ENCLOSURE

U.S. NUCLEAR REGULATORY COMMISSION
REGION IV

Docket Nos.:	50-498 50-499
License Nos.:	NPF-76 NPF-80
Report No.:	50-498/98-08 50-499/98-08
Licensee:	STP Nuclear Operating Company
Facility:	South Texas Project Electric Generating Station, Units 1 and 2
Location:	FM 521 - 8 miles west of Wadsworth Wadsworth, Texas 77483
Dates:	July 26 through September 5, 1998
Inspectors:	Cornelius F. O'Keefe, Senior Resident Inspector Wayne C. Sifre, Resident Inspector Gilbert L. Guerra, Resident Inspector
Approved By:	Joseph I. Tapia, Chief, Project Branch A
ATTACHMENT:	Supplemental Information

EXECUTIVE SUMMARY

South Texas Project Electric Generating Station, Units 1 and 2
NRC Inspection Report 50-498/98-08; 50-499/98-08

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

Operations

- In general, the conduct of operations was professional and safety-conscious. Control room logs accurately recorded changes in plant conditions, equipment operability, and Technical Specification entries. Shift turnover briefings effectively communicated plant status and upcoming planned activities. Shift supervisors closely monitored tropical storm activity in the Gulf of Mexico and directed appropriate precautionary steps per station procedures (Section O1.1).

Maintenance

- The inspectors identified examples of poor documentation of work activities performed following initial failure of postmaintenance testing in two safety-related systems. In each case the problems were added to existing condition reports, minimizing the effectiveness of problem reporting. Additionally, the inspectors identified that a safety battery surveillance procedure included conflicting guidance for setting charger float voltage (Sections M1.1 and M8.1).

- The extended Standby Diesel Generator (SDG) 23 outage to perform 18-month inspections and preventive maintenance was well planned, detailed, and completed without problems. The configuration risk management program was properly implemented to ensure conformity to the plant risk analyses during this extended outage. Work activities were closely coordinated, adequately supervised, and were fully supported by system engineering and vendor personnel (Section M2.1).

- The licensee identified that inservice tests were missed for 21 check valves required to perform a containment isolation function as required by the ASME Boiler and Pressure Vessel Code. The NRC exercised enforcement discretion in accordance with the NRC Enforcement Policy (NUREG 1600 Revision 1) on August 28, 1998, to permit additional time to test the affected valves in order to avoid an unnecessary plant shutdown (Section M3.1).

Engineering

- New fuel receipt inspections and irradiated fuel bowing inspections were properly supervised and procedurally controlled. Bypassing the new fuel dry storage racks resulted in time savings and reduced fuel handling operations (Section E2.1).

Plant Support

- The licensee failed on two previous occasions to adequately investigate the cause of unexpected power transfers, which led to loss of power to portions of the security system. As a result, the underlying equipment deficiency was not recognized and corrected, and the first event repeated itself. Additionally, a breaker interlock that was not included in operator training or operating procedures contributed to these events. Inadequate security response to the precursor alarm also contributed to the loss of power (Section M8.2).

Report Details

Summary of Plant Status

Unit 1 began this inspection period at 100 percent power and remained at full power throughout the majority of this inspection period. Power was reduced to 90 percent between August 8-10 to facilitate planned repairs to Feedwater Heater 15B.

Unit 2 began this inspection period in the process of starting up from a brief outage to conduct control rod testing. The generator was synchronized to the grid on July 26. The unit was promptly returned to full power, remaining at full power for the remainder of the inspection period.

I. Operations

O1 Conduct of Operations

O1.1 General Comments

Using Inspection Procedure 71707, the inspectors conducted frequent reviews of plant operations. During control room observations, the inspectors determined that licensed operators' response to annunciators was proper. Control room logs accurately recorded changes in plant conditions, equipment operability, and Technical Specification entries. Control room staffing was observed to be proper. Shift turnover briefings effectively communicated plant status and upcoming planned activities. In general, the conduct of control room activities was professional and safety-conscious.

During this inspection period, the licensee closely monitored tropical storm activity in the Gulf of Mexico. The shift supervisor was kept informed of the latest weather information when possible storm activities developed. The operations organization was supported in carrying out severe weather preparations by various departmental severe weather coordinators. Appropriate precautionary steps were observed to be taken per station procedures.

