

U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Reports No. 50-295/82-28(DPRP); 50-304/82-25(DPRP)

Docket Nos. 50-295, 50-304

Licenses No. DPR-39, DPR-48

Licensee: Commonwealth Edison Company
P. O. Box 767
Chicago, IL 60690

Facility Name: Zion Nuclear Power Station, Units 1 and 2

Inspection At: Zion, IL

Inspection Conducted: December 2, 1982 through January 17, 1983

Inspectors: J. R. Waters

D. C. Boyd for
2-7-83

F. R. Dunaway

D. C. Boyd for
2-7-83

P. L. Hartmann

D. C. Boyd for
2-7-83

Approved By: D. C. Boyd
Projects Section 2A

D. C. Boyd
2-7-83

Inspection Summary

Inspection on December 2, 1982 through January 17, 1983 (Reports No. 50-295/82-28(DPRP); 50-304/82-25(DPRP))

Areas Inspected: Routine, unannounced inspection by Resident Inspectors of Licensee Action on Previous Inspection Items, Unit Start Up with Penetration Pressurization Air Compressor Out of Service, Spent Fuel Shipment, Radioactive Release of December 15, 1982, Radioactive Release of December 16, 17, 1982, Delay of Emergency Preparedness Drill, Failure of Both Hydrogen Recombiners, Unit 2 Shutdown Due to Degraded ESF Busses, Action taken on NBFD Relays, Action taken on ITT Barton Transmitters, Work Practices on Safety Related Equipment, Spurious Trips of Safety Related Components, Overall Operations, Audits, Committee Activities, Operational Safety, Maintenance, Surveillance, Licensee Event Reports, and IE Circulars. The inspection involved a total of 291 inspectors-hours onsite by three NRC inspectors including 22 hours onsite during off-shifts.

Results: No items of noncompliance or deviations were identified.

DETAILS

1. Persons Contacted

- K. Graesser, Station Superintendent
- *E. Fuerst, Assistant Station Superintendent, Operations
- *G. Pliml, Assistant Station Superintendent, Administrative and Support Services
- K. Kofron, Assistant Station Superintendent, Maintenance
- R. Budowle, Unit 1 Operating Engineer
- J. Gilmore, Unit 2 Operating Engineer
- L. Pruett, Assistant Technical Staff Supervisor
- P. LeBlond, Assistant Technical Staff Supervisor
- A. Miosi, Technical Staff Supervisor
- B. Schramer, Station Chemist
- F. Ost, Health Physics Engineer
- C. Silich, Technical Staff Engineer, ISI
- *B. Harl, Quality Assurance Engineer
- *B. Kurth, Master Instrument Mechanic
- F. Lentine, Nuclear Licensing Administration
- J. Marianyi, Operating Engineer
- E. Broccolo, Quality Control Technician
- J. Johnson, Westinghouse Site Representative
- A. Amoroso, Technical Staff
- P. Cantwell, Technical Staff
- T. Rieck, Rad/Chem Supervisor
- A. Bless, Technical Staff
- R. Chin, Technical Staff
- K. Shim, Technical Staff
- A. Nykiel, Assistant Fire Marshal
- *W. Stone, Quality Assurance Engineer
- *F. Woodin, Personnel Administrator
- *R. Placko, Quality Control Inspector

*Denotes those present at the exit meeting of January 17, 1983

2. Licensee Action on Previous Inspection Findings

(Closed) Violation (304/81-01-01): Failure to Maintain Adequate Operator Logs. The licensee's corrective action was reviewed and found to be acceptable.

(Closed) Open Item (295/81-20-02; 304/81-16-03): Zion Management Effort to Identify and Correct Leakage in the Waste Gas Collection System. The corrective action consisted of identification of leaking components and subsequent repair. Review of gas balance calculations and trending indicates that system integrity has vastly improved.

Further review of this item is contained in Report 50-295/82-07; 50-304/82-07.

