

U.S. NUCLEAR REGULATORY COMMISSION

REACTOR III

Report No. 50-461/89032(DRP)

Docket No. 50-461

License No. NPF-62

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

Facility Name: Clinton Power Station

Inspection At: Clinton Site, Clinton, Illinois

Inspection Conducted: October 7 - 31, 1989

Inspectors: P. Brochman

S. Ray

Approved By: M. Ring, Chief *M. Ring*
Reactor Projects Section 3B

11/14/89
Date

Inspection Summary

Inspection on October 7 - 31, 1989 (Report No. 50-461/89032(DRP))

Areas Inspected: Routine, unannounced safety inspection by the resident inspectors of licensee action on previous inspection findings; onsite followup of written reports; NRC information notice followup; operational safety verification; monthly maintenance observation; monthly surveillance observation; and safety assessment and quality verification.

Results: Of the seven areas inspected, one violation was identified in the area of safety assessment and quality verification due to inadequate corrective actions. Additionally, one unresolved item was identified in the operations area and dealt with the classification of diesel generator failures. The violation is a further example of a systemic weakness in the corrective action portion of the licensee's Quality Assurance program. This weakness is considered significant.

DETAILS

1. Personnel Contacted

Illinois Power Company (IP)

- *J. Cook, Manager, Clinton Power Station
- *R. Campbell, Manager, Quality Assurance
- R. Freeman, Manager, Nuclear Station Engineering Department
- *S. Hall, Director, Nuclear Program Assessment
- *D. Holtzcher, Acting Manager, Licensing & Safety
- *J. Miller, Manager, Scheduling & Outage Management
- *J. Palchak, Manager, Nuclear Planning & Support
- *R. Wyatt, Manager, Nuclear Training
- *J. Weaver, Director, Licensing
- *K. Baker, Supervisor, I&E Interface

Soyland

- *J. Greenwood, Manager, Power Supply

The inspectors also contacted and interviewed other licensee and contractor personnel.

*Denotes those attending the monthly exit meeting on October 13, 1989.

2. Followup of Previously Identified Items (92701 & 92702)

- a. (Closed) Unresolved Item (No. 461/87013-01): Lack of Requirement to Conduct a Design Review Subsequent to the Incorporation of a FDDR into a Drawing.

This item was previously discussed in Inspection Report No. 461/87013, Paragraph 5.b.(1). The inspectors' concerns were resolved during the Maintenance Team Inspection reported in Inspection Report No. 461/89003. This item is considered closed.

- b. (Closed) Violation (No. 461/87013-02): Licensee's Inspection Program Failed to Identify Discrepancies Between Drawings and Field Configuration of the High Pressure Core Spray Switchgear.

This item was previously discussed in Inspection Report No. 461/87013, Paragraph 5.b.(2). Corrective actions for this violation were reviewed during the Maintenance Team Inspection reported in Inspection Report No. 461/89003. This item is considered closed.

- c. (Closed) Unresolved Item (No. 461/89027-02): Weaknesses in Procedures and Training on Radiation Monitors.

This item was previously discussed in Inspection Report No. 461/89027, Paragraph 5.e. It involved the licensee's failure to perform a daily channel check when a standby process radiation monitor was placed in service. During the critique and inspector's investigation of the

event, weaknesses were noted in the procedures and training of the radiation protection technicians, in the area of operation of the area/process radiation monitor (AR/PR) system.

During this inspection period, the licensee completed their evaluation of the event and determined that the checks conducted by the technician upon energizing the standby monitor were not sufficient to positively demonstrate operability and thus, the monitor was ~~not~~ considered inoperable, for approximately 12 hours. The licensee intended to submit an LER reporting the event. The inspectors reviewed Procedure Deviation for Revision 89-738 to CPS Procedure No. 7410.75, "Operation of Digital AR/PR Monitors," and noted that it added clear requirements to perform the channel check surveillance upon starting monitors or taking them out of standby. The inspectors also noted that the Shift Supervisor started tracking standby monitors for which surveillance intervals had been exceeded. In addition, the licensee rearranged the radiation protection office so that the AR/PR system monitor technician would have fewer interruptions. The Director - Radiation Protection required that the AR/PR system procedures be present at the monitor and that the technician be qualified to operate the monitor by a formal training program. Technical Specification 4.0.3 requires that the failure to perform a surveillance within its prescribed interval shall render a component inoperable. The failure to perform a channel check surveillance when starting up the monitor is a violation of Technical Specification 4.0.3 (No. 461/89032-01(DRP)). However, this violation meets the tests of 10 CFR 2, Appendix C, Section V.G.1; consequently, no Notice of Violation will be issued, and this matter is considered closed.

