

U.S. NUCLEAR REGULATORY COMMISSION

REGION II

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Report Nos: 50-338/97-03, 50-339/97-03

Licensee: Virginia Electric and Power Company (VEPCO)

Facility: North Anna Power Station, Units 1 & 2

Location: 1022 Haley Drive
Mineral, Virginia 23117

Dates: April 6 through May 17, 1997

Inspectors: K. Poertner, Acting Senior Resident Inspector
R. Gibbs, Resident Inspector
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Approved by: G. Belisle, Chief, Reactor Projects Branch 5
Division of Reactor Projects

Enclosure

EXECUTIVE SUMMARY

North Anna Power Station, Units 1 & 2
NRC Inspection Report Nos. 50-338/97-03, 50-339/97-03

This integrated inspection included aspects of licensee operations, engineering, maintenance, and plant support. The report covers a six week period of resident inspection.

Operations

- Operator actions to reduce power following detection of oil in the Unit 2 main generator were appropriate based on the alarm response procedure guidance. Licensee management actions to verbally approve a change to the alarm response procedure were conducted in accordance with approved administrative procedures and based on sound technical information (Section 01.2).
- A main feedwater pump swap was carefully controlled (Section 01.3).
- A non-cited violation was identified for failure to perform the appropriate attachment to align the B boric acid transfer pump resulting in a loss of configuration control of the Unit 1 Boric Acid Transfer System. The loss of configuration control resulted from a lack of attention to detail on the part of the operators performing the evolution (Section 01.4).
- Unit 1 was shutdown for a scheduled refueling outage on May 11, 1997. Shutdown activities observed were conducted in accordance with approved procedures. Control room command and control during the power reduction was good (Section 01.5).
- Unit 1 Reactor Coolant System draindown activities were adequately controlled and water inventory was closely tracked by the operators and the shift technical advisor (Section 01.6).
- The Quench Spray System was properly aligned. The inspectors noted several minor material deficiencies that were appropriately addressed by the licensee. The inspectors expressed a concern to plant management about the presence of teflon tape on stainless steel threaded connections (Section 02.1).
- Simulator training observed appeared challenging and training personnel provided appropriate feedback to the operating crew following completion of the simulator exercise (Section 05.1).
- A Management Safety Review Committee meeting complied with Technical Specification (TS) requirements, and substantive assessment issues were addressed in committee discussions (Section 07.1).

- The inspectors reviewed the most recent World Association of Nuclear Operators Peer Review Report during the inspection period (Section 07.2).

Maintenance

- An unresolved item was identified concerning TS testing requirements for the Number 4 turbine governor valve. The licensee has submitted a TS change request to clarify the testing requirement (Section M1.1).
- Operations took appropriate actions to halt an emergency diesel generator pre-lube operation when procedure clarification was required (Section M1.2).
- Maintenance activities observed were properly approved, associated procedures were present at the job sites, and the work was performed by knowledgeable individuals (Section M1.3).
- Control rod drop time testing was performed in accordance with approved procedures. Drop times met TS requirements and all control rods exhibited recoil following entry into the dashpot region (Section M1.4).

Engineering

- Safety Evaluation 97-SE-PROC-22 adequately justified installation of an electrical jumper to initiate manual spray actuation during the performance of Periodic Test 1-PT-66.3 (Section E1.1).

Plant Support

- Radiation protection practices observed were conducted properly (Section R1.1).
- The protected area perimeter barrier was properly manned and maintained (Section S1.1).

Report Details

Summary of Plant Status

Unit 1 began the inspection period at 100 percent reactor power and operated at or near full power until May 11 when the plant was shutdown for a scheduled refueling outage.

Unit 2 operated at or near full power for the entire inspection period.

I. Operations

01 Conduct of Operations

01.1 Daily Plant Status Reviews (71707, 40500, 92901)

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

01.2 Unit 2 Power Reduction

a. Inspection Scope (71707)

The inspectors monitored activities associated with a Unit 2 power reduction due to oil being detected in a main generator water detector.

b. Observations and Findings

On April 9, at 11:18 a.m., a Unit 2 power reduction commenced due to hydrogen seal oil intrusion into the main generator. The oil was detected due to a high alarm on the generator leads end water detector. Prior to the oil detection, a hydrogen seal oil transient had occurred resulting in a high level in the hydrogen seal oil defoaming tank. The power reduction was initiated in accordance with the alarm response procedure. Subsequent to the initiation of the power reduction the vendor was contacted and vendor reference material was reviewed. The review determined that the amount of oil collected from the water level detector (approximately 14 ounces) was acceptable and removal of the generator from service was not required. The alarm response procedure was revised verbally by station management and the power reduction was terminated at 11:44 a.m. at 97.5 percent power. The unit was returned

to 100 percent power at 12:36 p.m. The alarm response procedure was subsequently revised to reflect the vendor guidance.

