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WOODY, C. O. Florida Power & Light Co.
RECIP. NAME RECIPIENT AFFILIATION
GRACE, J. N. Region 2, Ofc of the Director

SUBJECT: Forwards summary of mgt-on-shift repts, per NRC 871019 order.

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Dr. J. Nelson Grace
Regional Administrator, Region II
U.S. Nuclear Regulatory Commission
101 Marietta Street, N.W., Suite 2900
Atlanta, Georgia 30323

Re: Turkey Point Units 3 and 4
Docket Nos. 50-250 and 50-251
Management-on-Shift Weekly Report

Dear Dr. Grace:

Pursuant to the Nuclear Regulatory Commission Order dated October 19, 1987, the attached summary of Management-on-Shift (MOS) reports is submitted.

Should there be any questions on this information, please contact us.

Very truly yours,

For C. O. Woody
Executive Vice President

COW/SDF/cn
Attachment

cc: J. Lieberman, Director, Office of Enforcement, USNRC
D. G. McDonald, Project Manager, NRR, USNRC
Senior Resident Inspector, USNRC, Turkey Point Plant
R. E. Tallon, President, FPL

MOS001

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MANAGEMENT ON SHIFT (MOS)

WEEKLY SUMMARY REPORT

WEEK STARTING: December 21, 1987

Five MOS observers were on shift: B.M. Parks, St. Lucie Plant (12/21-28, 1987, Day); Garry A. Harris, Westinghouse Electric Corporation (12/21-28, 1987, Night); Vito A. Kaminskas, Turkey Point Reactor Supervisor (12/21-28, 1987, Night); R.J. Earl, Quality Control Supervisor (12/22-27, 1987, Night); and J.W. Kappes, Maintenance Superintendent (12/27-28, 1987, Night). While on shift these MOS observers reported any potential safety problems, questionable work practices, operating strengths, areas for improvements, and general recommendations.

During this period Unit 3 had two reactor startups (one subcritical reactor trip occurred) and is presently at 48% power. Unit 4 was maintained in Mode 1 (100% power). No immediate safety problems were observed.

The following questionable work practices were identified during the week:

- A number of security force personnel failed to wear hearing protection in the required areas.
- A rod position indication and a group step counter deviated by >12 steps. The deviation criteria on the log sheet is inadequate and is being upgraded.

Areas observed that need improvement are:

- Trainee awareness concerning effects of rod withdrawal at elevated subcritical multiplication levels.
- Power range operability test procedure.
- Fire door 106. 1 (Control Room to Inverter Room door) does not seal properly.
- Appropriate Main Control Board annunciators (should be checked to verify bistable position after bistables are tripped).
- Trainees remain at assigned stations during plant transients.
- Maintain the Control Room unobstructed by nonessential personnel during plant transients.
- Work control/status methods (may be improved by developing written turnover logs for maintenance departments).
- Post Maintenance Testing sheets (not always clear on what is to be tested nor performed at the earliest opportunity).
- Plant Work Orders (not complete if the plant status is not identified for when the equipment must be operable).
- NPO logsheets (not large enough to permit ease of recording data).

ATTACHMENT: MOS DAILY REPORTS

- 3-ONOP-41.5 (did not provide expanded guidance for Pressurizer spray leakage or possible sources of the problem).
- Procedure simplification for plant shutdown (number of procedures required to get the plant from Mode 1 to Mode 3 is >10).
- Cancellation of PWOs without sufficient investigation into root cause (Pressurizer pressure control problems).
- Attention to conduct of operations (during all phases of a reactor startup).
- Turbine controls (recondition and/or modify to improve reliability during frequent manual manipulations).
- Training briefs posted in the Control Room entrance (need to be maintained and updated).
- Fall protection safety chains across handrail entry ports (needed for timing valve and MSR intercept platforms).

Numerous recommendations continue to be submitted by the MOS observers. While many of these address previously mentioned items, the following additional items are being evaluated.

- Procedure 4-OSP-59.3 needs an upgrade to include recovery steps for all possible operability test failures.
- Auxiliary feedwater flow control valve "3C" flow transmitter labeling is reversed.
- A controlled copy of Procedure Index is needed in the Control Room.
- Issue guidelines concerning Control Room professionalism.
- Ensure all operators are aware of standard background noises on Metal Impact Monitoring System equipment. It should be maintained in the ENABLE mode for auto recording as necessary.
- A subcritical reactor trip occurred while driving rods when the source range detectors were energized with one detector out of service. Upgrade the ONOP for failed source range channel to include bypassing reactor trip signal.
- Ensure ERT recommendations are thoroughly communicated and understood.
- The Hagan Interconnection Diagram book has degraded from use and needs to be repaired.
- The participants of all departments during shift turnover should improve cooperation and communications.

ATTACHMENT: MOS DAILY REPORTS

MANAGEMENT ON SHIFT (MOS)

WEEKLY SUMMARY REPORT

WEEK STARTING: December 21, 1987

- Senior plant personnel should be very aware that their control room presence in no way usurps the authority of the PSN or APSN.

During the week of observations, MOS observers noted 48 strengths. Control Room professionalism, with the few exceptions noted above, was cited by several observers as an area of strength. Procedural inadequacies and work practices constitute the majority of MOS observer comments. The operators continue to be very responsive to identified problems.

ATTACHMENT: MOS DAILY REPORTS

0-ADM-019	Management on Shift (MOS) MOS DAILY REPORT	Page 1

To: Operations Superintendent - Nuclear Date: 12/21/87

From: B.M. Parks (MOS Observer) Shift: ☒ Day ☐ Night

A. **Plant evolutions observed**

- Morning meeting
- Shift briefings
- Toured the Unit 4 Turbine Building
- Observed Control Room activities
  - Unit 4 steady state
  - Unit 3 Mode 3 547°F making preparations for reactor startup
- Checked randomly selected Plant Work Order tags in the Control Room against information in the Equipment Out of Service Log. No discrepancies were noted.

