

U. S. NUCLEAR REGULATORY COMMISSION

REGION V

Report Nos: 50-528/87-39, 50-529/87-38, 50-530/87-40

Docket Nos: 50-528, 50-529, 50-530

License Nos: NPF-41, NPF-51, NPF-74

Licensee: Arizona Nuclear Power Project
P. O. Box 52034
Phoenix, AZ. 85072-2034

Facility Name: Palo Verde Nuclear Generating Station Units 1, 2 & 3.

Inspection Conducted: November 01, 1987 through December 05, 1987.

Inspectors:	<u>A. D. Toth for</u>	<u>12-18-87</u>
	J. Ball, Resident Inspector	Date Signed
	<u>A. D. Toth for</u>	<u>12-18-87</u>
	G. Fiorelli, Resident Inspector	Date Signed
	<u>A. D. Toth for</u>	<u>12-18-87</u>
	K. Ivey, Resident Inspector	Date Signed
	<u>A. D. Toth for</u>	<u>12-18-87</u>
	C. Sorensen, Project Inspector	Date Signed
Approved By:	<u>S. Richards</u>	<u>12-21-87</u>
	S. Richards, Chief, Engineering Section	Date Signed

Summary:

Inspection on November 01, 1987 through December 05, 1987 (Report Nos. 50-528/87-39, 50-529/87-38, and 50-530/87-40).

Areas Inspected: Routine, onsite, regular and backshift inspection by the three resident inspectors and one region based inspector. Areas inspected included: followup of previously identified items; review of plant activities; plant tours; engineered safety feature system walkdowns; surveillance testing; plant maintenance; startup testing; allegations; and review of periodic and special reports.

During this inspection the following Inspection Procedures were covered: 36301, 36301-1, 37700, 37700-1, 37700-2, 60710, 61701, 61726, 62700-1, 62703, 71707, 71707-1, 71710, 72302, 72308, 72583, 92701, 92702.

Results: Of the 12 areas inspected, no violations were identified.

DETAILS

1. Persons Contacted:

The below listed technical and supervisory personnel were among those contacted:

Arizona Nuclear Power Project (ANPP)

J. Allen,	Plant Manager, Unit 1
L. Brown,	Manager, Radiation Protection and Chemistry
F. Buckingham,	Operations Manager, Unit 2
R. Butler,	Director, Standards and Technical Support
B. Cederquist,	Manager, Chemical Services
W. Fernow,	Manager, Training
R. Gouge,	Operations Manager, Unit 3
*J. G. Haynes,	Vice President, Nuclear Production
W. E. Ide,	Plant Manager, Unit 2
J. Kirby,	Director, Site Services
R. Papworth,	Director, Quality Assurance
G. Perkins,	Manager, Central Radiation Protection
G. Sowers,	Manager, Engineering Evaluations
E. E. Van Brunt, Jr.,	Executive Vice President
J. Vorees,	Manager, Nuclear Safety
R. Younger,	Operations Manager, Unit 1
O. Zeringue,	Plant Manager, Unit 3

The inspectors also talked with other licensee and contractor personnel during the course of the inspection.

*Attended the Exit Meeting on December 10, 1987.

2. Previously Identified Items.

Unit 1

(Closed) Violation 50-528/87-01-03 Failure to Post All Accesses to a Radiation Area

The licensee failed to post the required warning sign on a door which allowed entry into a radiation area and at the 100' elevation of the Turbine Building. It was subsequently posted with the required sign and documented on the applicable survey record. The root cause was determined to be personnel oversight of the door as an entrance to the Turbine Building during the initial posting. Radiation Protection Technicians were instructed by memo to ensure required radiation area postings are properly completed.

This item is closed.

(Closed) Followup Item 50-528/87-10-02 - Followup Training Records and Generic Issues Concerning Bypassing MSIS

This item was originated when a Unit 1 Shift Supervisor authorized intentionally defeating an engineered safety feature and voluntarily entering Limiting Condition for Operation (LCO) 3.0.3 during a plant cooldown. Region V sent the licensee a Confirmatory Action Letter (CAL) dated March 6, 1987, confirming the licensee's commitments to:

- Revise administrative procedures to preclude intentionally entering LCO 3.0.3 except under emergency conditions.
- Ensure all operations personnel understand the revision.
- Ensure that all plant personnel understand the above policy.

