

U.S. NUCLEAR REGULATORY COMMISSION

REGION V

Report Nos. 50-206/85-20, 50-361/85-19, 50-362/85-18

Docket Nos. 50-206, 50-361, 50-362

License Nos. DPR-13, NPF-10, NPF-15

Licensee: Southern California Edison Company
P. O. Box 800, 2244 Walnut Grove Avenue
Rosemead, California 92770

Facility Name: San Onofre Units 1, 2 and 3

Inspection at: San Onofre, San Clemente, California

Inspection Conducted: May 22 through July 26, 1985

Inspectors:

PP Narkh for 8/5/85
F. R. Huey, Senior Resident
Inspector, Units 1, 2 and 3 Date Signed

PP Narkh for 8/5/85
J. P. Stewart, Resident Inspector Date Signed

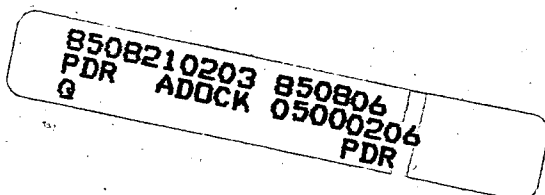
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Approved By:

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P. H. Johnson, Chief
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Inspection Summary

Inspection on May 22 through July 26, 1985 (Report Nos. 50-206/85-20, 50-361/85-19, 50-362/85-18)

Areas Inspected: Routine resident inspection of Units 1, 2 and 3 Operations Program including the following areas: operational safety verification, evaluation of plant trips and events, monthly surveillance activities, monthly maintenance activities, Engineered Safety Feature walkdown, refueling activities, independent inspection, licensee event report review and follow-up of previously identified items. This inspection involved 111 inspection hours on Unit 1, 232 inspection hours on Unit 2 and 173 inspection hours on Unit 3 for a total of 516 inspection hours by five NRC inspectors.

Results: Of the nine areas examined, one apparent violation was identified: Failure to follow an approved station procedure.

DETAILS

1. Persons Contacted

Southern California Edison Company

H. Ray, Vice President, Site Manager
*G. Morgan, Station Manager
*P. Croy, Acting Deputy Station Manager
D. Schone, Quality Assurance Manager
D. Stonecipher, Quality Control Manager
*R. Krieger, Operations Manager
*D. Shull, Maintenance Manager
J. Reilly, Technical Manager
*P. Knapp, Health Physics Manager
P. Croy, Compliance Manager
*J. Wambold, Training Manager
D. Peacor, Emergency Preparedness Manager
P. Eller, Security Manager
W. Marsh, Operations Superintendent, Units 2/3
J. Reeder, Operations Superintendent, Unit 1
V. Fisher, Assistant Operations Superintendent, Units 2/3
B. Joyce, Maintenance Manager, Units 2/3
H. Merten, Maintenance Manager, Unit 1
R. Santosuosso, Instrument and Control Supervisor
*T. Mackey, Compliance Supervisor
G. Gibson, Compliance Supervisor
*C. Kergis, Compliance Engineer
*R. Waldo, Supervising Engineer

*Denotes those attending the exit meeting on July 8, 1985.

The inspectors also contacted other licensee employees during the course of the inspection, including operations shift superintendents, control room supervisors, control room operators, quality assurance (QA) and quality control (QC) engineers, compliance engineers, maintenance craftsmen, and health physics (HP) engineers and technicians.

2. Operational Safety Verification

The inspectors performed several plant tours and verified the operability of selected emergency systems, reviewed the Tag Out log and verified proper return to service of affected components. Particular attention was given to housekeeping, examination for potential fire hazards, fluid leaks, excessive vibration, and verification that maintenance requests had been initiated for equipment in need of maintenance.

a. Use of Part Length Control Element Assemblies (CEA's)

During a tour of the Unit 2 control room on June 21, 1985, the inspector observed that the licensee was using part length CEA's for control of axial flux distribution. Technical Specification 3.1.3.7 addresses reactivity control using part length CEA's and requires that insertion of part length CEA's into the core be limited to less

than 7 effective full power days (EFPD's) during any 30 EFPD period. The inspector noted that control room operators, supervisors and station technical personnel did not consider that the Technical Specification was clear and were not in agreement as to when time should be charged against the 7 EFPD clock.

