U. S. NUCLEAR REGULATORY COMMISSION

REGION III

Report No. 50-346/84-06(DPRP)

Docket No. 50-346 License No. NPF-3

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

Facility Name: Davis-Besse 1

Inspection At: Oak Harbor, Ohio

Inspection Conducted: April 2 - June 11, 1984

Inspector: W. G. Rogers

M. J. Jordan

Approved By: I. N. Jackiw, Chief
Projects Section 2B

6-29-84
Date

Inspection Summary

Inspection on April 2 - June 11, 1984 (Report No. 50-346/84-06(DPRP))
Areas Inspected: Routine, unannounced inspection by resident inspectors of licensee action on previous inspection findings; operational safety; maintenance; surveillance; Licensee Event Reports; IE Bulletins; IE Circulars; receipt of new fuel; ACRS meeting participation; management meetings; and operational events. The inspection involved a total of 312 inspector-hours onsite by three NRC inspectors including 105 inspector-hours onsite during off-shifts.
Results: Of the eleven areas inspected, no items of noncompliance were identified in eight areas. One item of noncompliance was identified in the areas of licensee action on previous inspection findings and licensee event report followup (failure to take adequate corrective action - Paragraph 2); and one item of noncompliance was identified in the area of followup on operational events (failure to report RPS actuations to the NRC - Paragraph 12).

DETAILS

1. Persons Contacted

*T. Murray, Station Superintendent
B. Beyer, Assistant Station Superintendent
S. Quennoz, Assistant Station Superintendent
D. Miller, Operations Engineer
D. Briden, Chemist and Health Physicist
L. Simon, Operations Supervisor
*C. Daft, QA Director
J. Greer, QA Supervisor
*J. Faris, Administrative Coordinator

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

*Denotes those personnel who attended the exit meeting on June 1, 1984.

2. Actions on Previous Inspection Findings

(Closed) Noncompliance (346/81-04-02): The inspector reviewed AD 1844.00, Maintenance, to ensure that the instructions for when shift supervisor approval is necessary for maintenance are clear. The instructions were clear. Also, the inspector reviewed the deviation report associated with the event. The inspector considered the corrective action adequate for the circumstance.

(Closed) Open Item (346/81-13-03): The inspector verified that the interlocks associated with the makeup pumps' suction valve were reflected in the drawings. The "as-built" condition was incorporated into the drawings under Facility Change Request 81-208.

(Closed) Noncompliance (346/82-27-01): The inspector reviewed the implementation of the licensee's corrective action and found it acceptable.

(Closed) Unresolved Item (346/81-18-03): Facility Change Request 83-095 Supplement modified the Woodward PG-PL governors on the Auxillary Feedwater Pumps with a newly designed slip clutch, different mounting of the DC bodice motor and installation of adjustable high/low speed stops. Since completion of this modification, equipment reliability has improved. More improvements are scheduled for pump #1 during the 1984 refueling outage and based upon pump #1's performance, pump #2 is scheduled for modification during the 1986 refueling outage. These modifications will be performed under Facility Change Request 83-136. Based upon implementation of Facility Change Request 83-095 supplement, this item is no longer considered unresolved. However, implementation of Facility Change Request 83-136 will be considered an open item (346/84-06-01) until implementation is complete.

(Closed) Noncompliance (346/82-34-03): The inspector reviewed procedure ADMIN-013, Safety Evaluations, of the Nuclear Practices and Procedures Manual. The procedure provided general guidance in what elements compose a safety evaluation.

(Open) Noncompliance (346/83-19-05 - item c): While reviewing records in the records vault on April 23, 1984, the inspector noted records management personnel reviewing completed test procedures for proper evidence of Station Review Board review. The inspector interviewed records management supervision regarding procedures for reporting conditions adverse to quality. The inspector determined that there was no procedure for records management personnel to report conditions adverse to quality.

This is in direct contradiction to the licensee's commitment to an item of noncompliance to have each organization involved in implementing the QA program to have procedures for reporting and correcting conditions adverse to quality by April 1, 1984.

The inspector reviewed other areas of the licensee's organization to see if their procedures were in place. The inspector noted that no organization had in place procedures to report conditions adverse to quality except QA/QC and the Station Engineering, Nuclear Services, Procurement and Records Management did not have procedures in place on April 1, 1984.

