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U. S. NUCLEAR REGULATORY COMMISSION

REGION 1

Report No. 50-334/83-01
Docket No. 50-334
License No. DPR-66 Priority -- Category C
Licensee: Duquesne Light Company
435 Sixth Avenue
Pittsburgh, Pennsylvania
Facility Name: Beaver Valley Power Station, Unit 1
Inspection at: Shippingport, Pennsylvania
Inspection conducted: January 4 - January 31, 1983
Inspector: W. M. Troskoski 2-2-83
W. M. Troskoski, Resident Inspector date signed
J. E. Tripp 2/9/83
for J. J. Lazarus, Project Engineer date signed
Approved by: J. E. Tripp 2/9/83
J. E. Tripp, Chief, Reactor Projects date signed
Section No. 2A, Reactor Projects
Branch 2

Inspection Summary: Inspection on January 4 - January 31, 1983 (Inspection No. 50-334/83-01).

Areas Inspected: Routine inspections by the resident inspector (99 hours) and a Region-based inspector (11 hours) of: licensee action on previous inspection findings, plant operations, housekeeping, fire protection, radiological controls, physical security, maintenance activities, surveillance testing, engineered safety features verification, liquid radwaste handling, respiratory protection program, in office and onsite licensee event report followup.

Results: No violations were identified.

DETAILS

1. Persons Contacted

F. Bissert, Manager, Nuclear Support Services
J. Carey, Vice President, Nuclear Division
H. Caldwell, Assistant Station Superintendent
M. Coppola, Superintendent of Technical Services
K. Grada, Superintendent of Licensing and Compliance
R. Hansen, Maintenance Supervisor
H. Harper, Security Assistant
J. Indovina, I&C Supervisor
T. Jones, Manager, Nuclear Operations
J. Kosmal, Radiological Operations Coordinator
W. Lacey, Station Superintendent
V. Linnenbom, Radiochemist
J. Lukehart, Security Director
L. Schad, Operations Supervisor
E. Schnell, Radcon Supervisor
J. Sieber, Manager, Nuclear Safety and Licensing
R. Swiderski, Superintendent of Nuclear Construction
N. Tonet, Manager, Nuclear Engineering
J. Wenkhous, Reactor Control Chemist
T. Zyra, Plant Performance and Testing Supervisor

The inspector also contacted other licensee employees and contractors during this inspection.

2. Licensee Action on Previously Identified Inspection Findings

The NRC Outstanding Items (OI) List was reviewed with cognizant licensee personnel. Items selected by the inspectors were subsequently reviewed through discussions with licensee personnel, documentation review, and field inspection to determine whether licensee actions specified in the OIs had been satisfactorily completed. The overall status of previously identified inspection findings was reviewed, and planned and completed licensee actions were discussed for those items reported below.

(Closed) Violation (80-02-01): Failure to review and approve NDE procedure prior to its implementation. The licensee response dated March 25, 1980, and subsequent NRC letter dated April 11, 1980, were reviewed. Engineering documentation indicated that the licensee's ISI contractor re-performed the liquid penetrant test on the safe-end weld of loop 2 reactor coolant pipe on April 15, 1980. ISI-11, Liquid Penetrant Examination Procedure, used to perform this inspection was reviewed and approved by the Station Superintendent.

(Closed) Violation (82-22-03): Failure to implement equipment clearance controls. The inspector verified that the affected drawings and status boards were updated to reflect current plant conditions. Through discussions with operational personnel, it was determined that they were aware of equipment clearance program changes as set forth in OM Chapter 48, and that a review of clearance activities is performed on a daily basis. Routine reinspection of this area has determined that the licensee is in compliance with their program.

(Closed) Inspector Follow Item (82-13-03): Verify MSP-1.05, Reactor Protection Logic System Train B Bi-Monthly Test, is revised to ensure that appropriate safety injection blocks are entered during system restoration. The latest completed copy of MSP-1.05 (Revision 20) was reviewed. If reactor coolant pressure is less than 2000 psig, it now requires that the pressurizer low pressure and steam line safety injection blocks be verified prior to returning the system to service by performing a resistance check across the test contacts.

