U. S. NUCLEAR REGULATORY COMMISSION
REGION V

Report Nos. 50-275/84-26 and 50-323/84-18

Docket Nos. 50-275 and 50-323 License No: DPR-76 Construction Permit No.: CPPR-69

Licensee: Pacific Gas and Electric Company

77 Beale Street, Room 1435

San Francisco, California 94106

Facility Name: Diablo Canyon Units 1 and 2

Inspection at: Diablo Canyon Site, San Luis Obispo County, California

Inspectors: R J Dodds for — 9/20/84
M. M. Mendonca, Sr. Resident Inspector — Date Signed

R J Dodds for — 9/20/84
M. L. Padovan, Resident Inspector — Date Signed

R J Dodds for — 9/20/84
T. M. Ross, Resident Inspector — Date Signed

R J Dodds for — 9/20/84
T. J. Polich, Resident Inspector — Date Signed

Approved by: R J Dodds — 9/20/84
R. T. Dodds, Chief, Reactor Project, Section 1 — Date Signed

Summary: Inspection from August 5, through September 1, 1984, (Report Nos. 50-275/84-26 and 50-323/84-18).

Areas Inspected: Routine inspection of: plant operations, conditions, and events; maintenance; surveillance; startup test procedures; independent inspection; and followup of open items, LER's, and enforcement actions. This inspection effort required 425 inspector-hours for Unit 1, and 26 inspector hours for Unit 2 by four resident inspectors.

Results: No violations or deviations were identified.

DETAILS

1. Persons Contacted

*R. C. Thornberry, Plant Manager
R. Patterson, Assistant Plant Manager/Superintendent
*J. M. Gisclon, Assistant Plant Manager for Technical Services
*W. B. Kaefer, Assistant Plant Manager for Support Services
C. L. Eldridge, Quality Control Manager
*R. G. Todaro, Security Supervisor
*D. B. Miklush, Supervisor of Maintenance
J. A. Sexton, Supervisor of Operations
*J. V. Boots, Supervisor of Chemistry and Radiation Protection
*W. B. McLane, Material and Project Coordination Manager
L. F. Womack, Engineering Manager
*B. W. Giffin, Acting Instrumentation and Control Manager
*E. T. Murphy, Regulatory Compliance Supervisor
*C. M. Seward, Supervisor of Quality Assurance
M. N. Norem, Lead Startup Engineer
R. A. Hobgood, Quality Control Supervisor
J. Molden, Licensed Training Coordinator

The inspectors interviewed several other licensee employees including shift supervisors, reactor and auxiliary operators, maintenance personnel, plant technicians and engineers, quality assurance personnel and general construction personnel.

*Denotes those attending the exit interview on September 7, 1984.

2. Operational Safety Verification

a. General:

During the inspection period, the inspectors observed and examined activities to verify the operational safety of the licensee's facility. On a daily basis, the inspectors observed control room activities to verify compliance with selected limiting conditions for operation (LCO) as prescribed in the facility Technical Specifications (TS). Logs, instrumentation, recorder traces, and other operational records were examined to obtain information on plant conditions, trends, and compliance with regulations. Shift turnovers were observed on a sample basis to verify that all pertinent information on plant status was relayed. At least weekly the inspectors toured the accessible areas of the facility to observe the following:

(1) General plant and equipment conditions.

(2) Surveillance and maintenance activities.

(3) Fire hazards and fire fighting equipment.

(4) Ignition sources and flammable material control.

(5) Conduct of selected activities for compliance with the licensee's administrative controls and approved procedures.

(6) Interiors of electrical and control panels.

(7) Implementation of selected portions of the licensee's physical security plan.

(8) Plant housekeeping and cleanliness.

(9) Operability of selected engineered safety features systems by performing comprehensive walkdowns of the system's components.

The inspectors talked with operators in the control room, and other plant personnel. The discussions centered on pertinent topics of general plant conditions, procedures, security, training, and other aspects of the involved work activities.

No violations or deviations were identified.

b. Inoperable Containment Ventilation Isolation (CVI) During Purging

At 4:11 am on August 26, 1984, while performing surveillance activities on one of two plant vent noble gas radiation monitors, the CVI protective function was determined to be inoperable. This function became inoperable when the other plant vent noble gas radiation monitor was cleared and deenergized at 6:00 pm on August 23, 1984. With the CVI protection signal reset, a high radiation signal from the remaining operable radiation monitor would not cause a containment purge system isolation. A containment purge had been underway from 10:13 am on August 22, 1984, through 12:44 pm on August 24, 1984, while the containment purge system isolation function was inoperable. Analysis determined no release of radioactive effluents was made via this pathway during the purge. This was reported to the NRC Emergency Operations Center as a significant event.

