

U. S. NUCLEAR REGULATORY COMMISSION
REGION III

Report No. 50-255/91009(DRP)

Docket No. 50-255

License No. DPR-20

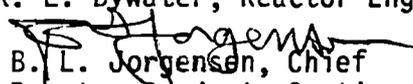
Licensee: Consumers Power Company
212 West Michigan Avenue
Jackson, MI 49201

Facility Name: Palisades Nuclear Generating Plant

Inspection At: Palisades Site, Covert, MI

Inspection Conducted: April 6 through May 13, 1991

Inspectors: J. K. Heller, Senior Resident Inspector
J. A. Isom, Senior Resident Inspector
J. R. Roton, Resident Inspector
R. L. Bywater, Reactor Engineer

Approved By:  B. L. Jorgensen, Chief
Reactor Projects Section 2A

5/29/91
DATE

Inspection Summary

Inspection on April 6 through May 13, 1991 (Report No. 50-255/91009
(DRP))

Areas Inspected: Routine unannounced inspection by the resident inspectors of plant operations, maintenance, surveillance, reportable events, and NRC Region III and Headquarters requests. No Safety Issues Management System (SIMS) items were reviewed. A routine management meeting was conducted on April 18, 1991.

Results: Of the five areas inspected, no violations or deviations were issued.

The strengths, weaknesses and open items are discussed in paragraph 9, "Management Interview." In summary:

Two strengths were noted pertaining to communications with the NRC and the licensee response to a fire.

Five weaknesses were noted pertaining to a personnel safety hazard, control of flammable liquids, control of vendor manuals, control of an outage related work activity, and use of a temporary repair versus temporary modification.

An open item pertaining to control of vendor manuals was identified.

DETAILS

1. Persons Contacted

Consumers Power Company

- *D. P. Hoffman, Vice President, Nuclear Operations
- *D. W. Joos, Vice President, Energy Supply
- +*G. B. Slade, Plant General Manager
- + R. M. Rice, Plant Operations Manager
- *D. J. Vandewalle, Engineering Programs Manager
- *R. D. Orosz, Engineering & Construction Manager
- +*P. M. Donnelly, Safety & Licensing Director
- + K. M. Haas, Radiological Services Manager
- J. L. Hanson, Operations Superintendent
- R. B. Kasper, Maintenance Superintendent
- K. E. Osborne, System Engineering Superintendent
- + C. S. Kozup, Technical Engineer
- + W. L. Roberts, Senior Licensing Analyst
- R. W. Smedley, Staff Licensing Engineer
- K. A. Toner, Electrical/I&C/Computer Engineering Manager
- T. W. Bowes, Mechanical & Civil/Structural Engineering Manager
- T. A. Buczwinski, Reactor & Thermal-Hydraulic Engineering Manager
- T. J. Palmisano, Administrative & Planning Manager
- + M. G. Mlynarek, Plant Reactor Engineer

Nuclear Regulatory Commission

- *A. B. Davis, Regional Administrator
- *H. J. Miller, Director, Division of Reactor Safety
- *M. P. Phillips, Chief, Operation Programs Section 2
- *Brent Clayton, Chief, Reactor Projects Branch 2
- +*B. L. Jorgensen, Chief, Projects Section 2A
- +*J. K. Heller, Senior Resident Inspector
- + J. R. Roton, Resident Inspector

*Denotes some of those present at the Management Meeting held in the Nuclear Regulatory Commission (NRC) Region III office on April 18, 1991.

+Denotes some of those present at the Exit Interview on May 13, 1991.

Other members of the plant staff, and several members of the contract security force, were also contacted during the inspection period.

