

U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Docket Nos: 50-282, 50-306

License Nos: DPR-42, DPR-60

Report No: 50-282/96010; 50-306/96010

Licensee: Northern States Power Company

Facility: Prairie Island Nuclear Generating Plant

Location: 1717 Wakonade Drive East
Welch, MN 55089

Dates: August 30 - October 8, 1996

Inspectors: S. Ray, Senior Resident Inspector
R. Bywater, Resident Inspector

Approved by: B Jorgensen, Acting Chief, Projects Branch 7
Division of Reactor Projects

EXECUTIVE SUMMARY

Prairie Island Nuclear Generating Plant, Units 1 & 2 NRC Inspection Report 50-282/96-10, 50-306/96-10

This inspection included aspects of licensee operations, maintenance, engineering, and plant support performed by the resident inspectors.

Operations

- The inspectors found the auxiliary feedwater system to be in good material condition. (Section 02.1)
- The Safety Audit Committee (SAC) activities were observed to be in accordance with Technical Specifications. Technical discussions during a SAC meeting were thorough and candid. (Section 08.3)

Maintenance

- Most observed maintenance and surveillance activities were well conducted with good communications, proper planning, and safe work practices. Electricians performing one surveillance identified several procedural enhancements. (Section M1.1)
- An error by a relatively inexperienced reactor operator during a surveillance resulted in an automatic start of a component cooling water pump. (Section M1.2)
- The inspectors identified that required quarterly testing of two check valves in the chemical feed system had not been adequately performed for about two years because test pressure gauges were isolated. Weaknesses in configuration control and an inadequate questioning attitude by operators contributed to the problem. (Section M3.2)
- During performance of a diesel breaker surveillance, the licensee identified that the procedure was inadequate. (Section M3.3)

Engineering

- The inspectors identified an error in an Updated Safety Analysis Report (USAR) drawing. The inspectors determined that the licensee was already aware of the error. (Section E2.1)

Plant Support

- The inspectors determined that the material condition of the normally inaccessible spent resin storage tank room and the low level gas decay tank room was excellent. (Section R2.1)

Report Details

Summary of Plant Status

Both units operated at or near full power for the entire inspection period.

During this period, the fifth dry spent fuel storage cask was inspected and prepared for loading.

I. Operations

01 Conduct of Operations

01.1 General Comments (71707)

Using Inspection Procedure 71707, the inspectors conducted frequent reviews of plant operations. In general, the conduct of operations was acceptable. However, operator performance during surveillance testing was a concern as discussed in Section M1.2 and M3.2 of this report.

02 Operational Status of Facilities and Equipment

02.1 Engineering Safety Feature System Walkdowns

a. Inspection Scope (71707, 92903)

The inspectors used Inspection Procedures 71707 and 92903 to walk down selected portions of the auxiliary feedwater system. Updated Safety Analysis Report (USAR) Section 11.9, "Condensate, Feedwater and Auxiliary Feedwater Systems," revision 12, was reviewed as part of this inspection.

b. Observations and Findings

The system was found to be in good material condition. No discrepancies were noted between system operation and the USAR description. On September 17, 1996, the #12 auxiliary feedwater pump to #12 steam generator throttle valve, MV-32382, failed to stroke during a surveillance test. The inspectors observed the troubleshooting and repair of the valve. Although a definitive cause was not determined, a corrosion film on the torque switch contacts was thought to be the cause of the failure. The valve was repaired and satisfactorily tested. All the other throttle valves in the system worked normally.

c. Conclusions

No significant issues were identified.

