

U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Docket No.: 50-263
License No.: DPR-22

Report No: 50-263/96011(DRP)

Licensee: Northern States Power Company

Facility: Monticello Nuclear Generating Station

Location: 414 Nicollet Mall
Minneapolis, MN 55401

Dates: October 17 through November 27, 1996

Inspectors: A. M. Stone, Senior Resident Inspector
J. Lara, Resident Inspector
S. Ray, Senior Resident Inspector
Prairie Island

Approved by: J. Jacobson, Chief, Projects Branch 4
Division of Reactor Projects

EXECUTIVE SUMMARY

Monticello Nuclear Generating Station, Unit 1
NRC Inspection Report 50-263/96011(DRP)

This inspection included aspects of licensee operations, engineering, maintenance, and plant support. The report covers a 6-week period of resident inspection.

Operations

- Operations personnel responses were appropriate to the increasing "D" safety relief valve tailpipe temperature and to the high radiation levels in the discharge canal. (Sections 02.1 and 04.1)
- A lack of self-checking resulted in a licensed operator and system engineer placing a jumper in the wrong relay. This action resulted in a trip of both recirculation pumps. Control room operators responded appropriately to the event. (Section 04.2)

Maintenance

- Work observed was conducted in a professional and thorough manner. The inspectors identified a concern with timeliness of documenting Quality Control inspections. A licensee Quality Control inspector identified inadequate wear rings which were to be installed in the #11 residual heat removal service water pump. This demonstrated a good questioning attitude. (Section M1.2)
- Material condition of plant equipment was acceptable. The licensee identified a degraded fire barrier. (Sections M2.1 and M2.2)

Engineering

- The licensee's actions to resolve the residual heat removal service water air vent valve failure to seat were mixed. After several failures, a surge check valve was installed which appeared to eliminate the air vent valve failures. However, a root cause was not determined. (Section E1.1)

Plant Support

- The inspectors noted that all observed contaminated areas except one were clearly marked and posted. (Section R1.2)
- The licensee's performance during a planned emergency preparedness exercise was acceptable. Appropriate operator and plant personnel response to the drill scenarios were evident. (Section P4.1)

Report Details

Summary of Plant Status

The unit operated at power levels up to 100 percent thermal power for most of the period. However, on November 12, a licensed operator and system engineer inadvertently caused both recirculation pumps to trip during the performance of a surveillance. Control room operators manually tripped the reactor in accordance with procedures. This event is discussed in Section 04.1. On November 13, the operators synchronized the generator to the grid; however, about 20 minutes later a turbine trip occurred. The turbine bypass valve opened and the reactor remained critical. No annunciators or failure flags were received. On November 14, the operators synchronized the generator to the grid and maintained power at about 43 MWe for further troubleshooting. This additional troubleshooting did not identify the cause of the previous turbine trip. About an hour later, the operators manually unloaded the generator because of increasing turbine vibrations. The unit was re-synchronized to the grid later on November 14 without incident.

On November 15, operations personnel noted that the "D" safety relief valve tailpipe temperature was higher than expected. This trend is discussed in Section 02.1.

I. Operations

01 Conduct of Operations

01.1 General Comments (71707)

Using Inspection Procedure 71707, the inspectors conducted frequent reviews of ongoing plant operations. In general, the conduct of operations was acceptable; specific events and noteworthy observations are detailed in the sections below.

02 Operational Status of Facilities and Equipment

02.1 Response to Increasing "D" Safety Relief Valve Tailpipe Temperature

a. Inspection Scope (71701)

On November 15, 1996, operations personnel noted the tailpipe temperature for the "D" safety relief valve (SRV) was higher than expected and was trending upward. The inspectors evaluated the licensee's response to this equipment problem. The following documents were reviewed:

- Technical Specification (TS) 3.6.E, 3.7.A.2 and 4.7.A.1.b;
- Abnormal procedure C.4-B.3.3.B, "Relief Valve Leaking;" and
- Operations Manual B.3.3, "Reactor Pressure Relief."

b. Observations and Findings

The inspectors reviewed the "D" SRV tailpipe temperature data history and confirmed that the temperature was about 145°F and increasing about 1°F per hour. The shift manager directed operators to increase cooling to the drywell in an attempt to slow the rate down. The inspectors observed that operations personnel were knowledgeable of a procedure requirement to initiate a controlled shutdown if the tailpipe temperature approached 200°F. The temperature decreased to about 140°F and appeared to be constant. The inspectors also verified that the operators were monitoring torus temperature. No notable temperature changes were observed.