In a subsequent letter dated March 13, 1987, Region V asked the licensee to address additional questions including:

- Should preshift briefings be held when conducting complex evolution?
- Do operations personnel understand that, when unclear situations arise, they should stop, if possible, and contact management?
- What plant design aspects conflict with the Technical Specifications?

The inspector reviewed the revision to procedure 40AC-9ZZ02, Conduct of Shift Operations prohibiting intentionally entering LCO 3.0.3.

The inspector also reviewed a memorandum from the Operations Supervisor to the individual Unit Superintendents instructing Shift Supervisors they are prohibited from intentionally disabling safety systems, except under certain specific circumstances. The licensee is currently in the process of ensuring that all ANPP personnel have been instructed concerning verbatim compliance to procedures and consulting management when unclear situations arise.

The inspector also reviewed evidence of licensee action to address the other issues stated above, and therefore this item is considered closed.

(Closed) Violation 50-528/87-10-03 Failure to Identify and Segregate Nonconforming Measurement and Test Equipment (M&TE)

This violation was initiated when the inspector found the calibration past due on a rotometer that was part of a grab sample cart. The licensee subsequently removed the overdue rotometer and replaced it with a calibrated rotometer. Also, the licensee took action to enable radiation protection technicians to more closely monitor and control the calibration of their equipment.

Since the limited accuracy of rotometers does not qualify them as M&TE, rotometers that are used as part of radiation protection equipment have been removed from the M&TE calibration lists and future calibrations will be performed by radiation protection under the Radiation Protection Calibration Program.

This item is closed.

(Closed) Unresolved Item 50-528/87-10-04 - Transient Loading Considerations for Cable Raceway

This item was initiated when the inspector noticed two boards lying on some cable raceway and tied to some nearby scaffolding. The boards were to be used by maintenance personnel to stand on and access a damper located over the cable tray. The inspector had expressed a concern over the additional loading on the raceway supports after noting that a safety analysis accounting for this type of transient loading had not been performed.

The licensee had committed to completing a bounding calculation for the loading effect on the worst case cable support, and also to evaluate the need for bounding calculations for other transient loading situations.

The licensee completed a bounding calculation for transient loads on cable trays and supports dated April 24, 1987. The inspector reviewed the calculation and concluded that it had demonstrated the adequacy of the trays and supports for access by personnel. In addition, the licensee had determined that a transient load analysis was also needed for HVAC ducts and supports. The calculation was performed and while it showed the supports and stiffeners to be adequate, it showed the walls of the larger ducts themselves to be inadequate for transient loads. This information was forwarded to the maintenance department for use in planning work activities.

This item is closed.

(Closed) Violation 50-528/87-17-02 - Inadequate Corrective Action for Gravity Drain Through Containment Spray to Containment

This violation resulted from an event that occurred in Unit 1 that was identical to an event that occurred in Unit 2 approximately three weeks before. This occurred when ASME Section XI stroke time testing was conducted on a containment spray header discharge valve. The associated upstream isolation valves were not shut and 270 gallons of water drained from the RWT to the containment building. In the case of Unit 1, about 100 gallons drained to containment.

The licensee determined the root cause to be a personnel error by a licensed operator who did not follow a caution statement contained in a surveillance test procedure. Further, the caution statement included an action statement; the procedure writers guide prohibits such inclusions.

The licensee committed to the following corrective action:

1. A procedure change which changes the closure of the associated spray line valves from a caution statement to a required action statement. This action was completed for all three units.
2. These events were issued to the operations staff as Operations Department Experience Reports which were reviewed by the operations staff.
3. The ASME Section XI surveillance test procedures were reviewed to incorporate human factors changes which could prevent this type of incident.
4. The program for performing Special Reports and Investigations was revised. This revision included a mechanism for expeditiously disseminating information from a Special Report or Investigation prior to final approval if it is determined that a similar event has a high probability of recurring in a short time.

The inspector reviewed documentary evidence of the completion of these four corrective actions and was satisfied with the actions taken. This item is closed.

(Closed) Unresolved Item 50-528/87-17-03 - 9000 Gallon Spill
Through Containment Spray Vent Valves

This item was originated when approximately 9000 gallons of contaminated water was spilled from the Refueling Water Tank (RWT) to the Auxiliary Building through the Containment Spray System. The water was lost through two open vent valves during system venting and filling, after the system had undergone a maintenance outage. A valve lineup had been accomplished after system restoration prior to system filling and venting, however, these two valves were excluded. The reason given by the licensee for the exclusion of these two valves was that they had been replaced during the system outage and had been neglected to be included in the valve lineup.

