

U.S. NUCLEAR REGULATORY COMMISSION

REGION V

Report No: 50-397/84-31

Docket No: 50-397

License No: NPF-21

Licensee: Washington Public Power Supply System
P. O. Box 968
Richland, Washington 99352

Facility Name: Washington Nuclear Project No. 2 (WNP-2)

Inspection at: WNP-2 Site near Richland, Washington

Inspectors:

P. H. Johnson
for A. D. Toth, Senior Resident Inspector

12/3/84
Date Signed

P. H. Johnson
for R. S. Waite, Resident Inspector

12/3/84
Date Signed

Approved by:

P. H. Johnson
P. H. Johnson, Chief
Reactor Projects Section 3

12/3/84
Date Signed

Summary:

Inspection on October 1 - November 2, 1984 (Report No. 50-397/84-31)

Areas Inspected: Routine, unannounced inspection by the resident inspectors of control room operations, engineered safety feature status, surveillance program, maintenance program, power ascension test program, and licensee action on previous inspection findings.

The inspection involved 239 inspector-hours onsite by two resident inspectors, including 70 hours of backshift/weekend inspections, plus 24 inspector-hours onsite by two regional office management personnel.

Results: No items of noncompliance were identified.

DETAILS

1. Persons Contacted

Washington Public Power Supply System

+D. Bouchey, Director of Support Services
*R. Corcoran, Operations Manager
*K. Cowen, Technical Manager
*J. Landon, Maintenance Manager
*+J. Martin, Plant Manager
+M. Monopoli, Manager of Quality Assurance Operations
J. Peters, Administrative Manager
P. Powell, Licensing Manager
*+C. Powers, Assistant Plant Manager
J. Shannon, Director of Power Generation
+J. Sorensen, Manager of Regulatory Programs
*+D. Walker, Plant Quality Assurance Manager
M. Wuesterfeld, Reactor Engineering Supervisor

The inspectors also interviewed various control room operators, shift supervisors and shift managers, engineering, quality assurance, and management personnel relative to activities in progress and records.

2. General

The Senior resident inspector and/or the resident inspector were onsite October 1-5, 9-12, 14-26, and 29-31. Backshift inspections were conducted 5:00 a.m. to 7:00 a.m. on several days. Several regional office inspectors visited the site this month for routine inspection activities. Their activities were documented in other separate inspection reports. These included:

A regional office inspector (G. Hamada) was onsite October 1-4 with the regional independent measurements van to assess licensee radiological measurement techniques.

Regional office operations inspectors (D. Willett and R. Kanow) were on site October 1-5 to review power ascension program test results.

Regional office inspectors (C. Sherman and E. Garcia) were onsite October 9-12 to review radiological program implementation.

A regional office operations inspector (D. Willett) was onsite October 22-26 to review status of previous inspection findings.

Regional office management personnel (J. Crews and A. Johnson) were onsite October 24-26 to discuss licensee/regional office relationships and corrective action plans for previous inspection findings. Activities of these managers are summarized in paragraph 10 of this report.

3. Plant Status

Test conditions 3, 4 and 5 were completed this month, with ascension to test condition 6 (100% power) commencing at the end of the month. A power level of 98 percent was achieved but continued ascension was delayed due to excessive pressure losses in the condensate system resulting in low suction pressure trips of condensate booster pumps.

4. Operations Verifications

The resident inspectors reviewed the control room operator and shift manager log books on a daily basis for this report period. Reviews were also made of the Jumper/Lifted Lead Log and Nonconformance Report Log to verify that there were no conflicts with Technical Specifications and that the licensee was actively pursuing corrections to conditions listed in either log. Events involving unusual conditions of equipment were discussed with the control room personnel available at the time of the review and evaluated for potential safety significance. The licensee's adherence to LCO's, particularly those dealing with ESF and ESF electrical alignment, were observed. The inspectors routinely took note of activated annunciators on the control panels and ascertained that the control room licensed personnel on duty at the time were familiar with the reason for each annunciator and its significance. The inspectors observed access control, control room manning, operability of nuclear instruments, and availability of onsite and offsite electrical power. The inspectors also made regular tours of accessible areas of the facility to assess equipment conditions, radiological controls, security, safety and adherence to regulatory requirements. The following items received in-depth review.

