SALP 10

INITIAL SALP REPORT

U.S. NUCLEAR REGULATORY COMMISSION

REGION III

SYSTEMATIC ASSESSMENT OF LICENSEE PERFORMANCE

Inspection Report No. 266/93001; 301/93001

Wisconsin Electric Power Company

Point Beach Nuclear Plant

February 1, 1992, through March 31, 1993

CONTENTS

I. INTRODUCTION

The systematic assessment of licensee performance (SALP) program is an integrated U. S. Nuclear Regulatory Commission (NRC) staff effort to collect available observations and data on a periodic basis and to evaluate licensee performance on the basis of this information. The program is supplemental to normal regulatory processes used to ensure compliance with NRC rules and regulations. It is intended to be sufficiently diagnostic to provide a rational basis for allocating NRC resources and to provide meaningful feedback to the licensee's management regarding the NRC's assessment of the facility's performance in each functional area.

This report is the NRC's assessment of the licensee's safety performance at the Point Beach Nuclear Plant for the period February 1, 1992, through March 31, 1993.

An NRC SALP Board, comprised of the staff members listed below, met on May 12, 1993, to review the observations and data on performance and to assess licensee performance in accordance with the guidance in NRC Manual Chapter 0516, "Systematic Assessment of Licensee Performance."

Board Chairman

E. G. Greenman, Director, Division of Reactor Projects (DRP)

Board Members

T. O. Martin, Acting Director, Division of Reactor Safety (DRS)
J. N. Hannon, Director, Project Directorate III-3, Office of Nuclear Reactor Regulation (NRR)
L. R. Greger, Chief, Reactor Projects Branch 3, DRP
C. D. Pederson, Chief, Reactor Programs Branch, Division of Radiation Safety and Safeguards (DRSS)
K. R. Jury, Senior Resident Inspector
A. T. Gody, Jr., Senior Project Manager, NRR

Other Attendees at the SALP Board Meeting

J. R. Creed, Chief, Safeguards Section, DRSS
I. N. Jackiw, Chief, Section 3A, DRP
F. A. Maura, Reactor Inspector, DRS
T. J. Kozak, Radiation Specialist, DRSS
T. J. Madeda, Security Specialist, DRSS
J. E. Foster, Emergency Preparedness Specialist, DRSS

II. SUMMARY OF RESULTS

The performance of the facility was considered good and in general followed the trends noted during the previous assessment period. The prior improving trends seen in the Radiological Controls and Safety Assessment/Quality Verification areas were sustained over the period and resulted in improved ratings. Actions taken to reverse the previously noted declining trend in Plant Operations were not fully successful and resulted in a lower rating for

the assessment period. Performance in the areas of Maintenance/Surveillance, Emergency Preparedness, Security, and Engineering/Technical Support remained consistent with the previous assessment period.

The improving trend previously noted in Radiological Controls continued during this assessment period and resulted in excellent performance. The total station dose decreased for the third consecutive year and a program challenge identified last period was addressed through better participation in exposure reduction committee meetings. Solid waste generation was significantly reduced by making changes to the routine radiological work practices and a marked improvement was noted in the radiological condition of the auxiliary building.

The improving trend noted in the Safety Assessment/Quality Verification area continued throughout the period and resulted in good performance. Management emphasized a high level of safety awareness and made several organizational changes to assure the proper focus on safety by plant and corporate staff. Safety reviews, quality assurance audits and other self assessment programs were effective in providing insights and identifying safety issues. However, corrective actions were not always timely because of inconsistent management oversight and ineffective guidance for prioritizing issues.

Actions taken to reverse the previously noted declining trend in Plant Operations were not fully successful. While performance was considered good, significant personnel errors continued to cause operational problems. An automatic reactor trip and several contaminated water and chemical spills occurred because of personnel errors and miscommunication. Operator error also caused an excessive cooldown of the reactor vessel which led to the issuance of a civil penalty. Management oversight of the activities which lead to these personnel errors was not effective. However, operators responded well to abnormal events and prevented at least one unnecessary automatic reactor trip. Daily shutdown risk assessments and utilization of extra senior reactor operators were excellent initiatives.

