



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

Report Nos.: 50-250/87-22 and 50-251/87-22

Licensee: Florida Power and Light Company
 9250 West Flagler Street
 Miami, FL 33102

Docket Nos.: 50-250 and 50-251

License Nos.: DPR-31 and DPR-41

Facility Name: Turkey Point 3 and 4

Inspection Conducted: April 27 - May 18, 1987

Inspectors: <u><i>D.R. Brewer</i></u> D. R. Brewer, Senior Resident Inspector	<u>6/10/87</u> Date Signed
<u><i>K.W. Van Dyne</i></u> K. W. Van Dyne, Resident Inspector	<u>6/10/87</u> Date Signed
<u><i>J.B. Macdonald</i></u> J. B. Macdonald, Resident Inspector	<u>6/10/87</u> Date Signed
Approved by: <u><i>Bruce A. Wilson</i></u> Bruce Wilson, Section Chief Division of Reactor Projects	<u>6/11/87</u> Date Signed

SUMMARY

Scope: This routine, unannounced inspection entailed direct inspection at the site, including backshift inspection, in the areas of annual and monthly surveillance, maintenance observations and reviews, operational safety, and plant events.

Results: One violation - Failure to meet the requirements of TS 6.8.1 (paragraph 10).

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REPORT DETAILS

1. Persons Contacted

Licensee Employees

- *J. W. Dickey, Vice President, Nuclear Operations
- *C. M. Wethy, Vice President - Turkey Point
- *C. J. Baker, Plant Manager-Nuclear - Turkey Point
- *F. H. Southworth, Maintenance Superintendent - Nuclear
 - D. A. Chaney, Site Engineering Manager (SEM)
- *D. D. Grandage, Operations Superintendent and Acting Plant Manager
 - R. G. Mende, Operations Supervisor
 - J. Webb, Operations - Maintenance Coordinator
 - J. W. Kappes, Performance Enhancement Coordinator
 - R. A. Longtemps, Mechanical Maintenance Department Supervisor
 - D. Tomaszewski, Instrument and Control (IC) Department Supervisor
 - J. C. Strong, Electrical Department Supervisor
- *W. Bladow, Quality Assurance (QA) Superintendent
 - R. E. Lee, Quality Control Inspector
- *M. J. Crisler, Quality Control (QC) Supervisor
- *J. A. Labarraque, Technical Department Supervisor
 - V. Kaminskis, Reactor Engineering Supervisor
- *J. Arias, Regulation and Compliance Supervisor
- *R. Hart, Regulation and Compliance Engineer
 - T. A. Finn, Training Supervisor.
 - P. W. Hughes, Health Physics Supervisor
 - G. Solomon, Regulation and Compliance Engineer
- *J. Donis, Engineering Department Supervisor
- *W. C. Miller, Senior Technical Advisor

Other licensee employees contacted included construction craftsmen, engineers, technicians, operators, mechanics, and electricians.

*Attended exit interview on May 18, 1987.

2. Exit Interview

The inspection scope and findings were summarized during management interviews held throughout the reporting period with the Plant Manager-Nuclear and selected members of his staff. An exit meeting was conducted on May 18, 1987. The areas requiring management attention were reviewed. The licensee acknowledged the findings without exception.

One violation was identified:

Failure to meet the requirements of Technical Specification (TS) 6.8.1, in that the in-plant equipment clearance order procedure was not properly implemented (paragraph 10, 250,251/87-22-01).

The licensee did not identify as proprietary any of the materials provided to or reviewed by the inspector during this inspection.

3. Followup on Items of Noncompliance (92702)

A review was conducted of the following noncompliances to assure that corrective actions were adequately implemented and resulted in conformance with regulatory requirements. Verification of corrective action was achieved through record reviews, observation and discussions with licensee personnel. Licensee correspondence was evaluated to ensure that the responses were timely and that corrective actions were implemented within the time periods specified in the reply.

(Closed) Violation 250/86-30-01, Failure to Meet the TS 6.8.1 in that OP 14004.1, Steam Generator Protection Channels - Periodic Test, was Improperly Implemented. This violation identified the use of a power supply other than that procedurally prescribed for in testing steam generator protection channels. This alternate method of obtaining accurate bistable trip points was reviewed and found to be acceptable and the test procedure was subsequently revised. Additionally, the requirement to adhere strictly to procedures was re-emphasized in shop meetings.

