

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

REGION III

Reports No. 50-266/81-13; 50-301/81-15

Docket Nos. 50-266; 50-301

Licenses No. DPR-24, DPR-27

Licensee: Wisconsin Electric Power Company
231 West Michigan
Milwaukee, WI 53203

Facility Name: Point Beach Nuclear Power Plant, Units 1 and 2

Inspection At: Point Beach Site

Inspection Conducted: July 1-3, 5-10, 13-17, 20-24, 27-31, 1981

Inspectors: *J. D. Smith*
for W. G. Guldemond 8-19-81
J. D. Smith
for R. L. Hague 8-19-81
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for J. E. Konklin, Acting Chief 8-19-81
Reactor Projects Section 2A

Inspection Summary

Inspection of July 1-3, 5-10, 13-17, 20-24, 27-31, 1981 (Reports No. 50-266/81-13; 50-301/81-15)

Areas Inspected: Routine resident inspection of Operational Safety Verification, Monthly Maintenance Observation, Monthly Surveillance Observation, Followup on Licensee Event Reports, IE Bulletin and Circular Followup, Review of Plant Observations, Primary Coolant System Pressure Isolation Valve Implementation, TMI Action Plan Inspection Requirements. The inspection involved a total of 268 inspector-hours onsite by two NRC inspectors including 80 inspector-hours onsite during offshifts.

Results: Of eight areas inspected, no items of noncompliance were identified in seven areas. Three items of noncompliance were identified in the area of Operational Safety Verification (Failure to make available and follow approved procedures, failure to adequately implement equipment control procedure, and failure to properly control transient fire hazards).

DETAILS

1. Persons Contacted

- *G. A. Reed, Manager, Nuclear Power Division
- *J. J. Zach, Superintendent Technical Services
 - T. J. Koehler, Operations Superintendent
 - J. C. Reisenbuechler, I&C Engineer
 - W. J. Herrman, Maintenance Superintendent
 - R. S. Bredvad, Health Physicist
- *R. E. Link, Assistant to the Manager
- *F. A. Zeman, Office Supervisor

The inspectors also talked with and interviewed members of the Operations, Maintenance, Health Physics, and Instrument and Control sections.

*Denotes personnel attending exit interviews.

2. Operational Safety Verification

The inspector observed control room operations, reviewed applicable logs and conducted discussions with control room operators during the month of July 1981. On September 30, 1980, the NRC sent a letter to the licensee addressing concerns on postulated boron dilution events during cold shutdown. Included in this letter was a request to recalculate boron dilution events for Units 1 and 2 and to provide commitments to revise plant procedures to ensure correct shutdown margin is maintained. The licensee responded on December 30, 1980 with the requested reanalysis and commitments for procedural changes. Subsequent telephone conversations between the NRC and the licensee led to a second licensee submittal dated March 31, 1981. This submittal and subsequent NRC confirmation dated April 29, 1981 committed the licensee to incorporate into their procedures a requirement to tag open the breakers on two charging pumps during cold shutdown. It further committed the licensee to install limit switches on the reactor makeup water flow control valves (FCU-III) with annunciator capability in the control room to alert the operators to potential dilution events. The switches and annunciators were made operational within 90 days of receipt of the NRC confirmation of commitment.

The licensee incorporated the requirement to tag out two charging pumps during cold shutdown in Step 4.15 of Operating Procedure OP-3C on June 23, 1981. This step, located before the step directing the reactor coolant pumps to be secured, reads, "Open and red tag the electrical supply breakers for the charging pumps as necessary to maintain only one charging pump operable in accordance with REI 19.0 to avoid an inadvertent boron dilution (NRC requirement).

