U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Report No. 50-461/91004(DRP)

Docket No. 50-461 License No. NPF-62

Licensee: Illinois Power Company
500 South 27th Street
Decatur, IL 62525

Facility Name: Clinton Power Station

Inspection At: Clinton Site, Clinton, Illinois

Inspection Conducted: February 1 - March 25, 1991

Inspectors: P.G. Brochman

F.L. Brush

Approved By: Roger D. Lanksbury, Chief
Reactor Projects Section 3B

APR 0 8 1991
Date

Inspection Summary

Inspection from February 1 - March 25, 1991 (Report No. 50-461/91004(DRP))
Areas Inspected: Routine, unannounced safety inspection by the resident inspectors of licensee action on previous inspection findings, operational safety, event follow-up, maintenance/surveillance, engineering and technical support, and licensee event reports.
Results: No violations or deviations were identified. One unresolved item was identified involving the failure to properly calculate class 1-E battery loads (Paragraph 5.c).

The following is a summary of the licensee's performance during this inspection period:

Plant Operations

- An event involving the spill of water from the residual heat removal (RHR) system was caused by a loss of control of system status by operations personnel and a breakdown in the safety tagging program, due to poor communication between operations, maintenance, and technical staff. There was no significant impact on the plant.

- Operator performance during the loss of service air compressors (SAC) event was mixed. Operators did not properly diagnose the reason the No. 1 SAC auto-started before they secured it. Operators did not follow

the procedures for starting the SAC and this delayed the return of instrument air and indicated a lack of familiarity with the procedure. Conversely, the reactor operator's response in initiating the manual scram to isolate the reactor vessel drain path, indicated a good evaluation of the situation and was indicative of prudent action.

- Operator actions in response to the loss of the 6.9 KV bus 1A were very timely and effective in stabilizing the plant and preventing a significant plant transient.

- During the final drywell closeout inspection, numerous pieces of small, readily observable, debris and tools were observed.

Maintenance/Surveillance

- Two events occurred, both involving electrical maintenance, that resulted in unnecessary plant transients. One involved the jarring of auxiliary relays in a switchgear door resulting in the stripping of a safety-related bus and starting and loading the Division III diesel generator. The second involved the failure to correctly indicate the status of a preventive maintenance task which resulted in not reinstalling a watt transducer in the protective relay circuitry for the normal feeder breaker for 6.9 KV bus 1A. This caused both the normal and alternate feeder breakers to trip and lockout when reactor operators attempted to shift the power source for the bus. The loss of power to the bus caused a loss of all circulating water pumps and a drop in condenser vacuum and necessitated a manual turbine trip. Taken together they were of concern.

Engineering and Technical Support

- Licensee personnel discovered two problems with the calculation for the Division III battery loading. One was that a motor, larger than designed, was installed on the DC bus. The second was the calculation did not account for the momentary locked rotor current in calculating the maximum load on the battery as required by standard IEEE-485. Licensee personnel tested the battery at the higher loading (for a 2.5 HP motor, assuming a locked rotor) and verified that it could perform its design function. Further review of this event and its root cause will be followed as an unresolved item (UNR 461/91004-01).

- Updates of the process computer to install the cycle 3 specific core parameters were accomplished correctly.

Safety Assessment and Quality Verification

- No problems were identified during the review of licensee event reports.

DETAILS

1. Persons Contacted

Illinois Power Company (IP)

*#J. Perry, Vice President
*#J. Cook, Manager - Clinton Power Station
*#J. Sipek, Supervisor, Regulatory Interface
* C. Elsasser, Director, Outage Management
* L. Everman, Nuclear Program Assessor
* D. Holtscher, Director, Nuclear Safety
* [illegible]. Daniel, Supervisor, Chemistry
[illegible]. Miller, Director, Plant Radiation Protection
* [illegible]. Bednarz, Principal Assistant to the Vice President
* K. Graf, Director, Quality Assurance
* S. Rasor, Director, Plant Maintenance
*#J. Miller, Manager, Nuclear Station Engineering
*#R. Phares, Director, Licensing
* J. Palchak, Manager, Nuclear Planning and Support
* G. Baker, Director, Plant Security Systems
* P. Yocum, Director, Plant Operations
* J. Brownell, Project Specialist, Licensing
Soyland Power Cooperative, Inc.
* J. Greenwood, Manager, Power Supply

The inspector also contacted and interviewed other licensee and contractor personnel during the course of this inspection.

