

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

Region I

Report No. 50-219/81-01

Docket No. 50-219

License No. DPR-16 Priority -- Category C

Licensee: Jersey Central Power and Light Company

Madison Avenue at Punch Bowl Road

Morristown, New Jersey 07960

Facility Name: Oyster Creek Nuclear Generating Station

Inspection at: Forked River, New Jersey

Inspection conducted: January 5-31, 1981

Inspectors: *L. E. Briggs* 3/16/81
J. A. Thomas, Resident Reactor Inspector date signed

L. E. Briggs 3/16/81
L. E. Briggs, Reactor Inspector date signed

date signed

Approved by: *Edward G. Greenman* 3/17/81
E. G. Greenman, Chief, Reactor date signed
Projects Section 2A

Inspection Summary:

Inspection on January 5-31, 1981 (Report No. 50-219/81-01)

Areas Inspected: Routine inspection by the resident inspectors (92 hours) of:
licensee action on previous inspection findings; tours of the facility; log and
record review; in-office LER review; on-site LER followup; and followup of IE
Bulletins and Circulars.

Results: One item of noncompliance was identified. (Failure to follow procedures,
detail paragraph 3.d.(2)).

DCS Numbers

50219-800512
50219-800507
50219-800523
50219-800709
50219-800716
50219-800730
50219-800711
50219-800716
50219-800806
50219-800814
50219-800826
50219-800829
50219-800905
50219-800911
50219-800925
50219-800930
50219-801002
50219-801101
50219-801106
50219-801118
50219-801130
50219-801203
50219-801204
50219-801205
50219-801211
50219-801217

DETAILS

1. Persons Contacted

J. Carroll, Director, Oyster Creek Operations
K. Fickeissen, Manager, Plant Engineering
J. Maloney, Manager, Plant Maintenance
A. Rona, Engineering Manager
W. Stewart, Plant Operations Manager
J. Sullivan, Manager, Operations
D. Turner, Radiological Controls Manager

The inspectors also interviewed other licensee personnel during the course of the inspection including management, clerical, maintenance, and operations personnel.

2. Licensee Action on Previous Inspection Findings

(Closed) Unresolved Item (219/80-16-04): Delete Procedure 218, Operation Below 10 Percent Power With RWM Bypassed or Inoperable. The inspector reviewed procedure 218, Revision 1 dated May 21, 1980. Rather than deleting this procedure, the licensee has made suitable revisions to bring it into compliance with Technical Specification Section 3.2.B.2. The inspector had no further questions on this item.

(Closed) Unresolved Item (219/80-28-04): Licensee to conduct a complete audit of all active equipment tagging requests. The inspector determined that the licensee had completed an audit of all active tagging requests on October 30, 1980 and documented the audit by a close out response to a QA noncompliance report. The inspector had no further questions on this item.

3. Facility Tours

a. During the course of the inspection, the inspector made observations and conducted multiple tours in the following areas:

- Control Room;
- Accessible areas of the Reactor Building;
- Turbine Building;
- Cable Spreading Room;
- 4160 Volt Room;
- 480 Volt Room;

- Cooling Water Intake Structure;
 - Maintenance Shop Areas;
 - Monitoring Change Areas;
 - Yard Areas, including perimeter fences; and,
 - Augmented Off-Gas Building.
- b. The following observations were made.
- The inspector verified that selected instrumentation was operable, demonstrated parameters within Technical Specification limits, and demonstrated proper correlation between channels. No unacceptable conditions were identified.
 - The inspector made observations to verify that control point procedures and posting requirements were being followed, and that work done in controlled areas was in accordance with approved radiation work permits. No unacceptable conditions were identified.
 - Systems and equipment in all areas toured were observed for evidence of fluid leaks and abnormal piping vibrations. No abnormal conditions were identified.
 - Plant housekeeping conditions including general cleanliness and control of materials to prevent fire hazards were observed in the areas listed. The condition of fire hose stations and implementation of the licensee's fire protection procedures was also observed. The inspector noted that a cleanup effort is in progress to improve the general cleanliness of the plant, improve storage of materials within the plant, and to reduce the number of contamination controlled areas within the plant. Progress in this area will continue to be monitored by the resident inspector.
 - Valve and breaker positions in ECCS systems were reviewed based on control room indications and alarm status. No system misalignments were identified.
 - The inspector selected plant components for which valid tagging requests were in effect to verify that the tags were in place and that the equipment was in the condition specified. Specific findings in this area are discussed in paragraph 3.d.(1).
 - Lit control board annunciators were reviewed with control room operators to determine if the reasons for the alarmed conditions

