APPENDIX B

U. S. NUCLEAR REGULATORY COMMISSION

REGION IV

NRC Inspection Report: 50-298/85-15 License: DPR-46

Docket: 50-298

Licensee: Nebraska Public Power District (NPPD)
P. O. Box 499
Columbus, Nebraska 68601

Facility Name: Cooper Nuclear Station (CNS)

Inspection At: Cooper Nuclear Station, Nemaha County, Nebraska

Inspection Conducted: April 1-30, 1985

Inspectors: _____ 5/20/85
D. L. DuBois, Senior Resident Inspector (SRI) Date

_____ 5/20/85
J. R. Boardman, Reactor Inspector Date
Special Projects and Engineering Section
Reactor Project Branch 1

Approved: _____ 5/20/85
J. P. Jaudon, Chief, Project Section A, Date
Reactor Project Branch 1

Inspection Summary

Inspection Conducted April 1-30, 1985 (Report 50-298/85-15)

Areas Inspected: Routine, unannounced inspection of operational safety verification, monthly surveillance and maintenance observations, and licensee action on previous inspection findings. The inspection involved 119 inspector-hours onsite by two NRC inspectors and 18 inspector-hours at the Columbus General Office by one NRC inspector.

Results: Within the four areas inspected, four violations were identified (failure to perform a safety question determination for installed temporary jumpers, paragraph 2; superseded procedures located in the control room, paragraph 2; failure to have procedures for activities affecting quality, paragraph 2; failure to follow procedures, paragraph 2).

DETAILS

1. Persons Contacted

Principal Licensee Personnel

*L. G. Kuncl, Assistant General Manager Nuclear
*J. M. Pilant, Technical Staff Manager Nuclear Power Group
+#*oP. V. Thomason, Division Manager Nuclear Operations
*R. E. Wilbur, Division Manager Nuclear Services
*G. A. Trevors, Division Manager Quality Assurance (QA)
+#*J. M. Meacham, Technical Manager, CNS
+oD. A. Whitman, Technical Staff Manager, CNS
#oR. B. Brungardt, Acting Operations Manager, CNS
#oV. L. Wolstenholm, QA Manager, CNS
+L. L. Roder, Admintrative Services Manager, CNS
+#*oE. M. Mace, Plant Engineering Supervisor, CNS
+#D. Norvell, Acting Maintenance Manager, CNS
*J. H. Ferneau, Records Supervisor, Records Administration Dept.
+#oC. R. Goings, Regulatory Compliance Specialist, CNS
*oJ. R. Sayer, Senior Technical/Radiological Advisor, CNS
oD. L. Reeves, Training Manager, CNS

The NRC inspectors also interviewed other plant, general office, and contractor personnel, including engineering, administrative, and clerical.

+Denotes presence at exit interview held April 4, 1985
#Denotes presence at exit interview held April 16, 1985
*Denotes presence at exit interview held April 18, 1985
oDenotes presence at exit interview held April 26, 1985

2. Licensee Action on Previous Inspection Findings

(Closed) 8421-02 (Unresolved). This item was identified by the NRC Performance Appraisal Team (PAT) and concerned the lack of 10 CFR 50.59 reviews of installed jumpers and bypasses in plant equipment. The SRI reviewed 47 records of installed jumpers, bypasses, and fuse removals in plant equipment over the period December 1984 through April 1985 and verified that none of the records indicated the performance of an evaluation to determine if the temporary alterations involved an unreviewed safety question. Eighteen of the 47 alterations affected safety-related or important to safety equipment. Discussions with shift supervisory personnel indicated that they would consult with mechanical, electrical, and/or instrument and control (I&C) personnel prior to installing the temporary alterations in order to determine the effect on

the system resulting from the alteration; but they had not performed nor documented a safety question review as required by 10 CFR 50.59.

