

U. S. NUCLEAR REGULATORY COMMISSION

REGION III

Report No. 50-346/92019(DRP)

Docket No. 50-346

Operating License No. NPF-3

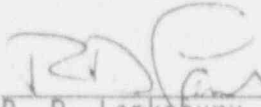
Licensee: Toledo Edison Company
Edison Plaza, 300 Madison Avenue
Toledo, OH 43652

Facility Name: Davis-Besse Nuclear Power Station

Inspection At: Oak Harbor, Ohio

Inspection Conducted: December 16, 1992, through January 25, 1993

Inspectors: S. Stasek
R. K. Walton

Approved By: 
R. D. Lanksbury, Chief
Reactor Projects Section 3B

2/10/93
Date

Inspection Summary

Inspection on December 16, 1992, through January 25, 1993
(Report No. 50-346/92019(DRP))

Areas Inspected: A routine safety inspection by resident inspectors of action on previous inspection findings, licensee event report followup, operational safety, surveillances, and maintenance.

Results: An executive summary follows:

Plant Operations: Overall, performance of the operating crews was good this inspection period. Inspector review of a December 14 inadvertent boron addition to the reactor coolant system determined operators responded appropriately and conservatively. In general, adherence to administrative controls was good. However, a clean waste monitor tank pump was inadvertently operated for several hours with its suction valve closed due to an incorrect performance of a valve lineup. Two control room emergency ventilation system valves that were found out of position on December 8 were due to an operator error while returning the system to standby and were classified as a non-cited violation.

Radiological Controls: The licensee implemented the revised 10 CFR Part 20 requirements on January 1, 1993. Results of a containment neutron distribution survey conducted in October 1992, were issued this period indicating significant neutron dose savings from those originally used. Adherence to radiation protection program requirements was good this period

with no substantive problems noted. However, the inspectors noted some inconsistencies with radiological postings on one occasion.

Maintenance/Surveillance: Overall, surveillance and maintenance activities observed during the inspection period appeared to be conducted in accordance with all applicable requirements. However, on one occasion, the inspector noted a failure of Instrument and Control (I&C) technicians to adhere to personnel red tagging requirements that resulted in a non-cited violation. Additionally, a failure to adequately perform an independent verification on September 16, 1992, that resulted in exceeding a Technical Specification limiting condition for operation was classified as a non-cited violation this inspection period.

Engineering/Technical Support: Engineering support to plant organizations on a day-to-day basis as well as in response to identified problems was good. In general, engineering expertise was routinely considered as a substantial resource to be utilized by other parts of the organization onsite.

DETAILS

1. Persons Contacted

a. Toledo Edison Company

D. Shelton, Vice President, Nuclear
G. Gibbs, Director, Quality Assurance
*L. Storz, Plant Manager
*J. W. Rogers, Manager, Maintenance
*S. Jain, Director, Engineering
*E. Salowitz, Director, Planning
J. K. Wood, Operations Manager
*J. Polyak, Manager, Radiological Protection
*V. Sodd, Manager, Independent Safety Engineering
*D. Timms, Manager, Systems Engineering
*G. Grime, Manager, Security
R. Schrauder, Manager, Nuclear Licensing
J. Wissner, General Supervisor, Instrument and Control Maintenance
*C. Hawley, Superintendent, Shift Operations
*J. P. Hartigan, Supervisor, Design Engineering
*J. E. Blay, Engineer, Independent Safety Engineering
*G. Honma, Supervisor, Licensing
*N. K. Peterson, Licensing
*A. W. Rabe, Supervisor, Quality Assurance
*D. R. Wuokko, Supervisor, Regulatory Affairs
*R. C. Zyduck, Manager, Nuclear Engineering
*J. L. Tabbert, Supervisor, Independent Safety Engineering

b. USNRC

*S. Stasek, Senior Resident Inspector
*R. K. Walton, Resident Inspector

*Denotes those personnel attending the January 25, 1993, exit meeting.

