

U. S. NUCLEAR REGULATORY COMMISSION
REGION I

Report Nos. 50-272/91-16; 50-311/91-16
Docket Nos. 50-272; 50-311
License Nos. DPR-70; DPR-75
Licensee: Public Service Electric and Gas Company
P. O. Box 236
Hancocks Bridge, New Jersey 08038
Facility Name: Salem Nuclear Generating Station, Units 1 & 2
Inspection At: Hancocks Bridge, New Jersey
Inspection Conducted: May 20 - 24, 1991

Inspectors: *P. D. Caphton* 8/16/91
for Donald L. Caphton, Sr. Technical Reviewer Date

P. E. Finkel 8/16/91
for Alan E. Finkel, Sr. Reactor Engineer Date

Approved by: *N. J. Blumberg* 8/16/91
for Norman J. Blumberg, Chief Date
Performance Programs Section
Operations Branch, DRS

Inspection Summary: Inspection May 20 - 24, 1991 (Combined Report Nos. 50-272/91-16 and 50-311/91-16)

Areas Inspected: Licensee's corrective actions taken in response to the April 9 - 27, 1990, maintenance team inspection findings including the August 21, 1990, Notice of Violation for Inspection Nos. 50-272/90-200 and 50-311/90-200, and the licensee's program for surveillance testing of safety-related equipment.

Results: Material conditions and housekeeping since the April 1990 MTI were noticeably improved as observed during walkdown inspections. The licensee's corrective action taken to the April 1990 maintenance team inspection (MTI) violation was found to be inadequate (a violation) in that water tight door locking dogs were again found to be inoperable, and the licensee's programs for

deficiency identification again failed to identify the problem. One unresolved item was closed relating to the control of a Q-listed consumable; however, a new unresolved item was opened because the licensee did not assure that other Q-listed consumables were being controlled, and a new unresolved item was opened relating to the Nuclear Services Departments's lack of procedures to assure control of contractors doing safety-related maintenance work. Surveillance testing and calibration control programs were inspected and found to be functioning well.

DETAILS

1.0 Scope (62700)

This inspection assessed the corrective action taken by the licensee to three violations issued by letter dated August 21, 1990, resulting from a maintenance team inspection (MTI) conducted during April 9 - 27, 1990. The inspection included the licensee's response letter to the MTI dated September 21, 1990. People were interviewed, hardware and equipment were inspected, and documents were reviewed.

Individuals contacted during the course of the inspection and the attendees at the inspection's exit meeting held on May 24, 1991, are identified on Attachment 1.

Findings

Violation 1 (50-272 and 50-311/90-200)(Closed)

This violation concerned modified hatch covers installed in the service water rooms of both units that did not meet the water tightness specified by the Updated Final Safety Analysis Report; no safety evaluation had been made pursuant to 10 CFR 50.59.

The inspector visually inspected the new permanent hatch installations and found that the hatches appeared to be tightly sealed. The inspector had no further questions regarding the installation of the hatches, the sealing of the hatches, or the 10 CFR 50.59 safety evaluation performed for the temporary hatches that since had been replaced with the permanent hatches.

The licensee's September 21, 1990, response letter to the Notice of Violation stated that "these hatches have been stenciled to identify them as having to be maintained water tight and to contact the Shift Supervisor prior to opening." The visual inspection of the accessible hatch areas did not find the stated stenciling. The licensee's representative stated that plastic plates with the subject information had been installed in lieu of stenciling, but appeared to have been broken off and lost. At the end of the inspection, the licensee's representative stated that the stenciling had now been completed. The new stenciling of the hatches was not verified by the NRC inspector.

The licensee's September 21, 1990, response letter stated that a "revised Temporary Modification Program procedure was approved in August 1990." The inspector noted that the procedure was approved in March 2, 1990, not in August 1990, as stated in the subject letter. The licensee's representative stated that the new procedure was actually implemented in August 1990. Implementation was phased in because the procedure replaced two station procedures which were controlling ongoing work. The inspector had no further questions except for the lack of specificity of the response letter.

