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

Report No.: 50-302/87-01

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 Dates: January 8 - February 5, 1987

Inspectors: _____ 2/24/87
W. F. Stetka, Senior Resident Inspector Date Signed

_____ 2/24/87
J. E. Tedrow, Resident Inspector Date Signed

Approved by: _____ 2/26/87
B. A. Wilson, Section Chief Date Signed
Division of Reactor Projects

SUMMARY

Scope: This routine inspection was conducted by two resident inspectors in the areas of plant operations, security, radiological controls, Licensee Event Reports and Nonconforming Operations Reports, facility modifications, review of IE Bulletins and Notices, 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 and one Deviation were identified: (Failure to adhere to plant procedures, paragraphs 5.b(8)(a), 5.b(8)(b), and 6.b(5); Failure to meet a commitment to the NRC, paragraph 3).

REPORT DETAILS

1. Persons Contacted

Licensee Employees

*J. Alberdi, Manager, Nuclear Site Support
*G. Becker, Manager, Site Nuclear Engineering Services
*P. Breedlove, Nuclear Records Management Supervisor
*R. Bright, Manager, Nuclear Licensing
*M. Collins, Nuclear Safety & Reliability Superintendent
G. Halnon, Nuclear Results Specialist
*B. Hickle, Manager, Nuclear Plant Operations
H. Koon, Assistant Nuclear Maintenance Superintendent
*K. Lancaster, Manager, Site Nuclear Quality Assurance
*M. Mann, Nuclear Compliance Specialist
R. Marckese, Nuclear Engineer
*P. McKee, Director, Nuclear Plant Operations
W. Neuman, Inservice Inspection Specialist
*J. Roberts, Nuclear Chemistry Manager
V. Roppel, Manager, Nuclear Plant Technical Support
*W. Rossfeld, Nuclear Compliance Manager
*E. Simpson, Director, Nuclear Operations Engineering and Licensing
P. Skramstad, Nuclear Chemistry/Radiation Protection Superintendent
F. Sullivan, Supervisor, Site Nuclear Engineering Services
*E. Welch, Manager, Nuclear Electrical/I&C Engineering Services
*G. Westafer, Director, Quality Programs
*K. Wilson, Manager, Site Nuclear Licensing
*M. Wilson, Senior Nuclear Maintenance Specialist
*R. Wittman, Nuclear Operations Superintendent

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

NRC Personnel

*B. Mozafari, NRC Licensing Project Manager
*H. Silver, NRC Licensing Project Manager
*B. Wilson, DRP Section Chief

*Attended exit interview

2. Exit Interview

The inspector met with licensee representatives (denoted in paragraph 1) at the conclusion of the inspection on February 5, 1987. During this meeting, the inspector summarized the scope and findings of the inspection with particular emphasis on the Violation, Deviation, and Inspector Followup Items (IFI).

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.

3. Licensee Action of Previous Inspection Items

(Closed) IFI 302/86-38-03: The licensee has provided the inspector with the new load profiles for the Unit 1 and Unit 2 batteries which supply control power to the 230 KV switchyard. This information was reviewed with the revised surveillance test procedures to ensure that the correct load profiles were being tested. No discrepancies were noted and this item is considered closed.

(Closed) IFI 302/86-33-04: The licensee has submitted a letter to the NRC on January 15, 1987 in response to Generic Letter 81-21 and NUREG-0737 Item II.E.1.1 clarifying the minimum amount of water required to be maintained in the Condensate Storage Tank (CST). The licensee has determined that approximately 350,000 gallons of feedwater would be required to cooldown the plant to cold shutdown in the event of a loss of off-site power. Although this volume of water exceeds the capacity of the CST, sufficient amounts of water from alternate sources on site are available to support cooldown. The licensee plans to correct the inaccurate statements in the Final Safety Analysis Report (FSAR) regarding the necessary volume of water required to achieve the cold shutdown condition. This item will remain open pending revisions to the FSAR.

(Closed) Violation 302/85-44-03: The licensee has completed and the inspector has verified the completion of the following items:

- Radiological Safety Incident Report (RSIR) #85-0482 was written on December 30, 1985, to describe the event and to formulate a corrective action path.

