

U.S. NUCLEAR REGULATORY COMMISSION

REGION III

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Report Nos.: 50-373/96016, 50-374/96016

Licensee: Commonwealth Edison Company

Facility: LaSalle County Station, Units 1 and 2

Location: 2601 North 21st Road  
Marseilles, IL 61341

Dates: October 1 - October 8, 1996

Inspectors: Frederick D. Brown, Project Engineer  
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Approved by: B. L. Jorgensen, Acting Chief  
Reactor Projects, Branch 5

## EXECUTIVE SUMMARY

LaSalle County Station, Units 1 and 2  
NRC Inspection Report 50-373/96007(DRP); 50-374/96007(DRP)

This inspection report includes aspects of licensee operations and engineering. The report covers a special inspection performed by regional inspectors in response to licensee identified problems with Technical Specification (TS) compliance when an Emergency Diesel Generator (EDG) was taken out of service (OOS), and with air operated valves (AOVs) which provided a Primary Containment Isolation system (PCIS) function. The purpose of this inspection was to assess the licensee's response to each specific issue, and to determine whether the licensee's staff had exhibited a proper safety consciousness as each issue was identified.

### Plant Operations

- The licensee identified that irradiated fuel movement was conducted while Containment Purge and Ventilation system valves were in a condition outside the applicable TS requirements. This condition was the result of inadequate attention to detail and poor review of an OOS on the part of licensed SROs. When the condition was identified, the on-duty operators misinterpreted the TS time clock. The licensee effectively communicated the need for SRO TS interpretation improvement to the staff. The inspectors identified a lack of formal documentation of a policy for OOSs associated with work on EDGs. No indications of a lack of proper safety consciousness were observed. A non-cited violation was identified (Section O1.2).
- Four channels of the Intermediate Range Monitoring (IRM) trip function were inadvertently removed from service under an OOS for the Average Power Range Monitoring (APRM) trip function. Compliance with the Reactor Protection System (RPS) TS was achieved fortuitously. The poor performance on the part of the SROs involved with this event is similar in nature to that described in Section O1.2, and previously identified in Inspection Report 50-373/374-96007 (Section O1.3).

### Engineering

- In March 1996, the licensee identified a problem with the adjustment of spring preloading for AOVs with a PCIS closure function. In September 1996, the licensee's preliminary determination, based upon conservative calculations, was that some AOVs would not close under their design basis dynamic loads. The licensee intended to perform as-found spring preload tests to determine whether the valves would have actually generated the required design basis closing and seating forces. The inspectors determined that the problem had not been formally documented by a PIF and had not received a formal operability assessment in March or April 1996 as required by plant procedures. This was characterized as a violation of 10 CFR 50, Appendix B, Criterion V (Section E1.1).
- The inspectors identified a potential weakness in the licensee's implementation of NRC guidance on TS required equipment operability, but no examples of inadequate operability determinations were observed.

## Report Details

### Summary of Plant Status

This special inspection was performed while LaSalle Unit 1 was in Mode 4 - Cold Shutdown, and LaSalle Unit 2 was in Mode 5 - Refueling.

### I. Operations

#### **O1            Conduct of Operations**

##### **O1.1   General Comments**

The inspectors reviewed two events associated with the licensee's program for taking equipment out of service (OOS). In one event, a non-cited violation (NCV) of a Technical Specification (TS) action statement occurred as the result of an OOS error. This event also involved the misinterpretation of a TS time clock by on-duty operators. The other event, an unintended entry into a TS action statement, was also the result of an OOS error. Both OOS errors were caused by inadequate preparation and review by licensed operators.

##### **O1.2   Failure to Meet Secondary Containment Isolation Requirements**

###### **a.        Inspection Scope (92901)**

On September 28, 1996, the licensee identified that irradiated fuel movement was conducted while Containment Purge and Ventilation system valves were in a condition not in conformance with the applicable TS requirements. The inspectors performed a special, regional initiative, followup inspection using the guidance of Inspection Procedure 92901. The inspectors interviewed the involved plant staff, and reviewed the procedures, work instructions, and log entries associated with the event.

