

U.S. NUCLEAR REGULATORY COMMISSION

REGION II

Docket Nos: 50-338, 50-339  
License Nos: NPF-4, NPF-7

Report Nos: 50-338/97-02, 50-339/97-02

Licensee: Virginia Electric and Power Company (VEPCO)

Facility: North Anna Power Station, Units 1 & 2

Location: 1022 Haley Drive  
Mineral, Virginia 23117

Dates: February 23 through April 5, 1997

Inspectors: R. McWhorter, Senior Resident Inspector (February 23 until  
March 6, 1997)  
K. Poertner, Acting Senior Resident Inspector  
R. A. Gibbs, Resident Inspector  
R. Aiello, Acting Senior Resident Inspector (Sections 01.2,  
01.3, 01.4, 02.1, M1.1, and M1.2)  
L. Garner, Project Engineer (Sections 02.2 and F5.1)  
R. D. Gibbs, Reactor Inspector (Section M8.1)

Approved by: G. Belisle, Chief, Reactor Projects Branch 5  
Division of Reactor Projects

ENCLOSURE 2

## EXECUTIVE SUMMARY

North Anna Power Station, Units 1 & 2  
NRC Inspection Report Nos. 50-338/97-02, 50-339/97-02

This integrated inspection included aspects of licensee operations, engineering, maintenance, and plant support. The report covers a six-week period of resident inspection; in addition, it includes the results of inspections by two regional specialists and a project engineer.

### Operations

- 10 CFR 70.24, Criticality Accident Requirements, were satisfied prior to the receipt of new fuel (Section 01.2).
- The inspectors concluded that the nuclear oversight meetings were of some substance. As the organization continues to mature and gain credibility, the organization's ability to identify issues prior to those issues becoming significant regulatory issues should improve (Section 01.3).
- One Unresolved Item (URI) concerning Station Nuclear Safety and Operating Committee (SNSOC) program reviews was identified (Section 01.4).
- An Inspection Follow-up Item (IFI) was identified to review the evaluation concerning boron concentration in the accumulator discharge lines (Section 01.4).
- A Violation (VIO) concerning the failure of the licensee to assure that the Control Room (CR) chart recorders were functioning properly was identified (Section 02.1).
- An unusual oil leak from the 2H Emergency Diesel Generator (EDG) exhaust manifold was identified and discussed with plant management (Section 02.2).

### Maintenance

- Maintenance work activities observed were performed in a professional and thorough manner. An NCV concerning the failure to perform a required Appendix R fire watch was identified (Section M1.1).
- Surveillance activities observed were generally performed in a professional and thorough manner. However, the inspectors noted a lack of attention to detail in completing the required documentation for 2-PT-80, AC Sources Operability Verification. Housekeeping in the Service Water Building was not as orderly as more frequently traveled areas in the plant (Section M1.2).
- Technical Specification (TS) requirements were satisfied for the quarterly turbine driven auxiliary feedwater pump and valve test. The

Training Department was not effective in preparing the licensed operator for the overspeed trip tappet exercise portion of the test (Section M1.3).

- The testing of the Auxiliary Shutdown facility clearly exceeded the requirements of TS and is identified as a strength (Section M8.1).
- Many of the switches on the Auxiliary Shutdown panel were not tested to verify operability, and the inside of the panel was found to be extremely dirty. An IFI was issued to followup licensee actions concerning this weakness (Section M8.1).

#### Engineering

- The safety evaluation associated with Unit 1 Temporary Modification (TM) 96-1635 adequately justified implementation of the TM (Section E1.1).

#### Plant Support

- Radiation protection practices observed were conducted properly (Section R1.1).
- The protected area perimeter barrier was properly manned and maintained (Section S1.1).
- Several deficiencies were noted during a fire drill which resulted in the fire drill being classified as a failure (Section F5.1).

## Report Details

### Summary of Plant Status

Units 1 and 2 operated the entire inspection period at or near full power.