- An investigation was conducted as required by procedure SNOP-5 and the individual involved received appropriate counseling as documented in an Interoffice Correspondence dated January 14, 1986.

- A management review board was convened on January 17, 1986, as required by procedure SNOP-5 to review the event and determine whether completed corrective actions were adequate.

Action on this item is considered to be complete.

(Closed) Violation 302/85-44-06: The licensee has completed and the inspector has verified the completion of the following items:

- Non-conforming Operations Report (NCOR) 85-249 was issued on December 10, 1985 to document the event and provide the mechanism for further review. As a result of this NCOR, Licensee Event Report (LER) 85-32 dated January 6, 1986 was issued.

- The individual involved in this event was made aware of the reporting requirements as documented in a Memorandum dated February 3, 1987.

Action on this item is considered to be complete.

(Closed) Violation 302/86-14-01: The licensee has completed and the inspector has verified the completion of the following items:

- Work Request (W/R) #076070 was issued on June 5, 1986 to reset the torque switch in accordance with enclosure 9 of procedure MOP-405. The switch was reset on this date as documented in enclosure 1 of this procedure.

- Site Nuclear Engineering Services (SNES) conducted an evaluation on December 16, 1986, and as a result of this evaluation required all engineering personnel to review procedure CP-113, Documenting, Reporting, and Reviewing Nonconforming Operations Reports. This review was completed as documented by a personnel sign-off sheet.

Action on this item is considered to be complete.

(Closed) Violation 302/86-14-05: The inspector verified that procedure MP-405 was revised (Revision 16 dated December 11, 1986). This new revision clarified the applicable test criteria for the various cable types and should prevent recurrence of this violation.

(Closed) Deviation 302/86-23-01: In a revised response to NRC Inspection Report 50-302/85-26 dated September 5, 1986, the licensee changed their commitments to delete those items that the licensee did not intend to make and to specify the actual actions taken. The revised commitments have been reviewed and are considered to be adequate. Additionally the licensee has established a system whereas compliance personnel are now required to verify that the corrective actions stated in an NRC response are completed.

(Open) Violation 302/86-23-02: The licensee has completed and the inspector has verified the completion of the following items:

- W/R #82071, which was written to correct the piping error, was completed on July 31, 1986. Additionally the inspectors walked down the system to verify correct installation.

- Procedure MOP-204, Orientation, Indoctrination, and Training of Nuclear Outage and Modifications Personnel, revision 2 dated July 8, 1986, contains appropriate training to assure that personnel complete their assigned duties.

The licensee still has not completed the post installation retest that was committed to be performed in their response dated October 17, 1986. The response stated that this retest would be accomplished "...during the next cold shutdown of sufficient duration or prior to start-up from the next refueling outage, whichever comes first.".

In a telephone call to the inspector on January 30, 1987, licensee personnel informed the inspector that the response to this violation was going to be revised such that the necessary retesting would not be accomplished until the next refueling outage. The basis for this revision was that there did

not appear to be an outage of sufficient duration to allow running the test. The inspector questioned licensee personnel to determine what duration of time and plant conditions were necessary to run the test. The response was that the plant would have to be in cold shutdown for five days with a Reactor Building (RB) purge in operation.

Subsequent to this telephone conversation, the inspector reviewed plant records and determined that the plant was in a cold shutdown condition with a RB purge in operation on November 14-21, 1986 (7 days), and on November 22 - December 23, 1986 (31 days). During these periods the licensee had sufficient time to perform the retesting but failed to do so. Furthermore, discussions with plant engineering personnel indicate that there were no plans to conduct the retest prior to the next refueling outage.

Failure to complete the corrective actions as stated in the October 17, 1986, response letter to the NRC is considered to be a deviation from a commitment to the NRC.

Deviation (302/87-01-01): Failure to meet a commitment as stated in the response letter to Violation 86-23-02 dated October 17, 1986.

For record purposes, Violation 86-23-02 is considered to be open pending completion of the post maintenance retest.

(Closed) Violation 302/86-23-05: The licensee has completed and the inspector has verified the completion of the following items:

- Previous test data was evaluated as documented in a letter dated October 3, 1986, and these tests were all satisfactory. Data for tests performed on July 12, 1983, July 20, 1985, and May 29, 1986, were also reviewed to verify that acceptable results were obtained.

