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

OCT 05 1982

Report Nos. 50-335/82-29 and 50-389/82-39

Licensee: Florida Power and Light Company
9250 West Flagler Street
Miami, FL 33152

Facility Name: St. Lucie Units 1 and 2

Docket Nos. 50-335 and 50-389

License Nos. DPR-67 and CPPR-144

Inspection at St. Lucie site near Ft. Pierce, Florida

Inspectors: K.D. Landis for — 10/4/82
S. A. Elrod — Date Signed

K.D. Landis for — 10/4/82
H. E. Bibb — Date Signed

Approved by: C. Julian — 10/7/82
C. A. Julian, Section Chief, Division of Project and Resident Programs — Date Signed

SUMMARY

Inspection on August 11 - September 10, 1982

Areas Inspected

This routine inspection involved 280 resident inspector-hours onsite in the areas of Licensee Action on Previous Inspection Findings, Licensee Actions Taken on TMI items, Operational Safety Verification, Inspector Follow-up on Previously Identified Items, IE Information Notices, IE Circulars, Surveillance Observation, Maintenance Observation and, Testing of Unit 2.

Results

Of the nine areas inspected, no apparent violations or deviations were identified in eight areas; one apparent violation was found in one area. (Violation - Failure to follow procedure - paragraph 6).

DETAILS

1. Persons Contacted

Licensee Employees

*C. M. Wethy, Plant Manager
*B. J. Escue, Site Manager
J. H. Barrow, Operations Superintendent
*G. J. Boise, Start-up Superintendent
D. A. Sager, Operations Supervisor
*N. G. Roos, Quality Control Supervisor
C. F. Leppla, Instrument and Control Supervisor
R. R. Jennings, Technical Department Supervisor
C. A. Pell, Reactor Engineering Supervisor
H. F. Buchanan, Health Physics Supervisor
J. G. West, Security Supervisor
J. Barrow, Fire Prevention Coordinator
L. W. Pearce, Nuclear Plant Supervisor
C. L. Burton, Nuclear Plant Supervisor
A. W. Bailey, Quality Assurance Supervisor
*P. Carier, Licensing Engineer

Other licensee employees contacted included construction craftsmen, technicians, operators, shift technical advisors, security force members, and office personnel.

*Attended exit interview

2. Exit Interview

The inspection scope and findings were summarized on September 10-12, 1982, with those persons indicated in paragraph 1 above. The licensee did not disagree with the findings. The inspector informed the licensee that NRC action on TMI Item I.C.3 - Shift Supervisor training - had been transferred to Regional Management.

3. Licensee Action on Previous Inspection Findings

a. (Closed - Unit 1) Violation 335/81-02-01: Failure to assure that Purchase Orders/Requisitions included technical requirements for the receiving site. This violation is also discussed in Performance Appraisal Branch report, PAS 80-4, paragraph 8.b(11), page 73. It is closed based on review of FP&L letter of response L-81-158, Review of Quality Procedure QP4.1 "Requisitions and Purchase Orders" Rev. 8 and the current Rev. 10, and interviews with corporate QA management. QP4.1 requires the plant QC group to approve quality requirements of purchase orders for that plant. The QP has been amended to require that the plant, which receives (uses) the material, accomplish the review. The inspector had no more questions in this area.

b. (Closed - Unit 1) Violation 335/81-02-02: Failure to assure that material received complied with technical requirements. This violation is also discussed in Performance Appraisal Branch report PAS 80-4, paragraph 8.b. (12), Page 73. It is closed based on review of FP&L response letter L-81-158, FP&L interoffice correspondence (IOC) (C. S. Kent - T. Lyons) dated April 9, 1981 and IOC (C. S. Kent - C. M. Wethy) dated May 19, 1982. Action taken to prevent recurrence is addressed by item 335/81-02-01. The correspondence reviewed shows that the specific material met technical purchase specifications and that documentation specifications had been changed (one year prior to inspection PAS 80-4) to delete routine reporting of this particular test data. The inspector had no more questions in this area.

c. (Closed - Unit 1) Violation 335/81-04-01: Failure to adequately identify how temporary changes to plant procedures are initiated, processed, approved and implemented. Subsequent review of Quality Instruction (QI) 5-PR/PSL-1, Rev. 20, Preparation, Revision, Review/Approval of Procedures, has shown this violation to now be corrected.

d. (Closed - Unit 1) Violation 335/81-04-02: Inadequate identification of valves in several procedures. Revision of these procedures coupled with FP&L's clarification that certain types of plant valves normally carry no identification number has resolved this violation.

