

APPENDIX B

U. S. NUCLEAR REGULATORY COMMISSION
REGION IV

NRC Inspection Report: 50-458/86-20

License: NPF-47

Docket: 50-458

Licensee: Gulf States Utilities Company (GSU)
P. O. Box 2951
Beaumont, Texas 77704

Facility Name: River Bend Station (RBS)

Inspection At: River Bend Station, St. Francisville, Louisiana

Inspection Conducted: May 1 through June 15, 1986

Inspectors: *Dwight D. Chamberlain* 6-23-86
D. D. Chamberlain, Senior Resident Inspector Date
(pars. 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11 and 12)

Dwight D. Chamberlain for 6-23-86
W. B. Jones, Resident Inspector Date
(pars. 1, 2, 3, 4, 5, 6, 7, 8, 9, and 11)

Approved: *J. P. Jaudon* 7/24/86
J. P. Jaudon, Chief, Project Section A Date
Reactor Projects Branch

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Inspection Summary

Inspection Conducted May 1 through June 15, 1986 (Report 50-458/86-20)

Areas Inspected: Routine, unannounced inspection of licensee action on previous inspection findings, status of operating license conditions, Nuclear Review Board activities, startup test witness, safety system walkdown, operational safety verification, maintenance witness, surveillance witness, licensee plans for coping with strikes and status of TMI action item.

Results: Within the ten areas inspected, two violations were identified (failure to follow administrative procedures for issue of temporary change notices, paragraph 9, and failure to implement procedures to maintain safety system drawing configuration, paragraph 6).

DETAILS

I. Persons Contacted

Principal Licensee Employees

- M. Arant, Technician, Instrumentation and Control (I&C)
- *R. J. Backen, Supervisor (Acting), Operations Quality Assurance (QA)
- W. J. Beck, Supervisor, Reactor Engineering
- *W. H. Cahill, Jr., Senior Vice President, River Bend Nuclear Group
- *E. M. Cargill, Supervisor, Radiation Programs
- *T. C. Crouse, Manager, QA
- *J. R. Cummings, Procedure Coordinator,
- *P. E. Freehill, Superintendent, Startup and Test
- A. O. Fredieu, Assistant Operations Supervisor
- P. F. Gillespie, Senior Compliance Analyst
- D. R. Gipson, Assistant Plant Manager, Operations
- *E. R. Grant, Supervisor, Nuclear Licensing
- *B. R. Hall, Supervisor, Plant Services,
- *R. W. Helmick, Director, Projects,
- *G. K. Henry, Supervisor, Electrical Engineering
- K. C. Hodges, Supervisor, Quality Systems
- *R. J. King, Licensing Engineer
- *A. D. Kowalczyk, Assistant Plant Manager, Maintenance
- *W. H. Odell, Manager, Administration
- *T. F. Plunkett, Plant Manager
- *S. R. Radebaugh, Assistant Plant Manager, Services
- W. J. Reed, Director, Nuclear Licensing
- D. Reynerson, Director, Nuclear Plant Engineering (NUPE)
- N. Simpson, Technician I&C
- *M. H. Small, Acting Supervisor, Operations Quality Control (QC)
- R. B. Stafford, Director, Operations QA
- *K. E. Suhrke, Manager, Projects
- *P. C. Tomlinson, Director, Quality Services
- D. Williamson, Operations Supervisor

The NRC senior resident inspector (SRI) and resident inspector (RI) also interviewed additional licensee personnel during the inspection period.

- *Denotes those persons that attended the exit interview conducted on June 19, 1986. NRC Region IV Section Chief, J. P. Jaudon, NRC resident inspector (RI), W. B. Jones and Nuclear Reactor Regulation (NRR) licensing Project Manager, S. Stern also attended the exit interview.

2. Licensee Action on Previous Inspection Findings

- a. (Closed) Violation (458/8569-01): Failure of design document control program.

