

ENCLOSURE 2

U.S. NUCLEAR REGULATORY COMMISSION
REGION IV

Docket No.: 50-416
License No.: NPF-29
Report No.: 50-416/97-21
Licensee: Entergy Operations, Inc.
Facility: Grand Gulf Nuclear Station
Location: Waterloo Road
Port Gibson, Mississippi 39150
Dates: October 19 through November 29, 1997
Inspectors: J. Dixon-Herrity, Senior Resident Inspector
K. Weaver, Resident Inspector
Approved By: D. Kirsch, Chief, Project Branch F
Division of Reactor Projects

Attachment: Supplemental Information

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EXECUTIVE SUMMARY

Grand Gulf Nuclear Station
NRC Inspection Report 50-416/97-21

Operations

- Operations shift turnovers were thorough and conducted professionally (Section O1.1).
- Nonlicensed operators were knowledgeable of the equipment and their duties and responsibilities (Section O1.2).

Maintenance

- Workers were knowledgeable of equipment and the scope of the planned work activities. Foreign material exclusion controls were good during work activities in and around the spent fuel pool area (Section M1.1).
- The licensee identified a second maintenance preventable functional failure on the Division 2 standby diesel generator due to the failure of the jacket water couplings (Section M1.1).
- Control room operators demonstrated good independent verifications, self-checking techniques, and communications during the observed surveillance testing activities (Section M1.2).
- One example of a violation was identified for the failure to ensure that a procedurally required clearance between scaffolding and safety-related equipment was either maintained or approved by engineering (Section M4.1).

Engineering

- Reactor engineering personnel provided continuous oversight and good support during the irradiated control rod blade processing (Section M1.1).

Plant Support

- In general, housekeeping and component material condition in the plant were good. However, housekeeping and combustible material controls were in need of much improvement in the hot machine shop (Section M2.1).
- Health physics provided good support during the waste processing in and around the spent fuel pool area. Workers appropriately adhered to radiological work permit requirements and demonstrated good radiation worker practices (Section R1.1).

- A second example of a violation was identified regarding the failure to obtain engineering approval prior to securing three steel stanchions to an overhead safety-related cable tray and its associated supports (Section R1.2).

Report Details

Summary of Plant Status

The plant remained at or near 100 percent power throughout this inspection period.

I. Operations

O1 Conduct of Operation.

O1.1 General Comments (71707)

The inspectors conducted frequent reviews of ongoing plant operations, attended daily operations shift turnovers, plan-of-the-day meetings, and performed plant tours. Daily operations shift turnovers were thorough and conducted professionally. However, the inspectors observed that, generally, numerous telephone calls came into the control room during shift turnovers. Operations management had determined that shift turnover times were to be considered quiet time and had directed the plant staff to refrain from contacting the control room during these periods. The inspectors discussed this concern with the operations superintendent. During one of these observations, the superintendent observed and recognized the same concern and stated that management was discussing plans on how to eliminate these distractions.

O1.2 Nonlicensed Operator Rounds (71707)

On November 9, 1997, the inspectors accompanied the nonlicensed operators in charge of the outside areas on their routine rounds to the plant radial well pump houses, switchyard, and meteorological tower. The inspectors found the nonlicensed operators knowledgeable of the equipment and their duties and responsibilities. The nonlicensed operators appropriately documented all equipment parameters and instrument readings in accordance with procedures. The inspectors found that housekeeping and material condition in the switchyard and meteorological tower areas were good.

O1.3 Conclusions

Operations shift turnovers were thorough and conducted professionally. Nonlicensed operators were knowledgeable of the equipment and their duties and responsibilities.

O7 Quality Assurance in Operations

O7.1 Safety Review Committee Meeting (71707)

On October 21, 1997, the inspectors attended a safety review committee meeting. The inspectors observed good discussions among safety review committee members on the presentations made during the meeting. Contractors on the committee were appropriately critical of the licensee's actions. The members met

the quorum requirements specified by the Technical Specifications. The inspectors concluded that the safety review committee activities were effective.

