U. S. NUCLEAR REGULATORY COMMISSION

REGION III

Report No. 50-255/93002(DRP)

Docket No. 50-255 License No. DPR-20

Licensee: Consumers Power Company
212 West Michigan Avenue
Jackson, MI 49201

Facility Name: Palisades Nuclear Generating Facility

Inspection At: Palisades Site, Covert, MI

Inspection Conducted: December 29, through February 8, 1993

Inspector : J. K. Heller
D. G. Passehl

Approved By: B. L. Jorgensen, Chief
Reactor Projects Section 2A

2/17/93
DATE

Inspection Summary

Inspection from December 29, 1992, through February 8, 1993
(Report No. 50-255/93002(DRP))

Areas Inspected: Routine unannounced inspection by the resident inspectors of actions on previously identified items, operational safety verification, maintenance, surveillance, design changes, and quality program activities.

Results: Of the six areas inspected, no violations or deviations were identified in any areas.

The strengths, weaknesses, and Inspection Followup Items are discussed in paragraph 1, "Management Interview."

In summary, strengths were noted in the trending program for liquid leaks inside containment, the detail used to analyze a "post-event" report, and the well-managed repair to a chemical and volume control system charging line.

Weaknesses were noted in a personnel error that rendered an emergency diesel generator inoperable, inadequate updating of a work order after the scope of the work order had changed, and in the administrative process of writing and approving "periodic and predetermined activity control" documents.

DETAILS

1. Management Interview (71707)

The inspectors met with licensee representatives denoted in paragraph 9 on February 12, to discuss the scope and findings of the inspection. In addition, the informational content of the inspection report with regard to documents reviewed during the inspection was also discussed. The licensee did not identify any such documents or processes as proprietary.

Highlights of the exit interview are discussed below:

a. Strengths noted:

1) The licensee's trending program resulted in early detection of a leak in a containment air cooler (paragraph 3.b).

2) The detail of a post-event review (paragraph 3.d).

3) A well managed repair for the chemical and volume control system charging line (paragraph 4.c).

b. Weaknesses noted:

1) Personnel error that resulted in an inoperable diesel generator (paragraph 3.c). The frequency of personnel error appears to be increasing and will be evaluated in a subsequent report.

2) Documentation problems pertaining to changing the work scope of a work order and the updating of a "periodic and predetermined activity control" (PPAC) document. Additionally, the administrative process for writing and approving a PPAC was not clear and concise (paragraph 4.b).

c. The inspector questioned whether a surveillance test established artificial conditions that may mask integrated system response during an event (paragraph 5.a).

d. An inspection followup item was discussed (paragraph 7.b).

e. Problems that occurred at other plants were discussed. These included tampering with plant records and lack of an acceptance criteria for operator rounds (paragraphs 7.a and 7.b).

2. Actions on Previously Identified Items (92701, 92702)

(Closed) Open Item 255/90018-03(DRP): Heat trace circuit overheated causing the heat trace material to ignite.

On August 13, 1990, a fire occurred in the "B" evaporator area. Contractors were installing thermal insulation on the "B" evaporator when a heat trace temperature sensor was dislodged and -- when activated -- started sensing ambient room temperature instead of the output from the heat trace wiring. With the sensor registering ambient room temperature, the heat trace controller turned the heat trace full on. This resulted in overheating of the heat trace material and smoldering of insulation. The fire was extinguished. The heat trace and insulation were repaired.

The licensee re-trained the workers pertaining to the proper method to install the installation, sensors, and heat trace wiring. No similar events have occurred to date.

No violations, deviations, unresolved or inspection followup items were identified.

3. Operational Safety Verification (71707, 71710, 42700)

Routine facility operating activities were observed as conducted in the plant and from the main control room. Power operation of the plant was observed as applicable.

The performance of reactor operators and senior reactor operators, shift engineers, and auxiliary equipment operators was observed and evaluated. Included in the review were procedure use and adherence, records and logs, communications, shift/duty turnover, and the degree of professionalism of control room activities.

Evaluation, corrective action, and response for off normal conditions were examined. This included compliance to any reporting requirements.