As corrective action the Station Tagging and Clearance procedure, 40AC-9ZZ15, was revised to require system restoration not only on the equipment actually tagged by the clearance, but also any components that may have been worked within the boundary of the clearance. It went so far as to suggest performing a complete lineup within the clearance boundary, if any doubt exists as to the status of the components.

Shift Supervisors were then directed to familiarize themselves and their crew with this procedure change.

This item is closed.

3. Review of Plant Activities.

a. Unit 1

Unit 1 continued the first cycle refueling outage throughout this inspection period. The fuel shuffle was completed on November 8, and Mode 5 was entered on December 2. The licensee continued to work on replacement of reactor coolant pump (RCP) shafts, journal bearings, and seal assemblies throughout the period. Major activities completed were the five year inspections on both trains of emergency diesel generators, steam generator eddy current testing and tube plugging, and local leak rate testing on the shutdown cooling system penetration valves. The major activities that remained to be completed were the train "A" integrated safeguards test and reassembly and testing of the four RCPs.

b. Unit 2

Unit 2 has operated at 100% until November 21 when the plant was shutdown under controlled conditions in order to repair two reactor coolant pump speed sensors. The plant was restarted on November 22 but tripped from 7% power on the same day from a combination of a bad matrix relay in one channel and a high axial shape index condition in a second channel in the plant protection system. The plant was restarted on November 23 and operated 100% for the remainder of the period.

c. Unit 3

Having completed low power physics testing, Unit 3 was shutdown on November 1 in order to perform routine maintenance while awaiting Commission action on issuance of a full power license. On November 23 the plant was restarted. A full power license was issued on November 25 and the licensee commenced increasing power to above 5% power entering Mode 1 for the first time on November 26. By the end of this inspection period, the licensee had completed testing through the 20% power plateau. On December 5, the licensee successfully conducted a test shutting down the reactor from outside the control room and thus was in Mode 3 at the end of the period.

d. Plant Tours

The following plant areas at Units 1, 2 and 3 were toured by the inspector during the course of the inspection:

- o Auxiliary Building
- o Containment Building
- o Control Complex Building
- o Diesel Generator Building
- o Radwaste Building
- o Technical Support Center

- o Turbine Building
- o Yard Area and Perimeter

The following areas were observed during the tours:

1. Operating Logs and Records Records were reviewed against Technical Specification and administrative control procedure requirements.
2. Monitoring Instrumentation Process instruments were observed for correlation between channels and for conformance with Technical Specification requirements.
3. Shift Manning Control room and shift manning were observed for conformance with 10 CFR 50.54.(k), Technical Specifications, and administrative procedures.
4. Equipment Lineups Valve and electrical breakers were verified to be in the position or condition required by Technical Specifications and Administrative procedures for the applicable plant mode. This verification included routine control board indication reviews and conduct of partial system lineups.
5. Equipment Tagging Selected equipment, for which tagging requests had been initiated, was observed to verify that tags were in place and the equipment in the condition specified.
6. General Plant Equipment Conditions Plant equipment was observed for indications of system leakage, improper lubrication, or other conditions that would prevent the systems from fulfilling their functional requirements.
7. Fire Protection Fire fighting equipment and controls were observed for conformance with Technical Specifications and administrative procedures.
8. Plant Chemistry Chemical analysis results were reviewed for conformance with Technical Specifications and administrative control procedures.
9. Security Activities observed for conformance with regulatory requirements, implementation of the site security plan, and administrative procedures included vehicle and personnel access, and protected and vital area integrity.
10. Plant Housekeeping Plant conditions and material/-equipment storage were observed to determine the general state of cleanliness and housekeeping. Housekeeping in the radiologically controlled area was evaluated with respect to controlling the spread of surface and airborne contamination.

11. Radiation Protection Controls Areas observed included control point operation, records of licensee's surveys within the radiological controlled areas posting of radiation and high radiation areas, compliance with Radiation Exposure Permits, personnel monitoring devices being properly worn, and personnel frisking practices.

No violations of NRC requirements or deviations were identified.

