

UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
230 PEACHTREE STREET, N. W. SUITE 918
ATLANTA, GEORGIA 30303

IE Inspection Report Nos. 50-269/75-10, 50-270/75-11 and 50-287/75-11

Licensee: Duke Power Company
Power Building
422 South Church Street
Charlotte, North Carolina 28201

Facility Name: Oconee Units 1, 2 and 3
Docket Nos.: 50-269, 50-270 and 50-287
License Nos.: DPR-38, 47 and 55
Category: C, C and B2

Location: Seneca, South Carolina

Type of License: B&W, PWR, 2568, Mw(t)

Type of Inspection: Routine, Unannounced

Dates of Inspection: September 9-12, 1975

Dates of Previous Inspection: July 29-31, 1975

Principal Inspector: T. N. Epps 10-1-75
T. N. Epps, Reactor Inspector Date
Facilities Operations Branch

Accompanying Inspectors: A. K. Hardin, Reactor Inspector
Facilities Operations Branch

D. G. Hinckley, Reactor Inspector
Facilities Operations Branch

W. W. Peery, Radiation Specialist
Reactor Facilities
Radiological and Environmental Protection Branch

Reviewed by: F. J. Long 10/2/75
F. J. Long, Chief Date
Facilities Operations Branch



8001 031041

SUMMARY OF FINDINGS

I. Enforcement Items

A. Infractions

1. Contrary to Oconee Technical Specification 3.7.4.(a) on July 4, 1975 a Lee combustion turbine unit was not made available to Oconee, as a backup source of emergency electrical power, within the required time. (Details I, paragraph 2a)

This infraction had the potential for causing or contributing to an occurrence related to safety.

2. Contrary to Oconee Technical Specification 6.4.1.(a) procedures were not followed during the attempt to use a Lee combustion turbine unit for a backup source of emergency electrical power. (Details I, paragraph 2b)

This infraction had the potential for causing or contributing to an occurrence related to safety.

3. Contrary to Oconee Technical Specification 6.4.1(e) maintenance activities at the Keowee Hydro Station were not properly controlled as stated in section 2.7.1 of the licensee's Administrative Policy Manual. (Details I, paragraph 2c)

This infraction had the potential for causing or contributing to an occurrence related to safety.

II. Licensee Action on Previously Identified Enforcement Matters

Items of noncompliance identified in IE inspection report 50-269, 270 and 287/75-4 are closed.

The infraction identified in IE inspection report 50-269, 270, 287/75-3 is closed.

Items of noncompliance identified in IE inspection report 50-269, 270 and 287/75-1 are closed.

III. New Unresolved Items

None

IV. Status of Previous Reported Unresolved Items

Oconee 1 (50-269)

73-12/1 Calibration of Effluent Monitors

DPC provided a status report dated August 1, 1975.
This item remains open. (Details IV, Paragraph 5)

73-13/1 Wastewater Collection Basin Modification

Not inspected.

74-3/3 Training of Unlicensed Utility Operators

This item remains open.

74-12/1 Incomplete Inservice Inspection Plan

The licensee will obtain further information
from the NSS vendor on this subject. The item
remains open.

Oconee 2 (50-270)

74-7/4 LPI Valve Failure

This item is closed. (Details I, paragraph 5)

Oconee 3 (502287)

74-13/2 Reactor Coolant Flow Anomaly

This problem has been referred to the Office of
Reactor Regulation (Licensing). It remains open.

74-13/3 RPS Pressure Transmitter Check

The licensee is checking calibration of these trans-
mitters monthly in the hot condition. This item is
closed. (Details I, paragraph 6)

- 74-14/1 Deferral of Loss of Control Room Test
Not inspected.
- 74-14/2 Ventilation Control Between Auxiliary and Turbine Buildings
This item remains open.
- 75-2/4 Completion of Power Ascension Testing For Oconee 3
Not inspected.
- Oconee 1, 2 and 3 (50-269, 50-270 and 50-287)
- 74-10, 08, 11/3 Operator Replacement Training
This program has not received final approval.
The item remains open.
- 74-10, 08, 11/4 SRC Quorum
Not inspected.
- 74-10, 08, 11/5 Procedure Changes
Not inspected.
- 74-10, 08, 11/11 Non-Technical Specification Violations
Not inspected.
- 75-2/2 Sensitivity of Reactor Coolant Pressure Boundary Leakage
Detection Systems
Not inspected.
- 75-07, 08, 08/1 High pressure injection pump recirculation
flow orifice and letdown block orifice erosion
problem. This item is closed. (Details I,
Paragraph 7)

75-07, 08, 08/2 Retention of operating procedures. This item is closed. (Details I, Paragraph 8)

V. Unusual Occurrences

Selected incidents were reviewed by each of the four inspectors and appear in each detail section of this report.