Maintenance/Surveillance continued to show good performance and demonstrated an improving trend. The maintenance staff remained stable, well trained, and qualified which helped sustain high equipment reliability and good materiel conditions. Strong management oversight was present during the conduct of complex and sensitive evolutions. A long-standing weakness continued to be the lack of detailed maintenance procedures, consistent in quality and content. However, recently written procedures were of good quality and the ongoing procedure improvement initiative remained on schedule. Inconsistent procedure implementation contributed to the continuing problem of personnel errors.

Performance in the other three functional areas remained consistent with the previous assessment period. Emergency Preparedness continued to have excellent exercise performance and strong management support for the program. While security performance remained good with excellent staffing levels and training programs, enforcement history declined and remained a program challenge.

Performance in Engineering/Technical Support also remained good. Resolution of several challenges that were identified in the previous assessment period included increased staffing levels, more proactive engineering staff, and

improved safety evaluations for modification packages. However, some problems involving the improper assignment of priorities and poor work process controls continued to persist.

The performance ratings during the previous assessment period and this assessment period according to functional areas are given below:

Functional Area	Rating Last Period	Rating This Period	Trend
Plant Operations	1 Declining	2	
Radiological Controls	2 Improving	1	
Maintenance/Surveillance	2	2	Improving
Emergency Preparedness	1	1	
Security	2	2	
Engineering/Technical Support	2	2	
Safety Assessment/Quality Verification	3 Improving	2	

III. PERFORMANCE ANALYSIS

A. Plant Operations

1. Analysis

Plant operations' performance declined from the two previous assessment periods. While routine activities and operator response to events remained strong, inconsistent management effectiveness and significant personnel errors were primary causes of the performance decline.

Management effectiveness in ensuring quality during operations was mixed. On the positive side, management initiatives to minimize shutdown risk were excellent. For example, management assigned a dedicated extra senior reactor operator (SRO) to oversee reactor coolant system draindown to reduced inventory condition. However, management was not effective in identifying procedural inadequacies during reviews of a new steam generator crevice flushing procedure, which contributed to a reactor vessel cooldown event and resulted in a civil penalty. Additionally, management did not recognize these procedural inadequacies until the NRC identified them. Management did, however, effectively institute corrective actions, including thorough pre-evolution briefings for infrequently performed tests, critical surveillances, inventory reductions, and reactor startups.

Operator response to automatic reactor trips, engineered safeguards feature actuations, and several minor events, demonstrated an ability to respond effectively to plant transients and stabilize plant conditions. For example, rapid operator action during the loss of a vital direct current (DC) instrument inverter and during a turbine generator hydrogen pressure decrease averted two potentially unnecessary reactor trips. Personnel errors, which were a concern during the previous assessment period, continued to occur. Operator error was a primary cause of the reactor vessel cooldown event and the cause of the only automatic trip of Unit 2. In addition, operator errors resulted in several minor chemical spills and the simultaneous inoperability

of both emergency diesel generators. Although these significant personnel errors occurred, overall procedural adherence improved from the previous assessment period.

Operations personnel were alert, professional, and knowledgeable of plant and equipment status. Communications among operators, although informal, was usually effective. Communication between the control room and remote locations during refueling evolutions was excellent. However, miscommunication resulted in a contaminated water spill in the auxiliary building and a manual reactor trip while the unit was off line.

The approach to identifying and resolving technical issues was good. Experienced SROs were taken off shift to function as shift outage coordinators and to perform both pre-outage and daily shutdown risk assessments. Also, SROs performed initial operability determinations on condition reports, which was successful in escalating equipment operability issues. As a result, operators have gained a better understanding of operability requirements, which was an improvement from the previous assessment period. Individual shifts also have responsibility for oversight of systems assigned to their respective shifts. As such, they coordinate system procedure revisions and maintenance when practical. Additionally, experienced licensed personnel actively participated in the technical specification upgrade program. These initiatives provided beneficial operational insights to these programmatic efforts.

