



UNITED STATES
 NUCLEAR REGULATORY COMMISSION
 REGION II
 101 MARIETTA ST., N.W., SUITE 3100
 ATLANTA, GEORGIA 30303

Report No. 50-302/81-01

Licensee: Florida Power Corporation
 3201 34th Street, South
 St. Petersburg, Florida 33733

Docket No. 50-302

License No. DPR-72

Facility Name: Crystal River Unit 3 Nuclear Generating Plant

Inspection at Crystal River near Crystal River, Florida

Inspectors: V.L. Brunlee for
 T. F. Stetka, Senior Resident Inspector

2/26/81
 Date Signed

V.L. Brunlee for
 B. W. Smith, Resident Inspector

2/26/81
 Date Signed

Approved by: P. J. Kellogg
 P. J. Kellogg, Section Chief, RRPI Division

2/27/81
 Date Signed

SUMMARY

Inspection on January 6 through February 2, 1981
 Areas Inspected

Routine inspection by the resident inspectors of plant operations, security, radiological controls, Licensee Event Reports (LER's) and Non-Conforming Operations Reports (NCOR's), non-routine events, licensee action on IE Circulars, and licensee action on previous inspection items. Numerous facility tours were conducted and facility operations observed. Some of these tours and observations were conducted on back shifts. The inspection involved 171 hours onsite by two resident inspectors.

Results

Three violations were identified (Failure to properly control and post radiation areas, paragraph 5.b.(5)(a); Failure to control quality during performance of maintenance, paragraph 5.b.(11); Failure to report entry into a degraded mode of operation within 30 days, paragraph 10.b.(1).)

DETAILS

1. Persons Contacted

Licensee Employees

- P. Baynard, Manager, Nuclear Support Services
- *R. Bright, Assistant Manager, Nuclear Support Services
- D. Breedlove, Records Manager/Document Control Supervisor
- *J. Bufe, Compliance Auditor
- M. Collins, Reactor Specialist
- J. Cooper, QA/QC Compliance Manager
- W. Cross, Operations Engineer
- J. Hancock, Assistant Vice President-Nuclear Operations
- M. Harmon, Site Nuclear Administrative Manager
- *V. Hernandez, Compliance Auditor
- S. Johnson, Maintenance Staff Engineer
- W. Kemper, Plant Training Manager
- B. Lucas, Security Officer
- *T. Lutkehaus, Technical Assistant to the Nuclear Plant Manager
- *P. McKee, Operations Superintendent
- G. Perkins, Health Physics Supervisor
- *D. Poole, Nuclear Plant Manager
- *G. Ruzala, Chemistry/Radiation Protection Manager
- D. Smith, Technical Support Engineering Supervisor
- *J. Lander, Maintenance Superintendent
- L. Tittle, Performance Engineering Supervisor
- G. Williams, QA/QC Supervisor

Other personnel contacted included office, operations, engineering, maintenance, chem/rad, and corporate personnel.

*Present at the exit interview.

2. Exit Interview

The inspectors met with licensee representatives (denoted in paragraph 1) at the conclusion of the inspection on February 2, 1981. During this meeting the inspectors summarized the scope and findings of the inspection as they are detailed in this report. During this meeting the violations, unresolved items and inspector followup items were discussed.

3. Licensee Action on Previous Inspection Items

(Closed) Inspector Followup Item (302/80-42-C1) A critique of the fire service system isolation event was concluded by all personnel involved and a presentation of the lessons learned presented to all operational shifts. These activities were completed on January 6, 1981. The inspector reviewed the critique and the training records and consider the action to be complete.

(Closed) Unresolved Item (302/80-42-02) The licensee located the equipment clearance orders for October and November 1980, and the inspector reviewed the clearance orders for November 16 and 23. Misplacement of these clearances appears to be an isolated case; however, the licensee now requires clearances to be transmitted to their document control section under a transmittal sheet to assure traceability.

(Closed) Unresolved Item (302/80-42-04) The inspectors have identified areas on the plant berm with measured dose rates of up to 7 mr/hr that are out of the licensee's designated radiation areas. This finding is being elevated to a violation category as identified in paragraph 5.b.(5) of this report. This unresolved item is considered closed for record purposes.

(Closed) Inspector Followup Item (302/80-38-08) The licensee issued Revision 2 to LER 80-40 on December 16, 1980. This revision corrected the report date.

