

APPENDIX C

U. S. NUCLEAR REGULATORY COMMISSION
REGION IV

NRC Inspection Report: 50-267/84-15

License: DPR-34

Docket: 50-267

Licensee: Public Service Company of Colorado (PSC)
P. O. Box 840
Denver, Colorado 80201

Facility Name: Fort St. Vrain Nuclear Generating Station

Inspection at: Fort St. Vrain (FSV) Site, Platteville, Colorado

Inspection Conducted: June 1-30, 1984

Inspector: *G. L. Plumlee, III* 7-13-84
G. L. Plumlee III, Senior Resident Inspector (SRI) Date

Approved: *R. E. Ireland* 7/17/84
R. E. Ireland, Acting Chief Date
Special Projects & Engineering Section

Inspection Summary

Inspection Conducted June 1-30, 1984 (Report: 50-267/84-15)

Areas Inspected: Routine/Reactive, announced inspection of Operational Safety Verification; Maintenance; TMI Action Plant Requirement Followup; Independent Inspection; Licensee/NRR Meeting; and Review of Periodic and Special Reports. The inspection involved 42 routine inspector-hours onsite, 62 reactive inspector-hours onsite, and 8 Licensee/NRR meeting hours offsite by one NRC inspector.

Results: Within the six areas inspected, two violations (failure to follow procedures, paragraphs 2 and 5), one deviation (deviation from response addressing a TMI Action Item, paragraph 4), one unresolved item (control room annunciator index not updated, paragraph 2), and four open items (site tour findings, procedure deficiencies, and procedure change commitment tracking, paragraphs 2, 3, and 4) were identified.

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DETAILS

1. Persons Contacted

Principle Licensee Employees

- D. Alps, Security Supervisor
- L. Bishard, Maintenance Supervisor
- W. Craine, Superintendent of Maintenance
- M. Deniston, Shift Supervisor
- J. Eggebrotten, Technical Advisor
- D. Evans, Shift Supervisor
- M. Ferris, QA Auditing Coordinator
- W. Franek, Superintendent Operations
- *C. Fuller, Technical/Administrative Services Manager
- *J. Gahm, QA Manager
- J. Hak, Shift Supervisor
- M. McBride, Operations Manager
- P. Moore, QA Technical Support Supervisor
- M. Niehoff, Site Engineering Manager
- *F. Novachek, Technical Services Engineering Supervisor
- H. O'Hagen, Shift Supervisor
- J. Petera, Electrical Supervisor
- *T. Prenger, QA Engineering Coordinator
- J. Reesy, Nuclear Design Manager
- G. Redmond, MQC Supervisor
- *L. Singleton, Superintendent Operations QA
- *H. Starnier, Coordinator Nuclear Site Construction
- J. Van Dyke, Shift Supervisor Administration
- D. Warembourg, Manager Nuclear Production

The SRI also contacted other plant personnel including reactor operators, maintenance men, electricians, technicians, and administrative personnel.

*Denotes those attending the exit interview.

2. Operational Safety Verification

The SRI reviewed licensee activities to ascertain that the facility is being operated safely and in conformance with regulatory requirements and the licensee's management control system is effectively discharging its responsibilities for continued safe operation.

The review was conducted by direct observation of activities, tours of the facility, interviews and discussions with licensee personnel, independent verification of safety system status and limiting conditions for operations, and review of facility records.

Logs and records reviewed included:

- . Shift Supervisor Logs
- . Reactor Operator Logs
- . Equipment Operator Logs
- . Auxiliary Operator Logs
- . Technical Specification Compliance Logs
- . Operations Order Book
- . Operations Deviations Reports
- . Clearance Log
- . Temporary Configuration Reports
- . Plant Trouble Reports

During tours of accessible areas, particular attention was directed to the following:

- . Monitoring Instrumentation
- . Radiation Controls
- . Housekeeping
- . Fluid Leaks

- . Piping Vibrations
- . Hanger/Seismic Restraints
- . Clearance Tags
- . Fire Hazards
- . Control Room Manning
- . Annunciators

On June 18, 1984, with reactor power at 30 percent, the SRI verified the operability of critical equipment necessary for safe shutdown of the plant by selected partial walkdown of the licensee's "critical valve" and "sealed valve" lists generated in response to NUREG 0737, Article I.C.6 requirements, and documented in the licensee's final submittal of P-82424, dated September 28, 1982. One valve was identified as missing a "sealed valve" tag.

