APPENDIX B

U.S. NUCLEAR REGULATORY COMMISSION
REGION IV

NRC Inspection Report: 50-267/88-13 Operating License: DPR-34

Docket: 50-267

Licensee: Public Service Company of Colorado (PSC)
2420 West 26th Avenue, Suite 15c
Denver, Colorado 80211

Facility Name: Fort St. Vrain Nuclear Generating Station (FSV)

Inspection At: FSV Nuclear Generating Station, Platteville, Colorado

Inspection Conducted: June 1-30, 1988

Inspectors: for R.P. Mullikin — 8/8/88
R. E. Farrell, Senior Resident Inspector — Date

R.P. Mullikin — 8/8/88
R. P. Mullikin, Project Engineer, Project Section B — Date

Approved: T. F. Westerman — 8/11/88
T. F. Westerman, Chief, Project Section B — Date

Inspection Summary

Inspection Conducted June 1-30, 1988 (Report 50-267/88-13)

Areas Inspected: Routine, unannounced inspection of followup of licensee action on NRC bulletins, operational safety verification, followup of allegations, equipment qualification temperature profile, monthly maintenance observation, monthly surveillance observation, radiological protection, and monthly security observation.

Results: Within the eight areas inspected, one violation was identified (no procedure for a safety-related activity, paragraph 5; and an inadequate procedure for surveillance activities, paragraph 8).

DETAILS

1. Persons Contacted

PSC

D. Alps, Supervisor, Security
*H. Brey, Manager, Nuclear Licensing and Resources
*M. Block, System Engineering Manager
*R. Craun, Nuclear Engineering Manager
*M. Deniston, Superintendent, Operations
*D. Evans, Operations Manager
*M. Ferris, QA Operations Manager
*C. Fuller, Manager, Nuclear Production
J. Gramling, Supervisor Nuclear Licensing Operations
*D. Goss, Regulatory Affairs Manager
*M. Holmes, Nuclear Licensing Manager
*F. Novachek, Nuclear Support Manager
*H. O'Hagan, Outage Manager
*R. Sargent, Assistant to Vice President, Nuclear Operations
*L. Scott, QA Services Manager
*N. Snyder, Maintenance Manager
*P. Tomlinson, Manager, QA
R. Walker, Chairman of the Board and CEO
*D. Warembourg, Manager, Nuclear Engineering
*S. Wilford, Program Manager, Training Consolidation
*R. Williams Jr., Vice President, Nuclear Operations

The NRC inspectors also contacted other licensee and contractor personnel during the inspection.

*Denotes those attending the exit interview conducted July 5, 1988.

2. Plant Status

This inspection period covering the month of June 1988, was the most electrically productive month in the history of the plant. At 8 p.m., MDT, on June 29, the plant set a new 1-month generation record of 160,000 net megawatt hours. The plant continued to operate at approximately 80 percent power through the rest of the month, finishing with a net generation for the month of June of 167,699 megawatt hours. High oxidants in the reactor coolant in excess of the LCO 4.2.10 limit continued to be a problem. The NRC resident inspectors followed the licensee's actions to correct this problem, which were unsuccessful.

3. Followup of Licensee Action on NRC Bulletins (Module 92703)

(Closed) NRC Bulletin 88-01: Defects in Westinghouse Circuit Breakers - NRC Bulletin 88-01 requested licensees to perform and document inspections on Westinghouse Series DS circuit breakers used in Class 1E service. The licensee identified in Letter P-88112, that no circuit breakers subject to the requirements of this bulletin are utilized at FSV. This item is closed.

(Closed) NRC Bulletin 88-03: Inadequate Latch Engagement in HFA Type Latching Relays Manufactured by General Electric (GE) Company - The licensee documented to the NRC in letter P-88198 that no relays subject to NRC Bulletin 88-03 are utilized in safety-related applications at FSV. This is the same response as to NRC Bulletin 84-02, which also dealt with GE latching relays. This matter is closed.

No violations or deviations were identified in the review of this program area.

4. Operational Safety Verification (Module 71707)

The NRC resident inspectors reviewed licensee activities to ascertain that the facility is being operated safely and in conformance with regulatory requirements and that the licensee's management control system is effectively discharging its responsibilities for continued safe operation.