(Closed) Unresolved Item (82-01-11): Revise procedures used to transfer spent resin to include a stop work provision for abnormal conditions (TOP 81-07). The inspector reviewed Radcon procedure 3.7, Transfer of Highly Radioactive Material From Plant Systems to Solid Waste, approved on October 13, 1982. This procedure provides additional guidance to consider when transferring dewatered resin for shipment offsite. A list of specific recommendations that must be reviewed prior to transferring resin with a temporary hose arrangement has eliminated the need to write a Temporary Procedure for each evolution. The stop work provision to evaluate corrective actions if problems are encountered, is now contained in the body of the Radcon Procedure.

(Closed) Unresolved Item (80-27-21): Confirm implementation of Shift Technical Advisor operation assessment function. The inspector reviewed the Technical Advisory Group Administrative Manual and discussed the operational assessment function with several STAs. During the course of the inspection, implementation of the program was observed in the areas of ISI ASME pump and valve data trending, OST review, ESF equipment clearance verification, investigation of operational incidents, safety equipment failure trending, and routine shift technical assistance. Based on those observations, this item is closed.

(Closed) Unresolved Item (80-27-20): Establish policy for implementation of Technical Support Center recommendations for procedure deviations or actions not addressed by an approved procedure during accidents. Such guidance was developed and incorporated into the Emergency Preparedness Plan, Section 5.2.17, Relationship Between Normal and Emergency Organizations. This guidance reiterates the Operation Department's responsibility and authority to take whatever action they consider necessary to prevent personnel injury or damage to the plant or to equipment and to place the plant and equipment in a safe condition in the event that an emergency or casualty situation is not covered by an approved procedure. This includes recommendations by the TSC.

(Closed) Unresolved Item(82-29-01): Determine how the updated pump performance curve of CCR-P-1A was omitted from surveillance test OST 1.15.1. Through discussions with cognizant test personnel, the inspector determined that after completion of the new performance curve, the test results were forwarded to the Onsite Safety Committee for review and approval, and a standard distribution list was prepared to forward the revised curve to the procedures group through the plant mail. This was done in lieu of the old method where a letter copy was hand carried to the cognizant procedure engineer, because the Plant Performance and Test Group relocated to a new building. Apparently, the procedure group never received a copy of the approved revision through the plant mail. To preclude a similar occurrence, future test result reports will also be forwarded to the Technical Services Superintendent for action and tracked via a formal supervisory letter.

(Closed) Unresolved Item (82-29-03): Review the basis for determining operability of hydrogen recombiner 1B. Two separate failures of resistors in the same heater control circuit were reported in LERs 81-105 and 82-56. The first event occurred on December 23, 1981, two days before the licensee entered an extended refueling outage (December 25, 1981, to July 6, 1982), and did not receive prompt attention because that system is not required for plant shutdown conditions. The annual surveillance tests (OST 1.46.2 in conjunction with MSP 46.01B) were successfully completed on June 8, 1982. When the 6 month test (OST 1.46.4) was rerun according to schedule on November 26, 1982, the B hydrogen recombiner heater again failed to reach 700^oF in 90 minutes. The resistors were replaced and the system tested to the TS surveillance requirements. A review of equipment history records indicated that those were the only two failures attributable to that control circuit and that the problem was limited to the B train. The exact cause of the failure could not be readily determined and the licensee has initiated a design change to replace the entire control board with an environmentally qualified one from a different vendor. Because spare parts for that control unit are available on site and are easily replaceable within one-hour in a post-DBA inhabitable area, the inspector had no further concerns regarding the ability of the hydrogen recombiner system to perform its intended safety function. Progression of the design change is Inspector Follow Item (83-01-01).

(Open) Unresolved Item (82-22-05): Verify that control room abnormal procedures are updated. This concern was originally identified in September, 1982 (NRC Inspection Report No. 50-334/82-22). Through discussions with cognizant procedure writers, the inspector determined that though a number of procedures were prepared, none had been forwarded to the Onsite Safety Committee for review and approval. This was further discussed with the Superintendent of Technical Services, who stated that this would be corrected and that the remaining alarm procedures would be examined to place a higher priority on the more significant ones. This item remains open to track the licensee's progress in this area.