A meeting with appropriate personnel was held to discuss the trend and potential for a manual reactor shutdown. The inspectors observed good communication and conservative decision making during this meeting. The licensee reviewed outstanding outage-related work orders and developed an outage schedule in the event a shutdown was necessary. The system engineer recommended temporarily increasing the pressure to the valve bellows. This action was performed; however, the tailpipe temperature remained high. The engineer surmised a problem existed with the second stage disc. Operations and engineering personnel continued to monitor the tailpipe temperature and decided to re-evaluate the situation if the temperature increased above 150°F.

The inspectors confirmed that the tailpipe temperature varied between 135 to 145°F during the remainder of the inspection period. Further licensee actions to address this issue will be discussed in Inspection Report 50-263/96012.

c. Conclusions

Operations personnel response was appropriate to the increasing "D" SRV temperature. The licensee's actions in anticipation of an outage were proactive.

04 Operator Knowledge and Performance

04.1 Operator Response to High Discharge Canal Radiation Alarm

a. Inspection Scope (71707 and 93702)

The inspectors independently assessed operators response to numerous high discharge canal radiation alarms on October 17, 1996. As discussed in Inspection Report 50-263/96010, hard rains washed the emissions from the Monticello plant and nearby coal plant exhausts into the discharge canal.

The inspectors reviewed applicable emergency operating procedures (EOP) and TS.

b. Observations and Findings

The inspectors reviewed the Channel A and B discharge canal radiation monitor data and noted that the radiation levels gradual increased to about 25.4 cpm. Discussions with the operators and review of annunciator alarms confirmed that the operators appropriately entered the EOPs. The operators isolated the discharge of the #11 offgas storage tank through the stack as a precautionary measure. Notifications to licensee management and state and federal agencies were made in a timely manner. The operators exited the EOPs once the radiation levels decreased and trended toward expected values.

c. Conclusion

The operators responded appropriately to the high radiation levels in the discharge canal.

04.2 Licensee Response to Dual Recirculation Pump Trips

a. Inspection Scope (71707 and 93702)

On November 12, 1996, during a special surveillance test, both recirculation pumps inadvertently tripped. The inspectors reviewed the cause of the pumps trip and subsequent licensee actions.

The inspectors reviewed the following documents:

- Surveillance test 1448, Residual Heat Removal (RHR) Containment Spray/Cooling Logic Test;
- TS 3.5.F;
- Emergency Operating Procedures;
- Operating Procedure B.1.4.05.02, "Shutdown of One Pump with Reactor at Power;"
- Operating Procedure B.1.4-05.02, A.3, "Restart of a Shutdown Pump While in a Hot Shutdown Condition;"
- Operating Procedure B.1.4-05.03.6, "Isolation of Cooling Water to a Control Rod Drive to Determine Bottom Head Temperature;"
- Logic diagram NX 7905-46-5; and
- Quality Services Observation Report 1996416, "Plant Startup Activities in the Control Room."

b. Observations and Findings

The inspectors interviewed the operator and system engineer involved in the special surveillance test 1448. Step 8 of the test instructed the operator to momentarily place a jumper across studs 1 and 2 of relay 10A-K 74A. From the front of the panel, the operator observed that the desired relay was the fourth relay from the edge of the cabinet. The operator proceeded to the back of the panel and observed that the relay studs were obstructed by a vertical support and believed it would be easier to access the studs from the adjacent panel. The system engineer concurred. The operator then applied the jumper across the two studs of

the first relay in the second panel. However, the operator and engineer did not realize that the first relay in this panel was 10A-K 73A, not 10A-K 74A as desired.

The momentary jumper across 10A-K 73A caused both recirculation pumps to trip through the break detection portion of the low pressure coolant injection recirculation loop select logic circuitry. The inspectors independently verified that all automatic actions associated with this circuitry occurred as expected.