###### **b.        Observations and Findings**

At the time of the event, LaSalle Unit 2 was in Mode 5 and the core was being altered in that irradiated fuel was being unloaded. TS 3.6.5.2 required that secondary containment ventilation system automatic isolation valves be operable during core alterations. TS 3.0.5 required that both primary and backup power supply be available to motor operated valves (MOV) in order for them to be considered operable in Mode 4 or Mode 5. Isolation valve 2VQ038 in the Containment Purge and Ventilation system was an automatic isolation MOV which received its backup power from the "0" Emergency Diesel Generator (EDG).

As implemented by the licensee's work control program, TS 3.6.5.2 required that isolation valve 2VQ037 be shut and deenergized if isolation valve

2VQ038 was inoperable during core alterations. This action statement ensured that at least one containment isolation valve was closed and could not be inadvertently opened. This action statement condition was required to be completed within eight (8) hours of the time that 2VQ038 became inoperable (8 hour "time clock").

The "O" EDG was taken out of service (OOS) at 4:11 a.m. on September 26, 1996 using work package OOS 960007844. The SRO who prepared the initial OOS package recognized that isolation valve 2VQ038 was rendered functional but inoperable by removing the "O" EDG from service, and the OOS specified that 2VQ037 was to be closed and its power supply breaker opened as required by TS 3.6.5.2. These actions were completed within the TS required 8 hour time clock.

On September 28, 1996, a partial "lifting" of the OOS was initiated so that the EDG oil system could be warmed up. The EDG was not rendered operable, so 2VQ037 should have been left closed and deenergized. This was not recognized by the licensed senior reactor operators (SROs) who prepared and reviewed the work package for the partial lifting of the OOS. As a result of their inadequate attention to detail and poor review, the portion of OOS 960007844 applicable to the power supply breaker for 2VQ037 was cleared, and the breaker was closed.

A reactor operator clearing a separate portion of OOS 960007844 identified that 2VQ037 should not have been reenergized. The power supply breaker for 2VQ037 was reopened approximately four (4) hours after it was closed. Both 2VQ037 and 2VQ038 remained in the closed position during the 4 hours that 2VQ038 was energized.

In performing their initial review of this event, the on-duty operators characterized the reenergization of 2VQ037 as an inadvertent entry into a TS action statement rather than as a TS violation. This error was made because they incorrectly applied the 8 hour time clock to the point in time when the power supply breaker for 2VQ037 was closed rather than the point in time when valve 2VQ038 was rendered inoperable. This error led to a slight delay in reestablishing TS compliance. Plant Management identified this error, and recharacterized the event correctly.

The licensee implemented the following corrective actions:

- \* All SROs were briefed about the correct implementation of TS action statement time clocks.
- \* Remedial training was provided for the involved personnel.
- \* A special written examination was given to all station SROs to assess their performance at the interpretation of TS requirements. SROs who did poorly on this test were provided remedial training and were

required to take a second written examination to demonstrate proficiency at interpreting TSs. Any SRO who failed both examinations was to be administratively relieved from their licensed duties.

- \* An ongoing program of refresher training was established to address the weaknesses identified through review of the completed special examinations.
- \* An additional SRO review of OOSs was added.

The licensee-identified and -corrected failure to maintain 2VQ037 closed and deenergized, as required by TS 3.6.5.2, is being treated as a **non-cited violation (NCV 50-373/374-96016-01)**, consistent with Section VII.B.1 of the NRC Enforcement Policy.

The inspectors considered the Reactor Operator's identification of the inappropriate closure of the 2VQ037 power supply breaker to be an example of a good questioning attitude.

