

U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Reports No. 50-315/82-12(DPRP); 50-316/82-12(DPRP)

Docket Nos. 50-315; 50-316

Licenses No. DPR-58; DPR-74

Licensee: American Electric Power Service Corporation  
Indiana and Michigan Electric Company  
2 Broadway  
New York, NY 10004

Facility Name: Donald C. Cook Nuclear Power Plant, Units 1 and 2

Inspection At: Donald C. Cook Site, Bridgman, MI

Inspection Conducted: June 16 through July 31, 1982

Inspectors: *D. W. Hayes for*  
E. R. Swanson 8/12/82  
*D. W. Hayes for*  
N. E. DuBry 8/12/82  
Approved By: *D. W. Hayes*  
D. W. Hayes, Chief 8/12/82  
Reactor Projects Section 1B

Inspection Summary

Inspection on June 16 through July 31, 1982 (Report No. 50-315/82-12(DPRP); 50-316/82-12(DPRP))

Areas Inspected: Routine, onsite regular and backshift inspection conducted by two resident inspectors. Areas inspected included: Licensee Event Reports, Followup on Previous Inspection Findings, Operational Safety Verification, Inspection During Long Term Shutdown, Surveillance Observation, Maintenance Observation, Thermal Sleeve Weld Failures, NUREG-0737, and Regional Request. The inspection included a total of 288 inspector-hours onsite by two NRC inspectors including 79 inspector-hours onsite during off-shift hours.

Results: Of the eight areas inspected, no items of noncompliance or deviations were identified in seven areas. One item of noncompliance was identified in one area (Failure to comply with Design Change Controls, Paragraph 3).

## DETAILS

### 1. Persons Contacted

\*W. Smith, Jr., Plant Manager  
\*B. Svensson, Assistant Plant Manager  
\*E. Townley, Assistant Plant Manager  
\*E. Smarrella, Technical Superintendent  
\*J. Stietzel, Quality Assurance Supervisor  
\*K. Baker, Operations Superintendent  
R. Dudding, Maintenance Supervisor  
T. Beilman, Sr., Quality Assurance Auditor  
M. McAllister, Stores Supervisor  
D. Yount, Accounting Supervisor  
P. Jacques, Fire Protection Coordinator

\*Denotes those present at exit interviews.

The inspectors also contacted a number of licensee and contract employees and informally interviewed operations, technical, and maintenance personnel during this inspection period.

### 2. Licensee Event Report Followup

Through direct observations, discussions with licensee personnel, and review of records, the following event reports were reviewed to determine that reportability requirements were fulfilled, immediate corrective action was accomplished, and corrective action to prevent recurrence had been accomplished in accordance with technical specifications.

#### Unit 1

RO 76-045/03X-1	No PNSRC Review of Temporary Sheets
RO 78-004/04X-C	Chlorine Residuals Greater Than Allowed
RO 81-053/04T-0	Unplanned Release During VCT Venting
RO 81-058/04T-0	Unplanned Release During RCS Sampling
RO 82-003/04T-0	Unplanned Airborn Release
RO 82-010/04T-0	Unplanned Release
RO 82-016/03L-0	Control Room Air Space Handling Unit Inoperable
RO 82-020/99L-0	Automatic Fire Water Valve Inoperable
RO 82-022/03L-0	Fire Door Inoperable (damaged hardware)
RO 82-026/03L-0	Fire Door Inoperable (blocked open)
RO 82-031/03L-0	Fire Door Inoperable (latch)
RO 82-033/03L-0	Fire Door Inoperable (door closed)
RO 82-034/03L-0	Roll Up Fire Door Inoperable (blocked open)
RO 82-037/03L-0	Emergency Diesel Room Cardox System Isolated
RO 82-039/01T-0	Boron Injection Tank Dilution
RO 82-042/031-0	Fire Door Inoperable (hardware)
RO 82-041/03L-0	Feedwater Isolation Valve (FMO-202) Failed
RO 82-042/03L-0	R-11 Inoperable - Failed Power Supply
RO 82-044/03L-0	Emergency Diesel Room Cardox System Isolated