The operators in the control room responded appropriately to the recirculation pump trips. The shift manager directed the operators to manually trip the reactor in accordance with operating procedures. (At the time of the event, 1S 3.5.F prohibited operation with natural recirculation.) The inspectors confirmed through discussions with the operators and review of annunciator alarms that the operators appropriately entered and exited the emergency operating procedures. Following the reactor trip, the operators restarted the #11 recirculation pump without incident.

The inspectors observed the restart of the #12 recirculation pump. The inspectors noted that operators used either the bottom head drain temperature indicator or the vessel metal temperature. This action was in accordance with procedures. The inspectors observed good conflict resolution and conservative operation when operators noted a significant difference between the two temperature indications. The shift manager suspended the restart of the pump until the temperature discrepancy was resolved. The inspectors had no concerns.

c. Conclusions

A lack of effective self-checking and verification resulted in a licensed operator and system engineer incorrectly placing a jumper in a relay. This action resulted in a trip of both recirculation pumps. Control room operators responded appropriately to the event. This event will be further reviewed upon issue of the LER.

04.3 Operators Performance During Surveillances

a. Inspection Scope (71707 and 61726)

The inspectors observed operators perform several daily and routine equipment surveillances. The inspectors assessed operator knowledge, communication with other departments, and procedure adherence.

b. Observations and Findings

In general, the inspectors determined that the surveillances were performed in a professional and thorough manner. The operators performed the surveillances with the procedure at hand and acceptance

criteria were verified by shift management. Technical specification limiting conditions for operations were appropriately entered and adhered to.

However, the inspectors noted that the plant operators performed a step out of order during a #12 emergency diesel generator service water pump surveillance (0187-2). The surveillance required the plant operators to: (1) open the bypass valve to the strainer; (2) close and open a strainer outlet valve; (3) manually cycle a crosstie valve; and (4) reclose the bypass valve. The inspectors identified that the plant operators opened and immediately closed the bypass valve prior to manipulating the strainer outlet valve. This action caused the pump to be inoperable while the strainer outlet valve was momentarily closed. The plant operators immediately acknowledged the problem and reported the procedure adherence issue to the shift manager. Failure to follow procedure is a violation of 10 CFR 50, Appendix B, Criterion V. However, this violation is of minor significance since the pump was inoperable for less than 15 seconds. The plant operator was in attendance in the event that the emergency diesel generator started. This is considered a Non-Cited Violation consistent with Section IV of the NRC Enforcement Policy (50-263/96011-01).

II. Maintenance

M1 Conduct of Maintenance

M1.1 General Comments

a. Inspection Scope (62703)

The inspectors observed all or portions of the following work orders (WO) and surveillance activities:

- WO 9602046 De-terminate/Re-terminate #11 RHR pump motor
- WO 9602495 Changeout procedure for ASCO solenoid valve SV-2379
- WO 9602649 Tighten oil leak on #12 fuel oil fitting
- WO 9602719 Investigate/repair #12 RHR service water (SW) pump seal leakage
- WO 9602728 Replace #11 emergency diesel generator emergency service water pump
- WO 9602848 Perform test of surge check valve with AV-3147
- WO 9602849 Perform test of air vent valve AV-3147
- 0056 High Pressure Coolant Injection (HPCI) Hi Steam Flow Sensor Test
- 0060 Reactor Core Isolation Cooling (RCIC) Hi Steam Flow Sensor Test
- 0067 Spent Fuel Pool Monitor Functional Test and Calibration
- 0133 Daily Jet Pump Operability Check
- 0187-2 #12 Emergency Diesel Generator Testing
- 0439 Reactor Building Exhaust Plenum Monitor Functional

- 1025 Test and Calibration
- 1448 Area Radiation Monitor Functional Testing
- 1448 RHR Containment Spray/Cooling Logic Test

In addition, see the specific discussions of maintenance observed under M1.2 and M1.3 below.

b. Observations and Findings

In general, the inspectors found the work performed under these activities to be professional and thorough. Work observed was performed with the work package present and in active use. Technicians were experienced and knowledgeable of their assigned tasks. The supervisors and system engineers monitored job progress, and quality control personnel were present whenever required by procedure. When applicable, appropriate radiation control measures were in place. The inspectors also verified that redundant equipment remained operable during the maintenance activities and that operations personnel documented entries into applicable TS limiting condition for operations (LCO).

