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 50-251 Turkey Point Plant, Unit 4, Florida Power and Light C 05000251

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 CONWAY, W.F. Florida Power & Light Co.
 RECIP. NAME RECIPIENT AFFILIATION
 GRACE, J.N. Region 2, Ofc of the Director

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SUBJECT: Forwards mgt-on-shift weekly rept.

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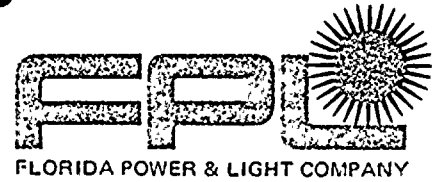
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	NUDOCS-ABSTRACT	1 1	OE LIEBERMAN, J	1 1
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JULY 27 1988

L-88-325

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

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MANAGEMENT ON SHIFT (MOS)

WEEKLY SUMARY REPORT

WEEK STARTING: 07/15/88

PAGE 1 OF 3

Six MOS Observers were on shift. Peter L. Walker, Westinghouse Electric Corporation (07/18-22/88, nights); Richard Coulthard, Westinghouse Electric Corporation (07/18-22/88, days); Jose Donis, Turkey Point Nuclear Plant Project Supervisor (07/19-22/88, nights); John Zudans, Principal Engineer, Plant Support, Juno Beach (07/15-18/88, days); Craig D. Bersak, Westinghouse Electric Corporation (07/15-18/88, nights); Ron C. Sontag, Turkey Point INPO Coordinator (07/15-18/88, nights).

Both Units 3 and 4 operated in Mode 1 for the duration of the reporting period.

No immediate safety problems were noted by any Observer during the reporting period.

No questionable work practices were identified by the MOS Observers. This group identified 10 areas for improvement, as follows:

Two recommended modifications to the Boric Acid Transfer pump seal pots.

- Three recommendations for procedure upgrades (one on when to notify NRC of shutdown, two on valve lineups).
- A suggestion to computerize the STA's work on CCW heat balances.
- A concern about steam from a leak impinging on cables in a tray.
- A recommendation to add whip restraints to hydrogen hoses.
- Two concerns about work in the Radiation Control Area (RCA); one on use of a crane extending outside the RCA, the other on a security guard's control of potential contamination.
- Preventive maintenance on an Emergency Diesel Generator taking more than 24 hours.

The Turkey Point Observers noted two questionable work practices, one concerning proper storage of an oxygen cylinder, and one concerning personnel not wearing a hard hat. They identified six areas for improvement, as follows:

ATTACHMENT: MOS DAILY REPORTS

8808150040



MANAGEMENT ON SHIFT (MOS)

WEEKLY SUMMARY REPORT

WEEK STARTING: 07/15/88

PAGE 2 OF 3

- A recommendation that the Plant Supervisor Nuclear (PSNs) be supplied with a WATS line access code.
- Two comments on maintenance of controlled drawings and technical manuals.
- One comment on housekeeping and drum storage in the Chemistry building.
- A comment on roof leaks in the Auxiliary Building. This is a repeat comment, and work has begun on repairs.
- A concern about the deterioration of exposed lifting equipment.

The PSNs reported seven questionable work practices during the period. They included:

- A problem with temporarily lifted clearance tags. This has been a recurring problem area and is being addressed by Turkey Point staff this week.
- A failure to complete a Quadrant Power Tilt Ratio calculation within 12 hours. Three recommendations resulted.
- A raincoat stuffed into the supports for safety-related flow transmitters.
- Difficulty in getting response from Chemistry while evaluating the possibility of a steam generator tube leak. This item was reiterated by two MOS Observers.
- A disparity between the requirements in an off-normal procedure and the Technical Specifications. This item was also reiterated by a MOS Observer.
- A lockwire discovered missing from a valve, and the shift's inability to locate any requirement that the valve be locked.
- Another concern about a new valve installed by PC/M, with no clearance on the valve. Opening the valve would depressurize the Instrument Air System.

ATTACHMENT: MOS DAILY REPORTS



MANAGEMENT ON SHIFT (MOS)

WEEKLY SUMARY REPORT

WEEK STARTING: 07/15/88

PAGE 3 OF 3

The PSNs also identified five areas for improvement, as follows:

- A concern about what parameters to monitor when a Reactor Coolant Pump bearing RTD failed.
- A suggestion for improving the "user-friendliness" of the RCO logs. This item was reiterated by a MOS Observer.
- A suggestion to remove the Nuclear Management Corporation radiation monitors which are no longer used.
- A complaint about graffiti on the access card readers.
- A concern about the degree of emphasis that Radiochemistry management has placed on evaluation of the Reactor Coolant System leakage.

ATTACHMENT: MOS DAILY REPORTS



Date 07/15/88

Shift Report

Shift Weakly
Peak

Shift Management

Schimkus

APSN

Murphy

NWE Spence

A. Questionable Work Practices/Actions Taken/Recommendations

Today the T-1 and T-2 Diesel Air Compressors were placed on the new header and released to Operations following Temporary System Alteration (TSA) being cleared up. On my PSN tour I noticed that there is a header isolation (for an extra diesel) with no control to prevent opening up an approximate 4" hole in the instrument air line.

Action: Had a NWE clearance hung on this isolation valve to be closed.

Recommend: Technical Department investigate entire PC/M to ensure no other discrepancies.

B. Areas for Improvement/Recommendations/Actions Taken

None

C. Good Practices/Professionalism Observed

Routine operations. Good shift teamwork investigating Unit 4 Steam Jet Air Ejector vacuum loss situation.

Reviewed By R. W. Spence Date 7/18/88 Actions Completed _____ Date _____



To: Operations Superintendent - Nuclear

Date: 07/15/88

From: John J. Zudans
(MOS Observer)Shift: ☒ Day
☐ Night

A. Plant Evolutions Observed

- Both units at 100% power
- Toured turbine decks, Emergency Diesel Generators (EDG), Radiation Control Area (RCA), (pipe and valve room, containment spray, generator)
- Observed High Pressure Safety Injection (HPSI) In Service Testing

B. Immediate Safety Problems

None noted

C. Questionable Work Practices

None noted

D. Areas for Improvement

1. During my tours of the RCA I observed two electrical personnel working on ultraviolet fire sensors in a portable crane that was extended from the RCA into the Intake Cooling Water (ICW) area (in the air). Upon further inquiry it was determined that H.P. coverage was obtained for this evolution, but Security was not contacted for coverage. An inquiry to Security Supervision determined that they should have been contacted. Electrical Supervisor in charge of the job understands the requirement, but believed it did not apply in this case. This unconservative approach could lead to potential serious consequences in other circumstances. The PWO preparation procedure (O-ADM-701, attachment 10) does not appear to cover this situation. It is recommended that clarification be provided, as necessary, to preclude such events, as well as potentially more serious situations.



2. During my tour of the EDGs, the "A" EDG ground elevation vital door lock was discovered malfunctioning. Discussion with Security revealed that repairs have been ordered and that the door has been devitalized. There was no PWO tag or label advising personnel of the condition. Further, the peak shift PSN contacted Security about this matter on 7/11/88 and requested a letter advising shifts of the condition and that a placard or some other measure be implemented to make all aware. It is recommended that the requested measures be implemented.
3. The cable trays directly above the gland steam condenser blower "B" outlet on Unit 3 are constantly being exposed to steam from this outlet. It is not known what type of cabling is in the cable tray and whether excessive aging is occurring due to the steam. It is recommended that the effects of the steam be determined and appropriate countermeasures taken.

E. Professionalism, Summary of Shift, Comments

Good shift, operators attentive to duty.

Completed By: John J. Zudans
MOS Observer

Date: 07/15/88

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

Date: 7/18/88

Management
Review By:

NO 1 7/18/88 VP 1 7/18/88
PM-N Date SVP Date VP Date

0/15/88



To: Operations Superintendent - Nuclear

Date: 07/15-16/88

From: Craig D. Bersak
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- Both Units 3 and 4 at 100% power
- Shift turnover and meeting
- Pressurizer pressure and water level periodic surveillance

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

None

E. Professionalism, Summary of Shift, Comments

Observed performance of pressurizer pressure and water level periodic surveillance by peak shift I & C Supervisor and two specialists. Excellent work practices were employed throughout the evolution - procedure in hand, technicians cross checking each other prior to operating switches and installing/removing jumpers.

Completed By: Craig D. Bersak
MOS Observer

Date: 07/15-16/88

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

Date: 7/18/88

Management
Review By:

JEC 1 7/18/88 VP 1 7/18/88
PM-N Date SVP Date VP Date

07/15-16/88



To: Operations Superintendent - Nuclear

Date: 07/15-16/88

From: R. C. Sontag
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- Control Room operation
- Watch Engineer shift turnover
- Unit 4 pressurizer level periodic
- Plant tour
 - Intake area
 - Radiation Control Area (RCA)
 - Computer room
 - Secondary plant

B. Immediate Safety Problems

None

C. Questionable Work Practices

1. Observed an unsecured oxygen bottle at the construction site near the intake area. Reported same to PSN. The PSN immediately had the bottle tied down.
2. Observed a Nuclear Operator, in a hard hat required area, without a hard hat. When reminded, he returned to the N.O. shack and retrieved his hard hat.

D. Areas for Improvement

Controlled Document #17 - a book of drawings in the Watch Engineers office needs attention. Some of the pages are torn, one drawing is identified as Controlled Document #11, the book cover is identified as Controlled Document #7. There is no table of contents, so it was not possible to verify that all drawings were present.

Recommend that a Document Control Technician inspect all controlled documents in the Control Room and other operating stations to ensure that these documents are in good shape and contain all the required pages.



B. Professionalism, Summary of Shift, Comments

The peak shift I & C Supervisor, Vern Miller, demonstrated excellent control and teaching techniques while supervising the execution of the pressurizer level periodic.

Completed By: R. C. Sontag
MOS Observer

Date: 07/15-16/88

Reviewed By: *R. W. P. Miller*
Operations Superintendent - Nuclear

Date: 7/18/88

Management
Review By:

RC 17/18/88 *VP* 17/18/88
PM-N Date SVP Date VP Date
07/15-16/88



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100	100

Shift Management

Harpel

APSN

Singer

NWE

Matuszewski

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 E. W. Glasse Date 7/18/88 Actions Completed _____ Date _____



Date 07/16/88

Shift Report

Shift _____ Day _____

Shift Management

PSN _____ Wogan _____ APSN _____ Singer _____ NWE Spence _____

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 *N.W. Spence* Date *7/18/88* Actions Completed _____ Date _____



Shift	Peak
-------	------

NWE Spence

Reviewed By T.W. Pearce Date 7/18/88 Actions Completed _____ Date _____



To: Operations Superintendent - Nuclear

Date: 07/16/88

From: John J. Zudans
(MOS Observer)Shift: ☒ Day
☐ Night

A. Plant Evolutions Observed

- ° Both units at 100% power
- ° Toured Radiation Control Area (RCA), (Auxiliary Building, Boric Acid room, Unit 3 Component Cooling Water (CCW) area, east perimeter fence)
- ° Toured turbine decks
- ° Observed containment entry
- ° Toured Intake Cooling Water (ICW)/Raw Water areas

B. Immediate Safety Problems

None noted

C. Questionable Work Practices

None

D. Areas for Improvement

1. RCA

Recommend installing hose restraints for the hose between the H2 trailer and main H2 isolation standard. This poses a potential fire or whip hazard.

2. With regard to the Boric Acid Transfer Pump seal pots

- a. Recommend the fill method be re-evaluated. Currently, the method is cumbersome (remove Pressure Indicator (PI), vent tank, etc.) A better design should be considered since the current method requires both Operations and Maintenance personnel to be involved thereby burdening resources. Alternate methods have been recommended by N.O.'s and RCO's in the past. It is recognized that this may have been evaluated in the past, however, reconsideration is requested.
- b. Recommend that the 4A seal pot be reoriented such that the sight gage and PI is easily accessible. This could prevent reading errors and reduce radiological exposure.

3. During the Unit 4 containment entry, the security guard unlocking the entrance hatch lock was observed taking the lock outside the contaminated area prior to having the lock frisked. He stepped off the clean pad, after placing the lock in his bare hand, then proceeded to the frisker. Fortunately, the lock was not contaminated. Recommend security personnel involved in these activities be provided additional guidance.

4. Turbine area

Followup on the 7/15/88 report, where the Emergency Diesel Generator (EDG) "A" vital gate was identified as devitalized and no formal notification was made it appears that the condition still remains the same. A sign should be posted on the gate (or PWO sticker) as well as a letter issued regarding the condition.

E. Professionalism, Summary of Shift, Comments

R-11 radiation monitor indications as well as the containment entry were handled in a professional, well coordinated and thought out manner. Prior to entry, coordination between entry personnel was very good. Control Room proactive planning contributed to a smooth evolution.

Completed By: John J. Zudans
MOS Observer

Date: 07/16/88

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

Date: 7/18/88

Management
Review By:

EC 17/18/88 gfo 17/18/88
PM-N Date SVP Date VP Date

07/16/88



To: Operations Superintendent - Nuclear

Date: 07/16-17/88

From: R. C. Sontag
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- ° Control Room operations
- ° I & C calibration of Rod Position Indication (RPI) G5 (Unit 3)
- ° I & C troubleshooting of R-11 (Unit 4)
- ° Plant tour
 - Radiation Control Area (RCA)
 - Water Treatment Plant (WTP) and Intake
 - Diesel House.
 - Secondary Plant

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

1. The Chemistry house (located just west of the Water Treatment Plant) needs considerable attention. Outside, there are 35 empty 55 gallon drums. Three of them were without vent caps and were emitting ammonia gas. Inside there were several more filled or partially filled drums. Four of these were also open to the atmosphere. Two had hand pumps loosely inserted in the vent holes, all were emitting considerable amounts of ammonia gas. The lab area itself was very messy, rags and trash littered the floor. The garbage can was overflowing. The chem. sink and counter tops were filthy. There were many objects strewn around. The room is in total disarray.
2. The PSN does not have a long distance (Watts) access code. This made it difficult to make notifications to individuals located in the new area code, (407).

E. Professionalism, Summary of Shift, Comments

1. In regard to the out of spec RPI on Unit 3:
 - a. Consideration should be given to a shorter interval for logging of Technical Specification related parameters. A shorter interval - perhaps every 4 hours instead of 8 hours or maybe $\frac{1}{2}$ the grace period might have prevented exceeding the grace period today.
 - b. A review of the RPI logs showed a definite trend for G5 during the last two days. Recommend that Operations personnel be cautioned to be alert for parameter trends.
2. The material condition and cleanliness of the plant is the best it has ever been. A work environment such as this promotes professionalism and pride. It is a shame that the Chemistry House is not kept to the same high standards as the rest of the plant. Recommend that this area receive increased supervisory attention. The lab area should be thoroughly cleaned and straightened up. The empty drums should be removed and properly disposed of. The full and partly filled drums should be capped or vented through a water trap when not in use.
3. The PSN needs access to long distance telephone lines - a TMS access code should be issued to each PSN.

Completed By: R. C. Sontag
MOS ObserverDate: 07/16-17/88Reviewed By: *[Signature]*
Operations Superintendent- NuclearDate: 7/18/88Management
Review By:*[Signature]* 17/18/88 *[Signature]* 17/18/88
PM-N Date SVP Date VP Date

07/16-17/88



To: Operations Superintendent - Nuclear

Date: 07/16-17/88

From: Craig D. Bersak
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- Unit 3 at 97% power and return to 100% power
- Unit 4 at 100% power
- Shift meeting and turnover
- Resolution of Rod Position Indication (RPI) deviation problem

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

The RPI deviation problem disclosed some problems with the RCO logs and ONOP-028.

1. Both the logs and the ONOP show a 12 step maximum deviation limit on rod to rod heights, neither the current Technical Specifications nor ADM-021 have this requirement. No basis for this limit could be found in the Control Room.
2. The RCO log format is lacking in "user friendliness". The rod heights are recorded but the acceptance criteria determination, that is the maximum deviation between rods in a group, is not.
3. Additionally, the logging requirement does not allow for delayed identification. If the acceptance criteria is exceeded, but not determined until the subsequent logging, the 8 hour period for corrective actions has been or is very soon to be exceeded. A revision of the logs such that the readings are taken no farther than $\frac{1}{2}$ the action statement corrective action period apart would allow a single oversight to be caught and corrected with some breathing room.
4. ONOP-028 is very poorly organized. The automatic, immediate and subsequent actions for each of the seven rod control problems should be grouped together into discrete sections. Having to flip from section to section to determine all the required actions for a problem is an avoidable mantrap waiting to ensnare the operators.



5. Clarification is needed for notification requirements under 10CFR50.72 (b) (i) (A), "The initiation of any nuclear plant shutdown required by the plant's Technical Specification." As the 8 hours allowed to correct the rod alignment problem had lapsed, actions were initiated to reduce power to the ADM-021 requirement of 50% and an NRC Operations Center notification was unnecessarily made. A note in the notification procedure saying that this notification is required for a Technical Specification action statement that requires a mode change would have simplified the PSN's decision making.
6. Consideration should be given to revising the time at which the RCO's take their logs. Currently they are taken at approximately 0730, 1530 and 2330 which coincides with the shift meetings and is a significant distraction as the RCO's attention must be split not only to monitoring the plant conditions and completing his logs, but additionally to the shift meeting to be apprised of upcoming evolutions.

E. Professionalism, Summary of Shift, Comments

The PSN and APSN took aggressive, positive and conservative actions on notification of the RPI problem.

The basis document for ONOP-028 was reviewed to attempt to determine the source of the 12 step rod to rod limit. For this symptom the rationale given is "Maximum allowable rod height difference." That much can be readily discerned from the procedure itself, to be useful the basis document should provide the reference location for the requirement. (For consideration in upgrading the basis documents, no response required.)

Completed By: Craig D. Bersak
MOS Observer

Date: 07/16-17/88

Reviewed By: *[Signature]*
Operations Superintendent - Nuclear

Date: 7/18/88

Management
Review By:

[Signature] 17/18/88 *[Signature]* 17/18/88
PM-N Date SVP Date VP Date

07/16-17/88



Date 07/17/88

Shift Report

Shift Day

Shift Management

PS Wogan APSN Singer NWE Vetromile

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

A problem arose with 4B Reactor Coolant Pump upper thrust bearing temperature. This point (#8) on the recorder started trending upward. There are no valid points on the recorder to help decide whether to shut down this pump and the point trending up has had an information tag on it since 2/87 (for outage work) as being erratic.

Recommend: Contacting Westinghouse for parameters to watch which could verify a failing pump or motor bearing.

Action taken: Contacted the Electrical Department to verify conditions of motor and pump did not support a failing thrust bearing.

C. Good Practices/Professionalism Observed

Numerous off-normal conditions on Unit 4 were handled well by the Operations staff. Support from Chemistry, Mechanical Maintenance and I & C is well appreciated.

Reviewed By R.W. Pearce Date 7/18/88 Actions Completed Date

Date 07/17/88

Shift Report

Shift Mids

Shift Management

Harpel

APSN

Singer

NWE Matuszewski

A. Questionable Work Practices/Actions Taken/Recommendations

ONOP-028, besides being user unfriendly in its format, has an operator reduce load if a Rod Position Indication (RPI) is greater than 12 steps mismatched with its group demand step counter or with other RPIs in the same bank. Both Technical Specifications and O-ADM-021 have RPIs compared only to their bank demand (group step counters). The requirement (step 2.4.1 pg. 6 of ONOP-028) to compare RPI to RPI caused a partial shutdown on peakshift 7/16/88 and possibly a false reporting of a significant event.

B. Areas for Improvement/Recommendations/Actions Taken

ONOP-028 needs to be overhauled for several reasons:

1. It needs to reflect what is addressed in Technical Specifications and O-ADM-021.
2. The various failures addressed in the procedure need to have required actions hand in a less cumbersome manner. I feel the various failures should be totally addressed in individual sections from symptoms to subsequent actions.
3. This type of failure occurs frequently and Turkey Point needs to address a decisive line of action to be taken. This will avoid this confusion in the future.

C. Good Practices/Professionalism Observed

Reviewed By

L.W. Pearce

Date

7/18/88

Actions Completed

Date

Shift Peak

Shift Management

Schimkus APSN Murphy NWE Spence

A. Questionable Work Practices/Actions Taken/Recommendations

On PSN tour I found a missing lock wire on 3B Main Steam Isolation Valve (MSIV) Nitrogen Isolation valve 3-5264 which supplies SV-3-2611 A & B. The PSN investigated 3-OP-072, 3-OP-065.2, 3-OSP-072, 3-OSP-072.1, 3-OSP-072.2, ADM-205, and Control Print 5610-M-339 sheet 2 which all address the required valve position. There was no reference to sealing this valve or any of the others on each of the MSIVs.

ACTION TAKEN: Had NWE place lock wire on ISOL 3-5264 in open position. Wrote inter-office memo to Start-up Department requesting research to see if procedures were supposed to designate these valves to be placed under SRO lock wire configuration.

B. Areas for Improvement/Recommendations/Actions Taken

On dayshift 7/17/88 many hours were spent by on-shift Operations personnel to verify if a Reactor Coolant System (RCS) leak exists in the containment. It appears that the lab is saying we have had an increase in containment Unit 4 air activity corresponding to the higher PRMS R-11 readings we are seeing. In reality we have had one mechanical failure of the R-11 detector and tonight the detector again appeared to be against the filter paper which could explain why R-11 counts are not at their usual 50K value. Since Operations has requested assistance starting Friday night, it appears that the management for Radiochemistry has been lacking in their effort to explain and confirm a valid containment air activity sample.

C. Good Practices/Professionalism Observed

The peak shift STA was a valuable tool to the PSN/APS in troubleshooting Unit 4 PRMS - R-11 high count rate following I & C releasing PRMS-R-11 after maintenance. It appears that the root cause for increasing from approximately 52K, 3 days ago to the value now is the detector location to the filter paper. We still need a valid answer from Radiochemistry to confirm no increase in air activity in containment.

Reviewed By J. J. G. G. G. Date 7/18/81 Actions Completed _____ Date _____

To: Operations Superintendent - Nuclear

Date: 07/17/88

From: John J. Zudans
(MOS Observer)Shift: ☒ Day
☐ Night

A. Plant Evolutions Observed

- Both units at 100% power
- Toured Turbine decks, Emergency Diesel Generators (EDG), Backup nitrogen stations, Unit 3 and 4 Motor Control Centers (MCC), Radiation Control Area (RCA)

B. Immediate Safety Problems

None noted

C. Questionable Work Practices

None

D. Areas for Improvement

Reviewed Component Cooling Water (CCW) heat exchanger cleaning procedures and associated documents. Procedure O-OSP-40.4 allows for heat transfer calculations to be performed with a computer which expedites the paper work and analysis associated with the process. It appears that STA duties with regard to plotting data and maintaining current status of all heat exchangers lend themselves to computerized techniques which are routinely used at FPL. The STA's job in this area could be enhanced by implementing this capability.

E. Professionalism, Summary of Shift, Comments

Operators, NOs and TOs performed very well in spite of a number of stressful situations this weekend. Each of the units was threatened with power reduction or shutdown due to Radiation Monitor R-11 and Rod Position Indication (RPI) difficulties. Their conservative, sound judgements were maintained through the past 2 days. Operator actions are delayed due to the number and complexity of documents necessary for them to interpret prior to taking actions. Hopefully, these concerns can be eliminated by the use of only one set of Technical Specifications and the clarification of procedures such as ONOP-028.

Completed By: John J. Zudans
MOS Observer

Date: 07/17/88

Reviewed By: *P. J. Pearce*
Operations Superintendent - Nuclear

Date: 7/18/88

Management
Review By:*McC* 17/18/88 *JRQ* 17/18/88
PM-N Date SVP Date VP Date



To: Operations Superintendent - Nuclear

Date: 07/17-18/88

From: Craig D. Bersak
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- Units 3 and 4 at 100% power
- Shift turnover and meeting
- Plant tours
- Intermediate Range Nuclear Instrumentation System (NIS) surveillance

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

Areas for Improvement

None

E. Professionalism, Summary of Shift, Comments

Chemistry Tech., Grace Keoun, demonstrated an excellent dedication to professionalism in the investigation and followup of Radiation Monitor R-11 problems. She presented the APSN George Murphy, with a well researched analysis and course of action recommendations that greatly clarified the problem for both the PSN and APSN. During the course of her explanation to the APSN a breach in communications was identified between the Operations and Chemistry Departments. Murphy emphasized and explained why Operations needs and expects Chemistry personnel at the shift meetings. Keoun presented some of the problems the Chemistry Tech. perceived with having to attend and who to send. A very open and frank discussion of this topic was conducted and an amicable, workable solution defined. This line of communication if implemented and pursued will greatly improve the teamwork between these two departments.