- d. (Closed) Unresolved Item (No. 461/89027-03): Procedure Did Not Contain Required Instructions for Torquing Terminal Screws on Agastat Relays.

This unresolved item is closed and upgraded to a violation.

One violation was identified and is discussed further in Paragraph 8.b of this report.

3. Onsite Followup of Written Reports of Nonroutine Events at Power Reactor Facilities (92700 & 90712)

For the LER listed below, the inspectors performed an onsite followup inspection to determine whether response to the event was adequate and met regulatory requirements, license conditions and commitments, and to determine whether the licensee had taken corrective actions as stated in the LER.

(Closed) LER 89013-LL: Lack of Attention to Inoperable Intermediate Range Monitor Channels by Utility-Licensed Operators Results in the Failure to Place Those Channels in a Tripped Condition.

This item was previously discussed in Inspection Report No. 461/89008, Paragraph 5.h. It was considered a "licensee-identified" item for which a Notice of Violation was not issued. Corrective actions consisted of counselling for the Shift Supervisor and Assistant Shift Supervisor who made the personnel errors, and a review of the lessons learned with the operating crew involved. The inspectors verified by document review that the corrective actions were completed. This item is considered closed.

No violations or deviations were identified.

4. Followup of Information Notices (61726)

(Closed) Information Notice 88-51, "Failure of Main Steam Isolation Valves."

This Information Notice was received by the licensee on July 29, 1988. It was assigned by the Licensing and Safety Department to the Plant Staff and Nuclear Station Engineering Departments for review on August 3, 1988. The review was completed by October 19, 1988. The review was conducted in conjunction with the licensee's review of General Electric's Rapid Information Communications Service Information Letter (RICSIL No. 21) covering the same subject.

The review determined that the licensee did not have a surveillance test to establish the ability of the Main Steam Isolation Valves (MSIVs) to close without the assistance of air pressure. However, Maintenance Procedure CPS No. 8216.11, "Main Steam Isolation Valve Maintenance," which was used to adjust the packing and conduct other maintenance on the MSIVs, contained steps to slowly bleed air pressure off the valve operator and allow spring pressure only to close the valve as the packing gland nut torque was set. That evolution was to be repeated several times to set the packing. The licensee determined that those steps, as well as administrative controls of packing materials and lubricants, were sufficient to insure that MSIVs would not fail to close on spring pressure alone.

In February 1989, a Procedure Deviation for Revision (PDR) was incorporated into Maintenance Procedure 8216.11. The PDR combined and eliminated steps in the procedure such that a maximum of three dry cycles of the MSIV were permitted during maintenance. This reduction in cycles reduced the assurance that the valves would close with spring pressure only. The procedure did not reference the Information Notice or RICSIL so the PDR was apparently written without the knowledge that the licensee had taken "credit" for stroking the valve several times without air pressure in their review of the Information Notice. In this case, if the maintenance procedure was properly followed, the MSIVs would still be closed without air assistance during the procedure, but not as many times. In addition, the MSIVs were designed such that, under operational conditions, main steam flow and pressure would also aid the closure of the valves.

The inspectors expressed their concern to the Licensing and Safety staff that procedures which the licensee identified or developed to correct

problems reported by NRC Information Notices did not reference the Information Notice. The inspectors acknowledged that suggestions contained in Information Notices were not requirements. However, when the licensee has recognized that the suggestions contained enough merit for them to identify or develop procedures to implement them, they should reference the source of the suggestion so that the procedures will not be changed later without an appropriate review. The Director - Licensing agreed to review the inspectors' concerns. Information Notice 88-51 is considered closed.

No violations or deviations were identified.