M1.2 Observations of Quality Control Activities

a. Inspection Scope (62703)

The inspectors observed maintenance and quality control personnel performing WO 9602046, "De-terminate/Re-terminate #11 RHR Pump Motor." The inspectors also reviewed documentation to ensure that the work performed was reflected in the work order.

b. Observations and Findings

The inspectors verified that maintenance personnel documented the work performed accurately in the work order. However, the inspectors noted that three items in the Quality Control (QC) Inspection Record were not signed. These items were signed off as complete in the WO package. The inspectors discussed this discrepancy with the lead reactor operator who verified with the QC inspector that the QC hold points had been adhered to with satisfactory results. The QC inspector had performed the required inspections but had not signed the inspection record following completion of the inspection activity (motor terminations). The NRC inspectors later observed the QC inspector sign the inspection record. Discussions with the QC supervisor indicated that QC observations should have been documented concurrent with the work performed.

The inspectors noted that a QC inspector identified that the newly machined wear rings tolerances for the #11 RHR pump were out of tolerance. The QC inspector found that the micrometer used during the machining of the wear rings was offset by 0.025 inches. This offset resulted in the out-of-tolerance dimensions. The licensee machined new rings to the correct dimensions.

c. Conclusions

The inspectors concluded the QC inspections were completed as required, but were not documented in a timely manner. The QC inspector's

identification of inadequate wear rings demonstrated a good questioning attitude.

M1.3 HPCI/RCIC Hi Steam Flow Sensor Tests

a. Inspection Scope (61726)

The inspectors reviewed the following materials:

- Surveillance test 0056, "HPCI Hi Steam Flow Sensor Test;"
- Surveillance test 0060, "RCIC Hi Steam Flow Sensor Test;"
- Updated Final Safety Analysis Report (UFSAR) Chapters 6.2.4.2.4 and 7.6.3.4.2;
- Schematic drawings NX-8292-12-1, and -2;
- Operations Manual B.3.2; and
- Operations Manual B.2.3.

The inspectors also reviewed the following condition reports (CR) associated with out-of-tolerance flow switches:

- CR 95000183 Flowswitch FS-23-78 HPCI Flow Switch out of Tolerance
- CR 96001917 Flowswitch FS-23-78 HPCI Flow Switch out of Tolerance for switches 1 and 2

b. Observations and Findings

The inspectors witnessed instrument and controls personnel perform surveillance tests 0056 and 0060 and noted that the trip setpoints of the HPCI and RCIC system pressure switches (e.g., PS-7414, PS-7415, and dPIS 13-83) were tested and recorded after these switches were previously tripped. The inspectors were concerned that the true as-found setpoint may be masked (i.e., the devices could be pre-conditioned prior to testing). The inspectors reviewed the applicable UFSAR Chapters, schematic drawings, and Operations manuals, and discussed this issue with the system engineer. Based on this review, the inspectors determined that the pressure switches were in series with other relays and switches, thereby requiring the actuation of these pressure switches to test the other devices. Additionally, the performance of pressure switches was generally repeatable and exercising does not affect the as-found condition. Therefore, the surveillance procedure was acceptable.

The inspectors reviewed the operability determination for the two out-of-tolerance HPCI flow switches and had no concerns with the licensee's conclusions or corrective actions as documented in the condition reports.

c. Conclusions

The inspectors concluded that the testing method was appropriate for the HPCI and RCIC pressure switches.

M2 **Maintenance and Material Condition of Facilities and Equipment**

M2.1 Degraded Fire Barrier in Control Room

a. Inspection Scope (37550 and 93702)

On October 16, engineering personnel identified that a fire barrier installed between redundant division panels in the control room was dislocated from the opening between the two adjacent panels. The inspectors reviewed the licensee's immediate actions.

b. Observations and Findings

The inspectors confirmed that the fiberboard which provided divisional separation between two adjacent panels was out of position. These panels contained the redundant division components associated with the RHR and Core Spray systems. The fiberboard provided a barrier between the floor and the bottom of the common panel side (3-inch opening). Due to its close proximity to the floor and relatively small size, the dislodged fire barrier was difficult to identify. The licensee's initial corrective actions included inspection of other control room panels for similar conditions and reinstallation of the barrier. No other deficiencies were identified. The inspectors independently verified the fire barriers were intact in the other control room panels.