were understood and if corrective action, when required, was being taken. Specific findings in this area are discussed in paragraph 3.d.(2).

- By frequent observations during the inspection, the inspector verified that control room manning requirements of 10 CFR 50.54(k) and the Technical Specifications were being met. In addition, the inspector observed shift turnovers to verify that continuity of system status was maintained. No unacceptable conditions were identified.
- c. The following acceptance criteria were used for the above items:
- Technical Specifications;
 - 10 CFR 50.54(k); and,
 - Inspector judgment.
- d. The following specific observations were made by the inspector and identified promptly to station management.
- (1) The inspector discussed the usage of "INFORMATION" tags on control switches and defeated or defective alarm annunciators when conditions existed warranting **a need for specific instructions** on operation of the tagged equipment, but did not warrant the use of "DANGER" or "CAUTION" tags as prescribed by procedure 108, Equipment Control. Examples of the uses of "INFORMATION" tags are to label inoperable alarms, to give warning of electrically backseated motor operated valves, and to label redundant equipment such as fans, motors, or pumps when operation of one unit is preferable over operation of the redundant unit. The licensee exercises no formal control or audit of "INFORMATION" tags other than a requirement for the Group Shift Supervisor to approve and sign the tags prior to their attachment to the affected switch. The tags that are used are the licensee's standard yellow "CAUTION" tags annotated in pen with the word "INFORMATION". They are not assigned serial numbers nor are they logged in an index. The inspector expressed concern that even though these tags perform a needed function in that they promulgate necessary information, there is no means of controlling their usage in a manner allowing easy discrimination of "INFORMATION" tags from "CAUTION" tags, and that there is no means of conducting periodic reviews to determine that all active tags are properly in place on the affected equipment. The licensee acknowledged the inspector's concern and stated that a program would be implemented using uniquely colored "INFORMATION" tags that would be serialized and recorded in a manner similar to "DANGER" and "CAUTION" tags. This item will be reviewed in a subsequent inspection (50-219/81-01-01).

- (2) On January 26, 1981, the Resident Inspector entered the control room at 10:20 a.m. and noted that the Standby Gas Treatment System I (SGTSI) was in operation. It was determined by review of the Control Room Log that the system had been started at 9:40 a.m. in order to perform maintenance on components of the normal reactor building ventilation system. The "FILTERS EGTS 8 HI DIFF PRESSURE OR HTR CKT FAILURE" alarm was annunciated on panel 5F/6F, section "L", indicating either a high differential pressure across SGTSI filters number 1-7, 1-8, and 1-9, or failure of the carbon filter heater to maintain temperature. Through discussions with the Control Room Operator (CRO), it was determined that the alarm had been annunciated since the startup of the systems at 9:40 a.m. When questioned about the cause of the alarm, the CRO stated that he didn't know the cause and that there had been "trouble" with the alarm during recent surveillance testing. The Group Shift Supervisor (GSS) was also unaware of the cause of the alarm but when informed of the inspector's concern started an investigation. The GSS subsequently determined that a high differential pressure condition existed across the SGTSI train but individual pressure drops across the absolute filters were within Technical Specification limits. Procedure 106, Conduct of Operations, states, in part, "Station Procedures shall be followed at all times...Alarms and indications are provided to shift operators in order to provide information and warnings. Operators are to believe the alarms and indications provided unless it is verified by other means (i.e., another indication or direct observation) to be false." Procedure 501, Annunciators and Alarms, specifies under operator actions for the subject alarm to "Start exhaust fan 1-9 and place Standby Gas Treatment System 2 in service as necessary. Check system 1 filters and heater circuit." Failure to investigate the cause of and take corrective action for the "FILTERS EGTS 8 HI DIFF PRESSURE OR HTR CKT FAILURE" alarm constitutes noncompliance with procedure 106 and procedure 501 (50-219/80-01-02).

