ENCLOSURE

U.S. NUCLEAR REGULATORY COMMISSION
REGION IV

Docket Nos.:	50-275 50-323
License Nos.:	DPR-80 DPR-82
Report No.:	50-275/97-012 50-323/97-012
Licensee:	Pacific Gas and Electric Company
Facility:	Diablo Canyon Nuclear Power Plant, Units 1 and 2
Location:	7 1/2 miles NW of Avila Beach Avila Beach, California
Dates:	July 20 through August 30, 1997
Inspectors:	D. B. Allen, Resident Inspector B. J. Olson, Project Inspector J. A. Sloan, Senior Resident Inspector (San Onofre)
Approved By:	H. J. Wong, Chief, Reactor Projects Branch E

Attachment: Supplemental Information

EXECUTIVE SUMMARY

Diablo Canyon Nuclear Power Plant, Units 1 and 2
NRC Inspection Report 50-275/97-12; 50-323/97-12

Operations

- Operators performing valve walkdowns to confirm containment integrity made observations outside the performance of the task of verifying valve positions and appropriately identified an additional vent valve and pipe caps, which should have been included in the surveillance procedure (Section O1.2).

- Operators' response to loss of cooling oil flow to Unit 1 Main Transformer Phase A was timely and effective in preventing an unnecessary shutdown of the unit. Subsequent actions were well planned and coordinated to protect the main transformer from potential overheating (Section O1.3).

Maintenance

- Surveillance testing of the main steam safety valves (MSSVs) per the augmented test program indicated that the high initial lift pressures due to bonding appears to have been effectively corrected by the replacement of the valve discs with new material. The test results also indicated the Mode 1 testing within 30 days of entry into Mode 1 may not be necessary. The test program has been effectively structured to meet the licensee's goals (Section M1.4).

Engineering

- The engineering backlog for action requests (ARs), action evaluations (AEs), and drawing changes has been very large and had not been effectively managed. The licensee's assessment of the process was thorough and provided excellent long-term and short-term recommendations for improving the process and permanently reducing the backlogs (Section E6.1).

Plant Support

- The technician performing postaccident sampling system (PASS) containment air sampling was knowledgeable of sampling procedures and the PASS equipment configuration and operation.

Report Details

Summary of Plant Status

Unit 1 began this inspection period at 100 percent power. On August 5, power was reduced to 85 percent when power was lost to the Main Transformer Phase A cooling oil pumps and fans. The unit was returned to 100 percent power on the same day. On August 23, the unit was down powered to approximately 85 percent power to perform turbine valve surveillance testing. The unit was returned to and remained at 100 percent power throughout the remainder of the inspection period.

Unit 2 began this inspection period at 100 percent power. On August 17, the unit was down powered to maintain generator cold gas temperature within limits due to high ocean temperatures. On August 22, power was reduced to 50 percent to clean the circulating water condenser, changeout the Main Feedwater Pump 2-1 lubricating oil, and replace a condensate booster pump seal. The unit was returned to 100 percent power on August 25 and completed the inspection period at 100 percent power.

I. Operations

O1 Conduct of Operations

O1.1 General Comments (71707)

Using Inspection Procedure 71707, the inspectors conducted frequent reviews of ongoing plant operations. In general, the conduct of operations was competent, professional, and safety conscious.

O1.2 Walkdown of Containment Isolation Valves

a. Inspection Scope (71707)

The inspector observed operators verifying the positions of main steam system valves to assure containment integrity surveillance requirements were met.

b. Observations and Findings

The operators reviewed plant drawings to confirm the valve lineup sheets contained the necessary valves and pipe caps. Two operators independently verified each valve on the list to be closed. Several drawing errors were noted by the operators, including instrument line caps and an instrument vent valve that were not indicated on the drawing and should have been included in the valve lineup.

c. Conclusions

The operators maintained a questioning attitude and made observations outside the strict performance of the task of verifying the required valves were closed. They were observant of the piping configuration and identified to the Shift Foreman several potential errors to be reviewed for inclusion in the valve lineup.

