U. S. NUCLEAR REGULATORY COMMISSION
REGION I

Docket/Report No.: 50-443/92-13 **License No.:** NPF-86

Licensee: North Atlantic Energy Service Company

Facility: Seabrook Station, Seabrook, New Hampshire

Dates: June 16 - July 27, 1992

Inspectors: N. Dudley, Senior Resident Inspector
D. Lew, Project Engineer

Approved By: _____ 8/18/92
William J. Lazaris, Chief, Reactor Projects Section 3B Date

OVERVIEW

The operators safely operated the facility. However, two different operating crews violated Technical Specifications associated with removal of a diesel generator from service while the other diesel generator was tagged out for maintenance.

The Station Manager implemented corrective actions for a previous violation involving management of overtime, but nonetheless routinely authorized overtime which exceeded overtime guidelines. The guidance was subsequently revised and clarified by the Station Operations Review Committee.

Maintenance, surveillance, radiological, and security activities were well controlled and conducted in accordance with program requirements.

Compensatory actions for a vital area barrier opening of questionable dimension were appropriate.

Timely engineering reviews of NRC Information Notices and nuclear industry experience led to Technical Specification waiver requests for surveillance testing of emergency bus undervoltage logic circuitry and reactor protection manual trip circuitry. The Technical Support engineering evaluation and corrective action for failed bolts on Tufline valve covers reflected a good safety perspective.

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DETAILS

1.0 SUMMARY OF ACTIVITIES [94702]

1.1 NRC Activities

One resident inspector was assigned. The inspector conducted backshift inspections on June 22, June 23, June 24, June 26 and deep backshift inspections on June 28 and July 4.

On June 15-19, a region-based inspector conducted a review of health physics instruments and programs. The results of the review were documented in NRC Inspection Report 50-443/92-14.

On June 15-19, a region-based inspector conducted an inspection to closeout items from the Maintenance Team Inspection. The results of the inspection were documented in NRC Inspection Report No. 50-443/92-12.

On June 26, the Region I Deputy Regional Administrator, the responsible Branch Chief for Seabrook, the State Liaison Officer, and the Senior Resident Inspector met with the New Hampshire Public Utilities Commission to discuss issues of mutual interest.

On June 26, the Regional Administrator approved a waiver request for the conduct of an 18-month surveillance test on the undervoltage relays for electrical breakers connecting offsite electrical power to the emergency buses.

On June 29, the responsibility for the management, operation, and maintenance of Seabrook Station was transferred from the New Hampshire Yankee Division of Public Service of New Hampshire to the North Atlantic Energy Service Corporation (North Atlantic). On May 29, the NRC had approved the transfer of 35.6% ownership interest in the Seabrook Station, from the Public Service Company of New Hampshire to North Atlantic Energy Company, a wholly owned subsidiary of Northeast Utilities. The NRC also had approved the transfer of operations and maintenance of Seabrook Station from the Public Service Company of New Hampshire to North Atlantic Energy Service Company, a wholly owned subsidiary of Northeast Utilities.

On July 16-24, a region-based inspector conducted routine inspections. The results of the inspections are documented in this report.

1.2 Plant Activities

The plant operated at 100% power until June 27 when power was reduced to 78% to conduct weekly turbine valve testing. Operators returned power to 100% the same day.

2.0 OPERATIONS [71707, 71710, 92702]

2.1 Plant Tours

The inspectors conducted daily control room tours, observed shift turnovers, and attended plan-of-the-day meetings. The inspectors reviewed plant staffing, safety tagging orders, safety system valve lineups, and compliance with Technical Specification requirements. Routine tours were conducted of safety related equipment, the turbine building, the waste handling building, the circulating water building, and the pipe chases.

The Operations and Maintenance Departments continued to reduce the number of outstanding tagging orders older than one year and the number of alarms displayed on the video alarm system (VAS) screens. Over the last six months electricians repaired six spare breakers and removed the six associated tagging orders, some of which had been in place since 1986. Instrument and Control technicians repaired failed instrument channels and installed jumpers to bypass continually alarming VAS channels after engineers and operators reviewed and approved the removal of the alarm function. The inspector reviewed the VAS alarm bypass log and determined that operators documented adequate justifications for removal of alarm functions.

