

U. S. NUCLEAR REGULATORY COMMISSION
REGION 1

Report Nos. 91-14
Docket Nos. 50-334
50-412
License Nos. DPR-66
NPF-73
Licensee: Duquesne Light Company
One Oxford Center
301 Grant Street
Pittsburgh, PA 15279
Facility: Beaver Valley Power Station, Units 1 and 2
Location: Shippingport, Pennsylvania
Inspection Period: June 2 - July 6, 1991
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Inspection Summary

This inspection report documents routine and reactive inspections during day and backshift hours of station activities including: plant operations; radiological protection; surveillance and maintenance; emergency preparedness; security; engineering and technical support; and safety assessment/quality verification.

EXECUTIVE SUMMARY
Beaver Valley Power Station
Report Nos. 50-334/91-14 & 50-412/91-14

Plant Operations

Overall, both units were operated safely throughout the period. An apparent violation was identified concerning the loss of the combined control room habitability envelope due to two isolation dampers being failed in the open position. The licensee was not able to demonstrate that the event, which occurred in a previous period, did not constitute a loss of safety function. Operator response to a Unit 1 river water pump failure was prompt and correct. Housekeeping at both units was excellent.

Radiological Protection

Routine review of this area identified no noteworthy observations.

Maintenance and Surveillance

Maintenance and surveillance activities were reviewed and except for one violation, no noteworthy observations were identified. One violation was identified with respect to the Unit 2 surveillance program. The violation involved the omission from the surveillance program of the alternate lube oil flow paths for the two emergency diesel generators.

Emergency Preparedness

Routine review of this area identified no noteworthy observations.

Security

Routine review of this area identified no noteworthy observations.

Engineering and Technical Support

An apparent Unit 1 violation was identified concerning the ascension in operating Modes with the low head safety injection (LHSI) system not operable contrary to Technical Specification requirements. The LHSI system was inoperable due to the failure to perform ASME required weld inspections on certain LHSI pipe fittings during the previous 10 year inservice inspection program. The licensee's program for responding to Generic Letter 89-13 was reviewed. It was considered to be a strong and comprehensive approach to assuring adequate Unit 1 river water flows.

Safety Assessment/Quality Verification

Routine review of this area identified no noteworthy observations.

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* The NRC manual inspection procedure (IP) or temporary instruction (TI) is listed for each applicable report section.

DETAILS

1.0 SUMMARY OF FACILITY ACTIVITIES

At the beginning of the period, Unit 1 was in Cold Shutdown (Mode 5) having completed core reload activities as part of plant recovery from the eighth refueling outage. Unit 1 entered Hot Shutdown (Mode 4) on June 27 and Hot Standby (Mode 3) on June 29. Indications of leakage were identified during a containment walkdown (see Section 2.3), and Unit 1 was returned to Mode 4 on July 3 and to Mode 5 on July 4 to effect repairs. With the exception of two brief power reductions for balance of plant maintenance, Unit 2 operated at full power throughout the period.

Shortly after the end of the period, with Unit 1 in Mode 4, a failure to meet the Technical Specifications was identified by the inspector (see Section 7.1). As a result of this finding, Unit 1 (in Mode 4 as of July 8) was returned to Mode 5 on July 9.

2.0 PLANT OPERATIONS (IP 71707, 71710, 93702, 71711)

2.1 Operational Safety Verification

The inspectors observed plant operation and verified that the plant was operated safely and in accordance with licensee procedures and regulatory requirements. Regular tours were conducted of the following plant areas:

- | | |
|-------------------------------|----------------------------------|
| -- Control Room | -- Safeguard Areas |
| -- Auxiliary Buildings | -- Service Buildings |
| -- Switchgear Areas | -- Turbine Buildings |
| -- Access Control Points | -- Intake Structure |
| -- Protected Areas | -- Yard Areas |
| -- Spent Fuel | -- Containment Penetration Areas |
| -- Diesel Generator Buildings | |

During the course of the inspection, discussions were conducted with operators concerning knowledge of recent changes to procedures, facility configuration, and plant conditions. The inspector verified adherence to approved procedures for ongoing activities observed. Shift turnovers were witnessed and staffing requirements confirmed. The inspectors found that control room access was properly controlled and a professional atmosphere was maintained. Inspector comments or questions resulting from these reviews were resolved by licensee personnel.

