ACCELERATED DISTRIBUTION DEMONSTRATION SYSTEM

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR:8807120366 DOC.DATE: 88/06/22 NOTARIZED: NO DOCKET #
FACIL:50-250 Turkey Point Plant, Unit 3, Florida Power and Light C 05000250
50-251 Turkey Point Plant, Unit 4, Florida Power and Light C 05000251
AUTH.NAME AUTHOR AFFILIATION
CONWAY,W.F. Florida Power & Light Co.
RECIP.NAME RECIPIENT AFFILIATION
GRACE,J.N. Region 2, Ofc of the Director

See Rpt.

SUBJECT: Forwards mgt on shift weekly repts for wk of 880613.

DISTRIBUTION CODE: IE36D COPIES RECEIVED:LTR 1 ENCL 1 SIZE: 50
TITLE: Immediate/Confirmatory Action Ltr (50 Dkt-Other Than Emergency Prepar

NOTES:

	RECIPIENT ID CODE/NAME		COPIES LTTR	COPIES ENCL	RECIPIENT ID CODE/NAME	COPIES LTTR	COPIES ENCL
	PD2-2 LA		1	0	PD2-2 PD	1	1
	EDISON,G		1	1			
INTERNAL:	NRR/DOEA/EAB	11	1	1	NUDOCS-ABSTRACT	1	1
	REG FILE	02	1	1	RES/DE/EIB	1	1
	RGN2 FILE	01	1	1	RGN2/DRSS/EPRPB	1	1
EXTERNAL:	LPDR		1	1	NRC PDR	1	1
	NSIC		1	1			

TOTAL NUMBER OF COPIES REQUIRED: LTTR 12 ENCL 11

R I D S / A D D S

R I D S / A D D S

JUNE 2 2 1988

L-88-273

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. The Plant Supervisor-Nuclear Shift Reports are also being submitted.

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

Very truly yours,

W. F. Conway
Senior Vice President - Nuclear

WFC/SDF/gp

Attachment

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

mos001

MANAGEMENT ON SHIFT (MOS)

WEEK STARTING: 06/13/88

WEEKLY SUMMARY REPORT

Five MOS Observers were on shift. Richard Coulthard, Westinghouse Electric Corporation (06/13-19/88, days); Peter L. Walker, Westinghouse Electric Corporation (06/13-19/88, evenings); Julio C. Balaguero, Turkey Point Nuclear Plant Operations Support Supervisor (06/14-19/88, evenings); and Larry L. Thomas, Turkey Point Nuclear Plant Outage Manager (06/13-19/88, evenings); and Terry A Finn, Turkey Point Training Department Superintendent (06/19-20/88, evenings).

Both Units 3 and 4 operated at 100% power throughout the reporting period, except for a Unit 3 reduction to 690 MWe gross for approximately 8 hours on June 15, 1988, to replace the generator air side seal oil pump.

Two questionable work practices were reported by the MOS Observers concerning noncompliances with the clearance tag procedure. One questionable work practice was reported concerning delay in reporting malfunctioning equipment to the Plant Supervisor - Nuclear.

During the reporting period, the MOS Observers noted seventeen recommendations and areas for improvement. These comments and suggestions involved:

- The inability of the Moveable Incore Detector System to support flux mapping (repaired 6/19/88).
- Two comments on inadequate communications between departments causing unnecessary delay.
- The unreliability of two radiation detectors.
- Operators lack of familiarity with the Technical Specification Implementation Procedure.
- Two comments regarding the perceived need to run flux maps.

ATTACHMENT: MOS DAILY REPORTS

MANAGEMENT ON SHIFT (MOS)

WEEKLY SUMMARY REPORT

WEEK STARTING: 06/13/88

- Two comments on the reliability of the inverter power supply to the Analog Rod Position Indication (ARPI).
- A suggested relaxation of the ARPI rod bottom runback bistable setpoint.
- The advisability of energized receipt inspections on certain I&C equipment.
- A recommended reordering of work under an LCO, for efficiency.
- Four comments on inadequate planning or scheduling.

During the reporting period the Plant Supervisor-Nuclear (PSN) MOS reporting program continued. In recognition that the PSN is in fact Management on Shift, the form used by the PSNs has been retitled "Shift Report," with the Shift Management personnel identified.

The PSNs reported nine questionable work practices. Two of these were also reported by MOS Observers (clearance tag violation and delayed report of malfunctioning equipment). Two others concerned inadequate support outside normal hours. The remaining items involved:

- Operation with a Reactor Protection channel out-of- service. (For an extended period within the LCO).
- Insufficient emphasis on LCO related repairs.
- Unauthorized manipulation of equipment by Maintenance personnel. (Fire Protection pressure switch in Turbine Building)
- Confusion on requirements for testing of redundant train equipment prior to maintenance.
- Attempted use of an out-of-date maintenance procedure.

ATTACHMENT: MOS DAILY REPORTS

MANAGEMENT ON SHIFT (MOS)

WEEKLY SUMMARY REPORT

WEEK STARTING: 06/13/88

The PSNs noted thirteen recommendations and areas for improvement. These comments and suggestions involved:

- The reliability of the Post Accident Hydrogen Monitors.
- Three comments on inadequate scheduling support outside normal working hours.
- One comment on poor housekeeping.
- A recommendation to improve the couplings on the Main Feed Regulating Valve actuators.
- An apparent conflict between Technical Specifications and a plant procedure.
- Difficulty in finding test data sheets to prove a valve operable.
- Metal Impact Monitors on both units out-of-service.
- Two comments on poor scheduling.
- A need for increased awareness of plant status by maintenance personnel.
- An option in the Technical Specification Implementation Procedure that cannot be used with one Nuclear Instrument channel out-of-service.

ATTACHMENT: MOS DAILY REPORTS

Date 06/13/88	**Shift Report**	Shift Day

Shift Management

I Wogan APSN Singer NWE Vetromile

A. Questionable Work Practices/Actions Taken/Recommendations

Continued operation with Reactor Protection channels out-of-service, with additional periodics being performed (required), that bring us closer to trip or safety injection.

B. Areas for Improvement/Recommendations/Actions Taken

I & C should maintain a continued awareness of safety-related system status as they perform maintenance. A heightened awareness will prevent any further misalignments as occurred 6/13/88 (refer to to APSN log entry).

C. Good Practices/Professionalism Observed

Unit 4 operator awareness - noticed opposite Auxiliary Feedwater Train flow pressure and notified NWE/APSN in a timely manner.

Reviewed By [signature] Date 6/14/88 Actions Completed _____ Date _____

Date 06/13/88	**Shift Report**	Shift Peak

Shift Management

L Reese APSN Dallau NWE fernandez

A. Questionable Work Practices/Actions Taken/Recommendations

Again, when Nuclear Job Planning System (NJPS) was needed tonight, it was two hours before we could input a PWO for N-41 into the system.

B. Areas for Improvement/Recommendations/Actions

If NJPS is required to get needed work performed, it should not have so much down time on the peak and mid shift.