a. Tour of FSV by NRC Commissioner

As identified in NRC Inspection Report 84-14, the SRI performed a followup to the NRC Commissioner's findings identified on May 21, 1984. Followup consisted of participating in a special inspection (NRC Inspection Report 84-16) resulting from the NRC Commissioner's observations as well as follow up to the following areas of concern:

(1) Housekeeping

The SRI reviewed the licensee's current program to improve the level of housekeeping at FSV as documented in PSC letter P-84169, dated June 8, 1984. The SRI has witnessed work in progress and determined this program to be adequate for near term corrective actions as an effort to improve the existing housekeeping conditions at FSV. However, this program does not address long term corrective actions. The SRI informed the licensee that to make successful, long term improvements would require all plant personnel to be informed by management that everyone must develop a conscious and positive attitude toward good housekeeping practices.

The SRI, has reported to the licensee many times the need for improved performance on the part of operations personnel in the area of housekeeping. However, the SRI is concerned that all departments (e.g., maintenance) must become conscious of the continuing need for "good housekeeping" if the near term improvements are not to be short lived. The SRI has been informed that he must follow up on housekeeping practices on a continuing basis and that Region IV personnel will conduct periodic audits.

(2) Control Room Distractions

The SRI verified issuance of Operations Order 84-06, dated June 6, 1984, which states,

"Effective immediately, NO non-job related reading material will be allowed in the control room. This OP Order replaces OP Order #80-15, which has been cancelled."

The SRI also verified removal of the control room stereo on June 13, 1984.

(3) Shift Turnover Procedures

Refer to paragraph 4 of this report.

(4) Maintenance and Operating Procedures

Concerns identified in these areas, as identified in NRC Inspection Report 84-16, are followed and evaluated by the SRI on a continuing basis. Findings are documented via NRC Inspection and SALP Reports.

b. Plant/Site Tour Findings

- (1) During a daily control room tour on June 6, 1984, at 7:00 a.m. MDT, the SRI determined that the annunciator on Panel I-06E Window 3-7, "480 V Bus Undervoltage," was "up solid" (i.e., had been acknowledged by the operator), and neither of the reactor operators (ROs) were aware of the reason, nor had they questioned the reason during their shift turnover.

The SRI verified that the Bus 1, 2, and 3 degraded voltage alarm annunciators were "up" at the local Panel I-93520 located in the 480V room. These annunciators resulted from the trip of ITE 27H undervoltage relays (three per bus) at 104 Volts \pm 5V and require resetting locally before the control room alarm can be cleared.

The SRI identified the following procedural problems:

- Standard Operating Procedure (SOP) 92-03, "Electrical Distribution 480 V System," Revision 5, dated January 15, 1981, Section 2.6, "Operator Actions," had not been updated to include operator actions to check Panel I-93520 as a followup to the I-06E alarm.
- Alarms Index, dated April 15, 1983, operator actions section, only refers to Section 2.6 of SOP 92-03.
- Operations data logger alarm index had not been updated to incorporate the required operator actions as a result of the newly added undervoltage relay protective system.

The undervoltage situation, which must have existed for less than 120 seconds since a bus trip did not occur, was believed to have occurred as a result of starting the "1B" boiler feed pump (BFP), on June 5, 1984, at 5:00 p.m. MDT; this is the plants largest electric pump. At the request of the SRI, this effect was verified when the "1B" BFP was next started on June 16, 1984, at 11:15 a.m. MDT. Therefore, the I-06E (3-7) alarm must have been "up" during both the swingshift to graveyard shift and the graveyard to dayshift turnovers.

The SRI verified, from a review of SCR 84-77, dated March 3, 1984, for XVR 92285-3 (i.e. the white copy maintained by the plant electrician), that setpoint change reports (SCR) had been issued as required by Administrative Procedure P-1, "Plant Operations," Issue 11, dated October 19, 1983. However, the requirements in P-1 for the superintendent of operations to review the SCR for system effects apparently had not identified that these relay setting changes required additional operator actions to clear the affected annunciator.

On June 6, 1984, the SRI verified that corrective action to restore the annunciator to normal had occurred by observing performance by the plant electrician of additional actions consisting of resetting the undervoltage relays and then resetting the local annunciators at I-93520. The RO was then able to reset I-06E (3-7).