a. Electrical Shop Turnover

The inspector observed a shift turnover which was performed in the electrical shop. There was no interface between the offgoing electricians and the oncoming electricians; however, the oncoming electricians were briefed by the system engineer who had been following the work in progress. The electrical department supervisor affirmed that he expects craftsperson involvement in the turnover process and will counsel his staff in this regard.

b. High Pressure Core Spray (HPCS) Service Water System

During a daily review of activated annunciators at 5:35 a.m. on October 16, 1984, the inspector observed the "HPCS SW Freeze Protection Trouble" annunciator lit. The HPCS Service Water System is an Engineered Safety Feature. The inspector attempted to follow the response actions specified in licensee procedure 4.826.P1-4.1 but discovered two discrepancies (The subject of procedure accuracy is addressed in paragraph 9.1, below, open item 84-22-02).

- ° Procedure 4.826.P1-4.1, step 1, specifies "Verify heat trace activated by checking heat trace panel HTP-7A-A in SW Pump House 1A." The inspector observed that panel HTP-7A-A has no

visible indication available from which to determine if the heat trace is activated.

- ° Step 2 specifies "If heat trace is not operating, as indicated at the panel, restore it to normal operation. If unable to restore it to operation, initiate a maintenance work request to troubleshoot/correct the problem." The heat trace is designed to initiate at 44 F and the alarm activates at 40 F. As of 9:45 a.m. an MWR had not been initiated.

The inspector questioned the Control Room Supervisor (CRS) regarding the system's operability. At 10:45 a.m., the CRS informed the inspector that the problem had been corrected, i.e., an Equipment Operator (EO) had identified that the heat trace was activated and the proper breakers closed, but the indicating lights on the local panel were burnt out. At 12:01 p.m. the inspector toured the area with the EO. The EO observed with the inspector that indication was not available for the heat trace on HTP-7A-A. He had previously observed indication on HTP-FP-7, an unrelated heat trace panel with indication, due to miscommunication with the control room operator.

The inspector discussed the above discrepancies with the Shift Manager, who had prepared a maintenance work request (AX-6467) based upon the prior information, i.e., trace heaters were in operation but the indicator did not work. The inspector advised the Shift Manager that the indication does not exist as described in the procedure; however, the Shift Manager declined to correct the MWR to reflect this information. The inspector subsequently accompanied the responsible system engineer and two electricians who used portable instruments to ascertain that the trace heaters were in fact activated. After several days of subfreezing temperatures the system engineer advised the control room to run the HPCS service water pump (in order to prevent freezing of the line) pending correction of the heat trace problem. This action was in accordance with guidance of WPPSS Procedure 4.826.P1-4.1. At the exit meeting, the inspector identified this matter as an example that operations staff aggressiveness should be increased in assessing indications of equipment inoperability. An October 31, 1984, revision to procedure 1.3.4 now includes clarified guidance to identify and log inoperable equipment. Additionally, the assistant plant manager has issued an instruction memorandum to plant personnel to be particularly alert to technical specification action statement conditions, and night orders have been issued to emphasize this area.

c. HPCS Service Water

During a surveillance test of the HPCS Service Water system on October 17, 1984, at 5:30 a.m. the inspector observed the annunciator "HPCS DG RM CLR #32 SW FLOW LOW" lit. The inspector followed the response actions of licensee procedure 4.601.A1-6.5 and found one discrepancy. Step 3 of this procedure specifies "Verify the motor operated combined cooler and HPCS diesel engine discharge valve (SW-V-4C) open (P601)." The inspector observed that indication for SW-V-4C does not exist on P601. Upon questioning at