The September 21, 1990, response letter for corrective action stated that, "A procedure revision has been initiated to incorporate these water tight hatches into Abnormal Operating Procedure (AOP) Wind 1. This revision will be completed by October 1990." On May 21, 1991, the inspector found that the current Wind 1 revision was Revision 0, approved September 29, 1987, and that the last periodic review of the procedure was completed on May 24, 1990. Based upon interviews, the inspector determined that SORC meeting 90-133 on September 19, 1990, had approved the commitment to revise Wind 1 and that there appeared to have been an oversight in the tracking of the commitment. Failure to track the commitment was stated by the licensee's representative to be the cause for not completing the committed corrective action. During this inspection, the licensee initiated revisions to Wind 1 and approved Revision 1 to the procedure for both units on May 24, 1991. Based upon the revised Wind 1 procedure, the inspector had no further questions, except for the lapse in the licensee's management controls that resulted in missing the corrective action commitment. A licensee's representative stated that the licensing group has now initiated an "Action Tracking" computer program to track corrective action commitments to the NRC. The representative stated that this was not being done at the time of the MTI.

In conclusion, for Notice of Violation No. 1, the new replacement hatches were found to be adequate. The licensee failed to maintain stencil signs on the hatches as committed by their response letter. The issue was identified by the inspector. The licensee's management control for commitments in their response letter to the NRC was inadequate in that stencilling was not maintained and a procedure revision was not completed.

Violation 2 (50-272 and 50-311/90-200)(Open)

This April 1990 MTI violation was "Water tight doors between the service water valve rooms and the surrounding areas of the auxiliary building had not been adequately maintained in that the door latching dogs required to be operated to make the door closure water tight were unmovable from their undogged position when reasonable force was applied. This condition had not been promptly identified and corrected."

The licensee's September 21, 1990, response letter stated that "All water tight doors specified in the FSAR, including those required by abnormal operating procedures (AOP) were inspected, adjusted, and re-gasketed to bring them to an acceptable condition."

During this current inspection, the inspector interviewed cognizant maintenance personnel, examined, and verified a sample of the work orders (approximately 60 noted) that had been written and completed to fix the water tight doors during the period of May to August 1990. Water tight doors in both units were inspected. The inspector found (in both units) that some latching dogs required unreasonable manual force to operate and several could not be operated due to mechanical interference (with the latching dog). No acceptance criteria were identified for a maximum acceptable force for latching a dog. The licensee provided no engineering analysis or other information to provide a basis for not requiring all

door latching dogs to be capable of latching. The inspector opined that the licensee's corrective action taken had not corrected (in total) the conditions cited in the Notice of Violation. Alternatively, if the corrective action previously taken had fixed the latching dogs as indicated in the licensee's response letter, the conditions identified on May 21, 1991, had not been promptly identified and corrected to maintain the doors' latching dogs in an operable condition. The inspector did note that all doors sampled would close against their gaskets and that the gaskets appeared to be in good condition.

The licensee's corrective action response letter stated that "to increase awareness of the FSAR requirements in this area, the General Manager of Salem Operations has issued a letter to all station personnel detailing this violation and the importance of water tight doors and hatches to the physical plant." The letter was issued on September 7, 1990. The letter stated the importance of the doors to protect against flooding in the event of a storm as well as to prevent flooding from internal sources in the event of a high energy water or steam line break. The letter stated that "deficiencies in water tight doors and hatches be identified, work requests initiated ... doors are significant to plant safety." The inspector had no further questions regarding the general manager's letter except for the effectiveness to implement identification of deficiencies in the water tight doors' latching dogs. This part of the licensee's quality assurance efforts appeared inadequate based upon the NRC inspector identifying problems with latching dogs.

The licensee's corrective action response letter stated that a periodic PM task request had been initiated. The inspector interviewed the cognizant PM person identified to have been assigned responsibility for initiating the PM procedures. This person stated that the PM procedures were scheduled to be issued by September 1991. Based upon interviews, no interim PM task was initiated to ensure water tight door operability, including their latching dog operability, i.e., the only PM action taken was the task to develop the PM procedures. The inspector concluded that, based upon finding the inoperable latching dogs during this inspection, the licensee's PM corrective action was less than adequate.

In conclusion, for Violation No. 2, the corrective action planned and taken to assure and maintain water tight door operability was inadequate. Findings during this inspection in May 1991 were similar to findings of the April 1990 MTI. Evidence exists that maintenance had been performed on the water tight doors; however, no definitive acceptance criteria for latching dog operability was established, including any engineering evaluation that would permit less than all latching dogs being fully operable. The failure to maintain water tight doors' latching dogs operable and to identify and promptly correct latching dog deficiencies is a recurring violation (50-272/91-16-02 and 50-311/91-16-02).

