

U.S. NUCLEAR REGULATORY COMMISSION
OFFICE OF INSPECTION AND ENFORCEMENT

REGION III

Report No. 50-346/79-13

Docket No. 50-346

License No. NPF-3

Licensee: Toledo Edison Company
Edison Plaza
300 Madison Avenue
Toledo, OH 43652

Facility Name: Davis-Besse Nuclear Power Plant, Unit 1

Inspection At: Davis-Besse Site, Oak Harbor, OH

Inspection Conducted: March 13-15, April 2-30, May 1-4, 17,
18 and 21-25, 1979

Inspectors:

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(3/13-15, 4/2-10, 16-29, 5/17, 18,
21-25/79)

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Inspection Summary

Inspection on March 13-15, April 2-29, May 17, 18, and 21-25, 1979
(Report No. 50-346/79-13)

Areas Inspected: A routine, unannounced inspection of plant operations, followup on licensee event reports, and a special unannounced inspection covering the TMI-2 incident and the licensee's response to IE Bulletin 79-05A and 79-05B. The inspection involved 781 inspector-hours onsite by six NRC inspectors.

Results: Of the three areas inspected, no items of noncompliance or deviations were found in two areas; one item of apparent noncompliance was identified in the other area (infraction - failure to follow procedure - Paragraph 7).

DETAILS

1. Persons Contacted

T. Murray, Station Superintendent
B. Beyer, Assistant Station Superintendent
P. Carr, Maintenance Engineer
S. Quennoz, Technical Engineer
G. Wells, Administrative Coordinator
D. Miller, Operations Engineer
D. Briden, Chemist and Health Physicist
J. Hickey, Training Supervisor
L. Simon, Operations Supervisor

The inspectors also interviewed other licensee employees, including members of the technical, operations, maintenance, I&C, training and health physics staff.

2. Licensee Action on Previous Inspection Findings

(Closed) Noncompliance (346/79-05-02 and 79-05-03). The inspector reviewed the corrective action taken by the licensee and has no further questions at this time.

3. Facility Operations

The inspector reviewed the following status records to determine whether reactor operations are in conformance with regulatory requirements.

Shift Foreman - Unit Log
Reactor Operator Log
Daily Log Sheets
Jumper/Lifted Lead Log
Tagout Log
Deviation Report Files
Special and Standing Orders

The review of the Daily (Shift) Log Sheets revealed that some of the maximum - minimum parameter limits were no longer applicable either because the units were not right or the operating parameters had changed. These findings were discussed with the Operations Engineer. The Operations Engineer stated that he would review the logs and make appropriate changes to the daily log sheets.

No items of noncompliance or deviations were identified.

4. Plant Tour

The inspector walked through various areas of the plant to observe operations and activities in progress, to inspect the general state of cleanliness, housekeeping, and adherence to fire protection rules, and to review with operators the status of various annunciators which were listed in the control room.

No items of noncompliance or deviations were identified.

5. CRDCS Trip Breakers

On June 12, 1978, B&W site representatives sent a letter (SOM #382) to the station concerning problems with the CRDCS trip breakers at other B&W plants. The inspector reviewed the actions taken by the licensee in regard to the recommendations for a preventative maintenance program. The following are the findings of this review:

- The B&W letter SOM #382 was logged in at the station on June 13, 1978.
- AIR 1-78-78 was issued to the maintenance group on June 22, 1978 to initiate a preventative maintenance program.
- The AIR was acted upon and completed June 26, 1978.
- Preventative maintenance MWO-78-1628 was issued with the following instructions: Every refueling outage, inspect, cycle, clean and lubricate CRDCS trip breakers. Document any deficiency found and record on the attachment to this MWO. GE instruction manual 502998 was referenced for specific details.
- MWO-78-1628 was initiated and completed the first time on July 1, 1978.
- A representative of the licensee stated that to the best of his knowledge they had not experienced any problems with their CRDCS breakers.

Per request this information was telecon to IE Headquarters on March 14, 1979.

6. Licensee's Review of March 20, 1978 Rancho Seco Event

On August 9, 1978, the B&W site representative sent a letter (SOM #403) to the station superintendent concerning the loss of power to the NNI instrumentation and the resulting transient that occurred at Rancho Seco on March 20, 1978. The B&W letters primary thrust was a

recommendation for operator training to respond to loss of instrumentation and procedures to restore power to instrumentation if power is lost.