(Closed) Violation 250/86-25-05, Failure of Maintenance Personnel to Properly Implement AP-0190.19, Control of Maintenance on Safety Related and Quality Related Systems. This violation identifies two examples where instructions for priority class "AA" plant work orders (PWO) were not properly implemented. In May, 1986, the licensee provided additional instructions to Instrumentation and Control Field Supervisors in regard to the use of "AA" PWOs. These instructions require more formal troubleshooting methods per O-GMI-102.1, Troubleshooting and Repair Guidelines. Additionally, instructions to operations personnel noted that because "AA" priority bypasses the normal documentation review process, this priority should only be given to emergency PWOs.

(Closed) Violation 251/84-35-03, Failure to Implement Written Procedures During Repair of the 4B RHR Pump. Procedure MP 3207.2, RHR Pump Disassembly, Repair, Seal Replacement and Assembly, was revised to reference MP 0707.33, Snubber Removal and Replacement, to ensure safety related snubbers are removed properly. Maintenance foremen and supervisors were counseled on the requirements of AP 0190.10.

4. Followup on Unresolved Items (URIs), Inspector Followup Items (IFIs), Enforcement and Information Notices (IENs), IE Bulletins (IEBs) (information only), NRC Requests (92701)

A review was conducted of the following items to assure that adequate applicability reviews were performed, appropriate distribution was made, and if required, adequate and timely corrective actions were taken or planned.

(Closed) IFI 251/80-06-02, Small Break LOCA Training Discrepancies. This item was adequately addressed in Inspection Report 50-250/80-33, 50-251/80-32 and is considered closed.

(Closed) IFI 250,251/86-30-02, Inspect the Interim Control of Measuring and Test Equipment (M&TE) Restricted Use Labels and the Procurement of New Decade Boxes. This item identified a concern that information on M&TE stickers may not provide adequate guidance regarding calibration tolerances. The licensee removed the restricted use stickers and has clarified and reduced the calibration tolerance on the decade boxes to more appropriate values.

(Closed) URI 250,251/87-06-03, Review of Licensee Evaluation of As Found Condition and Operability of Unit 3 and 4 ICW Check Valves. FPL Letter L-87-216 dated May 15, 1987, documents that a safety evaluation was performed to evaluate the past deficiencies identified in the ICW check valves to determine if an unreviewed safety question existed for the original valves. The acceptability of the replacement valves was also verified with respect to these identified deficiencies. For each deficiency the failure mechanism, failure mode, and failure mode effects were established. The safety evaluation concludes that no unreviewed safety question existed for the original valves or exists for the replacement valves. This item is closed.

(Open) IFI 250,251/85-37-03, Evaluate Control Room Noise Level Increase Due to Ceiling Insulation Removal. The licensee has committed to resolve this issue by December 31, 1987.

5. Unresolved Items

No unresolved items were identified during this inspection period.

6. Onsite Followup and In-Office Review of Written Reports Of Nonroutine Events (92700)

The Licensee Event Reports (LERs) discussed below were reviewed. On the LERs that were closed, the Inspectors verified that reporting requirements had been met, root cause analysis was performed, corrective actions appeared appropriate, and generic applicability had been considered. Additionally, the Inspectors verified that the licensee had reviewed the event, corrective actions were implemented, responsibility for corrective actions not fully completed was clearly assigned, safety questions had been evaluated and resolved, and violations of regulations or TS conditions had been identified.

(Open) LER 250/84-19 and LER 250/84-20, TS - Reactor Coolant System (RC) Leakage. The above LERs were generated on June 12 and June 25, 1984, as a result of RCS leakage exceeding TS limits due to a failed valve gland flange on a Rockwell Edwards 3/4 inch globe valve. On June 25, 1984 an

inspection of all Rockwell Edwards 3/4 inch valves was conducted on both units. A total of seven valves were found to be degraded. Plant Change/Modification (PC/M) 84-129 was implemented to fabricate and install a strongback plate and washer to replace the original gland flanges. The installation of the strongbacks was considered a temporary modification, as described in the PC/M safety analysis. Plant Engineering personnel were unable to verify that a permanent analysis or modification had been performed. The licensee continues to review the status of a permanent resolution. LERs 250/84-19 and 250/84-20 remain open.

