UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
101 MARIETTA ST., N.W.
ATLANTA, GEORGIA 30323

Report No: 50-302/88-24

Licensee: Florida Power Corporation
3201 34th Street, South
St. Petersburg, FL 33733

Docket No: 50-302 License No.: DPR-72

Facility Name: Crystal River 3

Inspection Conducted: July 16 - August 12, 1988

Inspectors: M. S. Lewis for 9/7/88
P. Holmes-Ray, Senior Resident Inspector Date Signed

M. S. Lewis for 9/7/88
J. Tedrow, Resident Inspector Date Signed

M. S. Lewis for 9/7/88
J. Petrosino, NRR, Division of Reactor Inspection and Safeguards Date Signed

Approved by: [signature] 9/13/88
R. D'Ienjak, Section Chief Date Signed
Division of Reactor Projects

SUMMARY

Scope: This routine inspection was conducted by two resident inspectors and an accompanying NRR inspector in the areas of plant operations, security, radiological controls, Licensee Event Reports and Nonconforming Operations Reports, facility modifications, control of incoming vendor related technical information, and licensee action on previous inspection items. Numerous facility tours were conducted and facility operations observed. Some of these tours and observations were conducted on backshifts.

Results: One violation was identified: Inadequate evaluation and procedures to control incoming vendor technical issues, paragraph 8.d.

Two unresolved items* were identified: To determine the significance of the findings from the licensee's review of the disposition of vendor identified technical issues, paragraph 8; and to determine the significance of the findings from the licensee's review of the procedural control of vendor identified technical issues, paragraph 9.

*Unresolved items are matters about which more information is required to determine whether they are acceptable or may involve violations or deviations.

REPORT DETAILS

1. Persons Contacted

Licensee Employees

T. Austin, Principal Nuclear Mechanical Engineer
K. Baker, Manager, Nuclear Engineering Assurance
*W. Bandhauer, Assistant Nuclear Plant Operations Manager
*G. Becker, Manager, Site Nuclear Engineering Services
*J. Brandely, Manager, Nuclear Integrated Planning
*G. Castleberry, Nuclear Engineering Supervisor
*M. Collins, Nuclear Safety and Reliability Superintendent
J. Fijouf, Nuclear Regulatory Specialist
H. Gelston, Supervisor, Site Nuclear Engineering Services
D. Green, Nuclear Licensing Specialist
*V. Hernandez, Supervisor, Nuclear Quality Assurance Surveillance
*B. Hickle, Manager, Nuclear Plant Operations
*R. Jones, Nuclear Modifications Specialist
K. Lancaster, Manager, Site Nuclear Quality Assurance
S. Loflin, Senior Nuclear Quality Assurance Specialist
*G. Longhauser, Nuclear Security Superintendent
*M. Martin, Supervisor, Nuclear Electrical/Instrument and Control
*P. McKee, Director, Nuclear Plant Operations
*R. Murgatroyd, Nuclear Maintenance Superintendent
G. Oberndorfer, Manager, Procurement and Material Quality Assurance
*S. Robinson, Nuclear Chemistry and Radiation Protection Superintendent
*V. Roppel, Manager, Nuclear Operations Maintenance and Outages
*W. Rossfeld, Manager, Nuclear Compliance
S. Stearns, Nuclear Site Engineering
P. Tanquay, Manager, Nuclear Operations Engineering
J. Vattamattam, Senior Nuclear Structural Engineer
H. Walker, Supervisor, Nuclear Electrical/Instrument and Control
*R. Widell, Director, Nuclear Operations Site Support
*M. Williams, Nuclear Regulatory Specialist

Other licensee employees contacted included office, operations, engineering, maintenance, chemistry/radiation and corporate personnel.

*Attended exit interview

Acronyms and initialisms used throughout this report are listed in the last paragraph.

2. Review of Plant Operations (71707)

a. Shift Logs and Facility Records (71707)

The inspector reviewed records and discussed various entries with operations personnel to verify compliance with the Technical Specifications (TS) and the licensee's administrative procedures.

The following records were reviewed:

Shift Supervisor's Log; Reactor Operator's Log; Equipment Out-Of-Service Log; Shift Relief Checklist; Auxiliary Building Operator's Log; Active Clearance Log; Daily Operating Surveillance Log; Work Request Log; Short Term Instructions (STI); and Selected Chemistry/Radiation Protection Logs.