This violation was a failure to post approved design changes against the effected design documents and a failure to distribute design change documents to document control stations. NUPE revised procedures NUPE-AA-54 and 59 to provide more control for the posting and routing of design change documents. A 100 percent audit of design change files was conducted, and all noted discrepancies were corrected. Training was conducted on the revised procedural requirements, and subsequent quality assurance surveillances revealed no recurrence of the problem. The SRI reviewed the revised procedures and the other corrective actions.

This violation is closed.

- b. (Closed) Violation (458/8569-02): Improper use of a field change notice.

NUPE issued procedure NUPE-AA-64, "Control and Approval of Field Change Notices (FCN's)" which provides detailed instructions and restrictions for the use of FCNs. The licensee had conducted an audit of the design change files and the discrepancies noted had been corrected. Training of NUPE personnel responsible for completing FCN's had been completed.

This violation is closed.

- c. (Closed) Violation (458/8604-01): Failure to control temporary circuit alterations administratively.

The licensee actions in response to this violation included: a complete inspection of control room panels for unauthorized lifted leads or jumpers; QC hold points included in electrical maintenance work requests to inspect for proper restoration; implementation of a main control room cabinet access and work monitoring program; the change of control room panel locks; a maintenance procedure revision serialized tagging of any lifted lead or jumper for accountability and the temporary alterations program was suspended and replaced by design modification request procedures. The SRI has monitored licensee actions relative to temporary alterations, and the additional controls appear to be effective.

This violation is closed.

- d. (Closed) Violation (458/8581-01): Failure to maintain a controlled copy of a temporary change notice (TCN) in front of the affected controlled procedure in the control room Station Operating Manual (SOM)

The licensee took immediate corrective actions by performing a departmental review of all station operating procedures (SOPs), abnormal operating procedures (AOPs), and emergency operating procedures (EOPs). During the review, the licensee identified several SOP's with duplicate copies of the same TCN and a few TCN's filed with the wrong SOP. These conditions were immediately corrected.

Responsibility for maintaining and ensuring that updates to the Main Control Room procedure manual are properly filed has been reassigned to Station Document Control (SDC). Periodic reviews of the Main Control Room SOMs are being conducted by the SDC in accordance with administration procedure ADM-005, "Station Document Control," Section 6.6.

This violation is closed.

3. Status of Operating License Conditions

Facility Operating License NPF-47 for River Bend Station was issued on November 20, 1985, and Attachment 1 to this license contains items which must be completed to the satisfaction of NRC Region IV. The following status is provided for the Attachment 1 license conditions:

- a. (Closed) License Condition 1.a.: Verify the station electric distribution voltage analyses are in accordance with the guidelines of Branch Technical Position PBS-1, Position 4, prior to completion of the initial test program.

GSU has completed special situation test 1-SST-6, "Bus Load Test," and the results were provided to Stone and Webster (S&W) for comparison to analytical model results. Memorandum S-CRB-9031 dated June 4, 1986, summarizes the results of that comparison and indicates that the test versus analytical results are acceptable with no test voltage drops more than 3 percent lower than the analytical values as recommended by Branch Technical Position PSB-1.

This license condition is closed.

- b. (Closed) License Condition 1.b: Evaluate and complete modifications on battery powered lighting systems used in areas of the plant outside the main control room required for safe shutdown and personnel evacuation prior to completion of the initial test program.

The RI reviewed the licensee's emergency lighting plan as detailed on Stone and Webster Lighting Plan drawings 12210-EE-65 thru 79. Emergency lighting stations were selected from the drawings and verified to be installed and operational for areas identified in Final Safety Analysis Report (FSAR) Table 9.5-2, "Illumination Level and Type of Fixtures used in Plant Areas Necessary for Safe Shutdown and Evacuation of Personnel." In addition, areas previously

identified as being deficient in illumination were selectively observed to meet the requirements of Table 9.5-2. As a result of this walkdown, one area was identified which did not meet the minimum illumination requirements. The area identified was an egress stairwell located on the east side of the turbine building between the elevation 95'0" and 123'6". The licensee initiated modification request (MR) 86-162 and maintenance work request (MWR) 41124 to install the emergency light. This work was completed on June 15, 1986.