Observations of the control room monitors, indicators, and recorders were made to verify the operability of emergency systems, radiation monitoring systems, and nuclear reactor protection systems. Reviews of surveillance, equipment condition, and tagout logs were conducted. Proper return to service of selected components was verified.

a. General

The plant operated at essentially full power during this reporting period.

b. Containment Sump Level Monitoring Program

NRC Inspection Report No. 50-255/92027(DRP) discussed the licensee's December 23, 1992, repair of a service water leak from one of the containment air coolers. Detection of this problem demonstrated the licensee's ability to monitor and trend leakage to the containment sump. The containment sump level monitoring program has proven to be effective in detecting, measuring, and trending liquid leaks inside containment.

The containment air cooler service water leak was initially identified when the licensee noted an unexpected containment sump level increase. The licensee initially speculated that the increase in sump level was due to increased leakage at the control rod drive (CRD) primary coolant pressure boundary seals. Leakage from these seals is monitored weekly and was trending upward (see paragraph 3.e, "Temporary Waiver of Compliance and Amendment to Facility Operating License"). The increase in containment sump level indicated that the leakrate to the sump was approximately 1200 ml/min.

CRD seal leakage is measured by auxiliary operators during weekly containment tours. Operators expected a leakrate of approximately 1200 ml/min but found a leakrate of approximately 700 ml/min. During the containment tour, the auxiliary operators discovered water in an area where safety injection piping is located. The licensee analyzed a sample of the water and concluded that it was service water from a containment air cooler. This leakage accounted for the additional leakrate of approximately 500 ml/min.

The licensee's containment sump level monitoring program resulted in quick identification and early resolution of the containment air cooler leak. This is another example of a strong trending and monitoring program that was recognized in the previous SALP report.

c. Two Emergency Diesel Generators Inoperable

On January 6, 1993, at 1 a.m. the licensee declared an unusual event when both emergency diesel generators (D/Gs) became inoperable. The unusual event condition was exited about two minutes later, when one of the D/Gs was returned to operable status. The inspector reviewed the emergency plan and concluded that this event was properly classified and reported.

An auxiliary operator was removing D/G 1-1 from service per switching and tagging order (S&TO) 93-0013. The operator had removed from service the electrical output breaker for D/G 1-1 and proceeded to activate the overspeed trip. Instead of activating the overspeed trip for D/G 1-1, the operator activated the overspeed trip for D/G 1-2. This made D/G 1-2 inoperable at the same time that D/G 1-1 was inoperable.

The auxiliary operator immediately recognized his error, reset the overspeed trip, and notified the control room of his error. The control room initially became aware of the error when a D/G 1-2 trouble alarm was received. Prior to declaring D/G 1-2 operable, the overspeed device was reset and a successful start of the D/G was completed.

The inspector interviewed the shift supervisor, shift engineer, control room operators, operations superintendent, and the

operations manager. The above information was confirmed, and the inspector was informed that the shift supervisor considered Fitness-For-Duty testing but concluded it was not necessary based on personal observations of the auxiliary operator before and after the error.

The inspector reviewed S&TO 93-0013. The S&TO was clear and concise. The S&TO required dual verification. However, the error was self disclosing before a second auxiliary operator was assigned to perform the dual verification.

The inspector reviewed the licensee's internal corrective action documents and found that written statements from the individuals involved in this event were included; this exceeded the administrative requirements for the corrective action program. The licensee internal investigation of this event was thorough.

The inspector concluded that this was a classic case of the wrong train being removed from service. However, the inspector noted positive aspects to the event, including the willingness of the auxiliary operator to identify his mistake and the timely response of the control room staff to the out-of-service condition.

d. Safeguards Transformer 1-1 Electrical Fault

During the midnight shift on January 28, 1993, a protective relay automatically removed the switchyard 345 kV "F" bus and the safeguards transformer from service. The safeguards transformer was the primary source of power for the "C" and "D" 2400 volt safeguards vital busses, as well as for the non-vital 2400 volt "E" bus. The loads transferred to the startup transformer (an alternate power supply). Also, momentarily lost was a non-safety related instrument bus, Y-01.

A number of systems were affected when Y-01 momentarily lost power during the transfer to its alternate power source. With Y-01 de-energized, the control valves for the moisture separator reheaters (MSR) went closed. This resulted in the unit settling at a new power level of 97 percent, due to an efficiency loss from the isolated MSRs. Additionally, there was a voltage transient that was sensed at the power supplies for turbine digital hydraulic controls (DEH). This transient was similar to a previous transient that had tripped the plant because the DEH controls did not transfer to an alternate power supply. As a result of modifications made subsequent to the last plant trip, the DEH successfully transferred to the backup power supply.

