



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

Report No.: 50-261/87-25

Licensee : Carolina Power and Light Company
 P. O. Box 1551
 Raleigh, NC 27602

Docket No.: 50-261

License No.: DPR-23

Facility Name: H. B. Robinson

Inspection Conducted: July 11 - August 10, 1987

Inspectors: S. J. Vias
 for H. E. P. Krug, Senior Resident Inspector

9/8/87
 Date Signed

S. J. Vias
 for R. M. Latta, Resident Inspector

9/8/87
 Date Signed

Approved by : S. J. Vias
 for P. E. Fredrickson, Section Chief
 Division of Reactor Projects

9/8/87
 Date Signed

SUMMARY

Scope: This routine, announced inspection was conducted in the areas of Technical Specification (TS) compliance; including observance of any Limiting Conditions for Operation (LCO), plant tour, operations performance, reportable occurrences, housekeeping, site security, surveillance activities, maintenance activities, quality assurance practices, radiation control activities, outstanding items review, IE Bulletin and IE Notice followup, organization and administration, independent inspection, Plant Status Report, and enforcement action followup.

Results: No violations or deviations were identified within the areas inspected.

Report Details

1. Licensee Employees Contacted

R. Barnett, Maintenance Supervisor, Electrical
G. Beatty, Vice President, Robinson Nuclear Project Department
J. Benjamin, Supervisor, Operations
R. Chambers, Engineering Supervisor, Performance
D. Crocker, Supervisor, Radiation Control
J. Curley, Director, Regulatory Compliance
J. Eaddy, Supervisor, Environmental and Chemistry
R. Femal, Shift Foreman, Operations
W. Flanagan, Manager, Design Engineering
W. Gainey, Maintenance Supervisor, Mechanical
P. Harding, Project Specialist, Radiation Control
E. Harris, Director, Onsite Nuclear Safety
D. Knight, Shift Foreman, Operations
E. Lee, Shift Foreman, Operations
F. Lowery, Manager, Operations
D. McCaskill, Shift Foreman, Operations
A. McCauley, Principal Specialist, Onsite Nuclear Safety
R. Moore, Shift Foreman, Operations
R. Morgan, Plant General Manager
M. Morrow, Specialist, Emergency Preparedness
D. Myers, Shift Foreman, Operations
D. Nelson, Operating Supervisor
B. Murphy, Senior Instrumentation and Control Engineer
M. Page, Engineering Supervisor, Plant Systems
R. Powell, Principal Specialist, Maintenance
D. Quick, Manager, Maintenance
B. Rieck, Manager, Control and Administration
D. Sayre, Senior Specialist, Regulatory Compliance
D. Seagle, Shift Foreman, Operations
R. Smith, Manager, Environmental and Radiation Control
R. Steele, Shift Foreman, Operations
R. Wallace, Manager, Technical Support
L. Williams, Supervisor, Security
H. Young, Director, Quality Assurance/Quality Control (QA/QC)

Other licensee employees contacted included technicians, operators, mechanics, security force members, and office personnel.

2. Exit Interview (30702, 30703)

The inspection scope and findings were summarized on August 10, 1987, with the Site Vice President, the Director of Onsite Nuclear Safety, the Director of Quality Assurance and the Director of Regulatory Compliance. The licensee acknowledged the findings without exception. The licensee did not identify as proprietary any of the materials provided to or

reviewed by the inspectors during this inspection. No written material was given to the licensee by the Resident Inspectors during this report period.

3. Plant Tour (71707, 62703, 71710)

The inspectors conducted plant tours periodically during the inspection interval to verify that monitoring equipment was recording as required, equipment was properly tagged, operations personnel were aware of plant conditions and maintenance activities, and plant housekeeping efforts were adequate. The inspectors determined that appropriate radiation controls were properly established, excess equipment or material was stored properly, and combustible material was disposed of expeditiously. During tours, the inspectors looked for the existence of unusual fluid leaks, piping vibrations, pipe hanger and seismic restraint abnormal settings, various valve and breaker positions, equipment clearance tags and component status, adequacy of fire fighting equipment, and instrument calibration dates. Some tours were conducted on backshifts. Plant housekeeping and contamination control were observed to be generally excellent.