Denoted those present at a management meeting on March 6, 1990.
* Denoted those present during the exit interview on March 25, 1990.

2. Action on Previous Inspection Findings (92702)

(Closed) Violation (461/90014-03(DRP)): Diesel generators 1A and 1B were inoperable when Shutdown Service Water (SX) valves were incorrectly positioned, preventing the SX system from performing its necessary attendant cooling support function. The inspectors reviewed the licensee's corrective actions in response to the civil penalty, which included revision of CPS Procedure 3211.01, Shutdown Service Water, to indicate the correct required valve position and issuing Operations Standing Order (OSO) 073 to address the positioning of throttle valves. The licensee modified the diesel generator SX system to eliminate the need to throttle flow using butterfly valves. Orifices have been installed which control the flow and the heat exchanger inlet valves are now left in the full open position. The inspectors have reviewed the corrective actions for this violation and no additional response is required; this violation is closed.

No violations or deviations were identified.

3. Plant Operations

The unit began the report period shutdown for its second refueling outage (RF-2). The unit was taken critical at 1:00 p.m. on March 4, 1991, and was synchronized to the grid at 2:10 a.m. on March 9, 1991, completing the 146 day outage. Major work during the outage included: refueling, splicing of containment electrical penetrations, performing an integrated leakage rate test (ILRT), inspection of a low pressure turbine rotor, and other maintenance and surveillance activities. On March 9, 1991, at 2:34 a.m. the turbine was manually tripped due to the loss of power to both operating circulating water pumps (see paragraph 3.b (4) below). After repairs, the unit was synchronized at 7:20 p.m. and reached 100% power on March 18, 1991. The unit remained online for the rest of the report period.

a. Operational Safety (71707)

The inspectors observed control room operation, reviewed applicable logs, and conducted discussions with control room operators during February and March 1991. During these discussions and observations, the inspectors ascertained that the operators were alert, cognizant of plant conditions, and attentive to changes in those conditions, and that they took prompt action when appropriate. The inspectors verified the operability of selected emergency systems, reviewed tagout records, and verified the proper return to service of affected components. Tours of the auxiliary, containment, drywell, fuel-handling, rad-waste, 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 inspectors verified by observation and direct interviews that the physical security plan was being implemented in accordance with the station security plan.

The inspectors observed plant housekeeping/cleanliness conditions and verified implementation of radiation protection controls. The inspectors also witnessed portions of the radioactive waste system controls associated with rad-waste shipments and barreling.

The observed facility operations were verified to be in accordance with the requirements established under Technical Specifications, 10 CFR, and administrative procedures.

(1) Fire Drill

On February 22, 1991, the inspectors observed a fire drill in the plant laundry area. The fire brigade responded promptly and took appropriate actions. They assembled quickly, donned their fire fighting gear, and established required communications. A critique was held following the drill to discuss the fire brigade's performance and no significant problems were identified.

(2) Drywell Closeout Inspection

The inspectors, accompanied by licensee management, performed a closeout inspection of the drywell on March 1, 1991. The inspectors discovered numerous pieces of tape, wire, screws, tags, tools, saw blades and other miscellaneous items. The items were readily observable. Several inspections had been made by licensee management prior to March 1, 1991. A number of them had been identified by the licensee in a previous inspection and they were in the process of cleaning them up when the inspectors arrived for their scheduled inspection.

