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

Report No.: 50-302/86-27

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

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

Facility Name: Crystal River 3

Inspection Dates: August 2 - September 5, 1986

Inspectors: _____ 10/9/86
T. F. Stetka, Senior Resident Inspector Date Signed

_____ 10/9/86
J. E. Tedrow, Resident Inspector Date Signed

Approved by: _____ 10/9/86
S. A. Elrod, 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, 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: (Failure to have an adequate equipment control procedure, paragraph 5.b.(1)).

REPORT DETAILS

1. Persons Contacted

*F. Bailey, Superintendent of Projects
*W. Bandhauer, Assistant Nuclear Plant Operations Manager
*P. Breedlove, Nuclear Records Management Supervisor
J. Buckner, Nuclear Security Superintendent
*J. Colby, Manager Nuclear Mechanical/Structural Engineering Services
*M. Collins, Nuclear Safety and Reliability Superintendent
M. Culver, Senior Nuclear Reactor Specialist
B. Hickle, Manager Nuclear Plant Operations
*M. Jacobs, Public Relations
*M. Mann, Nuclear Compliance Specialist
*P. McKee, Director, Nuclear Plant Operations
R. Murgatroyd, Nuclear Maintenance Superintendent
V. Ropnel, Manager, Nuclear Plant Technical Support
*W. Rossfeld, Nuclear Compliance Manager
*P. Small, Maintenance Department Coordinator
*E. Welch, Manager Nuclear Electrical/I&C Engineering Services
K. Wilson, Manger Site Nuclear Licensing
*R. Wittman, Nuclear Operations Superintendent

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

*Attended exit interview

2. Exit Interview

The inspectors met with licensee representatives (denoted in paragraph 1) at the conclusion of the inspection on September 5, 1986. During this meeting the inspectors summarized the scope and findings of the inspection as they are detailed in this report with particular emphasis on the Violation, Unresolved Item, 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 on Previous Inspection Items

(Open) Unresolved Item (302/82-28-04): The licensee has revised Surveillance Procedure (SP)-187, which tests the Auxiliary Building ventilation system. This procedure has been completely rewritten per the SP writer's guide to enhance the procedure's clarity. The inspector recently reviewed the latest revision (Revision 12) to this procedure and noticed

that the procedure's acceptance criteria was confusing when checked against the Technical Specification (TS) surveillance requirements. Also, step 9.2.9.9 of this procedure references a step 9.2.12 which does not exist. These items were discussed with licensee engineering personnel who agreed to make applicable changes. The licensee also plans to perform another review of procedures SP-185 and SP-186 to check for the existence of similar problems.

(Closed) IFI (302/85-42-04): The licensee has revised Administrative Instruction (AI)-1000, Good Housekeeping, and AI-1803, Safety Standards for Ladders, Scaffolds, and Ancillary Equipment, to include precautions and requirements to insure that safety related equipment is protected from ancillary items such as ladders and scaffolding. These revisions satisfy the concerns identified in IE Information Notice 80-21.

(Closed) Violation (302/86-07-01): In an Interoffice Correspondence dated August 1, 1986, the maintenance superintendent stated that the review of activities associated with the incorrectly classified Work Request (WR) was conducted on the WR in use on the job. A review of this WR indicates that the chief electrician and the electrical supervisor signed the WR (#73433) on October 9, 1985, which was after the incorrect classification was identified, thus indicating that they had reviewed the work. Action on this item is considered to be complete.

(Closed) Unresolved Item (302/86-23-09): The licensee has completed their investigation to determine why the missing wire for valve FWV-15 had been removed. This wire was removed during the performance of a plant modification procedure (MAR 82-10-19-06) which relocated several electrical components. This modification failed to provide instructions to reconnect the wire upon completion. The function of this wire was to provide feedwater pump protection during maintenance activities by interlocking this valve's position with the corresponding condensate booster pump's discharge valve. This non-saftey related function is not required by the Technical Specifications and is not required to be tested during routine surveillance activities. The modification functional testing did not test this feature. The missing wire has been replaced and the valve continues to operate satisfactory.