CNS Engineering Procedure (EP) 3.3, Revision 1, "Station Safety Evaluations," provides the mechanism for determining whether a change to the plant constitutes an unreviewed safety question; designates the design engineer to perform safety evaluations for station design changes; provides documentation of that safety evaluation; and directs that the safety evaluations be reviewed and approved by the Station Operations Review Committee (SORC). CNS Procedure 2.0.2, Revision 1, "Operations Logs and Reports," Section II.F., provides guidance for maintaining the Jumper Log (Attachment B to Procedure 2.0.2). Procedure 2.0.2 specifies that the shift supervisor (SS) must authorize initiation of a jumper but the requirements for the performance of a safety review are not addressed. The licensee is committed to ANSI 18.7-1972, "Administrative Controls For Nuclear Power Plants," which requires a review of changes made to equipment to comply with 10 CFR 50.59 and that procedure controls be implemented to identify equipment in a controlled status. Further, the procedures are to require independent verification to ensure that necessary measures were implemented correctly. ANSI N45.2.11-1974, "Quality Assurance Requirements For the Design of Nuclear Power Plants," requires the licensee to evaluate the effects of changes to previously verified designs on the overall design. The failure of the licensee to perform a necessary safety evaluation of the placement of jumpers in plant equipment is an apparent violation of 10 CFR 50.59 (8515-01).

The jumper installed in 1979 and still in effect to modify a flow input to the plant process computer will be removed or changed to a permanent design change as determined by the wiring requirements being performed as a result of the installation of a new process computer that is presently in progress.

Based upon the above violation, unresolved item 8421-02 is closed.

(Closed) 8421-04 (Unresolved). The PAT determined that the licensee had four outdated procedures located in the control room. Subsequent review by the SRI determined that the licensee had replaced the out-of-date procedures with present revised editions. However, the SRI identified that the Control Room Emergency Procedures Handbook, which is located in the SS's office, contained Revision 3 instead of current Revision 4 of CNS Procedure 5.7.1, Attachment B, "CNS Emergency Plan - Classification Checklist." The failure to maintain current approved procedures for use in the plant by station operators is an apparent violation of 10 CFR Part 50, Appendix B, Criterion V, and the licensee's approved Quality Assurance Plan (QAP), Section 2.5, both of which require documented procedures for the performance of activities affecting quality or having nuclear safety significance. Also, the licensee failed to adhere to the requirement of CNS Procedure 1.10, which states that

superseded pages/documents are to be destroyed, stamped "Superseded," or returned to the Administrative Services Department for disposition (8515-02).

Based upon the above violation, unresolved item 8421-04 is closed.

(Closed) 8421-07 (Unresolved). This PAT-identified item concerned the licensee's failure to implement a training program. Also evident was an apparent lack of direction and management commitment to the CNS training effort. The licensee committed to adhere to the guidance provided in ANSI N18.1-1971, "Selection and Training of Nuclear Power Plant Personnel." ANSI N18.1-1971 requires the licensee to establish a training program and an implementation schedule in order to develop and maintain a fully qualified plant staff. The SRI and region-based inspectors have documented and are presently tracking items in the area of training as listed below:

. 8113-069 Training Offsite Personnel

. 8113-107 QA for Effectiveness of Training

. 8212-001 Training Program Not Fully Implemented

. 8227-003 Lack of a Formal Training and Retraining Program for Radiochemistry Personnel

. 8236-001 Failure to Conduct Requalification Training (Violation)

. 8316-001 Quality and Quantity of Requalification Training

. 8319-002 Training Program for Radwaste Operators

. 8328-001 Failure to Follow an Approved Guard Training and Qualification Plan (Violation)

. 8412-002 The CNS Training Department Has Not Developed an Approved Official Training Program

. 8412-003 The Licensee Has Not Developed and Implemented a Formal Training Program for Offsite Technical Support Personnel

. 8412-004 The Licensee Has Not Developed an Approved General Employee Training Program

. 8412-005 Mechanical Maintenance Training Program

. 8412-006 Instrument and Control Training Program

. 8412-007 Engineering Department Training Program

. 8412-008 QA Department Training Program

. 8504-007 No Formal Training/Retraining Program for Health Physics Personnel

Since the PAT findings are being tracked under the above numbers, unresolved item 8421-07 is closed for record purposes.