VI. Other Significant Findings

A. Personnel Changes

C. L. Thames, Health Physics Supervisor, is to be transferred to DPC's Headquarters in Charlotte, North Carolina, effective September 12, 1975. C. T. Yongue, Assistant Health Physics Supervisor is apparently being considered as the replacement for Thames. This will be reviewed on a subsequent inspection.

VII. Management Interview

W. W. Peery held an exit interview on September 10, 1975, with J. W. Hampton, Superintendent of Administrative Services, and members of the Oconee staff. Items discussed included the previous enforcement items in Section II of this summary and the close out of these items. Also discussed was one remaining open unresolved item in Section IV of this summary. The review and close out of two abnormal occurrences were also discussed.

T. N. Epps, D. G. Hinckley and A. K. Hardin held an exit interview on September 12, 1975, with the following DPC personnel.

J. E. Smith - Manager, Oconee Nuclear Station
J. W. Hampton - Director, Administrative Services
L. E. Schmid - Operating Superintendent
O. S. Bradham - Maintenance Superintendent
R. M. Koehler - Technical Services Superintendent
T. S. Barr - Technical Services Engineer
M. S. Tuckman - Staff Engineer
E. H. Gladden - Superintendent, Keowee Hydro Station
J. Brackett - Quality Assurance Engineer
J. Dunlap - Assistant Quality Assurance Engineer

Items discussed included the noncompliance items and some unresolved items in this summary and a summary of other areas reviewed during this inspection.

T. N. Epps discussed the noncompliance items in section I with Duke Power Corporate Management on September 19, 1975.

Some corrective actions have been identified by the licensee and these as well as further actions will be identified in the licensee's response.

DETAILS I

Prepared by:

T. N. Epps
T. N. Epps, Reactor Inspector
Facilities Operations Branch

10-1-75
Date

Dates of Inspection: September 9-12, 1975

Reviewed by:

F. J. Long
F. J. Long, Chief
Facilities Operations Branch

10/2/75
Date

1. Individuals Contacted

Duke Power Company (DPC)

J. E. Smith - Manager, Oconee Nuclear Station
J. W. Hampton - Director, Administrative Services
L. E. Schmid - Operating Superintendent
O. S. Bradham - Maintenance Superintendent
R. M. Koehler - Technical Services Superintendent
T. S. Barr - Technical Services Engineer
M. S. Tuckman - Staff Engineer
E. H. Gladden - Superintendent, Keowee Hydro Station

2. Emergency Electrical Power Systems

The following discussions illustrate a general weakness in Oconee's management control over the emergency electrical power systems required by the Oconee Technical Specifications.

- (a) Oconee Technical Specification 3.7.4.(a) requires that, under certain conditions when one Keowee unit is unavailable, one Lee Turbine be used to energize the 4160 volt standby busses through an isolated 100 KV circuit.

Contrary to the above, on July 4, 1975, when one Lee Turbine was required to energize the 100 KV transmission circuit as a backup source of emergency electrical power to Oconee, a Lee Turbine was not made available to Oconee within the required time.

On July 3, 1975, at 1835 hours, it was determined that Keowee Unit 2 was inoperable. At approximately 1600 hours on July 4, 1975, it was determined that Keowee Unit 2 would possibly not be operable by 1835, the end of the 24 hour period that Keowee-2 had been inoperable. (AO-269/75-8)

Oconee personnel stated that a call was placed to the system dispatcher at 1600 hours on July 4, 1975, where Oconee personnel requested that a Lee unit be tied to Oconee standby busses through the 100 KV transmission line.

The licensee's abnormal occurrence report (AO-269/75-8) stated that due to highly active thunderstorms in the area and heavy usage of the two transmission lines between Lee station and the central switch yard, the system dispatcher waited an additional 2 hours before notifying the Lee station operator that a backup source of emergency electrical power was needed at Oconee.

