

U.S. NUCLEAR REGULATORY COMMISSION
OFFICE OF INSPECTION AND ENFORCEMENT

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Region I

Report No. 50-244/81-04

Docket No. 50-244

License No. DPR-18 Priority -- Category C

Licensee: Rochester Gas and Electric Corporation

89 East Avenue

Rochester, New York 14649

Facility Name: R. E. Ginna Nuclear Power Plant

Inspection at: Ontario, New York

Inspection conducted: February 1, 1981 thru March 31, 1981

Inspectors: R P Zimmerman
R. P. Zimmerman, Senior Resident Inspector

5/11/81
date signed

date signed

date signed

Approved by: H B Kister
H. B. Kister, Chief, Reactor Projects
Section 1C, Division of Resident &
Project Inspection

5/15/81
date signed

Inspection Summary:

Inspection on February 1, 1981 thru March 31, 1981 (Report No. 50-244/81-04)

Areas Inspected: Routine, onsite, regular, backshift, and weekend inspection by the resident inspector (109.5 hours). Areas inspected included plant operating records; surveillance testing; maintenance; implementation of Three Mile Island Lessons Learned; performance of annual Radiation Emergency Drill; periodic and special reports; Licensee Event Reports; and accessible portions of the facility during plant tours.

Results: No items of noncompliance were identified during this inspection.

DETAILS

1. Persons Contacted

The below listed technical and supervisory level personnel were among those contacted:

- W. Backus, Operations Supervisor
- J. Bodine, QC Engineer
- L. Boutwell, Maintenance Supervisor
- W. Dillion, Supervisor of Nuclear Security
- C. Edgar, I & C Supervisor
- D. Filkens, Supervisor Health Physics and Chemistry
- D. Gent, Results and Test Supervisor
- G. Larizza, Technical Engineer
- R. Morrill, Training Coordinator
- T. Meyer, Nuclear Engineer
- J. C. Noon, Assistant Plant Superintendent
- C. Peck, Operations Engineer
- B. Quinn, Health Physicist
- B. A. Snow, Plant Superintendent
- S. Spector, Maintenance Engineer

The inspector also interviewed and talked with other licensee personnel during the course of the inspection.

2. Review of Plant Operations

a. General

The inspector reviewed plant operations through direct inspection throughout the reporting period. Activities in progress included routine power operations; replacement of two leaking drain plugs on the motor cooler for the '1C' containment fan cooler on 2/11 (paragraph 6); and a power reduction to 48% to allow tube plugging in the 'B' condenser on 3/21.

b. Shift Logs and Operating Records

Operating logs and records were reviewed against Technical Specifications and administrative procedure requirements. Included in the review were:

Control Room Log	-	daily during control room surveillance
Daily Surveillance Log	-	daily during control room surveillance
Shift Supervisor's Log	-	daily during control room surveillance

Plant Recorder Traces	-	daily during control room surveillance
Plant Process Computer Printout	-	daily during control room surveillance
Station Event Reports	-	2/1/81 through 3/31/81

The logs and records were reviewed to verify that entries are properly made; entries involving abnormal conditions provide sufficient detail to communicate equipment status, deficiencies, corrective action restoration and testing; records are being reviewed by management; operating orders do not conflict with the Technical Specifications; logs and event reports detail no violations of Technical Specification or reporting requirements; logs and records are maintained in accordance with Technical Specification and administrative procedure requirements.

Several entries in these logs were the subject of additional review and discussion with licensee personnel. No unacceptable conditions were identified.

c. Plant Tour

1. During the course of the inspection, tours of the following areas were conducted:
 - Control Room
 - Auxiliary Building
 - Intermediate Building (including control point)
 - Service Building
 - Turbine Building
 - Diesel Generator Rooms
 - All Volatile Treatment Building
 - Battery Rooms
 - Screenhouse
 - Yard Area and Perimeter
2. The following observations resulted from the tours:



- a. Monitoring instrumentation. Process instruments were observed for correlation between channels and for conformance with Technical Specification requirements.
- b. Annunciator alarms. Various alarm conditions which had been received and acknowledged were observed. These were discussed with shift personnel to verify that the reasons for the alarms were understood and corrective action, if required, was being taken.
- c. Shift manning. Control room and shift manning were observed for conformance with 10 CFR 50.54 (K), Technical Specifications and administrative procedures.
- d. Radiation protection controls. Areas observed included control point operation, posting of radiation and high radiation areas, compliance with Radiation Work Permits and Special Work Permits, personnel monitoring devices being properly worn, and personnel frisking practices.
- e. Equipment lineups. Valve and electrical breakers were verified to be in the position or condition required by Technical Specifications and plant lineup procedures for the applicable plant mode. This verification included control board indications daily, and field observations through the performance of partial equipment lineups of the Standby Auxiliary Feedwater System and the 'B' Diesel Generator on February 6 and 14, respectively.
- f. Equipment tagging. Selected equipment, for which tagging requests had been initiated, was observed to verify that tags were in place and the equipment in the condition specified.
- g. Fire protection. Fire detection and fire fighting equipment was observed for conformance with Technical Specifications and administrative procedures.
- h. Security. Areas observed for conformance with regulatory requirements, the site security plan and administrative procedures, included vehicle and personnel access, protected and vital area integrity, escort and badging.
- i. Plant housekeeping controls. Plant conditions were observed for conformance with administrative procedures. Storage of material and components was observed with respect to prevention of fire and safety hazards. Housekeeping was evaluated with respect to controlling the spread of surface and airborne contamination.

No items of noncompliance were identified.

3. Inspector Witnessing of Surveillance Tests

- a. The inspector witnessed the performance of surveillance testing of selected components to verify that the surveillance test procedure was properly approved and in use; test instrumentation required by the procedure was calibrated and in use; Technical Specifications were satisfied prior to removal of the system from service; test was performed by qualified personnel; the procedure was adequately detailed to assure performance of a satisfactory surveillance; and test results satisfied the procedural acceptance criteria, or were properly dispositioned.
- b. The inspector witnessed the performance of:
 - Health Physics (HP)-7.14, RO-2A Operation and Calibration, Revision 0, October 23, 1979, performed February 9, 1981.
 - Periodic Test (PT)-11.2, Security 60 Cell Battery Bank, Revision 2, February 3, 1981, performed February 25, 1981.
 - PT-17.3, RMS Channel Response to Portable Radiation Source-Area Monitor R9, Process Monitors 10A & 10B and R11 thru R21, Revision 7, June 26, 1980, performed February 26, 1981.

No items of noncompliance were identified.

4. Inspector Witnessing of Plant Maintenance and Modifications

- a. During the inspection period, the inspector observed various maintenance and problem investigation activities. The inspector witnessed these activities to verify compliance with regulatory requirements, including those stated in the Technical Specifications; compliance with administrative and maintenance procedures; compliance with applicable codes and standards; required QA/QC involvement; proper use of safety tags; proper equipment alignment and use of jumpers; personnel qualifications; radiological controls for worker protection; retest requirements and ascertain reportability as required by Technical Specifications. In a similar manner the implementation of design changes and modifications were reviewed. Compliance with requirements to update procedures and drawings were verified and post modification acceptance testing was evaluated.
- b. The inspector witnessed the following activities:
 - Replacement of two leaking drain plugs on the motor cooler for the 'C' Containment Fan Cooler, performed February 11, 1981. (paragraph 6)
 - Troubleshooting the Bus 16 circuit breaker to the 'C' Safety



Injection Pump, performed March 3, 1981. (paragraph 6)

- Functional testing of the 'C' Safety Injection Pump, performed March 4, 1981, to observe the outboard thrust bearing temperature following flushing of the associated service water cooler. The cooler was flushed as a result of a high bearing temperature being experienced during the periodic test, performed March 3, 1981.

No items of noncompliance were identified.

5. Implementation of Three Mile Island (TMI) Lessons Learned

- a. The inspector reviewed the licensee's actions on requirements resulting from the NRC staff investigations of the TMI accident.
- b. Each item is categorized by the action plan item assigned in NUREG-0737.

I.A.1.1 Shift Technical Advisor (STA)

Requirements

- References: (a) H. Denton (NRC) letter to All Operating Nuclear Power Plants, dated October 30, 1979.
 (b) NUREG-0737

- Provide trained STA's by January 1, 1981.
- Describe the current training program and demonstration of conformance with reference (a).
- Describe the long-term STA program.