Subsequent discussions with licensee management on this item revealed that management was aware of the fact that the subject alarm frequently annunciated during operation of SGTSI even though pressure drops across the absolute filters were within Technical Specification limits. An engineering request had been submitted to evaluate the alarm set point and to determine possible causes of the alarm. However, licensee management acknowledged that the operators were unaware that an evaluation was in progress. Licensee management also acknowledged that there were other possible abnormal conditions which could have caused the alarm, and that the CRO should have initiated an investigation of the alarm in accordance with station procedures.

4. Shift Logs and Operating Records

- a. The inspector reviewed the following plant procedures to determine the licensee established requirements in this area in preparation for review of selected logs and records:
 - Procedure 106, Conduct of Operations;
 - Procedure 108, Equipment Control; and
 - Procedure 115, Standing Order Control.

- b. Shift logs and operating records were reviewed to verify that:
 - Control Room logs were filled out and signed;
 - Equipment logs were filled out and signed;
 - Log entries involving abnormal conditions provided sufficient detail to communicate equipment status;
 - Shift turnover sheets were filled out, signed, and reviewed;
 - Operating orders did not conflict with Technical Specification requirements;
 - Equipment tagging did not violate Technical Specifications; and,
 - Logs and records were maintained in accordance with the procedures in a. above.

- c. The review included the following plant shift logs and operating records as indicated and discussions with licensee personnel. Reviews were conducted on an intermittent selective basis:
 - Control Room Log, January 5 through January 31;
 - Control Room Alarm Sheets;
 - Control Rod Status Sheets;
 - Technical Specification Log;
 - Reactor Auxiliary Log;

- Reactor Log;
- Equipment Tagging Log, all active entries;
- Lifted Lead and Jumper Log, all active entries;
- Defeated Alarm Log, all active entries;
- Control Room Turnover Check List;
- Standing Orders, all active entries; and,
- Operational Memos and Directives, all active.

No items of noncompliance were identified.

5. In Office Review of Licensee Event Reports (LER's)

The inspector reviewed LER's received in the NRC:RI and Resident Office to verify that details of the event were clearly reported including the accuracy of the description of cause and adequacy of corrective action. The inspector also determined whether further information was required from the licensee, whether generic implications were involved, and whether the event warranted on site followup. The following LER's were reviewed:

<u>LER</u>	<u>EVENT</u>
*80-16/1T	Generator load rejection sensor, pressure switch PSL 'D', found defective due to component failure.
*80-18/3L	Reactor high pressure scram sensor RE-03D set point found to be less conservative than required.
*80-23/3L	One electromatic relief valve high pressure sensor setpoint found to exceed the value specified.
80-26/3L	Snubber 75/5 failed to lock up in compression during testing.
*80-27/1T	The reactor building to suppression chamber vacuum breaker inlet pipe was found covered by a plastic bag.
*80-28/3L	Reactor high pressure scram sensors RE-03C and RE-03D tripped at values less conservative than specified.
80-29/3L	High drywell pressure sensor RV-46B actuated causing the core spray pumps and diesel generators to start.

