



UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
WASHINGTON, D. C. 20555

September 16, 1988

Docket No. 50-267

Mr. Robert O. Williams, Jr.  
Vice President, Nuclear Operations  
Public Service Company of Colorado  
2420 W. 26th Avenue, Suite 15c  
Denver, Colorado 80211

Dear Mr. Williams:

This letter forwards the report and executive summary of the Operational Safety Team Inspection (OSTI) conducted by Mr. J. E. Cummins and other NRC personnel during the period May 9-20, 1988. The activities involved are authorized by NRC Operating License No. DPR-34 for the Fort St. Vrain Nuclear Generating Station. We discussed our findings with you and other members of your staff at the conclusion of this inspection.

Selected activities in the areas of operations, maintenance, surveillance, engineering, management oversight, safety review, and quality programs were examined during the inspection. As a part of the operations performance evaluation, the team observed approximately 120 hours of on-shift operation-related activities; included in this were random backshift and weekend inspections.

The findings of the team indicated the existence of an apparent inconsistency in the overall operation of the plant. While there appeared to be acceptable programs and an appropriate concern by management and operations personnel for safe operation of the plant, the team also observed the issuance and use of what it considered to be inadequate maintenance instructions and inadequate control and documentation of maintenance activities. This problem appeared to occur between the first line supervision and higher levels of management.

No response to this letter is required, but some of the findings identified by the team may be potential enforcement items. The Region IV office will review this report and will followup on any enforcement items identified.

In accordance with 10 CFR 2.790(a), a copy of this letter and the enclosure will be placed in the NRC Public Document Room.

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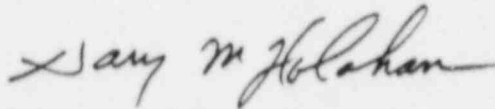
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Mr. Robert O. Williams, Jr.

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Should you have any questions concerning this inspection, please contact me or Mr. J. Cummins (301 492-0957) of this office.



Gary M. Holahan, Acting Director  
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IV, V, and Special Projects  
Office of Nuclear Reactor Regulation

Enclosures:

1. Executive Summary
2. Inspection Report 50-267/88-200

cc w/enclosure: See next page

September 16, 1988

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## EXECUTIVE SUMMARY

INSPECTION REPORT 50-267/88-200

## FORT ST. VRAIN NUCLEAR GENERATING STATION

During the period May 9-20, 1988, a team of nine inspectors performed an Operational Safety Team Inspection (OSTI) at the Fort St. Vrain Nuclear Generating Station. The plant was inspected to determine if it was being operated in a safe manner. The primary emphasis of the inspection was observation of operating plant personnel and the review of activities that interfaced with and supported the operations department. During the inspection, the team observed approximately 120 hours of on-shift activities related to operations. Inspections were conducted in the areas of operations, maintenance, surveillance testing, management oversight, safety review and quality programs.

Licensee Strengths

- ° Generally sound acceptable programs had been implemented and the licensee's staff appeared to be knowledgeable and capable and to have a positive attitude toward safe operation of the plant.
- ° Even though the team identified a problem with the quality of maintenance instructions and with maintenance personnel working outside instructions, the experienced maintenance personnel's ability to maintain the plant was considered a strength.
- ° The extension of surveillance activities to determine operability of components and subsystems not explicitly listed in the Technical Specifications was considered by the team to be an enhancement to safety.
- ° There appeared to be a high degree of station manager and operations manager involvement in all aspects of operations, including their frequent presence in the control room. There also appeared to be strong support of operations by personnel from all plant departments.
- ° The quality of quality assurance audits was good.
- ° The operations staff was well trained; they exhibited a professional attitude and a strict sensitivity to procedure adherence. Good communications were maintained between shifts via thorough shift turnovers.
- ° The actions of the offsite review committee appeared to be aggressive.

## Licensee Weaknesses

- ° Many procedures did not contain adequate specific information and relied on the experience of the personnel implementing the procedure (especially in operations) to perform the task intended by the procedure. There was also duplication of procedures used by different groups that could be confusing. The licensee had instituted a program to improve the quality of the procedures.
- ° Inadequate craftsman maintenance instructions and maintenance craftsmen working outside existing instructions was a major weakness identified by the team. Related to this, craftsmen did not stop work when instructions were inadequate, but knowingly continued the job without adequate instructions.
- ° Measuring and Test Equipment (M&TE) laboratory personnel did not evaluate, in a timely manner, a digital multimeter that had been classified as being out of calibration. The evaluation should have been performed to ensure that any equipment the multimeter had been used on was operable. This occurred while a plant startup was in progress.
- ° Quality control inspectors present on the job did not intervene and ask questions when personnel were performing activities using inadequate instructions or were performing activities outside the scope of existing instructions.
- ° Reactor operators did not take sufficient prompt action to initiate the investigation of a reheat steam system temperature controller that had an abnormal temperature offset. The problem was later found to be an open thermocouple.
- ° The licensee was unable to retrieve nonconformance report information promptly to evaluate repetitive failures and prevent them.
- ° The stop work process was cumbersome mainly because several different procedures addressed the stop work process and the licensee's quality control personnel were not familiar with the process.
- ° Training of personnel on remote shutdown outside the control room was identified as a weakness. This was especially true for equipment operators and equipment tenders who had not received any specific training in the procedure, but would be directly involved in the remote shutdown. In addition, the licensee had never performed a remote shutdown test to verify that all the necessary equipment that had been independently tested would perform as designed in the integrated operation of remote shutdown.
- ° Both the offsite and onsite review committees conducted telephone polls on a limited basis for voting.

## Conclusions

Management involvement, including managers' meetings, monthly summary letters, senior planning meetings, and morning meetings (plant managers and superintendents) appeared to be good. However, on the basis of the type of problems

observed in the field by the team, the "nuclear attitude" demonstrated by the managers needed to be reinforced at all levels of the Fort St. Vrain staff, especially at the craftsman and engineer levels, to ensure acceptable implementation of quality activities in the plant.

After reviewing work activities and interviewing craftsmen and supervisors, the inspection team concluded that the first-line supervisors were well aware of inadequacies in maintenance procedures and documentation of maintenance activities. The team further determined that these procedure and documentation problems had apparently not been communicated to management, nor had any corrective action been initiated.

The findings of the team indicated an apparent inconsistency in the overall operation of the plant. There appeared to be acceptable programs and a good management and operations personnel attitude toward safe operation of the plant, including the initiation of programs designed to enhance efficiency and safety. However, the team observed the issuance and use of what it considered to be inadequate maintenance instructions and a lack of control and documentation of maintenance activities.