B. **Immediate safety problems**

None

C. **Questionable work practices**

None observed

D. **Actions taken**

None

12/21/87

E. Strengths

- Log keeping
- Shift briefings

F. Areas for improvement

None

G. Recommendations

None

Completed By: B.M. Parks
MOS Observer

Date: 12/21/87

Reviewed By: L.W. Pearce
Operations Superintendent- Nuclear

Date: 12/22/87

GJB 12/22/87 12/22/87 12/22

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0-ADM-019	Management on Shift (MOS) MOS DAILY REPORT	Page 1

To: Operations Superintendent - Nuclear

Date: 12/21-22/87

From: Garry Harris
(MOS Observer)

Shift: ☐ Day ☒ Night

A. Plant evolutions observed

- Control Board/Plant Tour
- Shift turnover meeting
- Unit 4 N-41 Analog Channel Test
- Unit 3 startup
- Auxiliary Feedwater Operability Test

B. Immediate safety problems

None

C. Questionable work practices

None

D. Actions taken

None

E. Strengths

The operator on Unit 3 should be commended for an controlled, orderly and methodically executed plant startup. With well supervised and obviously learned trainees the plant was taken from a hot standby to mode 2 (startup) ~~made~~. The stage in this event was set with the reviewing of the procedural precautions and limitations. Although the area was a bit crowded for a planned startup, each person present was assigned and carried out his assigned duty with a cautious, safety conscious attitude. The procedure was followed verbatim with communications being stressed through the entire evolution. In all, the startup evolution with minor exceptions was a text book maneuver, clearly displaying the essential traits of teamwork and group cooperation to reach a successful end point.

F. Area(s) for improvement

1882

- Ensure trainees are aware of the effects of rod pulls at increased subcritical multiplication levels.

G. Recommendations

- Startup Procedure should reference inverse count ratio at an appropriate point to ensure background counts are recorded. Will investigate procedure this evening.

1883

- An operability test was performed on Unit 4 N-41 power range channel. The channel failed the operability test when the operator came to step in the procedure (4-OSP-59.3) which asked for a specific delta I deviation to be met. This criteria could not be met and the channel was subsequently taken out of service. The procedure was followed verbatim by the operator. However the procedure offered no guidance in this matter, only if the channel was in a failed high or low position. To remedy this situation, the APSN, within his authority, chose the failed high event path, which lead him to the correct endpoint. The procedure if it is to be followed verbatim, must provide suitable paths to enable the operator to remove the instrument from service.

1884

- During operability testing of the auxiliary feedwater valves verification of flow control valve position was requested. The procedure requires that the valves be stroked to their full open and full closed position. (Ref. procedure: 3-OSP-075.1) While observing the testing from the train 1 feedwater valve platform, the on-shift MOS noticed the cycling of flow transmitter 3C to its full closed (150-O GPM) and full open (150-200 GPM): position. The posted SNPO went to flow control valve and observed its motion and reported it to the Control Room. The labeling on the flow control transmitter is reversed and should be corrected to show the corresponding flow transmitter/valve.

Completed By: Garry Harris — MOS Observer — Date: 12/22/87

Reviewed By: L.W. Pearce — Operations Superintendent-Nuclear — Date: 12/22/87

CJB 12/22/87 12/22/87 12/22

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0-ADM-019	Management on Shift (MOS) MOS DAILY REPORT	Page 1

To: Operations Superintendent - Nuclear Date: 12/21-22/87

From: Vito A Kaminskas (MOS Observer) Shift: ☐ Day ☒ Night

A. **Plant evolutions observed**

- Unit 4 100% power; Unit 3 Mode 2 at 1% power
- Unit 4 NIS Power Range Channel Test 4-OSP-59.4
- Unit 3 Source Range Periodic Test 3-OSP-59.1
- Unit 4 remove power range N42 from service 4-ONOP-59.4
- Unit 3 criticality OP-1009 and 3-GOP-301
- Toured intake area
- Toured Secondary Plant
- Toured Auxiliary Feedwater Pump area
- Group 11 trainees on shift
- Unit 3 "A" AFW Pump Test

B. **Immediate safety problems**

None

C. **Questionable work practices**

None

D. **Actions taken**

None

12/21-22/87

E. Strengths

- Review of precautions and limitations by PSN prior to taking Unit 3 critical.
- Unit 3 criticality was very controlled and orderly.

F. Areas for improvement

None

G. Recommendations

PQ5
- Need controlled copy of Procedure Index in Control Room.

PQ6
- Bathroom in RCA needs to be repaired.

Completed By: Vito A. Kaminskas, *MOS Observer* Date: 12/22/87

Reviewed By: *Operations Superintendent-Nuclear* Date: 12/22/87

12/22/87 12/22/87 12/22

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0-ADM-019	Management on Shift (MOS) MOS DAILY REPORT	Page 1

To: Operations Superintendent - Nuclear Date: 12/22/87

From: B.M. Parks (MOS Observer) Shift: ☒ Day ☐ Night

A. Plant evolutions observed

- Morning meeting
- Shift briefings
- Observed performance of procedures 3-OSP-75.2 and 3_OSP-75.7. These procedures involved testing of the Auxiliary Feedwater System.
- Observed placing of Unit 3 on line

B. Immediate safety problems

None

C. Questionable work practices

None

D. Actions taken

None

E. Strengths

Procedures for the observed evolutions were strictly adhered to.

F. Areas for improvement

Noted that fire door 106.1 (Control Room to Inverter Room) was not properly sealed. Informed the PSN. The PSN took immediate action to call fire protection. A PWO was written and a Fire Protection Impairment Tag. A fire watch was already posted in the Inverter Room.

G. Recommendations

The operators were attentive to their stations during plant evolutions. However, during steady state situations, or awaiting actions by others there were occasionally situation where excess personnel were present. The PSN/APSN took prompt action to ensure decorum. However this observer believes that it might be beneficial to issue guidelines on control room professionalism. That is, ensure this shift crews know what is expected. It should be noted that the cramped Control Room enhances the appearance of crowded Control Room. The half dozen people needed for the Auxiliary Feedwater Test appeared to crowd the Unit 3 RCO desk area, but all were needed for the test briefing. In regards to professionalism: a) The observer looked for failure to scan the annunciators to clear alarms - No instances were noted. b) The operators except for brief discussions stayed on the assigned unit.