Violation 3 (50-272 and 50-311/90-200)(Closed)

This violation included four examples involving failure to follow procedures during work performance by contractor individuals. The inspector concluded that the licensee had taken reasonable corrective action for each of the performance violations which included emphasizing that contractor employees need to follow procedures. The licensee also verified that corrective actions had been completed for the items involving hardware deficiencies.

The inspector had no further questions regarding these specific items.

ConclusionViolation 1

The replacement hatches were found to be installed adequately, thus closing the violation. The licensee did not maintain an information sign on the hatch covers as committed in their September 21, 1990, response letter; during this inspection, the licensee took corrective action to identify the hatches. The licensee's management controls for commitments in their response letter was inadequate.

Violation 2

The corrective actions planned and taken to assure and maintain water tight door operability were inadequate. The licensee's failure to identify and promptly correct latching dog deficiencies is a recurring violation. This violation remains open.

Violation 3

The corrective actions taken to specific items involving failure to follow procedures were adequate. This violation is closed.

2.0 Scope

This inspection assessed the action taken by the licensee to correct five MTI weaknesses identified in Appendix B of the August 21, 1990, NRC letter to the licensee. The weaknesses were identified during the MTI conducted during April 9 - 27, 1990. The licensee responded by letter dated October 19, 1990. People were interviewed and records and documents were inspected.

FindingsWeakness 1

"Management of maintenance backlog items and an absence of an effective backlog reduction program."

The actual maintenance backlog was stated to be approximately 3100 work orders at the time of this inspection or slightly higher than at the time of the MTI. The licensee's representative stated that, currently, more work orders are being written than are being worked off by the available resources.

The inspector toured areas of both units and noted a number of material condition improvements. The facilities visited were noted to be maintained clean and well painted, reflecting improvements that have taken place since the MTI. The licensee has instituted a maintenance backshift to more efficiently use resources. Improvements have been made in planning and scheduling to improve work effectiveness.

Based upon the continuing large work order backlog, this weakness remains an open concern until the licensee has demonstrated effectiveness in his backlog reduction program.

Weakness 2

"Lack of root cause analysis training for system engineers. General lack of adequate root cause analysis."

The licensee's October 19, 1990, response letter stated that four one-week sessions of root cause analysis training had been scheduled for 1991 and that "ten seats have been reserved for system engineers in each session. The Technical Department will schedule two or more engineers from each discipline to attend these classes. Based upon this schedule, all system engineers will be root cause analysis trained by the end of 1991." The technical manager stated that, due to imposed budget restraints, the schedule given in the October 19, 1990, response letter will not be met. Two of the four 1991 root cause analysis training classes have been postponed. To date, eleven system engineers have been trained in root cause analysis, 12 system engineers are in the course, and 17 are expected to complete the training in 1992, not "by the end of 1991," as stated in the licensee's October 19, 1990, letter. The licensee's representative stated intent to provide this change in commitment information to the NRC by letter.

The licensee's October 19, 1990, response letter stated a general guidance procedure on root cause would be issued by January 31, 1991, for use by system engineers. The Technical Department procedure was approved on February 14, 1991; however, it was not issued January 31, 1991, as stated in the licensee's response letter. The procedure TI-37, "Root Cause Analysis Guidelines," Revision 0, sets down the minimum training requirements for a root cause investigation team, provides guidance for the analysis process, data and information collection, methods for event analysis including corrective actions for root causes.

The inspector concluded that the licensee's issued procedure and completed training of system's engineers has provided a positive base upon which to improve root cause analyses. This weakness is closed.

Weakness 3

"Lack of capability to readily analyze older maintenance data for performance monitoring and evaluation."

The Maintenance Management Information System (MMIS) data base includes equipment history and records from 1987 forward. This data base is improving with time. Also, NPRDS data is available since 1984.

A new initiative to improve reliability of equipment and components is the Reliability Centered Maintenance (RCM) program which is doing indepth reviews of systems and identifying critical components relative to establishing improved maintenance. The licensee's October 19, 1990, response stated that "To date, the RCM has completed the review of 12 systems..." Based upon interviews and a review of the May 13, 1991, Preventive Maintenance Improvement Project Monthly Report - April 1991, the inspector determined that only 10 systems were complete as of May 1991, not "12 systems" as stated in the licensee's October 19, 1990, response letter. The RCM group manager stated that 7 systems were completed for Salem and 3 for Hope Creek. The RCM group plans to do 4 systems in 1991. He stated that the RCM budget had been reduced for 1991; however, efficiencies achieved in their work methods permit meeting their schedule for 1991. He stated that, in the original RCM scope, it was planned to do a total of 60 systems.