C. Good Practices/Professionalism Observed

Reviewed By J. A. Kiani Date 6/14/88 Actions Completed _____ Date _____

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

Operations Superintendent - Nuclear

Date: 06/13/88

From: Richard Coulthard
(MOS Observer)

Shift: ☒ Day ☐ Night

A. Plant evolutions observed

- Units 3 and 4 at 100% power
- Periodic Rod exercise on Unit 4 per OP-1604.1
- Quarterly I & C surveillance of Unit Nuclear Instrumentation Channel N-41 per 3-PMI-059.8
- 0720 & 1300 Plan-of-The-Day meetings
- 1535 peaks start of shift meeting
- Operations monthly surveillance on Channel N-41 (Nuclear Instrumentation) per 3-OSP-59.5

B. Immediate safety problems

None

C. Questionable work practices

None

D. Areas for improvement

This item was noted in the morning Plan-of-the-Day meeting. The Unit 4 flux map system does not have 38 operable paths, and a flux map to satisfy ADM-021 (Interim Technical Specifications) cannot be run. ADM-021 requires this within 12 hours of a Power Range Nuclear Instrumentation Channel is out-of-service. The concern this morning was that the spike on the N-44 channel observed Sunday Night could have evoked this Technical Specification if taken out-of-service to investigate the problem.

This afternoon when I & C returned a Unit 3 Channel N-41 to operations, the operating surveillance test found the currents to be out of specification. This channel has been out-of-service since 1140 and could evoke the need for a flux map. Had this N-41 problem occurred on Unit 4, the flux map option to avoid the action statement to reduce power to 75% after 12 hours would not be available.

E. Professionalism, Summary of Shift, Comments

1. All observed shift activities in the Control Room on day and peak shifts were conducted in a professional manner.
2. Unit 4 peak shift Reactor Operator took the initiative to provide scenario training for on shift trainees.

Completed By: Richard Coulthard *MOS Observer* Date: 06/13/88

Reviewed By: *Operations Superintendent - Nuclear* Date: 6/14/88

Management Review By:

PM-N	Date	SVP	Date	VP	Date
	6/14/88		6/14/88		06/14/88

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

To: Operations Superintendent - Nuclear Date: 06/13-14/88

From: L. L. Thomas *(MOS Observer)* Shift: ☐ Day ☒ Night

A. Plant evolutions observed

- Adjustment to N-41 and test
- Shift turnover and shift briefing
- Steady state operations

B. Immediate safety problems

None

C. Questionable work practices

None

D. Areas for improvement

1. The communications between Operations and I & C on N-41 being out-of-service and its affect on the plant needs improvement. At 1740 the peak shift I & C Supervisor was asked by the MOS Observer if he realized Unit 3 was in an action statement, per O-ADM-021, which ends at 2340. He said he had not been informed. Once he found out he took the appropriate actions to get the PWO ready and work accomplished.
2. The Flux Map should have been started sooner. Various problems encountered caused it to be completed 27 minutes after the required time of 2340.

E. Professionalism, Summary of Shift, Comments

Good use of training time on peak shift with trainees and reactor operator.

Mid shift performed in a professional and highly efficient manner when confronted with N-41 problem.

Completed By: L. L. Thomas *MOS Observer* Date: 06/13-14/88

Reviewed By: *Operations Superintendent - Nuclear* Date: 6/14/88

Management Review By: PM-N Date: 6/14/88 SVP Date: 6/14/88 VP Date: 6/14/88

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

To: Operations Superintendent - Nuclear Date: 06/13-14/88

From: P. L. Walker *(MOS Observer)* Shift: ☐ Day ☒ Night

A. **Plant evolutions observed**

- Units 3 and 4, 100% steady state power operation
- Plant staff reaction to failure of Unit 3 Power Range Channel N041 during periodic test

B. **Immediate safety problems**

None

C. **Questionable work practices**

None

D. **Areas for improvement**

1. Instrumentation and Control department had six hours, 55 minutes (minus approx. 15 minutes to perform operability check) to repair the offending Power Range Channel. It was returned to service too late to avoid overrunning the 12 hour LCO time. Directions to the technicians performing the repair lacked the emphasis required to ensure that the job would be completed on time.
2. Reactor Engineering did not include any contingency time when they scheduled the start of the QPTR Flux Map. Problems arose which prevented them from supporting the required 12 hour action limit.
3. The operation staffs did not have a crystal clear idea of what was to happen when the 12 hour limit was reached. There were three paths to success: Fix the channel; get acceptable QPTR results; or obtain a waiver of the applicable O-ADM-021 Interim Technical Specification. A fourth path, reducing power to 75% and reducing power range setpoints, was out of the question due to being procedurally impossible, given that one channel was already failed. When the shift was turned over, many options were already precluded, and the oncoming crew was jammed into a crisis situation. Proper planning would have already resolved any interpretation of Technical Specification questions, have had a pre-authorized waiver of O-ADM-21 Technical Specifications available, had enough information available to adequately supervise supporting group actions, and have a definite plan of what was to occur when the action statement time expired.

E. **Professionalism, Summary of Shift, Comments**

Question: Why, when a perfectly valid method of determining QPTR via the 3 operable power range NIS channels exists, is the O-ADM-021 Technical Specification worded to require the use of the much more cumbersome (albeit more accurate) flux mapping method?

Completed By: Peter L. Walker — *MOS Observer* Date: 06/13-14/88

Reviewed By: [signature] — *Operations Superintendent- Nuclear* Date: 6/14/88

Management Review By: [signature] *PM-N* Date 6/14/88 [signature] *SVP* Date 6/14/88 [signature] *VP* Date 6/14/88

Date 06/14/88	**Shift Report**	Shift Mid

Shift Management

Jones APSN Haley NWE

A. **Questionable Work Practices/Actions Taken/Recommendations**

At 1140 6/13/88, N-41 was declared out-of-service for calibration and testing. At 1645 N-41 failed its periodic test and a PWO was issued. Maintenance was not started until late on peak shift - Reactor Engineering did not perform Flux Map until 2025 and did not get it complete until 0007 6/14/88, which was greater than 12 hour requirement per ADM-021. It doesn't seem the correct effort was placed on getting N-41 repaired when a 12 hour action statement was in effect.

Areas for Improvement/Recommendations/Actions Taken

1. If a Power Range Channel is out-of-service greater than 2 hours perform Flux Map to ensure it is complete within the required time frame.
2. Investigage changing ADM-021 requirement for a Flux Map to verify QPTR values, to perform QPTR calculation per ONOP 12308.2.
3. If it is expected that maintenance will go beyond 4PM, formulate a game plan with contingencies.
4. ADM-021 Table 3.3-1 action 2C, reducing power to less than or equal to 75% and reduce hi flux trip to less than or equal to 85% is not a possible option due to minimum degree of redundancy with one channel in trip mode (out-of-service), removing another channel to reset trip setpoints will cause a reactor trip. Therefore flux map, or returning channel to service is the only option.