The primary cause of this event was plant operators, rather than Instrumentation and Control (I&C) technicians removing the first radiation monitor from service. A policy has been in affect for approximately three years which specifies that clearance of instrumentation, such as radiation monitors, would be performed by I&C technicians. However, with a recent decrease in such activities, the clearance coordinator had not been regularly implementing this policy and mistakenly turned the clearance activity over to operations.

Operations personnel deenergized the radiation monitor and reset the CVI signal so it would not interfere with the ongoing purge. The instrumentation logic for this feature of the Solid State Protection System (SSPS) is similar to that for the Safety Injection signal; i.e., once the signal is reset and the original initiating signal remains in affect, no further signals can actuate the SSPS protection logic. If I&C would have performed the clearance activities, the radiation monitor should have been removed from service with its leads lifted in accordance with I&C procedures rather than

operations procedures. This would permit the original signal to be removed and thus allow any subsequent initiating signal to actuate SSPS protection logic.

To assure that similar errors do not recur, the licensee has revised administrative procedures for clearance of equipment. Nuclear Plant Administration Procedure C-6 Supplement 1 will be revised to require appropriate I&C approval for all work affecting plant instrumentation. In the interim, a shift foreman's memo dated August 27, 1984, has been issued to clarify for operations the role of I&C supervisors to approve clearances and verify scheduled work.

In reviewing the event, it was determined that the Plant Staff Review Committee (PSRC) has previously considered the potential for a non-operative containment ventilation system in cold shut down (mode 5) conditions (minutes dated June 15, 1984). The PSRC issued an interpretation of TS 3.3.3.10 in these minutes. The interpretation found that (1) "Radioactive Effluents" (as stated in TS 3.3.3.10) are not normally present in the containment in mode 5; (2) in mode 5 the SSPS is not required to be operable so that CVI which is actuated by the SSPS need not be operable; and (3) containment integrity is not required in mode 5, so that CVI would not necessarially isolate the containment since containment hatches may be open. This interpretation concluded that CVI was not necessary in mode 5, thus TS 3.3.3.10 was flawed and should be revised.

This interpretation has been discussed with the NRC's Office of Nuclear Reactor Regulation, and appears to be acceptable. Given this interpretation, which the shift foreman did not previously have available, the event may not need to be reportable as a significant event, nor may it need be reportable as a licensee event report.

No violations or deviations were identified.

c. Mis-positioned Incore Neutron Detectors

As a prerequisite for maintenance on reactor coolant pump 1-2, the Radiation Protection (RP) foreman was generating a Special Work Permit which would allow access through the seal table room (which is normally locked) to support the associated maintenance activities. As an added precaution beyond required surveys, the RP foreman contacted the control room to verify positions of all moveable incore detectors. The control panel for moveable incore detector system (MIDS) is normally de-energized. On the afternoon of August 24, pursuant to RP foreman's request, a control operator energized MIDS revealing none of the incore detectors were inside their stored position. All six detectors (identified as detectors A, B, C, D, E and F) were discerned to be positioned between the 10-path transfer device and the seal table. Following this discovery, a reactor engineer was requested to immediately returned all six incore detectors into their storage positions and de-energized the MIDS control panel. Whereupon, in accordance with Operating Procedure (OP) B-5A, "MIDS - Shutdown and Clearing", a Shift Foreman (SFM) clearance was authorized to prevent any subsequent unapproved operation of MIDS.

MIDS is normally used for obtaining full or partial-core flux maps. Surveillance Test Procedure (STP) R-3A, "Use of Flux Mapping Equipment", in conjunction with OP B-5A provide the detailed instructions for operating this system. Whenever mapping is complete, STP R-3A requires returning incore detectors to the stored position. At the present, neither the specific circumstances or time frame surrounding the event of mis-positioned incore detectors is known.

The licensee is actively pursuing the occurrence and evaluating the need for implementation of corrective action. Radiologically, the impact has been considered by the licensee to be insignificant in relation to probable personnel exposure. This assessment was based upon the following: 1) minimal irradiation history and previous surveys performed of incore detectors, 2) daily surveys performed in the seal table room, and 3) on-line area monitor (RE-7) within the seal table room.