While interviewing the personnel involved with the partial lifting of OOS 960007844, the inspectors found that normal practice had been to issue separate OOS control packages for equipment rendered inoperable by work on EDGs. This normal practice meant that all physical work directly associated with the EDGs was controlled within one OOS package, and that TS required action(s) for associated equipment were controlled by one or more separate, but administratively linked, OOS packages.

The inspectors concluded that the involved SRO's inadequate review of the partial lifting of OOS 960007844 was in part attributable to an assumption that any TS associated equipment operability issues would be covered by separate OOS packages. The licensee had taken informal action to ensure that separate OOS packages would be used in the future. The inspectors concluded that the lack of a single, formally documented, consistently applied, approach to OOS package content for EDG work was a weakness which contributed to this event. This concern was discussed with the Plant Operations Superintendent, who informed the inspectors that the policy would be formally documented.

The inspectors reviewed the special examination which was given to the plant's licensed SROs. The inspectors concluded that the examination provided a fair but challenging test of performance in reading and interpreting TS requirements.

The inspectors discussed the results of the special examination with on-shift SROs. The inspectors concluded that the use of a special written examination had been effective in heightening the SROs' sense of ownership of the need to improve performance in the interpretation of TS requirements.



The inspectors found no indication of poor safety consciousness on the part of the Operations Staff while reviewing this event.

c. Conclusion

A Non-cited Violation of a TS action statement occurred as the result of inadequate attention to detail and poor review of an COS on the part of licensed SROs. The inspectors independently determined that the licensee's method of issuing OOSs for TS required equipment affected by work on EDGs lacked formality. The licensee identified and effectively addressed a weakness in the SRO staff's application of TS time clocks through the use of a special written examination and follow-up training.

O1.3 Reactor Protection System Trip Function Inadvertently Rendered Inoperable

a. Inspection Scope (92901)

The licensee identified that a portion of the Reactor Protection System (RPS) had inadvertently been rendered inoperable. The inspectors interviewed the personnel involved, and reviewed the licensee documentation of the event.

b. Observations and Findings

At the time of the event on September 26, 1996, LaSalle Unit 2 was undergoing core alterations. TS 3.3.1 required that a minimum of three (3) Intermediate Range Monitors (IRMs) be operable for each of the RPS trip channels while core alterations were in progress. The Action Statement for TS 3.3.1 required that a RPS trip channel with fewer than the minimum number of operable IRMs be placed in the "tripped" condition. Placing both RPS trip channels in the tripped condition produced a reactor scram.

On September 25, 1996, a reactor scram was inserted as part of an OOS associated with work on the scram air header. This action was taken independently of the subsequent events.

On September 26, two OOSs, 960010110 and 960010113, were issued for work on the Average Power Range Monitor (APRM) channels E and F. As part of these OOSs, four (4) RPS trip channel contacts associated with APRM E and F trip functions were jumpered out of service. The licensed SROs who prepared and reviewed OOS 960010110 and 960010113 did not recognize that the 4 RPS contacts which were jumpered out of service each received a trip input from IRM inoperative and IRM high flux trip functions (IRM channels E, F, G, and H) as well as from the APRM trip function. As a result of the jumpers installed on the RPS trip channel contacts, only two IRM trip functions were operable per RPS trip channel. The failure to have a

minimum of 3 operable IRM trip functions operable per RPS trip channel placed the unit in the Action Statements of TS 3.3.1, which required that both RPS channels be placed in the tripped condition while core alterations were underway. Fortuitously, this condition was satisfied because of the reactor scram which had been inserted for the unrelated scram air header work.

On September 29, 1996, a reactor operator reviewing the work necessary to reset the reactor scram inserted for the scram air header work made the initial discovery of the inoperable condition of the IRM trip functions E, F, G, and H. The operations staff promptly initiated Problem Identification Form (PIF) 96-2857 in accordance with plant procedures.