C. **Good Practices/Professionalism Observed**

Reviewed By [signature] Date 6/14/88 Actions Completed _____ Date _____

Date 06/14/88	**Shift Report**	Shift Days

Shift Management

R Wogan APSN Singer NWE Vetromile

A. Questionable Work Practices/Actions Taken/Recommendations

A valve on the 3C Bus deluge was manipulated during the resetting of the fire deluge clapper which had a clearance tag hung on it which stated "Do Not Open". The Turbine Operator and mechanic doing the job were both cautioned about the proper use of the clearance system.

B. Areas for Improvement/Recommendations/Actions Taken

Assure that all plant personnel are retrained in the use of clearances and discuss this also at plant safety meetings.

C. Good Practices/Professionalism Observed

Reviewed By [signature] Date 6/14/88 Actions Completed _____ Date _____

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

Operations Superintendent - Nuclear

Date: 06/14/88

From: Richard Coulthard
(MOS Observer)

Shift: ☒ Day ☐ Night

A. **Plant evolutions observed**

- Units 3 and 4 operations at 100% power
- Unit 4 Reactor Protection System Logic Test, OSP 49.1
- Unit 3 Reactor Coolant Average Temperature/Delta Temperature Test per procedure TP-433
- 0720 and 1300 Plan of the Day meetings
- 1540 peaks start of shift meeting

B. **Immediate safety problems**

None

C. **Questionable work practices**

As a result of a misunsderstanding of whether Operations or Maintenance was controlling the PWO on the 3C transformer deluge valve, the fire protection deluge isolation valve was opened in accordance with a procedure, but in violation of a clearance tag. This problem came to the attention of the day shift APSN during the course of his duties and resulting actions are discussed in the PSN shift report. It is felt that the APSN responded properly to this event.

The requirement that all clearance tags not be violated is presumably is well known. Operations and shift management should re-emphasize to all personnel the importance of not violating clearance tags.

D. **Areas for improvement**

None

E. **Professionalism, Summary of Shift, Comments**

No unprofessional conduct observed.

Completed By: Richard Coulthard
MOS Observer

Date: 06/14/88

Reviewed By: [signature]
Operations Superintendent - Nuclear

Date: 6/15/88

Management Review By: [signature] 6/15/88 / [signature] / [signature] /
PM-N Date SVP Date VP Date

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

To: Operations Superintendent - Nuclear Date: 06/14-15/88

From: J. C. Balaguero *(MOS Observer)* Shift: ☐ Day ☒ Night

A. **Plant evolutions observed**

- Normal 100% power operations on both units
- Plant walkdown
- Conversations with several Operations and Maintenance personnel
- Shift turnover
- Shift meeting

B. **Immediate safety problems**

None

C. **Questionable work problems**

None observed

D. **Areas for improvement**

None observed

E. **Professionalism, Summary of Shift, Comments**

No comments

Completed By: J. C. Balaguero *MOS Observer* Date: 06/14-15/88

Reviewed By: *[signature]* *Operations Superintendent - Nuclear* Date: 6/15/88

Management Review By: *[signature]* 6/15/88 *PM-N* *Date* / *SVP* *Date* / *VP* *Date* 06/14-15/88

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

To: Operations Superintendent - Nuclear Date: 06/14-15/88

From: P. L. Walker *(MOS Observer)* Shift: ☐ Day ☒ Night

A. **Plant evolutions observed**

- 100% steady state operation, both units 3 and 4
- Evaluation and resolution of possible Unit 3 containment
- Boundary leakage via sample line from Reactor Coolant System
- Shift turnover at 11:00 PM

B. **Immediate safety problems**

None

C. **Questionable work practices**

None

D. **Areas for improvement**

None

E. **Professionalism, Summary of Shift, Comments**

Quiet night

Completed By: P. L. Walker *MOS Observer* Date: 06/14-15/88

Reviewed By: [signature] *Operations Superintendent- Nuclear* Date: 6/15/88

Management Review By: James E Cross 6/15/88 / / /
PM-N Date SVP Date VP Date 06/14-15/88

Date 06/15/88	**Shift Report**	Shift Mid

Shift Management

Schimkus APSN Murphy NWE Spence

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

Need to have a little more attention paid to cleaning up loose items in obscure areas of the plant. A lot of small trash is accumulating in the corners of different operating areas such as the Feedwater platforms or beside pumps, etc.

Recommendation: Have the foreman in charge of the helpers tour the Secondary with some helpers and point out these minor discrepancies off the beaten path. The plant generally looks good.

C. Good Practices/Professionalism Observed

A concern was raised about possible by-leakage on the Reactor Coolant System sample valves SV-3-6427 A & B inside containment and SV-3-6428 outside containment. These are boundary isolation valves. Upon calling the Technical Department Supervisor at midnight, he showed immediate concern and came to the plant with a technician and was able to verify no unacceptable leakage from these boundary valves.

Reviewed By [illegible] Date 6/15/88 Actions Completed ____ Date ____

Date 06/15/88	**Shift Report**	Shift Day

Shift Management

Wogan APSN Singer NWE Vetromile

A. Questionable Work Practices/Actions Taken/Recommendations

I&C GEMS Planners are manipulating equipment without authorization. PSN stopped further testing and informed personnel they needed to abide by work controls established. Recommend PWO initiation and work to be done by journeyman. Also recommend work be authorized through Control Room. i.e., NWE/APSN/PSN rather than Mr. Perrine.

The equipment being manipulated was a fire protection valve in the turbine building, being manipulated by a contract individual.

B. Areas for Improvement/Recommendations/Actions Taken

None noted

C. Good Practices/Professionalism Observed

Great maintenance support in the air side seal pump replacement minimizing the impact on unit instability.

Reviewed By T.L. Pierce Date 6/16/88 Actions Completed _____ Date _____

Date 06/15/88	**Shift Report**	Shift Peak

Shift Management

Reese APSN Dallau NWE Fernandez

A. **Questionable Work Practices/Actions Taken/Recommendations**

None

B. **Areas for Improvement/Recommendations/Actions Taken**

None

C. **Good Practices/Professionalism Observed**

None

Reviewed By [signature] Date 6/16/88 Actions Completed _____ Date _____

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

To: Operations Superintendent - Nuclear Date: 06/15/88

From: Richard Coulthard *(MOS Observer)* Shift: ☒ Day ☐ Night

A. **Plant evolutions observed**

- Unit 4 operations at 100% power
- Unit 3 power reduction to 690 MWe gross to replace generator air side seal oil pump and return to 100% power
- 0720 Plan of the Day meeting
- 1540 peaks start of shift meeting
- Tour of Radiation Control Area (RCA) and Auxiliary Building

B. **Immediate safety problems**

None

C. **Questionable work practices**

None

D. **Areas for improvement**

1. Discussions with various personnel during the last three days indicate that various process control modules do not receive an energized receipt inspection when received by Stores. This has resulted in defective modules not being discovered until I&C draws them from Stores and performs bench testing prior to taking them to the Control Room, when they are needed. A number of plants do perform an energized receipt inspection to determine proper spans, power supply conditions, bistable functioning, input and output conditions, etc. at time of receipt, rather than waiting until the controller, power supply, amplifier, etc. is required by the plant. It is suggested that I&C, Quality Control, and Stores review this issue and determine if energized receipt inspections of certain I&C components would be useful to provide an early determination of faulty components.
2. Discussions with operators since the Nuclear Instrumentation Channel N-41 Operability and Action statement determinations on June 13 indicate a continued lack of ease with the technical content of the Interim Technical Specifications and seem to indicate a need for additional familiarization with the content of Interim Tech. Specs. Traditional classroom training is not suggested due to the "dryness" of the topic. It is suggested that the Interim Tech. Specs. be first reviewed for which sections are the most complex or unique (3/4.0 Applicability 3/4.3.1 Reactor Trip Instrumentation and 3/4.8 Electrical Power Systems are three examples). Training could be provided on these selected sections through discussion groups using example situations to make Tech. Spec. determinations.