(Closed) Violation (302/86-09-05): The licensee has completed and the inspector has verified the completion of the following items:

- Operating Procedure (OP)-404 has been revised (revision 58, dated July 29, 1986) to require either valve RWV-32 or RWV-33 to be open at all times, and,

- An Immediate Temporary Change (ITC) was made to OP-407-A which required valve RWV-33 to be returned to its required position upon radioactive liquid release termination.

Action on this item is considered to be complete.

(Closed) Violation (302/84-12-02): The licensee has completed and the inspector has verified the completion of the following items:

- The cables in cable tray 522 were properly secured;
- Covers were properly installed on cable trays 171 and 183;
- Contractor personnel were instructed in the importance of returning systems back to their previous status as documented in a memo dated 9/4/84. Additionally, this memo stated that such instruction is now included in maintenance operating procedure (MOP)-410 and that all contractor personnel are trained in this procedure.

Action on this item is considered to be complete.

(Closed) Deviation (302/84-09-02): Based upon a supplemental response by the licensee dated 11/13/84, the NRC agreed that a Deviation to a commitment did not occur. This item is closed for record purposes.

(Closed) Violation (302/86-09-04): The licensee has completed and the inspector has verified the completion of the following items:

- Preventative Maintenance Procedure (PM)-123 has been revised in revision 6 dated 8/11/86 to include all the provisions identified as deficient in the NRC letter of 7/8/86;

- A review of other preventative maintenance procedures was completed on 8/5/86 to insure that similar procedure problems do not exist;

- Counseling of the electrician involved in the performance of PM-123 was documented as completed on 4/22/86.

Action on this item is considered to be complete.

(Closed) Deviation (303/85-21-01): The licensee has completed and the inspector has verified the completion of the following items:

- Procedures SP-300, SP-301, SP-354A, and SP-354B were revised so that the minimum allowed Emergency Diesel Generator (EDG) starting air pressure is now 225 psig.; and,

- Modification (MAR) 85-07-05-01A, which was completed on 5/28/86, installed new switches to provide the correct setpoint for the EDG starting air pressure alarm.

Action on this item is considered to be complete.

(Closed) Deviation (302/84-26-01): Items for this Deviation were verified as complete in NRC Inspection Report 50-302/85-11 except for revision of the nuclear operations policy procedure (NOD). This procedure, NOD-10, was revised and implemented on May 31, 1985. It appears that the new policy has improved the licensee's commitment tracking system.

Action on this item is considered to be complete.

(Closed) Violation (302/84-02-03): The licensee has completed and the inspector has verified the completion of the following items:

- Health Physics Violation Reports and Non-Conforming Operations Reports (NCOR's) were written as stated in the licensee's response letter and each involved individual was counseled as to the requirements of Radiation Protection procedure (RP)-101;

- The chemistry section's shift turnover sheet was revised to require signatures of both the on-coming and off-going shifts and log keeping practices were changed to insure that a proper turnover is conducted;

- Chemistry Procedure (CH)-338 was revised as revision 8 on 7/24/84 to clarify the purging steps and to make the valve lineup applicable to procedure requirements. Additionally, use of the revised procedure was observed in the field;

- In a memo dated 3/15/84 the training department reaffirmed that their training stresses procedure compliance and will continue to do so.

Action on this item is considered to be complete.

(Closed) Violation (302/85-08-01): The licensee has completed and the inspector has verified that the Operations Section Implementation Manual (OSIM) has had the instructions involving safety or license compliance removed and incorporated into revision 50 of AI-500, Conduct of Operations, that was issued on 9/16/85. Action on this item is considered to be complete.

