



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

Report No.: 50-302/84-09

Licensee: Florida Power Corporation
3201 34th Street, South
St. Petersburg, FL 33733

Docket No.: 50-302

License No.: DPR-72

Facility Name: Crystal River 3

Inspection at Crystal River site near Crystal River, Florida

Inspectors: John F. Rogge, Jr. 4/18/84
J. F. Stetka, Senior Resident Inspector Date Signed

John F. Rogge, Jr. 4/18/84
D. O. Myers, Senior Resident Inspector Brunswick Date Signed
(8/5-9/84)

Approved by: V. W. Panciera 4/12/84
V. W. Panciera, Chief, Project Section 2B Date Signed
Division of Project and Resident Programs

SUMMARY

Inspection on February 28 - March 27, 1984

Areas Inspected

This routine inspection involved 113 inspector-hours on site by one resident inspector in the areas of plant operations, security, radiological controls, licensee action on IE Bulletins, Licensee Event Reports and Nonconforming Operations Reports, and licensee action on previous inspection items. This inspection also involved 28 inspector hours onsite by a second resident inspector during the period March 5-9, 1984, in the areas of the Fire Protection Program and licensee action on NUREG-0737, Item III.D.3.4. Numerous facility tours were conducted and facility operations observed. Some of these tours and observations were conducted on back shifts.

Results

Three violations and one deviation were identified: (Failure to test the control room emergency ventilation system as required by Technical Specification (TS) 4.7.7.1.C.4, paragraph 5.b.(8)c; Failure to follow the surveillance procedure used to determine reactor coolant system (RCS) leakage, paragraph 5.b.(8)a; Failure to use calibrated instrumentation for the determination of the RCS leakage, paragraph 5.b.(8)b; Failure to establish and implement the administrative controls for starting of the control room emergency ventilation system as committed to in FSAR Section 9.7.2.1.g, paragraph 5.b.(2)a.

8407180225 840625
PDR ADOCK 05000302
Q PDR

REPORT DETAILS

1. Persons Contacted

Licensee Employees

- *G. Boldt, Operations Manager
- R. Clarke, Plant Health Physicist
- *J. Bufe, Nuclear Compliance Specialist
- *R. Carbiener, Nuclear Compliance Specialist
- *J. Colby, Manager, Site Nuclear Operations Engineering
- *J. Cooper, Manager, Site Nuclear Quality Control
- *D. Eggleston, Nuclear Shift Supervisor
- E. Howard, Director, Site Nuclear Operations
- W. Johnson, Acting Maintenance Superintendent
- B. Komara, Nuclear Quality Control Supervisor
- J. Kraiker, Operations Superintendent
- *M. Mann, Nuclear Compliance Specialist
- *S. Mansfield, Compliance Supervisor
- *P. McKee, Plant Manager
- *R. Murgatroyd, Assistant Nuclear Maintenance Superintendent
- *D. Porter, Assistant Nuclear Shift Supervisor
- *J. Roberts, Nuclear Chemistry Manager
- *S. Robinson, Nuclear Waste Manager
- *V. Roppel, Assistant Engineering and Technical Services Manager
- *B. Rossfeld, Compliance Manager
- *P. Skramstad, Nuclear Chemistry and Radiation Protection Superintendent
- *D. Spires, Nuclear Compliance Specialist
- *R. Thompson, Engineer I
- *M. Unger, Quality Programs Auditor
- *K. Wilson, Site Nuclear Licensing Supervisor

Other licensee employees contacted included office, operations, engineering, maintenance, chem/rad and corporate personnel.

*Attended exit interview

2. Exit Interview

The inspector met with licensee representatives (denoted in paragraph 1) at the conclusion of the inspection on March 27, 1984. During this meeting, the inspector summarized the scope and findings of the inspection as they are detailed in this report. During this meeting, the violations, deviation, unresolved item and inspector followup items were discussed.

3. Licensee Action on Inspection Findings

(Closed) Inspector Followup Item (302/83-17-01): The licensee completed examination of the Nuclear Services Seawater Cooling (RW) System piping and replaced degraded portions during the past refueling outage. Procedure PT-704, Rev. 0, RW System Piping Pressure Boundry Integrity Examination, was approved on March 20, 1984, and will provide periodic ultrasonic testing inspection of the piping.