E. **Professionalism, Summary of Shift, Comments**

1. Shift operations were conducted in an entirely professional manner.
2. My first entry and exit from the RCA were handled in a proficient manner.

Completed By: Richard Coulthard — *MOS Observer* — Date: 06/15/88

Reviewed By: [signature] — *Operations Superintendent - Nuclear* — Date: 6/16/88

Management Review By: [signature] *PM-N* 6/16/88 Date — [signature] *SVP* 16/16/88 Date — [signature] *VP* Date 06/15/88

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

To: Operations Superintendent - Nuclear Date: 06/15-16/88

From: J. C. Balaguero *(MOS Observer)* Shift: ☐ Day ☒ Night

A. **Plant evolutions observed**

- Both units at steady state 100% power
- Plant walkdown
- Shift meeting
- Shift turnover

B. **Immediate safety problems**

None

C. **Questionable work practices**

Checked the clearance on the 4A Component Cooling Water (CCW) Heat Exchanger and found a clearance tag for vent valve 4-50-585 hung on valve 4-50-375A which is a redundant vent valve on the same heat exchanger. Notified the PSN (peakshift) who immediately took corrective action and had the tag hung on the correct valve.

D. **Areas for improvement**

Strict adherence to procedural requirements shall be reiterated to all operators so that clearance orders are followed verbatim.

Operators have a difficult time isolating CCW Heat Exchangers after scaffolding has been erected because of limited space. Realizing that the amount of time on LCO's should be limited, it might be a good compromise to isolate the heat exchanger first and erect the scaffolding second, while the heat exchanger is being drained. This should make it easier to operators to isolate the heat exchanger and allow Maintenance plenty of time to erect the scaffolding, especially if we drain the side of the heat exchanger that is not being opened.

E. **Professionalism, Summary of shift, Comments**

No comments

Completed By: J. C. Balaguero *MOS Observer* Date: 06/15-16/88

Reviewed By: *Operations Superintendent - Nuclear* Date: 6/16/88

Management Review By: *PM-N* *Date* 6/16/88 *SVP* *Date* 6/16/88 *VP* *Date* 06/15-16/88

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

To: Operations Superintendent - Nuclear Date: 06/15-16/88

From: P. L. Walker *(MOS Observer)* Shift: ☐ Day ☒ Night

A. Plant evolutions observed

- Units 3 and 4, 100% steady state operations
- PSN noticed a loose coupling on a Unit 4 main feed regulating valve - action was taken to stabilize the valve in a timely fashion.

B. Immediate safety problems

None

C. Questionable work practices

None

D. Areas for improvement

None

E. Professionalism, Summary of Shift, Comments

The degraded (loose) coupling on the feed regulating valve was handled quickly and efficiently. Further action to evaluate the operability of the valve will be done during day shift.

Completed By: P. L. walker *MOS Observer* Date: 06/15-16/88

Reviewed By: K. W. Frazier *Operations Superintendent - Nuclear* Date: 6/16/88

Management Review By: *PM-N* 6/16/88 *SVP* 6/16/88 *VP* *Date* 06/15-16/88

Date 06/16/88	**Shift Report**	Shift Mid

Shift Management

I Schimkus APSN Murphy NWE Spence

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

Need a better method to couple the Main Feedwater Regulator valves to their actuators. In the past two years we have had at least 2 load reductions to 60 Megawatts electric, due to the presently installed "split couplings," loosening up from vibration and causing valve shaft actuator separation. Tonight we almost had the same situation, however the coupling had only slightly loosened and the actuator and valve stem threads didn't have a chance to misalign.

Recommendations: Better method to lock coupling together or re-design the coupling mechanism.

C. Good Practices/Professionalism Observed

Excellent support from I&C and Mechanical Maintenance to immediately focus their efforts on 4A Main Feedwater Regulator loose coupling. They were on the scene approximately 3 minutes from my notification of the problem.

Reviewed By [signature] Date 6/16/88 Actions Completed _____ Date _____

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

To: Operations Superintendent - Nuclear Date: 06/16/88

From: Richard Coulthard *(MOS Observer)* Shift: ☒ Day ☐ Night

A. Plant evolutions observed

- Units 3 and 4 operations at 100% power
- 0720 Plan of the Day meeting
- 1535 peaks start of shift meeting
- Unit 3 Nuclear Instrumentation Channels N-42 and N-43 quarterly calibration per MP-12307.3
- Unit 3 Nuclear Instrumentation Channels Operability Test for N-42 and N-43 per OSP-059.4

B. Immediate safety problems

None

C. Questionable work practices

None

D. Areas for improvement

None

E. Professionalism, Summary of Shift, Comments

1. The I&C conduct of the Power Range Nuclear Instrumentation Quarterly Calibration proceeded quite smoothly and only required slightly over 2 hours per channel using procedure MP-12307.3. This is significantly below the 5 to 8 hours per channel previously reported using the new PMI-059 series of procedures.
2. Control Room operations were again conducted in a professional and cooperative manner.

Completed By: Richard Coulthard *MOS Observer* Date: 06/16/88

Reviewed By: [signature] *Operations Superintendent-Nuclear* Date: [signature]

Management Review By: [signature] *PM-N* *Date* [signature] *SVP* [signature] 6/17/88 *Date* _____ *VP* _____ *Date*

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

To: Operations Superintendent - Nuclear Date: 06/16-17/88

From: J. C. Balaguero *(MOS Observer)* Shift: ☐ Day ☒ Night

A. Plant evolutions observed

- Steady state full power operations
- Plant walkdown
- Shift turnover
- Shift meeting

B. Immediate safety problems

None

C. Questionable work practices

None observed

D. Areas for improvement

None

E. Professionalism, Summary of Shift, Comments

No comments

Completed By: J. C. Balaguero *MOS Observer* Date: 06/16-17/88

Reviewed By: *Operations Superintendent- Nuclear* Date: 6/17/88

Management Review By: *PM-N* *Date* *SVP* 6/17/88 *Date* *VP* *Date*

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

To: Operations Superintendent - Nuclear Date: 06/16-17/88

From: P. L. Walker *(MOS Observer)* Shift: ☐ Day ☒ Night

A. Plant evolutions observed

- Units 3 and 4, 100% steady state power operation
- Rebolting of Unit 4 feed regulating valve
- Electrical Bus testing - both units
- 2330 shift change meeting

B. Immediate safety problems

None

C. Questionable work practices

None

D. Areas for improvement

Radiation detectors continue to be a problem. R-15 & 20 detectors for both units are out.