2. Operational Safety Verification (71707, 71710, 42700)

Routine facility operating activities were observed as conducted in the plant and from the main control room. The performance of Reactor Operators and Senior Reactor Operators, Shift Engineers, and Auxiliary Equipment Operators was observed and evaluated. Included in the review were procedure use and adherence, records and logs, communications, shift/duty turnover, and the degree of professionalism of control room activities. Observations of the control room monitors, indicators, and recorders were made to verify the operability of emergency

systems, radiation monitoring systems, and nuclear reactor protection systems. Reviews of surveillance, equipment condition, and tagout logs were conducted.

a. General

The plant began and ended the reporting period at essentially full power.

b. Fire at P-47A, "Cooling Tower Chemical Addition Pump"

On May 2, the licensee extinguished a small fire at the motor for P-47A. The fire brigade response was appropriate. During the subsequent morning meeting, the fire was discussed and the need for a deviation report (internal corrective action document) was considered. It was concluded that this was a random failure of a 110 volt motor which did not require a deviation report. After the morning meeting, the inspector toured the site of the fire and determined by discussion with another NRC inspector that personnel had worked on the pump during the shift prior to the fire. In addition, there was an outstanding work order indicating the need to repair an oil leak on the pump. This was discussed with plant management and property protection personnel. Property protection personnel had separately learned of the outstanding work order and were requesting that a deviation report be written; Deviation Report 91-085 was written.

c. Safety Injection Pump Recirculation Lines

During reviews of the safety injection pump mini flow lines and shutdown heat exchanger recirculation lines to the Safety Injection and Refueling Water (SIRW) tank, the licensee determined that the leak tight integrity of the valve seats had never been verified. The tank is vented directly to the atmosphere. The licensee determined that minor leakage past the valve seats during LOCA conditions, with maximum core damage, would result in a significant unmonitored release path. It could also result in habitability problems in the control room due to the location of the tank vent near the control room ventilation intake. Further, it could involve potential exposure problems at the site boundary. The licensee discussed this problem with NRC Region III and Headquarters personnel during conference calls on May 9 and 10. Leak tight integrity testing of the isolation valves was not a regulatory requirement. Current plant configuration does not permit leak testing. Because of plant configuration, testing cannot be performed until the next cold shutdown - scheduled for 1992. Evaluation of means to provide a filtered vent path continues. The licensee has classified this as an unreviewed safety question because this plant configuration has not been reviewed by the NRC. This information was provided to the NRC Office of Nuclear Reactor Regulation (NRR) by separate correspondence.

d. Tours

- 1) During a tour of the turbine building, the inspector found scaffolding that was not properly installed. The scaffolding, installed on the east side of the condenser adjacent to a main feed water pump, was missing the kick plate on one side. The inspector himself narrowly avoided a fall off this scaffold. This was discussed with the safety officer and at the exit interview. The safety officer implemented corrective action.
- 2) During a tour of the storage area, located on the mezzanine below the north end of the turbine deck, the inspector observed a number of items that raised questions of material accountability and flammable material control.

The inspector found a large quantity of flammable material stored in a flammable storage locker. This amount may have been appropriate to support a large outage work force, however, the outage was over and the vendor was no longer on site. This was discussed with property protection personnel who agreed and had the materials removed. The inspector verified the cabinet storage rating was not exceeded.

While inspecting the general storage area, the inspector found two sealed weld rod canisters that did not have a Consumers Power receipt inspection number. In addition, some of the liquid stored in the flammable storage cabinet did not appear to have markings indicating receipt inspection. This was discussed with system engineering who indicated that all material should be receipt inspected prior to use. An attempt was made to determine if the material in question had been receipt inspected. However, clean up of the area had begun and the materials in question were discarded.