### I. Operations

#### 01 Conduct of Operations

##### 01.1 Daily Plant Status Reviews (71707, 40500)

The inspectors conducted frequent CR tours to verify proper staffing, operator attentiveness, and adherence to approved procedures. The inspectors attended daily plant status meetings to maintain awareness of overall facility operations and reviewed operator logs to verify operational safety and compliance with TSs. Instrumentation and safety system lineups were periodically reviewed from CR indications to assess operability. Frequent plant tours were conducted to observe equipment status and housekeeping. Deviations Reports (DRs) were reviewed to assure that potential safety concerns were properly reported and resolved. The inspectors found that daily operations were generally conducted in accordance with regulatory requirements and plant procedures. Good equipment material conditions were also evident by extended problem-free plant operations.

##### 01.2 Preparation for Refueling (New Fuel Receipt Inspection)

###### a. Inspection Scope (60705)

On March 19, the inspectors observed the facility conduct an inadvertent criticality evacuation drill. On March 20, the inspectors reviewed plant systems and licensee procedures for the receipt of new fuel.

###### b. Observations and Findings

On March 19, the facility conducted two drills in order to ensure compliance with the requirements of 10 CFR 70.24, Criticality Accident Requirements, prior to receiving a new fuel shipment. The inspectors identified to the licensee during the first post drill critique that the first drill did not simulate the anticipated conditions during an accidental criticality. Specifically, all of the participants were huddled in a group and the drill coordinator said, "The criticality alarm is alarming." Everyone at that point exited the Fuel Handling Building. The facility elected to conduct a second drill. This time the drill coordinator had everyone assume normal fuel receipt inspection positions. The inspector reviewed the safety evaluation (97-SE-TM-08) that discussed the placement and operation of the temporary criticality alarm system in the Fuel Handling Building. No problems were identified. Procedure 0-OP-4.2, Receipt and Storage of New Fuel, Revision 10, was revised to incorporate the addition of the new temporary criticality monitors.

c. Conclusions

The inspectors verified that the requirements for 10 CFR 70.24, Criticality Accident Requirements, were satisfied prior to the receipt of new fuel.

01.3 Nuclear Oversight Department Quarterly Meeting

a. Inspection Scope (71707)

On March 25, the inspectors attended the licensee's Nuclear Oversight Department (NOD) quarterly meeting. The NOD ensured that nuclear activities were conducted with focus on nuclear safety, regulatory compliance and performance.

b. Observations and Findings

The NOD quarterly report inputs included department interfaces, safety evaluations, maintenance rule implementation, personnel safety, safety related ventilation maintenance, conduct of operations during transient events, reduction in engineering effectiveness and control of the ionics system. Issues that required increased management attention were identified as "Red Issues." These "Red Issues" were categorized based on evaluation of nuclear safety significance, regulatory compliance, personnel safety, the ability to self identify the concern, and the timeliness and effectiveness of the corrective action. The NOD identified several areas that required increased management attention. Two examples were:

- the lack of a Probabilistic Safety Assessment representative at the weekly maintenance rule meetings on site, and
- untimely and ineffective corrective actions for identified deficiencies.

The NOD consisted of four nuclear specialists, one for each SALP discipline. Two of the specialists were relatively new.

c. Conclusions

The inspectors concluded that the nuclear oversight meetings were of some substance. As the organization continues to mature and gain credibility, the organization's ability to identify issues prior to those issues becoming significant regulatory issues should improve.