The SRI determined on June 30, 1984, that Station Managers Administrative Procedure (SMAP)-6, "Control of the Alarm Index," Issue 1, dated March 22, 1984, now requires the SCR initiator to complete an alarm index change request (AICR) form and attach it to the SCR, and that Results Engineering now has the overall responsibility for ensuring that all control room alarms affected by an SCR are properly updated on the control room alarm index. SMAP-6 was apparently not in effect when the above SCRs were initiated. Had SMAP-6 been retroactive to include SCRs in effect at the time SMAP-6 was issued, the problem with the alarm index most likely would not have occurred.

Based on the need to obtain additional information in this area, the licensee was informed that this would be considered an unresolved item (8415-01). The licensee was also informed that this is another example of apparent inadequate shift turnover as well as questionable operator performance in allowing the annunciator to remain "up" without attempting to find out why it was "up."

- (2) During a tour of the site on June 18, 1984, the SRI determined that N-4855 and N-4856, "Electric Fire Pump Room Vent Fan and Damper Motor Electric Power Transfer Switch" and "Diesel Fire Pump Room Vent and Damper Motor Electric Power Transfer Switch," were both in the alternate cooling method (ACM) position without operations personnel knowledge. On June 19, 1984, the SRI verified that the normal feed breaker for the electric fire pump room vent fan C-7521 at Turbine Plant MCC 1 was open and the normal feed breaker for the diesel fire pump room vent fan C-7522 at Turbine Plant MCC 3 was closed.

The fans are controlled by a thermostat switch that closes at 87 degrees Fahrenheit and opens at 85 degrees Fahrenheit. With the switches in the ACM position both fans were inoperable, since the ACM feed to fire water pump house power distribution panel breakers at N-4870, "ACM 480 V Motor Control Center," was in the off position.

The licensee was informed that the situation described above adds to the examples of previous findings made by the SRI concerning operators' failure to be aware of current system status.

SOP 48-01, "Alternate Cooling Method," Issue 13, dated February 16, 1984, provides the procedure for placing the fire water pump house fans in operation on ACM power and for restoring them to the normal source. The SRI was unable to determine the exact reason why or for how long the system was in a deviation condition, however, the SRI determined that the licensee was in violation of Administrative Procedure P-2, "Equipment Clearances and Operation Deviations," Issue 9, dated May 24, 1984, since no operation deviation report had been issued authorizing this deviation from established operational procedures. The licensee was informed that the failure to follow procedures which are Technical Specification requirements is considered a violation (8415-02).

- (3) The SRI's site and reactor building tour of June 18, 1984, identified numerous housekeeping, fire protection, and maintenance deficiencies of a kind previously identified to the licensee on numerous occasions. The SRI has informed the licensee that the examples listed below are items that should have been identified and corrected by plant personnel, especially, the operators who make routine tours for equipment log readings. These examples also indicate poor housekeeping for which previously committed corrective actions are in progress.

Emergency Diesel Fire Pump House

- . Oil absorbent left on deck at rear of engine
- . Oil leaking from bottom of engine and concrete pedestal soaked with oil
- . Paper wipes stored on top of I-4501X

Electric Fire Pump House

- . Used paper wipes on top of Panel N-4856

Circulating Water Pump Pit

- . Dirty rags on hand rail by Circulating Water Pump 1A
- . HV-4108/-4110 packing leaks
- . Ground cable broke at HV-4108

Fire Water Makeup Valve Pit

- . Dirty rags, paper wipes, cigarette packs/butts, etc. laying on the deck

Main Cooling Tower Breaker Panels

- . Bus Tie 6-7 N-9216 charging spring power switch off
- . Chair and portable heater found inside the panel
- . Panels and transformers are not labeled
- . No high voltage warning labels on the breaker panel access doors
- . Breaker access rear panel doors contain posted drawings that are noncontrolled and torn up

Bahnon Building

- . Numerous load center breaker position lights burned out

4160 V Switchgear

- . Numerous breaker position/relay reset lights burned out

Reactor Building

- . Trash and dirty rags identified on Levels 11, 10, 7, and 1
- . Fire hoses identified as pressurized at various locations
- . Exposed cable in overhead by Reactor Building Blowout Panel G17-2
- . "Seal Open" label missing from Sealed Valve V-11334
- . Conduit broken to light at elevator entrance
- . Operation lights out on purification helium compressor and M-G set panels
- . Dirty radioactive contamination area located at the truck bay entrance (i.e. loose dirt on the deck)
- . Handwheel loose on V-91349 located on hydraulic pump P-9104X

These are examples of some of the findings reported to the licensee on June 19, 1984. The SRI has considered these to be typical of problem areas pointed out to plant management in the past for which corrective actions have apparently not been taken. Discussion with licensee management indicates management's concern over the SRI's findings, but no commitments were made in regard to resolution. The licensee was informed that this is considered an open item (8415-03), pending an evaluation of the licensee's efforts to ensure that obvious housekeeping, fire protection, and maintenance deficiencies are identified and corrected by plant personnel.