Control room instruments and plant computer indications were observed for correlation between channels and for conformance with Technical Specification (TS) requirements. Operability of engineered safety features, other safety related systems, and onsite and offsite power sources were verified. The inspectors observed various alarm conditions and confirmed that operator response was in accordance with plant operating procedures. Compliance with TS and

implementation of appropriate action statements for equipment out of service was inspected. Logs and records were reviewed to determine if entries were accurate and identified equipment status or deficiencies. These records included operating logs, turnover sheets, system safety tags, and the jumper and lifted lead book. The inspector also examined the condition of various fire protection, meteorological, and seismic monitoring systems.

Plant housekeeping controls were monitored, including control and storage of flammable material and other potential safety hazards. The inspector conducted detailed walkdowns of accessible areas of both Unit 1 and Unit 2. Housekeeping at both units was excellent.

2.2 Engineered Safety Features System Walkdown

The operability of selected engineered safety feature systems was verified by performing detailed walkdowns of the accessible portions of the systems. The inspectors confirmed that system components were in the required alignments, instrumentation was valved-in with appropriate calibration dates, as-built prints reflected the as-installed systems, and the overall conditions observed were satisfactory. The systems inspected during this period include the emergency diesel generators, service water, auxiliary feed, and recirculation spray systems. No concerns were identified.

2.3 Event Followup

During the inspection period, the inspectors provided onsite coverage and followup of unplanned events. Plant parameters, performance of safety systems, and licensee actions were reviewed. The inspector confirmed that the required notifications were made to the NRC. The following events were reviewed:

2.3.1 Unit 1 River Water Pump Failure

On June 20, 1991, river water system pump WR-P-1A failed when started. The pump was being started manually in preparation for a surveillance test of a Recirculation Spray system heat exchanger. The local operator heard the motor start but observed the discharge pressure to remain zero. After confirming the discharge pressure instrument to be on line, the operator reported the problem by phone to the control room staff. After noting lower than expected motor current (indicating that the motor was probably not driving the pump), WR-P-1A was secured. A second start was attempted later with the same results. The pump was declared inoperable and was removed from the electrical bus for investigation. A mechanical coupling on the shaft was found to have failed, effectively detaching the pump from the motor. The failure of river water pump WR-P-1A did not result in a technical specification limiting condition since there are three pumps in the river water system and only two are required to be operable per technical specifications. At the end of the inspection, the pump remained disassembled for repairs.

Operator recognition of the failure was found to be prompt and correct.

2.3.2 Unit 1 Conoseal Leak

On July 2, a Conoseal on the Unit 1 reactor vessel head was found to be leaking (about 80 drops per minute). The leak was identified during a Mode 3 walkdown at normal reactor coolant system (RCS) temperature and pressure. There was also steam leakage and boric acid crystal buildup. Unit 1 was returned to Mode 5 for repairs. A second Conoseal was also found to have some boric acid crystal buildup and was also cleaned and inspected. Repairs and investigation were still in progress at the close of the inspection.

2.4 Unit 1 and Unit 2 Control Room Habitability

A control room (CR) habitability issue with potential safety significance was identified in NRC Inspection Report 50-334/91-09 (Unresolved item 50-334/91-09-01). Specifically, on May 17, 1991, with Unit 1 defueled and Unit 2 at full power, the two in-series Unit 1 CR outside air exhaust dampers were found deenergized "Open" versus deenergized "Closed." The dampers were required by Unit 1 Technical Specification (TS 3.7.7.1.C) to be deenergized "Closed" when the Unit 1 solid state protection system (SSPS) was out of service. The licensee's immediate corrective actions included closing the dampers and reporting the event as required by 10 CFR 50.72.

The inspector reviewed the licensee's description of the causes of the event and the corrective actions as contained in LER 50-334/91-15. The inspector concluded that the event did not involve a willful violation nor could it have been reasonably prevented by the licensee's corrective actions for a previous violation. The inspector also concluded that the licensee's corrective actions to date were adequate. In this regard, the inspector had certain observations as follows:

1. The inspector agreed with the licensee's analysis that concluded that, except for an 18½ hour period when damper VS-D-40-1D was open, the CR pressure boundary was maintained by at least one of the two series dampers.
2. The licensee promptly characterized the deenergized open dampers as a potential loss of safety function for the CR envelope habitability upon discovery.
3. For the 18½ hour period while the CR envelope habitability was at risk, the licensee had not performed any quantitative analysis to determine the radiological consequences during assumed accident analyses listed in the FSAR. However, DLC engineering personnel made the following qualitative determinations which potentially would have mitigated the negative consequences to CR envelope habitability during the 18½ hour period of risk.
 - A. The CR Emergency Bottled Air Pressurization System was still functional and its injection under accident conditions probably would have promoted air flow out of the control room envelope. The licensee did not have an estimate for how long the pressurization system would be effective.

