

ENCLOSURE 2

U.S. NUCLEAR REGULATORY COMMISSION  
REGION IV

Docket No.: 50-483  
License No.: NPF-30  
Report No.: 50-483/96-09  
Licensee: Union Electric Company  
Facility: Callaway Plant  
Location: Junction Hwy. CC and Hwy. O  
Fulton, Missouri  
Dates: September 1 through October 12, 1996  
Inspectors: D. G. Passehl, Senior Resident Inspector  
F. L. Brush, Resident Inspector  
Approved By: W. D. Johnson, Chief, Projects Branch B

ATTACHMENT: Supplemental Information

## EXECUTIVE SUMMARY

Callaway Plant  
NRC Inspection Report 50-483/96-09

### Operations

- The licensee identified that an operator had inadvertently closed a nitrogen accumulator outlet valve which rendered inoperable the power operated relief valve for Steam Generator C and the auxiliary feedwater flow path from the turbine-driven auxiliary feedwater pump to Steam Generator C. Plant operators did not adequately review this activity prior to performance. The failure to utilize a procedure or guidance appropriate to the circumstances was identified as a noncited violation (Section O4.1).
- Plant operators responded well to an unplanned isolation of low pressure Heater String C. The inspectors identified that there was no off-normal procedure to guide operator actions in response to unplanned automatic isolation of low pressure feedwater heater strings (Section O4.2).
- The inspectors found that the licensee's program for minimizing shutdown safety risk was good. Use of the simulator to practice the heatup and cooldown indicated good preparation and planning (Section O7.1).

### Maintenance

- The licensee met its goals on outstanding corrective maintenance work requests prior to the start of Refueling Outage 8. The goal was to have less than 200 corrective maintenance work requests prior to the start of Refueling Outage 8. There were 104 corrective maintenance work requests outstanding. Additionally, there was a goal of no more than 30 corrective maintenance work requests greater than six months old. There were 23 corrective maintenance work requests greater than six months old (Section M2.1).

### Engineering

- The inspectors identified a violation involving failure to maintain proper configuration control during a modification to a hydrogen recombiner. The inspectors found that the licensee's use of the "Request For Resolution" process to implement modifications did not have a feedback loop to ensure that procedures, drawings, or other documents affected by the modification were changed (Section E1.1).

## Report Details

### Summary of Plant Status

The reactor began this inspection period at 100 percent power. The reactor remained at full power for most of the inspection period. On October 6, 1996, plant operators began a gradual reduction of reactor power to support planned activities for Refueling Outage 8. On October 12, 1996, operators opened the main generator output breaker to commence the refueling outage.

## I. Operations

### **O1 Conduct of Operations**

#### **O1.1 General Comments (71707)**

Using Inspection Procedure 71707, the inspectors conducted frequent reviews of ongoing plant operations. In general, the conduct of operations was professional and safety-conscious. Plant status, operating problems, and work plans were appropriately addressed during daily turnover and plan-of-the-day meetings. Plant testing and maintenance requiring control room coordination were properly controlled.

### **O2 Operational Status of Facilities and Equipment**

#### **O2.1 Engineered Safety Feature System Walkdowns (71707)**

The inspectors used Inspection Procedure 71707 to walk down accessible portions of the following Engineered Safety Feature systems:

- Auxiliary Feedwater Trains A and B;
- Essential Service Water Trains A and B;
- Residual Heat Removal Trains A and B;
- Component Cooling Water Train A; and
- Emergency Diesel Generator Train B.

Equipment operability, material condition, and housekeeping were acceptable. Several minor discrepancies were brought to the licensee's attention and were corrected.