7:05 the CRS indicated that the indication for this valve does exist on Board N. The subject of procedural inaccuracy has been addressed as described in paragraph 9.1, below, open item (84-22-02).

d. Radwaste Control Room Logs

The inspector examined the radwaste control room log for the October 1-31, 1984 period. No unusual events were noted. In-plant transfers of sampling tanks to the condensate storage tanks averaged about six per day. Transfers of resins to the Chem Nuclear contractor for packaging averaged about three per week. There were seven releases to the river, well within the maximum permissible concentrations (less than .55 MPC) without any need for dilutions. The number of transfers appeared adequate to provide operating crew continued experience with operations of the radwaste systems. Release point radiation monitors and recorders were operable with indications within the setpoints.

No violations or deviations were identified.

5. Engineered Safety Feature Verification

The inspector verified the operability of the Residual Heat Removal System (Loop C) by performing a walkdown of all accessible portions of the system. The inspector verified that valves were in the correct positions and locked as appropriate. The inspector verified that power was available to the system by examining related switchgear and electrical panels. While trying to confirm that the licensee's system lineup procedures match plant drawings and as-built configuration the inspector noted that three valves for the suction and discharge of the water leg pump (RHR-V-82, RHR-V-85B, RHR-V-85C) were not listed in licensee procedure 2.4.8, "ECCS Manual Valve Position Verification", as requiring valve position verification. This item was presented to the licensee at the exit meeting for evaluation and will be followup item (84-31-01).

No violations or deviations were identified.

6. Surveillance Program Implementation

The inspectors ascertained that surveillance of safety-related systems or components was being conducted in accordance with license requirements. In addition to observation of, and sometimes witnessing and verifying daily control panel instrument checks, the inspectors observed portions of several surveillance tests by operators and instrument and control technicians. Typical activities included the following:

a. RCIC Operability Test

The inspector observed performance of approved procedure 7.4.7.3.3, "RCIC Operability Test," by the operations staff at a reactor pressure of 144 psig. This test was run to verify operability of the RCIC turbine and pump prior to achieving normal rated pressure conditions. The inspector observed that required administrative

approvals were obtained prior to initiating the test, that testing was performed by qualified personnel in accordance with the approved test procedure, and that technical specifications were adhered to.

No violations or deviations were identified.

b. Main Steam Line Hi Hi Flow

The inspector observed the performance of a portion of surveillance procedure 7.4.3.2.1.22D, "Main Steam Line Hi Hi Flow Channel D Channel Calibration." The inspector verified that required test instrumentation was calibrated, testing was coordinated with the control room operators, testing was conducted in accordance with the approved test procedure, and independently verified that the system was returned to service.

No violations or deviations were identified.

7. Monthly Maintenance Observation

Portions of selected safety-related systems maintenance activities were observed. By direct observation and review of records the inspector determined whether these activities were violating Limiting Conditions for Operations (LCOs), that the proper administrative controls and tagout procedures were followed, and that equipment was properly tested before return to service; and independently verified that the equipment was returned to service. The inspector also reviewed the outstanding job orders to determine if the licensee was giving priority to safety-related maintenance and that backlogs which might affect system performance were not developing. The systems selected for maintenance observation are listed below:

a. Division-A RPS Motor-Generator (MG) Set

The inspector observed work being performed on the Division-A MG Set of the Reactor Protection System by maintenance personnel. Work was being performed under a Maintenance Work Request (MWR) and was coordinated and followed by the system engineer. The work being performed required the replacement of several bearings and a motor-generator set due to high wear which had occurred on the removed unit. The inspector verified that proper administrative approvals and tagouts were obtained prior to commencement of work, that a redundant power supply was available to the RPS during the work, and that the equipment was returned to service.

b. Agastat Relay Replacement

The inspector observed a portion of a maintenance activity which involved the replacement of Agastat Relays in the Standby Liquid Control System. Work was completed by the electrical shop under the coordination of the system engineer. The inspector verified that removing the SLC system from operation was in accordance with Technical Specifications and that required administrative approvals and tagouts were obtained prior to commencement of work.