The licensee notified the resident inspectors of this condition and also notified the NRC pursuant to 10 CFR 50.72. The licensee determined the plant was outside design basis as described in General Electric Specification 22A2501, "Separation Requirements for Reactor Safety and Engineered Safeguards Systems," which required floor to panel fire barriers between adjacent panels having closed ends.

c. Conclusions

The licensee's immediate corrective actions were acceptable. The licensee's long-term actions will be evaluated concurrent with review of the licensee event report.

M2.2 Current Material Condition and Impact on Operations Personnel

a. Inspection Scope (71707)

The inspectors conducted control room and plant inspections and interviewed operations personnel to assess the material condition of plant equipment.

b. Observations and Findings

During inspections in the plant and control room, the inspectors noted that the following degraded conditions were outstanding:

- #11 reactor water cleanup pump seal leak As discussed in Inspection Report 50-263/96008, the inspectors identified increasing leakage. Maintenance performed during this period was unsuccessful in reducing the leakage. The licensee was pursuing a new seal package. The pump remained inoperable.
- Increasing tailpipe temperature on the "D" Safety Relief Valve This condition is discussed in Section 02.1.

The inspectors also noted that the licensee resolved some previously discussed material condition concerns during the November forced outage. Maintenance personnel replaced the limit switch on a turbine stop valve which had previously caused a half scram signal during routine surveillances.

c. Conclusions

The inspectors verified that the above conditions did not violate TS. The operators interviewed were knowledgeable of the conditions. The inspectors verified that work orders were initiated to repair the degraded equipment.

III. Engineering

E1 Conduct of Engineering

E1.1 Residual Heat Removal Service Water #11 Pump Declared Inoperable Due to an Inoperable Air Vent Valve

a. Inspection Scope

The inspectors continued a review of the licensee's troubleshooting, maintenance, and engineering activities pertaining to the inoperable #11 RHRSW pump. The problems associated with the inoperable pump were of concern due to the recurring failure of the air vent valve. The licensee documented these failures in CRs 96002076 and 96002578.

b. Observations and Findings

As discussed in NRC Inspection Reports 50-263/96006 and 50-263/96008, the licensee declared the #11 RHRSW pump inoperable on several occasions due to the failure of air vent valve, AV-3147, to close when the #11 RHRSW pump was started. The air vent valve was designed to close after air was ejected from the pump column and system piping.

The pump was declared inoperable on October 11, 1996, when the air vent valve failed to seat. The licensee discussed the results of previous troubleshooting and system performance with the valve manufacturer and a discernible root cause was not determined. The licensee installed an orifice plate in the inlet to the air vent valve. The purpose of the orifice was to allow the entrapped air in the system to escape but would throttle the flow and allow the valve to seat. The inspectors previously reviewed the licensee's modification package 96Q150 and safety evaluation, UFSAR, and installation of the modification (orifice plate) as documented in Inspection Report 50-263/96008.

The licensee performed post-modification testing which included daily pump starts for 7 days and followed by an additional start one week later. The inspectors observed the tests and independently verified the test results reflected acceptable air vent valve performance. On November 1, the inspectors attended an operations committee (OC) meeting where the system engineer presented the modification and test results. The OC members approved the modification and concluded that the #11 RHRSW pump and air vent valve were operable. Operations personnel declared the pump operable and exited the 30-day TS 3.5 LCO.