#### **O2.2 Review of Equipment Tagouts (71707)**

The inspectors walked down the following tagouts for the Residual Heat Removal System Train B planned maintenance outage:

Worker Protection Assurance 20312

Component Cooling Water to Residual  
Heat Removal Heat Exchanger B Isolation  
Valve

Worker Protection Assurance 20357	Residual Heat Removal Pump B
Worker Protection Assurance 20358	Residual Heat Removal Pump B Suction Valve From the Refueling Water Storage Tank
Worker Protection Assurance 20359	Residual Heat Removal Pump B Minimum Flow Control Valve
Worker Protection Assurance 20360	Residual Heat Removal Pump B Room Cooler

The inspectors did not identify any discrepancies. All tags were on the correct devices and the devices were in the position prescribed by the tags.

#### **O4 Operator Knowledge and Performance**

##### **O4.1 Inadvertent Closure of Nitrogen Accumulator Outlet Valve KAC0637**

###### **a. Inspection Scope (71707)**

The inspectors reviewed the licensee's response to an inadvertent closure of nitrogen accumulator Outlet Valve KAV0637. Closure of this valve rendered the main steam to atmosphere power operated relief valve for Steam Generator C and the auxiliary feedwater flow path from the turbine-driven auxiliary feedwater pump to Steam Generator C inoperable.

###### **b. Observations and Findings**

On September 18, 1996, the system engineer for the compressed air system requested operations department personnel to close four nitrogen accumulator tank valves to obtain leak rate data for trending. The accumulators serve as a backup gas system to supply compressed gas to the four steam generator main steam to atmosphere power operated relief valves and the four auxiliary feedwater flow control valves at the discharge of the turbine-driven auxiliary feedwater pump.

The system engineer gave operations personnel a marked-up copy of the associated piping and instrument drawing with the valves to be closed. While intending to mark Accumulator Tank TKA03 Inlet Valve KAV0636, the system engineer mistakenly marked Accumulator Tank TKA03 Outlet Valve KAV0637. The shift and control room supervisors reviewed the drawing and erroneously concurred on the valves to be closed, failing to realize an incorrect valve was marked. The shift supervisor assigned an equipment operator to close the valves indicated on the drawing. Closing Valve KAV0637 made two components inoperable: Steam Generator C main steam to atmosphere power operated relief Valve ABPV0003, and turbine-driven auxiliary feedwater pump to Steam Generator C discharge

Valve ALHV0012. Because of persistent questioning by the equipment operator, approximately 3.3 hours later, senior operators and the system engineer realized the mistake and had Valve KAV0637 reopened.

The licensee convened an Event Review Team to investigate the facts and causes surrounding this event. The shift supervisor realized he had misread the marked-up drawing. In addition, the licensee identified the following:

- There was no procedural guidance or work request directing this activity. A plant engineer voided a preventive maintenance task that performed this activity in June 1995 because it was viewed as no longer needed. The basis was that the preventive maintenance task was effectively accomplished in a separate surveillance procedure. The surveillance procedure placed the nitrogen accumulator system in the accident lineup and checked leakage from each accumulator in accordance with the Technical Specifications.
- Plant operators did not perform an adequate review of the drawing prior to allowing the marked valves to be closed. One reason was that control room personnel were busy covering several different activities at the time. This included routine and nonroutine activities for the upcoming refueling outage. The licensee lessened the amount of control room activity by rescheduling many activities for off-hours.

The inspectors found:

- The licensee's basis for deleting the preventive maintenance task was inaccurate. The established lineup for the preventive maintenance task allowed for detection of leakage past check valves that separate instrument air from the nitrogen system during normal plant operations. The Technical Specification surveillance procedure established a different lineup that could not check for leakage past these check valves.
- The equipment operator performed the requested lineup and immediately informed the control room supervisor that all requested valves were closed. The equipment operator specifically pointed out to the control room supervisor that he had closed a nitrogen accumulator tank outlet valve while closing inlet valves for the other accumulator tanks. Still the control room supervisor did not realize a problem existed.
- The equipment operator showed a strong questioning attitude in following up his question with the system engineer.
- Use of a controlled drawing in lieu of a reviewed and approved work document to reposition the accumulator valves was minimally acceptable. The licensee agreed and stated that a reviewed and approved work

document would be used if there is a future need to test the check valves for leakage.