E. Professionalism, Summary of Shift, Comments

1. Very quiet shift.
2. I have noticed an increase in the number of unauthorized noises over the page system.

Completed By: P. L. Walker *MOS Observer* Date: 06/16-17/88

Reviewed By: *Operations Superintendent - Nuclear* Date: 6/17/88

Management Review By: PM-N 6/17/88 Date; SVP 6/17/88 Date; VP Date

06/16-17/88

Date 6/16/88	**Shift Report**	Shift Day/Peak

Shift Management

SN Schimkus/Harpel APSN Singer NWE Fernandez

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

None

C. Good Practices/Professionalism Observed

Routine operations

Reviewed By [signature] Date 6/17/88 Actions Completed _____ Date _____

Date 06/17/88	**Shift Report**	Shift Mid

Shift Management

Schimkus APSN Murphy NWE Spence

A. **Questionable Work Practices/Actions Taken/Recommendations**

1. Compliance and Regulation letter PTN-TECH-88-288 addressing redundant train operability testing prior to maintenance, or testing required upon failure of an Engineered Safety Features (ESF) component has created a gray area. Current Technical Specifications definition 1.4 defined operability which states that any ESF equipment plus its support functions must be operable and capable of performing its design functions. We are currently receiving clearance requests on ESF equipment support equipment. Examples being:

   A. Residual Heat Removal pump 3A-PC-3-601. This is a pressure interlock on 3A RHR Loop which when valved out will take 3A RHR Loop out-of-service. Compliance and Regulation reply was to test this PC-3-600 on 3B RHR pump. To test this will involve valving out PC-3-600 which will take 3B RHR Loop out-of-service.
   B. Containment Spray Pumps (C.S.P.) 3A and 3B must have their seal cooler flow indicators (FIC-657 and FIC-659) P.M.'d one at a time. This involves racking out the associated C.S.P. This means that a surveillance operability test will be required on the companion pump prior to maintenance activities.

If either of the above examples were to occur on any shift other than dayshift (Monday - Friday) and it was due to a discovered failure of the support component, Operations personnel would not be able to meet the redundant train required test within the specified 4 hour time limit thus non-compliance to a Tech. Spec. action statement per licensing letter.

Recommendations:

1. Re-evaluate PTN-TECH-88-288 letter. Contact USNRC and discuss problem to arrive at a solid answer of how to meet redundant train operability requirements in the cases of Preventive Maintenance, etc. on support equipment.
2. Evaluate the need for special procedures to utilize (by on-site operators) for operability testing of ESF equipment. Note: Many of our test procedures are performed by the Technical Department with Operations support.
3. Prior to sending clearance requests to the Control Room on ESF type equipment, ensure that Technical Department is set up to test the redundant train if required. If not required, have responsible department supervisor sign and state that "no testing required" on redundant train.

Reviewed By [signature] Date 6/17/88 Actions Completed _____ Date _____

Continuation Page

B. Areas for Improvement/Recommendations/Actions Taken

Due to Intake Cooling Water/Component Cooling Water (ICW/CCW) basket strainers frequent fouling, they must be backwashed approximately 1 - 3 times per day. At the same time we have had at least 1 CCW Heat Exchanger (HX) out-of-service (either unit) every day for cleaning due to higher intake temperatures. Procedure 3/4-OP-019 steps 7.1.1.1 thru 7.1.1.5 require all 3 CCW HX to be operable to backwash. ADM-021 and current Tech. Specs don't list this requirement (copies attached). PUP supplied me with a reason; that it was addressed and reviewed by the Plant Nuclear Safety Committee (PNSC) for the current procedure.

Recommendations:

Re-evaluate and make procedure changes.

C. Good Practices/Professionalism Observed

Routine operations. Excellent observation by Nuclear Watch Engineer (NWE); informed PSN that while removing fuse block SV-6428 (Reactor Coolant System sample) his hand slammed into the Reactor Trip Switch casing and connectors behind Vertical Panel B. The PSN observed this and verified the same condition exists on Unit 4 on fuses for CV-956 A. This occurrence is nearly unpreventable due to close proximity of fuse blocks to Reactor Trip Switch. NWE placed caution tags on both fuse blocks. This could cause unit trip. Need attention.

Date 06/17/88	**Shift Report**	Shift Day

Shift Management

N Jones APSN Haley NWE

A. Questionable Work Practices/Actions Taken/Recommendations

It needs to be emphasized to all personnel to use up-to-date procedures per AP 190.86 paragraph 5.7.1. An I&C technician was attempting to use an out-of-date procedure and he said he was only required to check for new On The Spot Changes. We pointed out the above procedure requirement.

B. Areas for Improvement/Recommendations/Actions Taken

C. Good Practices/Professionalism Observed

Reviewed By [signature] for CWO **Date** 6-20-88 **Actions Completed** _____ **Date** _____

Date 6/17/88	**Shift Report**	Shift Peak

Shift Management

N Harpel APSN Reese NWE

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

None

C. Good Practices/Professionalism Observed

None

Reviewed By RJ Wenke for us Date 6-20-88 Actions Completed _____ Date _____

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

To: Operations Superintendent - Nuclear Date: 06/17/88

From: Richard Coulthard *(MOS Observer)* Shift: ☒ Day ☐ Night

A. Plant evolutions observed

- Units 3 and 4 operations at 100% power
- 0720 Plan-of-the-Day meeting
- 1535 Peaks start of shift meeting
- Preplanned fire drill in 480 volt Motor Control Center. Complete complement of the fire brigade was at the scene in 6 minutes.
- PMI-028.2, Axial Flux, Rod Deviation, and Rod Position Indication (RPI) monthly test on Unit 3

B. Immediate safety problems

None

C. Questionable work practices

None

D. Areas for improvement

1. During the morning, confusion surfaced over controls on moving a large crane from the Unit 4 containment to the Unit 3 containment during which the load must pass over Intake Cooling Water lines and safety-related cable trenches. There was also conflicting information over the weight of the crane; initially reported at 240,000 lbs. , but later reported to be below the 165,000 lbs. limit for this move.

   If movements of this size are very infrequent (less than annually), action such as revising ONOP 3408.2. Intake Cooling Water Failure Due To Transport of Heavy Loads, or a notice in the Control Room shift order book, are not appropriate. If frequency of occurrence is greater, some guidance for the Control Room to evaluate and monitor this type of event might expedite future movements. Operations was correct to look for guidance on this issue because of regulatory sensitivity to heavy loads.