4. Engineered Safety Feature System Walkdowns - Units 1, 2 and 3.

Selected engineered safety feature systems (and systems important to safety) were walked down by the inspector to confirm that the systems were aligned in accordance with plant procedures. During the walkdown of the systems, items such as hangers, supports, electrical cabinets, and cables were inspected to determine that they were operable, and in a condition to perform their required functions.

Unit 1

Accessible portions of the following systems were walked down on the indicated date.

<u>System</u>	<u>Date</u>
Low Pressure Safety Injection Aligned for Shutdown Cooling System, Train "B"	November 13
High Pressure Safety Injection Aligned for Boron Injection, Train "B"	November 17
Emergency Diesel Generator System, Train "B"	November 22
Emergency Diesel Generator System, Train "A"	December 2

Unit 2

Accessible portions of the following ESF systems were walked down on the indicated dates.

<u>System</u>	<u>Date</u>
Class 1E Battery Supply, Channels "B" and "D"	November 13
Safety Injection Tanks	November 14
Emergency Diesel Generator System, Train "A"	November 17
Auxiliary Feedwater System, Train "A"	November 25

Unit 3

Accessible portions of the following systems were walked down on the indicated dates.

Emergency Diesel Generator, November 18
Train "B"

<u>System</u>	<u>Date</u>
Diesel Generator System, Train "A"	November 14
High Pressure Safety Injection System, Trains "A" and "B"	November 28
Low Pressure Safety Injection, Trains "A" and "B"	November 28
Auxiliary Feedwater System, Trains "A" and "B"	December 4

No violations of NRC requirements or deviations were identified.

5. Surveillance Testing - Units 1, 2 and 3.

- a. Surveillance tests required to be performed by the Technical Specifications (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 performance of the surveillance tests; 3) the surveillance tests had been performed at the frequency specified in the TS; and 4) test results satisfied acceptance criteria or were properly dispositioned.
- b. Portions of the following surveillances were observed by the inspector on the dates shown:

Unit 1

<u>Procedure</u>	<u>Description</u>	<u>Dates Performed</u>
73ST-9DG05	Diesel Engine Five Year Inspection, Train "A"	November 17, and 22

Unit 2

<u>Procedure</u>	<u>Description</u>	<u>Dates Performed</u>
36ST-9SB02	Plant Protection System Bistable Trip Units Functional Test.	November 17, 18, and 25

42ST-2ZZ23

Control Element Assembly
Position Log.

November 18

No violations of NRC requirements or deviations were identified.

6. Plant Maintenance - Units 1, 2 and 3.

- a. During the inspection period, the inspector observed and reviewed documentation associated with maintenance and problem investigation activities to verify compliance with regulatory requirements, compliance with administrative and maintenance procedures, required QA/QC involvement, proper use of safety tags, proper equipment alignment and use of jumpers, personnel qualifications, and proper retesting. The inspector verified reportability for these activities was correct.
- b. The inspector witnessed portions of the following maintenance activities:

Unit 1

Description

Dates Performed

- o Various Corrective Maintenance on Diesel Generator, Train "A"

November 17

Unit 2

Description

Dates Performed

- o Correct Cable Bending Problem on Control Room Recorders.
- o Installation of the Breathing Air Hold Tank.
- o Troubleshooting RU-141 Operability.

November 16

November 24

November 25

Unit 3

Description

Dates Performed

- o Troubleshooting Main Steam Isolation System Logic Cabinet

November 9, 10

No violations of NRC requirements or deviations were identified.

7. Main Steam Isolation Valve (MSIV) - Unit 3

A troubleshooting effort to determine the cause for the spurious opening of MSIV 170 following reenergization of its control circuit confirmed the problem to be related to a bad logic card. The valve malfunction could be repeated several times with the card installed

as well as during bench tests. Replacement of the card corrected the problem. The card along with a second card which had produced similar anomolus operation of the valve were returned to the vendor for evaluation. A main steam valve isolation signal would not have allowed the valve to open, or would have closed the valve had it opened due to the failed card.

No violations of NRC requirements or deviations were identified.