Completed By: B.M. Parks — *MOS Observer* — Date: 12/22/87

Reviewed By: L.W. Pearce — *Operations Superintendent- Nuclear* — Date: 12/23/87

12/23

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0-ADM-019	Management on Shift (MOS) MOS DAILY REPORT	Page 1

To: Operations Superintendent - Nuclear Date: 12/22/87

From: Garry A. Harris (MOS Observer) Shift: ☐ Day ☒ Night

A. **Plant evolutions observed**

- Reactor protection S/G level Channel III Test
- MSIV nitrogen leak
- Main feed pump 3B seal failure
- S/G level channel failure
- Unit 3 - 28% power
- Unit 4 - 100% power

B. **Immediate safety problems**

None

C. **Questionable work practices**

None

D. **Actions taken**

None

12/22/87

E. Strengths

- I&C Technicians started operability testing on S/G level channels for Unit 4. The team consisting of the I&C supervisor and two technicians displayed ~~evaluated~~ sense of professionalism through teamwork, good communication, efficiency of job performance, and keen attention to duties resulting in incident free testing of the protection channel.
- It was noted through earlier leak testing that an excessive amount of nitrogen was being lost through the air fittings used to supply emergency nitrogen to the S/G 3B MSIV. A decision was made to effect repairs. This required entry into an Technical Specification action statement. The Technical Specification was entered at 10:07 p.m. and terminated at 11:25 p.m. Good efficient work, communication, and effective cooperation between Quality Control, Maintenance and Operations resulted in the timely response and remedy to the event.
- While performing the S/G periodic level operability testing (OP-14004.1) a failure of the S/G level channel LI-4-496 occurred. The incident materialized as the control board operator was directed procedually (Step 8.9.70) to switch from manual control back to normal (Auto) position for FCV-496. This initiated a feedwater transient causing the regulating valve to go to its full open position. As water level increased, alarms on level and feed/steam mismatch were acknowledged. Persons in the immediate area including the PSN, APSN and RCO's trained their attention on the transient. Although the off-normal procedures were still shelved at this point due to the quick nature of the transient, the RCO knew and executed the immediate actions in text book fashion (i.e. taking manual control of valve position and decreasing level close to setpoint and selecting the alternate channel (LI-4-498) and placing the valve controller back in AUTO). Bistables for the affected channel were immediately positioned. A review of the appropriate off-normal procedure was conducted first by the STA, and then by the night shift MOS team. All immediate and subsequent actions were met. A PWO was written and clearance information tag was hung on the affected level channel selector switch. Technical Specifications were reviewed by the STA for applicable action statements. The quick immediate observations and actions taken by the RCO prevented an impending reactor trip. His alertness to duty and knowledge of immediate actions was a key factor in mitigating the transient.

F. Areas(s) for improvement

- Bistables were tripped in timely fashion immediately after mitigation of the transient. It was not clearly observed that appropriate main control board annunciators were checked for corresponding bistable position. A methodical check is necessary at this point to ensure that the appropriate bistables were positioned.
- Stress to trainees the importance of maintaining assigned posts during transients to ensure dual unit coverage.
- Ensure operator surveillance area is left unobstructed by nonessential personnel during transients to lessen chances of interference.

12/22/87

G. Recommendations

None

Completed By: Garry A. Harris
MOS Observer

Date: 12/22/87

Reviewed By: L.W. Pace
Operations Superintendent-Nuclear

Date: 12/23/87

12/23

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0-ADM-019	Management on Shift (MOS) MOS DAILY REPORT	Page 1

To: Operations Superintendent - Nuclear

Date: 12/22-23/87

From: R.J. Earl
(MOS Observer)

Shift: ☐ Day ☒ Night

A. Plant evolutions observed

- Unit 4 steam generator water level periodic OP-14004.
- Unit 3 "B" MSIV Nitrogen leak repair (4 hr. LCO)
- Shift turnover/briefing (no I&C representative present)
- Unit 3 loss of 3PO6 breaker 20
- Unit 4 "C" S/G feed reg. valve failed open

B. Immediate safety problems

None

C. Questionable work practices

None

D. Actions taken

Spoke with I&C relieving supervisor on importance of shift turnover meeting.

12/22-23/87

E. Strengths

- Peak shift I&C supervisor and two I&C specs performance of OP-14004.1 was very well coordinated and controlled. The RCO was kept well informed of each step.
- PSN/APSN used good judgement and all available resources to determine actions necessary to repair 3 "B" MSIV Nitrogen leaks.
- Entire Control Room became a very professional team during 4C S/G level control event. RCO responded to his indications. NWE and STA located proper ONOP. Communications were very clear and concise. There was no doubt who was in charge nor what actions were required.

F. Areas for improvement

- Work control/status methods need improving.
  Examples:
  - 3P06 Breaker 2O tripped at 0135. Breaker listed as #3 exiter ground detection. Walkdown of exciter revealed lead for checking RPM still attached to north end of exciter but other end lying on deck. Two vibration probes (Wooden Dowels) penetrating exciter house on west side. No monitoring was in progress. No one on site knew status of why these were there.
  - 3B SGFW pump seal water was out on clearance # 3-87-12-81 to I&C Department. Seal pump itself was not on clearance but information tag on control switch referenced seal water not available. Clearance was hung 12/21/87 at 1100. Neither peak shift nor mid-shift knew status of job. Mid-shift located PWO but could not determine of job had been completed. This could have been a hold on Unit 3 power escalation if it were not for S/G chemistry problems.

G. Recommendations

Develop written turnover logs for all maintenance Departments which can be used during turnover meetings to update status of equipment. This would also be a means to ensure information is passed on from night shifts to day shifts.

Completed By: R.J. Earl — Date: 12/23/87
MOS Observer

Reviewed By: L.W. Pearce — Date: 12/23/87
Operations Superintendent-Nuclear

12/23

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0-ADM-019	Management on Shift (MOS) MOS DAILY REPORT	Page 1

To: Operations Superintendent - Nuclear Date: 12/23/87

From: B.M. Parks (MOS Observer) Shift: ☒ Day ☐ Night

A. Plant evolutions observed

- Morning meeting
- Shift turnover
- Unit 4 steady state
- Unit 3 steady state. Then starting shortly after 1500 at 3%/hr power increase

B. Immediate safety problems

None

C. Questionable work practices

Though not nuclear safety related, I noted that a number of security force personnel were not wearing hearing protection in the Turbine Building.

D. Actions taken

Notified Safety of the hearing protection problem. Safety promptly went to the Turbine Building. I noticed that personnel had hearing protection on in the afternoon.