One cause of the incident was identified by the licensee as failure to put a Lee unit on the 100 KV line initially due to the dispatcher's assessment of the most reliable system configuration during the thunderstorm.

The inspector stated that the dispatcher does not have the authority to determine when Oconee can have emergency electrical power sources.

- (b) Oconee Technical Specification 6.4.1(a) requires that operating procedures for the complete facility and all systems and components involving nuclear safety of the facility be followed.

Contrary to the above, step III.B.3 of Oconee operating procedure OP/0/1107/3 requires Oconee personnel to notify the Lee station when a Lee unit is required as a backup source of emergency power; and on July 4, 1975, Oconee personnel attempted to handle communications through the dispatcher rather than contacting the Lee facility directly.

Also contrary to Technical Specification 6.4.1.(a) the dispatcher delayed the request to Lee facility for about 2 hours; and when the request was made for the backup emergency power source, the dispatcher requested that a step requiring the isolation of the 100 KV line from the system not be performed. This was attempted by Lee station personnel and caused the Lee unit to trip.

The inspector stated that the dispatcher does not have the authority to change safety related procedures nor do Lee facility personnel have authority to deviate from the Oconee License requirements when providing emergency electrical power to Oconee.

During the review of the above incident the inspector noted that a connection exists on the 100 KV transmission line from the Lee station to Oconee. This is a Michlin Tire Co. backup electrical power source. When the 100 KV line is isolated as required by the Oconee Technical Specifications, a Duke Power Company employee must be dispatched to the field to manually isolate the Michline connection from the 100 KV line. This action is initiated by the system dispatcher and could take longer than the 30 minutes required in some cases by the Oconee Technical Specifications.

This was identified by the inspector as another weakness. A licensee representative stated that a modification request was initiated to alleviate this problem. The licensee is reporting this item as an Unusual Event.

- (c) Oconee Technical Specification 6.4.1(e) requires that the station be maintained in accordance with approved procedures.

The licensee's Administrative Policy Manual section 2.7 (Control of Interfacing Individuals and Organizations) states that in order to assure that the activities of interfacing individuals and organizations do not compromise the safety of the station, or the quality of its safety-related structures, systems and components, each nuclear station shall establish measures for the control of such interfacing individuals and organizations.

It further states that the station Manager shall have the final responsibility for the implementation of the above requirements.

Contrary to the above the following three reportable incidents demonstrate inadequate implementation of administrative controls over maintenance on emergency electrical power systems.

- (1) Keowee modifications were conducted in February, 1975, without prior authorization. (UE-269/75-7)
- (2) On August 11, 1975, Keowee Unit-1 batteries and the Keowee Unit-2 hydro generator were removed from service simultaneously contrary to Oconee Technical Specification 3.7. (AO-269/75-11)
- (3) On July 28, 1975, it was discovered that one string of Keowee batteries and one string of switching station batteries were out of service simultaneously contrary to Oconee Technical Specification 3.7. (AO-270/75-13)

The inspector met with the Superintendent of the Keowee Hydro Station on September 12, 1975, to discuss administrative controls on Keowee maintenance activities. Following are some questions and answers from this meeting.

1. Generally how is the maintenance organization at Keowee organized? Maintenance at Keowee is conducted by several different organizations within Duke Power Company. A Keowee employee accompanies them when maintenance is done.
2. How do Keowee administrative procedures control maintenance activities and assure that the Oconee Technical Specifications are not violated by maintenance personnel?

There are no Keowee Administrative Procedures. Oconee Administrative procedures apply to Keowee.

3. Are Keowee maintenance activities controlled under steam production department station work requests? Yes
4. What written instruction requires Keowee personnel to get Shift Supervisor permission to take equipment out of service? Work requests and Keowee maintenance procedures.

3. Unusual Occurrences

The inspector reviewed the following incidents and had no further questions.

- AO-269/75-7 RCS Leakage
- AO-269/75-4 Keowee trip during test
- AO-269/75-5 LPSW Pump Operation

4. Plant Operations (Unit-3)

The inspector reviewed log books including shift supervisor's, control room and out of normal logs as well as other control room activities.

It was observed that both core flood tanks are requiring frequent makeup - approximately each 24 to 48 hours. Licensee management personnel stated that this problem is identified as a maintenance item for the next planned shutdown. Technical specifications relating to core flood tank level, pressure and boron concentration are being met and the inspector had no further questions.