2. The conduct of 3-PM-028.2 resulted in a loss of all power to the Rod Position Indicators (RPI) for several minutes (i.e., all rods were indicated on bottom). The conduct of this test raises two concerns: a) Because of fluctuations in the RPI inverter power supply, the power supply for the RPI's is always switched to the Emergency Power Supply (a lighting panel) for this test in order to get steady-state data. Is there a reason the inverter power supply cannot be repaired or restored so these fluxuations do not exist? b) During the conduct of this test, the Rod Bottom Bistable alarm setpoint is verified and reset if not in tolerance. These bistables chatter during this process which reduces bistable life. Since this has been done monthly for some time, there is no reason to suggest this caused the lighting panel to trip. However, the acceptance criteria for resetting this alarm is 0.209 to 0.310 Volts D.C. (less than $\pm$ 1 step). A $\pm$ 10 step tolerance on the rod bottom alarm is probably acceptable since it has only an information/condition indication function and is not a calculated setpoint. It is quite possible this alarm would have to be reset less often (with less time spent with a chattering relay) if the tolerance were opened to something like 0.15 to 0.45 Volts D.C.

E. Professionalism, Summary of Shift, Comments

1. The Operations response to the loss of power of the Unit 3 Rod Position Indicators was carried out in an organized and timely manner. OP-9700.2, Operation of RPI Power Supply System was used to transfer power from the Lighting Panel back to the RPI Inverters. The Off-Normal Operating Procedure was pulled out in case the above action did not solve the problem. Shift turnover was in progress when this occurred.
2. I witnessed and concur with the PSN day shift report concerning the desire of an I&C Specialist to use an out-of-date procedure. I consider the overall incident a "good practice" because it demonstrates the Control Room review of On-The-Spot-Changes can prevent out-of-date procedures going to the field for use.
3. About 1700 on the peak shift, the Licensing Engineer brought a letter concerning testing requirements for Emergency Diesels to the Control Room. He took the time to review the contents of the letter with the PSN and APSN. A good practice, especially for a late Friday afternoon.

Completed By: Richard Coulthard — *MOS Observer* — Date: 06/17/88

Reviewed By: Richard J. Wardle FOR CWP — *Operations Superintendent- Nuclear* — Date: 6-20-88

Management Review By:

PM-N	Date	SVP	Date	VP	Date
J. Klose	6/20/88		/		/

06/17/88

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

To: Operations Superintendent - Nuclear Date: ~~06/17-18/88~~

From: P. L. Walker *(MOS Observer)* Shift: ☐ Day ☒ Night

A. Plant evolutions observed

- Units 3 and 4, 100% steady state operation
- Unit 3, Reactor Coolant Pump seal package acted up again. Actions were taken to stabilize and recover it.
- 2330 shift change meeting

B. Immediate safety problems

None

C. Questionable work practices

None

D. Areas for improvement

None

E. Professionalism, summary of Shift, Comments

Quiet shift

Completed By: P. L. Walker *MOS Observer* Date: 06/17-18/88

Reviewed By: [signature] for LWP *Operations Superintendent- Nuclear* Date: 6-20-88

Management Review By: [signature] 6/20/88 *PM-N Date* / *SVP Date* / *VP Date* 06/17-18/88

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

To: Operations Superintendent - Nuclear Date: 06/17-18/88

From: J. C. Balaguero (MOS Observer) Shift: ☐ Day ☒ Night

A. **Plant evolutions observed**

- Both units at 100%
- I&C calibration of FM-3-484 steam flow protection channel
- Unit 3, 3A RCP #1 seal leakoff decrease
- Plant walkdown
- Shift meeting
- Shift turnover

B. **Immediate safety problems**

None

C. **Questionable work practices**

None observed

D. **Areas for improvement**

None observed

E. **Professionalism, Summary of Shift, Comments**

Communications betwen Maintenance and Operations on the status of FM-484 calibration were excellent. The I&C technician was very informative and gave the Reactor Operator a thorough explanation in a very professional manner.

Shift meeting in the midnight shift continues to be excellent. The APSN and PSN encourage open communication and insist on getting good feedback on plant problems. The use of the Plan of the Shift form is a very good idea. This form gets filled out by the APSN or PSN and distributed to everyone in the shift meeting to serve as an agenda and keep the meeting on track.

Tours of the plant continue to exhibit a high level of cleanliness.

Completed By: J. C. Balaguero, *MOS Observer* Date: 06/17-18/88

Reviewed By: [signature] FOR CWP, *Operations Superintendent- Nuclear* Date: 6-20-88

Management Review By: [signature] / 6/20/88 *PM-N / Date* ____ / ____ *SVP / Date* ____ / ____ *VP / Date*

06/17-18/88

Date 06/18/88	**Shift Report**	Shift Mid

Shift Management

SN Schimkus APSN Murphy NWE Spence

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

The Post Accident Hydrogen Monitor (PAHM) is required to be in service 30 minutes after a valid Safety Injection Signal. Every time we attempt to test PAHM's for a monthly surveillance, either one or both channels fail to meet acceptance criteria. The support to have this problem repaired usually appears close to the end of the required LCO time, i.e., 7 days or 30 days. The problem appears generally with the span check in which I&C calibrates, tests, and then releases the channel for an Operations operability test which usually passes.

Recommend: A speedier method to calibrate this instrument.

C. Good Practices/Professionalism Observed

None

Reviewed By [signature] for LWP **Date** 6-20-88 **Actions Completed** _____ **Date** _____

Date 6/18/88	**Shift Report**	Shift Day

Shift Management

NSN Schimkus APSN Murphy NWE Mataszewski

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

6/17/88 Unit 3 Auxiliary Feedwater Train 2 was removed from service for Preventive Maintenance on flow control valve air filters. Numerous small air leaks were discovered on Swagelok fittings, etc., including some air leaks on the instrument air root valves to the same equipment. I&C repaired their portion of leaks and PWO's were generated to Mechanical Maintenance to repair/adjust the packing on their valves (10 valves). I was questioned by the Maintenance Supervisor why we were creating a crisis over a non-safety related set of valves which would cause an inconvenience to a GEMS Planner who would have to be called out to plan the work package. I explained the importance of having a totally reliable core heat sink system on our nuclear units and requested that GEMS initiate the package.

Recommend:

1. Prior to PMS on an Engineered Safety Features (ESF) system by any work group, have the system engineer walk down the system and initiate PWO's on any discrepency not already identified by a PWO. This should be an in depth hand-over-hand walk down.
2. If adequate support personnel is not available on weekends, quit scheduling ESF PMS on weekends, holidays or schedule GEMS to be here for each Department.

C. Good Practices/Professionalism Observed

Routine operations

Reviewed By [signature] for CWP Date 6-20-88 Actions Completed _____ Date _____

Date 6/18/88	**Shift Report**	Shift Peak

Shift Management

PSN Harpel APSN Reese NWE Spence

A. Questionable Work Practices/Actions Taken/Recommendations

While performing 3 PMI-028.2 Axial Flux Rod Deviation Periodic on 6/17/88 day shift the breaker for the Rod Position Indication (RPI) backup power supply tripped. The test was stopped to investigate. Due to other problems and manpower, I&C didn't restart on the procedure right away. The 6/18/88 Peak shift I&C Supervisor, who planned to get back into the periodic, went to check the working copy of the procedure to see what progress had been made and noticed that the I&C specialist on Friday had determined Rod Bottom Bistable E-9 to be inoperable. He promptly notified the PSN. The RPI was determined to be inoperable and Reactor Engineering was requested to run a flux map. Any time a piece of equipment is determined inoperable or suspected inoperable the PSN should be promptly notified so approproate actions can be taken to avoid possible violations and initiate corrective action.