8. Seismic Event - Units 1, 2 and 3

At 6:18 AM, on November 24, 1987, floor motion was experienced in the control rooms of all three units and throughout the plant area. At the time of the disturbance Unit 1 was in mode 6, Unit 2 in mode 1 and Unit 3 in mode 2. An analysis of the seismic event to determine its intensity was undertaken. At the time of the event the seismic monitoring system was out of service, due to a malfunction in the playback unit. Troubleshooting was in progress. The monitoring portion of the system however, was capable of sensing an alarm condition. There are three monitors which produce direct alarming of the monitor. They are located (1) on the 55' level of the tendon gallery - setpoint: 0.01g, (2) on the 140' level of containment - setpoint: 0.02g and (3) on the tendon gallery floor - setpoint: 0.01g. No alarms were received in the Unit 1 control room.

Observations noted throughout the plant area included:

- o The unit 1 RV head was in the process of being set on the vessel. The System Engineer noted that the head, suspended from the polar crane, appeared to "jerk slightly up and down." Additionally, motion was felt by an individual on the "D-Ring". Water movement in the upper guide structure pit was also seen.
- o An individual reported floor motion on the second floor of the Annex Building. No objects were observed to fall on the floor.
- o In Unit 3 water movement was noted in the spent fuel pool and the fuel building door swung on its hinges, approximately 1-2".

Based on these observations the event was classified, per procedure 9IS-9SM01 "Analysis of Seismic Events", as an intensity level V seismic event corresponding to a ground acceleration of 0.015 to 0.033g. Since the seismic triggers did not activate, the ground acceleration would be expected to be 0.01 to 0.02g. This was considered consistent with the range of the Level V event.

The Evaluations Engineering group was contacted to implement the inspections in procedure 73TP-9SM01, "Control Building Wall Seismic Limits." No problems were noted.

The PVNGS action level for declaring a Notification of Unusual Event (NUE), is a ground acceleration 0.1g. As a result the occurrence was not classified as a NUE.

During the review of the analysis results, the following considerations were made by the licensee. The seismic triggers noted above did not alarm during the course of the event. As a result the digital tape system was not activated. The setpoints for the seismic triggers were verified to be correct by Instrumentation and Control. Additionally, though the playback unit was in the process of being repaired, it was verified that the unit would have alarmed for a seismic event of 0.01g's in magnitude.

The event was conservatively classified as being 0.02g's (Technical Specification reportability intensity) and that no further analysis would be required.

No violations of NRC requirements or deviations were identified.

9. Startup Testing - Unit 3

The inspector witnessed portions of the following tests:

<u>Procedure</u>	<u>Description</u>	<u>Dates Performed</u>
73TI-3MB01	Initial Generator Excitation	November 28
73PA-3FW03	FWCS Valve Transfer from Downcomer to Economizer	December 1
72PA-3RX09	Linear Power Subchannel Calibration	December 2, 3
73PA-3SF02	Shutdown from Outside Control Room	December 5

The inspector verified that approved procedures were used, test personnel were knowledgeable of the test requirements, and data was properly collected. Procedure changes and test exceptions were identified and significant events were recorded in the test log. Other test related activities such as the use of calibrated measuring and test equipment and completion of test prerequisites were also verified to have been accomplished in accordance with administrative control procedures. Successful completion of 73PA-3SF02, "Shutdown from Outside Control Room" closes Followup Item 50-530/87-09-01.

No violations of NRC requirements or deviations were identified.

10. Containment Local Leak Rate Testing Unit 1

The inspector reviewed procedure 73ST-9CL01 "Containment Leakage Type "B" and "C" Testing" for the observation of local leak rate testing (LLRT) on penetration #26 (shutdown cooling loop 2). The inspector noted that the procedure included:

- o notification of the Shift Supervisor prior to the start of any work,
- o requirements for the number of test personnel and their qualifications,

- o verification of test equipment calibration and the current revision of the procedure,
- o detailed test instructions and system valve lineups,
- o acceptance criteria for completion of the test, and
- o contingencies to be taken in the event of an unsuccessful test.

The inspector observed the performance of the LLRTs for containment isolation valves SI-UV-656 and SI-HV-690 associated with shutdown cooling loop #2. The inspector verified that procedural controls were followed including venting and draining of the system, test equipment setup, pressurization of the penetration, and satisfactory completion of the tests.

No violations of NRC requirements or deviations were identified.

11. Allegation Followup

Allegation RV-87-A-54

Characterization

A caller to the resident inspector's office stated that many fire penetrations in the Auxiliary Building and Control Building of all three units were either open or had holes in the seals.