5. LPI Valve Failure

Problems with these valves have not recurred since the licensee removed appropriate guide pins. This item is closed.

6. RPS Pressure Transmitter Check

The problem of trip setpoint drift has not recurred since the licensee started calibrating the subject transmitters in the hot condition on a monthly basis. The licensee stated that replacement transmitters will be available during the first half of 1976. This item is closed.

7. HPI Pump Recirculation Flow Orifice and Letdown Block Orifice Erosion

The licensee defined surveillance and replacement plans on this subject in the July 21, 1975, letter to the Region II Director. This unresolved item is closed.

8. Retention of Operating Procedures

The licensee's practice appears to be adequate. This general subject is under review, however, by the Nuclear Regulatory Commission.

This unresolved item is closed.

9. IE Bulletins

Bulletins 75-03 and 75-06 are considered closed.

DETAILS II

Prepared by:

A. K. Hardin
A. K. Hardin, Reactor Inspector
Facilities Operations Branch

9/19/75
Date

Dates of Inspection: September 9-12, 1975

Reviewed by:

F. J. Long
F. J. Long, Chief
Facilities Operations Branch

10/2/75
Date

All information with details applies equally to Oconee 1, 2, and 3, except where information is identified with a specific reactor.

1. Individuals Contacted

O. S. Bradhan - Maintenance Superintendent
T. S. Barr - Technical Services Engineer
W. Morgan - Assistant Shift Supervisor
D. Riden - Technical Services Engineer

2. Plant Operations - Units 1 and 2

a. Log Books

The shift supervisor's logs for the period 9/1/75 through 9/9/75 were reviewed for content. Log entries in conjunction with supporting control room logs provided sufficient information to record significant operational evolutions and events.

b. Station Work Requests - Units 1 and 2

The licensee's system for accomplishing and controlling station repair and maintenance was reviewed. The administrative system provides that each job to be performed is assigned a priority and whether it is safety or non-safety related or an engineered safeguards system. On Unit 1, the inspector observed a backlog of more than 200 work requests, some of which were designated as priority I and safety related. The designations of safety related, priority I were observed on work requests more than one month old. The licensee defines priority I work in terms such as real emergency, start immediately, work on expeditiously to completion. Because of the inconsistency of the actual work request file with the stated intent of accomplishing work, the observations on the status of the work request system was discussed at the exit interview. A licensee representative had previously stated that the large number of outstanding work requests could be due to failure to

update the file. The plant manager acknowledged that failure to maintain the file current could be the problem or the misuse of assigning priority designations might also be part of the problem. The licensee agreed to review the status of the work request system.

c. Annunciator System - Units 1 and 2

The operational status of Units 1 and 2 was observed. Unit 1 was operating at rated power. Unit 2 was in cold shutdown for replacement of primary coolant pump seals. On Unit 1, annunciator lights in an alarm condition were reviewed with the assistant shift supervisor on duty. At the exit interview, the inspector discussed inadequacies observed in the status of annunciator alarms. For example on panel ISA-8 the RM Process Monitor-Hi was in alarm. The panel showed 6 locations to be in hi alarm. The first channel out gives the alarm, masking any other channel which may reach high trip. The licensee stated that revisions were in progress to prevent masking of alarm conditions due to a previous alarm. On ISA-4, the Electrical Trace Heating Problem Annunciator light was in alarm. On questioning of the control operator for the cause of the alarm condition, it was found a review had to be made as to when the alarm initiated and whether a work request to investigate and repair the system had been issued. The inspector stated at the exit interview that responsible operators were expected to know why alarms were on and what was being done to eliminate alarms. The licensee stated that they believed they had progressed significantly in making the alarm system a meaningful tool and they were continuing efforts to attain a "dark board" alarm system.

d. Plant Tour - Units 1 and 2

An inspection of several areas of the plant was made including turbine building, portions of the auxiliary building, cable spreading rooms, and emergency electrical transformer cubicles. Selected switch and valve positions and operation of process parameter recorders were observed. No questions regarding observations made during the plant tour were raised at the exit interview.