2. Followup of Previous Inspection Findings (92701)

- a. (Closed) Unresolved Item (346/92014-01(DRP)): Improperly performed independent verification (IV) of a Steam and Feedwater Rupture Control System (SFRCS) detector equalizing valve. On September 16, 1992, Instrument and Controls (I&C) technicians completed testing of a differential pressure switch and returned the detector to service with the equalizing valve three turns open in lieu of closed. As documented in Licensee Event Report 346/92-008, this error rendered two SFRCS detectors inoperable and was not detected until September 19, 1992.

The licensee concluded that the technician directed to "restore the switch" failed to completely close the valve and a second technician failed to properly perform an independent verification.

The licensee's corrective actions for this event were discussed in Inspection Reports 50-346/92014(DRP) and 50-346/92017(DRP).

The inspectors interviewed the individual, an I&C journeyman level mechanic with about 5 years experience, who incorrectly performed the IV and concluded that he had been adequately trained to perform independent verification activities and had recognized that an IV was required by the surveillance test. Further, he indicated he could not explain why he failed to perform the independent verification correctly.

The initial mispositioning of the valve and the improperly performed independent verification that would have detected the error, appeared to be isolated actions by the two technicians.

The technicians were subsequently counseled and disciplined. This event was discussed with personnel in the maintenance shop and a memorandum was issued to shop personnel on how to properly perform independent verifications. Maintenance management also subsequently submitted a training action request (TAR) to ensure that all shop personnel received adequate independent verification training. The inspectors observed the performance of DB-MI-03204, Channel Functional Test and Calibration of SFRCS Actuation Channel 2, on January 6, 1993, and noted that the individuals utilized a copy of the procedure in the field and properly performed the independent verifications in accordance with the licensee's guidance memorandum.

The test procedure, DB-MI-03203, Channel Functional Test and Calibration of SFRCS Actuation Channel 1, revision 1, step 8.4.1.4.c., required that the subject equalizing valve to PDS-2686A be closed. In fact, the valve was found three turns open. This same step required that the equalizing valve position be independently verified. The step was improperly signed as having been independently verified. Additionally, Technical Specification (TS) Limiting Condition for Operation 3.3.2.2., Action statement a., states in part, "With a SFRCS instrumentation channel trip setpoint less conservative than the value shown in the Allowable Values column, declare the channel inoperable and apply the applicable ACTION requirement of Table 3.3.11, until the channel is restored to OPERABLE status..." With the equalizing valve for PDS-2686A not closed, the detector was rendered inoperable on September 16, 1992, but the channel was not placed in the tripped condition within 1 hour as required by Action 16 of Table 3.3.11. The failure to adequately implement DB-MI-03203 is considered a violation of TS 3.3.2.2. as well as TS 6.8.1.c (which specifies written procedures be established and implemented for surveillance and test activities relating to safety-related equipment). However, further review determined that SFRCS remained functional with the instrument inoperable, the event was isolated in nature, and that the failure to do the IV was made at the technician level.

Therefore, the violation will not be cited since the criteria specified in Section VII.B.2. of the "General Statement of Policy and Procedures for NRC Enforcement Actions," (Enforcement Policy 10 CFR Part 2, Appendix C (1992)) were satisfied.

- b. (Closed) Open Item (346/92017-01(DRP)): On December 8, 1992, during performance of DB-SS-03041, "Control Room Emergency Ventilation System (CREVS) Train 1 Monthly Test", an operator found valves HA15 and HA17 open when their required position was closed. Valves HA15 and HA17 are capped isolation valves which are maintained closed to prevent freon from migrating to the air cooled condenser located on the roof of the auxiliary building.

The licensee subsequently determined that DB-OP-06505, "Control Room Emergency Ventilation System Procedure," (which included manipulation of the subject valves), was last used on November 25, 1992, when CREVS was placed into service to provide control room ventilation while the normal ventilation system was unavailable due to maintenance. On that day, to return CREVS to a normal standby lineup, the control room operator secured the CREVS fan by simply operating its control switch from the control room (and documented that the system was secured on the turnover sheet), but valves HA15 and HA17 were not locally repositioned closed as specified by step 5.2.6. of DB-OP-06505. Because the operator apparently felt returning the system to standby was a routine evolution, in-hand usage of the procedure was not required by DB-OP-00000, "Conduct of Operations".