c. Control Room Emergency Filtration Isolation Valves

The inspector observed maintenance being performed on Control Room Emergency Filtration Isolation Valves WOA-V-51A, 52A, and 52B under MWR AY 3931. This work involved removal and replacement of the valve actuators. During the time the actuators were removed the valves were danger tagged out and in the open position. This system is covered by Technical Specification 3.7.2, which requires operability of this system in all operational modes. Because these valves were inoperable, entry into TSAS 3.7.2.b.2 was required at the time they were removed from service. Entry into a TSAS was not noted in the log by the Shift Manager on duty at the time the clearance order was approved nor by the end of the shift of the equipment operator who tagged out the equipment. The inspector brought this matter to the attention of the Shift Manager on duty the following shift. Investigation was done by the Shift Manager and entry into TSAS 3.7.2.b.2 was promptly logged. It appeared that the operations staff did not recognize that entry into TSAS 3.7.2.b.2 was required. On October 23, 1984, after the valves were tested and returned to service, the Shift Manager did not log exit from the TSAS. In response to the inspector's query, the Shift Manager contacted the System Engineer and verified that the valves had been tested; he then made an entry in the logs that the TSAS was exited. The inspector verified testing and return to service of the valves. The control room log procedure has subsequently been revised to clarify requirements to log entry into technical specification action statements. Implementation of the amended controls of logging entry/exit of action statements will be considered with followup of item (84-15-01, part f.).

d. Repair Pressure Relief Valve Discharge Line Vacuum Valves

The inspector interviewed the work foreman and examined work control documents for replacement of damaged and missing O-ring seals on the vacuum relief valves on the discharge lines from the pressure relief valves in the drywell. Routine surveillance activities had discovered the degraded seals, and 100 percent inspection was performed and detected defects corrected.

No violations or deviations were identified.

8. Power Ascension Test Program

The inspectors examined equipment, interviewed personnel, and reviewed records and procedures relative to conduct of the power ascension program described in Chapter 14 of the FSAR. The inspector attended the Plant Operations Committee meetings on October 3 and 17, at which Test Condition No. 3 apparent test results were presented and approved prior to management approval to proceed to the next test condition. The inspector noted that level II and level III test criteria were discussed where applicable. The inspector also interviewed the Quality Assurance Manager and Plant Technology Manager to ascertain that their participation in the meetings was supported by staff reviews. The inspector reviewed the interim report of power ascension test results for

test conditions Fuel Load, Heatup and Test Condition No. 1, noting that the licensee committed to provide some additional details of numerical test results and problems experienced, when the final report is issued.

a. Control Rod Drive Tests

During the turbine trip test at 68 percent power the licensee monitored the scram times of the four control rods of Group A which had been determined to be the slowest in that group during the heatup power ascension phase at rated pressure. The times of FSAR Section 14.2.12.3.5.4 were met, with the slowest rod reaching position 05 at 2.53 seconds.

The inspector noted that several control rods appeared to overdrive into the core, beyond the limit switches for fully inserted indication, such that rod drift and non-fully-inserted indicators illuminated. Subsequent settling of these hydraulically driven rods properly cleared the indicators. The alarm printer, rod sequence control system display, and the control board displays appeared to properly respond to the conditions. The operators adequately responded to the conditions, using all available indicators to assess the performance.

No violations or deviations were identified.

b. Recirculation Pump Trip Test

During the previous report period, on September 26, 1984, the test was performed which tripped both recirculation pumps. Test criteria involved pump inertia effects and associated flow coastdown with time. The flow coastdown for individual pumps appeared to be longer than desired. Pump A did not meet a maximum six second time constant for the full six second period established in the initial test procedure. The licensee conducted tests of the time constants involved in the flow instrumentation system and adjusted the flow criteria for each pump accordingly. The six second criterion appears to have been met with the exception that after five seconds the flow decayed to 44 percent rather than 42.3 percent at six seconds. The licensee consulted with the NSSS system designer (General Electric) and determined that the five second and six second time constants were not required beyond the initial three seconds of coastdown. A procedure deviation was issued and the tests results approved by the Plant Operations Committee prior to entry into the next plant test condition (TC-5).