08 Miscellaneous Operations Issues

08.1 (Closed) Inspection Followup Item (IFI) 306/96002-03: Failure to Recognize Closed Control Valve During Power Change.

a. Inspection Scope (92701)

This issue was discussed in Inspection Report 282(306)/96002, Section 1.6. It involved operators failing to notice a deviation between actual control valve position and programmed position during a power change when turbine control valve CV-4 failed closed. The inspectors reviewed Operating Procedures 1C1.4, "Unit 1 Power Operation," revision 13, and 2C1.4, "Unit 2 Power Operation," revision 13, as part of this inspection.

b. Observations and Findings

Corrective actions included temporary procedure changes to direct operators to check control valve positions during power changes. These temporary changes were later replaced by permanent revisions (1C1.4 and 2.C1.4, revision 13). In addition, figures showing the programmed control valve positions versus power level were permanently attached to the control board at the turbine control station. The licensee also issued work orders to add alarms to the Emergency Response Computer System to indicate when any turbine control valves deviate from the programmed positions.

c. Conclusions

The inspectors verified that corrective actions were completed and concluded that they should be sufficient to prevent recurrence of the event.

08.2 (Closed) IFI 282/96008-06: Concerns with Technical Specification Interpretation.

a. Inspection Scope (92901)

This issue was discussed in Inspection Report 282(306)/96008, Section M3.1. During this inspection period, the licensee submitted an amendment request to change the Technical Specifications to allow the option of not realigning the "121" motor-driven cooling water pump for safeguards operation when one of the diesel-driven cooling water pumps was inoperable. The inspectors reviewed the request dated September 11, 1996, and the licensee's Technical Specification Interpretation (TSI) 3.3-15, "Cooling Water System - Safeguards Cooling Water Pump Alignment and Operability," revision 0, as part of this inspection.

b. Observations and Findings

The inspectors had some concerns with the amendment request which were passed on to the licensee and the NRC reviewer.

One concern was that the Determination of Significant Hazards Consideration section of the amendment request appeared to primarily compare the hazards of the proposed amendment to the configuration the plant was licensed to several years ago, before the modification which upgraded the 121 cooling water pump. The hazards of the amendment request did not appear to be adequately compared to the current configuration.

A second concern was that the amendment request stated that the TSs, as currently written, required the 121 cooling water pump to be placed in service any time one of the diesel-driven cooling water pumps was inoperable. However, TSI 3.3-15 stated that the licensee may elect not to place the 121 pump in service as a safeguards pump. The licensee's position in the amendment request and the interpretation appeared to be in conflict.

The above inspector concerns would be addressed during the NRC review of the amendment request and thus additional inspector followup was not required.

A third concern was that neither the TSI nor the amendment request contained sufficient guidance to operators on whether it was preferable to realign the 121 pump or enter the 7-day limiting condition for operation with a diesel-driven pump inoperable. There was no guidance on the consideration of the relative risks of the two actions. However, paragraph (a)(3) of 10 CFR 50.65 (The Maintenance Rule) provided NRC expectations that, prior to removing equipment from service, the licensee should conduct an assessment of the total plant equipment that is out-of-service to determine the overall effect on performance of safety functions. A separate NRC inspection (Report No. 282(306)/96012) of the licensee's implementation of the Maintenance Rule addresses this inspector concern.

c. Conclusions

Although inspector concerns remained regarding the issue, they will be dealt with through the license amendment request review process.

08.3 Review of Safety Audit Committee (SAC) Activities

a. Inspection Scope (40500)

The inspectors observed the SAC meeting at the Prairie Island site on September 19, 1996. The inspectors also reviewed the meeting final agenda and a compilation of questions for meeting presenters submitted in advance of the meeting by SAC members.

b. Observations and Findings

Requirements of the SAC were contained in TS 6.2. The inspectors observed that membership, quorum, and meeting frequency requirements were met for the meeting. The inspectors also verified that each subject

required to be reviewed by the SAC as delineated in TS 6.2.A.5 were discussed in the meeting.

Discussions during the meeting were led by licensee staff members most familiar with the issues. Discussions were thorough and candid. Questions by the SAC members were either resolved or scheduled for further discussion at the next meeting. In this meeting, the SAC made no recommendations to the Vice President Nuclear Generation.

c. Conclusions

The inspectors determined that the SAC activities observed adequately met the TS requirements.