(Closed) 8421-08 (Unresolved). This item was identified by the PAT and concerns qualification, training, and independence of licensee QC inspectors. The licensee acknowledged the apparent procedural weaknesses in these areas. Corrective actions include hiring a QC coordinator who will be assigned to the plant QA organization (target date of July 1, 1985). The QC coordinator will develop necessary procedures (target date of February 1, 1986) covering QC inspector qualification, training and organizational independence. The QC coordinator will implement these procedures, and will also supervise assigned QC inspectors to assure their organizational independence. The licensee is presently drafting Revision 2 of the NPPD nuclear QA policy document. This revision, which will make a commitment to a later version of ANSI N45.2.6, will delete previous exceptions to this standard and will clarify the required independence of QC inspectors. The licensee will approve and issue Revision 2 by the end of April, 1985.

Regulatory action taken on the identified lack of licensee procedures for qualification, training, and independence of QC inspectors is addressed in the summary below.

Based upon the licensee's corrective steps and NRC regulatory actions stated above, unresolved item 8421-08 is closed.

(Closed) 8421-09 and 8421-10 (Unresolved). These items were identified by the PAT and concerned audit program procedure inadequacies resulting in an apparent failure to report properly deficiencies and to address specific QA program audit objectives. Audits were referenced that did not address all objectives of the QA Program. The NRC inspector found that the licensee believed that it was not practical to address all objectives of a specific QA plan in every audit. The NRC inspector concluded that if such were the case, this should be clearly documented on this specific audit. The QA staff has been instructed that all QAP objectives must be addressed in an audit report whenever possible. In addition, the format of the report of an audit has been revised to include a separate attachment which states each QAP audit objective achieved, how it was accomplished, and a list of QAP objectives which were not addressed during the audit. QAP audit objectives not addressed during an annual audit will be carried over to the next audit scheduled

for the QAP. QAI-5, "Guidelines for QA Audits," was revised in July 1984 to clarify the definitions of audit findings and observations and to require justification in an audit for why an observation is not classified as a finding. Significant audit observations now require responses and follow-up to assess the effectiveness of the corrective actions.

The QA audit program has been upgraded to address the weaknesses noted in the PAT inspection. Continued monitoring of audit reports and training of the QA staff will ensure that the licensee's audit program becomes stronger.

Regulatory action taken on the identified lack of licensee procedures for accomplishing audits is addressed in the summary below.

Based upon the licensee's corrective steps and NRC regulatory actions stated above, unresolved items 8421-09 and 8421-10 are closed.

(Closed) 8421-16 (Unresolved). The PAT identified an apparent failure by the licensee to have procedures that required corrective action for vendors having identified QA program deficiencies. The licensee's corporate QA department had approved sole-source suppliers even though the supplier QA programs did not meet certain parts of 10 CFR Part 50, Appendix B. In recognition of this weakness, licensee procedure QAI-16, "Supplier Approval," Revision 9, issued in December, 1984, required additional quality controls (QCs), such as alternative supplier QA programs, and receipt tests or inspections for components purchased from this type of supplier. In addition, the NPPD QA staff conducted supplier evaluations resulting in an improved list of qualified suppliers. More detail is now required in specifying QA requirements in purchase documents to ensure that adequate QC is applied to material purchased from sole-source suppliers.

Regulatory action taken on the identified lack of licensee procedures to assure corrective action on supplier QA program deficiencies is addressed in the summary below.

Based upon the licensee's corrective steps and NRC regulatory actions stated above, unresolved item 8421-16 is closed.

