

U.S. NUCLEAR REGULATORY COMMISSION (NRC)

REGION II

Docket Nos: 50-321 and 50-366
License Nos: DPR-57 and NPF-5

Report No: 50-321/97-06, 50-366/97-06

Licensee: Southern Nuclear Operating Company, Inc. (SNC)

Facility: E. I. Hatch Units 1 and 2

Location: P. O. Box 439
Baxley, Georgia 31513

Dates: June 9 through June 13, 1997

Inspectors: C. Ogle, Senior Resident Inspector (Vogtle)
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Enclosure 2

EXECUTIVE SUMMARY

Plant Hatch, Units 1 and 2
NRC Inspection Report 50-321/97-06, 50-366/97-06

This routine announced inspection examined the licensee's corrective action program including problem resolution, operating experience feedback programs, self-assessment activities, and commitment identification and tracking. Conclusions included the following:

- All deficiency cards (DCs) reviewed by the inspectors for a two-week period were appropriately categorized for resolution (Section 07.1).
- Event Review Teams (ERTs) effectively determined the root causes of events. Team members were adequately trained in root cause analysis techniques and effectively implemented them. The corrective actions recommended by the ERT were appropriate for the identified root causes. Actions were generally completed in a timely manner to prevent recurrence (Section 07.2).
- The licensee's disposition of NRC Information Notices was generally in accordance with procedural requirements (Section 07.3).
- The licensee had an informal process to evaluate events that occur at other of the licensee's facilities. However, some events were not captured for review at Hatch (Section 07.3).
- The inspectors identified no discrepancies between the licensee's implementation of the corrective action program and the requirements of the Updated Final Safety Analysis Report (UFSAR) (Section 07.3).
- The failure to properly implement site management's disposition of a Service Information Letter (SIL) was identified as a weakness (Section 07.4).
- The failure to follow procedure for dispositioning minor findings found in NRC inspection reports was identified as a weakness (Section 07.5).
- Formal audits of NRC promulgated items, such as non-cited violations, weaknesses, and negative observations, did not reflect historical trends (Section 07.6).

- The Safety Audit and Engineering Review (SAER) audits reviewed by the inspectors were appropriate and met licensee program requirements. A negative observation regarding SAER auditor performance was made for two readily apparent shortcomings identified by the inspectors, but not by the auditor (Section 07.6).
- A violation was identified for inadequate corrective actions which failed to prevent recurrence of improperly stored material in the control room. This issue was the subject of a closed Audit Finding Report Item (Section 07.6).
- The inspectors identified two examples of shortcomings in the licensee's tracking of commitments made in response to NRC violations (Section 07.7).
- Three self-assessments reviewed by the inspectors were well done and reflected the willingness of the responsible departments to identify problems (Section 07.8).

Report Details

I. Operations

07 Quality Assurance in Operations

07.1 Resolution of Problems

a. Inspection Scope (40500)

The inspectors assessed the licensee's programs for identifying and correcting problems. Procedure 10AC-MGR-004-0S, "Deficiency Control System," Revision 10, described the guidelines for initial disposition of problems via review of Deficiency Cards (DCs) by the dispatcher. The inspectors reviewed all DCs submitted during a two-week period to evaluate the dispatchers' ability to identify and characterize problems.

b. Observations and Findings

All individuals performing the duties of the dispatcher had significant experience. Most of them currently or formerly held a Senior Reactor Operator license. DCs submitted during a two-week period and reviewed by the inspectors indicated that the dispatchers adequately assessed the potential significance of the deficiency. Significant DCs were forwarded to the Shift Supervisor for review and action such as entering a limiting condition for operation (LCO) or reporting an event. DCs which the dispatchers had evaluated as not significant were forwarded to a Performance Team and entered in the Action Item Tracking (AIT) system. The AIT effectively tracked the status of the deficiencies and their corrective actions. Most items were closed by immediate corrective actions or by transferring the item to be tracked as a Maintenance Work Order (MWO) or Design Change Request (DCR).

c. Conclusions

All DCs reviewed by the inspectors for a two-week period were appropriately categorized for resolution.