(3) Breakdown of Safety Tagging System Causes Spill

At 9:30 a.m. on February 4, 1991, water was reported coming from a 3/4 inch hydrostatic test connection on the train B residual heat removal (RHR) system. At the time of the event, the RHR system was being filled with recycled condensate water. The leakage was isolated by 9:45 a.m. and the spill was cleaned up. Several motor operated valves that were sprayed were meggered to verify that no grounds were present.

Licensee management conducted an investigation that day and determined that the spill was caused by two problems; removal of a danger tag when the system was not intact and simultaneously performing two separate, conflicting valve lineups for local leakage rate tests (LLRT).

Prior to the spill, a test connection was installed on the B RHR heat exchanger vent line between valve 1E12-F074B and containment to support a post-modification hydrostatic test. After the hydrostatic test was completed the test connection would be cut off and a cap welded on.

The licensee split the activity into two maintenance requests (MWRs); one to install the test connection and the other to remove it and weld the cap on. Tagout No. 91-0036 was issued to danger tag shut valve F074B and only referenced the installation MWR. After the connection was installed the tagout was cleared (Note - the test connection did not have any isolation valves or caps). The tagout boundary to support the hydrostatic test was not moved back to include the test connection. Additionally, the BRHR heat exchanger inlet and outlet isolation valves were opened to fill the RHR system. This resulted in an open system without a safety tag and caused the spill.

This event was indicative of a loss of control of system status by operations personnel and a breakdown of the safety tagging system due to poor communications between operations, maintenance and technical staff.

b. Onsite Event Follow-up (71707 & 93702)

The inspectors performed onsite follow-up activities for events which occurred during February and March 1991. These follow-ups included reviews of operating logs, procedures, condition reports, Licensee Event Reports (where available), and interviews with licensee personnel. For each event, the inspector developed a chronology, reviewed the functioning of safety systems required by plant conditions, and reviewed licensee actions to verify consistency with procedures, license conditions, and the nature of the event. Additionally, the inspector verified that the licensee's investigation had identified the root causes of equipment malfunctions and/or personnel errors and that the licensee had taken appropriate corrective actions prior to restarting the unit. Details of events and the licensee's corrective actions developed through inspector follow-up are provided in paragraphs (1) through (4) below:

(1) Division I Nuclear System Protection System (NSPS) Bus Deenergization

At 11:35 a.m. on January 18, 1991, with the reactor in cold shutdown, the Division I NSPS bus was deenergized for maintenance. The following actuations then occurred: the Division I diesel generator started, a half scram signal was received, the containment instrument air isolation valves closed, the inboard main steam isolation valves (MSIV) closed, and some Division I 480 V motor control center (MCC) shunt trip breakers tripped, including the containment polar crane's breaker. (The polar crane was making a lift at that time.) The probable cause of the actuations was a "relay race" when the various components deenergized. The licensee had performed an impact assessment to support NSPS bus deenergization. The assessment addressed the types of actuations listed above (except for the polar crane). However, the operations personnel performing the surveillance misinterpreted the information and failed to take actions to prevent the actuations. Some of the Division I equipment did not start or was in pull-to-lock when the event happened. No problems were identified with the performance of the equipment. The polar crane's breaker was closed and the suspended load was placed in a safe condition. The load was not suspended over the reactor vessel at the time of the power interruption.

This was a "first time evolution" and the information contained in the impact assessment was intended to be used in developing procedures for all of the safety-related busses to prevent equipment from being unnecessarily exercised. Operations department supervisors misunderstood the assessment to be a list of components which MIGHT be affected; rather than a list of components which SHOULD be blocked from starting or, in cases where equipment can not be prevented from starting due to technical specification considerations, appropriate preparations were to be made before the equipment started. The licensee plans to incorporate the assessment into procedures and to discuss the event with operations department personnel.