The inspector will continue to follow-up on the licensee's investigation and resolution. Until such time as all pertinent facts have been collected, this event will be tracked as an unresolved issue (84-26-01).

No violations or deviations were identified.

3. Maintenance

The inspectors observed portions of and review records for the following maintenance activities on safety related components and systems, to assure that these activities were conducted in accordance with approved procedures, technical specifications, and appropriate industry codes and standards:

a. Diesel Generator (DG) Air Compressor Motor

The inspector observed selected portions of electrical maintenance performed on DG starting air compressor motor 1-2A. Repair and retests of the motor were necessary due to a failed megger test identified in nuclear plant problem report DC- 1-84-EM-P0167. Shop Work Follower (SWF) EM-1-84-184 provided the detailed instructions necessary to conduct this scheduled maintenance. The inspector observed bench testing of the compressor motor. Megger, running current, and revolutions per minute measurements were performed with calibrated test equipment. The inspector also observed electrical reinstallation of the motor and associated electrical and rotations/ checks. A licensee Quality Control (QC) inspector inspected the motor redetermination and testing in accordance with the hold point identified on the SWF.

No violations or deviations were identified.

b. Exhaust Fan E-6

Portions of preventive maintenance activities on the Fuel Handling Building Ventilation Exhaust Fan E-6 were observed by the inspector. Maintenance was conducted in accordance with Maintenance Procedure E-53.1. Fan E-6 was disassembled, inspected, reassembled and subsequently tested. All work was performed by a qualified journeyman electrician. The clearance for this work was authorized and appropriate electrical equipment was de-energized and tagged out. Applicable LCO's were addressed. In addition, radiological and cleanliness controls were observed and appeared to be acceptable.

No violations or deviations were identified.

c. Condensate Booster Pumps

The inspector observed significant aspects of a major maintenance activity intended to reduce vibration in condensate booster pump 1-2 and improve its projected service lifetime. This project comes pursuant to information generated during similar maintenance performed on pump 1-3, where a serious vibration problem resulted in severe degradation of the pump impeller. Both condensate booster pumps 1-1 and 1-2, including their motors, will be disassembled, inspected, balanced (impeller and rotor), staked (motor), regrouted (base plate), reassembled, and then operationally pressure tested. These activities require the coordinated interface of mechanical and electrical maintenance, I&C, Engineering, and In-Service Inspection organizations. The inspector examined applicable SWF's, verified clearance documentation and tagouts, monitored various mechanics' work practice, and observed balancing operations. Although condensate booster pumps are not safety related, the aforementioned activities were determined by the inspector to be consistent with Nuclear Plant Operations (NPO) maintenance control requirements. This project demonstrated that a corrective and preventive maintenance program has been implemented that also applies to plant important equipment other than safety-related equipment.

No violations or deviations were identified.

4. Surveillance

By direct observations and record reviews of licensee surveillance testing the inspectors verified that the following activities were in accordance with technical specification requirements and implementing plant procedures:

a. Purge Exhaust Valves

STP V-662 was performed to verify operability of containment purge exhaust valves RCV-11 and RCV-12, as required by TS 4.6.3.4. The inspector observed selected portions of this STP, which also included a leak rate test of penetration 62. The leak rate determined by the STP was within the acceptance criteria for penetration 62.

No violations or deviations were identified.

b. Containment Fan Cooler Units (CFCU) and Valves

This surveillance activity was conducted in accordance with STP M-51. The inspector observed that a CFCU started and aligned to its safeguards position. The CFCU was then run for 15 minutes, while damper position and coolant flows were verified.

STP M-51 was conducted by an auxiliary operator, who appeared to be familiar with both the procedure and equipment. Performance of this STP was coordinated with the control operator to assure control room awareness of plant conditions and compliance with LCO's. Test equipment in use was verified to be in calibration. STP M-51 was determined to conform with T.S. 4.6.2.3.a requirements. Test data was recorded on the STP data sheet and reviewed by the shift foreman.

No violations or deviations were identified.

5. Routine Inspection

a. Design Changes and Modifications

The inspector reviewed the licensee's documentation on four safety related design changes. These design changes were controlled by approved written procedures. They were appropriately reviewed and authorized in accordance with established Quality Assurance (QA) and QC controls. In addition, documented test results were reviewed and were documented to be within previously established acceptance criteria.