On June 25, the Shift Superintendent started a third condensate pump to increase feedwater pump suction pressure which had gradually decreased due to the degradation of the operating condensate pumps. Six hours later, the operators secured the condensate pump due to high temperature in the motor thrust bearing. Maintenance technicians found that the pump casing had dropped onto the impeller when all the casing bolts failed. Maintenance technicians replaced the failed pump and the operators started the condensate pump on June 29.

On June 27 the operators reduced power to 78% to assure that main feedwater pump (MFP) suction pressure stayed above the MFP trip setpoint during weekly turbine generator valve testing. Operators restored power to 100% following successful completion of the testing.

On June 27, a lightning strike on site disrupted fire and security panels. The Shift Superintendent initiated immediate compensatory actions and short term troubleshooting activities.

On July 20, the three reciprocating air compressors were operating due to repairs to the Centac air compressor. Reciprocating air compressor A failed and a check valve failed to reseat, causing instrument air header pressure to drop to 55 psig. Some air operated feedwater heater level control modulating valves failed shut. The operators reduced power to 97% to stabilize reactor power and started the Atlas Copco diesel driven air compressor to restore instrument and service air header pressure. The Operation Department rented two additional Atlas Copco air compressors to provide a primary source of instrument air until the Centac compressor was returned to service.

The inspector concluded that the operators safely operated the plant and responded well to equipment failures which had the potential to cause a reactor trip.

2.2 Diesel Generator Technical Specifications

On June 17, operators tagged diesel generator B out of service in order to conduct maintenance and to perform pre-outage inspections of two cylinder liners. The Shift Superintendent entered Technical Specification 3.8.1.1, "A.C. Sources," which required verifying the operability of offsite electrical power circuits every 8 hours and verifying operability of diesel generator A within 24 hours by performing Technical Specification surveillance 4.8.1.1.2a.5. During the subsequent post maintenance operability test, the operators terminated the test when the auxiliary jacket water coolant pump started unexpectedly. Maintenance technicians and Technical Support engineers began troubleshooting and repair activities.

After entering Technical Specification 3.8.1.1 for diesel generator B, the Work Center Coordinator reviewed and the Unit Shift Supervisor approved calibration of the pressure switch on the ventilation fan for the train A charging pump room. Unbeknownst to the Work Center Coordinator and Unit Shift Supervisor, the work caused the A train of Containment Enclosure Emergency Air Cleanup system (EAH) to be inoperable in violation of Technical Specification Action Statement 3.8.1.1.c.1. The action statement required all systems that depend on the remaining diesel generator for emergency power be operable whenever the other diesel generator is inoperable. Approximately 1 1/2 hours later, the Shift Superintendent noted the violation of the Technical Specifications and directed the maintenance workers to restore fan operability. The fan had been inoperable for approximately 3 1/2 hours.

There was a minimal safety consequence as a result of this event. The ability to manually start the "A" charging room fan was maintained throughout the event; if the fan had not started when required, the status panels and emergency operating procedures would have directed the operators to start the fan manually. Secondly, the inoperability of this fan would not prevent the overall EAH system from maintaining a negative pressure in the containment enclosure ventilation area in the event of design basis accident (DBA). Finally, the high head injection pumps would not be exposed to potentially contaminated coolant that could leak into the charging pump room until 6 hours after a DBA. Therefore, the potential for an unmonitored radioactive release was minimal. The condition existed for a relatively brief period of time before being identified and corrected by shift supervision. The event was appropriately reported in LER 92-07 on July 17, 1992, and included adequately focused corrective actions.

On June 18, the oncoming day shift crew identified that the required diesel generator A operability surveillance had not been performed within 24 hours of taking the other diesel operator out of service. The Shift Superintendent directed the control room operators to conduct the surveillance, and entered Technical Specification 3.0.3, "Limiting Conditions for Operations," which required the plant to be placed in Hot Standby within the next six hours. The operators completed the diesel generator surveillance within 30 minutes and exited Technical Specification 3.0.3 without initiating a plant shutdown. Mechanics completed repairs to the cooling water jacket system and operators successfully completed the post maintenance operability test.