The inspector reviewed the licensee's internal commitment tracking system and found that the item had been closed out based on the licensee's QA Manaul being changed.

The QA Director was the individual designated to ensure the commitment was implemented. The inspector discussed the situation with the Director and confirmed that the Director had informed all responsible organization of the need to establish procedures for reporting conditions adverse to quality. However, the organizational heads did not implement the procedure changes when required. Also, the QA Director did not assure the procedures were in place by April 1, 1984.

The inspector found that the licensing individual who closed out the commitment on the licensee's internal tracking system based on the QA Director's input was aware that the commitment had not been met when he closed out the item. The licensing individual had been the author of the Nuclear Services procedure on reporting conditions adverse to quality and was aware the procedures had not been approved for implementation.

The failure of the Engineering, Nuclear Services, Procurement and Records Management organizations to have procedures in place on April 1, 1984 and the failure of adequate oversite by the cognizant individual to ensure proper commitment implementation are considered an example of a noncompliance (346/84-06-02) for failure to take adequate corrective action.

(Closed) Open Item (50-346/76-20-01): The inspector reviewed ST 503006, RCS Temperature Input to RPS Refueling Period Calibration. The inspector determined that the immersion of a calibrated temperature sensing device and the RTD to be calibrated in an oil bath and comparing the sensing device temperature to the RTD temperature via expected resistance readings to actual resistance readings meets the intent of calibrating a channel through input or signal at the sensor.

(Closed) Noncompliance (346/83-05-02): Failure to take adequate action regarding a reactor trip breaker failure. The inspector verified that a supplemental report was issued to the NRC on July 12, 1983. The inspector also verified that maintenance procedure MP 1405.05 has been issued and a preventive maintenance program established for trip breakers. General Electric recommendations have been incorporated into this procedure and the trip breakers are now being tested on a six month frequency.

(Open) Unresolved Item (346/84-01-03): During a normal plant tour in a pervious inspection period, the inspector noticed that steam generator #2's pressure differential switches were located in the turbine building. The inspector pursued this matter with the licensee's engineering department and determined that the location of the switches was adequate. This is because the switches are required to actuate on a feedwater break produced by a non-seismic event. The inspector also questioned whether these switches should be located in a vital area under the vital area security criteria. The Nuclear Facility Engineering Director stated that the switches' location would be evaluated under the vital area security criteria. This item remains unresolved until the licensee completes the evaluation and the inspector reviews the licensee's evaluation.

(Closed) Noncompliance (50-346/82-27-02): The inspector observed the performance of ST 5013.14 SFRCS Monthly Test, and reviewed the results at its completion. Emergency Technical Specification Admendment #46 was approved allowing pressure switch testing beyond the original Technical Specification late-date. The testing was performed inside the time extension. The inspector was aware of the discussions concerning this event. The licensee has designated the Instrument and Control Supervisor as the responsible individual for ensuring that all surveillance tests required to be performed are known to the Instrument and Control Shop. This responsibility is assigned in the Instrument and Control Supervisor's elements of performance. The licensee also issued Special Order #99 which informs all station personnel that exceeding a Technical Specification surveillance test time interval constitutes inoperability of the affected component.

3. Operational Safety Verification

The inspector observed control room operations, reviewed applicable logs and conducted discussions with control room operators during the month of April and May. The inspector verified the operability of selected emergency systems, reviewed tagout records and verified proper return to service of affected components. Tours of auxillary reactor buildings 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.

The inspector observed plant housekeeping/cleanliness conditions and verified implementation of radiation protection controls. During the months of April and May, the inspector walked down the accessible portions of the high pressure injection, emergency diesel generator, borated water storage tank, and high voltage switchgear systems to verify operability. The inspector also witnessed portions of the radioactive waste system controls associated with radwaste shipments and barreling.

