UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
101 MARIETTA STREET, N.W.
ATLANTA, GEORGIA 30303

Report Nos.: 50-250/84-22 and 50-251/84-23

Licensee: Florida Power and Light Company
9250 West Flagler Street
Miami, FL 33102

Docket Nos.: 50-250 and 50-251 License Nos.: DPR-31 and DPR-41

Facility Name: Turkey Point 3 and 4

Inspection Dates: June 10 - July 14, 1984

Inspector: _____ 8/21/84
T. A. Peebles, Senior Resident Inspector Date Signed

Accompanying Personnel: D. R. Brewer

Approved by: _____ 8/21/84
S. A. Elrod, Chief, Project Section 2C Date Signed
Division of Reactor Projects

SUMMARY

Scope: This routine, unannounced inspection involved 380 inspection hours on site, including 98 hours of backshift, in the areas of licensee action on previous inspection findings, LER followup, annual and monthly surveillance, annual and monthly maintenance, operational safety verification, emergency safety features (ESF) walkdown, plant events, and independent inspection.

Results: Of the eight areas inspected no violations or deviations were identified in four areas: four violations were found in four areas; paragraph 8, lack of operability criteria for Technical Specification (TS) required charging pumps and boric acid transfer pumps; paragraphs 7 and 9, failure of supervisory personnel to implement corrective actions per requirements and failure to establish an adequate procedure to perform maintenance; paragraph 9, failure to establish QC holdpoints; and paragraph 5, failure to perform a TS surveillance for the second time.

REPORT DETAILS

1. Persons Contacted

Licensee Employees

*K. N. Harris, Vice President - Turkey Point
*C. J. Baker, Plant Manager - Nuclear
G. J. Boissy, PEP Program Manager
*J. P. Mendietta, Services Manager - Nuclear
D. W. Haase, Operations Superintendent - Nuclear
J. P. Lowman, Assistant Superintendent Mechanical Maintenance - Nuclear
W. R. Williams, Assistant Superintendent Electrical Maintenance - Nuclear
*J. W. Kappes, Maintenance Superintendent - Nuclear
E. F. Hayes, Instrumentation and Control Supervisor
T. A. Finn, Operations Supervisor
W. Miller, Training Supervisor
V. A. Kaminskas, Reactor Engineering Supervisor
J. S. Wade, Chemistry Supervisor
P. W. Hughes, Health Physics Supervisor
M. J. Crisler, Quality Control Supervisor
J. A. Labarraque, Technical Department Supervisor
J. Arias, Regulation and Compliance Lead Engineer
*K. Jones, Operations QA Supervisor
D. Grandage, Plant Engineering Supervisor
W. Bladow, QA Operations Supervisor
J. E. Moaba, Section Supervisor Licensing
R. E. Garrett, Plant Security Supervisor
*P. A. Roach, Plant Engineer
*E. R. LaPierre, Plant Supervisor
*F. A. Houtz, QC
*T. A. Coleman, HP Administrative Supervisor
*R. A. Longtemps, Mechanical Maintenance
*D. Tomaszewski, Technical Support

Other licensee employees contacted included construction craftsmen, technicians, operators mechanics, electricians, and security force members.

*Attended exit interview

2. Exit Interview

The inspection scope and findings were summarized during management interviews held throughout the reporting period with the Plant Manager - Nuclear and selected members of his staff.

An exit meeting was held on July 5, 1984, with the persons noted above. The following areas which required management attention were reviewed: lack of operability criteria for TS required charging pumps and boric acid transfer pumps (250/84-22-01 and 251/84-23-01); failure to establish an adequate

procedure to perform maintenance and failure of supervisory personnel to implement corrective actions per requirements (250/84-22-02 and 251/84-23-02); failure to establish QC holdpoints (250/84-22-03 and 251/84-23-03); and failure to perform a TS surveillance which was a specific repeat violation and should have been corrected if the initial corrective actions had been sufficient (250/84-22-05). The licensee acknowledged the findings.