O2 Operational Status of Facilities and Equipment

O2.1 Engineered Safety Feature System Walkdowns (71707)

The inspectors used Inspection Procedure 71707 to walk down accessible portions of the following engineered safety feature systems:

- Auxiliary Feed Water (AFW) (Units 1 and 2)
- Essential Cooling Water (Units 1 and 2)
- Safety Injection (Unit 1)
- SDGs 11 and 23

The inspectors observed that these systems were properly aligned for standby operation, had power available, and had the necessary support systems available. The physical condition of the equipment was good. Some minor leaks in the essential

cooling water intake structure were brought to the attention of the licensee. The inspectors noted an equipment deficiency tag on a capped vent connection in the Unit 1 safety injection system, which should have been cleared when the prior condition was eliminated. The inspectors identified no substantive concerns as a result of these walkdowns.

II. Maintenance

M1 Conduct of Maintenance

M1.1 Maintenance and Surveillance Observations

a. Inspection Scope (62707, 61726)

The inspectors observed all or portions of the following maintenance and surveillance activities. For each surveillance, the test procedures were reviewed and compared to the Technical Specification surveillance requirements and bases to ensure the procedures satisfied the requirements. Maintenance work was reviewed to ensure adequate work instructions were provided, the work performed was within the scope of the authorized work, and the work performed was adequately documented. In all cases, the impact to equipment operability and applicable Technical Specifications actions were independently verified.

Maintenance:

- Troubleshooting of Unit 1 solid state protection system
- Troubleshooting on Unit 2 control room emergency makeup filter unit

Surveillance:

- Plant Surveillance Procedure 0PSP03-AF-0001, Revision 10, "Auxiliary Feedwater Pump 21 Inservice Test"
- Plant Surveillance Procedure 0PSP06-DJ-0001, Revision 8, "125 Volt Class 1E Battery 7 Day Surveillance Test"
- Plant Surveillance Procedure 0PSP05-AF-7523, Revision 0, "Auxiliary Feedwater Flow Loop Calibrations"
- Plant Surveillance Procedure 0PSP11-ZH-0009, Revision 12, "EAB and FHB HVAC In-Place Adsorber Leak Test"

b. Observations and Findings

The inspectors observed that the work was well performed and thorough during these activities. Work was generally within the scope of the work document, with exceptions discussed below. Technicians were experienced and knowledgeable of their assigned

tasks, equipment performance, and the significance of the systems being worked. The inspectors observed that work supervisors and system engineers were frequently present to monitor job performance.

Unit 2 Control Room Emergency Make-up Filter Postmaintenance Testing

On August 12, the licensee replaced the charcoal in the Unit 2 Train "C" control room emergency make-up filter, because the filter failed Plant Surveillance Procedure 0PSP11-ZH-0009, "EAB and FHB HVAC In-Place Adsorber Leak Test." On August 13, the inspectors observed four postmaintenance tests of the new filter, each of which failed. The technicians repeatedly opened the system and made adjustments to the filter trays and sample canisters in unsuccessful attempts to eliminate unacceptable filter bypass flow. Troubleshooting was stopped only when the shift supervisor instructed the workers to inform their supervisor and the system engineer and to create a troubleshooting plan. Discussions with licensee staff indicated that the system was tested at least twice more before it passed the surveillance test.

The inspectors noted that the licensee did not document the steps taken to troubleshoot and correct the filter bypass leakage, nor were the repeated test attempts documented in either the work order or the surveillance package. Instead, a comment was placed in the original condition report (98-12470) that requested that the filter be replaced. No corrective actions were identified, despite having identified work deficiencies that included improperly centered filter tray gaskets, sample canisters that were not sufficiently full of charcoal, and deficient canister gaskets that required replacement. The inspectors determined that the licensee's work control procedures permitted limited rework in order to pass postmaintenance testing which appeared to cover the troubleshooting work observed by the inspector; however, the work performed to correct these deficiencies was not documented.

Battery Charger Testing

The inspectors noted that the Unit 1 Train "D" battery charger float voltage required adjustment because voltage was at the high limit only 3 days after performance of the weekly surveillance. The inspectors reviewed Plant Surveillance Procedure 0PSP06-DJ-0001, Revision 8, "125 Volt Class 1E Battery 7 Day Surveillance Test," and noted that the procedure required adjustment of normal float voltage to the optimum voltage even if it was within the acceptable range. The inspectors observed performance of the surveillance the following week and noted that the electricians did not adjust float voltage to the optimum value. The inspectors reviewed 6 weeks of test data for all eight chargers and concluded that significant voltage drift was not present.