O1.3 Operations Response to Loss of Cooling to Unit 1 Main Transformer

a. Inspection Scope (71707)

On August 5, the inspectors observed the control room operators' response to the loss of cooling to the Unit 1 Main Transformer Phase A.

b. Observations and Findings

Upon receipt of a main transformer bank loss of oil flow alarm, an operator was dispatched to investigate and found all Main Transformer Phase A cooling oil fans and pumps off. The operator successfully started three of the six cooling oil pumps and their associated fans. The operators in the control room had begun a controlled ramp down in power to reduce the load on the transformer. After confirming the transformer temperatures were stabilized and half the pumps and fans were running, operations stopped the power decrease. Initial troubleshooting indicated the transformer cooling system was stable, although in an abnormal configuration since all six pumps should have been operating, based on the control switch position. Operations stationed a watch at the transformer to ensure the cooling system remained in operation while the troubleshooting continued.

c. Conclusions

Operator response was timely and effective in restoring cooling to the transformer, preventing a potential shutdown of the unit. Corrective actions were well planned and well coordinated to minimize impact on plant operations and to protect the transformers from overheating.

O1.4 Use of Overtime

a. Inspection Scope (71707)

The inspector reviewed a sample of time records for operations personnel covering the period for Refueling Outage 1R8 and reviewed authorizations to exceed work hour limitations.

b. Observations and Findings

The licensee's use of overtime was specified by Procedure OM14.ID1, "Overtime Restrictions." The inspector found that the licensee's procedure was consistent with the overtime guidelines of Technical Specifications (TS). The licensee's program also included administrative guidelines in addition to the TS guidelines. Personnel in the operations department monitored work hours to ensure that

authorizations were completed for exceeding overtime guidelines. The inspector did not find discrepancies with the time sheets and the authorizations that were reviewed.

c. Conclusions

Overall, the inspector concluded that the licensee's program for monitoring working hours of licensed operators and authorizing exceeding overtime guidelines was satisfactory and resulted in meeting TS guidelines.

02 Operational Status of Facilities and Equipment

O2.1 Control Room Ventilation System

a. Inspection Scope (71707)

The inspector walked down the control room ventilation system for equipment condition and alignment, reviewed active ARs, past and pending design changes, associated operating and surveillance procedures, Design Criteria Memorandum S-23F, "Control Room Heating, Ventilation and Air Conditioning System", and applicable portions of the Updated Final Safety Analysis Report (UFSAR) and TS. The inspector also reviewed Independent Safety Evaluation Group Assessment Report 961500195, Nuclear Quality Services Third Quarter Audit 961790046, and system availability performance for compliance with the maintenance rule (AR 0439713).

b. Observations and Findings

The system was aligned in accordance with operation procedures with equipment performance acceptable and minor equipment problems identified by ARs. The general condition of the equipment was acceptable with minor discrepancies noted, such as a burned-out indicating light on a local panel and minor lubricant leaks. The operation of the system was in compliance with the operating procedure and the UFSAR, TS, and Design Criteria Memorandum.

A pending design change was to add a spectacle flange on the pressurization system cross tie to provide train isolation during maintenance. The engineering evaluation was thorough and addressed such issues as installation instructions; precautions and limitations during installation; procurement requirements and material specifications; revisions to engineering, operations, and maintenance documents; seismic integrity; post modification testing; and impact on other operating equipment.

The surveillance procedures satisfied the testing requirements of the TS and were adequate to demonstrate the ability of the system to function in all modes of operation.

c. Conclusions

The design, operation, maintenance, and surveillance testing of the control room ventilation system was in compliance with the UFSAR, TS, and applicable plant procedures and design documents.

II. Maintenance

M1 Conduct of Maintenance

M1.1 Maintenance Observations

a. Inspection Scope (62707)

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

- Verification of MSSV lift point using Furmanite's Trevitest equipment in accordance with Maintenance Procedure M-4.18A, Revision 2
- Inspection and repair of fire barriers in Units 1 and 2 cable spreading area, and removal of old fire barrier in wall between Units 1 and 2's battery rooms.

b. Observations and Findings

The main steam safety valves (MSSVs) were tested in accordance with the maintenance procedure, test equipment was within calibration, prerequisites and precautions were satisfied, the specified number of lifts were performed, the required 10-minute wait between lifts was observed, and adjustments were made as specified to meet the as-left tolerance. Communication was established between the test personnel and the control room, as specified in the procedure, as required to administratively control the position of containment isolation valves, ensure inadvertent perturbation of main steam pressure transmitters would not cause an actuation, and to obtain required operations permission during the test. The test results satisfied the as-found and as-left requirements.