3. Summary of Operations

Unit 1

Unit 1 operated at power levels up to 80% during the inspection period. No reactor trips or shutdowns occurred. The licensee has limited Unit 1 power to 80% due to fuel burnup considerations.

Unit 2

Unit 2 operated at power levels up to 100%. The following reactor trips occurred during the inspection period: On December 2, 1982 the reactor tripped from 100% power at 3:08 a.m. The first-out annunciator indicated that the trip was caused by exceeding the OPΔT (Overpower Delta Temperature) limits. Recorder traces indicate that the OPΔT set point had dropped suddenly while actual ΔT stayed constant. Approximately two minutes prior to the trip the generator output breaker open alarm activated even though the output breakers had not actually opened. After the trip the 86 GT2B relay indicated that the generator had tripped on reverse power. Coincident with the reactor trip the process computer failed and no sequence of events print out was available. The licensee was unable to determine for certain the exact cause of the trip, but suspects that it was induced by heavy lightning activity in the area at the time. The OPΔT instruments and generator breaker trips were verified to be operating properly.

After receiving a Technical Specifications change (see Paragraph 4) the unit was made critical at 9:25 p.m. December 3, 1982. The reactor tripped during the power ascension due to low low level in the C steam generator and was made critical again at 4:05 a.m. on December 4, 1982. The unit was tied to the grid at 6:20 a.m. December 4, 1982.

An unscheduled shutdown occurred January 14, 1983. The events are described in Paragraph 10.

No items of noncompliance or deviations were identified.

4. Unit 2 Startup with Penetration Pressurization Compressor Out of Service

One of the three PP (Penetration Pressurization) air compressors was out of service when Unit 2 tripped on December 2, 1982. Technical Specifications allow continued reactor operation in this condition for 15 days. However, in preparation for restarting Unit 2 it was determined that the provisions of Technical Specification 3.0.4 would prohibit a return to criticality. Section 3.0.4 states that Technical Specifications operability requirements must be met without reliance on the action statement prior to changing plant condition modes. The licensee requested and was granted an emergency revision to the PP section of the Technical Specifications. The revision entailed a downgrading of the operability requirements for various portions of the PP system and exemptions from the requirements of Section 3.0.4.

The revision was granted based on the existence of redundant PP compressors, redundant nitrogen supply, and backup by the instrument air system. Receipt of the Technical Specification revision allowed the restart of Unit 2 on December 3, 1982.

No items of noncompliance or deviations were identified.

5. Spent Fuel Assembly

At 3:00 a.m. December 15, 1982 a spent fuel assembly (C15R) was transported by truck from Zion Unit 1 to Battelle Laboratories, Columbus, Ohio. The shipment arrived 2:00 p.m. December 15. The spent fuel assembly contained 16 fuel pins from other assemblies to represent various core exposures. Battelle Laboratories will perform destructive analysis on the spent fuel assembly. When analysis is complete the assembly will be transported to Zion for permanent disposal. The Senior Resident Inspector witnessed portions of the spent fuel assembly cask receipt and handling.

No items of noncompliance or deviations were identified.

6. Radioactive Release of December 15, 1982

On December 15, 1982, an unplanned gaseous release occurred during the change of Unit 2 Reactor Coolant System Filters, when the filter being placed on service was vented to the Auxiliary Building atmosphere at 11:30 a.m. The venting resulted in an increase in R-14 (auxiliary building vent stack monitor) to a reading approximately 3 times normal, but below the alarm setpoint. Following the peak reading, the reading decreased to normal by 1:30 p.m. The elevated reading was noted at 12:15 p.m. and the NRC notified by Emergency Notification System at 12:45 p.m. The licensee calculated the maximum instantaneous release rate to be 0.17 uc/sec which is much less than 1% of the Technical Specification limit. A total of 390.7 uc was released.

No items of noncompliance or deviations were identified.