The inspectors discussed the concerns with the system engineer and the component engineer. The system engineer acknowledged that the procedure required voltage adjustments, but stated that the voltage was not routinely optimized because that practice was not desirable. When the disparity between the procedure and desired practice were pointed out, the licensee agreed that the procedure should be changed to clearly reflect current expectations.

AFW Turbine Governor Valve Work

As discussed in detail in Section M8.1, the inspectors identified additional examples of poor documentation of rework done in response to a failed postmaintenance test. These were identified during a review of a completed work order for AFW Pump 24 preventive maintenance performed in July 1998.

c. Conclusions

The inspectors identified examples of poor documentation of work activities performed following initial failure of postmaintenance testing in two safety-related systems. In each case, the problems were added to existing condition reports. Additionally, the inspectors identified that a safety battery surveillance procedure included conflicting guidance for setting charger float voltage.

M2 Maintenance Support of Facilities and Equipment

M2.1 Standby Diesel Generator Extended Outage and Risk Management

a. Inspection Scope (62707)

The inspectors observed preparations for and execution of various work activities associated with the SDG 23 system outage. Licensee implementation of the configuration risk management program was also observed. Work documents were reviewed. Foreign material control measures were observed during the work. Tagouts were walked down to ensure accuracy and adequacy of protection.

b. Observations and Findings

This system outage was scheduled in order to perform 18-month preventive maintenance and inspection activities. The work was performed as permitted by the extended allowed outage time of Technical Specification 3.8.1.1.b. In order to assure that the extended system outage time did not adversely impact the plant safety analyses, the licensee had committed to instituting a Configuration Risk Management Program. This program was used to verify that redundant safety equipment and power sources were available to ensure the ability to respond to plant transients with the SDG out of service for up to 14 days.

The inspectors verified that the configuration risk management program was appropriately implemented through Plant Operating Procedure 0POP01-ZO-0006, Revision 4, "SDG, ECW, or Essential Chilled Water Extended Allowed Outage Time." The inspectors observed that the required periodic equipment verifications and the once per shift briefings for operators were completed. The inspectors noted that the briefings effectively raised awareness of which equipment was required to remain operable and actions to be taken if "protected" equipment became unexpectedly inoperable.

The inspectors observed that work preparations were detailed for this outage. The licensee maintained the expertise to perform all the work activities using site personnel. Specialized equipment was maintained in a trailer, which was positioned at the work site. Plexiglass engine covers were fabricated to facilitate inspection activities while maintaining effective foreign material exclusion controls. The SDG engine room was deposted as a vital area during the work, improving access to the work area. This helped minimize the outage time.

The inspectors observed that the work activities were carefully coordinated. This was important due to the limited work area and the large number of work activities in progress simultaneously. Different work groups communicated well to ensure that conflicts were avoided and the work area remained safe. The inspectors also observed that system engineering personnel and a vendor representative were closely involved, supporting the work activities. In addition, the outage planning included assigning an outage management team to facilitate coordination. A high degree of management involvement was observed during the preparation and execution of this outage.

The inspectors verified that the SDG 23 engine room was deposted and reposted as a vital area in accordance with NUREG 0908, "Acceptance Criteria for the Evaluation of Nuclear Power Reactor Security Plans." Area walkdowns were completed by security and operations personnel to verify proper equipment condition and configuration, as well as vital area integrity prior to restoring the area and before declaring the system operable.

c. Conclusions

The extended SDG 23 outage to perform 18-month inspections and preventive maintenance was well planned and completed without problems. The configuration risk management program was properly implemented to ensure conformity to the plant risk analyses during this extended outage. Work activities were closely coordinated, adequately supervised, and fully supported by system engineering and vendor personnel.

M3 Maintenance Procedures and Documentation

M3.1 Enforcement Discretion Granted for Containment Isolation Valve Testing Requirements

On August 26, the licensee identified that inservice tests were missed for 21 check valves in both units that were required to perform a containment isolation function. On August 27, the licensee verbally requested enforcement discretion to allow additional time to perform the testing required by Technical Specification 4.0.5 and the ASME Boiler and Pressure Vessel Code. This request was followed up with written requests on August 28. Additional time was required in order to avoid an unnecessary plant shutdown while the valves that could be tested on line were tested, and a Technical Specification change was submitted for the valves that could not be tested on-line. The

licensee documented a satisfactory performance history for each of the affected valves, providing reasonable assurance of continued functionality, as well as a minimal impact to plant risk if the valves failed to function when called upon.