On July 5, 1981 the inspector performed a walkdown of the Unit 1 control boards. At the time, Unit 1 was in a cold shutdown condition in preparation for a steam generator inspection program. The inspector noted two charging pumps running contrary to the apparent requirements of Step 4.15 of OP-3C. Further checking revealed that proper plant operating conditions existed but that the procedurally referenced REI 19 had not been issued to control and was not in the control operators' REI Book. Understanding of the NRC requirement was confirmed by the on-shift operations supervisor who stated that the charging pumps would be tagged out after securing the remaining running reactor coolant pump.

This condition is not in conformance with Technical Specification 15.6.8.1 which requires, in part, that, "The plant shall be operated and maintained in accordance with approved procedures, Major procedures, supported by appropriate minor procedures (such as check-off lists, operating instructions, data sheets, alarm responses, chemistry analytical procedures, etc.) shall be provided for the following operations where these operations involve nuclear safety of the plant: 1. Normal sequences of startup, operation and shutdown of components, systems and overall plant..." This is an item of noncompliance.

In response to this item of noncompliance, the licensee established proper plant conditions and made procedure REI-19 available to control operators. Furthermore, Procedure REI-19 was revised to provide increased charging system flexibility as required by plant conditions. This item is considered closed.

The inspector verified the operability of selected emergency systems, reviewed tagout records and verified proper return to service of affected components. With respect to tagout records, the inspector audited 115 cleared series for proper administration. Of these, 59 had very minor clerical errors. However, 14 had more significant errors including no annotation as to whether any post work testing was required, no shift supervisor clearance authorization, and no signatures for tag removal. Further investigation revealed that the licensee has no formal audit program for the tagout system which would internally identify these types of problems.

Review of the tagout procedures, Operating Point Beach Nuclear Plant Administrative Control Policies and Procedures Manual Section 4.13, further revealed that only the Duty Shift Supervisor can authorize tag clearance. However, numerous series were cleared under the authorization of the Operating Supervisor. That this is inappropriate is further supported by Section 4.2.2 of the above referenced manual which is the position description for the Operating Supervisor. This section authorizes the Operating Supervisor to authorize tagouts with the concurrence of the Shift Supervisor. It does not authorize him to authorize clearance of tagouts.

The tagout procedure referenced above is written to satisfy a 10 CFR 50, Appendix B, Section XIV requirement that, "Measures shall also be established for indicating the operating status of structures, systems,

and components of the nuclear power plant or fuel reprocessing plant, such as by tagging valves and switches, to prevent inadvertent operation." As such, the above noted administrative shortcomings represent an item of noncompliance.

In response to this item of noncompliance the licensee conducted a comprehensive audit of the tagout system and based on the results conducted personnel training to correct and preclude noted deficiencies. Based on these actions this item is considered closed.

Tours of the Unit 1 containment, the auxiliary building and turbine building were conducted to observe plant equipment conditions, including potential fire hazards, fluid leaks, and excessive vibrations and to verify that maintenance requests had been initiated for equipment in need of maintenance. On July 8, 1981, during a routine tour of the auxiliary building, the inspector noted an open locker outside primary pipeway No. 1. The locker was observed to contain a large assortment of flammable agents including numerous aerosol cans and two open cans of paint thinner. As such, the locker represented a significant fire hazard. This same locker had been found in a similar condition dating as far back as two months. In each case, the condition had been reported to licensee supervision and management they in turn, informed the contractor who was using the locker to correct the problem. The contractor corrected the situation for a while but later flammables were again found in the locker. This condition was in violation of Section 6.3 of the Point Beach Fire Protection Safety Evaluation Report, dated August 2, 1979 and incorporated as license amendments DPR-24/39 and DPR-27/44. This is an item of noncompliance.

The inspector, by observation and direct interview, verified that the physical security plan was being implemented in accordance with the station security plan.

The inspector observed plant housekeeping/cleanliness conditions and verified implementation of radiation protection controls. During the month of July 1981, the inspector walked down the accessible portions of the safety injection, containment spray, auxiliary feed, and diesel generating systems to verify operability. The inspector also witnessed portions of the radioactive waste system controls associated with rad-waste shipments and barreling.