(Closed) Violation (302/85-08-02): The licensee has completed and the inspector has verified that administrative guidelines were added to the OSIM on 6/25/85. These guidelines, called "Special Lineups" restricted the use of Compliance Procedure (CP)-115, In-Plant Equipment Clearance and Switching Orders, and clarified when clearances, test procedures, or procedure changes must be used to change system lineups. At a later date this OSIM change was deleted and the requirements were incorporated into procedure CP-115 as step 5.2.25 where they presently exist. Action on this item is considered to be complete.

(Closed) Violation (302/85-08-07): The licensee has completed and the inspector has verified the completion of the following items:

- Initial guidance to operations personnel concerning the use of N/A (Not Applicable) on procedural step signoff was transmitted via Short Term Instruction (STI) 85-18 dated 3/19/85;

- An Interoffice Correspondence dated 7/31/85 was issued by the Operations Superintendent to further clarify when the use of an N/A on a procedure step is appropriate;

- A determination was made by plant management in a memo dated 8/6/85 that no further procedure changes are necessary.

Based upon the inspector's observations concerning the use of N/A in facility procedures, the inspector concurs with the licensee's determination and action on this item is considered to be complete.

(Closed) Violation (302/84-29-01): The licensee has completed and the inspector has verified the completion of the following items:

(Item 1)

- Personnel were reminded to adhere to procedures as documented in the minutes of a maintenance personnel shop meeting conducted on 1/18/85;

- Procedure SP-154 "Testing and Calibration of Seismic Monitors" was revised as revision 13 on 7/10/85 to delete the requirement to have operations personnel restore the system to normal (it can now be restored by maintenance personnel) and to delete the reference to procedure SP-336.

(Item 2)

- The data sheets for procedure SP-317 dated 9/28/84 were corrected on 10/10/84 to reflect the correct data and to confirm that TS requirements were not exceeded;

- Personnel were re-instructed on procedure SP-317 regarding data placement and post data review as documented in an Interoffice Correspondence dated 12/7/85;

- Procedure SP-317, enclosure (3), was revised in revision 23 to clarify when valve RCV-150 is open or closed.

Action on this item is considered to be complete.

(Closed) Violation (302/84-09-06): The licensee has completed and the inspector has verified the completion of the following items:

- Procedure SP-186 was revised in revision 11 by adding a new Enclosure (4A) that verifies that the ventilation dampers are placed in the recirculation mode positions prior to running the test and added steps to insure that the proper flow is attained;

- Revision 11 to procedure SP-186 was successfully performed on May 1, 1984.

Action on this item is considered to be complete.

(Closed) Violation (302/83-18-01): The licensee has completed and the inspector has verified the completion of the following items:

- Procedure reviewers were instructed to perform a system walk down whenever valve checklists are being reviewed. This instruction was documented in an Interoffice Correspondence dated 9/6/83;

- System walkdowns were conducted to verify the accuracy of the valve lineups and flow diagrams.

Based upon this verification and the observations made by the inspectors during their own system walkdowns, action on this item is considered to be complete.

(Closed) Violation (302/85-11-01): Items for this Violation were verified as complete in NRC Inspection Report 50-302/85-26 except for revision of AI-401. This instruction was revised as revision 8 and implemented on 10/7/85. It appears that this revision, which requires Interdepartmental reviews for all applicable procedures, will prevent recurrence. Action on this item is considered to be complete.

(Closed) Violation (302/85-19-05): The licensee completed and the inspector verified that STI 85-27 dated 5/7/85 was written to remind personnel to adhere to the requirements of procedure SP-601 as they relate to the refueling bridge startup and shut down. Based upon the issuance of this STI and observations by the inspectors of refueling bridge operations at that time, action on this item is considered to be complete.

(Closed) Violation (302/85-19-01): The licensee completed and the inspector verified that independent walk downs of the annunciator panels were completed by 7/26/85 and that the procedures were revised to correct the identified discrepancies. The inspector's walk down of the annunciator panels verified the accuracy of the procedures and action on this item is considered to be complete.