Materiel condition of the plant was good as evidenced by high equipment reliability, low forced outage rate, and normal operation with no illuminated control room annunciators. The operations staff initiated prompt actions to repair malfunctioning alarms and placed a high priority on completing these repairs. General plant housekeeping, a weakness in the previous assessment period, improved and was good. However, management was not completely effective in alleviating equipment stowage concerns.

Staffing was excellent and overtime use was limited. A policy of having an additional SRO on each crew was implemented during the assessment period for all but one operating crew. When an additional SRO was needed for an evolution, an SRO from either an off-shift or other group was utilized. This enhanced oversight from the additional SRO was evident during abnormal and infrequent operations. However, even though an additional SRO was on shift, a lack of supervisory oversight contributed to the excessive reactor vessel cooldown event.

The effectiveness of the training and qualification program for licensed operators was good. The pass rates for initial and requalification examinations were 58 percent and 100 percent, respectively.

2. Performance Rating

Performance is rated Category 2 in this area. Performance was rated Category 1 with a declining trend during the previous assessment period.

3. Recommendations

None.

B. Radiological Controls

1. Analysis

Radiological controls were characterized by excellent management and good inter-sectional support, resulting in low dose expenditures and easily accessible safety-related equipment. The overall excellent implementation of the radiological controls program resulted in few program challenges, and those that occurred were handled effectively.

Management effectiveness in ensuring quality was excellent. Hydrogen peroxide addition, use of remote video monitoring and inspection equipment, and the downsizing of reactor coolant filters demonstrated the excellent support to maintain exposure as-low-as-reasonably-achievable (ALARA). ALARA program concerns identified during the previous assessment period were addressed through better participation in exposure reduction committee meetings and each department providing and meeting yearly personnel exposure goals. There was significant improvement in the radiological condition of the auxiliary building and the requirements of the revised 10 CFR Part 20 were implemented on January 1, 1993, a year prior to its required implementation.

The approach to the identification and resolution of technical issues from a safety standpoint was excellent. The total station dose in 1991, including the contribution from two refueling outages, was low at 265 person-rem. Total station dose for 1992, also with two refueling outages, decreased to 256 person-rem. This was the third consecutive decline in yearly dose expenditure and is indicative of effective planning and execution of work activities. Although doses were already low, a source-term reduction program to further reduce dose was being developed at the end of the assessment period. The number of personnel contamination events was low. Several long standing contaminated areas containing safety-related equipment were decontaminated during the assessment period providing for easy operator accessibility. Gaseous and liquid radioactive effluent releases continued to remain well within technical specification limits. Solid waste generation declined significantly due to the elimination of protective clothing routinely used in the auxiliary building and implementation of a clean waste program. Vendor-supplied volume reduction techniques were effectively used, compensating for the somewhat limited onsite volume reduction capability. No radwaste shipping or transportation problems were experienced in this period. The radiological environmental monitoring program was appropriately implemented and the equipment was well maintained. Performance in the NRC nonradiological confirmatory measurements program was excellent with 30 agreements in 32 comparisons.

Staffing, training, and qualification of personnel in the radiation protection and chemistry departments were excellent. The staffs were knowledgeable and experienced and maintained a low turnover rate. An excellent training program was implemented on the revised 10 CFR Part 20 for all plant personnel.

2. Performance Rating

Performance is rated Category 1 in this area. Performance was rated Category 2 with an improving trend during the previous assessment period.

3. Recommendations

None.

C. Maintenance/Surveillance

1. Analysis

Performance in this area was characterized by effective management working with an experienced and qualified staff to sustain high equipment availability and good materiel condition. The overall excellent level of performance was detracted from by continued personnel errors.