The inspector reviewed the actions taken by the licensee in response to the B&W letter. The following are the findings of this review:

- The letter was put on the reading list for licensed operators.
- The B&W simulator training included loss of instrumentation power losses in casualty training program.
- Loss of NNI and ICS power is monitored and alarmed on the plant computer. The ICS power trouble is alarmed on an alarm panel.
- There is an alarm procedure for loss of power to the ICS.
- A comparison was made between Rancho Seco and Davis-Besse 24 VDC power supplies indicating a low probability of a short causing loss of power to the NNI's. (one amp fuses vs 5 and an alternate automatic power supply)
- The NNI control functions include pressurizer level and pressure control and reactor coolant pump seal injection flow. On loss of power the transfer relay reverts the control back to manual.
- The event was reviewed by TECo in response to an inspection by American Nuclear Insurers.
- Plant has a file on the event including NRC Current Events, Rancho Seco's report to the NRC, minutes of SMUD Management Safety Committee review of the event and Rancho Seco's proposed Alarm procedures for restoring NNI power.

The inspector noted that although there is an alarm procedure for loss of power to an ICS channel and the system procedure for the NNI addresses operation with the loss of one NNI power channel, the procedures do not specifically address immediate restoration of power by an operator. This item is unresolved pending further review. (79-13-01)

Per request this information was telecon to IE Headquarters on March 14, 1979.

7. LER 79-29

The licensee reported on March 6, 1979 by telephone and with a 14 day report dated March 16, 1979 the inadvertent closure of DH7A and

DH7B valves. DH7A and 7B valves are normally open isolation valves for the BWST. DH7A controls the BWST supply to one ECCS train (HPI, LPI and CS pumps) and DH7B controls the supply to the other ECCS train.

An equipment operator (EO) had been instructed by a reactor operator to close manual valve BW-7 as part of a valve line up to complete the draining of the spent fuel pool. The EO stated that he could not find BW-7, but found DH7A and 7B. He proceeded to close the motor operated DH7A and 7B from the local control switches. The EO immediately returned to the control room and reported that he had closed DH7A and 7B. The reactor operator properly reopened DH7A and 7B on learning of the error. Based upon the computer printout, the valves were closed approximately seven minutes.

The inspector reviewed the event and held discussions with the personnel involved. The findings of this review are:

- a. A properly reviewed temporary modification (T-3431) to procedure SP 1104.29 was being used to complete the pump-out of the spent fuel pool.
- b. All the valves on the temporary procedure except BW-7 were located inside the Auxiliary Building. These valves were aligned by two other operators.
- c. The third operator scheduled to make rounds outside the building was instructed by the reactor operator to close BW-7 to complete the lineup. The reactor operator stated that he felt the instructions were clear and he remembered saying that BW-7 was a manual valve.
- d. The EO with the access key inhand proceeded to the valve and pipe trench connecting the BWST to the Auxiliary Building. The BWST is located outside the Auxiliary Building. A steel-grate-covered, key-locked pipe trench is used to connect the BWST to the ECCS equipment inside the Auxiliary Building.
- e. The following is based upon an interview with the EO:
 - He could not locate a valve tagged BW-7.
 - He found two remote control switches marked DH7A and DH7B. He noted that the valves were motor operated, but that the actual valves were not tagged with the valve number, however, the control cable from the switches could be traced to the valves.

- He did not remember hearing the instruction that the valve he was to close was manual.
 - He did not know at the time that DH7A and DH7B were in a safety related system.
 - He felt at the time he was closing the right valves, although there was some initial confusion but not sufficient to go back to clarify the instructions (did not know that there was a telephone located around the corner from the BWST).
 - After closing DH-7A and 7B, he went straight back to the control room and questioned why he had been sent out to close motor operated valves that could be closed from the control room.
 - He had been employed with the company for approximately 6 months and was in the company's licensed operator training program. He had not been specifically instructed in part of the system. This was the first time he had been instructed to operate a valve on his own (normal company policy is for an EO in training to be directed by an experienced operator until he has been instructed in the operation of a system).
 - He had 6 years previous associated experience and training prior to being employed by the company.
 - He stated that he had a bad headache that shift (0000-0800 hrs) and had mentioned it to his foreman but felt he could make it through the shift. However, he felt new employees were under pressure during their probationary period to stay on the job.
- f. The valve position indications for DH7A and DH7B are located on the SFAS vertical panel. The valve positions are also monitored via the computer and any change in position is printed on the alarm typewriter. However, this change in valve position is not alarmed.
- g. The alarm printout for March 6, 1979 indicated that DH7A and DH7B were closed at 4:08:25 and 4:08:39 and reopened at 4:15:15 and 4:15:17 respectively.
- h. Special Order No. 72, Equipment Operation by New Personnel, dated April 14, 1976 and still in force states in part that the Shift Foreman is responsible to insure whenever a person is requested to operate a piece of equipment or controls that he