E. Strengths

Steady state power operation on two units is quiet and businesslike.

F. Area(s) for improvement

- Post Maintenance Testing Sheets (AP-0199.28) are not always clear on what needs testing, and are not always tested at the earliest opportunity. I reviewed the test sheets currently in the Control Room. Some could have been tested several days ago. Others were not sufficiently clear to allow leak inspections without first contacting maintenance to determine the location of the item. The two Unit 3 Turbine Cooling Water Heat exchangers indicate that a tube leak test is required.

  I understand that the system has been identified by plant management as an area needing improvement and is being worked. In addition, it should be noted that the examples identified above involved secondary systems.

  The operators were working a large majority of the outstanding tests. In addition, discussions with the operators indicate that they have noted the brief component descriptions and compensate by contacting maintenance on an individual basis. The revised system needs to be user friendly for operations and the Maintenance and Technical Staff. The system should be able to administer the large post outage test loads which the plant experiences.

- Per request of the night shift MOS observers, the PWOs for the "3B" Feedwater Pump Seal System were investigated.
  - PWO 7557/63 WA 872571740 was written on 9/14/87 to indicate a defect "Turning of loader knob will not move indicators".
  - PWO 7557/63 WA873160546 was written on 11/12/87 to identify an "air leak on HA-3-2209".

  Both PWOs were written by operators. Neither indicated the need to have the components back by a given plant status. I&C gave the PWOs a priority C7 which should have been done in 21 days. However, higher priority work delayed the work.

  On December 20th, I&C attempted to obtain clearance and noted on the report the need to return the equipment to service by 60% power. On 12/21/87 a clearance was granted and the jobs were completed on 12/23/87 at 8:30 a.m.

G. Recommendations

None

Completed By: B.M. Parks Date: 12/23/87
MOS Observer

Reviewed By: J.W. Pence Date: 12/28/87
Operations Superintendent- Nuclear

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JJB 12/28/87

12/23/87

0-ADM-019	Management on Shift (MOS) MOS DAILY REPORT	Page 1

To: Operations Superintendent - Nuclear

Date: 12/23-24/87

From: R.J. Earl
(MOS Observer)

Shift: ☐ Day ☒ Night

A. Plant evolutions observed

- End of peak shift meeting
- I&C troubleshooting LT-4-496
- Flux Map and resetting Unit 3 control bank "D" RPIs
- NPO Log taking
- Walked down AFW area and secondary systems

B. Immediate safety problems

None

C. Questionable work practices

None

D. Actions taken

Informed APSN of error on NPO Logsheet where "3A" battery was listed twice. On shift PUP representative directed to process a change.

E. Strengths

- Very quick response by Reactor Engineering in determining actual rod position when rod deviation > 12 steps was noted by Unit 3 RCO on Control Bank "D".
- PSN, APSN, RX Engineering Supervisor outlined a game plan to address rod deviation, Rod F-4 RPI Cycling and Quadrant Power Tilt Ratio problems in an orderly, conservative yet aggressive manner.
- PSN stresses the importance of attention to details to all watch standers.

F. Areas for improvement

NPO Logsheets are not very easy to read and require data recording in a space less than ¼ inch square. Acceptance criteria is not always clear on readings taken.

G. Recommendations

Evaluate possible revision to operators' logs. Need to be at least 8½" x 11" in size (Current ones appear to be a reduced copy cut and pasted to 8½" x 11" paper). Clearly marked acceptance criteria or normal bands for easier detection of abnormal conditions is needed.

Completed By: R.J. Earl — *MOS Observer* — Date: 12/24/87

Reviewed By: L.W. Pearce — *Operations Superintendent- Nuclear* — Date: 12/28/87

CJB 12/28/87

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12/23-24/87

0-ADM-019	Management on Shift (MOS) MOS DAILY REPORT	Page 1

To: Operations Superintendent - Nuclear

Date: 12/23-24/87

From: Garry A. Harris
(MOS Observer)

Shift: ☐ Day ☒ Night

A. Plant evolutions observed

- Unit 3 Ramp 3%/hr (42% to 48% power)
- Unit 4 100% power
- MIMS alarms - Unit 4
- Intermittent Feed Regulator Valve Control Channel failure - Unit 3
- RPI indicated misalignment at rods H-8 and H-12 - Unit 3

B. Immediate safety problems

None

C. Questionable work practices

During routine control board surveillance the RCO noticed that rods H-8 and H-12 were visually at 199 steps and 197 steps. This alignment was in violation of Technical Specification 3.2 which did not allow rod misalignment to be greater than 12 steps between rods within a given bank. The PSN and APSN were notified and promptly entered the appropriate off normal procedure (ONOP-028). All procedural steps were adhered to resulting in the notification of Reactor Engineering Supervisor to declare the rods operable or inoperable. A PWO (317504) A-1 was written to allow I&C to verify position via voltage readings. The voltage readings along with a subsequent Flux Map revealed the actual position of the rods were within the Technical Specification limitations. At the same time, the RCO twice noticed a momentary decrease in position (approximately 15 steps) for rod F-4. The PSN declared the rod inoperable and reentered the appropriate ONOP taking action in acordance with step 5.4.4.

The on-shift MOS observer reviewed the RCO Daily Logs to ensure past shift compliance. No deviations were found, however it was learned and later confirmed that it was common practice to note deviations between group-step and RPI bank indication versus deviation between any two RPI's in a given bank. This practice was reinforced by the RCO Daily Logs (3-OSP-201.1 pg. 18) which referred to an abnormal alignment only as the difference between bank indication and group-step demand indication. It cannot clearly be determined how long the deviation actually existed. Given the routine reinforcement of the deviation criteria on the log sheet, it is clearly possible that RPI deviation in a bank could exist (Especially in the case of trainees recording RCO log data).

D. Actions taken

This condition was pointed out to the PSN and APSN and both agreed that this could be a safety concern. Therefore to ensure compliance an OTSC was written to the RCO Daily Logs (3-OSP-201.1.). The criteria was changed to read:

If any one of the following occurs, refer to ONOP-028:

- A difference of greater than 1 step between group step counters in a bank.
- A difference of greater than 12 steps between any two RPI's in a bank or between an RPI and its bank step counter.