II. Maintenance

M1 Conduct of Maintenance

M1.1 General Comments

a. Inspection Scope (61726, 62707)

The inspectors observed all or portions of the following maintenance and surveillance activities. Including in the inspection was a review of the surveillance procedures (SP) or work orders (WO) listed as well as the appropriate USAR sections regarding the activities.

- SP 1130 Containment Vacuum Breakers, revision 27
- WO 9609013 Troubleshoot 2B Starting Air Compressor on D5
Emergency Diesel Generator
- SP 1095 Bus 16 Load Sequence Test, revision 8
- WO 9609167 Repair MV 32382, #12 Auxiliary Feedwater Pump to #12
Steam Generator Throttle Valve
- WO 9609100 Measure and Adjust Annunciator Sound Level
- SP 1355 Checking Chemical Feed and Auxiliary Feedwater Check
Valves - Unit 1, revision 6
- SP 1306 D2 Diesel Generator Functional Test

b. Observations and Findings

- For SP 1095, the inspectors observed that the electricians performing the surveillance identified several procedural enhancements and submitted recommended changes. The inspectors noted that SP 1095 could be adequately performed without the changes.
- For SP 1355, the operators performing the surveillance promptly informed the shift supervisor of each section of the surveillance that had failed to meet the acceptance criteria or for which the

data was inconclusive. Additional discussions regarding this surveillance are contained in Section M3.2 of this report.

- SP 1306, which had been recently revised, proved inadequate as written. This is discussed further in Section M3.3.

c. Conclusions

Most observed maintenance and surveillance activities were well conducted with good communications, proper planning, and safe work practices. An exception, where operators failed to demonstrate a questioning attitude, is discussed in Section M3.2.

M1.2 Operator Error During Surveillance

a. Inspection Scope (92700)

On September 7, 1996, while performing a surveillance on the residual heat removal system pumps, an error by a reactor operator resulted in the automatic actuation of an engineered safety feature system. The inspectors reviewed the circumstances of the event. The inspectors also reviewed Surveillance Procedure SP 1089, "Residual Heat Removal Pumps and Suction Valves from the Refueling Water Storage Tank," revision 41, and Licensee Event Report (LER) 282(306)/96-16, "Auto-start of No. 11 Component Cooling Water Pump Due to Personnel Error," revision 0, as part of this inspection.

b. Observations and Findings

The surveillance required the operator to start the standby component cooling (CC) pump during a portion of the test. Step 7.3.17 of the procedure directed the operator to return the CC pumps to normal as directed by the shift supervisor. At the end of SP 1089, he was directed to stop the #11 CC pump. A note before step 7.3.17 warned the operator that when stopping a CC pump, ensure the CC system stabilizes prior to releasing the start/stop switch to prevent an inadvertent automatic restart.

The reactor operator performing the surveillance was newly licensed and was unfamiliar with the amount of time required for the system to stabilize. He held the switch in the stop position for 2 1/2 seconds, according to the sequence of events recorder, and then released it. However, system flow and pressure had not yet stabilized, resulting in an automatic restart of the #11 CC pump on low system pressure.

Later, the operator properly stopped the pump. The licensee reported the event to the NRC in accordance with 10 CFR 50.72 and issued LER 282(306)/96-16 as a followup. Corrective actions included reinforcing the proper use of the procedure with the operator. In addition, the licensee installed caution labels on the control boards providing

guidance on stopping the component cooling water pumps. The LER is closed in Section M8.6 of this report.