The licensee provided the inspector a copy of a work order associated with a turbine work activity. All items associated with this work order, including those provided by the vendor, had been receipt inspected. The inspector had no additional questions.

e. Head/Pressurizer Vents

During the post refueling outage plant heatup, the indicated pressure on PIA-1066, "Gaseous Vent Pressure Gauge," increased as the primary coolant system was pressurized. The pressure increase lagged the primary coolant system pressurization by approximately a shift. The vent system is connected to both the head and pressurizer and relieves to either the pressurizer quench tank or directly to the containment atmosphere. The system configuration provides for dual isolation from either the head or the pressurizer to the containment atmosphere. PIA-1066 is installed on the common piping between the first and second isolation valves. The increase of pressure at PIA-1066 may indicate that one of the first isolation valves was

leaking. The second isolation valve appeared to be holding, as evidenced by constant pressurizer quench tank readings and by stable containment atmospheric temperature/humidity.

Inspection Reports 50-255/90015(DRP) and 50-255/89012(DRP) document that this problem has occurred in the two previous operating cycles. The only difference between the previous problem and the current problem is that the pressurization previously occurred a couple of months after the plant was on line and not while the plant was heating up. Currently, there is no tag affixed to the vent system indicating that corrective action is required during the next cold shutdown. The inspector discussed this with operations personnel, planning personnel, and system engineers. All were aware of the problem and were formulating corrective actions. The problem appears to be associated with the type of isolation valves used and the fact that the piping configuration ensures solid water in the line between the isolation valves. Operations personnel and system engineers all agree that additional testing is required to determine if a repair is required. The inspector expressed concern that, since the problem was not captured by a formal mechanism, the potential exists that the opportunity for testing during the next outage may be missed. Operations personnel entered this activity on the work order system to ensure testing is scheduled during the next cold shutdown.

No violations, deviations, unresolved, or open items were identified.

3. Maintenance (62703, 42700)

Maintenance activities in the plant were routinely inspected, including both corrective maintenance (repairs) and preventive maintenance. Mechanical, electrical, and instrument and control group maintenance activities were included as available.

The focus of the inspection was to ensure that the maintenance activities were conducted in accordance with approved procedures, regulatory guides, industry codes or standards, and were in conformance with Technical Specifications. The following items were considered during this review: Limiting Conditions for Operation were met while components or systems were removed from service, approvals were obtained prior to initiating the work, activities were accomplished using approved procedures, and post maintenance testing was performed as applicable.

The following activities were inspected:

- a. Work Order 24102323, "F-13B continues to have high D/P problems. Disassemble F-13B and clean filter element manually." F-13B is a permanently installed makeup system raw water supply strainer manufactured by Hayward Manufacturing Company.

The inspector observed portions of the work activity and reviewed the work order package. The work order (WO) required review of the vendor manual. The package contained a copy of the vendor

manual. The manual was not marked "controlled copy", nor did the manual have any markings indicating the manual was reviewed and approved for use. The inspector discussed this with mechanical maintenance department supervision who indicated that the strainer had recently been installed and the vendor manual was still being reviewed by system engineering. Since the vendor manual was required to support the maintenance activity, a copy of the manual was obtained from system engineering and attached to the work order. The planner had intended to mark the copy "Information Only", however, the manual had not been so marked.

In addition, the inspector discussed this item with a work order planner. The planner indicated that he knew vendor manuals were required to be controlled and how controlled copies were marked. The planner showed the inspector a xerox copy of a vendor manual that the planner had obtained from the Document Control Center. The copy had the marks indicating the original was controlled. The copy was marked "Information Only". The planner indicated that he had obtained the copy as an aid for work order planning. The inspector noted that use of an uncontrolled copy of a vendor manual while planning a work order could result in inadequate, inaccurate, or incomplete maintenance. This was discussed at the exit interview.

The inspector reviewed Palisades Administrative Procedure AP 10.45, "Vendor Manuals" and found that AP 10.45 does not contain provisions for use of "Information Only" copies of vendor manuals. In addition, AP 10.45 does not permit use of uncontrolled vendor manuals. Failure to control vendor manuals as described above, is a violation of AP 10.45.