The licensee was informed of a number of minor items observed by the inspectors during numerous plant tours including a leaking Y-strainer in the steam supply line to the steam driven auxiliary feed water pump, valve packing leakage, inadequate housekeeping in specific areas, an oil leak on the "B" charging pump, oil leaks on the "A" emergency diesel generator, and a leak on the "A" emergency diesel generator turbo blower outlet flange. These items were responded to by the licensee in a timely manner and corrective actions were prompt.

The inspectors performed system status checks on the following systems:

- a. Safety Injection (SI) System
- b. Component Cooling Water (CCW) System
- c. Auxiliary Feedwater (AF) System
- d. Vital Station Batteries (VSB)
- e. Electrical Switchgear
- f. Chemical and Volume Control System (CVCS)
- g. Containment Spray System
- h. Residual Heat Removal System (RHR)
- i. Emergency Diesel Generators (EDG's)

No violations or deviations were identified within the areas inspected.

4. Technical Specification Compliance (71707, 62703, 61726)

During this reporting interval, the inspectors verified compliance with selected limiting conditions for operation and reviewed results of certain surveillance and maintenance activities. These verifications were

accomplished by direct observation of monitoring instrumentation, valve positions, switch positions, and review of completed logs and records.

In addition, on a daily basis in the control room, the inspectors independently examined Emergency Response Facility Information System (ERFIS) and Safety Parameter Display Systems (SPDS) display of safety related parameters, including component status information, for indications related to conformance with the TS.

No violations or deviations were identified within the areas inspected.

5. Plant Operations Review (71707, 62703, 61726, 61707)

On work days during the reporting period, the inspectors arrived in the control room at 6:00 a.m. and stayed until approximately 7:30 a.m. at which time a plant tour was conducted. The inspectors supplemented these regular control room tours with random plant and control room tours during the weekends and at night, to ensure that operations and security were maintained in accordance with plant procedures. The control room inspection included a review of the control board with an emphasis on changes in indications, alarm lights and switch positions from their previously observed status. Each morning, the inspectors interviewed the operators concerning the present condition and configuration of the plant, any evolutions performed during the night, as well as plans in place for work to be performed during the day. The inspectors then reviewed shift logs and operations records, including data sheets, instrument traces, and records of equipment malfunctions. This review included control room logs, maintenance work requests, auxiliary logs, operating orders, standing orders, jumper logs, and equipment tagout records. The inspectors questioned the operators regarding entries, the implications of which were not immediately obvious.

The inspectors also observed the performance of the shift turnover in the control room during 6:45 a.m. to 7:15 a.m. every morning, including the tours made by other licensee personnel at the beginning of the working day. As time permitted, in the control room prior to the shift turnover, the inspectors reviewed documentation, correspondence, reports and drawings related to plant operations.

The inspectors conducted random off-hours inspections during the reporting interval to assure that operations and security were maintained in accordance with plant procedures.

The inspectors periodically verified the reactor shutdown margin. The inspectors also periodically observed the reactor axial flux difference and compared the observed values with those required by the TS.

During this month, extensive inspection, evaluation and coordination was performed by the inspectors, especially in areas still in progress from previous activities, such as the NRC Safety System Functional Inspection and, in particular, recent NRC Equipment Qualification (EQ) Inspections. Based upon certain EQ test results generated at a vendor's site, the

licensee conservatively shut down the plant for eight days to upgrade 46 electrical splices. Some of this effort is described in paragraph 10 of this report.

No violations or deviations were identified within the areas inspected.

6. Physical Protection (71707)

In the course of the monthly activities, the inspectors included a review of the licensee's physical security program. The inspectors verified by general observation, perimeter walkdowns and interviews that measures taken to assure the physical protection of the facility met current requirements. The inspectors routinely observed the alertness and demeanor of security force personnel during plant tours.