(2) Loss Of Instrument And Service Air Results In A Manual Scram (LER No. 50-461/91002-LL)

At 3:25 a.m. on February 18, 1991, with the reactor in cold shutdown, the No. 1 service air compressor (SAC) automatically started. The No. 2 SAC, which had previously been running, appeared to remain loaded; consequently, the plant operators shutdown the No. 1 SAC. Service air pressure then decreased rapidly. The operators attempted to start the No. 1 SAC but its electrical supply breaker tripped. The No. 2 SAC then tripped and the instrument air dryer's low pressure alarm annunciated. The instrument air system was being supplied from the service air compressors.

At 3:27 a.m. the Scram Discharge Instrument Volume (SDV) HI level alarm annunciated which indicated that the control rod drive (CRD) hydraulic control unit (HCU) scram valves had began opening as instrument air pressure slowly decreased. The reactor vessel level began to decrease because of the drain path which had been created from the CRDs to the HCUs to the SDV to the containment equipment drain sump. The drain path was created when the scram valves began to open before the SDV vent and drain valves began to close. This was due to lower spring pressure in the SDV vent and drain valves (normal design). Both types of valves utilize springs to position the valves to their "safe" condition upon the loss of instrument air.

The reactor operators responded by initiating a manual scram to close the SDV vent and drain valves, which isolated the drain path. The SDV vent and drain valves would have eventually shut, but the reactor operators reacted conservatively to isolate the reactor vessel. Reactor vessel water level decreased approximately five inches during this event and remained within the normal operating range.

At 3:38 a.m. the operations personnel attempted to start the No. 0 SAC, but did not correctly follow the procedure. Consequently, it did not start. At 3:45 a.m. the operators attempted to start the No. 1 SAC using the same method and achieved the same results. Next the operators successfully started the No. 2 SAC at 3:50 a.m. However, the SAC tripped when the normal instrument air system was valved in, due to an operator mistakenly isolating the instrument air dryers. The dryers were unisolated and the No. 2 SAC was restarted and loaded at 4:00 a.m. The No. 1 SAC was started and loaded at 5:14 a.m. and the No. 2 SAC was shutdown at 5:22 a.m.

The inspectors identified two concerns to operations department management regarding this event: 1) the error in judgement in stopping the No. 1 SAC after it had auto started (it started for a reason); and 2) the operators unfamiliarity with, and failure to follow, the procedure for starting the SAC with no instrument air available unnecessarily delayed the return of instrument air

to the plant. This aspect of the operators performance was not consistent with the usual performance of Clinton's operators in responding to events, especially as typified in paragraph 3.b(4) below. The inspectors will review this event further, in a subsequent report, after the LER is evaluated.

(3) Division III Emergency Diesel Generator Start (LER No. 50-461/91003-LL)

At 2:50 p.m. on February 20, 1991, the Division III emergency diesel generator (DG) automatically started and its output breaker closed to energize the Division III 4.16 KV bus after the normal and alternate feeder breakers locked out. The cause of this event was due to electrical maintenance personnel bumping auxiliary relays on the switchgear cubicle door for the diesel generator output breakers. This aspect is discussed further in paragraph 4 (maintenance/surveillance). In parallel with this event, an alarm was received for low voltage on the Division III DC bus. The computer indicated that voltage had decreased from 125 VDC to approximately 72 VDC for 20 seconds and then returned to its normal value. The licensee tested the protection circuitry and verified it was working correctly. The Division III DC wiring and buswork was inspected and no indication could be found of a current flow which would equate to a voltage drop of 60 volts for this bus. No reason was found for the computer alarm for low DC voltage.

Some time after the DG had loaded, a reactor operator noticed that the control switch "targets" for the normal, alternate, and DG circuit breakers supplying the Division III bus did not match the breaker position. The operator "matched the targets." (This is a commonly accepted practice.) Unknown to the operations department, in this electrical configuration the plant was designed to prevent paralleling the bus supplied by the DG with its normal or alternate power supply. At 1:47 a.m. on February 21, 1991, the Division III DG output breaker was tripped and the normal supply breaker closed.

