UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
101 MARIETTA STREET, N.W.
ATLANTA, GEORGIA 30323

Report No: 50-302/89-11

Licensee: Florida Power Corporation
3201 34th Street, South
St. Petersburg, FL 33733

Docket No.: 50-302 License No.: DRP-72

Facility Name: Crystal River 3

Inspection Conducted: April 29 - June 2, 1989

Inspectors: William K Poertner for 6/28/89
P. Holmes-Ray, Senior Resident Inspector Date Signed

William K. Poertner for 6/28/89
J. Tedrow, Resident Inspector Date Signed

Approved by: R. V. Crlenjak 6/28/89
R. Crlenjak, Section Chief Date Signed
Division of Reactor Projects

SUMMARY

Scope:

This routine inspection was conducted by two resident inspectors in the areas of plant operations, security, radiological controls, Licensee Event Reports and Nonconforming Operations Reports, facility modifications, review of IE information notices, followup of onsite events, review of drawing control, and licensee action on previous inspection items. Numerous facility tours were conducted and facility operations observed. Some of these tours and observations were conducted on backshifts.

Results:

Two violations were identified: Failure to properly implement plant procedures, paragraphs 2.a, 3.b(1), and 3.b(2); Failure to implement the emergency plan, paragraph 3.b(1).

Two non-cited violations were identified and reviewed: Failure to properly implement procedure for containment leak tests, paragraph 3.b.(3); Failure to properly implement the drawing control process, paragraph 7.

REPORT DETAILS

1. Persons Contacted

Licensee Employees

*G. Becker, Manager, Site Nuclear Engineering Services
G. Boldt, Vice President Nuclear Production
*P. Breedlove, Nuclear Records Management Supervisor
*R. Fuller, Senior Nuclear Licensing Engineer
B. Hickle, Manager, Nuclear Plant Operations
*J. Holton, Senior Nuclear Results Engineer
*A. Kazemfar, Supervisor, Radiological Support Services
*H. Koon, Assistant Nuclear Maintenance Superintendent
R. Marckese, Nuclear Engineer II
*W. Marshall, Nuclear Operations Superintendent
D. McCollough, Nuclear Chemistry Supervisor
*P. McKee, Director, Nuclear Plant Operations
V. Roppel, Manager, Nuclear Operations Maintenance and Outages
*W. Rossfeld, Manager, Nuclear Compliance
*J. Stephenson, Supervisor, Radiological Emergency Planning
*R. Widell, Director, Nuclear Operations Site Support
*M. Williams, Nuclear Regulatory Specialist
K. Wilson, Manager, Nuclear Licensing

Other licensee employees contacted included office, operation, engineering, maintenance, chemistry/radiation and corporate personnel.

*Attended exit interview

Acronyms and initialisms used throughout this report are listed in paragraph 10.

2. Review of Plant Operations (71707)

The plant began this inspection period in the cold shutdown (Mode 5) condition. The outage began on February 26, 1989 to initiate repairs to the "A" Reactor Coolant Pump (RCP-1A). The repair included the replacement of the pump shaft for RCP-1A, and the rebuild of all four RCP motors. Also during this outage, substantial environmental qualification work was performed along with eddy current testing of the once through steam generators. On June 1 a plant heatup was commenced and the plant entered the hot standby (Mode 3) condition at 11:40 A.M. The plant remained in Mode 3 for the duration of this inspection period. Upon entering Mode 3, problems were experienced with the mechanical seal packages for pumps RCP-1A/1C/1D. A plant cooldown was commenced to initiate repairs to the seal packages.

a. Shift Logs and Facility Records (71707)

The inspector reviewed records and discussed various entries with operations personnel to verify compliance with the Technical Specifications (TS) and the licensee's administrative procedures.