01.4 DR Review

a. Inspection Scope (71707, 40500)

The inspectors reviewed numerous DRs during the report period.

b. Observations and Findings

Additional reviews were necessary for the following DRs:

- DR N-97-577: TS 6.5.1.6.a requires that SNSOC review the programs and all changes thereto described by TS 6.8.4. TS 6.8.4.a states, in part, that there will be a program to reduce leakage from primary coolant sources outside containment. The technical procedures that implemented the requirement did not require SNSOC approval. This condition is being corrected by the licensee. The inspectors are reviewing other programs to verify that SNSOC reviews are being performed. Pending completion of this review, this item is identified as URI 50-338, 339/97002-01.
- DR-N-97-494: On February 24, the licensee identified that procedure 1/2 OP-14.1 Residual Heat Removal, Revision 41/31, Units 1 and 2 respectively, Step 5.1.9, did not take into account that the space between the accumulator discharge check valves on B and C accumulators could be at a much lower boron concentration than either the Reactor Coolant System or the accumulator discharge line due to cold shutdown requirements. Until the inspectors review the evaluation concerning boron concentration in the accumulator discharge lines, this item is identified as IFI 50-338, 339/97002-02.

c. Conclusions

One URI concerning SNSOC program reviews was identified. An IFI was identified to review the evaluation concerning boron concentration in the accumulator discharge lines.

02 Operational Status of Facilities and Equipment

02.1 Review of Shift Logs

a. Inspection Scope (71707)

On March 18, the inspectors checked the CR chart recorders to assure that pens were marking properly and the recorders were timing correctly. The inspectors also verified that each chart had been checked by each shift and annotated as required by procedures.

b. Observations and Findings

The inspectors identified where the licensee failed to properly check the CR chart recorders as required by the following procedures:

- 1-GOP-1.0, Unit 1 CRO Turnover Checklist, Revision 12
- 2-GOP-1.0, Unit 2 CRO Turnover Checklist, Revision 11
- 0-OPAP-0004, Logs and Operating Records, Revision 5

Chart recorders 1-RC-FR-1154B, Unit 1 number 1 Seal Leakoff; 2-RC-FR-2154B, Unit 2 number 1 Seal Leakoff; and 2-NI-NR-46, Unit 2 Nuclear Instrument (NI) 43 Overpower were not inking and had not been for several days. Furthermore, the operators on each shift had initialed and dated the recorders without verifying that the recorders were functioning properly for several days. When the inspectors identified that the above recorders were not inking properly, the CR licensed operator immediately re-primed the pens to allow a trace to be read. The facility wrote a DR (DR 97-671) and the shift supervisor briefed the on-coming shifts in order to re-emphasize the requirements of the above procedures. The failure to assure that the CR chart recorders were working properly is identified as VIO 50-338, 339/97002-03.

c. Conclusions

The inspectors identified one violation concerning the failure of the licensee to assure that the CR chart recorders were functioning properly.

02.2 2H EDG Walkdown (71707)

On March 14, while performing a routine tour of the 2H EDG room, the inspectors observed oil dripping off the diesel's side. It seemed to originate around the exhaust manifold header flange. An operator performing rounds was notified of the condition and the oil was cleaned up. Approximately 2 hours later, the inspectors observed that approximately two tablespoons of oil had accumulated in this same area.

The 2H EDG had last been operated on March 10. After operation, the diesel generator is barred over with air to clear the cylinders of oil. This oil is blown into the exhaust manifolds and may later leak out the flanged connection. The inspectors considered that the observed flow rate five days after the diesel's last operation was unusual. This was discussed with the system engineer and the Station Manager who indicated that the observed condition would be evaluated and action taken as appropriate.

## II. Maintenance

M1 Conduct of Maintenance

M1.1 General Comments

a. Inspection Scope (62707)

The inspectors observed and reviewed maintenance activities to verify that activities were conducted in accordance with TS, procedures, regulatory guides, and industry codes or standards. The inspectors observed all or portions of the following Work Order (WO) activities:

- 0-MCM-0101-01, Main Feedwater Pump and Motor Alignment, Revision 2

- 0-MPM-0103-01, Preventive Maintenance on Charging/High Head Safety Injection (SI) Pumps, Revision 7
  - WO 00358792-01, Change Oil In Pump Speed Increaser
  - WO 00355939-01, Clean Lube Oil Coolers
  - WO 00354318-01, Clean Filters/Inspect Seal Coolers
  - WO 00344087-01, Charging Pump Casing Replacement and DCP 95-127, Remove Seal Coolers
- 0-MPM-0710-01, Quarterly Preventive Maintenance on the Caterpillar Station Blackout Diesel, Revision 1.

b. Observations and Findings

The inspectors found the work performed under these activities was professional and thorough. All of the work observed was performed with the work package present and in use. The blocks of the fire and missile barrier for the Unit 1 A charging pump cubicle were removed for the planned maintenance under the WOs mentioned above. Therefore, an hourly fire watch was required per VPAP-2401, Fire Protection Program, Revision 5, for 10 CFR 50 Appendix R non-compliance. The inspectors identified on March 25, that this fire watch was not performed between 6:00 a.m. and 9:00 a.m. on March 25, as required by VPAP-2401, Paragraph 6.5.3b. A dedicated welding and cutting fire watch was present in the charging pump cubicle during this time as required by VPAP-2401, Paragraph 6.5.4a. The welding and cutting fire watch was not observing the general area outside the charging pump cubicle that was to be observed by the hourly fire watch. The licensee has taken correct actions to address this failure to follow procedures. This failure constitutes a violation of minor significance and is being treated as an NCV, consistent with Section IV of the NRC Enforcement Policy. This is identified as NCV 50-338/97002-04.

The inspectors also noted that a contract Quality Control (QC) inspector had written a note, approximately 30 minutes earlier, on the fire watch log indicating that hourly fire watches had not been performed. The inspectors spoke with the QC inspector who stated that he had not yet reported the problem. The inspectors informed CR personnel of the missed hourly fire watch and discussed with management the failure of the QC inspector to immediately report the condition.

c. Conclusions

The inspectors concluded that maintenance was performed satisfactorily. The inspectors identified one NCV concerning the failure to perform a required Appendix R fire watch.



## M1.2 Surveillance Observations

### a. Inspection Scope (61726)

The inspectors observed and reviewed surveillance testing activities to verify that testing was performed in accordance with procedures, test instrumentation was calibrated, Limiting Conditions for Operation were met, and any deficiencies identified were properly reviewed and resolved. The inspectors observed all or portions of the following surveillance tests:

- 2-PT-17.1, Control Rod Operability Test, Revision 17
- 2-PT-36.9.1.J, Degraded Voltage/Loss of Voltage Functional Test: 2J Bus, Revision 26
- 1-PT-34.3, Turbine Valve Freedom Test, Revision 10
- 2-PT-75.2A, Service Water Pump (2-SW-P-1A) Quarterly Test, Revision 27
- 2-PT-80, AC Sources Operability Verification, Revision 9
- 2-PT-32.3.1, Loop 1 Steam Flow and Feedwater Flow Protection Channel III (2-FW-F-2477) Functional Test, Revision 26
- 1-PT-30.2.4, Nuclear Instrument System Power Channel IV (N-44) Channel Functional Test, Revision 25.

### b. Observations and Findings

The inspectors found that the work performed under these activities was professional and thorough. All of the surveillances observed were performed with the procedure present and in use.

During the performance of 2-PT-80, the inspectors observed that the Reactor Operator (RO) failed to initial Step 6.1, which checked the closed position of 4160V J Bus Normal Feed, Breaker 25J11. Furthermore, the Senior Reactor Operator (SRO) had reviewed the test documentation and failed to discover the error. The inspectors questioned the SRO and the RO to determine if the breaker had been checked closed. Both operators confirmed that the breaker was closed as required. Additionally, the inspectors had earlier checked the breaker to be closed.

The inspectors noted while observing 2-PT-75.2A that housekeeping in the Service Water Building was not as orderly as other more frequently traveled areas in the plant.

c. Conclusions

The inspectors concluded that the surveillance tests had been performed satisfactorily, but noted a lack of attention to detail in completing the required documentation for 2-PT-80. The inspectors also concluded that housekeeping in the Service Water Building was not as orderly as more frequently traveled areas in the plant.