This license condition is closed.

4. Nuclear Review Board Activities

The RI reviewed the Nuclear Review Board (NRB) minutes for the period February 1985 thru December 1985, to assess the overall effectiveness of the licensee's implementation of the off-site review committee. These minutes were evaluated against the NRB responsibilities outlined in Section 6.5.3 of the Technical Specifications (TS) and the NRB Manual. The RI noted during the above review, that the NRB has chartered four subcommittees to assist the NRB in fulfilling their responsibilities. These subcommittees are:

- o "Unreviewed Safety Questions Committee" (USQC);
- o "Quality Assurance Program Audit Committee" (QAPAC);
- o "Quality Concern Subcommittee;" and
- o "NRB/FRC Committee"

The USQC was established to assist the NRB in meeting its responsibilities for reviewing proposed changes to the plant and its documentation to ensure that changes are not made which constitute an unreviewed safety question. Specifically, the USQC will review:

- o all safety evaluations for changes to procedures, equipment, systems or experiments which were determined not to involve unreviewed safety questions;
- o selected procedures, equipment, systems, tests and experiments which did not receive an evaluation to verify that they were properly classified and did not require a safety evaluation;
- o changes which were determined to be unreviewed safety questions and the associated changes to licensing documents;
- o. proposed changes to the Operating License or TS; and
- o violations of codes, regulations, orders, TS license requirements, procedures and instructions having nuclear safety significance.

The QAPAC was chartered to advise the NRB on the effectiveness of the Quality Assurance Program. This is accomplished thru the QAPAC's participation in and review of audits performed by the QA audit group for the areas required by 6.5.3.8 of the TS. The requirement of the QAPAC to audit the Operational Quality Assurance Program every 24 months for compliance with 10 CFR part 50, Appendix B, is being fulfilled thru the Joint Utility Audit Group (JUAG).

The Quality Concern Subcommittee receives and coordinates quality concern inquiries dealing with the operation of the quality assurance department and management of the River Bend Nuclear Group. This committee insures that proper action is taken by all departments to allegations or inquiries which are received.

The NRB established the NRB/FRC Committee to monitor the FRC's activities. This Committee assesses the FRC's fulfillment of its responsibilities by:

- o reading all FRC minutes and other reports issued by the FRC;
- o occasional attendance at FRC meetings;
- o occasional verification of an FRC review item; and
- o semi-annual meetings to discuss FRC activities.

The above subcommittees chartered by the NRB appear to be adequate to meet the function and responsibilities established in the Technical Specifications for the licensee's off-site review committee. The NRB meeting minutes reviewed by the RI for the period February 1985 thru December 1985 demonstrate that the NRB members are cognizant of their responsibilities and have established programs to fulfill these responsibilities. The NRC inspectors will evaluate the effectiveness of the NRB during future inspections.

No violations or deviations were identified in this area of the inspection.

5. Startup Test Witness

During this inspection period, the SRI and RI witnessed startup testing conducted under the startup testing program. The NRC inspectors observed that: personnel conducting the test were cognizant of the test acceptance criteria, precautions and prerequisites prior to beginning the test; the test was conducted in accordance with an approved procedure; the test procedure was being used and signed off by the personnel conducting the test; and data were being collected and recorded as required. The NRC inspectors witnessed the following startup tests:

- o 1-ST-27 Turbine Trip and Generator Load Reject
- o 1-ST-28 Shutdown from Outside the Control Room
- o 1-ST-25B Main Steam Isolation Valve (MSIV) Full Closure
- o 1-ST-19 Core Performance

The following observations were made during the performance of the above startup tests:

- o Test 1-ST-27 Turbine Trip and Generator Load Reject:

The SRI and RI observed the performance of Section 6.3, "High Power Generator Load Rejection" to startup test 1-ST-27, "Turbine Trip and Generator Load Rejection" on May 29, 1986. The reactor was at approximately 96 percent thermal power when a generator load rejection was initiated by tripping a generator differential relay. This caused both generator output breakers to open and a turbine control valve fast closure (TCVFC) to occur. The reactor scrambled, as expected, when the TCVFC signal was initiated. The peak reactor pressure reached during the transient was 1106 psig. The NRC inspectors noted that the bypass valves opened along with nine safety relief valves (SRV) to reduce and control reactor pressure. Following the initial SRV blowdown, only 1 SRV was observed to reopen, which is consistent with the test acceptance criteria. The licensee is presently evaluating SRVs B21*F041D and B21*F041F which apparently opened briefly in their safety mode. The results of this evaluation will be reviewed by the NRC inspectors during their review of 1-ST-27 test results. The licensee has collected test data to evaluate for conformance to acceptance criteria.

No violations or deviations were identified in this area of inspection.

- o 1-ST-28 Shutdown from Outside the Control Room:

The SRI and RI observed the performance of Section 6.3, "Cold Shutdown from Outside the Control Room", on May 30, 1986. Following the reactor scram initiated during 1-ST-27, reactor pressure was reduced to 120 psig from the main control room (MCR). The licensee had previously demonstrated the ability to scram and maintain the reactor in hot shutdown from outside the control room on February 15, 1986. With reactor pressure at 120 psig, control of the Division I residual heat removal (RHR) system was transferred from the MCR to the remote shutdown panel (RSP). When the nuclear control operators (NCO) began to realign the RHR system from the low pressure coolant injection (LPCI) mode to the RHR mode, the suppression pool suction valve 1E12*F004A indication failed in the intermediate position.

After verifying locally that 1E12*F004A was closed, the NCO attempted to open 1E12*F006A valve as required to establish shut down cooling. This attempt failed however because of the interlock that prevents the F006A valve from opening if the F004A is not in the closed (indicated) position. Control of the division II RHR system was then transferred to the division II RSP and the system aligned to the shut down cooling mode without incident. The NCO established a cooldown rate of approximately 80°F per hour with the heat transfer path to the standby service water system. The licensee has collected the test data to evaluate for conformance to acceptance criteria.

No violation or deviations were observed in this area of inspection.

o Test 1-ST-25B Main Steam Isolation Valve (MSIV) Full Closure:

The RI witnessed the performance of startup test 1-ST-25B, "MSIV Full Closure", on June 8, 1986 with reactor power at 100 percent and rated core flow at 96 percent. The licensee initiated the test at 1733 hours by simulating a loss of condenser vacuum which results in the MSIVs closing when in the run mode. Upon initiation of the MSIV full closure, the reactor tripped and the SRVs opened momentarily to control pressure. Following the initial opening of the SRVs, only 1 SRV was observed to reopen. The high pressure core spray (HPCS) and reactor core isolation cooling (RCIC) systems initiated on reactor vessel water level reaching the level 2 setpoint. The reactor vessel water level recovered quickly because of the subsequent swell of vessel water and the continuous feed from the reactor feed water pumps. The NCO secured the HPCS injection valve prior to the system injecting based on the rising vessel water level. Approximately 3 minutes into the transmit, the reactor feed pumps tripped on vessel high level. The reactor feed water B pump was subsequently restarted and vessel level maintained within the normal band. Control room conduct during the test was observed to be well coordinated and efficient. The licensee has collected the test data to evaluate for conformance to acceptance criteria.