Licensee Commitments

- References: (a) L. White, Jr. (RG&E) letter to D. Ziemann (NRC), dated December 28, 1979.
 (b) L. White, Jr. (RG&E) letter to D. Crutchfield (NRC), dated August 5, 1980.
 (c) J. Maier (RG&E) letter to D. Crutchfield (NRC), dated December 15, 1980.
 (d) J. Maier (RG&E) letter to D. Crutchfield (NRC), dated December 30, 1980.

The licensee representative provided the following information.

- Initial training to meet the requirements listed in the NRC October 30, 1979 letter has been completed. This included a four week classroom training and two day simulator training program. Additionally,

a four week course in nuclear and reactor physics was presented by Memphis State University for those engineers who did not have previous nuclear engineering education.

- Additional expanded training which will include plant design, operation and accident analysis will be held in 1981, with re-qualification beginning in 1982.
- The long term STA program will continue to utilize degreed individuals, or individuals with an SRO license who have received the necessary technical education and training. Degreed individuals will be replaced by SRO-licensed individuals as the licensed personnel receive education similiar to that outlined in reference (a). The STA program will be phased out when the man-machine interface control room review has been completed and the shift supervisor and senior operator on a shift each meet the proposed future educational requirements of approximately 60 technical credit hours for SRO licensing.

Inspection Findings

Based on the inspector's review of training records for the currently qualified STAs, the licensee appears to have satisfied the above requirement and associated commitment.

I.A.1.3 Shift Manning

Requirements

References: (a) NUREG-0737

- An individual should not be permitted to work more than 12 hours straight (not including shift turnover time).
- There should be a break of at least 12 hours (which can include shift turnover time) between all work periods.
- An individual should not work more than 72 hours in any 7-day period.
- An individual should not be required to work more than 14 consecutive days without having 2 consecutive days off.

Licensee Commitments

References: (a) L. White, Jr. (RG&E) letter to D. Crutchfield (NRC), dated October 13, 1980.

- (b) J. Maier (RG&E) letter to D. Crutchfield (NRC), dated December 15, 1980.
- (c) J. Maier (RG&E) letter to D. Crutchfield (NRC), dated December 30, 1980.

The licensee representative proposed alternatives to some of the staff overtime guidelines for individuals who perform safety-related work.

- An individual shall not be permitted to work more than 16 hours straight (not including shift turnover or lunch relief time).
- An individual shall not be permitted to work more than 24 hours in any 48 hour period (not including shift turnover or lunch relief time).
- An individual shall not work more than 72 hours in any pay week (not including shift turnover or lunch relief time).
- An individual shall not work more than 14 consecutive days without having two consecutive days off.
- The shift working during the change from Eastern Daylight Savings Time to Standard Time will be considered to have worked 8 hours.
- The hours worked by licensed personnel participating in plant evolution in order to observe completion of the evolution to provide necessary operational experience are excluded from the calculation of the total number of hours permitted.
- The hours required for license training, license retraining and the R.I.T. Training Program are excluded from the calculation of the total number of hours permitted.
- The hours worked by licensed Auxiliary Operators that do not require use of their license are excluded from the calculation of the total number of hours permitted. In other words, time worked by a licensed operator as an Auxiliary Operator will not be included in the total permitted.

Inspection Findings

Based on the inspector's review of the control room log and review of the following documentation, the licensee appears to have implemented the commitments stated above. Acceptability of the proposed alternatives in lieu of the overtime guidelines presented by the NRC is presently being evaluated.

- Administrative Procedure (A)-52.9, Overtime Work Policy, Revision 1, December 23, 1980.

- A-52.10, Overtime Work Policy, Health Physicists, I & C Technicians and Maintenance Personnel, Revision 0, December 24, 1980.

I.A.2.1 Immediate Upgrading of Reactor Operator and Senior Reactor Operator Training and Qualifications

Requirements

- References: (a) H. Denton (NRC) letter to All Power Reactor Applicants and Licensees, dated March 28, 1980.
(b) NUREG-0737

- Applicants for senior operator licenses shall have 4 years of responsible power plant experience.
- Applicants for senior operator licenses shall have held an operator's license for 1 year.
- Applicants for each license shall have 3 months training on shift as an extra person.
- Training programs (including requalification) shall be modified, as necessary, to provide training in accident mitigation, transient analysis, heat transfer fluid flow and thermodynamics.
- Training instructors shall hold senior operator licenses.
- Instructors shall be enrolled in appropriate requalification programs to assure they are cognizant of current operating history, problems, and changes to procedures and administrative limitations.
- Requalification exam new passing grade; 80% overall and 70% each category.
- Requalification programs should require the control manipulations listed in enclosure 4 to reference (a).