Completed By: Craig D. Bersak
MOS Observer

Date: 07/17-18/88

Reviewed By: [Signature]
Operations Superintendent - Nuclear

Date: 7/18/88

Management
Review By:

EC 17/18/88 [Signature] 17/18/88
PM-N Date SVP Date VP Date

07/17-18/88

Operations Superintendent - Nuclear

Date: 07/17-18/88

From:

R. C. Sontag

(MOS Observer)

Shift:

☐

Day

☒

Night

A. Plant Evolutions Observed

- o Control Room operations
- o Shift turnover
- o N-44 troubleshooting
- o Plant tour
 - Radiation Control Area (RCA)
 - Intake area
 - Secondary plant

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

In the intake area, there is a storage track filled with lifting equipment. This rack is in the open and the lifting equipment is exposed to the elements. Many of the cables are very rusted and several chains were severely rusted. Many of the equipment certification tags were over a year old. This equipment was readily available for use.

This discrepancy was previously noted by INPO in finding MA.1-1 (1988).

Recommend that this equipment be removed from service and tested to ensure reliability. Storage facilities should be in an area protected from the elements.

E. Professionalism, Summary of Shift, Comments

Today marks the beginning of a new record for a dual unit run at Turkey point to teamwork, professionalism and dedication to quality and points the way to our future.

Congratulations, Turkey Point!

Completed By:

Ron C. Sontag

MOS Observer

Date: 07/17-18/88

Reviewed By:



Operations Superintendent - Nuclear

Date:

7/18/88

Management
Review By:
PM-N

Date

7/18/88

SVP

Date

7/18/88

VP

Date

07/17-18/88



Date 07/18/88

Shift Report

Shift Mid

Shift Management

Harpel

APSN

Murphy/Singer

NWE Matuszewski

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 LW Pearce Date 7/18/88 Actions Completed _____ Date _____

Date 07/21/88

Shift Report

Shift _____ Day _____

Shift Management
Schimkus/Anderson APSN Murphy/Reese Hellriegel
NWE

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 L.W. Ponce Date 7/22/88 Actions Completed _____ Date _____



Date 07/21/88

Shift Report

Shift Peak

Shift Management

Anderson

APSN

Murphy

NWE Dallau

A. Questionable Work Practices/Actions Taken/Recommendations

Unit 4's R-15 started climbing and R-19 seemed to be trending up indicating a large tube leak in a Steam/Generator (S/G). The RCO had a very hard time getting the lab technicians to answer the page until he yelled for them to answer "now". Then he got an answer. He explained to them what was going on and that they needed to check Special Particulate, Iodine and Noble Gas (SPING) monitor, (wide range radiation monitor) and get a grab sample immediately! By then R-15 went back down and we saw that R-19 was just fluctuating in its usual manner. We looked at other parameters and brought a trend up on the Safety Assessment System (SAS) and tried the source check on R-15 trying to troubleshoot it. About an hour later we thought about the lab technicians had never called us back. The APSN called the lab supervisor and he had to call back to tell us that SPING had been checked and was showing nothing and then 3 hours later we got the results of the grab sample. Had this been a real tube leak, this kind of response from the lab would have been unacceptable. When they looked at SPING they should have called us immediately, and if it takes 3 hours to get the results of a grab sample for this purpose, we need a better system. What I really think is wrong is that no one thinks the "big one" will ever happen to us. I think everyone should perform their jobs as if this were the "big one". We should always be prepared for it.

B. Areas for Improvement/Recommendations/Actions Taken

None

C. Good Practices/Professionalism Observed

None

Reviewed By S.W. Pearce Date 7/22/88 Actions Completed _____ Date _____



Date 07/22/88

Shift Report

Shift Mid

Schimkus

APSN

Shift Management

Murphy

Matuszewski/

NWE ^{Dallau}

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

None

C. Good Practices/Professionalism Observed

Excellent support in repairing the Unit 4 Auxiliary Feedwater (AFW) steam supply Motor Operated Valve (MOV) trap drain steam leak. Mechanical Maintenance formulated a method to seal off the vacuum from the hole in the pipe, then do a good weld repair.

Reviewed By P. D. Pearce Date 7/22/88 Actions Completed _____ Date _____



Operations Superintendent - Nuclear

Date: 07/21/88

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

A. Plant Evolutions Observed

- 100% power operations, Units 3 and 4
- 0715 Plan of The Day
- 1535 shift turnover meeting
- Operations response to Unit R-15 Air Ejector Alarm

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

1. The Chemistry Department was somewhat reluctant to respond to an Operating shift request for a sample of the Unit 4 Air Ejector discharge. Unit 4 did receive an alarm on R-15 about 1615. ONOP 11108.1 states Operations should request a chemistry sample in accordance with procedure NC-70. Procedure NC-70 requires an air ejector sample upon detection of a noticeable increase in radiation level.
2. The B Diesel Preventative Maintenance (PM) program was still not complete at 1730. Operations was gearing up to run the A Diesel to demonstrate operability since the B Diesel might not be released to Operations and run prior to the required time. An effort should be made to emphasize the expeditious conduct of PM's on equipment with short LCO times.



E. Profesisonalism, Summary of Shift, Comments

1. Fairly quiet shift. Control Room operations were conducted in a professional manner.
2. At about 1740 on the way back to the NAB office building, I stopped by the Chemistry office area to quickly research requirements for the sampling condenser air ejector after receiving an alarm. While leafing through a procedures book, I was approached by Ed English and he asked if he could be of help. I merely said I could find what I was looking for. It was a definite error on my part not to bring up and discuss with him the concern listed as item D.1. (Written 0600, 7/22/88)

Completed By:

Richard Coulthard

MOS Observer

Date: 07/21/88

Reviewed By:

J.W. Pearce

Operations Superintendent- Nuclear

Date: 7/22/88

Management
Review By:*J.E.*
PM-N1 7/22/88
Date

SVP

1 7/22/88
Date*J.E.*
VP1 7/22/88
Date

07/21/88



To: Operations Superintendent - Nuclear

Date: 07/21-22/88

From: J. M. Donis

(MOS Observer)

Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- Units 3 and 4 at 100% power
- Emergency Diesel Generator (EDG) Operability test: O-OSP-23.1
- Addition of Boron to Unit 3 Refueling Water Storage Tank (RWST) O-OP-46
- Shift turnover meeting

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

None

E. Professionalism, Summary of Shift, Comments


No comment

Completed By: J. M. Donis

MOS Observer

Date: 07/21-22/88

Reviewed By:



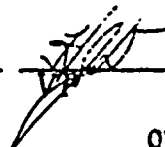
Operations Superintendent - Nuclear

Date:

7/22/88

Management
Review By:
PM-N17/22/88
Date

SVP

17/22/88
Date
VP17/22/88
Date



To: Operations Superintendent - Nuclear

Date: 07/21-22/88

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

A. Plant Evolutions Observed

- ° Units 3 and 4, 100% steady state power operation
- ° Test of Diesel Generator A

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

Chemistry Department was very slow in responding to Operation's request for a confirmatory sample of condenser offgas. See Tom Anderson's report. A prompt response to this type of request is important to aid in diagnosing a potential Steam Generator tube leak.

E. Professionalism, Summary of Shift, Comments

Smooth, quiet, productive shift.

Completed By: Peter L. Walker
MOS Observer

Date 07/21-22/88

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

Date: 7/22/88

Management
- Review By:

PM-N 17/22/88 SVP 17/22/88 VP 17/22/88
Date Date Date Date



Date 07/18/88

Shift Report

Shift R Hart Day

Shift Management

PS Wogan APSN Singer NWE Vetromile

A. Questionable Work Practices/Actions Taken/Recommendations

B. Areas for Improvement/Recommendations/Actions Taken

Removal of Nuclear Measurements Corporation instruments from the process racks would be an improvement. These instruments serve no purpose.

C. Good Practices/Profesisonalism Observed

Timely reaction of the fire team leader to a medical emergency is to be commended (7/18/88 @ 0910)

Reviewed By R.W. Paine Date 7/19/88 Actions Completed Date



Shift Report

Shift	Peak
-------	------

Shift Management

PS Anderson APSN Reese NWE Dallau

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

None

C. Good Practices/Profesisonalism Observed

Routine operations

Reviewed By XW Please Date 7/9/88 Actions Completed _____ Date _____



Shift	Mid
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100	100

Shift Management

SN Harpel A'SN Singer NWE Matuszewski

A. Questionable Work Practices/Actions Taken/Recommendations

Unit 4 entered O-ADM-21, section 3.0.3. at 0445 due to Quadrant Power Tilt Ratio (QPTR) not being verified within 12 hours. This was due to two things:

1. That Engineering allowed for little grace time when running their surveillance.
2. The company computer had CMS (needed for QPTR verification) out-of-service $\frac{1}{2}$ hour earlier than was previously put out on the terminal monitor.

B. Areas for Improvement/Recommendations/Actions Taken

1. All departments need to allow time for snags when performing Technical Specifications required surveillances.
2. The computer people need to stick to their schedules.
3. Reactor Engineering should have a backup computer program which can be used on an IN-PLANT computer.

C. Good Practices/Profesisonalism Observed

Reviewed By J.W. France Date 7/19/88 Actions Completed _____ Date _____



To: Operations Superintendent - Nuclear

Date: 07/18/88

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

A. Plant Evolutions Observed

- Units 3 and 4 operations at 100% power
- 0715 morning Plan of The Day meeting
- 0340 shift turnover meeting
- Conduct of Unit 4 Channel 2 Steam Generator S/G level protection per procedure OP-14004.1
- Troubleshooting on Unit 3 control bank A Rod Position Indicators
- Troubleshooting and current checks on Unit 4 Nuclear Instrumentation Channel N-44
- Declaration of Unit 4 B S/G Blowdown Isolation valve CV-4-6275B inoperable
- Partial conduct of Component Cooling Water (CCW) system periodic test of pumps per OP-3104.1

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

During the conduct of OP 3104.1 low flow alarms came in on cooling water supplies to seal coolers for the Unit 3 Safety Injection, Residual Heat Removal and Containment Spray pumps. The test was quickly suspended and the alarms cleared. It might be worthwhile to review the valve lineup at the start of this test to see if this occurrence can be prevented in the future.

E. Professionalism, Summary of Shift, Comments

Day shift was quite busy with the I & C group quite active working on outstanding problems. The PSN on one or two occasions checked with unit control operators to verify their comfort level with number of activities in progress. Level of activity appeared properly monitored and under control.

Completed By: Richard Coulthard
MOS Observer

Date: 07/18/88

Reviewed By: *[Signature]*
Operations Superintendent - Nuclear

Date: 7/19/88

Management
Review By:

[Signature] 7/19/88 *[Signature]* 7/19/88 *[Signature]* 7/19/88
PM-N Date SVP Date VP Date

07/18/88



To: Operations Superintendent - Nuclear

Date: 07/18-19/88

From: R. C. Sontag
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- Control Room operations
- I & C troubleshooting, 4C charging pump
- Shift turnover meeting
- Plant tour
 - Radiation Control Area (RCA)
 - Intake area
 - Secondary plant
 - Maintenance building

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

1. A hard rain resulted in the formation of several puddles in the Auxiliary building apparently due to leaks in the roof. Recommend that the roof be repaired as soon as possible. The intrusion of rain water increases the potential for the spread of contamination and unnecessarily increases the liquid radiation waste inventory.
2. The troubleshooting of the charging pump control actuator was hampered by the unavailability of a technical manual in the I & C area.

E. Professionalism, Summary of Shift, Comments

None

Completed By: R. C. Sontag
MOS Observer

Date: 07/18-19/88

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

Date: 7/19/88

Management
Review By:*JSC* 7/19/88 *JAD* 7/19/88 *JAD* 7/19/88
PM-N Date SVP Date VP Date

07/18-19/99



To: Operations Superintendent - Nuclear

Date: 07/18-19/88

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

-A. Plant Evolutions Observed

- Units 3 and 4, 100% steady state operation
- Entered a 24 hour LCO due to loss of a second charging pump on Unit 4
- Unit 4 was readied for shutdown due to exceeding the time allowed for Quadrant Power Tilt Ratio (QPTR) calculation as a result of Unit 4 Channel N-44 being out-of-service. Shutdown was not required because QPTR analysis became available.

B. Immediate Safety Problems

None

C. Questionable Work Practices

Reactor Engineering began their flux map [required to support QPTR verification for one nuclear instrument (Power Range 4-N44) out-of-service] at 0130, with an LCO expiration time of 0445. As they were finishing the computer-aided data reduction, the Miami General Office computer was taken out-of-service at 0430, 30 minutes earlier than planned. As a result, 0445 came and went, and preparation to shutdown Unit 4 began. The General Office was asked to restart their computer, and the verification of QPTR was done at 0455, 10 minutes into the shutdown period. The questionable practice is not allowing enough time for contingencies when performing QPTR flux maps. This is the second time this year that this event has occurred, and this one was load threatening. Please start the flux map at the beginning of the LCO period versus toward the end.



D. Areas for Improvement

None

E. Professionslism, Summary of Shift, Comments

Miami General Office is to be commended for fast restart of their computer when asked by Operations. Unit 4 was beginning shutdown.

Completed By: P. L. Walker
MOS ObserverDate: 07/18-19/88Reviewed By: *P. L. Walker*
Operations Superintendent- NuclearDate: 7/19/88Management
Review By:*JSC* 12/19/88 *JD* 12/19/88 *JSC* 12/19/88
PM-N Date SVP Date VP Date

07/18-19/88



Date <u>07/19/88</u>	<h1>Shift Report</h1>	Shift <u>Randy Hart</u> Day
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Shift Management	
PSN <u>Wogan</u>	APSN <u>Singer</u> NWE <u>Vetromile</u>

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

None

C. Good Practices/Professionalism Observed

No comment at this report.

Reviewed By J. P. Paine Date 7/20/88 Actions Completed _____ Date _____



Date 07/19/88

Shift Report

Shift _____ Peak _____

Shift Management

PS Anderson APSN Reese NWE Dallau

A. Questionable Work Practices/Actions Taken/Recommendations

Today the PR N-44 was Post Maintenance tested satisfactory and placed back in service on day shift. On peak shift the clearance that had been on it was discovered still on a temporary lift. This problem has happened many times before.

Recommendation: There needs to be a sign off column in the Equipment Out-of-Service book to verify that the clearance is completely lifted prior to calling it back in-service and signing it out of the Equipment Out-of-Service book.

B. Areas for Improvement/Recommendations/Actions Taken

I have been told by several people that we are working on doing away with temporary lifts. I think this is a bad mistake. We need temporary lifts for post maintenance testing and leak checks. For instance, if a strainer is being valved in and it is discovered to be leaking we don't want to have to write another clearance to be able to valve it out again. On a temporary lift the same tags can be hung right back on it in the clearance isolation positions. Another would be a temporary lift to bump a motor for rotation. We would end up with two clearances on the piece of equipment when you write a new one on the motor breaker. Even if you just add another tag to the same clearance to re-open the breaker, this will cause us to have to change the control tag for the clearance since the breaker is most always the control tag. Another example is the cold shutdown clearance. We are always needing temporary lifts on it during outages and we will be in a big mess if we have to keep writing new clearances for tags we need to remove temporarily.

C. Good Practices/Professionalism Observed

Reviewed By R.W. France Date 7/20/88 Actions Completed _____ Date _____



Date 07/20/88

Shift Report

Shift Mid

Shift Management

P Schimkus APSN Murphy NWE Spence

A. Questionable Work Practices/Actions Taken/Recommendations

On shift tour, found that someone had stuffed a "large" raincoat right into the center of Unit 4 Steam Generator S/G Feed Flow Transmitters FT-476,486, and 496. Had any steam flow bistables been made up associated with these channels, possible logic matrix could have been made up if the feed flow transmitters were jarred.

Actions: Removed raincoat

Recommend: Protection for the transmitters and tubing to prevent jarring.

B. Areas for Improvement/Recommendations/Actions Taken

None

C. Good Practices/Professionalism Observed

Routine operations. Unit 4 NTO traced down the steam trap piping for the Auxiliary Feedwater pump steam supply Motor Operated Valves (MOV's) and feels he has a viable method to isolate the loud leak on the common header for all 3 steam traps. This is an item listed as HC-4 in Nuclear Jobs Planning System (NJPS) ie., cold shutdown job. Will pass this information on to the Operations-Maintenance Coordinator.

Reviewed By A. Spence Date 7/20/88 Actions Completed Date



To: Operations Superintendent - Nuclear

Date: 07/19/88

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

A. Plant Evolutions Observed

- Units 3 and 4, operation at 100% power
- 0715 Plan-of-the-Day meeting
- 1535 shift turnover meeting
- Conduct of Unit 3 Safeguard Relay Rack Train A, B periodic test per OP 4004.2
- Conduct of C Auxiliary Feed Pump Speed Adjustment and Operability Verification test per 3 and 4 OSP 075.2
- Troubleshooting and return of Unit 4 Nuclear Instrumentation Channel N-44 to service
- Start of conduct of two practice NRC Control Room oral examinations by instructors at start of peak shift

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

None

E. Professionalism, Summary of Shift, Comments

Another busy shift with both Operations and Maintenance personnel working together, business-like manner.

Completed By: Richard Coulthard
MOS Observer

Date: 07/19/88

Reviewed By: *[Signature]*
Operations Superintendent - NuclearDate: 7/20/88Management
Review By:

RC 1 7/20/88 *[Signature]* 1 7/20/88 *[Signature]* 1 7/20/88
PM-N Date SVP Date VP Date

07/19/88



To: Operations Superintendent - Nuclear

Date: 07/19-20/88

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

A. Plant Evolutions Observed

- 100% steady state operations, both units

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: 07/19-20/88

Reviewed By: *P. L. Walker*
Operations Superintendent - Nuclear

Date: 7/20/88

Management
Review By:*MC* 17/20/88 *VP* 7/20/88
PM-N Date SVP Date VP Date

07/19-20/88



To: Operations Superintendent - Nuclear

Date: 07/19-20/88

From: J. M. Donis
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- Units 3 and 4 at 100% power
- Troubleshooting in effort to return valves 6275 A and C to service (Steam Generator Blowdown Isolation)
- PRMS test per 3 and 4 OSP 67.1
- Reviewed Equipment Out-of-Service Log

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

None

E. Professionalism, Summary of Shift, Comments

Shift turnover meeting very well organized and conducted in a professional manner. PSN and APSN provided a concise status of both units and shift goals/objectives for the resolution of outstanding problems. Good participation by Maintenance Department representatives.

Completed By: J. M. Donis
MOS Observer

Date: 07/19-20/88

Reviewed By: [Signature]
Operations Superintendent - Nuclear

Date: 7/20/88

Management
Review By:

[Signature] 17/20/88 [Signature] 17/20/88 [Signature] 17/20/88
PM-N Date SVR Date VP Date

07/19-20/88



R. Hart

Shift Report

Date 07/20/88

Shift _____ Days _____

Shift Management

ON Wogan APSN Singer NWE Vetromile

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 *R. Hart* Date 7/21/88 Actions Completed _____ Date _____



Shift Report

Date 07/21/88

Shift Mids

Shift Management

PSN Schimkus APSN Murphy NWE Matuszewski

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

Noticed on PSN tour that there is an extensive amount of graffiti on card readers in Unit 3 Feedwater platform, both units' Auxiliary Feedwater (AFW) steam supply Motor Operated Valve (MOV) (inside) card readers and associated conduit shielding, and also on card reader in Unit 4 Feedwater platform. It appears to be Security-initiated graffiti as it has overtones of ZONES that guards surveil.

Recommend: Security Supervisor investigate - find out who the various nicknames belong to - have them clean area or terminate them.

C. Good Practices/Professionalism Observed

1. Have observed a radical change in Maintenance's support role to help Operations with their immediate problems to keep the units running. I & C has vigorously been attacking their back-log on the back-shifts and feedback to the Control Room has been excellent. Mechanical Maintenance has readily assisted Operations in every instance where breakdowns are occurring and I am especially satisfied at the support that Maintenance is giving to attack the steam leaks on our secondary systems.
2. The Lab personnel should be commended for the continuous feedback they are giving to Operations on changes in unit 4 Containment air activity and other various parameters associated with a possible small Reactor Coolant System (RCS) leak inside containment.

Reviewed By *[Signature]* Date 7/21/88 Actions Completed Date

To: Operations Superintendent - Nuclear

Date: 07/20/88

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

A. Plant Evolutions Observed

- Units 3 and 4, operation at 100% power
- 0715 Plan-of-the-Day meeting
- 1535 shift turnover meeting
- Conduct of Unit 4 Power Range Nuclear Instrumentation tests in accordance with MP-12307.3 and 4-OSP-059.4
- Initiation of Operator valve watch on Pressurizer steam space sample line valve, 989A (a 3/8" tubing valve)

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

This item is associated with the requirement in Table 6.6.1 in the FSAR that valves 989A, 989B and 989C be "open only during sampling and under the constant control of the operator". Today the shift set up to purge the pressurizer steam space through it's sample line, since it was felt there could be a significant amount of non-condensibles in the steam. At this time, it was determined due to the above requirement that a valve watch on 989A would be required. This purge is conducted in accordance with OP-1200.1, "Pressurizer Steam Space Venting". Ed English of the Chemistry group provided orientation for operators to perform this function since the Chemistry specialist do this during sampling operations. After discussions with Dan Meils and Ed English, I have few suggestions to make in pursuit to efforts already initiated by Ed English.

1. Procedure OP-1200.1 has an Independent Verification signoff for closing valve 989A. Procedure NC-6 for Chemistry Sampling Operations does not have IV signoffs for valves 989A; 989B and 989C. Consistency would be advisable.
2. Ed English is in the process of marking up procedure OP-1200.1 to include the need for an operator valve watch when venting the pressurizer steam space. Should procedure NC-6 note a similar requirement for its operations?
3. Will this valve watch be required when degassing the pressurizer prior to a primary system opening?

The above items have been discussed with Ed English.



E. Professionalism, Summary of Shift, Comments

1. Shift operations were conducted in a professional manner.
2. The efforts of the Chemistry Section to observe this FSAR commitment in an area outside Chemistry's normal technical concern is commendable.

Completed By: Richard Coulthard
MOS ObserverDate: 07/20/88Reviewed By: [Signature]
Operations Superintendent- NuclearDate: 7/20/88Management
Review By:[Signature] 1 7/21/88 [Signature] 1 7/21/88
PM-N Date SVP Date VP Date

07/20/88



Operations Superintendent - Nuclear

Date: 07/20-21/88

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

A. Plant Evolutions Observed

° Both units at 100% steady state operations

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

None

E. Professionalism, Summary of Shift, Comments

Just the way it should be - smooth and quiet.

Completed By: P. L. Walker
MOS Observer

Date: 07/20-21/88

Reviewed By: *[Signature]*
Operations Superintendent - Nuclear

Date: 7/21/88

Management
Review By:*[Signature]* 17/21/88
PM-N Date SVP Date*[Signature]* 7/21/88
VP Date

07/20-21/88

Operations Superintendent - Nuclear

Date: 07/20-21/88

From: J. M. Donis
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- Units 3 and 4 at 100% power
- Emergency Diesel Generator (EDG) Operability Test OSP 023.1
- Control Room D. C. Lighting Test
- Plant tour - Intake Cooling Water (ICW) area

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

None

E. Professionalism, Summary of Shift, Comments

No comment

Completed By: J. M. Donis
MOS Observer

Date: 07/20-21/88

Reviewed By: *[Signature]*
Operations Superintendent - Nuclear

Date: 7/21/88

Management
Review By:*[Signature]*
PM-N1 7/21/88
Date

SVP

Date

[Signature]
VP1 7/21/88
Date

07/20-21/88



MANAGEMENT ON SHIFT (MOS)

WEEKLY SUMARY REPORT

WEEK STARTING: 09/23/88

PAGE 1 OF 2

Six MOS Observers were on shift: John J. Zudans, Senior Engineer, Nuclear Energy, Juno Beach (09/23-25/88, days); John W. Patterson, Westinghouse Electric Corporation (09/23-26/88, nights); Russ Gouldy, Principal Engineer, Nuclear Licensing, Juno Beach (09/26-30/88, days); Gregg M. Smith, Westinghouse Electric Corporation (09/26-30/88, nights); Paul M. Banaszak, Electrical Engineer, Turkey Point Nuclear Plant (09/23-27/88, nights); and R. John Gianfrancesco, Assistance Maintenance Superintendent, Turkey Point Nuclear Plant (09/27-30/88, nights).