The performance of various shifts of the security force was observed in the conduct of daily activities to include: protected and vital areas access controls; searching of personnel, packages and vehicles; badge issuance and retrieval; escorting of visitors; and patrols and compensatory posts. In addition, the inspectors observed protected area lighting, protected and vital area barrier integrity and verified an interface between the security organization and operations or maintenance. The inspectors also visited the central and secondary alarm stations.

No violations or deviations were identified within the areas inspected.

7. Monthly Surveillance Observation (61726, 61700, 71710)

The inspectors observed certain surveillance related activities of safety-related systems and components to ascertain that these activities were conducted in accordance with license requirements. The inspectors observed portions of selected surveillance tests including all aspects of one major surveillance test involving safety-related systems. The inspectors determined that the surveillance test procedure conformed to TS requirements, that all precautions and LCO's were met and that the surveillance test was completed at the required frequency. The inspectors also verified that the required administrative approvals and tagouts were obtained prior to initiating the test, that the testing was accomplished by qualified personnel in accordance with an approved test procedure and that the required test instrumentation was properly calibrated. Upon completion of the testing, the inspectors observed that the recorded test data was accurate, complete and met TS requirements; verified that test discrepancies were properly rectified, and; verified that the systems were properly returned to service.

In particular, the inspectors witnessed the operability test of the emergency diesel as it was performed on the "A" Emergency Diesel Generator (EDG) on July 27, 1987. This test was conducted using Operations Surveillance Test procedure OST-401 (Revision 10) titled "Emergency Diesels - Weekly."

Since the loss of offsite power event, which occurred on January 28, 1986, the inspectors have regularly observed the Operations Surveillance Tests on both emergency diesel generators, as well as those performed on the dedicated shutdown diesel generator. The January 28, 1986 event is described in inspection report 50-261/86-01. Offsite power is supplied to Robinson 2 via a single line and a single startup transformer. The inspectors observed the operation of the "A" emergency diesel generator because of considerations described in subsequent paragraphs.

During the 1987 outage, which started on March 28, 1987, the licensee performed an extensive amount of work on both the "A" and "B" emergency diesel generators. Some of this work was precipitated by the findings of the NRC Safety System Functional Inspection (SSFI) team while other work was mandated by the licensee's program of preventative maintenance for these engines. The SSFI findings are available in inspection report 50-261/87-06.

This work included modifications to both governors, the refurbishment of both voltage regulators, and the replacement of the scavenging air blowers. Additionally, both exhaust manifolds of the "A" engine were refaced by machining in order to tighten the seal thereby reducing the exhaust leakage into the "A" diesel room - especially during the first fifteen minutes following a cold engine start.

Also, the licensee replaced the tube bundles on all three coolers on both engines after determining that the failure mechanism was gradual interaction between the water and the tube metal, leaching zinc out of the tube bundle metal; and that this mechanism was operative since the construction of the plant. This tube bundle replacement effort was not completed until after plant restart.

OST-401 is designed to verify the mechanical performance and operational readiness of the emergency diesels; and that the requirements of TS 4.6.1.1 and 4.6.1.4 are satisfied. With respect to tests and surveillances which are performed as stated, TS 4.6.1.1 requires a:

"Manually-initiated start of the diesel generator, followed by manual synchronization with other power sources and assumption of load by the diesel generator up to the nameplate rating. Normal plant operation will not be affected."

TS 4.6.1.4 requires that:

"Diesel generator electric loads shall not be increased beyond the long term rating of 2500 kw."

The inspectors noted that although the TS requires that this test be performed on a monthly basis, the licensee performs the test bi-weekly in

accordance with a vendor recommendation. As part of the test, the operator verified the operation of the redundant solenoid valves on the "A" diesel prior to the engine start. The inspectors observed that the surveillance test procedure had been changed to provide for a continuous fire watch during the duration of the test now that the fire doors are normally required to be closed.