With valves HA15 and HA17 open, the licensee indicated that the compressor would still have had starting capability but could subsequently trip on a low suction pressure (caused by the freon migration). Over a short period of time, freon pressure would have returned, the compressor trip would have automatically reset, and the compressor would have started again. The number of times the compressor could have cycled was dependent upon the degree of freon migration to the air cooled condenser, however, the licensee's position was that the system remained operable with valves HA15 and HA17 open. The inspectors spoke with engineering staff and concluded that the air cooled mode of cooling would be in service well before exceeding any room temperature limits.

Step 5.2.6 of DB-OP-06505, revision 0, Control Room Emergency Ventilation System Operating Procedure, required that valves HA15 and HA17 be positioned closed. On December 8, 1992, valves HA15 and HA17 were found open. This was a violation of Technical Specification 6.8.1.a, (required written procedures specified in Regulatory Guide 1.33 be established, implemented, and maintained), in that procedure DB-OP-06505 was not properly implemented.

The violation will not be cited since the criteria specified in Section VII.B.1 of the "General Statement of Policy and Procedures

for NRC Enforcement Actions," (Enforcement Policy 10 CFR Part 2, Appendix C (1992)) were satisfied.

The licensee documented this event on a Potential Condition Adverse to Quality Report (PCAQR 92-0462). The individual who improperly secured CREVS was removed from licensed duties and disciplinary actions were implemented in accordance with company policy. Additionally, during discussions with the Manager-Operations, the inspector was informed that administrative procedure DB-OP-00000 was currently in process of revision to, in part, better address procedural adherence requirements and management expectations in that area.

- c. (Closed) Unresolved Item (346/92017-03(DRP)): Inadvertent boric acid addition to the reactor coolant system during a dilution operation. On December 14, 1992, with the #1 Boric Acid Addition Tank (BAAT) being recirculated to support chemistry sampling, control room operators attempted a series of reactor coolant system (RCS) dilution evolutions to maintain a target of about 96% withdrawn on Control Rod Group (CRG) 7. These evolutions had been ongoing for some period of time and included using substantial amounts of water due to the core being near the end of the operating cycle. With CRG 7 approaching 98% withdrawn position, operators anticipated adding approximately 2000-2400 gallons of water to reach the target rod position.

At 7:39 p.m., operators added 800 gallons of water to the RCS, but noted about 30 minutes later that the water addition had little affect on CRG 7 and the rod group continued to move slowly out of the core. Around 8:20 p.m., CRG 7 was at 100% withdrawn from the core. The shift supervisor thought that the lack of rod response was possibly due to a xenon imbalance in the core from earlier control rod maneuvers and that the water addition was of insufficient volume to overcome this xenon imbalance. At 8:58 p.m., operators added an additional 1611 gallons to the RCS in an attempt to return CRG 7 to the 96% position. Again, after the second water addition, operators noted that the control rods did not appear to respond to the water addition. The operators, suspecting that a boric acid addition to the RCS was made during the second water addition, verified that chemistry had completed sampling of the #1 BAAT and at 9:23 p.m., secured the #1 BAAT pump and checked that valves MU23 and MU356 used to isolate the #1 BAAT recirculation piping from the makeup system were closed. About the same time, the boronometer showed a slight increase in RCS boron concentration and operators commenced decreasing reactor power to maintain T_{AVE} constant. At 9:30 p.m., operators noted that the #1 BAAT had decreased about 100 gallons and requested that the chemistry department sample the RCS for boron concentration. Reactor power was stabilized about 10:45 p.m., with power at 90%. Chemistry confirmed that RCS boron concentration

had increased about 10 ppm. Subsequently, water additions to the RCS continued during the night and reactor power was returned to 100% about 5:15 a.m. on December 15, 1992.