Management was effective in ensuring quality as evidenced by the continued high equipment availability, low forced outage rate, and good materiel condition of the plant. Strong management oversight was present during the conduct of such complex evolutions as the extensive preventive maintenance on safeguards buses, restructuring of the DC distribution system, and resetting of degraded grid voltage relays. Establishment of an outage manager position, an expanded maintenance planning group, and shift outage coordinators enhanced outage planning. Timely and safe completion of two refueling outages was directly attributable to effective management oversight, as was an emergency replacement of a residual heat removal pump seal which prevented the need for a plant shutdown. A long-standing weakness continued to be the lack of detailed maintenance procedures, consistent in quality and content, to control work. Procedure implementation was inconsistent. For example, a main steam isolation valve test failure resulted from a maintenance crew not initiating a needed procedure change. However, procedural inadequacies were identified and corrected during diesel generator maintenance which demonstrated increased procedure acceptance. Recently written procedures were of good quality and the ongoing procedure improvement initiative remained on schedule.

The approach to identification and resolution of technical issues was good. Inservice inspection activities were suitably planned and prioritized. The maintenance work backlog, consisting primarily of low priority items, was high. However, a decreasing trend was evident toward the end of the assessment period. Additionally, the number of priority categories was increased from three to four to improve prioritization. Although the maintenance group primarily used the computer data base for reactive reviews of performance history, its employment for proactive maintenance analysis increased. The instrument and control group utilized this database for proactive analysis. Results of surveillance testing and preventive and corrective maintenance were reviewed to determine failure trends and to re-evaluate testing periodicity.

The plant continued to manage and successfully implement the technical specification surveillance program with surveillances routinely completed on time and in a professional manner. Most surveillance procedures were well written with clear directions provided. Technicians appropriately stopped performing surveillances on several occasions when they discovered errors in procedures. Unexpected equipment response was brought to the attention of supervision for evaluation and resolution. Instrument and control technicians maintained good communications with operations personnel during the performance of tests, thereby allowing operators to remain cognizant of test status.

Personnel errors continued as a weakness from the previous assessment period. These included two instances of safeguards buses being de-energized, violation of the equipment isolation procedure, and improper turbine testing that caused an automatic reactor trip. These various errors were primarily attributable to workers failing to perform adequate self-checking while performing the evolution. Management recognized this deficiency and conducted a Human Performance Enhancement System evaluation so that appropriate corrective action could be developed.

Staffing was sufficient to accomplish required maintenance and surveillance activities without excessive overtime. Maintenance craft workers were well qualified and highly experienced and had a low turnover rate. Retirements and a maintenance group reorganization resulted in significant personnel changes in first line maintenance supervision starting late in the previous assessment period and continuing into the early part of this period. Although the new supervisors were skilled in their maintenance craft area, they required time to acclimate to their new responsibilities. Their effectiveness improved toward the end of this period.

Effectiveness of the training and qualification program was excellent. Maintenance personnel consistently demonstrated excellent skill in the conduct of work. The balance between formal training and on-the-job training was appropriate and provided assurance that technicians were qualified. Non-destructive examination training and qualification programs complied with applicable code requirements.

2. Performance Rating

Performance is rated Category 2 with an improving trend in this area. Performance was rated Category 2 during the previous assessment period.

3. Recommendations

None.

D. Emergency Preparedness

1. Analysis

Performance was characterized by strong management support for the program and excellent exercise performance.

Management effectiveness in ensuring quality was excellent. Enhancements continue to be made to the emergency response facilities (ERFs) including relocation of the joint public information center to Manitowoc, Wisconsin. The dedicated ERFs and their equipment continued to be maintained at an excellent level of operational readiness.

The approach to resolution of technical issues from a safety standpoint remained excellent. The operability of the public alert and notification system following system malfunctions was aggressively addressed.