07.2 Corrective Action Programs

a. Inspection Scope (40500)

Procedure AG-MGR-27-0687N, "Root Cause Analysis," Revision 3, described the licensee's methods for determining the root causes of events. The inspectors selected the following nine recent events to analyze, in detail, the licensee's disposition of the event for significance and root cause analysis:

- Licensee Event Report (LER) 50-321/96-04: Inadequate Procedure Results in Reactor Pressure Increase and Auto Reactor Shutdown.

- Event Review Team Report 97-003: Unit 1 Emergency Core Cooling System (ECCS) Room Cooler Control Switches Found Mispositioned on 3/17/97.
- LER 50-321/96-015: Failed Control Relay Results in an Automatic Primary Containment Isolation System Actuation.
- Two main transformer fan grounds result in trip of feedwater (FW) heater drain pump and subsequent power reduction.
- Emergency diesel generator (EDG) tripped on reverse power during surveillance testing.
- Failure to verify Unit 1 plant service water pump discharge valve position as required by Technical Specifications (TS).
- Engineered Safety Features (ESF) actuation during surveillance testing.
- Reactor feed pump minimum flow valve failed open and caused a 1A reactor recirculation pump trip.
- Notice of Unusual Event (NOUE) declaration for nitrogen release on Unit 2.

The inspectors reviewed the corrective actions associated with events to determine their effectiveness in preventing recurrence. Completion of selected corrective actions was verified by the inspectors.

b. Observations and Findings

Plant events which were categorized as "High Level Risk," were evaluated by an Event Review Team (ERT). ERT members had appropriate training in root cause analysis techniques such as Management Oversight and Risk Tree (MORT) and Kepner Tregoe. Application of these techniques resulted in a thorough root cause analysis of the selected events. The ERT reports contained a broad range of contributing causes. For example, on March 23, 1997, the Unit 1 reactor automatically scrammed due to a pressure increase following shutdown of the main turbine. Control room operators deduced that the Turbine Bypass Valves (TBVs) had improperly operated, causing the pressure transient. Through comparison of strip charts for reactor pressure from this event with strip charts from previous main turbine shutdowns, the ERT concluded that the TBVs had operated properly and recommended procedure changes to preclude recurrence of the event.

The licensee documented events as required by 10 CFR 50.73, *Licensee Event Report (LER) system*. However, one minor technical inaccuracy was identified to the licensee for resolution. LER 50-321/96-03 reported that there had been no previous similar events in which failure of a CR 120 relay had caused an ESF actuation in the last two years when there

b. Observations and Findings

Disposition of the following INs was reviewed by the inspectors:

- IN 96-24 Preconditioning of Molded - Case Circuit Breakers Before Surveillance Testing
- IN 96-27 Potential Clogging of High Pressure Safety Injection Throttle Valves During Recirculation
- IN 96-67 Vulnerability of EDG to Fuel Oil/Lubricating Oil Incompatibility
- IN 96-68 Incorrect Effective Diaphragm Area Values in Vendor Manual Result in Potential Failure of Pneumatic Diaphragm Actuators
- IN 97-09 Inadequate Main Steam Safety Valve Setpoints and Performance Issues Associated with Long MSSV Inlet Piping
- IN 97-12 Potential Armature Binding in General Electric Type HGA Relays

The inspectors reviewed the licensee's disposition of the above items. The review included memorandum to file that documented reviews for those INs not applicable to Plant Hatch; the tracking of action items; IN typed response letters; and response completion time (normally within 60 days).

The requirements of Procedure 10AC-MGR-005-05 were met for the six INs reviewed. The inspectors observed, however, that the question "Why this is or is not a problem at Plant Hatch" was not clearly answered in the response letter for IN 96-24. Further review by the inspectors indicated that the licensee appropriately addressed the issues identified in the IN but licensee actions were not clearly documented in the IN response letter.