The licensee's stated intent is to include the old pre-1987 maintenance data for critical components with history problems into the RCM database. The inspector noted the slow progress being made in completing the RCM program. However, the MMIS database initiated in 1987 is growing with time and NPRDS and other historical maintenance data are used during RCM system reviews. This results in evaluation of older data. This weakness is closed.

Weakness 4

"Inadequate technical procedures, absence of formal maintenance procedures for important and repetitive tasks."

Specific procedural concerns identified by the MTI inspection report in paragraph 4.1.7, "Maintenance Procedures," were addressed by the licensee through revisions to procedures. No other concerns were identified regarding the action taken.

The licensee's procedure upgrade project (PUP) was initiated in September 1989, PUP is providing a general technical upgrade to approximately 388 (on May 21, 1991) maintenance procedures. The total PUP project includes 3949 procedures per the PUP manager. The total project was stated to be 32.5% complete. As of May 5, 1991, 160 maintenance and

electrical procedures were upgraded. Based upon the actions taken to address the specific MTI findings and the overall actions underway in the PUP, this weakness is closed.

Weakness 5

"Poor control of contractor maintenance activities."

During the MTI, the licensee took immediate and satisfactory corrective action to specific concerns the team identified relative to contractor control. However, the team was concerned that the licensee had not taken any broad actions to identify, evaluate, and correct potential problems indicated by the team's findings.

The inspector first determined the PSE&G departments that were controlling contractors performing safety-related maintenance activities in the plant. Based on interviews, these departments were Maintenance, Engineering and Plant Betterment, and the Nuclear Services (site services) Department. The inspector next assessed contractor controls for each of these departments.

Maintenance Department

The licensee's October 19, 1990, response letter stated that the Salem Administrative Procedure, SC.MD-AP.ZZ-0005, "Control of Contractor Work," Revision 1, had been revised. This is a Maintenance Department procedure and defines the requirements for control of work performed by contractors under the direction of the Maintenance Department. Responsibilities are clearly defined, including requirements for monitoring of contractor work. The procedure covers personnel qualification, procedure requirements, and makes the Salem Handbook of Standards a qualification requirement for contract personnel. The inspector interviewed three maintenance contract administrators. Based upon the interviews and a review of maintenance monitoring observation reports of contractors, the inspector concluded that the Maintenance Department has a program to achieve acceptable control over their contractors.

Engineering and Plant Betterment (E&PB)

Procedure DE-CS.ZZ-0031(Q), "E&PB Contractor Site Qualification & Training," Revision 0A, provides a program to assure that E&PB contractors are knowledgeable of the site procedures and controls for conducting work. The procedure includes responsibilities for both E&PB and contractor personnel. The procedure also calls for job specific briefings and training. E&PB conducts periodic meetings with contractors and conducts a formalized contractor evaluation including a weekly published report card. E&PB maintains a core of 24 contractor staff full time, 12 from Bechtel and 12 from Stone and Webster. Each staff is permitted to work up to 50 craftsmen with the existing core team. Although the E&PB did not have an overall

procedure delineating all of the controls, the inspector concluded, based on interviews and sampling of documentation, that existing controls over contractors, although somewhat fragmented, appeared adequate.

Nuclear Services

Cognizant Nuclear Services representatives stated that Nuclear Services Department has no formal department procedures for delineating qualification and management controls of contractors performing maintenance work. They stated that their department did not use the Maintenance Department's procedure for control of contractor work. Nuclear Services was stated to have conducted the bulk of the maintenance work within containment the last outage. The representatives stated that, for example, Westinghouse used their own procedures for performing steam generator work; the procedures were reviewed by Nuclear Services before the job. Also, the Nuclear Services Department qualified contractors to form NC.NA-AP.ZZ-0014-4, which is from the Nuclear Department's "Training, Qualification, and Certification," procedure. A representative further said that nuclear services only checks to see if qualifications of contractors are in order, whereas QA verifies contractor qualification. It was stated that Nuclear Services conducted daily meeting with contractor managers, e.g., Westinghouse doing steam generator work and that all contractor supervisors were also briefed regarding the "Salem Handbook of Standards."