The licensee was still evaluating whether the preventive maintenance task for the check valves would be re-established. This was because the check valves were recently replaced with little evidence of leakage.

The Technical Specification Action Statement under 3.7.1.2.d allowed 72 hours for Valve ALHV0012 to be inoperable since it disabled one of the flow paths from the turbine-driven auxiliary feedwater pump to the steam generators. Valve ABPV0003 being inoperable did not require entry into any Technical Specification Action Statement since the other three main steam to atmosphere power operated relief valves remained operable. The duration of Accumulator Tank TKA03 Outlet Valve KAV0637 being closed did not exceed the 72 hour limit.

The failure to provide procedural guidance or work document to direct this activity, and the subsequent use of a controlled drawing with the incorrect component identified for operation is a violation of 10 CFR 50, Appendix B, Criterion V, in that the guidance provided was inappropriate for the circumstances. Given that the condition was licensee identified, no Technical Specification Action requirements were exceeded, and the response to the event was prompt and comprehensive, this violation is being treated as a noncited violation consistent with Section VII.B.1 of the NRC Enforcement Policy (483/9609-01).

c. Conclusions

The inspectors found that the licensee did not utilize a procedure or guidance appropriate to the circumstances to perform the work proposed by the system engineer. The need for a formal review was evident in that the consequence of the error was inadvertent entry into a Technical Specification Limiting Condition for Operation. The lack of formal review was a weakness that contributed to the occurrence of this event.

04.2 Unplanned Isolation of Condensate Flow to a Low Pressure Feedwater Heater String

a. Inspection Scope (93702)

The inspectors observed the licensee's response to an unplanned isolation of low pressure Heater String C.

b. Observations and Findings

On September 27, 1996, an unplanned isolation of condensate flow to low pressure Heater String C occurred. Plant operators responded appropriately per plant procedures to minimize the effects of the transient on the primary and secondary



systems. The licensee held an Event Review Team to investigate the causes and develop an action plan for corrective and preventive actions.

The licensee found the probable cause was inadvertent bumping of the hi-hi level switch for low pressure feedwater Heater 2C. Investigation showed that bumping of this switch would have resulted in the transient by causing the inlet and outlet condensate isolation valves for the low pressure Heater String C to close. At the time of the event, contractors were removing insulation in the vicinity of the hi-hi level switch and may have inadvertently bumped or otherwise contacted the switch.

The licensee identified a list of proposed corrective and preventive actions. This included re-emphasizing good work practices with contract personnel and assigning additional licensee personnel to observe field activities. Also, the licensee was investigating ways to identify sensitive balance-of-plant instrumentation which might cause unplanned activation of plant equipment.

The inspectors found that plant operators responded well to this event. The operator immediately recognized the feedwater heater string had isolated by visual indication of a digital alarm on the main control board computer console. The alarm failed to sound. The licensee later performed troubleshooting on the alarm and could not identify a cause for the alarm not sounding since the alarm functioned properly during troubleshooting.

The inspectors reviewed plant procedures and identified that there was no off-normal procedure to guide operator actions in response to unplanned automatic isolation of low pressure feedwater heater strings. The guidance was contained in multiple places in existing procedures for normal planned removal of low pressure heater strings. The licensee also recognized this and began to evaluate issuing an off-normal procedure for this type of event.

Overall, the inspectors found good teamwork by plant operations, maintenance, and engineering personnel in responding to this event. Licensee management appropriately monitored and assisted in the recovery effort.

c. Conclusions

The inspectors concluded that licensee's overall response to this event was good.

**O5 Operator Training and Qualification**

**O5.1 Refueling Outage Training for Licensed Operators**

The inspectors observed a refueling training seminar held for plant operators. The seminar covered topics such as refueling outage work scope, schedule, lessons learned from the previous refueling outage, safety, and testing. The licensee required all licensed operators attend one of two seminars.