No violations or deviations were identified in this area of inspection.

o Test 1-ST-19 Core Performance

The SRI witnessed the running of traversing incore probe (TIP) traces in preparation for computer calculation of reactor power/thermal limits. The required data was extracted and inserted into startup test procedure 1-ST-19, "Core Performance" by the licensee for test condition (TC) 6 verification of core thermal limits and core thermal power. A preliminary review of the test data by the SRI revealed that core thermal limits were well within the TS limits and core thermal power was approximately 99.3 percent of rated thermal power.

No violations or deviations were identified in this area of inspection.

6. Safety System Walkdown

During this inspection period, the SRI and RI performed a walkdown of the "C" RHR system to verify proper system alignment for operability as required by TS for Operational Conditions 1, 2, 3, 4, and 5. It was observed that:

- o system valves were properly aligned;
- o abnormal control room instrumentation readings or alarms were present;
- o no leakage from major components was present;
- o the "C" RHR pump upper and lower bearing oil reservoirs were properly filled; and
- o accessible hangers and supports were intact.

No anomalies were noted that would have affected "C" RHR system operability for low pressure coolant injection (LPCI). However, certain discrepancies were noted when comparing the system condition/lineup with the engineering piping and instrument diagrams (PIDs). It was noted that pipe caps were missing from five vent and drain locations where PID-27-7C indicated caps were installed; valve E12*MOVF064C which was open showed closed on PID-27-7C; and valve E12*VF063C was not locked as shown on PID-4-3C. Also, several valves were locked closed although the drawings did not indicate locks installed. The failure to implement procedures to maintain a safety system condition/lineup as shown on design output drawings or to modify the design output drawings to reflect the required system condition was identified by the SRI as an apparent violation (458/8620-02). Subsequent discussions with licensee management revealed that minimum flow valve E12*MOVF064C is open for standby operation and condensate fill and flush valve E12*VF063C (not a major flow path valve) had been identified as unlocked during an operations review of all valves on the locked valve list. It had been noted that the valve was unlocked and inaccessible without a scaffold or ladder. No action had been taken to gain access to the valve to install a lock. The licensee took immediate action to obtain ladders, and the valve was locked as shown on PID-4-3C when the SRI identified that the valve was not locked. It was also noted that the system operating procedure valve lineup did not indicate that valve E12*VF063C was to be locked closed as show on the PID. In response to the identified violation, the licensee should address how they will assure that PID drawing, Stone and Webster flow diagrams, system operating procedure valve lineups, locked valve lists and actual system configuration are consistent for an identified system operational condition and they should identify procedural controls which allow deviation from drawing requirements. For example, procedures may allow

the locking of more valves than shown on the drawings at the discretion of the operations staff. This issue should also be addressed for other drawings/documents used routinely by operations and/or maintenance for performance of work activities.

7. Operational Safety Verification

The SRI and RI observed operational activities throughout the inspection period and closely monitored operational events. Control room activities and conduct were observed to be well controlled and efficient. Proper control room staffing was maintained and access to the control room operational area was controlled. The licensee was adhering to limiting conditions for operation (LCO) as they occurred. Operators were questioned regarding lit annunciators and they understood why the annunciators were lit in all cases. Selected shift turnover meetings were observed, and all necessary information concerning plant status was apparently being covered in these meetings. A walkdown of the "C" RHR system was conducted, and the valves were observed to be in the proper position for standby operation. Several plant tours were conducted and overall plant cleanliness was good. During these plant tours, radiation protection area postings were observed to be accurate.

During this inspection period the licensee completed a 100 hour verification run at full power operation, and all planned startup testing was completed.

No violations or deviations were identified in this area of inspection.

8. Maintenance Witness

During this inspection period, the RI observed portions of selected corrective maintenance activities to verify that maintenance activities are being conducted in accordance with approved procedures, TS and appropriate industrial codes and standards. The RI verified through direct observation and review of records that:

- o maintenance activities did not violate LCOs;
- o redundant components were available;
- o required administrative approvals and tagouts were obtained before initiating work;
- o procedures were adequate to control the work;
- o radiological controls were properly implemented where applicable;
- o QC hold points were established and observed; and
- o replacement parts and materials used were properly certified.