5. Operational Safety Verification (71707)

The inspectors observed control room operations, attended selected pre-shift briefings, reviewed applicable logs, and conducted discussions with control room operators during the inspection period. The inspectors verified the operability of selected emergency systems and verified tracking of LCOs. Routine tours of the auxiliary, fuel, containment, control, diesel generator, turbine buildings and the screenhouse were conducted to observe plant equipment conditions including the potential for fire hazards, fluid leaks, and operating conditions (i.e., vibration, process parameters, operating temperatures, etc). The inspectors verified that maintenance requests had been initiated for discrepant conditions observed. The inspectors verified by direct observation and discussion with plant personnel that security procedures and radiation protection (RP) controls were being properly implemented.

Inspections were routinely performed to ensure that the licensee conducted activities at the facility safely and in conformance with regulatory requirements. The inspections focused on the implementation and overall effectiveness of the licensee's control of operating activities, and the performance of licensed and nonlicensed operators and shift technical advisors. The following items were considered during these inspections:

- Adequacy of plant staffing and supervision.
- Control room professionalism, including procedure adherence, operator attentiveness and response to alarms, events, and off-normal conditions.
- Operability of selected safety-related systems, including attendant alarms, instrumentation, and controls.
- Maintenance of quality records and reports.

The plant was operated continuously at approximately 85% of full power during the inspection period. There were no operational events during the period that required reporting via the ENS or LER reporting systems.

On October 30, 1989, during a routine monthly test of the Division 2 Diesel Generator (DG), the diesel had to be shut down due to a failure of the remote voltage regulator switch in the lower voltage position. Upon

reviewing the DG Start Log the next day, the inspectors noted that the failure had been evaluated as an invalid failure. After discussing the start with the Supervisor - Plant Operations and the Shift Supervisor, it was determined that the start should have been classified as a valid failure. The Shift Supervisor said that it had been marked as an invalid failure on the recommendation of the DG system engineer. This was one of several cases of disagreement between the plant staff and the system engineer on the proper classification of DG starts.

The DG Start Log for the Division 1 DG showed that on October 19, 1989, a failure occurred which brought the total divisional failures to five in the last 100 valid tests and two in the last 20. Technical Specification Table 4.8.1.1.2-1 required that with that number of failures, the DG test frequency should have been increased to at least once per seven days. The test frequency was not increased because some of the starts which had been logged as failures by plant staff had been reevaluated as invalid tests by the system engineer. However, there was no indication that the disagreements had been resolved by management and the logs had not been revised.

Inadequate DG Start Logs has been previously discussed by the inspectors and resulted in the issuance of violation No. 461/88023-02. The inspectors requested that the licensee perform a timely evaluation of DG starts and resolve all questions of start classification. This item is considered an unresolved item (No. 461/89032-02) pending the licensee determination and the inspectors' review of the correct number of diesel generator failures.

One unresolved item was identified.

6. Monthly Maintenance Observation (62703)

Selected portions of the plant maintenance activities on safety-related systems and other components were observed or reviewed to ascertain that the activities were performed in accordance with approved procedures, regulatory guides, industry codes and standards, and that the performance of the activities conformed to the Technical Specifications. The inspection included activities associated with preventive or corrective maintenance of electrical, instrumentation and control, mechanical equipment, and systems. The following items were considered during these inspections: 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; functional testing and/or calibration was performed prior to returning the components or systems to service; parts and materials that were used were properly certified; and appropriate fire prevention, radiological, and housekeeping conditions were maintained.

The inspectors observed/reviewed the following work activities:

Maintenance Work Procedure No.	Activity
MWR D11790	Troubleshoot Drywell Leak Detection Air Particulate Monitor
Various PCIVCM541	Post Maintenance Testing of RCIC Calibrate OTSVC611A Control Room Chiller Temperature Switch

For MWR D11790, the inspectors noted that the technicians performing the troubleshooting had considerable difficulty in identifying the problem. They were using Surveillance Procedure CPS No. 9443.03, "Leak Detection System Drywell Air Particulate (E31-K610) Radiation Monitor Calibration," to help them find the cause of the monitor failure. Section 8.3 of the procedure contained instructions for detector adjustments. The technicians noted that Step 8.3.5 required that they connect an electrostatic voltmeter across a capacitor. The procedure did not specify the terminal polarity of the capacitor nor did the vendor's manual show the correct polarity. Knowing that an electrostatic voltmeter can be damaged by incorrect polarity, the technicians verified the polarity with another type of voltmeter before connecting the electrostatic voltmeter. They also submitted a Comment Control Form to specify the polarity in the procedure.