II. Maintenance

M1 Conduct of Maintenance

M1.1 General Maintenance Comments

a. Inspection Scope (62707)

The inspectors observed portions of maintenance activities, as specified by the following work orders (WOs):

- WO 00195697 Blowdown/clean standby liquid control system tank level indication bubbler tube
- WO 00197427 Troubleshoot/replace Division 2 standby diesel generator solenoid Valves 1P75F537B and 1P75F538B
- WO 00196569 Perform Division 2 standby diesel generator pneumatic control simulated engine run
- WO 00194183 Process, package, and ship for disposal: irradiated control rod blades, incore detectors, jet pump beams, etc.
- WO 00197629 Division 2 standby diesel generator jacket water coupling leak repair
- WO 00111897 Bench test of failed Agastat control relays

b. Observations and Findings

In general, the inspectors found this work to be well planned and performed satisfactorily. Workers were knowledgeable of the equipment and the scope of the work activities. In general, foreign material exclusion controls were good during the processing of the irradiated control rod blades in and around the spent fuel pool area. However, the licensee did identify, and document in Condition Report (CR) 1997-1150, that an unmarked clear plastic wrapping was found in the spent fuel pool area during the evolution. Reactor engineering personnel provided continuous oversight and good support during the irradiated control rod blade processing.

During the postmaintenance test of the Division 2 standby diesel generator, operators identified that the jacket water couplings on the diesel were leaking

approximately 80 drops per minute. The operators had maintenance personnel tighten the couplings, then started the diesel for a surveillance run. The leakage increased to approximately a pint to a quart per minute. The operators secured the diesel. The licensee identified this event as a valid maintenance preventable functional failure of the diesel. The inspectors observed the replacement of the coupling on November 12, 1997. The licensee replaced the coupling with a modified coupling from the same manufacturer that had better sealing capability. This was the second maintenance preventable functional failure identified on the Division 2 standby diesel generator due to jacket water coupling leakage. The first maintenance preventable functional failure was described in NRC Inspection Report 50-416/97-12. The licensee ran the Division 1 standby diesel generator to verify that there was not a potential for common mode failure. The operators observed that there was no leakage from the jacket water couplings. The licensee plans to replace all of the jacket water couplings through a design change in the near future; however, the parts had not arrived at the site at the time of this failure.

c. Conclusions

Workers were knowledgeable of equipment and the scope of the planned work activities. Foreign material exclusion controls were good during work activities in and around the spent fuel pool area. Reactor engineering personnel provided continuous oversight and good support during the irradiated control rod blade processing. The licensee identified a second maintenance preventable functional failure on the Division 2 standby diesel generator due to the failure of the jacket water couplings.

M1.2 General Surveillance Comments

a. Inspection Scope (61726)

The inspectors observed the performance of portions of the surveillance test, Procedure 06-CP-1E21-Q-0006, "Low Pressure Core Spray Quarterly Functional Test," Revision 100.

b. Observations and Findings

Control room operators performed well during the surveillance tests. Good communications were observed between personnel in the field and the control room operators. Independent verifications were properly performed. All equipment acceptance criteria specified in the test procedure were verified to be in compliance with Technical Specifications and were met with no discrepancies.

c. Conclusions

Control room operators demonstrated good independent verifications, self-checking techniques, and communications during the observed surveillance activities.

M2 Maintenance and Material Condition of Facilities and Equipment

M2.1 General Plant Tours

a. Inspection Scope (71750)

During tours of the plant, the inspectors reviewed the areas for proper housekeeping, components for material condition, and any nonconforming conditions.

b. Observations and Findings

The general housekeeping and material condition continued to be good throughout the plant. However, during a tour of the hot machine shop in the turbine building on November 9, 1997, the inspectors found weaknesses regarding housekeeping in the area. For example, bags of contaminated and noncontaminated trash had not been removed from the area. In addition, work incomplete tags, used cotton gloves, plastic material, and various trash were scattered on the floor and in the surrounding area. A container of liquid combustible material was found left unattended with no material safety data sheet label. The inspectors had previously found weak housekeeping in this area and documented this concern in NRC Inspection Report 50-416/97-06. The inspectors notified maintenance personnel and CR 1997-1158 was initiated. The area was subsequently cleaned and a material safety data sheet label with the combustible classification was affixed to the container.