The inspectors monitored activities in the control room during the power reduction and attended the meeting where plant management verbally changed the alarm response procedure based on the vendor recommendations. The inspectors also reviewed the completed procedure action request following verbal approval of the change.

c. Conclusions

Operator actions to reduce power following detection of oil in the Unit 2 main generator were appropriate based on the alarm response procedure guidance. Licensee actions to verbally approve a change to the alarm response procedure were conducted in accordance with approved administrative procedures and based on sound technical information.

01.3 Main Feedwater (MFW) Pump Swap

a. Inspection Scope (71707)

The inspectors observed operators starting Unit 2 MFW pump 2-FW-P-1C and securing MFW pump 2-FW-P-1B.

b. Observations and Findings

On April 11, the inspectors observed a swap of MFW pumps in which MFW pump C was started and MFW pump B was secured. The inspectors attended the pre-brief in the control room and noted that all personnel involved in the evolution were present. The inspectors noted that communications by the unit Senior Reactor Operator (SRO) were difficult to hear, but observed that personnel involved asked questions to ensure the SRO's directions were clear. Overall, the inspectors concluded the brief was good. The inspectors also observed local operation of placing the standby condensate pump in service and found no problems. In the control room, the inspectors observed that procedure execution, communications, and supervisory oversight were appropriate. The inspectors also observed that a third reactor operator carefully monitored steam generator water level. There were no unexpected equipment problems during the swap.

c. Conclusions

The inspectors concluded that the MFW pump swap was carefully controlled.

01.4 Boric Acid Transfer Pump (BATP) Operation With No Suction Path

a. Inspection Scope (71707)

The inspectors reviewed the circumstances surrounding an inadvertent isolation of the suction flow path to the C BATP.

b. Observations and Findings

At 9:00 a.m. on May 8, BATP B was placed in service to allow installation of a suction pressure gauge on the A BATP. This evolution was accomplished using procedure 0-OP-8.8, "Transferring Boric Acid," Revision 1. At 10:15 a.m., the A BATP was restarted per 0-OP-8.8 and the B BATP was secured. On May 8, at approximately 3:15 p.m. during review of the completed procedure by the unit supervisor, it was determined that the wrong attachment was used to place the B BATP in service. This resulted in the B BATP being aligned to the B Boric Acid Tank (BAT) as opposed to the A BAT and it also resulted in isolation of the C BATP suction isolation valve with the C BATP still operating. The C BATP was secured, the system was realigned, and the C BATP was restarted and tested. The pump did not exhibit any degradation when tested.

TS 3.1.2.2 requires that a boron injection flowpath from the BATs via a BATP and a charging pump be operable during power operation. The inspectors verified that the boration flowpath to Unit 1 was operable during the period that the boric acid transfer system was misaligned. The failure to properly implement procedure 0-OP-8.8 to align the B BATP to the A BAT is identified as a violation. This item was identified by the licensee and corrective actions were initiated to address the failure to adequately implement the procedure. This licensee identified violation is being treated as an NCV consistent with Section VII.B.1 of the NRC Enforcement Policy. This item is identified as NCV 50-338/97003-01.

c. Conclusions

An NCV was identified for failure to perform the appropriate attachment to align the B BATP resulting in a loss of configuration control of the Unit 1 boric acid transfer system. The loss of configuration control resulted from a lack of attention to detail on the part of the operators performing the evolution.

01.5 Unit 1 Shutdown for Refueling

a. Inspection Scope (71707)

On May 11, the inspectors observed portions of the Unit 1 shutdown for a scheduled refueling outage.

b. Observations and Findings

On May 11 at 1:45 a.m., Unit 1 was removed from service to commence a scheduled refueling outage. The inspectors observed portions of the power reduction, removal of the generator from service, turbine overspeed testing, power reduction to below the point of adding heat, opening of the reactor trip breakers, and rod drop time testing.