The technicians also noted that the steps in the procedure for establishing the high voltage setting may have been incorrect. Step 8.3.6 required that the detector preamplifier gain be set for maximum while collecting data for a high voltage plateau curve. The technicians experienced excessive noise when the gain was set to maximum such that the detector may have been saturated and the high voltage plateau could not be determined. It was also noted that the procedure did not contain a step requiring that the gain be reset to a normal level. Step 8.3.31 instructed the technicians to adjust the preamplifier and/or the high voltage potentiometers for the proper pulse height. This step was to be performed just after establishing the optimum high voltage setting. In addition, Step 8.3.37 instructed the technicians to adjust the high voltage again to obtain a maximum count rate.

In summary, the procedure for setting the high voltage on the air particulate monitor was confusing and may have been technically incorrect. Step 8.3.21 determined the optimum high voltage for the detector based on the plateau curve but did not actually set the high voltage for that optimum value, Step 8.3.31 adjusted the high voltage for an average pulse height indication of between 1.2 and 1.4 volts, and Step 8.3.37 adjusted the high voltage for a maximum count rate indication. Thus the steps to determine the optimum high voltage seemed to be unnecessary because the voltage was never set to that value. The as found high voltage on the detector was at the maximum setting of 1400 vdc. At this voltage the detector was not operating in the plateau region of the high voltage curve and, although the count rate was at a maximum, it appeared that much of the count rate could be attributed to noise.

The inspectors noted that the calibration procedure for the Drywell Iodine Monitor (CPS No. 9443.07) was the same as that for the Drywell Particulate Monitor. However, the calibration procedure for the Drywell Gas Monitor (CPS No. 9443.08) contained steps to ensure that the detector was not saturated during the calibration and also directed the technicians to leave the high voltage set at the optimum value determined by the plateau curve. The licensee was reviewing the calibration procedures to determine if revisions are needed.

No violations or deviations were identified.

7. Monthly Surveillance Observation (61726)

An inspection of inservice and testing activities was performed to ascertain that the activities were accomplished in accordance with applicable regulatory guides, industry codes and standards, and in conformance with regulatory requirements.

Items which were considered during the inspection included whether adequate procedures were used to perform the testing, test instrumentation was calibrated, test results conformed with Technical Specifications and procedural requirements, and tests were performed within the required time limits. The inspectors determined that the test results were reviewed by someone other than the personnel involved with the performance of the test, and that any deficiencies identified during the testing were reviewed and resolved by appropriate management personnel.

The inspectors observed/reviewed the following activities:

<u>Surveillance/Test Procedure No.</u>	<u>Activity</u>
CPS No. 7002.02	Weekly Inspection of SCBA Bottles
CPS No. 9067.03	Standby Gas Treatment System Operability

No violations or deviations were identified.

8. Safety Assessment/Quality Verification

a. Evaluation of Licensee Self-Assessment Capability (40500)

This inspection consisted of reviews of selected Licensee Event Reports (LERs), event critiques, condition reports, inspection reports, audits, review group minutes, and other documents to determine the effectiveness of the licensee's self-assessment programs. The inspection was also based on the inspectors' attendance at various critiques, management meetings, and review group meetings throughout the Systematic Assessment of Licensee Performance (SALP) period.

Based on the above reviews, as well as discussions with NRC regional inspectors and management, the overall conclusions were that the licensee was generally effective at self-identification of problems and moderately effective at root cause determinations.