M1.3 Unit 2 Turbine Driven Auxiliary Feedwater Pump Operability Test

a. Inspection Scope (61726)

On April 1, the inspectors observed portions of 2-PT-71.Q, 2-FW-P-2, Turbine Driven Auxiliary Feedwater Pump, and Valve Test, Revision 18, to ensure TS surveillance requirements 4.7.1.2.b.1 and 4.0.5 were satisfied. The inspectors observed the test locally at the turbine and in the CR.

b. Observations and Findings

During the test, the inspectors noted that the instruments used for pump speed and vibration were in calibration. The inspectors observed that procedure usage and supervisory oversight were appropriate. The inspectors reviewed the completed test results to ensure TS requirements were satisfied for pump differential pressure, vibration and miscellaneous valve operations including stroke times. No discrepancies were identified. The inspectors concluded that TS requirements were met.

The inspectors observed the performance of step 6.6.45 to ensure the operator was familiar with resetting the overspeed trip device for Overspeed Trip Valve, 2-MS-TV-215. The inspectors observed that the reset function was performed properly; however, the operator experienced some difficulty performing the previous step (step 6.6.44) that exercised the overspeed trip tappet and verified that it fell back to its original position. The operator, who was licensed, did not recall any specific training for this evolution, and did not remember doing it before. A representative from the Training Department later informed the inspectors that specific training for exercising the overspeed trip tappet had been provided for non-licensed operators, but not for licensed operators. The inspectors concluded that training had not adequately prepared the licensed operator to perform the overspeed trip tappet evolution and the evolution had not been discussed in the pre-job brief. This observation was discussed with the Training Superintendent.

c. Conclusions

The inspectors concluded that TS requirements were satisfied for the quarterly turbine driven auxiliary feedwater pump and valve test. The Training Department was not effective in preparing the licensed operator for the overspeed trip tappet exercise portion of the test.

## M8 Miscellaneous Maintenance Issues

M8.1 Auxiliary Shutdown Facilities Maintenance/Surveillancea. Inspection Scope (62700)

This portion of the inspection was conducted to review the licensee's practices concerning maintenance and surveillance of the plant's Auxiliary Shutdown facilities. The purpose of the inspection was to determine what actions were being taken by the licensee to assure that the facilities would perform their safety function if called upon during a plant event. In order to complete the inspection, the licensee was requested to provide the following information: a list of all surveillances, PMs, and calibrations performed; a list of all deficiency reports and work orders written on the Unit 1 facility in the last year, and a list of any design changes implemented on the facility in the last 3 years. This information was provided and reviewed during the course of the inspection. Additionally, the inspector reviewed the Updated Final Safety Analysis Report (UFSAR) Sections 7.7.1.12, 7.7.1.13.1, 7.7.1.13.2, and 7.4, TS Section 3.3.3.5, and the licensee's abnormal procedure AP-20, Operation from the Auxiliary Shutdown Panel, Revision 14. A walkdown of the Auxiliary Shutdown Panel, Reactor Coolant Monitoring Panel, and the Auxiliary Monitoring Panel was conducted. This walkdown compared installed equipment to the applicable drawing, verified system lineup to the applicable site procedure, and included an inspection of the inside of the Auxiliary Shutdown Panel for material condition. In addition, a sample of TS required surveillances and non-TS required surveillances were reviewed for technical adequacy. TS surveillance frequency was also confirmed.

b. Observations and Findings

The inspection resulted in the following observations and findings:

- The licensee determined that there were no work orders or deficiency reports written on the Unit 1 Auxiliary Shutdown Panel in the last year, and no design changes had been made to this panel within the last three years.
- The inspector determined that the installed equipment and the documentation reviewed during this portion of the inspection were in agreement with the UFSAR.
- The licensee's actions with regard to the Auxiliary Monitoring Panel and the Reactor Coolant Monitoring Panel in the Fuel Handling Building were commendable. The licensee performs surveillance testing for all instruments on these panels which includes both a channel check and a functional test (instrument loop calibration) similar to the TS testing required on the Auxiliary Shutdown panel.