The inspectors also observed that two INs had response letters dated substantially greater than the normal 60 days specified in Procedure 10AC-MGR-005-05. One response was dated 4 months and the other was dated 6 months after receipt of the IN. The inspectors discussed this observation with the Nuclear Safety and Compliance supervisor responsible for the INs. The inspectors were informed that the 60 days specified in the procedure was used as a guideline. During refueling outages, personnel responsible for the IN response letters were assigned various tasks in assisting the refueling activities. This contributed to the delay in developing response letters. One individual was designated to review and prepare responses to the INs on a part-time basis during the refueling outage. However, the supervisor continued to receive the INs and screen them for urgency. Those INs deemed urgent were assigned to an

had been a similar event reported in LER 50-366/94-09. In this instance, the oversight did not impact problem resolution since the corrective actions for the CR 120 relays were ongoing.

The corrective actions were appropriate for the root causes identified by the licensee's analysis. Completion of corrective actions was tracked using the Commitment Identification and Tracking System. Items were generally well tracked. In one case, a commitment to analyze all Unit 2 CR 120 relays for replacement by February 28, 1997, was made in LER 50-321/96-15. The Commitment Identification and Tracking System indicated on March 25, that this had not been completed. The individual assigned to perform the evaluation had not properly completed it. However, another individual had completed the analysis in preparation for the Unit 2 outage. In effect, the commitment had been met, however, the commitment tracking system did not reflect that it had been completed.

Inspectors verified, through direct inspection, the completion of corrective actions such as procedure revisions, and posting of warning signs. Corrective actions were generally completed in a timely manner to prevent recurrence of events. However, age-related failures of the General Electric (GE) CR 120 relays and spurious actuations of Root Mean Square RMS-9 trip devices occurred over extended periods. Corrective actions, now in place, appear to be sufficient to prevent future problems.

c. Conclusions

Event Review Teams effectively determined the root causes of events. Team members were adequately trained in root cause analysis techniques and effectively implemented them. The corrective actions recommended by the ERT were appropriate for the identified root causes. Actions were generally completed in a timely manner to prevent recurrence.

07.3 Review of Operating Experience Feedback, Information Notices and Other Facility Licensee Events

a. Inspection Scope (40500)

The inspectors reviewed six NRC Information Notices (INs) and verified their disposition in accordance with Procedure 10AC-MGR-005-05, "Operating Experience Program and Corrective Action Program," Revision 10. Selected events at the licensee's other nuclear facilities (Farley and Vogtle) were reviewed in accordance with NRC Inspection Manual 40500, "Effectiveness of Licensee Controls in Identifying, Resolving, and Preventing Problems." Additionally, the inspectors reviewed the Updated Final Safety Analysis Reports (UFSARs) for Units 1 and 2 associated with the licensee's corrective action program.

individual for a timely review. INs that were not urgent are deferred until after the outage. The inspectors were informed that this was the case for these two INs.

NRC Inspection Procedure 40500 states that an effective corrective action program will ensure that corrective actions applicable at more than one of the licensee's facilities is considered at all of the licensee's facilities. (This is not a regulatory requirement.) Vogtle and Farley fall within the purview of this guideline. The inspectors provided the licensee, prior to the start of the corrective action inspection, three events that occurred at Vogtle. The following are the LER number and title associated with the Vogtle events:

- 50-424/96-10-00 Safety Injection Pump Rendered Inoperable Due to Lack of Motor Cooling
- 50-424/97-01-00 Thermal Overload Bypass Jumper Connection Renders ECCS Valve inoperable
- 50-424/97-03-00 Unlatched Doors on Motor Control Centers Changes Seismic Qualifications

The licensee was aware of these events and provided information that indicated that at Hatch, training had been conducted; procedural enhancements had been made; and a policy letter from management had been issued as a result of these events.

Seven events/issues that occurred at Farley were provided to the licensee subsequent to the start of the inspection. The licensee did not have any information associated with these events. The licensee informed the inspectors that there was no formal program to address events that occurred at Plants Vogtle and Farley. Through an informal process, the licensee stated that some of the events at Vogtle and Farley were captured and addressed, but not all events.