During the current SALP period (September 1, 1988 to October 31, 1989), the NRC resident staff documented 12 "licensee-identified" items for which Notices of Violation (NOV) were not issued in order to encourage the licensee's self-identification initiatives in accordance with 10 CFR 2, Appendix C, Section V.G.1. In addition, of 30 violations issued by the NRC this period, the inspections indicated that 14 of the conditions had originally been identified by the licensee. Review of LERs, condition reports, Part 21 notifications, ENS notifications, and other documents indicated that the licensee was generally prompt, thorough, and self-critical in identifying conditions adverse to quality and reporting them to the NRC. Noteworthy examples were the feedwater temperature transient reported in LER 88-025, other design errors reported in LERs 88-026, 89-006, 89-022, and 89-023, installation errors reported in LERs 89-017, 89-019, and 89-027, and Technical Specification errors reported in LER 89-002 and Violation No. 461/89014-04. The majority of these problems involved a significant amount of self-assessment and would probably not have been identified by routine NRC inspections.

Based on this review the inspectors believe the licensee's self-assessment program is effective at identifying problems.

b. Evaluation of Licensee's Quality Assurance Program (35502)

The inspectors evaluated the effectiveness of the licensee's implementation of its Quality Assurance (QA) program. The inspectors reviewed inspection reports for the last 14 months, the SALP 8 report, licensee event reports for the last 14 months, the Region III outstanding items list, and selected licensee condition reports. Based upon these reviews, the inspectors have identified a significant problem with the licensee's ability to correct conditions adverse to quality. The events listed below were previously treated as individual problems. However, when viewed collectively they are indicative of a systemic weakness in the corrective action portion of the licensee's QA program. These weaknesses were related to the identification, implementation and verification of corrective actions for conditions adverse to quality. This problem exists in several functional areas at the Clinton Power Station, such as operations, maintenance, surveillance, security, and engineering and technical support.

Numerous NRC findings during the SALP 9 cycle involved corrective actions which were found to be ineffectual in preventing the recurrence of conditions adverse to quality. Some examples of this problem are listed below:

- (1) On August 9, 1989, the licensee identified that maintenance workers had begun to disassemble a flange on the Reactor Water Cleanup System that was subject to high temperature, high pressure reactor coolant. The workers had failed to verify that the system was properly isolated, drained, and vented prior to their work. The licensee determined that corrective actions for a previous similar event discussed in Inspection Reports No. 461/88014, Paragraph 12.b.(2), and No. 461/88017, Paragraph 7.a, were not effective in preventing a serious personnel hazard. In the previous event workers began disassembly of the wrong Radwaste System Evaporator. Three individuals were burned, one severely, in that event. Part of the corrective action for that event was to improve the maintenance program so that measures to ensure systems were safe to work were strengthened. The licensee used these events as the basis for an ongoing training program in improving their corrective action program.
- (2) On November 9, 1988, the licensee identified several floor drains which penetrated the secondary containment boundary which had no traps installed or had traps that had dried out. The licensee reported the issue as LER 88-026. Corrective action discussed in the LER included installing traps in those lines that didn't have them and establishing a Preventative Maintenance (PM) task to refill the traps bi-monthly. This issue was discussed in Inspection Report No. 461/88027, Paragraph 10.b.(3). The item was considered a "licensee-identified" item for which a NOV was not issued.

On August 21, 1989, the licensee identified that the PM task to fill the drain traps was not being performed in many cases. The trap in the Reactor Core Isolation Cooling Tank Room had not been filled for eight months, for no apparent reason, and drain traps in several other areas were not being filled when due because they were in restricted high radiation areas. The missed PMs were being recorded as failed, not deferred. The PM tracking system did not flag failed PMs as being overdue. No explanation was provided for not accomplishing the PM on the floor drain in the RCIC tank room. The corrective action committed to in the LER was not being effectively implemented in that provisions to maintain secondary containment by insuring that drain traps penetrating the boundary remained sealed were not always being accomplished.

- (3) As documented in Inspection Report No. 461/89006, Paragraph 3, the NRC identified that the licensee had taken inadequate corrective actions to previously identified environmental qualification deficiencies for Kynar electrical splices and junction box drainage. The deficiencies had been previously reported in Inspection Reports No. 461/87026 and No. 461/88010. As a result of those inspections, a \$75,000 civil penalty was

imposed on Illinois Power. On June 29, 1988, the licensee submitted a response to the violations which stated that the conditions had been corrected.