RO 82-045/03L-0	Aux Cable Vault Cardox System Isolated
RO 82-048/03L-0	ESW Discharge Valve Inoperable (WMO-737)
RO 82-049/03L-0	Vital Switchgear Room Cardox System Isolated

Unit 2

RO 78-040/03L-0	Rod H-8 Did Not Indicate Fully Inserted After Trip
RO 78-048/03L-0	Rod H-8 Did Not Indicate Fully Inserted
RO 80-032/03L-0	RHR Pump Inoperable
RO 81-055/04T-0	Unplanned Release From VCT To WDS
RO 81-058/03X-1	Normal Letdown Relief Lifting Below Setpoint
RO 81-066/04L-0	Unmonitored Release Path (blowdown flow)
RO 82-020/04T-0	Unplanned Release
RO 82-024/03L-0	Roll Up Fire Door Inoperable
RO 82-031/03L-0	Roll Up Fire Door Inoperable
RO 82-043/03L-0	Fire Door Inoperable (hardware)
RO 82-045/03L-0	Fire Door Inoperable (hardware)
RO 82-048/03L-0	Roll Up Fire Door Inoperable (blocked open)
RO 82-049/03L-0	Fire Doors Inoperable (blocked open)
RO 82-052/03L-0	Fire Doors Inoperable (blocked open)
RO 82-053/03L-0	Overhead Fire Door Inoperable (blocked open)
RO 82-054/03L-0	Reactor Cable Tunnel Cardox System Isolated

LER (50-315/82-049/03L-0: This event was typical of several on both units where the CO<sub>2</sub> suppression system was disabled while personnel occupied the protected room, and the system was not returned to normal after leaving the area. Several other personnel error caused events are related to fire doors being blocked open and made inoperable. Corrective actions include additional warning signs, lanyards on the stop pins for the overhead doors and the preparation of a video film to increase personnel awareness of fire protection system requirements. The completion and effectiveness of these corrective actions will be evaluated in future inspections (Open Item 315/82-12-01; 316/82-12-01).

(Closed) LER 50-316/056/03L-0: At 1044 EDT on June 29, 1982 the licensee began a surveillance test on Reactor Logic Train A, Unit 2. This surveillance has a 1 hour time limit per TS 3.3.1.1. At 1120 EDT the licensee identified a bad logic card. The licensee entered the action statement at 1144 EDT and started a slow shutdown 3%/hr at 1212 EDT to minimize iodine spiking problems. The plant declared an unusual event at 1243 EDT due to the malfunction in the safeguards logic system.

At 1342 EDT the safeguards output relay driver card was identified as the failed component. The card was replaced, power reduction stopped at 97%, and the surveillance started again. At 1410 EDT the surveillance was completed satisfactory, the Unusual Event was cancelled and the plant started increasing power at 1.5%/hr.

### 3. Followup on Previous Inspection Findings

(Closed) Noncompliance Items (315/79-11-01; 315/81-21-01; 316/81-24-01): The PNSRC failed to Review a Modification and Corrective Actions were not completed. On inspection it was found that the licensee has patched over the exposed anchor bolts and has conducted a safety review as documented for RFC-DC-12-2254 (Request for change) on December 8, 1981. The licensee also reviewed the change and the proposed response on January 8, 1982. This is recorded in the PNSRC minutes for meeting #1095.

(Closed) Unresolved Item (315/80-01-02; 316/80-01-02): Inspectors found that there was no Quality Assurance Manual in use at the corporate offices where design, procurement, and other quality related activities were conducted. Licensing correspondence dated May 17, 1977 discussed the "AEPSC QA Manual" but there was no evidence to show that it had ever been implemented in the corporate office. Subsequent to this finding, a management meeting was held on April 15, 1980 when the licensee provided the NRC with a copy of a newly generated document titled "American Electric Power Company Quality Assurance Program for the Donald C. Cook Nuclear Plant." This procedure was later incorporated into the AEPSC General Procedures Manual as Procedure No. 2.1 on May 19, 1981.