3. Plant Operations

a. General

Inspection tours of the plant areas listed below were conducted during both day and night shifts with respect to Technical Specification (TS) compliance, housekeeping and cleanliness, fire protection, radiation control, physical security and plant protection, operational and maintenance administrative controls.

- Control Room
- Primary Auxiliary Building
- Turbine Building
- Service Building
- Main Intake Structure
- Main Steam Valve Room
- Purge Duct Room
- East/West Cable Vaults
- Emergency Diesel Generator Rooms
- Containment Building
- Penetration Areas
- Safeguards Areas
- Various Switchgear Rooms/Cable Spreading Room
- Protected Areas

Acceptance criteria for the above areas include the following:

- BVPS FSAR Appendix A, Technical Specifications (TS)
- BVPS Operating Manual (OM), Chapter 48, Conduct of Operations
- OM 1.48.5, Section D, Jumpers and Lifted Leads
- OM 1.48.6, Clearance Procedures
- OM 1.48.8, Records
- OM 1.48.9, Rules of Practice
- OM Chapter 55A, Periodic Checks - Operating Surveillance Tests
- BVPS Maintenance Manual (MM), Chapter 1, Conduct of Maintenance
- BVPS Radcon Manual (RCM)
- 10 CFR 50.54 (k), Control Room Manning Requirements
- BVPS Site/Station Administrative Procedures (SAP)
- BVPS Physical Security Plan (PSP)
- Inspector Judgement

b. Operations

The inspector toured the Control Room regularly to verify compliance with NRC requirements and facility technical specifications (TS). Direct observations of instrumentation, recorder traces and control panels were made for items important to safety. Included in the reviews are the rod position indicators, nuclear instrumentation systems, radiation monitors, containment pressure and temperature parameters, onsite/offsite emergency power sources, availability of reactor protection systems and proper alignment of engineered safety feature systems. Where an abnormal condition existed (such as out-of-service equipment), adherence to appropriate TS action statements were independently verified. Also, various operation logs and records, including completed surveillance tests, equipment clearance permits in progress, status board maintenance and temporary operating procedures were reviewed on a sampling basis for compliance with technical specifications and those administrative controls listed in paragraph 3a.

During the course of the inspection, discussions were conducted with operators concerning reasons for selected annunciators and knowledge of recent changes to procedures, facility configuration and plant conditions. The inspector verified adherence to approved procedures for ongoing activities observed. Shift turnovers were witnessed and staffing requirements confirmed. Except where noted below, inspector comments or questions resulting from these daily reviews were acceptably resolved by licensee personnel.

- (1) The inspector observed licensee response to an Unusual Event that occurred at about 9:35 a.m., on January 7, 1983. The No. 1 offsite power source (138 KV line) was temporarily lost when a substation timer malfunctioned and caused a differential relay to open oil circuit breaker (OCB) 92. This effectively killed all power to the "A" and "B" 4 KV buses as the alternate supply was unavailable due to the January 1982 failure of the C Unit Station Service Transformer. The reactor tripped from 100% power on a 2 of 3 underfrequency-reactor coolant pump trip. The inspector observed good operator response in stabilizing the transient and bringing the plant to a safe shutdown condition. All systems responded normally with the No. 1 diesel generator picking up the 1 AE emergency bus loads. NRC headquarters was immediately notified of the event via the "hotline" per 10 CFR 50.72. The Unusual Event was terminated at 10:14 a.m. when power was restored.

During the 1-1/2 day outage, the licensee conducted equipment repairs that included a containment entry to trouble shoot an inoperable incore flux detector (A). The inspector verified that the licensee was aware of NRC concerns detailed in IE Information Notice No. 82-51, Overexposures in PWR Cavities, and that appropriate precautions were undertaken. No radiological problems were noted.