(Closed) 8421-17 (Unresolved). The PAT identified an apparent failure by the licensee to have procedures requiring verification of the validity of vendor certificates of conformance. The PAT questioned the validity of supplier Certificates of Conformance for identical replacement parts, and how NPPD QA was verifying those certificates. To correct this deficiency, the QA Division no longer accepts a Certificate of Conformance as the sole basis of approving a supplier for the procurement of essential material, components, or services for CNS. When a

Certificate of Conformance is requested from the supplier as additional quality documentation, the licensee now requires that the supplier identify on the certificate the original date of part purchase for CNS and a summary of all design changes that have been performed on the part since the original purchase. Prior to using the part, each design change must be evaluated by either CNS Engineering or NED to establish the equivalency of the new part to the one originally purchased. This requirement is specified on the Approved Supplier List. In addition, receipt acceptance testing is required on these "equal to or better than" parts prior to use. Revision 10 to QAI-16 will be issued by the end of April, 1985, and will clarify this updated approach to the procurement of parts from sole-source suppliers.

Regulatory action taken on the identified lack of verification of the validity of vendor Certificates of Conformance is addressed in the summary below.

Based upon the licensee's corrective steps and the NRC regulatory actions stated above, unresolved item 8421-17 is closed.

(Closed) 8421-18 (Unresolved). The PAT identified an apparent licensee failure to have procedures requiring performance of additional receipt inspection for items not examined or inspected at the source.

ANSI N45.2.2, Section 5.22, specifies additional receipt inspection requirements for items not inspected or examined at the source. Licensee procedures, such as CNS Procedure 1.5, Revision O, "Receiving," did not require the performance of the additional inspections.

The licensee committed to perform the following corrective actions:

. Hiring a receipt inspector as soon as possible who would be dedicated solely to receipt inspections.

. Have in place within 6 months after hiring the receipt inspector, procedures covering additional receipt inspections of essential/safety-related items.

Regulatory action taken on the identified lack of procedural requirements for additional receipt inspections is addressed in the summary below.

Based upon the licensee's corrective steps and NRC regulatory actions stated above, unresolved item 8421-18 is closed.

(Closed) 8421-19 (Unresolved). The PAT identified an apparent failure by the licensee to have procedures requiring proper storage for hazardous material.

ANSI N45.2.2-1972, Section 6.3.3, prohibits storage of hazardous chemicals, paints, solvents and other materials in close proximity to important nuclear plant items. The PAT inspector found hazardous materials adjacent to important nuclear plant items. Licensee procedures did not address or prohibit such storage. The licensee has subsequently included, in the CNS calendar year 1986 budget, a request for a building that would be dedicated to storage of hazardous material. Necessary procedures will be developed and implemented at that time.

The PAT inspection report also discussed in observations 5.a and 5.b of the procurement section, minor deficiencies in the care and storage of spare parts. The licensee committed to review these areas, to make necessary procedure revisions, and to correct identified problems by December 1, 1985.

Regulatory action taken on the identified lack of procedural requirements for proper storage of hazardous materials is addressed in the summary below.

Based upon the licensee's corrective steps and NRC regulatory actions stated above, unresolved item 8421-19 is closed.

(Closed) 8421-20 (Unresolved). The PAT identified a licensee failure to have procedures requiring the establishment of control of vendor technical information. In a letter from Mr. L. G. Kuncl (NPPD) to Mr. D. G. Eisenhut (NRC), dated November 4, 1983, the licensee stated, "Vendor manuals at CNS are controlled distribution documents and are presently the responsibility of the CNS Engineering Department." The PAT ascertained that vendor manuals were not controlled documents. The NRC inspector found that the licensee had no documented program to respond to NRC Generic Letter 83-26 relative to control of vendor technical information. Licensee efforts in the area of vendor manuals were limited to the assignment of one site engineer to review safety-related, nonsafety-related, and facility vendor manuals for consistency. Site engineering did not have copies of nor had they reviewed all safety-related technical manuals that had been used by the maintenance department, particularly in the area of I&C. Reactor trip systems vendor technical information was not controlled nor had reactor trip systems equipment been classified as discussed in Generic Letter 83-28, Section 2. The licensee did have a consultant classifying safety-related equipment, although no priority had been given to reactor trip systems.