E. Strengths

- Decisions were made in a quick, accurate fashion resulting in minimal delays. The procedure was strictly adhered. Good group cooperation and communication between Reactor Engineering, Operations and I&C Departments was strongly evident.
- Strong attention to duty was again a factor in mitigating a feedwater transient induced by a control channel intermittent failure on Unit 3 "A" steam generator.

F. Area(s) for improvement

None

G. Recommendations

- Review change to 3-OSP-201.1 with crews during shift meetings to ensure timely compliance.
- Ensure all RCO's and trainees are aware of standard background noises on MIMS equipment and that equipment is placed in ENABLE mode for auto recording per procedure.

Completed By: Garry A. Harris, *MOS Observer* Date: 12/23/87

Reviewed By: L.W. Pearce, *Operations Superintendent-Nuclear* Date: 12/28/87

CJB 12-28-87

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0-ADM-019	Management on Shift (MOS) MOS DAILY REPORT	Page 1

To: Operations Superintendent - Nuclear

Date: 12/24/87

From: B.M. Parks
(MOS Observer)

Shift: ☒ Day ☐ Night

A. Plant evolutions observed

- Shift turnover
- Shift briefing
- Toured RCA and RAB twice

B. Immediate safety problems

None

C. Questionable work practices

None observed

D. Actions taken

None

12/24/87

E. Strengths

The PSN and APSN took great care and effort to resolve the plants approximate 4% Quadrant Power Tilt and comply with both the Technical Specifications and Interim Technical Specifications. The wording of Technical Specification section 3.6.6.i and Interim Technical Specification 3.2.4 are open to interpretation as to applicability and cannot be readily implemented (adjustment of Trip Setpoints). The PSN and APSN consulted with among others, the Plant Manager, the NRC, Reactor Engineering and Licensing. The plant was released from the action statement condition by a successful Flux Map calculation by Reactor Engineering.

F. Areas for improvement

None

G. Recommendations

As Plant Management is aware, the Technical Specification conditions need to be resolved. The "dual" Technical Specification condition (See E.) appeared in this case to be a handicap for the operators to overcome.

Completed By: B.M. Parks — Date: 12/24/87
MOS Observer

Reviewed By: L.W. Pearce — Date: 12/28/87
Operations Superintendent-Nuclear

CJB 12/28/87 **FINAL PAGE**

0-ADM-019	Management on Shift (MOS) MOS DAILY REPORT	Page 1

To: Operations Superintendent - Nuclear Date: 12/24-25/87

From: R.J. Earl (MOS Observer) Shift: ☐ Day ☒ Night

A. Plant evolutions observed

- Unit 4 100% steady state
- Unit 3 loss of Pressurizer pressure control

B. Immediate safety problems

None

C. Questionable work practices

None

D. Actions taken

None

E. Strengths

- Excellent coordination, control and communications resulted in a very smooth power reduction. Teamwork was very evident. Procedure usage was good. Independent verifications and backing up each other was common place.
- PSN took time to brief everyone on status of event and long term game plan after unit was stabilized.

F. Areas for improvement

- 3-ONOP-41.5 should be reviewed to determine need to expand actions. It appeared that more information could be provided after point of pulling spray valve fuses.
- RCS/Containment parameters were checked at initiation of event but should have been reverified during course of event. This was discussed with APSN who agreed that this should be done until event cause is fully confirmed.

G. Recommendations

Same as F.

Completed By: R.J. Earl (MOS Observer) Date: 12/25/87

Reviewed By: R.W. Pearce (Operations Superintendent- Nuclear) Date: 12/28/87

CJB 12/28/87

0-ADM-019	Management on Shift (MOS) MOS DAILY REPORT	Page 1

To: Operations Superintendent - Nuclear

Date: 12/24-25/87

From: Garry A. Harris
(MOS Observer)

Shift: ☐ Day ☒ Night

A. Plant evolutions observed

- Unit 3 pressure control problem
- Unit 4 at 100%
- Shift meeting
- Shift turnover
- Steam flow channel failure - Unit 3 S/G "A"

B. Immediate safety problems

None

C. Questionable work practices

None

D. Actions taken

None

E. Strengths

- While operating at a steady state power level of 50% the Unit "3" RCO was conducting routine surveillance on the spray valve controllers LC-455A/LC-456B. The surveillance required the operator to cycle the sprays open and then closed to test operability. The RCO noticed pressure decreasing in an uncontrolled manner with heater indicating full on. Sprays were immediately taken to a full shut position, allowing nothing but the normal 0.5 GPM bypass flow to enter the Pressurizer. The off-normal procedure was entered and immediate and subsequent actions were executed. This included removing the control power fuses. Pressure continued to decrease to approximately 2190 psig. The APSN and STA conducted continuous parameter observations at the beginning of the evolution. The pressure problem placed the plant in a two hour Technical Specification mode. The PSN ordered the plant to be ramped down in an orderly fashion (5 MWE/min). At the same time the PSN ordered I&C to check control/backup heater output. After some delay due to unfamiliarity with the equipment, the heater output values were given to be 250 kw, 350 kw and 350 kw. Spray line temperatures were checked early in the transient and again later. A temperature difference of approximately 15°F existed between the spray loops. However, this temperature difference was normal when checked against RCO Daily Logs. Since a power reduction of greater than 15% was in progress, the PSN ordered an appropriate chemistry sample be taken. The transient and subsequent actions of the off-normal procedure ONOP-41.5 require off-site notification of the Operations Superintendent and the formation of a ERT Team. Both actions were promptly executed. Power was leveled off approximately 135 MWE. Subsequent troubleshooting included monitoring spray temperature lines, Control/Backup Heater output monitoring, and spray valve manual manipulation. A purge permit was ordered to facilitate containment entry for valve repair.

- Concise, accurate decision making on the part of the PSN and APSN resulted in a prompt analysis of the problem and subsequent mitigation of the transient.

- The team concept was extremely evident during the transient as a result of strong, continuous communications between Nuclear and Turbine Operators during the transient and power ramp down.

- The PSN conducted a timely, concise and brief shift meeting to ensure all participants are aware of current plant conditions and subsequent actions or "Game Plan".

- The PSN encouraged and solicited feed back from RCOs and crew during the decision making process.