Activities observed were conducted in accordance with approved procedures. Control room command and control during the power reduction was good. When the reactor was tripped in accordance with the controlling procedure, all rods indicated less than ten steps as required and emergency boration was not required. Operations management was in the control room during the shutdown activities.

c. Conclusions

Unit 1 was shutdown for a scheduled refueling outage on May 11, 1997. Shutdown activities observed were conducted in accordance with approved procedures. Control room command and control during the power reduction was good.

01.6 Unit 1 Reactor Coolant System (RCS) Draindown

a. Inspection Scope (71707)

On May 14, the inspectors observed control room activities associated with RCS draindown to the 74-inch vessel level.

b. Observations and Findings

The inspectors observed control room activities associated with reducing RCS level below the reactor vessel flange to allow detensioning of the reactor vessel head. Prior to reducing RCS level below the pressurizer, the RCS loops were isolated and drained. The inspectors observed that procedural compliance was good and water inventory was being closely tracked by the operators and the shift technical advisor.

c. Conclusions

RCS draindown activities were adequately controlled and water inventory was being closely tracked by the operators and the shift technical advisor.

02 Operational Status of Facilities and Equipment

02.1 Unit 1 Quench Spray (QS) System Walkdown

a. Inspection Scope (71707)

On April 30, the inspectors performed a walkdown of the primary and recirculation flowpaths of the Unit 1 QS system. The inspectors did not inspect inaccessible components in the containment. Since teflon tape was observed on the Unit 1 QS system, other plant areas were walked down to check for further evidence of teflon tape.

b. Observations and Findings

The inspectors reviewed the Updated Final Safety Analysis Report (UFSAR), Figure 6.2-67, Revision 30; "Piping and Instrument Diagram

(P&ID), " 11715-FM-091A, Revision 26, sheets 1 and 2; and 1-OP-7.4A, "Valve Checkoff - Quench Spray System," Revision 7, as references for the required system valve positions. The inspectors found that all valves listed in 1-OP-7.4A were in their required positions.

The inspectors observed that housekeeping in the safeguards and QS pump houses was excellent. It was noted that all components were properly labeled and that minor boron accumulations, none with observed active leakage, had Work Order (WO) requests in place that were not excessively old. Instrumentation was properly installed and indicated expected values with the QS system in standby.

The inspectors noted several conditions that were brought to the attention of operations and engineering. These conditions included the following:

- There was an inconsistent representation of heat traced piping on the referenced P&IDs and the UFSAR figure listed above. The licensee subsequently prepared DR N-97-1054 to address the inconsistencies.
- Piping insulation at the Refueling Water Storage Tank (RWST) area was in need of repair. The licensee subsequently prepared a deficiency card to initiate repairs.
- QS pump recirculation piping supports and spring cans supporting the high and low recirculation piping, which are attached to the RWST, were corroded. The licensee subsequently determined the supports to be operable, but in need of repair and issued DR N-97-1053.

The inspectors observed that teflon tape was used in two different locations in the QS system. Specifically, teflon tape was found at the pipe cap threaded connection for 1-QS-104, which is located at test connection penetration 63, and at QS pump suction pressure gauge, 1-QS-PI-104B, both of which consisted of stainless steel piping. The inspectors informed appropriate licensee personnel and DR N-97-1087 was subsequently issued to document the use of teflon tape.

On May 2, the inspectors walked down the Unit 2 QS, Outside Recirculation Spray, and Low Head Safety Injection systems to determine if the teflon tape found on the Unit 1 QS system was an isolated occurrence. The inspectors identified that teflon tape was present on various stainless steel instrument connections. On later dates throughout the inspection period, the inspectors observed that teflon tape was in use in other plant locations, including the Auxiliary Building, Fuel Handling Building, and the Unit 1 containment. These findings were also discussed with the licensee.

The inspectors reviewed the licensee's program requirements to determine the restrictions on the use of teflon tape. Document N-95-122, "Consumable Material Evaluation (CME)," Revision 2, was reviewed to

determine if the use of teflon tape was acceptable on systems with stainless steel piping such as QS, Outside Recirculation Spray, and Low Head Safety Injection. The review determined that teflon tape was not allowed for use on these systems.