(Closed) Inspector Followup Item (302/84-02-02): The licensee investigated the discrepancy between procedures OP-605 and SP-381 and determined that valve EFV-49 had been inadvertently omitted from the SP. Procedure SP-381 was revised on March 19 to include EFV-49.

4. Unresolved Items

Unresolved item are matters about which more information is required to determine whether they are acceptable or may involve violations or deviations. New unresolved items identified during this inspection are discussed in paragraph 6 b.

5. Review of Plant Operations

The plant continued power operation (Mode 1) until approximately 10:40 a.m. on February 28 when a reactor/plant trip occurred due to a fault on the 230 Kilovolt (KV) grid (see paragraph 8.a of this report for details). The plant returned to power operation at 6:35 p.m. and continued in this mode until March 22 when the plant was shutdown to hot standby (Mode 3) at 8:00 a.m. to add oil to a reactor coolant pump motor and perform other minor maintenance in the reactor building. The plant returned to power operations at 9:10 p.m. on March 22 and continued operation in this mode for the remainder of the inspection period.

a. Shift Logs and Facility Records

The inspector reviewed records and discussed various entries with operations personnel to verify compliance to Technical Specifications (TS) and the licensee's administrative procedures.

The following records were reviewed:

Shift Supervisor's Log; Reactor Operator's Log; Equipment Out-of-Service Log; Shift Relief Checklist; Auxiliary Building Operator's Log; Active Clearance Log; Daily Operating Surveillance Log; Work Request Log; Short Term Instructions (STI's); and selected Chemistry/Radiation Protection Logs.

In addition to these record reviews, the inspector independently verified clearance order tagouts.

While reviewing the Reactor Operator's Log on March 14, the inspector noted an apparent discrepancy between the recorded levels of the emergency diesel generator (EDG) in ground fuel storage tanks and the corrected level specified in the plant curve book, OP-103. With the inspector observing, the tanks were subsequently "sounded" and determined to be within specification. The licensee has experienced problems with the tank's installed level indication and has decided to perform the tank level verifications using the sounding technique exclusively. Procedure SP-354, the monthly EDG surveillance procedure, will be revised to reflect this practice.

Inspector Followup Item (302/84-09-01): Review revision to SP-354 to require sounding of the EDG fuel oil tanks to determine oil level.

b. Facility Tours and Observations

Throughout the inspection period, facility tours were conducted to observe operations and maintenance activities in progress. Some operations and maintenance activity observations were conducted during backshifts. Also, during this inspection period, licensee meetings were attended by the inspector to observe planning and management activities.

The facility tours and observations encompassed the following areas: Security Perimeter Fence; Control Room; Emergency Diesel Generator Room; Auxiliary Building; Intermediate Building; Battery Rooms; Electrical Switchgear Rooms; and Reactor Building.

During these tours, the following observations were made:

- (1) Monitoring Instrumentation - The following instrumentation was observed to verify that indicated parameters were in accordance with the TS for the current operational mode:

Equipment operating status, Area, atmospheric and liquid radiation monitors; Electrical system lineup; Reactor operating parameters; and Auxiliary equipment operating parameters.

No violations or deviations were identified.

- (2) Safety Systems Walkdown - The inspector conducted walkdowns of the High Pressure Injection System and the Control Room Emergency Ventilation System to verify that the lineup was in accordance with license requirements for system operability and that the system drawing and procedure correctly reflect "as-built" plant conditions.

As a result of these walkdowns and reviews, the following items were identified:

- a. During a review of the operation of the control room emergency ventilation system, the inspector noted that upon an engineered safeguards system (ESS) actuation, the only automatic function of this system is to reposition the system dampers such that the system is lined up in the recirculation/emergency mode. The emergency fans with their associated emergency filter banks must be manually started after manually securing the non-emergency normal running fans.

Final Safety Analysis Report (FSAR) Section 9.7.2.1.g recognizes this system limitation and specifies that administrative procedures will be provided to insure that the emergency fans are started within approximately ten minutes of an initiating event.

Review of abnormal procedure AP-580, ESS Actuation, which is the procedure personnel utilize in the event of an ESS actuation, indicates that the procedure does not provide the instructions to effect this fan switchover. Further discussion with licensee representatives indicates that the only procedure that directs the fan switchover is abnormal procedure AP-245, RMA-5 Actuation. Procedure AP-245 directs this switchover because when RMA-5, the control room in-duct radiation monitor, is tripped, the dampers are repositioned into the recirculation mode and the normal running fans are tripped thus necessitating manual starting of the emergency fans. This method of operation would require a challenge of the RMA-5 actuation circuitry before flow through the emergency filter banks is initiated.