c. Conclusions

The inspectors concluded that the automatic start of the CC pump was an unnecessary challenge to the system, but was not safety significant. The system performed as designed. Technical Specification 6.5.A.4 required, in part, that detailed written procedures be prepared and followed for surveillance testing requirements that could have an effect on nuclear safety. Surveillance Procedure SP 1089, "Residual Heat Removal Pumps and Suction Valves from the Refueling Water Storage Tank," step 7.3.17, was not followed in that a note informing the operator to hold the switch in the stop position until the system stabilized was not adhered to. This failure constitutes a violation of minor significance and is being treated as a Non-Cited Violation, consistent with Section IV of the NRC Enforcement Policy. (282/96010-01)

M3 **Maintenance Procedures and Documentation**

M3.1 Drawing Discrepancy in Updated Safety Analysis Report (USAR)

a. Inspection Scope (62707)

While reviewing a maintenance activity to perform a temporary repair of a steam leak on the connection between a chemical feed line and a feedwater line, the inspectors noted that a drawing in the USAR contained errors. The inspectors reviewed the following documents:

- USAR Section 11.9, revision 12
- USAR Figure 11.1-5, revision 13
- USAR Figure 11.1-14, revision 13
- Drawing NF-39240-1, revision A
- Drawing Request PI-96-154

b. Observations and Findings

The inspectors noted that USAR Figure 11.1-5 (Drawing NF-39222, revision AT), showed a transition to drawing NF-39239 for a continuation of the chemical feed lines upstream of where they tie into the feedwater lines. However, drawing NF-39239, revision AL (USAR Figure 11.1-14, revision 13), was revised on January 18, 1995, to eliminate the chemical feed system from the drawing. The chemical feed system was actually continued on drawing NF-39240-1, Revision A.

The inspectors were informed by the chemical feed system engineer that he was aware of the drawing discrepancy and intended to take action to correct it. Drawing Request PI-96-154 was submitted on September 20, 1996, to correct the problem.

c. Conclusions

This issue is considered an IFI pending completion of the USAR update.
(282/96010-02)

M3.2 Failure to Adequately Perform Check Valve Tests

a. Inspection Scope (61726)

On September 30, 1996, the inspectors observed the performance of Surveillance Procedure SP 1355, "Checking Chemical Feed and Auxiliary Feedwater Check Valves - Unit 1." As part of this inspection, the inspectors reviewed the following documents:

- Surveillance Procedure SP 1355, "Checking Chemical Feed and Auxiliary Feedwater Check Valves - Unit 1," revision 6
- Surveillance Procedure SP 2355, "Checking Chemical Feed and Auxiliary Feedwater Check Valves - Unit 2," revision 2
- Procedure H10.1, "ASME Section XI Inservice Testing Implementation Program," revision 6
- Form 1190, "Unit 1 Chemical Feed System Pre-Startup Checklist," revision 0
- Form 1191, "Unit 2 Chemical Feed System Pre-Startup Checklist," revision 0
- Drawing NF-39240-1, revision A

b. Observations and Findings

Section 7.3 of SP 1355 contained instructions for performing ASME Section XI testing of check valves, CF-11-1 and CF-11-2, on the chemical feed injection lines to the auxiliary feedwater system. During the performance of that section, operators noted that some valves were not in the positions indicated on SP 1355 and discussed the situation with a chemist and the shift supervisor.

They were informed by the chemist that the normal system lineup had been changed by the chemistry department about two years ago because the system was no longer operated in automatic. The shift supervisor authorized the operators to position the valves as specified in the surveillance procedure and continue with the test.

The test lineup consisted of measuring pressure on both sides of the check valves using temporarily installed gauges. A differential pressure with high pressure on the downstream side of the valves would indicate proper reverse seating. The operators recorded 735 psig on the downstream side of CF-11-2 and 0 psig on the upstream side. They recorded on the procedure that the test results were acceptable. A similar test lineup was used for testing the unit 2 check valve, 2CF-11-2.