<u>LER</u>	<u>EVENT</u>
80-31/3L	Snubber 75/23 failed to lock up in tension during testing.
80-33/3L	Torus oxygen concentration exceeded five (5) percent 24 hours after placing mode switch in "RUN".
*80-35/3L	Containment spray system high drywell pressure switches IP-15A and IP-15D tripped at a value greater than specified.
*80-38/3L	Reactor triple low water level sensor RE-18B exceeded its required setpoint.
*80-39/3L	Low pressure main steam line sensors RE-23B and RE-23D tripped at values less than specified.
80-41/3L	Core Spray System II removed from service to repair a leaking pump vent line.
*80-42/3L	Containment Spray System high drywell pressure switches IP-15A, IP-15B, and IP-15C tripped at values greater than specified.
*80-43/3L	Reactor triple low water level sensor RE-18D exceeded its required setpoint.
*80-44/3L	Core Spray System I was removed from service to dry out and inspect the booster pump motors following inadvertent initiation of the fire protection system.
80-45/3L	Core Spray System I was removed from service to repair a leaking pump vent line.
*80-47/3L	Core Spray System high drywell pressure switches RV-46A, B, C, and D tripped at values greater than specified.
*80-50/3L	Containment Spray System high drywell pressure switches IP-15A, B, C, and D tripped at values greater than specified.
*80-52/3L	Reactor triple low water level sensors RE-18A and RE-18D tripped at values greater than specified.
*80-54/3L	Core Spray System I was removed from service to inspect pumps NZ01A and NZ01C after the pumps had been sprayed with water.

<u>LER</u>	<u>EVENT</u>
*80-55/3L	Core Spray System high drywell pressure switches RV-46B, C, and D tripped at values greater than specified.
*80-56/3L	Main Steam Line high flow switches RE-22C and RE-22G tripped at values greater than specified.
*80-57/3L	Containment Spray System high drywell pressure switches IP-15A, B, C, and D tripped at values greater than specified.
*80-60/3L	Isolation Condenser pipe break sensors IB-11A1, IB-11A2, IB-11B1, and IB-11B2 tripped at values greater than specified.
*80-63/3L	Reactor triple low water level switch RE-18A tripped at a value greater than specified.

No items of noncompliance were identified.

6. On-Site Licensee Event Followup

For those LER's selected for on-site followup, the inspector verified that reporting requirements of Technical Specifications and Regulatory Guide 1.16 had been met, that appropriate corrective action had been taken, that the event was reviewed by the licensee as required by facility procedures, and that continued operation of the facility was conducted in accordance with Technical Specification limits. The LER's selected for on-site followup are denoted by an asterisk(*) in detail 5. above. The following specific observations were made and discussed with licensee management:

- a. Of the 20 LER's selected for on-site followup, 16 were the result of safety related instrument setpoints being found during surveillance testing to have trip points less conservative than specified by Technical Specifications. The cause of these events had not been determined by the licensee at the conclusion of this inspection. It is **thought to be** setpoint drift. Design setpoint repeatability is 0.2 percent of instrument scale; however, demonstrated repeatability has been much greater than instrument specifications. An engineering study into the instrument problem and possible setpoint changes is being conducted by the licensee. In some cases, changing of the instrument setpoints in a more conservative direction is not feasible because normal operating parameters may approach the setpoint to the extent that further setpoint drift in the conservative direction could result in spurious actuation of safety systems. The licensee's Plant Operations Review Committee (PORC) has recommended replacement of the affected switches with more suitable models. The licensee's engineering staff is studying the PORC recommendation. This item is unresolved pending further review by the licensee and the NRC (50-219/81-01-03).