The licensee committed to the following actions prior to reactor start-up from the present outage:

. Classifying all safety-related equipment which function as reactor trip system components required for shut down of the reactor.

- Inclusion of all necessary vendor technical information relating to reactor trip systems into a document control system. This will include assurance that the vendor technical information is correct and current for CNS equipment.

- A schedule will be developed for inclusion of all other safety-related vendor technical information into the document control system.

- CNS Procedure 3.13, Revision 0, "Equipment Classification," will be approved by May 15, 1985.

Regulatory action taken on the identified lack of procedural requirements for control of vendor technical information is addressed in the summary below.

Based upon the licensee's corrective steps and NRC regulatory actions stated above, unresolved item 8421-20 is closed.

(Closed) 8421-21 (Unresolved). The PAT identified that a procedure did not exist for controlling calibration of mechanical measuring and test equipment (M&TE). Subsequently, the licensee originated and approved CNS Procedure 7.1.1, Revision 0, "Mechanical Gauging Equipment Control and Calibration," which provided the procedural controls for calibration of M&TE. The NRC inspector reviewed Procedure 7.1.1, Revision 1, and noted that it had not been fully implemented (e.g., all present onsite M&TE calibrations were not controlled as directed by Procedure 7.1.1). Licensee personnel stated that all M&TE used for safety-related work since Procedure 6.1.1 was approved and implemented were controlled and calibrated. Remaining M&TE calibrations will be controlled in accordance with Procedure 7.1.1 prior to the instruments being used for any safety-related activities.

Because a procedure did not exist for controlling calibration of M&TE at the time of the PAT, regulatory action is being taken as addressed in the summary below.

Based upon the licensee's corrective steps and NRC regulatory actions stated above, unresolved item 8421-21 is closed.

(Closed) 8421-22 (Unresolved). The PAT identified that the licensee utilized written instructions and guidelines called "shop guides" for accomplishing safety-related activities. The shop guides had not received the same level of review, approval, or control as other CNS maintenance related procedures. The licensee has committed to perform a complete review of all shop guides used in safety-related activities. Shop guides will be converted to approved maintenance procedures, or, if found to contain only recommendations or guidelines, will receive

appropriate technical reviews and approvals, and will be controlled. All of the actions are committed to be completed by June 1, 1986.

Regulatory action taken on the lack of procedural controls of shop guides is addressed in the summary below.

Based upon the licensee's corrective steps and NRC regulatory actions stated above, unresolved item 8421-22 is closed.

(Closed) 8421-23 (Unresolved). The PAT identified that CNS EP 3.4, "Station Design Changes," Revision 0, appeared inadequate in the following areas:

. Lack of documentation of design verification.
. Only 10 of the 28 design input requirements of ANSI N45.2.11 were addressed.

The licensee committed to revise EP 3.4 by June 1, 1985, to correct these inadequacies.

The PAT also identified that final close-out of minor design changes (MDCs) were not timely. Licensee personnel acknowledged that closure delays were a problem and attributed the delays to manpower restraints. Though not documented in approved procedures, the licensee stated that verification of completed MDCs included the following minimum checks:

. Affect on the CNS Technical Specification.
. Affect on the Updated Safety Analysis Report (USAR).
. Affect on the CNS Training Manual.
. Affect on CNS operational procedures.
. Need for interim revised drawings.

The licensee committed either to revise procedures to reflect a 2-stage closure of MDCs or to modify the present procedures to provide guidance for timely review and closure. The 2-stage method, if selected, will consist of a release for operations and an administrative closure. All actions will be completed by June 1, 1986.