(Open) Unresolved Item (315/80-01-05; 316/80-01-05): Record Keeping and Record Storage Facilities do not meet the criterion of ANSI N 45.2.9, 1974 "Requirements for Collection, Storage, and Maintenance of Quality Assurance Records for Nuclear Power Plants." As previously noted, the safeguarding of QA records does not meet the recommendations of the standard in that the Master Plant File vault does not meet the NFPA class A fire rating with a recommended four hour minimum rating. The plant has been aware of this issue for approximately 2 1/2 years and had not taken any steps to get approval of their deviation from the committed standard and Regulatory Guide. The licensee is currently evaluating upgrading the rating of this storage facility.

Considerable attention has been given to the records control program over the last several years including the hiring of a consultant firm and research into the various information retrieval systems available. As stated in the newly revised Plant Manager Instruction 2040 "Plant Files", a revised indexing and retrieval system for the Master Plant File, including the records check list identification of Quality Assurance records and receipt control check list shall be developed and implemented by August 1, 1982. AEPSC General Procedure No. 17.0 "Quality Assurance Records" was issued February 11, 1982 setting the ground work for defining QA records and their storage requirements. Another procedure currently under revision, PMI 2130 "Plant Records Preparation and Retention" will complete the administrative frame work for this revision and improvement effort.

(Closed) Unresolved Item (315/80-01-06; 316/80-01-06): Evidence of poor control over operating drawings has continued since this unresolved

item was generated. In a subsequent inspection, 50-315/82-04; 50-316/82-04(DPRP) a Notice of Violation was issued on the same topic. This unresolved item is closed and further corrective action and inspection will be documented under tracking item 315/82-04-02.

(Closed) Unresolved Item (315/80-01-13; 316/80-01-13): The licensee's corporate office did not consider themselves to be committed to applicable portions of Regulatory Guides and ANSI Standards which the plant was committed to by the FSAR. As referenced in the above paragraph, AEPSC General Procedure 2.1 contains information as to the applicability of the Guides and Standards.

(Closed) Noncompliance Items (315/80-04-01; 316/80-03-01, 315/80-04-02; 316/80-03-02; 315/81-21-02, 316/81-24-02; 315/81-21-03, 316/81-24-03): Cross Contamination of the Demineralized Water System with the Spent Fuel Pit Water; less than 2000 ppm Boron During Spent Fuel Storage Rack Modification; Lack of Refueling Procedure for Filling the Fuel Transfer Canal; Non-Factual Licensee Response to Noncompliance Item.

Confirmation of the above corrective actions found the following:  
To prevent cross contamination of the demineralized water system with the Spent Fuel Pit Water the licensee has installed check valves on each local demineralized water outlet and padlocked closed the manual valves. These valves are now administratively controlled by Standing Order No. 050.040 which requires notification of the Shift Supervisor and recording of the valve position in the non-conforming equipment log while it is unlocked and open.

The license Amendments No. 32 and No. 13 applicable to Units 1 and 2 respectively, which requires Spent Fuel Pit boron concentration of greater than 2000 ppm, no longer exists since the storage rack modification is complete.

Operations Department Procedure 12 OHP 4021.018.013, "Filling, Emptying, and Refilling Fuel Transfer Canal," was revised to include instructions for filling the transfer canal from the Boric Acid Blender via temporary hosing. Included in this procedure and in Procedure 12 OHP 4021.018.002, "Placing In Service and Operating the Spent Fuel Pit Cooling System," are precautions to prevent making up to the pit via hoses. Finally, the inspector confirmed the licensee's actions as stated in the response letters of May 30, 1980 (AEP:NRC:00413), and January 14, 1982 (AEP:NRC:0640) to now be factual. However it was noted during this inspection effort that the most current operating flow prints do not accurately reflect the check valve additions. The licensee committed to update these prints before the Unit 1 1982 refueling outage is completed.

(Closed) Noncompliance (315/80-20-02; 316/80-16-01): The inspector verified that the licensee revised plant procedure 12 THP 4030 STP.222 "ISI Pump Test Program" to include evaluation of low and high suction pressures for each pump.

(Open) Open Item (315/80-20-05; 316/80-16-03): As discussed previously there have been numerous events whose cause was related to improper return to service of equipment and systems. There has not been any final decision made on exactly how to improve equipment control methods, but several proposed changes are being evaluated.