Licensee management presented a majority of the topics. In addition to technical discussions, management presented their expectations for operator performance. There were open discussions on the various topics. The inspectors found the outage training to be beneficial for plant operators in understanding outage work scope and potential problems and contingencies.

## **O5.2 Fire Brigade Training**

The inspectors reviewed the licensee's fire brigade training and qualification tracking program. The inspectors did not discover any problems in this area. The details are discussed in Section F5 of this report.

## **O7 Quality Assurance in Operations**

### **O7.1 Refueling Outage Shutdown Safety**

#### **a. Inspection Scope (71707)**

The inspectors reviewed the licensee's plans for ensuring that the plant meets all Technical Specification and Final Safety Analysis Report requirements during the upcoming refueling outage. This included discussions with licensee management, attending one of the operator refueling outage training seminars, and reviewing Procedure PDP-ZZ-00015, "Shutdown Safety Management", Revision 0.

#### **b. Observations and Findings**

Prior to the refueling outage, the licensee's Independent Safety Evaluation Group reviewed the outage schedule to determine if there were any shutdown safety problems. The group compared the planned equipment out-of-service schedule with Technical Specification and Final Safety Analysis Report requirements. To assist in the review, the group used a software package prepared by the Electric Power Research Institute. The package used probabilistic shutdown safety assessment models and various shutdown safety function assessment trees. The group identified no significant concerns in this area.

The inspectors noted that all operator crews practiced the plant heatup and cooldown on the plant simulator. Operators recommended some enhancements to the procedures that were appropriately evaluated and included into the procedures. The inspectors found that no outstanding issues needed to be resolved as a result of the shutdown safety review or from use of the procedures on the plant simulator.

The inspectors found that during the outage, the operations shift supervisor performs a formal risk assessment during each shift. Any maintenance schedule changes are compared to the equipment out-of-service list. The shift supervisor then presents the results of the risk assessment during the twice daily outage schedule meetings. Any actual or potential problems concerning shutdown risk are



resolved during the meeting. The licensee displays the updated outage risk assessment to ensure personnel are aware of the plant status.

c. Conclusions

The inspectors concluded that the licensee's program for minimizing shutdown safety risk is good. In addition, use of the simulator to practice the heatup and cooldown indicated good preparation and planning. The inspectors did not identify any concerns.

**O8 Miscellaneous Operations Issues**

**O8.1** (Closed) Violations 50-483/9508-01 and 50-483/9518-02: Failure of the Control Room Operators to Review Control Room Narrative Logs Prior to Assuming the Watch

In several instances the operators failed to read completed control room logs prior to assuming the watch. In addition, the inspectors noted problems in the quality of shift turnovers.

Since March 1996, the inspectors have observed numerous shift turnovers. The inspectors did not identify any instances of a control room operator failing to read the control room logs prior to assuming the watch.

Additionally, the quality of the shift turnovers has improved. Prior to assuming the watch, the operators discuss the plant status with the offgoing reactor operators, walk down the control boards, and review the status of plant equipment. The operators also review the current night orders to determine if there are any issues that could affect plant operations. The inspectors have no further concerns in this area and these violations are closed.

**II. Maintenance**

**M1 Conduct of Maintenance and Surveillance**

**M1.1** General Comments - Maintenance

a. Inspection Scope (62707)

The inspectors observed or reviewed all or portions of the following work activities:

- Work Document W180963, Repair seat leakage on essential service water Train A to turbine-driven auxiliary feedwater pump Valve ALHV0032;

- Work Document C575003, Install new molded case circuit breaker for Emergency Diesel Generator A room Supply Fan CGM01A;
- Work Document P587582, Perform functional test of ultimate heat sink sump heaters Train A;
- Work Document P587583, Perform functional test of ultimate heat sink sump heaters Train B; and
- Work Document W179860, Rebuild nitrogen supply regulator for turbine-driven auxiliary feedwater pump to Steam Generator C flow control Valve ALHV0012, and Steam Generator C atmospheric relief Valve ABPV0003.

b. Observations and Findings

The inspectors found most work performed to be professional and thorough. All work observed was performed with the work packages present and in active use. The inspectors frequently observed supervisors and system engineers monitoring job progress, and quality control personnel were present when required. Housekeeping and foreign material exclusion controls were satisfactory. Some minor weaknesses were identified and discussed with appropriate licensee personnel.