The following two corrective maintenance activities were observed:

o Control Rod Drive (CRD) Cooling Water Check Valve:

On May 7, 1986, the licensee experienced a failure of control rod 24-33 to insert or withdraw during control rod manipulations. Trouble shooting of the hydraulic control unit (HCU) revealed that CRD cooling water check valve C11-V138 was not reseating when drive water was applied to HCU 24-33. This condition allowed the drive water to flow back thru the cooling water line and thus the necessary lift was not being provided to the CRD drive piston to insert the rod or retract the collet finger to allow withdraw of the control rod. This condition would not have prevented the control rod from inserting during a reactor scram.

The licensee initiated prompt maintenance work request (MWR) 39099 to clean, inspect and replace if necessary the ball checks to CRD cooling water check valve C11-V138 on HCU 24-33. The RI verified prior to initiating work that the MWR had been properly initiated; QC notification points were established, the job plan was appropriate to control the work; and a job briefing had been performed as evidenced by maintenance personnel signatures on the job briefing sheet. In addition, the RI verified the requirements of T.S. 3.1.3.1 for an inoperable control rod were being complied with.

Prior to initiating work, the nuclear equipment operator (NEO) obtained the shift supervisors permission to isolate HCU 24-33. The HCU was then isolated and tagged out using clearance number 86-192, and the ball was removed from the check valve. Inspection of the ball revealed surface scratches and abrasions. Subsequent flushings of the cooling water line produced a 1/2" x 1/16" round metal sliver. A new ball was then installed in the check valve and the system verified operable using surveillance test procedure STP-052-0101, "Control Rod Movement Operability Check." LCO 86-394, which was initiated to track the action requirements of T.S. 3.1.3.1 was closed based on the acceptable performance of STP-052-0101.

No violations or deviations were identified in this area of inspection.

o Division II Emergency Diesel Generator:

During the performance of surveillance test STP-309-0202, "Diesel Generator Division II Operability Test," on June 5, 1986, the "ready to load" light did not illuminate after the diesel generator achieved rated frequency and voltage. The licensee noted this condition and immediately shut down the diesel. The failure of the "ready to load light" to illuminate indicates that the standby generator breaker 1ENS*ACB27 would not have closed onto standby buss 1ENS*SW61B. Prompt MWR 41549 was then initiated to trouble shoot and restore the ready to load circuit to operable status. The RI reviewed the MWR

prior to the initiation of work and verified that a deficiency tag had been placed and the applicable LCO initiated. The appropriate hold points were placed in the procedure and a quality control representative was present during the performance of this MWR. The RI verified that the lifted leads were identified in the Lifted Lead and Jumper Log as tag numbers 86-3101-001 thru 006 and that the restored leads were independently verified.

The licensee identified that relays EGS*UVRA-UVRB needed the pick up voltages adjusted to within the setpoint limits. This work was subsequently performed under MWR 41549, and the diesel restored to operable status at 2041 hrs after the successful completion of surveillance STP-309-0202. LCO 86-472 was then cancelled at 2045 hours.

No violations or deviations were identified in this area of inspection.

9. Surveillance Witness

The SRI and RI witnessed surveillance testing conducted by the licensee during this inspection period and the following observations were made:

o Surveillance Test STP-051-4210:

The SRI witnessed a portion of the instrumentation surveillance STP-051-4210, "RPS/RHR Reactor Vessel Steam Dome Pressure - High, Monthly Chfunct, 18 Month Chcal, and 18 Month LSFT (B21-N078B, B21-679B)" conducted on May 28, 1986. The portion of the test observed was known to cause a half scram signal and the technicians were cautious in verifying the other division was not tripped prior to test performance. They also limited the time that the half scram was allowed to be in by close coordination with the operations staff. During the performance of this test it was noted that there were more than one copy of certain pages of the procedure in the official work copy. This created some confusion during test performance. The SRI discussed this with instrumentation maintenance supervision and it was discovered that there were seven open TCNs against this procedure and the preparer of the last TCN (No. 86-0581) had failed to use copies of previous permanent TCN pages to markup for the new TCN as required by administrative procedure. This resulted in the official work copy of the procedure containing three page eights and three page elevens with a different TCN number on each page. This failure to follow administrative procedures for issue of TCNs was identified by the SRI as an apparent violation (458/8620-01).