The inspector reviewed the Operations Management Manual, held discussions with the Operations Manager, and observed portions of the maintenance on diesel generator B. The operators understood the requirements of the action statements and knew that diesel generator B was

inoperable. However, they failed to fully appreciate the impact of the pressure switch calibration on the charging pump room fan operability. Program requirements existed for identifying, tracking, and documenting Technical Specification action statement requirements. But, these failed to prevent the late surveillance. The Operations Manager stated that the handling of the Technical Specification requirements needed improvement and that several different operator aides for tracking Technical Specification Action Statement requirements were being evaluated. The inspector concluded that the failures to comply with Technical Specification action statements 3.8.1.1.a and 3.8.1.1.c represented two violations of Technical Specification requirements. (NOV 92-13-01 and 92-13-02)

2.3 Engineered Safety Features Walkdown

The inspector conducted a valkdown of the Residual Heat Removal (RHR) system and verified the positions of valves, switches, and breakers both remotely and locally. The last valve lineup for the system showed hot leg suction valves to the RHR system (RC-22, 23, 87, and 88), and RHR supply valves to the hot legs (RH-59 and 61) in positions different than required for power operations. Operators subsequently shut and removed power from the hot leg suction valves when performing operations procedure OS 1013.05, "RHR train A shutdown." Operators marked RH-59 and RH-61 as exceptions on the valve lineup sheet based on maintenance activities. Following maintenance, operators cleared the danger tag and locked open the valves as required. Operators also performed an independent verification using the locked valve list as part of the containment closeout.

The inspector reviewed the calibration data for the RHR pump discharge pressure gauges and the inservice inspection (ISI) program for verifying the integrity of the RHR piping. The ISI program required a functional test every 10 years of service for all class 1 and 2 piping systems. The RHR system is a class 2 system and was scheduled for inspection during the third refueling outage. The inspector reviewed the results of the safety injection system functional inspection conducted by the Engineering Department during the first refueling outage. The inspection was thorough and well documented. No discrepancies were noted. The inspector concluded that the RHR system was able to perform its safety function and that effective configuration control, instrument calibration, and ISI programs were being implemented.

2.4 Management of Overtime: Notice of Violation 92-05-01 (Open)

North Atlantic responded to the Notice of Violation on management of overtime issued in NRC Inspection Report 50-443/92-05 in a letter (NYN-92075) issued on June 4, 1992. North Atlantic determined the cause of the violation was inadequate implementation of Seabrook Station Management Manual (SSMM), Chapter 2, concerning the policy for Working Hours. Shift crews changing from 8 hours shifts during the week to 12 hour shifts during the weekends routinely exceeded the overtime guidelines without obtaining the required Station Manager's permission. To preclude recurrence of the event, the Operation's Manager issued a night order directing the shift crews to adhere to the established 11:00 a.m. to 11:00 p.m. weekend schedule, which did not violate overtime guidelines. The Operations Manager revised the shift schedule form to delineate the exact working hours for a 12 hour shift, enhanced the program for tracking working hours, and developed a procedure to control shift schedule changes.

The inspector reviewed the Operation Manager's night order, the revised shift schedule form, and the overtime hours worked by station personnel over a two week period. The inspector determined that the SSMM procedure guidance was followed; however, at least thirty-two people received the Station Manager's authorization to exceed the overtime guidelines during the two week period.

The Station Operations Review Committee (SORC) approved a revision to SSMM, Chapter 2, which delegated the Station Manager's authority for approving exceeding overtime guidelines to the Operations Manager for routine shift exceedances on weekends. Due to confusion during implementation of the new revision, two shift firefighters, who do not perform work on safety related equipment, exceeded overtime guidelines without receiving documented authorization. After the NRC raised questions concerning the authorization for exceeding overtime guidelines on a routine basis, the SORC rescinded the revision to SSMM, Chapter 2.

The inspector determined that even though corrective actions were in place to manage the use of overtime, exceedences of overtime guidelines were routinely approved. This violation remains open pending resolution of NRC concerns on shift schedules and the routine use of Station Manager's overtime approvals.

3.0 RADIOLOGICAL CONTROLS [71707]

The inspector conducted tours of the Radiologically Controlled Area (RCA) to verify that radiation protection requirements and practices were implemented. Areas reviewed during the tours included radiation postings and surveys, radiation monitoring equipment calibration, contamination control practices, locked high radiation doors, and radiation work permits. Additionally, the inspector used a calibrated radiation survey meter and independently verified that the radiation levels specified by radiation postings and surveys accurately reflected plant conditions. The inspector noted no deficiencies in the areas reviewed. Based on these tours and observations, the inspector concluded that Seabrook was appropriately implementing their radiological controls program.