Unit 3 operated in Mode 1 for the duration of the reporting period.

Unit 4 is shutdown for a refueling outage.

No immediate safety problems were noted by any observer.

The independent observers did not note any questionable work practices. They did note five areas for improvement, as follows:

- One item on improving a procedure
- One item on communication
- One item on control of vehicles
- One item on hardware maintenance
- One item on hardware storage

The Turkey Point observers did not note any questionable work practices. They did note seven areas for improvement, as follows:

- Two items on procedure improvement
- Three items on industrial safety
- One item on hardware protection
- One concern on a technician's attitude

ATTACHMENT: MOS DAILY REPORTS

8810250128

MANAGEMENT ON SHIFT (MOS)

WEEKLY SUMARY REPORT

WEEK STARTING: 09/23/88

PAGE 2 OF 2

The Plant Supervisors - Nuclear (PSNs) reported five questionable work practices. Three of these involved inadequate preparation for work (insufficient engineering research, inadequate staging of parts), one was in regard to an inaccurate operating diagram, and one concerned an apparent valve manipulation without the prior knowledge of the control room. It was subsequently determined that there were no unapproved valve manipulations and that the no flow condition actually resulted from plugged sample lines. This last item included three specific recommendations. The PSNs also noted five areas for improvement, as follows:

- One item on procedure improvement
- Two items on problems with the Plant Clearance Order Network
- One item on communication
- One item on updating the emergency response directory

ATTACHMENT: MOS DAILY REPORTS

Shift Report

Date 09/23/88

Shift Ed Zyras
Mids

Shift Management

Wogan

APSN

Haley

NWE Matuszewski

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

None

C. Good Practices/Professionalism Observed

Routine operations

Date 9/24/88



To: Operations Superintendent - Nuclear

Date: 09/23/88

From: John J. Zudans
(MOS Observer)Shift: ☒ Day
☐ Night**A. Plant Evolutions Observed**

- Morning meeting
- Unit 3, 100% power, Unit 4, shutdown
- Toured Radiation Control Area (RCA)
- Observed "B" Emergency Diesel Generator (EDG) test
- Shift turnover

B. Immediate Safety Problems

None noted

C. Questionable Work Practices

None noted

D. Areas for Improvements

1. Upon further review of item 1 (9/22/88), it was determined that the loose oilers may have gotten that way due to the method used in filling them. The majority of the oilers found loose on 9/22/88 were of the "tube" type as shown in the 9/16/88 "To the Point" flyer. In the past these oilers have been refilled by removing the bottle as well as the outer sleeve, rather than unscrewing the bottle from the outer sleeve. The 9/16/88 "To the Point" flyer was provided to plant staff in order to improve worker understanding of these components. The document provides excellent guidance, however does not appear to have been read by all personnel affected. It is recommended that this information be provided to all appropriate personnel as soon as possible. (MOS item 88-2520.)
2. After further review of item (9/22/88 report), it is clear that the Intake Cooling Water (ICW) pump lubewater flow issue has been extensively reviewed by plant, engineering and pump vendor. Based on this, vendor recommendations and current plant activities, this item is withdrawn. (MOS item 88-2522 is closed.)

OILER MAINTENANCE ASSURES PUMP RELIABILITY

The importance of maintaining oil levels in pumps via oilers is underscored by the recent spent fuel pool cooling pump failure and spill. Oilers supply makeup oil for the lubrication of pump bearings.

Oiler position is set to ensure oil level in the bearing housing is at design level. As long as oil is visible in the glass supply bottle, no oil need be added.

Maintenance and operations personnel responsible for surveilling and maintaining oiler levels must recognize the different types of oilers and correct methods for adding oil.

There are two types of oilers in use at Turkey Point: tube and cross-bar. While the principles by which both types operate is essentially the same, there is a

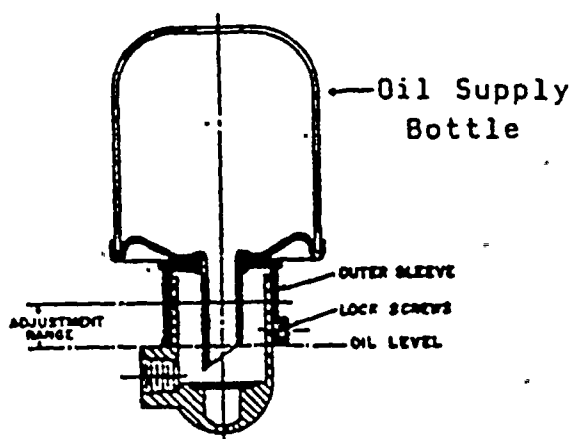
crucial difference in how oil is added.

When oil is added to cross-bar oilers, the upper portion of the oiler assembly is removed along with the supply bottle. This is accomplished by loosening a thumb screw on the side of the assembly and lifting it from the oiler.

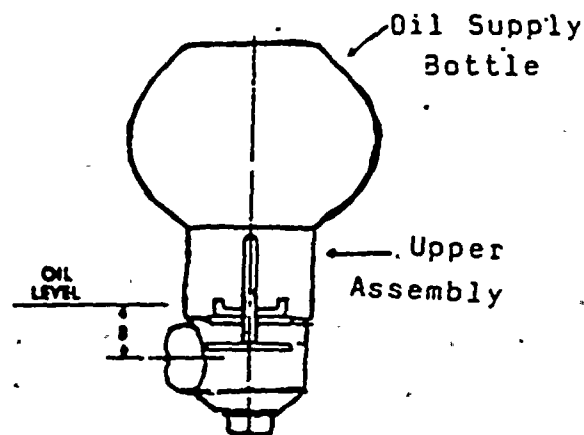
On tube oilers, only the supply bottle is unscrewed from the oiler assembly. There is no need to lift the upper portion of the assembly. In fact, doing so will cause inadvertent change of the oil setpoint.

"Oilers are designed to make oil supply simple, but proper maintenance of the oiler is essential to the operation of the pump", said Mechanical Maintenance Production Supervisor Jack Kenney. "It's important that personnel distinguish and remember these differences."

*maintenance



Tube Oiler: Oil supply bottle unscrews from assembly.



Cross-bar Oiler: Remove bottle and upper assembly together.



B. Professionalism, Summary of Shift, Comments

All aspects of plant operations were conducted in a professional manner.

Completed By: John J. Zudans
MOS Observer

Date: 09/23/88

Reviewed By: *[Signature]*
Operations Superintendent - Nuclear

Date: 9/24/88

Management
Review By:

[Signature] 19/26/88 *[Signature]* 19/26/88
PM-N Date SVP Date VP Date

09/23/88



To: Operations Superintendent - Nuclear

Date: 09/23-24/88

From: John Patterson
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- Unit 3, 100% power, Unit 4, shutdown
- "B" Emergency Diesel Generator (EDG) surveillance test
- Shift turnover
- Shift briefing

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

None

E. Professionalism, Summary of Shift, Comments

The Operations crew was very confident and collected when performing testing on the "B" Emergency Diesel Generator. Though only a few hours from a Technical Specification action statement, the crew performed with precision.

Completed By: John Patterson
MOS Observer

Date: 09/23-24/88

Reviewed By: *[Signature]*
Operations Superintendent - Nuclear

Date: 9/26/88

Management
Review By:*RC* 19/26/88 *RC* 19/26/88
PM-N Date: SVP Date: VP Date: 09/23-24/88

(10)



To: Operations Superintendent - Nuclear

Date: 09/23-24/88

From: Paul M. Banaszak
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- Shift turnover meeting, peaks to mids
- Unit 3, 100% power, Unit 4, cold shutdown
- Observed
 - "B" Emergency Diesel Generator (EDG) load test
 - Rigging and removing of Unit 4 Low Pressure Turbine cover
- Plant tour

B. Immediate Safety Problems

None noted

C. Questionable Work Practices

None noted

D. Areas for Improvement

1. A number of valves, motors, etc., which have been determined for maintenance activities have motor leads covered with plastic bags to keep them dry. The plastic bags appear too thin (waste basket bags). This was discussed with Electrical Maintenance and they agree. Bags with more substance will be used.
2. Hearing protection signs on Unit 4 have been covered over. A sign by main transformer at stairs to turbine deck was not. This may not be a problem because of the proximity to the main transformer.

E. Professionalism, Summary of Shift, Comments

All aspects of plant operation, maintenance interface activities were conducted in a cooperative manner.

Low Pressure turbine shroud removal effort was evidenced by good teamwork and professional spirit.


Completed By:

Paul Banaszak

MOS Observer

Date: 09/23-24/88

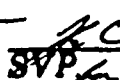
Reviewed By:



Operations Superintendent - Nuclear

Date:

9/24/88

Management
Review By:
PM-N19/24/88
Date
SVP19/24/88
Date

VP

Date
09/23-24/88

Date 09/24/88

Shift Report

Shift Nide

Shift Management

SN Wogan AP'SN Haley NWE

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

Plant status has been miscommunicated on the start of several jobs. If a job requires a specific plant condition e.g., Reactor Coolant System (RCS) pressure, temperature, level, the supervisor of the job should verify that condition with the "Control Room" only.

C. Good Practices/Professionalism Observed

Routine operations

Reviewed By L.W. Pinner

Date 9/26/88



Date 09/24/88

Shift Report

Shift Days

Shift Management

Wogan

APSN

Vetromile

NWE

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

None

C. Good Practices/Professionalism Observed

Routine operations

Shift Report

Date 09/24/88

Shift _____ Peaks _____

Shift Management

IN Reese APSN Vetromille NWE Newton

A. Questionable Work Practices/Actions Taken/Recommendations

#3 Reactor Control Operator had indication of a loss of Intake Cooling Water (ICW) when boiler header pressure indicators went to zero and ICW low pressure alarm annunciated. It turned out to be Bechtel pipe fitters removing multi tubing that Power Plant Engineering designated as being abandoned. This also effected intake screen Delta P indications in the control room. A total of six indicators were lost. Recommendation: JPE and PPE engineers may need to spend more time in the field on the systems they are engineering. Also, interfacing with Turbine Point System Engineers could be of help.

B. Areas for Improvement/Recommendations/Actions Taken

None

C. Good Practices/Professionalism Observed

Power reduction for turbine valve test and the valve test went smooth.

Reviewed By X.W. P. 11

Date 9/26/88



To: Operations Superintendent - Nuclear

Date: 09/24/88

From: John J. Zudans
(MOS Observer)Shift: ☒ Day
☐ Night

A. Plant Evolutions Observed

- Toured Auxilliary Feedwater back up nitrogen stations and Main Steam Isolation Valve (MSIV) back up nitrogen
- Morning shift meeting
- Observed local leak rate test on Unit 4 purge valves
- Observed Unit 3 containment entry

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

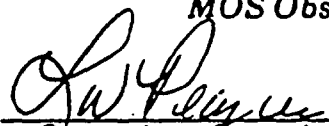
None

E. Professionalism, Summary of Shift, Comments



1. Plant operations, Security and Fire Team responded well to fire alarm in Radiation Control Area access building.
2. During Unit 3 containment entry, personnel experienced problems closing inner door when exiting the containment. As a result of excellent pre-planning, a hand tool was brought along which was used to correct the problem and avoid use of the emergency escape hatch. These personnel should be commended for their efforts.

Completed By: John J. Zudans
MOS Observer

Date: 09/24/88

Reviewed By: 
Operations Superintendent - Nuclear

Date: 9/26/88

Management
Review By: PM-N 19/24/88 Date  BVP 19/26/88 Date VP 1 Date

09/24/88

To: Operations Superintendent - Nuclear

Date: 09/24-25/88

From: John Patterson
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- Unit 4, shutdown, Unit 3 reduced to 40%
- Shift turnover
- Shift briefing
- Power reduction 3-GOP-103 "Power Operation to Hot Standby"
- "Main Turbine Valves Operability Test" 3-OSP-089

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

One fork lift and one heavy truck were left running in the Unit 4 Turbine Building lay down area with no one in immediate attendance. The Assistant Plant Supervisor Nuclear (APSN) took action to prevent recurrence. It may be appropriate to review the protected area vehicle rules with outage personnel.

E. Professionalism, Summary of Shift, Comments

The control room team responded in a very competent, confident manner when indication was lost on Intake Cooling water (ICW) header pressure. An investigation by the Plant Supervisor Nuclear (PSN) revealed the cause. Quick corrective action was taken to station a pressure gauge watch to monitor the lost parameters.

Completed By: John Patterson
MOS Observer

Date: 09/24-25/88

Reviewed By: *[Signature]*
Operations Superintendent - Nuclear

Date: 9/26/88

Management
Review By:*[Signature]*
PM.N19/26/88
Date*[Signature]*
SVP19/26/88
Date

VP

1
Date



To: Operations Superintendent - Nuclear

Date: 09/24-25/88

From: Paul Banaszak
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- Unit 3 100% power down to 40% up to 56%, Unit 4, cold shutdown
- Shift turnover, peak to mids
- Plant secondary tour
- Plant procedure, 3-OSP-89, Main Turbine Valves operability test

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

1. While working PC/M 88-330, Construction cut into a multitube bundle which Engineering had identified as abandoned. Intake Cooling Water (ICW) header pressure indication on Unit 3 was resultantly lost. A more thorough inspection of the area before issuance of the PC/M may have prevented this miscommunication. PC/M's 88-247 and 88-259 (screen wash differential pressure transmitter/tubing replacement) need to be revised to take this additional tubing into account. The I&C lead engineer has been notified of this.
2. Hearing protection signs in the Unit 3 Gland Steam Condenser Drain pump area and Condensate pump pit disagree with signs posted at access points to turbine building at the 18' elevation: (6 and 3 hour requirements versus a no time limit signing of entry points).

E. Professionalism, Summary of Shift, Comments

Operations and Maintenance personnel showed excellent cooperation in the execution of turbine valve testing.

Completed By: Paul Banaszak
MOS Observer

Date: 09/24-25/88

Reviewed By: [Signature]
Operations Superintendent - Nuclear

Date: 9/26/88

Management
Review By:

[Signature] 19/24/88 [Signature] 19/26/88
PM-N Date SVP Date VP Date



Shift Report

Date 09/25/88

Shift Mids

Shift Management

Wogan

APSN

Haley

NWE Spence

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 9/26/88

Date 09/25/88

Shift Report

Shift Peaks

Shift Management

Reese

APSN

Hollinger

NWE Newton

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

9/26/88

To: Operations Superintendent - Nuclear

Date: 09/25/88

From: John J. Zudans
(MOS Observer)Shift: ☒ Day
☐ Night

A. Plant Evolutions Observed

- Morning meeting
- Toured Intake Cooling Water (ICW) area
- Toured primary containment and remaining Radiation Control Area (RCA)

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

None

E. Professionalism, Summary of Shift, Comments

During reactor draindown, operators identified a discrepancy between level indication in control room and backup indication in the containment. The draindown was terminated, followed by determination of the problem. All measures taken were orderly and well thought out which led to a successful resolution of the problem.

Completed By: John J. Zudans
MOS Observer

Date: 09/25/88

Reviewed By: [Signature]
Operations Superintendent - Nuclear

Date: 9/25/88

Management
Review By:

[Signature] 19/25/88 [Signature] 19/25/88
PM-N Date SVP Date VP Date

09/25/88

To: Operations Superintendent - Nuclear

Date: 09/25-26/88

From: John Patterson
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant Evolutions

- Unit 3, 100% power, Unit 4, shutdown
- Shift turnover
- Shift briefing
- Reactor Vessel drain down to mid loop

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

The traveling screen housings for Circulating Water and Intake Cooling Water are well preserved, however, the drive gears and chain on 4B2 have no lubricant on them. The lack of lubricant may lead to rusting and premature failure of the gear teeth and chains.

E. Professionalism, Summary of Shift, Comments

A notice of Significant Event was made to the NRC because steam generator blowdown was isolated to radiation monitor R-19. The crew took the prescribed Technical Specification actions.

Completed By: John Patterson
MOS Observer

Date: 09/25-26/88

Reviewed By: *[Signature]*
Operations Superintendent - Nuclear

Date: 9/26/88

Management
Review By:*[Signature]*
P.M.N.19/26/88
Date*[Signature]*
SVP19/26/88
Date

VP

1
Date



To: Operations Superintendent - Nuclear

Date: 09/25-26/88

From: Paul Banaszak
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- Shift turnover, peak to mids
- Unit 3, 100% power, Unit 4, cold shutdown
- Plant tour

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

As a result of installing temporary tubing to reactivate a screenwash Differential Pressure (DP) indication and Intake Cooling Water (ICW) header pressure indication, a Temporary System Alteration (TSA) was initiated per procedure 0-ADM-503. The following observations are provided concerning this procedure:

1. Per the definitions given in the procedure, the safety classification is incorrect. (It should be non-nuclear safety). However, in discussing with the Watch Engineer (W/E) and Shift Technical Advisor (STA) their opinion is that it should be safety related.
2. STA review checklist does not require independent verification. This could be a concern because checklist answers could allow implementation before final review is complete.
3. Item 3.5.3 requests power plant engineering (JPN) review but no references for why review is required. Flow chart on enclosure 3 does not reference any JPN interface.
4. STA review checklist only requires a 10CFR 50.59 evaluation if certain responses are yes. JPN procedures require a 50.59 evaluation for any modification before implementation.
5. The log in the controlled drawing book (attachment 6) does not provide for pagination. (Present in use forms have blank spaces on page 1 which would lead one to not look for page 2 which does exist on Unit 3. This could lead to overlooking information.)



B. Professionalism, Summary of Shift, Comments

Excellent operations attention to detail (refer to non-PTN MOS report for unusual event concerning R-19 isolation on Unit 3.)

Completed By: Paul Banaszak
MOS Observer

Date: 09/25-26/88

Reviewed By: *[Signature]*
Operations Superintendent - Nuclear

Date: 9/26/88

Management
Review By:

gpc 19/24/88 gpc 19/26/88
PM-N Date SVP Date VP Date

09/25-26/88



Date 09/26/88

Shift Report

Shift

Ed Lyons

Mide

Shift Management

Jones

A'PSN

Haley

NWE

A. Questionable Work Practices/Actions Taken/Recommendations

We need to find out how manual valves 530, 531, 532 and 534 were closed without control room's knowledge.

Nuclear Chemistry found sample flow to PRM R-19 isolated with manual valves 530, 531, 532 and 534 closed. Therefore R-19 could not react to hi activity, and close flow control valves CV 6278 A, B, C and blowdown to canal CV 6275. This was reported to the NRC as a Significant Event.

Recommend:

1. Nuclear Chemistry re-initiate shiftly check of these flows. (At one time in the past this was done).
2. We have a low flow alarm installed in this system which would alarm in control room.
3. N.O. logs be changed to require flow indication readings.

B. Areas for Improvement/Recommendations/Actions Taken

None

C. Good Practices/Professionalism Observed

Routine operations

(1)



Shift Report

Date 09/26/88

Shift _____ Days _____

Shift Management

SN Wogan APSN Vetromille NWE Newton

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

Emergency response directory contains numerous hand written telephone numbers in section 1. Some personnel listed in section 1 no longer hold their designated positions. Attempts to contact someone in emergency planning for upgrade of the directory were unsuccessful. Recommend update of directory once per month.

C. Good Practices/Professionalism Observed

Routine operations

Date 09/26/88

Shift Report

Shift _____ Peaks _____

PSN

Anderson

APSN

Dallau

NWE Eddinger

Shift Management

A. Questionable Work Practices/Actions Taken/Recommendations

Another work package has come out with unqualified gauges on the equipment. Tonight the Spent Fuel Pool (SFP) pumps were being turned over with a requirement of hanging a clearance on the gauges to shut their isolation valves due to them not being seismic qualified. As long as this problem has existed in this plant, I think we would have found a source of obtaining qualified gauges. I think prior to implementing any more work packages that require qualified gauges we need to find gauges that are qualified.

We are also tied in putting the 4B SFP pump in service due to the clearance being tied with the 4A SFP pump. The 4A SFP pump has not been turned over to Start-up due to a Plan of the Day change that should have been ready to go prior to actual work being done. Also, I just found that the grouting work on the emergency pump has been tied with the seismic work on the 4A pump which will hold that package from being cleared up. One other thing is the motor heaters are in the package and wiring is installed but other parts needed to complete the circuitry are not available.

It seems to me that if the packages are not planned better with parts available, we would be better off with the old systems.

B. Areas for Improvement/Recommendations/Actions Taken

C. Good Practices/Professionalism Observed

③



To: Operations Superintendent - Nuclear

Date: 09/26/88

From: Russell Gouldy
(MOS Observer)Shift: ☒ Day
☐ Night

A. Plant Evolutions Observed

- Unit 3, 100% power, 181 continuous days on-line
- Unit 4, cold shutdown refueling, Reactor Coolant System (RCS) temperature 115° F mid-nozzle operations

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

None

E. Professionalism, Summary of Shift, Comments

Asked both day and mid shift Unit 4 operators to review plant status and provide mid-nozzle operations review. Operators were aware of heat loads and Residual Heat Removal (RHR) flow related problems. A dedicated Reactor Coolant System (RCS) level watch was in place to detect RCS perturbations. It is my observation that these shifts were briefed and followed mid-nozzle operation precautions.

Completed By: Russell Gouldy
MOS Observer

Date: 09/26/88

Reviewed By: L. L. Plante
Operations Superintendent - Nuclear

Date: 9/27/88

Management
Review By:

J.C. 19/27/88 J.M. 19/27/88 J.B. 19/27/88
PM-N Date SVP Date VP Date

To: Operations Superintendent - Nuclear

Date: 09/26-27/88

From: Gregg M. Smith
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- 0-OSP-023.1, Diesel Generator operability test
- Beginning of shift (nights) meeting
- Disassembly of low pressure turbines (Unit 4)
- Backfeeding through main transformer to auxiliary transformer

B. Immediate Safety Problems

None observed

C. Questionable Work Practices

None

D. Areas for Improvement

None

E. Professionalism, Summary of Shift, Comments

No unprofessional behavior was observed.

When Unit 4 Reactor Control Operator (RCO) (peak shift) learned that new personnel who had never stood a reactor vessel level watch before would be used for the watch, he did a very good job of ensuring that the watchstanders were briefed on the watch and its importance, report to control room regarding level change requirements, containment evacuation routes, etc. prior to them taking the watch.

(5)

Completed By: Gregg M. Smith
MOS Observer

Date: 09/26-27/88

Reviewed By: *[Signature]*
Operations Superintendent - Nuclear

Date: 9/27/88

Management
Review By:

[Signature] 19/27/88 *[Signature]* 19/27/88 *[Signature]* 19/27/88
M.M.N. Date SVP II Date VP Date



To: Operations Superintendent - Nuclear

Date: 09/26-27/88

From: Paul Banaszak
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- Unit 3, 100% power, Unit 4, cold shutdown
- Shift turnover, peaks to mids
- Plant tour
- Procedure TP 475 Backfeed of 4KV Bus thru auxiliary transformer
- Procedure O-OSP-023.1, operability tests of Emergency Diesel Generators (EDG)

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvements

While touring the auxiliary building it was noticed that local alarm for laundry tanks A and B were in and level was exceeding 90%. The Nuclear Operator was elsewhere. When I asked the Health Physics Technician about the alarm, the person had an indifferent attitude concerning the alarm. This MOS observer called the control room and the Nuclear Operator responded. We need to act as a team, everyone on the same team.