Portions of the initial reactor startup were observed until 6:00 p.m. on January 8, 1982. At about 7:00 p.m. the reactor was tripped from a high steam generator level (B S/G) due to sluggish response of the feedwater control system. The inspector was notified of the trip and the reactor restarted at about 8:30 p.m.

The Substations and Shops Department, after Station review and approval, moved OCB 92 breaker protection to the No. 1 138 KV Bus by performing appropriate relay protection changes. This was done because OCB 92 had developed an internal hydraulic oil leak that would prevent its re-closing, should it trip open. Additionally, TOP 83-3, Supplying 1AE Bus from No. 1 Emergency Diesel Generator with Bus 1A and 1B De-energized due to Breaker Failure, was written and approved to provide operations personnel with appropriate guidance for the estimated 8 hour period that it would take to repair OCB 92. These precautions were judged necessary because the alternate supply to Bus 1A and 1B, the C USST, is out of service, and any failure in the No. 1 138 KV line would trip the plant, requiring the No. 1 diesel generator to supply Bus 1 AE emergency loads.

The inspector found the licensee's actions to be correct and timely.

- (2) While obtaining shift log readings, an operator noted low voltage readings on the No. 1 D.C. battery bank charger at about 5:45 a.m. on January 10, 1983. After initial investigation, the licensee performed the D.C. battery surveillance test (OST 1.39.1A) and declare the bank inoperable at 6:30 a.m. when it failed specific gravity and pilot cell voltage acceptance criteria. Technical Specification 3.8.2.3, D.C. Distribution-Operating, requires that the bus be restored to operable status within 2 hours or be in at least Hot Standby within the next 6 hours.

To trouble shoot the low battery charger voltage readings, the shift supervisor isolated the battery bank from 125 V DC bus number 1. This action interrupted DC power to selected solenoid operated valves for less than one minute, resulting in a partial containment isolation and the main feedwater regulator valves failing closed. Steam generator levels dropped from 44% to almost 24% after feedwater flow recovered. The inspector observed operator response to this transient from the control room and noted that actions taken to stabilize the plant were acceptable. No trip occurred.

The inspector discussed this event with the Station Superintendent and expressed a concern that the trouble shooting methodology was inappropriate for the circumstance in that the actions were not pre-planned to evaluate their effect on a safety system. The Station Superintendent acknowledged the inspector's comments and stated that due to the past reliability and complexity of the 125 V DC system, no trouble shooting procedures had been developed and most personnel were unfamiliar with the system. The Station Superintendent further stated that such a procedure would be developed. This is Unresolved Item (83-01-02).

The cause of the low voltage was subsequently determined to be an open in one end of the collector resistor (a variable resistor with two 20 ohm resistors in parallel, shunted at one end) of the battery charger. The resistor was flip-flopped such that the open end was taken out of the circuit. The system was restored to an operable condition at about 10:00 a.m. The inspector reviewed the completed surveillance test and confirmed operability. An apparent discrepancy identified by the licensee between the vendor technical manual (No. 1.24-GSA) and the actual installed value of the collector resistor is currently being reviewed by engineering. This is Inspector Follow Item (83-01-04).

- (3) A second Unusual Event occurred at about 5:00 p.m. on January 14, 1983, when an overvoltage protection relay (59-109) failed, tripping oil circuit breaker 83. This interrupted the No. 2 offsite power source which was acting as a backup supply to "C" and "D" 4 KV buses. Primary supply was being provided from Unit System Service Transformer "D" at the time, and no power interruption was experienced. The Unusual Event was terminated at about 10:00 p.m., after the No. 2 offsite power source had been restored. The relay crew determined that the overvoltage protection relay was making up at a lower test voltage than its setpoint. It has since been replaced.

The inspector was notified of the event in a timely manner to permit onsite followup. NRC headquarters received notification within one hour via the hotline per 10 CFR 50.72. Licensee actions were found to be in compliance with the Emergency Preparedness Program procedures.

c. Plant Security/Physical Protection

Implementation of the Physical Security Plan was observed in the areas listed in paragraph 3a above with regard to the following:

- Protected area barriers were not degraded;
- Isolation zones were clear;
- Persons and packages were checked prior to allowing entry into the Protected Area;
- Vehicles were properly searched and vehicle access to the Protected Area was in accordance with approved procedures;
- Security access controls to Vital Areas were being maintained and that persons in Vital Areas were properly authorized;
- Security posts were adequately manned, equipped, and security personnel were alert and knowledgeable regarding position requirements, and that written procedures were available; and
- Adequate lighting maintained.