Failure to provide the administrative controls to direct starting of the emergency fans after an ESS actuation is contrary to the commitment of FSAR Section 9.7.2.1.g and is considered to be a Deviation.

Deviation (302/84-09-02): Failure to provide administrative controls to direct operation of the Control Room Emergency Ventilation system upon ESS Actuation.

- b. Review of the system drawing for the control room ventilation system indicates the presence of an in-duct smoke detector installed for fire protection. The Final FSAR Section 9.7.2.1.g recognizes this in-duct smoke detector and discusses its operation, however, there is no commitment nor is there any license requirement to test this detector.

This finding was discussed with licensee representatives and the licensee is developing a test to verify the operability of this detector.

Inspector Followup Item (302/84-09-03): Review development of the test to verify operability of the control room ventilation systems in-duct smoke detector.

- (3) Shift Staffing - The inspector verified that operating shift staffing was in accordance with TS requirements and that control room operations were being conducted in an orderly and professional manner. In addition, the inspector observed shift turnovers on various occasions to verify the continuity of plant status, operational problems, and other pertinent plant information during these turnovers.

No violations or deviations were identified.

- (4) Plant Housekeeping Conditions - Storage of material and components and cleanliness conditions of various areas throughout the facility were observed to determine whether safety and/or fire hazards exist.

No violations or deviations were identified.

- (5) Radiation Areas - Radiation Control Areas (RCA's) were observed to verify proper identification and implementation. These observations included selected licensee conducted surveys, review of step-off pad conditions, disposal of contaminated clothing, and area posting. Area postings were independently verified for accuracy through the use of the inspector's own monitoring instrument. The inspector also reviewed selected radiation work permits and observed personnel use of protective clothing, respirators, and personnel monitoring devices to assure that the licensee's radiation monitoring policies were being followed.

No violations or deviations were identified.

- (6) Security Control - Security controls were observed to verify that security barriers are intact, guard forces are on duty, and access to Protected Area (PA) is controlled in accordance with the facility security plan. Personnel within the PA were observed to insure proper display of badges and that personnel requiring escort were properly escorted. Personnel within vital areas were observed to insure proper authorization for the area.

No violations or deviations were identified.

- (7) Fire Protection - Fire protection activities, staffing and equipment was observed to verify that fire brigade staffing was appropriate and that fire alarms, extinguishing equipment, actuating controls, fire fighting equipment, emergency equipment, and fire barriers are operable.

No violations or deviations were identified.

- (8) Surveillance testing was observed to verify that approved procedures were being used; qualified personnel were conducting the tests; testing was adequate to verify equipment operability; calibrated equipment, as required, were utilized; and TS requirements were followed.

The following tests were observed and/or data reviewed:

- SP-354A, Emergency Diesel Fuel Oil Quality and Diesel Generator Monthly Test;
- SP-130, Engineered Safeguards Monthly Functional Test;
- SP-370, Quarterly Cycling of Valves;
- SP-317, RC System Water Inventory Balance;
- SP-422, RC System Heatup and Cooldown Surveillance;
- SP-421, Reactivity Balance Calculations; and,
- SP-321, Power Distribution Breaker Alignment and Power Availability Verification.

A special review was also conducted of the following procedures to verify proper testing of the control room emergency ventilation system:

- SP-186, Control Room Emergency Ventilation System Testing;
- SP-417, Refueling Interval Integrated Plant Response to Engineered Safeguards Actuation; and,
- SP-456, Refueling Interval ES Manual and Automatic Actuators Functional Test.

As the result of these reviews, the following items were identified:

- a. During a review of the data recorded on March 6 for SP-317, the inspector noted that data sheet Enclosure 1 was completed at approximately 1300 and that data sheet Enclosure 2 was completed at 1600. Procedure SP-317 utilizes the data from Enclosures 1 and 2 to compute the reactor coolant system (RCS) leakage on data sheet Enclosure 3. Upon review of Enclosure 3, it was determined that the 1300 data and 1600 data was used to compute the leakage.

