

ACCELERATED DISTRIBUTION DEMONSTRATION SYSTEM

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR: 8811010042 DOC. DATE: 88/10/12 NOTARIZED: NO DOCKET #
 FACIL: 50-250 Turkey Point Plant, Unit 3, Florida Power and Light C 05000250
 50-251 Turkey Point Plant, Unit 4, Florida Power and Light C 05000251
 AUTH. NAME AUTHOR AFFILIATION
 CONWAY, W.F. Florida Power & Light Co.
 RECIP. NAME RECIPIENT AFFILIATION
 ERNST, M.L. Region 2, Ofc of the Director

SUBJECT: Forwards mgt-on-shift weekly rept for wk starting 880930.

DISTRIBUTION CODE: D036D COPIES RECEIVED: LTR 1 ENCL 1 SIZE: 51
 TITLE: Turkey Point Management Onshift Program

NOTES:

RECIPIENT		COPIES		RECIPIENT		COPIES	
ID CODE/NAME		LTTR	ENCL	ID CODE/NAME		LTTR	ENCL
DRP/ADR-2		1	1	NRR/DRP-1/2		1	1
PD2-2 PD		1	1	EDISON, G		2	2
INTERNAL: AEOD		1	1	DEDRO		1	1
NRR DEPY		1	1	NRR DIR		1	1
NRR MORISSEAU, D		1	1	NRR/ADP 12-G-18		1	1
NRR/ADT 12-G-18		1	1	NRR/DLPQ/PEB		1	1
NRR/DOEA DIR 11		1	1	NRR/DRIS DIR 9A		1	1
NUDOCS-ABSTRACT		1	1	OE LIEBERMAN, J		1	1
OGC/HDS2		1	1	REG FILE 01		1	1
RGN2 FILE		1	1				
EXTERNAL: LPDR		1	1	NRC PDR		1	1
NSIC		1	1				

NOTE TO ALL "RIDS" RECIPIENTS:

PLEASE HELP US TO REDUCE WASTE! CONTACT THE DOCUMENT CONTROL DESK,
 ROOM P1-37 (EXT. 20079) TO ELIMINATE YOUR NAME FROM DISTRIBUTION
 LISTS FOR DOCUMENTS YOU DON'T NEED!

TOTAL NUMBER OF COPIES REQUIRED: LTTR 23 ENCL 23

Incident 381



08 OCT 17 03:20

OCTOBER 12 1988

L-88-452

Mr. Malcolm L. Ernst
Acting Regional Administrator, Region II
U.S. Nuclear Regulatory Commission
101 Marietta Street, N. W., Suite 2900
Atlanta, Georgia 30323

Dear Mr. Ernst:

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

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
for W. F. Conway

Senior Vice President - Nuclear

WFC/RHF/gp

Attachment

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

mos001

8811010042 881012
PDR ADOCK 05000250
R PDC

an FPL Group company

0036

MANAGEMENT ON SHIFT (MOS)

WEEKLY SUMARY REPORT

WEEK STARTING: 09/30/88

PAGE 1 OF 2

Seven MOS Observers were on shift: Russell Gouldy, Principal Engineer, Nuclear Licensing, Juno Beach (09/30-10/02/88, days); Gregg M. Smith, Westinghouse Electric Corporation (09/30-10/01/88, nights); William Detwiler, Westinghouse Electric Corporation (10/03-06/88, days); John W. Patterson, Westinghouse Electric Corporation (10/01-07/88, nights); Craig L. Mowrey, Westinghouse Electric Corporation (10/01/88, nights); R. John Gianfrancesco, Assistance Maintenance Superintendent, Turkey Point Nuclear Plant (09/30-10/02/88, nights); Lee C. Huenniger, Startup Superintendent, Turkey Point Nuclear Plant (10/02-07/88, nights).

During the reporting period, Unit 3 was shut down as a result of mechanical seal leakage from 3A RHR pump. The unit was taken to Mode 4 to effect repairs. Unit 4 continued in Mode 6 for the reliability outage.

No immediate safety problems were observed.

The independent observers reported one questionable work practice regarding confusion and inconsistency in the use of procedures. This item was reported on October 6, 1988. On October 7, 1988, management (Plant Manager, Operations Superintendent, etc.) met with on shift operating personnel to discuss the importance of adhering to PTN procedures and Control Room demeanor. Actions were initiated to resolve points of confusion. The independent observers also noted fourteen areas for improvement, as follows:

- One item on professionalism
- Two items on procedure improvement
- Two items on wearing hard hats in containment
- Four items on protection of equipment
- Two items on improving communication
- Two items on repair of equipment (Additional information attached, see letter, PTN-VP-88-329)
- A recommended addition to technical specifications

ATTACHMENT: MOS DAILY REPORTS

8811019042



MANAGEMENT ON SHIFT (MOS)

WEEKLY SUMARY REPORT

WEEK STARTING: 09/30/88

PAGE 2 OF 2

The Turkey Point observers did not report any questionable work practices or areas for improvement.

The Plant Supervisors - Nuclear (PSNs) reported two questionable work practices. One questioned the need for, and advisability of, a physical valve alignment verification on the pressurizer while it is at 440 degrees. The other concerned manipulation of a valve by a system engineer. Immediate disciplinary action was taken and further action is under consideration. The PSNs also noted three areas for improvement, as follows:

- One item on procedure improvement
- One item on communication of work scope
- One item on work controls and impact on operability



INTER-OFFICE CORRESPONDENCE

W. F. Conway

LOCATION: PTN-VP-88-329
Turkey Point Nuclear

FROM: J. S. Odom

DATE: October 5, 1988

SUBJECT: MOS REPORT BY RUSS GOULDY
DATED OCTOBER 2, 1988

COPIES TO: D. A. Chaney
J. E. Cross
D. A. Sager

In the subject report the observer refers to 16 equipment problems under Areas for Improvement. The statement is made that "the operating crew experienced and handled 16 separate failures" implying that the failures occurred during the shutdown.

