



UNITED STATES
 NUCLEAR REGULATORY COMMISSION
 REGION II
 101 MARIETTA STREET, N.W.
 ATLANTA, GEORGIA 30323

Report Nos.: 50-269/92-15, 50-270/92-15 and 50-287/92-15

Licensee: Duke Power Company
 P. O. Box 1007
 Charlotte, NC 28201-1007

Docket Nos.: 50-269, 50-270, 50-287, 72-4

License Nos.: DPR-38, DPR-47, DPR-55, SNM-2503

Facility Name: Oconee Nuclear Station

Inspection Conducted: June 28 - July 25, 1992

Inspector:	<u><i>[Signature]</i></u>	<u>8/21/92</u>
	P. E. Harmon, Senior Resident Inspector	Date Signed
	<u><i>[Signature]</i></u>	<u>8/21/92</u>
	B. B. Desai, Resident Inspector	Date Signed
	<u><i>[Signature]</i></u>	<u>8/21/92</u>
	W. K. Poertner, Resident Inspector	Date Signed
	<u><i>[Signature]</i></u>	<u>8/21/92</u>
	W. H. Miller, Jr., Project Engineer	Date Signed
Approved by:	<u><i>[Signature]</i></u>	<u>8/21/92</u>
	G. A. Belisle, Section Chief	Date Signed
	Division of Reactor Projects	

SUMMARY

Scope: This routine, resident inspection was conducted in the areas of operations, surveillance testing, maintenance activities, Keowee Hydro Station, review of Licensee Event Reports, and inspection of open items.

Results: Two violations were identified. A violation with two examples involved failure to follow procedures during modification implementation (paragraph 4.c). The second violation involved the inoperability of both the standby emergency power sources for a period in excess of Technical Specification requirements (paragraph 5.b).

REPORT DETAILS

1. Persons Contacted

Licensee Employees

- *H. Barron, Station Manager
- S. Benesole, Safety Review
- D. Coyle, Systems Engineering
- *J. Davis, Safety Assurance Manager
- D. Deatherage, Operations Support Manager
- B. Dolan, Manager, Mechanical/Nuclear Engineering (Design)
- W. Foster, Superintendent, Mechanical Maintenance
- *J. Hampton, Vice President, Oconee Site
- *O. Kohler, Regulatory Compliance
- *C. Little, Superintendent, Instrument and Electrical (I&E)
- *M. Patrick, Performance Engineer
- B. Peele, Engineering Manager
- *S. Perry, Regulatory Compliance
- G. Rothenberger, Work Control Superintendent
- *R. Sweigart, Operations Superintendent

Other licensee employees contacted included technicians, operators, mechanics, security force members, and staff engineers.

NRC Resident Inspectors:

- *P. Harmon
- *W. Poertner
- *B. Desai

*Attended exit interview.

2. Plant Operations (71707)

a. General

The inspectors reviewed plant operations throughout the reporting period to verify conformance with regulatory requirements, Technical Specifications (TS), and administrative controls. Control room logs, shift turnover records, temporary modification log and equipment removal and restoration records were reviewed routinely. Discussions were conducted with plant operations, maintenance, chemistry, health physics, instrument & electrical (I&E), and performance personnel.

Activities within the control rooms were monitored on an almost daily basis. Inspections were conducted on day and on night shifts, during weekdays and on

weekends. Some inspections were made during shift change in order to evaluate shift turnover performance. Actions observed were conducted as required by the licensee's Administrative Procedures. The complement of licensed personnel on each shift inspected met or exceeded the requirements of TS. Operators were responsive to plant annunciator alarms and were cognizant of plant conditions.

Plant tours were taken throughout the reporting period on a routine basis. The areas toured included the following:

- Turbine Building
- Auxiliary Building
- CCW Intake Structure
- Independent Spent Fuel Storage Facility
- Units 1, 2 and 3 Electrical Equipment Rooms
- Units 1, 2 and 3 Cable Spreading Rooms
- Units 1, 2 and 3 Penetration Rooms
- Units 1, 2 and 3 Spent Fuel Pool Rooms
- Station Yard Zone within the Protected Area
- Standby Shutdown Facility
- Keowee Hydro Station

During the plant tours, ongoing activities, housekeeping, security, equipment status, and radiation control practices were observed.

Within the areas reviewed, licensee activities were satisfactory.

b. Plant Status

Unit 1 The unit operated at power for the entire reporting period.