E. Professionalism, Summary of Shift, Comments

Routine operations

⑥

Completed By: Paul Banaszak
MOS Observer

Date: 09/26-27/88

Reviewed By: *[Signature]*
Operations Superintendent - Nuclear

Date: 9/27/88

Management
Review By:

<i>[Signature]</i>	1 9/27/88	<i>[Signature]</i>	1 9/27/88
BLM	Date	SVB	Date



4

Date 09/27/88

Shift Report

Shift

Ed Lyons
Days

Shift Management

PSN

Wogan

APSN

Vetromile

NWE

Newton

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions taken

None

C. Good Practices/Professionalism Observed

Routine operations

①

2 P.M.

1 - 1012



To: Operations Superintendent - Nuclear

Date: 09/27/88

From: Russell Gouldy
(MOS Observer)Shift: ☒ Day
☐ Night**A. Plant Evolutions Observed**

- Unit 3, 100% reactor power operation
- Unit 4, cold shutdown, Reactor Coolant System (RCS) at 105° F 2½ feet below vessel flange

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

None



E. Professionalism, Summary of Shift, Comments

1. Dan Janis, PTN electrician, noticed grease on the room wall where the Reactor Control Rod drive Motor Generator (M/G) sets are located. He traced this grease to the 3B M/G set, he contacted the Nuclear Watch Engineer (NWE), Andy Newton. The NWE quickly formed a team to analyze the problem. M/G set vibrations were taken and compared to last weeks data. Vibration was good. There was an apparent over-packing of grease which released itself. Watches were set to monitor this M/G set.
 - a. Electrician Janis showed alertness and attention to plant status while touring thru the plant to notice this problem and take corrective action.
 - b. NWE Newton realized the importance of this M/G set problem to unit operation and provided good leadership in forming a team to quickly address the problem.
2. Plant Manager, Jim Cross, at the morning meeting noticed that the Operations Department had issued a code of professionalism, but asked if results were being monitored.

While on plant tour with the Site Vice President, they noticed an unprofessional act during shift turnover at the water treatment plant.

Shift supervision, the PSN and APSN, contacted the union steward and then counseled the individuals involved. The PSN set a meeting with plant management for the next morning.

Shift supervision briefed the crew that "horseplay will not be tolerated no matter how good and hard working the individuals may be."

(4)

Completed By: Russell Gouldy
MOS Observer

Date: 09/27/88

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

Date: 9/28/88

Management
Review By:

RC 19/28/88 VP 9/28/88
PM-N Date SVP Date VP Date

09/27/88



To: Operations Superintendent - Nuclear

Date: 09/27-28/88

From: Gregg M. Smith
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- Unit 3, full power operations
- Fill Unit 4 Reactor vessel to flange level
- Nuclear Instrumentation System (NIS) daily surveillance test

B. Immediate Safety Problems

None observed

C. Questionable Work Practices

None observed

D. Areas for Improvement

None at this time

E. Professionalism, Summary of Shift, Comments

No unprofessional behavior observed.

(5)

Completed By: Gregg M. Smith
MOS Observer

Date: 09/27-28/88

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

Date: 9/28/88

Management
Review By:MC 10/1/88 VP 9/29/88
M.M.N. Date Date VP Date

To: Operations Superintendent - Nuclear

Date: 09/27-28/88

From: John Gianfrancesco
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- Unit 3, 100% power
- Unit 4, 0% power, Mode 5 vessel level approximately 5" above flange level
- Control Rod Drive Mechanism (CRDM) ventilation duct removed
- Observed control room shift turnover and shift briefing
- Toured work areas at intake structure, turbine building, auxiliary building and containment

B. Immediate Safety Problems

None observed

C. Questionable Work Practices

None observed

D. Areas for Improvement

None observed

E. Professionalism, Summary of Shift, Comments

While observing activities on the refueling floor in containment, I noticed that there is no personnel safety barrier along the south side of the reactor cavity. This is a fairly narrow passageway and is frequented by personnel accessing the north side of the refueling floor. In addition, individuals climbing the ladder from the reactor vessel flange area have nothing to grab onto at the top of the ladder and had to climb over breathing air lines at the top of the ladder. The FP&L safety coordinator should inspect this condition and construct some type of safety rail to prevent personnel injury.

Completed By: John Gianfrancesco
MOS Observer

Date: 09/27-28/88

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

Date: 9/28/88

Management
Review By:

KC	19/28/88	VP	19/28/88	1
DMN	Date	VP	Date	Date

Shift Report

Date 09/28/88

Shift Ed Lyons
Mids

Shift Management

PSN Reese APSN Dallau/Vetromile NWE Spence

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions taken

None

C. Good Practices/Professionalism Observed

Routine operations

①

at 11

Date 09/28/88

Shift Report

Shift Mids

Shift Management

Reese

APSN

Dallau/Newton

NW Spence

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions taken

None

C. Good Practices/Professionalism Observed

Routine operations

(2)

2/11/89

2/11/89



Date 09/28/88

Shift Report

Shift _____ Days _____

Shift Management

Salkeld

APSN

Vetromlle

NWE

Newton

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions taken

None

C. Good Practices/Professionalism Observed

Routine operations and outage work

(2)

10.10

10.10



Date 09/28/88

Shift Report

Shift _____ Peaks _____

Shift Management

Anderson APSN

Dallau

NWE Eddinger

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions taken

During all our preparations for refueling, we have raised and lowered reactor vessel level. I time we are forced to use our fill or vent procedure (4-OP-041.8) to raise level and the down procedure (4-OP-041.7) for lowering level. These procedures have a lot of steps prerequisites that have no application for these small level changes and have to be NA'ed. Some of the unnecessary steps are commitment stops (such as testing OMS prior to filling) and should not be NA'ed. We need a procedure that we can use for minor level changes during times when we need small changes in vessel level.

C. Good Practices/Professionalism Observed

We have been very well informed by the people working the outage on the outage program what is being worked, and what is expected from Operations on a shift by shift basis. Operations Coordinator, G. Murphy, has been especially informative and a very good work practice he is using is; the outline of work being done and expected to be done, he writes in the Order Book. This is an excellent reference to be used as a quick reminder of where we are and where we should be headed in the short term.

To: Operations Superintendent - Nuclear

Date: 09/28/88

From: Russell Gouldy
(MOS Observer)Shift: ☒ Day
☐ Night

A. Plant Evolutions Observed

- Unit 3, 100% reactor power operation
- Unit 4, refueling shutdown
 - Disassembly of low pressure turbines
 - Removal of Steam Generator safety valves
 - Containment walkdown
 - Auxiliary building walkdown

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

New computer software, CRTs and terminals are being installed on the ERDADS. The DDPS computer has been removed from service. The NRC was notified by letter that the system would be out-of-service for up to six weeks. However, no "game plan" or action plan was provided to the STA, Operators or SROs on what to do. They will just follow the routine DDPS out-of-service remarks in the post trip review procedure.

E. Professionalism, Summary of Shift, Comments

No comment

(4)

Completed By: Russell Gouldy
MOS Observer

Date: 09/28/88

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

Date: 9/29/88

Management
Review By:

MC 9/29/88 JP 9/29/88 VP 9/29/88
PM-N Date SVP Date VP Date

09/28/88

To: Operations Superintendent - Nuclear

Date: 09/28-29/88

From: Gregg M. Smith
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- 4-OSP-034.1 Source Range (SR) operability check
- Tour of the following:
 - Auxiliary building
 - Unit 4 containment
 - Units 3 and 4 secondary plant
- Disassembly of Unit 4 turbine
- Shift - peaks to nights and pre-shift briefing (nights)

B. Immediate Safety Problems

None observed

C. Questionable Work Practices

None observed

D. Areas for Improvement

None

(5)

E. Professionalism, Summary of Shift, Comments

No unprofessional behavior was observed.

Procedure 4-OP-041.7 "Draining the Reactor Coolant System (RCS)" step 22 has the reactor head and pressurizer vent valves shut if the RCS is to be degassed prior to removing the spool piece and installing the eductor unit. The eductor is then placed in service and the system is degassed. After the degassing is completed, the procedure directs maintenance to remove the eductor but makes no further mention of the reactor head and pressurizer vent and therefore those valves remained shut rather than returning them to the lineup required for draining the RCS. It appears by having those valves shut caused some error in the reading on the tygon vessel level indication (at times there was as much as 15" difference between this and the control room indication). At no time does it appear that level was actually at a point to cause problems with Residual Heat Removal (RHR) pump operation. The operating crew felt the procedure should have had the valves re-opened to provide a vent path. I recommend that the procedure be reviewed and modified as necessary to ensure those valves are in their proper position to minimize adverse effects on vessel level indication.

(6)

Completed By:

Gregg M. Smith
MOS ObserverDate: 09/28-29/88

Reviewed By:

L.W. Fauce
Operations Superintendent- NuclearDate: 9/29/88Management
Review By:PM-N 10/29/88 SVP 9/29/88 VP 9/29/88
Date Date Date Date
09/28-29/88

To: Operations Superintendent - Nuclear

Date: 09/28-29/88

From: John Gianfrancesco
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- Unit 3, 100% power
- Unit 4, 0% power, Mode 5 prerequisite complete. for vessel head detensioning and transfer to Mode 6
- Stud tensioning pump has been placed at vessel flange level, stud tensioners are not yet lowered down
- Observed control room shift turnover and shift briefing
- Toured work areas at intake structure, turbine building, auxiliary building
- Made two tours of containment work activities at beginning and toward end of shift

B. Immediate Safety Problems

None observed

C. Questionable Work Practices

None observed

D. Areas for Improvement

None observed

(7)



E.

Professionalism, Summary of Shift, Comments

As part of the prerequisites for vessel head detensioning procedure 4-OP-038.1 step 5.1.2.4 requires that the reactor cavity drain valves 4-12-001 and 4-12-002, and refuel cavity valves to the Reactor Coolant Drain Tank (RCDT) 4-4651 and 4-4651B be tagged closed. These valves are located in high radiation areas in containment. During previous outages a general Radiation Work Permit (RWP) had been established for operator access to manipulate valves in high radiation areas in containment and the PSN assumed this was the case for this outage. When an operator was sent to tag these valves, Health Physics informed him that following the previous refueling outage a commitment had been made to the NRC that general RWPs would not be used for entry to high radiation areas. As a result an HP-3 had to be submitted, a survey performed and a specific RWP prepared. Health Physics was responsive to the PSN in expediting this effort. The PSN questioned why this commitment had not been communicated to operations so that this activity could have been coordinated earlier.

(4)

Completed By:

John Gianfrancesco

MOS Observer

Date: 09/28-29/88

Reviewed By:

R.W. Polue

Operations Superintendent - Nuclear

Date: 9/29/88

Management
Review By:*JSC*
PM-N10/20/88
Date

SVP

MD
10/24/88
Date*VP*10/29/88
Date
09/28-29/88

Date 09/29/88

Shift Report

Shift Ed Lyons
Mids

Shift Management

Reese

APSN

Dallau/Guyer

Spence
NWE

A. Questionable Work Practices/Actions Taken/Recommendations

Instrument air was lost to Unit 3 Train 1 Auxilliary Feedwater flow control valves. The unit was put in a 72 hour LCO and the nitrogen bottles in service were depressurized on Train 1. The instrument air was lost when a clearance was being hung on the Unit 4 instrument air system. The operating diagram showed no supply to Unit 3 Auxilliary Feedwater from the valves being isolated.

Action taken: Instrument air valve clearance was lifted and valves opened - nitrogen bottles changed out - valve lineups and independent verifications completed on nitrogen system. Train 1 returned to service.

Recommendation: All operating diagrams for instrument air (5610-T-E-4064) be hand verified in the field and new prints made.

B. Areas for Improvement/Recommendations/Actions Taken

None

C. Good Practices/Professionalism Observed

Routine operations

①

[Handwritten signature]

al. luv



Date 09/29/88

Shift Report

Shift Peaks

Shift Management

Anderson APSN

Dallau

NWE Eddinger

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions taken

We are running into a very confusing and time consuming problem with clearances on our PCON system. We are limited to eleven names per clearance. When we have a clearance with more than eleven names (which happens quite often during the outage), we have to write a complete new procedure including hanging tags. We end up with more than one procedure with exactly the same tags isolating the same piece of equipment for the same job. If we then require a partial release for something such as a motor bump for rotation we have to partial lift all these extra procedures. The time consumed as well as the confusion of duplicate tags is costing us, when during the outage we are overwhelmed with clearances as it is.

Another problem exists: whenever it is necessary to add a foreman to clearances because someone is temporarily relieving another foreman, we have to add him to all jobs being worked. Tonight, for instance, we have a request to add an Electrical Foreman to all the clearances that have been hung for the foreman he is replacing. This amounts to 64 clearances, plus the 64 control tags spread around the plant. We are very lucky that he is not the twelfth one to be put on all these clearances or we would be writing new clearances.

I recommend that even though the "Safe Work Practices" manual says that the clearance will be obtained by the employees "foreman" that we change it to read "supervisor". I recommend this be done immediately to do away with the two mentioned problems for the remainder of this outage.

The use of the employee's supervisors name on the clearance does not compromise the safety of the clearance in any way. All tags necessary to isolate the equipment will still be there. The employee to work on this equipment will still be able to verify by identifying these tags to assure it is safe to work on. The only difference is the name on the clearance and the control tag.

C. Good Practices/Professionalism Observed

Routine operations

(2)

2140 . . . *01/2/88*

To: Operations Superintendent - Nuclear

Date: 09/29/88

From: Russell Gouldy
(MOS Observer)Shift: ☒ Day
☐ Night**A. Plant Evolutions Observed**

- ° Unit 3, 100% reactor power operation
- ° Unit 4, refueling shutdown Mode 6
 - High pressure turbine lift and removal
 - Containment walkdown

B. Immediate Safety Problems

None

C. Questionable Work Practices

Walked down Unit 4 containment with NRC resident inspectors. Several areas of concern were identified and will be resolved. One item, however, requires a closer look. The Unit 4 Reactor Cavity seal ring strong back was found stored above the "A" Emergency Containment Cooler (ECC) next to the cooling fan motor, on the cooler frame. This device weighs several tons. It was not secured nor was there indication that this was the proper storage location.

1. Can the safety related ECC frame hold this mass during a seismic event?
2. Is Unit 3 lifting rig stored correctly?
3. Did QC containment close out inspection identify this concern?

Please provide response to residents on this item.

D. Areas for Improvement

None

(4)

E. Professionalism, Summary of Shift, Comments

A large number of outage items are occurring, including equipment clearances. I noticed on several occasions the operators on Unit 4 stopping work and resolving potential problems before they became problems. An example, Rick Adamson, RCO, stopped a clearance on isolating a valve that was different than was wanted to be worked. The clearance was rewritten for the correct valve.

I commend the Operations staff today for controlling the work rate that allows each job to get it's required attention.


Completed By:

Russell Gouldy

MOS Observer

Date: 09/29/88

Reviewed By:


Operations Superintendent - Nuclear

Date: 9/30/88

Management
Review By:

 19/30/88  19/30/88  19/30/88  19/30/88

PM-N Date BVP Date VP Date

09/29/88

6

To: Operations Superintendent - Nuclear

Date: 09/29-30/88

From: John Gianfrancesco
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- Unit 3, 100% power
- Unit 4, 0% power, Mode 6
- Observed Emergency Diesel surveillance
- Observed shift turnover and shift briefing
- Toured turbine building, auxiliary building, intake structure and containment
- #1 low pressure turbine rotor removed
- Alterrex housing removed
- Head detensioning held up due to tensioner study on stud (see comments)

B. Immediate Safety Problems

None observed

C. Questionable Work Practices

None observed

D. Areas for Improvement

None observed

E. Professionalism, Summary of Shift, Comments

No progress made in detensioning of vessel head due to a tensioner being stuck on a stud. Various methods were used to attempt to remove the tensioner without success. Mechanical Maintenance personnel familiar with the tensioning equipment assisted in this effort. Presently processing an OTSC to remove the stud and tensioner and disassemble the tensioner to dislodge it. Consideration is also being given to the possibility of detensioning the remainder of the head with this stud removed.

Completed By: John Gianfrancesco
MOS Observer

Date: 09/29-30/88

Reviewed By: *[Signature]*
Operations Superintendent - Nuclear

Date: 9/30/88

Management
Review By:

[Signature] 9/30/88 *[Signature]* 9/30/88 *[Signature]* 9/30/88
PM-N Date BVP Date VP Date

6

To: Operations Superintendent - Nuclear

Date: 09/29-30/88

From: Gregg M. Smith
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- OSP-023.1 Diesel Generator operability test (from control room and local at Diesel)
- 4-OSP-034.1 source Range operability check
- Removal of Unit 4 Low Pressure Turbine and main generator exciter housing
- Tour of the following areas
 - Unit 4 containment
 - Auxiliary building
 - Units 3 and 4 secondary plant

B. Immediate Safety Problems

None observed

C. Questionable Work Practices

None observed

D. Areas for Improvement

None

E. Professionalism, Summary of Shift, Comments

No unprofessional behavior was observed.

Completed By: Gregg M. Smith
MOS Observer

Date: 09/29-30/88

Reviewed By: *[Signature]*
Operations Superintendent - Nuclear

Date: 9/30/88

Management
Review By:

[Signature] 9/30/88 *[Signature]* 9/30/88 *[Signature]* 9/30/88
PM-N Date SVP for Date VP Date
09/29-30/88

(7)

Date 09/30/88

Shift Report

Shift Mid

Shift Management

Reese

APSN

Guyer

NWE

Spence

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

None

C. Good Practices/Professionalism Observed

Routine operations

3

D. D. D.

Date 9/30/88

MANAGEMENT ON SHIFT (MOS)

WEEKLY SUMARY REPORT

WEEK STARTING: 08/26/88

PAGE 1 OF 2

Six MOS Observers were on shift: Craig D. Bersak, Westinghouse Electric Corporation (08/29-31/88, days); Peter L. Walker, Westinghouse Electric Corporation (08/29-09/01/88, nights); Sidney G. Brain, Chairman, Independent Safety Evaluation Group, St. Lucie Nuclear Plant (08/26-29/88, days); Joseph P. Brannin, Senior Engineer, Nuclear Licensing, Juno Beach (08/26-29/88, nights); Daryle L. Osborn, Construction Superintendent, Turkey Point Nuclear Plant (08/28-09/01/88, nights); and Don Haase, Chairman, Safety Engineering Group, Turkey Point Nuclear Plant (08/26-28/88, nights).

Units 3 and 4 operated in Mode 1 for the duration of the reporting period.

No immediate safety problems were noted by any observer during the reporting period.

The independent observers did not note any questionable work practices. They did note twenty-four areas for improvement, as follows:

- Four items on attendance at shift briefings. Two of these were also noted by the Turkey Point observers.
- Nine items on plant material condition and housekeeping.
- Four items on procedures or other control room paperwork.
- Two items on inadequate communications.
- Four concerns on hardware problems.

The Turkey Point observers did not note any questionable work practices. They did note four areas for improvement, two of which were also noted by the independent observers (see above), and one of which echoed a comment by a Plant Supervisor-Nuclear (PSN). The remaining item was a repeat concern on the screenwash system not working in automatic.

MANAGEMENT ON SHIFT (MOS)

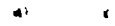
WEEKLY SUMARY REPORT

WEEK STARTING: 08/26/88

PAGE 2 OF 2

Two questionable work practices were noted by the PSNs. One concerned a system out of service longer than allowed by O-ADM-021. The other revolved around the addition of workload on the third reactor control operator. They also noted nine areas for improvement, as follows:

- Two concerns on procedures.
- Three items regarding inadequate communications.
- One concern on post-work housekeeping.
- A request for better graphs for component cooling water heat exchanger efficiency testing.
- A concern over modifications of priorities by work planners.
- A concern over adequate work controls on plant air conditioners.



To: Operations Superintendent - Nuclear

Date: 08/26/88

From: Sidney G. Brain
(MOS Observer)Shift: ☒ Day
☐ Night

A. Plant Evolutions Observed

- 0715 Plan of the Day meeting
- Portions of Accumulator 3C level indication maintenance per 3-PMI 62.8 and 3-PMI 62.7
- Unit 4 fire drill - Front Turbine Standard
- EP 20106 Natural Emergencies - Appendix B for Hurricane Watch
- Peak shift

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

1. Obtain longer coaxial cables so that oscilloscopes do not have to be placed on top of the Nuclear Instrumentation System racks for tests.
2. Secure the step ladder behind the Unit 3 racks, and the mobile I&C test instrument cart.
3. On two different occasions I observed seven different groups (total of 11 people) including MOS Observer, in the Control Room in addition to shift crews, working on or around the vertical panels or consoles. Suggest develop method of scheduling work on the Control Room instruments to limit the number of extra people in the Control Room.
4. While observing 3-PMI 62.7 and 62.8, an apprentice was observing and receiving instructions. However, he did not have a copy of the procedure to follow along. Recommend that apprentices receiving instructions/observing a procedure, be given a copy of the procedure to follow the procedure steps.
5. There seems to be a fair amount of dust in the Control Room. Investigate the appropriate frequency of cleaning Control Room air conditioning filters.
6. Increase frequency of cleaning Control Room equipment consistent with safe operation of the equipment.



11

12



E. Professionalism, Summary of Shift, Comments

1. Unit 3 day shift Reactor Control Operator (RCO) challenged personnel who came into the Control Room by the back door.
2. Unit 3 RCO posted sign as you enter the Control Room that reads "Ask RCO's permission before entering in front of vertical panel A or console." Recommend this sign be made permanent and the Plant Manager and Operations Superintendent endorse this position for all site and visiting personnel.
3. Good peak shift discussion of accountability. Went through the NRC actions at Philadelphia Electric.
4. Observed J. Labarraque in Control Room checking on housekeeping needs and how to best support the Control Room crews in the area of housekeeping, e.g., carpet cleaning, trash removal, general cleanup.

Completed By: Sidney G. Brain
MOS ObserverDate: 08/26/88Reviewed By: *L.W. Pearce*
Operations Superintendent - NuclearDate: 8/29/88Management
Review By:*PM-N* *18/28/88* *SVP* *18/29/88* *VP* *1* *Date*

08/26/88



To: Operations Superintendent - Nuclear

Date: 08/26-27/88

From: Joseph P. Brannin
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- Preparations for a hurricane
- B Emergency Diesel Generator (EDG) test
- Unit 3 Turbine Valve test
- Down-power to less than 40% power (Unit 3)
- Up-power operation (Unit 3)
- Evolution concerning dual indication of valve CV-4-200B
- Investigation and action concerning increase in Reactor Coolant Pump (RCP) motor vibration

B. Immediate Safety Problems

None observed

C. Questionable Work Practices

None observed

D. Areas for Improvement

Management's reasons for making decisions is not always being made clear in all situations. The initiation of the procedure to prepare for a hurricane when only a tropical depression was present caused a lot of questions to be raised.

E. Professionalism, Summary of Shift, Comments

All of the evolutions were performed in a very competent and professional manner.

Completed By: Joseph P. Brannin
MOS Observer

Date: 08/26-27/88

Reviewed By: *[Signature]*
Operations Superintendent - Nuclear

Date: 8/29/88

Management
Review By:

[Signature] 8/29/88 *[Signature]* 8/29/88
PM-N Date SVP Date VP Date

08/26-27/88



4



To: Operations Superintendent - Nuclear

Date: 08/26-27/88

From: D. W. Haase
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- Unit 3, load reduction to 40% for turbine valve test in accordance with 3-GOP-103, Power Operations to Hot Standby
- Unit 3, Control Room and field activities associated with 3-OSP-089, Turbine Valve Test
- Unit 3, return to 100% at 3% per hour in accordance with 3-GOP-301, Hot Standby to Power Operation
- Unit 4, steady state operation at 100% power
- Unit 4, activities associated with failure to get a closed indication on CV-4-200B, letdown orifice isolation valve
- Units 3 and 4, preparations for approaching storm per EP-101
- Units 3 and 4, toured the intake area

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

The screen wash system at the intake has been operated 24 hours a day since the 9th of August. There doesn't appear to be the needed activity directed towards getting the system working in automatic.

E. Professionalism, Summary of Shift, Comments

The turbine valve test was well coordinated and executed.

Response to the failure to get a closed indication on letdown valve CV-4-200B showed very good coordination among Operations, Maintenance (I&C), Chemistry and Health Physics.

