

ENCLOSURE

U.S. NUCLEAR REGULATORY COMMISSION
REGION IV

Docket No.: 50-482
License No.: NPF-42
Report No.: 50-482/98-15
Licensee: Wolf Creek Nuclear Operating Corporation
Facility: Wolf Creek Generating Station
Location: 1550 Oxen Lane, NE
Burlington, Kansas
Dates: July 12 through August 22, 1998
Inspectors: B. A. Smalldridge, Acting Senior Resident Inspector
J. F. Ringwald, Senior Resident Inspector
R. V. Azua, Project Engineer, Project Branch B
F. L. Brush, Resident Inspector, Callaway
Approved By: W. D. Johnson, Chief, Project Branch B

ATTACHMENT: Supplemental Information

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EXECUTIVE SUMMARY

Wolf Creek Generating Station NRC Inspection Report 50-482/98-15

Operations

- Excellent attention to detail and questioning attitudes on the part of the control room operators resulted in the detection of a small reactor coolant letdown system leak inside containment before the leak was detectable on the control board indicators. This enabled plant operators to locate and isolate the leak before the leak rate increased, prevented the radiation levels inside containment from increasing, and limited the spread of contamination to the local area (Section O4.1).
- The licensee failed to comply with Technical Specification 3.6.1.3 when the containment outer personnel airlock door was found open with the plant in Mode 4. This nonrepetitive, licensee identified and corrected violation is being treated as a noncited violation, consistent with Section VII of the NRC Enforcement Policy (O8.5).
- The licensee failed to compare excore power indication to a calorimetric when reactor power was greater than 15 percent during a plant startup as required by Technical Specification Table 4.3-1. This nonrepetitive, licensee identified and corrected violation is being treated as a noncited violation, consistent with Section VII of the NRC Enforcement Policy (O8.8).

Maintenance

- During emergent work on a weekend to repair a leak in the letdown system inside containment, welding technicians stopped work and asked for help in the face of delaying time-sensitive work to resolve a minimum pipe wall thickness issue at one of the weld locations. This was a good example of plant personnel placing safety, procedural, and program adherence before other concerns and licensee management's support of this philosophy when working on plant equipment (Section M4.1).
- The licensee failed to comply with Technical Specification Surveillance Requirement 4.3.2.1 in that three surveillance procedures, related to several slave relays and the disabling of the manual block of safety injection, did not adequately test all of the required circuitry. This nonrepetitive, licensee identified and corrected violation is being treated as a noncited violation, consistent with Section VII of the NRC Enforcement Policy (Section O8.1).
- The licensee determined that a 10-year interval inspection requirement for a VT-3 visual examination of the pressurizer safety valves had not been conducted during the first 10-year interval as required by Technical Specification 4.4.2.2. This nonrepetitive, licensee identified and corrected violation is being treated as a noncited violation, consistent with Section VII of the NRC Enforcement Policy (O8.3).
- The licensee failed to comply with Technical Specification surveillance requirements in that the feedwater isolation surveillance procedures did not completely test all of the

required circuitry. This nonrepetitive, licensee identified and corrected violation is being treated as a noncited violation, consistent with Section VII of the NRC Enforcement Policy (O8.4).

Engineering

- Support engineering personnel failed to use due caution while performing work in the vicinity of safety-related equipment, resulting in the inadvertent misalignment and draining of an oil reservoir level indicator on a motor-driven auxiliary feedwater pump. This indicated a lack of sensitivity for the potential to impact safety system configuration while performing work in the plant and did not meet licensee management expectations (Section E4.1).

Plant Support

- The licensee's contamination control program lacked specific procedural guidance related to the inspection process for drip bags, which may have contributed to a one-time loss of contamination control within the radiologically controlled area (Section R3.1).
- Observations and discussions with plant personnel indicated a potential deficiency in the knowledge of some radiation workers regarding the radiation worker guidance requirement to contact health physics before performing work in the overhead of the radiologically controlled area (Section R4.1).

Report Details

Summary of Plant Status

The plant operated at essentially 100 percent power throughout the inspection period.