The source of this equipment list was the Operations Supervisor, who was present in the Control Room during the shutdown. The Operations Supervisor observed some of the items and received the others from the operators, whom he had requested to provide a list of equipment that needed repair prior to startup.

In fact, 8 of the 16 items were failures that occurred during the shutdown and subsequent cooldown to 350°. The remaining 8 items were covered by plant work orders (PWO) and were either being worked or awaiting shutdown so they could be worked. Of the 8 malfunctions that occurred during the shutdown and cooldown, the most significant were the S. E. bus lockout, 2 spiking source range channels which subsequently displayed normal indication, and a charging pump relief line failure which occurred due to the charging pump flow control valve failing shut. These and the remaining problems are detailed on the attached list.

The problems are receiving the proper attention for corrective action.

J. S. Odom
Site Vice President

Attachment

JSO/14:046



1. N-31 Spiking
2. N-32 Spiking

Those occurred when energized after 6 month run. That is the first time we have observed this phenomenon--to spike and then settle out.

3. N-36 Spiked High

Did not track down in conjunction with N-35, the other intermediate range channel. Declared out of service and PWO written 10/01/88.

4. "A" Steam Generator Level Control

Level does not follow it's programmed amount from 40 to 30% power. Pwo had been written 07/31/88 to be worked during the next planned shutdown.

5. "B" MSR Steam Stop Dual Indication

Intermittent problem indicated shut after several hours. PWO written 10/09/87 to be accomplished during planned shutdown.

6. Auxiliary Oil Pump Did Not Auto Start

PWO being written.

7. Bearing Oil Lift Pump Did Not Auto Start

PWO written 02/11/88 to be worked during planned shutdown.

8. MSR Timing Valve Problems

PWO dated 09/15/88 (rewritten when the previous PWO was found not to be in the computer). This was being worked prior to the shutdown.

9. "D" MSR Timing Valve Did Not Go Full Open

Valve stroke tested 09/30/88 satisfactorily during post maintenance testing. Will work again this outage to ensure proper operation.

10. "B" CHRRM

This is B channel of Containment High Range Radiation Monitoring system. Declared out of service and PWO written 07/15/88. Troubleshooting isolated the problem to the containment. To be worked during planned outage.

11. S.E. Bus Lockout (Switchyard)

This was an isolation of S.E. bus in the switchyard--should not normally occur upon opening generator breaker. T&D is investigating. Required no immediate operator action.

12. A Gland Steam Exhauster

PWO written 06/30/88 based upon predictive and preventive maintenance readings. Mechanical work completed 09/23/88, electrical work in progress during shutdown. 3B Gland Steam Exhauster was operating. Only one is required.



13. A Charging Pump
No High Speed Alarm

Work was started but was on hold for parts qualification. Completed on 10/02/88 after the shutdown.

14. 3B Reactor Cooling Pump
Number 1 Seal Delta P
Indication (too low)

Occurred during cooldown. PHO written 10/02/88

15. Hand Control Valve
(HCV-121) Valve Closed
(Broken Feedback Linkage)

Failure occurred during cooldown and is believed to have caused item 16.

16. 3A Charging Pump Relief
Line Weld Cracked

PHO written 10/02/88. NCR being dispositioned.



Date 09/30/88

Shift Report

Shift Ed Lyons Days

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 operations

①

To: Operations Superintendent - Nuclear

Date: 09/30/88

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

- Unit 3, 100% power operation
- Unit 4, refueling, Reactor Coolant System (RCS) - 105° F
 - Turbine disassembly - low pressure turbine
 - Health Physics (HP) control of containment access

B. Immediate Safety Problems

None

C. Questionable Work Practices

See yesterdays MOS report. Calculations indicate that the cavity seal ring lifting device weighs 500 lbs. Please consider my "several tons" estimate as too high.

QC records show that the containments are closed out correctly according to their records. Consider this item closed when Unit 3 is inspected for placement of the lifting device.

D. Areas for Improvement

Air blower/filter for Steam Generators are secured with stainless steel wire but are pushed up against two RCS pressure transmitters. Recommendation: Care should be taken to assure the method of securing an item meets its intended goal and does not have freedom to be moved or vibrated into equipment.

(7)

E. Professionalism, Summary of Shift; Comments

HP operations at the containment hatch was very smooth.

1. The layout was designed to facilitate entry, removal of PCs, frisking and check out.
2. Staffing was adequate such that no lines were caused by this process of checking in or checking out.
3. Prompt attention was given to those at the blue tag station and frisk area.

I watched the removal of the stud tensioner and stud. HP controlled this job and made their requirements known to the construction forces prior to the removal from containment. This operation was performed smoothly which indicated that the planning and staffing by HP was correct for equipment removal.

(8)

Completed By:

Russell Gouldy

MOS Observer

Date: 09/30/88

Reviewed By:

L. W. France

Operations Superintendent- Nuclear

Date: 10/3/88

Management
Review By:*KE*
PM-N1 10/3/88
Date

SVP

1
Date

VP

1
Date

09/30/88



To: Operations Superintendent - Nuclear

Date: 09/30-10/01/88

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

A. Plant Evolutions Observed

- Unit 3, 100% power operation
- Removal of #2 Low Pressure turbine rotor
- Tour of the following areas
 - Unit 4 containment, (de-tensioning at reactor head)
 - Auxiliary building
 - 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.

There appears to be a noticeable improvement in the cleanliness of the Unit 4 containment. This was particularly noticeable on the floors and surfaces by the walkways.

(9)

Completed By: Gregg M. Smith
MOS Observer

Date: 09/30-10/01/88

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

Date: 10/3/88

Management
Review By:*[Signature]* 10/3/88
PM-N Date SVP Date VP Date

09/30-10/01/88



To: Operations Superintendent - Nuclear

Date: 09/30-10/01/88

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

A. Plant Evolutions Observed

- Unit 3, 100% power
- Unit 4, 0% power, Mode 6
- Observed shift turnover and shift briefing
- Toured turbine building, auxiliary building, intake structure 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

Vessel head detensioning progressed well. As of the end of the shift the crew was on the 17th sequence of the second pass.