(Closed) LER 250/86-01, AFW System - Steam Supply Stop Check Valves

(Closed) LER 251/86-01, ESF [Engineered Safety Feature] Actuation - AFW [Emergency Feedwater] System Start

(Closed) LER 250/86-07, TS - Safety Injection Pump

Enforcement Action, EA 86-20, was generated as a result of the events described in the above LERs. The licensee's response to EA 86-20 was reviewed and the issues associated with the LERs above were addressed in Inspection Report 250,251/86-37. The adequacy of corrective action is being tracked along with EA 86-20. LERs 250/86-01, 251/86-01 and 250/86-07 are closed.

(Closed) LER 250/84-40, Inadequate Emergency Diesel Generator (EDG) Surveillance Procedure. This procedure was the subject of a violation (250/84-14-03) which was closed in Inspection Report 250/84-18. LER 250/84-40 is closed.

(Closed) LER 250/86-10, TS Surveillance - Area Radiation Monitoring System (ARM). The failure to perform the ARMS surveillance as required by TS Table 4.1-1, Item 18, is a previous example of the missed TS surveillances cited in Inspection Report 250,251/86-39, paragraph 9, Violation 250,251/86-39-02. The licensee response and corrective actions were reviewed and the violation was closed in Inspection Report 250,251/87-10. LER 250/86-10 is closed.

(Closed) LER 250/84-32, TS Limiting Conditions for Operation (LCO) Exceeded - AFW Pump Operability. Violations 250/84-39-01, 251/84-40-01 and 251/84-40-02 were issued in Inspection Report 250/84-39 and 251/84-40, as a result of the event described in LER 250/84-32. The licensee response to the Notice of Violation was reviewed and closed in Inspection Report 250,251/86-25. LER 250/84-32 is closed.

(Closed) LER 250/87-07, Diesel Fuel Storage Tank Sample Did Not Meet TS Surveillance Requirements. On January 28, 1987, the licensee declared the EDG fuel storage tank out of service because an analysed sample exceeded the TS acceptance criteria. Because it was believed that the technique used in obtaining the sample was contrary to the procedure and contributed to the unacceptable results, the licensee requested discretionary enforcement of Region II to allow both units to remain at power pending the

results of the analysis of a new sample. Region II granted the discretionary enforcement and on January 29, 1987, the new sample analysis results were within TS acceptance criteria and the tank was declared back in service. The long term corrective action was to completely drain down and thoroughly clean the tank. This effort was accomplished between March 27 and April 1, 1987 and is documented in Inspection Report 250,251/87-14, paragraph 7. LER 250/87-07 is closed.

(Closed) LER 251/87-06, Loss of Flow From Primary Water Storage Tank. On February 24, 1987, the Unit 4 PWST was isolated following a condition that caused the low discharge pressure alarm for the primary water pumps to annunciate. The valve lineup was verified to be correct and the pump suction check valve was inspected and found to be operational. PWST level was verified and the floating diaphragm was visually inspected. An Event Response Team (ERT) was formed to evaluate further corrective actions. The PWST was drained and thoroughly cleaned in accordance with PWO 64/2586, during the present unplanned Unit 4 outage. LER 251/87-06 is closed.

The following LER's were reviewed and closed based on an in-office review. The inspectors verified that reporting requirements had been met, root cause analysis was performed, corrective actions appeared appropriate, and generic applicability had been considered. In addition, each LER was reviewed for and determined not to require further onsite inspector followup.

LER 250/85-37	LER 250/87-04	LER 251/86-03
LER 251/85-42	LER 250/86-06	LER 250/86-04
LER 250/85-44	LER 251/86-02	

7. Summary of International Atomic Energy Agency (IAEA) Activities

In fulfillment of the Safeguards Agreement between the United States and the IAEA, the IAEA selected, on July 19, 1985, Turkey Point Unit 4 for participation in its international safeguards inspection program. A major portion of this program requires the continuous surveillance of the fuel inventory through camera monitoring and seal wire placement. The surveillance program ensures that the fuel inventory does not change between physical audits.

The US/IAEA Safeguards Agreement has been in force since July 31, 1980. The commitments by the U.S. in this treaty, which carries the force of law, are defined in the Code of Federal Regulations, the treaty itself, and the site-specific Facility Attachments. On April 10, 1987, the Commission issued Amendment 117 to the Facility Operating Licence No. DPR-41 for the Turkey Point Plant, Unit 4. The amendment adds License Condition 3.J regarding implementation of the IAEA Safeguards program for Unit 4.