The inspector discussed this observation with the station Operations Manager, who stated that he had already recognized this problem. The licensee took prompt action to clarify the intent of the Technical Specification with NRR and implemented consistent guidance to cognizant station personnel.

b. Radiological Postings

While touring the Unit 3 Auxiliary Feedwater Building, the inspector observed several craftsmen working inside a radiologically controlled area which was posted "Radiological Exposure Permit (REP) Required for Entry". The inspector noted that the craftsmen did not have an REP covering the work being performed, nor were they wearing pocket dosimetry which is usually required for entry into radiation areas. When questioned, the craftsmen stated that they were told by a Health Physics Technician that an REP was not required. Based on discussions with the licensee, the inspector determined that the radiation levels in the posted area were less than 2.5 mr/hr, and posting was not required. The postings for the area were subsequently removed and the licensee instructed the craftsmen and Health Physics Technicians to ensure that posting instructions are adhered to for entering radiologically controlled areas. The licensee also reviewed all radiation area postings to insure that they were appropriate. Since the area was not required to be posted as a radiation area and the individuals did not receive improperly monitored radiation exposure, this was not a violation of regulatory requirements.

c. Breaker Operation (Units 2 & 3)

The inspector observed operating techniques and reviewed procedural requirements for racking in breakers to ensure that breakers are fully operational when they are racked in. In all cases reviewed by the inspector, the racking in of breakers required independent verification that the breaker was racked in, the DC power was on and the charging spring motor was energized.

No violations or deviations were identified.

3. Evaluation of Plant Trips and Events

a. Unit 1

(1) Reactor Shutdown Due to Power Operated Relief Valve (PORV) Block Valve Failure

On June 4, 1985, PORV Block Valve CV-530 failed to close during In-Service Testing. The Unit was taken off line, entered Mode 3 per Technical Specification requirements and entered a 30 hour action statement to restore CV-530 to service. On June 5, repairs to CV-530 were completed and the Unit was returned to service.

(2) Unit Runback to 70 Percent Power

On June 11, 1985, a unit runback to 70 percent power occurred due to a dropped rod signal from Power Range Nuclear Instrument Channel NIS-1206. The licensee accomplished calibration and testing of the NIS channel and determined that the dropped rod signal was due to spurious indication. NIS-1206 was returned to service on June 11, 1985.

(3) Reduction in Load due to Circulating Water Pump Failure

On July 4, 1985, the North Circulating Water Pump was stopped due to high vibration, and load was reduced to 59% power. The licensee subsequently discovered that the suction bell-housing had fallen off of the pump. Evidently, pump vibration caused enough of the bell-housing bolts to loosen so that the remaining bolts could not support the bell-housing and consequently sheared off. Repairs were completed on July 7, and the unit was returned to full load. The licensee is evaluating the vibration problem and more closely monitoring pump operation.

b. Unit 2

(1) Manual Trip of a Control Element Assembly (CEA) During Reactor Power Operation

While manipulating Group 6 CEA's for Axial Shape Index (ASI) control, CEA #20 exhibited sticky behavior in that it consistently did not move the same number of steps as the other rods in the group. The licensee tested the electrical components of the CEA and found them to operate properly. On June 12, 1985, the licensee manually tripped CEA #20 to demonstrate that the control rod could satisfy the Technical Specification drop time requirements. The CEA insertion time was satisfactory. The CEA moved properly during the subsequent monthly surveillance test. The licensee is closely monitoring CEA #20 for any further malfunction.

c. Unit 3

(1) Reactor Trip Due to Fuse Failure

On May 24, 1985, while performing CEA Drive Mechanism operability tests on Subgroup 15 CEA's, the reactor tripped. The licensee determined that a fuse failure in the Hold Bus DC Logic Power Supply caused the Subgroup 15 CEA's to lose power and drop into the core. The resulting low DNBR values caused the reactor to trip. The failed fuse was replaced, and the unit was returned to service on May 25.