M1.2 General Comments - Surveillance

a. Inspection Scope (61726)

The inspectors observed or reviewed all or portions of the following test activities:

- Surveillance Procedure OSP-AL-P0002, "Section XI Turbine-Driven Auxiliary Feedwater Pump Operability";
- Surveillance Procedure OSP-AL-P001B, "Section XI Motor-Driven Auxiliary Feedwater Pump B Operability"; and
- Surveillance Procedure CTP-ZZ-01010, "Sampling of Secondary Grab Sample Points."

b. Observations and Findings

Surveillance testing was performed satisfactorily.

In addition, see the specific discussions under Section M1.3 below.

**M1.3 Section XI Motor Driven Auxiliary Feed Pump B Operability Test**

**a. Inspection Scope (71707)**

The inspectors observed the normally scheduled motor-driven auxiliary feedwater Pump B pre-job briefing and operability test. In addition to the operability test, mechanical maintenance personnel adjusted the pump's packing while the pump was running.

**b. Observations and Findings**

The control room supervisor conducted a thorough pre-job briefing. All personnel involved in the effort were present. The briefing included an overview of the work to be accomplished as well as potential problems and plant transients. The communications between the control room operators and field personnel during the test were good. Licensee management was also present for the briefing and pump run and reinforced their expectations on coordination and communications. The inspectors did not note any problems.

**M2 Maintenance and Material Condition of Facilities and Equipment**

**M2.1 Review of Plant Material Condition**

The inspectors reviewed licensee data on material condition of the plant. The licensee's goal was to have less than 200 corrective maintenance work requests prior to the start of Refueling Outage 8. The licensee met the goal, with 104 corrective maintenance work requests. Additionally, a goal of no more than 30 corrective maintenance work requests greater than six months old was established. The licensee met the goal, with 23 corrective maintenance work requests greater than 6 months old. In all, the licensee started the cycle with 985 plant work requests, and ended the cycle with 495 work requests. Plant work requests included corrective maintenance work requests but did not include work activities performed on spare parts or in buildings outside the power block.

**M8 Miscellaneous Maintenance Issues**

**M8.1 (Closed) Inspection Followup Item 483/9518-01: Ultimate Heat Sink Train B Sump Blocked with Ice**

On January 3, 1996, while performing his daily sump inspection, a plant equipment operator found the ultimate heat sink Train B sump blocked with several inches of ice. Plant operators declared the ultimate heat sink Train B sump inoperable. Workers immediately broke up the ice, returning the sump to an operable status.

The licensee found the formation of ice to be due to the failure of both temperature switches in the ultimate heat sink Train B sump. As an immediate corrective action,

the licensee implemented a temporary modification to jumper around the temperature switches so that the heaters remained energized. As a long term corrective action, plant engineers developed a permanent modification to increase the reliability of the system.

The licensee removed the temporary modification and installed the permanent modification as discussed in NRC Inspection Report 50-483/95-18. The inspectors reviewed the modification package, observed functional testing of the Train B heaters, and reviewed documentation on testing of the Train A heaters. The test results were satisfactory. The licensee has included annual testing of the heaters in the preventive maintenance program.

### III. Engineering

#### **E1 Conduct of Engineering**

##### **E1.1 Installation of New Temperature Indicator for Hydrogen Recombiner Train B**

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

The inspectors reviewed a plant modification to install a like-kind replacement for an indicator to monitor containment hydrogen recombiner Train B temperature.

###### **b. Observations and Findings**

Instrument and control personnel replaced the old analog temperature indicator, GSTI0029, for hydrogen recombiner Train B with a new digital indicator. The old indicator was obsolete. The licensee termed the modification a "material equivalency", and used the "Request For Resolution" process to approve and install the replacement temperature indicator. The inspectors reviewed the modification package and saw no items of concern except that changes to operations department procedures affected by the modification were not made.