The NRC inspectors verified, during routine tours of the Unit 4 Spent Fuel Pool (SFP) and the accessible portions of the containment building, that seal wires were in place and intact and that surveillance cameras were operable. Seal wires are placed by IAEA inspectors on the containment equipment access hatch, the missile shields and the reactor vessel head seismic restraints. Only the seal wires on the equipment hatch can be observed from outside the containment building. The containment building is not normally entered during power operation. Two surveillance cameras are installed in the Unit 4 SFP. The SFP area is always accessible through locked and alarmed doors.

IAEA inspectors arrived May 2, 1987, as mutually agreed, to attach seals to the Unit 4 reactor vessel head and, if possible, the fuel transfer gate. Work on the head vent system, however, conflicted with attachment of the seals. Because of IAEA inspectors' time constraints, the seals were not installed. However, the Unit 4 IAEA surveillance camera was serviced and remains in place. The vessel head seal attachment was subsequently postponed until May 21, 1987.

8. Monthly and Annual Surveillance Observation (61726/61700)

The inspectors observed TS required surveillance testing and verified: that the test procedure conformed to the requirements of the TS, that testing was performed in accordance with adequate procedures, that test instrumentation was calibrated, that limiting conditions for operation (LCO) were met, that test results met acceptance criteria requirements and were reviewed by personnel other than the individual directing the test, that deficiencies were identified, as appropriate, and were properly reviewed and resolved by management personnel and that system restoration was adequate. For completed tests, the inspectors verified that testing frequencies were met and tests were performed by qualified individuals.

The inspectors witnessed/reviewed portions of the following test activities:

- Operating Procedure (OP) 0209.1, Valve Exercising Procedure for RCS vent valves
- Temporary Procedure (TP) 334, DWST Recirculation and Release to Discharge Canal
- TP 335, Flushing the Demineralized Water System Header
- TP 339, Backleakage Determination of Check Valves 10-3-513 and 10-3-510
- TP 340, B EDG Day and Skid Tank Cleaning

No violations or deviations were identified within the areas inspected.

9. Maintenance Observations (62703/62700)

Station maintenance activities of safety related systems and components were observed and reviewed to ascertain that they were conducted in accordance with approved procedures, regulatory guides, industry codes and standards and in conformance with TS.



The following items were considered during this review, as appropriate: That LCOs were met while components or systems were removed from service; that approvals were obtained prior to initiating work; that activities were accomplished using approved procedures and were inspected as applicable; that procedures used were adequate to control the activity; that troubleshooting activities were controlled and repair records accurately reflected the maintenance performed; that functional testing and/or calibrations were performed prior to returning components or systems to service; that Quality Control (QC) records were maintained; that activities were accomplished by qualified personnel; that parts and materials used were properly certified; that radiological controls were properly implemented; that QC hold points were established and observed where required; that fire prevention controls were implemented; that outside contractor force activities were controlled in accordance with the approved QA program; and that housekeeping was actively pursued.

The following maintenance activities were observed and/or reviewed:

Disassembly and Inspection of Unit 3 B Main Steam Isolation Valve (PWO 63-1210)

Disassembly and Inspection of Unit 3 A Main Steam Check Valve (PWO 63-1211)

MP 3107.2, Component Cooling Water Pump - Disassembly, Repair, and Assembly

- a. Installation of Unit 3 Component Cooling Water (CCW) Ammertap System
In attempting to reduce out of service time for the CCW heat exchangers the licensee is installing a continuous cleaning system (Ammertap) on the Unit 3 CCW System during the current refueling outage. Because of high calcium carbonate buildup (from the closed canal cooling system) on the CCW heat exchanger tubes, heat transfer capability is reduced requiring frequent cleaning. A high pressure water technique (hydrolazing) is currently applied but is expensive and requires removing the heat exchangers from service for approximately 24 hours which is also the LCO time limit. The licensee is confident that installation of the Ammertap system will drastically reduce, if not eliminate, the high out of service and LCO time required to frequently clean the CCW heat exchangers. The Unit 4 CCW System will be modified to include Ammertap during the next refueling outage. Until then the licensee plans to experiment with a chemical addition system (Calgon) which is designed to reduce the rate of calcium carbonate fouling of the heat exchangers.
- b. Installation of Raychem splices on various equipment inside Unit 3 and 4 containments