Another exit was held with the Plant Manager - Nuclear on July 16, 1984. The following areas which required management attention were reviewed: the administrative procedure for the Corrective Action Tracking System (CATS) will be updated by August 1, 1984 (250/84-22-06); the corrective actions addressed in the report from the licensee's Auxiliary Feedwater (AFW) Pump Task Force incorporated in the CATS by August 1, 1984 (250/84-22-07); prioritization of maintenance activities (250/84-22-04); and investigation into the basis for the spent fuel pit ventilation configuration (251/84-23-05). The licensee acknowledged the findings.

3. Licensee Action on Previous Inspection Findings

a. Quarterly meeting for evaluation of the Performance Enhancement Program

A quarterly meeting was held at the site on July 12, 1984, with the following people in attendance:

FP&L Attendees

E. A. Adomat
J. W. Williams, Jr.
C. O. Woody
K. N. Harris
C. J. Baker
G. J. Boissy
J. E. Vessely
J. D. Palmer
W. S. Windecker
L. D. Slepow
O. F. Pearson
K. E. Beatty
H. E. Yeager
J. H. Dager
E. F. Hayes
K. Jones
J. Moaba
D. W. Haase
J. P. Mendieta
C. M. Wethy
H. T. Young
J. A. Labarraque
R. E. Dawson
J. W. Kappes
D. D. Grandage
M. Crissler
P. J. Baum
T. A. Finn
P. W. Hughes
R. A. Longtemps
V. A. Kaminskas
W. R. Williams
R. E. Garrett
J. Sheets

NRC Attendees

J. P. O'Reilly
S. A. Elrod
D. R. Brewer
D. G. McDonald
R. C. Lewis
T. A. Peebles
S. A. Varga
C. M. Upright

The agenda was as follows:

10:00 a.m.	Preliminary meeting with Harris, Baker	
10:30 a.m.	Opening - E. A. Adomat J. W. Williams, Jr. C. J. Baker	
	Plant Progress	C. J. Baker
	Procedures	J. D. Palmer
	QA/QC	J. E. Vessely
	Schedule	G. J. Boissy
	Discussion	Attendees
1:00 p.m.	Tour	
2:45 p.m.	Leave Site	

It was determined that the next quarterly meeting would also be at the site and that the meeting had been very informative and productive.

b. Confirmatory Order EA-84-55

The order was received on site on July 13, 1983, requiring that commitments addressed in FP&L letter of April 11, 1984, to Mr. James P. O'Reilly and those in the PEP will be accomplished.

c. Monthly Update of Performance Enhancement Program

The inspectors met with site management concerning several aspects of the program and the following were agreed upon:

(1) The Corrective Action Tracking System (CATS) will be formalized in an updated administrative procedure by August 1, 1984. This is an Inspector Followup Item (IFI 250/84-22-06).

(2) The corrective actions recommended in the report from the Auxiliary Feedwater Pump Task Force will be reviewed and responsibilities for action and due dates will be assigned by August 1, 1984. This is an IFI (250/84-22-07).

(3) Items of significance (components, systems, etc.) which are not included in the TS but are in the standard TS will be identified and maintained on a priority basis. These items will be determined by plant management and the list now includes the source and intermediate range nuclear instruments. This is an IFI (250/84-22-04).

(4) Additional emphasis on labeling of equipment. Interim labels will be instituted.

d. Confirmation of Action Letter CAL 50-250, 251/84-02 of June 18, 1984

The letter was received on site and the affected operators were taken from licensed duties and are in requalification training.

e. Mr. S. A. Elrod was onsite on July 10 and 11, 1984, for an in depth update on the licensee's current performance.

4. Unresolved Items

Unresolved items were not identified in this report.