(Closed) Noncompliance (315/80-21-01; 50-316/80-17-02): The Auxiliary Feedwater Pump low suction pressure trips were not installed as committed. A management memorandum was written to encourage increased awareness of commitments made and the communication of information which impacts on meeting these commitments. Subsequent to this corrective action it was deemed necessary to make more extensive changes in the procedure used to control communications to the NRC (AEPSC GP-32).

(Closed) Noncompliance Item (315/81-01-03; 316/81-01-03): Missed Commitment Dates. The licensee has implemented AEPSC General Procedure 2.2, "Operation, Control, and Maintenance of the AEPSC Commitment List" (issued 9-8-81), to help identify and establish control of AEPSC commitments to insure they are thorough and timely. An updated commitment list is issued monthly by AEPSC. Some improvement has been noted and the licensee is continuing their efforts to improve this system. This area will continue to be monitored during routine future inspections.

(Open) Noncompliance (315/81-03-02; 316/81-03-02): Plant Nuclear Safety Review Committee (PNSRC) reviews for 10 CFR 50.59 determination were not done or documented. The inspector found that the promised PNSRC review checklist has still not been revised although it is referenced several times in the new Plant Manager Instruction No. 1040 "Plant Nuclear Safety Review Committee". Performance Appraisal Branch inspection during July 12-16, 1982 revealed additional deficiencies relative to committee activities.

(Closed) Unresolved Item (315/81-05-01; 316/81-05-01): A policy has been established to disallow the assignment of operators to duties which require crossing from one unit to the other. It is contained in Standing Order .041, issued December 22, 1981.

(Closed) Open Item (315/81-05-03; 316/81-05-05): The licensee has the applicable isometric drawing on site and they were made available to the inspector.

(Open) Noncompliance Item (315/81-21-05; 316/81-24-06): Failure to Conduct a PNSRC Review of RFC Before Its Implementation. A review of the licensee's response letter (AEP:NRC:0640/January 24, 1982) and review of the PNSRC meeting minutes revealed that the licensee has discussed the noncompliance and the response (PNSRC meeting of 11/24/81 and 1/8/82). However as of June 23, 1982, the licensee still has not conducted a PNSRC review nor approved the revision to design change No. RFC 12-2500 which was the basis of this noncompliance. The inspector also found that the design change revision material was still not avail-

able at the plant site. The licensee stated they would look into the delay of getting the design change revision onsite.

(Open) Open Item (315/81-21-06; 316/81-24-07): NESW Isolation Check Valve Replacement. The licensee has the parts onsite and plans to make the replacements during the 1982 refueling outages.

(Closed) Noncompliance Item (316/81-26-01): A Technical Specification Action Statement was not complied with resulting in non-conservative plant operation. The licensee's corrective action response letter dated January 19, 1982 was verified by the inspector. It was found that the event review was not done by Control and Instrument Section Personnel by February 28, 1982 as committed. It was conducted on April 27, 1982, after this was discovered by a Quality Assurance Department surveillance. Similarly, the Plant Manager's Standing Order was not issued by February 28, 1982 as committed. PMSO .070 "Reactor Protection System Instrument Failures" was issued May 5, 1982. The licensee indicated that their intentions are to followup on commitments more expeditiously and to improve the accountability of persons assigned corrective actions.

(Closed) Noncompliance Item (315/81-24-01): The inspector reviewed the documentation of the training of performance personnel concerning reporting requirements when surveillance testing results in exceeding Technical Specification tolerances.

(Open) Open Item (315/81-24-03; 316/81-26-03): Containment Airlock Interlock Modification. The licensee intends to make modifications to the airlocks, per RFC-DC-12-1874, during the 1982 refueling outages.

(Open) Open Item (315/81-24-04; 316/81-26-04): Ice Condenser Door Freezing. The licensee initiated design changes RFC 12-1758 and 12-1791 in October 1979 and April 1980 respectively. The licensee plans on installing RFC 12-1758, which implements a timed defrost cycle, has only recently (May 1982) been received onsite from AEPSC. Conversations with licensee personnel revealed that this RFC has low priority, there is no projected completion date, and equipment bids will be let by AEPSC no earlier than late 1982.