Completed By: D. W. Haase
MOS Observer

Date: 08/26-27/88

Reviewed By: *K. W. Pearce*
Operations Superintendent - Nuclear

Date: 8/29/88

Management
Review By:

REC 18/29/88 *JP* 8/29/88
PM-N Date SVP Date VP Date

08/26-27/88

To: Operations Superintendent - Nuclear

Date: 08/27/88

From: Sidney G. Brain
(MOS Observer)Shift: ☒ Day
☐ Night

A. Plant Evolutions Observed

- Day shift meeting
- Peak shift meeting
- Routine operations
- Unit 3 continued power escalation towards 100% power
- Turbine Building tour

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

1. Mechanical and Electrical Maintenance not at day shift meeting.
2. Mechanical and I&C Maintenance not at peak shift meeting.
3. Weekend Control Room garbage pickup frequency should be the same as rest of week, at least once per shift. Trash cans were overflowing by 5:00 PM.
4. Housekeeping needs continuous attention. Tours today identified 14 obvious items of housekeeping. These were discussed with Nuclear Watch Engineer (NWE) who requested helper to take care of the specific items. It is obvious that the various work groups are not totally cleaning up their work area upon job completion.
5. The Turbine Operators station ITT terminal used for entering PWOs into Nuclear Job Planning System (NJPS) has been out-of-service for approximately one month despite requests for help. This is unacceptable and should be corrected immediately.



6. The following items need attention:

- a. The Unit 3 6B Feedwater Heater to the B Reheater Drain Tank vertical line that penetrates the turbine deck is almost off its pipe supports and is hard against the side of the penetration.
- b. The Turbine deck concrete is spalling near the Unit 3 6A feedwater heater and the caulking needs replacing.
- c. West of the Unit 3 priming jets there is serious concrete spalling next to the turbine gantry crane rail.
- d. The turbine shelter wheel channel drains are plugged at various locations along its length.
- e. The Unit 3 turbine foundation isolation joint caulking badly needs replacing.
- f. There are numerous open pipe penetrations in the turbine deck south end of 3B MSR where pipes have been removed.
- g. Unit 3 turbine insulation is lying on the floor inside front standard housing.
- h. All over the Unit 3 mezzanine are empty temporary cable slings left from construction or the last outage.
- i. West side of the Unit 3/Unit 2 laydown area (north end of Unit 3 turbine building), there is lots of cutting debris.
- j. Around the Unit 3 Startup Transformer are several pieces of wood that appear to be left over from a job.
- K. There is sand or dirt on the rocks of the transformer pits that may impair the pits' ability to catch and hold the transformer oil if it ruptures.
- l. The Unit 3 blowdown line where it enters the ground has an opening around the pipe to allow for thermal expansion. However, the opening exposes the asphalt to undermining due to rainwater and it appears part of the pipe needs external corrosion protection.
- m. Throughout Unit 3 found various miscellaneous pieces of scaffolding (metal and wood) unistrut, angle iron, steel plate, etc. that appears to be left after jobs.
- n. Unit 3 condensate backwash receiver tank is overflowing and apparently has been for a long time due to the algae on the floor. According to the turbine operator there are valves that leak through the seats when the valves are closed.
- o. Various valves and polisher tanks leak on the Unit 3 condensate polisher.
- p. Many lights in the Unit 3 turbine building do not have safety globes installed.

These are examples of material condition of the plant that can be picked up on tours. Recommend the senior plant management make weekly tours, assess material conditions of the plant and achieve corrective actions.



7. After touring the turbine building with the turbine operator, I recommend that periodically a helper/laborer be assigned to each turbine operator or nuclear operator for housekeeping. The operators know the areas of the plant that need housekeeping attention.

E. Professionalism, Summary of Shift, Comments

The day shift meeting included a good discussion of the upcoming Unit 4 outage activities.

Solid routine shift operations.

Completed By: Sidney G. Brain
MOS Observer

Date: 08/27/88

Reviewed By: *[Signature]*
Operations Superintendent- Nuclear

Date: 8/29/88

Management
Review By:

[Signature] 1 8/29/88 *[Signature]* 8/29/88
PM-N Date SVP Date VP Date
08/27/88

FINAL PAGE



To: Operations Superintendent - Nuclear

Date: 08/27-28/88

From: Joseph P. Brannin
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- Shift turnover
- Shift briefings
- Loss of 1 circulating water pump
- Toured Radiation Control Area (RCA)

B. Immediate Safety Problems

None

C. Questionable Work Practices

None observed

D. Areas for Improvement

I&C Department representative was not present at mid shift briefing. It is very important for all departments to be there so a smooth coordination of work activities can be accomplished. He did arrive after the briefing had broken up and had called ahead of time.



E. Professionalism, Summary of Shift, Comments

2 X 4 on either end of the 3C Motor Control Center (MCC) and 4C MCC with yellow caution tape. It looks temporary and has been there for at least 3 years. It won't stop anyone from bumping it. I recommend removing it.

At Unit 3 containment entry point there is some equipment left laying around. "Rem" ball, flashlights, breathing apparatus, hood and gloves.

Containment Self Contained Breathing Apparatus (SCBA) locker was left open. Two Scot air pack containers were left on the floor.

Temporary lighting in passageway between Unit 3 and 4 containment entry points.

Completed By: Joseph P. Brannin
MOS Observer

Date: 08/27-28/88

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

Date: 8/29/88

Management
Review By:

PM-N 8/29/88 SVP 8/29/88 VP Date



3 4

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To: Operations Superintendent - Nuclear

Date: 08/27-28/88

From: Daryle L. Osborn
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- Unit 3 at 100% power
- Unit 4 at 100% power
- Shift turnover meeting
- Radiation Control Area (RCA) tour
- Observed cleaning of 3C Component Cooling Water (CCW) Heat Exchanger and 4B CCW heat Exchanger

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

None

E. Professionalism, Summary of Shift, Comments

Shift activities were performed in an orderly and professional manner.

Completed By: Daryle L. Osborn
MOS Observer

Date: 08/27-28/88

Reviewed By: L. D. L. Osborn
Operations Superintendent - Nuclear

Date: 8/29/88

Management
Review By:EC 18/29/88 JD 18/29/88
PM-N Date SVP Date VP Date

08/27-28/88

To: Operations Superintendent - Nuclear

Date: 08/28/88

From: Sidney G. Brain
(MOS Observer)Shift: ☒ Day
☐ Night

A. Plant Evolutions Observed

- Day shift meeting
- Peak shift meeting
- Instrument air dew point measurement

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

1. The duty call roster sheet for power plant engineering in the Control Room needs updating. Several of the documents are of questionable currency as the oldest is dated 9/10/86, several are dated 1987, and several are dated in early 1988. The format varies with the writer. Recommend a consistent approach be developed to routinely keep the duty call rosters up-to-date.
2. Mechanical and Electrical Maintenance were not represented at the day shift meeting. Electrical and I&C Maintenance were not represented at the peak shift meeting.
3. Maintenance recently had provided several work task completion dates to the APSN/PSN that are either unrealistic or are not diligently pursued to completion. Communications to the Control Room have not been provided as to why the completion dates keep slipping. Examples: 1) The 3A Boric Acid Pump Seal repair completion slipped approximately 3 days - net result, the "A" Boric Acid Storage Tank had to be declared out-of-service; 2) The APSN had lined up I&C to make a containment entry at approximately 8 AM today and discussed the activity at the shift meeting. Extra Health Physics coverage had been arranged on Saturday, 8/27 to support an early Sunday containment entry and this was communicated to the I&C Supervisor. This is responsible accountability on the part of the APSN. At 10:40 AM the containment entry still had not been made, requiring the APSN to get involved to assist I&C personnel in achieving ownership. Recommend commitments to Operations be kept or the Control Room be provided timely feed-back of difficulties encountered. The PSN/APSN should remind all personnel at shift meetings of these requirements until this becomes the routine way of conducting business.



E. Professionalism, Summary of Shift, Comments

Routine Shifts handled very well.

Completed By: Sidney G. Brain
MOS ObserverDate: 08/28/88Reviewed By: *[Signature]*
Operations Superintendent - NuclearDate: 8/29/88Management
Review By:*[Signature]* 8/29/88 *[Signature]* 8/29/88
PM-N Date SVP Date VP Date



To: Operations Superintendent - Nuclear

Date: 08/28-29/88

From: Joseph P. Brannin
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- ° Test run of the motor for the Unit 3 Circulating Water pump which was out-of-service
- ° Shift turnover
- ° Shift briefing
- ° Routine shift operation

B. Immediate Safety Problems

None observed

C. Questionable Work Practices

None observed

D. Areas for Improvement

One item from yesterday which I neglected to put down. I had entered and exited the Control Room several times when suddenly I was not allowed access. I waited a bit and tried again. After several tries a Security guard arrived, asked my name and then told me I'd been logged off site. I would like to know how this could happen? I had not logged into any other area.

During the past seven days, I saw the floor (carpet) of the Nuclear Administration Building, first floor, cleaned at least twice. I discussed this with the other MOS Observer (day) in relation to the Control Room. The Control Room was only cleaned once during the same period. The Control Room is a much higher used area and requires more frequent cleaning. It helps to be a professional if you are treated as one and have a well maintained work area.

Earlier this week the PSN asked during the shift briefing if anyone knew of light bulbs that needed replacing, none replied. During my tour of the turbine building I saw 2 lights close together that were out and decided to do a quick check. I identified 8 lights out on the mezzanine level and 1 on the ground level. I gave the list to the PSN. Tonight I checked my list again and 7 of the 9 had been replaced. I feel this is another example of a lack of attention to detail in completing a job. I have mentioned this earlier in connection with cleaning up after a job. There were no PWO stickers on the lights and I assume they would work.



E. Professionalism, Summary of Shift, Comments

During this week I noticed the PSNs and APSNs on the shifts making regular tours of the plant. This is very important as it gives them first hand knowledge of the condition of the plant. It also allows them the time to talk with the Turbine Operators and Nuclear Operators about any situations occurring. This is a very good practice and should become a commonplace occurrence.

On my previous shift I observed the loss of the 3B1 Circulating Water pump and subsequent actions. The PSN-MOS report of 8/28/88 (midshift) accurately describes the situation. I would add that both the peak and mid PSNs pursued this occurrence aggressively.

While the peak and mid personnel all work well together I feel there is not yet a strong team feeling and the realization that the PSN is the team leader.

Completed By: Joseph P. Brannin
MOS Observer

Date: 08/28-29/88

Reviewed By: *[Signature]*
Operations Superintendent- Nuclear

Date: 8/29/88

Management
Review By:

KC *8/29/88* *[Signature]* *8/29/88*
PM-N Date SVP Date VP Date

08/28-29/88

To: Operations Superintendent - Nuclear

Date: 08/28-29/88

From: Daryle L. Osborn
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant evolutions Observed

- Unit 3, 100% power
- Unit 4, 100% power
- Shift turnover meeting
- Tour on Intake and Secondary

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

1. Have a representative from each maintenance discipline be present for the entire shift turnover meeting. I&C Maintenance on two consecutive nights have missed the majority of the shift turnover meetings.
2. Enhanced inter-discipline maintenance coordination prior to attending the shift turnover meeting is recommended. It was apparent at the shift turnover meeting the Maintenance Department did not have a clear and coordinated plan concerning the 3B1 Circulating Water pump investigation/repair effort.

E. Professionalism, Summary of Shift, Comments

Normal shift activities conducted in an efficient and professional environment.

Completed By: Daryle L. Osborn
MOS Observer

Date: 08/28-29/88

Reviewed By: *[Signature]*
Operations Superintendent - Nuclear

Date: 8/29/88

Management
Review By:*[Signature]* PM-N *[Signature]* Date 8/29/88 *[Signature]* SVP *[Signature]* Date 8/29/88 *[Signature]* VP *[Signature]* Date

08/28-29/88



To: Operations Superintendent - Nuclear

Date: 08/29/88

From: Craig D. Bersak
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- Units 3 and 4 at 100% power
- Full length Rod Control Cluster (RCC) exercise surveillance (Unit 4)
- Day and peak shift meeting
- Plan of the Day meeting
- Coordination of ongoing maintenance activities
- Plant tours

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

Unit 4 entered a potential shutdown LCO due to high containmemt temperature at 0830. This was a result of the Safety Assessment System (SAS) computer being out-of-service and the Reactor Control Operator (RCO) relying on the containment temperature Recorder for indication of TE-6700, - 6701 and -6702 temperatures, and indicating in excess of 120° F on average. The voltage reading from each TE was obtained and converted to °F by I&C and the Technical Specification LCO exited when this showed less than a 120° F average temperature.

The following problems were encountered during this evolution:

1. The temperature recorder indication differed from the direct reading of the TEs.
-PWO the temperature recorder points for recalibration.
2. O-ADM-021 4.6.1.5 cites the TEs as the locations to be monitored as opposed to the indicator for that TE. It then says to use one of three alternate TEs when "any of the above temperature monitor(s) [are] out-of-service.);" "Out-of-service" needs to be clearly defined. Is a TE out-of-service when it's normal means of monitoring is inoperable (i.e., SAS) inoperable or temperature recorder reading erroneous or when the TE itself no longer functions (i.e., shorts or fails open)?

I feel the PSN and APSN reacted prudently and correctly in determining the containment temperature directly from the TE output in their interpretation of this Technical Specification.



E. Professionalism, Summary of Shift, Comments

RCOs maintained good control over the access to the Control Room's surveillance area and over the level of activity on their respective units.

Completed By: Craig D. Bersak
MOS Observer

Date: 08/29/88

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

Date: 8/30/88

Management
Review By:

KE *18/30/88* *GO* *1830/88*
PM-N Date SVP VP Date



To: Operations Superintendent - Nuclear

Date: 08/29-30/88

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

A. Plant Evolutions Observed

- ° Units 3 and 4, 100% power steady state
- ° Shift turnover (2330) meeting

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

None

E. Professionalism, Summary of Shift, Comments

Normal quiet shift.

Completed By: P. L. Walker
MOS Observer

Date: 08/29-30/88

Reviewed By: P. L. Walker
Operations Superintendent - Nuclear

Date: 8/30/88

Management
Review By:KC 1 8/30/88 AO 1 8/30/88
PM-N Date SVP Date VP Date

08/29-30/88



To: Operations Superintendent - Nuclear

Date: 08/29-30/88

From: Daryle L. Osborn
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- Unit 3 at 100% power
- Unit 4 at 100% power
- Shift turnover meeting
- Plant tour

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

None

E. Professionalism, Summary of Shift, Comments

Normal operations.

Completed By: Daryle L. Osborn
MOS Observer

Date: 08/29-30/88

Reviewed By: [Signature]
Operations Superintendent - Nuclear

Date: 8/30/88

Management
Review By:

[Signature] 18/30/88 [Signature] 18/30/88
PM-N Date SVPC Date VP Date

08/29-30/88



To: Operations Superintendent - Nuclear

Date: 08/30/88

From: Craig D. Bersak
(MOS Observer)Shift: ☒ Day
☐ Night

A. Plant Evolutions Observed

- Units 3 and 4 at 100% power
- Plan of the Day meeting
- Day and peak shift turnover
- Power Range Nuclear Instrumentation System (NIS) N-42 current adjust
- Plant tour

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

None

E. Professionalism, Summary of Shift, Comments

My comment in the 8/29/88 MOS report regarding calibration of the Unit 4 containment temperature recorder was incorrect and should be disregarded. I was not aware that the temperature elements being read directly were not the ones indicated by the recorder resulting in the difference in indication.

Routine, quiet shift.

Completed By: Craig D. Bersak
MOS Observer

Date: 08/30/88

Reviewed By: [Signature]
Operations Superintendent - Nuclear

Date: 8/31/88

Management
Review By:

[Signature] 8/31/88 [Signature] 8/31/88
PM-N Date SVP Date VP 08/30/88 Date



To: Operations Superintendent - Nuclear

Date: 08/30-31/88

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

A. Plant Evolutions Observed

- Units 3 and 4, steady state power operation
- 2330 shift turnover meeting
- Unannounced fire drill

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: 08/30-31/88

Reviewed By: [Signature]
Operations Superintendent - Nuclear

Date: 9/31/88

Management
Review By:MC
PM-N1 8/31/88
Date[Signature]
SVP1 8/31/88
DateVP1
Date

08/30-31/88



To: Operations Superintendent - Nuclear

Date: 08/30-31/88

From: Darlyle L. Osborn
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- Unit 3 at 100% power
- Unit 4 at 100% power
- Shift turnover meeting
- Tour with PSN of Radiation Control Area (RCA)
- Intake structure tour

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

None

E. Professionalism, Summary of Shift, Comments

Normal operation

Completed By: Darlyle L. Osborn
MOS Observer

Date: 08/30-31/88

Reviewed By: [Signature]
Operations Superintendent - Nuclear

Date: 8/31/88

Management
Review By:

PM-N [Signature] 18/31/88 Date SVP [Signature] 8/31/88 Date VP [Signature] 1 Date 08/30-31/88



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To: Operations Superintendent - Nuclear

Date: 08/31/88

From: Craig D. Bersak
(MOS Observer)Shift: ☒ Day
☐ Night

A. Plant Evolutions Observed

- Units 3 and 4 at 100% power
- Unit 3 Nuclear Instrumentation System (NIS) current adjustment
- Plan of the Day meetings
- Plant tour

B. Immediate Safety Problem

None

C. Questionable Work Practices

None

D. Areas for Improvement

Procedure 4-OP-064, Safety Injection Accumulators, section 7.1 has an erroneous note preceeding step 7.1.2. The note states, "An accumulator that has been previously emptied, should not be refilled until it has at least 500 gallons added and has been pressurized to 200-225 psig with nitrogen." The note should be changed, based upon the procedure basis document and enclosure to the procedure, to read, "An accumulator that has been previously emptied, should be refilled until it has at least 500 gallons added and then pressurized to 200-500 psig with nitrogen."

E. Professionalism, Summary of Shift, Comments

Routine, quiet shift.

The assignment of F. Clark to schedule overtime has greatly freed the NWE to enable him to provide greater attention to plant operations. Some operators have voiced concerns that in offering overtime on the basis of hours worked violates the guidelines given in AP 0103.2. While this is not a MOS item, plant management should confer with the operators to clarify/establish how the overtime policy will be implemented.

Completed By: Craig D. Bersak
MOS Observer

Date: 08/31/88

Reviewed By: *[Signature]*
Operations Superintendent - Nuclear

Date: 9/1/88

Management
Review By:*[Signature]* 9/1/88
PM-N Date SVP Date VP Date

To: Operations Superintendent - Nuclear

Date: 08/31-09/01/88

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

A. Plant Evolutions Observed

- Units 3 and 4, 100% steady state power operation
- 2330 shift briefing with new Plan of the Day discussion
- Fabrication of Heat Exchanger acid wash system
- Reporting of Significant Event - Control Room ventilation

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

Over the past year, there have been many, many incidents of reportable events/LERs generated from a very specific group of instruments which are definitely unnecessary. To be precise, testing and (to a lesser extent) spurious actuation of alarms of and from Radiation Detectors R-11 and R-12, RAI-6642 and RAI 6643 (both units) have caused inadvertant actuation of Control Room ventilation and containment purge isolation (actuation of Engineered Safety Features (ESF) equipment). These are 4 hour reportable events, and there are too many of them. Three courses of correcting actions are available: 1) repair the offending channels in such a way as to dramatically reduce the number of incidents; 2) legislate around the problem - obtain agreement that, when the channels are being tested, spurious actuations are not reportable, and corrective maintenance only is required or 3) install a blocking circuit in the racks to prevent actuation during testing. Events like tonight's 2315 actuation of Control Room ventilation would no longer be required to be spread out all over the industry.

E. Professionalism, Summary of Shift, Comments

Smooth shift, save for the Significant Event.

Completed By: P. L. Walker
MOS Observer

Date: 08/31-09/01/88

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

Date: 9/1/88

Management
Review By:

PM-N 1 9/1/88 SVR 1 9/1/88 VP 1 9/1/88

08/31-09/01/88

To: Operations Superintendent - Nuclear

Date: 08/31-09/01/88

From: Daryle L. Osborn
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- Unit 3 at 100% power
- Unit 4 at 100% power
- Shift turnover meeting
- Radiation Control Area (RCA) tour
- Reporting of Significant Event (ADM-0103.12)
- Set-up for Component Cooling Water (CCW) Heat Exchanger acid washing

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

None

E. Professionalism, Summary of Shift, Comments

Routine operations.

Completed By: Daryle L. Osborn
MOS Observer

Date: 08/31-09/01/88

Reviewed By: 
Operations Superintendent - Nuclear

Date: 9/1/88

Management
Review By:

PM-N 1 Date 9/1/88 SVP 1 Date 9/1/88 VP 1 Date 9/1/88

08/31-09/01/88

To: Operations Superintendent - Nuclear

Date: 09/01/88

From: Craig D. Bersak
(MOS Observer)Shift: ☒ Day
☐ Night

A. Plant Evolutions Observed

- Units 3 and 4 at 100% power
- Unit 3 Residual Heat Removal (RHR) test
- Plan of the Day meetings
- Plant tour

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: Craig D. Bersak
MOS Observer

Date: 09/01/88

Reviewed By: *[Signature]*
Operations Superintendent - Nuclear

Date: 9/2/88

Management
Review By:*[Signature]* 19/2/88 *[Signature]* 19/2/88
PM-N Date SVP Date VP Date

09/01/88

3

To: Operations Superintendent - Nuclear

Date: 09/01-02/88

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

A. Plant Evolutions Observed

- Both units at 100% steady state power operation
- 2335 shift turnover meeting
- Response to a small electrical fire in the Control Room

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

None

E. Professionalism, Summary of Shift, Comments

Operators handled the smoking recorder in the Unit 3 control room control panel quite well. The overheated circuit card was removed and other damage was checked for.

The new "Plan of the Day" related shift briefing format is being followed. It is slowing down the meetings right now - will speed up as PSN/APSNs work out more streamlined ways to cover it. However, it may not work well during the outage, when many, many more tasks will be performed simultaneously.

Completed By: P. L. Walker
MOS Observer

Date: 09/01-02/88

Reviewed By: [Signature]
Operations Superintendent - Nuclear

Date: 9/2/88

Management
Review By:MC
PM-N19/2/88
Date[Signature]
SVP19/2/88
Date1
VP1
Date
09/01-02/88

(4)



Date 08/26/88

Shift Report

Shift Day

Shift Management

Jones

APSN

Haley

NWE

A. Questionable Work Practices/Actions Taken/Recommendations

None

AUG 31 1988

B. Areas for Improvement/Recommendations/Actions Taken

None

C. Good Practices/Professionalism Observed

Routine Operations

Reviewed By S.W. Pearce Date 8/29/88 Actions Completed _____ Date _____



Date 08/27/88

Shift Report

Shift Mids

Shift Management

Schimkus

APSN

Reese

NWE Spence

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

Due to the current problem of Component Cooling Water (CCW) Heat Exchanger fouling the Technical Department must perform efficiency testing and plot "R" values against Intake Cooling Water (ICW) inlet temperature in which the CCW system will remove heat load for a Design Basis Accident. Tonight the on-shift Shift Technical Advisor (STA) reviewed the data from the efficiency testing and found by interpolation that it appeared the data supplied was giving less conservative values than his calculations. The test engineers felt that the STA was being over-conservative in his calculations. The PSN reviewed the "R" value curve and found that either party could be considered right. PSN found that the plotting chart supplied to Technical Department from JPE per JPE-LR-87-045 revision 1 has poor scaling which does not supply increments of tenths. The copies are of poor quality, too small, and force the test engineer to use a ruler using a scale of 50 to calculate allowable operating temperature. Calculations can be off by 2/10 degree Fahrenheit. During this hot weather, unit operation could easily be jeopardized by this much margin if the maximum temperature is reached.

Actions taken:

1. Had conference with STA and test engineers to determine root cause of discrepancies in temperature calculation.
2. Informed MOS Observer (Sid Brain-JPE) of problem and requested his assistance to obtain large scaled copies of this graph with proper scaling, in proper increments. He agreed to try and expedite my request.

Recommendations:

All actions above be implemented in an expeditious manner.

*See attached graph and notice that "R" factor pen marks are larger than scaling on the STA ruler.

C. Good Practices/Professionalism Observed

Routine operations.