The inspectors reviewed the PIF, and determined that licensee management properly characterized the significance of the inadvertent entry into the TS action statement. Licensee corrective actions included:

- \* A review of existing plant conditions was performed to determine whether the impact of ongoing work was properly characterized and controlled. No non-compliances were identified, but 12 additional caution tags or OOS modifications were made to provide increased assurance that the plant configuration was being adequately controlled.
- \* Operations Management met with each licensed SRO and discussed the details of this event and the need to maintain an appropriate level of attention to detail when preparing and reviewing OOSs.
- \* The lessons learned from this event were incorporated into the follow-up training associated with the event described in Section O1.2 of this report.

The inspectors considered the licensed operator's identification of the inoperable status of the IRM trip functions to be an example of a good questioning attitude. The inspectors considered the SROs' failure to adequately prepare and review OOS 960010110 and OOS 960010113 to be examples of human performance problems.

c. Conclusion

An inadvertent entry was made into a TS Action Statement because of inadequate preparation and review of an OOS for the RPS. Compliance with the TS was achieved fortuitously. The poor performance on the part of the SROs involved with this event is similar in nature to that described in Section O1.2 of this report, and previously identified in one of the problems described in Section M1.2 of Inspection Report 50-373/374-96007.

### III. Engineering

#### **E1            Conduct of Engineering**

##### **E1.1   Potential Generic Concern with Air Operated Valves**

###### **a.        Inspection Scope (37550)**

The licensee notified the NRC on September 28, 1996, that air operated valves (AOV) in the Primary Containment Isolation System (PCIS) were found to have actuator diaphragm areas less than specified in their written specifications, and that this condition had the potential to affect the AOVs' operation under accident conditions. The inspectors performed a review of the licensee's identification and processing of this issue using the guidance of Inspection Procedure 37550.

###### **b.        Observations and Findings Specifically Related to AOVs**

The licensee implemented a comprehensive program to perform periodic preventive maintenance (PM) on AOVs in safety and non-safety related service. The PM program for WKM Model 70-13 actuators included disassembly of the housing, replacement of worn parts, and resetting of the actuator spring preload to original vender specifications. For "spring to close" AOVs, the spring was preloaded (compressed) such that the valve closed when instrument air was vented from the actuator diaphragm. This design repositioned the valve to a "fail safe" configuration on a loss of air.

On March 17, 1996, during refueling outage L1R07 scheduled PM on AOVs, the licensee's maintenance and engineering staffs identified that five (5) AOVs in the Reactor Core Isolation Cooling (RCIC) system and two (2) AOVs in the Primary Containment Isolation System (PCIS) exhibited spring preload characteristics which were not consistent with the vender's written specifications. All seven AOVs had WKM Model 70-13, size 70 actuators. The AOVs in the RCIC system were associated with condensate drains. The PCIS AOVs were two (2) inch diameter, Drywell Floor Drain isolation valves. The Unit 2 RCIC and PCIS systems contained similar AOVs. Unit 2 was at power at the time of this discovery.

Licensee procedure LAP-1500-8A, "Initiating A Problem Identification Form" (PIF), Revision 0, directed that a material which failed to meet drawing or written specifications, or a material with faulty manufacturing, be documented on a PIF. Site Engineering immediately recognized that the actuator springs, or some other material aspect of the actuators, were in non-conformance with written specifications. A corrective action process was started, but no PIF was initiated to document this condition which affected quality. Because of the failure to initiate a PIF, a formal operability evaluation was not performed for the Unit 2 valves, or for the Unit 1 valves prior to unit restart. The inspectors considered the failure to initiate a PIF as



required by plant procedure to be an example of a **violation (VIO 50-373/374-96016-02a)** of 10 CFR 50, Appendix B, Criterion V.

