



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

Report No.: 50-302/89-19

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

Docket No.: 50-302

License No.: DPR-72

Facility Name: Crystal River 3

Inspection Conducted: July 8 - August 4, 1989

Inspectors:	<u>S. J. Uias</u>	<u>8/31/89</u>
	P. Holmes-Ray, Senior Resident Inspector	Date Signed
	<u>S. J. Uias</u>	<u>8/31/89</u>
	J. Tedrow, Resident Inspector	Date Signed
Approved by:	<u>[Signature]</u>	<u>8/31/89</u>
	R. Orlenjak, 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, radiological controls, security, fire protection, surveillance observation, maintenance observation, safety system walkdown, Licensee Event Reports and Nonconforming Operations Reports, 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: Two violations were identified: Failure to verify manual valve positions for containment penetrations, paragraph 3.a; Failure to perform channel functional tests on the containment hydrogen monitors, paragraph 6.b(2).

Weakness were identified in the licensee's surveillance testing program, paragraph 6.b(2); maintenance troubleshooting, paragraph 4; and entry into technical specification action statements, paragraph 6.b(1).

REPORT DETAILS

1. Persons Contacted

Licensee Employees

- G. Boldt, Vice President Nuclear Production
- *P. Breedlove, Nuclear Records Management Supervisor
- L. Clewett, Nuclear Project Engineer
- *M. Collins, Nuclear Safety and Reliability Superintendent
- *J. Cooper, Superintendent, Technical Support
- *E. Froats, Supervisor, Nuclear Licensing
- *B. Hickle, Manager, Nuclear Plant Operations
- *S. Johnson, Manager, Site Nuclear Services
- *G. Longhouser, Nuclear Security Superintendent
- P. McKee, Director, Nuclear Plant Operations
- *L. Moffatt, Nuclear Safety Supervisor
- *W. Pittman, Senior Nuclear Mechanical/Building Services Supervisor
- S. Primo, Senior Nuclear Mechanical Engineer
- *J. Roberts, Assistant Nuclear Chemistry and Radiation Protection Superintendent
- V. Roppel, Manager, Nuclear Operations Maintenance and Outages
- *W. Rossfeld, Manager, Nuclear Compliance
- F. Sullivan, Manager, Nuclear Configuration Management
- C. Williams, Nuclear Fire Protection Specialist
- *M. Williams, Nuclear Regulatory Specialist
- *K. Wilson, Manager, Nuclear Licensing

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

*Attended exit interview

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

2. Review of Plant Operations (71707)

The plant continued 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; Short Term Instructions (STI); and Selected Chemistry/Radiation Protection Logs.

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

No violations or deviations were identified.

b. Facility Tours and Observations

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

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

During these tours, the following observations were made:

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

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

No violations or deviations were identified.

- (2) 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.

- (3) 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.

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

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

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

No violations or deviations were identified.

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

No violations or deviations were identified.

- (6) 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.

The inspector reviewed the licensee's administrative controls governing the duties and responsibilities of fire watches. Procedure CP-118, Fire Prevention Work Permit Procedure, and General Employee Training on fire protection were reviewed. Presently the licensee trains all green badge personnel on fire protection and considers all personnel who pass this training to be considered qualified fire watches. Specific duties and responsibilities of the fire watch are specified in procedure CP-118 and on Enclosure 1 to the Fire Prevention Work Permit. Upon reviewing this procedure, the inspector noticed that although a fire watch is required to be assigned to observe for sparks in the area, there is no stipulation that this person be prohibited from performing other duties while acting as a fire watch. The inspector has routinely observed fire watches in the performance of their duties and has not observed any occasions where the fire watch was performing other duties.

This observation was discussed with licensee personnel who stated that the intent of procedure CP-118 was to prohibit fire watches from performing other concurrent duties. The licensee is planning to revise procedure CP-118 to more accurately state this. Also the inspector was informed that the licensee is considering a change to the training program to provide fire protection training to only fire watch designees. This training will be upgraded to include hands on use of fire fighting equipment as well. These efforts should help strengthen the licensee's fire protection program.