4. Unresolved Items

Unresolved Items were not identified during this inspection.

5. Licensee Actions Taken on TMI Action Items -

a. (Open - Unit 1) Item II.F.1.3 Containment High Range Radiation Monitor. On Friday, August 13, 1982, the inspector noted that Area Radiation Monitoring System (ARMS) channel No. 58, Containment High Range Radiation Monitor, was reading below zero. There are two of these detectors, channels 58 and 59, and each has an installed source which will cause a 1R/HR reading. Channel 59 was reading 1R/HR.

Research of procedures and technical specifications revealed no requirements for the system to be operational. TMI item II.F.1.3. required the system to be installed by January 1, 1982, but no other requirements are formalized. Calibration and channel check both require a shut down plant.

b. (Open - Unit 1) Item II.F.1.4, Containment Pressure. This item was previously held open in IE Report 335/82-04. The item continues open due to incomplete records in the following areas: Company Nuclear

Review Board Review, procedure revised, annual report complete, training complete, and design documents revised. Additionally, the calibration of the level instruments as reported in 82-04 continues to remain suspect with the following readings in effect:

Wide Range A	+3.5'
Wide Range B	0'
Narrow Range A	-3.6'
Rx Cavity Level L1-07-6	+12"

d. (Open - Unit 1) Item II.F.1.6., Containment Hydrogen Monitoring. Although the new hydrogen monitoring system is installed and apparently operational, this item is open due to an incomplete final turnover package from backfit engineering to the plant staff.

e. (Open - Unit 1) Item 1.C.3, Shift Supervisor Responsibility. This item was previously held open in report 335/82-11. This item was discussed with FP&L corporate staff in early September 1982. The area of concern is lack of management training for supevisors of shift activities (nuclear plant supervisors/nuclear watch engineers). Subsequently, the licensee stated the position that:

(1) FP&L had not committed to conduct such a program in response to NRC letter of October 30, 1979 (Denton - Licensee), item 2.2.1.a position.

(2) NUREG 0737 subsequently canceled that requirement.

(3) Additionally, the requirement was a short term one satisfied by training sessions conducted shortly after the TMI event.

Subsequent discussion with NRC Region II management and NRR reviewers, has indicated that the requirement to have such training remains valid. This item has been referred to regional management for resolution. Followup Item 335/80-35-04 remains open.

6. Operational Safety Verification

The inspector observed control room operations, reviewed applicable logs and conducted discussions with control room operators during the report period. The inspector verified the operability of selected emergency systems reviewed tagout records and verified proper return to service of affected components. Tours of the reactor, auxiliary and turbine buildings 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. The inspector, by observation and direct interview, verified that the physical security plan was being implemented in accordance with the station security plan.

On September 7, 1982, the inspector conducted an audit of equipment clearances issued and released during August and September. A total of eight clearances were found which did not confirm the "locked" condition of valves when releasing the clearance as required by paragraph 5.4 of Operating Procedure 0010122, Rev. 15, In-Plant Equipment Clearance Orders. This paragraph reads as follows:

5.4 When issuing or releasing a clearance the Watch Engineer shall insure that applicable valves, locks and switches under administrative control are properly denoted on the order.

Additionally, paragraph 8.2.11.9 of the same procedure reads:

9. Equipment under adminstrative control shall be listed as locked open or locked closed (L. Open or L. Closed).

These paragraphs were added to OP-0010122 after a previous violation in IE Report 50-335/82-15 of June 11, 1982. In spite of this procedure correction, the system still fails to assure correct placement of locks and chains when releasing a clearance. Additionally, plant supervisory and quality control department review of these completed equipment clearances failed to point out this condition. Failure to implement the procedure for locking safety-related valves in their required position is a violation of Technical Specification 6.8.1 (335/82-29-01).

The inspector observed plant housekeeping/cleanliness conditions and verified implementation of radiation protection controls. The inspector walked down the accessible portions of the auxiliary feedwater system to verify operability and witnessed portions of the radioactive waste system controls associated with radwaste shipments.

No other violations or deviations were identified in this area.