I. Operations

O4 Operator Knowledge and Performance

O4.1 Identification of Leak in Letdown System Piping

a. Inspection Scope (71707)

The inspector monitored and reviewed the events associated with the detection and identification of a small leak from the letdown system inside containment.

b. Observations and Findings

On August 1, 1998, reactor operators noticed that Plant Computer Data Point LF40769, which provides indication of the leak rate into containment sumps, had increased slightly. The computer data point which normally indicated a leak rate of less than 0.05 gpm had increased to 0.09 gpm. The operators began looking for other indications of a leak inside containment and at the same time commenced Procedure STS BB-004, "Reactor Cooling Water System Inventory Balance," Revision 20.

The operators noted that, while no single plant parameter indicated the presence of a leak from the reactor cooling system, there were slight changes in several parameters that, when taken as a whole, led operators to believe that there might be a leak inside containment. The results of Procedure STS BB-004 indicated that the unidentified reactor cooling system water leakage had increased to a rate of 0.14 gpm from a normal rate of 0.05 gpm. As a result, a containment entry was made and leakage from the welds on a coupling in a 2-inch pipe in the letdown system was identified. The leak was then isolated and repairs were completed over the next several days.

The inspector noted that excellent attention to detail and questioning attitudes enabled control room operators to detect and identify a small leak in containment from the letdown system before the leak was detectable on control board indications, annunciators, or on radiation monitors. The inspector also noted good management response to operator concerns. This prevented elevated airborne activity in containment, limited the spread of contamination to the local area, and allowed for the isolation and repair of the leak before it challenged safety systems or barriers.

c. Conclusions

Excellent attention to detail and questioning attitudes on the part of the control room operators resulted in the detection of a small reactor coolant letdown system leak inside containment before the leak was detectable on the control board indicators. This

enabled plant operators to locate and isolate the leak before the leak rate increased, prevented the radiation levels inside containment from increasing, and limited the spread of contamination to the local area.

O8 Miscellaneous Operations Issues (92901)

- O8.1 (Closed) Licensee Event Reports (LERs) 50-482/9710-00, 01, 02, 03: Failure to comply with Technical Specification Surveillance Requirement 4.3.2.1. This item was identified when the licensee reviewed the Wolf Creek Generating Station engineered safety features actuation test procedures and a number of other surveillance procedures following notification of a similar issue at another facility. The root cause of this event was inadequate or incomplete procedures due to misinterpretation, lack of understanding, and lack of clarification of Technical Specification requirements during the writing and/or revision process of the affected procedures. As part of the licensee's corrective actions, all affected procedures were revised. In addition, the licensee reviewed a number of other Technical Specification related surveillance procedures. Due to the fact that these errors were made approximately 13 years before, and the subsequent changes that the procedure writing process has undergone over that time period, no further actions were taken by the licensee. The described corrective actions were found to be appropriate for addressing this issue. The failure by the licensee to ensure that surveillance procedure guidance was consistent with Technical Specification requirements is a violation of NRC requirements. This nonrepetitive, licensee-identified and corrected violation is being treated as a noncited violation, consistent with Section VII of the NRC Enforcement Policy (50-482/9815-01).
- O8.2 (Closed) LER 50-482/9712-00: Failure by licensed operators to have prescribed corrective lenses, which fit inside self-contained breathing apparatus, for use while performing licensed duties. This item will be addressed during the review of Violation 50-482/9710-01.
- O8.3 (Closed) LER 50-482/9715-00, 01: Failure to comply with Technical Specification Surveillance Requirement 4.4.2.2. This item was identified by the licensee during a review of the inservice inspection requirements for the pressurizer safety valves, where it was determined that a 10-year inspection requirement for a VT-3 visual examination of the internal surface of the valves had not been performed during the first 10-year interval. The root cause of this event was determined to be an inadequate program-to-program interface between the inservice inspection program and maintenance work planning with respect to work activities which fall outside the scope of the Wolf Creek's ASME Section XI repair/replacement program. Corrective actions taken included performing a review to identify any other deficiencies with respect to the first 10-year inservice inspection requirement and revising Procedures STS MT-005, "Pressurizer Code Safety Valve Operability," and AP 16C-003, "Work Package Task Planning." The described corrective actions were found to be appropriate for addressing this issue. The failure by the licensee to ensure that surveillance procedure guidance was consistent with Technical Specification requirements is a violation of NRC

requirements. This nonrepetitive, licensee-identified and corrected violation is being treated as a noncited violation, consistent with Section VII of the NRC Enforcement Policy (50-482/9815-02).