The NRC resident inspectors toured the control room on a daily basis during normal working hours and at least twice weekly during backshift hours. The reactor operator and shift supervisor logs and Technical Specification compliance logs were reviewed daily. The NRC resident inspectors observed proper control room staffing at all times and verified that operators were attentive and adhered to approved procedures. Control room instrumentation was observed by the NRC resident inspectors and the operability of the plant protective system and nuclear instrumentation system were verified by the NRC resident inspectors on each control room tour. Operator awareness and understanding of abnormal or alarm conditions was verified. The NRC resident inspectors reviewed the operations order book, operations deviation report (ODR) log, clearance log, and temporary configuration report (TCR) log to note any out-of-service safety-related systems and to verify compliance with Technical Specification requirements.

The licensee's Manager of Nuclear Production, Operations Manager, and Superintendent of Operations were observed in the control room on a daily basis, with the superintendent of operations frequently in the control room during the day and during special evolutions.

The NRC resident inspectors verified the operability of a safety-related system on a weekly basis. The helium purification system, prestressed concrete reactor vessel (PCRV) auxiliary piping system, reserve shutdown system, and DC essential power distribution system were verified operable by the NRC resident inspectors during this report period. During plant tours particular attention was paid to components of these systems to verify valve positions, power supplies, and instrumentation were correct for current plant conditions. General plant condition and housekeeping was improved during the inspection period

Shift turnovers were observed at least weekly by the NRC resident inspectors. The information flow was good, with the shift supervisors routinely soliciting comments or concerns from reactor operators, equipment operators, and auxiliary tenders.

During the inspection period, the limit of 10 parts per million total oxidants in the reactor coolant from LCO 4.2.10 was exceeded. The licensee interprets LCO 4.2.10 to allow the integration of parts per million above 10 with respect to duration to amass a total grace period of LCO 4.2.10 in terms of parts per million days of oxidants in reactor coolant above the 10 parts per million limit. This interpretation of the grace period as an integration is not found in the existing LCO 4.2.10. The NRC resident inspectors discussed this interpretation with the NRR project manager and determined that NRR had reviewed this interpretation in the past and had concurred with the licensee that this was an appropriate interpretation of LCO 4.2.10. However, LCO 4.2.10 still requires that the continuous time that oxidants in the primary coolant exceed 10 parts per million not be greater than 10 calendar days. The licensee, during the inspection period, reduced power which had the effect of reducing oxidants in the primary coolant to come within the requirements of 10 parts per million and reset the clock on the 10 days continuous time exceeding 10 parts per million. The licensee then increased power and continued to track integrated part per million days versus LCO 4.2.10 requirements.

During tours of the control room, the NRC resident inspectors determined that no written instructions existed to preclude operation of the reactor outside the parameters tested in Procedure RT-500. The RT-500 test measures reactivity fluctuations caused by movement of fuel blocks in the core at various primary coolant pressure drops across the core. This was a problem early in the life of the reactor and was corrected by physical restraints applied to the fuel blocks. Procedure RT-500 verifies that these reactivity changes do not occur at various pressure drops across the core. The NRC resident inspectors verified that operations personnel were aware of the maximum pressure drop across the core measured by RT-500 and that the reactor was not to be operated above this maximum pressure drop. The licensee issued Operations Order 88-04, which prohibited reactor operation with a core pressure drop greater than 4.25 pounds per square inch.

The NRC resident inspectors also had the opportunity to watch the licensee perform an equipment manipulation with a potential for causing [illegible]ant transient. Specifically, the licensee was attempting to place [illegible] backup bearing water in service to the helium circulators while the [illegible] was operating. This is a delicate process since the monitors on [illegible] helium circulator bearing cartridges sense differences in pressure between bearing water, buffer helium, and reactor primary coolant. If the pressure differences change significantly, the helium circulator would trip causing a reduction in plant power. If two circulators would trip in one loop, an engineered safety feature actuation would occur that would result in a loop shutdown, a potentially significant plant transient. A two-loop trouble reactor scram would occur when all of the helium circulators would trip. The licensee wished to place the backup bearing water system back in service because it is normally in service supplying backup bearing water in the event normal bearing water makeup is lost. Backup bearing water supplies bearing water makeup to the helium circulators through pressure breakdown valves from the emergency feedwater header. The NRC resident inspectors attended the job briefing conducted in the control room and observed that plant engineers conducted the briefing and supervised the effort to place the backup bearing water on line. There was ample communication between the control room, the auxiliary electric room (where the engineers monitored the system parameters and also controlled the pressure breakdown valves), and Level 2 in the reactor building where the equipment operators manually opened the system isolation valves upon instruction and authorization from the engineers. The NRC resident inspectors observed that the precautions and control instituted by the licensee were appropriate for the job. All personnel involved indicated that they understood the importance and sensitivity of the operation they were performing. The plant did not experience a transient during this operation.