The licensee determined that root cause of the boric acid addition to be seat leakage past MU23. Operators had followed DB-OP-06031, "BAAT Operating Procedure", appropriately, but the procedure itself was deficient. This was because valve MU23 was apparently designed to function as a control valve and was not intended to provide a positive isolation function. Subsequently, Operations issued a temporary change to DB-OP-06031 to close manual isolation valve MU363 when recirculating a BAAT. This was to provide an additional isolation to prevent inadvertent addition of boric acid to the makeup tank when the BAAT system is pressurized.

The inspectors reviewed this event and the licensee's corrective actions and found operator actions were properly conducted during the event and the corrective actions taken should preclude repetition. This item is closed.

No violations or deviations were identified; however, two non-cited violation was identified in this area.

3. Licensee Event Report Followup (92700)

Through direct observation, discussions with licensee personnel, and review of records, the following licensee event report (LER) was reviewed to determine that reportability requirements were fulfilled, immediate corrective actions were accomplished in accordance with Technical Specifications (TS), and corrective action to prevent recurrence had been established.

(CLOSED) LER 92-006-00, Deficient reactor protective system (RPS) calibration procedures. This LER documented the licensee's discovery that procedures used for calibration of "High Flux" and "Flux/Delta Flux/Flow" and "High Flux/Number of Reactor Coolant Pumps On" trip functions did not address associated common circuitry and as a result, a non-conservative "High Flux/Number of Reactor Coolant Pumps On" trip function setpoint may not have been promptly detected. The licensee's review determined that no actual problem existed. The inspector reviewed the licensee's corrective actions for this event, with the exception of reviewing the modified RPS calibration procedures, to ensure that these procedures did not introduce any adverse variables into the calibration process. To finalize review of this matter, the inspector witnessed the performance of DB-MI-03057, "RPS Channel 1 Calibration of Overpower, Power/Imbalance/Flow, and Power/Pumps Trip Functions" utilizing the subsequent revision and determined that this procedure did not introduce any adverse variables into the calibration process. Additionally, the inspectors observed that the output voltages for the contact monitor (which provides inputs to the "High Flux/Reactor Coolant Pumps On" bistable) were set more conservatively than previously to account for instrument drift. The inspectors found a minor test

deficiency and spoke to the I&C foreman and systems engineer about a possible procedure change. This item is closed.

No violations or deviations were identified in this area.

4. Operational Safety Verification (71707) (71714) (40500)

The inspectors observed control room operations, reviewed applicable logs, and conducted discussions with control room operators during the inspection period. The inspectors verified the operability of selected emergency systems, reviewed tagout records, and verified tracking of limiting conditions for operation associated with affected components. Tours of the auxiliary and turbine buildings were conducted to observe plant equipment conditions including potential fire hazards, fluid leaks, and excessive vibrations, and to verify that maintenance requests had been initiated for certain pieces of equipment in need of maintenance. Walkdowns of the accessible portions of the following systems were conducted to verify operability by comparing system lineups with plant drawings, as-built configuration, or present valve lineup lists; observing equipment conditions that could degrade performance; and verifying that instrumentation was properly valved, functioning, and calibrated.

- Diesel Generators 1-1 and 1-2 and auxiliaries
- High Pressure Injection System - Divisions 1 and 2
- Hydrogen Dilution System

The inspectors, by observation and direct interview, verified that the physical security plan was being implemented in accordance with the station security plan, including badging of personnel; access control; security walkdowns; security response (compensatory actions); visitor control; security staff attentiveness; and operation of security equipment.

Additionally, the inspectors observed plant housekeeping, general plant cleanliness conditions, and verified implementation of radiation protection controls.

Specific observations and reviews included the following:

- a. On May 21, 1991, the NRC issued a revision to 10 CFR Part 20, "Standards for Protection Against Radiation". The revision to the rule was based on changes prepared by the International Council on Radiation Protection. This revision changed annual dose limits, radiological posting requirements, and required licensees to have programs which minimized radiation exposures to individuals to "as low as reasonably achievable" (ALARA). The new rule became effective on January 1, 1994, although licensees had the option of implementing the rule as early as January 1, 1993.