- Long-range planning was evident in the issurance of orders to facilitate a containment entry if needed and solution gathering to provide the ERT Team with timely data.

- RCOs allowed a minimum volume of water to exist in pressurizer during transient thus allowing the degraded heat input to maximize steam production and thus lessen the pressure reduction transient. Good analysis and creativity in problem solving was extremely evident.

- Failed S/G channel promptly identified and bistables tripped and verified in accordance with procedure.

F. Area(s) for improvement

- The ONOP provided minimal subsequent actions for trouble shooting the pressure transient including monitoring parameters for leakage and instructions on problem solving.
- Ensure technicians are familiar with components prior to assignment as to not cause further degradation of problem (i.e. I&C Technician infamiliarity with pressurizer heater components).

G. Recommendations

None

Completed By: Garry A. Harris
MOS Observer

Date: 12/25/87

Reviewed By: J.W. Pearce
Operations Superintendent- Nuclear

Date: 12/28/87

CJB 12/28/87

FINAL PAGE

12/24-25/87

0-ADM-019	Management on Shift (MOS) MOS DAILY REPORT	Page 1

To: Operations Superintendent - Nuclear Date: 12/25/87

From: B.M. Parks (MOS Observer) Shift: ☒ Day ☐ Night

A. Plant evolutions observed

- Shift meeting
- Implementation of portions of Pressurizer Pressure Offnormal Procedure 3-ONOP-041.6
- Implementation of Reactor Trip Pressure 3-EOP-ES-0.1
- Event response team meeting per O-ADM-011

B. Immediate safety problems

None

C. Questionable work practices

None

D. Actions taken

None

E. Strengths

- Operators worked well as a team handling the pressurizer pressure control problems, the power reduction to subcriticality and the reactor trip. Procedures were followed. Communications between the operators, PSN APSN, NPO, SNPO and Chemistry were excellent.
- Event Response Team covered possible problems thoroughly, planned trouble shooting, and estimated schedule in an organized and professional manner.

F. Area(s) for improvement

- The operators used 3-GOP-103 to change the unit from power operation to hot standby. To implement this document the operator must have a total of ten additional procedures to get to hot standby behind closed main steam isolation valves. In addition, the operator must provide a procedure to the NPO and may require three additional procedures if conditions warrant. The operators had copies available on the RCO desk. However, time was expended obtaining copies and then additional time was spent locating each procedure in turn as the plant conditions changed. This large number of procedures is a burden on the operators. A simpler system should be investigated.
- The Unit 3 Pressurizer pressure control problems were first noted by operators on 12/19/87. PWO WA873541710 was written to have the problem corrected. The defect statement was: "Cannot maintain Pressurizer pressure when plant stable with just control group heaters". The Serious/Reason statement was "Not sure if heaters are problem or Pressurizer spray or mini-spray valves". The PWO was cancelled based on the fact that "some heaters are burned out and not replaceable" on 12/20/87.
- A review of PWO procedure O-ADM-701 by this MOS observer could not find a clear statement regarding actions to address all aspects of the defects (e.g. spray valves on this case). In addition clear directions were not provided for passing PWO from one maintenance department to another department (e.g. Engineering to I&C).
- In this case it appears that the current system did not pursue the problem far enough. That is only part of the root cause that may have been identified and addressed.

G. Recommendations

The Unit 3 Reactor Trip occurred when the reactor approached the source range. Detector N-31 was out-of-service. When detector N-32 auto initiated there was a brief spike and the Reactor Trip occurred. The reactor control rods were 78 steps out on shutdown bank "B" and full out on shutdown bank "A". All control groups were fully inserted. The operators state that the detector used to be bypassed at this point to avoid this event and that a procedure change had been requested. This procedure change should be expedited and the bypassing reinserted, if permissible. If not permissible the spiking problem needs addressing.

It should be noted that the operators strict adherence to procedures were somewhat contributory to the event in that the operators did not go outside the procedure to take the logical step of bypassing the trip as was once done by procedure.

Completed By: B.M. Parks *MOS Observer* Date: 12/25/87

Reviewed By: L.W. Pearce *Operations Superintendent-Nuclear* Date: 12/28/87

CJB 12/28/87 **FINAL PAGE**

0-ADM-019	Management on Shift (MOS) MOS DAILY REPORT	Page 1

To: Operations Superintendent - Nuclear

Date: 12/25-26/87

From: R.J. Earl
(MOS Observer)

Shift: ☐ Day ☒ Night

A. Plant evolutions observed

- Unit 4 100% steady state operations
- Unit Mode 3
  - Troubleshooting PCV 455A
  - Toured Unit 3 containment
- Shift turnover meeting (Mechanical Maintenance, Health Physics not present)
- Secondary systems walkdown

B. Immediate safety problems

None

C. Questionable work practices

None

D. Actions taken

None required

E. Strengths

Both PSNs, APSN and NWEs developed a game plan for work to be performed on their shifts.

F. Areas for improvement

Information on ERT Findings/Recommendations appeared to not have been provided to the backshifts in sufficient detail. PSNs ended up developing their own game plan which they then communicated to management.

G. Recommendations

Provide copy of ERT minutes (if available) and/or written guidance on ERT direction desired to Control Room.

Completed By: R.J. Earl — *MOS Observer* Date: 12/26/87

Reviewed By: L.W. Pearce — *Operations Superintendent- Nuclear* Date: 12/28/87

CJB 12/28/87

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0-ADM-019	Management on Shift (MOS) MOS DAILY REPORT	Page 1

To: Operations Superintendent - Nuclear

Date: 12/25-26/87

From: Garry A. Harris
(MOS Observer)

Shift: ☐ Day ☒ Night

A. Plant evolutions observed

- Unit 3 Hot standby
- Unit 4 at 100% power
- Troubleshooting of Spray Valve "455A" - Containment Entry
- Containment Closeout Inspection
- Tour Water Treatment Facility

B. Immediate safety problems

None

C. Questionable work practices

None

D. Actions taken

None

E. Strengths

- Good troubleshooting techniques and follow-up on suggestions and observations lead to the discovery of Spray Valve 455A malfunction during containment entry.
- Thorough pre-planning before the containment entry simplified the problem analysis and shortened the stay time. Group cooperation among Health Physics, I&C and Operations along with the flexibility of Quality Control supervisory personnel was a key factor in the problem analysis and resolution.