No inadequacies were observed.

d. Radiation Controls

Radiation controls, including posting of radiation areas, the conditions of step-off pads, disposal of protective clothing, completion of Radiation Work Permits, compliance with Radiation Work Permits, personnel monitoring devices being worn, cleanliness of work areas, radiation control job coverage, area monitor operability (portable and permanent), area monitor calibration, and personnel frisking procedures were observed on a sampling basis.

While on a tour of the auxiliary building on January 31, 1983, two individuals were observed apparently loitering in a radiation area on top of a divider wall in the solid waste area without anti-Cs on. The inspector discussed this with the Radcon Supervisor in regard to good ALARA practices, and was subsequently informed that one person was a radtech assigned to cover a scheduled job in the vicinity, who should have been in anti-Cs only in case he was needed, while the other was an electrician who had finished his assignment. Background dose levels were measured at several mR/hr. and did not pose a problem. Due to past radiological problems experienced in solid waste, the Radcon Supervisor acknowledged the inspector's concerns and re-emphasized program requirements to the individuals involved.

e. Plant Housekeeping and Fire Protection

Plant housekeeping conditions including general cleanliness conditions and control of material to prevent fire hazards were observed in areas listed in paragraph 3a. Maintenance of fire barriers, fire barrier penetrations, and verification of posted fire watches in these areas were also observed. The general appearance of the plant was good.

4. Maintenance Activities

Portions of various safety-related maintenance activities were observed by the inspector to verify that the activities did not violate a limiting condition for operation, redundant components were operable, required administrative approvals and tagouts were obtained prior to initiating work, approved procedures were used or the activity was within the "skills of the trade", radiological controls were properly implemented where required, ignition/fire prevention controls were appropriate, and the equipment was properly tested prior to returning to service.

The following activities were observed:

1. Overhaul of the 1A River Water Pump per CMP No. 1-30-WR-P-1A-1M. Due to high vibration readings on the motor top hat (about 30 mils), the licensee declared this pump inoperable. The motor was run uncoupled from the pump shaft and the top hat vibration dropped to about 1-2 mils. Maintenance supervision informed the inspector that the pump would be out of service for about 30 days while all parts are taken to the shop and inspected to determine the cause of the high vibrations. The "C" river pump has been aligned to the "A" ESF train while the overhaul progresses. The cause and corrective actions are receiving continued inspector followup.
2. No. 3 Vital Bus Inverter trouble shooting per Technical Manual 1.24-111B, Cyberex, Inc. 20 KVA UPS, on January 14, 1983, (Equipment Clearance No. 486312).
3. Repair of FW-35 flange leak and preventive maintenance for Auxiliary Feedwater Pump 3A, on January 17-18, 1983. The inspector also observed repacking of the pump shaft and successful surveillance testing.

Within the scope of this inspection, no violations were identified and observed licensee activities were determined to be in compliance with applicable administrative controls and requirements detailed in Section 3.a.

5. Engineered Safety Features (ESF) Verification

A. The operability of the 125 V DC system was verified on January 18, 1983, by performing a complete walkdown of all accessible portions that included the following as appropriate:

- (1) System lineup procedures match plant drawings and the as-built configuration.
- (2) Equipment conditions were observed for items which might degrade performance. Hangers and supports are operable.
- (3) The interior of breakers, electrical and instrumentation cabinets were inspected for debris, loose material, jumpers, etc.
- (4) Instrumentation was properly valved in and functioning; and had current calibration dates.
- (5) Valves were verified to be in the proper position with power available. Valve locking mechanisms were checked, when required.
- (6) Technical Specification required surveillance testing was current.

No violations were identified by the inspector. Licensee trouble shooting efforts related to the low battery charger voltage are detailed in paragraph 3.b.2 of this inspection report.