The following records were reviewed:

Shift Supervisor's Log; Outage Shift Manager's Log; Startup Log; Reactor Operator's Log; Equipment Out-Of-Service Log; Shift Relief Checklist; Auxiliary Building Operator's Log; Active Clearance Log; Daily Operating Surveillance Log; Work Request Log; Short Term Instructions (STI); and Selected Chemistry/Radiation Protection Logs.

In addition to these record reviews, the inspectors independently verified clearance order tagouts.

On May 25, 1989, during a verification of equipment clearance #89-05-206 on the emergency feedwater system, the inspector noticed that valve EFV-14 was not tagged as required by the equipment clearance. The clearance required that the handwheel for valve EFV-14 be red tagged in the closed position to prevent operation. Upon verification of this clearance, the inspector discovered that the tag created for the handwheel of valve EFV-14 was located on the wrong valve (EFV-33). A review of this clearance order revealed that the clearance had been independently verified and accepted for work. This matter was brought to the attention of licensee personnel who immediately corrected the clearance.

Procedure CP-115, In-Plant Equipment Clearance and Switching Orders, section 6.4 specifies the actions required to implement an equipment clearance and requires that items listed on the clearance order be tagged in the position specified by the clearance. Failure to properly implement the clearance for valve EFV-14 is contrary to the requirements of CP-115 and is considered to be a violation of TS 6.8.1.a.

Violation (302/89-11-01): Failure to adhere to the requirements of plant procedures as required by TS 6.8.1.a.

b. Facility Tours and Observations (71707)

Throughout the inspection period, facility tours were conducted to observe operations and maintenance activities in progress. Some operations and maintenance activity observations were conducted during backshifts. Also, during this inspection period, licensee meetings were attended by the inspectors to observe planning and management activities.

The facility tours and observations encompassed the following areas: security perimeter fence; control room; emergency diesel generator rooms; auxiliary building; reactor building; intermediate building; battery rooms; and, electrical switchgear rooms.

During these tours, the following observations were made:

(1) Monitoring Instrumentation - The following instrumentation and/or indications were observed to verify that indicated parameters were in accordance with the TS for the current operational mode:

Equipment operating status; area atmospheric and liquid radiation monitors; electrical system lineup; reactor operating parameters; and auxiliary equipment operating parameters.

No violations or deviations were identified.

(2) Safety Systems Walkdown (71710) - The inspectors conducted a walkdown of the Decay Heat Closed Cycle Cooling (DC) system to verify that the lineup was in accordance with license requirements for system operability and that the system drawing and procedure correctly reflect "as-built" plant conditions.

No violations or deviations were identified.

(3) Shift Staffing (71707) - The inspectors verified that operating shift staffing was in accordance with TS requirements and that control room operations were being conducted in an orderly and professional manner. In addition, the inspectors observed shift turnovers on various occasions to verify the continuity of plant status, operational problems, and other pertinent plant information during these turnovers.

No violations or deviations were identified.

(4) Plant Housekeeping Conditions (71707) - Storage of material and components, and cleanliness conditions of various areas throughout the facility were observed to determine whether safety and/or fire hazards existed.

No violations or deviations were identified.

(5) Radiological Protection Program (71707) - Radiation protection control activities were observed to verify that these activities were in conformance with the facility policies and procedures, and in compliance with regulatory requirements. These observations included:

- Entry to and exit from contaminated areas, including step-off pad conditions and disposal of contaminated clothing.
- Area postings and controls.
- Work activity within radiation, high radiation, and contaminated areas.
- Radiation Control Area (RCA) exiting practices.
- Proper wearing of personnel monitoring equipment, protective clothing, and respiratory equipment.

Area postings were independently verified for accuracy by the inspector. The inspector also reviewed selected Radiation Work Permits (RWPs) to verify that the RWP was current and that the controls were adequate.

No violations or deviations were identified.