(Closed) Open Item (315/81-29-01; 316/81-33-02): Breach of Containment Integrity. The licensee's actions and instructions to operations personnel appears appropriate to preclude future occurrences.

(Closed) Noncompliance Item (316/80-07-02): No Logging of Significant Event. The licensee's response letter (AEP:NRG:00447) of August 4, 1980, states "late entries" were made to applicable logs, the Shift Superintendent and Unit Supervisor were instructed on the matter, and that a memo (7-22-80) was issued to all licensed operators stating the requirements and importance of accurate logs.

The above items were verified by the inspector and since issuance of this noncompliance there have been two revisions to OHI-2211, "Maintenance of Operations Department Logs", which have been reviewed by all operations personnel.

(Closed) Noncompliance Item (316/80-07-03): Inadequate review resulting in exceeding Technical Specification Action Statement. The inspector found the licensee's corrective action to be the inclusion of setpoints and specific actions to be taken at "key points" within the surveillance procedures. Instructions at the end of data signoff sheets state that they be forwarded to Operations Department QCIC for review immediately so as to remain within specified time limits constraints for ISI review.

(Open) Noncompliance Item (316/81-01-02): Unmonitored release, Steam Generator Blowdown Sample Flow Blocked. A review of licensee actions in this area found that chemical technicians were reinstructed in Appendix B Technical Specifications; and Technical Department and Plant Manager Standing Orders (TSO-021 and PMSO 066 respectively) were issued delineating condition identification and actions to be taken to prevent future problems in this area. A request for change (RFC-DC-12-2825), to modify flow meters on the steam generator blowdown lines to radiation monitor R-19 to incorporate a loss of flow alarm capability, was initiated, reviewed by the Plant Nuclear Safety Review Committee on January 27, 1981, and forwarded to AEPSC for their handling. There is no evidence that any further action has been taken on this matter since that time until March 22, 1982. On July 13, 1982, during an exit meeting, the licensee stated that the mechanical drawings were onsite, the electrical drawings were expected by August 1982, and all necessary equipment for the design change would be available in September 1982. The licensee representative states an installation date would be given in late August 1982.

(Closed) Noncompliance Item (316/81-05-02): Unit 2 Spray Addition Tank out of specification; level low. The inspector found on review that procedures have been changed to agree with Technical Specification requirements; and surveillance changes have been modified in technique and frequency to prevent recurrence. Surveillance changes, initiated prior to the event, which were not incorporated into the procedures were found to have been a clerical filing error and have been corrected. The miswiring and loss of fluid in the additive tank were attributed to work in the area during installation of TMI Modification. The instruments have been rewired to be functional and drawings are being changed accordingly. Manual valves and positions for the tanks are now controlled by operations with chains, locks, and seals.

(Closed) Unresolved Item (316/81-05-03): Auxiliary Feed System; Safety Analysis Review of Suction Strainer and Incorrect Engineering Flow Diagram. During this inspection period as a followup the inspector determined that the onsite safety review was not done until June 29, 1982; after inspector inquiries. The licensee stated the replacement duplex strainer, which was to have been ordered on July 7, 1981, did

not arrive onsite until June 6, 1982, due to shipping difficulties and was held in stores until July 1, 1982, when certification was complete. The controlled engineering flow diagram still had not been revised to reflect plant status.

(Closed) Unresolved Item (316/81-24-05): Design Adequacy of Turbine Stop Valve Indication Switches. On followup the inspector found that a design change revision was developed to RFC DC-02-2248 and installed on March 11-26, 1982. The original RFC package had been completed November 9, 1978. During this review the inspector determined that this RFC revision was completed without an "Engineering Review", "Design Change Authorization", or "Processing Data Sheet". It was also established that the Plant Outage/Design Change Coordinator had no information or knowledge of this revision. His only data was a completed package on the original change. The above is contrary to the licensee's general procedure, AEPSC general procedure 25, which states in part that an RFC cannot be further modified once on site work to implement the original change has been completed; and distribution shall be made to the Plant Outage/Design Change Coordinator and the Plant Manager and no others. This is an item of noncompliance. (316/82-12-02).