The inspectors discussed the use of teflon tape with engineering. The Engineering Department provided procedure NAI-0001, "Specification for Installation of Instrumentation," Revision 3, Section 7.2.9.7.1, which stated that types of teflon or other materials shall not be used on control pneumatic, control hydraulic, or primary instrument tube national pipe thread fittings, piping, or on instrument air distribution tubing fittings. Specification NAI-0001 also stated that when teflon tape is discovered in the plant during the course of maintenance activities, the tape should be removed and another approved sealant should be used. The specification further stated, however, that it is not necessary to disassemble threaded connections for the sole purpose of removing the tape. This guidance was added to the specification on February 15, 1994. The licensee subsequently issued engineering transmittal, CME 97-0055, "Justification for Installed Teflon Tape," Revision 1, to formalize their position on the use of teflon tape.

The inspectors did not identify any instances where teflon tape has been incorrectly used during maintenance activities. The fact that teflon tape was installed on systems was discussed with the station manager and he stated that the use of teflon tape would be reviewed further.

c. Conclusions

The inspectors concluded that valves in the main and recirculation flow paths for the QS system were properly aligned. The inspectors noted several minor deficiencies in the QS system that were appropriately addressed by the licensee. The inspectors expressed a concern to plant management about the presence of teflon tape on stainless steel threaded connections.

05 **Operator Training and Qualification**

05.1 Licensed Operator Regualification Simulator Training

a. Inspection Scope (71707)

On April 25, the inspectors observed licensed operator regualification simulator training.

b. Observations and Findings

The inspectors observed a simulator training scenario conducted as part of the licensed operator regualification program. The exercise also included participation by Security personnel. The scenario observed appeared challenging to the operating crew and training personnel were professional and provided appropriate feedback to the crew following completion of the exercise.

c. Conclusions

Simulator training observed appeared challenging and training personnel provided appropriate feedback to the operating crew following completion of the simulator exercise.

07 Quality Assurance in Operations

07.1 Management Safety Review Committee (MSRC) Meeting (4/15/00)

On April 30, the inspectors attended a regularly scheduled MSRC meeting at the North Anna site, and observed Station Manager's plant status reports. The inspectors determined that the MSRC meeting met TS 4.5.2 requirements for member composition and quorum and that the agenda appropriately included review items required by TS 6.5.2.7. The inspectors observed that the Station Manager's reports generated significant self-critical discussions of station performance. The inspectors concluded that the MSRC meeting was in compliance with TS requirements and that substantive assessment issues were being addressed in the discussions.

07.2 World Association of Nuclear Operators (WANO) Peer Review Report

During the inspection period, the inspectors reviewed the WANO Peer Review Report and discussed the report with the Branch Chief. The North Anna Branch Chief also reviewed the report during a site visit conducted during the inspection period. The WANO report findings were generally consistent with previous NRC observations.

II. Maintenance

M1 Conduct of Maintenance

M1.1 Unit 2 Turbine Valve Freedom Test

a. Inspection Scope (61726)

On April 11, the inspectors observed operators performing 2-PT-34.3, "Turbine Valve Freedom Test," Revision 19. The test implements TS surveillance requirement 4.7.1.7.2.a to demonstrate the operability of the turbine governor and throttle valves. Reactor power was reduced to approximately 92 percent for the test.

b. Observations and Findings

The inspectors attended the pre-brief and found that it was effective. All personnel involved with the work were present and clear direction was provided by the unit Senior Reactor Operator (SRO) for personnel responsibility during the test. Good discussions regarding reactivity management were provided by the shift supervisor.

The inspectors observed the test both in the control room and locally at the high pressure main turbine. In the control room, the inspectors found that procedure execution, operating crew communications, and supervisory oversight were effective. In particular, the inspectors noted the effective SRO oversight provided to the reactor operator during the power reduction.

The inspectors verified governor valve operation locally. All governor valves fully cycled when individually tested except governor valve Number 4. The inspectors observed that when the Number 4 governor valve was tested it stroked from less than approximately 10 percent open. The inspectors, however, observed that the Number 4 valve stroked from various other open positions when the other three governor valves were tested. The inspectors observed that the Number 4 governor valve was not tested from the full open position.