The inspectors contacted fire protection personnel to ascertain whether the trash and combustibles could exceed the fire protection heat load calculations for the area. Fire protection personnel walked down the area on November 10 and determined that the heat load calculations for the area had not been exceeded.

The fire protection personnel performed a walkdown of the area again on November 18 and found (1) weaknesses in housekeeping with rubber gloves, rubber mats, and plastic bag material scattered on the floor, (2) paint spray cans with no combustible permits, (3) polyethylene plastic combustible material with no permit, and (4) two fire extinguishers that had not had a monthly inspection. The fire protection personnel initiated CR 1997-1212 to document these concerns. The licensee determined that CR 1997-1212 should be classified as a station level CR, which would require a formal root cause evaluation in accordance with their corrective action process.

During a tour of the auxiliary building on November 10, 1997, the inspectors identified a paper suit that had been inappropriately discarded in a cable tray with energized cables in the Division 2 safety-related switchgear room. The inspectors notified health physics personnel and the paper suit was removed and surveyed for

contamination. The inspectors were informed that no contamination was found on the suit.

c. Conclusions

In general, housekeeping and component material condition in the plant were good; however, housekeeping and combustible material controls in the hot machine shop were in need of improvement.

M.4 **Maintenance Staff Knowledge and Performance**

M4.1 Scaffold Constructed Next to Safety-Related Component

a. Inspection Scope (62707)

The inspectors reviewed equipment material condition related to maintenance during tours of the plant.

b. Observations and Findings

On October 28, 1997, the inspectors observed that one member of a scaffold built under electrical penetrations on the 166-foot level of the auxiliary building contacted the insulation of a small gauge pipe just under containment atmosphere sample inlet Valve 1P33F572A, a safety-related valve. The inspectors reviewed Procedure 15-S-01-106, "Scaffolding Erection," Revision 0, and Standard GGNS-CS-05, "Standard for Erection of Scaffolding in Safety-Related Areas," Revision 0. These procedures required nuclear plant engineering approval for scaffolding with clearances less than 6 inches from safety-related systems or components.

The inspectors discussed the concern with modification and construction personnel and requested a copy of the engineering evaluation performed. The inspectors observed that the evaluation did not address the concern identified and that the independent inspection required by Procedure 15-S-01-106, Step 7.4, for Seismic II/I scaffolding had not been signed off on the scaffold request form. The inspectors discussed the concerns with a modification and construction supervisor. The supervisor explained that the carpenters were aware that an evaluation had been performed and thought that the proximity to safety-related equipment had already been addressed. The supervisor initiated CR 1997-1129 to document and resolve the concerns.

The inspectors discussed the general process of scaffolding construction and approval with engineering personnel. The nuclear plant engineer, who approved deviating from Standard No. GGNS-CS-05, walked down the area with modification and construction personnel to plan the scaffold. However, there was no requirement for the engineer who approved the deviation to review the scaffold

after it was constructed to ensure it met the plans. The inspectors observed that this was a potential weakness in the licensee's program.

The licensee acknowledged that the clearances between the scaffold and the valve should have been evaluated by engineering. The licensee had the scaffold modified to provide 6 inches of clearance from safety-related equipment and performed a review of all scaffolding that was erected at the site. The remaining scaffolding was constructed in accordance with the procedure.

The inspectors determined that the failure to build the scaffold in accordance with Procedure 15-S-01-106 was the first example of a violation of 10 CFR Part 50, Appendix B, Criterion V (50-416/9721-01). The second example is identified in Section R1.2.

c. Conclusions

One example of a violation was identified for the failure to ensure that a procedurally required clearance between scaffolding and safety-related equipment was either maintained or approved by engineering.