Regulatory action taken on the lack of licensee procedures for design verification is addressed in the summary below.

Based on the licensee's corrective steps and NRC regulatory actions stated above, unresolved item 8421-23 is closed.

(Closed) 8421-24 (Unresolved). The PAT identified that the licensee did not have procedures for the conduct and documentation of safety evaluations for temporary lead shielding installed on systems or components discussed in the CNS USAR. Further, the PAT found that static

stress calculations were documented for temporary lead shielding but dynamic stress calculations and safety evaluations were not documented.

Subsequent to the PAT notifying the licensee of the above deficiencies, the licensee immediately implemented the following actions and plans:

- Proper analysis and documentation was implemented.
- A CNS EP, "Temporary Shielding Installations," will be developed and approved by June 1, 1985. The procedure will contain necessary controls to preclude a recurrence of the deficiencies.
- Temporary installed lead shielding will be removed from two of three areas prior to startup from the present outage.
- Temporary shielding in the remaining area of the scram discharge volume will remain. The analysis for this area will be complete by August 1, 1985.

Regulatory action taken on lack of licensee procedures for the conduct and documentation of safety evaluations for temporary lead shielding installed on systems or components discussed in the CNS USAR is addressed in the summary below.

Based upon the licensee's corrective steps and NRC regulatory actions stated above, unresolved item 8421-24 is closed.

(Closed) 8421-26 (Unresolved). This PAT-identified item concerned the licensee's practice of closing-out CNS Nonconformance Reports (NCRs) prior to completing all identified corrective actions. As a result, the licensee practice resulted in the removal of NCRs having significant safety implications from the NCR tracking system.

CNS Procedure 0.5, "Nonconformance and Corrective Action," was revised subsequent to the PAT inspection. The present Revision 1, Section III.A.15, states that the QA staff will perform the final review of all NCRs, concur with all the recommended actions, sign and date their concurrence, and close-out the NCR for record purposes. A NOTE following the QA staffs' responsibilities permits close-out of NCRs prior to completion of all corrective actions providing that the incomplete action(s) is duly referenced on the NCR and another tracking mechanism is in place and monitored to verify completion of the action of which exception was taken. In the case of MDCs referenced in the PAT findings, an MDC tracking system is not closed out until all actions required by the MDC are complete.

This item is closed.

(Closed) 8421-27 (Unresolved). This PAT-identified item concerned the licensee's failure to adequately identify and discuss personnel errors in Licensee Event Reports (LERs) 84-003 and 84-007. LER 84-003 discussed an

inadvertent trip of an operating reactor feedwater pump (RFP) by I&C technicians during troubleshooting operations which indirectly resulted in a reactor trip. LER 84-007 discussed a plant shutdown required by the CNS Technical Specification which occurred when both trains of the Standby Gas System (SGT) System were rendered inoperable by inadvertent wetting of the SGT system charcoal beds by the fire protection sprinkler system.

Concerning LER 84-003, the PAT determined that the licensee failed to discuss the fact that an I&C technician had neither an approved procedure for nor the SS's approval to troubleshoot a problem with the RFP. In addition, the LER did not discuss whether the operator had failed to follow approved procedures or if the approved procedures were adequate. The SRI verified that I&C technicians were not performing troubleshooting using an approved plant procedure or a maintenance work request (MWR). An MWR must be approved by the SS prior to commencement of work activities. Had an MWR been issued prior to the start of troubleshooting the RFP, it would have provided necessary approvals, controls, and step-by-step guidance of the proposed activity to technicians and control room personnel alike. The SRI determined that MWR 84-01 was issued after-the-fact.