(6) Security Control (71707) - In the course of the monthly activities, the inspectors included a review of the licensee's physical security program. The performance of various shifts of the security force was observed in the conduct of daily activities to include: protected and vital area access controls; searching of personnel, packages, and vehicles; badge issuance and retrieval; escorting of visitors; patrols; and compensatory posts. In addition, the inspectors observed the operational status of Closed Circuit Television (CCTV) monitors, the Intrusion Detection system in the central and secondary alarm stations, protected area lighting, protected and vital area barrier integrity, and the security organization interface with operations and maintenance.

No violations or deviations were identified.

(7) Fire Protection (71707) - Fire protection activities, staffing and equipment were observed to verify that fire brigade staffing was appropriate and that fire alarms, extinguishing equipment, actuating controls, fire fighting equipment, emergency equipment, and fire barriers were operable.

No violations or deviations were identified.

(8) Surveillance (61726) - Surveillance tests were observed to verify that approved procedures were being used; qualified personnel were conducting the tests; tests were adequate to verify equipment operability; calibrated equipment was utilized; and TS requirements were followed.

The following tests were observed and/or data reviewed:

- SP-157B, Meteorological System Surveillance (weekly).
- SP-340B, "B" Train ECCS Pump and Valve Operability.
- SP-422, RC System Heatup and Cooldown Surveillance.
- SP-456, Refueling Internal Equipment Response to a ESAS Test Signal.
- SP-457, Refueling Interval ECCS Response to a Safety Injection Test Signal.
- SP-902, 4.160 KV ES Bus "A" Undervoltage Trip Test and Auxiliary Relay Calibration.

During the performance of procedure SP-902 the inspector was informed by technicians performing the test that the breakers for some of the equipment to be tested had not yet been placed in the "test" position as required by step 8.5 since this equipment was not yet being tested. The breakers were placed in the test position upon reaching step 9.3.20 which required that all the breakers be closed in the test position. The inspector discussed this matter with the procedure's author who was present during the performance of the test. The intention of the procedure was not to place the equipment in test until step 9.3.20 was reached. The inspector considers the steps specified to place the breakers in the test position to be confusing and heavily reliant on the skill of the craft to be performed correctly. The procedure's author agreed with the inspector's comment and stated that the procedure would be revised to clarify the steps during the next annual review.

Inspector Followup Item (302/89-11-02): Review the revision to procedure SP-902 to clarify steps.

(9) Maintenance Activities (62703) - The inspector observed maintenance activities to verify that correct equipment clearances were in effect; work requests and fire prevention work permits, as required, were issued and being followed; quality control personnel were available for inspection activities as required; and, TS requirements were being followed.

Maintenance was observed and work packages were reviewed for the following maintenance activities:

- Replacement of valve RWV-35 and flange in accordance with procedures MP-122, Disassembly and Reassembly of Flanged Connections, and MP-132, Erection of Piping.
- Inspection of valves RCV-157, RCV-158, and RCV-163 for environmental qualification discrepancies in accordance with procedures MP-199D, Target Rock Valve Maintenance

Model 80K and Model 81VV Valves Direct Acting Normally Closed Solenoid Valves, CP-113A, Work Request Initiation and Work Package Control, and post maintenance testing in accordance with procedure SP-410, Valve Testing During Refueling Outages.

- Inspection of valves CAV-3 and CAV-5 for environmental qualification discrepancies in accordance with procedures MP-402A, Maintenance of Limitorque Valve Operator Type SMB-000, and MP-405, Installing Repairing and Terminating Control Power and Instrumentation Cables.
- Rework of environmentally qualified transmitter splices in accordance with modification MAR 89-05-03-01 and procedure MP-405.
- Troubleshoot and replace grounded cells in "B" Station Battery in accordance with procedures MP-401, DC System Maintenance, and MP-531, Troubleshooting Plant Equipment.
- Observed flow test and inspection of decay heat pump 1B.
- Observed maintenance on raw water check valve RWV-34.

No violations or deviations were identified.