- The licensee's actions concerning the Auxiliary Shutdown Panel met and exceeded the requirements of TSs. TSs require a channel check and a functional test (instrument loop calibration) of all instruments on the panel. The inspectors' sampling of this testing determined that the testing was technically sound and was being performed at the required frequency. In addition, the licensee also conducts periodic testing of the switches that control the Charging Pumps and the Auxiliary Feedwater Pumps, which is not required by TSs. One weakness was identified regarding this panel. There are approximately forty other switches on this panel in each unit which are not subject to any periodic testing or preventative maintenance. These switches control the Boric Acid Pumps and key system valves, which are needed for safe shutdown of the plant in case of a control room evacuation. Once this weakness was identified, the licensee took immediate corrective actions to evaluate the condition by issuance of DR N-97-567.
  
- Walkdown of the Auxiliary Shutdown Panel, Reactor Coolant Monitoring Panel, and the Auxiliary Monitoring Panel determined that the installed equipment was in accordance with the applicable drawing. The equipment was clearly labeled, and a verification of the switch position lineup determined that the lineup was in accordance with the licensee's procedure (1-PT-41.3, Safe Shutdown Equipment Control Verification, Revision 8). Equipment appeared to be in good condition; however, the inside of all four of the Auxiliary Shutdown Panels was extremely dirty. Once the licensee was advised of this condition, immediate action was taken by the Maintenance Superintendent to establish a preventative maintenance procedure to periodically clean these panels.

As a result of the observations and findings noted above an IFI is identified, IFI 50-338, 339/97002-05.

c. Conclusions

The licensee's actions with regard to testing of the Auxiliary Monitoring Panel and the Reactor Coolant Monitoring Panel were commendable. Actions concerning the Auxiliary Shutdown Panel met and exceeded the requirements of TSs. However, one weakness was identified concerning the lack of testing, inspection, or preventative maintenance concerning many of the switches on this panel. Equipment on all panels appeared to be in good condition; however, the inside of all four of the Auxiliary Shutdown Panels was extremely dirty. An IFI was identified to followup licensee actions concerning testing and cleaning of the Auxiliary Shutdown Panel.

### III. Engineering

#### E1 Conduct of Engineering (37551)

##### E1.1 Temporary Modification Review

###### a. Inspection Scope (37551)

The inspectors reviewed Unit 1 Temporary Modification (TM) 96-1635.

###### b. Observations and Findings

Unit 1 TM 96-1635 was installed on July 10, 1996, to cut and cap the drain line associated with pressurizer pressure transmitter 1-RC-PT-1456. The drain line isolation valve was leaking past the seat and the leakage resulted in level transmitter 1-RC-LT-1460 reading slightly high. The inspectors reviewed the TM package and associated safety evaluation. The safety evaluation adequately justified implementation of the TM. The licensee plans to remove the TM during the upcoming refueling outage.

###### c. Conclusions

The safety evaluation associated with Unit 1 TM 96-1635 adequately justified implementation of the TM.

### IV. Plant Support

#### R1 Radiological Protection and Chemistry (RP&C) Controls

##### R1.1 General Observations (71750)

On numerous occasions during the inspection period, the inspectors reviewed Radiation Protection (RP) practices including radiation control area entry and exit, survey results, and radiological area material conditions. No discrepancies were noted, and the inspectors determined that RP practices were proper.