4.0 MAINTENANCE/SURVEILLANCE [61726, 62703, 61700]

4.1 Maintenance

The inspector attended morning meetings of the mechanical, electrical, and I&C maintenance managers, observed the performance of maintenance activities, and reviewed the work packages for selected activities. The maintenance work observed or reviewed included work covered by the following work requests:

92W2923	Steam Generator 'D' Feedwater Isolation Valve
92W2935	NI-44 Rate Trip on UL-6

The responsible Maintenance supervisor or Technical Support engineer provided pre-work briefings to maintenance and operations personnel. The work packages at the job sites contained the directions, procedures, and forms necessary to perform the work. The completed work packages contained descriptions of the completed work, configuration control forms, and completed post maintenance test results. The inspector concluded that maintenance activities were well controlled, coordinated with other departments, and properly documented.

The inspector observed an examination of emergency diesel generator (EDG) "B" cylinders 2 and 5. Workers performed the inspection using a boroscope and remote camera to determine if scoring of the cylinder liners had occurred due to the cylinders running at higher than normal pressures. The higher pressures were caused by several exhaust leaks that lowered the efficiency of the turbocharger. The examination revealed no signs of cylinder scoring or piston damage which validated the determination that the diesel could be operated at its current pressure (1380 psi) until the next refueling outage without excessive engine damage. The vendor had previously provided data showing that the diesel could be operated at pressures as high as 1400 psi for 30 continuous days with no adverse effects.

The Technical Support engineer conducted a pre-job briefing that covered all aspects of the work. A Technical Support supervisor was at the work site and verified the adequacy of the work prior to proceeding. The maintenance workers followed the work procedure and employed appropriate safety measures in a disciplined manner. The inspector noted one minor tagout error which was corrected by the Work Center Supervisor.

While the EDG was tagged out, mechanics replaced a discharge check valve on the air compressor and adjusted the belt tension of the compressor. The mechanics noticed errors in the procedure and the tagout. They corrected the procedure to reference a technical manual requirement vice a general alignment procedure, and corrected the tagout to clear a tag on a component that needed to be removed. Both of the changes were properly implemented.

The technicians found the check valve internals eroded and replaced the valve. Due to two evious check valve failures, the system engineers initiated a root cause analysis of the failure. e inspector noted that the technicians were knowledgeable of station maintenance procedure uirements and that the Technical Support engineer promptly recognized the need for a nponent level root cause analysis.

Surveillance

spector observed the performance of portions of surveillance and calibration procedures, scussions with cognizant personnel, and reviewed completed work requests and repetitive cets.

During performance of surveillance procedure IX 1680.922, "Solid State Protection System Train-B Actuation Logic Test," the I&C technicians received unexpected test light indications. After discussions with the I&C supervisor, the Technical Support engineer, and the Shift Superintendent, the I&C technicians returned the train to normal and tripped the affected bistables as required by Technical Specifications. The technicians identified and replaced a failed relay, and completed procedure IX 1680.922, to establish system operability and meet surveillance testing requirements.

The Technical Support engineer scheduled a calibration of the feedwater header pressure transmitter, FW-PT-508, based on the performance monitoring program indicating a continued instrument drift. The transmitter provided an input into the feed flow portion of the feedwater regulating valve control circuit. As a result of the calibration, the feedwater regulating valves closed about 5%, resulting in a reduced speed of the main feedwater pumps.

During performance of the monthly rod operability surveillance, the operators identified problems with the local readout of control bank D position indication. The Technical Support engineer determined that the local position indicator affected the operability of the rod sequencer. The I&C technicians, Technical Support engineer, and the I&C Supervisor identified and corrected the problem.

The inspector noted that surveillance tests were effective in identifying equipment problems and that good interdepartment cooperation resolved the problems. The inspector concluded that the surveillance program was well planned and implemented.

5.0 SECURITY [71707]

The inspector toured the protected and vital areas of the plant. In general, the security plan and procedures were appropriately implemented. On several occasions, prompt response to security alarms was noted. Security personnel initiated compensatory actions as required for maintenance activities and equipment failures. The inspector observed the proper operation of access control equipment and the appropriate implementation of access control measures. The inspector determined that fitness for duty pre-employment and random testing failures were handled in accordance with program procedures.