5. Licensee Event Reports

(Open) LER 250/84-16. On June 12, 1984, the inspectors received LER 250/84-16 concerning a failure on May 13, 1984, to perform an isotopic analysis for iodines as required by TS 4.1, Table 4.1-2, Item 1.(h)(2). This LER is similar to an event that occurred on November 12, 1983, which was documented in LER 251/83-19. In the November 1983 incident, a reactor coolant sample taken for isotopic analysis of iodine in the coolant did not satisfy the TS surveillance frequency as specified in Table 4.1-2, Item 1.(h)(2). The sample was taken prior to the specified 2 to 6 hour time frame. This failure to conform with TS requirements was licensee identified and met the criteria of 10 CFR Part 2, Appendix C, Section IV and consequently a Notice of Violation was not issued.

On May 13, 1984, the licensee again failed to conform with the surveillance frequency as specified in TS 4.1, Table 4.1-2, Item 1.(h)(2). As on November 12, 1983, the iodine sample was taken prior to the 2 to 6 hour time frame. However, this time the event did not meet the criteria of 10 CFR Part 2, Appendix C, Section IV because it was a violation that could reasonably have been expected to have been prevented by the licensee's corrective action for a previous violation.

An investigation was conducted to determine why the iodine samples were not taken as required and why the corrective action for the first incident did not prevent the second incident. It was determined that the problem stemmed from the Chemistry Department not being aware of the initiation and completion of certain power transients. Consequently, the chemistry technicians were unable to accurately determine a base time on which to center the 2 to 6 hour sample window. Corrective actions for the November 1983 event, as documented in LER 251/83-19, included a commitment to make a procedure change to better instruct personnel on the frequency and notifications required to meet the surveillance criteria. In April 1984, a procedure change was made to NC-65 (the procedure itemizing the method of obtaining iodine samples). This change did not address the communication problem between the Chemistry and Operations Departments. It did specify that the desired sample time was four hours after the transient. Efforts to increase communications were made verbally between the Supervisors of the Chemistry and Operations Departments, but their decisions were never incorporated into an administrative procedure defining an acceptable method of interdepartmental communications. Consequently, the method by which chemistry technicians should learn of a power transient remained unclear. Lack of an administrative procedure on interdepartmental communications contributed to the second iodine surveillance violation.

After the second iodine surveillance violation, the Chemistry Department instituted a policy which requires the on shift chemistry technician to call the control room every four hours. Since the required iodine sample can be obtained quickly, this periodicity should prevent exceeding the six hour TS time limit and will also allow the chemistry technician to accurately establish the time of the transient. The licensee has not yet formalized this policy in a written procedural requirement, consequently, it is not considered a permanent corrective action.

The failure to perform an isotopic analysis for iodines, as required by TS 4.1, Table 4.1-2, Item 1.(h)(2), which occurred on May 13, 1984, constitutes a violation (250/84-22-05). LER 250/84-16 remains open.

6. Monthly and Annual Surveillance Observation (61726 and 61700)

The inspectors observed TS required surveillance testing and verified that testing was performed in accordance with adequate procedures; that test instrumentation was calibrated; that limiting conditions for operation (LCO) were met; that test results met acceptance criteria requirements and were reviewed by personnel other than the individual directing the test; that any deficiencies identified during the testing were properly reviewed and resolved by appropriate management personnel; and that system restoration was adequate. For completed tests, the inspector verified that testing frequencies were met and tests were performed by qualified individuals. Tests inspected included:

Emergency Diesel Generator Operational Test
Control Rod Drive Movement Periodic Test
Nuclear Instrument Source Range Calibration
Reactor Protection Logic Periodic Test
Auxiliary Feedwater Pump Periodic Test
3A High Head Safety Injection Pump Periodic

The testing for operability of the 3A High Head Safety Injection pump, which was conducted after the pump was rebuilt, was done in accordance with ASME Section XI which provides an exclusion from data taking for the pump driver. In this case, the driver is a 4160 volt AC 350 horsepower electric motor which was first operated in March 1970. Pump vibration data during the test run was normal; however, the motor visually seemed to be vibrating and indicated 3-5 mils. This was reported to the licensee management. A consultant took data and analyzed that rotor bars in the motor were loose. The rotor was shipped to be inspected and repaired. The inspection showed that 14 rotor bars had cracks and/or breaks in the rotor bar base material at the braised joint between the rotor bar and the shorting ring.