From September 17-18, 1996, hydrogen recombiner Train B was inoperable for installation of the new indicator. On September 19, 1996, the inspectors found that procedures for operating and testing the recombiner were not changed. Specifically, Procedure OTN-GS-00001, "Containment Hydrogen Control System", Rev. 5, contained instructions at Step 4.4 for placing the hydrogen recombiner in service during post LOCA conditions. Step 4.4.9.2 required the operator to check that temperatures of the hydrogen recombiner were increasing by reading temperatures from selected thermocouples. Step 4.4.9.2 also contained a "note" informing the operator to gently tap the "knurled setpoint ring" on Temperature Indicator GSTI0029 when changing selected thermocouples to ensure a true reading. Installation of the new indicator invalidated the note since there was no knurled setpoint ring on the new indicator. The same note appeared in

Procedure OSP-GS-00001, "Containment Hydrogen Recombiner Functional Test", Rev. 6., Step 6.2.

The licensee explained that procedure notes are for information only and are used to provide information that can help the procedure user in performing the procedure. Although the inspectors agreed, it was evident that the licensee did not review procedures affected by the modification to determine whether any changes were needed. The licensee changed the procedures to remove the note. The failure to update the operations department procedures was a violation of Technical Specification 6.8.1 (483/9609-02).

Upon further review, the inspectors found that the licensee's use of the "Request For Resolution" process to implement modifications did not have a feedback loop to ensure that procedures, drawings, or other documents affected by the modification were changed. The licensee agreed and issued a corrective action document to evaluate this concern. The inspectors will review of the results of the licensee's evaluation when the violation is closed.

The licensee supplied the inspectors with results of a recent audit by quality assurance personnel. The audit sampled 16 modifications implemented using the Request For Resolution process. The auditors identified no substantive concerns.

c. Conclusions

The licensee's overall configuration control process following plant modifications was satisfactory. A violation was identified for one example of failing to maintain proper configuration control.

**E2 Engineering Support of Facilities and Equipment**

**E2.1 Review of Facility Conformance to Updated Final Safety Analysis Report Commitments**

A recent discovery of a licensee operating their facility in a manner contrary to the Final Safety Analysis Report description highlighted the need for a special focused review that compares plant practices, procedures, and/or parameters to the Final Safety Analysis Report description. While performing the inspections discussed in this report, the inspectors reviewed the applicable portions of the Final Safety Analysis Report that related to the areas inspected. No inconsistencies were noted between the wording of the Updated Safety Analysis Report and the plant practices, procedures, and/or parameters observed by the inspectors.

**E8      Miscellaneous Engineering Issues**

**E8.1    (Closed) Licensee Event Report 50-483/96002: One train of essential service water inoperable due to revised accuracy of the butterfly valve analysis and review test system**

In April 1996, Innovative Technology Incorporated notified the licensee that an error assumption in calculating the setpoints for certain butterfly valve torque switches was nonconservative. The licensee performed a reanalysis with the correct error assumption for all affected safety related butterfly valves.

Following the reanalysis, the licensee determined that service water to essential service water Isolation Valve EFHV0025 could not be proven to close under all design basis scenarios. The licensee processed a temporary modification to jumper out the torque switch when the valve closes. The torque switches were used for testing purposes only. A limit switch controls the actuator during stroking of the valve.

As a long term corrective action, the licensee planned to jumper out the closing torque switch contacts for all safety related butterfly valves. This modification would preclude the valves from failing to close due to errors in torque switch settings. The modifications are scheduled to be completed during routine maintenance on the valve actuators. The inspectors have no further concerns with this item and consider it closed.