B. Areas for Improvement/Recommendations/Actions Taken

None

C. Good Practices/Professionalism Observed

None

Reviewed By [signature] for CWP Date 6-20-88 Actions Completed _____ Date _____

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

To: Operations Superintendent - Nuclear Date: 06/18/88

From: Richard Coulthard *(MOS Observer)* Shift: ☒ Day ☐ Night

A. Plant evolutions observed

- Units 3 and 4 operations at 100% power
- 0735 and 1535 beginning of shift briefing
- 3-OP-14004.1, Steam Generator Protection Channels - periodic test

B. Immediate safety problems

None

C. Questionable work practices

None

D. Areas for improvement

None

E. Professionalism, Summary of Shift, Comments

None

Completed By: Richard Coulthard *MOS Observer* Date: 06/18/88

Reviewed By: [signature] For LWP *Operations Superintendent- Nuclear* Date: 6-20-88

Management Review By:

PM-N	Date	SVP	Date	VP	Date
[signature]	6/20/88		/		/

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

To: Operations Superintendent - Nuclear Date: 06/18-19/88

From: P. L. Walker *(MOS Observer)* Shift: ☐ Day ☒ Night

A. Plant evolutions observed

- Units 3 and 4, 100% power, steady state operations
- Analog Rod Position Indication (ARPI) Rod Bottom Bistable repairs - ARPI calibration - another trip of ARPI alternate power supply
- 2330 shift turnover

B. Immediate safety problems

None

C. Questionable work practices

The Instrumentation and Control technicians performing the ARPI periodic failed to report the Rod Bottom Bistable malfunction to the PSN (which occurred around 1515 on June 17) until approximately 2000 on June 18, 1988. The failure should have been reported almost immediately.

D. Areas for improvement

Licensing referred to "System Operation Review Program" document to resolve the ARPI operability question. The channel was declared inoperable and flux mapping every 8 hours was initiated. The basis for doing the flux map is to determine the position of the rod(s). In this case, the ARPI channel was clearly able to determine the position of the rod, and the map was unnecessary. A differentiation between the ARPI function of determining position of the rod and the runback bistable function needs to be made.

E. Professionalism, Summary of Shift, Comments

None

Completed By: P. L. Walker *MOS Observer* Date: 06/18-19/88

Reviewed By: [signature] FOR LWP *Operations Superintendent - Nuclear* Date: 6-20-88

Management Review By: [signature] *PM-N* *Date* / *SVP* *Date* / *VP* *Date* 06/18-19/88

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

To: Operations Superintendent - Nuclear Date: 06/18-19/88.

From: J. C. Balaguero *(MOS Observer)* Shift: ☐ Day ☒ Night

A. Plant evolutions observed

- Full power steady state operation
- Plant walkdown
- Shift turnover
- Shift meeting
- RPI Bistable replacement

B. Immediate safety problems

None

C. Questionable work practices

None

D. Areas for improvement

None

E. Professionalism, Summary of Shift, Comments

There has been a noticeable improvement in professionalism in the Control Room as well as communications beteween Maintenance and Operations since the last time I was here as a MOS Observer.

Completed By: J. C. Balaguero *MOS Observer* Date: 06/18-19/88

Reviewed By: *Operations Superintendent- Nuclear* Date: 6-20-88

Management Review By:

PM-N _____ Date _____ SVP _____ Date _____ VP _____ Date 06/18-19/88

Date 6/19/88	**Shift Report**	Shift Mid

Shift Management

N Schimkus APSN Murphy NWE Spence

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

It was noticed by the midshift APSN that the Unit 4 Containment purge valve data sheet in our Redbook Surveillances indicated that valve POV-4-2603 had not been tested prior to exceeding 200° F. during past outage. There was no data in our Control Room to prove or disprove the operability concern. The dayshift PSN/APSN followed up on this concern and solicited Technical Department support to find the test data sheets proving operability. Actions taken were to update the data sheet with proper information and transmit old data sheets to Document Control.

Recommendations:

Note: The PSN is responsible for review of O-OSP-200.1 (Redbook Surveillances).
The PSN is responsible for review of the RCO logs.

1. Make the Containment Purge Valve Cycle Data Sheet Checkoff, a PSN surveillance check per O-OSP-200.1 on a monthly basis in Modes 1,2 and a daily check in Modes 3,4,5,6.
2. Make the Startup Surveillance O-OSP-200.2 reflect a Technical Departmemt Signoff (TDS) to ensure prior to Mode 4 during heat up; they review 3/4-OSP-201.1 attachment 5 and update cycle data sheets in accordance with current number of cycles, remove old sheets in book and transmit them to Document Control.

Note: Tracking of actual Local Leakrate Test (LLRT) status and tracking of valve cycles beyond 10 cycles is beyond the scope of Control Room staff capabilities. This information is under Technical Department jurisdiction outside our Control Room.

C. Good Practices/Professionalism Observed

While performing Unit 3 RPI periodic, the alternate RPI power supply breaker tripped causing all rods to indicate on bottom. APSN took appropriate actions to meet Technical Specification requirements. The APSN/I&C Supervisor/Electrical Department Chief, immediately conferred about problem and decided on the following course of action: a) Complete RPI periodic, after breaker reset, b) Document what conditions existed at time of trip, c) Document any further occurrences and their conditions, d) Change defective breaker and bench test for trip set point (weak breaker). This will determine if root cause is breaker or RPI system. Excellent logic!

Reviewed By [signature] for CWP Date 6-20-88 Actions Completed _____ Date _____

Date 6/19/88	**Shift Report**	Shift Day

Shift Management

PSN Schimkus APSN Murphy NWE Mateszewski

A. Questionable Work Practices/Actions Taken/Recommendations

I&C Supervisor said that I&C Specialist forgot to bring tools out of containment and re-install flux mapper E-drive cover plate. Due to low manpower staffing the Health Physics Department did not have adequate personnel to support containment entry.

Actions taken:

PSN requested HP perform call out for support. PSN requested I&C to make preparations to perform entry for above discrepencies. PSN notified Maintenance Superintendent of situation.

B. Areas for Improvement/Recommendations/Actions Taken

Due to Unit 3 RPI alternate power breaker tripping twice during I&C scheduled surveillance a PWO was initiated at 0154 on 6/19/88 to replace defective breaker (LP-317 Bkr-18). At this time the midshift Electrical Chief was instructed by PSN to call out a GEMS Planner to incorporate a work package. This was questioned by Electrical Chief but he reassured PSN that he would do this immediately. At 0735 pre-shift briefing the day shift Electrical Chief informed us that work package was not prepared yet, as the GEMS Planner came in at approximately 0630.