Inspector Followup Item (302/89-19-01): Review the revision to procedure CP-118 and changes to the licensee's fire watch training program.

3. Surveillance Observation (61726)

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

The following tests were observed and/or data reviewed:

- SP-160A, Functional and Operability Check of the Containment Hydrogen Monitor WS-11-CE;
- SP-160B, Functional and Operability Check of the Containment Hydrogen Monitor WS-10-CE;
- SP-312, Heat Balance Calculations;
- SP-317, RC System Water Inventory Balance;
- SP-341, Monthly Containment Integrity Check;
- SP-412, ECCS and Containment Spray System Leak Rate Test;
- SP-430, Containment Air Locks Seal Leakage Test;
- SP-511, Quarterly Battery Check (Units 1 & 2); and,
- SP-521, Quarterly Battery Check.

- a. On July 25, 1989, the inspector verified a selected portion of the containment isolation valve lineup utilizing procedure SP-341. The inspector noticed that several manual valves (FWV-203, FWV-204, FWV-205, FWV-206, CGV-17 and CGV-18) associated with emergency feedwater containment penetrations #109 and #424 were not included in procedure SP-341 to be verified closed on a monthly basis.

Technical Specification 4.6.1.1.a.1 requires that valves associated with containment penetrations be verified closed every 31 days. Procedure SP-341 was written by the licensee to implement the requirements of this TS.

This matter was discussed with licensee personnel, and the manual valves were verified to be closed. A plant modification (MAR 88-07-11-01/02) was completed in October 1988 which installed the feedwater valves. Apparently the licensee's modification process did not identify the need for a change to procedure SP-341.

Failure to verify the closed position of manual valves associated with containment penetrations #109 and #424 every 31 days is contrary to the requirements of TS 4.6.1.1.a.1 and is considered to be a violation.

Violation (302/89-19-02): Failure to verify the closed position of manual valves associated with emergency feedwater containment penetrations every 31 days as required by TS 4.6.1.1.a.1.

- b. During a review of the data collected during the performance of procedure SP-521 on July 9, the inspector noticed that the specific gravity for cell #55 in DPBA-1A (1.209) had decreased approximately .04 from the value recorded during the previous quarterly test (1.251). The acceptance criteria for a change in specific gravity is less than .01. The operability of this cell was discussed with licensee engineering personnel. Based upon previous recorded data during the past year which indicated that this cell's specific gravity was approximately constant at 1.210, the reading of 1.251 was considered to be erroneous and the cell was considered to be operable.

A similar event occurred in January 1988 (NCOR 88-19) in which an excessive decrease in specific gravity occurred in the fossil unit batteries. The cause for this condition was also considered to be erroneous readings from the previous performance of the test. Part of the licensee's corrective action for this problem included supervisory review of collected data to identify obvious erroneous readings. Apparently this corrective action was not sufficient to prevent recurrence. The inspector discussed this matter with licensee personnel who are considering corrective action to prevent recurrence of erroneous readings during the performance of these tests.

Inspector Followup Item (302/89-19-03): Review the licensee's corrective action to prevent erroneous readings during the performance of battery surveillance tests.

- c. Procedure SP-412 was written by the licensee to implement the requirements of TS 4.5.2.e.5 and 4.6.2.1.c which requires that the Decay Heat Removal (DHR) and Reactor Building Spray (BS) system's total leakage be checked periodically at system operating pressure. The inspector noticed that the acceptance criteria stated in the procedure was much more restrictive than that required by the TS.

The surveillance procedure required the total leakage for the two systems to be less than .57 gallons per hour (GPH) with the DHR system pressurized to greater than 225 psig and the BS system pressurized to 285 psig. TS allow up to 6 GPH total leakage when the systems are pressurized to 150 psig and 190 psig respectively.