7. Radioactive Release of December 16 and 17, 1982

On December 16 and 17, 1982, an unplanned gaseous release from Unit 2 occurred. At 6:15 p.m. on December 16, an alarm was received on PR-18 (Volume Control Tank (VCT) room failed fuel monitor). A primary coolant sample indicated elevated Xenon activity, but showed no evidence of fuel failure. At 8:25 p.m., the VCT was vented to the Waste Gas system, and PR-18 readings returned to normal levels. At 8:45 p.m., based on increasing readings on R-14 (auxiliary building vent stack monitor) and PR-06 (2B Charging Pump room monitor), the NRC was notified by Emergency Notification System of the unplanned release. Following the notification, readings on both monitors decreased to pre-release levels, and the release was declared terminated at 4:00 a.m. on December 17, 1982.

The licensee calculated the maximum instantaneous release rate to be 440 uc/sec which is 0.73% of the Technical Specification limit. A total of 19 curies was released.

Subsequent to the release, the licensee determined that the atmospheric isolation valve on the 2B charging pump casing vent line leaked past the seat. The line was capped, and the R-14 reading decreased to background levels. The licensee attributes the unplanned release of December 16 and 17, 1982, to leakage past that valve.

No items of noncompliance or deviations were identified.

8. Generating Station Emergency Plan (GSEP) Exercise Rescheduled

As a result of extensive flooding in downstate Illinois, the Illinois Emergency Service Disaster Agency (ESDA) requested that the GSEP Exercise planned for December 17, 1982 be rescheduled. The exercise will be conducted on January 18, 1983.

No items of noncompliance or deviations were identified.

9. Failure of Both Hydrogen Recombiners December 28, 1982

At 9:45 p.m. on December 27, 1982, the surveillance testing required by Technical Specification 4.8.8.B.1 was commenced on the Unit 1 Hydrogen Recombiner. The Hydrogen Recombiner failed to reach and maintain the minimum temperature required by PT (Periodic Test)-15C, and was declared inoperable at 3:30 a.m. In accordance with Technical Specification 4.8.8.B.2, PT-15C was commenced on the Unit 2 Hydrogen Recombiner to prove that unit operable. The equipment Operator conducting the PT noticed an odor of overheated insulation emanating from the Controller for the Unit 2 Hydrogen Recombiner, and de-energized the unit. The Unit 2 Hydrogen Recombiner was declared inoperable at 10:00 a.m., placing both Unit 1 and Unit 2 in the Action Statement of Technical Specification 3.8.8.B.3. In accordance with the Zion Annex of the GSEP (Generating Station's Emergency Plan), an unusual event was declared. Notification of the Unusual Event was made via the Emergency Notification System at 10:30 a.m. The cause of the failure of the Unit 2 Hydrogen Recombiner was determined to be a high resistance connection in the power supply cabinet caused by loose lugs. The lugs were tightened and PT-15C recommenced at 10:20 a.m. The PT was satisfactorily completed and the Unit 2 Hydrogen Recombiner declared operable at 11:30 a.m. The Unusual Event was terminated at 12:00 noon. Neither Unit 1 nor Unit 2 commenced power ramp-down.

The cause of the failure of the Unit 1 Hydrogen Recombiner was identified as a pressure controller which was removed for maintenance. The recombiner was repaired and successfully passed PT-15C, at 4:15 a.m. on December 29, 1982.

No items of noncompliance or deviations were identified.