- (4) During the daily morning control room tour on June 19, 1984, the SRI identified that operations personnel were attempting to restore the LN2 level in T-2501, "Liquid Nitrogen Storage Tank." The SRI noted that annunciator I-01B (5-7), "LN2 System Outside Malfunction," was "up," and determined that neither the control room alarm index file book nor the data logger printout had been updated to reflect this newly installed annunciator, resulting from modifications to the nonsafety-related outside LN2 storage system that supplies makeup to T-2501. The licensee was informed that this is considered an open item (8415-04) pending procedure updates. As a result of having low levels in both newly installed, larger capacity outside LN2 storage tanks, the licensee entered the limiting condition for operation (LCO 4.2.12) limited operation time restriction (grace period) at 6:04 a.m. MDT, and returned to unrestricted operation at 6:53 a.m. MDT, upon restoration of >650 gallons in T-2501.
- (5) On June 14, 1984, at 7:30 a.m. MDT, during a daily control room tour, the SRI identified that HS 7201, "1A Reactor Building Sump Pump Handswitch," had a red flag with both the "on" and "off" lights out. Operators on duty at that time were not aware of this problem even though annunciator I-13C (5-6), "Reactor Building Sump High Level," was "up" and the RO had just completed shift turnover, thus indicating poor shift turnover performance. Apparently the pump had tripped on overload.

The SRI had no further questions in this area.

3. Maintenance (Monthly)

The SRI reviewed records and observed work in progress to ascertain that the following maintenance activities were being conducted in accordance with approved procedures, Technical Specifications, and appropriate Codes and Standards. The following maintenance activities were reviewed and observed:

CN 1280B/CWP 84-123 Install Bar Straps on 20 Additional Block Walls

PTR 6-754 Removal, Inspection, and Reinstallation of Region 14 Control Rod Drive in Accordance with MP 12-6, "Maintenance and Repair of Control Rod Drive and Orificing Assembly," and RP-5, "Control Rod Drive Checkout"

During a review of RP-5, Issue 7, dated April 23, 1984, the SRI identified the following deficiencies:

- . The watt recorder required in Steps 4.1.3a) and 4.1.6a) was not included under Section 3.5, "Special Tools Required."
- . Section 3.5 does not provide for verification of special tool calibration.
- . Watt recorder required in Steps 4.1.3a) and 4.1.6a) apparently has not been required to be calibrated which is in disagreement with Administrative Procedure Q-12, "Control of Measuring and Test Equipment."

The licensee was informed that this is considered an open item (8415-05) pending procedural corrections.

No violations or deviations were identified.

4. TMI Action Plan Requirement Followup

As a result of continuing problems identified by the SRI concerning shift turnover and operator awareness of equipment status, the SRI performed a followup in regard to the licensee's previous response to TMI Action Item 1.C.2, "Shift and Relief Turnover Procedures." The NRC staff requirements concerning this item were forwarded to the licensee via an October 30, 1979, NRC letter (G-79214):

"SHIFT AND RELIEF TURNOVER PROCEDURES (2.2.1.c)

"POSITION

"The licensees shall review and revise as necessary the plant procedure for shift and relief turnover to assure the following:

- "1. A checklist shall be provided for the oncoming and offgoing control room operators and the oncoming shift supervisor to complete and sign. The following items, as a minimum, shall be included in the checklist.
 - "a. Assurance that critical plant parameters are within allowable limits (parameters and allowable limits shall be listed on the checklist).

"b. Assurance of the availability and proper alignment of all systems essential to the prevention and mitigation of operational transients and accidents by a check of the control console.

"(what to check and criteria for acceptable status shall be included on the checklist);

"c. Identification of systems and components that are in a degraded mode of operation permitted by the Technical Specifications. For such systems and components, the length of time in the degraded mode shall be compared with the Technical Specifications action statement (this shall be recorded as a separate entry on the checklist).