During a review of the latest revision to the licensee's Health Physics Procedures, the inspector noted a deficiency in this procedure for donning the MSA self-contained breathing apparatus. The deficiency involved failure to include a step to reopen the cylinder isolation valve after testing the regulator and prior to donning the mask. This deficiency was brought to the attention of the Health Physicist who made a verbal commitment to revise that section of the procedure. The inspector has verified that the new revision has been made.

These reviews and observations were conducted to determine whether facility operations were in conformance with the requirements established under technical specifications, 10 CFR, and administrative procedures.

3. Monthly Maintenance Observation

Station maintenance activities of safety related systems and components listed below were observed/reviewed to determine whether they were conducted in accordance with approved procedures, regulatory guides and industry codes or standards and in conformance with technical specifications.

The following items were considered during this review: limiting conditions for operation were met while components or systems were removed from service; approvals were obtained prior to initiating work; activities were accomplished using approved procedures and were inspected as applicable; functional testing and/or calibrations were performed prior to returning components or systems to service; quality control records were maintained; activities were accomplished by qualified personnel; parts and materials used were properly certified; radiological controls were implemented; and, fire prevention controls were implemented.

On July 8, 1981, during a routine tour of the auxiliary building, the inspector noted the yellow copy of a Radiation Work Permit (RWP) posted at the access to the holdup tank room. Review of the RWP revealed that it was issued on July 2, 1981 to specify radiological conditions and precautions associated with contractor work on pipe supports. That the RWP was still posted six days after its issuance is in violation of major Health Physics Procedure HP 2.7 which requires, in part, that, "Where more than one shift is required to complete a job, an RWP is issued for each shift. Each RWP shall be terminated at the end of the work shift. Each RWP shall be terminated at the end of the work shift it was written for." This procedure goes on to require of the yellow (posted) copy of the RWP that, it be, "Posted at or near the work area and removed at completion of the work." In the case described, this later requirement was not satisfied. This was brought to the attention of the licensee. The RWP in question was removed and plant and contractor personnel were instructed in proper administration and use of RWPs. The finding is considered to be a minor problem and is closed.

Work requests were reviewed to determine status of outstanding jobs and to assure that priority is assigned to safety related equipment maintenance which may affect system performance.

On July 21, 1981 the inspector reviewed 277 Outstanding Maintenance Requests (MR) for Units 1 and 2. Of the requests reviewed, 81 requests had a total of 123 items not in compliance with the licensee's procedures for MR administration. Included in the errors were 64 instances in which either the originator or his supervisor failed to sign the MR or the originator and supervisor signatures were one and the same. Section 3.19 of the Operating Point Beach Nuclear Power Plant Administrative Control Policies and Procedures Manual is the procedure for MR administration. This procedure specifically requires that, "The supervisor evaluates the request for completeness, accuracy, necessity, plant conditions necessary for repair, radiation hazards, and signs the form." There were 39

instances in which the requirements for designating a special or routine maintenance procedure were incomplete, special radiation protection precautions were not addressed, or Technical Specification requirements were not identified. Section 2.4 of the above cited procedure requires, in part, that the Operations Superintendent, "Determines and indicated whether a Special Maintenance Procedure (SMP) or Routine Maintenance Procedure (RMP) is required, what special radiation protection precautions are required, if any, and indicates if a Technical Specification requirement is involved." There were six instances in which the Quality Assurance reviewer failed to initial the quality assurance designation as required.

The licensee was aware of our initial findings (prior to the exit interview) and has undertaken a comprehensive audit of the MR system which has resulted in upgrading of the system. We shall reinspect this area in a subsequent inspection.

The following maintenance activities were observed/reviewed:

Replace Seals 2P2A Charging Pump.
Installation/Modification of Safety Related Pipe Hangers.
Repair RHR Check Valves - Unit 1.