3. Review of Licensee Event Reports (92700) and Nonconforming Operations Reports (71707)

a. Licensee Event Reports (LERs) were reviewed for potential generic impact, to detect trends, and to determine whether corrective actions appeared appropriate. Events that were reported immediately were reviewed as they occurred to determine if the TS were satisfied. LERs were reviewed in accordance with the current NRC Enforcement Policy.

(1) (Open) LER 89-07: This LER reported that portions of the Chill Water System were not seismically qualified. This matter was identified by the licensee during an evaluation of Control Complex HVAC instrument air tubing in accordance with corrective action associated with LER 88-13. The licensee has isolated the portions of the system which are not seismically qualified from the seismically qualified section by shutting manual isolation valves (CHV-76/77) and has revised applicable operating procedures to maintain these valves closed. The licensee is presently developing a modification (MAR 89-03-06-01) to correct this design deficiency and will review other safety related system flow diagrams for similar problems. The LER will remain open pending implementation of the modification and completion of the engineering review.

(2) (Open) LER 89-08: This LER reported that the main steam line containment wall penetration was not as described in the Final Safety Analysis Report (FSAR). The inspector reviewed and

verified implementation of the corrective actions as stated in this report. The licensee has issued a supplement to this report dated May 23, 1989. During efforts to resolve this matter, the licensee identified that the steam generator tube rupture accident analysis in chapter 14.2.2.2 of the FSAR conflicted with the plant's emergency and abnormal procedures. The licensee reanalyzed the accident consistent with plant procedures and determined that although a slight increase in the offsite dose is involved, this increase is below 1% of the 10 CFR Part 100 limits required by the NRC. The licensee plans to revise the FSAR to reflect the new accident analysis. This LER will remain open pending completion of the FSAR revision.

(3) (Open) LER 89-09: This LER reported that the low pressure safety injection pumps (DHP-1A/1B) were unable to perform all their safety functions during certain small break loss of coolant accidents. This matter was identified by the licensee in response to NRC Bulletin 88-04, Potential Safety Related Pump Loss. The licensee has evaluated the test data to confirm that the pumps can operate reliably at lower flow rates and has submitted correspondence to the NRC dated May 30, 1989, which included a justification for plant startup and operation. This LER will remain open pending NRC review of the correspondence.

(4) (Open) LER 89-10: This LER reported that electrical cable splices associated with main feedwater pump suction valve FWV-14 were installed incorrectly and did not satisfy environmental qualification requirements. This report has been referred to the NRC Region II Office for followup by regional inspectors and will remain open pending further NRC review.

(5) (Open) LER 89-11: This LER reported that the Circulating Water (CW) system flooding analysis described in Section 9.5.2.3.2 of the Final Safety Analysis Report (FSAR) was incorrect. The licensee is presently re-evaluating this analysis and is developing recommendations to prevent equipment damage during this type of event. In the interim, the licensee has stationed a flood watch in the vicinity of the CW system to alert the control room of any flooding. This LER will remain open pending completion of the licensee's evaluation.

(6) (Closed) LER 89-12: This LER reported inadequate temperature rated solenoid valves for containment isolation valves CIV-34/35/40/41. This matter was identified by the licensee during the implementation of corrective action associated with LER 89-01. The inspector has reviewed and verified the corrective actions as stated in this report.

(7) (Open) LER 89-13: This LER reported an inadvertent start of the emergency diesel generators due to a degraded voltage condition on the engineered safeguards buses. This event was previously discussed in NRC Inspection Report 50-302/89-08. The licensee has attributed the cause for this event to be the overloading of the fossil unit startup transformer which resulted in the degraded bus condition. The licensee has developed administrative controls to limit the loading on the fossil unit startup transformer and has installed a modification to provide an alarm in the nuclear unit's control room which will identify when this transformer is overloaded. The licensee is also evaluating the impact of a sequential occurrence of an engineered safeguards actuation followed by a degraded voltage condition and will issue a supplement to this report. This LER will remain open pending issuance of the supplemental report.