The inspectors also observed that Revision 10 to OST-401 also requires that the governor speed droop be set at 50% for grid operation and back to 0% for normal lineup. The required engine run time has been increased to one and one-half hours instead of one hour.

The "A" diesel generator successfully completed the test requirement of OST-401. The engine governor and the generator voltage regulation systems closely controlled the engine output. However, the machining of the exhaust manifold seating surfaces was only partially successful. As a result, the licensee has new exhaust manifolds on order for installation at the earliest opportunity. The licensee, in the interim, is evaluating a way to reduce the accumulation of lubricating oil in the exhaust manifolds following engine shutdown, although the licensee has concluded that the solution to the problem is the installation of the new exhaust manifolds.

Upon completion of the testing, the inspectors verified that the system was properly returned to service.

No violations or deviations were identified within the areas inspected.

8. Monthly Maintenance Observation and Maintenance Program Evaluation
(62703, 62700, 62704, 62705)

The inspectors observed maintenance related activities of safety-related systems and components to ascertain that these activities were conducted in accordance with approved procedures, TS and appropriate industry codes and standards. The inspectors determined that these activities were not violating LCO's and that redundant components were operable. The inspectors also determined (1) that the procedures used were adequate to control the activity, (2) that QC hold points were established where required, (3) that required administrative approvals and tagouts were obtained prior to work initiation, (4) that proper radiological, and appropriate ignition and fire prevention controls were implemented, and (5) that replacement parts and materials used were properly certified. The inspectors verified that these activities were accomplished by qualified personnel using approved procedures. The inspectors independently verified that equipment was properly tested before being returned to service.

Specifically, the inspectors witnessed repair efforts on the "A" feed water regulating valve FCV-478 on July 17, 1987. It is noted that operational difficulties experienced with this valve resulted in two reactor trips during this reporting period. Additional information is provided in paragraph 10. The inspectors determined that the maintenance

activities were properly controlled under the auspices of work request WR/JO 87-A1 R1.

The inspectors witnessed portions of the valve internal inspection including examination of the seating surfaces, maintenance work practices, and operator reassembly. The inspectors determined that the corrective maintenance procedures utilized; CM-101 (Revision 4) "Quick Change Trim Air Operated Control Valve Maintenance" and CM-119 (Revision 0) "Copes-Vulcan Series D-100 Air Actuator Overhaul", were available at the work site and were referred to by the maintenance personnel involved. The inspectors also determined that the replacement Q-list parts were properly controlled and that they matched the work list descriptions, that required materials, rigging and tools were prestaged, and that the torque wrenches used were properly calibrated. It was observed that the removed valve parts were properly stored and that the system and valve internals were protected from foreign material entry by the use of a temporary cover over the valve body opening.

During the execution of repairs, the inspectors observed a high level of site management involvement and that appropriate emphasis was placed on quality commitments. Work efforts were observed to progress effectively and in an orderly manner.

Additionally, the inspectors reviewed several outstanding job orders to determine that the licensee was giving priority to safety-related maintenance and that a backlog which might affect its performance was not developing on a given system.

No violations or deviations were identified within the areas inspected.

9. Operational Safety Verification (71707, 82301)

The inspectors observed licensee activities to ascertain that the facility was being operated safely and in conformance with regulatory requirements, and that the licensee management control system was effectively discharging its responsibilities for continued safe operation by direct observation of activities, tours of the facility, interviews and discussions with licensee management and personnel, independent verification of safety system status and limiting conditions for operation, and reviewing facility records.

On July 22, 1987, the inspectors witnessed the execution of a combined functional emergency preparedness drill. This exercise was predicated on a seismic event followed by a failure of the reactor to trip on demand, subsequent fuel damage, a loss of coolant accident, and the release of radioactivity to the environment from a stuck open containment exhaust purge valve.