The #2 low pressure rotor was removed and placed on the truck.

The upper HP turbine shell was placed back on the lower half for clearance measurements.

There appears to be a marked improvement in containment housekeeping.

Completed By: John Gianfrancesco
MOS Observer

Date: 09/30-10/01/88

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

Date: 10/3/88

Management
Review By:*[Signature]* 10/3/88
PM-N Date SVP Date VP Date

09/30-10/01/88



Date 10/01/88

Shift Report

Shift _____ Days _____

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 operations

(2)

[Signature]

Date 10/3/88

To: Operations Superintendent - Nuclear

Date: 10/01/88

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

- Unit 3, 100% power operation
- Unit 4, refueling shutdown, Reactor Coolant System (RCS) at 105° F
 - Containment walkdowns (AM and PM)
 - Turbine disassembly
- Emergency Response Team (ERT) formed to evaluate excessive Residual Heat Removal (RHR) pump seal leakage on the 3A RHR pump. This will help determine corrective actions necessary to reduce seal leakoff.

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

1. RCS tygon level hose needs to be protected inside the bio-wall.

Recommend the use of a Plexiglass tube that is clear to allow monitoring of the hose condition (no entrained air).

2. Containment has been cleaned up over this week but still needs a dedicated effort to bring the cleanliness up, i.e., boric acid and rust problems.
3. There is no current guidance in the Technical Specification to address the reactor when it is de-fueled (off-loaded).

Recommend the formation of a QIP team to develop a section in standard format to address the off-load core requirements and the transfer of concern to the Spent Fuel Pool where the core is stored. In the past, licensing generates a letter of what needs to be done and which surveillances can be dropped. This would be a good basis to start the effort to formalize this condition in our Technical Specification.

(11)

B. Professionalism, Summary of Shift, Comments

No unprofessional or unproductive conditions noted.

(12)

Completed By: Russell Gouldy
MOS ObserverDate: 10/01/88Reviewed By: [Signature]
Operations Superintendent - NuclearDate: 10/3/88Management
Review By:[Signature] 10/3/88 1 VP 1 Date
PM-N Date SVP Date

10/01/88



To: Operations Superintendent - Nuclear

Date: 10/01/88
1730 - 2230From: Craig Mowrey
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- Unit 3, 100% power, Unit 4, Reliability outage
- Emergency Response Team - 3A Residual Heat Removal (RHR) pump seal leakage
- Unit 3 shutdown

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

Plant Clearance Operating Network (PCON) does not allow modification of component IDs while they are tagged out on a clearance (but will allow the same component IDs to be "disapproved"). Therefore, when the third Reactor Control Operator (RCO) discovered a change on a revised operating diagram, he could not correct the component ID description.

Recommendation: Include a step in the implementation of PC/M's to update PCON. Consider creating an "Update" file in the PCON database to allow flagging of those component IDs needing revision.

(13)



E. Professionalism, Summary of Shift, Comments

The operators' obvious pride in the Unit 3 record run was readily apparent in their disappointment at having to terminate the run. Despite the disappointment, and despite some hardware problems (Intermediate Range N36, pressurizer steam space sample line leak), the Unit 3 shutdown was prompt, very smooth, and well-controlled.

(14)

Completed By: Craig Mowrey
MOS ObserverDate: 10/01/88Reviewed By: J. W. Paine
Operations Superintendent - NuclearDate: 10/3/88Management
Review By:J. C. 10/3/88 1 1
PM-N Date SVP Date VP Date

10/01/88

To: Operations Superintendent - Nuclear

Date: 10/01-02/88

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

A. Plant Evolutions Observed

- Units 3 and 4, shutdown
- Hot standby to cold shutdown (3-GOP-305)
- Volume Control Tank (VCT) gas concentration control (3-OP-047.1) -
Venting the Volume Control Tank
- Location of grounds on Auxiliary 125 DC system (off-normal OP 9608.1)

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

None

E. Professionalism, Summary of Shift, Comments

The cooldown on Unit 3 was a very smooth, very controlled evolution.

(15)

Completed By: John Patterson
MOS Observer

Date: 10/01-02/88

Reviewed By: [Signature]
Operations Superintendent - Nuclear

Date: 10/3/88

Management
Review By:

[Signature] 10/3/88 1 VP 1 Date
PM-N Date SVP Date VP Date
10/01-02/88

b: Operations Superintendent - Nuclear

Date: 10/01-02/88

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

A. Plant Evolutions Observed

- Unit 4, Mode 6, 0% power
- Unit 3, Mode 4, 0% power 435 psig 335° F
- Attended Emergency Response Team (ERT) meeting, 3A Residual Heat Removal (RHR) seal leak
- Observed control room activities associated with shutting down Unit 3
- Observed shift turnover and briefing

B. Immediate Safety Problems

None observed

C. Questionable Work Practices

None observed

D. Areas for Improvement

None observed

(16)

E. Professionalism, Summary of Shift, Comments

Due to the 3A RHR pump being considered out-of-service due to excessive seal leakage, and the 3B High Head Safety Injection (HHSI) pump being out-of-service for maintenance, a decision was made based on Technical Specification 3.4.1.6 to shutdown on Unit 3. Shutdown commenced at 2006 and the turbine was taken off-line at 2126. The appropriate NRC red phone notification was made at 2105.

The operating crew performed a coordinated and efficient effort to systematically remove Unit 3 from power operations to hot standby (procedure 3-GOP-103) without tripping the unit.

During shutdown activities the southeast bus locked out on reverse power. The PSN requested the operating crew to review the loss of off-site power procedure as a precaution.

A containment entry was made on Unit 3 to check for leaks. Water was observed on the 14" elevation, approximately 1" of water was observed on the seal table with signs of boric acid on the fittings, boric acid buildup was also observed on 955B.