A Notice of Violation was not issued for this because a Notice of Violation for an identical problem was issued in inspection report 255/91006(DRSS). If this work activity had been observed at that time, this would have been an additional example for that Notice of Violation. Since this was an additional example of a violation for which insufficient time had elapsed to fully implement corrective action, a second Notice of Violation was not issued. Until the corrective action is reviewed this item is an open item. (Open Item 255/91009-01(DRP))

- b. WO 2401854 air line to CV-0510, "Main Steam Isolation Valve," leaking. The repair was discussed in Paragraph 5.d, "Maintenance" of Inspection Report 50-255/91005(DRP). The inspector performed additional reviews to determine if a temporary modification was performed without implementing the controls of Administrative Procedure AP.9.31, "Temporary Modification Control". In this case, the system engineer classified the activity as a temporary repair which was controlled by Administrative Procedure AP 5.01, "Processing Work Requests/Work Orders". A temporary modification would require additional reviews -including a 10 CFR 50.59 review- prior to returning the component to service. The inspector has reviewed both Administrative Procedures and determined it was not clear if this was a temporary modification or temporary repair.

The WO required installation of a brace to hold two pieces of the air line together. The brace will remain in place until a permanent repair is completed. The brace adds weight to the air line which could change the stress calculations for the system. The added weight would be evaluated by the temporary modification process but was not evaluated by the temporary repair processes. The inspector discussed his concern with a design change supervisor, who agreed to evaluate and determine if the addition of weight was adequately controlled. Deviation Report D-PAL-91-090 was written to capture this question.

An additional example of a previously cited Violation and one open item were identified. No deviations or unresolved items were identified.

4. Surveillance (61702, 61708, 61710)

The inspector reviewed Technical Specifications required surveillance testing as described below. The review confirmed that testing was performed in accordance with adequate procedures, that test instrumentation was calibrated, and that the Limiting Conditions for Operation were met. Additionally, removal and restoration of the affected components were properly accomplished, and test results conformed with Technical Specifications and procedure requirements. The results were reviewed by personnel other than the individual directing the test, and deficiencies identified during the testing were properly reviewed and resolved by appropriate management personnel.

Special Test T-191, "Startup Physics Test Program" was inspected.

The inspector reviewed the results of startup physics testing through 30 percent reactor power and discussed the results with the reactor engineer. Special Test T-191 was performed in March 1991, during restart from the refueling/steam generator replacement outage.

Measurements of hot zero power (HZP) critical boron concentration, HZP moderator temperature coefficient, and differential soluble boron worth all met procedure "review criteria". "Review criteria" were more restrictive than any corresponding Technical Specification limits. Predicted values of physics parameters for each operating cycle were obtained from the licensee's fuel vendor, Advanced Nuclear Fuels (ANF).

Measurements of control rod worth for each rod group were all within review criteria limits with the exception of Group A. The worth of Group A was overpredicted by ANF by 0.158 percent delta rho, which exceeds the licensee's review criterion for individual rod group worth by 0.008 percent delta rho. This deviation for an individual rod worth from the review criterion was considered small; the total sum of measured rod group worths satisfied its review criterion.

Core parameter measurements at less than 25 percent reactor power successfully met applicable review criteria. Core parameters at less than 30 percent reactor power failed to meet applicable review criteria. Predicted power of the two most in-board fuel assemblies on the major axis of the licensee's octant core model exceeded the actual power in these assemblies by greater than the 10 percent review criterion. The licensee noted that the computer model, used to predict fuel assembly power, was developed and bench marked against full power data. The licensee subsequently obtained results of fuel assembly power predictions from ANF. The ANF model for predicting fuel assembly power contained a correction factor for power dependent albedo effects and showed reasonable agreement with the measured data.

No violations, deviations, unresolved or open items were identified.

5. Reportable Events (92700, 92720)

The inspector reviewed the following Licensee Event Reports (LERs) by means of direct observation, discussions with licensee personnel, and review of records. The review addressed compliance to reporting requirements and, as applicable, that immediate corrective action and appropriate action to prevent recurrence had been accomplished.