Personnel inspecting the fire barriers in the cable spreading rooms were meticulous in identifying the penetrations from both sides of the wall. The personnel removing the old fire barrier material from the wall between the Unit 1 and 2 battery rooms were also thorough and meticulous. Safety-related equipment in the rooms had been protected from dirt and debris by tarps.

c. Conclusions

The maintenance activities were performed in accordance with the procedural requirements. The personnel performing the activity were knowledgeable of the

equipment, tools, and methods used. The results of the maintenance appeared to be effective in ensuring the components will function as designed.

M1.2 Technical Maintenance Response to Loss of Cooling to Unit 1 Main Transformer

a. Inspection Scope (62707)

On August 5, the inspectors observed Technical Maintenance's response to the loss of cooling to Unit 1 Main Transformer Phase A.

b. Observations and Findings

Technical Maintenance began an immediate investigation and determined that a poor electrical connection between a wire and lug in the power circuit to the fans and pumps had caused an excessive current, tripping the thermal overload devices on the pumps and fans. The technicians also determined that the overcurrent condition had damaged other components in the circuit. After verifying that the load side circuitry was not damaged, temporary power was provided and the unit was returned to 100 percent power.

Technical Maintenance inspected the circuitry for the other main transformer banks and identified a hot connection in the same location in the Phase C control cabinet. Both transformer bank connections were repaired, the damaged components were replaced, and the control circuits returned to normal alignment.

c. Conclusions

The investigation by Technical Maintenance was thorough, and corrective actions were well planned and well coordinated to minimize impact on plant operations and to protect the transformers from overheating.

M1.3 Battery Operated Emergency Lighting System

a. Inspection Scope (62707)

The maintenance and testing history of the battery operated lights (BOL) was reviewed for compliance with 10 CFR 50.65 (Maintenance Rule) and requirements for emergency lighting for fire protection in 10 CFR Part 50, Appendix R. Maintenance Procedure E-67.5A was reviewed for technical adequacy.

b. Observations and Findings

Diablo Canyon has approximately 240 BOLs with approximately 70 percent of these designated as Appendix R emergency lighting. The remaining are primarily for personnel safety during a loss of normal lighting. Over the past 27 months, approximately 30 equipment failures were identified, 9 of which were failures to

illuminate when tested. Those BOLs, which are relied upon to provide illumination in support of mitigating accidents and transients during loss of normal lighting, are considered to be covered by the Maintenance Rule. Of the nine failures of BOLs to illuminate, four failures are covered by the Maintenance Rule. Only one of the four failures had been evaluated and documented on an AR for Maintenance Preventable Functional Failures (MPFF). The licensee's evaluation of the one failure determined that it was not an MPFF but a premature failure of an individual battery, and not indicative of a maintenance program failure.

The licensee has a time-dependent maintenance plan to replace the batteries in the BOLs when they reach 7 years of service. The failures of the batteries have occurred with 4 to 5 years of service. The system engineer was trending the number and types of failures that occur during each monthly and yearly surveillance period, but did not believe he had collected sufficient data to draw conclusions based on statistical analysis.

The lighting systems were added to the scope of the Maintenance Rule at Diablo Canyon in February 1997. ARs for equipment failures prior to that time were not reviewed for MPFF. The performance criteria for this system was established as two MPFFs within 24 months per unit. Since the previous failures had not been evaluated, it could not be determined if the BOLs met the performance criteria, or if the failures were maintenance preventable. When this was identified to the Maintenance Rule coordinator, the previous BOL ARs were submitted to the system engineer for review for MPFF. The system engineer determined that the although some of the previous BOL ARs were functional failures, none were MPFFs based on being premature battery failures. The inspectors questioned whether the licensee had properly evaluated the premature battery failures of the BOLs in that although these failures may not be caused by failure to perform the currently specified maintenance, or by incorrectly performed maintenance, failures could be avoided by a change to the current maintenance program. The system engineer's dismissal of these failures as not being MPFFs appeared to the inappropriate. The failure to review and evaluate previous equipment failures as MPFFs is an unresolved item (URI) pending further NRC review (URI 50-275;323/97012-01).

c. Conclusions

The BOLs were tested at the frequency specified by the maintenance procedure. The maintenance procedure was adequate to determine if the BOLs would function upon demand. The equipment problems identified by the surveillance tests have been corrected or resolved.