(8) (Closed) LER 89-14: This LER reported improperly set radiation monitor trip setpoints. This matter was discussed previously in NRC Inspection Report 50-302/89-08 and is the subject of a violation (302/89-08-04). The LER will be closed and further action tracked by the violation.

(9) (Closed) LER 89-15: This LER reported that an air operated containment isolation valve did not have a seismically supported solenoid valve (MUV-253-SV). This matter was identified by the licensee during the implementation of corrective action associated with LER 89-01. The inspector has reviewed and verified the corrective actions as stated in this report.

(10) (Closed) LER 88-14: This LER reported excessive temperatures in emergency feedwater system piping. This report was previously discussed in NRC Inspection Report 50-302/89-01. The licensee has implemented leakage criteria for the check valves in procedure SP-604, FWV-43/44 Leak Test.

(11) (Closed) LER 89-01: This LER reported that solenoid air valves for several containment isolation valves were undersized. This matter was previously discussed in NRC Inspection Reports 50-302/89-03 and 50-302/89-01 and was the subject of a violation (302/89-01-01). The licensee has also submitted a supplemental report dated March 6, 1989, on this subject. Currently the licensee has completed a field verification and engineering evaluation of all safety related solenoids. This effort has identified the problems reported by LERs 89-12 and 89-15. The inspector reviewed and verified the licensee's corrective action for the deficiencies found.

(12) (Closed) LER 88-18: This LER reported the failure to incorporate a TS revision into the applicable procedure prior to its performance. This matter was previously discussed in NRC

Inspection Report 50-302/88-31. The licensee has revised procedures AI-400A, Description and General Administration of Plant Procedures, and AI-400C, Revising Procedures, to require timely incorporation of TS changes. The licensee has also started requesting grace periods for implementation of TS changes upon issuance.

(13) (Open) LER 88-23: This LER reported a discrepancy in the emergency power supply for the pressurizer heaters and was previously discussed in NRC Inspection Report 50-302/88-34. The licensee has completed the corrective action stated in this report and in correspondence to the NRC dated January 12, 1989, committed to provide independent power supplies for these heaters. The licensee plans to install this modification during the next refueling outage presently scheduled for March 1990. The NRC issued a safety evaluation dated November 22, 1988 which concluded that operation with the existing design until the refueling outage is acceptable. The LER will remain open pending completion of plant modifications.

b. The inspector reviewed Nonconforming Operations Reports (NCORs) to verify the following: TS are complied with, corrective actions as identified in the reports or during subsequent reviews have been accomplished or are being pursued for completion, generic items are identified and reported as required by 10 CFR Part 21, and items are reported as required by TS.

All NCORs were reviewed in accordance with the current NRC Enforcement Policy.

(1) NCOR 89-105 reported the loss of Reactor Coolant System (RCS) inventory due to an improper valve lineup. On May 7 at approximately 2:31 A.M. control room operators noticed an unusual increase in the reactor building sump level. The RCS was in the process of being filled and vented in accordance with operating procedure OP-301, Filling and Venting Reactor Coolant System. Plant operators immediately began investigating the cause for the inventory loss and by 3:26 A.M. had identified and isolated the source of leakage. The licensee found pressurizer drain valves (RCV-1 and RCV-2) in the open position instead of closed as required.

Procedure OP-301, Valve Checklist 1, specifies that valves RCV-1 and RCV-2 be in the closed position for filling and venting the RCS. This valve lineup had been performed and independently verified by licensee personnel on May 3. Failure to establish and maintain the drain valves in the closed position is contrary to the requirements of procedure OP-301 and is considered to be another example of the violation discussed in paragraph 2.a of this report.