Other observations by the NRC resident inspectors during plant tours are as follows:

- The oil filled viewing windows to the reactor building hot cell on Levels 9 and 10 were both seeping oil. The accumulation was not significant. This was brought to the licensee's attention and corrected.

- The No. 2 battery light on the diesel driven firewater pump was out. The NRC resident inspectors notified the shift supervisor and the outside tender advised that the problem was simply a burned out indicating light. The problem was immediately corrected.

- The fire door between the auxiliary electric room on Elevation 6 of the turbine building and the walkover to Building 10 had a defective latch. The licensee repaired the latch.

- The special handling document station in the helium bottle farm area was noted as having documents in poor physical condition. Specifically, Drawing PI-24, Issue BG had been ripped from the drawing holder and was laying on the floor of the bottle farm area. Drawing PI-25-3 was partially ripped from the holder. The NRC resident inspectors noted that the drawing holder was suspended by wire hook from the handwheel of Valve V-24105. The licensee corrected this condition and took steps to prevent recurrence.

- A small oil leak was observed from an unknown source dripping on the top of Valve PDV-2191-1 on Level 2 of the reactor building. The licensee cleaned up the oil and was troubleshooting to identify and correct the source.

- On June 27, 1988, it was noted that there was no thermometer in the plant protection system battery pilot cell. It is the licensee practice to leave a thermometer in the pilot cell of each battery. The licensee advised that the thermometer had been removed for routine checks and had since been returned to the pilot cell.

No violations or deviations were identified in the review of this program area.

5. Followup of Allegations (Module 92701)

   a. Followup of Allegation 4-87-A-0092

   This allegation concerned the melting of conductor insulation while attempting to install heat shrinkable insulation (HSI) sleeves. HSI sleeves are installed over splices and connectors of electrical cables to create an environmentally qualified seal. The sleeves are heated by a heat gun and shrunk to conform to the splice or connector. The alleger stated that, while heating some HSI sleeves, the insulation on the conductor melted.

   The NRC inspector interviewed licensee personnel and reviewed documentation which resulted in the following information.

   - During the installation of Raychem HSI sleeves in 1985 and 1986 the licensee used heat guns capable of reaching 1000°F. In addition, the procedure used stated that the Raychem sleeve was adequately shrunk when the outer surface was smooth and glossy. The licensee stated that the problem was as a result of the craft's and QC's interpretation of "smooth and glossy." In order to obtain the "smooth and glossy" acceptance criteria, the heat gun was sometimes applied for too long a time which did result in some conductor insulation melting. However, each Raychem installation was QC inspected and nonconformance reports were written against melted insulation.

   - The applicable installation procedures were subsequently changed, according to instructions from Raychem, to clarify the acceptance criteria. These criteria are: (1) apparent conformance to substrate, (2) no flat surfaces on tubing, (3) visible flow of adhesive at each end of tubing, and (4) "possible" glossy appearance. In addition, the 1000°F heat guns were replaced with 700°F heat guns with deflector shields.

   - In response to IE Information Notice 86-53, "Improper Installation of Heat Shrinkable Tubing," the licensee issued

Corrective Action Request (CAR) 86-140 on September 18, 1986, to perform a 100 percent reinspection of all Raychem installations. Raychem sleeves were used mainly for environmental qualification splices and a few other applications at FSV.

The NRC inspector reviewed CAR 86-140 and two NCRs (EQ-0026 and EQ-0127) that were initiated during the original installation of Raychem sleeves. In addition, a field inspection was performed by the NRC inspector to verify that the dispositions of the two NCRs reviewed were correct and that no conductor insulation damage existed. There were no problems noted during this review and inspection.

This allegation was substantiated, but it appears that, with two 100 percent QC inspections of all Raychem installations, all melted insulation has been identified and corrected. This allegation is closed.

b. Followup of Allegation 4-88-A-0036

This allegation concerned the adequacy of the safety-related station batteries. The allegation consisted of three parts which are addressed below.

(1) No Automatic Action or Proceduralized Instructions to Shed Some DC Loads

The NRC inspector determined that, according to Design Criteria DC-92-1, there are some DC loads that are required to be removed from the DC safety-related battery bus after a specified amount of time following loss of all AC power. After discussions with licensee personnel it was acknowledged that there was no automatic action that would shed these loads nor was there any proceduralized instructions to do so. The licensee stated that this requirement will be proceduralized.