(Closed) Inspector Followup Item (302/80-42-07) The automatic closure mechanism on the vital area access door has been repaired. The inspector verified by visual examination that the door is operable.

(Open) Unresolved Item (302/80-33-04) The inspector witnessed a gas release and reviewed Gaseous Radwaste Release Permit 80-8 and Operating Procedure OP-412. The inspector noted that the initial conditions of this procedure had not been initialed by the operator; however, discussions with various operators indicated that the initial conditions had been verified. A management memorandum has been issued to remind operators of this requirement. This item remains open pending further observation of licensee activities.

4. Unresolved Items

Unresolved items are matters which more information is required to determine whether they are acceptable or may result in violations. New unresolved items identified during this inspection are discussed in paragraphs 5.a.(1) and 5.a.(2).

5. Review of Plant Operations

The plant continued with power operations (Mode 1) throughout this inspection period.

a. Shift Logs and Facility Records

The inspectors reviewed the records listed below and discussed various entries with operations personnel to verify compliance with technical specifications and the licensee's administrative procedures:

- Shift Supervisor's Log;
- Operator's Log;

- Equipment Out-of-Service Log;
- Equipment Clearance Order Log;
- Shift Relief Checklist;
- Short Term Instructions;
- Auxiliary Building Operator's Log;
- Operating Daily Surveillance Log; and
- Jumper Log.....

In addition to these record reviews, the inspectors independently verified selected clearance order tagouts. These record reviews identified the following:

- (1) During review of the Plant Jumper Log Book, the inspector noted that there were a number of jumpers that have been installed in various systems in the plant considerably longer than is appropriate for the short-term nature of the jumper system. Some of these jumpers date back to October 1977. Some of the jumper log sheets were marked "unknown" in the jumper expected removal time slot and some expected removal dates were past due. The inspector discussed this item with the licensee. The licensee acknowledged the inspector's comments and will initiate a comprehensive review of the jumper log to clear any outstanding jumpers and determine the status of, or requirement for, permanent or deviation modifications.

UNRESOLVED ITEM: Perform a comprehensive review of the jumper log to clear any outstanding jumpers and determine the status of, or requirement for, permanent or deviation modifications (302/81-01-01).

- (2) During review of the Plant Equipment Clearance Order Log Book, the inspector noted two items that were not being followed in strict compliance with CP-115, "In-Plant Equipment Clearance and Switching Orders". The first item had to do with not performing weekly audits on clearances which remain active for long periods of time. The inspector noted that this problem did not exist with the operations staff but rather with maintenance and contractor personnel. A discussion with the licensee indicated that this problem was identified in a recent FPC QA audit and that a management memorandum was to be issued on this subject.

INSPECTOR FOLLOWUP ITEM: Verify effectiveness of licensee's management memorandum associated with performance of required weekly audits on clearances (302/81-01-02).

The second item had to do with the requirement in CP-115 to enter on the clearance order the complete name of the equipment or system to be taken out of service. The inspector noted on numerous instances that only the equipment component identification number was being entered on the clearance order without including the complete name of the system or component. This

issue was discussed with the licensee and a Short Term Instruction was issued to emphasize the requirement of CP-115 to include a complete name of the system or component.

UNRESOLVED ITEM: Ensure the complete name of the system or component to be taken out of service is entered on clearance orders (302/81-01-03).

b. Facility Tours and Observations

Throughout the inspection period, facility tours were conducted to observe operations and maintenance activities in progress. Some operations and maintenance activities were observed during back shifts. Also during this inspection period, numerous licensee meetings were attended by the inspectors to observe planning and management activities.

The facility tours and observations encompassed the following areas:

- Security perimeter fence;
- Turbine building;
- Control room;
- Emergency Diesel Generator rooms;
- Auxiliary building;
- Intermediate building;
- Battery rooms;
- Electrical switchgear rooms; and
- Cable spreading room.

During these tours the following observations were made:

(1) Monitoring Instrumentation

The following instrumentation was observed to verify that indicated parameters were in accordance with Technical Specifications for the current operational mode:

- Equipment operating status;
- Area, atmospheric and liquid radiation monitors;
- Electrical system lineups;
- Reactor operating parameters; and
- Auxiliary equipment operating parameters.