7. Monthly and Refueling Maintenance Observations (627031)

Station maintenance activities of safety-related systems and components were observed/reviewed to ascertain that they were conducted in accordance with approved procedures, regulatory guides and industry codes or standards and in conformance with TS. The following items were considered during this

review: LCOs were met while components or systems were removed for service; approvals were obtained prior to initiating the work; activities were accomplished using approved procedures and were inspected as applicable; functional testing and/or calibrations were performed prior to returning components or systems to service; quality control records were maintained; activities were accomplished by qualified personnel; parts and materials used were properly certified; radiological controls were implemented; and fire prevention controls were implemented. The following maintenance activities were observed/reviewed:

3A safety injection pump
Charging pumps 4A and 4B
Auxiliary feedwater valve 2832
Replacement of hold downs for packing gland followers

During the reporting period, Unit 3 was forced to shutdown twice (on June 25 and July 12) due to excessive primary leakage. Both instances were caused by 3/4 inch Rockwell valves having their packing blown out and the packing gland follower breaking in two pieces at the stem. After the second incident, the licensee inspected all primary pressure boundary, normally open, valves of this type. The inspection methods were both visual and dye penetrant. One defective valve packing gland follower was found on Unit 4. The broken pieces were sent to a metallurgical lab for analysis. The followers were replaced and the valves left on their backseat.

On June 19, 1984, the inspector observed maintenance repairs on the Unit 3 "A" High Head Safety Injection (HHSI) Pump. The rotating element was being replaced due to excessive pump vibrations. Review of Maintenance Procedure (MP) 4107.7 "High Head SIS Pump Disassembly, Replacement of Rotating Element and Reassembly" revealed four discrepancies which together and individually rendered the maintenance procedure inadequate. Each discrepancy is discussed below:

1. MP 4107.7 contained three separate and different versions of page 7, the Engineering Data Sheet. Two of the versions were superseded and not included on the list of effective pages but had not been removed from the procedure. Several other controlled copies of MP 4107.7, including the archival copy in the Document Control Office, contained the extra pages. The dates on the superseded pages were August 12, 1982 and November 4, 1982. The currently valid page 7 is dated December 2, 1982. The August version of page 7 contained running clearance values for the pump which were incorrect. The inspector verified that the licensee had not used the running clearance values from the August 1982 version of page 7 when assembling the pump.

2. MP 4107.7 did not provide a detailed discussion of proper bearing installation and consequently the bearings were installed incorrectly. Section 9.10 of MP 4107.7 merely states, "Remove coupling, bearing housings, bearings and mechanical seals. Reinstall on spare rotating element." The maintenance technicians installed the bearings "front-to-back." The Worthington technical manual for the safety

injection pump states that the bearings must be mounted "back-to-back." The licensee discovered the error because the total-float measurement taken in Step 9.19 was not as expected.

3. MP 4107.7 did not contain a procedural step requiring the SIS pump to be refilled with oil after completion of the reassembly. Section 9.5 of the procedure states, "Drain oil from bearing housings and remove constant level oilers." Section 9.24 addresses installation of bearing housings. The installation of constant level oilers and the type of oil required for use are not addressed.

4. MP 4107.7 did not address a method of priming the pump subsequent to reassembly. Section 9.26 of the procedure states, "Note: Do not rotate pump without filling casing with water." The means of venting the pump is not addressed. The technical manual specifies the use of the installed vent valve to release all entrapped air. MP 4107.7 also does not address a means of verifying that the casing is full of water.