No violations or deviations were identified.

c. Main Steam Isolation Valve Tests

On October 20, 1984, the inspector witnessed the individual valve closure test of the fastest main steam isolation valve (MSIV-28C) while at test condition No. 5. The inspector verified that the fastest valve (3.15 seconds travel time for closure) had been selected based upon data obtained during test condition Heatup. The

real time data plots showed that the closure time appeared to meet the level I criteria. The plant responded with a reactor water level change of less than two inches and pressure change of approximately 10 psi.

No violations or deviations were identified.

d. Core Performance Tests

The inspector reviewed the 71.7 percent (test condition No. 5) core performance printout from the process computer on October 18, 1984. This included data (Procedure 8.2.12) showing that APRM high flux setpoints had been adjusted to read thermal power consistent with heat balance data. The data showed the following compliance with technical specification thermal limits:

MCPR: 1.86
MFLPD: 0.680
APLHGR: 8.23

No violations or deviations were identified.

e. Turbine Trip Test

On October 1, 1984, the inspector witnessed the turbine trip test from 68 percent power (Test Condition No. 3 conditions). A reactor scram and recirculation pump trip occurred as expected. There was no pressure relief valve, emergency core cooling, or reactor core isolation automatic activation. Reactor water level swelled 16 inches and dropped 20 inches during the transient; pressure increased 60 psi (to 1020 psig).

The inspector ascertained that applicable criteria were identified prior to the test, the precursor tests had been conducted, proper APRM and LPRM channels were monitored as prescribed by the procedure, steps had been taken to identify the most limiting LPRM for monitoring, and operators had reviewed the abnormal condition procedure for turbine trip prior to the test. The inspector examined the on-line data plots and reviewed these with the test engineer following the test. Recirculation pump coastdown, electrical breaker arc suppression and bypass valve timing were particularly considered, in addition to the reactor pressure, level, and power transients.

During this test the engineers determined that the opening time of the bypass valves did not initially meet the criterion for 80 percent flow capacity in 0.2 second. Modifications were made to the electrical circuit for the hydraulic control valves, accumulator pressure setpoints were increased, and hydraulic system operating pressure was increased. The valves were retested at power. Examination of the retest data showed that the valves exhibited differing speeds, but the net total flow capability was achieved.

No violations or deviations were identified.

f. Reset of Average Power Range Monitor (APRM) High Level trip

The inspector examined procedures and checklists, operator logs, and scram reports, and interviewed the test engineer and other plant staff relative to circumstances of incorrect setting of the APRM low power scram setpoint.

The APRM test procedure 8.2.12 provides that for added conservatism in the startup program the APRM flow bias scram clamps should be set down to a value no greater than 20 percent beyond the maximum power level allowed for the present test condition or the highest power test condition already completed. In preparation for the next test condition at 100 percent power, the 118 percent scram trip point was reset to its full 118 percent limit. The reactor was at power with the mode switch in "Run". In accordance with a plant policy to utilize existing approved plant procedures where applicable, the test engineer instructed two technicians to reset the trip points in accordance with three specific pages of the routine APRM surveillance procedure. The technicians did not interpret that the second section of the second page was applicable and did not implement it. This second section addressed reset of the 15 percent fixed trip point for conditions when the plant mode switch is not in "Run". Unrecognized were the details of the electronic trip circuit which resulted in change of the 15 percent setpoint when the 118 percent setpoint was changed.