The SRI's review of other related plant procedures indicated the following:

- CNS Abnormal Conditions Procedure 2.4.9.4.3, "Loss of Single Feed Pump," Revision 6, included a CAUTION which stated, "Restarting the tripped feed pump with a low reactor level may start a cold water injection transient unless precautions are taken to limit the initial feed rate to an acceptable feed rate increase." The only direction given to the operator following the above CAUTION was, "attempt to restart the tripped pump."

- CNS Abnormal Conditions Procedure 2.4.9.4.4, "Loss of Feedwater," Revision 7, assumes the reactor has tripped due to low level so, therefore, it does not provide guidance to the operator for attempting to prevent a reactor trip.

- CNS Alarm Procedure 2.3.2.1, "Panel A - Annunciator A-1," concerns a RFP trip monitor. This procedure does not provide a CAUTION such as given above when it directs the operator to restart a tripped RFP.

It is apparent from the above that CNS abnormal conditions procedures lack specificity concerning starting/restarting a tripped RFP. Also, the abnormal conditions procedures do not reference normal feedwater startup Procedure 2.2.28 which does provide clearer and more precise direction.

Concerning LER 84-007, the PAT determined that the LER did not discuss whether the operators adhered to procedures or if the procedures were inadequate. The SRI reviewed the following CNS procedures applicable to the event that was described in LER 84-007:

- Alarm Procedure 2.3.2.40, "Fire Protection (Gate Valve Alarm and Fire Pumps) - Annuciators 4-4 and 5-2," which gave corrective actions for a fire header low pressure condition and fire pump running conditions respectively.

- System Operating Procedure 2.2.30, "Fire Protection System," Revision 22.

The SRI's review of this unresolved item substantiates the PAT findings. Although the licensee addressed personnel errors in LERs 84-003 and 84-007, the LERs lacked specificity with regard to the extenuating circumstances responsible for the initiation of personnel errors. Extenuating circumstances not included in the LERs were:

- Failure to have an approved I&C procedure for troubleshooting RFP controls/indication problems, or

- Failure to follow CNS Procedure 7.0.1, "Work Item Tracking-Corrective Maintenance," which establishes work controls using an MWR.

- Operations personnel failed to remember and apply the CAUTION stated above when restarting the tripped RFP.

- Failure to follow CNS Procedure 2.2.30, "Fire Protection System," Revision 22, Section K, titled, "Recovery From Header Inadvertent Depressurization."

- Inadequacies exist in procedures 2.4.9.4.3, 2.4.9.4.4, and 2.3.2.1 as previously discussed above.

- Alarm Procedure 2.3.2.40 is inadequate in that it does not state operator actions that should be performed to correct the alarming condition except if the cause of annunciation is an actual fire.

- Procedure 2.2.30, Section K, should be an annunciator, abnormal, or emergency procedure rather than a normal operating procedure.

The SRI reviewed two other LERs issued by the licensee during 1984 which involved lack of procedural adherence and/or personnel error (LERs 84-006 and 84-008). These LERs appeared to properly address causative effects and extenuating circumstances surrounding the events. Also, the SRI reviewed CNS Procedure 0.19, "Licensee Event Report Procedure,"

Revision 1, dated November 29, 1984, and determined that it requires more narrative regarding personnel errors found to be a contributing factor in an event.

Regulatory action taken on the failure to follow procedures is addressed in the summary below. Based upon this action, unresolved item 8421-27 is closed for record purposes.

SUMMARY

10 CFR Part 50, Appendix B, Criterion V, requires activities affecting quality to be prescribed in appropriate documented procedures. Each Pat-identified unresolved item listed below is an example of a failure to have procedures:

- 8421-08
- 8421-09
- 8421-16
- 8421-17
- 8421-18
- 8421-19
- 8421-20
- 8421-21
- 8421-22
- 8421-23
- 8421-24

The failure to have documented procedures for activities affecting quality constitutes an apparent violation of 10 CFR Part 50, Appendix B, Criterion V. (298/8515-03)