M8 Miscellaneous Maintenance Issues (92902)

M8.1 (Closed) Violation 50-416/9617-02: failure to revise work packages in accordance with procedures on work scope. An electrician was electrically shocked as a result of the failure to revise the work package to reflect the current equipment status in the plant. The licensee determined that this event resulted from the failure to update the work package, an inadequate prejob briefing, and a failure to thoroughly check the panel to verify that it was deenergized. In addition, the licensee determined that the personnel had failed to follow the procedure for flagging temporarily energized equipment and that a temporary alteration package should have been used to route temporary power in this case, rather than a temporary procedure.

The inspectors reviewed the corrective actions taken and discussed how the corrective action would prevent recurrence with the electrical and instrumentation superintendent. The licensee had determined that the barriers to prevent recurrence included insuring that the temporary alteration process was used in the future. The licensee revised Procedure 01-S-07-1, "Control of Work on Plant Equipment and Facilities," Revision 31, to require the impact statement be revised to reflect changes in work scope or plant conditions. With the information provided by the temporary alteration process, supervisors reviewing packages to be placed on the schedule would be able to identify changes and would be required to have the packages revised. The prejob briefing process was changed to require a 30-minute supervisor turnover time. Electrical maintenance personnel were given training to stress the importance of voltage checks and flagging. The inspectors concluded that the licensee's corrective actions were acceptable.

III. Engineering

E8 Miscellaneous Engineering Issues (92903)

- E8.1 (Closed) Violation 50-416/9606-02: unsecured locker in remote shutdown panel room. The licensee determined that Procedure 01-S-07-43, "Safe Handling of Loose Items Inside the Plant," did not contain adequate direction for ensuring that safety-related equipment would not be affected by loose, nonsafety-related items in the plant. The licensee conducted an extensive tour and identified 59 different items which did not meet the criteria specified in the procedure. The inspectors reviewed the corrective actions taken in response to these items and concluded that the loose items had been acceptably addressed. The inspectors reviewed the revised procedure and performed walkdowns of the plant to determine if the corrective actions were effective. Although the inspectors identified no similar loose items, as documented in NRC Inspection Report 50-416/97-12 and Section R1.2 in this report, the failure to ensure an engineering evaluation is conducted prior to securing items to safety-related equipment was still a concern. The inspectors concluded that the corrective actions taken adequately addressed the concern of leaving items unsecured in the plant.
- E8.2 (Closed) Unresolved item 50-416/9703-02: evaluation of licensee conformance with regulatory guide. This item was opened to further evaluate the licensee's conformance with Technical Specification 5.5.7 for testing of ventilation filters and to review the Office of Nuclear Reactor Regulation's response to the licensee's request for an interpretation of the wording in Regulatory Guide 1.52, "Design, Testing and Maintenance Criteria for Post Accident Engineered-Safety-Feature Atmosphere Cleanup System Air Filtration and Adsorption Units of Light-Water-Cooled Nuclear Power Plants." The inspectors reviewed the response from the Office of Nuclear Reactor Regulation to Mr. Jerrold Dewease dated September 11, 1997. In the letter, the staff determined that the licensees were expected to develop interpretations of the terms in regulatory guides to limit the high efficiency particulate air and charcoal filter testing to situations which have the potential to degrade engineered safety feature filtration system efficiency. The interpretations must be based on a well-documented, sound, and conservative technical basis. The staff also documented that painting, fire, or chemical release is not communicating with a ventilation system if the ventilation system is not in operation and the isolation dampers for the system are closed and leak tight, thereby preventing air from passing through the filter.

The inspectors had identified that the licensee did not have a basis for the 1.5-hour required wait time that they identified for the standby fresh air system and that the licensee had no controls over the amount of paint that was being used in the areas that communicated with the filtration systems. The licensee changed the 1.5-hour wait time to 16 hours and instituted controls to limit the amount of paint or volatile organic compounds that could be taken into the areas to an amount that would not degrade the filtration systems. The inspectors found that the dampers on the

standby gas treatment system were not leak tight and questioned whether the filters could be affected by painting. The licensee addressed this concern and documented their response to the letter in a package titled, "Programs Package for Control of Volatile Organic Compounds in the Control Building." The package documented that the auxiliary building was maintained at a negative pressure in relation to the outside. The leakage past the dampers was coming from the discharge vent from the outside, through the filter, and out a drain valve. The inspectors reviewed the system drawings and concluded that this was the case and that volatile organic compounds released during painting would not have the opportunity to pass through the filters.