The inspector observed a vital barrier opening which contained an apparent large dimensional tolerance. This condition was brought to the attention of the licensee, who implemented appropriate compensatory actions until the size of the opening was reduced. The dimensional adequacy of this opening is unresolved pending review of the licensee's initial design, installation and permanent resolution of the barrier. (92-13-03)

6.0 EMERGENCY PREPAREDNESS [71707]

On July 3, the Shift Superintendent declared an Unusual Event when a fire inside the security fence lasted for greater than 10 minutes. An Atlas Copco portable diesel-driven air compressor used for sand blasting the exterior stairs to the component cooling tower caught fire. The station fire brigade responded to the fire and extinguished the flames in 11 minutes. The air compressor

was located outdoors. No structures or plant equipment were affected by the fire. The Town of Seabrook Fire Department was not required. The Operations Department procured a replacement air compressor the same day.

The inspector reviewed the shift logs and the Incident Response Notification Work sheets, and held discussions with Operations personnel, and observed a video tape of the event. The inspector determined that the Shift Supervisor had properly classified the event and completed the required notifications.

The security surveillance system recorded the fire and fire brigade response on video tape. The Operations Department planned to critique the response and to use the video tape as a training tool for future firefighter training. The Emergency Preparedness Department planned to review and critique the event due to problems with communicating the termination of the Unusual Event to station responders.

7.0 ENGINEERING/TECHNICAL SUPPORT [37700, 61700, 71707]

7.1 Diesel Surveillance Waiver

During a review of NRC Information Notice 92-40, "Inadequate Testing of Emergency Bus Undervoltage Logic Circuitry," a North Atlantic licensing engineer determined that undervoltage relays on the offsite power feed breakers to the emergency buses had not been properly surveilled. During normal surveillance testing the offsite feed breakers was manually opened to initiate the test, thereby preventing evaluation of the undervoltage circuitry to open the feed breakers. Failure of a normally closed feed breaker to open automatically in response to a loss of offsite power could prevent the emergency diesel from automatically energizing the emergency bus.

North Atlantic Energy Service Company (North Atlantic) requested a temporary waiver of compliance from the requirement to perform a loss-of-offsite power test in a letter (NYN-92085) to the NRC issued on June 26, 1992. The request was based on equivalent testing of the undervoltage relay circuitry having been performed during the Preoperational Test Program in 1986, the Power Ascension Test Program in 1990, and an operational event in June, 1991. North Atlantic committed to change surveillance test procedures EX1804.001 and EX 1804.015 to require that an appropriate test of the emergency bus undervoltage logic circuitry be performed as part of the loss-of-offsite power test. North Atlantic also initiated compensatory actions which included prohibiting unnecessary activities in the switchyard or electrical distribution panels and notifying Operations personnel of the waiver and compensatory actions.

The NRC reviewed the waiver request and held discussions with North Atlantic managers and engineers. A letter was issued by the NRC on June 30, 1992 which confirmed the granting of the waiver until the successful completion of the test during the refueling outage commencing no later than September 7, 1992, or the next time the plant entered Mode 5. The inspector reviewed Operations Department's standing operating order number 92-017 and held discussions

with licensed operators. The inspector determined that the compensatory actions were
and well understood by the operators. The inspector also noted that North Atlantic identified
requested a waiver for the inadequate surveillance of the undervoltage circuitry within a month
of the issuance date of the Information Notice.

7.2 Cracked Bolts

North Atlantic identified several broken bolts on three-inch valve covers in the Chemical Volume and Control System (CS). These valves were supplied by Tufline, the company that had procured the failed bolts from Texas Bolt. The covers for these valve are held down to the valve body by four bolts. A Station Information Report, SIR No. 92-35, was initiated to address the immediate concerns and long term corrective actions.

North Atlantic conducted an inspection of 134 Tufline valves and identified additional valves affected in the Waste Processing Liquid Drain System (WLD) and the Liquid Waste System (WL). Six valves were identified which contained either loose, broken or missing bolts. Three of these valves were identified with one loose bolt; two of these valves were identified with two broken or missing; the remaining valve was identified with three of the four bolts missing. The licensee planned to inspect 90 additional Tufline valves in the spent fuel pool cooling system, boron recovery system, and the secondary component cooling water system.