The setpoint adjustment was made on October 17, 1984, while the reactor was in Mode 1 (Mode switch in Run), at which time the 15 percent setpoint is not applicable by technical specifications. On October 20, at 10:25 p.m., the reactor scrammed and the mode switch was placed in Shutdown in accordance with scram procedures. The plant was in Mode 3 (hot shutdown, above 200F), and the APRM 15 percent setpoint became applicable. As part of scram recovery, prerequisite to plant manager approval for startup, IRM and APRM surveillances were initiated at about 1:50 a.m., October 21, 1984. During the APRM surveillance, the setpoints of the APRM channels were found to be 35 percent rather than the 15 percent required by technical specifications. The shift manager had the mode switch locked into shutdown at 4:49 a.m., as required by the technical specification action statement. An emergency work request was issued and the setpoints of all six APRM channels were properly adjusted by 7:45 a.m. The shift manager notified the NRC operations center in accordance with 10 CFR 50.72.

The licensee identified this matter in accordance with surveillance procedures intended to assure proper instrument setpoints prior to startup, reported this to NRC as required, took prompt corrective actions, and has initiated a review to prevent recurrence. No release of radioactivity was involved. This matter was not related to corrective actions for any previous violations of NRC regulations. A Licensee Event Report discussing this event has been submitted.

No violations or deviations were identified.

9. Licensee Actions on Previous NRC Inspection Findings

During this report period, the licensee and the resident inspector applied considerable time to address previously identified inspection issues. During management reviews with the resident inspector (and regional managers onsite the week of October 22), licensee management defined commitments to actions and reviews to complement corrective actions previously described in WPPSS letters to the regional office. These matters are discussed below with regard to specific inspection items. The Plant Manager stated that plant management planned to issue a supplemental letter to NRC by December 1, 1984, to clarify previous WPPSS replies to notices of violation, and define additional corrective actions planned relative to items 84-09-01, 84-09-03, and 84-18-03. Additionally, the inspectors reviewed records, interviewed personnel, and inspected plant conditions relative to licensee actions relative to these and other previously identified inspection findings:

- a. (Closed) Followup Item (83-60-03) - Forms/logs for documenting jumpers and lifted leads contained limited space for entry of information; also, review requirements for Shift Manager appeared overly burdensome.

The log has been revised to provide additional space for recording information relevant to the purpose of the jumpers/lifted leads, and operations affected. The Plant Operations Committee reviewed the alternatives and decided that the existing requirements for Shift Manager review of proposed installations were satisfactory. The inspector noted that the Shift Manager may delegate the details of the review (in complicated cases) to the Control Room Supervisor or Shift Technical Advisor on the operating crew or the relief crew available on-shift to support the operating crew. The current arrangement appears to be acceptable.

- b. (Closed) Followup Item (84-06-01) - Plant policies/procedures for followup on electrical grounds were not apparent.

Subsequent discussion with operations supervisors indicated that standard practices included operations staff checking of ground indicator lights on panels for subsystems, and associated attempts to isolate the fault. Such actions are prescribed by typical annunciator response instructions (e.g. Abnormal Condition Procedure (*4.800.C1-3.5 Bus 71 Ground). Each operations shift also includes electrical, instrumentation, and mechanical technicians who could be called to support the investigations and take corrective steps. The inspectors have observed operations in the control room since identification of this question, and have observed such inquiries into indications of ground faults.

- c. (Closed) Followup Item (84-06-03) - Failure to properly disable a diesel generator prior to maintenance highlighted the need for description of planned generic maintenance instructions for removal of equipment from service.

The inspector examined the maintenance procedures manual, and noted several procedures already in existence for removal and return to service of diesels, valves, motors, and pumps. Additional procedures have been added since the diesel event. Additionally, the clearance order process has been strengthened, and activities involving troubleshooting planning and jumpers and lifted leads verification are undergoing refinement, as discussed in items e, h and j below. This item is closed.

- d. (Open) Violation (84-09-01) - Containment access was made through the airlock although the mechanical door interlock was broken.

