ENCLOSURE 2

U.S. NUCLEAR REGULATORY COMMISSION
REGION IV

Docket No.:	50-285
License No.:	DPR-40
Report No.:	50-285/97-20
Licensee:	Omaha Public Power District
Facility:	Fort Calhoun Station
Location:	Fort Calhoun Station FC-2-4 Adm. P.O. Box 399, Hwy. 75 - North of Fort Calhoun Fort Calhoun, Nebraska
Dates:	December 7, 1997, through January 17, 1998
Inspectors:	W. Walker, Senior Resident Inspector V. Gaddy, Resident Inspector D. Graves, Senior Project Engineer
Approved By:	W. D. Johnson, Chief, Project Branch B.

ATTACHMENT: Supplemental Information

EXECUTIVE SUMMARY

Fort Calhoun Station
NRC Inspection Report 50-285/97-20

Operations

- In general, the conduct of operations was professional and safety-conscious, with clear and thorough turnovers conducted (Section 01.1and 01.2).
- The licensee maintained good control of operator aids (Section O2.2).
- Operations memorandums were being used, in effect, to implement procedure changes without being processed in accordance with administrative requirements (Section 03.1).

Maintenance

- No preventive maintenance order existed to ensure periodic testing of a fan required for alternate cooling of the control room (Section 02.2).
- A sparger will be installed at the diesel-driven fire pump suction. The sparger is intended to prevent sand accumulation in the pump (Section M2.1).

Engineering

- The inspectors concluded that the maintenance rule audit was thorough and that the maintenance rule program improvement action plan was adequate (Section E7.1).
- Failure to maintain adequate trisodium phosphate in containment resulted in an inadequate amount of trisodium phosphate to neutralize the postaccident sump water following an accident (Section E8.1).

Plant Support

- Two licensee personnel entered the radiological controlled area without proper dosimetry (Section R1.2).

Report Details

Summary of Plant Status

The Fort Calhoun Station began this inspection period at 100 percent power and maintained that level until December 20, 1997. On December 20, 1997, power was reduced to 95 percent to perform a Technical Specification required surveillance for moderator temperature coefficient. On December 21, 1997, a power ascension began with 100 percent power attained on December 22, 1997. The plant remained at 100 percent power throughout the remainder of the inspection period.

I. Operations

O1 Conduct of Operations

01.1 General Comments (71707)

Using Inspection Procedure 71707, the inspectors conducted frequent reviews of ongoing plant operations. In general, the conduct of operations was professional and safety conscious; specific events and noteworthy observations are detailed in the sections below.

01.2 Shift Turnovers

The inspectors noted that shift turnovers and midshift briefings were good. Control room personnel reviewed the control room logs, walked down control room panels, and discussed the status of equipment during turnovers. The shift supervisor held good briefings for the shift crews. Operators remained cognizant of plant conditions during the turnovers and briefings.

O2 Operational Status of Facilities and Equipment

02.1 Review of Equipment Tagouts (71707)

The inspectors reviewed the following tagouts:

- Serial Number 98-0010, Repair of Seal Leak on Main Feed Pump FW-4C
- Serial Number 98-0015, Remount of Diesel Driven Auxiliary Fire Pump

The inspectors found all tags were on the proper components and that components were in the required tagged position. Housekeeping was observed to be good.

02.2 Control of Operator Aids

a. Inspection Scope (71707)

The inspectors walked down a sample of operator aids throughout the plant to assess how these aids were being controlled.

b. Observations and Findings

The inspectors performed a walkdown of the equipment that the licensee had identified as being operator aids. An operator aid was defined as information including sketches, graphs, procedures, drawings, prints, and other documents used to assist operators in performing assigned duties. This equipment was controlled by Standing Order SO-O-41, "Control of Operator Aids and Emergency Equipment." Based on a sample of equipment walked down, the inspectors concluded that, with few exceptions, operator aids were being properly controlled.