The inspectors requested the licensee provide documentation for other events/issues that occurred at Farley for which Plant Hatch had taken some action. The licensee provided the inspectors with information regarding four events. Three of them were addressed in a response to an IN and one was a response to a third party document promulgated to the industry. The inspectors reviewed the documentation associated with these events. The licensee's responses appropriately addressed the issues for Hatch.

The inspectors reviewed Appendix D, section D.5.5.11 of the Unit 1 UFSAR and section 17.2.16 of the Unit 2 UFSAR. These sections of the UFSAR addressed the licensee's corrective action program. The inspectors identified no discrepancies between the licensee's implementation of the corrective action program and the information contained in the applicable sections of the UFSARs.

c. Conclusions

The licensee's disposition of INs was generally in accordance with the procedural requirements of Procedure 10AC-MGR-005-05. The licensee had an informal process to evaluate events that occurred at other of the licensee's facilities. However, some events were not captured for review at Hatch. The inspectors identified no discrepancies between the licensee's implementation of the corrective action program and the requirements of the FSAR.

07.4 Operating Experience Feedback, Disposition of GE Service Information Letters (SILs)

a. Inspection Scope (40500)

General Electric (GE) Services Information Letters (SILs) are issued as a service to GE Boiling Water Reactors (BWR) owners. The inspectors reviewed the licensee's resolution and disposition of four SILs to determine if the corrective actions appeared to be proper and to determine if the disposition had been accomplished.

b. Observations and Findings

The purpose of the SILs is to promote plant performance improvements and alert owners to actual or potential occurrences which can degrade plant performance. The inspectors reviewed the following SILs:

- SIL No. 196, Supplement 17- This letter involved two potential problems with Target Rock Safety Relief Valves (SRV), one was main disc spring relaxation and another was tip breakage on the spring;
- SIL No. 590- This letter involved two potential problems, one with fasteners coming loose and potentially releasing the top cover on a NUMAC instrument and fabrication dimension problems with square receptors; and
- SIL No. 601- This letter involved the potential for loose connections at some of the Reactor Protection System (RPS) terminals if the wrong size wiring was used. The correct wiring was used at Hatch and this SIL was dispositioned with a memorandum to file.

The inspectors evaluated the licensee's initial screening (applicable/non-applicable); validated the non-applicable SILs; verified the response times, and evaluated corrective action items for the three previous SILs listed above. No problems were identified. A problem was identified for the following SIL:

- SIL No. 602- This letter involved Traversing Incore Probe (TIP) ball valve roll-pin cracking. Roll-pin cracking was noted in 50 percent of the valves at another site including some of the valves in stock. The cracking was longitudinal, i.e., parallel to the axis of the pin. The alloy 420 martensitic stainless steel pin was installed into the valve stem using an interference fit thereby creating residual stresses in the pin. These stresses were considered the likely cause for the intergranular stress corrosion cracking (IGSCC). Also, contributing was the fact that an improper heat treatment for the pin made the pin susceptible to the IGSCC. The inspectors independently verified that this was a feasible root cause by reviewing appropriate technical information (Metals Handbook, Volume 4, Heat Treating, Section on Heat Treating of Stainless Steel and Heat Resisting Alloys; and Volume 4, Corrosion, Section on Corrosion of Stainless Steels). No failure to function had been reported for these valves at the time of the SIL.

The licensee's decision was to replace all of the pins (only four containment isolation valves involved) with new pins supplied by the vendor. These replacement pins were in the properly heat treated condition, which would not make the pins susceptible to IGSCC. The SIL only recommended that the pins be inspected and if any were found to be cracked then to replace only those pins. During a review of the work done on maintenance work order (MWO) No. 29602291 01 during the most recent Unit 2 outage (mid March through April 1997), the inspectors and the licensee noted that the work performed on the four valves was a partial disassembly, visual inspection of the pins, and then reassembly. The pins were not replaced because they were not cracked. This failure to properly carry out the SIL disposition recommended by site management (replace all pins whether cracked or not) is identified as a weakness.

c. Conclusions

Most of the SILs were properly dispositioned, but one SIL (No. 602) had a disposition that was not properly implemented during a recent outage on Unit 2. This failure to properly carry out the site's management disposition for the SIL is identified as a weakness.