Licensee Commitments

- Reference: (a) L. White, Jr. (RG&E) letter to D. Crutchfield (NRC), dated August 25, 1980.

The licensee representative agreed to implement the operator licensing requirements, and addressed the administrative changes which had been made to the licensed operator training program.

Inspection Findings

Based on the inspector's review of the following documentation, the licensee appears to have satisfied the above requirement and associated commitment. The inspector also reviewed training records and the course outline for classroom lectures on heat transfer, fluid flow and thermodynamics.

- Administrative (A)-102.13, R. E. Ginna NRC Licensing Training Program, Revision 3, December 29, 1980.
- A-102.14, R. E. Ginna Operator Requalification Program, Revision 4, December 22, 1980.

I.C.5 Procedures for Feedback of Operating Experience to Plant Staff

Requirements

References: (a) NUREG-0737

- Clearly identify organizational responsibilities for review of operating experience, the feedback of pertinent information to operators and other personnel, and the incorporation of such information into retraining programs.
- Identify the administrative and technical review steps necessary in translating recommendations by the operating experience assessment group into plant actions.
- Identify the recipients of various categories of information from operating experience.
- Assure that plant personnel do not routinely receive extraneous and unimportant information such that it would obscure priority information.
- Provide periodic internal audit to assure that the feedback program functions effectively at all levels.

Licensee Commitments

Reference: (a) J. Maier (RG&E) letter to D. Crutchfield (NRC), dated December 15, 1980.

The licensee representative agreed to prepare procedures to assure that operating information pertinent to plant safety originating both within and outside the utility organization is continually supplied to operators and other personnel, and is incorporated into training and retraining programs.



Inspection Findings

Based on the inspector's review of the following documentation, the licensee appears to have satisfied the above requirement and associated commitment.

- Administrative Procedure (A)-201, Ginna Station Administrative and Engineering Staff Responsibilities, Revision 9, December 19, 1980.
- A-1404, Operational Assessment Program, Revision 0, January 13, 1981.
- Meeting minutes from the Operational Assessment Group-February 11 and 24, 1981.

The inspector noted that the requirement for a periodic internal audit had not been addressed in the implementing procedure for the Operational Assessment Program. The licensee representative stated that an internal audit would be performed by the Quality Assurance Department on an annual frequency, and the Quality Assurance Manual would be revised to reflect the addition of the new audit requirement.

I.C.6 Guidance on Procedures for Verifying Correct Performance of Operating Activities

Requirements

Reference: (a) NUREG-0737

- Except in cases of significant radiation exposure, a second qualified person should verify correct implementation of equipment control measures such as tagging of equipment.
- Equipment control procedures should include assurance that control room operators are informed of changes in equipment status and the effects of such changes.
- For the return-to-service of equipment important to safety, a second qualified operator should verify proper system alignment unless functional testing can be performed without compromising plant safety, and can prove that all equipment, valves, and switches involved in the activity are correctly aligned.

Licensee Commitments

Reference: (a) J. Maier (RG&E) letter to D. Crutchfield (NRC), dated December 15, 1980.

The licensee representative agreed to meet the intent of the requirements for verifying correct performance of operating activities. The licensee

representative further stated that in addition to licensed operators, individuals knowledgeable of the systems involved would perform verification of equipment control activities.

Inspection Findings

- References: (a) Administrative (A)-1401, Stations Holding Rules, Revision 7, October 2, 1980.
 (b) A-1402, Bypass of Safety Function or Jumper Control, Revision 0, April 16, 1980.

The inspector noted that equipment control activities such as bypassing or jumpering of safety-related equipment were not being verified in the field by a second qualified individual. The inspector stated that the lifting of wires or installation of jumpers has a direct effect on control of equipment and should be included in the independent verification for proper implementation. The licensee representative acknowledged the inspector's comment and stated that procedure A-1402 would be revised to require a second verification.

II.B.4 Training for Mitigating Core Damage

Requirement

- References: (a) H. Denton (NRC) letter to All Power Reactor Applicants and Licensees, dated March 28, 1980. (Enclosure 3)
 (b) NUREG-0737

- Licensees are required to develop a training program to teach the use of installed equipment and systems to control or mitigate accidents in which the core is severely damaged.
- The training program is to be developed by January 1, 1981, initiated by April 1, 1981, and completed by October 1, 1981.