Installation of Raychem splice on Unit 3 pressure transmitter PT-3-495 (S/G C Channel III pressure) outside containment. Prior to commencing Raychem splice work on both units the licensee presented

in depth training classes for electricians and quality control personnel. Instruction was given by Raychem representatives and observed by the inspectors. It stressed application techniques and current industry splice problems. The training was presented professionally and beneficial to all attendees.

c. Low Pressure (LP) Turbine Blade Fatigue Failures

Westinghouse issued Customer Advisory Letter 86-02 documenting the potential fatigue failures of the last stage rotating blades in LP turbines. Operation of the turbine under low load and high back pressure conditions may subject the last stage blading to excessive vibratory stress levels caused by stall flutter. Stall flutter is a substantial concern at the final stage blading because unlike all other stages, it is subject to variable volumetric flow conditions. Mass flow through all blading varies proportionally to turbine load. Since the inlet and outlet static pressure of all stages is essentially constant, except for the final stage, the volumetric flows are also essentially constant. The inlet pressure of the final stage also varies proportionally to turbine load but the outlet pressure, and consequently volumetric flow, is governed by vacuum conditions in the main condenser. Low volumetric flow and high condenser back pressure result in stall flutter and excessive vibration fatigue of the last stage blading.

During the current Unit 3 refueling outage, the two Unit 3 LP turbine rotors were replaced with rotors of a more efficient design. Inspection of the last stage blading of the LP rotors replaced indicated areas of fatigue cracking and revealed that approximately six inches of the tip section of one blade had actually broken off and was later found in the main condenser. Based on the Westinghouse letter, the licensee performed a ultrasonic test (UT) nondestructive examination (NDE) inspection of the Unit 4 LP turbines and on the as found condition of the Unit 3 LP turbines. The Unit 4 number one LP turbine last stage blading had three cracked blades at the south (turbine) end and one cracked blade at the north (generator) end. The Unit 4 number two LP turbine had no cracked blade indications. The blades with indications were replaced with blades from the Unit 3 LP rotors that were removed.

d. EDG Day and Skid Tank Cleaning

Based on the results of the inspection and cleaning effort of the EDG storage tank (Inspection Report 250,251/87-14, paragraph 7) and the issuance of IE Notice 87-04, Diesel Generator Fails Test Because Of Degraded Fuel, the licensee determined that it was necessary to inspect and clean the day and skid tanks for the A and B EDGs. The B EDG day and skid tanks were cleaned on May 12, 1987 in accordance with



temporary procedure TP 340. The as found condition of the B day tank revealed a moderate to heavy film of sludge on all but approximately two inches of the circumference at the top of the horizontal cylindrical tank. The tank was subsequently pressure cleaned and the walls were wiped clean. The skid tank was inaccessible to visual inspection. It was drained and repeatedly pressure cleaned until fuel oil samples were confirmed to be clean by the nuclear chemistry department. There was direct QC involvement with inspection hold points at the completion of each cleaning cycle. The A EDG tanks will be cleaned immediately following the return of the B EDG to service and prior to the restart of either unit.

e. Status of Process Radiation Monitor System (PRMS) Drawer Replacement Update

The PRMS drawer replacement schedule documented in Inspection Report 250,251/87-14, paragraph 6, has been delayed pending further human factors review and the completion of higher priority reactor protection system I&C maintenance work. The PRMS drawers and supportive equipment have been QC approved and released to I&C. The replacement will be implemented via Controlled Plant Workorder (CPWO) 87-60 for Unit 3 and 87-61 for Unit 4. The Resident Inspectors will track and document the replacement effort in Inspection Report 250,251/87-27.

10. Operational Safety Verification (71707)

The inspectors observed control room operations, reviewed applicable logs, conducted discussions with control room operators, observed shift turnovers and confirmed operability of instrumentation. The inspectors verified the operability of selected emergency systems, verified that maintenance work orders had been submitted as required and that followup and prioritization of work was accomplished. The inspectors reviewed tagout records, verified compliance with TS LCOs and verified the return to service of affected components.

By observation and direct interviews, verification was made that the physical security plan was being implemented.

Plant housekeeping/cleanliness conditions and implementation of radiological controls were observed.

Tours of the intake cooling water structure, diesel, auxiliary, control and turbine buildings were conducted to observe plant equipment conditions including potential fire hazards, fluid leaks and excessive vibrations.