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

During the walkdown of the borated water storage tank piping on April 20, 1984, the inspector determined that hanger 33A-HCB-2-M15 was located 24" from valve DH 7A instead of 13" as shown on the piping hanger drawing. The Civil/Structural Engineering Supervisor was informed of the hanger location discrepancy. The improper dimension was inputed from walkdowns performed for IE Bulletin 79-14 and used in design calculations for this piping. Based upon the actual dimension for hanger 33A-HCB-2-H15 the calculations were reevaluated and considered acceptable by the Civil/ Structural Engineering Supervisor. The inspector will review the recalculations and the appropriate drawing revisions at a later date. This is considered an open item (346/84-06-03) until this review is completed.

Based upon the small sampling size used, the inspector does not consider this to be an item of noncompliance. However, the inspector will continue comparing plant configuration to drawing configuration to determine whether a significant amount of incorrect information exists on the drawings. This is considered an unresolved item (346/84-06-04).

No items of noncompliance or deviations were identified.

4. Monthly 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 approved procedures, regulatory guides and industry codes or standards and in conformance with technical specifications.

The following items were considered during this review: the limiting conditions for operation were met while components or systems were removed from service; approvals were obtained prior to initiating the work; activities were accomplished using approved procedures and were inspected as applicable; quality control records were maintained; activities were accomplished by qualified personnel; parts and materials used were properly certified.

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.

Ongoing maintenance on the diesel fire pump.

No items of noncompliance or deviations were identified.

5. Monthly Surveillance Observation

The inspector observed technical specifications required surveillance testing on the Reactor Protective System, ST 5030.07 CTMT Pressure to RPS Monthly Functional Calibration Test and verified 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.

The inspector also reviewed portions of the following test activities:

ST 5031.14, SFRCS Monthly Test
ST 5082.01, On-Site AC Bus Sources Lineup
ST 5083.01, On-Site DC Bus Sources Lineup
ST 5016.01, Diesel Fire Protection Sys Pump Weekly
ST 5016.02, Electric Fire Pump Weekly Test
ST 5080.01, Independent Off-Site AC Source Lines
ST 5081.01, Diesel Generator Monthly Test
ST 5099.01, Miscellaneous Instrument Shift

No items of noncompliance or deviations were identified.

6. 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.

81-19, Control Rod 4-7 Absolute Position Indication Fluctuations
81-12, Control Rod 1-3 Absolute Position Indication Fluctuations
81-37, Loss of Bus E2 and Reactor Trip due to Bumping of Instrument Bus
81-32, Inoperable Trip Output to Valve AF 599
81-21, SFRCS Half Trip Caused by Loss of +24 VDC Power Supply
81-75, RTD Failure Causing RPS Channel to Fail High
81-77, Conduits Penetrating Fire Walls Not Sealed
81-10, Failure of Valve MS 100-1 to Close during Surveillance Testing
80-82, Failure of Valve MS 100-1 to Close during Surveillance Testing

83-33, Fire Detection Zone on Reactor Coolant Pump 1-2 Went into Alarm
83-26, Failed Input Buffer Caused 1/2 Trip of SFRCS Actuation Channel #2
83-25, Fire Detection Zone on Containment Passages Went to Alarm
83-34, Failure of Pzr Level Indicator, LTRC 14-
82-45, Change of Auxillary Feed Pump Suction Position for No Apparent Reason
82-36, Hole Found in a Fire Wall
82-23, High Pressure Injection Stop Check Valves Found Stuck Closed
82-42, Steam Generator #1's Level Exceeded Technical Specification Limit
NP-09-82-01, Liquid Discharge Exceeded 20°F Difference From Lake Erie Temperature
82-44, SFRCS Pressure Switches Not Tested at Required Frequency
78-78, Surveillence Tests not Being Performed
80-38, Failure of Service Water Relief Valve PSV-3962
82-54, Negative Pressure Boundry Door Left Open
82-43, Fire Door 429A Found Open
82-48, Fire Door 101A Left Open
82-37, Negative Pressure Door 306 Found Open
82-27, Containment Isolation Valve Leakage
82-31, Fire Doors 500, 426 and 302 Found Open
82-25, Surveillance Requirements Not Completed in Prescribed Interval
82-26, Fire Door 504 Blocked Open on Three Different Occasions
82-24, Minimum Boron Injection Flowpaths Available
82-22, Fire Door 302 Found Open
82-20, Blown Fuse For Inverter YV2
82-18, Loss of One Source Range Indication
82-16, Door 108's Latch Mechanism Found Broken
82-04, Door 108 Found Open
82-03, Door 400 Found Open
83-49, Door 306's Latch Mechanism Found Broken
83-37, SFAS Channel 3, Level 3 Actuation Output Logic Found Short Circuited
82-30, Wrong Boron Sample Taken on Decay Heat Removal System
80-84, Pressure Switch on Auxillary Feedwater Suction Failed