Following completion of maintenance on 2P2A Charging Pump, and the Unit 1 RHR Check Valves, the inspector verified that these systems had been returned to service properly.

4. Monthly Surveillance Observation

The inspector observed technical specifications required surveillance testing on the Primary Coolant System Pressure Isolation Valves (TS-30), Control Rod Exercising (TS-6), Unit 1 Reactor Protection System to determine that testing was performed in accordance with adequate procedures, that test instrumentation was calibrated, that limiting conditions for operation were met, that removal and restoration of the affected components were accomplished, that test results conformed with technical specifications and procedure requirements and were reviewed by personnel other than the individual directing the test, and that any deficiencies identified during the testing were properly reviewed and resolved by appropriate management personnel.

During recovery operations from the Unit 1 steam generator inspection outage on July 14, 1981 the licensee performed primary coolant system pressure isolation valve leak testing on Unit 1 in accordance with an April 20, 1981 Order for Modification of License. During this testing, core deluge Check Valves 1-853C and 1-853D were found to exceed the 5 gpm leakage criteria. Attempts to flush the valves to obtain better seating were unsuccessful. On July 15, 1981 the licensee decided to drain Unit 1 to a half pipe condition to inspect/repair the valves.

The valves, six inch Velan swing checks No. 78704, were disassembled on July 16, 1981. Inspection revealed that both valves were jammed fully open. The lockwire for the nut attaching the disk to the pivot arm had contacted the valve body with the valve fully open and had bound such that the valve stayed open.

The second-off check valves in the same line, 1-853A and 1-853B, were also disassembled and inspected as they are the same type of valves as 1-853C and 1-853D. The lockwires on the second-off valves were oriented differently than on the first off valves and no binding was apparent. By rotating the disk, binding could be induced.

Review of the drawing for the valves revealed that the lockwire is supposed to be tack welded in place. This was not the case for any of the valves inspected. The lockwires were removed and replaced with cotter keys. The valves were successfully tested on July 17, 1981.

Based on the problems encountered with the Unit 1 valves, the licensee committed to inspect the corresponding valves in Unit 2 during its next cold shutdown.

In 1978 the licensee was experiencing an increasing failure rate of the originally installed Westinghouse NBFDF relays utilized in the reactor protective system. The mode of failure was binding of the operating slug inside the coil apparently caused by degradation of the plastic sleeve surrounding the slug. At that time Westinghouse recommended the replacement of those relays with a Model NBFDF 315 Westinghouse No. 5072A49G03. Replacement commenced in October 1978 for Unit 1 and in March 1979 for Unit 2.

The licensee has been experiencing an increasing rate of failure with those replacement relays. There are 62 normally energized relays of this type in each unit. In 1979 each unit experienced one failure. To date in 1981 Unit 1 has experienced five failures and Unit 2 has experienced two failures. The mode of failure in each case is coilwire insulation breakdown apparently from overheating. This results in coil wire shorting and burnout.

The licensee has contacted Westinghouse and supplied them with a burned out relay for inspection. Resolution is expected on this problem by August 4, 1981. Failures in this manner of normally energized relays causes the protective system logic to become more conservative. However, each failure represents a potential unnecessary safety system challenge.

5. Licensee Event Reports Followup

Through direct observations, discussions with licensee personnel, and review of records, the following event reports were reviewed to determine that reportability requirements were fulfilled, immediate corrective action was accomplished, and corrective action to prevent recurrence had been accomplished in accordance with technical specifications.