(17)

Completed By: John Gianfrancesco
MOS Observer

Date: 10/01-02/88

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

Date: 10/3/88

Management
Review By:

J.C. 10/3/88 PM-N Date SVP Date VP Date

10/01-02/88



Date 10/02/88

Shift Report

Shift _____ Days _____

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 operations

(4)

Date 10/3/88

Date 10/02/88

Shift Report

Shift Mids

Shift Management

PSN Reese APSN Dallau/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

3

Date 10/3/88

Date 10/02/88

Shift Report

Shift _____ Peaks _____

Shift Management

Anderson

APSN

Dallau

NWE Fernandez

A. Questionable Work Practices/Actions Taken/Recommendations

In OSP-041.4 Overpressure Mitigating System (OMS) (required to be performed prior to cooling down $< 275^{\circ}\text{F}$ in the Reactor Coolant System) it allows us to check the PSN file for a previous completed attachment #1 and if we have a current one on file to go ahead and complete the procedure which tests the operability of the OMS. Then on the next to the last step of the procedure it requires attachment #1 to be performed.

At the time we are required to do this walkdown the pressurizer steam space temperature is around 440°F , which causes high ambient temperatures in the top of the pressurizer where the NO's have to crawl, with scott air packs on, and physically try to turn the valves to verify their position. This is a safety hazard. There is a chance a man can pass out inside the top of the pressurizer and would be very difficult if not impossible to get out immediately by the one man who is accompanying him. There is also a great possibility of receiving burns while crawling around in this confined space.

The OSP for this system is required on the first Monday of the month after going below 275°F . This procedure requires a lineup check before it is concluded. We have other procedures that allow a walkdown recorded in the PSN file to be used for valve alignment verification without doing the actual walkdown.

Recommend: If a current attachment #1 is in the PSN file an actual walkdown should not be required. Then do OSP-041.4 as soon as we reach cold shutdown conditions and containment atmosphere is purged to the correct oxygen content. If the integrity of the valves is a worry from the previous walkdown, we may want locks on the valves.

B. Areas for Improvement/Recommendations/Actions taken

None

C. Good Practices/Professionalism Observed

Routine operations

(5)



To: Operations Superintendent - Nuclear

Date: 10/02/88

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

- ° Unit 3 Hot shutdown and cooling down to cold shutdown
- ° Unit 4, refueling shutdown Tave 100° F
 - Unit 3 cooldown and placing Residual Heat Removal (RHR) into service
 - Unit 4, containment walkdown

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

1. Review of last night's shutdown indicated that the operating crew experienced and handled 16 separate failures. The Operations Supervisor was on hand and listed the problems as such:

1. N-31 spiking
2. N-32 spiking Nuclear Power Range instrument channels
3. N-36 spiked high
4. A Steam Generator level control
5. "B" MSR steam stop dual indication
6. Auxilliary oil pump did not auto start
7. Bearing oil lift pump did not auto start
8. MSR timing valve problems
9. "D" MSR timing valve did not go full open
10. "B" CHARM
11. S.E. bus lockout (switchyard)
12. "A" gland steam exhauster
13. "A" charging pump - no high speed alarm
14. 3 B Reactor Coolant Pump (RCP) #1 seal Delta P indication (too low)
15. Hand Control Valve (HCV)-121 failed closed (broken feedback linkage)
16. "3A" Charging pump relief line weld cracked.

The operating crews performed their job well as seen in this shutdown despite these problems. Improvement is still needed in the attention to correcting equipment problems.



2. I&C is closing out PWOs in the control room to reduce their QIDW indicator. An example is "B" charm Unit 3 (see item 1 #10) which was closed out without fixing the problem by an I&C foreman yesterday. The problem was identified as "approaching it's acceptance criteria". The operator agreed and stated, "we write PWOs as such so Turkey Point won't enter LCOs." During the shutdown, B charm is logged as out-of-service and the LCO is entered. "Time in LCO" is also a QIDW indicator, however, it is someone elses.

The problems: Operators need a way to pass on an item that is trending to a failure mode if PWOs are not the mechanism to get it fixed. The pressure to show QIDW indicators trending toward the good has not led to the desired effect, but has just transferred from one indicator to another. Our operators recognize this fact and I was asked to point it out. Operators expect the problems identified to be fixed. I witnessed this with item #10 which failed and the PWO was cleared when I was in the control room earlier that day.

3. Containment closeout procedure 0-SMM-51.3 does not provide a positive record of what is stored in containment during operation. This procedure has 11 pages of text followed by an appendix for deviations. A better format would have a place to indicate that each item of equipment on a stowage list was properly stored.

Recommendation: Provide a column for initials and date for verification of the stowage list.

Note: Unit 3 was verified as having correctly stored the cavity seal ring lifting device today.

4. A newly hung drain hose was not properly connected together in the Unit 4 containment which leaked and created two puddles under the Steam Generator. HP was notified and taped the joint and resolved the problem.

Recommendation: HP should look for and take corrective action on leaking hoses.

19



E. Professionalism, Summary of Shift, Comments

1. Outage management (Webb and Thomas) did an excellent job, of taking charge and obtaining from the departments work which was needed to be done, at this morning's meeting. At the end of the meeting they passed out the short notice outage work schedules and asked for departmental reviews for a finalized outage to be presented at 11:00 AM. This 7:15 AM meeting was very productive in setting up our game plan.
2. Operators assuming the shifts reviewed last night's shutdown and had two comments:
 1. A large number of problems and still a smooth shutdown.
 2. There was not a good communication of the reason for the time factor involved in shutting down Unit 3. The rate was that of Technical Specification 3.0.1, but 3.4.1 was the Technical Specification cause of the shutdown.