7. Reactor Trips and Safety System Challenges

a. Unit 1 tripped at 1:03 a.m. August 16. Safety systems appeared to function normally. The reactor was restarted and on-line by 7:13 a.m. The reactor was tripped manually when a circuit breaker opening caused the control indication to show control rods fully inserted.

b. The reactor tripped at 10:28 a.m. September 2. Technicians working on the generator alarms shorted contacts which caused the generator output breakers to open. This action caused the generator governor valves to shut. It also starts a 10-cycle timer that will prevent transfer of auxiliary loads from the auxiliary transformers to startup transformers unless the transfer is completed within 10 cycles. The reactor tripped from overpressure and generator overspeed, but not before the 10 cycles were exceeded, therefore no transfer of auxiliary loads occurred. The operators restored offsite power and conducted a routine recovery.

c. At 1:10 p.m. September 7, Unit 1 tripped again with a failure to transfer auxiliary loads to the startup transformers. Emergency equipment appeared to function properly. The cause was determined to be a switchyard worker cycling the motor and gearbox for a motor-operated disconnect in the generator output. This motor had been uncoupled from the disconnect linkage shaft for years to prevent inadvertent operation, however, the control circuit contacts are located in the gearbox. Operation of this gearbox results in turbine governor valves shutting with resultant trip and failure to transfer emergency loads to the startup transformer as described in event b above. The plant was restarted and on line by 3:27 p.m.

Events b and c above highlighted a design weakness. The licensee reports that the control design, which allows this particular type of turbine governor closure without immediate reactor and generator trip, is based on a desire to be able to operate independent of the electric grid if necessary during grid problems. The rest of the plant will not always support this design. Engineering effort is in progress to redesign these control circuits. The inspector will review the results (335/82-29-02).

8. Surveillance Observation

The inspector reviewed OP-0700050 Rev. 13, Auxiliary Feedwater Periodic Test and noted that the valve cycling portion of the test was deferred due to failure of a flow control valve to open (MV-09-12). This placed the plant in an action statement per Technical Specification 3.7.1.2., and required repair within 72 hours. Followup via the nuclear plant supervisor's log showed the valve was returned to service within 48 hours. Cause of the failure was due to a faulty torque limiter switch. The inspector verified that testing was performed in accordance with adequate procedures, test instrumentation was calibrated, limiting conditions for operation were met, removal and restoration of the affected components were accomplished, test results met 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. No violations or deviations were identified.

9. Maintenance Observation

Station maintenance activities of safety-related systems and components listed below were observed/reviewed to ascertain that they were conducted in accordance with requirements. The following items were considered during this review: the limiting conditions for operation were met, activities were accomplished using approved procedures, functional testing and/or calibrations were performed prior to returning components or systems to service; quality control records were maintained; activites were

accomplished by qualified personnel; parts and materials used were properly certified; and radiological controls were implemented as required. 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.

10. Inspector Followup of Previously Identified Items.

a. (Closed) Followup Item 335/81-08-01: Weaknesses in Corporate Training Program. This item originated as a result of Performance Appraisal Branch audit PAS 80-04. The Performance Appraisal Branch envisioned a centrally organized corporate training program with centralized training records under a Corporate Training Director. There is no requirement for this type of organization.

The inspector reviewed corporate actions taken in response to Section 3 (b)(1) of report PAS 80-04. The departments had received written direction by the Executive Vice President to upgrade training programs, including most elements desired by PAB. These new/revised programs were then reviewed by a committee, and, after a year, were recently audited by the Quality Assurance Department with varying results. Departments now are expected to respond to audit findings. Quality Assurance Department personnel are also presently engaged in a study to recommend further program improvements based on this lat audit.