The inspector discussed this matter with licensee engineering and licensing personnel. As part of the TS improvement program, the licensee verified the basis and documents for these system's TS. The licensee discovered that the Final Safety Analysis Report (Table 6-11 and Table 14-57) and TS did not agree on the amount of system leakage which would be present following a design basis accident. Licensee verification of the calculations determined that the lower leakage rate and higher system pressures were correct. The licensee plans to request an amendment to correct the TS.

Inspector Followup Item (302/89-19-04): Follow the licensee's efforts to revise TS on DHR and BS system total allowable leakage.

4. Maintenance Observation (62703)

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

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

- Replacement of a Reactor Protection System (RPS) reactor building pressure switch (BS-62-PS) in accordance with procedures SP-110, Reactor Protective System Functional Testing, SP-112, Calibration of The Reactor Protection System, and SP-132, Engineered Safeguards Channel Calibration;
- Troubleshooting of a borated water storage tank level switch (DH-11-LS) in accordance with procedure MP-531, Troubleshooting Plant Equipment, SP-162, Post Accident Monitoring Instrumentation Calibration, and SP-111, Valve Lineup Verification for Critical Instrumentation;

- Troubleshooting of a failed reactor coolant system pressure transmitter RC-158-PT;
- Replacement of cell #11 on the "A" Station Battery (DPBA-1A) in accordance with procedures MP-401, DC System Maintenance, and SP-520, Weekly Battery Check; and,
- Preventive Maintenance on the "B" Battery Charger (DPBC-1B) in accordance with procedure PM-141, Battery Changer Preventative Maintenance Set Point Adjustments (DPBC-1A thru 1F).

During the troubleshooting of level switch DH-11-LS, the inspector observed that level transmitter DH-37-LT was replaced utilizing this work package. The inspector reviewed the work package associated with this troubleshooting and discussed this matter with the shop supervisor. The work package was written to troubleshoot switch DH-11-LS for causing alarms and referenced procedure MP-531 to be utilized for this troubleshooting. A typical technique used by the craft to perform troubleshooting is to replace suspected failed components in an attempt to correct the problem. After the components are replaced and the problem corrected, shop supervisors, planners and quality assurance personnel review the work package to verify quality parts were utilized, identify necessary quality control inspections, and determine appropriate post maintenance testing.

In this case the tank level transmitter (DH-37-LT) was believed to be in error due to a failed calibration check, so the transmitter was replaced and calibrated. Procedure MP-531 is written to provide general guidance such that the craft has a liberal amount of "freedom" to choose the scope of troubleshooting to be employed. Although the inspector considers a certain amount of "freedom" should be granted the craft in the performance of troubleshooting, when the troubleshooting expands to another component, or the troubleshooting identifies a component out of tolerance or faulty, the work package should be reevaluated to determine the change in work scope and the possible need for additional work instructions. The lack of guidance to the craft in troubleshooting this level switch which allowed the replacement of a transmitter is considered to be a weakness.

This observation was discussed with licensee management personnel who agreed in principle with the inspector's comments. The inspector was informed that this subject was already being reviewed for possible action.

5. Safety Systems Walkdown (71710)

The inspector conducted a walkdown of the Reactor Building Spray (BS) 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.