Unit 2 The unit operated at power for the entire reporting period.

Unit 3 The unit operated at power until July 21 when a power reduction was initiated for a scheduled End-of-Cycle 13 refueling outage.

c. Initiation of Residual Heat Removal With Valve 3BS-3 Open

On July 22, 1992, at 5:39 a.m., Operations released valve 3BS-3 for electrical preventive maintenance activities. The valve was left in the open position and deenergized. Valve 3BS-3 is the suction isolation

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Duke Power Company

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The responses directed by this letter and the enclosed Notice are not subject to the clearance procedures of the Office of Management and Budget as required by the Paperwork Reduction Act of 1980, Pub. L. No. 96-511.

Should you have any questions concerning this letter, please contact us.

Sincerely,

Orig signed by P. Skinner
Alan R. Herdt, Chief
Reactor Projects Branch 3
Division of Reactor Projects

Enclosures:

1. Notice of Violation
2. NRC Inspection Report

cc w/encls:

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cc: continued see page 3

valve for the 3A building spray (BS) pump and aligns the BS pump to the suction of the low pressure injection system.

Following the release of 3BS-3 to Maintenance, the low pressure injection system was subsequently placed in the residual heat removal mode of operation per the controlling procedure for Unit shutdown to cold shutdown conditions. The controlling procedure requires that valve 3BS-3 be shut prior to placing the low pressure injection system in service.

During a routine control room tour, the inspectors questioned the status of valve 3BS-3 and were told that the spray header had been isolated using the downstream valve 3BS-1 instead of 3BS-3. The decision to release the 3BS-3 valve to Maintenance had been coordinated between Operations and Maintenance to reduce the work activities during defueled maintenance activities.

The inspectors have expressed concerns about moving the Reactor Coolant System (RCS) isolation boundaries to support maintenance activities that could impact the outage schedule. The concern for this particular case was that even though valve 3BS-1 was closed and tagged, the building spray injection valves are historically known to leak past their seats. Additionally, the valves are throttle valves and may be partially open even when the valve indicates closed in the control room. In this instance, valve 3BS-1 was fully shut and did not exhibit seat leakage when the valve was subjected to reactor coolant system pressure when the low pressure injection system was placed in the residual heat removal mode of operation. The inspectors held discussions with plant management and expressed concern about maintaining an intact RCS boundary during refueling outages. The licensee stated that they would review the circumstances involved.

d. Fuse Control Problems

During the inspection period the licensee identified several instances where QA level certified fuses were not available in the supply system to replace fuses that had blown during plant operations. The licensee also identified an instance where the wrong size fuse was installed in a safety related breaker. The licensee has corrected the specific problems identified and is reviewing the issue for generic applications. The licensee is implementing a fuse walkdown program to verify that proper fuses are installed in safety

related applications. The licensee had already planned to implement the fuse walkdown program prior to the problems identified this inspection period. The licensee plans to walkdown Unit 3 and the Keowee hydro station during the present Unit 3 refueling outage. The inspectors plan to follow the results of the licensee's inspection efforts as the walkdown progresses.

No violations or deviations were identified.

3. Surveillance Testing (61726)

Surveillance tests were reviewed by the inspectors to verify procedural and performance adequacy. The completed tests reviewed were examined for necessary test prerequisites, instructions, acceptance criteria, technical content, authorization to begin work, data collection, independent verification where required, handling of deficiencies noted, and review of completed work. The tests witnessed, in whole or in part, were inspected to determine that approved procedures were available, test equipment was calibrated, prerequisites were met, tests were conducted according to procedure, test results were acceptable and systems restoration was completed.

Surveillances reviewed and witnessed in whole or in part:

PT/1/A/251/01	LPSW Pump Performance Test.
PT/0/A/0110/04	Penetration Room Ventilation System Performance Test

Within the areas reviewed, licensee activities were satisfactory.

No violations or deviations were identified.

4. Maintenance Activities (62703)

a. Observations

Maintenance activities were observed and/or reviewed during the reporting period to verify that work was performed by qualified personnel and that approved procedures in use adequately described work that was not within the skill of the trade. Activities, procedures, and work requests were examined to verify proper authorization to begin work, provisions for fire, cleanliness, and exposure control, proper return of equipment to service, and that limiting conditions for operation were met.