- B. Review of the meteorological tower data indicated that the wind was blowing predominantly in a northeast direction which would be away from the CR. For approximately one hour, the wind was blowing from the Unit 2 containment toward the CR.

The inspector considered these qualitative determinations to be a good first step, but incomplete. For example, no quantifiable data on air flow was available. Also, the wind direction factor did not appear to address non-radiological threats such as chlorine release.

- 4. The licensee's immediate corrective actions appeared to be adequate. However, the inspector noted that training should be conducted as soon as possible to ensure that all operators are aware that closing the breakers for the CR exhaust and intake damper MOVs cause the dampers to open automatically when the SSPS is out of service. Shortly following the discovery of the deenergized open valves, the valve control circuitry was discussed with each shift. Formal training is scheduled to begin August 5, 1991.
- 5. The other corrective actions included in the LER were of a long term nature. Their scheduled completion dates appear to be reasonable as follows:
 - A. Maintenance to investigate and repair the failed computer inputs associated with the position indicating limit switches of damper VS-D-40-1C by September 19, 1991.
 - B. Engineering to complete a design evaluation of the CR Ventilation System including a review of the isolation damper's position control and indication scheme by December 31, 1991.
 - C. Operations to complete Human Performance Enhancement System evaluation of the event and recommend any additional corrective actions by September 19, 1991.

Based on the above review, the inspector concluded that the licensee had failed to demonstrate that the open dampers did not constitute a loss of safety function. This is an apparent Violation.

3.0 RADIOLOGICAL CONTROLS (IP 71707)

Posting and control of radiation and high radiation areas were inspected. Radiation Work Permit compliance and use of personnel monitoring devices were checked. Conditions of step-off pads, disposal of protective clothing, radiation control job coverage, area monitor operability and calibration (portable and permanent), and personnel frisking were observed on a sampling basis.

There were no notable observations.

4.0 MAINTENANCE AND SURVEILLANCE (IP 61726, 62703, 71707)

4.1 Maintenance Observation

The inspector reviewed selected maintenance activities to assure that:

- the activity did not violate Technical Specification Limiting Conditions for Operation and that redundant components were operable;
- required approvals and releases had been obtained prior to commencing work;
- procedures used for the task were adequate and work was within the skills of the trade;
- activities were accomplished by qualified personnel;
- where necessary, radiological and fire preventive controls were adequate and implemented;
- QC hold points were established where required and observed;
- equipment was properly tested and returned to service.

Maintenance activities reviewed included:

MWR 910740	Replace No. 1-1 Emergency Diesel Generator Engine Driver Lube Oil Pump Gasket
MWR 912698	Repair Fuel Oil Leak on No. 1-1 Emergency Diesel Generator
MWR 913697	Inspect and Clean No. 1-1 Emergency Diesel Generator River Water Heat Exchanger
MWR 914031	Inspect and Repair Unit 1 Valve SOV-RC-103A
MWR 914032	Inspect and Repair Unit 1 Valve SOV-RC-104

There were no notable observations.

4.2 Surveillance Observations

The inspectors witnessed/reviewed selected surveillance tests to determine whether properly approved procedures were in use, details were adequate, test instrumentation was properly calibrated and used, Technical Specifications were satisfied, testing was performed by qualified personnel, and test results satisfied acceptance criteria or were properly dispositioned. The following surveillance testing activities were reviewed:

Unit 1

OST 1.13.11 Quench Spray System Operability Test (Train A)

OST 1.36.3 Diesel Generator No. 1 Automatic Test

Unit 2

OST 2.24.4 Steam Turbine Driven auxiliary Feed Pump (2FWE*P22) Test

OST 2.36.1 Emergency Diesel Generator (2EGS*EG2-1) Monthly Test

There were no notable observations.