During a surveillance data review, the licensee identified that 17 check valves in Unit 1 and four check valves in Unit 2 were not tested within the specified frequency to verify the valves stroked. The tests had previously been satisfied during local leak rate testing required by 10 CFR Part 50, Appendix J, "Primary Reactor Containment Leakage Testing for Water-Cooled Power Reactors." When the NRC approved the use of the Option B method to schedule leak rate testing based on component performance, the affected valves were rescheduled to allow greater time between leak rate tests. The fact that the ASME Code tests would not meet the required test frequency was not recognized by the licensee.

On August 27, the Office of Nuclear Reactor Regulation granted verbal enforcement discretion to the licensee to permit continued operation until an exigent Technical Specification change, allowing deferral of testing eight valves in Unit 1 until the next outage of sufficient duration, could be submitted and approved. The Technical Specification change was requested by letter dated August 28. Also on August 27, Region IV granted enforcement discretion to permit a 14-day extension to permit testing of nine valves in Unit 1 which could be safely tested with the plant operating. The verbal approvals were followed up with written Notices of Enforcement Discretion following the licensee's submission of the written request.

The four affected Unit 2 valves were successfully tested and declared operable within the 24-hour Limiting Condition for Operation action statement of Technical Specification 3.6.3 on August 27 and were, thus, not part of the enforcement discretion. The nine affected valves in Unit 1 were successfully tested by September 2. The resident inspectors observed portions of the testing using the new procedures and verified that satisfactory results were obtained.

This issue was a potential violation of NRC requirements. However, this issue will be tracked as an Escalated Enforcement Item (EEI) pending review of the licensee's root cause evaluation and corrective actions to be docketed in Licensee Event Report 50-498/98-04 (EEI 50-498;499/98-08-01).

M8 Miscellaneous Maintenance Issues (92902)

M8.1 AFW Turbine Maintenance Followup

a. Inspection Scope (92902)

As discussed in NRC Inspection Report 50-498;499/98-07, the inspectors assessed the licensee's response to governor problems identified during preventive maintenance to AFW Pump 24 on July 13-15, 1998. During the current inspection period, the inspectors performed followup inspection activities for that work with respect to past problems of a

similar nature. The turbine control system was inspected. Issues were discussed with the system engineer and mechanical maintenance personnel and the following documents were reviewed:

- NRC Inspection Reports 50-498;499/93-04, 93-05, 93-07, and 93-38
- Preventive Maintenance MM-2-AF-98000305, "Clean/Inspect/Lube/Replace Aux Feed Pump 24 Terry Turbine"
- Maintenance Procedure 0PMP04-AF-0002, Revisions 13 and 14, "Auxiliary Feedwater Pump Turbine Maintenance"
- Condition Report 98-10944

b. Observations and Findings

The inspection reports reviewed included brief discussions of past problems aligning linkages for the turbine-driven AFW pumps. However, the previous problems were associated with the overspeed linkage, while the recent problem was associated with the governor droop linkage. In the recent example, maintenance personnel exhibited a questioning attitude when they identified that the existing practice might inadvertently introduce some free play in the linkage if aligned per the procedure. The procedure was then improved to prevent undesirable contact that could prevent free motion of the governor linkage.

The licensee revised Plant Maintenance Procedure 0PMP04-AF-0002 to provide more detail and scheduled training for applicable maintenance workers on the change. The linkage was properly adjusted after a number of attempts during the July work, and the turbine was successfully tested. No concerns were identified with respect to linkage adjustments.

The inspectors noted that the work order for the July governor work documented that governor valve plug corrosion was identified during the work. The inspectors noted that, despite identifying what was considered by the system engineer to be more corrosion than previously experienced, the impact and significance of the corrosion were not formally evaluated nor a condition report written. Workers apparently mechanically removed the corrosion from the stainless steel, but did not document the method used.

The system engineer and mechanical maintenance workers discussed the corrosion and informally concluded the cause was related to known seat leakage from the steam supply isolation valve (MOV-0514). This valve was scheduled to be repaired during the upcoming refueling outage in October. The licensee reasoned that the condition did not affect operability of the pump, because no degradation was observed during surveillance testing.

The inspectors noted that the postmaintenance testing to verify proper system operability following this work was not fully specified or documented in the work documents. The inspectors verified that proper surveillance testing was actually completed prior to declaring the system operable.

c. Conclusions

The inspectors identified that unusual corrosion on the turbine-driven AFW pump governor valve internals noted during preventive maintenance was not properly reported and evaluated. Corrective actions to remove the corrosion were not controlled or documented.