Reviewed By

SW Spence

Date

8/29/88

Actions Completed

Date



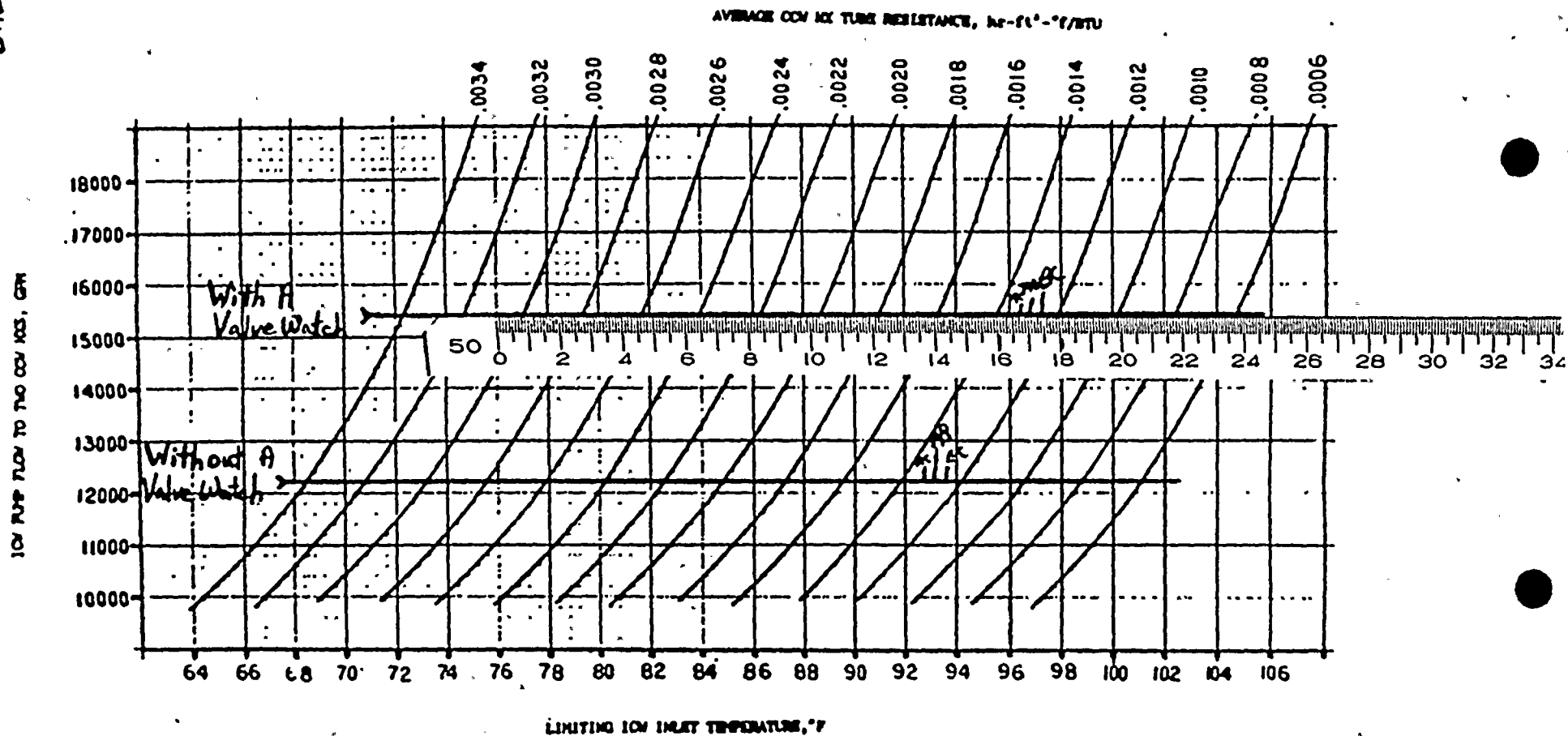


FIGURE 2: IGV FLOW VERSUS OCV KX TUBE RESISTANCE VERSUS IGV LIMITING INLET TEMPERATURE FOR HMA WITH TWO OCV KX OPERATION AND OX TUBE FLOCCAGE

ASSUMPTION: OCV KX DRILL SIDE FLOW IS 1,710,000 LBS/HR/KX



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ENCLOSURE 4

INTER-OFFICE CORRESPONDENCE

TO: Shift Technical Advisor

LOCATION: Turkey Point Nuclear

FROM: ICW System Engineer

DATE: 8-27-88

SUBJECT: CCW HEAT EXCHANGER
PERFORMANCE TEST RESULTS

COPIES TO: File

Date of test: 8-27-88
Time of test: 0100
Unit tested: 3
Heat Exchanger(s) tested: C

Summary of Performance:

1. Tube Resistances

HX A .00137 *
HX B .00123 *
HX C .00128

2. Temperature Limitations

2 worst CCW HX A, C: with valve watch = 95.3 °F
without valve watch = 91.5 °F2 best CCW HX B, C: with valve watch = 96.5 °F
without valve watch = 92.7 °F2 remaining CCW HX A, B: with valve watch = 96.0 °F
without valve watch = 92.2 °F3. The STA shall plot the temperature limits for the
AC and BC CCW heat exchanger pairs.

Comments: * Estimate from 8-25-88 (2100)

$$A \Rightarrow .00131 + 1\% (.000051) = .00137$$

$$B \Rightarrow .00117 + 1\% (.000051) = .00123$$

Submitted by:

Ken Dream

Reviewed by:

Perry N. Schen

Accepted by:

Paul A. Brown



$\frac{R}{.00130}$ AB $96.8 - .8 = 96.0$
 $.00133$ AC $96.4 - 1.1 = 95.3$
 $.00126$ BC $97.3 - .8 = 96.5$

WV

WOVW

$93.1 - .9 = 92.2$
 $92.7 - 1.2 = 91.5$
 $93.5 - .8 = 92.7$

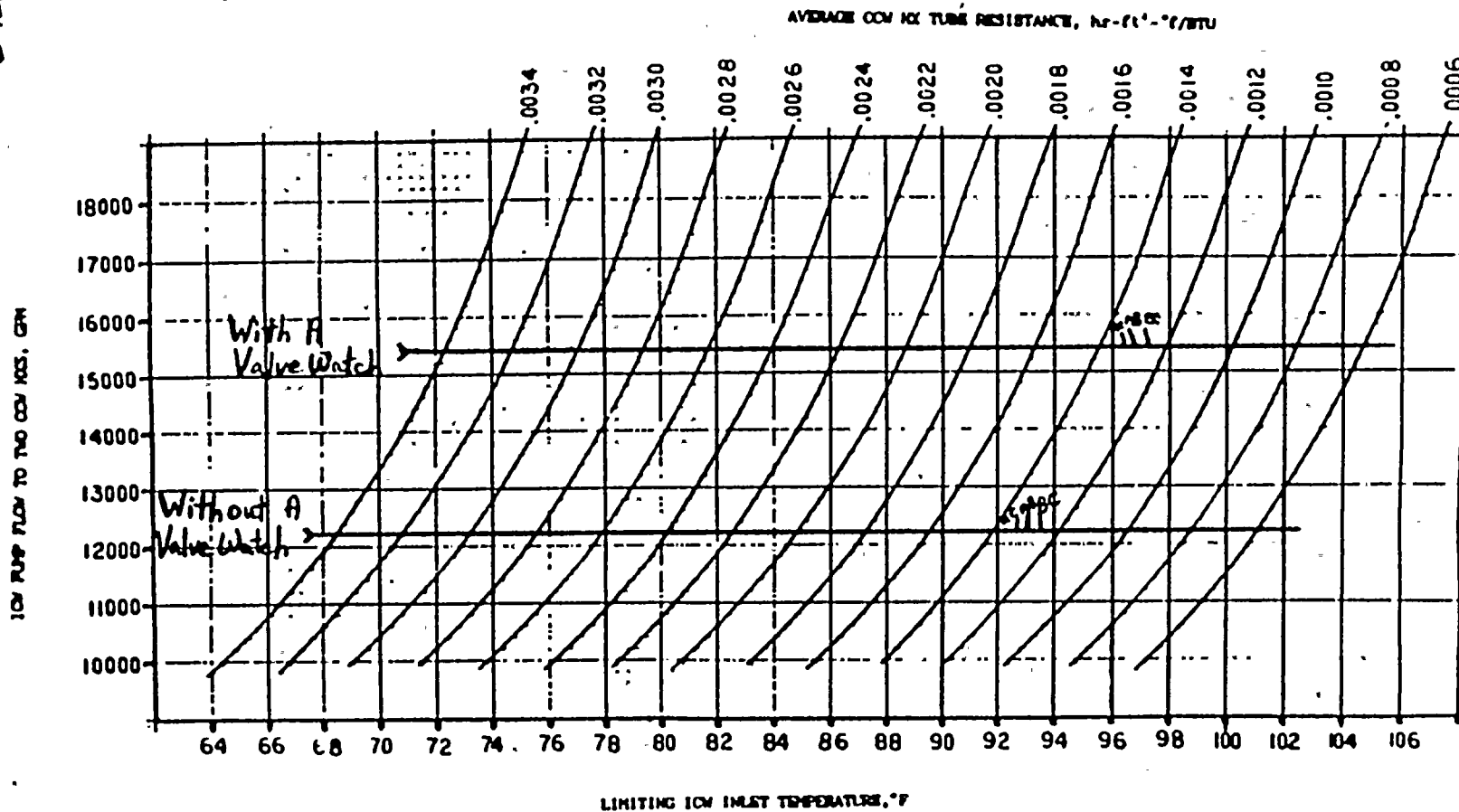


FIGURE 2: COV FLOW VERSUS COV HX TUBE RESISTANCE VERSUS COV LIMITING INLET TEMPERATURE FOR MHA WITH TWO COV HX OPERATION AND OX TUBE PLUGGAGE

ASSUMPTION: COV HX SHELL SIDE FLOW IS 1,710,000 LBS/H/HX



		PTN-3		

		CCW HX C		8-26-88

	CCW HX-A	CCW HX-B	CCW HX-C	NOTES
	-----	-----	-----	-----
TEMP				
ICW IN	DEG F	0.00	0.00	90.76 a conco 8-17
ICW OUT	DEG F	0.00	0.00	92.81 B CONCO 8-25
CCW IN	DEG F	0.00	0.00	99.53 C CONCO 8-26
CCW OUT	DEG F	0.00	0.00	94.30
FLOWS				
ICW	MH2O	0	0	94
ICW	lb/hr	0	0	3892248
CCW	lb/hr	ERR	ERR	1455322 Calc. by heat bal.
LMTD	DEG F	ERR	ERR	4.96
HEAT LOAD	Btu/hr	0	0	7596111
UA	Btu/hr-F	ERR	ERR	1531074
TUBE PLUGGED	%	3.2	1.5	3.1
U	Btu/hr-ft2-F	ERR	ERR	309.63
HI	Btu/hr-ft2-F	0.00	0.00	1471.80
HO	Btu/hr-ft2-F	ERR	ERR	883.26
R	HR-ft2-F/BTU	ERR	ERR	0.00128



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Unit 3

Valve Watch

with without

AB=2.4%

-0.8

-0.9

AC=3.2%

-1.1

-1.2

BC=2.3%

-0.8

-0.8

AVERAGE TUBE PLUGGAGE FOR TWO CCW HXS

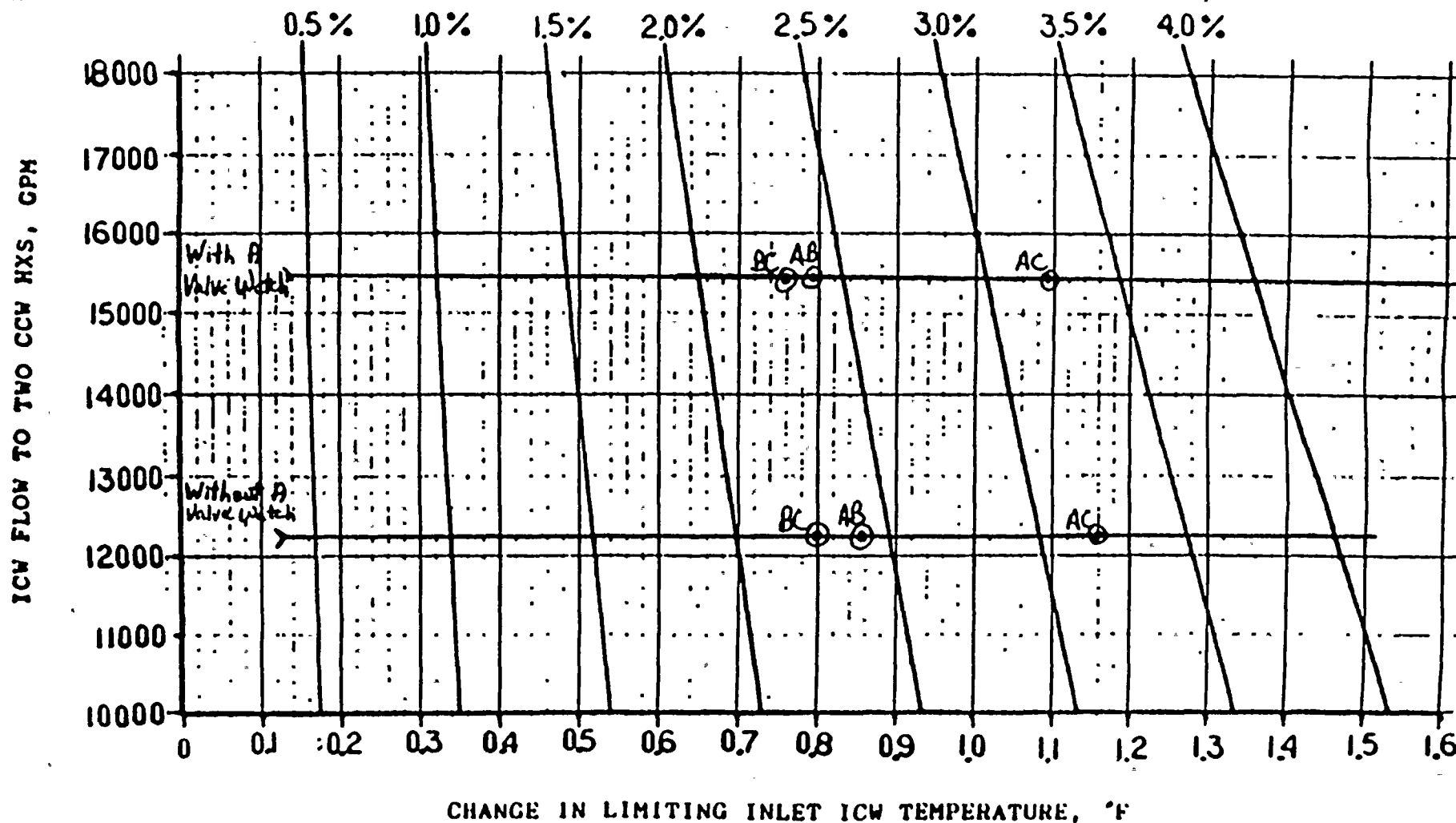


FIGURE 3: EFFECT OF INCREASED TUBE PLUGGAGE ON LIMITING ICW INLET TEMPERATURE FOR VARIOUS FLOWS

Date 08/27/88

Shift Report

Shift Day

Shift Management

Jones

APSN

Haley

NWE

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

R. L. Pearce

Date

8/29/88

Actions Completed

Date



Shift Mid

NWE Spence

Reviewed By W. Pearce Date 8/22/88 Actions Completed _____ Date _____

Date 08/28/88

Shift Report

Shift Day

Shift Management

Jones

APSN

Haley

NWE

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

This weekend we noticed that Emergency Procedure (EP) 20106 "Natural Emergencies" procedure reviewed and revised so that it is more practical in terms of what should be done. We don't want to overreact, but yet we want to assure that our response is appropriate to the threat. The procedure calls for action when a "Hurricane Watch" is declared (hurricane is between 24 and 48 hours from approaching). There are several things we could do while the disturbance is a tropical storm, before it becomes a hurricane which should be addressed in EP 20106.

Action: Sent a copy of this report to Procedure Upgrade Program.

C. Good Practices/Professionalism Observed

Reviewed By G. Pasa Date 8/29/88 Actions Completed Date



Date 08/28/88

Shift Report

Shift _____ Peaks _____

Shift Management

Anderson

APSN

Dallau

NWE Fernandez

A. Questionable Work Practices/Actions Taken/Recommendations

While making my rounds I have found many welding cables, electric cords, hoses, pieces of pipe, conduit and metal, among other things, left after jobs are completed. With the up-coming outage this can only become worse if nothing is done.

Recommend: The work packages have a sign off for the supervisor responsible for the job; and upon job completion that everything is picked up and cleaned up before the job package can be closed out.

B. Areas for Improvement/Recommendations/Actions Taken

C. Good Practices/Professionalism Observed

Reviewed By [Signature] Date 8/29/88 Actions Completed _____ Date _____



Date 08/29/88

Shift Report

Shift Mids

Shift Management

Schimkus

APSN

Reese

NWE Spence

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

1. This weekend 2 major pieces of balance of plant equipment went out-of-service (3B1 Circulation Water pump and 4A Charging pump). There did not appear to be any continuity of shift to shift turnovers on what steps to take next, within the maintenance departments. On Saturday, the PSN had to direct the Mechanical Supervisor to call out a GEMS planner to work up packages to repair both items. On Sunday the midshift PSN had to direct the electrical chief to remove the 3B1 Circulating Water pump motor as his last instructions were to wait until bearing pot oil samples were analyzed prior to removing the motor. When the Electrical Supervisor was contacted he agreed with the PSN that this was a proper decision. The motor removal process was started. The 4A Charging pump relief valve was to be replaced when manpower existed, if Component Cooling Water (CCW) Heat Exchanger cleaning did not rob these personnel.

Actions taken: Requested Maintenance Superintendent assistance.

Recommendations:

- a. Set up a better system of communication between maintenance departments to ensure continuity.
 - b. Influence the shift foreman or supervisor to call people out for work package preparation or to supply a maintenance force rather than waiting until the PSN demands action.
 - c. If a PSN shows concern over items which can cause unit problems, the responsible supervisor/foreman should call his supervisor for recommendations rather than ignore the PSN request.
2. Plant air conditioning problems are constantly re-occurring. It appears to be "bandaid" fixing to allow the quick return of an air conditioning system. In some instances the equipment is released without even being repaired. On 8/18/88 the Unit 4 Polishing Demineralizer control house air conditioner failed due to a ground. On 8/19/88 it was worked, tested and it failed, so clearance was re-hung. The PWO was coded out as repaired even though the equipment was still grounded. (See attached PWO and clearance).

Recommendation: Better work control processes.

C. Good Practices/Professionalism Observed

Good repair effort by Mechanical Maintenance in working 4A Charging Pump relief valve across the weekend and allowing us to return this balance of plant piece of equipment back to service. This is good because the 4C Charging pump failed on early midshift tonight and had 4A pump been disregarded until Monday dayshift, Unit 4 would have entered a 24 hour shutdown LCO.

Reviewed By J.W. Reese Date 8/29/88 Actions Completed _____ Date _____



NDL2DQ 03/88 GENERATION EQUIPMENT MANAGEMENT SYSTEM 08/29/88 04.03.22

NUCLEAR WORK REQUEST PLANNING DETAIL (1 OF 6)

WORK REQUEST NUM: WA880818223726 ORIGINATION DATE/TIME: 81888 2237

PLANT: PTN UNIT: 04 SYSTEM: 102 ORIG. NAME/DEPT: D A SPENCE / 4

LEAD MAINT DEPT(1,2,3): 3 REQ. PRI: B1 UNIT COND. REQD: 8

COMPONENT TAG#: ASSOC COMP:

DESC. : POLISHER AIR CONDITIONER

PLANT LOCATION: WEST SIDE OF ROAD UNIT 4

DEFECT/REQUEST: A/C UNIT ARCING FROM FAN MOTOR

SERIOUS/REASON: E' LOAD CENTER HOT

DEFICIENCY TAG#: 4086577

TROUBLE/BREAKDOWN: YES LCO REQUIRED: NO

STATUS: (CODED)

REWORK JOB: N IF YES, WHY?:

FAILURE DATE: 0 TIME: 0 STATUS: SYMPTOM: DETECTION:

==NFRDS ITEM == : (NO) DEFICIENCY TAG LOCATION: LOCAL BKR

HOLD DATES : 0 : 0

SUPERVISOR OR NPS APPROVAL: D A SPENCE

HOLD STATUS: :

CANCELED:

REASON FOR CANCELLATION:

DEPRESS THE PF5 KEY TO PAGE FORWARD PF4 KEY ... TO PAGE BACKWARDS
PF6 KEY TO RETURN
ENTER KEY.... TO PROCESS TRANSACTION



DL2DQ 03/88 GENERATION EQUIPMENT MANAGEMENT SYSTEM 08/29/88 04.03.22
NUCLEAR WORK REQUEST PLANNING DETAIL-JOURNEYMAN'S WORK REPORT (4 OF 6)

PLANT: PTN UNIT: 04 ER-PWO: 64-5050 WORK REQUEST: WA880818223726 SYS: 102

DESCRIPTION: POLISHER AIR CONDITIONER

COMPONENT TAG#:

ASSOC. CONF:

JOB: START DATE/TIME: 81988 / 1040 JOB: END DATE/TIME: 82288 / 1500

----- TROUBLE FOUND / WORK PERFORMED -----

#2 CONDENSER FAN MTR GROUNDED OUT. MAINTENANCE INDICATION

GROUNDING MOTOR / REPLACED FAN MTR AND CAP, CHECK ROTATION

AND AMPS. REPLACED EVAP' FAN BELT ALSO.

ROOT CAUSE COMPONENT / TAG NUMBER:

FIGURE 4

[illegible]



FIGURE

CLEARANCE ORDER

Sheet 1 of 1

1	UNIT: 04	2	CLEARANCE NO: 4-88-08-097	3	SYSTEM NO: 102	4	INDEPENDENT VERIFICATION REQUIRED (PER ADM-031) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	5	ORIGINATOR: SCOTT			
6	PRINCIPAL EQUIPMENT: U4 COND POLISHER AIR CONDITIONER							7	ENTERED IN EDDS BOOK INCLUDE CLEARANCE # <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
8	INSTRUCTIONS:		9	NO OF TAGS HUNG: 1		10	ISSUE: TAGS PLACED BY: <i>Benfer</i> I.V. _____ BY: _____		11	RELEASE: TAGS REMOVED BY: I.V. _____ BY: _____		
12												

STEP NUMBERING			ITEM TAGGED:		ACTION REQUIRED	POSITIONED	INDEP VERIF ED	CONTHT * BOUNDARY		REMOVAL AUTHORIZE AND DATE	REQUIRED POSITION	TAG REMOVED POSITION DATE/TIME INITIALS	INDEPENDENT VERIFICATION DATE/TIME INITIALS
issuing	releasing	tag no	item name	item no.				YES	NO				
1		1	U4 COND POLISHER AIR CONDITIONER LOCAL KNIFE SWITCH		PLACED OFF				X				

* Containment Boundary. If marked Yes, this valve may constitute a breach of containment integrity.