   Failure to provide an adequate procedure with which to perform maintenance is a violation. (250/84-22-02, 251/84-23-02)

While observing the maintenance activities associated with the repair of the 3A HHSI pump, the inspector observed general area cleanliness precautions. Numerous pieces of component cooling water pipe, which had been removed to allow access to the HHSI pump internals, were not protected against foreign material intrusion. The pipe sections were being stored on the floor in a corner of the work area. A quality control inspector tracking the repair efforts had not noticed the discrepancy. Administrative Procedure (AP) 0190.10, "Cleaning of Nuclear Safety Related Systems and Components." Section 8.1.1.5 states, "All openings in nuclear safety-related systems or components shall be protected from outside contaminants except when necessary to carry out required operations." The failure of the maintenance technicians working on the 3A HHSI pump to implement AP 0190.10, Section 8.1.1.5, is a second example of a violation (250/84-22-02, 251/84-23-02) and will be reviewed as an IFI (250/84-22-08 and 251/84-23-08).

During the review of MP 4107.7 for adequacy, it was noticed that quality control holdpoints had been established only to verify cleanliness and the absence of foreign material. AP 0190.70, "Inspection of Maintenance Activities of Nuclear Safety Related and Fire Protection Equipment." Section 8.3 addresses inspection holdpoints. Section 8.3.1 states that inspection holdpoints shall be inserted in procedures and Plant Work Orders (PWOs) where necessary in accordance with AP 0190.19, Appendix A, to assure certain maintenance activities are performed to the satisfaction of pre-set acceptance criteria." Appendix A of AP 0190.19 under the section labeled "Mechanical," states that holdpoints shall be included so that QC can witness, verify or perform. It further itemizes five holdpoint criteria. Criteria 3 covers critical measurements and/or adjustments on nuclear safety-related systems or components in circumstances where such adjustments or measurements

cannot be verified subsequent to the completion of the job. A review of MP 4107.7 revealed several procedural steps which deal with critical measure - ments and adjustments. No QC holdpoints exist for these steps. The failure to establish Quality Control Holdpoints in accordance with AP 0190.19, Appendix A, as required by AP 0190.70, constitutes a failure to implement AP 0190.70 and, in turn, 10 CFR, Appendix B, Criteria X (250/84-22-03 and 251/84-23-03).

8. Operational Safety Verification (71707)

The inspectors observed control room operations, reviewed applicable logs, conducted discussions with control room operators, observed shift turnovers, and confirmed operability of selected emergency systems, reviewed tagout records, verified compliance with TS LCOs and verified return to service of affected components.

The inspectors by observation and direct interviews insured that the physical security plan was being implemented in accordance with the station security plan. The inspectors verified that maintenance work orders had been submitted as required and that followup and prioritization of work was on-going. The inspectors observed plant housekeeping/cleanliness conditions and verified implementation of radiation protection control.

Tours of the auxiliary, diesel, and turbine buildings were conducted to observe plant equipment conditions, including potential fire hazards, fluid leaks and excessive vibrations.

The inspectors walked down accessible portions of the following safety-related systems on Units 3 and 4 to verify operability and proper valve alignment:

Emergency diesel generators.
4160 Vac & 480 Vac buses.
Charging pumps.
Boric acid transfer system.

On July 3, 1984, the charging system was inspected to verify operability, as required by TS 3.6, which requires that two charging pumps be operable. TS 1.4 states that the system or component is operable when it is capable of performing its intended function. The 3A charging pump was not performing its normal requirements of supplying seal water to the reactor coolant pumps and maintaining pressurizer level while letdown flow was maintained at a minimum of 45 gpm. A plant work order was being generated to have the pump repaired. The inspector questioned the nuclear plant supervisor if the pump was to be declared out of service. The response was that it was not being placed out of service because it still would pump some water. Though the TS do not require surveillance of these pumps and none was performed, operability per the above criteria is still required. There was no operability criteria for the charging pumps (or boric acid transfer pumps). This is a violation of TS 3.6 and TS 1.4 (250/84-22-01/251/84-23-01).