(2) Power Reduction Due to Core Operating Limit Supervisory System (COLSS) Failure

On May 31, 1985, a circuit board failure rendered COLSS inoperable, and reactor power was reduced to 85% to satisfy Technical Specification requirements. Repairs to COLSS were completed on May 31 by replacing the failed circuit board and the unit was returned to 100 percent power.

(3) Unit 3 Power Reduction to Delay Refueling Outage

On June 14, 1985, reactor power was reduced to about 60 percent in order to delay the unit refueling outage for about one month. This would allow the unit to be available during the period of peak electrical demand and minimize the effect of an unplanned outage at another SCE facility.

No violations or deviations were identified.

4. Monthly Surveillance Activities

a. Unit 1 Safety Injection System - Refueling Water Pump

During a tour of the Unit 1 control room on June 10, 1985, the inspector reviewed surveillance test S01-12.3-2, "Hot Operational Test of the Safety Injection and Containment Spray Systems," which had just been performed. As part of the refueling water pump portion of the test, the containment spray discharge valve is shut to prevent challenge of the auto containment spray valve when the pump is run up to full discharge pressure. When this test was performed on June 10, operations personnel performing the test did not complete the independent verification of returning containment spray isolation manual valves to their nominal "locked open" position on the north pump train before isolating the south pump train. This is not in accordance with the requirement of the procedure and could result in improper isolation of both trains of containment spray.

The inspector discussed this observation with the control room shift supervisor, who stated that the independent verification of the "locked open" valves was to be performed after the entire procedure was completed in order to reduce the number of shift personnel

needed to perform the test and to allow the test to be performed more efficiently.

The inspector subsequently discussed this item with the Unit 1 Operations Superintendent who stated that the Shift Supervisor was incorrect and all procedure steps must be fully completed in the order specified in the test procedure. He took prompt action to counsel the involved individuals and reviewed the subject of procedure compliance with all Unit 1 operations personnel.

This issue was identified to licensee management as an apparent violation of NRC requirements. (206/85-20-01)

b. In-Service Testing (Unit 3)

The inspector observed in-service testing of the Unit 3 High Pressure Safety Injection Pump 3P-018 and the Unit 3 steam driven Auxiliary Feed Pump 3P-140. These tests were conducted in accordance with the following procedures:

- ° S023-V-3.4.4, High Pressure Safety Injection In-Service Pump Test
- ° S023-V-3.4.1, Auxiliary Feedwater In-Service Pump Test

No violations or deviations were identified.

5. Monthly Maintenance Activities - Unit 2 Hot Leg RTD Failure

On June 14, 1985, one channel of the Accident Monitoring System was rendered inoperable due to failure of the associated hot leg wide range temperature element (TE-0921X2). This element is contained as part of a dual element RTD, the other element (2TE-0221X2) being used for input to COLSS for power computation, input to the Reactor Regulation System for average temperature calculation, and for Loop 2 hot leg temperature indication and alarm. The licensee wrote a Temporary Facility Modification (TFM) to use TE-0221X2 for the Accident Monitoring System since that element was not affected by the failure of 2TE-0921X2. The inspector monitored all aspects of this TFM and noted the following:

- ° Circuit terminations and determinations were documented in accordance with the procedure.
- ° The Accident Monitoring System circuitry and instrumentation were calibrated to respond to 2TE-0221X2.
- ° A 50.59 review was accomplished which ensured that 2TE-0221X2 and associated circuitry were qualified to the same requirements as 2TE-0921X2 and associated circuitry.
- ° The control functions previously associated with 2TE-0221X2 were evaluated and alternate means were specified to satisfy the control functions.

The licensee plans to replace the dual element RTD and restore all circuitry to normal operation during the next outage which is of sufficient duration (currently not scheduled).

No violations or deviations were identified.