Maintenance reviewed and witnessed in whole or in part:

WR 91020787	Disassemble, Inspect, Refurbish 1BLPSW Pump
WR 92029222	Perform Chemical Cleaning on 1A LPI Cooler
TN/5/AS/2917/AL1	Replace Keowee X Relay Electro-mechanical Scheme with X/Y Electrical Scheme.

b. Unit 3 Penetration Room Ventilation (PRV) Charcoal Replacement

On July 7, 1992, the licensee removed the 3A PRV system from service for charcoal replacement. The removal of the 3A PRV system from service resulted in the unit entering a 7 day Limiting Condition for Operation (LCO) per Technical Specification 3.15.1, Penetration Room Ventilation Systems. The 3A PRV system was returned to service on July 8, 1992, and the 3B PRV system was removed from service for charcoal replacement. The 3B PRV system was returned to service on July 9, 1992. During maintenance activities conducted on the PRV system, the inspectors questioned the necessity of charcoal replacement at power. The unit was scheduled to be taken offline 14 days later for a scheduled refueling outage at which time the PRV system would not be required to be operable. The inspectors discussed this item with operations personnel and were told that removal of the PRV system was allowed per the technical specifications as long as the LCO was not exceeded. Discussions with the involved maintenance personnel determined that the charcoal was replaced at power to reduce the work activities scheduled during the refueling outage. The inspectors have expressed concerns about the removal of safety systems at power to reduce outage work loads and will continue to monitor this issue. The licensee acknowledged that they perform maintenance activities in this manner.

c. Inadequately Installed Modifications

On July 13, 1992, the licensee completed the installation of a modification package to provide degraded grid protection for auxiliary transformer CT-5. Transformer CT-5 can be aligned to the emergency standby busses from the Lee gas turbines through the central switchyard and is not normally connected to the standby busses. During the post modification testing conducted after the installation of the modification, a control power fuse associated with breaker SL-2 blew

and was replaced with a non-QA fuse to allow operation of the breaker. QA fuses were not available onsite. The SL breakers connect the transformer to the standby busses to supply power to the busses. The post modification test was continued and this time a relay in the circuitry burned out during the testing of the circuitry. Subsequent investigation by the licensee determined that the modification had been wired incorrectly by the technicians performing the modification package and that the incorrect wiring had resulted in the control power fuse blowing and the relay burning out. The modification had also been inspected by QC personnel.

The inspectors reviewed the modification package associated with the work activity and determined that the installation procedure required that the wire which was installed incorrectly be independently verified by another technician and a QC inspector during the installation process. If the QC inspection had been adequately performed, it should have identified the improper wiring. The failure to properly perform the wiring as required by the modification package is identified as example one of violation 269, 270, 287/92-15-01, failure to follow procedure.

On July 19, 1992, during post modification testing associated with a modification performed on Keowee Hydro Unit number 1, the licensee experienced DC ground problems during the performance of the post modification test. Investigation by the licensee determined that during the modification process, leads had been lifted during the performance of step 8.9.3 of TN/5/A/2917/00/AL1. This step required that auxiliary switch contact 31-9 and 31-10 be changed from normally open to normally closed on DB-25, the generator field flashing breaker. The leads had been reversed by the technician when they were relanded. The inspectors determined that the modification package had not required that the leads in question be lifted and that the technician had lifted the leads to facilitate the ongoing work activity and that the lifting and relanding of the leads had not been documented. Maintenance Directive 7.5.3, Work Request Implementation, requires that disconnection or reconnection of wiring be documented and independently verified on Section V of the work request "Additional Sheet". The failure to meet the procedural requirements of Station Directive 7.5.3 is identified as example two of Violation 269, 270, 287/92-15-01, failure to Follow Procedure.

d. Low Pressure Injection (LPI) Cooler 1A Cleaning Activities

During the Unit 1 reactor coolant pump seal replacement outage, the licensee determined that the heat removal capability of the 1A LPI cooler had degraded. This occurred since the cooler was last tested during the previous refueling outage. The licensee determined that chemical cleaning of the cooler should be performed to increase cooler performance. The licensee decided to return the unit to service prior to cleaning the cooler since the heat removal capacity of the cooler exceeded the minimum heat removal capacity required per engineering calculations. Cleaning the cooler prior to returning the unit to service would have delayed returning the unit to service. The unit was returned to service and the cooler was chemically cleaned on July 21, 1992.

The inspectors followed the licensee's efforts to clean the 1A LPI cooler at power. Temperature requirements in the procedure for adding the cleaning chemicals and initiation of the chemical soak were not achieved. Also, the required soak time of eight hours was not achieved. The inspectors discussed the conduct of the evolution with the accountable maintenance engineer and were told that the overall intent of the cleaning process had been achieved and that no further cleaning activities were required at this time.