(Closed) Noncompliance Item (315/81-24-01): Failure to make a timely report. The licensee has held a training session to cover Technical Specification tolerances and reporting requirements as stated in their January 19, 1982, response letter (AEP:NRC:00643).

(Closed) Open Item (316/81-33-01): Plant Trip. The licensee determined the cause of the trip to be stator water low pressure. This was caused by a valve misalignment. The valve was restored to the correct position and the licensee is in the process of revising valve alignment procedures to prevent future occurrences.

(Closed) Open Item (316/82-04-04): The licensee revised Licensee Event Report 50-316/81-58/03L-0 on June 3, 1982 to reflect the actual cause of the letdown relief valve failure.

#### 4. Operational Safety Verification-Inspection During Long Term Shutdown

The inspectors observed control room operations, reviewed applicable logs and conducted discussions with control room operators during the period of June 16, 1982 through July 31, 1982. The inspectors verified the operability of selected systems, reviewed tagout records, and verified proper return to service of affected components. The inspectors also reviewed surveillance tests required during the Unit 1 refueling outage, verified tagouts and records used during the outage, and checked applicable containment integrity requirements. Tours of the Unit 1 containment, auxiliary building, turbine building, and screenhouse areas were made to assess equipment conditions, plant conditions, and radiological controls and safety. Verification that maintenance requests had been initiated for equipment in need of maintenance work was also made.

The inspectors observed plant housekeeping/cleanliness conditions and verified implementation of radiation protection controls. During the inspection period the inspectors walked down accessible portions of both Units Essential Service Water Systems and Containment Purge Systems to verify operability. By observation and interviews the inspectors verified that the station security plan had been implemented and observed controls associated with radwaste processing and shipping.

Steam generator 1-2 was opened for sludge lancing and it was discovered that the two cap screws which help retain tube lane blocking device were missing. The Westinghouse Search and Retrieval team was called in and conducted extensive examinations of Unit 1 steam generators secondary sides and tubes. The cap screws and nuts were recovered and had not caused any detectable damage. Also found was some wire, weld droppings, a piece of weld rod, a pocket knife and brass locknuts. The locknuts were from the 6A and 6B Feedwater Heater and were replaced by stainless steel ones when they were found eroding. No damage was noted from any of the debris which apparently was introduced during previous J-tube and feedwater ring modifications. Eddy Current testing was also done and revealed no defects. Continuation of previous corrective action after tube lane blocking devices were found loose included plugging of the inner row tubes in steam generators 1-2 and 1-3 (row 1; columns 1, 2, 3, 4, 5 and 90, 91, 92, 93, 94) and the welds on the cap screw retaining nuts were improved.

These reviews and observations were conducted to verify that facility operations and maintenance activities were in conformance with the requirements established under Technical Specification, 10 CFR, and administrative procedures.

#### 5. Surveillance Observations

The inspectors observed Technical Specification required surveillance testing 2 THP 4030 STP.145 "Reactor Logic Train A and B and Reactor Trip Breakers A & B", 2 OHP 4030 STP.029 "Thermal Power Calculation", 1 OHP 4030 STP.004 "Coolant Charging Pump Operational Test-Modes 5 and 6" for the "East" Pump, and 1 OHP 4030 STP.027 "Emergency Diesel Generator Operability Test", and verified testing was performed in accordance with adequate procedures, that limiting conditions for operations were met, that removal and restoration of the affected components were accomplished, that test results conformed with Technical Specifications and procedure requirements. The results were reviewed by personnel other than the individual directing the test. The inspectors also noted that any deficiencies identified during the testing were properly reviewed and resolved by appropriate management personnel.

The inspectors also witnessed/reviewed portions of the following test activities:

Unit 1

12 THP 4030 STP.203	"B" & "C" Leak Rate Testing
1 THP 4030 STP.100	Reactor Protection and Engineered Safeguard System Time Response
1 OHP 4021.032.001	Starting, Parallelling, Loading and Shutdown of Emergency Diesel Generator

Unit 2

2 OHP 4030 STP.005	ECCS Operability Test
2 OHP 4030 STP.020	West Component Cooling Water Operability Test
2 THP 4030 STP.153	Containment Radiogas Monitor (R-12)
2 THP 4030 STP.155	Containment Area Monitor At Airlock (R-2)
2 THP 4030 STP.163	Condenser Air Ejector Gas Process Monitor (R-15)
2 THP 4030 STP.129	Power Range Nuclear Instrumentation Protection Set III

6. Maintenance Observation

Station maintenance activities of safety-related systems and components listed below were observed/reviewed to ascertain that they were conducted in accordance with approved procedures, regulatory guides, and industry codes or standards, and in conformance with Technical Specifications.