Trouble shooting activities on the safeguards transformer identified a grounded current transformer cable. This resulted in actuation of protective relays that tripped the safeguards transformer. The cable was replaced and the safeguards transformer returned to service.

Although there was no reactor trip, the licensee used the information gathering techniques of their post-trip procedure to analyze and produce a "post-event" report for this event. The detail included in the post-event report enabled the licensee to perform a thorough analysis of this event. This was considered a strength.

e. Temporary Waiver of Compliance (TWOC) and Amendment to Facility Operating License

The licensee was granted a TWOC from the biweekly Technical Specification surveillance frequency requirements for testing two control rod drive mechanisms. The TWOC was verbally granted on January 14, 1993, and approved in writing on January 15, 1993.

The TWOC allowed the licensee to discontinue biweekly surveillance testing of control rods 20 and 31 until an amendment was granted that changed the surveillance test frequency of the two rods to quarterly. The amendment (number 155) was granted by letter dated January 29, 1993.

Control rods 20 and 31 developed increased primary coolant leakage at the boundary seal during the current operating cycle. The biweekly testing, which required movement of the control rods, was aggravating the leakage. The licensee stated that repeated testing of a control rod with a leaking seal could shorten seal life and increase the leakage of primary coolant past the control rod seals. This could lead to a forced shutdown due to excessive primary coolant leakage.

The licensee also stated in the January 14, 1993, letter that they would submit a subsequent license amendment request to revise the test frequency of all control rods during plant operation from biweekly to quarterly.

No violations, deviations, unresolved or inspection followup items were identified.

4. Maintenance (62703, 42700)

Maintenance activities in the plant were routinely inspected, including both corrective maintenance (repairs) and preventive maintenance. Mechanical, electrical, and instrument and control group maintenance activities were included as available.

The focus of the inspection was to assure the maintenance activities reviewed were conducted in accordance with approved procedures, regulatory guides and industry codes or standards, and in conformance with Technical Specifications. The following items were considered during this review: The Limiting Conditions for Operation were met while components or systems were removed from service; approvals were obtained prior to initiating the work; activities were accomplished

using approved procedures; and post maintenance testing was performed as applicable. The following activities were inspected:

a. Lube Oil Pressure Deficiencies in Charging Pump P-55B

The three work orders discussed below were reviewed after three separate occasions of lube oil pressure deficiencies in charging pump P-55B. The first two work orders addressed low pressure conditions; the third was a high pressure condition. All three conditions occurred during a four week time frame. The inspector reviewed these work orders to determine if the quality of maintenance was satisfactory, and if enforcement action was appropriate.

The inspector found that the overall work was satisfactory. The licensee identified and resolved several root causes during the course of its repair efforts. Not all of the problems were identified during the initial troubleshooting activities because some were masked by others. The inspector found the licensee made reasonable attempts at finding all of the problems. Support from the system engineer and maintenance supervision was adequate.

However, in the case of the high oil pressure condition, the licensee could have been more proactive in adjusting the pressure output of the oil pump, which was identified as the root cause. This was apparently a simple fix that the licensee let lapse for three weeks.

(1) Work Order 2404744, "P-55B; Correct Low Lube Oil Pressure."

The licensee found during performance of Technical Specification test QO-17, "Inservice Test Procedure - Charging Pumps," that lube oil pressure in charging pump P-55B was slightly low at 19 psig. The acceptance criteria stated in the QO-17 procedure was 20 to 50 psig. The licensee declared P-55B inoperable and commenced repair activities. No Technical Specification Action Statements applied since charging pumps P-55A and P-55C were operable. In addition to the work order, an upper tier Corrective Action Report (Deviation Report) was issued.

Maintenance and system engineering personnel performed extensive troubleshooting. The root causes identified were:

(a) A worn oil pump. The oil pump was replaced twice because the first replacement pump also exhibited low discharge pressure when tested.

(b) A minor crimp in the oil pump suction line. The suction line was replaced.

(c) Loose oil pump shaft packing follower and capscrews. Both the original and replacement oil pumps had this problem. Maintenance personnel did an excellent job in identifying this problem.

The need to verify the tightness of the capscrews was not in the procedure nor was it a vendor recommendation. The inspector considers this finding to be a strength on the part of the mechanics. The licensee identified the need to enhance the charging pump maintenance procedure CVC-M-22, "Charging Pump Maintenance for P-55B and P-55C."