50-301/81-003/01T-0	Momentary Loss of Containment Integrity Due to Sticking of Blowdown Isolation Valve
50-266/81-005/03L-0	Inadequate Control Room Emergency Filtration System Flow

50-266/81-006/01T-0	Isolated Spray Additive Tank
50-266/81-007/01T-0	Loss of Redundancy for Containment Pressure
50-301/81-005/03L-0	Trip of Auxiliary Feedwater Pump by Contractor
50-301/81-004/01T-0	Failure of an MSIV to Shut
50-266/81-008/01T-0	Unit 1 Degraded Steam Generator Tubes

6. IE Bulletin Followup

For the IE Bulletins listed below the inspector verified that the Bulletin was received by licensee management and reviewed for its applicability to the facility. If the Bulletin was applicable the inspector verified that the written response was within the time period stated in the Bulletin, that the written response included the information required to be reported, that the written response included adequate corrective action commitments based on information presented in the Bulletin and the licensee's response, that licensee management forwarded copies of the written response to the appropriate onsite management representatives, that information discussed in the licensee's written response was accurate, and that corrective action taken by the licensee was as described in the written response.

79-22	Tritium Timepieces
79-26	Boron Loss from BWR Control Blades
80-01	Operability of ADS Valve Pneumatic Supply
80-07	BWR Jet Pump Failure
80-13	Cracking in Core Spray Spargers
80-17	BWR Scram Failures
80-22	Radiography Sources
80-25	Problems with BWR Target Rock Relief Valves
79-20	Packaging Low-Level Radioactive Waste for Transport and Burial
79-12	Short Period Scrams at BWR Facilities

7. IE Circular Followup

Outstanding Circulars were reviewed. It was determined at the time of the review none could be closed out.

8. Review of Plant Operations

During the month of July 1981 the inspector reviewed the following activities:

a. Procurement

The inspector reviewed procurement and storage activities to ascertain whether the purchase of components, materials and supplies used for safety related functions, is in conformance with the licensee's approved QA program and implementing procedures; non-conforming items are segregated and marked

accordingly; applicable preventive maintenance is performed; housekeeping and environmental requirements are met; and, limited shelf-life items are controlled.

b. Review and Audits

On July 29, 1981, the inspector sat in on a safety review committee meeting. The inspector verified that provisions of technical specifications dealing with membership, review process, frequency, and qualifications were met. The inspector also verified that decisions made were reflected in the meeting minutes and that corrective actions proposed were taken.

c. Training

The inspector accompanied an auxiliary operator and his trainee on his log taking rounds. The inspector questioned the trainee on the importance of various parameters which are routinely monitored and received satisfactory responses from the trainee.

d. Environmental Protection

The inspector verified the installation and operability of four sampling (monitoring) stations and associated equipment and reviewed records for completeness and accuracy.

9. Primary Coolant System Pressure Isolation Valve Implementation

Temporary Instruction 2515/56 directed verification of licensee actions in response to an April 20, 1981 NKR Order for Modification of License Concerning Primary Coolant System Pressure Isolation Valves. The inspector conducted this verification in May 1981 prior to the issuance of the temporary instruction and found the licensee to be in compliance with all aspects of the order except the requirement that operators be trained with respect to cycling MOV's prior to implementing the requirements of the order. Since that time the required training has been completed. The results of this verification were documented in Inspection Reports No. 50-266/81-10 and No. 50-301/81-11.

10. TMI Action Plan Inspection Requirements

The inspectors reviewed licensee actions in accordance with the temporary instructions listed below. The attached tables present the current status of implementation of TMI Action Plan requirements called for by the referenced temporary instructions.

TI 2515/42 Revision 2
TI 2515/43 Revision 2
TI 2515/53

11. Exit Interview

The inspector met with licensee representatives (denoted in Paragraph 1) throughout the month and at the conclusion of the inspection period and summarized the scope and findings of the inspection activities. The licensee acknowledged these findings.

In addition to the items documented earlier in the inspection report, the following items were discussed during the exit interview.