M8.2 (Closed) Violation 50-499/98-05-02: Failure to properly control transient fire loads. The circumstances of this violation and the licensee's corrective actions were documented in NRC Inspection Report 50-498;499/98-05. The inspectors reviewed and verified that corrective actions were appropriate and complete. This item is closed.

III. Engineering

E2 Engineering Support of Facilities and Equipment

E2.1 Spent Fuel Pool Activities

a. Inspection Scope (37551)

The inspectors observed fuel inspection activities involving the Units 1 and 2 spent fuel pools. These included new fuel receipt and spent fuel integrity inspections. The inspectors reviewed the following procedures:

- 0PEP02-ZM-0002, Revision 8, "New Fuel Receipt, Inspection, and Storage"
- 0PEP02-ZM-0005, Revision 6, "Internal Transfer of Fuel Assemblies"

b. Observations and Findings

Unit 2 received new fuel for the upcoming refueling outage during this inspection period. The inspectors observed that work involving new fuel receipt, inspection, and storage was systematic and efficient. The fuel receipt was supported by engineering, operations, maintenance, and health physics. New fuel was inspected and handled in accordance with procedures.

The new fuel was visually inspected for defects and foreign objects. Following inspection, the fuel was placed into storage in the spent fuel pool. Bypassing the new fuel dry storage area resulted in time savings and reduced fuel handling operations.

Licensed operators were assigned to oversee activities associated with irradiated fuel inspections to measure rod bowing in the Unit 1 spent fuel pool. These activities were performed by vendor personnel, with proper oversight by licensee personnel. The inspections were completed without incident.

During both activities, special nuclear material accountability was properly maintained. Fuel movement was in accordance with approved special nuclear material movement forms. Health physics personnel performed radiation and airborne radioactivity surveys, and provided good support during the work.

c. Conclusions

New fuel receipt inspections and irradiated fuel bowing inspections were properly supervised and procedurally controlled. Bypassing the new fuel dry storage racks resulted in time savings and reduced fuel handling operations.

E8 Miscellaneous Engineering Issues (92700)

E8.1 (Closed) Licensee Event Report 50-498/ 97-012: Reactor/turbine trip due to invalid protection circuit actuation. On November 10, 1997, a Unit 1 main turbine overspeed protection control solenoid momentarily energized inadvertently a number of times in succession. The resulting steam transient caused an automatic reactor trip to occur on over temperature/delta temperature signals, followed by a main turbine trip.

The licensee identified that the problem was caused by a failed solid state relay. The failed relay was connected in parallel with a mercury-wetted relay. A vendor publication issued on November 1, 1976, identified the possibility of solid state relay failure and recommended the replacement of the solid state relays with mercury-wetted relays. This document was issued prior to the purchase of the South Texas Project turbines and was never sent to South Texas Project. The licensee was able to determine that the control panels were delivered during construction with both relays installed.

The licensee removed 12 solid state relays in each unit's main turbine control circuitry that were determined to perform a redundant function as instructed by the vendor document. The circuits were then satisfactorily tested. The inspectors verified that the licensee had performed adequate safety and design change evaluations. The desired configuration was verified to be correct on system prints and in the plant. Corrective actions were adequate. This item is closed.

IV. Plant Support

S8 Miscellaneous Security and Safeguards Issues (92700)

S8.1 (Closed) Safeguards Event Report 50-498;499/98-S01: Loss of security system power. As documented in NRC Inspection Report 50-498;499/98-07, this event involved the loss of power to portions of the security system during the removal of a circuit breaker for planned maintenance on July 7, 1998. To facilitate breaker maintenance, security power was manually shifted to an alternate supply and the normal supply bus was briefly

deenergized. Following reenergization of the bus, a security system alarm indicated that power had unexpectedly and automatically transferred back to the original source. The replacement breaker was then tested, causing an unexpected trip of the lighting diesel generator breaker and loss of power to the bus and the security system.

The licensee determined that an interlock between the normal supply breaker (being replaced) and the lighting diesel generator output breaker (alternate power supply), intended to prevent the diesel generator from connecting to an energized bus, caused the lighting diesel generator output breaker to open. This resulted in a loss of power to portions of the security system. The inspectors reviewed the licensee's response to this event and determined that appropriate compensatory measures were taken. Review of the licensee's root cause determination and corrective actions are discussed in Section S8.2 of this report.