3. Surveillance Tests

The licensee's system for controlling the performance of surveillance tests to assure the tests are completed within the frequencies specified in the Technical Specifications was reviewed. The licensee uses a computer system to provide for any given surveillance

test, an identification of the procedure on which the test is done, when the test was last performed, when it is due to be performed, the latest date it can be performed without failure to meet the technical specifications, and a tabulation of previous dates the tests were performed. No noncompliance items were observed in performance of the tests as per technical specification requirements. At the exit interview the inspector stated the system was difficult to use partially because Administrative Procedure No. 20 which provides the "key" to correlate technical specification surveillance test requirements with the computer program printout was not up to date. The licensee stated some procedure numbers had been changed but Administrative Procedure No. 20 had not been revised to reflect the changes. The licensee stated the procedure would be revised by October 15, 1975.

In addition to verifying that surveillance performance schedules were met by means of the computer print out, the results of four selected tests were reviewed for the last several intervals the test was completed. No noncompliance items were observed.

4. Unusual Event Review, Unit 3

The licensee's commitments and actions relative to four reported unusual events were reviewed.

a. Unusual Events Nos. 75-3, 75-8, and 75-9

For all of the above three unusual events the failure of personnel hatch interlocks was reported. The repeated failure of the personnel hatch interlock to perform as designed is considered generic within the station. However, the licensee believes the Oconee Station personnel hatch interlocks are unique and that such failures would not be expected elsewhere. The licensee reported the interlocks are supplied by the W. J. Wooley Company. The licensee stated they believe they have the failure problem under control. The inspector verified the issuance of two preventative maintenance procedures, MP/O/A/3006/3 and MP/O/A/3006/1 designed to preclude failure of the personnel hatch interlock. The three unusual event reports are closed.

b. Unusual Event No. 75-5, Unit 3

This unusual event reported the failure of an emergency feedwater pump to start during a test. The cause was believed to be a result of over-tightening the packing. At the exit interview the licensee was informed that failure to follow an approved procedure for packing an engineered safeguards pump was in noncompliance with Technical Specification 6.4.1.e which requires that corrective maintenance which could affect nuclear safety shall be performed

with approved procedures. The licensee has reemphasized to maintenance personnel the necessity to verify operability of equipment following maintenance. The noncompliance (infraction) is a no response item and is closed.

5. Abnormal Occurrence Review

The licensee's commitments and actions relative to two reported Abnormal Occurrences were reviewed.

a. Abnormal Occurrence 287/75-9

The licensee reported the power level cutoff limit was exceeded during transient xenon conditions, because of failure of turbine bypass valves dumping steam directly to the condensor. The analysis of the event was reviewed at the site. The analysis demonstrated that peak linear heat rate was at least 3 kw/ft below the limiting linear heat rate from data taken at a time just prior to the occurrence. The power level limit was exceeded for only a few minutes. The licensee was informed the occurrence was in noncompliance with Technical Specification 3.5.2.5.d (infraction) but that no further response was required.

b. Abnormal Occurrence 287/75-10

The licensee reported that upon calibration of the borated water storage tank level instruments, the instruments were found to be out of calibration and the level one-half foot lower than the Limiting Condition for Operation (LCO) on one tank. The licensee stated reactor shutdown was initiated while returning the tank to the correct (46 foot) level. The cause of the incorrect calibration was attributed to an incorrectly calibrated test gauge. The licensee stated that a copy of the AO report had been given to all involved personnel with emphasis on assuring correct calibration of test gauges. The licensee was informed that the incident was in noncompliance with Technical Specification 3.3.1.f. but that no additional response would be required.

DETAILS III

Prepared by: D. G. Hinckley 9/18/75
D. G. Hinckley, Reactor Inspector Date
Facilities Operations Branch

Dates of Inspection: September 9-12, 1975

Reviewed by: F. J. Long 10/2/75
F. J. Long, Chief Date
Facilities Operations Branch

1. Individuals Contacted

Duke Power Company

J. W. Hampton - Director, Administrative Services
O. S. Bradham - Maintenance Superintendent
T. S. Barr - Technical Services Engineer
J. Davis - Planning Engineer
R. L. Wilson - Performance Engineer
W. M. Harris - Operating Engineer
R. J. Brackett - Assistant QA Engineer

2. Procurement

Procurement records were reviewed to determine if the purchase, handling, and storage of safety related components were in conformance with the licensee's approved quality assurance program and implementing procedures. Records were reviewed for the following components and services: emergency feedwater pump runner assembly, reactor building spray pump impeller, reactor vessel head "O" rings, RCP stationary seal rings, repair of pressurizer relief valves, and repair of a CRD circuit breaker.