However, the inspectors noted that two manual valves (CF-2-35 and CF-2-36) between CF-11-2 and the upstream pressure gauge had not been included in the procedure to be verified in the correct position. Because other valves had been found out of position, the inspectors asked the operators to check the positions of those two valves. They were found to be closed. This invalidated the results of the test since the upstream pressure gauge had been isolated from the check valve being tested.

The shift supervisor then abandoned the surveillance and informed the system engineer of the situation. The shift supervisor isolated both the unit 1 and unit 2 chemical feed check valves from the auxiliary feedwater system until the situation was clarified. The next day the system engineer and shift supervisor approved a temporary change to the unit 1 surveillance procedure to correct the valve lineup problems. The test was reperformed and CF-11-2 was found to be acceptable. The surveillance was completed within the periodicity required by the Technical Specifications and ASME Section XI.

The licensee evaluated previous performances of the surveillance and determined that the tests for both CF-11-2 on unit 1 and 2CF-11-2 on unit 2 had most likely been invalid for each quarterly test performed in approximately the previous two years due to the temporarily installed gauges being isolated. At the conclusion of the inspection period, 2CF-11-2 remained isolated until it could be properly tested with a revised procedure.

The significance of the failure to properly test the valves was reduced because the valve lineup change conducted by the chemistry department had also isolated the chemical feed check valves from the auxiliary feedwater system except when actually in use for adding chemicals or for the quarterly tests. Normally, chemicals were only added through these paths during shutdown periods. Thus the untested check valves were probably isolated during most of the period in question.

c. Conclusions

Technical Specification 4.2.A.2 required that inservice testing of ASME Code Class 1, Class 2, and Class 3 pumps and valves be performed in accordance with Section XI of the ASME Boiler and Pressure Vessel Code and applicable Addenda as required by 10 CFR 50, Section 50.55a(g), except where specific written relief has been granted by the NRC.

The licensee was currently required to follow the 1989 revision of Section XI, which stated that valve testing shall be performed in accordance with the requirements stated in ASME/American National Standards Institute Operations and Maintenance Standards, Part 10, 1988 (ASME/ANSI OM-10), "Inservice Testing of Valves in Light-Water Reactor Power Plants." Paragraph 4.3.2.4(a) of OM-10 required quarterly verification that the disk of a normally open check valve traveled to its seat on cessation or reversal of flow by observing a position indicating device or changes in system pressure, flow rate, level, temperature, seat leakage testing or other positive means.

Because valves CF-2-35 and CF-2-36 on unit 1 and 2CF-2-35 and 2CF-2-36 on unit 2, were closed and effectively isolated the temporary upstream pressure gauges, the check valves CF-11-2 and 2CF-11-2 were not adequately tested quarterly from about March 1994 until October 1, 1996. This was a violation. (282/96010-03)

In addition to the fact that the surveillance procedures did not require verification of the positions of valves CF-2-35, CF-2-36, 2CF-2-35, and 2CF-2-36, the inspectors concluded that the event indicated a weakness in the licensee's configuration control program because chemistry department personnel had significantly changed the normal lineup of the chemical feed system from that shown on plant drawing NF-39240-1 and assumed in SP 1355 and SP 2355 without informing operations or engineering personnel or adequately considering the effect on other plant procedures. The normal system lineup was established by Form 1190(1191), "Unit 1(2) Chemical Feed System Pre-Startup Checklist." However, those forms were not required to be controlled as "procedures for systems involving nuclear safety of the facility" according to Technical Specification 6.5.A and thus had not been reviewed by the Operations Committee for potential effects on other procedures.

The inspectors also concluded that the operators performing the test and the shift supervisor failed to display an adequate questioning attitude when several valves were found out of their expected positions. SP 1355 included a system diagram figure which showed that valves CF-2-35 and CF-2-36 needed to be open to establish a valid test lineup and the operators should have anticipated that they could be out of position too. Since the test had been performed each quarter for both units for approximately the previous two years, multiple opportunities were missed by the operators to recognize the lineup problems.