Site Engineering diligently pursued the AOV problem during the last two weeks of March 1996 by directing that additional tests of WKM Model 70-13 actuators be performed. Based upon these additional tests, Site Engineering concluded that WKM Model 70-13 actuators in sizes 35, 70, 140, and 280 all exhibited spring closure forces less than expected when the spring preload was set using the vender's written specifications. This condition was the result of the actual effective diaphragm area (EDA) being less than that specified in the written specifications for the valves. The EDA affected the spring force because the spring preload was set by applying a known air pressure against the assumed area of the diaphragm and adjusting the spring compression for desired valve stem travel. For the known air pressure, a smaller than anticipated spring preload compression was achieved because of the smaller than assumed EDA. The spring preload was significant because it was relied upon to overcome dynamic loads on the valve's disc and friction loads on the valve's stem if the valve was called upon to close under accident conditions.

Site engineering determined that the discrepancy in EDAs was caused by:

- \* manufacturing/design error in the diaphragm dimensions,
- \* installation orientation of the diaphragm and actuator housing which caused hard contact between the diaphragm components and the housing,
- \* a tendency for the diaphragm to stretch when air was applied to one side.

Site Engineering determined that the Model 70-13 actuator was initially sold by Black, Syvals and Bryson (BSB). BSB was purchased by WKM. WKM supplied most of the Model 70-13 actuator fitted AOVs at LaSalle. WKM was purchased by Muesco. Muesco supplied LaSalle with two (2) Model 70-13 actuator AOVs. Finally, The Anchor Darling Valve Company (ADVC) purchased Muesco and became the vender of record.

On April 1, 1996, Site Engineering issued Nuclear Design Information Transmittal (NDIT) LS-0252, which provided corrective actions to be taken in repairing the Unit 1 and Unit 2 RCIC AOVs which had WKM Model 70-13 actuators in order to bring them into conformance with their written specifications. On April 2, 1996, Site Engineering issued NDIT LS-0253, which provided corrective actions to be taken in repairing the Unit 1 and Unit 2 Drywell Floor Drain PCIS valves to bring them into conformance with their written specifications. These NDITs included screening performed in accordance with 10 CFR 50.59, which determined that the repairs would improve performance of the valves' safety function.

Licensee procedure LAP-220-5, "Equipment Operability Determination," Revision 3, required that any operability issues, and supporting documentation, were to be provided to the Shift Engineer (SE). The procedure further required that the SE was to become familiar with the operability issue, was to ensure that a PIF was generated, and was to perform and document an operability determination on the PIF. Site Engineering initiated instructions to repair the valve actuators, but the plant did not initiate an operability assessment to determine whether these components could perform their safety function under accident conditions prior to repair. The inspectors considered the failure to perform an operability determination as required by plant procedure to be an example of a violation (VIO 50-373/374-96016-02b) of 10 CFR 50, Appendix B, Criterion V.

The licensee contacted ADVC to obtain assistance in evaluating the as-found conditions and to obtain guidance on corrective actions as early as March 23, 1996. Additional contact between the licensee and ADVC took place as each party continued to evaluate the as-found EDAs.

On April 10, 1996, Site Engineering initiated work scope revision forms to repair all 26 (total) PCIS AOVs fitted with Model 70-13 actuators during the current or upcoming outages. These valves were in the Recirculation Sample Line System, the Drywell Floor Drain System, the Drywell Equipment Drain System, and the Instrument Nitrogen System. The affected valves ranged in size from 3/4" to 2".

On May 7, 1996, ADVC committed to the licensee that they would review the as-found condition for reportability under 10 CFR 21. In accordance with licensee procedures, LaSalle initiated a Nuclear Tracking System (NTS) item to monitor the status of ADVC's 10 CFR 21 review.

On May 7 and 8, 1996, the LaSalle AOV component engineer presented the WKM 70-13 AOV actuator preliminary findings to a Institute of Nuclear Power Operations (INPO) AOV working group.

On September 20, 1996, LaSalle and ADVC completed enough evaluatory studies to proceed with corrective action plans for the effected PCIS valves. On September 26, 1996, Site Engineering determined that NDITs were not appropriate for the scope of corrective modifications required for the AOVs with Model 70-13 actuators. The licensee commenced preparation of Design Change Packages (DCPs) to implement the required changes.