Efforts had been ongoing since May 1991, under the guidance of Radiation Protection, to identify and prepare the necessary

changes to procedures, training, and equipment necessitated by the rule revision. As of January 1, 1993, the licensee implemented the mandatory portions of the 10 CFR Part 20 revision.

- b. During the inspection period, a review was conducted to verify that the plant had been adequately readied for cold weather operations. The inspector reviewed DB-OP-06913, "Plant Winterization Checklist," DB-OP-06331, "Freeze Protection and Electrical Heat Trace," and DB-OP-06222, "Condensate, Demineralized, and Primary Water Transfer and Storage System" as well as several preventative maintenance activities that had been completed to assure proper implementation of the licensee's program. In addition, walkdowns of selected portions of associated piping were conducted to verify proper operation of heat trace circuits. No substantive concerns were identified. The licensee's winterization program was found to be acceptable and adequately implemented.
- c. During a tour of the auxiliary building on December 18, 1992, the inspectors noted that the entrance way to the #2 Clean Waste Receiver Tank (CWRT) room was posted with a high radiation area sign due to draining reactor coolant water on the evening of December 14, 1992. The inspectors noted that the radiological survey map posted near the entrance was dated December 7, 1992, and as such, did not show the high radiation area. The inspectors then reviewed the radiological survey logs maintained by the radiological protection foreman at the entrance to the auxiliary building. These maps were dated December 14, 1992, and since the survey was taken before discharging reactor coolant, the log likewise did not reflect the change in radiological status of the #2 CWRT room. The inspectors reviewed the auxiliary building display boards in the hallway outside the entrance to the radiological control area and found that they too did not reflect the radiological conditions in the #2 CWRT room.

The inspectors questioned the foreman and found him to be knowledgeable of the change of radiological conditions in the room. The inspectors reviewed the licensee's administrative procedure DB-HP-00003, Radiological Surveillance Program, and found that there was no requirement to keep the survey maps or the display board updated. The General Supervisor, Radiological Controls, indicated that each radiological work permit was annotated to check with the radiological controls foreman prior to entering any radiation area.

Since the #2 CWRT room was properly posted for the existing radiological conditions, no violation of licensee procedures or regulatory requirements resulted. However, the licensee agreed that all postings should be consistent and that actions would be taken in the future to keep postings updated in an appropriate timeframe.

- d. In mid-October 1992, the licensee and a contractor performed a spectral analysis of neutron energy distributions in containment for use in both dose assessment and shielding evaluations. The study, issued this inspection period, concluded that the neutron energies encountered inside the containment building with the reactor operating at 100% power were typical of those seen in other pressurized water reactor (PWR) containments. In addition, the study indicated that the spectrum of neutron energies in containment at full power were lower than previously anticipated. The licensee intended to apply this data to modify the exposure received by individuals who made containment entries at power this past year and reduce the mean quality factor as allowed by 10 CFR 20.1004. This matter was being tracked by the Region III Division of Radiation Safety and Safeguards via open item (346/92009-01(DRSS)).
- e. On December 17, 1992, at 6:42 p.m., a zone operator noticed that the #1 Clean Waste Monitor Tank (CWMT) pump was operating at elevated temperatures. The operator found the tank outlet control valve (located on the suction of the pump) closed and contacted the control room. Subsequently, the #1 CWMT pump was stopped. The licensee subsequently documented this condition in a Potential Condition Adverse to Quality Report (PCAQR 92-0474).

Earlier, day shift operators had aligned the CWMT system in accordance with DB-OP-06101, Clean Radwaste System operating procedure, section 3.7., "Recirculation of the CWMTs". A valve lineup was performed using Attachment 30 of the procedure which allowed the operator to choose a position for pump suction valve, WC1704. The operator erroneously circled the "closed" position on the valve lineup sheet and checked the valve to be in the closed position. Attachment 30 was independently verified by a second operator. At 1:10 p.m., operators started the #1 CWMT pump with the tank in a recirculation condition to allow sampling of the tank. The pump continued to operate with its suction valve closed for approximately 5.5 hours until the misalignment was identified the following shift.