The licensee intended to issue LER 282(306)/96-17 for this event. The inspectors will review the LER when issued.

M3.3 Inadequate Procedure for Diesel Generator Trip Test

a. Inspection Scope (61726)

On September 25, 1996, the inspectors observed the performance of Surveillance Procedure SP 1306, "D2 Diesel Generator Functional Test," revision 2. The above procedure was reviewed as part of this inspection.

b. Observations and Findings

This was the first performance of the test after a significant revision to the procedure. The test was to verify that certain trips of the diesel generator were defeated when the diesel was operating during a loss of offsite power in conjunction with a safety injection signal, as required by TS 4.6.A.3.b.4. In the past, the test was done without actually physically tripping the generator output breaker, but the revision added steps to trip the breaker.

Step 7.15.2 of the procedure required the operators to close the output breaker from the control room in preparation for the trip test (with the diesel not operating). Operators attempted to close the breaker, but were unsuccessful. They then determined that the breaker would not close unless the synchro-check relay was energized. This was impossible with the engine not running. The surveillance was stopped and a temporary change was made to the procedure to add a step to jumper out the synchro-check relay. The surveillance was then successfully completed.

c. Conclusions

The inspectors concluded that SP 1306 was not appropriate for the circumstances because it did not require jumpering of the synchro-check relay. This was a violation of 10 CFR 50, Appendix B, Criteria V, which required that activities affecting quality be prescribed by documented instructions, procedures, or drawings, of a type appropriate to the circumstances. However, the procedure problem was not safety significant because the inadequacy simply resulted in the inability to complete the test until it was corrected. This failure constitutes a violation of minor significance and is being treated as a Non-Cited Violation, consistent with Section IV of the NRC Enforcement Policy. (282/96010-04)

M8 Miscellaneous Maintenance Issues (92700, 92902)

As part of the inspection for each LER discussed in this section, the inspectors reviewed the LER itself.

- M8.1 (Closed) IFI 306/94015-01: Performance of Foreign Material Exclusion (FME) Inspections. This issue was discussed in Inspection Report 282(306)/94015, Section 3.c. Inspectors' observations during maintenance activities since that time indicated no significant problems with FME controls.
- M8.2 (Closed) Unresolved Item 306/94015-02: Verbal Authorization for Equipment Control. This issue was discussed in Inspection Report 282(306)/94015, Section 5.b.a. Inspectors' observations during plant activities since that time indicated only one significant instance of verbal authorization for equipment control that was not properly documented. That case, discussed in Inspection Report 282(306)/96002, Section 1.1.1, involved manipulation of disconnect switches ordered by the shift supervisor and then not recorded in the appropriate log. That issue was considered an example of a violation (282/96002-01b) cited in the report. The unresolved item is considered closed and any additional corrective actions will be reviewed in followup on the violation.
- M8.3 (Closed) LER 306/96-02, revision 0: Reactor Trip Caused by Loss of Instrument Air Pressure. This event was discussed in Inspection Report 282(306)/96006, Sections 01.2, M1.2, and M8.3. The inspectors determined that the corrective actions in the LER were completed and concluded that the actions should prevent recurrence of the event. One corrective action, to implement a modification to add an automatic isolation valve to the instrument air dryer exhaust purge line, was not completed but

parts had been obtained and plans were in place to install it. That modification, when completed, would isolate the exhaust purge line on low air header pressure which would prevent a stuck exhaust valve from depressurizing the air header. Until the modification could be installed, the licensee was operating the system with the manual exhaust purge isolation valve throttled in order to give operators sufficient time to respond to a stuck valve.