10. Unit 2 Shutdown Due to Two Degraded ESF Busses

At approximately 9:55 a.m. on January 14, 1983, the normal 4KV supply breaker to ESF Bus 247 tripped open. The 0 Diesel Generator started and came up to speed but did not close onto the bus. Operators were unable to close the normal, reserve, or diesel generator feeder breakers from the control board. Since the 2A Diesel Generator was already out of service for maintenance, the unit was in a condition requiring immediate shutdown per Technical Specifications. An unusual Event was declared and operators commenced a power ramp down at 0.25%/min. The loss of Bus 247 resulted in loss of power to the solenoid valves controlling the instrument air isolation valves for the Unit 2 containment. Since the isolation valves fail closed, all instrument air was lost to the valves inside containment. Both normal and excess let-down were, therefore, unavailable and pressurizer level began to increase. The ramp down was halted until plant conditions could be stabilized. It was determined that the trip of the normal feeder breaker and lockout of all feeder breakers to Bus 247 was caused by a false phase C overcurrent signal from a protective device in the reserve feeder breaker. The reserve breaker was racked out and the overcurrent relay was reset. Operators then attempted to re-close the normal feeder breaker but the 0 Diesel Generator breaker closed instead. The Diesel Generator was then paralleled with normal power and the normal feeder breaker closed. The Diesel Generator was unloaded and its breaker opened with Bus 247 energized via its normal feed. The power ramp down was resumed. Meanwhile, mechanics ground checked the reserve feeder bus, the reserve feeder breaker, and the over current circuitry. They also checked the operation of the over current device and the overcurrent transformers. All checks were satisfactory.

At 1:20 p.m. the same day the normal feeder breaker to Bus 247 was opened and the reserve feeder breaker closed to demonstrate the operability of the reserve power supply. Operators then attempted to open the reserve feeder breaker but were unable to do so from the control room. The reserve power had to be removed by tripping the bus 141 breaker, and tripping the reserve feeder breaker locally. The 0 Diesel Generator did not close in on the dead Bus 247 as it should have. When operators attempted to close the normal feeder breaker the 0 Diesel Generator breaker closed instead. The 0 Diesel Generator was paralleled with the normal Bus 247 power supply and the normal feeder breaker closed. The 247 Bus was separated from the diesel and the ramp down rate increased. The Unit was subcritical at 2:05 a.m. the same day and the Unusual Event was terminated.

The Licensee's investigation determined the following:

- a. The initial trip of the normal power supply to Bus 247 was caused by contacts in the Phase C overcurrent relay being too narrowly gapped. The gap was small enough that the contacts were closing spuriously giving a false over current indication. This activated lockouts which prevented any of the three power supplies (normal, reserve, and emergency diesel generator) from closing onto the bus.

- b. An improperly installed fuse block in the reserve feeder breaker trip circuitry prevented the reserve feeder breaker from tripping when the O Diesel Generator achieved rated speed and voltage. This also prevented remote tripping of the reserve feeder breaker.
- c. Operators had placed the O Diesel Generator in and out of pull-to-lock during the initial sequence of events and also during the second attempt to restore reserve power. This activated "anti-pump" circuitry which resulted in the closing of the O Diesel Generator breaker when they attempted to close the normal feeder breaker.

In addition to correcting the deficiencies on the over current contacts and fuse block noted above, the licensee has taken the following corrective actions:

- a. Portions of TSS-15.6.37 breaker interlock test were performed to verify proper operation of the subject breakers after the deficiencies were corrected.
- b. Inputs to lectures and required reading for operator training on effects of placing the breakers in pull-to-lock have been made.
- c. A work request was initiated to clearly mark fuse blocks prevent improper installation.
- d. The licensee has examined contact gaps of related equipment to ensure that they were properly adjusted.

Following the return to service of the 2A Diesel Generator, the correction of the contact and fuse block deficiencies, and the completion of TSS.15.6.37, Unit 2 was made critical at 9:25 a.m. and tied to the grid at 12:17 p.m. January 15, 1983.

No items of noncompliance or deficiencies were identified.