The pump was initially run with the crankcase cover removed with no visual evidence of gross oil leakage observed. The crankcase was installed, and the pump was returned to operable service after successful performance of QO-17.

(2) Work Order 24204953. "P-55B; Oil Pressure at 10 psig."

This low oil pressure event occurred almost three weeks after the pump underwent the maintenance described in the previous paragraph. Charging pump P-55A, the normal in-service pump, was removed from service to repair its leaking seals. Charging pump P-55B was started to replace P-55A, and had run for about 45 minutes when an auxiliary operator reported P-55B running with an oil pressure of 10 psig. The licensee issued another Deviation Report.

Maintenance personnel found the root cause to be a crack in the copper tubing on the discharge side of the pump. The crack had likely been present during the low pressure condition described in the previous paragraph.

The inspector determined that it was reasonable that maintenance mechanics had not identified the presence of the crack during the preceding event. The crack was located under a fastener that connected the discharge tubing to the pump. Adequate lube oil pressure was obtained during the previous post maintenance test, and the pump was operated with the crankcase cover removed with no evidence of gross oil seepage.

The licensee's opinion was that the crack probably was forced shut during the preceding work order activity and had vibrated loose during subsequent running of the pump. The inspector agreed this was probably the case. Improper installation of the fastener was ruled out because the installation passed inspection by a maintenance supervisor.

Technical Specification test QO-17 was satisfactorily performed after the cracked oil line was replaced. The discharge pressure of the oil pump was 38 psig.

(3) Work Order 24205064, "P-55B; Lube Oil Pressure Too High At 59 psig."

A couple of days after the low (10 psig) oil pump discharge pressure condition was corrected (see the preceding paragraph), the system engineer noted oil pump discharge pressure to be 59 psig. The system engineer initiated a work request to decrease the oil pressure. No Technical Specification Action Statement applied since the other two charging pumps remained operable.

The licensee determined that there was no immediate operability concern since the ASME Section XI requirements were met. Additionally, the pump curve showed adequate output flow at the observed discharge pressure.

The root cause evaluation identified an apparent problem with the pressure adjustment on the new oil pump when it was installed as discussed in (1) above. The output pressure of the oil pumps is adjusted by an internal set screw. The maintenance procedure required that the pressure adjustment on a new oil pump be taken from the as-found setting from the old oil pump. In this case, the mechanical setting was transferred to the new pump as stated in the maintenance procedure. The problem was that this resulted in an oil pressure setting on the new pump which slowly increased out of specification with extended pump operation.

The system engineer wrote a Work Request to adjust the setting but this was not performed until approximately three weeks later. This was not a timely action considering potential pump operability questions. Had there been another charging pump inoperable during this time, then the licensee might have unnecessarily entered a 24 hour Technical Specification Action Statement on the charging pumps.

The system engineer stated in the Deviation Report that in the future, System Engineering would be more proactive in prompting corrective correction.

b. Work Order 24100585, "PASM Panel Instrument Calibration per Periodic and Predetermined Activity Control (PPAC) PCS 025."

The inspector did not observe the performance of this work order, but performed a technical review of selected subsections to determine how temperature elements TE/TIS-1902 and TE/TIS-1903 were calibrated. This review was performed to resolve questions identified in paragraph 5.a, "QO-1 Safety Injection System" of this report pertaining to the isolation capability of those temperature elements.

The inspector reviewed the following: microfilm and computerized version of the work order which was performed on March 16, 1992; revision 15 of Piping and Instrumentation Diagram (P&ID) M-219, sheet 1b dated July 9, 1992, for the process sampling system; PPAC 025 dated October 27, 1992; and, administrative procedure AD 5.14, "Periodic and Predetermined Activity Control." In addition, the inspector interviewed the system engineer for the sampling system, the recently re-assigned project engineer for the PPAC system, and the instrument and control (I&C) superintendent.

The results of the inspector reviews and interviews are documented below.

(1) P&ID M-219 documented the temperature rating at the output of the sample coolers was 105 degrees fahrenheit and identified that valves will automatically isolate the sample sink if high temperature is detected.

(2) Step 19 of PPAC PCS025 performed a calibration of TE/TIS-1902 and required verification that SV-1915 (low pressure safety injection sample bleed valve) goes closed. This is incorrect; P&ID M-219-1B documented that TE/TIS-1902 will isolate a portion of the sample sink by closing SV-1916 (reactor coolant sample block valve) and will isolate a bypass line by closing SV-1917 (reactor coolant sample bleed valve) when high temperature is detected. TE/TIS-1902 does not operate SV-1915.