F. Areas for improvement

Procedure inadequacy 3-ONOP-059.3

- During Unit 3 startup on 12/22/87, source range instrumentation N-31 re-energized spontaneously above P-6. The source range instrument power fuses were promptly removed to deenergize the instrumentation. The action also deenergized the associated bistable for the source range high flux trip. Operations to place the reactor in a hot standby condition included driving the reactor subcritical using rods. With all control banks in and the shutdown banks in motion, the intermediate range instrumentation fell below the P-6 set point, reenergizing the source range channels. As designed, the 1 out of 2 coincidence was met, and the reactor trip on source range high flux.
- The procedure should address the consequences of removing control power fuses in attempting to remove the source range channel from service. The procedures should have directed the operators to place the detectors in the BYPASS position to prevent an inadvertent reactor trip.

G. Recommendations

Procedure inadequacy should not replace nor circumvent operator awareness of equipment condition and response.

Ensure ERT recommendations are thoroughly communicated and understood to shift complement.

Completed By: Garry A. Harris — *MOS Observer* — Date: 12/26/87

Reviewed By: L.W. Pearce — *Operations Superintendent-Nuclear* — Date: 12/28/87

CJB 12/28/87

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0-ADM-019	Management on Shift (MOS) MOS DAILY REPORT	Page 1

To: Operations Superintendent - Nuclear Date: 12/26/87

From: B.M. Parks (MOS Observer) Shift: ☐ Day ☒ Night

A. Plant evolutions observed

- Shift briefings
- PSN turnover
- Toured RCA
- Attended ERT meeting
- Observed Control Room discussions regarding maintenance, scheduling of maintenance and clearance tagging.

B. Immediate safety problems

None

C. Questionable work practices

None

D. Actions taken

None

12/26/87

E. Strengths

PSN, APSN, NWE and Operators cognizant of maintenance activities, impact on plant and plan of action.

F. Areas for improvement

None

G. Recommendations

None

Completed By: B.M. Parks *MOS Observer* Date: 12/26/87

Reviewed By: L.W. Pence *Operations Superintendent- Nuclear* Date: 12/28/87

CJB 12/28/87

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0-ADM-019	Management on Shift (MOS) MOS DAILY REPORT	Page 1

To: Operations Superintendent - Nuclear

Date: 12/26-27/87

From: R.J. Earl
(MOS Observer)

Shift: ☐ Day ☒ Night

A. Plant evolutions observed

- Unit 4 at 100% steady state operation
- Unit 3
  - Containment walkdown
  - I&C repair of PCV 455A
  - Reactor startup
  - Warming steam lines
  - Turbine roll preparations
  - Placing unit on line to approximately 20%

B. Immediate safety problems

None

C. Questionable work practices

None

D. Actions taken

None

E. Strengths

Good briefing by APSN prior to each major evolution during startup.

F. Areas for improvement

- Turbine Controls
- Feedwater Controls

G. Recommendations

Recondition/modify Turbine Controls - Existing system appears unreliable requiring frequent manual manipulations.

Completed By: R.J. Earl *MOS Observer* Date: 12/27/87

Reviewed By: L.W. Pearce *Operations Superintendent- Nuclear* Date: 12/28/87

CJB 12/28/87

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0-ADM-019	Management on Shift (MOS) MOS DAILY REPORT	Page 1

To: Operations Superintendent - Nuclear

Date: 12/26-27/87

From: Garry A. Harris
(MOS Observer)

Shift: ☐ Day ☒ Night

A. Plant evolutions observed

- Unit 4 at 100% power
- Unit 3 Startup/Synchronize to grid, load to 112 MWE
- Unit 3 Containment Inspection
- Shift turnover meeting

B. Immediate safety problems

None

C. Questionable work practices

None

D. Actions taken

None

E. Strengths

- On site Quality Control Supervisory personnel conducted an extremely thorough inspection of containment ensuring past leakage suspect areas were investigated in detail.
- With minor exceptions, the reactor startup was a well coordinated evolution.
- Pre-planning, coordination, flexibility, innovativeness in problem solving and attention to duties was evident during the critical maneuvers which lead to synchronization to the grid and subsequent uploading.

F. Areas for improvement

Attention to the conduct of operations is a must during all phases of startup evolutions.

G. Recommendations

None

Completed By: Garry A. Harris — Date: 12/27/87
MOS Observer

Reviewed By: G.W. Pearce — Date: 12/28/87
Operations Superintendent-Nuclear

GB 12/28/87

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0-ADM-019	Management on Shift (MOS) MOS DAILY REPORT	Page 1

To: Operations Superintendent - Nuclear

Date: 12/27/87

From: B.M. Parks
(MOS Observer)

Shift: ☒ Day ☐ Night

A. Plant evolutions observed

- Shift briefings
- Shift turnovers
- Unit 4 steady state
- Unit 3 up-power from 30% to 48% power

B. Immediate safety problems

None

C. Questionable work practices

None

D. Actions taken

None

12/27/87

E. Strengths

- Good shift turnovers
- Good response to smell of "burning rubber" in Control Room. Source was determined to be belt on air handler.

F. Areas for improvement

- The training briefs posted in the entrance way needs attention. Some have been posted a long time. For example, dates include: 5/8/87, 6/16/87 and 7/17/87.
- Someone needs to ensure that the postings are neat and the signatures are obtained. If personnel are in SRO school or no longer licensed, the signatures should be obtained or marked out.

G. Recommendations

The Hagan Interconnection Diagram Books need some attention. Only four (4) pages in the Unit 3 book have not yet torn off the ring binder.