The following items were considered during this review: the limiting conditions for operation were met while the components or systems were removed from service; approvals were obtained before initiating the work; activities were accomplished using approved procedures and were inspected as applicable; functional testing and/or calibrations were performed before returning components or systems to service; quality control records were maintained; activities were accomplished by qualified personnel; parts and materials used were certified; and radiological controls were implemented.

The following maintenance activities were observed/reviewed:

Unit 1

1 MHP 5021.032.001	18 Month Diesel Generator Maintenance
1 MHP 5021.001.037	Setting Of Rotor And Torque Limit Switches On Limitorque Operators (IMO-128)
1 MHP 5021.001.024	Inspection And Repair Of Copes Vulcan Valves (IMO-128)
1 MHP 5021.001.006	Repair Of Limitorque Valve Operators (IMO-128)
12 THP 6040	Per.075 Mass Ice Addition
MHI 5075	Weld Repair Of FW-118-4
1 THP 6040 Per.058	Retracting And Inserting Incore Instrument Thimbles
1 THP SP.031	Incore Flux Thimble Cleaning And Lubrication

## Unit 2

### Westinghouse Solid State          SSPS Troubleshooting And Repair Protection System Manual

#### 7. Westinghouse Thermal Sleeve Weld Failures

The licensee received information from the NRC on the recently discovered thermal sleeve weld failures experienced at Trojan, McGuire and North Anna as well as a letter from the regional Westinghouse Nuclear Service Division. The Westinghouse letter states that the Donald C. Cook Units do not have thermal sleeves of the affected design. The plant staff has evaluated this information and is planning to verify that a problem does not exist at D. C. Cook by radiography during the current Unit 1 and upcoming Unit 2 outages.

#### 8. NUREG-0737 Task Action Plan

##### Item I.C.1: Revised Emergency Procedures

As stated in their June 28, 1982 letter (AEP:NRC:0678A), the licensee does not plan to revise their Emergency Procedures until the 1983 and 1984 refueling outages for Unit 1 and Unit 2 respectively. This re-write involves considerable work and coordination with the NRC to assure the quality and acceptability of the revised procedure.

##### Item II.B.2.3: Radiation Qualification of Safety Related Equipment

Review of this item has been incorporated into the IE Bulletin 79-01B reviews. Two components identified as having degradeable radiation sensitive parts were the containment sump level indicators and certain components of the interim post accident sampling system. The sump level instruments were replaced by design change RFC-2451 and the final post accident sampling system is being installed under design change RFC-2465 (Task Item II.B.3). This item is closed.

##### Item II.K.3.25: Effect of Loss of AC Power To Reactor Coolant Pump Seals

The licensee's letter to NRR dated December 29, 1981 (AEP:NRC:0649) described the existing design features which provide cooling to the reactor coolant pump seals during a loss of off site power. NRR evaluated this item in their June 23, 1982 letter. This item is closed.

#### 9. Regional Request

San Onofre Unit 1 recently experienced operational difficulties with both emergency diesel generators. Investigation into the problem indicated the cause to be a low oil level in the diesel governor system. At the request of the NRC inspector the licensee communicated with the Woodward Governor Company and received the recommendation to maintain

the level between the lines of the sightglass when the governor is operating. Maintenance for the model EGB-35 governor is contained in MHP 5021.032.001L "Maintenance Procedure for Emergency Diesel Generator System Periodic Inspection" which includes appropriate operability checks.

10. Exit Interview

The inspector met with licensee representatives (denoted in Paragraph 1) throughout the month and at the conclusion of the inspection period and summarized the scope and findings of the inspection activities. The licensee acknowledged receipt of the item of noncompliance and commitments found in Paragraph 3.