M1.4 Surveillance Observations

a. Inspection Scope (61726)

Selected surveillance tests required to be performed by the TS were reviewed on a sampling basis to verify that: (1) the surveillance tests were correctly included on the facility schedule, (2) a technically adequate procedure existed for the performance of the surveillance tests, (3) the surveillance tests had been performed at a frequency specified in the TS, and (4) test results satisfied acceptance criteria or were properly dispositioned.

The inspectors observed all or portions of the following surveillances:

- STP P-AFW-11 — Routine Surveillance Test of Turbine-Driven Auxiliary Feedwater Pump 1-1, Revision 4
- STP M-6A — Routine Surveillance Testing of Control Room Ventilation System, Revision 26
- STP M-83A — Penetration Overcurrent Protection, Revision 17
- STP M-77B — Augmented Test Program For MSSVs With X-750 Inconel Disc, Revision 0

b. Observations and Findings

During the performance of Surveillance Test Procedure (STP) P-AFW-11, the turbine governor oil level increased and the turbine speed decreased with operating time. There was little or no indication of cooling water flow to the governor. A small amount of leakage from the trip and throttle valve stem was noted. The test results satisfied the test acceptance criteria and the minor discrepancies were documented in an AR. Discussions with the system engineer revealed that a previous evaluation had determined that the governor cooling water flow was not required, and the increase in oil level and decrease in turbine speed are expected due to the governor temperature increasing.

During the performance of Procedure STP M-6A, each train of the control room ventilation system was placed in Mode 3 (Recirculation) and Mode 4 (Pressurization) and the related fans and dampers were verified to align properly. Both units' filter trains were operated continuously for a minimum of 10 hours with flow through the charcoal filters. The proper equipment alignment was verified and system indications compared to the test acceptance criteria. The test criteria were satisfied and the equipment operated properly.

During the performance of Procedure STP M-83A, the overcurrent protective devices for the pressurizer heater breakers in Unit 2 pressurizer heater distribution

Panel 21R were tested. The electricians were meticulous in performing the test and reviewed the data as the test progressed to ensure it was complete and satisfactory.

MSSVs

The licensee and the nuclear industry have had a long and difficult history with MSSV maintenance and testing. The problems have resulted in numerous occasions when the MSSVs have been found to lift at pressures outside the TS allowable limits, both during surveillance testing and during plant transients. The MSSVs provide overpressure protection for the secondary system and protect against overpressurizing the reactor coolant pressure boundary by providing a heat sink for the removal of energy if the preferred heat sink is not available. The tolerance on the MSSV setpoint ensures the secondary side will not be overpressurized if the MSSVs lift too high and ensures the steam generators will not be overfilled during a tube rupture if the MSSVs lift too low.

In November 1995, the licensee made a commitment to perform augmented testing of the MSSVs. This was due in part to the high initial lift point test results identified during surveillance testing. As MSSV test results had a direct relation to time in service, testing at a shorter frequency than was required by the American Society of Mechanical Engineers code was implemented to assure satisfactory performance.

The high initial lift point phenomenon was determined by the licensee to be caused, in part, by disc bonding resulting from disc galling during thermal transients of heatup/cooldown and subsequent time, pressure, and temperature service conditions. The galling was a result of differential thermal expansion between the 422SS disc and the 347SS nozzle.

The corrective action for the high initial lift pressures due to bonding was the changeout of the disc material. The selected material, Inconel X-750, resulted in much lower differential expansions between the disc and nozzle, minimizing galling. Additionally, the discs were preoxidized to provide a passive layer expected to reduce bonding that develops over time. It was anticipated that the resulting time dependency of bonding with the minimal galling would be beyond the length of a 24-month fuel cycle.

A test program was structured to meet the licensee's goals of: (1) assuring the MSSV setpoints remain within TS limits, (2) minimizing cycling of the MSSVs to reduce risk of damage or degradation, (3) demonstrating that Mode 1 testing may be eliminated, and (4) extending the test interval such that operability is maintained for a full cycle without midcycle testing. The initial augmented test plan, which is continuing on Unit 2, included testing in Mode 1 within 30 days of entering Mode 1 from Mode 4 to break the initial bond. The test results have shown that breaking the initial bond resulted in less sticking, evidenced by subsequent test results. One

steam lead was tested in each unit every 30 days after entering Mode 1. The time between test cycles was being extended by 30 days at each successful test interval to determine the time-dependency of the sticking phenomenon.