(Closed) LER 81-70: Failure of Control Rod Drive Trip Breaker. As part of noncompliance 83-05-02, the inspector reviewed the licensees actions taken regarding taking adequate and prompt corrective action when equipment malfunctions are identified. The inspector verified that the following: (1) Special Order #35 has been revised to include steps to ensure that updates from equipment manufacturers are factored into the maintenance program; (2) the maintenance work order (MW) has been expanded to ensure that appropriate maintenance procedures are designated; (3) maintenance personnel have been instructed on the importances of determining the root cause of a problem; (4) the Station Review Board is reviewing the DVR open items log to ensure that outstanding corrective action items are receiving proper management attention; and (5) administrative procedure AD 1807.00 has been revised to ensure that followup information is incorporated into the original LER in a timely manner.

A number of LERs were reviewed and could not be closed out at this time. The LERs were:

(Open) LER 80-88, Inadverant Actuation of the Safety Features Actuation System determination as to whether the system complied with IEEE Std 279-1971. The IEEE Std. question remains open until NRR review is complete and the LER updated (if necessary) with additional corrective actions taken. This LER will remain open.

(Open) LER 82-01, BWST Water Heated Greater Than FSAR LOCA Assumptions. The last revision to this LER states "Toledo Edison is analyzing these events to determine if any equipment modifications could assist in maintaining the BWST within temperature limits." Until the licensee determines what actions to take and revises the LER, this LER remains open.

(Open) LER 82-08, Clogging of a Emergency Ventilation Transmitter Sensing Line with Ice/Snow Causing Transmitter Failure. The LER states "It is presently being investigated whether a cost effective facility change can be designed to prevent recurrence." The licensee has yet to provide an effective protection of the sensing line from ice/snow as evidenced from failure of the same transmitter by the same mechanism during the 1983/1984 winter. Also, the inspector requested that licensee to review the original licensee response to IE Bulletin 79-24 as to whether the response should be broadened and updated. This is considered an open item (346/84-06-05).

(Open) LER 84-04, 50 Fire Doors Found Not to Conform to NFPA 80, "Code of Fire Doors". The inspector reviewed the events leading up to the declaration of the inoperability of these fire doors causing this LER. Based on this review, the inspector determined that the licensee did not take adequate and timely corrective action in declaring the doors inoperable. This is considered an example of noncompliance (346/84-06-02) for failure to take adequate corrective action.

On January 23, 1984, the licensee's Quality Control personnel identified 56 fire doors which did not comply with NFPA volume 7 section 80 for gap clearances between the door and the frame/floor on Nonconformance Report 84-11. On February 6, 1984, the Facility Engineering General Supervision dispositioned the Nonconformance Report (NCR) stating to repair the doors and marked N/A to the question "Can item perform its intended safety functions?" on the NCR form. The NCR was sent to the station's maintenance department to repair the doors. Based on informal discussions between maintenance and operations department personnel the doors were determined to be inoperable. The Limiting Condition of Operation Action Statement for these fire doors was entered into and fire watches established on March 21, 1984.

The inspector discussed the "N/A ing" of the NCR with the Facility Engineering General Supervisor. He stated that his procedures governing NCR dispositioning only required an operability determination, if the equipment in question was on the "Q" (safety related) list. The inspector attributes the failure to declare the doors inoperable on February 6, 1984, to an inadequate procedure for dispositioning NRCs and a personnel error. The NCR operability determination should have ensured items covered on the "S" (fire) and "5" (security) lists were also included.

The procedure has since been changed to reflect this. Also, considering the level of the NCR disposition in Facility Engineering, a Technical Specification item should have been recognized.

The inspector reviewed the fire suppression, detection and barriers associated with the rooms "guarded" by the degraded doors and determined that the degradation of the fire control doors was not significant to substantially degrade the fire protection system.

The LER will remain open until the 56 doors are returned to operability.