S8.2 (Closed) Inspection Followup Item 50-498;499/98-07-02:

a. Inspection Scope (92904)

The inspectors reviewed the licensee's root cause determination for the loss of power event documented in Safeguards Event Report 50-498;499/98-S01, dated July 7, 1998 and also reviewed the effectiveness of corrective actions for a similar event documented in Safeguards Event Report 50-498;499/97-S02, dated July 21, 1997.

b. Observations and Findings

The inspectors reviewed the licensee's root cause determination and corrective actions for the 1997 event and noted that the licensee had identified the event as a significant condition adverse to quality. The documented root cause for the event was a failure on the part of security officers to recognize the significance of the alarms associated with the power transfer. As a result, the licensee's corrective actions for that event primarily addressed training of the security force officers. The licensee had concluded that the actual power transfer was caused by a power supply transient, even though none was observed and the circuit appeared to be working normally.

On September 26, 1997, the static switch transferred unexpectedly during the startup of a reactor coolant pump. The licensee wrote Condition Report 97-15629 to troubleshoot the circuit in an attempt to identify the cause of the unexpected transfers. On October 23, 1997, the licensee began their troubleshooting effort, but suspended the activity when problems developed in the lighting diesel generator. The activity was then rescheduled for July 1998. The second loss of power event occurred before any troubleshooting had been performed.

The licensee determined that both loss of power events were initiated by an intermittent failure of the static transfer switch that caused the security load center to switch from the battery power source to the alternate source while the alternate source was deenergized for planned maintenance. Contributing to this, security did not respond promptly or appropriately to the alarm, indicating a power transfer and operators were unaware that

the breakers were interlocked. The inspectors identified that the licensee had an opportunity to identify and correct the failed transfer switch in October 1997 but delayed troubleshooting for an additional nine months.

c. Conclusions

The licensee failed on two previous occasions to adequately investigate the cause of unexpected power transfers, which led to loss of power to portions of the security system. As a result, the underlying equipment deficiency was not recognized and corrected, and the first event repeated itself. Additionally, a breaker interlock that was not included in operator training or operating procedures contributed to these events. Inadequate security response to the precursor alarm also contributed to the loss of power.

V. Management Meetings

X1 Exit Meeting Summary

The inspectors presented the inspection results to members of licensee management on September 8, 1998. Management personnel acknowledged the findings presented. The inspector asked whether any materials examined during the inspection should be considered proprietary. No proprietary information was identified.

ATTACHMENT

SUPPLEMENTAL INFORMATION

PARTIAL LIST OF PERSONS CONTACTED

Licensee

A. Aldridge, Supervisor, System Engineering Department
M. Berrens, Manager, Work Control
T. Cloninger, Vice President, Nuclear Engineering
W. Cottle, President and Chief Executive Officer
J. Crenshaw, Manager, Mechanical Fluid Systems Engineer
W. Dowdy, Manager, Plant Operations Unit 2
R. Fast, Manager, Unit 2 Work Control
J. Groth, Vice President, Nuclear Generation
E. Halpin, Manager, Maintenance Unit 2
S. Head, Lead, Licensing Engineering
J. Johnson, Manager, Engineering Quality
A. Kent, Manager, Electrical/Instrumentation and Controls System
M. Lashley, Manager, Reliability Engineer
D. Leazar, Director, Nuclear Fuel and Analysis
R. Lovell, Manager, Generation Support
F. Mangan, Vice President, Plant Services
L. Martin, Vice President, Nuclear Assurance and Licensing
R. Masse, Plant Manager, Unit 2
M. McBurnett, Director, Nuclear Licensing
G. Parkey, Plant Manager, Unit 1
G. Powell, Manager, Health Physics
D. Rencurrel, Manager, Electrical Instrumentation and Controls, Design Engineering
V. Simonis, Manager, Production Support
S. Thomas, Manager, Design Engineering Department
W. Waddell, Manager, Maintenance Unit 1

INSPECTION PROCEDURES USED

IP 37551: Onsite Engineering
IP 61726: Surveillance Observations
IP 62707: Maintenance Observation
IP 71707: Plant Operations
IP 71750: Plant Support
IP 92700: Onsite Followup of Written Reports of Nonroutine Events at Power Reactor Facilities
IP 92902: Followup - Maintenance
IP 92904: Followup - Plant support

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

50-498;499/9808-01	EEI	Failure to Perform ASME Code Check Valve Testing

Closed

50-498;499/98-S01	LER	Loss of Power to Security System
50-498;499/9807-02	IFI	Review of Corrective Actions for Loss of Security Power
50-498/ 97-012	LER	Reactor/Turbine Trip Due to Invalid Protective Trip
50-499/9805-02	VIO	Failure to Properly Control Transient Fire Loads