Licensee Commitment

- References: (a) J. Maier (RG&E) letter to D. Crutchfield (NRC), dated December 15, 1980.
 (b) J. Maier (RG&E) letter to D. Crutchfield (NRC), dated March 13, 1981.

- The licensee representative stated that the training program would not begin by April 1, 1981, as scheduled, due to a manpower shortage at the contracted supplier, Westinghouse Electric Corporation. Reference (b) included a tentative schedule for the training classes which will be provided five times between June and August, 1981.

Inspection Findings

The inspector verified that the basic curriculum for the scheduled training program was in conformance with Enclosure 3 to H. Denton's March 28, 1980 letter.

II.E.4.2 Containment Isolation Dependability

Requirement

Reference: (a) NUREG-0737

- When containment integrity is required, emphasis should be placed on limiting all purging and venting to as low as achievable.
- The operability of butterfly isolation valves may, on an interim basis, be demonstrated by limiting the valve to be no more than 30 to 50 degrees open.
- Segregate the containment ventilation isolation signals to ensure that as a minimum, at least one of the automatic safety injection actuation signals is uninhibited and operable to initiate valve closure when any other isolation signal may be blocked, reset, or overridden.

Licensee Commitments

- References: (a) L. White, Jr. (RG&E) letter to D. Ziemann (NRC), dated December 14, 1979.
 (b) L. White, Jr. (RG&E) letter to D. Crutchfield (NRC), dated May 29, 1980.

The licensee representative stated that on an interim basis the containment purge valves would be mechanically limited to be no more than 50 degrees open. Further, emphasis would be placed on limiting all purging and venting times to as low as achievable.

Inspection Findings

- References: (a) System Modification (SM)-79-2504.1, Containment Purge Valve Travel Limitation, Revision 0, December 12, 1979.
 (b) Radwaste Discharge Procedure (RD)-2, Containment Purge Release, Revision 7, November 28, 1980.
 (c) Containment Isolation and Containment Spray Reset Modification-Safety Analysis and Design Criteria, Revision 0, November 17, 1980.
 (d) System Modification (SM)-2950.1, Safeguard System Reset Modification, Revision 0, November 26, 1980.

During the review of RD-2, the inspector noted that reference was made to limiting containment purging to 90 hours per year. This was not in accordance with the licensee's letter dated May 29, 1980, which stated that based on NRC staff review the 90 hour per purge limit was being superseded to emphasize limiting purging and venting times to as low as achievable with justification for venting and purging. The licensee has initiated a procedure change to RD-2 to incorporate the containment purge and vent operating requirements.

II.K.3.9 Proportional Integral Derivative Controller Modification

Requirement

Reference: (a) NUREG-0737

- Raise the interlock bistable trip setting to preclude derivative action from opening the power-operated relief valve (PORV), or
- change the derivative action setting to zero, thereby eliminating it from consideration.

Licensee Commitment

Reference: (a) L. White, Jr. (RG&E) letter to D. Crutchfield (NRC), dated June 13, 1980.

The licensee representative stated that the PID controller had been modified as required.

Inspection Findings

Based on the inspector's review of the following documentation, the licensee appears to have satisfied the above requirement and associated commitment.

- Safety Injection Logic Modification-Safety Analysis, Revision 1, May 14, 1979.
- Safety Injection Logic Modification-Design Criteria, Revision 1, June 4, 1979.
- System Modification Procedure (SM)-79-2449.1, Safety Injection Logic Modification, Revision 0, June 29, 1979.

The interlock bistable has been set above the operating pressure range so that the system does not normally operate with a permissive signal present. In this fashion no single channel failure (high) can cause spurious opening of the PORV.

III.D.3.3 Improved In-Plant Iodine Instrumentation Under Accident Conditions

Requirements

Reference: (a) NUREG-0737

- Provide equipment and associated training and procedures for accurately determining the airborne iodine concentration in areas within the facility where plant personnel may be present during an accident.
- Each licensee shall have the capability to remove the sampling cartridge to a low-background, low-contamination area for further analysis.

Licensee Commitments

- References: (a) L. White, Jr. (RG&E) letter to D. Ziemann (NRC), dated October 17, 1979.
- (b) L. White, Jr. (RG&E) letter to D. Ziemann (NRC), dated November 19, 1979.