- O8.4 (Closed) LER 50-482/9721-00: Failure to comply with Technical Specification Surveillance Requirement 4.3.2.1. This item was identified when the licensee reviewed surveillance procedures for testing feedwater isolation on steam generator Hi-Hi level and safety injection feedwater isolation, following notification of a similar issue at another facility. The root cause of this event was determined to be inadequate original testing design supplied by the vendor that did not fully verify operation of the circuits involving universal logic boards in a memory configuration. Corrective actions taken included a review of the solid state protection system for similar memory configurations of this unique logic circuit design and revision of the procedures related to testing the solid state protection system logic. The described corrective actions were found to be appropriate for addressing this issue. The failure by the licensee to ensure that surveillance procedure guidance was consistent with Technical Specification requirements is a violation of NRC requirements. This nonrepetitive, licensee-identified and corrected violation is being treated as a noncited violation, consistent with Section VII of the NRC Enforcement Policy (50-482/9815-03).
- O8.5 (Closed) LER 50-482/9723-00: Failure to comply with Technical Specification Action Statement 3.6.1.3. With the plant in Mode 4, the containment outer personnel airlock door was found to be open. The root cause of this event was inadequate communications due to insufficient detail in procedures. Corrective actions included closing the outer airlock door and revising Procedures GEN 00-002, "Cold Shutdown to Hot Standby," GEN 00-006, "Hot Standby to Cold Shutdown," and FHP 02-001, "Refueling Operation." In addition, the licensee revised Training Lesson Plan TIN OP 12 032 00, "Containment Operations," to address this event. The described corrective actions were found to be appropriate for addressing this issue. The failure by the licensee to comply with Technical Specification requirements is a violation of NRC requirements. This nonrepetitive, licensee-identified and corrected violation is being treated as a noncited violation, consistent with Section VII of the NRC Enforcement Policy (50-482/9815-04).
- O8.6 (Closed) LER 50-482/9725-00: Failure to comply with Updated Safety Analysis Report (USAR) Section 16.8.1.1.1 testing requirements. The licensee identified that one of the two Type QO low voltage circuit breakers may not have previously been tested in the appropriate frequency as required by USAR Section 16.8.1.1.1 (formerly Technical Specification 4.8.4.1). The root cause of this historical issue was the failure of personnel to ensure that Technical Specification requirements were incorporated during the initial development of the listing of breakers in the surveillance test procedures. Corrective actions included verifying that appropriate breaker testing was current, and Procedure STS MT-024, "Penetration Breaker Surveillance," was revised to correct the testing frequency discrepancy. The described corrective actions were found to be appropriate for addressing this issue.
- O8.7 (Closed) Inspection Followup Item 50-482/9704-08: Review of the licensee's evaluation of training techniques for the control room simulator. The licensee implemented

operator scenario training using a technique called "poison pill." This involved giving false information to the control room operators in order to provide more realistic scenarios which would enable them to develop methods when dealing with problems in high stress situations. The inspectors reviewed the licensee's evaluation and had no concerns.

- O8.8 (Closed) LER 50-482/9711-00: Failure to compare the excore power indication to a calorimetric when the reactor power level was greater than 15 percent as required by Technical Specification Table 4.3-1. The licensee revised Surveillance Procedures STS SE-001, "Power Range Adjustment to Calorimetric," and STS SE-002, "Manual Calculation of Reactor Thermal Power," in July 1996 in response to a bulletin from the reactor vendor. However, licensee personnel did not identify a conflict between the bulletin and the plant Technical Specifications.