"2. Checklists or logs shall be provided for completion by the offgoing and ongoing auxiliary operators and technicians. Such checklists or logs shall include any equipment under maintenance or test that by themselves could degrade a system critical to the prevention and mitigation of operational transients and accidents or initiate an operational transient (what to check and criteria for acceptable status shall be included on the checklist); and

"3. A system shall be established to evaluate the effectiveness of the shift and relief turnover procedure (for example, periodic independent verification of system alignments)."

As identified in NRC Inspection Report 84-16, the previous conclusions regarding completed actions are considered as not correct. The licensee clearly does not have a shift turnover checklist nor do they have procedures that implement operation-oriented shift turnover requirements.

Concerning Item 3 above, the licensee's February 20, 1980 (P-80028), response to this requirement states:

"The shift relief turnover procedures are included in the QA surveillance and audit program and additionally in the NFSC audit program. The operational QA program provides routine QA surveillance of all administrative controls and specifically under QA Surveillance Procedure, QASP-301, Plant Operations, the shift turnover procedures are included. Logs, operational records, and specific valve positions are checked on a random basis. Portions of this surveillance program are conducted on at least a quarterly basis. The QA audit program provides additional checks in this same area. The QA audit program is scheduled to provide complete coverage of all aspects of the QA program once every two years.

"The combination of the QA surveillance program, the QA audit program and the NFSC audit program provide independent checks of plant operations and specifically shift turnover procedures on a more than adequate frequency to meet the annual requirements of the October 30, 1979, NRC letter."

In followup to this, the SRI has determined the following:

- . The referenced QASP-301 was last performed September 19, 1978, whereby the station logs in affect at that time were reviewed. The purpose of the QASP was not to evaluate adequacy of shift relief turnover, but to verify that shift turnover had occurred as verified by operator signatures in the station logs. QASP-301 has since been deleted from the licensee's program.
- . NFSC Audit A-75-1, dated August 17, 1979, was the last time the NFSC looked at shift turnover and again this consisted of verification that shift relief had occurred and that log entries were being made.
- . QA Audit QAA-301-82-01, dated February 1982, was the last time QA looked at shift turnover and again this consisted of verification only that shift relief had occurred.
- . No program had apparently been established to evaluate the effectiveness of shift and relief turnover procedures (e.g. no efforts were apparently made to independently verify operator knowledge of current plant conditions).

The fact that the annual review as committed to in P-80028 was not complied with during 1983 was discussed with the licensee as well as the inadequacy of their response. The licensee was informed that this is considered a deviation (8415-06).

During the above followup on previous NRC commitments, the SRI determined that the licensee's QA department was not aware of the commitments (obligations) set forth in P-80028. This is a concern since QASP-301 was deleted without first reviewing for existing obligations or ongoing requirements. The SRI has also previously identified cases involving deletion of sections from procedures that had been incorporated as a result of previous commitments to the NRC. Many of the licensee's procedures or procedure sections exist as a result of corrective action commitments for which no program exists that would ensure these ongoing requirements are not inadvertently deleted. The licensee was informed that this is considered an open item (8415-07), pending development of a system to ensure that ongoing requirements are not inadvertantly deleted.

The SRI had no further questions in this area.

5. Independent Inspection

On June 23, 1984, at 12:30 a.m. MDT, an automatic reactor scram from 23 percent reactor power occurred from a high primary coolant pressure trip signal which resulted in the failure of six control rod drives (CRD) in Regions 6, 7, 10, 14, 25, and 28 to freely drop into the core. Due to high primary coolant moisture, the licensee was in the process of reducing load and depressurizing the core through the purification train. At approximately 10:00 p.m. MDT, on June 22, 1984, the on-line purification train froze up resulting in the inability to depressurize the core. As a result of having a circulator inlet temperature versus primary coolant pressure high pressure program trip, a high primary coolant pressure trip signal occurred when the circulator inlet temperature continued to decrease with primary coolant depressurization stopped. A "courtesy" call from the licensee's Technical/Administrative Services Manager was received by the SRI at home on June 23, 1984, at approximately 8:50 a.m. MDT, informing the SRI of the CRD problem. The SRI informed the licensee's representative that the CRD problem should be reported to the NRC Headquarters Duty Officer immediately. The SRI identified this as a sensitive area and departed immediately to arrive at the site for a briefing with the licensee management at 9:48 a.m. MDT.