9. Engineered Safety Features Walkdown (71710)

The inspectors verified the operability of the Unit 3 and Unit 4 Residual Heat Removal (RHR) systems on June 18, 1984, by performing a complete walkdown of the accessible portion of the system. The following specifics were reviewed/observed as appropriate: that the licensee's system lineup procedures match plant drawings and the as-built configuration; that equipment conditions and items that might degrade performance (hangers and supports are operable, housekeeping, etc.) were identified; with assistance from licensee personnel that the interior of the breakers and electrical or instrumentation cabinets were inspected for debris, loose material, jumpers, evidence of rodents, etc.; that instrumentation was properly valved in and functioning and calibration dates were appropriate; and that valves were in proper position, power was available and valves were locked as appropriate; and local and remote position indication was compared.

Valves and piping flow paths were verified to be built in accordance with plant drawing 5610-T-E-4510, Rev. 28. During the inspection of the area, various discrepancies were noted:

a. Numerous valves in the RHR system have no valve identification tags. The problem is more prevalent in Unit 4 than in Unit 3. The valves have been numbered on applicable drawings. This is another example of inadequate equipment identification which is being addressed by the PEP (see paragraph 3.c.iv).

b. No loud speaker announcements could be heard in the areas. Installed speakers were apparently nonfunctional. The inspectors observed one disconnected speaker.

c. Numerous light fixtures in the area were nonfunctional.

d. In both Units 3 and 4 RHR areas, pieces of wood were found wedged between pipe runs as if to provide additional piping support. Some new pipe supports had been installed and the temporary wooden braces had not been removed.

e. In both Units 3 and 4 RHR areas, boric acid residue from valve leakage was readily apparent. Several large valves showed signs of long term minor leakage with boric acid build up and valve stud corrosion.

f. In the Unit 3 RHR room, seepage through a wall penetration from an unidentified source resulted in a wet 25 square foot floor area which had evidence of being there a very long time.

g. Numerous temporary plastic drain hoses, which were not in use, remained connected to various drain valves. In some cases, the hoses were left draped across piping or lying randomly on the floor. In other cases, the hoses ran from drain valves to the sump. These hoses all had the potential for blocking the sump level control floats and in one case, the inspectors observed a blocked float which was causing a sump pump

to remain running even though the sump was empty. The RHR sumps did not have protective gratings to prevent foreign materials from entering the sump. Consequently, the sumps had accumulated foreign objects such as pieces of metal, paper, and general debris.

h. Radiological controls in the Unit 4 RHR pump area were inadequate. Yellow bags used for the collection of contaminated materials were filled to overflowing and some of the material had fallen on the floor. Other bags of contaminated materials were full and had not been removed from the area. The radiological control posting sign at the entrance to the lower level was dangling as only one end of the rope was tied to a support. The other end of the rope had been untied, allowing the sign to fall down.

The Unit 4 RHR pump and heat exchanger rooms were excessively dirty. Pipe lagging has been in progress in the area and consequently most horizontal surfaces are covered with dust. Accumulated dirt and debris exist on the lower floor areas. The "clean" step off pads at the lower level entrance were completely covered with dirt.

The inspectors observed pipe clamps, chain falls, nuts, bolts, wire, insulating tools, pieces of wood and pieces of plastic strewn around the area. While work had obviously been in progress at one time, no workers were present during the inspection and work was not scheduled to resume for two weeks.

Radiological controls for Unit 3 RHR pump area were inadequate. Step off pads at stairs leading from the lower levels were missing. Yellow bags in which to place the contaminated show covers used while in the lower level were missing.