be properly trained and indoctrinated to operate the equipment. For new persons who have not operated specific equipment, an EO or person having such training should accompany the person and instruct him in proper operation.

- i. On an SFAS initiating signal DH7A and DH7B get a confirmatory open signal (the valves are normally open during reactor operation to insure the proper response time of the ECCS pumps).

Corrective action taken or being taken by the licensee includes:

- a. The employee was officially reprimanded.
- b. A copy of the LER and a memorandum from the Operations Engineer were sent to all operations personnel stressing the importance of the event, giving clear instructions, requesting clarification of instructions if there is any doubt, identification of systems, and reporting illnesses that could hamper performance.
- c. Design and procurement were initiated to provide key lock control over remotely operable safety related valves.
- d. An expanded locked valve and logging system was initiated for vital safety related valves.
- e. Also as part of the response to Bulletin 79-05 and 79-05A, the licensee is strengthening independent verifications of valve lineups and changes to valve lineups.

The licensee is currently evaluating the potential consequences of DH7A and DH7B being closed and a SFAS actuation occurring. Preliminary results indicate that the HPI and LPI pumps would not have been damaged assuming DH7A and/or DH7B would open as designed on a SFAS actuation. This item is unresolved pending completion of this evaluation. (79-13-02)

Technical Specification 6.8.1 requires written procedures to be established, implemented and maintained. The failure of the licensee to properly implement Temporary Modification T-3431 to procedure SP 1104.29, Clean Liquid Radwaste Operating Procedure, March 6, 1979 is considered to be an item of noncompliance with Technical Specification 6.8.1. This is evident from the fact that:

- DH7A and DH7B were closed rather than BW-7 as called for in the procedure T-3431.
- An operator who was not fully qualified by his own statement was requested to close BW-7 contrary to the station superintendent's written policy, Special Order 72.

- The closing of DH7A and DH7B represented a potential degradation of both trains of the ECCS and is contrary to the valve lineup required by procedure SP 1104.07, HPI System Operating Procedure, SP 1104.04 DH and LP Injection Operating Procedure and SP 1104.66 BWST Operating Procedure.

This particular IER was used as one of several to express Region III's concern over the number of personnel errors and breakdown in management control systems at the station during a management conference held April 18, 1979 (Inspection Report No. 50-346/79-08). During that conference the licensee was asked to address what additional steps they would take to reduce the number of personnel errors and improve their management controls. These concerns were addressed by the licensee and are documented in Inspection Report No. 50-346/79-12.

8. LER 79-34

The licensee reported by telephone on March 12, 1979 and via a 14 day written report dated March 23, 1979, the freezing of the common recirculation line of the HPI pumps 1-1 and 2-1 that was discovered on January 3, 1979.

At the time of the event the plant management assessed the consequences of the frozen recirculation line and concluded the HPI pumps were still operable and would perform their intended function if called upon. This decision was documented in the shift foreman's log. In addition, the reactor operators were instructed to shut down the pumps if for some reason they operated and there was no flow into the reactor coolant system.

On March 12, 1979 during a discussion on heat tracing problems between station personnel and TECo Power Engineering, the operability of the HPI pumps with the minimum recirculation line frozen came up. Based upon previous analysis, Power Engineer personnel concluded that the HPI pumps should have been considered inoperable at the time of the event and that the event should have been reported to the NRC.

The recirculation line for the HPI pumps serves two functions. It provides for flow testing of the pumps and it provides a minimum flow path to prevent possible heatup and seizing of the pumps. A minimum flow path is needed to cover the situation in which the pressure in the reactor coolant system is greater than the discharge head of the pumps (approximately 1600 psig). In such situations the pumps could operate "dead headed" with no water flow through the pumps. Continued operation in this mode would cause the pump casing and internals to heat up. The heating or temperature change affects internal pump clearances and can cause the pump to seize at some maximum temperature limit.