07.5 Operating Experience Feedback, Review of Disposition of Minor NRC Findings

a. Inspection Scope (40500)

The inspectors reviewed the licensee's disposition of five minor, unnumbered NRC findings noted in Inspection Reports. These findings were not violations, deviations, unresolved items, or inspector follow up items, i.e., did not have an NRC report number designation.

b. Observations and Findings

The inspectors reviewed the licensee's disposition of the following items from recent NRC Inspection Reports (IRs):

- Negative observation IR 97-01 (P1.1) - Emergency Preparedness (EP) drill performance where Health Physics (HP) and other support personnel were not notified to respond, the staff was short 3 HP personnel. This item was still being resolved through the use of the Deficiency Card (DC) system.
- Negative observation IR 96-11 (O2.1) - Special Report required by TS. Some required sections of the report were not clear. This item was dispositioned through a Significance Occurrence Report (SOR).
- Negative observation IR 96-11 (R4.1) - Poor sampling techniques demonstrated by chemistry technicians. This item was dispositioned through the use of a DC.
- Weaknesses IR 97-02 (M1.7) - Inspection personnel climbing on piping and poor MT inspection techniques. These items had not been addressed in any manner. The licensee stated that they did not agree with the inspection findings. The licensee agreed that these items should have been addressed in the manner discussed in the following paragraph.

The inspectors reviewed the procedure for handling unnumbered findings, such as weaknesses and negative observations, that appear in NRC reports. Procedure 10AC-MGR-005-GS, Step 8.7.1.12 stated, "For other NRC items NOT discussed in the preceding steps ... (items discussed previously were violations, deviations, unresolved items, and inspector followup items)... the following actions will be taken: Step 8.7.1.12.1 Nuclear Safety and Compliance (NSC) will forward applicable portions of the NRC inspection report to the responsible department... Step 8.7.1.12.2 The responsible department will take action as necessary to resolve the concern and submit a response to NSC..." When asked to provide the correspondence/documentation for accomplishing this part of the procedure, the licensee realized that they were not implementing this part of the procedural requirements.

c. Conclusions

Review of unnumbered inspection findings from several NRC inspection reports revealed that the licensee was not following their procedural requirements for addressing these inspection findings. Given that there is no regulatory basis for requiring licensee's to respond to unnumbered inspection report item, this will not be cited as a violation. However, it is identified as a weakness.

07.6 Self-Assessment Activities

a. Inspection Scope (40500)

The inspectors reviewed onsite audits performed by the Safety Assessment and Engineering Review (SAER) Group in the corrective action area. The following audits were reviewed:

- 97-CA-1 Corrective Action Program May 23, 1997
- 96-CA-2 Corrective Action Program October 18, 1996
- 96-CA-1 Corrective Action Program April 9, 1996
- 95-CA-3 Corrective Action Program December 27, 1995

Additionally, the inspectors interviewed SAER personnel concerning the conduct of audits.

b. Observations and Findings

The inspectors verified that these four audits met UFSAR requirements. Further, each audit contained the elements specified in the SAER Audit Planning Matrix, Schedule, and Status Report provided by the licensee.

The inspectors noted that in accomplishing Audit Item Number 1, NRC Inspection Reports, for Audits 97-CA-1, 96-CA-2, and 96-CA-1, the SAER auditor reviewed the licensee's disposition of five violations and 1 non-cited violation. However, during the 1996-1997 time frame which encompassed these audits, approximately twenty-eight violations and fourteen non-cited violations (NCVs) were identified. The inspectors expressed concern to the licensee regarding the small number of NCVs audited in these last three audits. The basis of this concern was that NCVs typically receive less formal NRC followup and closeout of the corrective actions than violations. Hence, more review of NCVs by the licensee may be warranted.