TS 4.7.1.7.2.a requires that each turbine governor valve be cycled through one complete cycle of full travel. The inspectors questioned whether the as tested condition of the Number 4 governor valve met the TS requirement. The licensee stated that their interpretation of "complete cycle" for the Number 4 governor valve was the position of the valve at 100 percent power and that the valve was cycled above the 100 percent value when the other governor valves were cycled. The licensee further stated that testing the valve from the fully open position was not possible due to the design of the electrohydraulic system.

Based on the inspectors' question, the licensee contacted the vendor and verified that the testing conducted was in accordance with the vendor's requirements for operability. This information was provided to the inspectors for review. The purpose of the surveillance requirement is to exercise the valves and verify freedom of movement. Standard TSs do not contain a requirement to test the turbine governor valves and the licensee's testing meets vendor requirements. The licensee has submitted a TS change request to clarify the testing requirements for the Number 4 governor valve. This item is identified as Unresolved Item (URI) 50-338, 339/97003-02 pending further NRC review of the licensee's TS interpretation.

c. Conclusions

A URI was identified concerning TS testing requirements for the Number 4 turbine governor valve. The inspectors considered that the testing conducted adequately demonstrated operability of the Number 4 governor valve. The licensee has submitted a TS change request to clarify the testing requirement.

M1.2 2H Emergency Diesel Generator (EDG) Fast Start Test

a. Inspection Scope (61726)

On May 7, the inspectors observed portions of 2-PT-82.3A, "2H Diesel Generator Test (Simulated Loss of Offsite Power in Conjunction with an

ESF Actuation Signal)," Revision 37. The inspectors also observed operators performing portions of 2-OP-6.6A, "Emergency Generator Pre-Operational Check for 2H and 2J Diesel," Revision 15. The purpose of the test was to demonstrate the operability of the 2H EDG to fast start from a simulated loss of offsite power with a Safety Injection signal and to be loaded and operated for 60 minutes in accordance with TS 4.8.1.1.2.c(b) and 4.8.1.2.

b. Observations and Findings

The inspectors attended the pre-brief and observed that the Unit 2 SRO conducted it effectively. The SRO used the "Operations Evolution Checklist" as a guide to ensure the brief was beneficial. The inspectors concluded that all personnel involved with the test were properly briefed.

The inspectors observed the pre-lube operation of the EDG. One of the notes in the procedure, before Step 5.1.20, informs the operator to not run the EDG if any liquid is observed coming from the cylinder exhaust petcocks. When the EDG was cranked, using starting air, some evidence of liquid oil was observed. The operator therefore elected to halt the test and obtain an engineering clarification. The licensee subsequently performed a procedure action request to the procedure which clarified the liquid as water. The inspectors concluded that appropriate actions were taken by operations to clarify the note before proceeding with the test.

The inspectors observed operation of the diesel from the control room and found that the operator carefully monitored its operation and that supervisory oversight for the test was appropriate. The inspectors also discussed with the shift technical advisor the results of the test to determine if the TS requirements were satisfied. The shift technical advisor effectively demonstrated understanding of the test results for engine speed, generator frequency, and generator voltage.

The inspectors reviewed previous test results to determine if the required surveillance interval was satisfied and found no discrepancies. Additionally, the inspectors ensured that test instrumentation was properly calibrated.

c. Conclusions

The inspectors concluded that TS requirements were satisfied for the 2H EDG during the simulated loss of off-site power and engineered safety features actuation signal fast start test. Additionally, the inspectors concluded that operations took appropriate actions to halt the EDG pre-lube operation when procedure clarification was required.

M1.3 Maintenance Activities

a. Inspection Scope (62707)

On May 2 through May 6, the inspectors observed various maintenance activities. Specifically, the inspectors observed the replacement of the Service Water (SW) intake screen for SW pump 1-SW-P-1B, removal of the MFW pump motor for MFW pump 1-FW-P-1B, repair of the Refuel Purification Ion Exchange Resin Fill Valve, 1-RP-71, and heat trace troubleshooting efforts.

b. Observations and Findings

The inspectors reviewed the following WOs at the job site to ensure the maintenance crews were authorized by operations to perform the activities and to ensure the actual work reflected the WO instructions.

- WO 00262090-01, "Install Rebuilt SW Screen Assembly for 1-SW-P-1B"
- WO 00363008-01, "1-FW-P-1B Pump Motor #1 (Outboard) Removal"
- WO 00364537-01, "Refuel Purification Ion Exchange Resin Fill Valve, 1-RP-71 Repair"
- WO 00362731-01, "Check/Repair Heat Trace Circuit"

The inspectors verified that plant management was aware of the work by ensuring the activities were included on the plan of the day. The inspectors also observed that applicable procedures were at the job site and were properly executed by knowledgeable individuals. When replacement parts were used, the inspectors verified the parts were identical.