Procedure SP-317 requires in steps 6.4.1 through 6.4.3 that Enclosures 1 and 2 be completed after at least eight hours of steady state operation. The data run for this leakage from Enclosure 2 was as follows:

<u>Time</u>	<u>Hourly Average (gpm)</u>
0500	N/A
0600	1.429
0700	1.455
0800	1.44
0900	*
1000	1.80
1100	1.60
1200	*
1300	1.96
1400	1.33
1500	*
1600	1.84

*Data not recorded due to unstable plant condition.

The data recorded from 0500 to 1600 represents eight hours of steady state data whereas the data recorded from 0500 to 1300 (on Enclosure 1) represents only six hours of steady state data. Variations in plant parameters during the three hour period from 1300 to 1600 were not identified on Enclosure 1 thus resulting in a potential leakrate error when the data from Enclosures 1 and 2 was used to calculate the leakrate on Enclosure 3.

Failure to adhere to the requirements of procedure SP-317 is contrary to the requirements of TS 6.8.1.c and is considered to be a violation.

Violation (302/84-09-04): Failure to follow surveillance procedure SP-317.

- b. While reviewing procedure SP-317 data for the period March 3 through March 21, the inspector noted that various computer points were being used to determine and record the necessary plant parameters. A review of the calibration records for these computer points indicates that computer points R-731 which measures average RCS temperature (Tave) and P-714 which measures reactor power have not been calibrated. When this finding was identified to the licensee, procedure SP-317 was reperfomed using other calibrated instrumentation and the RCS leakage was determined to be within specification.

Failure to calibrate instrumentation used to measure and monitor safety-related systems is contrary to the requirements of 10 CFR Part 50, Appendix B, Criterion 12 and is considered to be a violation.

Violation (302/84-09-05): Failure to use calibrated instrumentation in the performance of surveillance and testing.

- c. Procedure SP-186 provides testing of the filter banks and a measurement of system flow rate for the control room emergency ventilation system. Review of this procedure indicates that the flow rate test is conducted with the system in the normal operating mode with the emergency fans running but not in the emergency recirculation mode.

TS 4.7.7.1.C.4 requires the system flow rate to be tested during system operation which is the emergency recirculation mode.

Failure to test the system flow rate in the emergency recirculation mode is contrary to the requirements of TS 4.7.7.1.C.4 is considered to be a violation.

Violation (302/84-09-06): Failure to test the control room emergency ventilation system flow rate in the emergency mode as required by TS 4.7.7.1.C.4.

When notified of this finding, the licensee performed a flow rate test in the emergency recirculation mode and determined that the system was within specification.

- d. Procedures SP-417 and SP-456 provide the testing required by TS 4.7.7.1.E.2 to determine the operability of the control room emergency ventilation system automatic functions with a containment isolation test signal. Review of these SPs indicates that while both these SPs require verification of damper positions, the data sheets are not consistent in the observation of applicable damper indication that could result in data taker confusion (though both procedures do verify proper operation). The licensee will review these procedures

and revise them accordingly to insure consistency between procedures.

Inspector Followup Item (302/84-09-07): Review revisions to SP-417 and SP-456 to insure consistency between procedures for the control room emergency ventilation damper positioning.

- (9) Maintenance Activities - The inspector observed maintenance activities to verify that correct equipment clearances were in effect; Work Requests and Fire Prevention Work Permits, as required, were issued and being followed; Quality Control personnel were available for inspection activities as required; and TS requirements were being followed.

Maintenance was observed and work packages were reviewed for the following maintenance activities:

- Calibration of the tachometer on the 'A' Emergency Diesel Generator (EDG) in accordance with PM-132;
- Repair of the generator output terminal on 'B' EDG;
- Repair of the seat on valve CAV-60; and
- Adjustment of the AC and DC alarms on the 'A' Battery Charger in accordance with PM-141.

No violations or deviations were identified.

- (10) Radioactive Waste Controls - Selected liquid and gaseous releases were observed to verify that approved procedures were utilized, that appropriate release approvals were obtained, and that required surveys were taken.

While observing a liquid release from the 'A' laundry and shower monitoring tank (WDT-11A), the inspector noted a discrepancy between the tank level indicator (scaled in feet of water) and the tank level recorder (scaled in per cent level). The level recorder (WD-271-LR) is a dual pen recorder, one pen for each tank (A & B) and the inspector noted that the discrepancy existed between the recorder and both the A & B level indicators. The licensee has implemented corrective action to resolve this discrepancy.