An interview of a cognizant station QA person and review of station QA surveillance report (91-049) determined that the qualification and work history of Westinghouse people doing containment work had been verified by QA. A review of the "IR9 Outage QA critique," dated May 8, 1991, identified contractor problems relative to steam generator work under the cognizance of Nuclear Services.

The Nuclear Services Department has not demonstrated that existing procedures are adequate to control contractors conducting safety-related maintenance, i.e., they meet Regulatory Guide 1.33, "Quality Assurance Program Requirements," and ANSI N18.7-1976, "Quality Assurance for the Operational Phase of Nuclear Power Plants," relative to administrative and management controls. This is an unresolved item (50-272/91-16-03, 311/91-16-03).

In conclusion regarding "Poor control of contractor maintenance activities," the Maintenance Department has improved their control over contractors and this was found to be acceptable; E&PB Department's control was adequate; However, Nuclear Services Department's management and administrative controls over contractors performing safety-related maintenance were not demonstrated and were made an unresolved item.

Conclusion of Review of Identified MTI Weaknesses

Three of the five weaknesses (numbers 2, 3, and 4) were closed. Weakness 1, "Management of maintenance backlog items and an absence of an effective backlog reduction program remains open pending the licensee demonstrating effectiveness in his backlog reduction program. The backlog has slightly increased (worsened) since the MTI. Regarding weakness No. 5, "Poor control of contractor maintenance activities." This control has improved and is at an acceptable level in the Maintenance Department and E&PD Department; however, the Nuclear Services Department appears to lack management and administrative procedural control coverage for conducting safety-related maintenance work using contractors. This issue is an unresolved item. During inspection of Weakness 3, the inspector identified an apparent inaccurate statement in the licensee's October 19, 1990, response letter regarding the number of completed RCM analyses.

3.0 Technical Specification Surveillance Testing (61700 and 61725)

A technical specification (TS) audit project was established for the Salem Generating Station resulting from a series of overdue surveillance requirement tasks identified in 1987 and 1988. A TS verification project was initiated in September 1988 to review the managed maintenance information system (MMIS). (Note: The MMIS is a work order database program the licensee uses to schedule surveillance requirement tasks with a frequency of greater than 7 days). This was subsequently expanded to include: (1) a Technical Specification Surveillance Monitoring Program, (2) a Technical Specification Amendment Implementation Program, and (3) a line-by-line reverification that all Technical Specification surveillance requirements were covered by surveillance procedures.

The objective of the audit project was to eliminate noncompliance with TS surveillance requirements due to improper TS scheduling, amendment implementation, and surveillance requirement identification. The TS audit project included four distinct, but related activities: (1) the MMIS database reverification, (2) the TS surveillance monitoring program, (3) the TS amendment implementation program, and (4) the TS surveillance reverification project.

The results of the audit project are: (1) all recurring tasks in the MMIS database have been verified to reflect the TS requirements they fulfill; (2) a PC-based database has been developed that cross-references the TS, the procedures used to meet TS requirements, and the department responsible for each recurring TS requirement; (3) LERs have been submitted to the NRC for all cases of noncompliance that this program identified (Attachment 2 to this report contains a listing), and (4) administrative controls have been established to monitor TS surveillances and insure that the present program provides controls over TS amendments. The completion of the audit project and the controls the licensee has established to maintain their present TS status should ensure that future changes will be captured by the system and effect any needed updating.

The licensee has scheduled audits of the technical specification program for June 24, 1991, and the inservice testing program (IST) for August 5, 1991. These audits are designed to test the function of the various systems and interfaces developed as a result of the technical specification audit project.

The inspector had no further questions regarding TS surveillance testing within the sample taken. No violations or deviations were found.

4.0 Inservice Test Program (IST) (Module 73756)

The "Inservice Testing Program Revision and Request for Interim Approval of Second Ten Year Interval IST Program Salem Generating Station, Unit Nos. 1 and 2," dated June 26, 1987, has been submitted to the NRC for approval. In May 1991, the licensee submitted to the NRC the latest revision of the Inservice Testing (IST) Program for Salem Unit Nos. 1 and 2.