Subsequently, it was determined that the pump had not been damaged by the event.

Although there was no effect on the safe operation of the plant, the inspectors were concerned that the improper position of a valve on a lineup sheet could also occur on a safety-related system. The inspectors spoke to the operations superintendent and sampled valve lineup sheets of safety system operating procedures and found that two of the procedures provided a choice for the position of valves. However, the licensee indicated that those valve positions were selected by the shift supervisor before being given to the operator.

The inspectors also noted that the valve lineup sheet had a signoff requiring a review by a senior operator, and that this review signoff was not made prior to starting the pump. Operations management specified that the review signoff was performed at the completion of the procedure and not after the completion of the valve lineup. However, a shift supervisor stated that the lineup review signoff could be performed after the lineup was completed during infrequent system operations but may not be performed during routine evolutions.

The inspectors could not locate a written policy stating when the valve lineup review signoff should be signed. The inspectors spoke with operations management about the corrective action to PCAQ 88-0934, (which documented an event involving starting decay heat pump #1 with its suction valve closed) which stated "a review of major plant component prestarts is performed to ensure that equipment can be placed in service in a safe and logical order." Operations management indicated that Management Corrective Action Report (MCAR) 89-0001, which implemented the corrective actions to PCAQ 88-0934, made no reference to the review signoff and could not determine what initiated the signoff requirement.

The inspectors were concerned that the system was placed into service prior to supervisory review of the system's status and that a signoff for such a review was included in the valve lineup. It appeared that step 3.7.2.a., which required performance of Attachment 30, was also improperly initialed by the operator as being completed, when in effect, the attachment was not completed since the review signoff was not made.

Operations management, subsequently, issued a memorandum to all operators specifying the policy for completion of procedural steps that referenced attachments in the procedure.

This appeared to be an example where management expectations were not adequately communicated to the operators. In addition, discussions with the Manager-Operations, revealed that administrative procedure, DB-OP-00000, was under revision to incorporate certain Institute of Nuclear Power Operations (INPO) recommendations, some of which addressed procedure adherence. The revision was also to clarify procedure usage to provide better guidelines to address the type of operator errors as discussed in paragraph 2.b of this report. It appeared that the revision to DB-OP-00000 may address the inspectors' concerns with providing more specific guidelines on procedural adherence to the operators. Therefore, this matter is considered an open item (346-92019-01(DRP)) pending incorporation of the INPO recommendations into DB-OP-00000 and subsequent review of the procedure by the inspectors.

No violations or deviations were identified in this area.

5. Surveillance (61726)

The inspectors observed safety-related surveillance testing and verified that the testing was performed in accordance with adequate procedures, that test instrumentation was calibrated, that limiting conditions of operation (LCO)s were met, that removal and restoration of the affected components were accomplished, that test results conformed with Technical Specification and procedure requirements and were reviewed by personnel other than the individual directing the test, and that any deficiencies identified during the testing were properly reviewed and resolved by appropriate management personnel.

The following test activities were observed and/or reviewed:

DB-MI-03057	Reactor Protective System, Channel 1 Calibration
DB-MI-03204	Channel Functional Test and Calibration of Steam and Feedwater Rupture Control System Channel 2
DB-SC-03070	Emergency Diesel Generator #1 Monthly Test
DB-SC-03113	Safety Features Actuation System Channel 4 Functional Test
DB-SP-03321	Hydrogen Dilution System Train 2 Quarterly
DB-SS-03091	Motor Driven Feedwater Pump Quarterly Test
ST 5091.01.10	Source Range Functional Test

No violations or deviations were identified in this area.

6. Maintenance (62703)

Station maintenance activities of safety-related systems and components were observed and/or reviewed during the inspection period to ascertain that they were conducted in accordance with approved procedures, regulatory guides, and industry codes or standards, and in conformance with Technical Specifications.