6. Review of Licensee Event Reports (92700) and Nonconforming Operations Reports (71707)
- a. Licensee Event Reports (LERs) were reviewed for potential generic impact, to detect trends, and to determine whether corrective actions appeared appropriate. Events that were reported immediately were reviewed as they occurred to determine if the TS were satisfied. LERs were reviewed in accordance with the current NRC Enforcement Policy.
- (1) (Open) LER 89-13: This LER reported the inadvertent start of the emergency diesel generators due to a degraded voltage condition on the engineered safeguards buses. This matter was previously discussed in NRC Inspection Report 50-302/89-11 and the licensee has issued a supplement dated July 5, 1989. The licensee has reanalyzed the thermal-hydraulic effects resulting from this condition and has determined that an additional delay time of 28 seconds (25 seconds was assumed in the original analysis) results for water from the high pressure injection system to reach the reactor core. The total 53 second delay was determined by the licensee to not to have a significant effect on the analysis results. The inspector has requested this analysis for review. This report will remain open pending NRC review of the analysis.
- This event, and the events discussed in LERs 89-23 and 89-25 have prompted the licensee to consider enhancements to the offsite power supply. These enhancements will be followed as corrective actions associated with LER 89-23.
- (2) (Closed) LER 89-16: This LER reported that several containment isolation valves and a pressurizer relief block valve (CAV-1/3/4 and RCV-11) were not environmentally qualified. This condition was identified during a NRC inspection (NRC Inspection Report 50-302/89-09) and was the subject of a violation (Violation 302/89-09-06). The LER will be closed and further action on this matter will be tracked by the violation.
- (3) (Closed) LER 89-18: This LER reported the unexpected heatup of the reactor coolant system and overheating of a containment penetration. This event was previously discussed in NRC Inspection Reports 50-302/89-11 and 50-302/89-14 and was the subject of a violation (Violation 302/89-14-01). This LER will be considered closed and corrective action tracked by the violation.
- (4) (Open) LER 89-19: This LER reported the actuation of the Reactor Protection System (RPS) while the plant was in cold shutdown. This LER remains open pending a review of this event with the nuclear shift supervisors and resolution of the minimum documentation necessary to pre-plan for a RPS actuation.

- (5) (Open) LER 89-20: This LER reported a RPS actuation while the plant was in hotstandby. Corrective action for this event will include an evaluation of protective devices for plant equipment which could result in inadvertent reactor trips, and an inspection of a reactor trip breaker which inadvertently tripped open by the breaker manufacturer (General Electric). This LER will remain open pending completion of this corrective action.
- (6) (Closed) LER 89-21: This LER reported a RPS actuation when the plant was in the hot standby condition. The inspector verified completion of the corrective actions as stated in the LER.
- (7) (Open) LER 89-22: This LER reported a manual actuation of the emergency feedwater system which occurred during the performance of a surveillance procedure. The licensee plans to revise surveillance procedure SP-417, Refueling Interval Integrated Plant Response to an Engineered Safeguards Actuation, to provide a precaution for loss of main feedwater pump indication and are investigating a loss of integrated control system indications which were observed during the performance of the test. The licensee will issue a supplemental report with the results of the investigation. The LER will remain open pending completion of this corrective action.
- (8) (Open) LER 89-23: This LER reported the loss of the normal offsite power source due to personnel error and equipment failure. This event was previously discussed in NRC Inspection Reports 50-302/89-15 and 50-302/89-17. During this event, the motor driven emergency feedwater pump (EFP-1) failed to automatically start. The circumstances which contributed to this failure resulted in a violation (302/89-17-01) and the corrective actions associated with the pump failure will be tracked by the violation.

Due to several other events affecting the offsite power source (LERs 89-13 and 89-25), the licensee is considering enhancements to the offsite power source. By correspondence dated July 27, 1989, the licensee committed to install a new dedicated alternate offsite power source and will attempt to install this modification during the spring 1990 outage.

The following corrective action associated with this event remains to be accomplished:

- Changeout fault detector relays in the 230 KV switchyard during the spring 1990 outage; and,
- Install new dedicated offsite power source during the spring 1990 outage.

This LER will remain open pending completion of this corrective action.