The review consisted of verifying proper documentation of required quality assurance specifications, quality assurance inspections, adequate handling, and proper storage of the selected components. The storage area was inspected and those selected components in storage were identified.

The records reviewed appeared to contain the required documentation. The storage area for safety related components and equipment was separated from non safety related storage and had controlled access. The flow of material into and out of the storage area appeared to be well controlled, and storage was in accordance with approved procedures.

3. Records Storage

The licensee's program for control, storage retention and retrieval of various plant records was reviewed for compliance with Section 6.5 of the Technical Specifications and Section 2.2 of the Administrative Policy Manual for Nuclear Stations. Selected records included:

- a. Inservice inspection QA records
- b. Power mapping records
- c. Fuel assembly records
- d. Secondary system chemistry records
- e. Switchboard records
- f. Keowee hydro governor maintenance records
- g. HPI valve maintenance records
- h. Design change review of "Seismic Restraints, for Low Pressure Service Water, Reactor Building Spray, and Component Cooling Systems".
- i. Reactor building tendon surveillance records
- j. Design cycles of operation records.

Item J, Design Cycles of Operation, was not available. The licensee has assigned personnel to gather and document the required information. No items of noncompliance were identified.

4. Drawing Control

The licensee's program for maintenance and control of as-built drawings was not reviewed as required by the inspection module for records. This item was inspected as part of an investigation documented in IE Report Nos. 50-269/75-8, 50-270/75-9 and 50-287/75-9.

5. Microfilming of Records

Where possible, Oconee Nuclear Station records are being microfilmed. The microfilmed records are being stored in a fire-proof vault. Drawings are being put on aperture cards; completed tests and permanent records are put on cartridges; procedures and records requiring updating are put in jacket files. The first year of routine performance records are being microfilmed for each unit. After the first year of operation, performance records are kept for the current and previous year and are not microfilmed.

6. Unusual Occurrences

a. Infractions Identified by Licensee

Oconee Technical Specification 3.3.1(a) requires that one reactor building spray pump and its associated spray nozzle header be operable when reactor coolant pressure is 350 psig or greater or reactor coolant temperature is 250°F or greater.

Contrary to the above on August 8, 1975, the Unit 2 reactor coolant system was elevated above 250°F and 350 psig without a reactor building spray train being operable.

Corrective action described in the licensee's abnormal occurrence report AO-270/75-16 was verified and there were no further questions.

b. Other Licensee Reported Occurrences Reviewed

The following reported occurrences were reviewed:

1. UE-270/75-9, "Excessive Reactor Building Emergency Hatch Leak Rate"
2. AO-270/75-12, "Standby Bus Breaker Failure"
3. AO-270/75-15, "Failure of Amplifier in RPS Channel D Power Imbalance Circuit"
4. AO-287/75-11, "Failure of Control Rod Drive Breaker 10".

DETAILS IV

Prepared by: W. W. Peery

W. W. Peery, Radiation Specialist
Facility Radiological Protection
Section
Radiological and Environmental
Protection Branch

9/26/75
Date

Dates of Inspection: September 9-10, 1975

Reviewed by: A. F. Gibson

A. F. Gibson, Senior Health
Physicist, Reactor Facility
Section, Radiological and
Environmental Protection Branch

9/29/75
Date

All information in these details applies equally to Units 1, 2 and 3 except where information is identified with a specific reactor.

1. Individuals Contacted

Duke Power Company (DPC)

J. W. Hampton - Superintendent of Administrative Services
R. M. Koehler - Superintendent of Technical Services
T. S. Barr - Technical Services Engineer
C. L. Thames - Health Physics Supervisor
C. T. Yongue - Assistant Health Physics Supervisor
M. G. Kriss - Assistant Health Physics Supervisor
D. L. Davidson - Assistant Health Physics Supervisor

2. DPC System Health Physics Manual (IE Inspection Report Nos. 50-269/75-7, 50-270/75-8, and 50-287/75-8, Item I.A.2)

Revisions of the Health Physics Manual were reviewed and found to be as stated in the DPC's letter dated July 21, 1975. As stated the manual was revised to permit storage of respiratory protective equipment in any appropriate location rather than specifically in the personnel change room only. The manual was revised to state that all tools and equipment being transferred from the reactor building or radioactive control zones within the radiation control area to the contaminated tool crib must be properly monitored, and wrapped and tagged as required by contamination levels. The licensee takes the position that personnel are required to utilize monitoring equipment to ensure that they are free of contamination when leaving radiation control areas and since the majority of personnel passing through portal monitors have not been in radiation control areas it

is not considered necessary that they use the portal monitor. The Health Physics Manual had been revised to make use of the portal monitor optional upon leaving the restricted area. After verification of the Health Physics Manual revisions and inspection of facilities and equipment involved the inspector had no further questions.

