrective actions included drying out limit switch internals and replacing the valve motor degraded terminal blocks. A tee drain was installed on the limit switch compartment cover to provide a drain path for any future moisture accumulation, and a shield was installed around the conduit in the immediate vicinity of the motor-operated valve. The licensee plans to replace the cracked conduit during the 1993 refueling outage and to inspect other motor-operated valve installations where flexible conduit containing motor-operator leads may be in close proximity to valve packing glands.

The inspectors reviewed the documentation of the completion of the licensee's corrective actions and concluded that the licensee appropriately addressed safety.

7.3 <u>(Closed) Licensee Event Report 298/92-013: Error in Limiting Single Failure Assumption for the Emergency Core Cooling System Performance Analysis</u>

This event involved the discovery of a nonconservative assumption in the emergency core cooling system performance analysis, under postulated design basis loss-of-coolant accident conditions. The nonconservative assumption was that the most limiting single failure was the failure of one low pressure coolant injection subsystem injection valve. During the licensee's review of their design basis reconstitution program, they determined several failure modes existed for the 125-Vdc power system which would result in a more limiting single failure condition than previously analyzed. The licensee's immediate corrective action was to reduce power toward hot shutdown in 6 hours and cold shutdown in 30 hours as required by Technical Specifications, and a Notification of Unusual Event was declared. Prior to achieving hot shutdown, a vendor analysis indicated that meeting the design basis for emergency core cooling systems was possible with certain operating restrictions. An operating restriction of 90 percent power was imposed and remained in effect until modifications were completed which restored the validity of the original assumptions used in the emergency core cooling system performance loss-of-coolant analysis.

On September 14, 1992, the licensee completed Design Change 92-141B which allowed control of low pressure coolant injection and reactor recirculation discharge valves to be independent of the 125-Vdc battery system and, thus, not subject to failure due to loss of one 125-Vdc battery system.

The inspector observed changes made to the 250-Vdc control power and verified documentation for completion of the design change.

8 MANAGEMENT MEETINGS (30702)

On September 25, 1992, the Region IV Regional Administrator and members of his staff accompanied the resident inspectors on a site tour and attended a presentation by the licensee. The licensee presentation included site communications, quality assurance training, and their deficiency reporting program, followed by an open discussion between the licensee and the NRC staff.

On October 1 and 2, the Division Director for the Division of Reactor Projects was onsite for a site tour and discussions with select members of the licensee's staff.

ATTACHMENT 1

1 PERSONS CONTACTED

1.1 Licensee Personnel

R. L. Beilke, Radiological Support Manager
L. E. Bray, Regulatory Compliance Specialist
R. Brungardt, Operations Manager
M. A. Dean, Nuclear Licensing and Safety Supervisor
J. W. Dutton, Nuclear Training Manager
C. M. Estes, Senior Manager of Operations
J. R. Flaherty, Engineering Manager
R. L. Gardner, Plant Manager
M. D. Hamm, Security Supervisor
H. T. Hitch, Plant Services Manager
R. A. Jansky, Outage and Modifications Manager
E. M. Mace, Senior Manager Site Support
J. M. Meacham, Site Manager
C. R. Moeller, Acting Technical Staff Manager
S. M. Peterson, Senior Manager of Operations
G. E. Smith, Quality Assurance Manager
M. E. Unruh, Maintenance Manager
R. L. Wenzl, NED Site Engineering Manager

The personnel listed above attended the exit meeting held on November 16, 1992. In addition to the personnel listed above, the inspectors contacted other personnel during this inspection period.

2 EXIT MEETING

An exit meeting was conducted on November 16, 1992. During this meeting, the inspectors reviewed the scope and findings of this report. The licensee did not identify as proprietary any information provided to, or reviewed by, the inspectors.