11. Response to Report of Malfunctioning Nbfd Relays

In response to reports of nonconservative failures of safety related Nbfd relays at Point Beach Nuclear Power Plant, the licensee surveyed the installed and stored Nbfd relays to ascertain if any of the affected Lot 8203 existed at Zion Station. Fourteen were found in storage and five were found installed in the Unit 1 reactor protection system. The defect reported at Point Beach station involves an improper epoxy resin mixture that melts when the relay is energized. The epoxy can flow into the relay mechanisms and cause the relay to stick in its energized position. Hold tags were placed on the fourteen Lot 8203 relays found in stores pending receipt and implementation of testing instructions from Westinghouse. The five installed Lot 8203 relays were inspected and no signs of deterioration were found. These relays are installed in the Unit 1 reactor protection system and are continuously energized. Records indicate that the 5 relays were installed during the 1982 refueling outage and have been energized in excess of 3000 hours. Seven monthly surveillance tests of the reactor protection system have

been performed satisfactorily with the Lot 8203 relays installed. The licensee's position is that if the subject relays were made with the improper epoxy resin mixture the melting problem would have manifested itself within the first few hours of energization. Westinghouse concurs with this position. Additionally the licensee plans to manually exercise these relays when they are de-energized during surveillance testing. Any relays that exhibit stickiness or are slow to operate will be replaced.

No items of noncompliance or deviations were identified.

12. Defective ITT Barton Electronic Transmitters

In accordance with 10CFR Part 21, ITT Barton notified the NRC on October 29, 1982, of a potential defect in certain electronic pressure transmitters supplied to both the licensee and to Westinghouse (among others), which manifests itself in the form of thermal nonrepeatability. The licensee has determined that none of the suspect transmitters were supplied directly to this site by the vendor. Westinghouse, in conjunction with the vendor, is currently determining the location of suspect transmitters distributed by them.

This item remains open pending identification and resolution of required corrective action (50-295/82-28-01, 50-304/82-25-01).

No items of noncompliance or deviations were identified.

13. Maintenance on Safety Related Components

During the inspection period the inspectors examined the licensee's practices regarding the use of procedures for performing maintenance on safety related components. Technical Specifications Section 6.2.A requires detailed approved procedures for maintenance operations which could have an effect on the safety of the facility. Per the licensee's Maintenance Department Administrative Instruction MDAI-O and conversations with the Assistant Superintendent for Maintenance, work on safety related components may be performed with or without a detailed, station approved procedure depending on the complexity of the job and whether the job is within the craft capability. In either case all work is performed under a work request which ensures proper isolation is established, documents authorization from the operations section, and provides re-test instructions. The concept of craft capability is used throughout the Commonwealth Edison nuclear plants and is recognized in Regulatory Guide 1.33. However, no written guidance exists at Zion Station for what type maintenance falls within craft capability. The inspectors will continue to monitor the licensee's use of detailed approved procedures for the performance of various maintenance operations.

No items of noncompliance or deviations were identified.

14. Safety Related Equipment Failures of Indeterminate Cause

Occasionally during operation or routine surveillance testing, a component will fail to function or its power supply breaker will trip for no apparent reason. Such cases where the trip or failure to operate is not repeatable and trouble shooting reveals no apparent cause are termed spurious trips. The inspectors and the licensee agreed that under these circumstances, the following general guidance may be applied when evaluating such occurrences:

A component which exhibits a spurious trip need not be considered inoperable if:

- a. The malfunction is nonrepeatable. The component must start and operate properly on subsequent attempts, and
- b. The cause of the trip or failure cannot be determined. A reasonable effort must be expended to determine and correct the cause of the trip, and
- c. The component passes a full surveillance test subsequent to the trip. If a component experiences a spurious trip during a surveillance test the entire test must be repeated satisfactorily, and
- d. The component does not have a history of spurious trips. The spurious trip must be an isolated event.

The particular circumstances surrounding a spurious trip should also be considered when evaluating the equipment operability.

No items of noncompliance or deviations were identified.