In addition to these record reviews, the inspector independently verified clearance order tagouts.

No violations or deviations were identified.

b. Facility Tours and Observations (71707)

Throughout the inspection period, facility tours were conducted to observe operations and maintenance activities in progress. Some operations and maintenance activity observations were conducted during backshifts. Also, during this inspection period, licensee meetings were attended by the inspector to observe planning and management activities.

The facility tours and observations encompassed the following areas: security perimeter fence; control room; emergency diesel generator room; auxiliary building; intermediate building; battery rooms; and electrical switchgear rooms.

During these tours, the following observations were made:

(1) Monitoring Instrumentation - The following instrumentation and/or indications were observed to verify that indicated parameters were in accordance with the TS for the current operational mode:

Equipment operating status; area atmospheric and liquid radiation monitors; electrical system lineup; reactor operating parameters; and auxiliary equipment operating parameters.

No violations or deviations were identified.

(2) Safety Systems Walkdown (71710) - The inspector conducted a walkdown of the Nuclear Services Closed Cycle Cooling (SW) system to verify that the lineup was in accordance with license requirements for system operability and that the system drawing and procedure correctly reflect "as-built" plant conditions.

No violations or deviations were identified.

(3) Shift Staffing (71707) - The inspector verified that operating shift staffing was in accordance with TS requirements and that control room operations were being conducted in an orderly and professional manner. In addition, the inspector observed shift turnovers on various occasions to verify the continuity of plant status, operational problems, and other pertinent plant information during these turnovers.

No violations or deviations were identified.

(4) Plant Housekeeping Conditions (71707) - Storage of material and components, and cleanliness conditions of various areas throughout the facility were observed to determine whether safety and/or fire hazards existed.

During a plant tour, it was noticed that the housekeeping in the SW room of the Auxiliary Building was less than desired. The condition was conveyed to FPC management who took immediate action to have the SW room cleaned up. Clean up of the SW room was prompt and thorough.

No violations or deviations were identified.

(5) Radiological Protection Program (71709) - Radiation protection control activities were observed to verify that these activities were in conformance with the facility policies and procedures, and in compliance with regulatory requirements. These observations included:

- Selected licensee conducted surveys;
- Entry to and exit from contaminated areas, including step-off pad conditions and disposal of contaminated clothing;
- Area postings and controls;
- Work activity within radiation, high radiation, and contaminated areas;
- Radiation Control Area (RCA) exiting practices; and
- Proper wearing of personnel monitoring equipment, protective clothing, and respiratory equipment.

Area postings were independently verified for accuracy by the inspector. The inspector also reviewed selected Radiation Work Permits (RWPs) to verify that the RWP was current and that the controls were adequate.

The implementation of the licensee's As Low As Reasonably Achievable (ALARA) program was reviewed to determine personnel involvement in the objectives and goals of the program.

No violations or deviations were identified.

(6) Security Control (71881) - In the course of the monthly activities, the inspector included a review of the licensee's physical security program. The composition of the security organization was checked to insure that the minimum number of guards were available and that security activities were conducted with proper supervision. The performance of various shifts of the security force was observed in the conduct of daily activities to include: protected and vital area access controls; searching of personnel, packages, and vehicles; badge issuance and retrieval; escorting of visitors; patrols; and compensatory posts. In addition, the inspector observed the operational status of Closed Circuit Television monitors, the Intrusion Detection system in the central and secondary alarm stations, protected area lighting, protected and vital area barrier integrity, and the security organization interface with operations and maintenance.

No violations or deviations were identified.

(7) Fire Protection (71707) - Fire protection activities, staffing and equipment were observed to verify that fire brigade staffing was appropriate and that fire alarms, extinguishing equipment, actuating controls, fire fighting equipment, emergency equipment, and fire barriers were operable.

On August 8 a fire drill was observed and the post drill critique was attended. Several problems were noted:

- The fire team was slow to respond. All members (5) were not on the scene until about 20 minutes after the drill started.
- One team member had a SCBA, but no face mask and had to leave his position on the fire hose to get his mask.
- When backup fire fighters arrived, not enough SCBAs were readily available.
- The PA system was weak in some areas.