On May 25, 1997, during startup from a forced outage, the licensee failed to perform the comparisons as required by Technical Specifications. On June 4, 1997, during a review of the outage activities, the licensee identified that compliance with Technical Specification Table 4.3-1 was not met. The licensee identified the conflict between the vendor bulletin and the Technical Specifications and revised the appropriate procedures.

The failure of the licensee to perform the comparisons was a violation of Technical Specifications. This nonrepetitive, licensee-identified and corrected violation is being treated as a noncited violation, consistent with Section VII of the NRC Enforcement Policy (50-482/9815-05).

II. Maintenance

M1 Conduct of Maintenance

M1.1 General Comments on Maintenance Activities

a. Inspection Scope (62707)

The inspectors observed all or portions of the following work activities.

WO 98-201153-000	Replace charcoal in auxiliary/fuel building normal exhaust filter/adsorber unit
WO 98-202564-000	Troubleshoot Emergency Diesel Generator A mechanical governor
WO 98-202603-000	Replace coupling, pipe, and downstream elbow on Line BG-007-ECB-2
WO 98-115686-002	Remove, rebuild, and reinstall Safety Injection Pump A; Monitor pump alignment

WO 98-201147-000

Clean boron crystals from inboard and outboard seals on Safety Injection Pump A

b. Observation and Findings

The inspectors found no concerns with the maintenance observed.

c. Conclusions

The inspectors concluded that the maintenance activities were being performed as required.

M1.2 General Comments on Surveillance Activities

a. Inspection Scope (61726)

The inspectors observed all or portions of the following surveillance activities:

STS BG-100B, Revision 22, Centrifugal Charging System Train B Inservice Pump Test;

STS IC-202, Revision 17, Analog Channel Operational Test 7300 Process Instrumentation Protection Set II (white);

STS IC-204, Revision 16, Analog Channel Operational Test 7300 Process Instrumentation Protection Set IV (yellow);

STS IC-641A, Revision 7, Slave Relay Test K641 Train A Turbine-Driven Auxiliary Feedwater Pump Start;

STS CH-008A, Revision 16, Emergency Diesel Storage Tank Sampling;

STS KJ-15A, Revision 6, Emergency Diesel Generator A 1-Hour Run; and

STS BG-005A, Revision 14, Boric Acid Transfer System Inservice Pump A Test.

b. Observations and Findings

The inspectors found no concerns with the surveillances observed.

c. Conclusions

The inspectors concluded that the surveillance activities were being performed as required.

M4 Maintenance Staff Knowledge and Performance

M4.1 Repair Activities Associated With Leak in Letdown System Piping

a. Inspection Scope (62707)

The inspector monitored and reviewed the events associated with the planning and execution of repair activities associated with letdown system piping replacement inside containment.

b. Observations and Findings

On Saturday, August 2, 1998, at 2:45 a.m., station operators located a leak inside containment from the welds on a coupling in a 2-inch pipe in the letdown system. After the leak was identified and management notifications were made, the maintenance and system engineering organizations responded quickly to plan and complete the repairs.

By 8 a.m. the next morning, the system was isolated and multiple containment entries were accomplished to remove insulation, decontaminate the area, obtain measurements, and otherwise prepare for the cutout and replacement of the defective section of pipe. In parallel, engineers and maintenance planners completed the work packages necessary to begin the repair work. Throughout the execution of the work, the inspector noted that effective communication between the maintenance, health physics, operations, and engineering departments provided the work planners and management team with accurate knowledge of the status of work and plant conditions. The inspector also noted that workers accomplished the repairs in a high heat, high humidity, contaminated environment without any personnel contaminations.