The inspectors reviewed the results of all of the past tests conducted on the charcoal. The charcoal in the filtration units has passed tests performed every 18 months, indicating that there is no buildup due to volatile organic compounds. The inspectors determined that the lack of controls that the licensee had in place prior to the concerns being identified did not have a safety-significant effect on the plant due to the results of past tests. The inspectors concluded that the programs that the licensee recently put in place, to address Regulatory Guide 1.52, were appropriate.

- E8.3 (Closed) Unresolved Item 50-416/9720-02: discrepancies identified with containment electrical penetration nitrogen supply pressure. This item was opened to review the purpose of Updated Final Safety Analysis Report Table 6.2-19, "Primary Reactor Containment Penetration and Containment Isolation Valve Leakage Rate Test List," Note 14, and its relation to the electrical penetrations. The inspectors discussed the concerns with the Office of Nuclear Reactor Regulation and determined that the note could be interpreted to mean that the electrical penetrations only had to be continuously pressurized at $> P_0$ when leak rate testing was being performed. Although the electrical penetrations were designed to allow continuous monitoring, the Updated Final Safety Analysis Report does not address this function. The Office of Nuclear Reactor Regulation agreed that the inner two o-rings are the safety-related seals required for containment isolation and the outer two o-rings and the nitrogen supply system are nonsafety-related and were installed to allow testing of the inner two o-rings. Maintaining the penetrations pressurized served no safety-related function. The licensee initiated CR 1997-1024. The inspectors concluded that the concern was nonsafety-related and would appropriately be addressed by CR 1997-1024.

IV. Plant Support

R: Radiological Protection and Chemistry Controls

R1.1 Packaging of Irradiated Waste

a. Inspection Scope (71750)

The inspectors attended the crew prejob briefing for Radiation Work Permit (RWP) 97-10-001 which was written for the packaging of the irradiated waste in the spent fuel pool performed under WO 00194183.

b. Observations and Findings

The crew prejob briefing performed on November 5, 1997, for RWP 97-10-001 was thorough, and the RWP covered all the necessary information. Workers adhered to the RWP requirements and demonstrated good radiation worker practices in high contamination areas and high radiation areas during the work activities. Dedicated health physics personnel continuously monitored the work activities performed under RWP 97-10-001. In addition, health physics personnel installed additional area radiation monitors on the fuel handling platform and on the fuel pool heat exchanger prior to processing the control rod blades.

c. Conclusions

Good health physics support was provided during the waste processing in and around the spent fuel pool area. Workers appropriately adhered to RWP requirements and demonstrated good radiation worker practices.

R1.2 Health Physics Equipment Found Suspended From Safety-Related Plant Equipment (71750)

a. Inspection Scope (71750)

The inspectors frequently performed walkdowns of the radiological controlled access area and assessed radiological postings and worker adherence to protective clothing requirements.

b. Observations and Findings

In general, radiological areas were properly posted, and area survey maps were appropriately updated. During a tour of the 139-foot elevation of the auxiliary building on November 10, 1997, the inspectors identified three health physics stanchions suspended approximately 2 feet from the floor. The stanchions, each weighing approximately 40 lbs., were tied with a rope to a Division 1 safety-related cable tray and its associated supports in the overhead. The inspectors questioned

contract workers in the area to ascertain the reason for securing the three stanchions to safety-related equipment. The contract workers stated that they were preparing the auxiliary building floor for painting activities and that health physics personnel had directed them to hang the stanchions from overhead equipment in order to retain the posted radiation area boundary. Nuclear plant engineering had not been required to evaluate the practice. The inspectors informed the contract workers and health physics personnel that plant procedures did not allow securing loose items in the plant to safety-related equipment without nuclear plant engineering approval. The stanchions were subsequently removed from the safety-related equipment and CR 1997-1181 was initiated.