(2) Shift Staffing

The inspectors verified by numerous checks that the operating shift was in accordance with Technical Specification requirements. In addition, the inspectors observed shift turnovers on different occasions to verify continuity of information regarding plant operating status, operational problems and other pertinent plant information was being accomplished.

(3) Plant Housekeeping Conditions

Storage of material and components and cleanliness conditions of various areas throughout the facility were observed to determine whether safety and or fire hazards exist. The inspectors noted that the Auxiliary Building housekeeping had been deteriorating over the past few weeks. This issue was discussed with the licensee. The licensee acknowledged the inspector's comments and has initiated the necessary actions required to return the Auxiliary Building to an acceptable level of cleanliness.

(4) Fire Protection

Fire extinguishers and fire fighting equipment were observed to be unobstructed and inspected for operability. No evidence of smoking was observed in designed "No Smoking Areas".

(5) Radiation Areas

Radiation control zones were observed to verify proper identification and implementation. These observations included review of step-off pad conditions, disposal of contaminated clothing and area posting. Area postings were verified for accuracy through the use of the inspector's own radiation monitoring instrument. As a result of these observations, the following items were identified:

- (a) On January 26, while touring the plant berm inside the protected area and outside of the designated radiation control areas, the inspector measured dose rates of from 5 to 7 millirem per hour in two locations near trailers containing refueling support equipment. These trailers, located on the west side of the plant, were encircled by a posted radiation barrier. The inspector noted that the 5 to 7 millirem per hour dose rate could be received while standing outside the posted barriers.

The inspector notified licensee chem-rad management personnel and accompanied their personnel while surveys were performed. The inspector's findings were confirmed by the licensee's surveys.

Failure to identify and post radiation areas is contrary to the requirements of 10 CFR 20.202 and 20.203 and is a violation.

Violation: Failure to properly control and post radiation areas around refueling equipment trailers on the plant berm. (302/81-01-04).

- (b) During the inspector's review of radiation area activities, the inspector was notified by licensee personnel of an accuracy problem with the thermoluminescent dosimeters (TLD's) used for personnel monitoring. It appears that the licensee's contractor (Eberline) has returned inconsistent TLD reading results. The licensee has verified these inconsistencies exist by submitting duplicate TLD's worn by the same person in the same area on the body and receiving wide variations in these duplicate TLD reading results.

The licensee has a tracking system that enables the comparison of TLD results with dosimeter records. When discrepancies are identified, the persons involved are summoned and a detailed analysis of their activities are reviewed. The licensee is also reviewing their inaccuracy issues with their contractor to determine the cause of the problem.

Inspector Followup Item: Review licensee's activities to resolve TLD reading inaccuracies. (302/81-01-05)

(6) Fluid Leaks

Various plant systems were observed to detect the presence of leaks. No problems were identified in this area.

(7) Piping Vibration

No excessive piping vibrations were noticed.

(8) Pipe Hangers/Seismic Restraints

Several pipe hangers and seismic restraints (snubbers) on safety-related systems were observed. No problems were identified in this area.

(9) Security Controls

Security controls were observed to verify that security barriers are intact, guard forces are on duty and access to the protected area is controlled in accordance with the facility security plan. No problems were identified in this area.

(10) Surveillance Testing

Surveillance testing was observed to verify that:

- Approved procedures were being used;
- Qualified personnel were conducting the tests;
- Testing was adequate to verify equipment operability; and
- Calibrated equipment, as required, were utilized.

The following tests were observed:

- SP-354, EDG Monthly Test ("B" EDG Only)
- SP-340, ECCS Pump Operability (Only for Makeup Pump "A");
- SP-510, Weekly Battery Check (Units 1 and 2)(Only for Unit 1)
- SP-511, Quarterly Battery Check (Units 1 and 2) (Only for Unit 1); and
- SP-179, Containment Leakage Test - Types "B" and "C" (only for type "C" testing of AHV-1C and 1D).

During the performance of SP-179 on January 29, excessive leakage was discovered through Air Handling Valves (AHV) 1C and 1D (Reactor Building purge supply isolation valves). Unit shutdown was commenced as required by Technical Specifications. Subsequent testing of AHV-1C and 1D indicated the leakage had been reduced to within allowable limits and unit shutdown was stopped. The licensee has initiated an extensive testing program for these valves in order to determine the cause of the leakage.

Inspector Followup Item: Review the results of the testing program on AHV-1C and 1D. (302/81-01-06).