The SRI coordinated that day with NRC Headquarters and Region IV to provide facts concerning the event. The SRI also determined that no procedural violations had occurred. However, the SRI was concerned that the plant protective system trip was reported as required by 10 CFR 50.73, but at the same time the CRD problem was not included in this initial report. The SRI has since informed the licensee about the need to provide details, such as identified above, when reporting events that involve sensitive issues involving safe shutdown components.

Followup to this event by Region IV and the SRI is continuing and consists of:

- . Confirming on June 23, 1984, that the licensee had performed a GAUGE code calculation verifying that the reactor was shutdown even with the six CRDs not inserted. A 30 minute transient time was assumed until all CRDs could be manually driven in.
- . Issuance of Confirmatory Action Letter, dated June 26, 1984, to ensure that the FSV reactor will be maintained in a shutdown, cooled down, depressurized (≤ 100 psia) state until the NRC notifies PSC that it is authorized to proceed to a different status.

- . In-progress review of Special Test T-214, whose objective was to determine the power drawn by CRD motors and/or the motor insulation integrity.
- . Review of Licensee Event Report (LER) 82-007 that discusses a similar problem previously reported.
- . In-progress followup on the inspection of the CRD removed from Region 14, as performed in accordance with Plant Trouble Report (PTR) 6-754.
- . Review of Special Test T-226 whose purpose is to make observations that will allow determination of the cause for the failure of CRD's in Regions 6, 7, 10, 14, 25, and 28 to insert on "scram" on June 23, 1984.
- . Numerous conference calls between the licensee, NRR, and Region IV concerning the event circumstances, work in progress, and resolution of technical issues.
- . The SRI is currently awaiting the formal submittals committed to by PSC regarding their inspection plan to determine the basic cause of the event, and a complete report on the circumstances of the event.

On June 25, 1984, the SRI determined that a technical services engineer was performing T-214 without the shift supervisor's signature/date providing permission to initiate the test, and that the test conductor section had not been completed. The test conductor immediately stopped the test upon notification of the problems and corrective action was initiated. The licensee was informed that this is considered a violation (8415-08) of the requirements of Administrative Procedure Q-11, "Test Control," Issue 3, dated December 29, 1981.

Corrective actions taken as a result of this failure to follow procedure took place on June 27, 1984, and is documented in PSC Inter-Department Memo PPC-84-1541, dated June 27, 1984. A formal training session was held to review the incident and all administrative procedures associated with performance monitoring and testing that are generally applicable to technical services engineers. The consequences of failure to follow procedures was also reviewed. All personnel were informed that the next such occurrence would be cause for the initiation of formal disciplinary action.

The SRI had no further questions in this area.

6. Licensee/NRR Meeting

On June 8, 1984, the SRI attended a meeting in Bethesda, Maryland. The purpose of the meeting was for the NRC and licensee to discuss fire protection issues related to compliance with 10 CFR 50.48 and Appendix R. During the meeting the criteria for the alternate shutdown capability for FSV as provided to the licensee in a June 4, 1984, NRC letter was discussed. Several interpretation problems became evident, such as FSV's definitions for hot and cold shutdown versus light water reactor definitions, as well as FSV's methods for plant shutdown (i.e. normal, backup, safe shutdown, and emergency cooling). The meeting concluded with the licensee's commitment to submit proposed revisions to Enclosure 1 of the June 4, 1984, letter and to submit a schedule for exemption requests. PSC letter P-84133, dated June 22, 1984, was submitted in response to this commitment. The SRI submitted, via telecon, comments regarding P-84133 to Region IV.

The SRI had no further comments in this area.

7. Report Reviews

The SRI reviewed the following reports for content, reporting requirement, and adequacy:

Monthly Operations Report for the month of May 1984

Thirty-first Startup Report covering the period from February 23, 1984, through May 22, 1984

No violations or deviations were identified.

8. Unresolved Items

Unresolved items are matters about which more information is required in order to ascertain whether or not the items are acceptable, violations, or deviations. The following unresolved item was discussed in this report:

<u>Paragraph</u>	<u>Item</u>	<u>Subject</u>
2.b.(1)	8415-01	Control Room Annunciators

9. Exit Interview

Exit interviews were conducted at the end of various segments of this inspection with Mr. D. Warembourg, Manager, Nuclear Production, and/or other members of the PSC staff as identified in paragraph 1. At the interviews, the SRI discussed the findings indicated in the previous paragraphs. The licensee acknowledged these findings.