Inspector Followup Item (302/84-09-08): Review corrective actions to resolve discrepancies between the level recorder and the level indicators for tanks WDT-11A and B.

- (11) Pipe Hangers and Seismic Restraints - Several pipe hangers and seismic restrains (snubbers) on safety-related systems were observed to insure that fluid levels were adequate and no leakage was evident, that restraint settings were appropriate, and that anchoring points were not binding.

No violations or deviations were identified.

6. Review of Licensee Event Reports and Nonconforming Operations Reports

- a. Licensee Event Reports (LER) were reviewed for potential generic impact, to detect trends, and to determine whether corrected actions appeared appropriate. Events, which were reported immediately, were reviewed as they occurred to determine if the TS were satisfied.

LER 84-02 were reviewed in accordance with current NRC enforcement policy. The LER remains open pending implementation of a revision to procedure OP-407-N, Liquid Releases From the Secondary Plant, and implementation of a Preventive Maintenance (PM) program on plant recorders.

- b. The inspector reviewed Non-Conforming Operations Reports (NCOR) to verify the following: compliance with the TS, corrective actions as identified in the reports or during subsequent reviews have been accomplished or are being pursued for completion, generic items are identified and reported as required by 10 CFR Part 21, and items are reported as required by TS.

All NCOR's were reviewed in accordance with the current NRC enforcement policy.

NCOR 84-73 reported that TS Limiting Condition for Operation (LCO) 3.8.1.1a was exceeded on March 13, when the 'A' emergency diesel generator (EDG) was removed from service for maintenance. The TS requires the cable tunnel sump pumps to be tested within one hour after removing an EDG from service. Due to operator error, the sump pumps were tested two hours and 36 minutes after the EDG was removed from service and were determined to be operable. This issue is considered to be a licensee identified violation in which prompt corrective action was taken. To prevent recurrence of this event, the licensee is revising procedures to insure operators are aware of this TS requirement.

Unresolved Item (302/84-09-09): Revise necessary procedures to insure cable tunnel sump pumps are tested during EDG maintenance outages.

7. Review of IE Bulletins

The licensee's activities in response to the following IE Bulletins (IEB) were reviewed to verify that the Bulletin requirements had been accomplished.

- IEB 79-13, Cracking in Feedwater System Piping;
- IEB 82-02, Degradation of Threaded Fasteners in the Reactor Coolant Pressure Boundary of PWR Plants; and
- IEB 83-08, Electrical Circuit Breakers with an Undervoltage Trip Feature in Use in Safety-Related Applications Other Than the Reactor Trip System.

As a result of this review, IEBs 79-13 and 83-08 are considered complete and are closed. Bulletin IEB 82-02 remains open pending receipt and review by the NRC of the licensee's post outage response as required by paragraph 4 of this Bulletin.

8. Plant Trips - Safety Systems Challenges

- a. On February 28 at 10:40 a.m., a reactor trip from approximately 74% reactor power occurred due to a fault in the offsite 230 KV electrical system. The fault was caused by a lightning strike and subsequent lightning arrester failure in the 230 KV system. The fault caused a momentary interruption in power to the control rod drive system resulting in the reactor trip. With the exception of an anomaly in the operation of the 'B' Emergency Diesel Generator (EDG), the trip resulted in a normal plant shutdown.

When the event occurred, the 'B' Emergency Diesel Generator (EDG) was operating and loaded on its respective engineered safeguards (ES) bus for testing purposes. The fault caused this diesel's breaker to open and fail to reclose. Power to this ES bus was supplied via the alternate offsite supply.

As a result of this event, the licensee has developed a number of corrective actions to be taken. Three of these actions involving a review of the EDG's breaker circuitry, an examination of EDG testing policies, and additional operator training regarding EDG breaker operation will be reviewed for resolution.

Inspector Followup Item (302/84-09-10): Review corrective actions for the February 28, 1984 reactor trip discussed in UOER 84-01.

- b. On March 12 at approximately 11:21, an engineered safeguards (ES) actuation occurred on the 'B' side during surveillance testing of the ES system. The plant was operating at near full power during this event and a plant trip did not occur due to rapid operator action. The actuation resulted in approximately 400 gallons of borated water being injected into the reactor coolant system.

After investigation of the system circuitry for failures (there were none) and review of the surveillance procedure for errors, the test was re-run a number of times and no other actuations occurred. The inspector observed these investigations, questioned licensee personnel and observed the subsequent retests.