6. Engineered Safety Feature Walkdown

During this inspection period, the inspector walked down the HPSI and LPSI systems outside of containment on Unit 3. The systems were aligned as required by the Unit 3 Technical Specifications, FSAR, and Station Procedures.

The inspector noticed that the Refueling Water Storage Tank isolation valves, 3HV-9300 and 3HV-9301, were not locked open at the valve although they are locked open at the remote operating switches in the control room. The licensee demonstrated to the inspector that these valves could not be closed manually without first de-energizing the control circuit. Valves 3HV-9300 and 3HV-9301 have Limitorque operators, and the limit switches are arranged such that the Limitorque operators must be de-energized for manual operation.

No violations or deviations were identified.

7. Refueling Activities (Unit 1)

During this inspection period, new fuel was received for the Unit 1 refueling outage, currently scheduled for November, 1985. The inspector observed the fuel inspection activities, and the handling and storage of the new fuel assemblies, and reviewed the licensee's procedures for accomplishing these activities. Work was being conducted in accordance with the following procedures:

- ° S01-I-3.1 "Handling and Storage of New Fuel Assemblies"
- ° S0123-X-6.0 "Receipt Inspection of New Fuel Assemblies and New Fuel Assembly Inserts"

The inspector examined the spent fuel pool for penetrations that could allow the water to be drained or siphoned, causing the spent fuel to be uncovered and exposed to the atmosphere. Based on this inspection and discussions with the licensee, the inspector determined that penetrations to the spent fuel pool are designed such that draining or siphoning of water does not allow the fuel to become uncovered.

No violations or deviations were identified.

8. Independent Inspection

a. Rad Waste Processing

During the week of June 24, 1985, the inspector observed licensee operations to prepare spent demineralizer resin for shipment. Particular attention was paid to activities involved with a new

procedure for dewatering resin, S023-VIII-8.5.5. All activities were observed to be done properly and in accordance with approved procedures. Pre-work briefings were well done, the job was properly staffed and supervised and all personnel were aware of their individual responsibilities. The only comment noted by the inspector was that cam lock fittings on some of the dewatering hoses were not wired to prevent inadvertent disconnection during system operation. The licensee committed to lock wire these fittings during future dewatering operations.

b. Allegation concerning Inexperienced Maintenance Engineer (RV-85-A-030)

(1) Characterization of Individual's Concern

An anonymous allegation was received by the inspector which stated that the "Maintenance Engineer" monitoring the work on the Unit 2 refueling machine was an "Outage Scheduler" who had no experience as a Maintenance Engineer. This allegation resulted from the inspector's observations of maintenance being conducted on the Unit 2 refueling machine discussed in paragraph 9.b of Inspection Report 50-361/85-04.

(2) Inspection Findings

Based on discussions with the licensee, the inspector determined that the individual in question was not acting as a maintenance engineer. In fact, the individual was borrowed from the scheduling group to act as an assistant refueling coordinator. At that time, there were no qualification or training requirements associated with this position. This allegation appears valid to the degree that the individual was not well qualified to act as assistant refueling coordinator. The licensee took steps to rectify this in that the individual no longer works in maintenance and specific qualification and training requirements have been implemented for refueling (maintenance) personnel. Since there are no Regulatory requirements regarding training and qualification of refueling (maintenance) personnel, this is not a Regulatory issue. This allegation is closed.

c. General Electric Relay Qualifications

During this inspection period, the inspector performed a review to determine if General Electric relays (#12CFD12B1A) were being used at San Onofre Nuclear Generating Station for any safety related applications, since Region V had expressed a concern that these G.E. relays may not be seismically qualified for their applications. Based on document review, the inspector determined the following:

- ° The seismic qualification of these G.E. relays was the topic of INPO SER 18-84 and INPO SER 18-84 Supplement 1.

- ° The licensee's investigation (as the result of the INPO reports) concluded that: (1) the G.E. relays in question are not seismically qualified in the de-energized condition, but that they are seismically qualified in the energized condition. (2) These relays are used at San Onofre Units 2 and 3 in each reactor coolant pump electrical protection circuit and also in the main generator electrical protection circuit. During operation of the reactor coolant pumps and main generator, the associated CFD relays are energized which is the seismically qualified state of operation.