These and other minor problems prompted FPC to declare the drill unsatisfactory and to schedule another drill. The rescheduled drill was conducted on August 9 satisfactorily.

No violations or deviations were identified.

(8) Surveillance (61726) - Surveillance tests were observed to verify that approved procedures were being used; qualified personnel were conducting the tests; tests were adequate to verify equipment operability; calibrated equipment was utilized; and TS requirements were followed.

The following tests were observed and/or data reviewed:

- SP-317, Reactor Coolant System Water Inventory Balance;
- SP-715, Containment Building Spray Semiannual Surveillance Program; and
- PT-213, Seating Test for FWV-43.

No violations or deviations were identified.

(9) Maintenance Activities (62703) - The inspector observed maintenance activities to verify that correct equipment clearances were in effect; work requests and fire prevention work permits, as required, were issued and being followed; quality control personnel were available for inspection activities as required; and TS requirements were being followed.

Maintenance was observed and work packages were reviewed for the following maintenance activities:

- Shoot and clean SWHE-1A in accordance with PM-112, Heat Exchanger Maintenance Inspection/Cleaning/Shooting and Plugging.

- PT-213, Seating Test for feedwater valve FWV-43. This test was performed to attempt to seat check valve FWV-43 as a follow-up to the leak from the bonnet of EFV-18. Four attempts to seat FWV-43 were made without success. The temperature of penetration 109 was monitored and held below 110 degrees F. A similar test was performed earlier on emergency feedwater check valve EFV-44; and EFV-44 was successfully seated.

- June 19 - Open and inspect decay heat exchanger (DCHE)-B in accordance with PM-112, Heat Exchanger Maintenance Inspection/Cleaning/Shooting and Plugging. During the beginning of the job, tools were selected by trial and error. To determine which wrench was needed to remove the closure nuts, several were tried for size prior to finding the correct size. The procedure was not on the job site at this time. The inspector obtained a copy of the procedure (PM-112). Review of PM-112 revealed that the procedure was not adequate to be performed on a DCHE as written. The procedure was written for a service water heat exchanger (SWHE) and could not be followed for a DCHE, since the applicable enclosure for DCHE is not referred to in the procedure. When maintenance management was questioned about PM-112, they agreed that the procedure was inadequate. The procedure was last revised on June 18, 1988. A temporary revision was processed to allow completion of DCHE-B work. Maintenance management informed the inspector that the shop also realized that the procedure was inadequate and had initiated action to get it changed.

There are two weaknesses illustrated by this event:

1) The review cycle which allowed the procedure to be issued in its inadequate form was less than effective.

2) Review of the procedure prior to job commencement was inadequate in that the plant entered a 72 hour LCO for removal of the DCHE from service when the procedure was inadequate to perform the work.

No citation is issued for this event since the licensee (concurrently with the inspector) identified the inadequate procedure and corrected the procedure prior to its use.

No violations or deviations were identified.

(10) Pipe Hangers and Seismic Restraints (71707) - Several pipe hangers and seismic restraints (snubbers) on safety-related systems were observed to assure fluid levels were adequate and no leakage was evident, restraint settings were appropriate, and anchoring points were not binding.

No violations or deviations were identified.

3. Review of Licensee Event Reports (92700) and Nonconforming Operations Reports (71707)

a. Licensee Event Reports (LERs) were reviewed for potential generic impact, to detect trends, and to determine whether corrective actions appeared appropriate. Events that were reported immediately were reviewed as they occurred to determine if the TS were satisfied. LERs 86-18 and 88-14 were reviewed in accordance with the current NRC Enforcement Policy. LER 86-18 is closed.

(1) (Closed) LER 86-18: This LER reported that contaminated material was found outside of the radiation control area. This matter is already being tracked by an unresolved item (Unresolved Item 302/86-35-05).

(2) (Open) LER 88-14: This LER reported excessive temperatures in Emergency Feedwater (EFW) system piping. This event is discussed in more detail in NRC Inspection Report 50-302/88-18. The licensee's short term corrective actions as stated in the LER have been completed, however the following corrective actions remain to be done:

- Disassembly and repair of leaking valves in the EFW system (EFV-18, EFV-33, and FWV-43);

- Analysis to upgrade the EFW system piping to operate at higher temperatures;

- Development of leakage criteria and test procedures for EFW system check valves; and,

- Evaluation of the possibility of "water hammer" effects by formation of steam voids in these lines.