**IV. Plant Support**

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

**R1.1    Radiological Protection Program Observations**

The inspectors toured various areas of the radiologically controlled areas of the plant. Health physics personnel were observed routinely touring the radiologically controlled areas. Pre-job briefs for work in radiological controlled areas were satisfactory, with open discussions on radiological and personal safety. Licensee personnel observed performing work in radiological control areas exhibited good radiation worker practices. Contaminated areas and high radiation areas were properly posted. Area surveys posted outside rooms in the auxiliary building were current.



## **F5 Fire Protection Staff Training and Qualification**

### **a. Inspection Scope (71750)**

The inspectors reviewed the fire brigade training program and qualification tracking system. The inspectors also reviewed the program to determine if it was in compliance with the Final Safety Analysis Report requirements.

### **b. Observations and Findings**

The initial fire brigade program training is performed for all operators during initial licensed operator training and is described in the Final Safety Analysis Report site addendum Section 9.5. The licensee's fire brigade training program is implemented by Procedure FPP-ZZ-00009, "Fire Protection Training Program," Revision 0.

The training subject matter correlated to the requirements of the Final Safety Analysis Report. The fire brigade members attend on-going fire protection training. The fire protection requalification classes were comprised of six modules that were taught at least once every 2 years. These modules were taught as part of the licensed operator requalification program.

The fire brigade member qualification status was tracked using the licensee's computerized training tracking program. This program lists each person's qualification and medical certification expiration dates. The inspectors reviewed this status list and verified that all operators assigned to the fire brigade were qualified.

### **c. Conclusions**

The inspectors concluded that fire brigade training met the licensee's program requirements. The inspectors did not note any problems with the fire brigade member qualification tracking program. The training program met the requirements of the Final Safety Analysis Report.

## **V. Management Meetings**

### **X1 Exit Meeting Summary**

The exit meeting was conducted on October 11, 1996. The licensee expressed a position on some of the inspection findings documented in this report:

- During the discussion of the unplanned feedwater heater string isolation (Section 04.2), the licensee stated that an off-normal procedure would be developed to respond to an unplanned automatic isolation of a low pressure feedwater heater string.

- During the discussion of the installation of the new temperature indicator for the hydrogen recombiner (Section E1.1), the licensee stated that failure to delete a note in the hydrogen recombiner procedure did not rise to the level of significance to warrant a violation.

ATTACHMENT

**SUPPLEMENTAL INFORMATION**

PARTIAL LIST OF PERSONS CONTACTED

Licensee

R. D. Affolter, Manager, Callaway Plant  
J. D. Blosser, Manager, Operations Support  
H. D. Bono, Supervising Engineer, Licensing Fuels and Site Licensing  
F. J. Forck, Quality Assurance, Scientist  
J. M. Gloe, Superintendent, Maintenance  
G. A. Hughes, Supervising Engineer, Independent Safety Engineering Group  
K. W. Kuechenmeister, Superintendent, Design Engineering  
C. D. Naslund, Manager, Nuclear Engineering  
D. W. Neterer, Shift Supervisor  
J. R. Peevy, Manager, Emergency Preparedness and  
Organizational Support  
G. L. Randolph, Vice President, Nuclear Operations

The above personnel attended the exit meeting. In addition to these personnel, the inspectors contacted other personnel during this inspection period.

INSPECTION PROCEDURES USED

IP 37551:	Onsite Engineering
IP 61726:	Surveillance Observations
IP 62707:	Maintenance Observations
IP 71707:	Plant Operations
IP 71750:	Plant Support Activities
IP 93702:	Prompt Onsite Response to Events at Operating Power Reactors

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

9609-02      VIO      Failure to change operating procedures following a modification.

Opened and Closed

9609-01      NCV      Failure to provide guidance opportunities to the circumstances to perform evaluations requested by the system engineer.

Closed

9508-01      VIO      Failure of control room operators to review logs prior to assuming watch.

9518-02      VIO      Failure to control room operators to review logs prior to assuming watch.

9518-01      IFI      Ultimate heat sink Train B sump blocked with ice.

96002      LER      Essential service water valve inoperable due to revised accuracy of butterfly valve analysis.

Discussed

None.