Procedure 01-S-07-43, "Safe Handling of Loose Items Inside the Plant," Revision 1, Paragraph 5.11, stated in part, that equipment; piping; conduit; tubing; cable trays; instrumentation; heating, ventilation, and air conditioning; and their associated supports (safety-related and nonsafety-related) are not considered structural elements and cannot be used for securing loose items without nuclear plant engineering approval.

The failure of health physics personnel to obtain nuclear plant engineering approval prior to securing the three stanchions to the overhead safety-related cable tray and its associated supports was a second example of a violation of 10 CFR Part 50, Appendix B, Criterion V (50-416/97021-01). The first example is addressed in Section M4.1.

The inspectors identified a similar violation in NRC Inspection Report 50-416/97-12. The violation is discussed in Section R8.1 of this report.

c. Conclusion:

Radiological areas were properly posted and area survey maps were appropriately updated. However, a second example of a violation was identified regarding the failure to obtain engineering approval prior to securing three steel stanchions to the overhead safety-related cable tray and its associated supports.

R1.3 Contamination Event and Unmonitored Release

a. Inspection Scope (93702)

The inspectors reviewed the circumstances surrounding the unmonitored release and contamination event and monitored the licensee's interim corrective actions and cleanup activities.

INSPECTION PROCEDURES USED

61726	Surveillance Observations
62707	Maintenance Observation
71707	Plant Operations
71750	Plant Support Activities
92902	Followup - Maintenance
92903	Followup - Engineering
92904	Followup - Plant Support
93702	Prompt Onsite Response to Events at Operating Power Reactors

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

97021-01	VIO	Failure to ensure clearance from safety-related equipment was evaluated (Section M4.1) and failure to evaluate the attachment of steel stanchions to a safety-related cable tray and the associated supports (Section R1.2)
97021-02	IFI	Further review of the licensee's investigation, the cause and the licensee's corrective actions associated with the unmonitored release and contamination event (Section R1.3)

b. Observations and Findings

At approximately 6 p.m. on November 24, 1997, two workers who were exiting the protected area, alarmed the portal monitors at the security access point. The individuals had contamination on their shoes.

Licensee investigation traced the contamination to the area around the condensate storage tank, where a skid mounted hydrolaser was set up. This hydrolaser was being used to provide wash water in the cask wash area of the spent fuel pool. The licensee determined that contaminated water was siphoned from the spent fuel pool on November 21, 1997. The hydrolaser wand had been lowered to the bottom of the cask wash area and pressurized water was supplied to the wand to stir up sediment in order that it could be vacuumed from the cask wash area. At one point, the wand began floating towards the surface. As an emergency action measure, personnel involved secured the pressurized water for about a two minute time period until the wand could be removed from the cask wash down area. The licensee believed that during this two minute period, the static head from the spent fuel pool may have caused a siphon effect to occur. The licensee estimated that the amount of contaminated water from the spent fuel pool that could have migrated outside the radiological controlled access area onto the concrete and gravel area was approximately 1.5 gallons.

Surveys of the area found contamination levels as high as 60,000 counts per minute. This was the result of a direct frisk of a foot pedal for the hydrolaser skid. The smearable contamination level for this pedal was approximately 30,000 disintegrations per minute. The licensee roped off the area as a contamination area. Surveys detected contamination in a gravel area at a nearby storm drain. Upon opening the drain cover and performing a large area survey in the drain, the licensee detected contamination levels in the range of 1,500 disintegrations per minute. This indicated that there was likely an unmonitored release from the radiological controlled access area. The drain flows to a hold up basin and eventually flows to the river. Upon further investigation, the licensee found that the contamination was contained inside the storm drain piping upstream of the basin. The licensee had implemented interim measures in anticipation of rain. These measures included sealing the concrete surfaces by painting and digging up and removing contaminated rocks and gravel around the drain.