While inventorying the alternate shutdown panel lockers, the inspectors and a licensed operator noted that one of five flashlights required for Abnormal Operating Procedure AOP-06, "Fire Emergency," implementation was not functional. Also 3 of 12 door chocks required by Abnormal Operating Procedure AOP-13, "Loss of Control Room Air Conditioning," were missing from the lockers. These chocks were used to prop open doors to assist in control room cooling in the event normal control room cooling was lost. The inspectors verified that the deficiencies documented above were corrected.

The inspectors also verified that the alternate control room fan required by Abnormal Operations Procedure AOP-13 was in its designated location. This fan provided an option for cooling the control room in the event normal cooling was lost. The inspectors asked if there was a preventive maintenance order for the alternate control room fan to ensure it was maintained in a reliable condition. The maintenance manager stated there was not a preventive maintenance order that periodically verified the alternate control room fan was capable of cooling the control room. In response to the inspectors' questions, the licensee initiated a preventive maintenance order to test the fan on a yearly basis. The fan was scheduled to be tested during the week of January 26, 1998. The inspectors questioned the licensee concerning the last time the fan had been tested. The licensee indicated that the fan was last tested in the spring of 1995, however, the licensee could not locate any test documentation.

c. Conclusions

In general, the licensee maintained good control of operator aids throughout the plant. The inspector identified a weakness in which the alternate control room fan, required by Abnormal Operating Procedure AOP-13 to cool the control room, did not have a preventive maintenance order to ensure it was periodically tested and verified operational.

O3 Operations Procedures and Documentation

03.1 Review of Operations Memorandums (71707)

a. Scope of Inspection

The inspectors reviewed the active Operations Memorandums to determine whether they provided the appropriate document to direct operator actions.

b. Observations and Findings

On October 16, 1997, the licensee discovered that the Updated Safety Analysis Report, Section 8.4, stated that the capacity of the emergency station batteries in the two separate dc systems was adequate for instrument and control power for up to 8 hours following a design basis accident. A review of documentation by the licensee determined that no calculation supported the 8-hour capacity of the station batteries. This was reported to the NRC on October 17,1997, and in Licensee Event Report 97-015 dated November 17, 1997.

Subsequently, the licensee issued Operations Memorandum 97-11 regarding operator actions to take during a design basis accident that would ensure that sufficient battery capacity was available to meet design requirements. The memorandum required that, if the plant was in a condition such that the Emergency Operating Procedures were implemented, and the battery charger supply to either dc bus was lost, the operators were to minimize dc loads in accordance with Emergency Operations Procedure/Abnormal Operations Procedure, Attachment 6, "Minimizing DC Loads." The inspectors questioned the licensee regarding whether it was appropriate to direct emergency operator actions using an operations memorandum instead of making a procedure change or revision to the emergency operating procedures. The licensee stated that the operations memorandum process was controlled by Standing Order Procedure SO-O-13, "Operations Memorandums" Standing Order Procedure SO-O-13 defines "Operations Memorandums," as documents which communicate operational limitations, instructions, and/or other items of interest from management to the operating staff. The memorandum may be more conservative or restrictive than existing procedures, but cannot allow less conservative or restrictive operations.

The inspectors reviewed the active operations memorandums to determine the scope of operator guidance provided and discussed with the licensee what controls were placed on memorandum initiation and approval. The initial review of eight active memorandums was begun in the previous inspection period.