This combined functional drill included participation by licensee personnel in the technical support center (TSC), emergency operations facility (EOF), and operations supports center (OSC). The licensee

assigned an evaluation team to overview and critique the drill and to assure that the intended objectives were achieved. The stated objectives included the successful demonstration of the following activities:

- The ability of the operations staff to recognize plant abnormal conditions, to properly respond and escalate the emergency response based on the events classification, and demonstrate the adequacy of plant emergency procedures.
- The ability to notify and communicate initial and follow-up emergency information to state and local authorities.
- The ability to mobilize emergency response plant personnel as well as the adequacy of communications procedures and methods.
- The initial activation and functional adequacy of the TSC, EOF, and OSC, as well as the clear and precise transfer of responsibilities from the control room to the TSC and ultimately to the EOF.
- The ability to formulate off-site radiological dose projections, evacuation plans, and the coordination of the radiological and environmental assessment process.
- To exhibit the proper and timely response of emergency personnel to the TSC and EOF as well as to properly carry out the assigned roles and responsibilities.

Specifically, the inspectors witnessed the manning of the Technical Support Center (TSC) and the transition of site responsibility from the control room to the TSC. During this transition period, the inspectors observed that frequent plant status updates by TSC response personnel were provided, and that clear delineation of responsibilities was established. The inspectors also observed that immediate steps were taken by the TSC response personnel to mitigate the consequences of the accident and to prioritize recovery efforts.

Emergency operating procedures network flow path requirements were observed to be followed and the simulated messages and plant status postings were promptly transcribed. The inspectors also determined that the radiological and environmental controls and accident assessment personnel in the TSC adequately performed situational analysis and made appropriate evacuation recommendations.

No violations or deviations were identified within the areas inspected.

10. Onsite Followup of Events and Subsequent Written Reports of Nonroutine Events at Power Reactor Facilities (92700, 90714, 93702)

For onsite followup of nonroutine events, the inspectors determined that the licensee had taken corrective actions as stated in written reports of the events and that these responses to the events were appropriate and met

regulatory requirements, license conditions, and commitments. During this reporting period, the inspectors reviewed the events described below to verify that the report details met license requirements, identified the cause of the event, described appropriate corrective actions, adequately assessed the event, and addressed any generic implications.

When the LER has been issued during the report period, the LER number is identified in the appropriate paragraph.

(Closed) LER 87-05: This event which occurred on May 12, 1987, involved a contract employee who received 0.045 rem in excess of the 1-1/4 rems whole body occupational dose specified for a calendar quarter by 10CFR20.10(a) without a completed Form NRC-4 or similar record. The inspectors determined that this inadvertent overexposure was caused by the failure of the individual to disclose 1.201 rems previously accumulated in the second quart of 1987 prior to first entry into the Unit 2 Protected Area. Between 3:58 a.m. and 10:16 a.m. on May 12, the individual received 0.094 rem exposure while working on Steam Generator "A" manway bolts. Following this, the individual's prior exposure records were received and the total accumulated occupational dose to the whole body was found to be 1.295 rems.

The inspectors determined that the corrective measures taken by the licensee appeared adequate and that this event did not represent a programmatic breakdown in that the contract employee was removed from the site and the individual's management was notified of the incident. Additionally, a CP&L Radiation Safety Violation was issued against the individual for providing incorrect exposure information and, a Plant Operating Experience Report was prepared to detail the incident for Site Management, to preclude the occurrence of a similar event. This item is closed.

(Closed) LER 87-15: This event, which involved the inadvertent isolation of a portion of the Safety Injection System, was addressed in Inspection Report 50-261/87-15. This item is closed.

At 7:23 a.m. on July 10, 1987, the reactor tripped on steam generator "A" low level coincident with steam flow greater than feed flow when main feedwater regulating valve (FWRV), FCV-478, failed closed. The unit was at 100% power (698 MWe). Following the trip, the unit was placed in hot shutdown, and all safety systems functioned as designed.