On September 28, 1996, preliminary calculations performed by Site Engineering indicated that some of the affected PCIS AOVs might not close under all accident conditions if the most conservative assumptions were made about how the original spring preloads were set. A PIF was promptly generated and the AOVs with WKM Model 70-13 actuators were declared

inoperable. The NRC was notified in accordance with 10 CFR 50.72(b)(2). On October 4, 1996, the licensee made an interim notification regarding the potential generic concern with the WKM Model 70-13 AOV actuators in accordance with 10 CFR 21, Sections 21.1(b), 21.3a(3), and 21.3d(4).

At the conclusion of the special inspection, the licensee was developing plans to test the as-found spring preload for those PCIS AOVs which were not repaired during L1R07. This testing was necessary to determine whether the springs had been originally set with more preload compression than the licensee achieved using the vender's procedure. The licensee informed the inspectors that individual 10 CFR 50.72 notifications would be issued for any valves which were found to have spring preloads which were inadequate to ensure performance of the AOV's safety function. The inspectors considered the regulatory significance of the PCIS AOVs' as-found spring preloads to be an **unresolved item (URI 50-373/374-96016-03)** pending receipt of the licensee's test results.

The inspectors concluded that the licensee's AOV PM initiative was thorough and well conceived. The inspectors further concluded that Site Engineering diligently pursued resolution of the technical aspects of the problem with WKM Model 70-13 AOV actuators. The inspectors identified that Site Engineering and all other plant staff involved in the identification, evaluation, processing, and scheduling of the AOV issue failed to adequately implement the plant's procedures for identifying and assessing non-conformances. The inspectors found no indication that the failure to initiate a PIF or perform an operability determination was the result of deliberate omission.

c. Additional Observations and Findings Related to AOVs

i. Weakness in the Bases for Determining Component Operability

The inspectors interviewed various members of the plant staff to determine why the difficulties with obtaining AOV actuator conformance to written specifications were not documented on a PIF or identified as an operability issue. On three occasions, plant staff indicated that they believed the AOVs were operable because they had passed TS required surveillances for local leak rates and for stroke times. The inspectors reviewed plant procedure LAP-220-5 "Equipment Operability Determination," Revision 3, Paragraph 2.m.(1)(l), and found that the procedure appeared to stress conformance to TS specified functions as being the principal indication of operability.

The inspectors concluded that some plant staff were interpreting LAP-220-5 to mean that a SSC was presumed operable if it passed its TS surveillances. This interpretation was inconsistent with the NRC's documented position that TS surveillances provide indication of operability, but do not assure conformance to all design requirements. The NRC's guidance was documented in Generic Letter (GL) 91-18 "Guidance on Non-Conforming

Conditions and Operability." An example of the need to look beyond TS surveillances when making operability determinations was provided in GL 89-10 "Motor Operated Valves."

The inspectors concluded that the views expressed by plant staff members and the lack of clarity in LAP-220-5 were indicative of a weakness in the licensee's program for identifying and assessing non-conformances.

ii. Review of Completed and Open Operability Determinations

The inspectors reviewed four PIFs which described conditions for which Site Engineering was providing technical assistance in completing an on-going operability determination. The inspectors selected six PIFs which documented conditions for which completed operability determinations had been made. No examples of poor safety consciousness or inadequate technical bases for operability determinations were identified.

iii. Review of NDITs

The inspectors noted that Site Engineering's initial response to the problems identified with WKM AOV actuators was to provide corrective actions via NDITs. Two NDITs were prepared and issued without performing a rigorous assessment of the impact of the as-found condition on valve operability.