The licensee representative stated that mobile air monitors having a single channel analyzer calibrated to the I-131 energy were located in various areas throughout the plant to detect the presence of iodine. Portable air samplers with charcoal and silver zeolite cartridges were said to be available in the Health Physics Office and at the Emergency Survey Center. The licensee representative further stated that a low background, low contamination counting facility was available where a sample could be purged of noble gases to assure accurate iodine measurements. Procedures were said to be in use and Health Physics technicians were trained to use the GeLi detector in isotopic analysis.

Inspection Findings

Based on the inspector's observations of the low background, counting facility available in the on-site environmental trailer, mobile instrumentation and portable air sampler (including cartridge) locations, and the review of the following documentation, the licensee appears to have satisfied the above requirement and associated commitment.

- Health Physics Procedure (HP)-11.1, Iodine In-Plant Air Drying Method, Revision 2, December 2, 1980.
- Site Contingency Procedure (SC)-1.7B, Determination of Iodine or Particulate, Revision 8, January 30, 1981.
- SC-1.9, In-Plant Radiation Monitoring, Revision 5, October 3, 1980.

The inspector had the following comments, as a result of the above procedure review.

- The main counting room, located adjacent to the Auxiliary Building, may have significant background levels following an accident. The low background, low contamination counting facility in the environmental trailer was not addressed in plant procedures as an alternate location to analyze sample results.

- Although silver zeolite cartridges are available the above procedures do not address the preferential use of silver zeolite over charcoal for accident in-plant iodine sampling.

The licensee representative stated that the inspector's comments would be incorporated in plant procedures by May 15, 1981.

6. Licensee Event Reports (LER's)

The inspector reviewed the following LER's to verify that the details of the event were clearly reported, including the accuracy of the description of cause and adequacy of corrective action. The inspector determined whether further information was required, and whether generic implications were involved. The inspector also verified that the reporting requirements of Technical Specifications and Station Administrative and Operating Procedures had been met, that appropriate corrective action had been taken, that the event was reviewed by the Plant Operations Review Committee, and that the continued operation of the facility was conducted within the Technical Specification limits.

81-03:

'A' Boric Acid Pump Suction Valve Found Partially Throttled Shut-January 15, 1981. During normal reactor coolant boration, a control room operator observed low suction pressure and an absence of flow indication from the 'A' Boric Acid Pump. The 'B' pump was placed in service and the 'A' pump declared inoperable. Investigation by the licensee found the suction valve to the 'A' pump partially closed. The valve was immediately reopened. Further investigation determined that on January 5 a technician had throttled the valve during sampling and apparently had not fully reopened it. Additionally, on January 15, in response to a trouble report a loose valve stem indication riser on the valve was screwed in, which in turn appears to have caused the valve to close further. Proper operation of the pump was not affected until the action on January 15.

A valve alignment for the boric acid system was performed and the 'A' pump tested with no discrepancies noted. The Plant Superintendent issued a memorandum stressing use of approved maintenance procedures for safety related systems. The boric acid pump suction valves (334 and 338) have been subsequently locked open. A primary chemistry sampling procedure is being written to address the required valve manipulation at each sample location, replacing a generic sampling procedure.

During the review of corrective action to preclude recurrence, the inspector stated that consideration should be given to locking open valves 331 and 345, which are also in the boric acid



pump suction piping from the boric acid storage tanks. The licensee representative agreed to lock open the additional suction valves.

81-04: 'C' Containment Fan Motor Cooler Service Water Leak- February 11, 1981. The 'C' Containment Fan Cooler was taken out of service following a 45 minute interval between containment sump pump actuations (normal interval is several days) and an increasing level in the 'C' Containment Recirculation Fan Cooler Condensate Collection System. Licensee investigation revealed a carbon steel, low point drain plug from the 'C' Containment Fan Cooler Motor Cooler had corroded and fallen on the floor. The plug was replaced as well as an adjacent plug that appeared to also be leaking. Cause of the corrosion is believed to have been from galvanic action between the carbon steel plugs and the copper cooling coils. The fan cooler was subsequently returned to service. The licensee inspected the remaining motor coolers for leakage, with no discrepancies found and plans to replace all motor cooler drain plugs during the upcoming spring refueling outage. An inspection of other heat exchangers which may have the potential for similiar galvanic action will also be conducted.