- A visual inspection was conducted on September 9, 1986.

  SNES personnel were directed by an Interoffice Correspondence dated November 5, 1986, to read the violation, violation response, and procedure AI-400, Plant Operating Quality Assurance Manual Control Document, and document completion of this reading. All applicable personnel have completed this reading.

  Procedure SP-187 has been revised as revision 13, dated November 7, 1986, to include a note in step 9.2.5 specifying that the step implements a TS requirement.

  Action on this item is considered to be complete.

(Open) Violation 302/86-23-08: The licensee has installed and bolted down all of the missile shields. The status of the missile shields was verified by the inspectors at the time of installation and periodically during routine plant tours. Procedure SP-434 was revised as revision 18 dated August 22, 1986, to specify that the shields must be bolted in place, however the procedure does not appear to cover all the missile shields and

does not recognize that one of the shields only uses two in lieu of four bolts. The licensee will review procedure SP-434 and make the necessary revisions. This item remains open pending completion of these revisions.

(Closed) IFI 302/84-30-04: The licensee implemented procedure PM-164, Raw Water Lining Inspection, on November 11, 1986, and has added this inspection to the preventative maintenance program. The next inspection is scheduled for September 22, 1987.

(Closed) IFI 302/85-33-08: The licensee completed their evaluation and determined that a verification that instrument power was available was an appropriate addition to procedure VP-580, Plant Safety Verification Procedure. Procedure VP-580 was revised as revision 4 on October 18, 1985, to include this verification.

(Open) Unresolved Item 302/85-26-02: The licensee revised procedure AI-401, Origination of and Revisions to POQAM Procedures, as revision 8 to clarify the Interim Change (IC) revision requirements. Recent events, however, have indicated that further clarification is necessary. The licensee is making additional revisions to AI-401 and this item remains open pending NRC review of these revisions.

4. Unresolved Items

No new unresolved items were identified during this inspection period.

5. Review of Plant Operations

The plant began this inspection period in the cold shutdown (Mode 5) condition. Following repairs to all four reactor coolant pump seals, a plant heatup was conducted and the hot standby (Mode 3) condition was reached at 12:53 a.m. on January 22. At 11:45 a.m. on January 23, a reactor startup was performed and criticality achieved. Power operation (Mode 1) was resumed at 1:00 p.m. on January 23. The plant continued power operation for the remainder of this inspection period.

a. Shift Logs and Facility Records

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

The following records were reviewed:

Shift Supervisor's Log; Outage Shift Manager'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 (STIs); 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

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; reactor building; battery rooms; and, electrical switchgear rooms.

During these tours, the following observations were made:

(1) Monitoring Instrumentation - The following instrumentation was 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 - The inspector conducted a walkdown of the Containment Hydrogen Monitor (WS) 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 - 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 - 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.

No violations or deviations were identified.

(5) Radiation Areas - Radiation Control Areas (RCAs) were observed to verify proper identification and implementation. These observations included selected licensee conducted surveys, review of step-off pad conditions, disposal of contaminated clothing, and area posting. Area postings were independently verified for accuracy by the inspectors. The inspectors also reviewed selected radiation work permits and observed the use of protective clothing, respirators, and personnel monitoring devices to assure that the licensee's radiation monitoring policies were being followed.

No violations or deviations were identified.

(6) Security Control - Security controls were observed to verify that security barriers were intact, guard forces were on duty, and access to the protected area (PA) was controlled in accordance with the facility security plan. Personnel within the PA were observed to verify proper display of badges and that personnel requiring escort were properly escorted. Personnel within vital areas were observed to ensure proper authorization for the area.

While touring the plant on January 9, 1987, the inspector observed a plant security guard sleeping while on watch. The inspector notified plant security personnel and immediate actions were taken to correct the situation. This finding resulted in a violation. Further details of this event and the violation are discussed in NRC Inspection Report 50-302/87-02.

(7) Fire Protection - 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.

No violations or deviations were identified.