The licensee plans to revise operating procedures to reflect the plant design. The operations department will receive additional training on the electrical plant design. The inspectors will review the event and additional corrective action, in a subsequent report, after the LER is evaluated.

(4) Loss Of 6.9 KV Non-Vital Bus 1A

At 2:10 [illegible] on March 9, 1991, the main generator was synchronized to the [illegible] following turbine overspeed testing. Subsequently, reactor [illegible]ors transferred 6.9 KV bus 1A from its shutdown power s[illegible], the Reserve Auxiliary Transformer (RAT), to its operating power source, the Unit Auxiliary Transformer (UAT). At 2:30 a.m., when the UAT breaker was closed, both the RAT and UAT breakers tripped and locked out. Significant loads which were powered by bus 1A were the 1A and 1C main circulating water

pumps. The loss of these two pumps resulted in a loss of cooling water to the main condenser. Vacuum started to decrease from 28.5 inches Hg. The reactor operators tripped the turbine when condenser vacuum decreased to 24.5 inches Hg, at 2:34 a.m. The operators reset the lockout relays on the 1A bus by 2:35 a.m. and closed the RAT breaker, reenergizing the bus. An operator was dispatched to the circulating water pumps to start a local seal water pump and the 1A circulating water pump was then successfully started.

Had operations personnel been unable to restart the circulating water pump, the main turbine vacuum would have continued to decrease until the bypass valves isolated. This would have resulted in a main steam line isolation and reactor trip at 11 inches Hg. Timely action by the plant operators prevented a significant transient.

The licensee's investigation of the problem with the RAT and UAT breakers revealed that a watt transducer was missing from the A and C phases of the protective relay circuitry for the UAT breaker. The watt transducer does not perform a safety-related function, but is in the overcurrent relay circuitry. Removal of this device affected the circuitry between the A and C phases' connections to the neutral wye connection of the overcurrent protection relays. Consequently, since no offsetting voltages existed at the wye, when the breaker was closed, the current flow from the B phase and back through the neutral conductor resulting in a neutral overcurrent trip. This error was caused by electrical maintenance personnel and is discussed further in paragraph 4 (maintenance/surveillance).

At 2:36 a.m. the control room received a report of water cascading down onto the main generator iso-phase bus ducting from the 800 foot elevation of the turbine building. The source of the water was the generator stator cooling system in the main generator's exciter house. The licensee investigation determined that a pressure transient had occurred in the stator cooling system. The running pump, powered from the 1A bus, stopped and then restarted when the bus was deenergized and then reenergized. The pump that was powered from the 1B bus was out of service at the time of the event. This pressure transient caused a hose to come off its fitting and sprayed down the electrical equipment in the exciter house and caused a ground in the generator exciter circuit. The hose was attached to the fitting with a standard General Electric designed crimp connection.

The license dried out the exciter house and verified that the exciter ground was cleared. The hose was reattached and the crimp connection secured. The generator was synchronized at 7:20 p.m. on March 9, 1991.

Due to miscommunication between the operations department and electrical maintenance management, reactor operators attempted to shift the 1A bus to the UAT at 11:35 p.m. on March 10, 1991. The results were the same. Operators had shifted significant loads before hand and no transient occurred. However, the trouble shooting for the initial event had not been completed. On March 11 the missing transducers were identified as the root cause and were reinstalled. The 1A bus was successfully shifted to the UAT at 12:40 p.m. on March 11. 1991.

The Inspectors will review the event further, in a subsequent report, after the LER is evaluated.

c. Startup from Refueling (71711)

The reactor was taken critical at 1:00 p.m. on March 4, 1991, after a 146 day refueling and maintenance outage. The licensee continued to preform required startup testing and escalating power to 100%. The inspectors monitored various startup activities in the control room and were present when the unit was taken critical. The inspectors observed operations department personnel conducting briefings before major evolutions, consulting other departments when problems arose, and performing in a generally conservative manner. The inspectors observed no major problems during the startup.