(11) Maintenance Activities

The inspector observed maintenance activities to verify that:

- Approved procedures were being utilized;
- Correct equipment clearances were in effect;
- Work Requests (WR's), Radiation Work Permits (RWP's), and Fire Prevention Work Permits, as required, were issued and being followed; and
- Quality Control personnel were available for inspection activities as required.

The following maintenance activities were observed:

- Replacement of "B" Emergency Diesel Generator (EDG) bearing oil;
- Cleaning of Boric Acid Storage Tank (BAST) transfer pump discharge gage and gage sensing line; and
- Activities on the spent fuel pool floor associated with the installation of the high density fuel racks.

As a result of these reviews the following item was identified:

On February 13, during review of the safety-related work request associated with replacement of "B" EDG bearing oil, the inspector noted that the Quality Control (QC) Supervisor's concurrence had not been obtained on WR#20904; dated 1/13/81, as required by CP-113, Procedure for Handling and Controlling WR's. As a result of this finding, the inspector reviewed sixteen other safety-

related work requests and identified two more instances where the QC supervisor had not concurred in the WR's (WR#20627 dated 12/12/80 and WR#20686 dated 12/15/80). In addition, on February 18, 1981, the inspector determined that maintenance activities were conducted on a safety-related piece of equipment (Control Complex Air Compressor, AHP-1) without a WR as required by AI-500, Conduct of Maintenance.

Failure to control quality by adhering to the requirements of procedures CP-113 and AI-500 are contrary to the requirements of 10 CFR Part 50, Appendix B, Criterion V and the licensee's Quality Program as delineated in the Final Safety Analysis Report (FSAR) Section 1.7.6.7.1 and is considered to be a violation.

VIOLATION: Failure to control quality in accordance with procedures CP-113 and AI-500 during performance of maintenance (302/81-01-07).

6. Review of IE Circulars

The following IE Circulars (IEC) were reviewed to verify adequacy of the licensee's actions.

a. IEC 80-07, Problems with HPCI Turbine Oil System

This Circular recommended action by Boiling Water Reactor (BWR) licensees and was sent to Pressurized Water Reactor (PWR) licensees for information. As a result of the licensee's review of this Circular, it was determined that periodic sampling of the Emergency Feedwater Turbine (a Terry Turbine) was beneficial and would improve reliability of this safety equipment. The licensee has established a periodic Woodward governor and turbine bearing oil sample program. The licensee's action on this Circular is commendable and considered complete.

b. IEC 80-21, Regulation of Refueling Crews

c. IEC 80-22, Confirmation of Employee Qualifications

d. IEC 80-23, Potential Defects in Beloit Power Systems Emergency Generators

This review did not identify any inadequacies with the licensee's actions.

7. Safety Listing Book Review

In order to determine whether or not a component or system is nuclear safety-related, the licensee utilizes the Safety Listing Book and flow diagrams. The Safety Listing Book was prepared for the licensee by Gilbert Associates, Inc., and is basically a composite tabulation of all the

electrical, heating, ventilation and air conditioning, instrumentation and control, mechanical and structural components associated with the plant. The listing correlates the component tag numbers (or component description) with the required safety designation. This book is utilized by licensee personnel in making a safety/non-safety classification on a component prior to conducting maintenance on that component. The inspector discussed the use of this book with numerous licensee personnel who routinely use this book in the course of performing their duties. During these discussions, it was revealed that there are a number of safety-related components that are not listed in the Safety Listing Book. At the present time there has not been a revision to the Safety Listing Book since issue in September 1979. The inspector discussed this issue with a licensee representative and stated that the Safety Listing Book may not be adequate to ensure proper classification of equipment and/or components. The licensee acknowledged the inspector's comments and will review the Safety Listing Book to determine whether a revision is required.

Inspector Followup Item: Review the licensee's progress in determining whether a Safety Listing Book revision is required (302/81-01-08).

8. Review of Offsite Power Capability

During review of correspondence between the licensee and Nuclear Reactor Regulation (NRR) dated December 22, 1980, concerning "Adequacy of Station Electric Distribution Systems Voltages", the inspector noted that the licensee's response to question number 2 concluded that no potential for violation of General Design Criteria (GDC) 17 existed. GDC 17 requires that offsite power be supplied through two independent supplies.