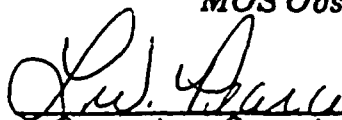
Completed By:

Russell Gouldy

MOS Observer

Date: 10/02/88

Reviewed By:



Operations Superintendent - Nuclear

Date: 10/3/88

Management
Review By:
PM-N10/3/88
Date

SVP

1
Date

VP

1
Date

10/02/88

FINAL PAGE



To: Operations Superintendent - Nuclear

Date: 10/02-03/88

From:

John Patterson

(MOS Observer)

Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- Units 3 and 4, shutdown
- Shift turnover
- Shift briefing
- Tour of Radiation Controlled Area (RCA)
- Tour of Unit 4 containment
- Overpressure Mitigating System (OMS) 3-OP-041.4

B. Immediate Safety Problems

None

C. Questionable Work practices

None

D. Areas for Improvement

None

E. Professionalism, Summary of Shift, Comments

While reviewing the Refueling Containment Penetration Alignment procedure (4-OSP-051.12) the control crew detected a potential conflict with the Independent Verification procedure (O-ADM-031). Alertness and attention to detail prevented the implementation of penetration alignment procedure prior to conflict resolution. The Plant Supervisor Nuclear (PSN) notified Operations management of the situation. The Independent Verification procedure specifically calls for "Independent Verification" (IV) on containment penetrations but the Refueling Containment Penetration Alignment procedure does not.

Completed By:

John Patterson

MOS Observer

Date: 10/02-03/88

Reviewed By:

LW Pearce

Operations Superintendent - Nuclear

Date: 10/3/88

Management
Review By:*RC*
PM-N10/3/88
Date

SVP

Date

VP

10/02-03/88
Date



To: Operations Superintendent - Nuclear

Date: 10/02-03/88

From: Lee C. Huenniger
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- Unit 3 holding at 278°
- Unit 4 at refueling shutdown
- Shift turnover meeting peak to mids, Operations, Health Physics, and three Maintenance Departments
- Testing of 4A Spent Fuel Pump (SFP) (4-OSP-033.1)
- Toured Unit 4 containment

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

None

E. Professionalism, Summary of Shift, Comments

The Health Physics Technician worked well with the Operations and Technical Departments in setting up and supporting the Inservice Testing of the 4A Spent Fuel Pit pump.

(22)

Completed By: Lee C. Huenniger
MOS Observer

Date: 10/02-03/88

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

Date: 10/3/88

Management
Review By:*JEC* 10/3/88
PM-N Date SVP Date VP 10/02-03/88

10/02-03/88



Date 10/03/88

Shift Report

Shift

Ed Lyons.
Days

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 operations

(1)

Reviewed By

K. L. F. L. L. L.

Date

10/4/88



Date 10/03/88

Shift Report

Shift Mid

Shift Management

PSN Reese 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

(6)

Date 10/03/88

Shift Report

Shift Mids

Shift Management

PSN Reese 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

(3)

Reviewed By RW Spence

Date 10/4/88



Date 10/03/88

Shift Report

Shift _____ Peaks _____

PSN _____ Salkeld _____ APSN _____ Guyer _____ NWE _____ Eddinger _____

Shift Management

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions taken

None

C. Good Practices/Professionalism Observed

The decision not to cooldown the Reactor Coolant System (RCS) less than 200° F until both Residual Heat Removal (RHR) loops are operable was a good practice. Taking credit for an RCS loop in Mode 5, while permitted by Technical Specifications, would require a mode change before it could be an effective heat sink. That mode change would violate Technical Specifications.

(2)

Reviewed By [Signature]

Date 10/4/88

To: Operations Superintendent - Nuclear

Date: 10/03/88

From: William Detwiler
(MOS Observer)Shift: ☒ Day
☐ Night

A. Plant Evolutions Observed

- ° Entered LCO in order to energize and open SV-6428 for Reactor Coolant System (RCS) sampling
- ° Vented Volume Control Tank (VCT)
- ° Toured Unit 4 containment
- ° Unit 3 in Mode 4 maintaining temperature with Steam Generator (S/G)
- ° Unit 4 in Mode 6

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: William Detwiler
MOS Observer

Date: 10/03/88

Reviewed By: [Signature]
Operations Superintendent - Nuclear

Date: 10/4/88

Management
Review By:10/11/88 10/4/88
PM-N Date SVN Date VP Date

10/03/88



To: Operations Superintendent - Nuclear

Date: 10/03-04/88

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

A. Plant Evolutions Observed

- Units 3 and 4, shutdown
- Shift turnover
- Shift briefing
- Tour of Radiation Controlled Area (RCA)
- Tour of Unit 4 containment
- Tour of intake structure

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

None

E. Professionalism, Summary of Shift, Comments

During the shift briefing the Assistant Plant Supervisor Nuclear (APSN) reviewed Training Brief number 60, Potential Spent Fuel Pit Overflow. This is a good example of being alert to previous problems and taking positive steps to prevent recurrence.

(5)

Completed By: John Patterson
MOS Observer

Date: 10/03-04/88

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

Date: 10/4/88

Management
Review By:

PM-N 10/4/88 SVP 10/4/88 VP 10/03-04/88



To: Operations Superintendent - Nuclear

Date: 10/03-04/88

From: Lee C. Huenniger —
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- Units 3 and 4 control room operator and shift turnover meeting
- Unit 4 turbine disassembly
- Unit 4 condenser pit welding
- Unit 4 containment work
- Toured Radiation Controlled Area (RCA) and observed Mechanical Maintenance working 3A Residual Heat Removal (RHR) pump

B. Immediate Safety Problems

None

C. Questionable Work Practices

None observed

D. Areas for Improvement

None observed

E. Professionalism, Summary of Shift, Comments

No unprofessionalism was observed.

Entry into and out of the containment has been handled in a professional manner. The facility is manned by knowledgeable personnel who render assistance as needed.