81-05: Failure of Bus 16 Breaker to Close for 'C' Safety Injection Pump- March 2, 1981 (repeat event, LER 81-02). The 'C' Safety Injection Pump failed to close onto Bus 16 following a 45 minute run on Bus 14. On a second attempt the breaker closed onto Bus 16 properly. Plant electricians put the breaker in the test position and operated the breaker three times with no discrepancies.

The surveillance test frequency was increased from monthly to weekly. In addition, the closing interlock and trip circuits were monitored in an attempt to identify the cause for the previous failures. On March 12 and 19 the breaker operated successfully. On March 26, the breaker again failed to close on Bus 16. The second attempt was successful. The faulty breaker was replaced and inspected by RG&E and Westinghouse Electric Corporation representatives. The apparent cause for the failures has been attributed to the occasional closing of the tripper bar switch prior to the tripper bar arm obtaining the proper position. Based on Westinghouse Electric Corporation recommendations to prevent recurrence, a mechanical adjustment to the closing circuit will be performed.

Review of Periodic and Special Reports

- a. Upon receipt, periodic and special reports submitted by the licensee pursuant to Technical Specification 6.9.1 and 6.9.3 were reviewed by the inspector. This review included the following considerations:

the report includes the information required to be reported by NRC requirements; test results and/or supporting information are consistent with design predictions and performance specifications; planned corrective action is adequate for resolution of identified problems; determination whether any information in the report should be classified as an abnormal occurrence; and the validity of reported information. Within the scope of the above, the following periodic reports were reviewed by the inspector.

- Monthly Operating Reports for January and February, 1981.
- Annual Environmental Operating Report - 1980.
- Semi-annual Effluent Release Report - July 1980.
- Standard Report of Personnel Whole Body Exposure by Exposure Groups - 1980.
- Standard Report of Personnel and Man-Rem by Work and Job Function - 1980.
- Annual Report of Changes to Station Facilities and Procedures - 1979.

- b. The Semi-annual Effluent Release Report did not include the date of each solid radioactive waste shipment. The licensee representative stated that the date of each shipment will be incorporated in future reports.

The 1979 Annual Report of Changes to Station Facilities and Procedures was noted to not have been submitted in a timely fashion. The licensee representative stated that the 1980 report is expected to be issued in the next several months.

No items of noncompliance were identified.

8. Inspector Witnessing of Radiation Emergency Drill

- a. The radiation emergency drill commenced at 5:00 P.M., February 18, 1981 with initial conditions of full power and a simulated containment purge in progress. The drill scenerio consisted of a small break, loss of coolant accident in containment with a failure of the purge valves to shut.

The inspector observed the actions taken by the licensee's organization to determine the following:

- Response was in accordance with approved procedures and plans;
- Response was coordinated, orderly, and timely;

- Designated persons were being used to evaluate the response; and
 - Critique was held shortly following the drill.
- b. The inspector witnessed portions of the licensee's response from the Control Room, Technical Support Center (TSC), and Emergency Survey Center (ESC).

Licensee actions in response to the drill (including the critique) were considered satisfactory; however, the inspector had the following comments concerning the running of the drill itself.

- The on-duty shift in the control room did not participate in the drill. Only one off-duty licensed operator and several Shift Technical Advisors took action concerning detection and response to the simulated emergency condition. The inspector stated that if the on-duty shift is not participating in the interest of plant safety, consideration should be given to providing a "second shift" of off-duty licensed operators to provide for additional operator training.
- The individuals manning the TSC were unable to fully participate in the initial detection and response in that the plant computer, the major source of plant parameter data to the TSC, was printing out actual full power data as would be expected. The inspector stated that by stationing an audit number in the TSC and providing verbal or written drill scenerio plant parameter data to the TSC members, they would receive additional training in accident analysis.
- At the close of the inspection period formal critique minutes and recommendations for corrective action had not been submitted for Plant Operations Review Committee action. Although the inspector did not consider any of the deficiencies identified at the critique to warrent immediate corrective action, the timeliness for submittal of identified problems to PORC appears excessive. The inspector will continue to monitor the licensee's actions to correct deficiencies identified during the drill and addressed at the critique.

9. Exit Interview

At periodic intervals during the course of the inspection, meetings were held with senior facility management to discuss the inspection scope and findings.