The inspectors reviewed Commonwealth Edison Company procedure NEP-12-03, "Nuclear Design Information Transmittals (NDIT)," Revision 0. NEP-12-03 clearly indicated that NDITs were to be used to transmit data in a controlled manner and were not to be used as design or installation documents. The inspectors reviewed NEP-12-03LA, "LaSalle Nuclear Design Information Transmittals (NDIT) Site Appendix," Revision 2. This Appendix expanded the scope of NDIT usage at LaSalle to include minor changes to safety-related design documents.

The inspectors reviewed the index of LaSalle NDITs and selected 10 that dealt with safety-related or important to safety equipment. The inspectors performed a cursory review to determine if the 10 NDITs dealt with conditions for which a PIF should have been issued and an operability assessment would have been required. No examples were found. The inspectors reviewed the index of NDITs to see whether any of the descriptions appeared to involve "intent" changes to safety-related design documents for which TS 6.2 would have required additional review and approval by the on-site review committee. No examples were found within the time frame available during this special inspection.

The inspectors were concerned with Appendix NEP-12-03LA changing the intent of the NDIT process defined in corporate procedure NEP-12-03. This matter is considered to be an **inspection followup item (IFI 50-373/374-96016-04)** pending further NRC review.

d. Conclusions

The inspectors concluded that the licensee was proactive and thorough in identifying and addressing the technical aspects of a concern with the EDA of WKM Model 70-13 AOV actuators. The inspectors identified a violation of 10 CFR 50, Appendix B, Criterion V, in that the licensee did not promptly identify the AOV concern on a PIF or perform an operability assessment as required by the plant's procedures. The inspectors reviewed the licensee's performance of other operability determinations. No additional violations were identified, but a potential weakness in implementing the NRC's generic guidance for determining the operability of TS required equipment was found. An unresolved item was opened to track the results of licensee "as-found" testing of AOV actuator spring preloads.

**X1 Exit Meeting Summary**

The inspectors presented the results of the inspection to members of licensee management at the conclusion of the inspection on October 8, 1996. The licensee acknowledged the findings presented.

The inspectors asked the licensee if any materials examined during the inspection should be considered proprietary. No proprietary information was identified.



## PARTIAL LIST OF PERSONS CONTACTED

### Licensee:

- \*W. Subalusky, Site Vice President
- \*D. Ray, Station Manager
- \*L. Guthrie, Operations Manager
- \*R. Fairbank, System Engineering Supervisor
- \*J. Burns, Regulatory Assurance Supervisor

\* At exit meeting on October 8, 1996.

## INSPECTION PROCEDURES USED

IP 37550	Engineering
IP 92901	Followup - Operations

## ITEMS OPENED, CLOSED, AND DISCUSSED

### Opened

373/374-96016-01	NCV	Secondary Containment TS Action Statement not met for Ventilation Valve.
373/374-96016-02a	VIO	Failure to promptly initiate a PIF for AOVs.
373/374-96016-02b	VIO	Failure to promptly perform an Operability assessment of AOVs.
373/374-96016-03	URI	PCIS AOVs with undersized actuators.
373/374-96016-04	IFI	Scope change in NDIT procedure.

## LIST OF ACRONYMS USED

ADVC	Anchor Darling Valve Company
AOV	Air Operated Valve
APRM	Average Power Range Monitor
BSB	Black, Syvals and Bryson
EDA	Effective Diaphragm Area
EDG	Emergency Diesel Generator
GL	Generic Letter
INPO	Institute of Nuclear Power Operations
IRM	Intermediate Range Monitors
NCV	Non-cited Violation
NDIT	Nuclear Design Information Transmittal
NRC	Nuclear Regulatory Commission
NTS	Nuclear Tracking System
OOS	Out of Service
PCIS	Primary Containment Isolation System
PIF	Problem Identification Form
PM	Preventive Maintenance
RCIC	Reactor Core Isolation Cooling

RPS	Reactor Protection System
SE	Shift Engineer
SRO	Senior Reactor Operator
TS	Technical Specification