The inspector reviewed licensee actions and evaluations with respect to this event to verify that the event was reviewed and corrective action was taken in accordance with regulatory requirements. The findings of this review are:

- a. The freezing of recirculation line was the result of design defects that did not compensate for extreme cold weather. The thermal sensing element controlling the heat tracing for the line is located in a sheltered area and thus did not sense the minimum exposure temperature for the line. Also there was an insulation installation defect at the apparent point of freezing.
- b. An initial attempt to unblock the frozen recirculation line was made on January 3, 1979. The line was finally freed on January 5, 1979. At that time, Surveillance Test ST 5051.41 was successfully performed to demonstrate pump and recirculation line operability.
- c. Temporary measures were taken to prevent refreezing of recirculation line.
- d. The licensee is currently evaluating further methods to prevent freezing of the line.
- e. TECo Power Engineer personnel are continuing to evaluate the consequences of the frozen recirculation line. Preliminary evaluation based on information from the pump manufacturer indicates that the pump could run "dead headed" for approximately ten minutes before the pump casing temperature would reach a critical level.

This item will remain unresolved pending the final review of the licensee's corrective action and engineering evaluation. (79-13-03)

9. IE Bulletin 79-05A and 79-05B

a. General Background

The plant was shutdown for a general maintenance outage on March 30, 1979. The outage was initially scheduled for approximately 10 days. In view of the TMI-2 incident, the licensee extended the outage to provide the TECo staff time for independent review of information coming from the TMI-2 incident and its relationship and effect on the Davis-Besse plant. This included review of administrative and procedural controls and plant design, supplemental operator and staff training, and review and implementation of the requirements of IE Bulletins 79-05A and 79-05B. As of May 25, 1979, the plant remained in Mode 5 (Cold Shutdown).

NRC inspectors were dispatched to the site starting April 2, 1979 to follow day to day operations, to insure that the operating staff was trained on the events associated with the TMI-2 incident, and to conduct an independent review of the licensee's administrative and procedural controls over engineered safety features.

This inspection report covers the period from April 2 to May 25, 1979. This is an interim report for the activities inspected. The inspection effort on the licensee's reponse to Bulletins 79-05A and 79-05B is continuing and will be reported in a subsequent report.

b. Training on the TMI-2 Incident

To insure that the plant operating staff was fully aware of the specific details of the TMI-2 incident, the inspectors participated in special training classes conducted by the licensee. The inspector lead off each training session with a discussion on specific events and/or actions that lead to the transient and the actions that lead to fuel damage and release of gaseous activity to the environment. The licensee's instructor continued the training with a detailed discussion of the sequence of events supplemented by graphs of operating parameters during the event.

Special emphasis was made on ensuring the operability of safety related systems, not blocking the ECCS systems, and not securing RCP's during transients, looking for failures in the PORV, not relying on one set of parameters for RCS condition and the need to look at the overall problem in assessing what to do.

Three training sessions were held starting April 9-11, 1979. These sessions included the personnel from the five operating shifts and technical staff personnel. The licensee also conducted simular training sessions for maintenance and I&C personnel on April 17 and 18, 1979 and Chemistry and Health Physics personnel on April 19 and 20, 1979.

The inspector verified also by review of plans and discussions with licensed operators that licensee sent their licensed operators to the B&W simulator at Lynchburg, Virginia for special training on the TMI-2 incident. These sessions were conducted April 16-20, 1979.

The licensee is planning to conduct additional training on design changes and procedure changes resulting from their review of Bulletins 79-05A and 79-05B when these changes are complete. The inspector will audit their training at that time.

The inspector verified that all operators and supervisory personnel were instructed in the provisions and directives for early NRC notification of serious events.

c. Review of Engineered Safety Feature Procedural Lineups

To verify the adequacy of alignment procedures for Engineered Safety Features (ESF), the inspectors reviewed the procedures for correct valve breaker, and switch alignments. The procedures were compared against current P&ID and single line diagrams. The systems included in this review were:

Core Flood - SP 1104.01
Decay Heat and Low Pressure Injection - SP 1104.04
Containment Spray - SP 1104.05
High Pressure Injection - SP 1104.07
Containment Air Cooling - SP 1104.08
Service Water - SP 1104.11
Component Cooling Water - SP 1104.12
Emergency Ventilation System - SP 1104.15
Borated Water Storage Tank - SP 1104.66
Safety Features Actuation System - SP 1105.03
Steam Feedwater Rupture Control System - SP 1105.16
Auxiliary Feedwater System - SP 1106.06
Emergency Diesel Generators - SP 1107.11

As a result of this review several omissions were found in valve and breaker verification checklists attached to the system procedures. The inspectors did not attempt to verify whether these omissions were covered by other procedures. This position was based upon the philosophy that the system procedure should list all valves and breakers associated with the system.