The inspector queried licensee representatives on this conclusion based on the apparent fact that offsite power was only being supplied through one start-up transformer and that an additional connection to the plants class 1E 4160 volt busses from the Units 1 and 2 start-up transformers were not being considered as an additional independent offsite power supply. Licensee representatives responded that they did not consider the Class 1E 4160 volt bus connection as an independent offsite power supply because they did not consider this connection as being approved as a license condition. They further responded that they were taking a conservative approach to this situation by requiring fast starting and testing of the emergency diesel generators (EDG's) whenever the Unit 3 startup transformer and/or the associated transmission lines and switchyard breakers were out of service.

The inspector evaluated the licensee's conclusions and determined that the Class 1E 4160 volt connection was analyzed (Final Safety Analysis Report (FSAR) Paragraph 8.2.3.1d) and is periodically tested as required by Technical Specification 4.8.1.1.1b in accordance with Surveillance Procedure SP-415, Transfer from Preferred Offsite Power Source to Alternate Offsite Source and Return to Preferred Offsite Source.

The inspector's findings were discussed with licensee representatives at which time the inspector stated that the licensee appeared to be

unnecessarily cycling (i.e., starting and stopping) the EDG's. Licensee representatives acknowledged the inspector's comments and, after review of the findings, issued a management memorandum to clarify these Technical Specifications to the plant staff. In addition, the licensee is conducting a training session to assure that plant operators are aware of the intent of these Technical Specifications.

Inspector Followup Item: Review completion of operator training with respect to Technical Specification 4.8.1.1.1c. (302/81-01-09).

9. Anticipated Transient Without Scram (ATWS) Procedure Implementation Survey

The inspector reviewed the licensee's status of implementation of procedures to respond to ATWS events.

The following items are presently covered by the procedures indicated:

- Inability to move or drive control rods is covered by Emergency Procedure EP-110, CRD Malfunction Action; section 8.0; and,
- Reactor trip or scram is covered by Abnormal Procedure AP-110, Reactor Turbine Trip.

The following items are not presently covered by procedures:

- Failure to scram when required;
- Failure to complete scram when initiated automatically or manually;
- Failure to automatically scram when a parameter exceeds its trip value; and,
- Anticipated transient without scram.

The licensee's criteria for use of an Emergency Boration System indicates that while procedures for boration are available (Operating Procedure OP-304, Soluable Poison Concentration Control and Emergency Procedure EP-107, Loss of Boron (Moderator Dilution)), these procedures do not address the specifics of borating to a shutdown condition if control rod insertion does not occur.

Due to the design of the Babcock and Wilcox (B&W) reactor plant at Crystal River, there is no method to directly inject boric acid from the Boric Acid Storage tanks (BAST) to the makeup pump suction for direct injection into the reactor coolant system via the safety injection nozzles. This injection can only occur by passage through the normal makeup system path. The licensee has initiated an engineering design change to modify the makeup system thus providing such an injection path.

The licensee is presently working with the B&W Owner's Group to develop guidelines for ATWS procedures. It is expected that B&W will issue proposed

ATWS procedure guidelines. This plan appears to be consistent with item I.C.1 of NUREG-0737, Clarification of TMI Action Plan Requirements. Inspector Followup Item: Review the status of implementation of ATWS procedures and modifications (302/81-01-10).

10. Review of Licensee Event Reports and Non-Conforming Operations Reports (NCOR)

a. The inspector reviewed Licensee Event Reports (LER's) to verify that:

- The reports accurately describe the events;
- The safety significance is as reported;
- The report satisfies requirements with respect to information provided and timing of submittal; and,
- Action has been taken.

LER's 80-52, 80-53, 80-54, and 80-56 were reviewed. This review identified the following items:

- (1) LER 80-54 reported exceeding the regulating rod group insertion limits following a power increase to 100% rated thermal power. The licensee's corrective action was adequate and timely. The licensee has initiated a study to determine possible actions to prevent recurrence. The results of this study will be completed by June 30, 1981.

Inspector Followup Item: Review results of licensee study to prevent exceeding rod insertion limits. (302/81-01-11)

- (2) LER 80-56 reported a failure of radiation monitoring instrument RM-A5. The cause of this event was a seized sample vacuum pump. These pumps have failed before and the licensee is performing an engineering evaluation of these failures.