Based on the results of the licensee's investigation and document review, the inspector confirmed that the application of G.E. relays at San Onofre is acceptable.

d. Post Maintenance Testing (Unit 2)

The inspector examined start-up testing records for the Unit 2 Low Pressure Safety Injection (LPSI) System following completion of a design change (DCP 29N), which altered the system so that Shutdown Cooling could be placed in service from the control room. During this modification, valves and piping were altered on the discharge line common to both LPSI pumps and a check valve was added on each LPSI pump suction line. These modifications could affect LPSI flow, and paragraph 4.5.2.g.3.b of the Technical Specifications requires that a flow test be performed. The licensee's start-up procedure, SO2-SPSU-806, documents that a flow test was accomplished, but additional inspection is required to verify adequacy of the start-up procedure and certification of Flow Element FE-0306 which was used to measure the LPSI flow rate. This will be examined during a future inspection. (50-361/85-19-01)

e. Allegation Concerning Qualification Testing of Contract I&C Technicians (RV-84-098)

1) Characterization of Individual's Concern

An anonymous allegation was received which stated that copies of qualifying tests for screening contract I&C technicians are being sold to the suppliers of contract I&C technicians. A copy of the qualifying test was attached to the allegation.

2) Inspection Findings

Based on discussions with the licensee, the inspector determined that initial qualification exams are given to both contract and Edison I&C technicians. These exams have been subjected to extensive certification processes, and they are strictly controlled at all times. I&C technicians are not allowed to keep the exam, and they are monitored during the testing process to ensure that copies are not made.

The inspector compared the licensee's I&C qualification exams with the exam provided with the allegation. There was no

resemblance between the exams. They were substantially different in both format and content.

This allegation is closed.

No violations or deviations were identified.

9. Review of Licensee Event Reports

Through direct observations, discussions with licensee personnel, or review of the records, the following Licensee Event Reports (LER) were closed:

Unit 1

85-002 Hydrogen Monitors
 85-003 Missed In-Service Inspection Test on Salt Water Cooling Pump
 85-009 Plant Vent Noble Gas Activity Monitor
 85-010 Stack Wide Range Gaseous Monitor

Unit 2

85-001 Missed Fire Watch
 85-008 North Gas Stripper Leakage
 85-010 Spurious Toxic Gas Isolation System (TGIS) Actuations
 85-011 Isolation of Portion of Fire System
 85-017 Delinquent Surveillance Test on the Source Range Neutron Flux Monitors
 85-025 Improperly Installed Sample Pump
 85-026 Unanalyzed Chemistry Samples
 85-027 CPIS Train "A" Spurious Actuation
 85-028 Reactor Trip - Main Steam Isolation Valve (MSIV) Failed Shut
 85-029 Spurious TGIS Actuations
 85-030 Delinquent 7 Day Locked fire Door
 85-031 Reactor Trip - Dropped CEA
 85-033 Spurious Actuation of the Control Room Isolation System

Unit 3

85-007 Inadvertent Entry into Mode 3
 85-009 Containment Emergency Cooling Unit 3E-401 Low Flow
 85-013 Actuation of Reactor Protective System (RPS)
 85-014 Containment Purge Isolation System (CPIS) Actuation
 85-015 3RT-7821 (Turbine Plant Area Sump) Inoperable
 85-017 Inoperable Snubbers, Main Steam to Auxiliary Feedwater Pump
 85-018 CPIS Actuation
 85-019 Spurious Fuel Handling Isolation System Actuations
 85-020 RPS Actuations - Dropped Control Rod Assemblies

Unit 3 LER 3-85-009 identified that cooling water to a containment emergency cooling unit was found improperly throttled and resulted in failure of a surveillance flow test. The cause of the improperly

throttled valve was primarily attributed to the absence of any local valve position indication for use by the valve positioner and verifier. The inspector noted that the report did not address whether the licensee had checked to ensure that no other Technical Specification related valves which are required to be throttled might be in an improper position. The licensee performed a review and confirmed that no other Technical Specification related valves were involved, and documented this review in a revised Station Incident Report.