The inservice inspection and testing programs for the Salem Unit Nos. 1 and 2 is described in procedures WPN-PLP-10 and AP27. These procedures, both titled "Inservice Inspection and Testing Program," are implemented at the Salem Unit Nos. 1 and 2. The Technical Department Inservice Testing Engineer maintains the status of the IST program and is developing a system for analyzing test results and issuing trending information based on test data.

The technical specification (TS) requirements for IST have been incorporated into procedures and identified in their second ten year plan. A verification to ensure that each TS requirements has been procedurally covered is completed. A Quality Assurance Audit of the TS vs. the IST procedures is scheduled for August 5, 1991. The Inservice Test Engineer has completed an inspection to verify that the TS requirements for IST are in procedures.

Procedures describing TS testing requirement have been written using the guidance defined in procedure QA-PJ.ZZ-1031(Q), "Procedure Upgrade Project Manual," (PUP) issued April 26, 1991. A sample review of IST procedures verified that such areas as post-maintenance testing are considered and included where necessary, TS references are identified, both TS and ASME Boiler and Pressure Vessel Code, Section XI, are referenced, and an acceptance criteria is required. No violations or deviations were identified.

Attachment 2 also provides a listing of surveillance-related documents reviewed and Attachment 3 provides completed surveillance test work orders that were reviewed by the inspector during the course of the inspection. These WOs were inspected to verify that the licensee met TS requirements and tests were performed in accordance with the test procedure. The inspector also verified that when a requirement was not met, the required documentation was completed and a review of the item was performed and documented by the responsible supervisor.

No violations or deviations were identified.

5.0 Inspection of a Previous Unresolved Item

(Closed) Unresolved Item 50-272/89-15-01. Improper mix of boric acid compounds had been inadvertently used in the batching process and, subsequently, injected in the reactor coolant system (RCS).

The licensee has revised their boron concentration operations procedures II-3.3.6, Revision 2, for Unit 2 and procedure II-3.3.6, Revision 11, for Unit 1 to include a verification test and sign-off by the Chemistry Supervisor before this type of material can be issued. A training procedure change and retraining courses on this subject have also been given.

Based on the above actions taken by the licensee and the present controls that have been put in place to control this material, this item is considered closed.

The inspector found, however, that other licensee programs to control Q-listed expendable and consumable items had not been addressed by the licensee. Reviews and evaluations by the licensee to assure that acceptable programs exist to control Q-listed expendable and consumable items is a new unresolved item. (50-272/91-16-01, 50-311/91-16-01).

6.0 Unresolved Items

Unresolved items are matters about which additional information is necessary in order to determine whether they are acceptable or they constitute a violation. Unresolved items are discussed in the details of Sections 2 and 5.

7.0 Management Meetings

Licensee management was informed of the scope and purpose of the inspection at an entrance meeting conducted on May 20, 1991. The findings of the inspection were periodically discussed with licensee personnel during the course of the inspection. The inspector met with the licensee representatives (denoted in Attachment 1) at the conclusion of the inspection on May 24, 1991. The inspector summarized the scope and findings of the inspection as described in this report.

Attachments:

1. List of Individuals Contacted
2. LERs
3. Work Order Nos.

ATTACHMENT 1

Individuals Contacted

Public Service Electric and Gas Company

*R. Brown	Principal Engineer, Licensing and Regulation
*B. Connor	Technical Staff Engineer
*R. Donges	Licensing Engineer
*F. Kaminski	Inservice Testing Coordinator
*M. Morrone	Technical Department Manager
*A. Orticelle	Manager, Training
*L. Piotti	Quality Assurance Auditor
*V. Polizzi	Operations Manager
*M. Shedlock	Maintenance Manager
W. Schultz	Manager of Station Quality Assurance
*E. Villar	Station Licensing Engineer
*C. Vondra	General Manager, Salem Operations

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*S. Barr	Resident Inspector
*N. Blumberg	Chief, Performance Programs Section, DRS
*S. Pindale	Resident Inspector

*Denotes those present at the exit meeting on May 24, 1991.

Other plant, technical, and management personnel were contacted during the course of the inspection.

ATTACHMENT 2

- 1.0 The following LERs were sent to the NRC as a result of the Technical Specification Audit Project.

LERs applicable to both Units 1 and 2.