The CNS Technical Specification, Sections 6.3.2 and 6.3.3, requires that procedures shall be provided and adhered to for corrective maintenance of plant equipment that could have an effect on nuclear safety and for actions to be taken to correct specific and foreseen potential or actual malfunctions of safety-related systems or components. The licensee's failure to follow CNS Procedures 7.0.1 and 2.2.30 is an apparent violation of Technical Specification requirements. (298/8515-04)

The apparent inadequacies in CNS Procedures 2.4.9.4.3, 2.4.9.4.4, 2.3.2.1, 2.3.2.40, and 2.2.30 is an open item pending further reviews and inspection. (298/8515-05)

3. Operational Safety Verification

The SRI observed control room operations, instrumentation, controls, reviewed plant logs and records, conducted discussions with control room operators, and conducted system walkdowns to verify that:

- Minimum shift manning requirements were met.
- Technical Specification requirements were observed.
- Plant operations were conducted using approved procedures.
- Plant logs and records were complete, accurate, and indicative of actual system conditions and configurations.
- System pumps, valves, control switches, and power supply breakers were properly aligned.
- Licensee systems lineup procedures/checklists, plant drawings, and as-built configurations were in agreement.
- Instrumentation was accurately displaying process variables and protection system status to be within permissible operational limits for operation.
- Plant equipment that was discovered to be inoperable or was removed from service for maintenance was properly identified, redundant equipment was verified to be operable, and applicable limiting conditions for operation were identified and maintained.
- Equipment safety clearance records were complete and indicated that affected components were removed from and returned to service in a correct and approved manner.
- MWRs were initiated for equipment discovered to require repair or routine preventive upkeep, appropriate priority was assigned, and work commenced in a timely manner.
- Plant equipment conditions such as cleanliness, leakage, lubrication, and cooling water were controlled and adequately maintained.
- Areas of the plant were clean, unobstructed, and free of fire hazards. Fire suppression systems and emergency equipment were maintained in a condition of readiness.
- Security measures and radiological controls were adequate.

The SRI performed lineup verifications of the following systems:

. Emergency Power Distribution System

. Service Water System

The tours, reviews, and observations were conducted to verify that facility operations were performed in accordance with the requirements established in the CNS Operating License and Technical Specification.

No violations or deviations were identified in this area.

4. Monthly Surveillance Observations

The SRI observed Technical Specification-required surveillance tests. These observations verified that:

. Tests were accomplished by qualified personnel in accordance with approved procedures.

. Procedures conformed to Technical Specification requirements.

. Test prerequisites were completed including conformance with applicable limiting conditions for operation, required administrative approval, and availability of calibrated test equipment.

. Test data was reviewed for completeness, accuracy, and conformance with established criteria and Technical Specification requirements.

. Deficiencies were corrected in a timely manner.

. The system was returned to service.

The reviews and observations were conducted to verify that facility surveillance operations were performed in accordance with the requirements established in the CNS Operating License and Technical Specification.

No violations or deviations were identified in this area.

5. Monthly Maintenance Observation

The SRI observed preventive and corrective maintenance activities. These observations verified that:

. Limiting conditions for operation were met.

. Redundant equipment was operable.

- Equipment was adequately isolated and safety tagged.
- Appropriate administrative approvals were obtained prior to commencement of work activities.
- Work was performed by qualified personnel in accordance with approved procedures.
- Radiological controls, cleanliness practices, and appropriate fire prevention precautions were implemented and maintained.
- QC checks and postmaintenance surveillance testing were performed as required.
- Equipment was properly returned to service.

These reviews and observations were conducted to verify that facility maintenance operations were performed in accordance with the requirements established in the CNS Operating License and Technical Specification.

No violations or deviations were identified in this area.

6. Exit Meetings

Exit meetings were conducted at the conclusion of each portion of the inspection. Then NRC Inspectors summarized the scope and findings of each inspection segment at those meetings.