The inspector noted that, at one point during the work, welders identified an intrusion in the base metal of the pipe at a location where they had ground out a weld at a 90 degree elbow in order to replace the piping. The welders stopped work and asked that the pipe wall thickness be evaluated for use in the weld joint. Engineers determined that the minimum wall thickness was inadequate for use and a previously developed contingency plan was used to complete the repair. The willingness of the welders to stop work and ask for help in the face of delaying time-sensitive work was a good example of plant personnel placing safety and procedural and program adherence before other concerns and licensee management's support of this philosophy when working on plant equipment.

c. Conclusions

During emergent work on a weekend to repair a leak in the letdown system inside containment, welding technicians stopped work and asked for help in the face of delaying time-sensitive work to resolve a minimum pipe wall thickness issue at one of the weld locations. This was a good example of plant personnel placing safety, procedural, and program adherence before other concerns and licensee management's support of this philosophy when working on plant equipment.

M8 Miscellaneous Maintenance Issues (92902)

- M8.1 (Closed) LER 50-482/9718-00: Multiple failures of residual heat removal Pump B to start. NRC Inspection Report 50-482/97-22, paragraph E2.1, documented the licensee's investigation of the failures. The licensee determined that a switch in the pump's supply breaker, a General Electric Magna-Blast breaker, failed intermittently. The licensee also determined that weaknesses existed in the troubleshooting practices for the breakers. The licensee replaced the defective switch and the breaker operated properly. The licensee also revised the Magna-Blast circuit breaker troubleshooting procedure. The inspector reviewed the licensee's corrective actions and considered this item closed.

III. Engineering

E4 Engineering Staff Knowledge and Performance

E4.1 Misaligned Oil Reservoir on Motor-Driven Auxiliary Feedwater Pump B

a. Inspection Scope (37551)

The inspector reviewed the events associated with the misalignment of an oil reservoir on Motor-Driven Auxiliary Feedwater Pump B during support engineering testing of the room cooler.

b. Observations and Findings

On the afternoon of August 6, 1998, a nuclear station operator found the glass oil reservoir level indicator for the outboard bearing on Motor-Driven Auxiliary Feedwater Pump B empty. The oil reservoir level indicator and associated piping were rotated approximately 25 degrees from vertical. It was determined that the oil in the reservoir level indicator had run into the bearing housing when the level indicator was rotated out of the upright position sometime after the operator morning rounds. This did not affect the operability of the pump. The oil reservoir level indicator was returned to the upright position and the oil levels in both the bearing housing and the indicator were restored to normal.

The licensee determined that the oil reservoir level indicator most likely became misaligned when inadvertently bumped by support engineering personnel who conducted Procedure STN PE-037, "Essential Service Water Heat Exchanger Flow and Differential Pressure Trending," Revision 12, on the room cooler during the day. This was documented in Performance Improvement Request 98-2257. The inspector observed that Throttle Valve GFV-0008, which was repositioned several times during the test, was located overhead and directly adjacent to the oil reservoir level indicator that was misaligned. The individual operating the valve would have to climb on a pipe stanchion just below the valve and utilize the pump foundation near the level indicator for stability.

Licensee management expects personnel to have a heightened sensitivity and awareness of the potential to impact system configuration when performing work that requires close proximity to plant equipment. The inspector noted that support engineering personnel failed to use due caution while performing work in the vicinity of a motor-driven auxiliary feedwater pump and did not recognize that an oil reservoir level indicator had been bumped or that the oil level was no longer visible in the glass reservoir. The lack of sensitivity shown by support engineers for the potential to impact the configuration of a safety system while performing work did not meet with licensee management expectations. The licensee initiated actions to communicate the expectation to use caution while working around plant equipment to all station personnel.

c. Conclusions

Support engineering personnel failed to use due caution while performing work in the vicinity of safety-related equipment, resulting in the inadvertent misalignment and draining of an oil reservoir level indicator on a motor-driven auxiliary feedwater pump. This indicated a lack of sensitivity for the potential to impact safety-system configuration while performing work in the plant and did not meet with licensee management expectations.

E8 Miscellaneous Engineering Issues (92903)

- E8.1 (Closed) Inspection Followup Item 50-482/9711-02: Intrusion of lake water into the condensate storage tank and Steam Generators A and C. The licensee determined that lake water entered the condensate storage tank and steam generators from the auxiliary feedwater system. A manual isolation valve, which was normally open but closed for a surveillance test, leaked by allowing lake water into the turbine-driven auxiliary feedwater pump and associated discharge piping. When the pump was run at a later date, the lake water entered the condensate storage tank and Steam Generators A and C. The inspectors reviewed the licensee's corrective actions and have no further concerns.