⑥

Completed By: Lee C. Huenniger
MOS Observer

Date: 10/03-04/88

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

Date: 10/4/88

Management
Review By:

PM-N 10/4/88 SVR 10/4/88 VP 10/03-04/88



Date 10/04/88

Shift Report

Shift Ed Lynns
Days

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 operations

(1)

Date 10/6/88



To: Operations Superintendent - Nuclear

Date: 10/04/88

From: William Detwiler
(MOS Observer)Shift: ☒ Day
☐ Night

A. Plant Evolutions Observed

- ° Pressurizer power operated relief valve PCV-4-455C stroke test
- ° Securing 3C Reactor Coolant Pump (RCP)
- ° Reinitiation of cooldown
- ° Attempted filling of fuel transfer canal
- ° Containment tour

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

None

E. Professionalism, Summary of Shift, Comments

Suggestion:

The cover sheet of the Plan of the Day has information that is largely irrelevant to shutdown/refueling operations. Provide a cover sheet to be used during shutdown/refueling that provides data that is useful for this condition. Examples are boron concentration, RCS temperature, mode condition, heatup or cooldown rate, continuous days shutdown and other pertinent information.

Also useful information that could be added to the regular POD cover sheet would be burnup and boron concentration.

Good professionalism was demonstrated by the day shift in the operation of filling the fuel transfer canal. Communications were well maintained. As soon as it became apparent that the current procedure was not going to work, it was terminated. The PSN then immediately communicated the problems to his supervisor. These actions minimized the time and effort wasted in trying to perform the procedure.

Completed By: William Detwiler
MOS Observer

Date: 10/04/88

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

Date: 10/6/88

Management
Review By:

[Signature] 10/5/88 *[Signature]* 10/5/88
PM-N Date SVR Date VP Date
10/04/88



To: Operations Superintendent - Nuclear

Date: 10/04-05/88

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

A. Plant Evolutions Observed

- Units 3 and 4, shutdown
- Shift turnover
- Shift briefing
- Tour of Radiation Controlled Area (RCA)
- Tour of Unit 4 containment
- Tour of intake structure

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: John Patterson
MOS Observer

Date: 10/03-04/88

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

Date: 10/6/88

Management
Review By:

[Signature] 10/5/88 *[Signature]* 10/5/88
PM-N Date SVP Date VP
10/03-04/88



To: Operations Superintendent - Nuclear

Date: 10/04-05/88

From: Lee C. Huenniger
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- Units 3 and 4 control room operations
- Peak to mid shift turnover meeting with Operations, Health Physics and Maintenance
- Unit 4 containment tour and cavity seal ring efforts
- Outage activities on turbine deck, condenser pit and ground elevation oil flush, set-up
- Toured A & B diesel rooms

B. Immediate Safety Problems

None observed

C. Questionable Work Practices

None observed

D. Areas for Improvement

None observed

E. Professionalism, Summary of Shift, Comments

Construction responded effectively to concerns involving the cavity seal ring and seal table fitting. The appropriate support organizations were contacted to begin resolving the issues in question.

Completed By: Lee C. Huenniger
MOS Observer

Date: 10/04-05/88

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

Date: 10/6/88

Management
Review By:*[Signature]* 10/5/88 *[Signature]* 10/5/88
PM-N Date SVP Date VP

10/04-05/88



To: Operations Superintendent - Nuclear

Date: 10/05/88

From: William Derwiler
(MOS Observer)Shift: ☒ Day
☐ Night

A. Plant Evolutions Observed

- Recirculating C boric acid storage tank
- Unit 4, containment tour
- Plan of the Day meetings, 7:15 AM - 1:15 PM
- Shift turnover meeting

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

During my containment tour, I noticed a person coming up to the operating deck without a helmet. I asked him where it was and he immediately returned to the access and put one on. I know the word has been put out about wearing safety helmets, but apparently this person forgot. I suggest putting up a big sign by the barrels reminding people to put on their helmet. Also, the Security Guard could be alerted to make sure each person is properly dressed as they enter the personnel hatch.
(88-2725)

E. Professionalism, Summary of Shift, Comments

The shift turnover and briefing meeting was well conducted. The PSN emphasized that only business is to be conducted inside the red line and this included not participating in casual conversation inside the red line.

(2)

Completed By: William Derwiler
MOS Observer

Date: 10/05/88

Reviewed By: *Lee. P. [Signature]*
Operations Superintendent - Nuclear

Date: 10/6/88

Management
Review By:*Sup for Sec 10/6/88*
PM-N Date*[Signature]* 10/6/88
SVP Date

VP

Date

10/05/88



To: Operations Superintendent - Nuclear

Date: 10/05-06/88

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

A. Plant Evolutions Observed

- Units 3 and 4, shutdown
- Shift turnover
- Shift briefing
- Tour of Unit 4 containment

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

Hard hats are required inside containment. The signs posted in containment imply that hard hats are required when leaving the refueling floor (58 foot elevation). All areas below the refueling floor elevation are clearly posted. All exits to elevations below the refueling floor elevations are also clearly posted. The present configuration of posted signs does not suggest that hard hats must be worn on the refueling floor elevation.
(88-2725)

E. Professionalism, Summary of Shift, Comments

The cooldown evolution was conducted in a smooth, controlled manner.

(3)

Completed By: John Patterson
MOS Observer

Date: 10/05-06/88

Reviewed By: *R. W. Prince*
Operations Superintendent - Nuclear

Date: 10/6/88

Management
Review By:

PM-N

Date

SVP

Date

VP

Date

10/05-06/88

To: Operations Superintendent - Nuclear

Date: 10/05-06/88

From: Lee C. Huenniger
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- ° Units 3 and 4 control room operations
- ° Shift briefing, Operations, Health Physics and Maintenance disciplines
- ° Unit 3 4160 V switch gear room tour
- ° Unit 4 containment tour - no safety violations observed
- ° Followed activities involving cavity seal ring turnover and testing

B. Immediate Safety Problems

None observed

C. Questionable Work Practices

None observed

D. Areas for Improvement

None observed

E. Professionalism, Summary of Shift, Comments

Operation (PSN) briefed the shift on activities necessary to run the 3A Residual Heat Removal (RHR) pump and plan to have the Reactor Coolant System (RCS) cooled to less than 200° F by 3:30 AM. The shift then worked the plan and accomplished their goal. The Technical Department was standing by and completed pump testing by 5:00 AM.