#### S1 Conduct of Security and Safeguards Activities

##### S1.1 Physical Security Observations (71750)

On April 4, the inspectors walked down the protected area barrier with a security officer. The officer was professional and knowledgeable of security systems throughout the facility. The inspectors checked the protected area barrier to ensure there were no openings or degraded conditions and none were found. The inspector also observed that the isolation zones were clearly marked, free of obstructions, and of sufficient size to permit clear observation by security force members. Vehicles in the protected area were inspected to ensure the doors were either locked or the keys removed. The inspectors also observed that personnel access to the protected area and the security towers were

properly manned. The inspectors concluded that the protected area perimeter barrier was properly manned and maintained.

## F5 Fire Protection Staff Training and Qualification

### F5.1 Fire Drill

#### a. Inspection Scope (71750)

On March 13, the inspectors observed the fire brigade's response to a simulated fire in the Unit 2 switchgear room and attended the subsequent critique.

#### b. Observations and Findings

During the drill, a number of negative observations were made by the inspectors and the drill evaluators. These included: one fire brigade member, also a security officer, took eleven minutes to arrive at the fire scene; the fire plan for this area was not used since the Unit 2 fire plan book which was brought to the scene did not contain the fire plan for common areas which were contained in the Unit 1 fire plan book; personnel entered the fire area without being properly dressed out; a brigade member failed to monitor his air supply such that as he attempted a second entry into the fire area, the low air alarm sounded; and, personnel failed to clearly understand verbal instructions as to the location of a breaker to open so that the wrong breakers were opened. In addition, one fire brigade member reported that his dress out gear was sized improperly and another indicated that three of his snaps were broken.

The critique included the topics presented above, as well as, possible corrective actions. The critique also addressed positive observations to re-enforce good practices. The licensee considered this fire drill as a failure, and indicated another fire drill would be conducted for this group.

#### c. Conclusions

Several deficiencies were noted during a fire drill which resulted in the fire drill being classified as a failure.

## V. Management Meetings

### X1 Exit Meeting Summary

The inspectors presented the inspection results to members of licensee management at the conclusion of the inspection on April 15 and May 5, 1997. The licensee acknowledged the findings presented.

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

## PARTIAL LIST OF PERSONS CONTACTED

Licensee

W. Anthes, Superintendent, Outage Planning  
 B. Foster, Superintendent Station Engineering  
 J. Hayes, Superintendent, Operations  
 D. Heacock, Assistant Station Manager, Nuclear Safety and Licensing  
 M. Kansler, Vice President, Nuclear Operations  
 W. Matthews, Station Manager  
 M. McCarthy, Director, Nuclear Oversight  
 H. Royal, Superintendent, Nuclear Training  
 D. Schappell, Superintendent, Site Services  
 R. Shears, Superintendent, Maintenance  
 A. Stafford, Superintendent, Radiological Protection

## INSPECTION PROCEDURES USED

IP 37551: Onsite Engineering  
 IP 40500: Effectiveness of Licensee Controls in Identifying, Resolving, and Preventing Problems  
 IP 60705: Preparation for Refueling  
 IP 61726: Surveillance Observations  
 IP 62700: Maintenance Implementation  
 IP 62707: Maintenance Observations  
 IP 71707: Plant Operations  
 IP 71750: Plant Support Activities

## ITEMS OPENED AND CLOSED

Opened

50-338, 339/97002-01	URI	Review compliance with TS 6.5.1.6 requirement for SNSOC review of programs (Section 01.4).
50-338, 339/97002-02	IFI	Potential inadequate boron concentration in the accumulator discharge line (Section 01.4).
50-338, 339/97002-03	VIO	Failure to assure that CR chart recorders were marking properly (Section 02.1).
50-338/97002-04	NCV	Failure to perform a required Appendix R fire watch (Section M1.1).
50-338, 339/97002-05	IFI	Followup licensee actions concerning testing and cleaning of the Auxiliary Shutdown Panel (Section M8.1).

Closed

50-338/97002-04	NCV	Failure to perform a required Appendix R fire watch (Section M1.1).
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