M8.4 (Closed) LER 282(306)/96-14, revision 0: Simultaneous Inoperability of Cooling Water Pumps. This event was discussed in Inspection Report 282(306)/96008, Section M1.2, and a violation for the licensee's failure to issue the LER in a timely manner was discussed in Section M8.1 of the same report. The LER was issued on September 5, 1996, 41 days after the event was discovered by the licensee. The remaining corrective action was to review the diesel cooling water pump surveillance test procedure against the plant's Writer Guide to verify that it was well-written from a human-factors perspective. As discussed in Section M3.2 of Inspection Report 282(306)/96008, the licensee discovered a typographical error in the procedure which contributed to the event reported as LER 282(306)/96-15. Since one of the corrective action for LER 96-15 was also to review the procedure for possible revisions, LER 96-14 is closed to avoid duplicate tracking and the remaining corrective action will be verified when LER 96-15 is closed.

M8.5 (Open) LER 282(306)/96-15, revision 0: Auto-start of No. 22 Diesel Cooling Water Pump on Low Header Pressure During Surveillance. This event was discussed in Inspection Report 282(306)/96008, Section M3.2, as mentioned in the section above. At the time of that inspection the LER had not yet been issued. The LER was issued on September 23, 1996, and the inspectors' review determined that it met the requirements of 10 CFR 50.73. The LER remains open pending the completion of the corrective actions discussed therein.

M8.6 (Closed) LER 282(306)/96-16, revision 0: Auto-start of No. 11 Component Cooling Water Pump due to Personnel Error. This event was discussed in Section M1.2 of this report. The LER is closed based on the inspectors' verification of the completion of all corrective actions and the determination that the corrective actions should be adequate to prevent recurrence.

III. Engineering

E2 Engineering Support of Facilities and Equipment

E2.1 Review of USAR Commitments (37551)

While performing the inspections discussed in this report, the inspectors reviewed the applicable portions of the USAR that related to the areas inspected and used the USAR as an engineering/technical support basis document. The inspectors compared plant practices, procedures, and/or parameters to the USAR descriptions as discussed in each section. In Section M3.1, an error in a USAR drawing was discussed.

E8 Miscellaneous Engineering Issues (92903)

E8.1 (Closed) Unresolved Item 282/96006-01

(Closed) Apparent Violation 282/96007-02

(Open) Licensee Event Report (LER) 282(306)/96-10: Auxiliary Feedwater Pumps Not Protected Against Runout For All Conditions. This issue was discussed in Inspection Report 282(306)/96006, Section 01.3, and 282(306)/96007, Section E1.1.

In a letter to the licensee from the NRC dated October 1, 1996, the NRC elected to exercise enforcement discretion and not issue a Notice of Violation for this issue. Thus, the Unresolved Item and Apparent Violation are closed. LER 96-10 regarding the issue remains open pending NRC review of the licensee's completion of longer term corrective actions to remove reliance on operator action to preclude pump damage.

IV. Plant Support

R1 Radiological Protection and Chemistry Controls (71750)

During normal resident inspection activities, routine observations were conducted in the areas of radiological protection and chemistry controls using Inspection Procedure 71750. No discrepancies were noted.

R2 Status of Radiological Protection and Chemistry Facilities and Equipment

R2.1 Condition of Radioactive Waste Storage Tanks

As discussed in Inspection Report 282(306)/96002, Section 4.6, the inspectors looked at all accessible radioactive waste storage tanks to determine if their condition had degraded. At that time there was no access to the spent resin storage tank room or the low level waste gas decay tank room. During this inspection period the licensee took down block walls to gain access to the rooms in order to perform a modification. The rooms had not been entered for over 20 years. The inspectors entered the rooms for an inspection after the blocks were removed. The tanks, piping, supports, valves, and the rooms in general appeared to be in excellent material condition.

Additional issues with the licensee's activities in the rooms were discussed in Inspection Report 282(306)/96011.

P1 Conduct of Emergency Preparedness Activities (71750)

During normal resident inspection activities, routine observations were conducted in the area of emergency preparedness using Inspection Procedure 71750. No discrepancies were noted. The inspectors noted that one of the evacuation routes from the plant was restored when bridge construction was completed on Dakota County Highway 68. The road had been closed for most of the summer.