However, to gain additional reliability data, the OC members recommended performing the #11 RHRSW pump test on a weekly basis. On November 6, the inspectors witnessed the first pump start since declaring the air vent valve operable. When operators started the pump, the air vent valve failed to seat and the pump was secured after about 7 seconds. Operators attempted a second start; however, secured the pump again after 15 seconds when the air vent valve failed to seat. The #11 RHRSW pump was declared inoperable. On November 8, the licensee temporarily installed a surge check valve upstream of the air vent valve to determine if the check valve provided improved performance of the air vent valve. The inspectors witnessed the installation and testing of the surge check. The licensee determined that the surge check valve improved the air vent valve performance and proceeded to implement a permanent modification. No additional failures had occurred by the end of the inspection period.

c. Conclusions

The licensee's actions in evaluating the RHRSW air vent valve were determined to be mixed. Although the air vent valve modification was acceptably tested demonstrating proper system performance, reliability concerns remained. The implemented surge check valve modification allowed for system operation by compensating for the poor air vent valve performance. A root cause for the air vent valve failures has not been established.

E2 Engineering Support of Facilities and Equipment

E2.1 Cable Trays Not Labelled in Accordance With UFSAR Description

a. Inspection Scope (37550 and 71707)

While performing the inspections discussed in this report, the inspectors reviewed the applicable portions of the UFSAR that related to the areas inspected.

b. Observations and Findings

The inspectors verified that the UFSAR wording was generally consistent with the observed plant practices, procedures, and parameters. One discrepancy was identified with cable tray labeling. The inspectors identified numerous cable trays were not marked or labeled as discussed in UFSAR Section 8.8. This section stated that all conduit, cable trays, boxes and cables were assigned unique identification numbers. Markers were applied to cable trays not to exceed 20 feet, at points where trays change direction, and at points adjacent to all tray junctions. The inspectors discussed this observation with engineering personnel. The licensee planned to add the labels in conjunction with other walkdowns and painting efforts. This issue is considered an Inspection Followup Item (50-263/96011-02) pending completion of the licensee labeling program. The licensee initiated CR 96002444 to address this issue.

IV. Plant Support

R1 Radiological Protection and Chemistry Controls (RP&C)

R1.1 Ladder Leading to Contaminated Area Not Posted

a. Inspection Scope (71750)

The inspectors reviewed radiation and contaminated area postings during routine inspections. The inspectors also reviewed radiation protection procedure, R.07.02, Revision 8, "Area Posting, Special Status Signs and Hot Spot Stickers."

b. Observations and Findings

Concerns with radiation area postings were discussed in Inspection Report 50-263/96010. In general, contaminated areas were clearly marked and posted. However, the inspectors identified a ladder leading down to the "A" train of residual heat removal and core spray pump floor was not posted as contaminated. The inspectors reviewed the area survey map and verified that the floor elevation was correctly posted as contaminated. Radiation procedure R.07.02, Revision 8 step 5.d. required attaching a required posting sign at each access point barricade. Failure to post the ladder, an access point to the contaminated floor below, is a

violation of TS 6.5.B.1. However, this violation is of minor significance and is considered a Non-Cited Violation consistent with Section IV of the NRC Enforcement Policy (50-263/96011-03).

c. Conclusions

The inspectors noted that all observed contaminated areas except one were clearly marked and posted.

P1 **Conduct of Emergency Preparedness Activities**

P1.1 Emergency Preparedness Exercise

a. Inspection Scope (71750)

On October 30, the licensee performed an emergency preparedness exercise. The inspectors reviewed the exercise and observed activities in the TSC and control room simulator.

b. Observations and Findings

The planned exercise consisted of two primary events: an oil spill near the intake structure and a reactor coolant system leakage in the drywell. The inspectors witnessed the developing exercise from the simulator and TSC.

Simulator Control Room Activities witnessed included shift turnover, operator response to the primary events, classification of the unusual event and ALERT in response to the events, and activation of communicators in the simulator. Operator response to the exercise scenario was acceptable as evidenced by proper annunciator response, monitoring of plant parameters, use of the TS and EOPs, emergency classification of events, and entries into LCOs.

Technical Support Center The inspectors observed the site communicators in the technical support center (TSC). The site communicators notified appropriate state and federal agencies promptly when the shift manager declared an unusual event for the simulated oil spill. The site communicators provided additional information as the scenario progressed to an ALERT declaration. Minimum staffing as defined in the licensee's emergency plan required only one communicator; however, the inspectors noted that three communicators participated in the exercise. The licensee indicated that although only one was needed, the exercise permitted an excellent training opportunity for those who were assigned this function.