No violation or deviations were identified.

10. Follow-up of Previously Identified Items

a. (Closed) Open Item (50-361/80-16-03) Master Instruction Index

The inspector reviewed the Master Instruction Index and determined that the licensee maintains and updates the Index on a weekly basis, and this index includes the procedures required by Regulatory Guide 1.33. This item is closed.

b. (Closed) Open Item (50-361/82-10-02) Implementation of Turnover

The inspector reviewed the turnover of plant systems from project to the station organization and concluded that licensee implementation of NUREG 0660, item I.C.6, independent verification, was adequate based on review of selected surveillance procedures. This item is closed.

c. (Closed) Open Item (50-361/82-10-03) Implementation of S023-SP0-4.0

The inspector determined that this procedure, S023-SP0-4.0, is no longer in use and not applicable as system turnover has been completed. This item is closed.

d. (Closed) Open Item (50-361/82-23-02) Steam Generator (SG) Low Pressure Annunciator Setpoint

The inspector determined that during the period that the SG alarm is in solid (at low power) the operations surveillance procedure requires plant operators to observe, record, and compare all four steam generator low pressure channels in each steam generator once each shift. This item is closed.

e. (Closed) Open Item (50-361/82-23-04) Action Concerning Procedural Errors Correction

Based upon several observations the inspector noted that the reactor operators took prompt corrective action when errors in procedures were noted. This item is closed.

- f. (Closed) Open Item (50-361/82-23-05) Organization of Keys in the Watch Engineer's Office

Based upon several observations the inspector concluded that the organization and control of keys inside the Shift Superintendent's office was adequate. This item is closed.

- g. (Closed) Open Item (50-361/82-25-03) Auxiliary Feedwater System

The inspector determined that the Auxiliary Feedwater system (AFS) Kerotest valves have been replaced and that no backflow or vibration problems have been noted with the new cross connect valves which can be remotely operated. The new valves are scheduled to be installed in the Unit 3 AFS during the first refueling outage. This item is closed.

- h. (Closed) Open Item (50-361/82-30-06) Housekeeping Requirements

Procedure S0123-VI-23, "Implementation of Site Housekeeping and Cleanliness Controls" was issued by the licensee to implement Procedure S0123-A-130, "Station Housekeeping and Cleanliness Controls". Maintenance Procedure MPMG 206, Rev. 1, is no longer in use. This item is closed.

- i. (Closed) Open Item (50-361/82-30-07) Movement of Control Element Assemblies

The inspector verified that the licensee has obtained Amendment No. 26 dated October 26, 1980, to the Technical Specifications clearing up the inconsistencies with the movement of control element assemblies during refueling operations. This item is closed.

- j. (Closed) Open Item (50-361/82-39-02) Temporary Modification Control

The inspector reviewed the Unit 2 and 3 Temporary Modification Control Books and noted that the number of temporary modifications has been significantly reduced and that the temporary modifications in effect were properly documented. This item is closed.

- k. (Closed) Open Item (50-361/83-05-01) Closure of Access Doors on CREACUS

The inspector verified that the licensee revised procedure S023-5-2.6, "Ventilation 60-B Alarm Response Procedure" to require operators to ensure control room doors and ventilation alignment is correct per S023-3-2.22 and S023-IV-9.4.1, when a valid CRIS or TGIS alarm is received. Procedure S023-3-2.22 Attachment 11 requires the operator to notify security, which then implements closure of the control room envelope per S023-IV-9.4.1. This item is closed.

l. (Closed) Open Item (50-361/83-05-03) Control Room Pressure Boundary Integrity

The inspector noted that the licensee completed major design changes to the Control Room Pressure Boundary during the first Unit 2 Refueling Outage and that the new pressure boundary was tested satisfactorily. This item is closed.

m. (Closed) Open Item (50-361/83-21-01, 50-362/83-19-01) Auxiliary Feedwater (AFW) System

