



## REPORT DETAILS

### 1. Persons Contacted

#### Licensee Employees

- \*J. E. Smith, Station Manager
- \*R. J. Brackett, Senior QA Engineer
- C. B. Cheezem, ISI Engineer
- J. M. Crowe, Senior QA Technical Support
- R. L. Gill, Licensing Engineer
- P. Earnhardt, Assistant Engineer, Mechanical

Other licensee employees contacted included ISI technicians and engineering office personnel.

#### NRC Resident Inspector

- W. T. Orders, Senior Resident Inspector
- D. Myers, Resident Inspector

\*Attended exit interview

### 2. Exit Interview

The inspection scope and findings were summarized on February 12, 1982, with those persons indicated in paragraph 1 above. The inspector informed the licensee that the following new items were identified for follow-up on future inspections.

- a. Inspector Follow-up Item (50-270/82-05-01) - Condition of Incore Instrument Tubes (see paragraph 5).
- a. Inspector Follow-up Item (50-270/82-05-02) - Cause of R.V. Inspection Tool Malfunction (see paragraph 5).
- a. Inspector Follow-up Item (50-270/82-05-03) - Volumetric Inspection of H.P. Injection Line Welds (see paragraph 6).

### 3. Licensee Action on Previous Inspection Findings

Not inspected.

### 4. Unresolved Items

Unresolved items were not identified during this inspection.

5. Reactor Vessel Inspection Tool Malfunction (Unit 2)

The Unit 2 Reactor Vessel was being ultrasonically inspected utilizing the B&W ARIS II inspection system. At approximately 4:40 a.m. on February 7, 1982, the equipment was directed to re-inspect a weld in the lower vessel head. The vertical movement of the inspection tool was being controlled by the equipment computer which apparently malfunctioned in a way that read erroneous position indicating data causing the boom to overshoot. The boom continued to drive, after the lower section of the boom was stopped by the incore instrument tubes, until the drive carriage had raised from the tracks approximately 4½ feet. (The drive speed of the equipment was reported to be approximately 65 inches per minute at the time of impact and the weight of the equipment resting on the incore instrument tube was estimated to be approximately 5700 pounds.) After the drive carriage raised itself off the tracks, the boom toppled, coming to rest against the refueling bridge.

During February 8 and 9, 1982, the licensee and B&W assessed the situation and prepared procedures and equipment for the instrument recovery operation. On February 10, 1982, protective sleeves were placed over the incore instrument tubes adjacent to the boom resting site, and rigging required to manipulate the instrument during recovery was installed.

On February 11, 1982, the ARIS was carefully moved until the boom was vertical. After visual inspection to ensure that there were no interferences the equipment was raised vertically using the polar crane. The drive motor was then activated to move the drive carriage back down the boom to its proper location on the equipment rails.

As of the end of this NRC inspection, the licensee was waiting for the arrival of a computer specialist to inspect the ARIS computer and try to determine what caused the malfunction and to assess any other damage. This assessment would be made before the ARIS inspection tool was removed from the vessel. After removal of the ARIS from the vessel, the licensee plans to do a complete visual inspection of the bottom of the reactor vessel.

There were no violations or deviations noted during the instrument recovery operation. The inspector did inform the licensee that two new inspector followup items would be identified in this report, they are as follows:

50-270/82-05-01, "Condition of Incore Instrumentation Tubes".

50-270/82-05-02, "Cause of R.V. Inspection Tool Malfunction".

6. Inspection of High Pressure Injection Piping

The inspector held discussions with the licensee's QA, Licensing Engineering, and ISI personnel concerning the need for inspection of the Oconee High Pressure Injection Piping in light of the recently discovered pipe-crack problem at Crystal River Nuclear Plant.

The licensee's representatives stated that the welds in question had been visually and liquid penetrant inspected in Unit 2 during the current outage and that plans were being made to do radiographic inspection after the water level could be lowered enough to drain these lines. They also stated that there were no plans at this time to do any ultrasonic inspections.

During this inspection the Oconee Unit 1 was shut down because of a steam generator tube leak. Unit 3 was also showing indications of primary to secondary leakage which might cause the Unit to be shut down. The licensee indicated that the high pressure lines on Unit 1 and Unit 3 would be inspectable during a steam generator tube plugging outage and plans were being made to conduct those inspections.

The inspector visually inspected the high pressure injection piping inside the shield wall of Unit 2 and reviewed hanger and piping drawings for Units 1 and 2 to determine what similarities and differences there were between Oconee and Crystal River.

The inspector informed the licensee that an inspector followup item would be opened concerning the volumetric inspections of this high pressure piping. The item is as follows:

50-270/82-05-03, "Volumetric Inspection of H.P. Injection Line Welds".

There were no violations or deviations noted during this phase of the inspection.