Because the plant was in cold shutdown and the licensee was in the process of reviewing and revising these procedures as part of their response to Bulletins 79-05A and 79-05B, the inspector's findings were submitted to the licensee for review and resolution. This item remains unresolved pending completion of licensee's resolution of the inspector findings. (79-13-04)

d. Review of Procedural and Administrative Controls for Return to Service

To verify the adequacy of procedural and administrative controls for returning equipment or system to service following maintenance and testing, the inspector reviewed administrative, plant operating, and surveillance test procedures to determine the specific controls used. The procedures reviewed included the following (other procedures were reviewed without comment and are not listed).

AD 1805.00 - Procedure Preparation and Maintenance - Rev. 13.
AD 1839.00 - Station Operations - Rev. 4.
AD 1823.00 - Jumper and Lifted Wire Control Procedure - Rev. 8.
AD 1838.02 - Performance of Surveillance and Periodic Test - Rev. 4.
AD 1839.02 - Locked Valve Log - (new procedure in draft).
AD 1803.00 - Safety Tagging Procedure - Rev. 1
AD 1838.00 - Surveillance and Periodic Test Program - Rev. 3.
AD 1844.00 - Maintenance - Rev. 4.
PP 1102.01 - Pre-Startup Checklist - Rev. 6.
PP 1102.02 - Plant Startup Procedure - Rev. 9.
ST 5051.01 - ECCS Monthly Test - Rev. 6.
ST 5067.01 - Emergency Ventilation System - Rev. 6.
ST 5011.01 - Boron Injection Flow Path Test - Rev. 6.
ST 5031.18 - Steam-Feedwater Rupture Control System Integrated Test - Rev. 2.
ST 5081.01 - Diesel Generator Monthly Test - Rev. 6.
ST 5062.01 - Containment Spray System Monthly Test - Rev. 6.
ST 5075.01 - Service Water System Monthly Test - Rev. 5.
ST 5071.01 - Auxiliary Feedwater System Monthly Test - Rev. 7.
ST 5076.01 - Control Room Emergency Ventilation Monthly Test - Rev. 3.
ST 5076.02 - Control Room Emergency Ventilation System 18 Month or Special Test - Rev. 3.

ST 5031.03 - Containment Pressure to SFAS Refueling
Test - Rev. 3.

As a result of this review several specific weaknesses were noted in the licensee's procedures. Since the licensee was also reviewing these procedures as part of their commitments to Bulletins 79-05A and 79-05B, the specific comments were supplied to the licensee for resolution. This item is unresolved pending completion of the licensee's resolution of the inspectors findings. (79-13-05)

The general findings were:

- Administrative procedures were weak in providing policy, guidance and requirements to insure that the equipment and system are properly removed from service for maintenance or testing and the equipment or systems were properly returned to operation after a long outage.
- Surveillance test procedures provide more control than the governing administrative procedure would indicate. However, some specific weaknesses were noted.
- Plant procedures are generally adequate, but are weak in establishing criteria for performing valve lineups prior to startup and use of checkoff lists.
- Miniature tags are provided for use where large tags would obscure equipment status light or other indications. These miniature tags are used on control boards, but the use is not mandatory.

e. Locked Valves

As a commitment in their response to Bulletin 79-05 and 79-05A, the licensee drafted a new procedure (AD 1839.02) to cover the control of locked valves in engineered safety systems. The inspector reviewed and commented on this initial draft prior to the procedure going through the licensee's internal review process. The final procedure will be reviewed as part of the inspection followup on Bulletins 79-05A and 79-05B.

f. Review of the Licensee's Response to Bulletins 79-05 and 79-05A

The licensee submitted their initial responses to all twelve items of Bulletin 79-05A on April 11, 1979. The inspectors reviewed this response and submitted comments to IE Headquarters on April 14, 1979. A special task force has been set up to

evaluate the licensee's response to the bulletin. A subsequent inspection will verify the specific commitments made by the licensee.