4.3 Weakness in Unit 2 Emergency Diesel Generator Surveillance Program

During preoperational testing, the Unit 2 emergency diesel generators (EDGs) exhibited plating out of a black, tarry material on the lube oil strainers. The material was initially hypothesized to be an oil contaminant or an internal piping coating, but laboratory analysis concluded that the substance was primarily the normal breakdown of the lube oil. Extended test runs of the EDGs produced data which indicated that the material led to a rise in differential pressure across the strainer such that EDG shut down would be required for strainer cleaning after about three days of continuous operation. Strainer cleaning would require one or two hours and then the EDG could be restarted. The licensee elected to modify the EDG lube oil systems to provide two independent lube oil strainers, each with separate isolation valves. The above activities were extensively reviewed by the NRC as documented in Inspection Reports 50-412/86-38, 86-45, 87-47, 87-48, and 87-51.

The inspector noted that the valves and the strainer in the alternate lube oil flow path for each EDG did not appear to be in the surveillance program. The inspector questioned the licensee as to whether the second lube oil strainer had ever been placed in service since post modification testing in 1987. Licensee review confirmed that the components had been omitted from the surveillance program and that there was no documented indication that the added valves had been exercised during the four year period.

The alternate lube oil strainers were installed to enable the EDGs to meet the requirement to operate continuously for extended periods of time. Since the alternate flow path was installed to allow the EDGs to fulfill their design requirements, the components involved were required to be exercised periodically to demonstrate operability. Failure to include these components in the licensee's surveillance program is a Violation (50-412/91-14-03).

The licensee acknowledged the inspector's concerns and successfully utilized the alternate strainer in the next monthly EDG test. This required snutting the valve on the 2-2 EDG which had been locked open for over four years and opening the valves which had been shut for that time. At the close of the inspection, the 2-1 EDG had not yet been run using the alternate strainer.

5.0 EMERGENCY PREPAREDNESS (IP 71707)

The resident inspectors had no noteworthy findings during this inspection period.

6.0 SECURITY (IP 71707)

Implementation of the Physical Security Plan was observed in various plant areas with regard to the following:

- protected Area and Vital Area barriers were well maintained and not compromised;
- isolation zones were clear;
- personnel and vehicles entering and packages being delivered to the Protected Area were properly searched and access control was in accordance with approved licensee procedures;
- persons granted access to the site were badged to indicate whether they have unescorted access or escorted authorization;
- security access controls to Vital Areas were maintained and that persons in Vital Areas were authorized;
- security posts were adequately staffed and equipped, security personnel were alert and knowledgeable regarding position requirements, and that written procedures were available; and
- adequate illumination was maintained.

There were no noteworthy observations.

7.0 ENGINEERING AND TECHNICAL SUPPORT (IP 37700, 37828, 71707)

7.1 Unit 1 Low Head Safety Injection Weld Inspections Incomplete

On June 12, 1991, a licensee QA auditor observed a longitudinal pipe weld not to be on a drawing he was using in the field. On June 18, in follow up to this observation, engineering personnel identified a total of 76 longitudinal welds had been omitted from Unit 1 isometric drawings. The vendor (Westinghouse) supplied drawings also apparently did not identify the welds. As a result of the omission, the welds were not included in the Inservice Inspection (ISI) program and had not been inspected during the first ten year interval (1976 - 1988) as required by the ASME Code, Section XI. Compliance with the Code is required by the Technical Specifications (TS 4.0.5 and 3.4.10). The field identification of the problem was part of the followup to another NRC finding (IR 50-334/91-11).

At the time of the identification by the QA auditor, Unit 1 was in Mode 5. The welds were in the Low Head Safety Injection (LHSI) system which was not required to be operable in Mode 5. The licensee failed to recognize that because the LHSI system had not been inspected as required by the Code and the Technical Specifications, the LHSI system was not operable. As a result of this failure, the licensee continued startup activities and ascended in Mode (see Section 1.0) contrary to the Technical Specifications. This is an apparent Violation. This item is Unresolved (50-334/91-14-01).

The inspector identified the concern regarding operability shortly after the close of the period. The licensee reassessed the applicability of the ASME Code and the Technical Specifications, concurred with the inspector's concerns, and returned Unit 1 to Mode 5 pending corrective actions.

7.2 Unit 1 River Water Flow Testing (Generic Letter 89-13)

NRC Generic Letter 89-13, "Service Water System Problems Affecting Safety-Related Equipment," required licensees to confirm that the safety functions of their open cycle heat sink systems were being met. As part of the actions taken in response to the Generic Letter, Duquesne Light Company measured the flows cooling each of the Unit 1 safety related heat exchangers during the current refueling outage.