The corrective actions were inadequate in that the licensee subsequently determined that they had failed to identify and correct all applicable Kynar splices and the NRC identified that they had failed to provide drainage for all applicable junction boxes (Inspection Report No. 461/89006). The findings resulted in the imposition of an additional \$75,000 civil penalty.

- (4) As discussed in Inspection Report No. 461/89014, Paragraph 5.f, the NRC identified that several valves in the Scram Discharge Volume Instrument System, which should have been locked, were left unlocked. This finding resulted in the issuance of Violation No. 461/89014-06. This was a repeat of a similar event discussed in Inspection Report No. 461/87031, Paragraph 8.f, which resulted in the issuance of Violation No. 461/87031-05. Both of these violations involved the same valves.

As corrective action for the first violation, the licensee hung plastic signs on valves that were required to be locked. The purpose of the signs was to assure that any locks removed during maintenance and testing were properly replaced. Corrective actions for the first event were not effective in preventing a repeat violation involving the same valves.

- (5) On June 16, 1988, nine secondary containment electrical conduit penetrations, originally identified by the NRC, were found to have improperly installed external seals. This issue was discussed in Inspection Report No. 461/88014, Paragraph 8.b. On April 10, 1989, the licensee identified that five of the same conduits had no internal seals, the licensee did not examine the remaining four conduits in the population until prompted by the NRC. On June 24, 1989, the remaining four conduits were found to also have had missing internal seals. This issue was discussed in Inspection Reports No. 461/89014, Paragraph 5.e, and No. 461/89018, Paragraph 2.c. The corrective actions taken for the first conduits discovered with missing internal seals were not effective in identifying other similar deficient conduits because the generic possibilities were not pursued. This resulted in the issuance of Violation No. 461/89018-01 and was reported by the licensee in LER 89-023.
- (6) As discussed in Violation No. 461/89018-02 and reported by the licensee in LER 89-025, the licensee identified that corrective actions taken as a result of a previous Technical Specification violation were not effective in preventing a second violation regarding the performance of rod block surveillances after power changes. In this case, the corrective actions for the previous violation reported as LER 87-051 and discussed in Inspection

Report No. 461/87032, Paragraph 2.d, included revisions to two integrated operating procedures which involved power changes, but did not revise a third integrated operating procedure that also involved power changes. In addition, the licensee determined that the corrective actions for the first violation had been inadequate in that they did not correct the problem of misinterpretation of a confusing Technical Specification requirement, on an interim basis, while a Technical Specification change was being pursued.

- (7) As documented in Violation No. 89025-06, the licensee identified that a security watch at a compensatory post was sitting in a chair and was inattentive to his duties. In their response to a previous similar Violation, No. 461/88011-01, the licensee committed to removing chairs in the power block in areas where compensatory posts might be established. The corrective action was not effectively implemented in that two chairs were present at the post involved in the second violation.
- (8) As discussed in Inspection Report No. 461/89026, Paragraph 2.e, the NRC identified that a procedure for issuing caution tags, which had been revised as part of the corrective action for Violation No. 461/88016-02, was not being implemented correctly. The violation was discussed in Inspection Report No. 461/88016, Paragraph 4.a and involved a room cooling fan that was required to be running continuously that was found by the NRC to be off. One of the contributing factors to the event was that a caution tag on the fan's control switch did not contain a description of the caution and actions to be taken. The licensee reported the event as LER 88-018. Corrective actions included revising the caution tag procedure to require that the tags contain sufficient descriptive information.

On August 16, 1989, the NRC identified that miniature caution tags in the Main Control Room did not always contain information regarding the nature of the caution. This condition existed despite the fact that the caution tags were regularly audited by the licensee. None of the licensee's audits had noted that the corrective action was not being implemented.

Other recurring problems have been documented in various inspection reports and LERs for which corrective actions were not fully successful. Among those were unexpected protective system actuations as a result of jumper and test lead shorting, unexpected actuations as a result of hydraulic surges while performing valve manipulations on pressure instruments, failure to meet Technical Specification requirements during changes in plant conditions, and uncontrolled material in the containment.

10 CFR 50, Appendix B, Criterion XVI, requires that conditions adverse to quality are promptly identified and corrected. In the case of significant conditions adverse to quality, the measures shall assure that the cause of the condition is determined and corrective actions taken to preclude repetition.