FIGURE 2
CLEARANCE REQUEST (attached to Clearance Form)
TO: Nuclear Watch Engineer/Assistant PS-N/PS-N

1. ISSUED TO: (Notify <u>NWE</u> at ext: <u>6493</u> when clearance issued)					
Foreman/Supervisor	Date	Time	Foreman/Supervisor	Date	Time
NWE	08/17/88	17:44	7.		
			8.		
3.			9.		
4.			10.		
5.			11.		
6.			12.		
2. CLEARANCE REQUESTED ON UNIT <input type="checkbox"/> 3 <input checked="" type="checkbox"/> 4 <input type="checkbox"/> Common System					
3. REASON FOR CLEARANCE REQUEST					
<input type="checkbox"/> Preventative Maintenance Plant Work Order No. _____					
<input checked="" type="checkbox"/> Corrective Maintenance Construction Work Order No. _____					
<input type="checkbox"/> Trouble Shooting Construction Permit No. _____					
<input type="checkbox"/> Testing					
<input type="checkbox"/> Plant Change/Modification (C/M)					
<input type="checkbox"/> Other					
4. EQUIPMENT AFFECTED: <u>UNIT 4 CONDENSER AIR CONDITIONER</u> Work to be done: <u>REPAIR LOCAL RESET SWITCH</u>					
5. CLEARANCE IS REQUESTED BY: _____ <u>6:00 pm</u> on: <u>08/17/88</u>					
6. CLEARANCE DURATION EXPECTED TO BE: <u>8 HOURS</u>					
7. POST MAINTENANCE TESTING PER (Proc No.): <u>N/A</u>					
8. <u>W. Spill</u> authorized the above clearance request. T.S. Related: <input type="checkbox"/> yes <input checked="" type="checkbox"/> no (T.S.no.if applicable _____) Safety Related: <input type="checkbox"/> yes <input checked="" type="checkbox"/> no Independent Verif. Req'd: <input type="checkbox"/> yes <input checked="" type="checkbox"/> no (Per ADM-031) <u>W. Spill</u> <u>NWE/PSN/PSN</u> _____ <u>SRO</u> (Second sig. req'd for safety related systems only)					
9. NOTIFIED: <u>NWE</u> THAT CL# <u>4-88-08-097</u> HUNG AT: <u>2232</u> / <u>9/14/88</u> TIME DATE					



Date 08/29/88

Shift Report

Shift _____ Day _____

Shift Management

Jones

APSN

Haley

NWE

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 L.W. Price Date 8/30/88 Actions Completed _____ Date _____



Shift	Peak
-------	------

NWE Eddinger

- ## Routine operations

Reviewed By F. W. Pearce Date 8/30/88 Actions Completed Date



Date 08/30/88

Shift Report

Shift Mid

Shift Management

P Schimkus APSN Reese NWE Spence

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

1. A few months ago, a MOS Observer commented that the Nuclear Operators (SNPOs) could not accurately describe the function of the Post Accident Sampling System (PASS) Heat Tracing, Temperature Controller Indicating lights. It was found that there was a slight lack of emphasis on this subject in regards to training. Approximately 3 weeks ago a training representative made rounds of each shift, gave a quick explanation of how the indicator lights worked and took down the name of each person he talked to. As I was making my PSN tour, I stood in front of the PASS panel and realized that even after my quick training session, I could not state the total functions of these temperature controller lights. I found an interim training sheet issued to the Nuclear Operators and reviewed it to enlighten my memory. Sometimes, training is not the only method which should be incorporated at this plant to ensure an operator can perform his job. For all too many years, personnel have been penciling reference material on walls and equipment to ensure they won't have memory lapses when observing system parameters.

Actions Taken:

- a. Submitted request to operations support (Dan Clark) to have placards made which give needed information to operators at heat tracing panels.
- b. Drew up examples of placard information.

Recommendation:

Prior to a system being released, involving plant parameter indications, the Startup Department or Operations Department should add a step to the procedure which ensures that placards containing required setpoint data and operability parameters is placed on indicator panels adjacent to the equipment it is addressing.

Examples:

Local indications for Auxiliary Feedwater (AFW) back-up nitrogen or Main Steam Isolation Valve (MSIV) back-up nitrogen bottle pressures required for operability.

Note: I have had many non-operators call the PSN to notify of equipment alarming, etc., just because a placard said to notify the PSN.

This could enhance our ability to have more sets of eyes watching our equipment plus supply training to unknowledgeable individuals on how systems work.

Reviewed By R. W. Pearce Date 8/30/88 Actions Completed Date

Continuation Page

2. Over the past weekend Plant Clearance Operating Network (PCON) was re-programmed for system enhancement. The temporary lift system was deleted from PCON. A problem has arisen now because a large majority of all maintenance procedures request that a temporary lift be generated to allow testing of repaired equipment prior to its release.

Recommend: A total evaluation of all maintenance procedures to find and OTSC the procedural requirement to request a temporary lift.

C. Good Practices/Professionalism Observed

Routine operations



Date 08/30/88

Shift Report

Shift Ed Lyon
Days

Shift Management

P Jones APSN Haley NWE

A. Questionable Work Practices

None

B. Areas for Improvement/Recommendations/Actions Taken

None

C. Good Practices/Professionalism Observed

Routine operations

Reviewed By L. Pearce Date 8/31/88 Actions Completed _____ Date _____



Date 08/30/88

Shift Report

Shift Peak

Shift Management

P Salkeld APSN Guyer NW Eddinger

A. Questionable Work Practices

None

B. Areas for Improvement/Recommendations/Actions Taken

None

C. Good Practices/Professionalism Observed

Routine operations

Reviewed By L.W. Vance Date 8/31/88 Actions Completed Date



Date 08/31/88

Shift Report

Shift	Mids
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Anderson A'PSN Dallau NWE Eddinger

Anderson
NWE Eddinger

A. Questionable Work Practices

The Post Accident Sampling System (PASS) was taken out-of-service on 7/19/88. ADM-021 requires an alternate method of sampling be established within 30 days. I called the midnight shift lab technician and asked what this alternate method was, and he searched his procedures and could not find one and has not been informed of an alternate method. If the Chemistry Management has developed an alternate method, they need to communicate it to its back shift employees so they can be aware of contingency actions in case of an accident.

B. Areas for Improvement/Recommendations/Actions Taken

Good Practices/Professionalism Observed

Reviewed By J.W. Fawcett Date 8/31/88 Actions Completed Date

Date 08/31/88

Shift Report

Shift Day

Shift Management

P Jones APSN Haley NWE

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 SWP Date 9/1/88 Actions Completed Date



Date 09/01/88

Shift Report

Shift Mids

Shift Management

Anderson

APSN

Dallau

Anderson

NWE Newton

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 8/1/88 Actions Completed _____ Date _____



Date 09/01/88

Shift Report

Shift _____ Peaks _____

Shift Management

Salkeld

APSN

Guyer

NWE

Eddinger

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

None

C. Good Practices/Professionslism Observed

Good response to de-energize the LD-3-6308B recorder when a circuit card started smoking.

(2)

Reviewed By W. J. Jones

Date 4/2/88

Actions Completed _____

Date _____



Date 09/02/88

Shift Report

Shift _____ Mids _____

Shift Management

DON Anderson APSN Dallau NWE Spence Newton

A. Questionable Work Practices/Actions Taken/Recommendations

Recently we have changed Plant Clearance Operating Network (PCON) to track Inservice Testing (IST) components being worked and testing required. This is slowing down a system that was originally installed to enhance clearance writing for Operations. This requires the 3rd operator to look up the principle equipment ID number, choose what is IST required equipment, determine what testing is required, and causes "no tag" clearances to be written on equipment for minor adjustments. Also we have been told that the leak rate calculation will be going into PCON.

Along with the other 3rd operator duties such as: 1) writing all clearances on PCON and 2) reviewing all partial releases and contacting applicable supervisors, do leak rates, do all periodics in control room, stay aware of all LCOs and unit conditions, and do all administrative duties for both units; he is now required to track IST components which has always typically been the STA or Technical Department function.

Recommend: Delete this IST program from PCON and do not add other programs so as to keep PCON clean and simple so it will still be an asset for doing fast clearances during a high clearance time such as the coming outage.

B. Areas for Improvement/Recommendations/Actions Taken

In AP 103.2, Duties and Responsibilities of operators on shift, the PSN is required by a "shall", to notify the Duty call Supervisor (DCS) on back shifts, whenever we enter a 72 hour or less LCO. This requirement has not been followed and needs to be changed immediately because compliance would keep the DCS awake all night. Typically on a midnight shift we backwash 4 Intake Cooling Water (ICW) strainers (24 hour LCO) take out 2 Component Cooling Water (CCW) Heat Exchangers for cleaning (72 hour LCO) along with other various 72 hour or less LCOs.

Recommend: Delete this requirement from the procedure.

C. Good Practices/Professionalism Observed

①

Reviewed By L. H. H. H. Date 9/2/88 Actions Completed _____ Date _____



MANAGEMENT ON SHIFT (MOS)

WEEKLY SUMARY REPORT

WEEK STARTING: 10/21/88

PAGE 1 OF 1

Six MOS observers were on shift: M. B. Gilmore, Nuclear Energy Specialist, Plant Support Group, Juno Beach (10/21-23/88, days); L. A. Spalding, Operator Training Instructor, Plant St. Lucie (10/21-24/88, nights); D. R. Powell, Operating Experience Feedback Coordinator, Juno Beach (10/24-27/88, days); R. P. Sackschewsky, Westinghouse Electric Corporation (10/24-28/88, nights); J. A. Labarraque, Senior Technical Advisor, Turkey Point Nuclear Plant (10/21-22/88, nights); and M. A. Ammerman, INPO HPES Coordinator, Turkey Point Nuclear Plant (10/22-27/88, nights).

Unit 3 remained in Mode 5 and Unit 4 remained defueled for the duration of the reporting period.

No immediate safety problems or questionable work practices were noted by any observer.

The independent observers did note seven areas for improvement, as follows:

- Four items on communication
- One item on industrial safety
- One item On housekeeping
- One recommendation to create a valve location book

Because of the amount of work associated with the dual unit outage, Turkey Point assigned superintendents to backshifts. The superintendents are expected to resolve identified problems on a real time basis via their normal work channels and do not submit MOS reports. Because of this change and in accordance with the confirmatory order, only the independent observers and PSN shift reports will be included in future MOS weekly reports.

The Turkey Point observers noted four areas for improvement, as follows:

- Two items on communication
- One item on labelling
- One item on respirator requirements

The Plant Supervisors-Nuclear also noted four areas for improvement, as follows:

- Three items on communication (one was echoed by two independent observers)
- One item on updating a drawing

ATTACHMENT: MOS DAILY REPORTS

881140323



Date

10/21/88

Shift Report

Shift

Days

Shift Management

P:

Salkeld

APSN

Guyer

NWEddinger

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

None

C. Good Practices/Professionalism Observed

Routine operations

2

Reviewed By

[Signature]

Date

10/24/88

To: Operations Superintendent - Nuclear

Date: 10/21/88

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

A. Plant Evolutions Observed

- Unit 3 in mode 5
- Unit 4, fuel off-loaded
- Plan of the Day meeting
- Control room operation/evolutions
- Refueling cavity drain down - Procedure 4-OP-201
- Shift turnover

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

1. Many attempts have been made by Operations to drain the unit 4 refueling cavity since the fuel was off-loaded two (2) days ago. Equipment which would have expedited this evolution has been removed from service for maintenance, i.e., Residual Heat Removal pumps and Reactor Coolant Drain Tank pumps. This has required Operations to make numerous OTSCs and clearances to use alternate methods and flow paths for facilitating these attempts at lowering cavity level. It has also caused increased time spent in high airborne/radiation areas which causes increased radiation doses. Operations and Maintenance need to be aware of this type of evolution and the equipment required to perform future evolutions throughout the outage. The need is to ensure that equipment is not removed from service until the evolution is completed, unless absolutely necessary.

(88-2781)

2. Shift directors need to be aggressive to resolve issues which affect these critical or near critical path evolutions, and maintain constant contact with the department performing these evolutions. Outage coordinators should have constant communication with PSNs and maintenance supervision to address the issues such as in item #1.

(88-2830)

(10)

B. Professionalism, Summary of Shift, Comments

During outages much more time and effort is required to be spent on turnovers for a successful shift transition. The operators I've observed have been very thorough and competent. They have covered items of information necessary for present plant conditions and expectations.

(11)

Completed By: M. B. Gilmore
MOS ObserverDate: 10/21/88Reviewed By: [Signature]
Operations Superintendent - NuclearDate: 10/24/88Management
Review By:[Signature] 10/24/88 [Signature] 10/24/88
PM-N Date SVP Date VP Date

10/21/88

To: Operations Superintendent - Nuclear

Date: 10/21-22/88

From:

Lawrence A. Spalding
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- Unit 3 in mode 5
- Unit 4 defueled
- Peak/mid shift turnover
- Verified clearance #3-88-10-146 for proper tags in accessible areas
- Toured Radiation Control Area
- Toured auxiliary feed station
- Toured secondary

B. Immediate Safety Problems

None observed

C. Questionable Work Practices

None observed

D. Areas for Improvement

Questions being asked at the pre-shift brief give feedback that there are knowledges that individuals have (all departments) that would have impacted the decisions in the outage instructions. This is causing some delays and confusion in implementing the instructions.

As an example, systems are being removed from service for maintenance, prior to the evolutions requested being performed. (which require these systems, to be able to perform them).

Already existing snags or developing snags which could prevent carrying out requested evolutions are known by personnel prior to the pre-shift brief but are communicated at the pre-shift brief.

Real time decisions on correcting the flow path are slow and cumbersome.
(88-2781)

(12)

B. Professionalism, Summary of Shift, Comments

The shift conducted themselves in a professional and competent manner at all times.

(13)

Completed By: Lawrence A. Spalding
MOS ObserverDate: 10/21-22/88Reviewed By: *[Signature]*
Operations Superintendent - NuclearDate: 10/24/88Management
Review By:*[Signature]* 11/0/24/88 *[Signature]* 11/10/24/88
PM-N Date SVP Date VP Date

10/21-22/88

o: Operations Superintendent - Nuclear

Date: 10/21-22/88

om: Max Ammerman
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- Spent Fuel Pool - fuel inspection
- Chemistry - hot lab
- Health Physics - auxiliary buildings
- Shift briefing
- Units 3 and 4 turbine work
- Unit 3 containment tour
- Tour Radiation Control Area

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

1. Cover the sign at unit 3 personnel hatch requiring personnel to call control room and notify PSN prior to entry.
(88-2836)
2. In observing the shift briefing, there was an apparent breakdown of communications within departments, and coordination with planning, reducing the efficiency of the plant, resulting in:
 - I&C not ready to support Mechanical Maintenance in pulling the unit 3 valve 455A actuator to evaluate the need for rework.
 - The 13th attempt to fix casing leakage on 3B Safety Injection pump not occurring as scheduled.
 - Approximately 7 hour hold to set the head, by Westinghouse, after Operations was pushed to get the reactor cavity drained.
 - 4A Component Cooling Water Heat Exchanger - to work or not work being the question.
 - Operations being pressed to "start" the fill and vent a second time, when, like the first, all systems weren't ready to support the task.
(88-2837)

(14)

E. Professionalism, Summary of Shift, Comments

None

(15)

Completed By: Max Ammerman
MOS ObserverDate: 10/21-22/88Reviewed By: *[Signature]*
Operations Superintendent- NuclearDate: 10/24/88Management
Review By:*KC* 10/24/88 *[Signature]* 10/24/88
PM-N Date SVP Date VP Date

10/21-22/88

Date 10/22/88

Shift Report

Shift Mids

Shift Management

P. Wogan APSN Singer NWE etromile

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

None

C. Good Practices/Professionalism Observed

Routine operations

(3)

Reviewed By [Signature] Date 10/24/88

Date 10/22/88

Shift Report

Shift _____ Days _____

Shift Management

P Salkeld APSN Guyer NWE Eddinger

A. Questionable Work Practices/Actions Taken/Recommendations

None

3. Areas for Improvement/Recommendations/Actions Taken

None

C. Good Practices/Professionalism Observed

Routine operations

(4)

Reviewed By [Signature] Date 10/24/88

Date 10/22/88

Shift Report

Shift _____ Peaks _____

Shift Management

P Jones APSN Haley NWE

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

None

C. Good Practices/Professionalism Observed

Routine operations

(5)

Reviewed By [Signature] Date 10/24/88

To: Operations Superintendent - Nuclear

Date: 10/22/88

From: M. B. Gilmore

(MOS Observer)

Shift: ☒ Day
☐ Night

A. Plant Evolutions Observed

- Unit 3 in mode 5
- Unit 4, fuel off-loaded
- Plant of the Day meeting
- Shift briefing

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

None observed

E. Professionalism, Summary of Shift, Comments

An FPL employee notified the PSN of a craft person not obtaining proper authorization to access the control room area behind the unit 3 vertical board. The PSN dealt with the situation immediately.

(16)

Completed By: M. B. Gilmore
MOS Observer

Date: 10/22/88

Reviewed By: *[Signature]*
Operations Superintendent - Nuclear

Date: 10/24/88

Management
Review By:*[Signature]* 10/24/88 *[Signature]* 10/24/88
PM-N Date SVP Date VP Date

10/22/88

To: Operations Superintendent - Nuclear

Date: 10/22-23/88

From: Lawrence A. Spalding
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- Unit 3 in mode 5
- Unit 4 defueled
- Peak/mid shift turnover
- Toured secondary

B. Immediate Safety Problems

None observed

C. Questionable Work Practices

None observed

D. Areas for Improvement

Units 3 and 4 outage "quick look" package has enhanced communications as to what needs to be done as far as shift plan. However, more information needs to be included in the package:

1. What was the situation which required evolution to be performed, equipment to be removed from service, or maintenance to be performed, i.e., why are we doing what we are doing?
2. What snags are associated with this particular job or evolution and what is the desired completion time and acceptance criteria?
3. What do we intend to do after maintenance or evolution is performed and how does this fit into the long range plan. (Required to meet Technical Specifications for next evolution, etc.)

It seems who, what, why, where, when is coming through the grapevine.

If this information was documented so all could refer to one document, communication for all would be the same and smoother. Team effort implies all are informed.
(88-2837)

(17)

E. Professionalism, Summary of Shift, Comments

Pre-shift brief made all attendees aware of plant status and shift plan. The shift exhibited good communications.

Shifts conducted themselves in a professional and competent manner.

(15)

Completed By: Lawrence A. Spalding
MOS Observer

Date: 10/22-23/88

Reviewed By: *[Signature]*
Operations Superintendent- Nuclear

Date: 10/24/88

Management
Review By:

[Signature] 10/24/88 *[Signature]* 10/24/88
PM-N Date SVP Date VP Date

10/22-23/88

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Operations Superintendent - Nuclear

Date: 10/22-23/88

From: Max Ammerman
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- o Safety Injection pump room
- o Radiation Control Area tour
- o Toured work on Unit 4
- o Shift briefing
- o Health Physics
- o Unit 4 containment tour

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

None

E. Professionalism, Summary of Shift, Comments

The planning and communications were much improved from the previous day. Work in the Radiation Control Area and turbine deck went smoothly. Overall work went smoothly.

(19)

Completed By: Max Ammerman
MOS Observer

Date: 10/22-23/88

Reviewed By: *[Signature]*
Operations Superintendent - Nuclear

Date: 10/24/88

Management
Review By:*[Signature]* 10/24/88 *[Signature]* 10/24/88
PM-N Date SVP Date VP Date

10/22/23/88

Date 10/23/88

Shift Report

Shift Mids

Shift Management

PSN Wogan APSN Singer NWE Vetromile

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

None

C. Good Practices/Professionalism Observed

Routine operations

(6.)

Reviewed By

[Signature]

Date

10/24/88

Date <u>10/23/88</u>	Shift Report	Shift _____ Days _____
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Shift Management

p Salkeld APSN Guyer NWE Eddinger

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

None

C. Good Practices/Professionalism Observed

Routine operations

(7)

Reviewed By *[Signature]* Date 10/24/88

Date 10/23/88

Shift Report

Shift _____ Peaks _____

Shift Management

P. Jones APSN Haley NWE

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

None

C. Good Practices/Professionalism Observed

Routine operations

4

Reviewed By [Signature] Date 10/24/88

To: Operations Superintendent - Nuclear

Date: 10/23/88

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

A. Plant Evolutions Observed

- Unit 3 in mode 5
- Unit 4, fuel off-loaded
- Plan of the Day meeting
- Inservice Testing (IST) test on unit 3 Boric Acid Storage Tank (BAST)
- Preparation for/and IST test on 3B Safety Injection pump

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

None

E. Professionalism, Summary of Shift, Comments

Routine outage work - shift crew conducted themselves professionally.

(20)

Completed By: M. B. Gilmore
MOS Observer

Date: 10/23/88

Reviewed By: *[Signature]*
Operations Superintendent - Nuclear

Date: 10/24/88

Management
Review By:*[Signature]* 10/24/88 *[Signature]* 10/24/88
PM-N Date SVP Date VP Date

10/23/88

To: Operations Superintendent - Nuclear

Date: 10/23-24/88

From: Lawrence A. Spalding
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- ° Unit 3 in mode 5
- ° Unit 4 defueled
- ° Peak/mid shift turnover
- ° Toured secondary

B. Immediate Safety Problems

None observed

C. Questionable Work Practices

None observed

D. Areas for Improvement

None

E. Professionalism, Summary of Shift, Comments

The pre-shift brief was handled well. The shift plan was communicated to all attendees.

The shift conducted themselves in a professional and competent manner at all times.

(21)

Completed By: Lawrence A. Spalding
MOS Observer

Date: 10/23-24/88

Reviewed By: *[Signature]*
Operations Superintendent - Nuclear

Date: 10/24/88

Management
Review By:

[Signature] 10/24/88 *[Signature]* 10/24/88
PM-N Date SVP Date VP Date
10/23-24/88

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To: Operations Superintendent - Nuclear

Date: 10/23-24/88

From: Max Ammerman
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- Set head
- Radiation Control Area (RCA)
- Shift brief
- Unit 4 containment tour
- Turbine/Generator work

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

The cromate water pump in the RCA needs to be relabeled. There are no longer any cromated water systems.
(88-2838)

E. Professionalism, Summary of Shift, Comments

Good shift.

(22)

Completed By: Max Ammerman
MOS Observer

Date: 10/23-24/88

Reviewed By: *[Signature]*
Operations Superintendent - Nuclear

Date: 10/24/88

Management
Review By:*[Signature]* 10/24/88 *[Signature]* 10/24/88
PM-N Date SVP Date VP

10/23-24/88

Shift Report

Date 10/24/88

Shift Peaks

Shift Management

PSN Schimkus APSN Reese NWE Newton

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

Draining unit 4 Reactor Coolant System (RCS) to 4" < midnozzle was exceptionally slow due to the unavailability of Residual Heat Removal (RHR) pumps (removed per schedule) to quickly lower level to midnozzle or less. This is holding up removing the Steam Generator primary manways for Eddy Current testing and additionally adding hours onto reaching 4" < midnozzle to allow inspection of check valves for Chemical Volume Control System (CVCS) charging and letdown on the RCS loops.

Recommend: This is something we need to look at in future refuelings to expedite the job, if possible.
(88-2781)

F. Good Practices/Professionalism Observed

Routine operations

All personnel are working to incorporate the new shift priority list. It appears to give guidance but I found it hard to locate actual status of jobs in progress as there is not a continuous flow of information coming to the PSN as a job progresses. The PSN utilized shift director, NWE and operators to find out the status on most jobs. Also contacted Construction Supervisors for updates.

①

Reviewed By [Signature] Date 10/25/88

Date 10/24/88

Shift Report

Shift Ed Lyons
Days

Shift Management
PSN Salkeld APSN Guyer NWE Eddinger

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

None

C. Good Practices/Professionalism Observed

Routine operations

①

Reviewed By V. P. P. P. P. Date 10/27/88

To: Operations Superintendent - Nuclear

Date: 10/24/88

From: David Powell
(MOS Observer)Shift: ☒ Day
☐ Night

A. Plant Evolutions Observed

- Unit 4, defueled
- Unit 3 in mode 5
- Unit 3 containment entry
- Radiation Control Area (RCA), Turbine area tours
- Power Operated Relief Valve (PORV) stroke time testing
- Unit 4 drain down
- Monitored equipment removal from containment

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

None noted

E. Professionalism, Summary of Shift, Comments

Removal of test equipment from containment was conducted in a thorough conscientious manner. Health Physics did a good job of frisking the equipment for containment.

(3)

Completed By: David Powell
MOS Observer

Date: 10/24/88

Reviewed By: *[Signature]*
Operations Superintendent - Nuclear

Date: 10/25/88

Management
Review By:

EC 10/25/88 *[Signature]* 10/25/88 *[Signature]* 10/25/88
PM-N Date SVP Date VP Date

10/24/88

To: Operations Superintendent - Nuclear

Date: 10/24-25/88

From:

Roy Sackschewsky

(MOS Observer)

Shift:

☐

Day

☒

Night

A. Plant Evolutions Observed

- Shift turnover
- Unit 3, Mode 5
- Unit 4, fuel off-loaded
- Control room operation/evolutions
- Drain Reactor Coolant System (RCS)
- Testing for return of MOV-3-350
- Tour turbine deck/removal of main generator rotor

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

None observed

E. Professionalism, Summary of Shift, Comments

Health Physics was unable to verify my training since the computer was down. They therefore did not issue me a TLD or permit entry into the Radiation Control Area.