Observations regarding specific operations memorandums are discussed below.

b.1 Operations Memorandum 95-05

This memorandum directed operators to conduct evolutions to raise low pressure safety injection header pressure, if it dropped below a specified value, to prevent potential formation of nitrogen voids in the safety injection piping. This condition was documented in Licensee Event Report 97-017. The required operator actions included cycling of the low pressure safety injection loop isolation valves.

b.2 Operations Memorandum 97-06

This memorandum stated that, if MS-291 or MS-292, air assisted secondary system safety valves, were the preferred reactor coolant system heat removal path during a transient and they failed to fully open when required, the operators were to perform heat removal using one of three listed alternatives.

b.3 Operations Memorandum 97-07

This memorandum described the procedure that should be used to manually trip breakers during a fire which resulted in evacuation of the control room. These actions were in addition to the steps called for in Procedure AOP-06, "Fire Emergency," regarding breaker tripping during a control room evacuation.

b.4 Operations Memorandum 97-08

This memorandum related to the inoperability of Main Steam Line Radiation Monitor RM-064. During implementation of the Emergency Plan, the memorandum directed operators to use a radiation monitor other than RM-064 for the purpose of dose assessment. RM-064 was the normal monitor used for that purpose. If procedures necessary to assist in the determination of a leaking or failed steam generator tube were implemented, the operator was directed by the memorandum on how RM-064 should be placed in service to provide radiation level trending information.

b.5 Operations Memorandum 97-11

This memorandum directed that, in the event the plant was in an Emergency Operating Procedure, and the battery charger to either DC Bus is lost, the operators were to minimize dc loads per Attachment 6 to the Emergency Operating Procedures and Abnormal Operating Procedures. This memorandum was canceled following a revision to the Emergency Operating Procedures on November 18, 1997.

b.6 Procedural Requirements

The Updated Safety Analysis Report, Section 12.3.1, "Operating Procedures and Operating Instructions," stated that plant operations are conducted in accordance with written operating procedures and operating instructions. Section 12.3.2, "Emergency

and Abnormal Operating Procedures," stated that plant operation during abnormal conditions are conducted in accordance with written Emergency Operating Procedures and Abnormal Operating Procedures.

Standing Order SO-O-1, "Conduct of Operations," Revision 36, Section 12.1.2, "Procedure Adherence," stated that performance of an activity without referring to the procedure does not relieve the individual from responsibility for performing the activity in accordance with the latest revision of the approved procedure.

Standing Order SO-G-30, "Procedure Changes and Generation," identified the process by which plant operating procedures were revised or created. Operations Memorandums are not listed as one of the documents covered by this procedure.

Standing Order SO-O-13, "Operations Memorandums," provided the guidance for initiation and revision of operations memorandums. Section 5.1.3 of Standing Order SO-O-13 states that a review of the operating manual shall be conducted during the generation phase of the Operations Memorandum to ensure that appropriate guidance is given in all applicable operating procedures or instructions and that changes to affected procedures will be in accordance with Standing Order G-30.

The Operations Memorandums referenced above directed operator actions in addition to, or different from, those required by plant procedures. Those memorandums, in effect, constituted changes to the referenced procedures, or generation of new procedures, without implementing the requirements of Technical Specification 5.8.2 or Standing Order SO-G-30 regarding procedure changes or generation. Most significantly, Standing Order SO-O-13 did not require a 10 CFR 50.59 screen or evaluation that would normally be required of a procedure change or new procedure generation. The use of operations memorandums to direct operator actions, especially in the case of emergency operating procedures, abnormal operating procedures, and emergency plan procedures, precluded important steps or information, contained in the operations memorandum but not in the reference procedure, from being included in plant procedures. This, in turn, introduced the vulnerability that these required steps or actions may not get performed during periods of high stress such as those that may be present when those procedures are being implemented. Implementing changes to plant procedures without following the prescribed process is a violation of Technical Specification 5.8.2 (50-285/9720-01).

c. Conclusion

Operations memorandums that directed operator actions in addition to actions contained in existing plant procedures constituted procedures, or changes to procedures, that had not been processed in accordance with the administrative requirements regarding procedure changes and generation.