NRC letters dated June 13 and July 25, and WPPSS letters dated July 12 and August 24 discuss the technical specification requirements to maintain closed or lock closed an airlock door, when the door or airlock is inoperable. The current regional position was reinforced to the licensee during an exit meeting reported in Inspection Report 84-19. Current instructions to the Shift Managers, via procedures and the night order log, indicate acceptability of airlock entry under administrative control, consistent with the latest WPPSS letter to NRC, but inconsistent with the regional position. This is a matter of little safety significance, but rather the formality and somewhat ambiguity of the technical specification (license) requirement.

At the meetings on October 24-26, 1984, the licensee committed to submit a clarifying technical specification change request by December 21, 1984, and have management re-review the administrative instructions currently in the hands of Shift Managers. These actions are to be described in a pending letter to NRC. On November 2, 1984, the licensee stated that the review had been completed and interim night order instructions issued to the Shift Managers to assure higher level management involvement in any decision to proceed with containment entry if the door interlock is inoperative for more than 24 hours. The inspector verified existence of the night order and acknowledgement by operations staff. This matter remains open.

- e. (Open) Followup Item (84-09-03) - Control of troubleshooting. This item was originally identified in Inspection Report 84-09, and subsequently clarified in Report 84-19 (paragraph 10.b.). Various clearance order, jumper and lifted lead, and work planning controls exist for the plant operations; however, the licensee's letter to NRC dated July 12, 1984, suggested that troubleshooting activities involve degrees of freedom uninhibited by rigorous pre-analysis of potential operational impacts.

During meetings on October 25-26, 1984, and November 2, 1984, the licensee committed to consider the existing controls of troubleshooting (such as in maintenance procedure 10.1.6) and develop formal policies as appropriate to assure sufficient pre-planning of such activities on a more general basis. The inspector verified existence of the interim night order instructions to assure operations staff control of general troubleshooting

activities. This item remains open pending review of the licensee's completed actions.

- f. (Closed) Followup Item (84-09-04) - Some inspector questions existed as to timeliness of closing of clearance orders.

Subsequent review has shown that a monthly review is conducted of the log of outstanding clearance orders. This review was prescribed by the computerized scheduling system, which issued a card each month which must be positively responded to by the Operations Shift Managers. The records for August through October showed that the reviews had been conducted. Records for June, August, and October showed that the bi-monthly "Spot check of physical status of outstanding safety tags" was also being accomplished on the required schedule. The NRC questions have been resolved.

- g. (Closed) Followup Item (84-13-01) - Discrepancies existed between the abnormal condition procedure for the remote shutdown panel and the physical hardware.

Procedure 4.12.1.1, revision 3, resolved the discrepancies identified by the NRC inspector, and clarified other matters identified by the licensee's additional review. The generic aspect of this matter is discussed relative to item 84-22-02 (below).

- h. (Open) Violation (84-13-02) - Approval of additions to a clearance order were not documented (initialled) by the approving Shift Manager.

This matter was documented in NRC letter to WPPSS dated June 29 and August 24, and in WPPSS letter dated July 26, 1984. During the site reviews of October 24-26, 1984, the licensee management stated that this matter had been further reviewed and policy would be implemented to assure that approval of clearance order additions would be properly documented. A procedure deviation is reported to have already been issued to require that, once a clearance order has been signed by the shift manager, changes during any subsequent stage of the document require initialling by the shift manager. The licensee stated that a revised letter would be issued to NRC describing details of this action.

- i. (Closed) Unresolved Item (84-18-01) - The low pressure coolant injection system did not appear to be "capable" of taking suction from the suppression pool, without operator action to switch valving from the shutdown cooling mode.

The operations manager entered a night order which clarified the technical specification term "capable of taking suction from the suppression pool" to mean that manual valving action must not be necessary. Since the date of the finding, the inspectors have routinely observed plant operations on a daily basis, and have not found improper application of this suction mode. This item is closed.

- j. (Open) Violation (84-18-03) - Surveillance procedures utilized procedure prescriptive steps with associated sign-offs as equivalent to, and in lieu of, independent verification (especially relating to jumpers and lifted leads).