IV. Plant Support

R3 Radiological Protection and Chemistry Procedures and Documentation

R3.2 Contamination Control - Drip Bag Inspections

a. Inspection Scope (71750)

The inspector reviewed the licensee's program for inspection of drip bags used to control contamination in the radiologically controlled area.

b. Observations and Findings

On August 15, 1998, packing leakage from a valve in the safety-injection system leaked onto the floor as a result of an existing puncture in the drip bag. The spill area was cleaned and decontaminated and a new drip bag was installed. As a result of the spill, the inspector asked the licensee: (1) if drip bags were routinely inspected after installation, (2) what written procedural guidance was used to provide inspection criteria, and (3) what specific drip bag inspection training had personnel who inspect drip bags received?

The inspector was told that drip bags are monitored on a monthly basis to see if they are still required, because a performance indicator tracks the number of drip bags installed. Health physics technicians are also expected to include drip bags during routine surveys. However, the inspector was informed that drip bags were not inspected against specific criteria to ensure adequacy of installation or integrity and that no specific written procedures or training were provided to conduct drip bag inspections.

Technical Specification 6.8.1.a requires the establishment, implementation, and maintenance of procedures listed in Regulatory Guide 1.33, Revision 2 (February 1978), Appendix A. Appendix A, Section 7.e.(4), lists procedures for activities associated with control of contamination. After a review of applicable procedures, the inspector concluded that the licensee met the requirements of Technical Specification 6.8.1.a, with respect to contamination control because procedures were established and implemented. However, the inspector identified an area in the licensee's program that did not have procedural guidance. No proceduralized acceptance criteria or guidance was provided for the performance of drip bag inspections. Drip bags were installed to limit or prevent the spread of contamination in the radiologically controlled area. Had the drip bag with the puncture been inspected to specific criteria and the puncture discovered, the spill, which resulted in surface contamination levels of 5000 dpm/100 cm² on the floor, may have been avoided. The licensee acknowledged the inspector's conclusion, identified this issue in Performance Improvement Request 98-2365, and initiated action to evaluate this aspect of the contamination control program.

c. Conclusions

The licensee's contamination control program lacked specific procedural guidance related to the inspection process for drip bags, which may have contributed to a one-time loss of contamination control within the radiologically controlled area.

R4 Staff Knowledge and Performance

R4.1 Potential Knowledge Deficiency Regarding Radiation Worker Guidelines Criteria For Working Greater Than 8 Feet Above The Floor

a. Inspection Scope (71750)

The inspector questioned the posting of a high radiation area located at an elevated location in the radiologically controlled area and reviewed the licensee's response.

b. Observations and Findings

As a result of questions regarding the posting of a high radiation area located on the 2041 foot elevation of the radiological waste building on August 11, 1998, the inspector determined that radiation workers are required to contact health physics before working in the overhead (8 feet above the floor and higher). The requirement, located in paragraph 5.3.4 of Procedure AP 25B-100, "Radiation Worker Guidelines," Revision 7, applied to climbing on ladders, plant equipment, foundations, and hangers anywhere in the radiologically controlled area. The inspector observed that, on occasion, plant personnel climbed on plant equipment in the radiologically controlled area without first contacting health physics. Based on these observations, the inspector questioned a number of radiation workers from the health physics, operations, maintenance, and engineering departments regarding their knowledge of and how they complied with the policy of contacting health physics before working in the overhead.

Most of the radiation workers questioned by the inspector knew there were restrictions associated with working in the overhead in the radiologically controlled area. However, some were not sure about the specific height. There were other inconsistencies in the responses regarding how and when the radiation workers complied with the overhead work requirement. One worker stated that the requirements for working in the overhead in the radiologically controlled area were covered in the last radiation worker training session.