During subsequent interviews with operators on shift during this event, the inspector determined: (1) the leak rate was approximately 24 gallons per minute which is in excess of the one GPM unidentified RCS leakrate requiring declaration of an Unusual Event, (2) the Man-on-Call was called and concurred with the Shift Supervisor that a Notice of Unusual Event (NUE) was not necessary, (3) the Director of Nuclear Plant Operations was called, went to the Control Room, and stated that if the source of the leak was not discovered in a reasonable time, or for any other reason, the process was not under control he would declare an Unusual Event. The source of the leakage (RCV-1 & RCV-2 not shut) was found and the valves closed in about 55 minutes. No NUE was declared.

This failure to declare an Unusual Event when the leak rate trigger was exceeded is considered to be a violation of the Radiological Emergency Plan and EM-202.

Violation (302/89-11-03): Failure to declare an NUE.

(2) NCOR 89-119 reported that on May 24, an inadvertent isolation of the reactor building purge system occurred due to an isolation signal from radiation monitor RMA-1. During a routine weekly changeout of filters associated with this monitor, a high sample flowrate condition occurred as expected but the radiation monitor was not properly bypassed to prevent the purge isolation. This event is very similar to an event which occurred on March 8, 1989 discussed in NRC Inspection Report 50-302/89-06 (Unresolved Item *302/89-06-03). The licensee's corrective action for the previous event included increased supervision of technicians working on the radiation monitors.

Procedure CH-348, Sampling at the Reactor Building Purge Duct Gas Monitor RMA-1, controls the sampling and filter changeout activities for monitor RMA-1 and requires in section 4 that the monitor's trip interlock be bypassed. Failure to properly bypass the monitor's trip interlock is contrary to the requirements of procedure CH-348 and is considered to be another example of the violation discussed in paragraph 2.a of this report.

(3) NCOR 89-75 reported that test flanges were installed at three locations in the Chemical Addition and Sampling (CA) system and at three locations in the Demineralized Water (DW) system versus the required blank flanges. The test flanges had been plugged and thereby functioned as blank flanges. Procedure SP-179, Containment Leakage Tests, was signed off indicating the blank

*Unresolved items are matters about which more information is required to determine whether they are acceptable or may involve violations or deviations.

flanges were installed. The licensee took prompt corrective action to remove the test flanges and install blank flanges. This matter is considered to be a licensee identified non-cited violation (NCV) because the criteria specified in Section V.G. of the Enforcement Policy were satisfied.

Non-cited Violation (302/89-11-04): Failure to properly implement procedure SP-179.

4. Installation and Testing of Modifications (37828)

Installation of new or modified systems were reviewed to verify that the changes were reviewed and approved in accordance with 10 CFR 50.59, that the changes were performed in accordance with technically adequate and approved procedures, that subsequent testing and test results met acceptance criteria or deviations were resolved in an acceptable manner, and that appropriate drawings and facility procedures were revised as necessary. This review included selected observations of modifications and/or testing in progress.

Modification MAR 88-06-17-01, Modification to AHF-17,18 and 19 A and B Fan Dampers was reviewed.

No violations or deviations were identified.

5. Review of IE Information Notices (IEN) (92701)

The inspectors reviewed the licensee's activities associated with IEN 89-44, Hydrogen Storage on the Roof of the Control Room, in accordance with a request for information from the NRC Office of Nuclear Reactor Regulation dated May 2, 1989. Upon reviewing the FSAR section 9.9 for information on this subject, the inspectors noticed conflicting information between section 9.9 and Table 9-19 of the FSAR. Section 9.9 states that the hydrogen storage area is located approximately 450 feet south of the Auxiliary Building (AB) whereas Table 9-19 specifies 240 feet south of the AB. Further, section 9.9 states that the nitrogen storage is also located with the hydrogen storage. This information is inaccurate as the nitrogen storage has been moved adjacent to the east side of the turbine building. The inspector discussed these discrepancies with licensee personnel who stated that the FSAR would be revised to correct the conflicting information.

Inspector Followup Item (302/89-11-05): Review the revision to section 9.9 of the FSAR regarding hydrogen and nitrogen storage.