- a. (CLOSED) LER 255/89006: Component cooling water availability following a high energy line break.
- b. (CLOSED) LER 255/89022: Radiological consequences of a safety injection refueling water tank rupture.
- c. (CLOSED) LER 255/89023: Discrepancies within actions completed and documentation provided for IE Bulletin 79-14.

On October 10, 1989, engineering personnel identified that the U-bolt connection assembly for the main steam line support structure exceeded the stress allowable by FSAR by approximately 14 percent.

Enforcement action was considered and a Notice of Violation (255/89024-01(DRS)) was issued. The root cause and corrective action were addressed by Region III inspection specialists during evaluation of the licensee's response to the violation.

- d. (CLOSED) LER 255/90007: Reanalysis of main steam line break identifies that containment pressure could exceed FSAR values due to inadequate design.

On April 18, 1990, during a review of the main steam line break (MSLB) analysis being performed as part of the replacement steam generator effort, it was determined that the previous steam generator installation could result in containment pressures that exceed values referenced in the FSAR during MSLB scenarios where the break size is less than 100 percent of the steam line cross sectional area.

The cause of this condition was inadequate design. The methodology used by the Nuclear Steam Supply System supplier to assess the effects of MSLB transients on containment pressure incorrectly assumed that the large break constituted the most limiting design case for containment pressure.

A modification (FC-906) has been installed that provided a closure signal to the main feedwater regulator valves and main feedwater regulator bypass valves on high containment pressure (setpoint approximately 3.7 psig). Closure of the feedwater regulator and regulator bypass valves on high containment pressure provides faster response than the previously used low steam generator pressure initiated main steam isolation signal (MSIS).

An analysis of the effects of variously sized MSLBs on containment pressure has been performed for the post-modification configuration. This indicates that the maximum containment pressure for the most limiting case is now within the containment pressure design basis referenced in the FSAR. The problem addressed by this LER was reviewed and documented in Inspection Reports 50-255/90014(DRP) - Paragraph 3.b(2), "10 CFR 50.72 report", 50-255/90015(DRP) - Paragraph 8, "Design Changes", and 50-255/90018(DRP) - Paragraph 10, "Design Changes".

Enforcement action was considered and a Notice of Violation was issued (255/90018-04(DRP)).

- e. (CLOSED) LER 255/90011: Unexpected reactor protection system actuation during turbine trip breaker testing due to incorrect test procedure.

On June 15, 1990, during performance of Operations Checklist CL 36, an unexpected, automatic actuation of the reactor protection system was initiated by the "loss of load" turbine trip feature due to an input to the "loss of load" trip logic which had not been adequately blocked.

The root cause of this event was the inadequacy of Operations checklist, CL 36. Changes to this checklist necessitated by implementation of facility change package FC 800 were not recognized by engineering, or by the operations personnel who were contacted regarding the checklist changes necessitated by implementation of FC 800. Failure to properly revise procedures affected by a design change is contrary to requirements of 10 CFR 50, Appendix B, Criterion III. This is addressed further below.

To correct the deficiency, Operations Checklist, CL 36, has been revised to include appropriate position requirements in the turbine trip breaker testing sequence, and CL 36 has subsequently been performed without incident. In addition, a review of the Operations Checklist revision process and checklist controls had been performed.

The inspector concluded that the licensee had performed a prompt evaluation of the cause of this event with appropriate management attention. The corrective actions taken appeared adequate to prevent recurrence. Therefore, in accordance with 10 CFR 2 Appendix C, Section V.G, a Notice of Violation was not issued for the violation of Design Controls since it was licensee identified, classified as Severity Level IV or V, reported, not a willful violation, and corrected, including measures to prevent recurrence (Closed - Violation (NV6) 255/91009-02(DRP)).

- f. (CLOSED) LER 255/90014: Inadvertent start of an auxiliary feedwater pump.