(4)

Completed By:

Roy Sackschewsky
MOS Observer

Date: 10/24-25/88

Reviewed By:

Operations Superintendent - Nuclear

Date:

10/25/88

Management
Review By:KC
PM-N10/25/88
Date

SVP

Date

VP

Date

10/24-25/88

To: Operations Superintendent - Nuclear

Date: 10/24-25/88

From: Max Ammerman
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- o Health Physics check in
- o Radiation Control Area (RCA) tour
- o Unit 4 containment tour
- o Health Physics coverage
- o Turbine deck work

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

The planning and coordination of Steam Generator secondary side inspection had conflicting direction. The attached documents identify the confusion. The pre-planning should not have contradictory information and guidance.
(88-2838)

E. Professionalism, Summary of Shift, Comments

The shift went very smooth. Good night with the exception of the respirator issue.

(5)

Completed By: Max Ammerman
MOS Observer

Date: 10/24-25/88

Reviewed By: *[Signature]*
Operations Superintendent - Nuclear

Date: 10/25/88

Management
Review By:

EC 10/25/88 *[Signature]* 10/25/88 *[Signature]* 10/25/88
PM-N Date SVP Date VP Date

10/24-25/88

HP-1

RADIATION WORK PERMIT

RWP NO. 88 - 4113RWP REQUESTED BY S.MORRIS (W)1.16 CLASS NADATE 10 / 13 / 88 TIME 1400

EXPECTED DURATION

3 MONTHS

EXPIRATION DATE

12 / 31 / 88

EXTENDED TO/INITIALS

JOB LOCATION AND WORK TO BE PERFORMED

UNIT 4 CONTAINMENTA, B, & C STEAM GENERATORSSTEAM GENERATOR INSPECTION & "J" NOZZLE REPLACEMENT

LOCATION	RADIATION LEVEL MR/HR	CONTAMINATION LEVEL DPM/100cm ²	AIRBORNE ACTIVITY		
			PARTICULATE MPC	IODINE MPC	GAS MR/HR
S/G "A"	**	**	**	NA	NA
S/G "B"	**	**	**	NA	
S/G "C"	**	**	**	NA	

**TO BE DETERMINED BY
HP AS JOB PROGRESSES

PROTECTIVE CLOTHING REQUIREMENTS

<input checked="" type="checkbox"/>	NO PERSONAL OUTER CLOTHING	<input checked="" type="checkbox"/>	CLOTH CAP		EXTREMITY TLD ON
<input checked="" type="checkbox"/>	CLOTH GLOVES		CLOTH HOOD		MULTI-BADGE TLDs
<input checked="" type="checkbox"/>	RUBBER GLOVES (1) PAIR		LAB COAT		DOSE RATE METER
<input checked="" type="checkbox"/>	PLASTIC SHOE COVERS (1) PAIR		PLASTIC OR PAPER SUIT		RESPIRATOR W/CANNISTER
<input checked="" type="checkbox"/>	RUBBER SHOE COVERS		HIGH RANGE DOSIMETER		RESPIRATOR W/FORCED AIR
<input checked="" type="checkbox"/>	CLOTH COVERALLS		NEUTRON TLD		FORCED AIR HOOD

SPECIAL INSTRUCTIONS

1) H.P.S.S. APPROVAL IS REQUIRED TO ENTER SECONDARY SIDE OF THE STEAM GENERATOR.

2) XETEX RADIATION MONITORS WILL BE INSTALLED AND OPERABLE INSIDE THE SECONDARY SIDE OF THE STEAM GENERATORS.

3) IF XETEX RADIATION MONITORS ALARM IMMEDIATELY EXIT THE STEAM GENERATOR & NOTIFY HEALTH PHYSICS SUPERVISION.

4) CHECK WITH QUALITY CONTROL PRIOR TO MAKING ENTRIES INTO SECONDARY SIDE OF STEAM GENERATOR.

5) H.P. COVERAGE IS REQUIRED TO OPEN SECONDARY MANWAYS, AND AS DIRECTED BY THE H.P.S.S.

6) ENSURE REQUIREMENTS ARE MET FOR ENTRIES INTO CONFINED SPACES.

7) ENSURE STEAM GENERATOR SECONDARY SIDE WATER LEVEL HOSE IS INSTALLED PRIOR TO MAKING ENTRIES INTO THE STEAM GENERATOR.

8) PRE-JOB BRIEFING REQUIRED.

(REVISED 10-18-88)

☒ NOTIFY HP DAILY PRIOR TO START OF ANY WORK☒ HP COVERAGE REQUIRED (REFER TO #5)☒ BAG ALL ITEMS PRIOR TO REMOVAL FROM CONTAMINATED AREA, NOTIFY HP FOR SURVEY PRIOR TO REMOVING ITEM FROM AREA☒ OBSERVE AND OBEY ALL HP POSTINGS AND VERBAL INSTRUCTIONS☐ CHECK WITH HP AND CHEMISTRY PRIOR TO DISPOSAL OF LIQUIDS IN THE RCA☒ SIGN IN ON HP FORM 1.1☒ CLEAN WORK AREA TO ORIGINAL CONDITION AFTER JOB COMPLETION☒ CHECK WITH HP OR REFER TO AREA SURVEY STATUS MAPS FOR CURRENT RADIOLOGICAL CONDITIONS☒ AFTER REMOVAL OF PROTECTIVE CLOTHING PERFORM WHOLE BODY FRISK PRIOR TO DRESSING IN STREET CLOTHES (USE PCM 1B, WHEN AVAILABLE, FOR WHOLE BODY FRISK)

9) H-CUTS REQUIRED OVER RUBBER SHOE COVERS TO BE REMOVED AT ENTRANCE TO STEAM GENERATOR CLEAN AREA TO MAINTAIN CLEANLINESS IN STEAM GENERATOR.

10) PRIOR TO DRESSING OUT FOR EACH CONTAINMENT ENTRY, CONTACT THE HEALTH PHYSICS SHIFT SUPERVISOR TO DISCUSS PURPOSE OF ENTRY AND HP COVERAGE REQUIREMENTS.

H.P. SUPERVISION APPROVAL

DATE:

TIME:

N.P.S. AUTHORIZATION

DATE:

TIME:

RWP TERMINATED DUE TO:

TERMINATED BY

DATE:

TIME:

5.2.7 The entry crew shall assemble the following equipment for possible rescue operation for confined spaces listed in Substeps 5.2.5.1 through 5.2.5.3:

1. Three Scott air packs or equivalent systems, if applicable
2. Safety harnesses and lines, if applicable
3. An air horn or similar alarm device
4. Related safety equipment (such as air hoses) as designated by the Job Supervisor

5.2.8 General confined spaces that are normally vented to air or drained under air will require an entry crew consisting of a designated air testing technician and at least one attending person supplied by the Job Supervisor.

1. The person attending will monitor the air testing technician during air testing and remain within communicating distance.

5.2.9 Preplanning for rescue operations will be discussed with the entry crew for all types of confined space entries.

1. Preplanning considerations for deficient air conditions include whether to remove the victims to acceptable air conditions or how to supply the victim with acceptable air within three minutes.
2. Resuscitation provisions must also be considered.

NOTE

Air line respirators shall not be used in atmospheres that do not meet the air quality criteria stated in Step 5.3.4. When personnel use air line respirators, the Job Supervisor will ensure that someone is assigned to monitor the breathing air station.

CAUTION

Ensure that non-breathable, radioactive, or combustible atmospheres purged from confined spaces do not endanger personnel in the venting area.

①

5.2.10 Any confined space known to have potentially explosive gas atmospheres that cannot be purged unless the space is opened will require the use of non-sparking soft metal tools, explosion-proof flashlights, and other equipment deemed necessary by the Job Supervisor.

5.2.10 (Cont'd)

1. In addition, the Job Supervisor will rope off the area and place No Smoking signs around the area of the opening.
2. The Plant Supervisor - Nuclear will be kept informed of the job progress until satisfactory conditions are established.

5.3 Opening and Initial Entry

- 5.3.1 The Job Supervisor shall ensure all preplanning steps in Subsection 5.2 have been read and considered.
- 5.3.2 Ventilation shall be established as required by the Safety Supervisor or designee prior to initial entry for air testing.
- 5.3.3 The designated air testing technician will perform air test(s) in the confined space as directed by Safety Supervisor or designee.
- 5.3.4 Toxic or combustible gas analysis shall be performed by the Safety Supervisor or designee.

Acceptance Criteria: Oxygen must be greater than 19.5 percent and combustibles must be less than 25 percent of the lower explosive limit, and toxic gases are within their OSHA guidelines.

- 5.3.5 For steam generator entries (primary and secondary side), the air testing technician may be required to don air supply equipment to enter the confined space.
 1. If required, the air sample line can be strapped to the mask air line to be used as suction for the air sampler outside the space.
- 5.3.6 The oxygen content may be monitored continually from outside the confined space as determined by the Job Supervisor or Safety Supervisor.
 1. If there is indication of oxygen content at any time less than 19.5 percent and personnel inside are using air line respiratory equipment the personnel will exit the space until additional air purifying is performed.
- 5.3.7 If during the air testing, the air horn is sounded, the backup crew will respond according to the rescue plan.
- 5.3.8 When the Safety Supervisor determines that the space is safe for entry, the Safety Supervisor shall sign and date the Confined Space Air Quality Testing Form Attachment 2 and notify the Job Supervisor that the space is cleared for general entry.





INTER-OFFICE CORRESPONDENCE

TO: ALL PLANT PERSONNEL

FROM: R. D. BUNGARNUM

SUBJECT: SECONDARY STEAM GENERATOR

LOCATION: PTN

DATE: 10-24-88

COPIES TO: WESTINGHOUSE
D. HAMILTON
D. HICKS
K. ELEDGE
L. BENNET

THE FOLLOWING REQUIREMENTS HAVE BEEN IMPOSED ON
THE SECONDARY STEAM GENERATOR D. NOZZLE JOB.

- ① IF THE HYDROZINE LEVEL IS GREATER THAN ONE
PART PER MILLION - SUPPLIED AIR RESPIRATORY
PROTECTION IS REQUIRED
- ② IF THE LEVEL IS LESS THAN ONE PART PER
MILLION - NO RESPIRATORY PROTECTION IS REQUIRED
- ③ FOR WASH DOWN OF THE SECONDARY SIDE - SUPPLIED
AIR RESPIRATORY PROTECTION IS REQUIRED ALSO FULL
PLASTICS IS REQUIRED

R. D. Bungarnum

Safety Supervisor

(9)

Date 10/25/88

Shift Report

Shift _____ Days _____

PSN Salkeld APSN Guyer NWE Eddinger

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

None

C. Good Practices/Professionalism Observed

Routine operations

(2)

Reviewed By Lu Peau Date 10/27/88

Date 10/25/88

Shift Report

Shift Mids

Shift Management

PSN Wogan APSN Singer NWE Vetromile

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

None

C. Good Practices/Professionalism Observed

Routine operations

(2)

Reviewed By [Signature] Date 10/25/88

Date 10/25/88

Shift Report

Shift _____ Peaks _____

Shift Management

PSN Schimkus APSN Reese NWE Newton

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

None

C. Good Practices/Professionalism Observed

"COMMUNICATION" appeared to be excellent tonight on peak shift with personnel responding to needs dictated by the priority list. There were some slight miscommunications on the 4B Component Cooling Water (CCW) heat exchanger weld jobs as they were interfacing with CCW filtration system hot tap clearances which would involve CCW header separation. Meetings were immediately initiated to allow continued progress which would not jeopardize CCW operability. Excellent support from our Coordination Department, Shift Director, all work groups and 4 highly motivated nuclear operators who were in constant motion throughout the entire shift.

①

Reviewed By SN Reese Date 10/26/88

To: Operations Superintendent - Nuclear

Date: 10/25/88

From: David Powell
(MOS Observer)Shift: ☒ Day
☐ Night

A. Plant Evolutions Observed

- Unit 3 in mode 5; unit 4, defueled
- Unit 4 containment entry
- Installation of air blowers on code safeties - unit 4
- Plant tours - secondary side
- Shift turnover and briefing
- Monitoring of various jobs inside containment, Radiation Control Area (RCA) and turbine area

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

None noted

E. Professionalism, Summary of Shift, Comments

Shift turnover was performed in a thorough and professional manner. During the containment entry, Health Physics Technicians were making sure people who were not actively employed went to a no dose area to wait until they were needed again. This helps to keep down the number of people that don't need to be in radiation areas.

During a tour of the diesel rooms I forgot to press the exit button on my exit from the building to the stairs. A security guard arrived to check into my exit within 20 seconds. This was excellent security coverage.

Completed By: David Powell
MOS Observer

Date: 10/25/88

Reviewed By: *David Powell*
Operations Superintendent - Nuclear

Date: 10/26/88

Management
Review By:

PM-N 10/26/88 *SVP* 10/26/88 *VP* 10/26/88
Date Date Date

10/25/88

To: Operations Superintendent - Nuclear

Date: 10/25-26/88

From: Roy Sackschewsky
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- Unit 3, Mode 5
- Unit 4, fuel off-loaded
- Shift turnover
- Control room operations
- Radiation Control Area (RCA) tour
- Unit 4 containment tour
- Work on safety injection pump B, unit 3

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

None

E. Professionalism, Summary of Shift, Comments

During the shift turnover meeting, work being done on the Component Cooling Water (CCW) surge line caused a loss of indicated level in the CCW surge tank. Actions by the control room personnel was swift, accurate and indicated proper priorities be taken. The shift took actions required to refill the surge tank while monitoring indication to assure the pumps were operating properly.

(4)

Completed By: Roy Sackschewsky
MOS Observer

Date: 10/25-26/88

Reviewed By: LW Pearson
Operations Superintendent - Nuclear

Date: 10/26/88

Management
Review By:

JEC 10/26/88 VP 10/26/88
PM-N Date SVP Date VP Date
10/25-26/88

To: Operations Superintendent - Nuclear

Date: 10/25-26/88

From: Max Ammerman
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- Radiation Control Area (RCA) tour
- Unit 4 containment tour
- Shift brief
- Component Cooling Water (CCW) level loss
- Health Physics in containment
- Turbine deck work

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

None

E. Professionalism, Summary of Shift, Comments

Good shift. There was some misunderstandings on supporting each other and coordinating departments but this was resolved by constructive guidance by the Superintendent on Shift (SOS). He gave good coaching to direct better cooperation.

An apparent break in communications led to a drop in Component Cooling Water (CCW) expansion tank level during shift briefing. The control room operators monitored the pump/amps well and the field quickly identified the cause (plug removal from the heat exchanger) and took quick corrective actions.

Good job!

(5)

Completed By: Max Ammerman
MOS Observer

Date: 10/25-26/88

Reviewed By: [Signature]
Operations Superintendent - Nuclear

Date: 10/26/88

Management
Review By:

[Signature] 10/26/88 [Signature] 10/26/88 [Signature] 10/26/88
PM-N Date SVP Date VP Date

10/25-26/88

Date 10/26/88

Shift Report

Shift Mids

Shift Management

PSN Jones APSN Haley NWE Matuszewski

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

Component Cooling System operating diagram (560-T-E-4512 sheet 1 of 2, 2 of 2) for unit 4 has local sample valve 4-709 coming off a component cooling surge line, and actually it comes off "B" CCW surge line. This all led to Construction putting the plug in the "A" surge line instead of the intended "B" surge line.
(88-2840)

C. Good Practices/Professionalism Observed

Communications should have been better between Operations and Construction in reference to when Construction pulled the plug out of the 4A CCW surge line.
(88-2841)

(2)

Reviewed By LW Plana Date 10/26/88

Date 10/26/88

Shift Report

Shift Peaks

Shift Management

PSN Schimkus APSN Reese NWE Newton

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

The Planning Meeting at 15:00 is lengthy but exceptionally informative. A problem arises that the peak shift PSN cannot distribute and discuss the priority sheets with his on-coming peak shift at our pre-shift briefing. This causes the PSN to regroup activities and place new priorities at approximately 17:00. The issue is that this makes the PSN 15:30 pre-shift briefing ineffective.

Recommend: Either have an up to date peak shift activity sheet available to the control room at 15:30 or reschedule the 15:00 Planning Meeting.
(88-2874)

C. Good Practices/Professionalism Observed

It appears over the past 2 days, jobs needed to "progress" during the dual unit outage are being accomplished in an excellent manner. I feel the priority sheet distributed is one of the best things that has happened. This gives a clear priority path to those who must accomplish the physical tasks.

3

Reviewed By R.W. Reese Date 10/27/88

To: Operations Superintendent - Nuclear

Date: 10/26/88

From: David Powell
(MOS Observer)Shift: ☒ Day
☐ Night

A. Plant Evolutions Observed

- Unit 3 in mode 5; unit 4, defueled - shutdown operations
- Unit 3 containment tour
- Unit 4 containment tour
- Secondary plant tours
- Local Leakrate Test (LLRT) of CV-965C
- Removal of Steam Generator (S/G) B diaphragms and installation of ventilation
- Shift turnovers

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

1. While I was in the unit 3 pipe and valve room monitoring the LLRT I noticed a large amount of debris left behind from other jobs. This included rubber golves, plastic gloves, portions of procedures, paper wipes, etc. I was not able to determine at what frequency these contaminated areas are cleaned. This one looked like it had been some time since it had been cleaned. I picked up most of the easily accessible items and placed them into the contaminated trash container.
(88-2875)
2. During the unit 3 tour I noticed an individual overhead among various piping, looking for different valves and hanging valve information tags. While he was walking around, he stepped on some small bore piping (1" or 2" lines) which caused these lines to flex quite a bit. Using piping of this size to support a full persons weight is not a good idea. Piping can crack at key locations or bend at fittings which could leak in the future.
(88-2917)

(4)

3. Consideration should be given to developing a book of valve locations for certain procedures that are infrequently performed, and which require finding a large number of valves that are not normally manipulated, such as gage isolation valves, vents, etc. An example of where this would be helpful is the Residual Heat Removal (RHR) clearance that Operations has been trying to complete for about the last two days. Some of the delay has been caused by this valve location problem.
(88-2918)

E. Professionalism, Summary of Shift, Comments

Shift turnovers and briefing were very good. While I was in the unit 4 containment I talked with the 14 ft. and 58 ft. ALARA coordinators. Both of these individuals were knowledgeable of the different jobs being worked, approximate doses that are expected and of the various Health Physics items that had been installed (i.e., drains, shielding, etc.) The 58 ft. level coordinator was actively looking around for people just standing around and getting them out of there. The 14 ft. coordinator was monitoring the S/G work that was being performed. He was very knowledgeable about the work effort and reasons.

(5)

Completed By: David Powell
MOS Observer

Date: 10/26/88

Reviewed By: [Signature]
Operations Superintendent- Nuclear

Date: 10/27/88

Management
Review By:

[Signature] 10/27/88 [Signature] 10/27/88
PM-N Date SVP Date VP Date
10/26/88

To: Operations Superintendent - Nuclear

Date: 10/26-27/88

From:

Roy Sackschewsky

Shift: ☐ Day
☒ Night

(MOS Observer)

A. Plant Evolutions Observed

- Unit 3, Mode 5
- Unit 4, fuel
- Radiation Control Area (RCA), turbine area tours
- Containment unit 3 tour, observed work being done on pressurizer
- Observed "A" Diesel Generator operability test, 0-OSP-23.1
- Control room routine operations
- Shift turnover
- Toured deck area around Demin Water Storage Tank

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

None

E. Professionalism, Summary of Shift, Comments

- Health Physics assistance to workers in containment working on the pressurizer was thorough and helpful. Took his job seriously.
- Shift turnover went smooth - Joe Kappes's presence has helped give positive direction to those coordinating projects.
- A drum full of oily rags was found by the Demin Water Storage Tank that had its cover sitting on its retainer ring. The top was replaced when mentioned to a plant worker.

6

Completed By:

Roy Sackschewsky
MOS Observer

Date: 10/26-27/88

Reviewed By:

A. W. Pearce
Operations Superintendent - Nuclear

Date: 10/27/88

Management
Review By:

PM-N 10/27/88 SVP 10/27/88 VP 10/26-27/88

To: Operations Superintendent - Nuclear

Date: 10/26-27/88

From:

Max Ammerman

(MOS Observer)

Shift:

☐

Day

☒

Night

A. Plant Evolutions Observed

- Turbine deck
- Plant tour
- Shift brief
- Unit 4 containment tour
- Radiation Control Area (RCA) tour
- Turbine deck work

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

None

E. Professionalism, Summary of Shift, Comments

To clarify an earlier comment, (10/21-22/88 report, 88-2837)) I made on Safety Injection being taken out on clearances 13 times; all but 3 of these times were for various stages of post maintenance testing. The 3 problems are being evaluated by the Maintenance Department.

Joe Kappes continues to be a strong positive force on the night shift.

(7)

Completed By:

Max Ammerman

MOS Observer

Date: 10/26-27/88

Reviewed By:

Operations Superintendent - Nuclear

Date: 10/27/88

Management
Review By:

PM-N 10/27/88 SVP 10/27/88 VP 10/27/88

10/26-27/88

Date 10/27/88

Shift Report

Shift Ed Lyons
Mids

Shift Management

PSN Jones APSN Haley NWE

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

None

C. Good Practices/Professionalism Observed

Routine outage operations

①

Reviewed By

RW Plummer

Date

10/28/88

Date 10/28/88

Shift Report

Shift Mids

Shift Management

PSN Jones APSN Haley NWE

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

None

C. Good Practices/Professionalism Observed

Routine outage operations

2

Reviewed By

[Signature]

Date

10/28/88



To: Operations Superintendent - Nuclear

Date: 10/27/88

From: David Powell
(MOS Observer)Shift: ☒ Day
☐ Night

A. Plant Evolutions Observed

- Unit 3 in mode 5; unit 4, defueled
- Unit 4 containment tour
- Radiation Control Area (RCA)/Auxiliary building tours
- Shift turnovers
- Reactor Coolant Pump (RCP) motor removal effort
- On-going maintenance activities in containment and turbine areas

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

None

E. Professionalism, Summary of Shift, Comments

Shift turnovers were conducted in a thorough and informative manner. The priority item list has been helpful to the PSNs in delegating and coordinating the activities of their nuclear operators. Extra effort has gone into prioritizing clearances in support of maintenance efforts.

Prior to the stroke timing test of the Power Operated Relief Valve (PORV) on unit 4, the nuclear operator who was performing the visual verification had to first remove some piping that was laying on the PORV packing. This was a good response in that actuation of the valves could have caused the stems to be damaged. When the nuclear operator returned to the control room he reported that a lot of debris was on top of the pressurizer. The cognizant construction supervisor was advised of the situation and he indicated that he would have the problems corrected upon leaving the control room.

3

Completed By: David Powell
MOS Observer

Date: 10/27/88

Reviewed By: *David Powell*
Operations Superintendent - Nuclear

Date: 10/28/88

Management
Review By:*JP* 10/28/88 *PO* 10/28/88
PM-N Date SVS Date VP

10/27/88

To: Operations Superintendent - Nuclear

Date: 10/27-28/88

From: Roy Sackschewsky
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- Control room operations - Test of site evacuation alarm
- Unit 3 in mode 5
- Unit 4, defuel
- Containment unit 4 tour
- -J nozzle modification
- -Eddy current
- Unit 3 B Reactor Coolant Pump (RCP) electrical penetration work
- Turbine deck tours
- Shift turnover
- Unit 4 Component Cooling Water (CCW) system hot tap and heat exchanger repair

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

None

E. Professionalism, Summary of Shift, Comments

Health Physics personnel in the unit 3 containment were knowledgeable of work being completed within containment and the radiation levels within areas. Personnel were continuing pick up of trash around working areas.

Priority list for operations gives positive direction to focus efforts for the shift.

(4)

Completed By: Roy Sackschewsky
MOS Observer

Date: 10/27-28/88

Reviewed By: RW Pearce
Operations Superintendent - Nuclear

Date: 10/28/88

Management
Review By:

MC 10/28/88 JO 10/29/88 VP 10/27-28/88
PM-N Date SVP Date VP Date

10/27-28/88