II. Maintenance

M1 Conduct of Maintenance

M1.1 General Comments

a. Inspection Scope (62707)

- Repair of component cooling water pump casing vent valve,
- DG 1 relay replacement,
- Toxic gas monitor tape replacement,
- Repair of diesel fire pump discharge check valve.

b. Observations and Findings

The inspectors found the work performed under these activities to be professional and thorough. All work observed was performed with the work package present and in active use. Maintenance technicians were experienced and knowledgeable of their assigned tasks. The inspectors frequently observed supervisors and system engineers monitoring job progress, and quality control personnel were present when required by procedure.

c. Conclusions

The maintenance activities observed were conducted in a controlled and professional manner.

M1.2 Surveillance Activities

a. Inspection Scope (61726)

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

- SE-ST-AFE-3005, "Auxiliary Feedwater Pump FW-6, Recirculation Valve, and Check Valve Tests " Revision 14;
- IC-ST-1A-3003, "Raw Water Instrument Air Accumulator Check Valve Operability Test," Revision 7;
- IC-ST-AFW-0001, "Auto Initiation of Auxiliary Feedwater Functional Check of Initiation Circuits," Revision 18;
- CH-FT-01-6771B, "Functional Testing of B Steam Generator Blowdown Station Conductivity Sensor CE-6771B," Revision 1;

- EM-ST-ESF-0001, "Quarterly Engineered Safety Features Offsite Power Low Signal (OPLS) Sensor Check," Revision 7.

b. Observations and Findings

Surveillance activities were generally completed thoroughly and professionally.

c. Conclusions

The surveillance activities observed by the inspectors were completed in a controlled manner and in accordance with procedures.

M2 Maintenance and Material Condition of Facilities and Equipment

M2.1 Diesel-Driven Fire Pump Failure

a. Inspection Scope (62707)

The inspectors followed up on diesel-driven fire pump sanding issues.

b. Observations and Findings

On January 5, 1998, the diesel-driven fire pump was declared inoperable to perform Surveillance Test OP-ST-FP-0001D, "Fire Protection System Inspection and Test." During the test, the discharge valve of the pump was shut and flow was discharged to the pump suction well. Following the approximate 30-minute pump run, the discharge valve was opened and the fire protection system was repressurized using the jockey pump. During system repressurization, the jockey pump could not repressurize the system. The licensee suspected that the discharge check valve was not properly seated and water was leaking by the check valve through the pump. Since the system could not be repressurized, the diesel-driven pump remained inoperable.

On January 7, maintenance personnel disassembled the check valve and verified that sand prevented the check valve from properly seating. Maintenance personnel removed approximately 6 to 7 gallons of sand from around the check valve flapper.

On January 8, the licensee performed Surveillance Procedure OP-ST-FP-0001D to show that the pump was operable following maintenance on the check valve to remove the sand. When the pump received a start signal it failed to start. Operations personnel present at the pump stated that the pump shaft started to rotate and then stopped. A second attempt was made to start the pump, but this time the shaft did not turn. Operations personnel backed out of the procedure and a maintenance work request was written to troubleshoot the pump.

On January 9, during troubleshooting, maintenance personnel determined that the pump would not start because of sand accumulation in the pump suction. The pump was disassembled and the sand was removed.

Normally, during the monthly surveillance test of the motor-driven pump, the flow path was from the discharge of the motor-driven pump through 12-inch and 8-inch piping to the discharge tunnel back to the river.

The normal monthly surveillance flow path for the diesel-driven fire pump was from the discharge of the pump through a 2.5-inch pipe to the pump suction well. Engineering personnel suspected that the smaller diameter piping used during testing the diesel-driven pump may not be adequate to ensure that the piping was thoroughly flushed. On January 10, during the operability test following the January 9 maintenance, the licensee changed the flow path to direct flow through the 12-inch and 8-inch piping used to test the motor-driven fire pump. The operability test was successful using this flow path. Following the surveillance, the discharge check valve was disassembled and inspected and no sand was noted. The diesel-driven fire pump was then declared operable.