This matter was addressed in an NRC letter dated August 7 and a WPPSS letter to NRC dated September 6, 1984. During the October 24-26 management reviews the licensee acknowledged the NRC position of non-equivalency, and committed to incorporate independent verification into the surveillance program. This would address cases where there is no hardware feedback that a jumper/lifted lead had been removed/replaced or where the surveillance could be completed without removal/replacement. The licensee committed to provide details in a letter to NRC by December 1, 1984.

- k. (Closed) Followup Item (84-18-04) - Fabrication shop personnel appeared to be insufficiently familiar with the welding procedures manual.

This item was addressed by the site quality assurance organization in conjunction with an ongoing audit. The inspector interviewed the auditor, and examined his audit checklist, audit findings and records of response to the findings. The audit responses included participation and evaluation of technical aspects by the corporate welding engineer. Additional training of the shop personnel was conducted by the corporate office welding engineer who had been responsible for generation of the Maintenance Work Procedure (MWP) manual, (including the general and specific welding procedures). The general weld procedure MWP-6 includes weld joint preparation instructions. Also, administrative staff were assigned to assure that the controlled copy of the MWP manual was maintained current. The inspector also interviewed a welder engaged in current welding (who happened to be the same welder previously interviewed) and verified that he was familiar with welding procedures versus welding procedure qualification records, and that he could locate and use the current MWP manual. The licensee's efforts to review and strengthen this area appeared comprehensive, and included review of detailed welding procedures relative to specific ASME Code requirements.

- l. (Open) Followup Item (84-22-02) - The current findings of procedure inconsistencies with installed hardware appeared to have generalized aspects.

This matter was discussed during the management reviews on October 24-26, 1984. Other cases of hardware/procedure correspondence questions appeared in NRC Inspection Reports 84-09, 84-13, 84-15, 84-26, and in this Report, 84-31. Although the plant procedures have been on a two year review cycle, and many changes and deviations have already been processed, there appears to have been a problem with original reviewers assuring accuracy and first time users initiating needed corrections.

The licensee management committed to a near term program to particularly review the annunciator procedures, and to emphasize to plant staff to enter into the procedure change process any discrepancies which they identify during use. An ongoing program of review of master data sheets and annunciator procedures will be directed to address the procedure accuracy (for data sheets which have been revised since revision 0). Also, system operating procedures will be selected for review prior to the time their two year review cycle arises.

Future procedure/hardware discrepancies identified by the NRC inspectors will continue to be recorded under this open item 84-22-02, as an indicator of the effectiveness of the licensee's programs. This matter remains open.

- m. (Closed) Followup Item (84-26-02) - Reactor coolant pump performance. The licensee performed analyses and tests to verify compliance with test criteria prior to proceeding to the next test condition, as prescribed by FSAR Section 14.2.5.3. The pump coastdown performance was determined to meet applicable criteria. This is discussed further in paragraph 8, Power Ascension Test Program.
- n. (Open) Followup Item (84-29-03) - Power ascension test program test results reviews by the plant operations committee did not appear to address level II and III criteria. The licensee committed to implement such review, including revision of the procedure PPM-8.2.0.

Implementation of this review commenced during the review of test condition 5 apparent test results, as witnessed by the resident inspector. (The PPM-8.2.0 revision has not yet been issued). This item remains open pending review of general implementation of the revised procedure.

10. Management Meeting

On October 26, 1984, the senior resident inspector and two regional managers met with licensee management to discuss interfacing with the NRC regional office and responsiveness to NRC inspection findings. Attendees at this meeting are identified with a notation (+) in paragraph 1.

On November 2, 1984, the senior resident inspector met with the plant manager and his staff to discuss a summary of the inspection findings for this period. At this time the plant manager identified the scope and schedules for addressing the procedures upgrading activities. Attendees at this meeting are identified in paragraph 1 (*). Additionally, the inspector met with the Plant Manager weekly to review status of inspection findings, and weekly with department managers as necessary to define data and information needs relevant to the inspections in progress.