(Closed) Unresolved Item (302/84-22-06): The closeout of Violation (302/85-19-01) above resolves this item and this item is closed for record purposes.

(Open) Violation (302/83-17-04): The licensee completed and the inspector verified that responsible personnel were made cognizant of the need to identify and report procedural and design inadequacies during a series of on-shift seminars conducted during the period of October 17-21, 1983. This item remains open pending verification of:

- Completion of the modification to valves WDV-3 and WDV-60 to provide for testing in the post accident direction of flow;

- Revision to procedure SP-179 (the type B and C leakrate testing procedure) that provided for the proper testing of valves WDV-94, WDV-406, WSV-5, and WSV-6; and,

- Completion of the proper testing of these valves.

(Open) Violation (302/84-30-03): The licensee completed and the inspector verified that STI 84-96 was issued on 11/30/84 to emphasize the requirement of procedure SP-442 to notify appropriate personnel of all applicable surveillance requirements. This item remains open pending review and verification of the chemistry technician counseling and training that was described in the licensee's response letter dated 1/31/85.

4. Unresolved Items

Unresolved items are matters about which more information is required to determine whether they are acceptable or may involve violations or deviations. A new unresolved item is identified in paragraph 5.a of this report.

5. Review of Plant Operations

The plant remained in power operation (Mode 1) for the duration 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 (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; and Selected Chemistry/Radiation Protection Logs. In addition to these record reviews, the inspector independently verified clearance order tagouts.

On September 4, while observing plant operations, the inspector noted that two of the annunciators, Q-7-10 and Q-8-10, had open links (thereby making the annunciators inoperable) but were not listed in the annunciator's Equipment-Out-Of-Service log. These annunciators entitled "PERIMETER FENCE INTRUSION" and "CC (Control Complex) ACCESS DOOR OPEN" respectively, were disabled years ago and were not needed since the security system had appropriate alarms.

While these alarms were not needed, the inspector expressed concern as to whether there were other annunciators that had been made inoperable and were not properly logged as required by the licensee's procedures. Licensee personnel acknowledged the inspector's concern and will conduct a review of the annunciators to verify whether any additional annunciators have been disabled and not properly logged.

Unresolved Item (302/86-27-01): Review the annunciator panel status to verify that the annunciator Equipment-Out-Of-Service log is current.

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; 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.

On August 20, at approximately 3:30 P.M., the inspector noted that power was available to four containment isolation valves (CAV-429, CAV-430, CAV-433, and CAV-434). Procedure SP-341, Monthly Containment Integrity Check, requires these valves to normally have power removed by having switch #27 on electrical panel DPDP-5A locked open during plant operations because these valves do not receive an automatic containment isolation signal in the event of an accident. When operations personnel were notified of this finding, they immediately opened switch #27 that supplies power to these valves. The valves were de-energized by approximately 3:40 P.M.

The inspector's investigation into this event indicated that the licensee had just completed testing another containment isolation valve, CAV-431, and had just released equipment clearance 8-95 to restore the system to the normal status. Circuit breaker #27 was listed on this clearance to insure personnel safety and was "restored" at approximately 2:18 P.M. While the circuit breaker was tagged in the "OFF" position and should have been restored (i.e., only the tag removed) so that it was left in the "OFF" position, it was incorrectly directed to be restored to the "ON" position by clearance 8-95.

Equipment clearances are issued and controlled in accordance with procedure (CP)-115, In-Plant Equipment Clearance and Switching Orders. Step 5.3.5.h of this procedure specifies that the return-to-normal position of the valve, switch, or breaker after removal of a tag should be obtained from the applicable operating procedure (OP) and not from system flow diagrams. The licensee's Administrative Instruction AI-400, Plant Operating Quality Assurance Manual Control Document (POQAM), specifies in paragraph 4.1.3 that the word "shall" denotes a requirement and that the word "should" denotes a recommendation. Since the word "should" only provides a recommendation and not a requirement, the use of a procedure was only an option. In addition, since it appears that if CP-115 had directed the use of an appropriate procedure (in this case procedure SP-341) to determine the lineup, an incorrect restoration lineup would not have occurred. As a result of this investigation, procedure CP-115 is considered to be inadequate.