The licensee, in the interim, has issued Special Instruction To Operators No. 85-15, Issue 4, dated June 23, 1988, to alert operators of the need to shed certain DC loads after a specified amount of time following a turbine trip with a loss of offsite power. However, there is a discrepancy between DC-92-1 and No. 85-15 as to the time when Computer Inverter N-9234 should be removed from the DC bus.

The failure to establish proper procedural controls for DC load shedding as described above is considered a violation of Technical Specification 7.4.a (267/8813-01).

In addition, the NRC inspector will review the licensee's determination of the safety impact of removing these loads. The safety impact of removing these loads is an open item (267/8813-02).

This part of the allegation was substantiated.

(2) No Analysis Which Includes Cable Losses in Determining Minimum Required DC Voltage at the Individual Loads

This allegation was that, although batteries are tested to maintain a minimum voltage of 105 VDC, cable losses to the DC loads are not analyzed when determining minimum voltage at the loads.

The licensee stated that this was true. However, the licensee further stated that the voltage losses due to the resistance of the cables was negligible for the length and size of cables used. This is an open item (267/8813-03) pending a review of the cable losses by the NRC inspector.

This part of the allegation was substantiated.

(3) Batteries are not Tested Against a Load Profile as Degraded Cells are Replaced

The NRC inspector determined that the licensee does not have a commitment to perform a capacity or a service test on the batteries when a cell is replaced. IEEE 450-1980 recommends that a cell should be tested prior to installation. The licensee has proceduralized and performs the testing of new battery cells under Procedure MPE-1705, "Removal, Cleaning, and Installation of Battery Cells."

This part of the allegation could not be substantiated since no requirement exists for the licensee to perform a load profile test when new cells are replaced.

This allegation is considered closed. Certain parts were substantiated and will be followed up as open items. One part was substantiated and is an apparent violation of NRC regulations.

6. Equipment Qualification Temperature Profile (Module 37998)

During the inspection period, the licensee notified the NRC resident inspectors, the NRR licensing project manager, and NRC Region IV that they had received a letter from their reactor vendor identifying that the vendor had revised the computer code used to calculate post-pipe break temperature profiles within the plant and had obtained new results which indicated higher long-term temperatures following certain kinds of postulated pipe breaks within the plant. The NRC resident inspectors reviewed the licensee action and noted that the licensee was pursuing parallel avenues in an attempt to expeditiously close the matter and determine the validity of the vendor's new computer calculations. The licensee has, with permission from the NRC, contracted with the NRC vendor, who performed the confirmatory calculations for the NRC during the original equipment qualification program, to run comparative calculations to those run by the licensee's reactor vendor. Additionally, the licensee is reviewing the changes made to the computer program by the reactor vendor and has also contracted with an architect engineer to run parallel calculations using that firm's in-house equipment qualification temperature profile computer code. The licensee advised the NRC SRI that should the reactor vendor's higher temperature calculations be validated, 37 equipment qualification binders representing 398 components would be adversely affected. Additionally, 14 components qualified by thermal lag analysis may be affected and there is a potential adverse impact on the qualification of all in-plant cable. This activity will be followed by the NRC resident inspectors and is considered an open item (267/8813-04).

7. Monthly Maintenance Observation (Module 62703)

During the inspection period, a 1½-inch valve (PV-21105-1) in the helium circulator backup bearing water system developed a through body leak and was cut out of the line for replacement. It was noted by the licensee that the body hole was due to erosion. Additionally, upstream and downstream piping for several inches from the valve also displayed the effects of severe erosion. The NRC resident inspectors interviewed the licensee's maintenance manager regarding actions taken to determine the cause of the erosion and identify additional areas of erosion or possible erosion. The licensee's maintenance department documented in Action Request 2197, dated June 14, 1988, that significant erosion in the valve and inlet and outlet piping had occurred and that engineering was requested to determine the cause and identify other potential locations where this might be taking place.

The licensee subsequently reported to the NRC SRI that the valve erosion that was experienced in PV-21105-1, and its associated inlet and outlet piping, was due to the high velocity of flow in this valve and the use of this valve as a pressure breakdown valve. The licensee is planning to replace this valve with a valve specifically designed for pressure breakdown service. Additionally, the licensee is evaluating replacing the inlet and outlet piping, which has a 1½-inch diameter with 3-inch piping to reduce the erosion problem. The licensee noted that this same piping had been replaced in 1981 due to severe erosion. The licensee's engineering department did an evaluation of other piping locations in the plant with similar configurations and determined that the conditions experienced by this valve and this piping were unique. The licensee concluded that there were no other similar areas of concern in the plant.