(8) Surveillance - 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-110, Reactor Protective System Functional Testing;
- SP-157A, Meteorological System Surveillance (Daily);
- SP-181, Containment Air Lock Test (Semiannual);
- SP-312, Heat Balance Calculations;
- SP-317, RC System Water Inventory Balance;
- SP-332, Monthly Feedwater Isolation Functional Tests;
- SP-358A, Operations ES Monthly Automatic Actuation Logic Functional Test #1;

- SP-381, Locked Valve List (Position Verification of Locked Valves);
- SP-390, Startup Surveillance Log;
- SP-422, RC System Heatup and Cooldown Surveillance; and,
- SP-502, Fire Pump Diesel Batteries Weekly Check.

(a) During the review of the completed data for procedure SP-422, performed on January 13, 1987, it was noted that the Reactor Coolant System (RCS) heatup calculation was performed incorrectly. This procedure was performed to monitor RCS heatup while the plant was in Mode 5 with the decay heat removal system in operation and the reactor coolant pumps secured. Step 4.3 of the procedure requires that the indicated Decay Heat (DH) cooler outlet temperature be used for calculations with the plant in this condition. This step implements the requirements of TS 3.4.9.1, figure 3.4-3. Instead of using the DH cooler outlet temperature, the operator calculated the heatup using an average temperature difference. The RCS temperature was obtained by averaging the DH cooler inlet and DH cooler outlet temperatures. The difference between these average temperatures was then used for heatup calculations.

The inspector recalculated the inaccurate heatup calculations utilizing the required cooler outlet temperatures and verified that the TS heatup limits were not exceeded.

Failure to adhere to the requirements of a surveillance procedure is contrary to the requirements of TS 6.8.1 and is considered to be a violation.

Violation (302/87-0[illegible]02): Failure to adhere to procedures as required by TS 6.8.1.

(b) During the performance of procedure SP-181, conducted on January 13-14, 1987, two instances of failure to adhere to the procedure were observed.

This procedure is used to leak test the containment personnel air lock. This test is accomplished by pressurizing the air space inside the air lock and measuring the flow of test gas required to maintain the desired pressure. A fast charging hose is installed to provide a rapid source of service air to initially pressurize the test volume. Once test pressure is achieved, a leak rate monitor is connected to accurately measure the flow of test gas needed to maintain pressure.

The inspector observed that the fast charging hose was not disconnected from the service air header prior to measuring the air lock's leak rate as required by enclosure 1, step 3.2 of the procedure. When the test engineer was questioned about this discrepancy, he responded that a vent valve between the air source and test volume had been opened to prevent service air from entering the test volume and

affecting the measurements of the leak rate monitor. Although this action did not appear to have adversely affected the results of the test, it was not in compliance with procedure requirements.

Further, step 6.2 of the procedure requires that warning signs be posted on both sides of the air lock stating that a test is in progress and that the air lock must not be used. No warning signs were present. The test engineer stated that these signs were not posted since personnel were stationed at the air lock access to prevent the air lock from being used and that signs were, therefore, nor necessary.

When FPC management was informed of these findings, the warning signs were posted and the test was rerun strictly in accordance with the procedure. Test results were satisfactory.

Failure to adhere to the requirements of a surveillance procedure is contrary to the requirements of TS 6.8.1 and is considered to be another example of Violation (302/87-01-02) discussed above.

(9) Maintenance Activities - 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:

- Disassemble and rebuild reactor coolant pump seal packages in accordance with procedure MP-199;
- Troubleshooting of test channel "A" steam rupture matrix in accordance with procedure MP-531;
- Visual inspection of AC and DC reactor trip breakers;
- Inspection and repair of a spare AC reactor trip breaker (CRDM #10) in accordance with procedure PM-118; and,
- Repacking of valve MUV-16 in accordance with procedure MP-111.

No violations or deviations were identified.

(10) Radioactive Waste Controls - Solid waste compacting and selected liquid and gaseous releases were observed to verify that approved procedures were utilized, that appropriate release approvals were obtained, and that required surveys were taken.

No violations or deviations were identified.

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

No violations or deviations were identified.

6. Review of Licensee Event Reports and Nonconforming Operations Reports

a. Licensee Event Reports (LERs) were reviewed for potential generic impact, to detect trends, and to determine whether corrective actions appeared appropriate. Events, which were reported immediately, were reviewed as they occurred to determine if the TS were satisfied.

LERs 84-24, 86-22, 86-23, 86-25, 86-27 and 87-01 were reviewed in accordance with current NRC policy. LERs 84-24, 86-22, 86-27 and 87-01 are closed.