The backlog of design change requests was also reviewed by the inspector. Over the last year period, the design change notice backlog has decreased from about 700 to approximately 350 (250 issued with work not yet begun and 100 with the work in progress). The backlog consists predominately of plant improvement items not required for the power ascension test program.

No violations or deviations were identified.

b. Startup Test Procedure (STP) Review

The inspector reviewed Startup TP 43.4 "Plant Trip from 100% Power." The purpose of the procedure is to trip the main generator turbine while the plant is at 100% power on automatic control, in order to assess and verify that control system responses are acceptable. Startup TP 43.4 contains provisions for monitoring the opening of the plant's 500 KV breakers (to separate the main generator from the grid), but the TP did not specify that re-alignment of the 230 KV electrical power sources was to be monitored. Additionally, the test acceptance criteria did not require that the following criteria be met:

- reactor coolant pumps do not trip

- pressurizer spray valves open and close as expected

- steam generator power operated relief valves open and close as expected

- reactor coolant system pressure-temperature relationship remains within defined values

- pressurized level remains within prescribed limits

- steam generator level remain within prescribed limits

- turbine bypass system operates to maintain specific pressure.

The licensee has agreed to consider incorporating the above comments into Startup TP 43.4. Resolution of these items will be followed as open item (84-26-02).

No violations or deviations were identified.

c. Maintenance Program

An inspector examined the licensee's maintenance program including both the corrective and preventive maintenance portions of the program. Equipment control, cleanliness control, special processes, and housekeeping associated with the maintenance program were also examined during this inspection. Selected portions of the following Nuclear Plant Administrative Procedures (NPAP) were examined during this inspection:

- NPAP A-750, Rev. 0, 5/31/83, "Technical Assistance Group for the Maintenance Departments"

- NPAP C-3, Rev. 3, 6/7/82, "Conduct of Plant and Equipment Tests"

- NPAP C-6, Rev. 4, 3/10/83, "Clearances"

- NPAP C-6S3, Rev. 0, 8/11/83, "Post Maintenance Testing"

- NPAP C-40, Rev. 1, 3/10/83, "General Requirements for Plant Maintenance Programs"

- NPAP C-450, Rev. 2, 6/4/82, "Routine Preventive Maintenance--I&C Department"

- NPAP C-750, Rev. 3, 6/11/84, "Maintenance Department Preventive Maintenance Program"

- NPAP E-750, Rev. 4, 1/31/84, "Maintenance Records"

To verify that the above list of NPAP's acceptably complies with the licensee's commitments, the inspector reviewed Technical Specifications (TS), Section 6, and Final Safety Analysis Report (FSAR), Section 17. The inspector observed various preventive and corrective maintenance items and reviewed work packages to verify the licensee's procedures are being implemented during the performance of work as well as during document preparation and review.

No violations or deviations were identified.

d. Startup Test Program Review

STP 40.0 "Startup Program Master Document' was also reviewed by the inspector to assure that the licensee had specified appropriate power ascension tests. The inspector's review indicated that several tests, specified by regulatory guidance documents, were not incorporated into the licensee's Startup Test Program. These tests included reactor internals vibration monitoring during transient operation, verification of correct process computer function, and demonstration of the plant's dynamic response for the case of closure of all main steam line isolation valves. In discussions with the licensee, the licensee indicated that the additional tests would be considered for incorporation into the Startup Test Program. Resolution of this item will be followed as open item (84-26-03).

6. Independent Inspection

a. Simulator Training

The inspectors observed selected portions of licensed operator training on the plant specific simulator. Training included operator response to control system malfunctions and design basis accidents. Operator response was timely and in accordance with operating and/or emergency procedures.

No violations or deviations were identified.

b. Communicating Lessons Learned to Operational Staff

The inspector reviewed and assessed the licensee's program for transmitting lessons learned, to personnel of all operating shifts. Lessons learned, important enough to necessitate dissemination among operations personnel, were categorized into two distinct areas: 1) information pertinent to existing or imminent plant conditions which would require the prompt attention of all operating shifts to assure continued safe and consistent plant operation; and 2) information germane to the plant, coming as a result of industry and/or regulatory experience, which warrant operator awareness so that improvements or preventive measures can be established to benefit future plant operations.