Inspector Followup Item: Review progress of engineering evaluation of failed sample vacuum pumps. (302/81-01-12)

b. The inspector reviewed NCOR's to verify the following:

- Compliance with the Technical Specifications (TS);
- Corrective actions as identified in the reports or during subsequent reviews have been accomplished or are being pursued for completion;
- Generic items are identified and reported as required by 10 CFR Part 21; and,
- Items are reported as required by the Technical Specifications.

The following NCOR's were reviewed:

80-187	80-319	81-11
80-191	80-320	81-13
80-273	80-322	81-16
80-283	80-325	81-17
80-284	80-326	81-18
80-287	80-327	81-20
80-289	80-329	81-21
80-290	80-330	81-25
80-291	80-331	81-26
80-294	80-332	81-27
80-296	81-01	81-32
80-308	81-02	81-35
80-310	81-03	81-36
80-317	81-04	

As a result of these reviews, the following items were identified:

- (1) NCOR's 80-273, 80-287 and 80-319 identified failures of safety-related equipment as following:

80-273, dated 10/13/80, Failure of temperature instrumentation on the Meteorological Tower;

80-287, dated 11/3/80, Failure of cable tunnel sump pumps; and,

80-319, dated 12/15/80, Failure of building spray pump 1A due to mechanical seal leakage.

These failures placed the plant in a degraded mode of operation as permitted by the Technical Specification action statements. Technical Specification 6.9.1.9 requires a written report submitted to the Director of the Regional Office within 30 days of occurrence of the event. As of February 2, 1981, none of the identified events were reported. Failure to submit 30 day written reports as required by Technical Specification 6.9.1.9 is considered to be a violation.

Violation: Failure to submit 30 day written reports as required by Technical Specification 6.9.1.9 (302/81-01-13).

A similar violation of TS 6.9.1.9 was identified during the inspection period of October 4 - November 3, 1980 (NRC Report 50-302/80-38) and therefore this violation is considered to be recurrent.

- (2) NCOR 80-284 reported that a review by Babcock and Wilcox (B&W) of the Performance Data Output (PDO) generated during reactor startup testing indicated that the gains on the incore detector amplifiers were improperly set. Investigation by the licensee and review by

the inspector indicate that the gain errors resulted in conservative data. The gains were readjusted and core data updated. To prevent recurrence the licensee will revise Performance Test PT-120, Controlling Procedure for Power Escalation Testing, to include a check of various detector gains during each restart.

Inspector Followup Item: Verify procedure PT-120 is revised to include a check of the incore detector gain settings. (302/81-01-14).

- (3) NCOR 80-317 reported installation of non-safety-related equipment (Integrated Leakrate Testing (ILRT) Blowdown Mufflers) in a safety-related system (ILRT piping). A flange has been installed between the non-safety and safety systems and Deviation Modification Approval Record (MAR) 80-7-84 describes this installation. The licensee had also generated MAR 80-7-88 to modify the ILRT muffler for permanent installation.

Inspector Followup Item: Review licensee's actions in modifying ILRT piping to include blowdown mufflers. (302/81-01-15)

Nonroutine Event

Auxiliary Building (AB) Evacuation (NCOR 81-36)

At 1513 hours on January 28, an AB evacuation was initiated due to alarms on AB gaseous radiation monitors RMA-2 and RMA-3. The tripping of these radiation monitors resulted in the automatic securing and isolation of various AB supply fans and dampers. The licensee searched the AB and discovered the source of the high gaseous activity to be waste gas blowing out of the drain line on the Makeup Waste Evaporator (MWE) surge tank. The tank was isolated from the waste gas header and radiation levels on RMA-2 and RMA-3 decreased to normal. AB access was restored at 1617 hours.

Further investigation of this event indicates that due to failure of the level control switch on the surge tank, the automatic level control valve remained open causing the tank to drain empty thus providing a passage from the waste gas header to the AB sumps (and consequently the AB atmosphere). The licensee has issued a work request to repair the level control instrument.

The event resulted in a gaseous release from the plant consisting of 0.83% gamma and 0.36% beta of the Technical Specification instantaneous release limits. No quarterly or annual release limits have been exceeded.

The licensee has had numerous problems with the Reactor Coolant (RC) and MW Evaporators. A modification has been developed and will be implemented to improve the reliability of these units. It is expected

that this modification will be installed this spring subject to parts availability.

Inspector Followup Item: Review licensee actions to modify RCEVP and MWEVP to improve reliability. (302/81-01-16)