The 1992 evaluated exercise was successful, and all significant aspects of the emergency plan were effectively exercised. Overall performance was excellent, and no exercise weaknesses were identified. Challenging aspects of the 1992

exercise included the first use of the control room simulator, evacuation of the technical support center and the operational support center, and responses to separate releases of radioactivity. The 1992 routine inspection indicated excellent program maintenance with no significant problem areas. One activation of the emergency plan occurred during the assessment period and was appropriately classified.

The station's emergency planning unit continued to be staffed with excellent personnel. Initiatives have been implemented to keep the emergency preparedness program active and visible. The onsite emergency response organization (ERO) staffing also remained good, with at least three individuals assigned to each key emergency response position.

The emergency preparedness training program continued to be excellent. A conscious effort was being made to keep staff training current, varied, and interesting. The training program was effective in maintaining qualified ERO personnel in supervisory and support positions. Training was effective as demonstrated through exercise performance and interviews.

2. Performance Rating

Performance is rated Category 1 in this area. Performance was rated Category 1 during the previous assessment period.

3. Recommendations

None.

E. Security

1. Analysis

Performance in this functional area was characterized by a decline in enforcement history, mixed management effectiveness, good support relating to resolving technical issues and operational events, and excellent performance in staffing and training.

Enforcement history declined from the previous assessment period and was weak. Five violations were identified this period compared to three violations during the previous period. The violations involved both the security and the special nuclear material control and accountability programs.

Management effectiveness in ensuring quality was mixed. Plant and corporate support for improvements was excellent as evidenced by new security equipment upgrades and the continuing implementation of a goals and objectives program. Management was not effective in ensuring consistency in day-to-day operations. Management corrected weaknesses involving strained security management resources and specific overview deficiencies noted during the previous assessment period. However, during this assessment, weak management controls were identified in the followup of a fitness-for-duty issue, personnel access control, and the control of special nuclear material. Specific corrective actions were taken once these issues were identified.

The approach to the identification and resolution of technical issues was good. Excellent action by engineering and security resulted in significant improvement of vital area door control and the effectiveness and reliability of perimeter cameras. Tracking and trending programs were good and continued to improve. These programs increased site awareness and resulted in a reduction of personnel errors. The volume of security maintenance requests and the timeliness of completing these activities improved and was good. Engineering and security support was weak in the modification process of an alarm upgrade.

Evaluation and reporting of events was good, except for the failure to identify and report the potential loss of a small quantity of special nuclear material. Required security reports and logs were accurate and timely.

Staffing levels were excellent. Licensee and contractor resources were effectively utilized to support operational security program requirements. Contractor support was increased at the end of the assessment period to monitor the effectiveness of security maintenance activities. An effective working relationship continued between local law enforcement agencies and security management.

The effectiveness of the training and qualification program improved and was excellent. Upgraded tactical response contingency training improved response capabilities.

The fitness-for-duty program met the objectives of 10 CFR Part 26. Program strengths included management support, and a canine program to aid in the identification of controlled substances.

2. Performance Rating

Performance is rated Category 2 in this area. Performance was rated Category 2 during the previous assessment period.

3. Recommendations

None.

F. Engineering/Technical Support

1. Analysis

Engineering and technical support performance remained mixed. In most instances engineering support of the plant was good, showed a conservative approach, and was timely. However, there were several instances of poor work process controls that resulted in personnel errors and a spill of contaminated water. A major reorganization of engineering took place too close to the end of the assessment period to be evaluated.

Management effectiveness in ensuring quality remained mixed. On the positive side, there was ample evidence of prior planning and assignment of priorities during the extensive preventive maintenance of the electrical safeguards buses, the replacement of a DC distribution bus, and motor operated valve (MOV) work in response to Generic Letter 89-10. Aspects of the MOV program, such as the innovative techniques developed for test performance, were good.