Completed By: Lee C. Huenniger
MOS Observer

Date: 10/05-06/88

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

Date: 10/6/88

Management
Review By:

PM-N

Date

SVP

Date

VP

Date

10/05-06/88



Date 10/06/88

Shift Report

Shift _____ Days _____

PSN _____ Wogan _____ APSN _____ Singer _____ NWE _____ Newton _____

Shift Management

A. Questionable Work practices/Actions Taken/Recommendations

The Unit 3 turbine operator informed the APSN that he saw two engineers at the Generator Liquid Detectors manipulating valves. The APSN contacted engineer Louis Martos who stated that he had manipulated a valve. He said, "I have made a mistake." He also stated that the other engineer, L. McDougal, had not manipulated any valves.

The engineer should have known better than to manipulate valves. The engineer that was with him should have known better than to let the other engineer manipulate valves. The plant does not need any more system misalignments and these type of actions can lead to this.
(88-2729)

B. Areas for Improvement/Recommendations/Actions Taken

None

C. Good Practices/Professionalism Observed

A fire was reported that was put out in the Boric Acid room by the Mechanical Maintenance Department. The NWE, Fire Team Leader and Electrical Department personnel quickly responded to make sure that the fire was indeed out and to de-energize the heat tracing circuit. Good save to all.

(3)

R.W. Pearce

10/7/88



Date 10/06/88

Shift Report

Shift Mids

Shift Management

PS. Anderson APSN Dallau NWE Fernandez

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions taken

None

C. Good Practices/Professionalism Observed

Routine operations

(1)

Reviewed By

[Signature]

Date 10/6/88

Date 10/06/88

Shift Report

Shift _____ Peaks _____

Salkeld

Shift Management
Guyer

Eddinger

PSN _____

APSN _____

NWE _____

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

During implementation of the PC/M to install driers in the Emergency Diesel Generator (EDG) starting air system, Construction, in accordance with their process sheets, removed the security grating/missile shield from the east side of the "A" EDG room. The removal of this missile shield was not included in the PC/Ms safety evaluation because it was believed this PCM would be done in conjunction with the diesel outage. Because no evaluation was done, the operability of the "A" EDG was indeterminate. We therefore declared it out-of-service; performed operability checks of the "B" EDG and the startup transformer; and had the missile shield re-installed on the "A" EDG room. To prevent recurrence of this type of problem I recommend we consider:

1. Engineering should include mode and equipment status assumptions in their PC/Ms. (88-2730)
2. Identify and label all required missile shields; and (88-2746)
3. Require PNSC review of all process sheets involving safety related structures of Technical Specification requirements. (88-2747)

C. Good Practices/Professionalism Observed

None noted

(4)

Reviewed By *V.W. Pierre*

Date *10/7/88*



To: Operations Superintendent - Nuclear

Date: 10/06/88

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

1. Stopping and starting containment purge fans (0-OP-053)
2. Stopping 3C Main Condensate Pump
3. Performance of process radiation monitor operational test (OSP 67.1).
4. Collapsing the pressurizer bubble 3-OP-041.2
5. POD morning meeting

B. Immediate Safety Problems

NONE

C. Questionable Work Practices

Administrative Procedure 0-ADM-201 states in section 5.1.1 and 5.1.2 that "procedure that is documented by an initial or signature" must be present and referred to directly. On 10/04/88 I observed the RCO stopping a reactor coolant pump (RCP) without referring to, initialing, or signing the appropriate procedure (3-OP-041.1). He did fill out the procedure on 10/05/88 and so stated on the procedure. When I informed the PSN (on 10/04/88), he said that he considered securing a RCP a routine operation and that 3-OP-041.1 was not required to be filled out. This caused me to suspect that this may be a widespread problem so I used several more days to observe and investigate. I found by referring to the records that in May and September of 1988 RCP's were obviously stopped but sometimes there was no record of any sections of OP-041.1 which direct the stopping of RCP's (See Attached).

In addition, on 10/06/88 the third RCO attempted to start a containment purge supply fan without referring to or initialing procedure. This is a safety related procedure (4-OP-053). When the purge supply fan tripped, he began troubleshooting for the system engineer. He stopped the Unit 3 containment purge supply and exhaust fans, started the Unit 4 containment purge supply fan, then restarted Unit 3 containment purge supply and exhaust fans without ever referring to procedure.

When I later questioned the RCO who was overseeing the actions of the third RCO he stated the requirement to use procedure but didn't think to direct the RCO to use it for the purge fan operations at the time.

(5)

The PSN made sure that procedure was used for the next operation of the purge fans which I observed. The PSN also agreed to remind his operators of this requirement at the shift turnover briefing.

Over the past few days when I talked to other RCO's and PSN's, they were usually able to correctly state the requirements of 0-ADM-201, Section 5.1.1 and 5.1.2. But, some RCO's stated that not all RCO's fill out procedures for what they consider simple or routine operations.

I also talked to John Crockford who was very recently in charge of training operators. He stated that training did cover the requirements of 0-ADM-201 and the use of procedures. Several operators concurred.

As a result of my observations and research, I conclude that this questionable work practice is the result of several factors.

1. Some operators are not aware or do not understand the requirements of 0-ADM-201.
2. Other operators are aware of the requirements but don't understand how and when they apply. They can state the requirement yet don't always use the procedures when performing "routine" operations.
3. There is an inconsistency in the past and present among operators when they do and don't use procedures to perform what they consider simple or routine operations.
4. There is inconsistent enforcement and accountability of 0-ADM-201. PSN's aren't making sure operators always use and fill out procedures when required.

Since the lack of use and completion of procedures for "routine" operations appears to be widespread, I don't think "counseling" these individuals I observed is appropriate. To help prevent a recurrence all operators should be required to review 0-ADM-201. It also needs to be explained that if a procedure has blanks for initials or a signature you've got to refer to it and fill it out. This can be put out at shift turnover briefings.