Based on the inspector's observations and consultation with NRC Region II management, this item is closed.

b. (Closed) Followup Item 335/81-08-33: CNRB Charter Guidance Regarding Review Responsibilities. Closed based on review of CNRB charter revision 6 dated February 21, 1982. Section 4 of the charter was quite specific with respect to review responsibilities.

c. (Closed) Followup Item 335/81-08-39: CNRB not participating in Audits nor FRG meetings. This item originated in paragraphs 9.B.2 (b and f) of Performance Appraisal Branch report PAS-80-04. The item refers to stated PAB desires that the CNRB hold meetings at the reactor site, attend Facility Review Group meetings and participate as members of audit teams. The inspector could find no requirements in this area and, after consultation with NRC Region II management, is closing this item.

d. (Closed) Followup Item 335/81-08-41: CNRB Acting Executive Secretary did not have time to perform duties. Closed based on an interview with the new full-time CNRB Executive Secretary.

e. (Open) Followup Item - 389/82-34-02: Staffing levels differ from FSAR description. The inspector contacted the individual who reviewed FSAR table 13.1-1 and also the NRR Quality Assurance Branch and ascertained

that the staffing level differences described in this item would not have affected the findings of the reviewers. This item remains open pending correction of the FSAR.

f. (Open) Followup Item 389/82-34-01: Inclusion of ANS 3.1-1978 in QA Topical Report and Draft Technical Specifications. The inspector reviewed this item with NRR-QA Branch. The licensee was requested by the inspector to amend Chapter 13 and 17 of the FSAR to describe the differences in commitments. The inspector understands that the input for change has already been made. This item remains open pending issuance of the FSAR revision.

11. IE Circulars

The following IE Circulars were reviewed to ensure their receipt, review by appropriate management and appropriate action initiated.

a. (Closed Unit 2) IE Circular 79-10: Pipe Fittings Manufactured from Unacceptable Material. This report is an update of information previously reported in report 389/79-12. the licensee has reviewed pipefitting receiving documents for the period March 1978 - January 1979 and found no evidence of the subject materials. This is documented in FP&L memo PSL-82-517 to file L-310.4.3.

b. (Closed Unit 2) IE Circular 80-22: Confirmation of Employee Qualifications. Closed based on review of actions taken by FP&L and documented in memo PSL 2-82-436 to File L-310.4.2. Since this circular is applicable to Unit 1 also, the inspector reviewed the corrective action commitment request October 2, 1980 and responses. The inspector had no further questions.

c. Closed - Unit 1) IE Circular 81-14: Main Steam Isolation Valve Failure to Close. Closed based on review of licensee evaluations made in response to the circular and on the licensee's program for retest after maintenance. The inspector had no further questions on this item.

12. IE Information Notices

The following IE Information Notices were reviewed to ensure their receipt, review by appropriate management and appropriate action initiated:

a. (Closed - Unit 2) IE Notice 79-06 - Stress Analysis of Safety-Related Piping. Closed based on FP&L conclusion that this has been superceded by IE Bulletins 79-07 and 79-14. The inspector agrees.

b. (Closed - Unit 2) IE Notice 79-10 - Nonconforming Pipe Support Struts. The inspector reviewed several pieces of correspondence including FP&L memo - PSL-82-488 to file L-310.4.3; EBASCO letter SL-2-79-291 of

May 21, 1979; Bergen Patterson letter 7446/32/0032 of March 20, 1979, FP&L letter FLO-1422, and NRC Region IV Inspection Report 99900209/79-01 (Bergen Patterson). It was obvious that this condition had been reviewed for St. Lucie Unit 2 and the subject struts found to be acceptable. The inspector had no further questions.

c. (Closed - Unit 2) IE Notice 80-09 - Possible Occupational Health Hazard Associated with Closed Cooling Systems for Operating Power Plants. Closed based on FP&L review and conclusion that St. Lucie plant doesn't have a closed fresh water cooling system, but uses once-through salt water cooling.

d. (Closed - Unit 2) IE Notice 80-14 - Safety Suggestions from Employees. Closed based on review of memo PSL 2-82-486 to file L-310.4.3 detailing FP&L actions in response to this IE Notice. The actions appears to address the concern forwarded by the IE Notice.

e. (Closed - Unit 2) IE Notice 80-17 - Potential Hazards Associated with Interchangeable Parts on Radiographic Equipment. This IE Notice was evaluated by the licensee as not applicable to St. Lucie power plant since it applies to radiography licensees only.

f. (Closed - Unit 2) IE Notice 80-25 - Transportation of Pyrophoric Uranium. The licensee evaluated this IE Notice as not applicable to St. Lucie Plant. It applies only to certain materials licensees - not power plants.

g. (Closed - Unit 2) IE Notice 80-26 - Evaluation of Contractor QA Programs. Closed based on review of FP&L internal memo QAC-PSL-82-605 which described in some detail the actions taken by the FP&L Quality Assurance Department to notify and audit their suppliers.