A licensee evaluation found a shorted conductor at a splice in the conduit to one or two solenoids for the valve operator. Water of undetermined origin trapped in the conduit created the short thus causing the valve to fail closed. The water was removed, the leads repaired, and the valve satisfactorily tested. The other two FWRV's were checked for similar problems but none were found. The unit was returned to power operation less than 12 hours after the trip.

Then, on July 16, 1987 at 4:37 a.m. with the reactor at 72% power and while placing FCV-478 back in automatic control from field manual, the

valve again failed closed and tripped the reactor on low steam generator "A" level coincident with steam flow greater than feed flow. All safety systems functioned as designed. The valve had been put in field manual to replace the input-to-position (I/P) converter, thought to be causing the feed flow oscillations. Licensee personnel found foreign material clogging an orifice in the valve positioner discharge line. The material was removed and was sent to Harris Energy and Environmental Center for analysis. Inspection of the other FWRVs found them to be free of foreign material. The positioner and in-line filters were replaced and the unit was returned to power operation with FCV-478 being closely observed. The

valve continues to oscillate slightly and is being closely watched; however, the slight movement was not an operational problem.

On July 12, 1987, at 4:56 p.m., an orderly shutdown from 100% power was initiated by the licensee because of unidentified primary system leakage greater than one gallon per minute. TS 3.1.5.1 requires that, if the primary system leakage exceeds one gallon per minute (gpm) and the source of the leakage is not identified within twelve hours, the reactor shall be placed in the hot shutdown condition utilizing normal operating procedures. The licensee reported the shutdown decision in accordance with 10 CFR 50.72. An Unusual Event was declared at 9:45 p.m.

A primary system leak of approximately 2.4 gpm was discovered at 9:55 a.m. during the daily leak rate test. Since the leak exceeded one gpm, the plant entered a Limiting Condition for Operation (LCO) requiring the leak to be identified within 12 hours. Personnel dispatched into containment to identify the source reported that the leak was coming from somewhere at the top of the pressurizer cubicle; however, high temperatures in the cubicle precluded a more detailed inspection. Indications of the source of the leak included condensation dripping down the wall of the cubicle, a loud roar from the top of the cubicle, and excessive heat near the pressurizer relief and safety valves. Reactor shutdown was necessary to reduce cubicle temperature to allow personnel entry into the cubicle. The unit was taken off-line at 7:32 p.m.

At 11:05 p.m. on July 13, 1987, reactor coolant temperature was stabilized at 250 degrees F. Licensee personnel re-entered the containment, entered the pressurizer cubicle and determined that the steam was issuing from the packing on the pressurizer steam space sampling valve labeled RC-586.

Valve RC-586 was backseated and repacked. The cause of the packing failure is under evaluation by the licensee's Maintenance Engineering personnel to identify the root cause and to plan corrective actions to preclude the same or similar packing failures.

The Unusual Event was terminated at 4:00 a.m. on July 14, 1987, and Unit 2 was connected to the grid at 3:17 p.m. on July 15, 1987.

At 12:45 p.m. on Tuesday, August 4, 1987, the licensee began a normal shutdown of Unit 2 based upon its evaluation of the preliminary results of

some equipment qualification tests which were in process at an outside testing laboratory.

During the last refueling outage, which lasted from March 28, 1987 to June 16, 1987, the licensee respliced 46 PVC electrical instrumentation pigtail splices inside containment with a splice configuration which appeared not to be bounded by previous loss-of-coolant accident (LOCA) testing. These modifications were one component of licensee activities in response to recent NRC inspections in the area of equipment qualification.

Further evaluation and inspection of the 46 new splices led the licensee to subject 22 test specimens to a new loss-of-coolant test program at an outside testing laboratory in order to demonstrate adequate capability against moisture intrusion. Also, in anticipation of the possibility of problems with the 46 new splices, the licensee also tested a modified version of the splices which appeared to be clearly superior to those recently installed.

By August 4, 1987, it became clear to the licensee that two of the 22 test specimens were either exhibiting excessive leakage currents or that the complex test configuration was generating the anomalous results. The two specimens in question implicated the 46 previously mentioned PVC splices.