The following items were considered during this review: the limiting conditions for operation (LCO) were met while components or systems were removed from service; approvals were obtained prior to initiating the work; activities were accomplished using approved procedures and were inspected as applicable; functional testing and/or calibrations were performed prior to returning components or systems to service; quality control records were maintained; activities were accomplished by qualified personnel; parts and materials used were properly certified; radiological controls were implemented; and fire prevention controls were implemented.

Maintenance work orders (MWOs) were reviewed to determine status of outstanding jobs and to assure that priority was assigned to safety-related equipment maintenance which may affect system performance.

The following maintenance activities were observed and/or reviewed:

- MWO 3-93-2841-01 Calibration of #2 Boric Acid Addition Tank pump discharge gage.
- MWO 3-93-4801-01 Clean and Inspect #1 Emergency Core Cooling Room Cooler.
- MWO 7-92-0275-04 Replacement of Service Water Piping to Emergency Core Cooling System Room Coolers.
- MWO 7-92-0497-01 Troubleshoot Reactor Protective System Channel #1 Bypass Switch.

Regarding MWO 3-93-2841-01, on December 15, 1992, the inspectors witnessed I&C technicians reinstall a calibrated gage for the #2 BAAT pump discharge pressure gage. The inspectors observed that there were no red tags hung to isolate the maintenance area from the BAAT system, but instead the technicians had closed the gage isolation valve and placed a pressure tight plug at the gage fitting. The technician indicated that red tags were not required for the performance of the job and an administrative procedure allowed the technicians to set their own isolation.

Administrative procedure DB-OP-00015, Safety Tagging, section 6.1.21.b, stated "that a Personal Red Tag Clearance is not required when the necessary isolation can be provided by closing valves normally operated by the shop performing the work and those personnel involved in the work remain in the vicinity of the instrument and the isolation valve(s) at all times during the activity." The inspectors found the pressure gage removed and no personal red tags hung for the maintenance activity. There were no I&C technicians in the vicinity.

The inspectors spoke to the I&C General Supervisor about the administrative requirement and the observed work practice. The supervisor stated that other I&C technicians in the shop were aware of the administrative requirements for hanging personal red tags for maintenance activities and that this was practiced by the technicians. The work activity witnessed by the inspectors was classified by the supervisor as an isolated event. The individual was reinstructed on the administrative procedural requirements.

The inspectors noted that there was no safety significance to the observed equipment configuration but were concerned that the administrative requirements were not being adhered to by the individuals involved. The inspectors will continue to monitor the licensee's adherence to its administrative procedures.

The failure to implement DB-OP-00015, revision 1, section 6.1.21.b, was a violation of Technical Specifications 6.8.1.a, Safety Guide 1.33, Appendix A, A.3, Administrative Procedure for Equipment Control. However, since the criteria specified in Section VII.B.1 of the "General Statement of Policy and Procedures for NRC Enforcement Actions,"

(Enforcement Policy 10 CFR Part 2, Appendix C (1992)) were satisfied, this violation will not be cited.

No violations or deviations were identified; however, one non-cited violation was identified in this area.

7. Violations For Which A "Notice of Violation" Will Not Be Issued

The NRC uses the Notice of Violation to formally document failure to meet a legally binding requirement. However, because the NRC wants to encourage and support licensee's initiatives for self-identification and correction of problems, the NRC will not issue a Notice of Violation if the requirements set forth in 10 CFR Part 2, Appendix C, Section VII.B.1 or VII.B.2 are met. Violations of regulatory requirements identified during the inspection for which a Notice of Violation will not be issued are discussed in paragraphs 2.a, 2.b, and 6.

8. Open Items

Open items are matters which have been discussed with the licensee, which will be reviewed further by the inspectors, and which involve some action on the part of NRC or licensee or both. An open item disclosed during the inspection is discussed in paragraph 4.e.

9. Exit Interview

The inspectors met with licensee representatives (denoted in paragraph 1) throughout the inspection period and at the conclusion of the inspection on January 25, 1993, and summarized the scope and findings of the inspection activities. The licensee acknowledged the findings. After discussions with the licensee, the inspectors have determined there is no proprietary data contained in this inspection report.