The Unit 1 system involved is called the river water system which takes water from the Ohio River, through debris-removing travelling screens, and supplies the water to cool several safety related heat exchangers before discharge back to the river. Only the recirculation spray system heat exchangers have minimum acceptable flow rates specified by the Technical Specifications (TS). The other heat exchangers, such as the charging pump lube oil coolers, have design minimum flow rates listed in the FSAR. The significance of the difference in the document citation for the minimum flow rates is that the TS require periodic flow testing but the FSAR does not. The Generic Letter required all licensees to conduct testing for all such heat exchangers.

The large river water lines (nominal 24 inch diameter) were designed with flow measurement capability, but the smaller lines (e.g., nominal 3 inch diameter) did not have this design feature. The flow measuring devices in use during design and construction of Unit 1 (Operating License in 1976) were flow restrictive such as orifices for pressure drop measurement, which would have impacted flow in small lines. The licensee acquired stainless steel spool pieces and utilized ultrasonics during the current outage to measure transport time, hence flow velocity, in the smaller lines.

Initial tests indicated river water flows substantially below the FSAR values. The licensee cleaned piping and heat exchangers, performed minor system modifications, and reanalyzed component flow requirements. In all but one case, the licensee was able to demonstrate sufficient flow to meet component design heat removal requirements. The lines supplying the Control Room backup cooling coils did not have sufficient flow at the maximum allowable river water temperature to remove the required heat. The licensee placed a lower, more restrictive administrative limit on river water temperature for operability of the Control Room backup cooling coils. That is, the coils would be declared inoperable at a river water temperature below the current TS limit. The assumption of the lower river temperature allowed the heat exchanger to fulfill its design requirements at the reduced river water flow rates. Therefore, there is no safety significance to the lower flows.

Listed below are some of the safety significant heat exchanger flows for the smaller lines. Flows are given in gallons per minute with fractions deleted. Each train (A and B) of river water is listed separately although some components receive flow from both trains.

	<u>Initial Min. Design Flow</u>	<u>A Train Test Flow</u>	<u>B Train Test Flow</u>	<u>Reanalyzed Min. Flow</u>
1-1 EDG	400	268	297	260
1-2 EDG	400	266	283	260
B Charging Pump	55	-	24	20
C Charging Pump	55	31	-	20
CR Coils	180	95	106	100

The inspector reviewed the licensee's program for responding to Generic Letter 89-13 and considered it to be a strong and comprehensive approach to assuring adequate river water flows. The inspector noted that both Units 1 and 2 have experienced problems with their open cycle cooling systems. Some of these problems were documented in NRC IR 50-334/89-05; 50-412/89-05, in NRC IR 50-334/90-20; 50-412/90-20, and in Unit 2 LER 90-016. The inspector will continue to review the licensee's ongoing efforts to improve the performance characteristics of this system as part of the routine inspection program.

8.0 SAFETY ASSESSMENT AND QUALITY VERIFICATION (IP 40500, 71707, 90712, 91700)

8.1 Review of Written Reports

The inspector reviewed LERs and other reports submitted to the NRC to verify that the details of the events were clearly reported, including accuracy of the description of cause and adequacy of corrective action. The inspector determined whether further information was required from the licensee, whether generic implications were indicated and whether the event warranted onsite followup. The following LERs were reviewed:

Unit 1:

- | | |
|-----------|--|
| 91-013-00 | Pressurizer Code Safety Valve Lift Setting Less than Technical Specification Limit |
| 91-014-00 | Technical Specification Surveillance Testing Deficiency |
| 91-015-00 | Control Room Ventilation System Outside Air Exhaust Dampers Inadvertently Opened |
| 91-016-00 | One Train of High Energy Line Break Detection Element Inoperable |
| 91-017-00 | Incorrect Calibration of Vertical Movement Seismic Accelerometer |

Unit 2:

- | | |
|-----------|--|
| 91-011-01 | ESF Actuation - Containment Purge Isolation due to High Radiation Signal |
|-----------|--|

The above LERs were reviewed with respect to the requirements of 10 CFR 50.73 and the guidance provided in NUREG 1022. Generally, the LERs were found to be of high quality with good documentation of event analyses, root cause determinations, and corrective actions.