The inspectors reviewed AP 0103,11 "Housekeeping" and determined from Appendix A that the cleanliness of the area was assigned to the Health Physics Department. Initial cleanup should have been performed by the individual workers at the end of their shift. This requirement is documented in Section 5.4 of AP 0103.11 which states:

"It is the responsibility of each individual after he finishes a job to insure that the job area is left clean and safe and that his tools and equipment are properly stored and/or are removed from the area and that trash and debris in the job area is also removed and/or properly disposed of."

Additional guidance is given in Section 8.5.1, which states, in part:

"Following completion of a work activity, or at the end of each work shift, whichever is sooner, all waste debris, scraps, rags, oil spills, or other combustibles resulting from the work activity shall be removed. The equipment used shall be removed from area or properly stored."

The inspectors determined that the cleanup efforts discussed in Sections 5.4 and 8.5.1 of the housekeeping procedure were not performed. Additionally, the inspectors determined that supervisory personnel who entered the area after work was secured took no action to initiate a cleanup. Failure of supervisory personnel to initiate routine cleaning is contrary to the requirements of Section 5.2 of AP 0103.11, which states, in part:

> "Each Superintendent, Department Head, Supervisor, Chief Electrician and Foreman shall ensure and verify areas under their cognizance are maintained in a safe, clean condition, that inspections are conducted and routine cleaning is performed. Also, they are to ensure corrective actions are initiated to resolve unsatisfactory conditions."

Failure of individual workers to clean their work area at the end of a shift and failure of supervisory personnel to initiate corrective actions to resolve unsatisfactory conditions constitute a third example of violation (250/84-22-02; 251/84-23-02) and will be reviewed as IFI (250/84-22-09; 251/84-23-09).

10. Plant Events (93702)

a. Following the Unit 3 event of an unisolable 10 gpm leak on June 25, 1984, the inspector ascertained the status of the reactor and safety systems by observation of control room indicators and discussions with licensee personnel concerning plant parameters, emergency system status and reactor coolant chemistry. The inspector verified the establishment of proper communications and reviewed the corrective actions taken by the licensee.

   The root valve for a pressurizer level transmitter had blown its packing and the packing gland follower was found broken. This allowed an unisolable 10 gpm leak. The unit was shut down and the valve backseated, repacked and a new packing gland follower installed. An unusual event had been declared due to the leak and subsequent unit shutdown.

b. A similar event occurred on Unit 3 on July 12, 1984, when the packing blew out of another pressurizer level transmitter root valve and the packing gland follower was found broken. The immediate actions were the same as for the earlier event; however, the further corrective actions discussed in paragraph 7 were accomplished before either unit returned to service.

c. During the start-up of Unit 4 from its recent refueling outage, the negative TS requirements for a moderator temperature coefficient (or zero) above 70 percent power was violated. The licensee took prompt action to reduce power less than 70%. However, a discussion with licensee management was conducted to verify that management agreed that preparation for a TS required shutdown should be initiated when the first indication is received and not wait for the backup analysis. Backup analysis may be initiated at the same time and utilized when

appropriate. The licensee agreed to restate this position to the nuclear plant supervisors.

11. Independent Inspection Effort (92706)

The inspectors routinely attended meetings with licensee management and shift turnovers between nuclear plant supervisors, nuclear watch engineers and licensed operators during the reporting period. These meetings and discussions provided a daily status of plant operating and testing activities in progress as well as discussion of significant problems or incidents.

On July 9, 1984, the inspectors toured the spent fuel buildings. Some housekeeping had been accomplished; however, the major maintenance items remain. In the Unit 4 building, a portion of the duct work had been removed for maintenance of the ventilation fan. Air from the stack was backflowing from the duct as the damper was located upstream of the fan and therefore, no isolation of that duct or of the fan from the stack was possible. This installation is per the drawing in the FSAR. The licensee is pursuing the basis for the design, this will be a followup item (251/84-23-05).

No violations or deviations were identified in this area.