On August 28, 1990, an inadvertent start of the P-8C auxiliary feedwater (AFW) pump occurred while configuration control project personnel were performing electrical wiring diagram verification activities in the back of control panel C-187B. This panel contains the AFW actuation channel for this pump.

The root cause of this event may have been the bumping of the AFW actuation channel, channel "B", logic module by configuration control project personnel during their wiring verification inside control panel C-187B. No other root cause could be identified.

The corrective actions taken for this event included discontinuing the balance of the AFW control panel work until the AFW system was placed out of service during the 1990 outage. Additionally, during the aforementioned outage, I&C technicians attempted to duplicate the actuation. Negative results were achieved from those attempts.

Although the root cause of this event could not be absolutely attributed to the bumping of the AFW actuation logic module by the configuration control project personnel, the inspector concluded that the licensee had performed a prompt evaluation of the cause of this event with appropriate management attention.

- g. (CLOSED) LER 255/90019: Inadvertent Right Channel Containment Isolation.

On November 1, 1990, an inadvertent right channel containment isolation and a recirculation actuation occurred when configuration control project personnel, working in the EY-20 panel, caused a loss of the Y20 preferred bus. With half of the right channel containment isolation circuits de-energized to support post installation modification checkouts, the required two out of four logic was satisfied when the bus was lost.

The root cause of the event was personnel error. While verifying the wiring in panel EY-20, configuration control project personnel shorted the number two plant inverter when they placed a ruler with a metal edge across the terminal points of two heat sinks. This action tripped the inverter and resulted in the loss of the preferred bus Y20.

A work order was issued and the Y20 inverter was repaired. On November 2, 1990, a management review board was held to discuss the event with configuration control project personnel and their supervisor. Additionally, a Human Performance Enhancement System evaluation was conducted which led to additional follow-up corrective actions. These follow-up actions have been completed.

The inspector concluded that the licensee had performed a prompt evaluation of the cause of this event with appropriate management attention. Corrective actions taken appeared reasonable to prevent recurrence.

h. (CLOSED) LER 255/90020: Loss of 1C bus during startup breaker testing.

On November 10, 1990, bus 1C was lost when the station safeguards power breaker opened due to the racking in of the startup breaker into the "test" position.

The root cause of this event was inadequate instructions. Administrative Procedure (AP) 4.02, "Control of Equipment Status", failed to caution against closing the 2400 volt incoming stored energy breaker while racked in the "test" position. Standard Operating Procedure 30, "Station Power", Attachment 1, "System Testing" stated that testing of 4160 and 2400 volt incoming breakers may be done in the test position, but only when the plant is shutdown and the bus can be isolated. This requirement was not discovered when the requirements for the breaker testing were reviewed.

- Standard Operating Procedure 30 has been reviewed and revised to clarify the testing requirements of the 4160/2400 volt incoming breakers.
- AP 4.02 has been reviewed and revised to clarify requirements for testing 4160/2400 volt stored energy breakers and 4160/2400 solenoid operated breakers.
- Permanent Maintenance Procedure SPS-E-4, "Maintenance for 4160/2400 Volt Switchgear has been reviewed and revised to refer to Standard Operating Procedure 30 for testing.

The inspector concluded that the licensee had performed a prompt evaluation for this event with appropriate management attention. The corrective actions taken appeared adequate to prevent recurrence. In accordance with 10 CFR 2 Appendix C, Section V.G., a Notice of Violation was not issued for the personnel error and inadequate procedure since it was licensee identified, classified as Severity Level IV or V, reported, not a willful violation, and was corrected, including measures to prevent recurrence, in a reasonable period of time (Closed - violation (NV6)255/91009-03(DRP)).

Two licensee identified violations and two violations issued in previous inspection reports were identified. No deviations, unresolved or open items were identified.