(Closed) LER 84-24: This LER reported unanalyzed sulfur dioxide tank effects on control room habitability. This matter was discussed in NRC Inspection Report 50-302/86-38. Action on this item is already being tracked by IFI's 302/86-38-12 and 302/86-38-13.

(Closed) LER 86-22: The licensee has submitted a supplemental response which clarified the plants status during this event.

LER's 86-23 and 86-25 will remain open pending completion of the licensee's corrective actions as stated in the LERs.

b. The inspector reviewed Nonconforming Operations Reports (NCORs) to verify the following: compliance with the TS, 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.

(1) NCOR 87-18 reported that the "A" reactor trip breaker failed to open as required during the performance of procedure SP-110, Reactor Protection System Functional Testing. This breaker is a GE type AK-25. The test was performed on January 22 with the plant in the hot standby (Mode 3) condition.

The licensee contacted the manufacturer for assistance in investigating the breaker's mode of failure. Troubleshooting revealed that the breaker's undervoltage device had failed to operate properly but that the shunt trip device was operable and could trip the breaker. Preliminary findings from this troubleshooting revealed that a possible defective undervoltage device could have caused the breaker's trip paddle to become lodged on top of the armature paddle thereby preventing the correct operation of the undervoltage device. Another contributing cause may have been that the rivet to armature gap in the

undervoltage device exceeded the maximum gap recommended by the manufacturer (this type of situation is discussed in more detail in IE Information Notice 85-58).

The licensee's investigation of this incident is still continuing. Factory representatives, assisting the licensee onsite recommended that several clarifications be made to the licensee's procedure (PM-118) for inspecting these breakers. The licensee plans to implement these recommendations.

IFI (302/87-01-03): Review the licensee's failure analysis for the "A" reactor trip breaker, 10 CFR Part 21 evaluation, and clarifications to procedure PM-118.

(2) NCOR 87-13 reported that a modification performed on the tamper switches for security door card readers was installed incorrectly. It appears that incorrectly sized resistors were installed contrary to the requirements of the modification. This item was identified by the licensee during the modification functional test. Although the incorrect size resistors were installed, the net total resistance of the circuit was correct and the doors remained operable. The licensee is presently investigating this matter to determine if similar problems exist on other security doors and to determine the root cause for this event.

IFI (302/87-01-04): Review the licensee's investigation for incorrectly sized resistors being used in modifications to tamper switches on security doors.

(3) NCOR 87-16 reported that an equalizing valve for the containment personnel air lock was listed as non-safety related in the replacement parts list. This valve serves as a containment pressure boundary. Although non-quality parts have been used to repair this valve, containment air lock leakage tests have passed indicating that the valve is capable of performing its function. The licensee is presently evaluating this matter to determine necessary corrective action.

IFI (302/87-01-05): Review the licensee's evaluation and corrective action for the use of non-quality parts in the equalizing valve for the containment personnel air lock.

(4) NCOR's 87-27 and 87-28 reported that procedures SP-130, Engineered Safeguards (ES) Monthly Functional Test, and SP-358A, Operations ES Monthly Automatic Actuation Logic Functional Test #1, were not adequately testing the ES actuation matrix as required by TS 4.3.2.1.1. This item was found by the licensee during a routine procedure review. Temporary procedure changes have been made and the ES actuation matrix has been fully tested. The licensee plans to report this matter via a LER and will implement permanent procedure changes. This matter is considered to be a licensee identified violation in which adequate corrective action

was taken to prevent recurrence. This item will be reviewed further when the LER is issued.

(5) NCOR 87-23 reported the failure of an operator to perform a channel check of the release flow monitor prior to starting a waste gas release from a Waste Gas Decay Tank (WGDT).

Releases from the WGDTs are conducted in accordance with procedure OP-412, Waste Gas Disposal System. Steps 9.1.1 through 9.1.18 of this procedure require a channel check of the release flow monitor prior to starting the release from the WGDT. When the operator performing the release observed a yellow "Maintenance Deficiency Tag" on the release flow monitor he assumed that the monitor was out of service. While these yellow tags indicate that a piece of equipment has a Work Request (W/R) written against it, it does not necessarily mean that the equipment is inoperable. Furthermore, since the procedure could not be complied with, plant supervision should have been notified.