Within this area, one violation with two examples was identified.

5. Keowee Hydro Station

Events at Keowee Station during this inspection period included modification of the Keowee breakers containing "X" relays, problems during the modification that resulted in both Keowee Units and consequently both emergency power supplies to Oconee being inoperable at the same time for greater than the time allowed by Technical Specifications, and fuse control problems.

a. "X" relay modification at Keowee Unit 1

Problems associated with mechanical binding of "X" relays, an anti-pumping device, at Keowee have been discussed in previous NRC Inspection Reports as well as

Licensee Event Report 269/92-02. Binding of an "X" relay could prevent an automatic start of a Keowee unit. The licensee implemented Station Modification (NSM) ON-52917/0 and replaced the "X" relays on Keowee Unit 1 excitation supply breaker, field flashing breaker, field breaker, and load center 1X normal and alternate incoming breaker. Keowee Unit 2 breakers will be modified following completion of the currently ongoing Oconee Unit 3 refueling outage.

A pumping condition exists when a breaker has both a close and trip (open) circuit signal at the same time. The breaker would then continuously open and close. The anti-pumping device is designed into a breaker to prevent the pumping action from occurring when both a close and trip signal is present at the same time. Unlike the old "X" relay, the new "X/Y" relaying scheme will not rely on mechanical action, which led to binding, to accomplish the anti-pumping function. Instead, the new relaying scheme accomplishes this function electrically through a seal in circuit.

The inspector reviewed and observed portions of the modification as well as the 50.59 evaluation. The new relay scheme has no impact on the 23 second load acceptance time described in the Oconee Final Safety Analysis Report. The relays are QA Condition 1 and mounted for seismic loadings.

The inspectors will monitor the activities during the implementation of the modification on Keowee Unit 2.

b. Problems during the Keowee Hydro Station Operation

On July 16, with all three Oconee units at full power, the emergency power supplies for the station were both inoperable at the same time. Keowee Unit 1 was inoperable during a planned modification discussed above in paragraph 5.a, starting at 5:15 a.m., on July 16. Keowee Unit 2 was determined to also be inoperable at 2:15 p.m., on July 17, when operators discovered that the alternate Auxiliary Switchgear supply breaker was inoperable. Indication of Keowee Unit 2 inoperability had been noted by the operators at Keowee 24 hours before, at 2:30 p.m., on July 16, but they did not fully investigate the indications until the next day. The condition of two inoperable emergency power supplies existed for at least 24 hours, but the second unit was not declared inoperable due to a lack of timely action by the Keowee operator.

replaced, or that other position indication problems existed. At approximately 2:30 p.m., the HOS started to replace the bulb. When he cupped his hand over the bulbs, he noticed that the red (closed) light on the breaker was also dimly lit. At this time the HOS decided to wait to investigate the lamp problems when Unit 2 was scheduled to be taken out of service the next day, July 17.

When the HOS returned the next day, July 17, he learned that the modifications on Keowee Unit 1 had experienced delays, and therefore, Unit 2 would not be taken out of service that day. At 8:44 a.m., Keowee Unit 2 was again tested for operability per TS. At approximately 12:00 the HOS requested, via Work Request 59726C, a Component Engineer (CE) and an I&E Plant Maintenance Supervisor (IPMS) to assist in his investigation of the lamp problem on breaker ACB-8. The three individuals used electrical print KEE-27-2 to review the control power circuit, and MP/0/A/2000/13, Troubleshooting Procedure, to investigate the problem. At approximately 1:30 p.m., the CE and the IPMS opened the breaker cabinet and discovered that the 1B positive 10 amp fuse feeding the breaker control circuit was blown. A further check of the negative fuse for the breaker revealed that a 15 amp fuse was installed instead of the required 10 amp fuse. The 15 amp fuse was not blown.

At 2:15 p.m., the HOS notified the Oconee Nuclear Station Unit 2 Supervisor that a blown fuse had been found in the ACB-8 breaker, causing the CX transformer to be out of service. Oconee Nuclear Station operators then called the HOS back and informed him that Keowee Unit 2 was therefore inoperable and that a Lee gas turbine would have to be lined up to the CT-5 transformer within one hour. With Keowee Unit 1 out of service for the modification, a 24 hour LCO was entered by the Unit 2 Supervisor. TS 3.7.7 requires the energization of the Standby Buses via a Lee Gas Turbine through the dedicated 100 kv lines. The Oconee Unit 2 Supervisor notified the Lee Steam Station Operators at 2:23 p.m. of the condition of the Keowee units and advised them that their services would be required.