Completed By: B.M. Parks *MOS Observer* Date: 12/27/87

Reviewed By: L.W. Pearce *Operations Superintendent- Nuclear* Date: 12/28/87

CJB 12/28/87

FINAL PAGE

0-ADM-019	Management on Shift (MOS) MOS DAILY REPORT	Page 1

To: Operations Superintendent - Nuclear

Date: 12/27-28/87

From: Garry A. Harris
(MOS Observer)

Shift: ☐ Day ☒ Night

A. Plant evolutions observed

- Unit 4 at 100% power
- Unit 3 at 48% power
- Turbine Eccentricity Problem - "Unit 3" No. 9 bearing
- Shift turnover meeting
- I&C Calibration N-44/N-43 power range
- Channels -Unit 3

B. Immediate safety problems

None

C. Questionable work practices

None

D. Actions taken

None

B. Strengths

- Continuing No. 9 Bearing Turbine Vibration problems were resolved. After efforts by the Westinghouse Representative were exhausted, an earlier recommendation was tried and yielded successful results. The vibration was decreased from a maximum of 10.5 mils to a more tolerable 6.5 mils. It was surmised that a possible oil whip phenomena could be one of the possible causes. To alleviate this problem a decrease in seal oil viscosity was needed, Westinghouse recommendations were not to exceed air side oil temperature of 126°F. However, previous long-term operating experience and sound judgement factored in the PSNs decision to ramp temperature upward to a maximum 135°F (Subsequent measurements by the STA proved the temperature indicator T1-3413 may have been reading high). With subsequent repressurization of the generator to 75 psig, (Westinghouse recommendation maintain 60 psig) the eccentricity problem was alleviated.

- Although contrary to Westinghouse recommendations, PSNs decision to elevate seal oil temperatures based on previous operating experience, sound judgement and temperature band (Temperature band 80 to 135° F on TI-4-3413) as defined in NPO Daily Logs 4-OSP-201.3 was valid.

- PSNs decision to elevate hydrogen gas pressure to 75 psig, was valid despite Westinghouse recommendations. This was based on operating experience (Hydrogen leakage), PTP 3 and 4. Special instructions and 4-GOP-301 step 5.48.1.

- PSN/APSN solicited feedback from operators to ensure agreement and that the comfort index was high before attempting the maneuver.

F. Area(s) for improvement

None

G. Recommendations

The observations of professionalism during the past week (12/2-28/87) covers a broad spectrum of characteristics. Good sound engineering practices coupled with the awareness of procedural, accountability, and experience. during analysis and problem solving was evident during transients and subsequent recovery. The PSN and APSN attentiveness to detail within and outside the Control Room averted potential problems, strongly reflecting job pride and a positive attitude . For the most part, communication and interacting between personnel and other departmental groups was above average. For instance, the pressure control malfunction ramp down evolution was a clear example of on-shift personnel, especially the turbine operators, executing instructions quickly and accurately and at the same time provided timely feedback to the reactor control operators. This MOS observer is confident in exclaiming that the on-shift crews are increasingly displaying the characteristics of professionalism.

- Appearance is a contributory factor to professionalism and thus the conduct of operations. The lack of a comfortable, casual working uniform by the on-shift crews is a distinctive detraction. If implemented ensure crew input.
- Group cooperation and communications can be increased by consistent involvement of all groups in shift turnover meetings. i.e. (I&C, Electrical, Mechanical, Health Physics).
- Senior personnel should be mindful that their presence does not compromise the authority of the PSN or APSN during plant evolutions.

Completed By: Garry A. Harris *MOS Observer* Date: 12/28/87

Reviewed By: L.W. Pearce *Operations Superintendent-Nuclear* Date: 12/28/87

GAH 12/28/87

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0-ADM-019	Management on Shift (MOS) MOS DAILY REPORT	Page 1

To: Operations Superintendent - Nuclear

Date: 12/27-28/87

From: J.W. Kappes
(MOS Observer)

Shift: ☐ Day ☒ Night

A. Plant evolutions observed

- MP 12307.3 (NIS Quarterly Calibrations)
- #3 Turbine Vendor Field Vibration readings
- Iron Horse air side seal oil adjustment
- Extensive plant tours

B. Immediate safety problems

None

C. Questionable work practices

None

D. Actions taken

None

12/27-28/87

E. Strengths

- Turnover meetings are well attended and professional
- Plant is very clean after a short shutdown of Unit 3 over holiday.
- Observed a very positive attitude among plant personnel over cooperation between themselves during Christmas shutdown of Unit 3.

F. Areas for improvement

- #3 timing valve and 3 and 4 MSR intercept platforms need fall protection safety chains across the handrail entry ports.
  - Had mechanical generate a safety PWO to add chains and attachments.
  - Have closed the item on MOS. It will be tracked as part of my accountability.

G. Recommendations

None

Completed By: J.W. Kappes — MOS Observer — Date: 12/28/87

Reviewed By: L.W. Pearce — Operations Superintendent- Nuclear — Date: 12/28/87

GJB 12/28/87

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DISTRIBUTION
Docket File w/o encl.
PD22 Reading w/o encl.
D. Miller w/encl.
D. McDonald w/encl.

December 23, 1987

DOCKET NO(S). 50-250 and 50-251
Mr. C. O. Woody
Group Vice President
Nuclear Energy
Florida Power and Light Company
Post Office Box 14000
Juno Beach, Florida 33408

SUBJECT:

TURKEY POINT UNITS 3 AND 4

The following documents concerning our review of the subject facility are transmitted for your information.

- [ ] Notice of Receipt of Application, dated _____.
- [ ] Draft/Final Environmental Statement, dated _____.
- [ ] Notice of Availability of Draft/Final Environmental Statement, dated _____.
- [ ] Safety Evaluation Report, or Supplement No._____ dated _____.
- [ ] Environmental Assessment and Finding of No Significant Impact, dated _____.
- [ ] Notice of Consideration of Issuance of Facility Operating License or Amendment to Facility Operating License, dated _____.
- [x] Bi-Weekly Notice; Applications and Amendments to Operating Licenses Involving No Significant Hazards Considerations, dated 12/16/87 [*see page(s)*] _____.
- [ ] Exemption, dated _____.
- [ ] Construction Permit No. CPPR-_____, Amendment No. _____ dated _____.
- [ ] Facility Operating License No. _____, Amendment No. _____ dated _____.
- [ ] Order Extending Construction Completion Date, dated _____.
- [ ] Monthly Operating Report for _____ transmitted by letter dated _____.
- [ ] Annual/Semi-Annual Report- _____ _____ transmitted by letter dated _____.

Division of Reactor Projects-I/II
Office of Nuclear Reactor Regulation

Enclosures:
As stated

cc: See next page

OFFICE	LA:PDR22						
SURNAME	D:Miller:bg						
DATE	12/23/87						

NRC FORM 318 (10/80) NRCM 0240 OFFICIAL RECORD COPY