The system engineer informed the inspectors that the pump would be run weekly for a period of time and the surveillance test procedure was being changed to reflect the new discharge flow path. Following the weekly pump runs, the check valve was to be inspected for sand. The system engineer also stated that a modification to install a sparger at the pump suction was scheduled for February 1998.

c. Conclusions

The system lineup used for testing the diesel-driven fire pump may have contributed to sand accumulation at the suction of the pump. The licensee plans to install a sparger on the pump. The sparger is intended to prevent further sand accumulation problems.

M8 Miscellaneous Maintenance Issues

M8.1 (Closed) Inspection Follow-Up Item (IFI) 50-285/9608-01: replacement of jacket water temperature control valve. This item remained open to allow the licensee to determine why the vendor changed the dimensions of a critical quality element without informing the licensee. Specifically, the vendor changed the dimensions of the jacket water temperature control valve of the diesel generator. Also, the item remained open to allow the licensee to address why a material discrepancy notice report was not initiated in a more timely manner to document the nonconforming condition.

The licensee determined that the installed jacket water temperature control valve was manufactured using a drawing dated April 1959. The replacement part was manufactured using a drawing dated May 1983. In the late 1970s, the dimensions for both the upper and lower valve cases were changed, however, the overall valve dimensions remained the same. Although the dimension changed, the part numbers remained the same.

The licensee stated that the reason for the delay in initiating the material discrepancy notice report was unclear guidance as to when a material discrepancy notice report should be initiated. The guidance was changed to require that a material discrepancy notice report be initiated at the time of discovery of a nonconforming condition.

Since the replacement part would not fit, the licensee tagged the replacement part with a material discrepancy notice report and stated that the part would remain in the warehouse until the material discrepancy notice report evaluation resolved the problem.

M8.2 (Closed) Inspection Followup Item 50-285/9707-03: component cooling water leak. This item was opened following a leak in the component cooling water system following a cut made in an isolated section of piping while performing a modification to abandon the waste evaporator. The inspector reviewed Condition Report 199700479 which documented the event, evaluation, and subsequent corrective action. The work was determined to have been properly controlled. The isolation valve that had been closed to provide system isolation did not completely close. The failure of the valve to obtain complete closure was determined to be the result of sand that had built up in the valve seating area because of opening and closing of the raw water to component cooling water system interface valves in past years. The previous testing methodology had allowed raw water, including any entrained sand, to be introduced into the component cooling water system. The waste evaporator had not been operated since the early 1980's and the component cooling water supply and return lines associated with the waste evaporator had not been routinely cleaned or tested. The testing methodology for the interface valves was changed in 1990 such that raw water would not be introduced into the component cooling water system. Since that time, no indication of valve fouling due to residual sand buildup had been observed in other parts of the system. The inspector also verified that procedure revisions were made to add component cooling water to the list of systems that required briefings prior to work if single valve isolations were to be used.

III. Engineering

E1 Conduct of Engineering

E7.1 Maintenance Rule Quality Assurance Audit

Between November 3 and 8, 1997, the licensee performed a quality assurance audit of the implementation and effectiveness of the maintenance rule program. The audit was primarily conducted by contract personnel with a member of the licensee's quality assurance organization serving as the audit team leader. The inspectors noted that the contractors were industry personnel with experience in maintenance rule implementation and with probabilistic risk analysis. The inspectors noted that the audit was thorough and self-critical. The audit team concluded the following about the Fort Calhoun Station's implementation of the maintenance rule:

- The structure and current status of the probabilistic risk analysis was not commensurate with the needs for the maintenance rule. This has delayed fine tuning and verification of the performance criteria.

- The monitoring approach implemented by the Fort Calhoun Station will not adequately highlight troublesome systems for expedited attention.

- Previous internal maintenance rule assessments did not subject the program to challenges expected today and may have given management an unjustified sense of comfort.

- Integration of the maintenance rule into the daily routine has not been achieved and the maintenance rule was viewed as a separate and decentralized issue of regulatory compliance.