Additionally, the inspectors noted that in the last four SAER audits, no review had been performed of unnumbered NRC inspection report items such as weaknesses and negative observations. Procedure 10AC-MGR-005-05 contained actions to be taken for such items. This process had not been reviewed in the audits performed by SAER examined by the inspectors. While there is no regulatory requirement for a SAER review of this process, the inspectors did find problems in the area as outlined in

Section 07.5 of this report. Given the nature of these shortcomings, it was reasonable to assume that these errors would have been detected if audited. The failure of SAER to audit the actions required of Procedure 10AC-MGR-005-05 for unnumbered NRC inspection report requirements was identified as a negative observation.

The inspectors reviewed audits 97-CA-1 and 96-CA-2. This included a selected verification of licensee corrective actions identified as having been reviewed by the auditor. In general, the inspectors observed that the audits were logical, covered a wide range of issues, and for the most part appeared to be probing. Two Audit Finding Reports (AFRs) were identified which indicated that the auditor was willing to identify issues. However, several deficiencies were identified by the inspectors.

First, Audit 96-CA-2, Item 6, presented the auditor's review of Licensee Event Report (LER) 50-321/96-003, Component Failure Results in Unplanned Engineered Safety Feature System Actuation. The audit item stated that there were no previous similar events reported in the last two years in which an unplanned Engineered Safety Feature system actuation occurred due to a failed relay coil; that this event was considered an isolated failure. However, a similar occurrence within the previous two years was documented in LER 50-366/94-09. Furthermore, similar relay failures were the subject of licensee event reports for several years. This was considered a lack of attention to detail on the part of the auditor.

The second deficiency involved Item Number 1 in the same audit. This item presented the auditor's review of the licensee's response to Violation 50-321/96-06-04. During their independent review of this item, the inspectors determined that the procedure revision identified in the licensee's response to the violation had not been entered into the licensee's Commitments Identification and Tracking System. However, under Audit Technique for this item, the auditor included "Verify that commitments are in the Commitment Identification and Tracking System." When questioned on this point, both the auditor and his manager acknowledged that this had indeed not been verified by the auditor. Further, they also indicated that the results section for the same item did not state that this attribute had been verified by the auditor. The inspectors noted that presenting audit techniques which have not been performed in the final audit plan and checklist was not clear and could confuse the reader.

Additional followup in the area of commitment tracking was performed by the inspectors and is documented in Section 07.7.

Finally, a control room walkdown of AFR 96-SA-8/28, "Unsecured items were found in areas where safety related equipment is located. These items may present a safety or reliability hazard during a seismic event," was performed. This AFR documented unsecured equipment stored in plant areas adjacent to safety related, seismic Category I equipment. Six control room areas identified in the AFR as having unsecured stored equipment

were examined by the inspectors. The inspectors noted that many of the same item documented in the AFR were still stored immediately adjacent to control room cabinets.

The licensee informed the inspectors that many of the items had been previously analyzed in their observed storage locations. Information to support this position was provided by the licensee. However, the licensee informed the inspectors that approximately seven items identified required remedial actions to prevent potential seismic interactions with safety related equipment.

The inspectors noted from their review that this AFR, including the planned corrective actions, had been closed by the plant and SAER in October and November, 1996, respectively. However, these corrective actions failed to preclude repetition of this condition. During a review of this issue with the licensee, the SAER manager noted that this AFR had been closed by SAER approximately seven months before the inspector's observation and that a control room walkdown had not been performed as part of SAER's closeout of this issue.

Several SAER personnel were interviewed regarding audits and their performance. They all described a willingness to identify issues free from undue pressure.

c. Conclusions

The SAER audits reviewed by the inspectors were appropriate and met licensee program requirements. A negative observation regarding SAER auditor performance was made for two readily identified shortcomings identified by the inspectors, but not by the auditor. Additionally, the inspectors concluded that formal audits of NRC promulgated items, such as non-cited violations, weaknesses, and negative observations, did not reflect historical trends.

The failure to prevent recurrence of improperly stored material which had the potential to impact the seismic performance of equipment in the control room was contrary to the requirements of 10 CFR 50, Appendix B, Criterion XVI, Corrective Actions. This was identified as Violation 50-321, 366/97-06-01, Failure To Prevent Recurrence Of Improper Equipment Storage In Control Room.