The computerized version of the work order that performed the PCS025 on March 17, 1992, verified that SV-1915 went closed, and the microfilm version contained a "pen and ink" change that verified that the SV-1916 went closed. The inspector reviewed the microfilm version and was unable to find a technical reason or reference to the documents reviewed to justify the "pen and ink" change.

(3) Step 20 of PPAC PCS025 performed a calibration of TE/TIS-1903 and required verification that SV-1916 goes closed. This should be SV-1914. P&ID M-219-1B documented that TE/TIS-1903 will isolate the sample sink by closing SV-1914 (low pressure safety injection sample block valve) and bypass valve SV-1915 when high temperature is detected. TE/TIS-1903 does not operate SV-1916.

The computerized version of the work order that performed the PCS025 verified that SV-1916 was closed, and the microfilm version contained a "pen and ink" change that verified SV-1914 went closed. The inspector reviewed the microfilm version and was unable to find a technical reason or reference to the documents reviewed to justify the "pen and ink" change.

(4) The inspector looked at the sample sinks and found that a mimic of the system configuration was on the control panel. The mimic identified which valves go shut when high temperature was sensed at a temperature element. The inspector questioned whether the mimic may have been used as the justification for the "pen and ink" changes. If the mimic was used then the inspector questioned if the "pen and ink change" received the proper technical review.

The use of unjustified "pen and ink" changes in documenting steps 19 and 20 of PPAC PCS025 was discussed with the I&C superintendent and at the management interview.

(5) Based on the above, the inspector reviewed AD 5.14 and found that the procedure was not clear as to:

(a) the administrative mechanism to change a PPAC that was incorporated into a work order. As shown above, the inspector was unable to find that a technical review was performed when a change was made to PPAC PCS025 implemented by the work order.

(b) how to change the controlled copy of the PPAC when an error was identified. As shown above, the inspector found that the controlled copy of PPAC PCS025 contained errors approximately seven months after it was last performed. Additionally, PPAC PCS025 was not targeted for a revision.

(c) the administrative mechanism to issue a PPAC and what technical reviews were required before the PPAC was issued for unrestricted use. As shown above, the inspector identified technical and administrative errors that should have been identified during the initial review/approval process.

The inspector discussed the items addressed above with the system engineer, I&C superintendent, and the recently assigned PPAC project engineer. The inspector was informed that the licensee was aware of these types of weaknesses. This had prompted the maintenance manager to temporarily assign an individual as the PPAC project engineer. This position was filled in October of 1992 and resulted in programmatic changes that should address the weaknesses addressed above.

The inspector noted that the weaknesses identified above appeared administrative and did not result in inoperable equipment.

c. Work Order 24?05678, "Manual operation of Charging Pump P-55A discharge isolation valve was severely limited."

This repair required isolation of the normal charging path for the chemical and volume control system. This required a well planned maintenance effort because any delay could result in charging via an alternate flow path. That would introduce concentrated boric acid into the primary coolant system and possibly force a plant shutdown.

The inspector toured the work site before the repair activity was authorized. He found that the repair equipment and replacement parts were pre-staged at the work site. The inspector attended the prejob briefing and found that the meeting was well conducted, orderly, and demonstrated that communication barriers did not exist between the work groups involved.

The inspector observed the performance of this work activity and concluded, after interviews with the operators and mechanics, that this was a well coordinated and managed repair activity.

No violations, deviations, unresolved or inspection followup items were identified.

5. Surveillance (61726, 42700)

The inspector reviewed Technical Specifications required surveillance testing as described below and verified that testing was performed in accordance with adequate procedures. Additionally, test instrumentation was calibrated, Limiting Conditions for Operation were met, removal and restoration of the affected components were properly accomplished, and test results conformed with Technical Specifications and procedure requirements. The results were reviewed by personnel other than the individual directing the test and deficiencies identified during the testing were properly reviewed and resolved by appropriate management personnel.

The following activities were inspected:

a. QO-1 Safety Injection System.

The inspector did not observe the performance of this test but performed a limited post test review after the event discussed in paragraph 3. d, "Safeguard Transformer 1-1 Electrical Fault." The test was written to demonstrate the operability of the safety injection system initiation circuitry by using the internal test feature of the system.