New Inconel X-750 discs were installed in the Unit 1 MSSVs during 1R8. The new augmented test program for Units 1 and 2, after replacing the discs in 2R8, was based on the expectation that Mode 1 testing following heatup from Mode 4 would be demonstrated to be unnecessary. Validation of this assumption was included in the test plan by comparing the test results of Steam Leads 1 and 2, which did not have Mode 1 testing performed, to the test results of Steam Leads 3 and 4, which did have Mode 1 testing performed in June.

The MSSVs on all four main steam leads of Unit 1 were tested during the performance of STP M-77B, as specified in the Appendix 7.1 for August 1997. The tests were performed in accordance with the procedural requirements. The MSSVs on Steam Leads 1 and 2 had not been stroked since entering Mode 1, approximately 90 days previously. The test results indicated that MSSVs with Inconel X-750 discs did not stick after 90 days of operation, and furthermore, the Mode 1 testing within 30 days of entering Mode 1 was not necessary.

c. Conclusions

The inspectors found that the surveillances observed were being scheduled and performed at the required frequency. The procedures governing the surveillance tests were technically adequate, and personnel performing the surveillance demonstrated an adequate level of knowledge. The inspectors noted that test results appeared to have been appropriately dispositioned.

The test results of the augmented test program for MSSVs with Inconel X-750 have indicated that Mode 1 testing after entering Mode 1 from Mode 4 may not be necessary with the new discs. The testing seems to indicate that the sticking problem has been eliminated. The test results appear to indicate that the licensee's goals for the testing are being met.

M8 Miscellaneous Maintenance Issues (92700)

M8.1 (Closed) Inspection Followup Item (IFI) 50-275;323/9710-04: use of unauthorized material, Dow Corning RTV-732 sealant, in containment. The licensee identified those work orders that specified the use of RTV sealant, and in each case the sealant was either replaced by an approved sealant, RTV-159 (such as in sealing the reactor coolant pump oil collection system), or evaluated as acceptable. The evaluation included considering the potential to plug the containment sump if the sealant becomes loose and the impact on the effected components of the failure of the sealant to seal. A review of the equipment environmental qualification program confirmed that RTV had not been used as an engineering barrier. The licensee also determined that RTV-159 is acceptable for use and will restrict the use of other

RTVs in containment. The inspector concluded that the licensee's corrective actions had been appropriate.

M8.2 (Closed) Licensee Event Report (LER) 50-323/96-006-00: TS 3.0.4 was not met when Unit 2 entered Mode 1 while in 48-hour action requirements. The events described in the LER were previously reviewed in NRC Inspection Report 50-523/96-16, and a noncited violation was issued for this matter.

III. Engineering

E6 Engineering Organization and Administration

E6.1 Workload Management

a. Inspection Scope (37551)

Using Inspection Procedure 37551, the inspectors reviewed status reports depicting Nuclear Technical Services' (NTS) backlogs of engineering assignments, a list of modifications completed during the 1R8 refueling outage, the NTS Workload Management Manual, and the NTS Workload Management Team Report (completed in March 1997).

b. Observations and Findings

The licensee implemented 67 design changes during the 1R8 outage, which began on April 19, 1997, and was completed on June 2, 1997. All but 13 of the design changes had been issued in 1996, or earlier. The Engineering Services Quality Plan Report Card (June 1997) stated that all 62 preoutage-identified design changes were issued by the required dates.

As of August 8, 1997, only eight completed modifications were awaiting engineering closeout, indicating that engineering was prompt in closing completed modifications.

The licensee was not tracking the numbers of modification awaiting engineering design work that had been approved to be designed. However, approximately 55 incomplete design changes were pending approval or had been approved to begin design work. These numbers were typical of the industry.

Approximately 2170 drawing changes were in the revision process, with approximately 540 considered by the licensee as overdue. Approximately 100 Priority 1 drawings were considered overdue (more than the 30 days allotted for the revision process). The large backlog was due in part to a large inflow of drawing changes during and after the 1R8 outage.

The licensee trended the NTS, ARs, and AE workload. As of August 5, 1997, 4800 open AR and AE items were assigned to NTS. This was approximately the same number that had been open on August 1, 1996. Since then, however, the licensee had identified some categories of assignments that had been omitted from the count and had included them in the recent statistics. The licensee had also periodically reviewed the items and deleted or reassigned to other organizations large numbers of items, thus reducing the number of open engineering assignments.