No violations or deviations were identified.

4. Maintenance/Surveillance (61726 & 62703)

Station maintenance and surveillance activities of the safety-related systems and components listed below were observed or reviewed to ascertain that they were conducted in accordance with approved procedures, regulatory guides, and industry codes or standards, and in conformance with Technical Specifications:

Surveillance Procedure 9054.05 - RCIC Pump Flow Operability

The following items were considered during this review: the limiting conditions for operation were met while affected components or systems were removed from and restored to service; approvals were obtained prior to initiating work or testing; quality control records were maintained; parts and materials used were properly certified; radiological and fire prevention controls were accomplished in accordance with approved procedures; maintenance and testing were accomplished by qualified personnel; test instrumentation was within its calibration interval; functional testing and/or calibrations were performed prior to returning components or systems to services; test results conformed with Technical Specifications and procedural requirements and were reviewed by personnel other than the individual directing the test; any deficiencies identified during the testing were properly documented, reviewed, and resolved by appropriate management personnel; work requests were reviewed to determine the status of outstanding jobs and to assure that priority was assigned to safety-related equipment maintenance which may affect system performance.

a. Division III Diesel Generator Start

At 2:50 p.m. on February 20, 1991, the normal supply breaker to the Division III 4.16 KV safety-related bus opened and locked out, the alternate supply breaker locked out, and the diesel generator started and loaded the bus. The cause was that maintenance workers bumped two auxiliary relays (62S5X and 252X1-DG1C) mounted on the door of diesel generator's (DG) breaker in the Division III switchgear. An electrical supervisor, a work planner, and an engineer were planning work on the high pressure core spray (HPCS) pump breaker and had opened the door to its cubicle in the Division III switchgear. The individuals then decided to open the door of the DG breaker cubicle (adjacent cubicle) for reference to a properly working breaker. The door to the DG breaker cubicle was sticking and when it swung free, it came in contact with the door for the HPCS breaker, jarring the relays and causing certain contacts to actuate.

The individuals were unaware that the door was sticking or that it could contact the adjacent cubicle when it was opened. Also no preventative maintenance had been done on the door to minimize its sticking. The licensee ascribed these problems as the root cause of this event. The licensee has initiated preventative maintenance to lubricate the doors and placed warning signs on them.

b. Loss of 6.9 KV Bus due to a Maintenance Error

On March 9, 1991, operators were attempting to shift the source of power for 6.9 KV bus 1A from the RAT to the UAT when both breakers tripped open and locked out. Rapid intervention by the reactor operators prevented a significant plant transient. The licensee's initial investigation determined that a preventative maintenance (PM) task was performed on a watt transducer for the UAT breaker during the refueling outage. While performing the PM, the electricians were unable to calibrate a watt transducer to the required accuracy (+ 0.5%) due to drifting. The transducer was removed from the switchgear to perform the calibration and taken to the electrical shop. They contacted the engineering department for assistance and were told that the vendor had gone out of business and that a new transducer would have to be obtained. The installation of a new transducer was beyond the scope of the PM so a maintenance work request (MWR) was created to accomplish this task. However, the PM was signed off as completed, even though it was not. Also, since the electricians knew that the new transducer had to be installed they left the original sitting in the electrical shop. Consequently, when the breaker was closed the protective circuitry sensed a neutral over-current and tripped both breakers and locked them out to isolate the fault. Subsequently, the problem with the watt transducer was identified. The licensee's investigation of this event was in progress at the end of the report period and will be reviewed by the inspectors in a subsequent report. The old watt transducers were reinstalled pending resolution of the problem.

No violations or deviations were identified.