Newly designed flow orifices have been installed in the AFW system. This item is closed.

n. (Closed) Open Item (50-361/83-22-01) Control Room Emergency Air Cleanup System (CREACUS) Improvements

The licensee's actions in implementing Control Room Air Cleanup System design changes and improvements have reduced this frequency of spurious actuation and have increased the system reliability. This item is closed.

o. (Closed) Open Item (50-361/83-22-02, 50-362/83-11-01) Trending Licensee Event Reports (LER)

The LER Trending Program presently consists of trending performed as a collateral function by the licensee's compliance organization. Based on the gradual reduction in LER's issued over the last two years the licensee's trending appears to be adequate. This item is closed.

p. (Closed) Open Item (50-361/83-24-02) Motor Operated Valve Task Force

The inspector reviewed the actions completed by the licensee's valve motor operator task force and it appeared to be satisfactory based on the significant reduction in problems with the motor operators since 1983. The licensee's maintenance department has retained the responsibility for implementing the recommendations which include providing proper maintenance training. This item is closed.

q. (Closed) Open Item (50-361/83-29-02) Post Maintenance Testing

The licensee's task force to develop guidelines for post-maintenance functional testing, issued Post Maintenance Retest Program Procedure SO23-XV-1.0, on March 5, 1984. (TCN 6 issued on June 26, 1985). This item is closed.

r. (Closed) Open Item (50-361/83-29-03) Chain Fall Storage

Based upon several observations, the inspector concluded that the licensee's program to control and secure chain falls in the diesel generator room is adequate. This item is closed.

s. (Closed) Open Item (50-361/84-06-01) Charging Pump Flow

The inspector reviewed procedure S023-V-3.4.11, and determined that the licensee changed the acceptance criteria for observed charging pump flow to account for flow transmitter and flow indicator tolerances. This item is closed.

t. (Open) Open Item (50-361/84-35-03) Foreign Material Exclusion (FME) Practices

The licensee has revised Procedure S0123-I-1.18, "Foreign Material Exclusion/Inventory Control During Maintenance, Testing and Inspection Activities", to enhance the FME program. The revised procedure is currently under review by the licensee. This item remains open pending review of the revised procedure by the inspector and observation of FME controls during the Unit 3 refueling outage.

u. (Closed) Violation (50-362/84-09-01) Containment Cooling Inoperable

The underlying causes of this violation were addressed by the licensee and corrective actions were taken to improve administrative controls. The following actions were taken by the licensee:

- ° Partial alignment checklists are now given the same level of review and authorization as required by the Technical Specifications for temporary changes. Procedures have been changed to include this requirement.
- ° Procedures have been changed so that partial alignment checklists must be developed on a blank form instead of modifying a checklist that has already been used.
- ° Pre-planned partial checklists have been added to procedures to ensure that valves and components are not inadvertently forgotten, and P & ID's have been developed for various Shutdown Cooling system alignments.
- ° Procedures have been changed to lock-open valves MU-012 and MU-014, and also to verify flow through MU-012 and MU-014 upon leaving the Shutdown Cooling alignment.
- ° Valves MU-012 and MU-014 have been included in the monthly surveillance to verify valve position.

The licensee has also considered the applicability of these corrective actions to other safety systems, and changes have been made where warranted. This item is closed.

v. (Closed) Violation (50-362/84-11-01) Use of Equipment Control Form

Procedure S023-0-23, "Equipment Status Control", which previously controlled work on plant equipment, has been cancelled. Control of plant equipment is currently specified by Procedure S023-0-13, "Work Authorizations". This procedure implements administrative controls to control the status of plant equipment, and completed Work Authorizations are reviewed by the Operations Supervisor (SRO) to ensure that all equipment returned to service is operable. This item is closed.

11. Exit Meeting

On July 8, 1985, an exit meeting was conducted with the licensee representatives identified in Paragraph 1. The inspectors summarized the inspection scope and findings as described in this report. The apparent violation was also discussed with licensee management on July 26, 1985.