As a result of these reviews, the inspector has no further questions on this item at this time.

9. Fire Protection/Prevention Program Implementation

The inspector verified that administrative controls for combustible material control, control of ignition sources, maintenance of fire protection systems, and TS surveillance requirements were addressed in procedures. The following procedures were reviewed:

- AI-1000, Good Housekeeping;
- CP-118, Fire Prevention Work Permit Procedure;
- EM-101, Fire Protection Plan;
- SP-800, Monthly portable Fire Extinguisher Inspection and Yearly Portable Fire Extinguisher Maintenance Inspection;
- SP-190, Channel Functionality and Circuitry Operability of Fire Detection Instrumentation;
- EM-216, Duties of the Nuclear Plant Fire Brigade; and,
- SP-363, Fire Protection System Tests.

Facility tours were conducted to verify effectiveness of combustible material control; condition of fire pumps and piping; condition of turnout equipment and breathing apparatus.

During the tour, several noteworthy observations were made.

In the fire pump building, otherwise superior appearing equipment, was overshadowed by a "band-aid" patched jockey pump that intermittently started and stopped followed by a significant check valve slam. The resulting water hammer appeared to be responsible for the fractured piping on the jockey pump discharge. The current configuration was deemed acceptable as an interim fix, however, if left unchanged, failure of piping associated with

the system could jeopardize system operability. The licensee was evaluating the condition.

During performance of SP-190, the inspector noted that technicians were not verifying that all local alarm bells on a string within a specific detection zone were functioning. The multiple bell strings were designed to alert employees within a zone of danger during all modes of plant operation. As modes change, noise concentrations within buildings change, therefore, it is prudent to ensure all local bells energize. When this point was raised to the individual performing the test, he appeared very receptive and stated, after a proper detailed review, he would suggest a change if needed.

Inspector Followup Item (302/84-09-11): Review revision to procedure SP-190 to include all local alarm bells in an alarm string during testing.

Generally, the buildings appeared in good condition. Housekeeping of transient combustibles was well controlled. The only exception is that employee break area and temporary work shops with oil bath cutting tools located on the 119' level detracted from the overall appearance of the turbine building.

Of the areas inspected, no violations or deviations were noted.

10. Review of NUREG-0737, Item III.D.3.4 - Control Room Habitability

Task Action Plan Item III.D.3.4, "Control Room Habitability," required licensees to assure that control room operators will be adequately protected against the effects of accidental releases of toxic and radioactive gases and that the nuclear power plant can be safely operated or shut down under design basis accident conditions (Criterion 19, "Control Room", of Appendix A, "General Design Criteria for Nuclear Power Plants," to 10 CFR Part 50).

The licensee made a submittal to NRC on January 30, 1981, addressing Item III.D.3.4. NRC has reviewed the Florida Power Corporation (FPC) submittals and concluded, on the basis of the letter, that the proposed design meets the criteria specified in Item No. III.D.3.4 of NUREG-0737 and further, based on the review, that full implementation of the licensee's commitments will result in Control Room habitability systems which are acceptable. (Reference, letter Miner (NRC) to Hancock (FPC) on NUREG-0737, Item III.D.3.4, "Control Room Habitability.")

In the January 30, 1981 letter, the licensee stated: "Only failures of the chlorine or anhydrous ammonia storage vessels have the potential to result in toxic gas concentration in the control room that could, under discrete atmospheric conditions, exceed regulatory guidance. Based on these findings, FPC has undertaken a design development program to: (1) install chlorine detectors, (2) install ammonia detectors, and (3) upgrade the intake isolation dampers." Furthermore, in Attachment 1, item (5)(b) of this letter, reference is made to TS on control room filtration system

testing to include the capability to maintain the control room pressurized to 1/8 inch water gauge.

The inspector, during system walkdown, verified the installation of the chlorine and ammonia detectors and system modifications to inlet dampers. However, during a review of the proposed TS submitted to NRC on March 31, 1983, the inspector noted that the TS submittal did not provide for testing of the control room emergency ventilation system to assure the pressurization capability is maintained. The inspector also reviewed SP-186, which performs system flow test and found that the procedure acceptance criteria did not incorporate the pressurization requirement.

This issue is being reviewed by the licensee and NRC. This item will remain open pending resolution of the pressurization testing requirement.