During the replacement work on the SW intake screen, the inspectors observed that workers were kept aware of confined space conditions in the SW intake bay area. The inspectors observed multiple uses of the air quality monitor.

Before actual work began on the 1-RP-71 valve, the inspectors noted that maintenance personnel stopped the work when they determined the procedure was not adequate for the job. The inspectors also observed that careful radiological practices were followed and that health physics support was effective.

c. Conclusions

The inspectors concluded that the maintenance activities observed were properly approved, associated procedures were present at the job sites, and the work was performed by knowledgeable individuals.

M1.4 Control Rod Testing

a. Inspection Scope (61726)

On May 11, the inspectors observed control rod drop testing.

b. Observations and Findings

During the Unit 1 shutdown for refueling, the licensee performed hot rod drops prior to initiating plant cooldown. The inspectors monitored activities in the control room and at the control rod drive panels during the drop time tests. The testing was performed in accordance with procedure 1-PT-17.2, "Rod Drop Time Measurement," Revision 16. The inspectors verified that shutdown margin requirements were met prior to withdrawing control rods, rod drop times met TS requirements, and that all control rods exhibited recoil.

c. Conclusions

Control rod drop time testing was performed in accordance with approved procedures. Drop times met TS requirements and all control rods exhibited recoil following entry into the dashpot region.

III. Engineering

E1 Conduct of Engineering

E1.1 Unit 1 Electrical Jumper Safety Evaluation Review

a. Inspection Scope (37551)

The inspectors reviewed Safety Evaluation 97-SE-PROC-22, applicable electrical schematics, and held discussions with engineering personnel performing the safety evaluation.

b. Observations and Findings

During the performance of Periodic Test 1-PT-66.3, "Containment Actuation Functional Test," the A train failed to initiate using the manual spray actuation switches in the control room. Troubleshooting determined that the failure resulted from a defective switch and a replacement switch was not available. The safety evaluation was performed to allow a temporary jumper to be installed across the defective switch to allow testing to continue until a replacement switch could be obtained.

The manual spray actuation switches were not required to be operable when the unit is in Mode 5. A WO was initiated to replace the defective switch prior to startup.

c. Conclusions

Safety Evaluation 97-SE-PROC-22 adequately justified installation of an electrical jumper to initiate manual spray actuation during the performance of procedure 1-PT-66.3.

IV. Plant Support

R1 Radiological Protection and Chemistry (RP&C) Controls (71750)

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

S1 Conduct of Security and Safeguards Activities (71750)

On numerous occasions during the inspection period, the inspectors performed walkdowns of the protected area perimeter to assess security and general barrier conditions. No deficiencies were noted and the inspectors concluded that security posts were properly manned and that the perimeter barrier's material condition was properly maintained.

V. Management Meetings

X1 Exit Meeting Summary

The inspectors presented the inspection results to members of licensee management at the conclusion of the inspection on May 23, 1997. The licensee acknowledged the findings presented.

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

PARTIAL LIST OF PERSONS CONTACTED

Licensee

B. Foster, Superintendent Station Engineering
 C. Funderburk, Superintendent, Outage Planning
 E. Grecheck, Assistant Station Manager, Operations and Maintenance
 J. Hayes, Superintendent, Operations
 D. Heacock, Assistant Station Manager, Nuclear Safety and Licensing
 M. Kansler, Vice President, Nuclear Operations
 W. Matthews, Station Manager
 M. McCarthy, Director, Nuclear Oversight
 R. Shears, Superintendent, Maintenance
 A. Stafford, Superintendent, Radiological Protection
 T. Williams, Manager, Nuclear Oversight

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 92901: Followup - Plant Operations

ITEMS OPENED AND CLOSED

Opened

50-338/97003-01	NCV	Failure to properly implement procedure to align boric acid transfer pump (Section 01.4).
50-338, 339/97003-02	URI	Main steam governor valve Number 4 testing requirements (Section M1.1).

Closed

50-338/97003-01	NCV	Failure to properly implement procedure to align BATP (Section 01.4).
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