This LER will remain open pending completion of these corrective actions.

b. The inspector reviewed Nonconforming Operations Reports (NCORs) to verify the following: TS are complied with, corrective actions as identified in the reports or during subsequent reviews have been accomplished or are being pursued for completion, generic items are identified and reported as required by 10 CFR Part 21, and items are reported as required by TS.

All NCORs were reviewed in accordance with the current NRC Enforcement Policy.

No violations or deviations were identified.

4. Bulletin (BU) Followup (92703)

BU 88-05: Nonconforming Materials Supplied by Piping Supplies, Inc. at Folsom, New Jersey and West Jersey Manufacturing Company at Williamstown, New Jersey.

On July 14, 1988, in accordance with Supplement 1 to NRC Bulletin 88-05, the licensee made a report to NRC Operations Center of nonconforming material (17 flanges in the Nuclear Services and Decay Heat Seawater system (RW)). Licensee analysis of the strength of the flanges shows that the strength of the material exceeds the required safety factor, even though tensile strength and hardness are less than specification. The licensee concludes that the above mentioned material is suitable for use in the RW system.

The licensee continues to take action as required by BU 88-05.

5. Review of Multi-Plant Action Item B-03, PWR Moderator Dilution (71707)

The inspector reviewed the licensee's efforts to prevent the inadvertent injection of sodium hydroxide (NaOH) into the Reactor Coolant System (RCS). In LER's 77-17 and 77-52, the licensee reported that an unterminated injection of the NaOH tank (BST-2) into the RCS could result in inadvertent reactor criticality. In February 1977, with the plant in the cold shutdown condition, NaOH was introduced into the Decay Heat Removal (DH) system during the performance of a surveillance test to exercise the isolation valves associated with tank BST-2. The cycling of

the isolation valves allowed NaOH to drain into the DH system and the NaOH was then subsequently transmitted into the RCS during routine DH system operation. Although this event did not result in a sufficient reduction in RCS boron concentration to create an inadvertent criticality, subsequent analyses determined that the possibility existed to do so. In June 1977, the licensee imposed administrative safeguards to preclude such an event. This action was reviewed and approved by the NRC in an amendment to the facility operating license (license amendment #20). Subsequent amendments to the operating license restricted the shutdown reactivity margin to 3.0% delta k/k. This shutdown reactivity would prevent a moderator dilution accident of this type from resulting in an inadvertent reactor criticality.

In 1983, the licensee emptied and isolated tank BST-2 from the DH system and provided for NaOH addition from the present NaOH Spray Additive Tank BST-1. This tank provides NaOH to the reactor building spray system instead of the DH system and is isolated from the DH system by check valves. This modification prevented the introduction of NaOH into the DH system and RCS. The NRC reviewed and approved of this modification in license amendment #64 (dated August 2, 1983), which also restored the shutdown reactivity margin to the previous value.

In reviewing the above information, the inspector noticed that the moderator dilution accident described in the Final Safety Analysis Report (FSAR) Section 14.1.2.4.2, Unterminated Dilution Through the Decay Heat Removal System, still described the old BST-2 tank configuration with associated administrative controls to prevent this type of accident. This finding was discussed with licensee personnel who stated that Chapter 14 of the FSAR was in the process of being reviewed and revised for the next annual update in July 1989. The licensee will include revisions to the moderator dilution accident analysis to reflect the current method of NaOH addition as part of this annual FSAR update.

IFI (302/88-24-01): Review the licensee's revision to the moderator dilution accident analysis in the FSAR. (TI 2515/94 is closed.)

6. Inspection of Quality Assurance for Diesel Generator Fuel Oil (71707)

The inspector reviewed the licensee's purchasing requirements placed on fuel oil ordered for the emergency diesel generators. The licensee buys this product as a "Safety-Related" commercial grade purchase and utilizes the commodity method of procurement specified in the licensee's Nuclear Procurement and Storage Manual. This method requires a receipt inspection and test of the new fuel received.

The inspector discussed this process with licensee material quality assurance personnel and reviewed recent procurement, purchase order, and receipt inspection documentation for the purchase of this fuel oil. (TI 2515/93 is closed.)

No violations or deviations were identified.