15. Review of Plant Operations

During the months of January 1982 through January 1983 the inspector reviewed the following activities:

a. Review and Audits

On September 16 and 23 and December 3, 1982, the inspector sat in on an onsite review committee meeting. The inspector verified that provisions of Technical Specifications dealing with membership, review process, frequency, and qualifications were met. The inspector also verified that decisions made were reflected in the meeting minutes and that corrective actions proposed were taken.

On December 6, 1982, the inspector attended an exit meeting conducted by the licensee's offsite audit team and verified conformance with Technical Specifications and QA procedures.

b. Training

The inspector attended one of the licensee's operator requalification lecture series and verified that lesson plan objectives were met and that training was in accordance with the approved operator requalification program schedule and objectives. The inspector verified by direct questioning of one new, one existing, and one temporary employee that administrative controls and procedures, radiological health and safety, industrial safety, controlled access and security procedures, emergency plan, and quality assurance training were provided as required by the licensee's Technical Specifications; verified by direct questioning of one craftsman and one technician that on-the-job training, formal technical training commensurate with job classification, and fire fighting training were provided.

c. Environmental Protection

The inspector verified the installation and operability of an environmental monitoring station and associated equipment and reviewed records for completeness and accuracy.

d. Security

The inspectors observed that 3 individuals achieved acceptable scores during the conduct of weapons and physical fitness tests.

e. Emergency Preparedness

The inspector visited the newly constructed Emergency Offsite facility. The inspector also observed an emergency drill and verified that the licensee has a program for correcting identified discrepancies and that disrupted equipment was returned to its proper location after the drill.

f. Licensee Action Concerning Identified Problems

The inspector reviewed corrective actions taken by the licensee pertaining to recurring failures and resolution of identified discrepancies involving safety-related components.

No items of noncompliance or deviations were identified.

16. Audit Program Implementation

The inspector examined audit records for the period January through December 1982 to verify compliance of the audit program with Technical Specifications, other regulatory requirements and site-specific instructions. Included in this review was examination of: audit report content, applicability and clarity, qualification level of persons performing audits, compliance with applicable requirements for frequency of audit conduct, timeliness and appropriateness of follow-up action by the licensee in response to audit findings.

No items of noncompliance or deviations were identified.

17. Onsite Review Committee

The inspector examined the onsite review functions conducted during the period from September through December 1982 to verify conformance with Technical Specifications and other regulatory requirements. This review included: changes since the previous inspection in the charter and/or administrative procedures governing review group activities; review group membership and qualifications; review group meeting frequency and quorum; and, activities reviewed by the committee including proposed Technical Specification changes, noncompliance items and corrective action, proposed facility and procedure changes and proposed tests and experiments conducted per 10 CFR 50.59, and others required by Technical Specifications.

No items of noncompliance or deviations were identified.

18. Operational Safety Verification

The inspector observed control room operations, reviewed applicable logs and conducted discussions with control room operators during the months of December 1982 and January 1983. The inspector verified the operability of selected emergency systems, reviewed tagout records and verified proper return to service of affected components. Tours of the auxiliary building and turbine building were conducted to observe plant equipment conditions, including potential fire hazards, fluid leaks, and excessive vibrations and to verify that maintenance requests had been initiated for equipment in need of maintenance. The inspector verified by observation and direct interview, that the physical security plan was being implemented in accordance with the station security plan.

The inspector observed plant housekeeping/cleanliness conditions and verified implementation of radiation protection controls. During the month of December 1982 the inspector walked down the accessible portions of the Residual Heat Removal system to verify operability. The inspector also audited portions of the radioactive waste system controls associated with containment vent operations.

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

No items of noncompliance or deviations were identified.

19. Monthly Maintenance Observations

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 components or systems were removed from service; approvals were obtained prior to initiating the work; activities were accomplished using approved procedures and were inspected as applicable; functional testing and/or calibrations were performed prior to returning components or systems to service; quality control records were maintained; activities were accomplished by qualified personnel; parts and materials used were properly certified; radiological controls were implemented; and, fire prevention controls were implemented.