Further review of this event by the inspector determined that the maximum release rate of 15 CFM required by the Gaseous Radioactive Waste Release Permit (GRWRP) was not exceeded (the actual release rate was approximately 9 CFM) and that the operator was estimating the release rate as required by the TS since he believed that this instrumentation was inoperable.

While it is noted that this event was identified by the licensee, it is considered to be another example of Violation (302/87-01-02) discussed in paragraph 5.b(8) of this report.

(6) NCOR 86-226 reported the failure of the Auxiliary Building (AB) mid-range radiation monitor, RM-A2, during surveillance testing. As the result of this failure and in compliance with TS 3.3.3.9, the licensee initiated use of a back up monitoring system. The licensee's back up system is the Automated Inline Monitoring System (AIMS).

When the inspector reviewed this event, it was noted that there is no administrative guidance to identify the back up system for RM-A2. This finding was discussed with licensee personnel. These personnel acknowledged the inspector's comments and will revise procedures SP-701, Radiation Monitoring System Surveillance Program, and SP-442, Special Conditions Surveillance Plan, to specify the back up for RM-A2.

IFI (302/87-01-06): Review the revisions to procedures SP-701 and SP-442 to specify the back up system for RM-A2 mid-range monitor.

7. Nonroutine Event Followup

The plant entered an unusual event at 6:40 a.m. on January 22, 1987, due to a tornado sighting near the plant. The tornado did not cause any plant damage and the unusual event was terminated at 7:00 a.m. on January 22.

8. Review of IE Bulletins (IEB) and Information Notices (IEN)

a. As the result of the issuance of NUREG/CR-3963, "Closeout of IE Bulletin 83-03: Check Valve Failures in Raw Water Cooling Systems of Diesel Generators", the inspector reviewed the licensee's responses and activities with respect to IE Bulletin 83-03. This bulletin had previously been closed out in NRC Inspection Report 50-302/83-17, however the issuance of this NUREG in conjunction with additional responses by the licensee necessitated additional review. The licensee has completed the necessary check valve inspections as documented in the licensee's response dated September 16, 1983.

The inspector verified that the following activities had been accomplished:

- Surveillance procedure, SP-605, Emergency Diesel Generator Engine Inspection/Maintenance, had been revised to require an inspection of these valves on the 5000 hour/5 year frequency;

- An inspection performed during the period of April 21 through June 22, 1983 did not identify any valve structural failure; and,

- The valves had been added to Pump and Valve Program (as Revision 4 of the program).

The licensee's action on this item is considered to be completed.

b. IEN 87-04, Diesel Generator Fails Test Because of Degraded Fuel, was reviewed and discussed with plant management personnel when recent problems at the Turkey Point Nuclear Plant concerning EDG fuel oil sediment problems were identified. As the result of these discussions and after review of the EDG fuel monitoring program at CR-3 by the licensee, it was determined that the present monitoring program does not check for the existence of biological growths in the fuel oil. As the result of this finding, the licensee has sampled the EDG fuel oil and is analyzing for the existence of such growths. Additionally, a sample program that will include the detection of such growths is being developed.

IFI (302/87-01-07): Review the establishment of a EDG fuel oil monitoring program that samples for biological growths.

9. Design, Design Changes and Modifications

Installation of new or modified systems were reviewed to verify that the changes were reviewed and approved in accordance with 10 CFR 50.59, that the changes were performed in accordance with technically adequate and approved procedures, that subsequent testing and test results met acceptance criteria or deviations were resolved in an acceptable manner, and that appropriate drawings and facility procedures were revised as necessary. This review included selected observations of modifications and/or testing in progress.

Temporary Modification Approval Record (TMAR) T86-08-09-02, RW57 and RW63 Temporary Pedestal Changes Modification, and associated Work Requests were reviewed. Additionally a walkdown was conducted to verify proper installation of this TMAR.

No violations or deviations were identified.

10. Review of Special Reports

Special Report 86-01, dated January 9, 1987, reported that the auxiliary building and fuel handling area exhaust duct radiation monitor (RM-A2) was inoperable for a period in excess of seven days. This situation was reported in accordance with TS 3.3.3.9.

No violations or deviations were identified.