7. Licensee Action on Previously Identified Inspection Findings (92702 and 92701)

(Closed) Unresolved Item 302/84-21-05: Change the Plant Review Committee (PRC) Charter to Correct the Use of Alternate Members and Change PRC Meeting Activities

As stated in NRC Inspection Report 50-302/85-21, this item remained open pending a clarification of job position philosophy and subsequent revision to the PRC charter. Subsequent verbal communication between the NRC and the licensee on May 24, 1988, has clarified this issue. The temporary absence of a full time PRC member can only be filled by a designated alternate member. This requirement ensures that continuity of committee activities is maintained. The licensee has subsequently revised the PRC charter (revision 26 dated July 15, 1988) to reflect this position.

8. Licensee Disposition Actions in Regard to Vendor Related Issues (36100)

The inspector reviewed the licensee's hardware problem disposition actions associated with the following issues:

a. 10 CFR Part 21 report from Brown Boveri Company (BBC) dated May 13, 1985, in regard to an incorrectly configured short time delay band lever for BBC (also identified as ITE) K-Line circuit breakers.

This issue was previously identified as an inspector followup item (IFI 302/87-19-04) and was also discussed in Information Notice (IN) 85-64. NRC Inspection Report 302/87-19 stated, in part, that work request (WR) 69571, dated 7/11/85 was initiated to verify whether or not any of the safety-related or balance of plant (BOP) circuit breakers in the BBC K-Line breaker series contained the incorrectly configured lever. The vendor identified two circuit breakers as suspect at Crystal River in its May 13, 1985 letter; however, subsequent licensee communications with BBC discovered that the incorrect link may have been installed on K-Line circuit breakers manufactured earlier than was previously stated, but was limited to the 480 VAC auxiliary power BOP and safety-related breakers. Therefore, WR 69571 was written to inspect all of the 480 VAC BBC devices that may contain the incorrect lever.

The inspector followup on this issue revealed that the WR is not completed for the BOP circuit breakers; however, the safety-related circuit breakers have all been inspected and no incorrect band levers were found. The licensee has taken satisfactory corrective actions to determine the applicability of this issue to Crystal River. Action on this matter is complete and this issue is considered closed (P2185-03).

b. Two 10 CFR Part 21 reports from Brown Boveri Company in regard to other BBC K-Line circuit breaker problems were received by Crystal River as follows: (1) a March 19, 1985, BBC letter discussing the potential of cut auxiliary switch control wires on its K-Line circuit breakers, that can occur during racking operations due to interference with a sharp edge on a stationary breaker dust cover, and (2) a June 30, 1986 BBC letter discussing the potential of cut and shorted control wire harness wiring due to oversize clearance holes in the K-Line panel enclosure that allows the harness to come into contact with the racking gear teeth.

Adequate investigative and corrective actions are being performed by the licensee, as follows: (1) Work request 69571 discussed above was also scoped to include work activities to install protective gasket material over the sharp edge of the dust cover and secure the wires to the auxiliary switch, and (2) Work requests 94001-94011, dated September 14, 1987, were written to inspect and repair as necessary the applicable 480 VAC K-Line breakers. To date, WRs 94006, 94007, 94008, 94009, 94010 and 94011 have been completed with no problems found. WR's 94001, 94002, 94003, 94004, and 94005 are still uncompleted.

The licensee has taken action to determine the applicability of this issue to Crystal River. The above WRs are noted as open but should be adequately controlled by the licensee maintenance and quality control organizations. Therefore, action on this matter is complete and this issue is considered closed (P2185-06 and P2186-02).

c. A 10 CFR Part 21 report from Limitorque Corporation dated December 19, 1986, in regard to potential Limitorque DC motor lead wire grounding/shorting problems due to the type of lead wire insulating material (Nomex-Kapton) used by the motor vendor. IN 87-08 was subsequently issued and discusses the problem in greater detail.

The licensee performed inspections of all applicable Limitorque operators and discovered that none had the questionable insulation; instead, the DC motor leads have an epoxy impregnated glass braid on top of Nomex type insulation which is considered environmentally qualified by Limitorque. These actions are discussed in a Florida Power Letter, dated February 15, 1988, letter 3F0288-13, to the Region II Administrator.