Both of the above areas are addressed in the licensee's program to communicate lessons learned from on-site or off-site sources. At present there are no operating procedure instructions or administrative controls in effect to implement this program. The General Operating Foreman (GOF), in conjunction with the training department, have the primary responsibility for assuring distribution of important information among all operating shifts. SFM memos, shift orders and interdepartmental procedures are generated by the GOF. These management tools are used to transmit information identified as type (1) above. Generally, such topics as operator errors, operational occurrences, department policy or interpretation, special test requirements, TS changes, etc. are addressed. It then becomes the SFM's task to ensure that shift personnel are adequately briefed. Type (2) information such as Licensee Event Reports (LER), Design Change Notices, Non Conformance Reports, NPO Memos, Regulatory Bulletins and Reports, etc., are incorporated by the training department into regularly scheduled lesson plans. Training attendance is mandatory for operations personnel on a rotating five shift basis. Furthermore, the GOF meets with the training shift once a week, as part of the training schedule, to discuss plant status and recent events.

Although methods for disseminating important lessons learned have not been formally prescribed, this does not appear to detract from their effectiveness. The active participation of operations management and the training department to communicate lessons learned among operating shifts was apparent. These efforts seem reasonable to the inspector. Continued scrutiny in this area will be conducted during the power ascension test program as part of the routine inspection program.

No violations or deviations were identified.

c. Quality and Effectiveness of Facility Training for Licensed Staff

Due to the similarity between Unit 2 and Unit 1, the licensee's training department has developed and implemented a Unit 2 qualification training program based solely upon existing differences between the two units. A written package was submitted to the NRC Region V Operator Licensing (OL) division describing all significant control room and plant design differences, along with cross-connected or shared systems, which could impact upon plant operations. An agreement has been reached between the licensee and Region V OL that certification of operators for Unit 2 would consist of oral and written examinations administered to qualified Unit 1 operators on specific unit differences. This is in lieu of the usual comprehensive, initial qualification examination process by giving allowance for unit similarity.

Although Unit 1 licensed personnel have, by-in-large, completed all Unit 2 differences training, cross-qualification to Unit 2 was not expected until experience has been generated with Unit 1 at power levels exceeding twenty percent. Due to full power licensing delays of Unit 1, the schedule for Unit 2 operator examinations was questionable. Quality and effectiveness of Unit 2 and Unit 1 qualification training will be assessed later by the inspector in much greater detail within the planned routine inspection program. This will include a closer evaluation of the licensee's program to exploit the new on-site simulator as an integral part of initial and requalification training.

No violations or deviations were identified.

d. Class 1 Material Storage Area

On August 7, 1984, an inspector observed that access to a General Construction (GC) Foley contractor Class 1 material storage area did not appear to be controlled. The inspector entered the storage area (a valve maintenance warehouse), and for a period of approximately 15 minutes, gained unobstructed access to the materials in storage. Unable to locate any warehouse personnel, the inspector then left the warehouse to discuss his observations with Foley valve maintenance personnel and individuals from the licensee's QA/QC organization.

The licensee is committed to ANSI N45.2.2-1972 "Packaging, Shipping, Receiving, Storage and Handling of Items for Nuclear Power Plants...," which specifies that "access to storage areas is to be controlled and limited only to personnel designated by the responsible organization." However, the inspector observed that the GC QC Manual does not specify that access to these storage areas is to be controlled. In discussing this situation with GC QC management, the inspector was informed that the GC QC Manual was already being revised to correct this omission. Additionally, the inspector verified that access control to the Foley valve maintenance warehouse was established. Accordingly, these corrective actions were deemed to be acceptable.

While touring the Foley valve maintenance warehouse, the inspector observed that stored material was not identifiable and traceable to procurement documents. In response to the inspector's observation, the licensee removed all unidentified material form the warehouse and conducted QC surveys of other Class 1 material storage areas, to assure material traceability. Considering that 1) the valve maintenance warehouse was in a transitional stage at the time of the inspection, 2) the stored materials did not require high levels of protective measures to prevent damage, deterioration or contamination, and 3) the licensee's extensive corrective actions, this issue is also considered to be resolved.

Under the routine inspection program, the inspectors will continue to monitor the licensee's performance in these areas.

No violations or deviations were identified.

e. Work Planning

The licensee is presently developing an integrated work scheduling system. Although still being refined, the work schedule being used includes preventive maintenance tasks, surveillance tests, corrective maintenance tasks which are schedulable, and infrequent operational evolutions requiring interdepartmental coordination. Work scheduled by the Electrical, Mechanical, I&C, Chemistry and Radiation Protection, Security, Engineering, and Operations departments have been incorporated in this schedule. During this inspection period, an inspector observed portions of the initial implementation of the work scheduling system by attending weekly scheduling meetings, reviewing schedules, and observing interdepartmental coordination of work performed. The inspector will continue to monitor the implementation of the work schedule during future inspections.