The quarterly maintenance on Instrument Air Compressor C was observed. The NRC resident inspectors reviewed Station Service Request (SSR) 88503257 and the associated Control Work Instruction Procedure MAP-7, "Gardner-Denver Instrument Air Compressors, Quarterly."

No violations or deviations were identified in the review of this program area.

8. Monthly Surveillance Observation (Module 61726)

During the inspection period, the NRC resident inspectors observed performance of the following surveillances:

- SR-5.1.8, Minimum Helium Flow/Maximum Core Region Temperature Rise Surveillance Requirement
- SR-5.6.1.a, Weekly Emergency Diesel Generator Load Test
- SR-5.2.20, ACM Diesel Driven Generator Surveillance (Weekly and Monthly)
- SR-4.1.1.A.1.a, X-High Motor Temperature Partial Scram

The NRC resident inspectors also observed the sampling and analyses of primary coolant to determine compliance or extent of noncompliance within the limits of LCO 4.2.10, which governs the amount of oxidants allowable in primary coolant. The NRC resident inspectors also reviewed licensee calculations and method of calculations for determining compliance with LCO 4.2.7.c, 4.2.7.d, and 4.2.9. These LCOs govern the pressurization and leak rate of pressurizing helium gas from PCRV penetration interspaces. The space (referred to as the interspace) in between the primary and secondary closure seals of each PCRV penetration is pressurized with purified helium. The leak rate from each penetration is used as a measure of the operability of its seals.

On June 21, 1988, the licensee, in performing Procedure SR-5.2.16.a-Q, Issue 34, "PCRV Closure Leakage Determination," determined that the Group 4 penetrations (Loop 2 steam generator penetrations) leakage rate exceeded the rate specified in LCO 4.2.9. The maximum allowable leakage rate for the Group 4 penetrations is a total of 700 pounds per day at a differential pressure of 10 pounds per square inch with respect to cold reheat steam pressure or 400 pounds per day at a differential pressure of 10 pounds per square inch with respect to cold reheat steam if there is no leakage between the interspace and the reheat steam pipe. The licensee determined by performing the above surveillance that the Group 4 penetration leakage was 736.09 pounds per day at 10 pounds-per-square-inch differential pressure with respect to cold reheat steam. This measurement was performed with the reactor at 80 percent power.

Subsequently, the licensee lowered reactor power to see if the leakage rate was affected. The leakage rate, on the evening of June 21, was determined to be 626.8 pounds per day at 10 pounds-per-square-inch differential pressure with respect to cold reheat steam when the reactor power was lowered to 73.5 percent. (NOTE: Cold reheat steam pressure varies directly with reactor power.) The lowering of reactor power, and thus the lowering of the required pressure inside the penetration interspace to maintain a 10 pound-per-square-inch differential with respect to cold reheat steam, would affect the leakage rate out of the secondary seal into the reactor building but not necessarily affect the leakage rate into reheat steam. Without an established leakage rate into reheat steam the limit on this penetration is 400 pounds per day of helium at 10 pounds-per-square-inch differential with respect to cold reheat.

On June 22, 1988, in an attempt to show that the leak rate from the Group 4 penetrations was indeed acceptable, the licensee utilized the methodology, but not the actual calculations of Procedure SR-RE-151-X, Issue 2, "Penetration Interspace Leakage Pressure Decay Test." The methodology of this procedure is to pressurize a penetration interspace, seal the flow to and from the interspace, and measure and time the pressure decay from the interspace. From this information, a leak rate in terms of pounds per day at a given pressure as specified in the Technical Specifications is calculated. The licensee utilized this methodology but did not use the actual procedure because the licensee had identified a problem in the calculation instructions contained within the procedure. This problem, which the NRC resident inspectors understood to be a label of incorrect units, did not affect the numbers provided to the NRC because this problem was identified prior to utilizing the procedure. Utilizing this methodology and installed plant equipment, Pressure Gauge TDT-11380, which measures the differential pressure between the cold reheat steam and the penetration interspace, the licensee obtained a leak rate of 384 pounds per day at a differential pressure of 10 pounds-per-square-inch with respect to cold reheat steam. Later, utilizing this same methodology but installing a more finely calibrated pressure gauge measuring absolute pressure rather than pressure with respect to another variable pressure (Cold Reheat Steam), the licensee obtained a number of 308.5 pounds per day helium leakage rate at 10 pounds-per-square-inch differential pressure with respect to cold reheat steam from the Group 4 penetrations. This leak rate corresponds with the measured purified helium makeup flow to these penetrations.