- a. Per a discussion during a Region III Senior Resident Inspector training session, a policy was promulgated whereby NRC-requested copies of INPO audit results are to be provided to the Resident Inspector for subsequent NRC distribution. This policy was provided to the licensee.
- b. The licensee was informed of two typographical errors in Inspection Reports No. 50-266/81-11 and No. 50-301/81-13 for the severity levels for noncompliances Nos. 2 and 4. Region III is sending a formal letter of correction to the licensee.
- c. During a tour of the 480V switchgear room the inspector noted pieces of blotter paper taped to the inside of openings in several breaker cubicles. The inspector expressed concern that if the blotter paper were to fall into the cubicle, a fire might result. The licensee agreed to investigate the matter.
- d. During a review of the licensee's procedures for reporting requirements the inspector noted that Emergency Plan Implementation Procedure 1.1, Section 3.2 directs that security items should be reported via the emergency notification system pursuant to 10 CFR 50.72. No reference is made to the reporting requirements of 10 CFR 73.71. This was brought to the attention of the licensee who agreed to review the matter.

TMI ACTION PLAN STATUS

PROCEDURES AND STAFFING

TASK	SUBJECT	STATUS
I.A.1.1	STA INTERIM STAFFING	COMPLETE. STA'S HAVE BEEN ON DUTY SINCE 1/1/80 IN ACCORDANCE WITH A S. BURSTEIN (WE) TO H.R. DENTON (NRC) LETTER DATED 12/31/79.
I.A.1.1	STA TRAINED PER LL CAT "B"	ALL TRAINING EXCEPT THAT REQUIRED FOR MITIGATING CORE DAMAGE WAS COMPLETE AS OF 3/1/81. THE LICENSEE IS STILL ATTEMPTING TO ESTABLISH A TRAINING PROGRAM FOR MITIGATING CORE DAMAGE. PER A 12/23/80 LETTER FROM C.W. FAY (WE) TO H.R. DENTON (NRC) THIS REQUIREMENT WILL BE SATISFIED NO LATER THAN 10/1/81.
I.A.1.2	SHIFT SUPERVISOR RESPONSIBILITIES	COMPLETE.
I.A.1.3	SHIFT MANNING	COMPLETE. THE PROCEDURES ARE CONTAINED IN THE POINT BEACH NUCLEAR PLANT ADMINISTRATIVE POLICIES AND PROCEDURES MANUAL SECTION 4.3.3 DATED 1/5/81.
I.A.2.1	MODIFY TRAINING	COMPLETE. THE TRAINING PROGRAM WAS SUBMITTED IN A 8/7/80 LETTER FROM C.W. FAY (WE) TO H.R. DENTON (NRC).
I.C.1	SHORT TERM ACCIDENT AND PROCEDURE REVIEW (ITEM 1)	COMPLETE.
I.C.1	SHORT TERM ACCIDENT AND PROCEDURE REVIEW (ITEMS 2b & 3b)	NRR COMPLETED THE INITIAL REVIEW OF THE WESTINGHOUSE OWNER'S GROUP SUBMITTAL ON JUNE 17, 1981. THE REVIEW IDENTIFIED SEVERAL UNRESOLVED ISSUES. THIS ITEM REMAINS OPEN.
I.C.2	SHIFT RELIEF/TURNOVER	COMPLETE.
I.C.3	SHIFT SUPERVISOR RESPONSIBILITIES	COMPLETE.
I.C.4	CONTROL ROOM ACCESS	COMPLETE.
I.C.5	PROCEDURE FOR OPERATING EXPERIENCE FEEDBACK	COMPLETE. THE PROCEDURES ARE CONTAINED IN THE POINT BEACH NUCLEAR PLANT ADMINISTRATIVE POLICIES AND PROCEDURES MANUAL SECTION 3.15.7 DATED 12/19/80.
I.C.6	VERIFICATION OF OPERATING ACTIVITIES	COMPLETE. THE PROCEDURES ARE CONTAINED IN THE POINT BEACH NUCLEAR PLANT ADMINISTRATIVE POLICIES AND PROCEDURES MANUAL SECTION 4.14 DATED 6/20/80.