- b. LER's 80-44/3L and 80-54/3L were the result of the loss of safety related equipment due to actual or suspected water damage to electrical components. Event 80-44/3L resulted when an inadvertent actuation of the fire suppression system caused water leakage into the Core Spray System I booster pumps' motor lead connection box through open ended conduit and fittings on top of the connection box. Event 80-54/3L resulted when water spray from a Control Rod Drive Hydraulic pump seal water pipe leak caused water intrusion into the motor lead connection box (Core Spray Pumps NZ01A and NZ01C) through worn cover gaskets and conduits. The licensee's corrective action in both events was to reseal the components where the water intrusion had occurred. The inspector expressed concern that these two events may be indicative of a widespread problem in that the waterproof integrity of safety related components may be compromised by the field condition of water tight barriers in conduits, junction boxes, cable entries into Motor Control Centers, and motor terminal box covers. Component manufacturer's waterproof specifications may be negated due to failure to install or maintain waterproof barriers, or by equipment installation with conduit open ended at its termination point at cable trays. The licensee's Plant Operations Review Committee has requested an engineering survey to evaluate safety related electrical components outside of the primary containment to determine the extent of this problem and to determine corrective actions. This item is unresolved pending further review by the licensee and NRC (50-219/81-01-04).

7. IE Bulletins and Circulars

a. Bulletins

Licensee actions concerning the following IE Bulletins were reviewed by the inspector to verify that: the Bulletin was forwarded to appropriate on-site management; a review for applicability was performed; information discussed in the licensee's reply was accurate; corrective action taken was as described in the reply; and the reply was within the time period described in the bulletin.

- IEB 78-07, Protection Afforded By Air-Line Respirators and Supplied-Air Hoods. The inspector reviewed procedure 915.5, Respiratory Protection, Revision 12 dated August 21, 1980. It was verified that self contained breathing apparatus (SCBA) are operated only in the pressure demand mode, and that supplied-air hoods and full face piece air line supplied respirators are operated in the continuous flow mode only. No half mask air line supplied respirators are used at the facility. A protection factor of 10,000 is used for SCBA's; a protection factor of 2000 is used for full face piece air line supplied respirators; and a protection factor of 1000 is used for supplied-air hoods.

This item is closed.

- IEB 78-11, Examination of Mark I Containment Torus Welds. This bulletin was issued for information only and required no corrective action. The inspector verified that it was received and reviewed by the licensee.

This item is closed.

- IEB 80-23, Failures of Solenoid Valves Manufactured By Valcor Engineering Corporation. By review of a memo to file dated December 2, 1980 which stated that a search of procurement records had been completed, and discussions with cognizant licensee personnel the inspector verified that none of the subject Valcor solenoids are in use at the Oyster Creek facility as stated in the licensee's response of December 12, 1980.

This item is closed.

- IEB 80-24, Prevention of Damage Due to Water Leakage Inside Containment. By review of applicable systems drawings and discussion with cognizant licensee personnel, the inspector verified that the information given in the licensee's responses dated January 5 and January 12, 1981, was correct and complete and that no further corrective action is required.

This item is closed.

The following bulletins were reviewed and determined to be not applicable to Oyster Creek:

- IEB 78-08, Radiation Levels From Fuel Element Transfer Tubes.
- IEB 78-13, Failures in Source Heads of KAY-RAY, Inc., Gauges.
- IEB 80-22, Automation Industries, Model 200-520-008 Sealed Source Connectors.

These items are closed.

b. Circulars

Licensee actions concerning the following IE Circulars were reviewed to verify that the circular was received by licensee management, that a review for applicability was performed, and that action taken, or planned is appropriate.

- IEC 77-09, Improper Fuse Coordination in DWR Standby Liquid Control System Circuits. The inspector reviewed the Standby Liquid Control System (SLCS) electrical drawing, General electric

Drawing 885D949, and found that the SLCS explosive valves receive power from the system pump starter cabinet through a control power transformer. The explosive valve detonators are fused with two (2) ampere slow blowing fuses in series with the main control power circuit's 10 ampere fuses. The licensee is conducting an engineering evaluation to determine if the existing fuse coordination is correct.

This item will be reexamined in a subsequent inspection.