3. 10 CFR 20.203 Caution signs, labels, signals and controls (IE Inspection Report Nos. 50-269/75-7, 50-270/75-8, and 50-287/75-8, Item I.A.3)

The above noncompliance involved a radiation area not posted per 20.203(b), two high radiation areas not posted per 20.203(c)(1), a high radiation area not fully controlled per 20.203(c)(2), and two high radiation areas secured with padlock and chain such that an individual could be prevented from leaving the area contrary to 20.203(c)(3). DPC's letter dated July 23, 1975, stated that all discrepancies noted in this item have been corrected. Inspection revealed that the posting discrepancies had been corrected, the controls for the one high radiation area were established per 20.203(c)(2) and the locks had been changed on the two high radiation areas to comply with 20.203(c)(3). The licensee reported that to prevent recurrence, these items had been reviewed with the appropriate health physics and chemistry supervisors and their personnel. The inspector had no further questions on these items.

4. Radiological Training (IE Inspection Report Nos. 50-269, 50-270, and 50-287/75-4, Item I.A.1)

Inspection of records and discussions with licensee personnel revealed that the radiation-protection training program described in DPC's letter dated May 21, 1975 had been instituted to provide periodic training on a regular basis. The inspector had no further questions.

5. Personnel Exposure Records (IE Inspection Report Nos. 50-269, 50-270, and 50-287/75-1, Item I.B.3)

The inspector reviewed personnel exposure records for corrections made for terminated or temporary employees whose work assignments were completed as described in DPC's letters dated, March 26; April 11; May 6; and June 10, 1975. The inspector had no further questions.

6. 73-12/1 Calibration of Effluent Monitors

DPC letter dated August 1, 1975 reported that modification to permit an air purge to clear the waste gas monitors, RIA-37 and RIA-38, after a waste gas decay tank release and to install a

sample line in parallel with the monitor to allow grab samples to be taken at the monitor will be completed by November 1, 1975. This item remains open. The DPC letter dated August 1, 1975 also reports that particulate monitors RIA-43 and RIA-47 were initially believed to be unreliable because correlation could not then be established between the continuous monitor and laboratory analysis of the particulate filter removed from these monitors. Investigation by the licensee of this inconsistency is said to have shown the particulate monitors to be reliable and to be capable of early detection of changing particulate activity. The licensee reported that correlation between monitor and samples has been obtained in several isolated instances, but not continuously, due to short half-life Rubidium 88. The letter reports that grab samples are being taken as required by Technical Specification 3.10.7 and RIA-43 and RIA-47 provide reliable qualitative indication of changing activity. It was pointed out by licensee representatives and management that Technical Specification 3.10.7 requires grab samples only if the monitors are inoperable. Discussion was held concerning the lack of a firm position in the August 1st letter as to whether or not the monitors are operable with respect to the application of the requirements of Technical Specification 3.10.7 and the conclusion in the August 1st letter that the item is resolved. Licensee management indicated that a supplemental report to the August 1, 1975, letter will be submitted to clarify this matter. This item remains open.

7. AO-269/75-5 Liquid Waste Monitor Failure During Release

The inspector reviewed the subject abnormal occurrence and verified with licensee representatives the cause, analysis of the occurrence, and the corrective action described in the licensee's report dated May 20, 1975. The replacement of a gasket between the detector wall and sampler was apparently all that was necessary to correct the problem. There were no apparent discrepancies or limits exceeded. The inspector had no further questions and this item is considered closed.

8. AO-270/75-14 Release of Gaseous Activity to the Auxiliary Building

The inspector reviewed the subject abnormal occurrence and verified the corrective action described in the licensee's report dated August 8, 1975. The replacement of the high activity waste tank pump seals and correction of the quench tank level indicators appear adequate to correct the problem. There were no apparent discrepancies or failures to meet regulatory requirements. The inspector had no further questions and this item is considered closed.