Although these bolt failures had minimal impact on reactor safety, the failure of these valves would be a concern with respect to personnel safety and the containment of radioactive material. Consequently, the licensee promptly inspected and appropriately prioritized the inspection of the valves. Prompt action was taken to install a "strong back" on the valve with the three broken bolts. The inspector's review of the work activity documentation indicated that appropriate precautions were taken during the installation of the "strong back." The licensee took an additional precaution to install "strong backs" on boundary valves for highly radioactive resin lines, which did not have any broken or loose bolts, pending replacement of the installed bolts.

The licensee sent the failed bolts to Yankee Atomic for causal analysis. The review indicated that the bolts failed as a result of stress corrosion cracking. All the bolts which failed were marked as B6TB and supplied by Texas Bolt. The B6TB bolts were made of similar material, experienced the same stresses, and were exposed to the same environment as other bolts, but were determined to have a higher Rockwell hardness. The B6TB bo't material (193-B6) was identified to be within material specification; however, the hardness of the bolts was above the

[illegible] planned to replace all the bolts on the 134 valves with stainless steel bolts that are [illegible] stress corrosion cracking due to a different grain microstructure. The Nuclear [illegible] (NQG) conducted inspections of both the failed and intact bolts, and [illegible] Material Test Reports supplied by Tufline. The failed bolts were [illegible] by Texas Bolt. The NQG evaluation was continuing as [illegible] planned to review the reportability of this event

with licensed operators. The inspector determined that the compensatory actions were enacted and well understood by the operators. The inspector also noted that North Atlantic identified and requested a waiver for the inadequate surveillance of the undervoltage circuitry within a month of the issuance date of the Information Notice.

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North Atlantic planned to replace all the bolts on the 134 valves with stainless steel bolts that are less susceptible to stress corrosion cracking due to a different grain microstructure. The Nuclear Quality Assurance Group (NQG) conducted inspections of both the failed and intact bolts, and reviewed the bolts' Certified Material Test Reports supplied by Tufline. The failed bolts were all traced to one heat of bolts supplied by Texas Bolt. The NQG evaluation was continuing as of the end of this inspection. North Atlantic planned to review the reportability of this event

under 10 CFR Part 21 requirements. Overall, North Atlantic's actions in response to the bolt failures were noteworthy and reflected a good safety perspective. Prompt action was taken to identify the scope of the problem, to assess the potential safety significance, to compensate for identified problems and to determine the cause of the cracking.

7.3 Reactor Coolant Pump Undervoltage Trip

After reviewing Westinghouse Technical Bulletin NSD-TB-92-03.RO, "Undervoltage Trip Protection," a Technical Support engineer identified the potential for exceeding the response time in Technical Requirements for reactor coolant pump undervoltage. Exceedance of the response time could result in violation of Technical Specification 3.3.1, "Reactor Trip System Instrumentation." The Engineering Department determined that, due to the inappropriate exclusion of the time delay for the emergency bus voltage to fall to the setpoint for actuating the Reactor Coolant Pump (RCP) undervoltage relay, the total response time measured during surveillance testing could have exceeded the acceptance criterion of 1.5 seconds.

The inspector reviewed Westinghouse Technical Bulletin NSD-TB-92-30-RO, Technical Specification 3.3.1, Procedure EX1806.001, "RPS and ESFAS Response Time Summation Procedure," the Technical Requirement and Westinghouse's letter dated July 1, 1992. The inspector held discussions with Engineering, Operations, and Licensing personnel. North Atlantic determined, after reviewing loss-of-offsite power testing data and surveillance results that, in all cases, the total response time for the RCP undervoltage trip was within the required 1.5 seconds. North Atlantic planned to change the affected surveillance procedures to include the time delay in the calculation for the total response time. The inspector concluded that appropriate priority was assigned to resolve the potential for violating a Technical Specification acceptance limit.

8.0 VERIFICATION OF PLANT RECORDS: TI 2515/115 (Closed) [92720]

On March 1, 1992, New Hampshire Yankee (NHY) identified problems with an auxiliary operator's performance. Subsequently, NHY conducted a self-monitoring program to determine the extent of the initial problem. NRC Inspection Report 50-443/92-08 documented an inspection of NHY initial findings and corrective actions. NHY submitted a letter (NYN-92045) to the NRC on April 10, 1992 which reported the results of its assessment of the Auxiliary Operator watchstander performance concerns. Additional NRC inspections and assessments of the NHY self-monitoring program are documented in NRC Inspection Reports 50-443/92-05 and 92-09. Therefore, this Temporary Instruction was addressed and is closed.