Unit 1	#89-004	RCP Breaker Position Trip not tested.
Unit 1	#89-015	Mechanical Snubbers not fully tested.
Unit 2	#89-015	Containment Wide Range Pressure not calibrated within proper time frame.
Unit 1	#90-020	Setpoint for P-6 for both units.
Unit 1	#90-024	P-10 and P-12 permissives not fully tested.
Unit 1	#90-035	PORV secondary indication not tested within proper time frame.
Unit 2	#90-035	Safety Injection Input From SSPS not tested within proper time frame.

LERs applicable to Unit 1 only.

Unit 1	#89-022	TS Amendment 91 implementation problems.
Unit 1	#89-028	TS Amendment 94 implementation problems.
Unit 1	#89-029	AFW motor driven pumps not tested within proper time frame.

LERs applicable to Unit 2 only.

Unit 2	#89-025	AFW motor driven pumps not tested within proper time frame.
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- 2.0 The following documents and surveillance test results were reviewed by the inspectors to establish that Technical Specification (TS) surveillances were identified, tested, and conducted on schedule.

Documentation

AP-12	Technical Specification Surveillance Program
AP-27	Inservice Inspection and Testing Program
TI-28	Pumps Surveillance Testing Results Analysis
PLP-10	Vice President Nuclear Procedure, Inservice Inspection and Testing Programs

SP (0) 4.0.5-P (Gen)	Operations Department Surveillance Procedure
SP (0) 4.0.5-P-BA (11)	Inservice Testing - Boric Acid Pumps

Revised 1991 QA Audit Schedule

Audit Plan - Surveillance Testing (TS) Index No. 170

Audit Plan - Inservice Testing, Index No. 012

Surveillance No. 91-0094 - Assessment of Procedure Upgrade Project (PUP)

3.0 The following documents were reviewed by the inspector during the inspection of the sodium intrusion event of June 1989 (URR 50-272/89-15-01) and the calibration control program for safety-related instrumentation not specifically controlled by Technical Specifications:

- Operating Procedure II-3.3.6, Revision No. 11, Boron Concentration Control, Unit 1
- Operating Procedure II-3.3.6, Revision No. 2, Boron Concentration Control, Unit 2
- Quality Assurance Audit Report No. 91-142, Mechanical Maintenance, April 1 - 26, 1991.

ATTACHMENT 3

Work Order Nos.

WO-NO. 910424070 Unit 1	Nuclear Instrumentation System Channel Calibration Check on Power Range Channel IN43. (4/8/91)
WO-NO. 901010016 Unit 1	IPT457 Pressurizer Pressure Sensor CAL/CH 111 Sensor Calibration. I&C Procedure IPT-457 Pressurizer Sensor Calibration. (3/11/91)
WO-NO. 910328082 Unit 2	150UDC Reactor Trip Breaker B - SSTS Train B. Procedure NC.NA-AP.ZZ-0032-4. Solid State Protection System Functional Test - Train B (4/1/91)
WO-NO. 910227046 Unit 1	Containment Hydrogen Analyzer Functional IAW Procedure 1C-3.9.049 - Containment Hydrogen Analyzer Channel Functional Check. (4/3/91)
WO-NO. 901211030 Unit 1	Rod Control System/Measure Rod Drop Time. Procedure No. IIC-5.2.001 - Rod Drop Time Measurement Hot Full Flow (4/22/91)
WO-NO. 910430042 Unit 2	Radiation - Monitoring System/ Perform Channel Calibration Procedure No. 2PD 4.5.011 Channel Calibration Check. (5/1/91)
WO-NO. 910420069 Unit 1	14A NIS Power Range Drawer. Procedure No. IIC-16.4.0.24. Power Range Channel IN44 Detector Current Adjustment. (4/28/91)
WO-NO. 901021032 Unit 1	11STM Gen Feed and Cond Differential Pressure TMTR. Procedure No. IIC-2.5.033. Sensor Calibration. (2/21/91)
WO-NO. 91022034 Unit 2	2TE4131A/B/#23 Loop TAVG/Chan. Func./Ch. 111. Procedure No. 2TE-431A-B #23 Rx Coolant Loop Delta-T TAVG Prot. Ch 111. (2/25/91)
WO-NO. 920901003 Unit 2	2E11F/460V BKR Maint/21 RCP Mtr Htr. Procedure No. M94.5 (4/25/91)
WO-NO. 910423090 Unit 2	STA Batteries. Perform Weekly TS Surveillance. Procedure No. SC.MD-ST.ZZ-0003 (Q) (4/25/91)