In early 1997, the licensee established the NTS Workload Management Team to review the work processes and recommend improvements in the management of the workload. The Team's report identified 10 substantial recommendations, including establishing a better screening process to allow rejection of low priority or unnecessary work items, fostering a culture in which the due dates were more meaningful and personnel were more accountable, and developing a plan for reducing the existing backlog. The recommendations were projected to take over a year to implement. However, the NTS Workload Management Manual, which resulted from the recommendations, was issued on June 10, 1997, and provided guidance for work prioritization and described the responsibilities and expectations for engineers and their supervisors. The Team report was a good self-assessment of the organizational problems contributing to the backlog, and the manual was a good corrective action.

c. Conclusions

The NTS workload backlogs for ARs, AEs, and drawing requests were very large and had not been effectively managed. The licensee's assessment of the process was thorough and provided excellent long-term and short-term recommendations for improving the process and permanently reducing the backlogs. The NTS Workload Management Manual, resulting from the recommendations, provided necessary guidance for workload prioritization and personnel responsibility and accountability for the process.

IV. Plant Support

R3 Radiation Protection and Chemistry Procedures and Documentation

R3.1 Sampling and Chemistry (71750)

The inspector reviewed primary and secondary chemistry results for August 5, for compliance with TS and administrative limits. The required analyses were performed, including the Dose Equivalent I-131 analysis required for the thermal power change that occurred on that date. The results were within specified limits and no adverse trends were identified. Chemical sampling and analysis was performed as required.

R4 Staff Knowledge and Performance in RP&C

R4.1 Post Accident Sampling Procedures

a. Inspection Scope (71750)

On August 27, the inspector observed the calibration of the PASS gas chromatograph and the PASS containment air sample for Unit 2. The following procedures were also reviewed:

- CAP G-3, Revision 9, "Troubleshooting, Surveillance, and Maintenance for Sentry PASS"
- CAP P-1, Revision 4, "PASS Initial Actions"
- CAP P-3, Revision 1, "Sentry PASS Containment Air Sampling and Analysis"
- CAP P-4, Revision 1, "PASS Gas Chromatograph Calibrations"

b. Observations and Findings

The chemistry technician was knowledgeable of the sampling procedure and the PASS equipment configuration and operation. The chemistry technician used the current revisions of the procedures. The gas chromatograph was calibrated prior to use. The calibration was successfully performed and the analysis results were acceptable.

c. Conclusions

The calibration of the PASS gas chromatograph and the PASS containment air sample for Unit 2 was performed satisfactorily. The chemistry technician was knowledgeable of the sampling procedure, equipment use, and calibration requirements.

V. Management Meetings

X1 Exit Meeting Summary

The inspector presented the inspection results to members of licensee management at the conclusion of the inspection on September 5, 1997. In the meeting the licensee acknowledged the findings presented.

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

ATTACHMENT

PARTIAL LIST OF PERSONS CONTACTED

Licensee

C. C. Belmont, Director, Nuclear Quality Services, Operations and Strategic Programs
R. Cheney, Engineer, Nuclear Quality Services
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INSPECTION PROCEDURES USED

IP 37551: Onsite Engineering

IP 61726: Surveillance Observations

IP 62707: Maintenance Observations

IP 71707: Plant Operations

IP 71750: Plant Support

IP 92700: Onsite Followup of Written Reports of Nonroutine Events at Power Reactor Facilities

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

50-275;323/97012-01	URI	Failure to review previous BOL equipment failure for MPFF is an unresolved item pending NRC review

Closed

50-275;323/97010-04	IFI	Uncontrolled use of Dow Corning RTV-732 sealant in containment
50-323/96-006-00	LER	TS 3.0.4 not met when Unit 2 entered Mode 1 while in 48 hour action statements

LIST OF ACRONYMS USED

AE	action evaluation
AR	action request
BOL	battery operated light
DCPP	Diablo Canyon Power Plant
IFI	inspection followup item
LER	Licensee Event Report
MPFF	maintenance preventable functional failure
MSSV	main steam safety valve
NTS	Nuclear Technical Services
PASS	post accident sampling system
STP	surveillance test procedure
TS	Technical Specification
UFSAR	Updated Final Safety Analysis Report
URI	unresolved item
1R8	Unit 1 eighth refueling
2R8	Unit 2 eighth refueling