The inspectors walked down accessible portions of the following safety related systems to verify operability and proper valve/switch alignment:

A and B Emergency Diesel Generators
Unit 3 and 4 Containments



Control Room Vertical Panels and Safeguards Racks
Spent Fuel Pool (Units 3 and 4)

On May 7, 1987, while Unit 3 was in refueling shutdown and Unit 4 was in cold shutdown, electrical power to the 3B 4160 volt bus was lost momentarily. After the B Emergency Diesel Generator (EDG) started and auto-connected to the 3B bus the automatic loading of the 3D 480 volt load center caused the B EDG to be connected without synchronization to offsite power through the 3A 4160 volt bus.

Maintenance on the 3D 480 volt load center required an abnormal electrical lineup involving the energization of the 3D 480 volt load center from the 3C 480 volt load center (powered from the 3A 4160 volt bus) through cross tie breaker 30310. When the 3D load center was returned to its normal lineup (powered from the 3B 4160 volt bus through its associated step down transformer and breaker 30410) the metering and potential fuses had not yet been installed as required. As a result of a sensed undervoltage condition, a protection logic actuation stripped the 3B bus and the B Emergency Diesel Generator (EDG) started and auto-connected to the 3B bus. As loads were sequenced onto the 3B bus the 3D load center supply breaker (3AB14) closed which, in effect, caused the B EDG to be connected without synchronization to offsite power through the 3A 4160 volt bus. Although it was not known how far out of phase the EDG was from offsite power, no EDG protective trip occurred. The B EDG continued to pick up load until, at approximately 2900 KW, the 30310 breaker tripped open on overcurrent. When the 30310 breaker tripped, separating the 3A and 3B 4160 volt buses, the load on the B EDG dropped to approximately 350 KW. The B EDG was subsequently taken out of service to investigate and evaluate any operability concerns resulting from running the EDG out of synchronization with the 3A 4160 volt bus (offsite power).

The initiating cause of the event can be attributed to personnel error. Prior to returning the 3D 480 volt load center to its normal power supply as delineated in Procedure 3-OP-006, 480 Volt Switchgear System, the metering and potential fuses were required to be installed as per clearance order 87-5-XI-131. In this manner no undervoltage condition would have been sensed and bus stripping would not have occurred. Operations personnel failed, however, to release the clearance as specified by the clearance order release instructions. TS 6.8.1 requires that written procedures and administrative policies shall be established, implemented and maintained that meet or exceed the requirements of section 5.1. of ANSI N18.7-1972. Section 5.1.5 of ANSI N18.7-1972 specifies that procedures shall be provided for control of equipment, as necessary, to maintain reactor and personnel safety and to avoid unauthorized operation of equipment. Section 5.1.2 of ANSI N18.7-1972 specifies that procedures shall be followed. Administrative Procedure (AP) 0103.4, In-Plant Equipment Clearance Orders, revision dated March 10, 1987, specifies in section 5.4.1 that it is the responsibility of the clearance executor to follow the clearance tag-out and/or tag removal in the order given. If

any step cannot be executed exactly in the order given, he shall request clarification from the originator of the order before proceeding. Failure to implement AP 0103.4, In-Plant Equipment Clearance Orders constitutes a violation (250/87-22-01).

11. Plant Events (93702)

The following plant events were reviewed to determine facility status and the need for further followup action. Plant parameters were evaluated during transient response. The significance of the event was evaluated along with the performance of the appropriate safety systems and the actions taken by the licensee. The inspectors verified that required notifications were made to the NRC. Evaluations were performed relative to the need for additional NRC response to the event. Additionally, the following issues were examined, as appropriate: details regarding the cause of the event; event chronology; safety system performance; licensee compliance with approved procedures; radiological consequences, if any; and proposed corrective actions. The licensee plans to issue LERs on each event within 30 days following the date of occurrence.

On May 2, 1987, during a routine communication check it was discovered that the Emergency Notification System (ENS) telephone was out of service. Commercial telephone service was verified to be available. The ENS telephone was returned to service later the same day.

On May 16, 1987, while Unit 3 was in refueling shutdown and Unit 4 was in cold shutdown, start up personnel were performing wiring checks of the 3A sequencer when relay 2X4-3A was inadvertently bumped. This caused the vital 3A Motor Control Center (MCC) to lose power and resulted in the A EDG being declared out of service due to deenergization of its associated soak back (lube oil) pump. The B EDG had previously been taken out of service as a result of identified discrepancies with the local/remote switch and to evaluate operability concerns stemming from the May 7, 1987, event as described above. Power to the 3A MCC was restored after approximately 55 minutes and the A EDG was considered operable.