At 2:36 p.m., the Oconee Unit 2 Supervisor directed the Lee Steam Station Operators to start a gas turbine and energize the dedicated line per TS. The Lee operators experienced difficulty starting a gas turbine. Two subsequent starts of a gas turbine were

also unsuccessful. Another gas turbine was then started.

At 3:11 p.m., the Keowee personnel found QA-qualified fuses. They installed the fuses and tested the breaker. At 3:13 p.m., Keowee Unit 2 was declared operable and the LCO was exited.

At 3:26 p.m., the Lee Gas Turbine was placed on-line and the 100 kv line energized. At 4:15 p.m., the Oconee control room informed the Lee Station that the Lee Gas Turbine was no longer required.

The condition that caused the 2X Switchgear Bus to be inoperable was the blown fuse in the ACB-8 breaker control circuit. The blown fuse also caused the anomalous indication of a concurrent open/closed breaker which was initially identified at approximately 2:30 p.m., on July 16. The HOS who first identified the anomalous lights on the breaker did not perform an investigation into the cause until the next day. Although Keowee Unit 2 was declared inoperable at 2:15 p.m., on July 17, the unit had been inoperable since approximately 2:30 p.m., on July 16.

TS 3.7.7 requires that, in the event of both Keowee units becoming unavailable for unplanned reasons, the reactor(s) may remain critical for a period not to exceed 24 hours provided the 4160 volt standby buses are energized within one hour by a Lee gas turbine. In the instance detailed, both Keowee units were inoperable from approximately 2:30 p.m., July 16 when the HOS found both ACB-8 breaker indicating lights illuminated, until the breaker was restored at 3:13 p.m., on July 17. Failure to meet the requirements of TS 3.7.7 is identified as violation 269, 270, 287/92-15-02, Both Keowee Units Inoperable.

6. Review Of Licensee Event Reports (92700)

The below listed Licensee Event Reports (LERs) were reviewed to determine if the information provided met NRC requirements. The determination included: adequacy of description, verification of compliance with Technical Specifications and regulatory requirements, corrective action taken, existence of potential generic problems, reporting requirements satisfied, and the relative safety significance of each event. In plant reviews and discussions with plant staff were also conducted for the reports. The following LERs are closed:

LER 269/90-03 Engineered Safeguards Motor Operated Valves Declared Inoperable Due to Restraints of Available Technology

LER 269/91-07 Breaker Coordination Problem Due to Design Deficiency Results in TS Inoperability of Safety Related Equipment

LER 270/90-01 Manual Reactor Trip While Subcritical After 2A Feedwater Pump Trip Due to Equipment Malfunction

LER 270/91-01 Missed TS Surveillance Due to Inappropriate Action Caused Fire Detection System to be Technically Inoperable

LER 270/91-02 Flow Orifice Installed Backwards Due to Unknown Cause Results in Degraded Emergency Core Cooling System During Certain Small Break LOCA Scenarios

LER 287/91-03 High Pressure Injection System Crossover Flow Transmitter Inoperable Due to Installation Deficiency

LER 287/91-04 Inappropriate Action, Failure to Follow Procedure During a Nuclear Station Modification Implementation Results in a Degraded Fire Barrier

LER 269/92-02 Equipment Failure In Emergency Power System and Inappropriate Action Result in Technical Specification Violation

7. Inspection of Open Items (92700) (92701) (92702)

The following open items were reviewed using licensee reports, inspection, record review, and discussions with licensee personnel, as appropriate:

- a. (Closed) IFI 269,270,287/91-02-02: Review of Process to Verify Fuel Assembly Verification Prior to Loading Into Dry Shield Canister. Procedure OP/0/A/1510/14, Independent Spent Fuel Storage Facility (ISFSF), Enclosure 4.8 and the ISFSF TS Interpretation for TS Section 2.1.1 have been revised to require an independent verification of each fuel assembly number prior to being loaded into the Dry Shielded Canister. This resolves the inspector's concerns.