- IEC 78-07, Damaged Components on a Bergen-Paterson Series 25000 Hydraulic Test Stand. By review of an engineering memo to file, dated April 25, 1980, discussions with cognizant licensee personnel, and subsequent visual inspection of the licensee's hydraulic test stand, the inspector determined that the concerns of this circular are not applicable to the Oyster Creek facility. The series 25000 test stand in use at the facility employs a ball bushing type connection rather than a rigid two pin loading system as discussed in the circular.

This item is closed.

- IEC 78-08, Environmental Qualification of Safety Related Electrical Equipment at Nuclear Power Plants. This circular was previously reviewed in IE Inspection Report Numbers 50-219/78-17 and 50-219/78-28. The only outstanding items relative to this circular were verification that no aluminum terminal board enclosures are installed inside the primary containment, and evaluation of the environmental acceptability of ASCO series 8302 and 8314 solenoid valves with nylon exhaust port discs. The inspector reviewed a memo to file dated April 27, 1979, documenting a visual inspection of all terminal boxes inside the drywell. The inspection verified that no terminal boxes fabricated of aluminum were installed, and that all terminal boxes were equipped with a gasket and a drain hole. The inspector reviewed job order number 1855-I and verified that the ASCO series 8302 and 8314 series solenoid valves on the Main Steam Isolation Valve (MSIV) pilot valves had been replaced with environmentally qualified solenoid valves.

This item is closed.

- IEC 78-11, Recirculation M-G Set Overspeed Stops. The purpose of this Circular was to ensure proper selection of Kf factors used in determining the allowable minimum critical power ratio (MCPR). The Kf factor is taken from a plot of Kf versus core flow, and is a multiplicative factor applied to the operating MCPR limit to determine a required MCPR. This is necessary to ensure adequate margin to core thermal limits during a recirculation pump speed

increase transient due to control circuit failure when operating at less than rated core flow. The proper plot to be used in determining Kf is dependent upon the setpoint of the recirculation pump M-G set overspeed stops. The Oyster Creek facility does not have mechanical overspeed stops on the recirculation pump M-G sets. The present accident analysis for a recirculation pump speed increase transient has shown sufficient margin to core thermal limits without the application of Kf factors to the MCPR limit. Thus the requirements of this circular are presently not applicable. However, following fuel reload for cycle 10 with fuel supplied by a different vendor, core thermal limits will be modified necessitating the use of Kf adjusted MCPR limits. Recirculation pump M-G set overspeed stops are presently undergoing design review and will be installed prior to plant operation in cycle 10. This circular will remain open pending completion of the necessary modifications and subsequent NRC review.

- IEC 78-13, Inoperability of Service Water Pumps. The inspector reviewed an engineering memo to file dated April 29, 1980, and had discussions with cognizant licensee personnel concerning this item. The inspector verified that periodic surveillance for silt buildup in the intake canal is conducted. The Main Circulating Water pumps and the Dilution pumps are supplied with clean seal water from the fire protection system and the bearing oil cooler water supplies are provided with strainers that are frequently inspected for indications of clogging. The plant Service Water pumps have no external oil coolers. The existing cooling system design and current surveillance practices preclude pump failures of the type discussed in this circular.

This item is closed.

- IEC 78-16, Limitorque Valve Actuators. By review of an engineering memo to file dated May 12, 1980, and discussions with cognizant licensee personnel, the inspector determined that manual operation of limitorque valve actuators is infrequent and is considered an abnormal operating condition. In addition, there is no history of valve actuator failure due to wear or chipping of the clutch lugs at this facility.

This item is closed.

- IEC 79-04, Loose Locking Nut on Limitorque Valve Operators. Engineering Task 80-242 has been issued to perform the corrective actions required by this circular. **At present, no inspections** for loose locking nuts on Limitorque Operators Types SMB-000 through SMB-5 and type SMC have been conducted.

This item will be reexamined in a subsequent inspection.