07.7 Commitment Identification and Tracking System

a. Scope (40500)

The inspectors verified that licensee commitment control met the requirements of Procedure 00AC-REG-002-0S, "Commitment Identification and Tracking System." Revision 2. The inspectors reviewed the licensee's handling of commitments made in licensee responses to violations 50-321/96-06-04; 50-321, 366/96-04-02 (Example 2); 50-321, 366/97-01-01 (Example 1); and AFR 96-SA-8/28.

b. Observation and Findings

In each case, the inspectors observed that the appropriate licensee procedure had been changed to reflect the commitments made in response to the items listed above. However, the inspectors noted that for violations 50-321/96-06-04 and 50-321, 366/97-01-01 (Example 1), the appropriate commitments had not been entered into the licensee's Commitment Identification and Tracking System.

Procedure 00AC-REG-002-0S requires that long-term commitments be entered into the Commitment Identification and Tracking System. The same procedure identifies a procedure change made in response to a violation as a long-term commitment. When questioned on these apparent discrepancies, the licensee indicated that the failure to enter the procedure change made in response to violation 50-321, 366/97-01-01 (Example 1) into the Commitment Identification and Tracking system was an oversight. However, the licensee indicated that the procedure change made in response to violation 50-321/96-06-04 was intentionally not entered into the system. As described by the licensee, this decision was based on the licensee's belief that this procedure change represented an enhancement to the procedure and duplicated an existing procedural requirement which was captured by the system.

Subsequent to inspector questions, these items were entered into the Commitment Identification and Tracking System. The licensee indicated that they were also considering a review of other violation responses to ensure commitments were appropriately documented.

c. Conclusions

The inspectors identified two examples of shortcomings in the licensee's tracking of commitments made in response to NRC violations. These shortcomings did not impact implementation of the appropriate commitments.

At the exit, the inspectors acknowledged that there is no regulatory basis for a commitment tracking system. However, the licensee's procedure, as reviewed by the inspectors, did not provide the flexibility to not enter procedure changes made in response to violations into their commitment identification and tracking system.

07.8 Departmental Self-Assessments

a. Inspection Scope (40500)

The inspectors reviewed the following licensee self-assessments.

- Contamination Control and Personal Contamination Reports (PCR) Self-Assessment (dated July 16, 1996)
- Radioactive Material Control Assessment (dated November 15, 1996)
- Self-Assessment of E.I. Hatch Operations Department (September 1996)

b. Observations and Findings

Each of the self-assessments contained a broad range of observations, included strengths and weakness, and identified potential corrective actions. The inspectors noted many of the weaknesses identified reflected a critical review of licensee performance.

c. Conclusions

The three self-assessments listed above were well done and reflected the willingness of these departments to identify problems.

V. Management Meetings Other Areas

X.2 Review of UFSAR Commitments

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

X.4 Exit Meeting Summary

The inspectors presented the inspection results to members of the licensee management at the conclusion of the inspection on June 13, 1997. The licensee acknowledged the findings presented. Some of the departmental self-assessments discussed in Section 07.8 were proprietary and returned to the licensee at the end of the inspection. When questioned, no other material was identified by the licensee as proprietary.

PARTIAL LIST OF PERSONS CONTACTED

Licensee

Anderson, J.D., Unit Superintendent
 Davis, D., Plant Administration Manager
 Fraser, O.M., Safety Audit and Engineering Review Supervisor
 Metzler, E.T., Nuclear Safety and Compliance Supervisor
 Moore, C.T., Assistant General Manager - Plant Support
 Roberts, P.A., Outages and Planning Manager
 Tipps, S.B., Nuclear Safety and Compliance Manager

INSPECTION PROCEDURES USED

IP 40500: Effectiveness of Licensee Controls in Identifying, Resolving, and Preventing Problems

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

50-321, 361/97-06-01	VIO	Failure to prevent recurrence of improper equipment storage in control room
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