The NRC resident inspectors, having been provided with four different leak rates in the course of 24 hours, requested that the licensee review the calculations, the calculational methods, and the equipment used. The NRC inspectors also requested an explanation as to the actual leak rate from the Group 4 penetrations and the calculations that demonstrated Technical Specification compliance. During the course of this review, the licensee identified a problem with Procedure SR-5.2.16.a-Q, Issue 34, in that the procedure assumed that Group 4 penetrations were pressurized to above primary coolant pressure rather than to above cold reheat steam pressure, (Step 5.3.12 of the procedure). Cold reheat steam pressure varies with plant load but will be at least 50 pounds per square inch below primary coolant pressure.

The NRC resident inspectors noted that Procedure SR-5.2.16.a-Q, Issue 34, had six existing deviation reports against it with each change marked as a permanent change. None of these changes or previous issues of the procedure identified or incorporated a change to the Technical Specifications approved on March 18, 1982. The error in the procedure calculates a leak rate in the conservative direction, since it shows a worse leak rate by calculation than actually existed. However, the conservatism was such that the licensee erroneously placed the plant in Technical Specification Limiting Conditions for Operation 6.2.9 which would have required shutting down the plant. This information was also supplied to the NRC and was the subject of a conference call between the licensee, NRR, and Region IV.

This error in the procedure, which has apparently existed undetected for 6 years, is considered a violation of Technical Specifications (267/8813-01).

9. Radiological Protection (Module 71709)

The NRC resident inspectors verified that required area surveys of exposure rates were made and posted at entrances to radiation areas and in other appropriate areas. The NRC resident inspectors observed health physics professionals on duty on all shifts including the backshift. The NRC resident inspectors observed the health physics technicians checking area radiation monitors, air samplers, and doing area surveys for radioactive contamination.

The NRC resident inspectors observed that when workers are required to enter areas where radiation exposure is probable or contamination possible, the health physics technicians are present and available to provide assistance.

No violations or deviations were identified in the review of this program area.

10. Monthly Security Observation (Module 71881)

The NRC resident inspectors verified that there was a lead security officer (LSO) on duty authorized by the facility security plan to direct security activities onsite for each shift. The LSO did not have duties that would interfere with the direction of security activities.

The NRC resident inspectors verified, randomly and on the backshift, that the minimum number of armed guards required by the facility's security plan were present. Search equipment, including the X-ray machine, metal detector, and explosive detector, were operational or a 100 percent hands on search was being utilized.

The protected area barrier was surveyed by the NRC resident inspectors. The barrier was properly maintained and was not compromised by erosion, openings in the fence fabric or walls, proximity of vehicles, or crates or other objects that could be used to scale the barrier. The NRC resident inspectors observed the vital area barriers were well maintained and not compromised by obvious breaches or weaknesses. The NRC resident inspectors observed that persons granted access to the site were badged indicating whether they had unescorted or escorted access authorization.

Two items of note regarding the physical security program at FSV occurred during this inspection. The first security matter of interest during the inspection period involved backshift observation by the NRC SRI. Specifically, on June 23, 1988, at 11:30 p.m. MDT, while performing a deep backshift inspection, the NRC SRI visited the secondary alarm station as a routine part of his inspection. While in the secondary alarm station, the SRI was able to observe activities in the search/identification portion of the primary access facility without his presence being detected by those in the search/identification area. At this time, the NRC SRI observed a security officer placing parts of his body into the package X-ray machine. The machine was then turned on by a second security officer, thus, X-raying the first officer. These activities were brought to the attention of the licensee's security supervisor by the NRC SRI. The licensee took extensive and thorough corrective action and made this corrective action known to the entire security force in an attempt to preclude recurrence. The NRC SRI observing the licensee's corrective action concluded that it was timely and thorough.

On this same shift continuing into the morning of June 24, 1988, the NRC SRI observed the same security crew demonstrate high quality performance. This crew of security officers searching a truck making a delivery to the plant in the middle of the night did successfully discover and prevent a loaded hand gun from entering the plant. The gun was concealed within the tractor of a tractor-trailer making the delivery.

No violations or deviations were identified in the review of this program area.

11. Exit Meeting

An exit meeting was conducted on July 5, 1988, attended by those identified in paragraph 1. At this time the NRC resident inspectors reviewed the scope and findings of the inspection.