The SRI also discussed the status of incorporation of TCNs in procedure revisions in response to a previous NRC violation and it was found that there are a total of 38 procedures with more than three open TCNs out of a total procedure population of

approximately 3500. The SRI requested a date from licensee management for revision of these 38 procedures to incorporate the open TCNs and management stated that these procedures would be issued by September 1, 1986.

o Surveillance Test STP-309-0202:

The RI observed the performance of surveillance STP-309-0202, "Diesel Generator Division II Operability Test," Revision 5 on June 5, 1986, with the plant in operational condition 1. This surveillance is designed to demonstrate the operability of the Division II diesel generator and satisfies T.S. Sections 4.8.1.1.2.a.1 through 4.8.1.1.2.a.7 and 4.8.1.1.2.c.1 and c.2.

Prior to initiating the test, communications were established between the NEO at the remote diesel panel and the NCO in the Main Control Room. LCO 86-472 had previously been initiated in accordance with T.S. 3.8.1.1.b because of the preplanned preventive maintenance (PM) which had been performed on this diesel generator prior to beginning STP-309-0202. Upon initiation of the STP, the diesel generator was observed to attain rated frequency and voltage within the required 10 seconds, however the "ready to load" light did not illuminate at either the remote panel or in the main control room. The diesel generator was shutdown within 30 seconds of its starting and prompt MWR 41549 initiated. The failure of the "ready to load" light to illuminate indicates that the standby generator breaker IENS*ACB27 would not have closed onto standby bus IENS*SW61B. After verifying the diesel generator had failed its surveillance test, the licensee initiated the actions required by T.S. 3.8.1.1.b for an inoperable diesel generator, because of any cause other than the performance of preplanned preventive maintenance.

MWR 41549 was completed at 2015 hours on June 5, 1986, and STP-309-0202 was satisfactorily performed. LCO 86-472 was then closed based on the diesel generator satisfying the operability test.

No violations or deviations were identified in area of the inspection.

10. Licensee Plans for Coping With Strikes

The SRI reviewed licensee plans for coping with strikes during this inspection period. It was found that the licensee had addressed such issues as personnel/training requirements, security support requirements, offsite support, etc. This area will be reviewed further during future NRC inspections as required.

No violations or deviations were identified in this area of inspection.

11. Status of TMI Action Item

(Closed) NUREG-0737, Item I.G.1: Training during initial startup test phase.

The licensee has completed the initial startup test program training requirements as described in NUREG-0737, Item I.G.1 and FSAR Section 14.2.3 Training During Initial Startup Test Phase. The startup test training program was established to assure that personnel from each of the six operating shift crews:

- o observed a reactor scram;
- o observed a pressure regulator transient;
- o observed a water level setpoint transient;
- o operated the operation of RCIC system; and
- o observed a turbine trip or load rejection.

The startup test program was balanced, as much as practical, between the six shifts to assure that each shift was exposed to the above, off-normal events. This has resulted in each shift having at least four individuals who have observed actual plant responses for each of these events. Based on the shift experience that now exists for each shift crew, no further licensee action regarding NUREG-0737, Item I.G.1 is necessary.

This TMI action item is closed.

12. Exit and Inspection Interview

An exit interview was conducted on June 19, 1986, with licensee representatives (identified in paragraph 1). During this interview, the SRI reviewed the scope and findings of the inspection.