- (9) (Closed) LER 89-24: This LER reported that the station batteries were inoperable due to high electrolyte levels. This matter was previously discussed in NRC Inspection Report 50-302/89-15 and was the subject of a violation (Violation 302/89-15-01). This LER will be considered closed and corrective action tracked by the violation.
 - (10) (Closed) LER 89-25: This LER reported a loss of the normal offsite power source caused by a lightning strike. This event was previously discussed in NRC Inspection Report 50-302/89-15. The inspector verified completion of the corrective actions as stated in the LER.
 - (11) (Open) LER 89-26: This LER reported the failure of an emergency diesel generator which caused a plant shutdown. The licensee is investigating the cause for low crankcase vacuum in the diesel and will issue a supplement to this report when completed. This LER will remain open pending completion of the investigation and issuance of the supplemental report.
- b. The inspector reviewed Nonconforming Operations Reports (NCORs) to verify the following: TS are complied with, corrective actions as identified in the reports or during subsequent reviews have been accomplished or are being pursued for completion, generic items are identified and reported as required by 10 CFR Part 21, and items are reported as required by TS.

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

- (1) NCOR 89-168 reported that the Individual Cell Voltage (ICV) for battery cell #11 on the 3A1 station battery was found to have decreased by more than 0.1 volts from the value observed on the original acceptance test. TS 3.8.2.3 requires that the station batteries be operable and specifies in surveillance requirement 4.8.2.3.2 that the ICV of each connected cell must not have decreased more than 0.1 volts from the value observed during the original acceptance test for the battery to be considered operable.

This matter was identified by the licensee during the routine quarterly performance of a battery surveillance test (procedure SP-521, Quarterly Battery Check) at approximately 5:30 A.M. on July 10. Although this matter was discussed between the shop craft/supervisor and the Nuclear Shift Supervisor (NSS) at approximately 6:00 A.M., the NCOR was not delivered to the NSS until approximately 12:15 P.M. on July 10. The NSS then belatedly entered the action statement associated with TS 3.8.2.3. This action required the battery be restored to operable status within two hours or the plant be placed in the hot standby condition within the next 6 hours. The affected battery cell was disconnected from the battery bank by 1:20 P.M.

The delay which occurred from the time of discovery of the inoperable battery (5:30 A.M.) until the NSS entered the appropriate TS action statement (12:15 P.M.) is excessive (approximately 7 hours). Although this delay did not cause the TS action statement allotted time to be exceeded, the potential existed to do so. Delaying entry into a TS action statement until receipt of a NCOR is considered to be a weakness which could result in TS noncompliance.

This weakness was discussed with licensee management personnel. During the performance of this same test on the 3B1 station battery on July 20, out of specification voltage and specific gravity readings were also identified. These problems were expeditiously reviewed by supervisory personnel and promptly reported to the NSS who immediately entered the applicable action statement. Management involvement to correct this weakness was evident.

- (2) NCOR 89-171 reported the failure to perform a channel functional test on the containment hydrogen monitoring system (WS-10-CE and WS-11-CE). A monthly channel functional test of the containment hydrogen monitors is required by TS 4.6.4.1. The TS required functional test implementing procedure was issued on May 8, 1989. The test became due on June 7, 1989, 31 days after the procedure was issued. This situation was discovered by the licensee at approximately 4:30 P.M. on July 13, 1989.

TS 3.6.4.1 requires the plant be shutdown to hot standby if both hydrogen monitors are inoperable. If missed surveillance testing is the only reason equipment is considered inoperable, Generic Letter (GL) 87-09, Sections 3.0 and 4.0 of the Standard Technical Specifications (STS) on the Applicability of Limiting Conditions for Operation and Surveillance Requirements, contains a provision to allow a 24 hour delay in the application of the action requirements of the TS. This provision is to allow the time necessary to complete the required testing to show that the applicable equipment is operable prior to forcing the plant to unnecessarily shutdown. Channel functional tests were successfully completed within the 24 hour delay period.

Although the 24 hour delay in the application of the TS action statement is allowed, failure to perform a channel functional test on the containment hydrogen monitors is contrary to the requirements of TS 4.6.4.1 and is considered to be a violation.