h. (Closed - Unit 2) IE Notice 80-28 - Prompt Reporting of Information in Accordance with 10 CFR 50.55(e). Closed based on licensee review (PSL-2-82-327) that shows that 10 CFR 50.55(e) reports are made to the regional office as requested in the IE Notice.

i. (Closed - Unit 2) IE Notice 81-01 - Possible Failures of General Electric Type HFA Relays. Closed based on the licensee including this item with the 10 CFR 50.55(e) program as item number 82-001.

j. (Closed - Unit 2) IE Notice 81-24 - Auxiliary Feed Pump Turbine Bearing Failures. This IE Notice was evaluated by the licensee as applicable to Unit 2. Action was taken to determine proper oil levels and to mark the sight glass. Memos to file PSL-2-82-411 and EPM PSL-2-82-163 document actions taken. This item is closed.

k. (Closed - Unit 2) IE Notice 82-20 - Check Valve Problems. Closed based on FP&L investigation that shows that the subject valves are not installed at St. Lucie Unit 2.

l. (Closed - Unit 1 and Unit 2) IE Notice 82-21 - Buildup of Enriched Uranium in Effluent Treatment Tanks. Closed as not applicable based on both inspector and licensee evaluation that the circular applies to fuel fabrication plants not power reactors.

m. (Closed - Unit 2) IE Notice 79-18 - Skylab Reentry - Closed based on the notice being issued for a one-time occurrence.

n. (Closed - Unit 2) IE Notice 81-32 - Transfer and/or Disposal of Spent Generators. Closed as not applicable to power reactors. This notice applies to medical licensees only.

13. Control Room Design Review (Unit 2)

The inspector reviewed corrective action taken by the licensee to address control room human engineering discrepancies identified in NUREG-0843, Supplement 1, Appendix C. This review was requested by the Office of Nuclear Reactor Regulation (NRR). Items reviewed included NUREG 0843, Supplement 1, Appendix C; control panel vendor drawings and various design changes notices. Interviews were conducted with various responsible design and project coordination personnel.

The inspector made the general observation that the licensee's staff and contractors appeared to be quite aware of the discrepancies, had been redesigning control panels and were close to completion of modifications, but were not at the stage where a significant number of discrepancies could be inspected for completion.

It was apparent that the licensee and NRR did not share a common understanding of previous commitments concerning subsequent licensee submittals. The inspector informed the NRR project manager.

The inspector reviewed an August 2, 1982 draft NTOL Summary Human Engineering Report (FP&L and NRR). The report was quite lacking in the detail necessary for remote-from-the-site judgements by NRR. The inspector recommended to the NRR reviewer that the reviewer plan a site visit in late August or early September 1982. The inspector understands that subsequent NRR - FP&L dialog has occurred and an improved report is being prepared.

The applicant informed the inspector that the modifications and labeling should be completed by mid-to-late August 1982. This was not the case. As of the end of this inspection, demarcation and labeling had not started.

Specific inspector comments on items, as numbered in NUREG 0843, Supplement 1, are as follows:

a. (Open - Unit 2) A.1.7. Direct means of testing operability of control room emergency lighting. The Licensee pointed out the circuit breakers but did not provide the wiring diagram as requested.

b. (Open - Unit 2) A.3.6. Relocate Annunciator Audible Alarms Devices. This was physically accomplished. The licensee has not provided the design change notice for inspection as requested.

c. (Open - Unit 2) A.4.2. Remove non-functional control buttons from process controllers. The examples (a - d) were the totality of controllers with this condition. Example (e) was a repeat of (a). FP&L now says the buttons cannot be removed but has not communicated this information to NRR.

d. (Open - Unit 2) A.4.4. Remove nonfunctional control buttons. This controller is example (c) of A.4.2. The nonfunctional buttons were reversed. This part has been corrected. FP&L now says the buttons cannot be removed but has not communicated this information to NRR.

e. (Open - Unit 2) A.4.6. Black ring around some key switches. FP&L now says their response (that the black ring is a color code for "locked open") is wrong but has not communicated this to NRR. Also, the switches have not been modified.

f. (Open - Unit 2) A.4.9. Key Switch Orientation (Key Teeth Down). Example a) has been corrected, and example b) was not corrected.