TMI ACTION PLAN STATUS

HARDWARE

TASK	SUBJECT	STATUS
II.B.1	RCS VENTS	PER NUREG 0737 THIS ITEM IS COMPLETE THROUGH THE DESIGN PHASE.
II.B.2	PLANT SHIELDING	THE DESIGN REVIEWS HAVE BEEN COMPLETED USING THE SOURCE TERMS PROVIDED IN NUREG 0578. HOWEVER, NUREG 0737 CHANGED THE SOURCE TERM ASSUMPTIONS AND THE LICENSEE IS EVALUATING THE IMPACT ON THE PREVIOUS REVIEWS. PER A 12/23/80 LETTER FROM C. W. FAY (WE) TO H. R. DENTON (NRC) THE LICENSEE HAS COMMITTED TO COMPLETE PLANT MODIFICATIONS BY 6/1/82 SUBJECT TO EQUIPMENT AVAILABILITY.
II.D.3	DIRECT INDICATION OF RELIEF AND SAFETY VALVE POSITIONS	COMPLETE. TECHNICAL SPECIFICATIONS WERE SUBMITTED IN FEBRUARY, 1981.
II.E.1.2	AUXILIARY FEEDWATER SYSTEM AUTOMATIC INITIATION (ITEM 1a)	COMPLETE. ORIGINAL PLANT DESIGN.
II.E.1.2	AUXILIARY FEEDWATER SYSTEM AUTOMATIC INITIATION (ITEM 1b)	COMPLETE. ORIGINAL PLANT DESIGN.
II.E.1.2	AUXILIARY FEEDWATER SYSTEM FLOW INDICATION	COMPLETE. SAFETY GRADE INDICATION HAS BEEN INSTALLED IN THE LINES TO EACH STEAM GENERATOR. THE TRANSMITTERS ARE CURRENTLY BEING ENVIRONMENTALLY QUALIFIED AS PART OF A UTILITY SPONSORED PROGRAM. INSTALLATION OF BATTERY BACKED POWER IS PENDING A PLANT MODIFICATION TO THE INSTRUMENT POWER SYSTEM PLANNED FOR COMPLETION IN EARLY 1982.
II.E.3.1	EMERGENCY POWER FOR PRESSURIZER HEATERS	COMPLETE. TECHNICAL SPECIFICATIONS WERE SUBMITTED ON 2/4/81.
II.E.4.1	DEDICATED HYDROGEN PENETRATIONS	COMPLETE. ORIGINAL PLANT DESIGN.
II.E.4.2	CONTAINMENT ISOLATION DEPENDABILITY	COMPLETE.
II.F.1	ADDITIONAL ACCIDENT MONITORING INSTRUMENTATION	
II.G.1.1	POWER SUPPLIES FOR PRESSURIZER RELIEF VALVES, BLOCK VALVES AND LEVEL INDICATION	COMPLETE.
II.K.3.9	PID CONTROLLER	COMPLETE.

TMI ACTION PLAN STATUS

PROCEDURES AND STAFFING

TASK	SUBJECT	REMARKS
II.E.4.2.6	CONTAINMENT ISOLATION DEPENDABILITY	COMPLETE.
II.F.2.1	IDENTIFICATION OF AND RECOVERY FROM CONDITIONS LEADING TO INADEQUATE CORE COOLING	COMPLETE.
II.D.1.1.1	PRIMARY COOLANT OUTSIDE CONTAINMENT	COMPLETE.

TMI ACTION PLAN STATUS

HARDWARE

TASK	SUBJECT	STATUS
II.K.3.1b	AUTOMATIC PORV ISOLATION SYSTEM	LICENSEE HAS ADOPTED THE POSITION THAT SUCH A SYSTEM IS NOT REQUIRED BASED ON OPERATING HISTORY.
II.K.3.12b	ANTICIPATORY REACTOR TRIP UPON TURBINE TRIP	COMPLETE. ORIGINAL PLANT DESIGN.