In addition, PSN's should check for completed and signed procedures for all operations that occur on their shift not just the ones they see come across their desk. If they don't see the appropriate procedure being used or they don't see a completed procedure for an operation that has been performed they should find out why. (88-2748)

⑥

D. Areas for Improvement

NONE

E. Professionalism, Summary of Shift, Comments

On 10/05/88 I observed a RCO trainee playing with the Unit 3 ERDADS computer. He was continuously typing in rows of letters and deleting them for about 5-10 minutes while I watched. When I informed the PSN he immediately asked the RCO trainee to stop and the trainee immediately did so. Later that same day I observed that the Unit 4 ERDADS screen was filled with X's and in the middle of them was the statement "OP-201 filling the reactor cavity by the Niagara Falls Method". Early this morning I found another indiscrete statement flashing on the Unit 4 screen. This is an unprofessional use of the computer systems. RCO's and PSN's should be more aware of what is on the ERDADS computer screens. It should be made clear that using computer systems in this way is unprofessional. (88-2749)

(7)

Completed By:

MOS Observer

Date: 10/07/88

Reviewed By:

J. W. Peace
Operations Superintendent - Nuclear

Date: 10/7/88

Management
Review By:J. W. Peace
PM-N10/7/88
DateJ. W. Peace
SVP10/7/88
Date

VP

Date



To: Operations Superintendent - Nuclear

Date: 10/06⁶-06⁷/88From: John Patterson
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- Units 3 and 4, shutdown
- Shift briefing
- Tour of Unit 4 containment
- Tour of Radiation Controlled Area (RCA)
- "B" Emergency Diesel Generator (EDG) Operability Test (0-OSP-023.1)
- Source Range Nuclear Instrumentation Operational Test (4-OSP-059.1)
- Component Cooling Water (CCW) Heat Exchanger removal

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

None

E. Professionalism, Summary of Shift, Comments

The Plant Supervisor Nuclear (PSN) took prompt action to place the "A" EDG out of service when he discovered the missile shield removed for maintenance. The "B" EDG was run for operability as required. The PSN made contact with appropriate supervision to implement steps to prevent recurrence.

(8)

Completed By: MOS Observer

Date: 10/7/88

Reviewed By: John Patterson
Operations Superintendent - Nuclear

Date: 10/7/88

Management
Review By:

PM-N 10/7/88 SVP 10/7/88 VP 1
Date Date Date Date



To: Operations Superintendent - Nuclear

Date: 10/06-07/88

From: Lee Huenniger
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- Units 3 and 4 control room operations
- Tour of Radiation Control Area (RCA)
- Tour on Unit 4 containment
- Followed activities involving cavity seal ring partial turnover to plant

B. Immediate Safety Problems

None observed

C. Questionable Work practices

None observed

D. Areas for Improvement

None observed

E. Professionalism, Summary of Shift, Comments

The addition of "Access Control Area" signs, indicating person to check with prior to entry, provides the proper type of guidance to persons unfamiliar with area who are trying to obey rules and get the job done.

I contacted Mike Givens about posting low radiation area signs for people required to wait while in containment. He already had poster signs and Health Physics would be posting these areas shortly. No additional action required.

(9)

Completed By: Lee Huenniger
MOS Observer

Date: 10/06-07/88

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

Date: 10/7/88

Management
Review By:

McC 10/7/88 YRL 10/7/88
PM-N Date SVR Date VP Date

10/06-07/88



Date

10/07/88

Shift Report

Shift

Ed Lyons
Mids

Shift Management

Anderson

APSN

Dallau

NWE Spence

A. Questionable Work practices/Actions Taken/Recommendations

B. Areas for Improvement/Recommendations/Actions Taken

1. When I came on shift, a critical piece of equipment needed for the evolution in progress for operations, PORV 455C, was out-of-service. The turnover I received about 455C was that the work was complete on the regulator for nitrogen backup and was in service for observation. I also found that the work package said that the only work done was resetting the regulator (done for the second time in two days) and some small down stream leaks were repaired. No active work was actively being performed on the regulator. I asked the midnight shift supervisor to let me know what we had to do to call the regulator back in service and what work had actually been done on the regulator. After much extensive research on the work package including calling supervisors and the technician that worked the job, at home, we found out what had been done and what we had to do to put it back in service.

Recommend:

1. Important jobs like this be worked until complete and if there is a question on whether it should be worked continuously call Operations.
 2. More complete information of work that was done be written in the work package.
(88-2726)
2. On 9/1/88 an attachment was added to GOP 305 which described limits on pressurizer spray valve operation when a Delta T of 200° to 320° existed between the Reactor Coolant System (RCS) loops and the pressurizer. This limit is 6 cycles of the sprays \leq 60 seconds per cycle. These limits came from Engineering to prevent excessive thermal fatigue of the pressurizer spray line. We have also committed to not collapse the bubble until we are $< 200^\circ$ in the RCS. With these two restrictions, we cannot collapse the bubble using procedure 3/4 OP-041.2 Pressurizer Operation, unless auxiliary spray is used (due to the stopping Reactor Coolant Pump to cooldown the pressurizer). In this condition we are very close to the Delta T for use of auxiliary spray which is 320° Delta T between the Volume Control Tank (VCT) temperature and pressurizer steam space temperature. The procedure also indicates auxiliary spray should not be used.

Recommend:

1. We take another look at the Engineering evaluation to try to improve on the number of strokes and time limit criteria for the spray valves.
(88-2727)
 2. Before things such as this are put into procedures we need to have Operations input to determine other changes needed in the procedure to be able to comply with the restrictions.
(88-2728)
- ①

Reviewed By

K. P. Mice

Date

10/7/88



Date 07/07/88

Shift Report

Anderson

Page 2

Continuation Page

C. Good Practices/Professionslism Observed

I would like to commend the midnight shift I&C Supervisor, Ken Henry, for his hard work and the dilligent help he provided tonight on researching the work done on the PORV 455C work package.

2