Based on the inspector's observations and the discussions with plant personnel, the inspector noted that there was indication of a potential deficiency in the knowledge of some radiation workers regarding the requirement in paragraph 5.3.4 of Procedure AP 25B-100 to contact health physics before working in the overhead. The intent of this paragraph, which was to prevent contact with contamination or inadvertent exposure to unmonitored radiation levels above 8 feet in the radiologically controlled area, was not clearly communicated in the radiation worker guidelines. Health physics technicians did not routinely survey for radiation or contamination above 8 feet from the floor.

c. Conclusions

Observations and discussions with plant personnel indicated a potential deficiency in the knowledge of some radiation workers regarding the radiation worker guidance requirement to contact health physics before performing work in the overhead of the radiologically controlled area.

V. Management Meetings

X1 Exit Meeting Summary

The inspector presented the inspection results to members of licensee management at the conclusion of the inspection on August 21, 1998. The licensee acknowledged the findings presented.

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

SUPPLEMENTAL INFORMATION

PARTIAL LIST OF PERSONS CONTACTED

Licensee

M. J. Angus, Manager, Licensing and Corrective Action
G. D. Boyer, Chief Administrative Officer
J. W. Johnson, Manager, Resource Protection
S. R. Koenig, Acting Manager, Performance Improvement and Assessment
O. L. Maynard, President and Chief Executive Officer
B. T. McKinney, Plant Manager
R. Muench, Vice President Engineering
C. C. Warren, Chief Operating Officer

INSPECTION PROCEDURES USED

IP 37551	Onsite Engineering
IP 61726	Surveillance Observations
IP 62707	Maintenance Observations
IP 71707	Plant Operations
IP 71750	Plant Support Activities
IP 92901	Followup - Operations
IP 92902	Followup - Maintenance
IP 92903	Followup - Engineering

ITEMS OPENED AND CLOSED

Opened

50-482/9815-01	NCV	Failure to comply with Technical Specifications due to inadequate or incomplete procedures (Section O8.1)
50-482/9815-02	NCV	Failure to comply with Technical Specifications for pressurizer safety valve visual inspections frequency (Section O8.3)
50-482/9815-03	NCV	Failure to comply with Technical Specifications for feedwater isolation valve circuitry testing (Section O8.4)
50-482/9815-04	NCV	Failure to comply with Technical Specifications for control of containment outer personnel door (Section O8.5)
50-482/9815-05	NCV	Failure to compare excore power indication to calorimetric data (Section O8.8)

Closed

50-482/9710-00, 01, 02, 03	LER	Failure to comply with Technical Specification surveillance requirements (Section O8.1)
50-482/9711-00	LER	Failure to compare excore power indication to calorimetric data (Section O8.8)
50-482/9712-00	LER	Lack of corrective lenses for self-contained breathing apparatus (Section O8.2)
50-482/9715-00, 01	LER	Failure to comply with Technical Specification surveillance requirements for pressurizer safety valve (Section O8.3)
50-482/9718-00	LER	General Electric Magna-Blast breaker failures (Section M8.1)
50-482/9721-00	LER	Failure to comply with Technical Specification surveillance requirements for feedwater isolation testing (Section O8.4)
50-482/9723-00	LER	Containment outer personnel airlock door open instead of locked closed as required (Section O8.5)
50-482/9725-00	LER	Failure to comply with USAR Section 16 testing requirements for circuit breakers (Section O8.6)
50-482/9704-08	IFI	Use of "poison pill" operator simulator training (Section O8.7)
50-482/9711-02	IFI	Lake water intrusion into condensate storage tank (Section E8.1)
50-482/9815-01	NCV	Failure to comply with Technical Specifications due to inadequate or incomplete procedures (Section O8.1)
50-482/9815-02	NCV	Failure to comply with Technical Specifications for pressurizer safety valve visual inspections frequency (Section O8.3)
50-482/9815-03	NCV	Failure to comply with Technical Specifications for feedwater isolation valve circuitry testing (Section O8.4)
50-482/9815-04	NCV	Failure to comply with Technical Specifications for control of containment outer personnel door (Section O8.5)
50-482/9815-05	NCV	Failure to compare excore power indication to calorimetric data (Section O8.8)