The inspector's review of the prerequisite section (Section 5.) of QO-1 raised a question whether this section was creating artificial conditions that could mask the integrated system response during an actual safety injection signal (SIS). The

prerequisite section required closure of primary system sample isolation control valves CV-1910 and CV-1911 before performance of the test. These valves are in-series containment penetration isolation valves from the primary coolant system to a sample sink that are located in the auxiliary building. The valves were considered to be outside the scope of the test because they do not change position during a SIS. However, the prints show that cooling water to the sample sink is isolated during a SIS. Closing CV-1910 and CV-1911 prior to performance of the test ensured that hot primary coolant system (PCS) water was not introduced to the sample sink during the test. CV-1910 and CV-1911 are normally open for approximately five hours per day to facilitate sampling activities.

The inspector reviewed the corrective action file and found a deviation report (DR-PAL-80-160) that discussed performance of the test with CV-1910 and CV-1911 open. That report documented that delays in completion of the test permitted a sustained flow of hot primary coolant to a sample sink that did not have cooling water available because of the SIS. The hot water damaged some of the valves down stream of the sample sink.

According to P&ID diagram M-219-1B, the temperature rating at the output of the sample sinks is 105 degrees fahrenheit. Additionally, there is a temperature element (TE-1902) downstream of the sample sink that should close a supply line isolation valve if high temperature was detected. The emergency operating procedures required verification that valves CV-1910 and 1911 are closed following a SIS. The inspector was unable to determine the time duration from a SIS until the emergency operating procedures required verification that CV-1910 and CV-1911 were closed.

The inspector discussed the topic of integrated system response with the operation superintendent who acknowledged that the isolation feature of TE-1902 should be tested. He stated that performance of an integrated system test would put unnecessary stresses on the sample sink heat exchanger and that the isolation feature should be confirmed during calibration of the TE-1902.

The inspector reviewed the periodic and predetermined activity control (PPAC) index and found that the calibration of TE-1902 was performed by the post accident sampling panel instrument calibration PPAC number PCS025. This activity is discussed in paragraph 4.b, "Work Order 24100585 - PASM Panel Instrument Calibration" of this report. It did not accomplish complete, well documented testing of temperature-based isolation features of TE-1902.

The inspector acknowledged that an integrated system test was not the intent of QO-1, and that performance of an integrated system each quarter may put unnecessary stresses on the system. However, the test as written may mask a design problem or equipment problem

not identified during a calibration activity. This topic was discussed at the management interview.

b. DWO - 13 LLRT of the Containment Airlock

c. MO - 7A Emergency Diesel Generator 1-1 Monthly Surveillance

d. QO - 17A Inservice Test of Charging Pump P-55A

e. MO - 03 Reactor Protective Matrix Relay

No violations, deviations, unresolved or inspection followup items were identified.

6. Design Changes (37700)

Specification change (SC) Number 91-135 "Modification of the 2400/4160 Volt Breaker indication for Bus 1A, 1B, 1C, and 1D."

The inspector found that the overall preparation of SC 91-135 was assigned to a project engineer who was responsible for the project from conception to completion. There were several subsections of this SC that pertained to preparation of the work instructions, work orders, or test procedures. These subsections were assigned to different work groups but still remained the responsibility of the project engineer.

Several positive attributes were noted. The overall design change package, as well as each subsection received individual 10 CFR 50.59 evaluations. The work instructions and test procedures were very detailed, easy to follow, and the author did not take short cuts when preparing the test procedures or work instructions. For example, the work instructions and test procedures were unique to a breaker.

On the negative side, the package did not adequately restate the commitment and commitment dates that had been made to the NRC. This contributed to the communication problem between the NRC and the utility discussed in paragraph 6.a, "Incorrect Information Provided to the NRC" of Inspection Report No. 50-255/92027(DRP).

No violations, deviations, unresolved or inspection followup items were identified.

7. Quality Program Activities (37701, 38702, 40704, 92720)

The effectiveness of management controls, verification and oversight activities, in the conduct of jobs observed during this inspection, was evaluated.

The inspector frequently attended management and supervisory meetings involving plant status and plans and focusing on proper co-ordination among departments.

The results of licensee auditing and corrective action programs were routinely monitored by attendance at Corrective Action Review Board (CARB) meetings and by review of Deviation Reports, Event Reports, Radiological Deficiency Reports, and security deficiency reports. As applicable, corrective action program documents were forwarded to the NRC Region III technical specialists for information and possible followup evaluation.

a. Tampering with Plant Records.