6. Followup of Onsite Events (93702)

On May 29 at approximately 5:10 A.M. the licensee discovered that the emergency feedwater piping penetration had exceeded its design temperature. This matter was reviewed by NRC regional inspectors and will be discussed in more detail in NRC Inspection Report 50-302/89-14.

7. Followup of Review of Drawing Control (RAI 88-01) (37700)

During the review of Control Room drawings, flow diagram 302-673 sheet 4 of 4, Nitrogen, Hydrogen and Carbon Dioxide Flow Diagram, was found to have been revised to the wrong revision of a MAR. The piping modification was normally isolated during plant operation and therefore was not a significant error. The licensee reviewed the closeout of the MAR and found that the MAR had originally been issued as a temporary MAR then upgraded to permanent then revised twice. Each iteration was closed out separately and resulted in the drawing error. The licensee reviewed the status of other temporary MARs which became permanent and found that of 5,053 MARs issued since plant startup, 39 temporary MARs were made permanent. Six of the 39 involved Flow Diagram changes and only the one was made in error. The licensee revised the 302-673 sheet 4 to correctly show the modifications. This matter is considered to be a non-cited violation because the criteria specified in Section V.A of the Enforcement Policy were satisfied.

Non-cited Violation (302/89-11-06): Failure to properly implement NEP 271.

8. Licensee Action on Previously Identified Inspection Findings (92702 & 92701)

a. (Closed) Unresolved Item 302/88-14-06: Provide information regarding the operability of the incore thermocouple temperature monitoring system.

This item was previously discussed in NRC Inspection Report 50-302/88-29. The licensee has issued revision 11 to the FSAR and has corrected sections 1.3.2.5 and 7.3.3.2.1 to more accurately describe the systems in use.

b. (Closed) IFI 302/88-24-01: Review the licensee's revision to the moderator dilution accident analysis in the FSAR.

The licensee has revised paragraph 14.1.2.4 of the FSAR to reflect the plant modifications to prevent this type of accident. The licensee has included the old analysis, however, for historical purposes.

9. Exit Interview (30703)

The inspectors met with licensee representatives (denoted in paragraph 1) at the conclusion of the inspection on June 5, 1989. During this meeting, the inspectors summarized the scope and findings of the inspection as they are detailed in this report with particular emphasis on the violations, NCVs and inspector followup items (IFIs).

The licensee representatives acknowledged the inspector's comments and did not identify as proprietary any of the materials provided to or reviewed by the inspectors during this inspection.

Item Number	Description and Reference
50-302/89-11-01	Violation - Failure to adhere to the requirements of plant procedures as required by TS 6.8.1.a.
50-302/89-11-03	Violation - Failure to declare an NUE.
50-302/89-11-04	NCV - Failure to properly implement procedure SP-179.
50-302/89-11-06	NCV - Failure to properly implement NEP-271.
50-302/89-11-02	IFI - Review the revision to procedure SP-902 to clarify steps.
50-302/89-11-05	IFI - Review the revision to section 9.9 of the FSAR regarding hydrogen and nitrogen storage.

10. Acronyms and Abbreviations

AB - Auxiliary Building
CCTV - Closed Circuit Television
CFR - Code of Federal Regulations
CA - Chemical Addition and Sampling System
CW - Circulating Water System
DC - Decay Heat Closed Cycle Cooling System
DW - Demineralized Water System
FSAR - Final Safety Analysis Report
IEN - IE Information Notices
IFI - Inspector Followup Item
LER - Licensee Event Report
MAR - Modification Approval Record
NCOR - Nonconforming Operation Report
NRC - Nuclear Regulatory Commission
NUE - Notice of Unusual Event
RCA - Radiation Control Area
RCS - Reactor Coolant System
RWP - Radiation Work Permit
SP - Surveillance Procedure
STI - Short Term Instruction
TS - Technical Specification
UNR - Unresolved Item
VIO - Violation