- Training of personnel who are responsible for the implementation and integration of the maintenance rule program has not been adequate or effective.

- The processing of information, monitoring, trending, goal setting, and the updating of procedures must be expedited to assure that timely decisions can be made.

- Management oversight and cognizance of the maintenance rule had been weak and needs to be strengthened.

- Because the plant has a sound framework of the maintenance rule program in place, and has an effective data base for monitoring the performance of system, structures, and components, the audit team believed that a short-term upgrade plan can bring the maintenance rule program up to date.

In response to the audit conclusions, the licensee developed a maintenance rule program improvement action plan to address the above areas and other areas needing improvement. The action plan was scheduled to be completed prior to the beginning of the 1998 refueling outage. The inspectors concluded that the maintenance rule audit was thorough and that the maintenance rule program improvement action plan was adequate to resolve deficiencies identified during the audit.

E8 Miscellaneous Engineering Issues

E8.1 (Closed) Licensee Event Report (LER) 50-285/95-08: failure to maintain adequate trisodium phosphate inside containment due to a calculational error. On December 4, 1995, the licensee determined that, at the beginning of the last several plant operating cycles, the amount of trisodium phosphate in the containment was not sufficient to neutralize the postaccident containment sump water to a ph of 7.0.

Subsequently, the licensee performed an operability evaluation which determined, for current conditions, that the amount of trisodium phosphate inside containment was adequate for maintaining a ph of 7.0 or greater.

The licensee took the following corrective actions:

- Appropriate calculations and analysis were performed to ensure that a sufficient amount of trisodium phosphate in the containment sumps was available so that a neutral ph for each operating cycle can be achieved following a loss-of-coolant accident;

- Based on the revised calculations, additional trisodium phosphate was placed in the containment during the September 1996 refueling outage;

- A Technical Specification amendment was submitted to reflect the requirements for increased trisodium phosphate in the containment based on the revised calculations and analyses;

- The updated safety analysis report and design basis document were scheduled to be corrected during the next scheduled update;

- Training was provided to chemistry and operation personnel on the document changes and modifications;

- Chemistry Procedure CH-ST-CH-0002, "Phosphate Basket Inspection," was revised to ensure that the new Technical Specification requirements for trisodium phosphate were properly verified, and;

- To ensure the quantity of trisodium phosphate in the containment continues to be adequate for future operating cycles, the calculations and analyses used to determined the quantity of trisodium phosphate in containment will be reviewed as part of each operating cycle's core reload analysis.

Failing to maintain the Technical Specification required trisodium phosphate in containment which would ensure that a ph of 7.0 or greater could be achieved following a loss-of-coolant accident is a violation. This nonrepetitive, licensee-identified and corrected violation is being treated as a noncited violation consistent with Section V 11.B.7 of the NRC enforcement policy (50-285/9270-02).

IV. Plant Support

R1 Radiological Protection and Chemistry Controls

R1.1 Tours of Radiologically Controlled Areas

a. Inspection Scope (71750)

The inspectors performed frequent tours of the radiologically controlled area and observed work practices of plant personnel.

b. Observations and Findings

During this inspection period, the inspectors made frequent tours of the radiologically controlled area. Radiation protection personnel were observed performing their duties in a professional manner. Personnel performing maintenance in the radiologically controlled area were observed to be following all requirements of their radiation work permit.

While touring Room 6 (Charging Pump Room) on December 24, 1997, the inspectors noted that the high radiation and contaminated area rope boundary around Charging Pump CH-1C had fallen. The inspectors informed radiation protection personnel and the boundary was restored. Radiation protection personnel determined that duct tape had been used to hold the rope ends that formed the boundary. The heat generated from the operating charging pump caused the glue on the tape to melt and the rope boundary fell down. The licensee initiated a condition report to document this occurrence. As part of the corrective action to close the condition report, the licensee was evaluating whether the use of duct tape to establish radiation areas and contaminated areas was appropriate.

c. Conclusions

The inspectors identified a poor work practice in which duct tape was used in an elevated temperature environment to construct a boundary around a high radiation area and contaminated area. Plant workers exhibited good radiation protection practices.