However, the MOV program was excessively dependent on the knowledge of a single engineer. This approach lacked backup expertise and was vulnerable to the loss of the individual. The effective self-initiated system evaluation programs instituted over the last few years continued to uncover numerous deficiencies in original plant design. Safety evaluations for modification packages, a weakness during the last SALP period, improved.

On the other hand, some engineering calculations were not properly documented. An example was the absence of a basis for calculating the maximum differential pressure at which MOVs must operate. At times, engineering involvement with work in progress was not evident. Examples included the lack of test procedure acceptance criteria, a problem during the previous SALP period, and incomplete walkdowns of design and design verification packages. Comprehensive reviews and corrective action for NRC and industry information applicable to the station were sometimes untimely. This appeared to be caused by the improper assignment of priorities, a weakness identified during the last SALP period. An example was the delay in resolving the degraded grid voltage issue. The continuing high number of initial license examination failures and the large number of simulator discrepancies during 1992 indicated a lack of effective management involvement.

Enforcement history remained weak. A Severity Level III violation was issued for inadequate foreign material control during a modification and weak site contractor oversight. In addition, several Severity Level IV violations were issued reflecting some of the weaknesses discussed in this functional area.

The identification and resolution of technical issues remained mixed. On the positive side, most evaluations and corrective actions were technically sound and displayed an understanding of the safety implications. One example included the resolution to a problem with a leaking inter-system loss-of coolant accident (Event V) check valve. Four other similar valves also were modified even though they were not leaking. Additional examples included the installation of a fifth safety-related battery and two nonsafety-related batteries to enhance the capability of the DC electrical distribution system, and the actions taken after finding a visual defect in a fuel assembly.

On the other hand, the identification and resolution of problems were not always appropriate. For example, weaknesses included the incorrect use of inservice testing acceptance criteria, the practice of deferring operability determinations on test results until instrumentation accuracy was confirmed, and the improper use of stall efficiency to predict MOV capability. Weaknesses in the control of work also resulted in plant problems. One example was the use of inappropriate plastic tubing for a leak test of a charging system check valve, which resulted in a spill of contaminated water.

Although the number of reportable events increased during this period, most were the result of long standing design deficiencies. The remaining event reports were for isolated events and none were indicative of programmatic weaknesses.

Staffing was increased in response to previous concerns; however, the allocation of resources was not changed significantly. As a result, the backlog of open design changes and of completed modifications waiting for engineering post-installation review remained high. The engineering and technical support staff was competent and more proactive, the latter an

improvement over the last assessment period. The effectiveness of the major engineering reorganization could not be evaluated because it took place late in the assessment period. A good staffing level was maintained within the training organization.

The operator training and requalification program was mixed. While the requalification program experienced a high degree of success, the passing rate for initial operators continued to be low. The training and qualification of engineers was good. The corporate engineering staff had the necessary technical expertise to evaluate problems and to provide oversight of contractors. The technical support staff was knowledgeable of their assigned systems or components.

2. Performance Rating

Performance is rated Category 2 in this area. Performance was rated Category 2 during the previous assessment period.

3. Recommendations

None.

G. Safety Assessment/Quality Verification

1. Analysis

Management's effectiveness in improving the quality of work and an awareness of the importance of safety improved and was good. The timeliness and prioritization of corrective actions continued to be a concern.

Management took steps to convey the expectation that plant personnel must maintain a high level of safety awareness. Organizational changes were made to focus on plant and corporate staff resources to more efficiently support the safe operation of the plant.

Management involvement in ensuring quality and plant safety was evident in outage safety reviews (OSRs). The safety evaluation group (SEG) performed an OSR before each refueling outage. Outage containment closure drills to verify the effectiveness of procedures were performed as recommended by the SEG. The SEG did not, however, consider the negative effects of performing routine surveillance during refueling outages, particularly during reduced inventory operations or when grid stability could be an issue. For example, a surveillance performed during reduced inventory conditions in the Fall 1992 Unit 2 refueling outage resulted in the temporary de-energization of one train of safety-related electrical buses requiring operators to start the other residual heat removal pump.