Because of the complexity of the test configuration, the licensee was unable to prove that the anomalous results were attributable to the test rig. It was at this point, on August 4, 1987, that the licensee elected to shut down the reactor and modify the 46 splices to a configuration which had passed the recent LOCA qualification testing. This work was completed.

Concurrent with these activities, the licensee designed a new test consisting of only three samples. Two of the specimens consisted of the two specimens which exhibited the high leakage currents in the recent test, while the third consisted of a splice which had not been previously LOCA tested, and which had not been pre-aged using high temperature. All three specimens successfully passed the second LOCA test. This demonstrated that, while the licensee was conservative and prudent in shutting the reactor down to replace the questionable splices, the splices were, nonetheless, qualified without the modifications.

At 11:34 p.m. on August 10, 1987, and during a reactor startup after completing modifications of 46 equipment qualification splices and replacing the compensated ion chamber for the intermediate range detector NI-35, the reactor tripped from 7.5% power as indicated by the power range instrumentation. All safety systems functioned as designed.

Prior to the startup with the new NI-35 detector, the licensee performed Revision 15 to OST-001 titled "Nuclear Instrumentation Source Range-Intermediate Range-Power Range Weekly" and, per that procedure, the set points for the new detector were taken to be the ones from the previous

detector. During the startup, Revision 2 to EST-067 titled "Intermediate Range Detector Setpoint Determination" was also in progress, but was not to the point where NI-35 could be recalibrated.

Just before the trip, the unit was placed on the line and immediately picked up 35 megawatts. The resulting cooling of the primary system generated sufficient reactivity insertion to cause the flux to reach the 25% power set point on NI-35, but with the actual power level at 7.5%. While this trip involved an unusual combination of circumstances, the licensee is evaluating procedure modifications to eliminate recurrence.

No violations or deviations were identified within the areas inspected.

11. Organization and Administration (36700)

The inspectors reviewed the on-site licensee organization to ascertain whether changes made to the licensee's onsite organization are in conformance with the requirements of the TS by verifying that (1) the established organization is as described in the TS and is functioning effectively, (2) personnel qualification levels are in conformance with applicable codes and standards, and (3) the lines of authority and responsibility are in conformance with TS and applicable codes and standards. The inspectors also reviewed appropriate licensee records to ascertain whether the licensee's use of overtime is in conformance with regulatory requirements.

Comprehensive discussions of current safety-related activities were conducted with plant management and technical personnel during this reporting period including, and in particular, Operations, Environmental and Radiation Controls, Quality Assurance, Regulatory Compliance and Onsite Nuclear Safety organizations. Topics discussed included licensee activities associated with plant operations activities; plant modifications, including the security system upgrade; the fire protection system; ongoing construction activities; and communications interfaces.

No violations or deviations were identified within the areas inspected.

12. Onsite Review Committee (40700)

The inspectors reviewed certain activities of the plant nuclear safety committee (PNSC) to ascertain whether the onsite review functions were conducted in accordance with TS and other regulatory requirements. The inspectors reviewed meeting minutes to confirm that decisions and recommendations were accurately reflected in the minutes, and followed up on previously identified PNSC activities to independently confirm that corrective actions were progressing satisfactorily.

No violations or deviations were identified within the areas inspected.

13. Core Thermal Power Evaluation (61706)

On July 23, 1987, the inspectors verified that the calculation of core thermal power was properly performed in accordance with Revision 6 to Operations Surveillance Procedure OST-010 titled "Power Range Calorimetric During Power Operation Daily;" and that the power level instruments indicated that the reactor power was within prescribed limits. The inspectors also reviewed the current revision of OST-010 for technical adequacy and reviewed the results for a specific evaluation at 100% power. The licensee performed the evaluations every day, which is within the frequency prescribed by the TS.

No violations or deviations were identified within the areas inspected.

OST-010
REV 6
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