6. Inspection of Regional and Headquarters Requests (TI 2515/103 and 71707)
 - a. (Closed) Temporary Instruction (TI) 2515/103 "Loss Of Decay Heat Removal" (Generic Letter 88-17) - TAC 69761. The resident inspector performed the inspection activities applicable to the Division of Reactor Projects (see Paragraph 12 of Inspection Report No. 50-255/90014(DRP)). The inspection activities that remain are assigned to NRR, which are addressed by TAC #69761.
 - b. Region III requested information pertaining to the Shift Technical Advisor (STA). At Palisades, the Shift Engineer, who is a licensed (Senior Reactor Operator) member of the crew, would provide the STA function during an emergency. This information was provided to Region III.
 - c. Region III requested information pertaining to the seismic design and fuel storage capability of the Diesel Generator fuel oil system. The fuel oil system capacity was designed for seven days of operation. The portion of the fuel oil system from the underground storage tank to the day tank was not seismically qualified. The day tank to the diesel generator was seismically qualified. The day tank fuel oil capacity permits approximately 20 hours of operation. In addition, the day tank can be filled directly from a fuel oil tanker. This information was provided to Region III.

No violations, deviations, unresolved or open items were identified.

7. Management Meeting (30702)

On April 18, 1991, a management meeting was conducted in the NRC Region III offices (attendance was as indicated in Paragraph 1) to discuss licensee plans for changes in organizational structure and responsibilities. While these topics were discussed in various aspects, the main focus of the licensee's presentation on organizational changes was on the newly-created Nuclear Engineering and Construction group. Concerning assignments of responsibilities, special emphasis was directed to planned changes in the licensee's assessment of his own performance. Specifically, the planned removal of the old Quality Assurance group from in-line review functions and the expanded use of "peer" inspection for in-process quality verification were discussed in some detail. Further staff-level exchanges and evaluations are anticipated in some of these areas. The licensee addressed a number of questions raised during the meeting and expressed a willingness to keep the NRC Region III management and staff informed regarding future decisions which bear on the issues.

8. Open Item

Open Items are matters that require further review and evaluation by the inspector, including an item pending specific action by the licensee and a previously identified violation. Open items are used to document, track, and ensure adequate followup by the inspector. An Open Item disclosed during the inspection is discussed in Paragraph 3.a.

9. Management Interview (71707)

The inspectors met with licensee representatives - denoted in Paragraph 1 - on May 13, 1991 to discuss the scope and findings of the inspection. In addition, the likely informational content of the inspection report with regard to documents or processes reviewed by the inspectors during the inspection was also discussed. The licensee did not identify any such documents/processes as proprietary.

Highlights of the exit interview are discussed below:

a. Strengths noted:

- (1) Fire brigade and property protection response to a May 2 motor fire (paragraph 2.b, "Operations").
- (2) Communication with the NRC pertaining to safety injection pump mini flow and shutdown cooling recirculation line potential unreviewed safety question (paragraph 2.c, "Operations").

b. Weaknesses noted:

- (1) Potential safety hazard caused by incomplete scaffolding (paragraph 2.d(1), "Operations").
- (2) Control of flammable liquids. In this case the letter of the requirements was met however the intent of the requirements may not have been (paragraph 2.d(2), "Operations").
- (3) Outage work activity not identified on the outage work schedule (paragraph 2.e, "Operations").
- (4) Vendor manual control and apparent lack of understanding of the controlling Administrative Procedure (paragraph 3.a, "Maintenance")
- (5) Work activity that modified a system without a safety evaluation (paragraph 3.b, "Maintenance")

c. The eight LERs (paragraph 5, "Reportable Events") reviewed were discussed. In summary, two were the subject of a previous violation and two were licensee identified violations for which a Notice of Violation was not issued, as provided for in 10CFR2. The remaining four were closed without comment.

d. The open item (paragraph 3.a, "Maintenance") was discussed. The inspector will review the licensee's corrective action in a subsequent inspection.