Implied Significance to Design, Construction or Operation

Inadequate fire penetration seals would increase the possibility of a single fire spreading to more than one fire area without being detected or extinguished. This could result in the failure, due to fire, of redundant trains of safety-related systems.

Assessment of Safety Significance

The inspector reviewed the licensee's fire protection program to determine the method used to track and compensate for inadequate fire protection seals. Procedure 14AC-OZZ01 "Fire System Impairment" requires that an inoperable penetration seal be compensated for in one hour by a continuous fire watch or an hourly fire watch patrol and verification of the fire detection system on one side of the inoperable seal.

The licensee's fire protection (FP) group maintains a list of open penetration seals to ensure that compensatory measures are completed, when required. The input for the list comes from Fire Barrier Seal Removal Requests (FBSRR) submitted by maintenance planning personnel when a work order is issued which would include making a penetration seal inoperable. A

copy of the FBSRR is taken to the FP group for input to the list and the initiation of compensatory measures, if required.

The inspector verified that the FP group was maintaining a FBSRR list for each of the three units. The inspector also obtained a sample of penetration seals that were included on open and recently completed work orders for all three units and compared it to the FBSRR list. From a sample of 23 penetrations, the inspector identified 2 that were not included on the FBSRR list. One of these required no compensatory actions as it was not in a required fire wall. The inoperability of the other seal (#22, 30A-ZYD-442, W.O. #176408), however, required compensatory measures. The inspector noted that there were no FBSRRs included with the work package and no work order step requiring the completion of FBSRRs even though two fire penetration seals and several fire breaks were removed.

The inspector discussed the discrepancies with the fire protection supervisor who stated that this problem has occurred before and was due to the fact that FP personnel only receive the FBSRRs given to them by maintenance personnel and that they do not review all work orders. However, he also stated that revisions to the fire protection procedures were in progress to require that FP personnel review each work order for its impact on the fire protection program. The inspector also noted that due to problems with fire doors and the large number of inadequate penetration seals, the licensee has maintained hourly fire watch patrols in the auxiliary, control, diesel generator, fuel, and radwaste buildings for more than three years.

Staff Position

Inadequate fire penetration seals exist in all three units and the licensee's system for tracking them at the time of the inspection did not provide confidence that FP personnel were aware of all of them. However, hourly fire watch patrols have been in place in all three units for more than three years. An hourly fire watch is consistent with the compensatory requirements of the fire protection procedure. The licensee was also in the process of revising procedures to ensure that FP personnel review work orders for their impact on penetration seals and other fire protection concerns.

Action Required

This allegation is considered closed, however, followup inspection is required to verify completion of the procedure changes to include fire protection review of all maintenance work orders (50-528/87-39-01).

No violations of NRC requirements or deviations were identified.



12. Licensee Event Report (LER) Followup - Units 1, 2 and 3.

The following LERs associated with operating events were reviewed by the inspector. Based on the information provided in the report it was concluded that reporting requirements had been met, root causes had been identified, and corrective actions were appropriate. The below listed LERs are considered closed.

LER NUMBER DESCRIPTION

Unit 1

87-12 Late Surveillance Tests Due to Personnel Errors
87-23 Channel Check Not Performed Due to Personnel Error

Unit 2

87-18 CREFAS Actuation Caused By a Spurious Signal From a
Radiation Monitor
87-20 CREFAS Actuation Caused By a Spurious Signal From a
Radiation Monitor

No violations of NRC requirements or deviations were identified.

13. Review of Periodic and Special Reports - Units 1, 2 and 3.

Periodic and special reports submitted by the licensee pursuant to Technical Specifications 6.9.1 and 6.9.2 were reviewed by the inspector.

This review included the following considerations: the report contained the information required to be reported by NRC requirements; test results and/or supporting information were consistent with design predictions and performance specifications; and the validity of the reported information. Within the scope of the above, the following reports were reviewed by the inspector.

Unit 1

o Monthly Operating Report for September and October, 1987.

Unit 2

o Monthly Operating Report for September and October, 1987.

Unit 3

o Monthly Operating Report for September and October, 1987.

No violations of NRC requirements or deviations were identified.

14. Exit Meeting

The inspector met with licensee management representatives periodically during the inspection and held an exit on December 10, 1987.