No other items of noncompliance or deviations were identified.

7. 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 the 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.

(Closed) IEB 83-04, Failure of the Undervoltage Trip Function of Reactor Trip Breakers. The inspector verified that the required actions for this bulletin had been completed by the licensee. This was documented in IE Report 83-05.

(Closed) IEB 82-01, Alteration of Radiographs of Welds in Piping Subassemblies. The licensee found no evidence of alteration of radiographs. The inspector reviewed the licensee response and determined that actions taken by the licensee was adequate.

(Closed) IEB 79-05, Incident at Three Mile Island.

(Closed) IEB 79-05A, Nuclear Incident at Three Mile Island.

(Closed) IEB 79-05B, Nuclear Incident at Three Mile Island.

Other IE Bulletins reviewed but could not be closed out at this time were:

(Open) IEB 83-07, Apparently Fraudulent Products Sold by Ray Miller, Inc. The licensee has identified the companies that supplied material to the Davis-Besse facility and has sent letters to these suppliers inquiring about the shipments. Not all suppliers have replied and the licensee is continuing to solicit these responses. One supplier has been identified as having supplied TECO with flanges for the Boric Acid Addition

Tanks. These tanks are classified as ASME Class III and non-nuclear safety related.

(Closed) IEB 79-05C, Nuclear Incident at Three Mile Island. The Bulletin consists of six actions. Item #1 was documented as complete and inspected in IER 79-22. Items #2 and #3 were documented as complete and inspected in IER 79-25. Item #4 has been performed by revisions to EP 1202.06, Loss of Reactor Coolant and Reactor Coolant Pressure and operator training accomplished. Item #5 has been performed by generation of AB 1203.06, Inadequate Core Cooling Guidelines, which has been incorporated into the licensed operator training program. Item #6 deals with automatic tripping of reactor coolant pumps under all circumstances when required. This item has become II.K.3.5 of NUREG-737.

No items of noncompliance or deviations were identified.

8. IE Circular Followup

For the IE Circulars listed below, the inspector verified that the Circular was received by the licensee management, that a review for applicability was performed, and that if the circular were applicable to the facility, appropriate corrective actions were taken or were scheduled to be taken.

IEC 81-11, Inadequate Decay Heat Removal at BWR's

IEC 81-03, Seismic Monitoring System

No items of noncompliance or deviations were identified.

9. Receipt of New Fuel

The inspector verified prior to receipt of new fuel that technically adequate, approved procedures were available covering the receipt, inspection, and storage of new fuel. The procedures reviewed were:

SP 1503.03, Control Component Receipt, Inspection, and Storage for B&W Mark B2 Rod Assemblies

SP 1503.02, New Fuel Receipt, Inspection and Storage of B&W Mark B2 Fuel Assembly

No items of noncompliance or deviations were identified.

10. Advisory Committee on Reactor Safeguards (ACRS) Participation

On May 10, 1984, the inspector attended a full committee meeting of the ACRS. The committee members were briefed on the March 2, 1984 stuck open safety valve event (see IE Report 84-01). The inspector responded to ACRS questions regarding this event.

11. Management Meetings

On April 27, 1984, a meeting was held between the NRC and the licensee at the Toledo Edison corporate offices. During this meeting the licensee provided the following: a status of the interim actions, an update of the Regulatory Enhancement Program and a schedule of milestones for the Regulatory Enhancement Program.

On April 18, 1984, the inspector met with the licensee's training and operations management to discuss identified deficiencies in the licensee's licensed operator training program. The deficiencies dealt with the lack of documentation for licensed personnel relating to reading of required procedures and failure of personnel to perform all plant equipment manipulations (non NUREG-737 manipulations). The inspector reviewed the licensee's corrective action program and found it adequate. Corrective actions were completed by the end of this inspection period.

No items of noncompliance or deviations were identified.