g. Review of Surveillance Tests for Acceptance Criteria

To verify that the surveillance testing acceptance criteria had been met on engineered safety features (ESF) systems, the inspectors reviewed the last surveillance test on each ESF system. Seventy-five surveillance tests were identified dealing with ESF systems. The systems reviewed included:

- Core Flood
- Decay Heat and Low Pressure Injection
- Containment Spray
- High Pressure Injection
- Containment Air Cooling
- Service Water
- Component Cooling Water
- Emergency Ventilation System
- Borated Water Storage Tank
- Safety Feature Actuation System
- Steam Feedwater Rupture Control System
- Auxiliary Feedwater System
- Emergency Diesel Generators
- Containment Building
- Hydrogen Purge System
- Control Room Emergency Ventilation
- AC and DC Electrical Systems

Of the seventy-five procedures reviewed, 41 percent contained minor deficiencies in the final documentation that raised a concern over the thoroughness of the review of the surveillance tests by the designated reviewers. These findings ranged from failure to have all the signoffs on the test procedures, updating the procedures to cover changes made in the controlling administrative procedures and general regard for neatness, uniformity and completeness of recording data. To highlight these concerns, the inspector met with the designated reviewers as a group to discuss the specific problems. All these minor deficiencies were resolved and corrected by the licensee in a timely manner and the inspector has no further questions at this time.

In the review of ST 5050.02.02, Core Flood System Isolation Valve P/S Check, performed July 21, 1978, the inspector noted the data required by temporary procedure modification T-2289 (Step 6.2) was not taken as required. As apparent from the fact that the temporary procedure modification was not attached to the procedure and the

procedure had only the words "deleted by T-Mod" written across Step 6.2 (no T number), the latest revision of the procedure was not used to perform the test on July 21, 1978. Further review by the inspector verified that this appeared to be an isolated case, since the surveillance test prior to and following this specific test were properly completed.

10. Equipment Status Tagging

During a control room observation, the inspector noted that the licensee used plastic tags which state "closing fuse removed and/or breaker racked out" to signify that the equipment was out of service. There appeared to be no formal system to control these tags. No review or approval was required nor was any written record made of these tags.

On April 13, 1979 in Mode 5 the inspector observed that the licensee had plastic tags hanging on HPI pumps 1-1 and 2-1, containment spray pump 1-2 and the four reactor coolant pump control switches. Containment spray pump 1-1 had its breaker racked out and there was no tag hung on the control room switch, indicating lack of specific control over the plastic tags.

The inspector verified by review of procedures PP 1102.02, Plant Startup, and PP 1101.10, Station Shutdown and Cooldown, that these procedures control racking in and out of the electrical breakers for the HPI and Containment Spray pumps under specified plant conditions. Procedure, SP 1103.06 - RC Pump Operations covers the racking in of the RCP's motor breaker during startup of the pumps.

The present method of tagging the control room switches when a breaker is electrically disabled by either removal of control fuses or racking the breaker out does not appear to be in conformance with the standard ANSI 18.7-1972, paragraph 5.1.5.

The licensee stated that they would review the use and control of equipment status tags and revise their procedure accordingly. This item is unresolved pending the inspector's review of the changes to the tagging procedure. (79-13-06)

11. Auxiliary Feedwater Availability During Surveillance Testing

The inspector reviewed surveillance test procedures ST 5071.01, AFS Monthly Test, and ST 5031.14, SFRCS Monthly Test, to determine whether surveillance testing on one auxiliary feedwater train would make the other train inoperable.

Based upon this review, the inspector concluded that the testing of one train of auxiliary feedwater system (AFS) does not require

making the other train inoperable to complete the test procedures. ST 5071.01 also includes provisions for returning the AFS under testing to service in the event of a Steam Feedwater Rupture Control System (SFRCS) actuation.

12. Unresolved Items

Unresolved items are matters about which more information is required in order to ascertain whether they are acceptable items, items of noncompliance or deviations. Unresolved items discussed during this inspection are discussed in Paragraphs 6, 7, 8, 9.c, 9.d and 10.

13. Exit Interview

The inspectors met with the licensee representatives during the course of the inspection to discuss their findings and to resolve outstanding items as discussed in the report.