The licensee has taken satisfactory corrective actions to determine the applicability of this issue to Crystal River. Action on this matter is complete and this issue is considered closed (P2186-03).

d. Two 10 CFR Part 21 reports concerning Limitorque Corporation actuators were received in 1985 by Crystal River, and do not appear to have been evaluated for the design basis hardware functionality

aspect, as follows: (1) A May 8, 1985, Babcock and Wilcox letter discusses Limitorque actuators supplied to the Bellefonte Plant that have an actual weight that exceeds the valve vendor documents and stress analysis bases, which is therefore non-conservative, and (2) An August 13, 1985 Limitorque letter that discusses potential worm shaft gear failures when certain critical speeds are combined with repetitive actuator clutch mechanism transfer of size-2, type SMB, SB and SBD actuators.

The inspector and licensee reviews indicate that the two issues have not been evaluated for their effect on the operation of the plant systems, nor has all of the equipment or systems been identified. Failure to provide an adequate evaluation and procedures to control incoming vendor technical issues is contrary to 10 CFR Part 21 and 10 CFR Part 50, Appendix B, Criterion XVI, and is considered to be a violation (Violation 302/88-24-02). This issue is also discussed in section 9, below. Action on these issues as 10 CFR Part 21 items is complete, and will be followed as part of the corrective action for violation 302/88-24-02. This issue is therefore considered closed (P2185-02).

Violation (302/88-24-02): Inadequate evaluation and procedures to control incoming vendor technical issues.

e. A 10 CFR Part 21 report from GA Technologies (Sorrento Electronics Division), dated February 23, 1987 in regard to a Sorrento Electronics model RD-23 ion chamber detector Rockbestos coaxial cable insulation resistance problem at high temperatures (LOCA conditions). The letter identifies Crystal River as having procured the analog version of its post-LOCA high range radiation monitor (HRRM) system for use in containment.

The inspector reviewed the site nuclear engineering evaluation of the problem, and the package (Doc. Catl. No. T87-73) indicated that Crystal River does not use the RD-23 in the identified application. The package stated, in part, that the Crystal River HRRM devices "...are supplied by Gammametrics and not Sorrento Electronics. Rockbestos cable is not utilized in a safety related function for equipment located in a harsh environment...The attached technical information from Sorrento Electronics is not applicable..." However, contrary to the licensee statements the inspector's review of the Crystal River master instrument list and discussions with licensee staff indicated that Crystal River does have Sorrento Electronics RD-23 devices installed in the HRRM application (RM-G29/G30) and has the Sorrento Electronics RP-23 analog readout module. Additional verification efforts by the inspector appear to indicate that the Rockbestos cables are installed according to the electrical circuit schedules. The licensee's evaluation of this Part 21 report is considered incorrect, and is used as an example in violation 302/88-24-02 because procedures were inadequate to assure that a proper evaluation is conducted.

Subsequent discussions with the licensee staff revealed a second licensee evaluation of a Sorrento followup letter. This evaluation was handled correctly and resulted in a Gilbert/Commonwealth engineering heat transfer calculation being performed to determine if the problem was applicable. The calculation indicates that the cable is qualified for its application. This issue is therefore considered closed (P2187-01).

f. An April 30, 1987 letter from Colt Industries, as required by Section 21.21 of 10 CFR Part 21, identifies an indicator valve plug failure (P/N-92-002-S83) in its Fairbanks-Morse model 38TD8-1/8 EDG adapter relief and indicator valve. The letter recommends that Crystal River remove and inspect the brass plug threads for deterioration and to implement a periodic inspection program at least once in five years. Work Request 89688, dated May 5, 1987 was issued to inspect the plugs on EDG 1A and 1B. All plugs were replaced with new parts, even though no degradation was indicated on the WR. Crystal River interoffice letter No. SNES88-0486 was issued to incorporate an inspection attribute in the EDG preventative maintenance program.

The licensee has taken satisfactory corrective actions to determine the applicability of this issue to Crystal River. Action on this matter is complete, and this issue is considered closed (P2187-02).

g. The inspector reviewed a Crystal River engineering evaluation of a February 10, 1988 letter from Power Conversion, to determined whether or not the licensee evaluated the impact of an electrical circuitry design change (i.e., to increase an existing 100 ampere fuse to a 225 ampere fuse) contained in the Power Conversion letter.