Management's commitment to perform effective and independent safety reviews was evident. The SEG offsite and onsite review committees typically conducted thorough reviews and provided valuable insight into plant operations. However, the onsite review committee Managers Supervisory Staff (MSS) had a tendency to occasionally allow details to detract from the focus on the overall safety issue. Some improvement in the MSS focus was noted toward the end of the assessment period.

Further, the positions of shift outage manager and shift outage coordinators were created as part of a program to minimize shutdown risk. The responsibilities of these positions, in addition to assessing plant safety, included presenting daily risk assessment briefings and maintaining the risk status charts within the plant. Risk assessment briefings were beneficial to the continued conduct of safe operations. Senior plant management was successful in heightening the level of plant safety awareness among both plant operators and mid-level managers, particularly during reduced inventory operation.

Management's commitment to improve plant safety was also demonstrated by a number of plant improvements. These included the installation of new and additional station batteries and the scheduled installation of two new safety-related emergency diesel generators. Further, the quality assurance (QA) organization identified a number of significant deficiencies through the performance of quality "vertical slice" audits including the reactor protection and service water systems. Sound program audits were also conducted in the security and emergency planning areas.

The identification and resolution of technical issues improved and was good. For example, following a failed leak test on an Event V check valve, plant management demonstrated a clear focus on plant safety. This was evident in the decision to extend the refueling outage to modify additional Event V check valves. Management also demonstrated a commitment to resolve technical issues by revising the corrective action and commitment tracking procedures. For example, the corrective action process was revised to include a requirement for an SRO to assess equipment operability and reportability during the first 24 hours of writing a condition report, and a requirement for the plant manager to document a review of all Priority 1 and 2 condition reports. The identification and resolution of issues documented in condition reports originating from the vendor technical information program, quality assurance audits, and the licensee component failure analysis reports were considered program strengths.

Timeliness of corrective actions occasionally suffered due to inconsistent assignment of priority and plant resources. Examples include the resolution of degraded voltage issues and combustion turbine generator deficiencies.

Several findings involving corrective action program deficiencies, identified during a QA audit early in the reporting period, were addressed through procedure revisions. However, inconsistent management involvement and a lack of employee support in the condition reporting system continued to limit the effectiveness of these efforts. Further management oversight techniques continue to be developed, but were not fully successful. For example, a lack of management involvement resulted in scheduling delays of a test plan to assess potential safety injection pump cavitation problems.

2. Performance Rating

Performance is rated Category 2 in this area. Performance was rated Category 3 with an improving trend in the previous period.

3. Recommendations

None.

IV. SUPPORTING DATA AND SUMMARIES

A. Major Licensee Activities

Unit 1 refueling outage took place from April 11 through June 12, 1992. During steam generator crevice flushing, the reactor vessel was inadvertently cooled down at a higher than allowed rate.

An inspection of the gas turbine generator (used for fire protection and station blackout purposes) in April 1992, revealed significant degradation and wear of internal components, requiring an extensive overhaul. These efforts were completed in October 1992, with reliability testing continuing through the end of the assessment period.

Unit 2 refueling outage took place from September 26 through November 16, 1992. A foreign material exclusion plug was discovered in the suction piping leading to one train of containment spray and safety injection during routine surveillance testing. The plug had been inadvertently left in the piping after a modification performed during the previous outage and had rendered this section of piping inoperable.

Installation of a fifth safety-related battery and two non-safety-related batteries was completed in December 1992.

B. Major Inspection Activities

This assessment period consisted of the inspections conducted between February 1, 1992, and March 31, 1993, and documented in the inspection reports listed below under "Inspection Data." Significant inspection activities are listed below under "Special Inspection Summary."