g. (Closed - Unit 2) A.4.11. Paint Rotary Selector Switch Pointers a Contrasting Color. The inspector observed that the pointers had been painted white (switch handles are black).

h. (Closed - Unit 2) A.5.1. Install Dual Meter FI-09-2C/PI-09-8C. The dual meter was installed.

i. (Open-Unit 2) A.5.11. Lamps do not comply with green-left/red-right convention. The lamp covers were swapped but no verification test was performed to determine if a wiring error was the real problem.

j. (Open-Unit 2) A.5.13. Containment H_2 Purge Control Valve FCV-25-28 on HVAC Panel violates conventional color code for valve positions. FP&L swapped the lenses but did not test the circuit to see if a wiring problem existed.

k. (Closed - Unit 2) A.5.14. Pressurizer pressure meters PIC 11.5 and PIC 11.6 indicate an increase by a downward movement. A design change removed these meters.

l. (Closed - Unit 2) A.5.17. Incorrect Indication Range on PIS-07-2B. A 0-15 PSI instrument has been installed.

m. (Closed - Unit 2) A.4.27. Replace broken glass meter face on Reactor Protection System Panel. The inspector observed that no broken meter faces were now present on that panel.

n. (Closed - Unit 2) A.6.36. Remove temporary label from station battery 2B meter. It was removed.

o. (Closed - Unit 2) A.6.38. Control board tag outs obscure displays below them. The operating unit procedure OP-0010122, Rev. 13, paragraph 8.3.3.1 covers this subject.

p. (Closed - Unit 2) A.6.44. Incomplete lines/arrows on Line Repeat Panel. The mimic was completed.

q. (Closed - Unit 2) A.8.1. Lack of consistency in column alignment of similar displays. (Panel 203). FP&L found this to be a labeling problem. The inspector found the labels correctly installed.

r. (Closed - Unit 2) A.8.8. Auxiliary Feedwater Header Flow Trend Recorders on panel 202 arranged BCA vice ABC. The inspector observed the recorders to be arranged ABC.

s. (Closed - Unit 2) A.8.11. SI Tank level instrument LIA 3311 has improper range. The inspector observed this instrument to now have the same range as other SI tank level instruments.

t. (Closed - Unit 2) A.8.16. Relocate electrical test points. These test points were moved from the prime control area.

14. Safety Committee Activity (Onsite and Offsite) (40301B)

The inspector attempted to verity that the onsite Facility Review Group (FRG) and offsite Company Nuclear Review Board (CNRB) programs and activities were compatible with the Unit 2 FSAR and Draft Technical Specifications. Ordinarily, this would not be required for an add-on unit. In this case however, the Performance Appraisal Branch found many minor weaknesses and several significant weaknesses (report PAS 80-04). Completion of this inspection procedure is therefore deemed prudent.

During a trip to FP&L's new engineering office at Juno Beach, Florida, the inspector interviewed several persons including the new executive secretary of the CNRB. The status of upgrading the CNRB and correction of weaknesses were discussed. The following conditions prevented the inspection from proceeding:

a. The new CNRB executive secretary was close to completing an upgraded CNRB charter and operating guidelines for the subcommittee.

b. The Unit 2 technical specifications concerning the CNRB had not been submitted to NRC. As of the completion of this inspection the technical specifications have been submitted.

c. The St. Lucie procedure governing the FRG currently applies to Unit 1 only.

d. The CNRB subcommittee had not completed the backlog of items requiring review.

The CNRB executive secretary indicated that the CNRB items should be completed by the middle of September 1982. The few items that could be inspected are included in paragraph 7 of this report. The inspector deferred inspection activities in this area pending meaningful progress by the applicant.

15. Test Program Implementation (70302)

The inspector reviewed, in part, the implementation of the preoperational test program. Specific activities reviewed included testing of the reactor protective system, emergency diesels, control element assembly MG sets, and component cooling water operation. Test program attributes inspected included documentation of major test events and deviations to procedure, operating practices, instrument calibrations and correction of problems revealed by the test.

No violations or deviations were identified in this area.

16. Plant Tours (Unit 2) (71302)

The inspector conducted frequent tours of Unit 2 observing activities in progress regarding fire protection, housekeeping, equipment preservation, abuse of installed instrumentation, cable pulling security, and general construction progress.

No violations or deviations were identified in this area.