9.0 STATUS OF PREVIOUS INSPECTION FINDINGS (IP 71707, 90702, 92701)

The NRC Outstanding Items List was reviewed with cognizant licensee personnel. Items selected by the inspector were subsequently reviewed through discussions with licensee personnel, documentation reviews and field inspection to determine whether licensee actions specified in the OIs had been satisfactorily completed. The overall status of previously identified inspection findings was reviewed, and planned/completed licensee actions were discussed for the items reported below.

9.1 (Closed) Unresolved Item (50-412/90-18-02): The Unit 2 containment purge duct isolation dampers were found not to have a seal in feature for automatic closure. A seal in feature is required by IEEE 279-1971, "Criteria for Protection Systems for Nuclear Power Generating Stations." The IEEE Standard requirement is for the actuation of protection features following a serious reactor accident. This item was left Unresolved pending review of the applicability of the IEEE Standard to the normally deenergized, locked shut dampers.

The licensee position is that a fuel handling accident is not a "serious reactor accident" as specified by the IEEE Standard. The licensee also initiated modifications (SMR 2167 and 2168) to provide a seal in feature to the radiation monitors for closure of the above dampers and to other, similar monitors as a design enhancement.

The modifications committed to by the licensee resolve this item for Beaver Valley Unit 2. The generic issue concerning the intent of IEEE 279-1971 will be forwarded to NRR for resolution. This item is closed.

9.2 (Closed) Unresolved Item (50-334/90-28-01 and 50-412/90-28-01): This item involved core exit temperature instrumentation for use during reduced inventory or mid-loop conditions. The licensee had not provided reactor coolant temperature alarms consistent with the position of Generic Letter (GL) 88-17, "Loss of Decay Heat Removal." Subsequently, the licensee elected to provide high temperature alarms when in a reduced inventory condition. This change will be accomplished by lowering to 150 degrees F the plant variable computer incore thermocouple high alarm setpoint for two points (Trains A and B). Affected operating procedures had been prepared to incorporate these alarms as prerequisites prior to entering a reduced inventory or mid-loop condition. Since these changes are consistent with GL 88-17, this item is closed.

9.3 (Open) Unresolved Item 50-334/90-28-02 and 50-412/90-28-02: This item involves Reactor Coolant System (RCS) Water Level Technical Justifications Questions. During the review of the licensee's actions in response to GL 88-17, the inspector identified that the licensee had not established the technical justification for: (1) the BV1 wide-range level monitor accuracy and range, and (2) the BV2 wide-range level monitor accuracy and lack of alarms.

The inspector discussed the status of this item with the licensee and determined the following: (1) The licensee submitted a supplemental response to GL 88-17 on February 6, 1991, containing additional details concerning RCS water level instrumentation; (2) Discussions with engineering personnel indicated that work remains to be done to translate the design information into permanent plant equipment and procedures. For example, the water level alarm setpoint methodology was not yet fully agreed upon among all licensee working groups; and (3) The licensee indicated that the modification work would be completed for Unit 2 in March, 1992 and for Unit 1 in January 1993. This item remains open.

9.4 (Closed) Unresolved Item (50-412/91-05-01): Weaknesses were identified in adjustment of the turbine driven auxiliary feedwater pump (TDAFWP) governor and also in the documentation of corrective actions to free linkage. The inspector reviewed the revised

documentation and identified no deficiencies. Additionally, subsequent tests of the TDAFWP were witnessed and the significant hunting experienced in the earlier test was not repeated. The inspector also reviewed a sample of similar maintenance records and did not identify any additional weaknesses in documentation. This item is closed.

9.5 (Open) Unresolved Item (50-334/91-09-01): This item involved the potential loss of safety function associated with the control room exhaust dampers being found deenergized "Open." This item is discussed in Section 2.4 and has been identified as an apparent Violation, and is being considered for escalated enforcement action.

10.0 EXIT MEETING

10.1 Preliminary Inspection Findings Exit

Meetings were held with senior facility management throughout the inspection to discuss the inspection scope and findings. A summary of the findings was further discussed with the licensee at the conclusion of the report period on July 10, 1991.

10.2 Attendance at Exit Meetings Conducted by Region-Based Inspectors

<u>Dates</u>	<u>Subject</u>	<u>Inspection Report No.</u>	<u>Reporting Inspector</u>
6/04-14/91	Non-Destructive Examination	50-334/91-11	Modes
6/10-14/91	Chemistry	50-334/91-12; 50-412/91-12	Kaplan
6/10-14/91	Rad Waste Program	50-334/91-13; 50-412/91-13	O'Connell