R1.2 Entries Into the Radiologically Controlled Area Without Electronic Dosimetry

a. Inspection Scope (71750)

The inspectors followed up on two instances in which security personnel entered the radiologically controlled area without electronic dosimetry.

b. Observations and Findings

On January 1, 1998, a security officer entered the radiologically controlled area without an electronic dosimeter (ALNOR). The purpose of the entry was to perform fire door checks. On January 10, another security officer entered the radiologically controlled area without an electronic dosimeter. The purpose of this entry was to respond to a security alarm. Neither of the security officers entered high radiation areas. Both of these instances were identified by the licensee. In each instance, the officers were excluded from the radiologically controlled area.

During interviews with the individuals involved, the licensee determined that one individual needed additional radiation protection training.

As a corrective action, the officers involved were given verbal warnings and counseled by licensee management. The occurrences were also discussed on plant human performance day. The licensee identified three contributing causes for these occurrences. The licensee stated that the occurrences were caused by lack of personnel accountability, training deficiencies, and an unclear expectation for obtaining electronic dosimetry by security officers. Security management indicated that the expectation for obtaining electronic dosimetry was being clearly defined. The radiation protection manager indicated that they were considering reevaluating general employee training to ensure that all plant workers are aware of the licensee's expectations with regard to electronic dosimetry usage.

The inspectors reviewed Standing Order SO-G-101, "Radiation Worker Practices," and noted that Step 5.3.2F required personnel that entered the radiologically controlled area be monitored with a direct reading or electronic dosimeter. Entering the radiologically controlled area without a direct reading or electronic dosimeter is a violation. This nonrepetitive, licensee-identified and corrected violation is being treated as a noncited violation consistent with Section VII.B.1 of the NRC Enforcement Policy (50-285/9720-03).

c. Conclusions

A lack of personnel accountability, training deficiencies, and unclear expectations for obtaining electronic dosimetry by security officers were identified as being contributing causes for security personnel entering the radiologically controlled area without electronic dosimetry. The actions taken by the licensee appear to be adequate to ensure that entries into the radiologically controlled area are made with proper dosimetry.

V. Management Meetings

X1 Exit Meeting Summary

The inspectors presented the inspection results to members of licensee management on January 20, 1998. The licensee acknowledged the findings as presented.

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

ATTACHMENT

SUPPLEMENTAL INFORMATION

PARTIAL LIST OF PERSONS CONTACTED

Licensee

D. Buell, System Engineer
D. Dryden, Station Licensing Engineer
S. Gebers, Manager, Radiation Protection
B. Mierzejewski, Systems Engineer
R. Phelps, Manager, Station Engineering
C. Schaffer, System Engineer
J. Sefick, Manager, Security
R. Short, Manager, Operations

INSPECTION PROCEDURES USED

IP37551:	Onsite Engineering
IP 61726:	Surveillance Observations
IP 62707:	Maintenance Observations
IP 71707:	Plant Operations
IP 71750:	Plant Support Activities

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

50-285/9720-01	VIO	use of operations memorandums to implement procedure changes (Section 03.1)

Closed

50-285/9608-01	IFI	replacement of jacket water temperature control valve (Section M8.1)
50-285/9707-03	IFI	component cooling water leak (Section M8.2)
50-285/9508	LER	failure to maintain adequate trisodium phosphate inside containment (Section E8.1)

Opened and Closed

50-285/9720-02	NCV	failure to maintain adequate trisodium phosphate inside containment (Section E8.1)
50-285/9720-03	NCV	entry into the radiologically controlled area without electronic dosimetry (Section R1.2)