The inspectors noted that the TSC was promptly staffed. The emergency director quickly established command and control. Briefings were held periodically and were informative. Priorities were established and communicated to the simulated control room and operations support center. The inspectors observed that staff members were aware of equipment status and changes in priorities. Some problems occurred

resulting from the simulation of the event. For example, when the Bus 15 lock-out condition cleared, an emergency diesel generator automatically started. This occurred because operators simulated isolating the bus when maintenance and engineering personnel initiated work. The automatic start of the diesel did not impact the scenario objectives.

Critiques The inspectors also attended several post-exercise critiques. Participants and controllers provided constructive comments. The inspectors concluded that while the exercise scenarios were not technically challenging (e.g., no offsite dose assessment and calculations required, plant radiation levels were normal, etc.), the exercise did provide an opportunity for training of personnel and provided a test for effective communications between the various licensee organizations.

c. Conclusions

The licensee's performance during the exercise was acceptable. Appropriate operator and plant personnel response to the scenarios were evident.

P8 Miscellaneous Emergency Preparedness Issues

- P8.1 (Closed) Inspection Followup Item (50/263-95007-01): Exercise Weakness - Failure to Notify NRC Immediately After Notifying State and Local Agencies. As discussed in Section P1.1, the inspectors observed the site emergency communicators during the 1996 emergency drill. All notifications were made in a timely manner. The inspectors also noted that the licensee appropriately notified the NRC during two actual events as discussed in Sections O4.1 and M2.1. These notifications were accurate and timely.

V. Management Meetings

X1 Exit Meeting Summary

On December 2, 1996, the inspectors presented the inspection results to the plant manager and the manager of quality services. The licensee acknowledged the findings presented.

The inspectors asked the licensee whether any materials examined during the inspection should be considered proprietary. No proprietary information was identified.

PARTIAL LIST OF PERSONS CONTACTED

Licensee

E. Watzl, Vice President Nuclear
W. Hill, Plant Manager
M. Hammer, General Superintendent Maintenance
K. Jepson, Superintendent, Chemistry & Environmental Protection
L. Nolan, General Superintendent Safety Assessment
M. Onnen, General Superintendent Operations
E. Reilly, Superintendent Plant Scheduling
C. Schibonski, General Superintendent Engineering
W. Shamla, Manager Quality Services
J. Windschill, General Superintendent, Radiation Protection
L. Wilkerson, Superintendent Security
B. Day, Training Manager

INSPECTION PROCEDURES USED

IP 37550: Engineering
IP 40500: Effectiveness of Licensee Controls in Identifying, Resolving, and Preventing Problems
IP 61726: Surveillance Observations
IP 62703: Maintenance Observations
IP 71707: Plant Operations
IP 71750: Plant Support
IP 93702: Prompt Onsite Response to Events at Operating Power Reactors

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

50-263/96011-01	NCV	Plant operator failure to follow surveillance procedure
50-263/96011-02	IFI	UFSAR discrepancy with cable tray labeling
50-263/96011-03	NCV	Ladder leading to contaminated area not posted

Closed

50-263-95007-01	IFI	Exercise Weakness - Failure to notify NRC immediately after notifying state and local agencies
50-263/96011-01	NCV	Plant operator failure to follow procedure
50-263/96011-03	NCV	Ladder leading to contaminated area not posted

LIST OF ACRONYMS USED

CFR	Code of Federal Regulations
cpm	Counts per minute
CR	Condition Report
EOP	Emergency Operating Procedures
HPCI	High Pressure Coolant Injection
IFI	Inspection Followup Item
IR	Inspection Report
LCO	Limiting Condition for Operation
NCV	Non-Cited Violation
NRC	Nuclear Regulatory Commission
OC	Operations Committee
QC	Quality Control
RCIC	Reactor Core Isolation Cooling
RHR	Residual Heat Removal
RHRSW	Residual Heat Removal Service Water
RP&C	Radiological Protection and Chemistry Controls
SRV	Safety Relief Valve
TS	Technical Specification
TSC	Technical Support Center
UFSAR	Updated Final Safety Analysis Report
WO	Work Order