5. Engineering and Technical Support

a. Process Computer Data Update

The inspectors reviewed CPS 2820.06, NSS Process Computer Checks for Refueling. They also reviewed the computer printout from the OD-20, Refuel Update Monitor, program. The items checked included proper execution of the OD-20 program, validation of the process computer data bank, and procedure adequacy. The inspectors found no items of concern as a result of this effort.

b. Handrail Seismic Qualification

The licensee installed self-closing gates at the top of permanently installed vertical ladders in the power block to meet a personnel safety requirement. The inspectors questioned the licensee concerning the seismic qualification of these modifications. The licensee discovered during their investigation that no specific calculations existed which documented that handrails and self-closing gates were seismically acceptable. They also discovered that the galleries/platforms attached to, and supported by, the bio-shield wall were designed using the wrong seismic response spectra. The licensee performed calculations and verified that the handrails and gates were seismically acceptable. They also performed calculations using the correct bio-shield seismic spectra which determined that the galleries and platforms were qualified.

c. Battery Loading Calculation

On December 20, 1990, licensee engineers identified a problem with the loading calculation for the Division III battery. The Division III diesel generator has two starting air compressors, one of which was diesel powered with a 2.5 HP DC starting motor. The design and battery sizing calculations were based on a 2.0 H.P. starting motor. Additionally, battery sizing calculation 19-D-27, revision 5, did not utilize the locked rotor current value as a momentary random load as was required by IEEE Standard 485 for battery sizing. The Division III battery was required to provide at least 112 amps for 1 minute and at least 52 amps for the next 239 minutes. These values were defined in Clinton Updated Safety Analysis Report (USAR) Table 8.3-10 and Technical Specification 4.8.2.1.d. The revised analysis indicated that the 1 minute current needed was at least 179 amps, with a 2.5 HP motor, and 165 amps with the 2.0 HP motor.

The licensee subsequently performed a load test to verify that the battery had been capable of providing at least 180 amps since initial plant licensing. The inspectors will perform additional review of this issue into why it occurred and how incorrect design values were translated a into technical specification surveillance. This issue will be tracked as Unresolved Item (461/91004-01(DRP)).

No violations or deviations were identified. One unresolved item relating to the failure to translate design requirements into surveillance criteria was identified.

6. Safety Assessment/Quality Verification

Licensee Event Report (LER) Follow-up (90712 & 90700)

Through direct observation, discussions with licensee personnel, and review of records, the following LERs were reviewed to determine that the reportability requirements were fulfilled, immediate corrective action was accomplished, and corrective action to prevent recurrence had been accomplished in accordance with Technical Specifications.

LER No.	Title
461/89013	Lack of attention to inoperable intermediate range monitor channels by utility licensed operators results in the failure to place those channels in a tripped condition.
461/89040	Omission of mode limitations from surveillance procedure results in inoperable anticipated transient without scram recirculation pump trip system instrumentation.
461/89032	Failure to match manual control to automatic control prior to transferring feedwater pump to manual results in increase in reactor water level and manual scram.

No violations or deviations were identified.

7. 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. An unresolved item disclosed during the inspection is discussed in paragraph 5.c.

8. Meetings

a. Management Meeting

On March 6, 1991, a routine management meeting was held in NRC headquarters in Rockville, Maryland, between Messrs. J. Partlow, Associate Director for Projects, NRR, and members of his staff; R. Lanksbury, Chief, Reactor Projects Section 3B, RIII; and the senior resident inspector and with Mr. J. S. Perry and members of his staff designated in paragraph 1. Topics discussed at the meeting included: a summary of the current refueling outage performance, 1991 initiatives, and an overview of the 3rd fuel cycle.

b. Exit Interview

The inspectors met with the licensee representatives denoted in paragraph 1 at the conclusion of the inspection on March 25, 1991. The inspectors summarized the purpose and scope of the inspection and the findings. The inspectors also discussed the likely informational content of the inspection report, with regard to documents or processes reviewed by the inspectors during the inspection. The licensee did not identify any such documents or processes as proprietary.