S1 Conduct of Security and Safeguards Activities (71750)

During normal resident inspection activities, routine observations were conducted in the areas of security and safeguards activities using Inspection Procedure 71750. No discrepancies were noted.

An additional inspection of licensee activities in this area was conducted during this period and was discussed in Inspection Report 282(306)/96013.

F1 Control of Fire Protection Activities (71750)

During normal resident inspection activities, routine observations were conducted in the area of fire protection activities using Inspection Procedure 71750. No discrepancies were noted.

V. Management Meetings

X1 Exit Meeting Summary

The inspectors presented the inspection results to members of the licensee management at the conclusion of the inspection on October 8, 1996. 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

M. Wadley, Plant Manager
K. Albrecht, General Superintendent Engineering
J. Goldsmith, General Superintendent Design Engineering
J. Hill, Manager Quality Services
G. Lenertz, General Superintendent Plant Maintenance
D. Schuelke, General Superintendent Radiation Protection and Chemistry
M. Sleigh, Superintendent Security
J. Sorensen, General Superintendent Plant Operations

INSPECTION PROCEDURES USED

IP 37551: Onsite Engineering
IP 40500: Effectiveness of Licensee Controls in Identifying, Resolving, and Preventing Problems
IP 61726: Surveillance Observations
IP 62707: Maintenance Observations
IP 71707: Plant Operations
IP 71750: Plant Support Activities
IP 92700: Onsite Followup of Written Reports of Nonroutine Events at Power Reactor Facilities
IP 92901: Followup - Operations
IP 92902: Followup - Maintenance
IP 92903: Followup - Engineering

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

282/96010-01	NCV	Failure to Follow Surveillance Procedure
282/96010-02	IFI	Drawing Error in USAR
282/96010-03	VIO	Failure to Adequately Perform ASME Check Valve Tests
282/96010-04	NCV	Inadequate Procedure for Diesel Breaker Surveillance
282(306)/96-15	LER	Auto-start of No. 22 Diesel Cooling Water Pump on Low Header Pressure During Surveillance

Closed

306/96002-03	IFI	Failure to Recognize Closed Control Valve During Power Change
282/96008-06	IFI	Concerns with Technical Specification Interpretation
306/94015-01	IFI	Performance of Foreign Material Exclusion Inspections
306/94015-02	URI	Verbal Authorization for Equipment Control
306/96-02	LER	Reactor Trip Caused by Loss of Instrument Air Pressure
282(306)/96-14	LER	Simultaneous Inoperability of Cooling Water Pumps
282(306)/96-16	LER	Auto-start of No. 11 Component Cooling Water Pump on Low Header Pressure due to Personnel Error
282/96006-01	URI	Auxiliary Feedwater Pumps Not Protected Against Runout For All Conditions

282/96007-02 VIO Auxiliary Feedwater Pumps Not Protected Against Runout
For All Conditions

Discussed

282/96002-01b VIO Failure to Log Manipulation of Disconnect Switches
282(306)/96-10 LER Auxiliary Feedwater Pumps Not Protected Against Runout
For All Conditions

LIST OF ACRONYMS USED

ASME	American Society of Mechanical Engineers
ANSI	American National Standards Institute
CC	Component Cooling
CF	Chemical Feed
CFR	Code of Federal Regulations
FME	Foreign Material Exclusion
IFI	Inspection Followup Item
IP	Inspection Procedure
LER	Licensee Event Report
NCV	Non-Cited Violation
NRC	Nuclear Regulatory Commission
PDR	Public Document Room
PSIG	Pounds per Square Inch - Gauge
SAC	Safety Audit Committee
SP	Surveillance Procedure
TS	Technical Specification
TSI	Technical Specification Interpretation
URI	Unresolved Item
USAR	Updated Safety Analysis Report
VIO	Violation
WO	Work Order