The inspector discussed two recent events with plant management. These events occurred at other nuclear power plants and pertained to falsification of plant records. The first event resulted when an operator failed to report and document control rod movement errors. The operator incorrectly moved control rods and conspired with several operators to cover up the error. The error was identified and reported by another member of the plant staff when the conspirators were overheard discussing the coverup. The event resulted in strong disciplinary action by the utility and intensive inspection activity by the NRC because the event demonstrated a lack of trustworthiness and integrity on the part of the operators.

The second event pertained to a failure of several chemistry technicians to verify that liquid discharge limits to a river were not exceeded. In this case a state permit for discharge limits may not have been complied with because the required inspections were not performed. Legal action from the state is pending.

Both events were discussed with the licensee. The licensee was aware of the events and had emphasized the need for a working atmosphere that encouraged identification and documentation of personnel errors.

b. Failure of Plant Review Committee to Review Security Implementing Procedures.

During a review of the procedure revision processes, the licensee discovered that they were not in literal compliance with Technical Specification (TS) 6.8.1.d and 6.8.2. TS 6.8.1.d requires written procedures be established, implemented, and maintained covering the site security plan. TS 6.8.2 requires that procedures required by TS 6.8.1 be approved by the appropriate senior department manager and, by reference to TS 6.5.3, be approved by the Plant Review Committee (PRC). The security implementing procedures have never been approved by the PRC.

The NRR project manager reviewed this item and determined that the licensee had requested, by letter dated September 23, 1988, deletion of a sentence from TS 6.8.2 that stated: "PRC is responsible for the review of each procedure of 6.8.1 above, and changes thereto (except for Security Implementing Procedures which

are reviewed and approved in accordance with the Site Security Plan)." The NRC approved the request via TS Amendment No. 127, eliminating the exception for security implementing procedures.

When Amendment No. 127 was approved, the licensee never changed their administrative procedures to reflect the required PRC reviews of the Security Implementing Procedures. Instead, the licensee continued to review the Security Implementing Procedures in accordance with the Site Security Plan.

The licensee has revised the procedure review process to capture PRC review of security implementing procedures. Also, the licensee is preparing a TS change request to delete PRC review of security plant procedures.

The inspector reviewed this item for enforcement action. The inspector was unable to determine if this is an administrative problem or if there is a technical reason to require PRC review of the security implementing procedures. Additionally, the inspector was unable to determine if inadequate reviews were performed or items were missed because the PRC did not review security implementing procedures. The inspector has requested a technical review of this item by Region III security specialists. Pending their review, this is considered an Inspection Followup Item (255/93002-01(DRP))

c. Inoperable Equipment

The inspector discussed an event that occurred at another plant pertaining to the lack of an acceptance criteria in the operator's log sheet. In that case the log sheet did not provide an acceptance criteria for diesel generator lube oil level. The failure to provide an acceptance criteria resulted in an inoperable diesel generator when the diesel generator tripped due to low lube oil pressure.

One inspection followup item was identified. No violations, deviations, or unresolved items were identified.

8. Inspection Followup Items

Inspection Followup Items are matters which have been discussed with the licensee, and will be reviewed further by the NRC. These involve some action on the part of the NRC, licensee, or both. An inspection Followup Item disclosed during the inspection is discussed in paragraph 7. b.

9. Persons Contacted

Consumers Power Company

*G. B. Slade, Plant General Manager
*T. J. Palmisano, Plant Operations Manager
*P. M. Donnelly, Safety & Licensing Director
K. M. Haas, Radiological Services Manager
*J. L. Hanson, Operations Superintendent
*R. B. Kasper, Maintenance Manager
*K. E. Osborne, System Engineering Manager
D. D. Hice, Chemistry Superintendent
D. J. Malone, Radiological Service Superintendent
W. L. Roberts, Senior Licensing Engineer
K. A. Toner, Electrical/I&C/Computer Engineering Manager
T. A. Buczwinski, Engineering Programs Manager
*C. R. Ritt, Administrative Manager

Nuclear Regulatory Commission (NRC)

*J. K. Heller, Senior Resident Inspector
D. Passehl, Resident Inspector

*Denotes some of those present at the management interview on February 12, 1993.

Other members of the plant staff, and several members of the contract security force, were also contacted during the inspection period.