No violations or deviations were identified.

f. Quality Hotline

Eight Quality Hotline, Quality Concern Summary Reports were reviewed to assure that the Qaulity Hotline was addressing quality concerns. The reports, which were reviewed, dealt with quality concerns on a technical and administrative basis. The findings of the report establish causes and corrective actions. The persons that raised the concern were contacted when possible and the findings of the Quality Hotline were reviewed with them. When there was a disagreement with the Quality Hotline findings, the option to take the concerns to higher management was offered. The inspector's review of approximately 10% of the concerns identified to the Quality Hotline showed that Quality Hotline personnel acceptably followed their procedures for implementation of this program.

No violations or deviations were identified.

g. Senior Management Involvement in Operations Activities

The inspectors and other regional staff personnel have been observing licensee senior management involvement in day-to-day operations activities. Through low power physics testing, senior management was on shift to provide management direction. On a day-to-day basis, managers have been involved in site operations. The importance of management involvement has been discussed with the Manager of NPO and the Plant Manager. They agree that management attention is important and have implemented policies to assure continued attention in this area, (e.g., required plant management presence and active questioning of plant staff).

h. QA Trending System

Section 2 g of NRC Inspection Report 275/84-21 described the licensee's development of a QA trending system. Since that time, the licensee has issued Quality Assurance Department Procedure QADP-16.2 "Quality Management Reporting System" which prescribes methods for accumulating, documenting and reporting information required to assess the status, adequacy and effectiveness of the QA Program. Aspects of this QA Program examined by the inspector included the accumulation and verification of trend data, data evaluation, and reporting of trend results.

Data for trending is obtained from documents such as Nonconformance Reports, Audit Reports and Management Review Reports. Trend analyses of events with potential adverse impact on the QA program are subsequently generated utilizing a "Statistical Analysis System" (computer system). Trend analysis reports are prepared quarterly and annually. They are used to describe identified trends, highlight possible problem areas, and report on the status of previously identified trends. The approved report will be distributed to the Executive Vice President, Facilities and Electric Resource Development, the members of the General Office Nuclear Power Plant Review and Audit Committee, and affected department heads.

No violations or deviations were identified.

7. Open Item Followup

a. Use of Ultrasonic Testing (UT) for Stainless Steel Pipe Non-destructive Examination (Closed 83-26-01)

The licensee reviewed their program for acceptance of stainless steel pipe welds and determined the program was adequate to assure proper weld dimensions. Furthermore, the licensee conducted a test to verify acceptable UT deviations for an appropriate range of pipe sizes and schedules. These reviews and tests were examined by the inspector. This closes open item 83-26-01.

No violations or deviations were identified.

8. LER Follow-up

Circumstances and corrective actions described in LERs, as listed below, were examined by the inspectors. The inspectors found that these LERs have been reviewed by the licensee and were reported to the NRC within acceptable reporting intervals. The inspectors also verified selected corrective actions had been taken. Accordingly, these LERs are considered closed.

LER No. 84-17: Due to a typographical error in a STP, an incorrect action statement for failure of the plant vent iodine and particulate flow rate monitor was entered. There were no radioactive releases that would have required completion of the action statement. The error was corrected and operations' personnel reviewed TS action statements related to this equipment.

LER No. 84-18: Actuation of the control room ventilation pressurization mode resulted from failure of a turbine building radiation monitor. The instrument was repaired and returned to service.

LER No. 84-19: This LER topic was covered in report number 50-275/84-22.

LER No. 84-20: Start of the swing diesel generator was caused by a construction worker inadvertently jarring a relay panel on Unit 2. Corrective action included defeating Unit 2 inputs to the diesel, until Unit 2 fuel load.

LER No. 84-21: An inadvertent safety injection was caused by a failure of a steam generator level control valve. Repair and corrective action was considered acceptable to prevent recurring failures.

LER No. 84-22: This LER was covered in report number 50-275/84-22.

No violations or deviations were identified.

9. Exit Meeting

On September 7, 1984, an exit meeting was conducted with the licensee's representatives identified in paragraph 1. The inspectors summarized the scope and findings of the inspection as described in this report.