The inspector concluded that the design change was not addressed in the evaluation conducted by the licensee's engineering reviewer, and therefore represents an inadequate evaluation. This is used as an example in violation 302/88-24-02.

In conclusion four out of nine licensee evaluation packages of incoming vendor technical issues that were reviewed were found to be incomplete and/or inadequate. Two Limitorque items, which were in the Nuclear Operations Engineering Department REI format, were initiated in 1985 and 1986 but were found to be incomplete and still open. The other two issues (Sorrento Electronics and Power Conversion) were found in the Nuclear Site Engineering evaluation packages. All four evaluations, as discussed above, do not adequately determine the individual impact on the design function of the component or system.

Thus, the results of this inspection bring into question how many other inappropriate or incomplete technical issues were performed by the licensee staff. The licensee has committed to implement immediate corrective action to determine whether or not this is a problem to the plant components or systems.

UNR (302/88-24-03): To determine the significance of the findings from the licensee's review of the disposition of vendor identified technical issues.

9. Nuclear Operation Selected Procedure Establishment and Implementation Review (42700)

Based on the problems identified as Violation 302/88-24-02, the inspector performed a cursory review of the following procedures:

- NOD-06, Technical Information Program, dated 11/14/85;
- DC/RM-375, Routing and Processing Incoming Technical Information, dated 6/1/85;
- AI-404, Review of Technical Information, dated 7/22/88;
- CP-111, Documenting, Reporting, and Reviewing Nonconforming Operations Reports, dated 6/4/88;
- NL-06, Resolution of Safety Concerns, dated 11/8/85;
- NEP-144, 10 CFR Part 21, dated 6/1/88;
- NEP-141, Corrective Action, dated 6/1/88; and,
- NEP-201, Preparation and Processing of REIs, SPs, and Engineering Studies, dated 6/1/88.

The review indicated that the procedures were inadequate to assure compliance with the requirements of 10 CFR Part 21; therefore, violation 302/88-24-02 was identified.

Furthermore, a review of the procedures appears to indicate that the licensee may not be adequately controlling all of the incoming vendor technical information to assure that the information is addressed per the intent of NRC Generic Letter 83-28. Each department appears to be attempting to establish its own instructions and procedures without verifying that its controls will not negatively affect another procedure or department. The licensee staff is currently reviewing this concern.

UNR (302/88-24-04): To determine the significance of the findings from the licensee's review of the procedural control of vendor identified technical issues.

10. Exit Interview (30703)

The inspector met with licensee representatives (denoted in paragraph 1) at the conclusion of the inspection on August 12, 1988. During this meeting, the inspector summarized the scope and findings of the inspection as they are detailed in this report with particular emphasis on the violation, unresolved items, and inspector followup item.

The licensee representatives acknowledged the inspector's comments and did not identify as proprietary any of the materials provided to or reviewed by the inspectors during this inspection.

11. Acronyms and Abbreviations

ALARA - As Low As Reasonably Achievable
BBC - Brown Boveri Company
BOP - Balance of Plant
BU - Bulletin
CFR - Code of Federal Regulations
DC - Decay Heat Closed Cycle Cooling
DCHE - Decay Heat Heat Exchanger
DH - Decay Heat Removal
EDG - Emergency Diesel Generators
EFW - Emergency Feedwater
FPC - Florida Power Corporation
FSAR - Final Safety Analysis Report
HRRM - High Range Radiation Monitor
IFI - Inspector Followup Item
IN - NRC Information Notice
LCO - Limiting Condition for Operation
LER - Licensee Event Report
LOCA - Loss of Coolant Accident
MAR - Modification Approval Record
NaOH - Sodium Hydroxide
NCOR - Nonconforming Operation Report
NRC - Nuclear Regulatory Commission
NRR - Nuclear Reactor Regulation
PM - Preventive Maintenance
PRC - Plant Review Committee
RCA - Radiation Control Area
RCS - Reactor Coolant System
REI - Request for Engineering Information
RW - Nuclear Services and Decay Heat Seawater
RWP - Radiation Work Permit
SP - Surveillance Procedure
STI - Short Term Instruction
SW - Nuclear Services Closed Cycle Cooling
SWHE - SW Heat Exchanger
TS - Technical Specification
UNR - Unresolved Item
VIO - Violation
WR - Work Request