Inspection Report No. 461/89027, Paragraph 7 (Unresolved Item No. 461/89027-03) discussed an issue relating to a surveillance procedure affecting Agastat relays. The procedure did not specify any torquing requirements for the terminal screws on the relay nor did it reference Maintenance Procedure CPS No. 8801.16, "Wire or Component Removal/Jumper Installation," to provide the requirements for torquing the screws. Procedure 8801.16 requires that terminal screws for Agastat relays be torqued to eight inch-pounds; and that Procedure 8801.16 must be used or the torquing requirements be incorporated into the surveillance procedure. This problem was noted on September 15, 1989, by the inspectors during an observation of surveillance activities.

CPS Condition Report 1-89-10-032 documents a condition adverse to quality which occurred on July 29, 1989, and involved an operations monitoring report by the QA department in which QA personnel identified that the terminal screws on the same identical, safety related, Agastat relay were not required to be torqued by the surveillance procedure. This resulted in the plant entering a LCO due to the inoperable Agastat relay. The corrective action for this event was to write a procedure comment form to update the procedure during its next routine review. Failing to torque the terminal screws on the relay could render it susceptible to failure during a seismic event. The failure of the licensee's program to prevent recurrence of a condition adverse to quality which the QA department identified, is an example of a violation of 10 CFR 50, Appendix B, Criterion XVI (No. 461/89032-03a(DRP)).

On September 6, 1989, CPS Condition Report 1-89-09-012 was issued which documented the overpressurization of ASME Code Class III piping (safety-related) by mechanics who were using gaseous nitrogen as a source of pressure to remove a blockage in a pipe. On September 18, 1989, the licensee held a critique to review this improper and physically hazardous action. Corrective actions from the critique were to prohibit the use of this procedure in the future and to require written approval of the Nuclear Station Engineering Department (NSED) prior to pressurizing piping above its design pressure. On September 25 and 26, 1989, two additional instances of this same unsafe activity occurred and were detailed in Condition Reports 1-89-10-017 and 1-89-10-018. The failure of the licensee to prevent the pressurization of ASME Code Class III piping above its design pressure is an example of a violation of 10 CFR 50, Appendix B, Criterion XVI (No. 461/89032-03b(DRP)).

During this inspection period, the licensee instituted several new initiatives in an attempt to upgrade the effectiveness of its corrective action program. Among the initiatives were training on root cause determination, training on corrective action development, increasing the role of the Corrective Action Board, increasing management involvement in corrective actions, emphasizing "ownership" of corrective action plans, and increased verification of corrective

action implementation. The licensee has discussed these actions with the inspectors and the inspectors will continue to follow the licensee's actions in this area.

One violation was identified.

9. Unresolved Items

Unresolved items are matters about which more information is required in order to ascertain whether they are acceptable items, violations, or deviations. An unresolved item disclosed during the inspection is discussed in Paragraph 5.

10. Violations for Which A "Notice of Violation" Will Not be Issued

The NRC uses the Notice of Violation as a standard method for formalizing the existence of a violation of a legally binding requirement. However, because the NRC wants to encourage and support licensee initiative in the self-identification and correction of problems, the NRC will not generally issue a Notice of Violation for a violation that meets the tests of 10 CFR 2, Appendix C, Section V.G.1. These tests are: (1) the violation was identified by the licensee; (2) the violation would be categorized as Severity Level IV or V; (3) the violation was reported to the NRC, if required; (4) the violation will be corrected, including measures to prevent recurrence, within a reasonable time period; and (5) it was not a violation that could reasonably be expected to have been prevented by the licensee's corrective action for a previous violation. A violation of regulatory requirements identified during the inspection for which a Notice of Violation will not be issued is discussed in Paragraph 2.

11. Exit Meetings (30703)

The inspectors met with licensee representatives (denoted in Paragraph 1) throughout the inspection and at the conclusion of the inspection on October 31, 1989. The inspectors summarized the scope and findings of the inspection activities. The licensee acknowledged the inspection findings. The inspectors also discussed the likely informational content of the inspection report with regard to documents or processes reviewed by the inspectors during the inspection. The licensee did not identify any documents/processes as proprietary.