Actions Taken:

Notified Maintenance Superintendent.

C. Good Practices/Professionalism Observed

Acting Maintenance Supervisor (W.R. Williams) thanked PSN for notification of shift report and reassured that he will follow-up on the cause of why these situations occurred.

Reviewed By [signature] for LWP Date 6-20-88 Actions Completed _____ Date _____

Date 06/19/88	**Shift Report**	Shift Peak

Shift Management

N Harpel APSN Reese NWE Spence

A. **Questionable Work Practices/Actions Taken/Recommendations**

None

B. **Areas for Improvement/Recommendations/Actions Taken**

None

C. **Good Practices/Professionalism Observed**

None

Reviewed By [signature] for WJP **Date** 6-20-88 **Actions Completed** _____ **Date** _____

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

To: Operations Superintendent - Nuclear Date: 06/19/88

From: Richard Coulthard *(MOS Observer)* Shift: ☒ Day ☐ Night

A. Plant evolutions observed

- Units 3 and 4 operations at 100% power
- 0735 and 1535 beginning of shift meetings
- Unit 4 Incore Flux Map using two detectors

B. Immediate safety problems

None

C. Questionable work practices

None

D. Areas for improvement

This is a followup to my MOS report of June 17, item D-2 on Rod Position Indication (RPI) testing. When power is transferred from the RPI inverter to the LP-317 source, the Rod Position Indication on the affected rods drops 5 or 6 steps. This would seem to induce a significant uncertainty into the calibration data when the power supply is transferred back to the RPI inverter. This was reported by the operators and verified on the June 18 evening test on the RPI's.

E. Professionalism, Summary of Shift, Comments

The process from the time a relatively simple problem is identified and the PWO written, until work is initiated, should be reviewed. I have observed two instances this week (Nuclear Instrumentation Channel N-41 currents and lighting panel 317, Breaker 18) where the specialists and electricians were available on site to work the job, but had to wait for the work package process to start very simple jobs. It was 1530 today before a replacement breaker was located and work started on LP-317, Breaker 18.

Completed By: Richard Coulthard *MOS Observer* Date: 06/19/88

Reviewed By: P.F. Wentz FOR C.W.P *Operations Superintendent - Nuclear* Date: 6-20-88

Management Review By:

K. Cross 6/20/88 / / / /

PM-N Date SVP Date VP Date

06/19/88

*MOS 1 01.07 88

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

To: Operations Superintendent - Nuclear Date: 06/19-20/88

From: P. L. Walker *(MOS Observer)* Shift: ☐ Day ☒ Night

A. Plant evolutions observed

- Units 3 and 4, 100% steady state power operation until a Xenon ocscillation was induced in Unit 4 for a test.
- 2330 shift change meeting

B. Immediate safety problems

None

C. Questionable work practices

None

D. Areas for improvement

None

E. Professionalism, Summary of Shift, Comments

Extended runs at 100% are good for morale. Everyone appears to be doing a good job.

Completed By: P. L. Walker *MOS Observer* Date: 06/19-20/88

Reviewed By: [signature] for cwp *Operations Superintendent - Nuclear* Date: 6-20-88

Management Review By:

PM-N	Date	SVP	Date	VP	Date
[signature]	6/20/88		/		/
					06/19-20/88

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

To: Operations Superintendent - Nuclear Date: 06/19-20/88

From: T. A. Finn *(MOS Observer)* Shift: ☐ Day ☒ Night

A. Plant evolutions observed

- Units 3 and 4, 100 % steady state operation
- Plant tour
- PSN/APSN shift turnover
- Intermediate Range periodic 4-OSP 59.2

B. Immediate safety problems

None

C. Questionable work practices

None

D. Areas for improvement

None

E. Professionalism, Summary of Shift, Comments

Quiet professional shifts.

Completed By: T. A. Finn *MOS Observer* Date: 06/19-20/88

Reviewed By: D. J. Mauck FOR LWP *Operations Superintendent- Nuclear* Date: 6-20-88

Management Review By:

PM-N Date: 6/20/88

SVP Date: /

VP Date: /

06/19-20/88

Date 06/20/88	**Shift Report**	Shift Mid

Shift Management

PSN Schinkus APSN Murphy NWE Spence

A. **Questionable Work Practices/Actions Taken/Recommendations**

None

B. **Areas for Improvement/Recommendations/Actions Taken**

Steam Generator (SG) Tube Rupture is probably the most likely accident to occur in the nuclear industry. Based on numerous plants having found debris inside the secondary tube sides of their S/G (including Turkey Point) a method to detect loose debris while on line was formulated: Metal Impact Monitoring system (MIMS). At this time Unit 3 MIMS has been out-of-service since 3/04/88, and Unit 4 MIMS since 6/11/88. It is presently impossible to perform the mid-shift check for noise.

Recommendations:

Repair this system, it could be a valuable tool. (See attached comments).

C. **Good Practices/Professionalism Observed**

1. SRO candidate requested a PSN tour of plant as to enhance his knowledge of plant systems. He asked many questions and showed to me that he has indeed studied the systems in depth. Good work, Bill Lindsey.
2. Unit 3 NTO, (Fred Bennykofer) while making his rounds observed cloudy oil in the "A" Auxiliary Feedwater pump oil reservoir. His only requirement is to record level in sight glass. When I checked the situation it was obvious he stuck his head in the pipes to make this observation.

   Actions:

   Declared 3A Auxiliary Feedwater pump out-of-service and issued PWO to change oil.

Reviewed By [signature] for cwp Date 6-20-88 Actions Completed _____ Date _____

MIMS

SRO, Joe Scott initiated this list at PSN request.

Operator hardspots - the system is outside the unit operator surveillance area. Due to its location it's often forgotten about. When an alarm is received by the unit operator, he has to find someone to investigate it for him. This may include running the tape for 10 minutes. The system often gives false alarms, has tape problems, etc. Currently the machine has nowhere to hang the microphone so it hangs on the recorder power leads. Suggestions for improving MIMS:

1) Write operators a surveillance procedure.
2) Move the unit operators surveillance boundries to include the MIMS rack.
3) Present a MIMS lecture in requal including use ot the tape machine.
4) Increase I&C surveillance for PM's.

PWO'S UNIT 3

PWO	SYSTEM #	DATE	PROBLEM
C317705	99	01/13/88	Bin A-1 Ch.1 Not sounding
C317706	99	01/13/88	Bin A-1 Ch.2 Not sounding
C318495	99	12/14/87	Bin A-2 Ch.5 Excessive noise
C401006	99	05/13/88	Bin A-3 Excessive false alarms

PWO'S UNIT 4

C401455	99	06/06/88	Recorder doesn't work
C401463	99	06/11/88	All channels - rushing noise
C401110	99	06/06/88	Bin A-2 Ch.6 Constant false alarms
C404701	99	04/12/88	Bin A-2 Ch.3 Inoperable

Copies of PWO's attached, C401110 not found.