12. Followup on Operational Events

On May 7, 1984, at 0930, operators found the heat removal portion of the #2 control room emergency ventilation system inoperable. The operators noticed this condition while performing the prerequisites for performing the monthly surveillance test of this system which requires operator verification that the freon compressor control switch for the ventilation system be in the "ON" position. The switch was found in the "OFF" position. Further investigation revealed that the #1 control room emergency ventilation's freon compressor switch was also in the "OFF" position. The licensee entered Technical Specification Action Statement 3.0.3 for two inoperable ventilation systems. Five minutes later the switches were returned to the normal "ON" position and surveillance testing performed on both systems. The inspector requested the licensee to perform a safety analysis assuming both control room emergency ventilation systems are inoperable to determine the safety significance associated with this condition. Pending that analysis, this matter is considered unresolved (346/84-06-06).

On May 14, 1984, the licensee experienced a packing leak of 3-4 gpm on the pressurizer spray bypass valve causing the plant to shutdown. At 0736 on May 15, 1984, the operators entered into "Shutdown Bypass" on the reactor protection system per the shutdown procedure. However, the shutdown procedure requires that ST 5030.15, RPS Shutdown Bypass High Pressure Monthly Functional Test, be performed in the last 30 days or prior to initiating "Shutdown Bypass". The test was not performed and <30 days had passed since the test was last performed.

The inspector discussed this situation with the shift supervisor and the shift supervisor's perception was that the RPS shutdown bypass was operable and performed in the normal monthly RPS surveillance test.

During initiation of shutdown bypass and which the control rods were already inserted into the core, the RPS received a legitimate actuation signal at 0741 on high pressure shutdown bypass. The RPS actuation was not reported to the NRC as required. When the day shift relieved the grave shift at 0800, the days reactor operator noted that the grave reactor operator had not checked the performance of ST 50.30.15 for the 4 RPS channels. Aware that shutdown bypass had been initiated, the days reactor operator checked-off the performance of ST 5030.15 in the shutdown procedures. Later that day the swing shift supervisor noticed that ST 5030.15 showed up late on the surveillance test schedule. The supervisor directed that ST 5030.15 be performed for all four channels. Satisfactory testing of the RPS shutdown bypass was completed at 0100 on May 16, 1984. The inspector determined that the action statement of Technical Specification 3.0.3 had not been exceeded for the four RPS high pressure shutdown bypass channels.

Following repair of the packing leak, the licensee began heatup and restart preparations. On May 17, 1984 at 1245 during this heatup the licensee again experienced a legitimate RPS actuation on high pressure shutdown bypass at 1725 psig (normal trip setpoint is 1920 psig). The reactor was subcritical but the RPS actuation did cause insertion of safety control rod group #1. The licensee did not report this RPS actuation to the NRC.

Failure to report the unexpected RPS actuations on May 15, 1984 and May 17, 1984 are considered as examples of an item of noncompliance for failure to report RPS actuations under 10 CFR 50.72(b)(ii). (346/84-06-07)

In mid-May the licensee noted that section 3.6.2.7.2.12 of the Final Safety Analysis Report was not being met for flood protection of the #2 auxillary feed pump room. The discovery came about during an analysis for whether the door between the #1 and #2 auxillary feed pump rooms was needed for high energy break spectrum protection.

The startup feed pump suction valve was assumed closed for seismic analysis in the auxiliary feed pump #1 room. (The startup feed pump is located in this room). The startup feed lines is non-seismic. Procedures were changed to require that the valve be shut.

The inspector requested the licensee to analyze the startup feed valve being open to adequately determine the safety significance associated with this condition. This item is considered an unresolved item (346/84-06-08).

Also, in mid-May the licensee determined that the number of operable fire detectors were inadequate to protect the main steam isolation valves under the 10 CFR 50 Appendix R fire criteria. The detectors associated with the main steam isolation valves are not part of the Technical Specifications. The licensee established fire watches in the main steam isolation valve areas.

This situation is considered unresolved (346/84-06-09) and will be inspected at the next fire protection inspection.

No other items of noncompliance or deviations were identified.

13. Open Item

Open items are matters which have been discussed with the licensee, which will be reviewed further by the inspector, and which involve some action on the part of the NRC or licensee or both. Open items disclosed during the inspection are discussed in Paragraphs 2, 3 and 6.

14. Unresolved Items

Unresolved items are matters about which more information is required in order to ascertain whether they are acceptable items, items of noncompliance, or deviations. Unresolved items disclosed during the inspection are discussed in Paragraphs 3 and 12.

15. Exit Interview

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