- b. (Closed) Unresolved Item 269,270,287/91-03-02: Circuit Breaker Maintenance and Testing. The licensee has instructed technicians that work on safety and non-safety related breakers, relays and meters to utilize a procedure when working on these components. Presently, several generic procedures such as MP/0/A/2001/2, for circuit breakers and IP/0/A/4980/02A through 87G for relays, are being used until specific procedures are written. A program to write equipment specific procedures is being implemented with completion of all procedures scheduled for late 1995.
- c. (Closed) Violation 270,287/91-09-01: Inoperable High Pressure Injection Components (HPI). The licensee responded to this violation by letter dated July 11, 1991. The incorrectly installed HPI crossover flow instruments were properly reinstalled and functionally tested to verify operability. The flow orifices for the HPI and Emergency Feedwater Systems which were installed backwards were removed and reinstalled properly. The remaining safety related flow orifices installed in the systems were inspected and found to be properly installed. The personnel responsible for the installation of flow orifices were given training in the importance of proper flow orifice installation. Project Service Manuals were revised to incorporate the necessary changes to assure correct future installations.
- d. (Closed) Violation 287/91-09-02: Failure to Maintain Plant Configuration Control. The Licensee responded to this violation by letter dated June 4, 1991. All three unit startup procedures have been revised to require valves LPSW-563 and LPSW-564, fire protection system control valves, to be closed prior to closing the personnel hatch for leak rate tests. The procedures were also reviewed to identify any additional improvements. A training program was given to all licensed operators to emphasize the necessity of caution when signing off procedure steps and of processing completed checklists in a timely manner.
- e. (Closed) Violation 269/91-18-01: Failure to Follow Procedures. The licensee responded to this violation by letter dated October 17, 1991. Procedures OP/1,2&3/A/1502/07, Refueling Procedure, have been revised to require the fuel bridge to be indexed after the verification of the empty location. This index step is documented with the initials of the bridge operator and the spotter. Training was given to the fuel handling operators on these changes. Also,

training qualifications were developed for the spent fuel bridge spotter. This training will be given to the spotter prior to being assigned to the spotter position.

- f. (Closed) Violation 269/91-18-02: Failure to Follow Procedures Resulting in the Loss of Both Source Range Nuclear Instruments. The licensee responded to this violation by letter dated October 17, 1991. Procedure IP/0/A/0305/016, Bailey Meter Cabinet Module Inspection and Cleaning, was issued to be used on reactor protection system cabinets only. Procedure IP/0/A/0310/025, Engineered Safeguards System Bailey Meter Cabinet Module Inspection and Cleaning, was written to cover Engineered Safeguards cabinets. Appropriate training has been performed on these procedures.
- g. (Closed) Unresolved Item 269/91-18-03: Control of Outage Activities. Procedure MP/0/A/1720/010, System/Component Hydrostatic Test Controlling Procedure, has been revised to require double verification of boundary valves for hydrostatic tests, details on hydrostatic test procedures and the appropriate documentation requirements.
- h. (Closed) Violation 269/91-26-01: Failure to Follow Procedures. The licensee responded to this violation by letter dated November 25, 1991. Procedures OP/A/1103/11, Draining and Nitrogen Purging of RC System for Units 1 and 2 were revised to standardize the pressurizer level requirements with the loops "dropped" and to provide the operators with directions on actions to take to remove excess reactor coolant system inventory. The revision to the procedures for Unit 3 are in process and will be completed prior to the Unit 3 outage. The operations staff were given additional training on reactor coolant system drain and purge, fill and vent, tagout procedures, and an overview of the shutdown and startup procedures.
- i. (Closed) Violation 269,270,287/91-31-01: Failure to Follow Procedures Resulting in a Spill. The licensee responded to this violation by letter dated January 10, 1992. Procedure OP/1&2A/1104/23, Enclosure 4.3, Step 4.6 has been revised to be more manageable and to assure that valve 1HP-49 is closed prior to backflushing operations if the tank volume is not between 518 and 572 gallons. Training on this procedure for all licensed shift personnel has been completed.

8. Exit Interview (30703)

The inspection scope and findings were summarized on August 3, 1992, with those persons indicated in paragraph 1 above. The inspectors described the areas inspected and discussed in detail the inspection findings. The licensee did not identify as proprietary any of the material provided to or reviewed by the inspectors during this inspection.

<u>Item Number</u>	<u>Description/Reference Paragraph</u>
VIO 269,270,287/92-15-01	Failure to Follow Procedure (paragraph 4.c).
VIO 269,270,287/92-15-02	Both Keowee Units Inoperable (paragraph 5.b).