- IEC 79-08, Attempted Extortion-Low Enriched Uranium. This circular was issued for information only and required no corrective action. The inspector verified that the circular was received and reviewed by cognizant management personnel.

This item is closed.

- IEC 79-09, Occurrences of Split or Punctured Diaphragms in Certain Self Contained Breathing Apparatus. The inspector reviewed Task Completion Form 3209046.01 and discussed the corrective action with the responsible individual. All self contained breathing apparatus (SCBA) were inspected for damaged diaphragms by a qualified technician, and procedure 915.5, "Respiratory Protection", was revised to require monthly regulator function and diaphragm integrity tests.

This item is closed.

- IEC 79-10, Pipefittings Manufactured From Unacceptable Material. By review of Task Completion Form number 3209089.00 and a memo to file dated November 12, 1980, the inspector verified that a thorough search of procurement records had been completed by the licensee. There were no indications of receipt of pipefittings identified as Tube Turn Lot W6719.

This item is closed.

- IEC 79-12, Potential Diesel Generator Turbocharger Problem. Standing Order number 28, "Diesel Generator Operation", issued on July 13, 1979, is still in effect providing interim operator guidance. The modifications recommended by General Motors Corporation Electro-Motive Division have not yet been installed.

This item will be reexamined in a subsequent inspection.

- IEC 79-13, Replacement of Diesel Fire Pump Starting Contactors. The licensee's diesel fire pumps are the same model discussed in this circular. Replacement contactors have been purchased but are not yet installed. The mounting hardware for the modification kit is improperly sized for the replacement magnetic switch. Installation of the replacement parts will be completed following an engineering design review of a modified mounting bracket.

This item will be reexamined in a subsequent inspection.

- IEC 79-17, Contact Problem in SB-12 Switches on General Electric Metalclad Circuit Breakers. Discussions with cognizant licensee personnel indicated no known incidents of installation of type SB-12 control switches during the period of interest. However, no search of procurement records has been conducted to verify that none are on site.

This item will be reexamined in a subsequent inspection.

- IEC 79-19, Loose Locking Devices on Ingersoll Rand Pumps. Engineering Task 79-15 has been issued to complete the corrective actions required. The licensee has determined that pumps of the type discussed in this circular are installed at the facility, however, no verifications of proper installation of impeller locking devices have been performed. This circular will remain open pending completion of verification by the licensee.

This item will be reexamined in a subsequent inspection.

- IEC 79-20, Failure of GTE Sylvania Relay, Type PM Bulletin 7305, Catalog 5U12-11-AC With a 120V AC Coil. The inspector reviewed the licensee's close out action on Engineering Task 79-20 and a memo to file dated April 15, 1980. The licensee has adequately verified that no relays of this type are installed at the facility.

This item is closed.

- IEC 79-23, Motor Starters and Contactors Failed to Operate. The inspector reviewed the licensee's close out action on Engineering Task 79-71, and a memo to file dated January 15, 1980. The licensee had adequately verified that there are no Gould size 3 starters and contactors in use at the facility.

This item is closed.

The following circulars were determined to be not applicable to the Oyster Creek facility:

- IEC 79-03, Inadequate Guard Training and Falsified Training Records, IEC 78-17, applicat'ne to this facility, addressing the same subject was closed during IE Inspection 50-219/78-30.
- IEC 79-11, Design/Construction Interface Problem.
- IEC 79-14, Unauthorized Procurement and Distribution of Xenon-133.

- IEC 80-13, Grid Strap Damage in Westinghouse Fuel Assemblies.
- IEC 80-24, AECL Teletherapy Unit Malfunctions.
- IEC 80-25, Case Histories of Radiography Events.

These items are closed.

8. Unresolved Items

Unresolved items are matters about which more information is required in order to ascertain whether they are acceptable items, items of noncompliance, or deviations. Unresolved items identified during this inspection are discussed in paragraphs 6.a and 6.b.

9. Exit Interview

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