Failure to have an adequate procedure for equipment control is contrary to the requirements of TS 6.8.1.a and is considered to be a violation.

Violation (302/86-27-02): Failure to have an adequate procedure for plant equipment control.

(2) Safety Systems Walkdown - The inspector conducted a walkdown of the Nuclear Services and Decay Heat Seawater (RW) 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. The inspector 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.

No violations or deviations were identified.

(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-146, Emergency Feedwater Initiation and Control (EFIC) Monthly Functional Test;

- SP-160B, Functional and Operability Check of the Containment Hydrogen Monitor WS-10-CE;

- SP-163B, Waste Gas Hydrogen/Oxygen Analyzer Channel Functional Test;

- SP-312, Heat Balance Calculations;

- SP-317, Reactor Coolant System Water Inventory Balance;

- SP-341, Monthly Containment Integrity Check;

- SP-712, Core Flood Tank "B" Monthly Surveillance Program.

As a result of these reviews, the following items were identified:

(a) During a review of the plant logs, the inspector noted that operations personnel had determined that the plant's computer generated heat balance calculation was in error and that action was being taken to correct the situation. The inspector also noted that this error existed for about three days before it was identified.

Subsequent discussions with these personnel indicated that this error was identified by personnel when they noted that the heat balance results appeared to be inconsistent with the value for generated megawatt output. These discussions, in addition to the review of completed data for procedure SP-312 by the inspector, indicated that the errors were in the conservative direction (i.e., the nuclear instrumentation (NI's) power was higher than the heat balance calculated power).

The licensee performs a daily heat balance calculation in accordance with procedure SP-312. This procedure did not identify the erroneous heat balance calculation because the procedure only requires action to be taken if the heat balance shows that the NI's are not conservative with respect to the heat balance. Additionally the inspector noted that the procedure only compares the computer generated values for the NI's with the computer generated values for the heat balance thus raising the possibility that a computer malfunction may not be readily detected.

These findings were discussed with licensee personnel. As a result the licensee will revise procedure SP-312 to provide a limit for the conservative direction and to direct a check of the computer generated NI indications with other plant indications.

IFI (302/86-27-03): Review the revision to procedure SP-312 to provide a limit for conservative NI drift and an additional check of computer data with plant instrumentation.

(b) During the performance of SP-163B on September 3, 1986, the inspector noted that step 9.4.4 requires data to be recorded when two switches (WD-21-FIS#1 and WD-21-FIS#2) are activated. The technicians indicated that only one switch existed but this switch operated two relays, therefore only

one data point was required to be recorded. The inspector also observed that the nitrogen purge established in step 9.4.3 was not required to be secured. A temporary change to the procedure was made to secure the nitrogen purge. Finally, step 10.1 of this procedure required the technicians to open valves WDV-575 or WDV-576 if not already opened per section 9.4. However section 9.4 does not address operation of these valves. The discrepancies noted in these steps were discussed with licensee management personnel. The licensee will revise this procedure to clarify these steps.

IFI (302/86-27-04): Review the revision to procedure SP-163B to clarify steps.

(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:

- Troubleshooting of sluggish pressurizer heater controls in accordance with Maintenance Procedure (MP)-531;

- Repacking of a nuclear services seawater pump (RWP-2A) in accordance with procedure MP-150;

- Replacement and post maintenance testing for valve CAV-431 in accordance with procedures MP-132, MP-531, SP-370, and SP-358A.