Work requests were reviewed to determine status of outstanding jobs and to assure that priority is assigned to safety related equipment maintenance which may affect system performance.

The following maintenance activities were observed/reviewed:

2C Containment Spray Pump Diesel Engine Repairs

Following completion of maintenance on the 2C Containment Spray Pump and the Unit 2 Hydrogen Recombiner, the inspector verified that these systems had been returned to service properly.

No items of noncompliance or deviations were identified.

20. Monthly Surveillance Observation

The inspector observed Technical Specifications required surveillance testing on the 2A, 2B and 2C Containment Spray Pumps and the 0, 2A and 2B Diesel Generators and verified that testing was performed in accordance with adequate procedures, that test instrumentation was calibrated, that limiting conditions for operation were met, that removal and restoration of the affected components were accomplished, that test results conformed with Technical Specifications and procedure requirements and were reviewed by personnel other than the individual directing the test, and that any deficiencies identified during the testing were properly reviewed and resolved by appropriate management personnel.

No items of noncompliance or deviations were identified.

21. Licensee Event Reports 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

<u>LER No.</u>	<u>Description</u>
82-39	Radiation Monitor, PR-7B Failed
82-41	Low Steam Line Pressure Settings Incorrect
82-42	RHR Miniflow Control Valve Switch Failed
82-43	Loss of Heat Tracing on Boric Acid Make up System
82-45	Control Room Make up Charcoal Filter Less than 99% Efficient
82-46	Diaphragm on Crosstie Valve in Boric Acid Pumps Suction Failed
82-47	Loop "C" RTD Cold Leg Failed High (LER Update to be issued)
82-49	Both Hydrogen Recombiners Failed

Unit 2

<u>LER No.</u>	<u>Description</u>
82-29	2C Containment Spray Pump Failed During Monthly Operability Test

Regarding LER 50-295/82-40, this was a special report outlining plans to provide for the loss of fire pump redundancy. The LER stated that the OA fire pump would be in service by the end of 1982. This LER has been revised to indicate a return to service date of March 1, 1983, due to delays in obtaining proper repair parts. This LER will be closed when OA Fire Pump is returned to service.

Regarding LER 50-295/82-44, (Failure of "O" Penetration Pressurization Compressor to Unload), inspection of 1 and 2 Penetration Pressurization Compressors is underway for similar corrosion. This LER will be closed when the additional inspections are complete.

Regarding LER 50-295/82-49 (Failure of both Hydrogen Recombiners), this occurrence is discussed in detail in Paragraph 9.

No items of noncompliance or deviations were identified.

22. IE Circular Followup

For the IE Circulars listed below, the inspector verified that the Circular was received by the licensee management, that a review for applicability was performed, and that if the circular were applicable to the facility, appropriate corrective actions were taken or were scheduled to be taken.

<u>IEC No.</u>	<u>Title</u>
81-12	Inadequate Periodic Test Procedure of PWR Protective System

No items of noncompliance or deviations were identified.

23. Meetings, Offsite Functions

During the inspection period the Resident Inspectors attended the following offsite functions:

F. Dunaway

December 12-19, 1982	Simulator Training	Reactor Training Center Chattanooga, Tennessee
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P. Hartmann

December 19-26, 1982	Simulator Training	Reactor Training Center Chattanooga, Tennessee
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J. R. Waters, F. Dunaway

January 11-12, 1983	Resident Seminar	Region III Headquarters Glen Ellyn, Illinois
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24. Open Items

Open items are matters which have been discussed with the licensee, which will be reviewed further by the inspector, and which involve some action on the part of the NRC or licensee or both. An open item disclosed during the inspection is discussed in Paragraph 12.

25. Exit Interview

The inspector met with licensee representatives (denoted in Paragraph 1) throughout the inspection period and at the conclusion of the inspection on January 17, 1983, and summarized the scope and findings of the inspection activities.

The licensee acknowledged the inspector's comments.