Violation (302/89-19-05): Failure to perform channel functional tests on the containment hydrogen monitors.

The licensee had recently issued a LER (LER 88-18 dated October 13, 1988) which reported a similar problem. As reported in this LER, a TS required surveillance for testing containment airlocks was also not performed as required by a recently issued TS amendment. Historically the licensee's implementation of required technical specification surveillances has been weak. LER 88-11 issued May 23, 1988, reported that another surveillance test was not completed in the required time frame allowed by the TS. In previous Systematic Assessment of Licensee Performance (SALP) reports, weaknesses were identified in surveillance procedure adherence, procedure adequacy, and not performing refueling interval surveillance tests at the required frequency. Based on the recurrence of these problems, the licensee's efforts have not been successful in correcting this weakness.

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

- a. (Closed) IFI 302/87-31-01, Diesel generator fuel system check valves dropped from the Inservice Testing (IST) program in error.

The licensee has disassembled the fuel system to identify these check valves and found that no check valves existed in these locations. Plant drawings were correct for the system configuration and the check valves should not have been included in the IST program.

- b. (Open) Deviation 302/88-14-01, Failure to meet the seawater cooling temperature commitment as specified in the Final Safety Analysis Report (FSAR).

This matter was previously discussed in NRC Inspection Report 50-302/88-29. The licensee has revised the FSAR (revision 11 dated April 14, 1989) to reflect the results of the new thermal analysis for higher seawater cooling temperatures. Amendment #109 has been issued to the Technical Specifications to include the 95 degree Fahrenheit (F) inlet water temperature limit for TS 3.7.5.1.b. A hot temperature gas bypass system will be installed on the control complex chillers (MAR 88-09-01-01) to increase their reliability under increased system temperatures. This modification is presently scheduled to be performed during the next refueling outage in the spring of 1990. This item will remain open pending completion of the modification.

8. Exit Interview (30703)

The inspector met with licensee representatives (denoted in paragraph 1) at the conclusion of the inspection on August 4, 1989. During this meeting, the inspector summarized the scope and findings of the inspection as they are detailed in this report with particular emphasis on the violations and inspector followup item (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.

<u>Item Number</u>	<u>Description and Reference</u>
50-302/89-19-02	Violation - Failure to verify the closed position of manual valves associated with emergency feedwater containment penetrations every 31 days as required by TS 4.6.1.1.a.1. (Paragraph 3.a)
50-302/89-19-05	Violation - Failure to perform channel functional tests on the containment hydrogen monitors. (Paragraph 6.b.(2))
50-302/89-19-01	IFI - Review the revision to procedure CP-118 and changes to the licensee's fire watch training program. (Paragraph 2.b.(6))
50-302/89-19-03	IFI - Review the licensee's corrective action to prevent erroneous readings during the performance of battery surveillance tests. (Paragraph 3.b)
50-302/89-19-04	Follow the licensee's efforts to revise TS on DHR and BS system total allowable leakage. (Paragraph 3.c)

9. Acronyms and Abbreviations

BS	- Reactor Building Spray System
CCTV	- Closed Circuit Television
CFR	- Code of Federal Regulations
F	- Fahrenheit
FSAR	- Final Safety Analysis Report
GL	- Generic Letter
ICV	- Individual Cell Voltage
IFI	- Inspector Followup Item
ISI	- Inservice Inspection
IST	- Inservice Test
LER	- Licensee Event Report
NCOR	- Nonconforming Operation Report
NRC	- Nuclear Regulatory Commission

NSS - Nuclear Shift Supervisor
PM - Preventive Maintenance
RCA - Radiation Control Area
RPS - Reactor Protection System
RWP - Radiation Work Permit
SALP - Systematic Assessment of Licensee Performance
SP - Surveillance Procedure
STI - Short Term Instruction
STS - Standard Technical Specifications
TS - Technical Specification
VIO - Violation