At the end of this inspection period, the licensee had established a significant event review team to perform an investigation of this event to determine the root cause and corrective actions to prevent recurrence. Further review of the licensee's investigation, the cause, and the licensee's corrective actions will be conducted through an Inspection Followup Item (50-416/9721-02).

R8 Miscellaneous Radiological Protection & Chemistry Issues (92904)

- R8.1 (Closed) Violation 50-416/9712-01: failure to perform a required engineering evaluation prior to resting an extension ladder on a safety-related cable tray. In reviewing the violation, the inspectors noted that Procedure 01-S-07-43, may have contributed to the violation in that the requirement to obtain engineering approval could only be found by reading a note in the definition section of the procedure. The inspectors considered this to be a weakness in the procedure and discussed it with the licensee. Subsequent to the discussion, the licensee issued an addendum to its initial response. The addendum was dated October 2, 1997, and committed to enhance the procedure by putting the note in a more visible section of the procedure.

While reviewing the issue discussed in Section R1.2 of this report, the inspectors reviewed the changes made to Procedure 01-S-07-43. The licensee had added Step 6.10, titled "Scaffolding and Portable Ladders," and had placed the note under this step. The inspectors interviewed the personnel involved in the situation discussed in Section R1.2 and determined that the individuals were not aware of the requirement in Procedure 01-S-07-43 nor did Step 6.10 address securing "loose items" such as the three stanchions identified in violation 50-416/97021-01. The inspectors considered that the corrective actions taken in response to Violation 50-416/97012-01 were too narrowly focused and were not effective in preventing recurrence of the violation discussed in Section R1.2. Review of this issue will be included in the followup to violation 50-416/97021-01.

P8 Miscellaneous Emergency Preparedness Issues (92904)

- P8.1 (Closed) Violation 50-416/9706-03: failure to have a qualified individual for the offsite emergency coordinator position available. The licensee determined that the root cause for this event was personnel error. The individuals involved and the emergency preparedness staff were counseled. The inspectors concluded that the licensee's corrective actions were acceptable.

V. Management Meetings

X1 Exit Meeting Summary

The inspectors presented the inspection results to members of licensee management on December 2, 1997, following the conclusion of the inspection. The licensee acknowledged the findings presented.

The inspectors asked the licensee whether any materials examined during the inspection should be considered proprietary or proprietary information was identified.

ATTACHMENT

PARTIAL LIST OF PERSONS CONTACTED

Licensee

D. Bost, Director, Nuclear Plant Engineering
C. Bottemiller, Superintendent, Plant Licensing
J. Burton, Technical Assistant, Performance and System Engineering
L. Dale, Director, Plant Projects and Support
J. Hagan, Vice President, Plant Operations
C. Hayes, Director, Quality Programs
C. Holifield, Licensing Engineer, Plant Licensing
K. Hughey, Director, Nuclear Safety and Licensing
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E. Langley, Technical Assistant, Maintenance
T. Kriesel, Radiation Control Supervisor, Radiation Protection
L. Robertson, Outage Management, Maintenance
C. Stafford, Operations Assistant, Plant Operation
J. Venable, Manager, Operations

NRC

J. Donahew, NRR Project Manager

Closed

96006-02	VIO	Unsecured locker in remote shutdown panel room (Section E8.1)
96017-02	VIO	Failure to revise work packages in accordance with procedures on work scope (Section M8.1)
97006-03	VIO	Failure to have a qualified individual for the offsite emergency coordinator position available (Section P8.1)
97003-02	URI	Evaluation of licensee conformance with regulatory guide (Section E8.2)
97012-01	VIO	Failure to perform a required engineering evaluation prior to resting an extension ladder on a safety-related cable tray (Section R8.1)
97020-02	URI	Discrepancies identified with containment electrical penetration nitrogen supply pressure (Section E8.3)
97012-01	VIO	Failure to perform a required engineering evaluation prior to resting an extension ladder on a safety-related cable tray (Section R8.1)