1. Inspection Data

Unit 1, Docket 50-266

Inspection Reports: 92003, 92007 - 92019, 92021, 92023 through 92025, 92027, 92028 and 93002 - 93007.

Unit 2, Docket 50-301

Inspection Reports: 92003, 92007 - 92010, 92012 - 92019, 92021 through 92028, and 93002 - 93007

2. Special Inspection Summary

Significant inspections conducted during the SALP 10 assessment period are listed below:

An inspection was performed on March 16 - 20, 1992, of the annual emergency preparedness exercise (Inspection Reports 266/92003; 301/92003).

An inspection was conducted from April 20 - May 27, 1992, to review the inservice inspection program delineated in Generic Letter 89-04 (Inspection Reports 266/92008; 301/92008).

A special inspection of the reactor cooldown event on May 27, 1992, was conducted through June 14, 1992 (Inspection Reports 266/92014; 301/92014).

A safety inspection was performed from October 5 - 22, 1992, on the licensee's response to Generic Letter 89-10 for motor-operated valves (Inspection Reports 266/92021; 301/92021).

A team inspection was conducted from October 13, 1992, - February 4, 1993, to review the quality and effectiveness of engineering involvement in plant activities (Inspection Reports 266/92024; 301/92024).

A physical security and reactive material control inspection was performed from November 30 - December 4, 1992, to review the loss of a small quantity of special nuclear material (Inspection Reports 266/92028; 301/92028).

IV. SUPPORTING DATA AND SUMMARIES

A. Major Licensee Activities

Unit 1 refueling outage took place from April 11 through June 12, 1992. During steam generator crevice flushing, the reactor vessel was inadvertently cooled down at a higher than allowed rate.

An inspection of the gas turbine generator (used for fire protection and station blackout purposes) in April 1992, revealed significant degradation and wear of internal components, requiring an extensive overhaul. These efforts were completed in October 1992, with reliability testing continuing through the end of the assessment period.

Unit 2 refueling outage took place from September 26 through November 16, 1992. A foreign material exclusion plug was discovered in the suction piping leading to one train of containment spray and safety injection during routine surveillance testing. The plug had been inadvertently left in the piping after a modification performed during the previous outage and had rendered this section of piping inoperable.

Installation of a fifth safety-related battery and two non-safety-related batteries was completed in December 1992.

B. Major Inspection Activities

This assessment period consisted of the inspections conducted between February 1, 1992, and March 31, 1993, and documented in the inspection reports listed below under "Inspection Data." Significant inspection activities are listed below under "Special Inspection Summary."

1. Inspection Data

Unit 1, Docket 50-266

Inspection Reports: 92003, 92007 - 92019, 92021, 92023 through 92025, 92027, 92028 and 93002 - 93007.

Unit 2, Docket 50-301

Inspection Reports: 92003, 92007 - 92010, 92012 - 92019, 92021 through 92028, and 93002 - 93007

2. Special Inspection Summary

Significant inspections conducted during the SALP 10 assessment period are listed below:

An inspection was performed on March 16 - 20, 1992, of the annual emergency preparedness exercise (Inspection Reports 266/92003; 301/92003).

An inspection was conducted from April 20 - May 27, 1992, to review the inservice inspection program delineated in Generic Letter 89-04 (Inspection Reports 266/92008; 301/92008).

A special inspection of the reactor cooldown event on May 27, 1992, was conducted through June 14, 1992 (Inspection Reports 266/92014; 301/92014).

A safety inspection was performed from October 5 - 22, 1992, on the licensee's response to Generic Letter 89-10 for motor-operated valves (Inspection Reports 266/92021; 301/92021).

A team inspection was conducted from October 13, 1992, - February 4, 1993, to review the quality and effectiveness of engineering involvement in plant activities (Inspection Reports 266/92024; 301/92024).

A physical security and reactive material control inspection was performed from November 30 - December 4, 1992, to review the loss of a small quantity of special nuclear material (Inspection Reports 266/92028; 301/92028).