During the post maintenance testing on valve CAV-431 (a Target Rock solenoid-operated valve) the licensee discovered that the valve had been installed backwards. Investigation into the cause for this situation revealed that this valve has no markings to identify the flowpath and that the electrical cable penetration orientation is not the same for each valve (workmen utilized the cable penetration as a reference and installed the replacement valve in the same orientation as the valve removed). The valve was again replaced and orientation of the new valve checked by referencing the valve's internals. Post maintenance testing was subsequently completed satisfactory. The licensee plans on making changes to procedures and purchasing requirements to delineate flowpath markings on these types of valves.

IFI(302/86-27-05): Review the licensee's activities to establish correct orientation for Target Rock valves.

(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 86-10, 86-11, and 86-12 were reviewed in accordance with current NRC policy. LER's 86-10 and 86-11 are closed.

(1) (Closed) LER 86-10 reported the violation of Technical Specification (TS) 6.2.2.a which requires two Senior Reactor Operator licensees on watch during plant operation in the hot standby mode (Mode 3). Licensee corrective action on this matter has been completed including the remedial training and requalification of the backup licensee involved.

(2) (Open) LER 86-12 reported that the heat balance calculation surveillance procedure (SP-312) had not been performed within the required TS surveillance interval. This matter is considered to be a licensee identified violation in which adequate corrective actions have been taken to prevent recurrence. This LER will remain open pending the inspectors verification that all shift supervisors have reviewed this LER.

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 Policy.

(1) NCOR 86-103 reported that procedure SP-417, Refueling Interval Integrated Plant Response to Engineered Safeguards Actuation, was inadequate to implement the surveillance requirements of TS 4.8.1.1.2.c.3.a in that the load shedding of the 480 volt emergency busses was not being tested. The licensee is revising procedure SP-417 to incorporate a new method to verify this load shedding capability and will submit an LER on this matter. This matter is considered a licensee identified violation in which adequate corrective actions will be taken to prevent recurrence. This item will be reviewed further when the LER is issued.

(2) NCOR 86-139 reported the failure to comply with TS 3.3.3.1 in that the automatic functions of the control room radiation monitor instrument (RMA-5) were disabled and the control complex emergency ventilation system was not placed in the recirculation mode within one hour. The licensee plans to submit an LER to document this event. This matter is considered to be a licensee identified violation in which adequate corrective actions were taken to prevent recurrence. This item will be reviewed further when the LER is issued.

(3) NCOR 86-142 reported that DJ-11-TS, a temperature switch for the Jacket Water Cooling system on the "A" Emergency Diesel Generator, was improperly calibrated. The licensee discovered this condition during routine followup of a field problem report which identified a problem with the operation of the switch. The miscalibrated switch did not affect the operability of the diesel. The licensee attributed the cause for the improper calibration to be the use of an instrument calibration data sheet which was not revised following a plant modification (MAR 80-11-28-02) which established new higher operating setpoints for the switch. The calibration of the switch to lower setpoints still maintained the temperature of the system within manufacturer's recommendations. As part of their corrective action, the licensee has reassigned control of the instrument calibration data sheets to site engineering who will review and revise these sheets for future changes. Also new plant modifications will include new instrument calibration data sheets as part of the modification package. The licensee plans to recalibrate the temperature switch prior to the next monthly diesel generator surveillance test. The inspector has reviewed the work package used to perform this job and has verified that the correct instrument calibration sheet was included in this package. This matter is considered to be a licensee identified violation in which adequate corrective action has been taken to prevent recurrence.

7. 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.

The following modification approval records (MARs) were reviewed and/or associated testing observed:

- Testing of the replacement air handling dampers AHD-34 and AHD-35 in accordance with MAR 80-07-13-01;

- Installation of a waste gas decay tank sampling bypass to the waste gas analyzer in accordance with MAR 86-07-03-01; and,

- Temporary repairs to nuclear services seawater piping in accordance with MAR T86-08-09-01.

No violations or deviations were identified.