B. Other selected ESF trains were inspected on a weekly basis to verify operability of major flow paths and components. ESF trains so inspected were:

- (1) Auxiliary Feed Water System
- (2) Diesel Generator
- (3) River Water System

Within the scope of these inspections, no deficiencies were identified.

6. Surveillance Activities

Portions of various surveillance tests were observed to verify that: (1) technical specifications test frequencies were met, (2) the procedure was followed, (3) testing was performed by qualified personnel, (4) LCOs were being met, and (5) system restoration was correctly accomplished following the tests. The following activities were witnessed by the inspector:

- (1) OST 1.24.2, Motor Driven Auxiliary Feed Pump (FW-P-3A) Test, performed January 11, 1983.
- (2) OST 1.2.1, Nuclear Power Range Channel Functional Test, performed January 17, 1983.
- (3) MSP 43.26, Radiation Process Monitor, RM-VS 105, Leak Collection Area Gaseous - Calibration, performed January 18, 1983.
- (4) OST 1.1.1, Control Rod Partial Movement Test, performed January 18, 1983.

Additionally, the surveillance test schedule was reviewed for January, 1983, to verify that scheduled tests were performed within the required technical specification frequencies, and that increased ASME XI pump and valve testing was properly logged and performed. The inspector identified no discrepancies in the licensee's surveillance program.

7. Liquid Radwaste Handling

To verify licensee compliance with technical specifications for the release of radioactive liquid waste, the inspector reviewed procedure OM 1.17.4, Liquid Waste System, Revision 4, observed the discharge of a liquid waste tank and reviewed a sampling of Radioactive Waste Discharge Authorizations (RWDA) for previous releases.

- On January 11, 1983, the inspector observed the discharge of tank LW-TK-5A. The release had been authorized under RWDA 02124. The inspector verified that the discharge was performed in accordance with Procedure OM 1.17.4.W, Liquid Waste Discharge to the Cooling Tower Blowdown, including proper recirculation and sampling of the tank, authorization, and dilution flow. The discharge was performed correctly. No violations were identified.

- The inspector reviewed completed RWDA's for previous liquid waste discharges to verify that proper sampling was performed, the appropriate dilution flow established, proper authorization was obtained, and reviews performed. RWDA's 02047-02117 were reviewed, covering the period from October - December, 1982. No inadequacies were identified.
- To verify the proper operation of the continuous radiation monitor in the discharge to the cooling tower blowdown, the inspector reviewed the results of calibration procedure MSP 43.18, Radiation Process Monitor RM-LW-104 Liquid Waste Effluent Calibration, for calibrations performed during 1982. The calibration had been performed quarterly as required. No inadequacies were identified.

8. Respiratory Protection Program

The inspector was approached by several individuals who were concerned about the applicability of NUREG-0041, Manual of Respiratory Protection Against Airborne Radioactive Materials, Section 7.4.3, Periodic Medical Examination, requirements which specify that a physical examination be given to each respirator user before he wears the device and at least annually thereafter. The inspector reviewed the following documents to determine what medical requirements were applicable to the current DLC respiratory protection program.

- 10 CFR 20.103, Exposure of Individuals to Concentrations of Radioactive Materials in Air in Restricted Areas.
- Regulatory Guide 8.15, Acceptable Programs for Respiratory Protection, October, 1976.
- NUREG-0041, Manual of Respiratory Protection Against Airborne Radioactive Materials.
- NRC Letter to Licensees: Medical Surveillance for Respirator Users, March 14, 1978.

The above material was discussed with Region I Health Physics specialists. It was verified that after an initial medical determination, only an annual review of an individual's medical status by a physician was necessary to comply with RG 8.15 regulations (as endorsed by 10 CFR 20) and that the NUREG-0041 item specifying an annual physical is not a program requirement. The inspector had no further questions in this area.

9. In Office Review of Licensee Event Reports (LERs)

The inspector reviewed LERs submitted to the NRC:RI office to verify that the details of the event were clearly reported, including the accuracy of the description of cause and adequacy of corrective action. The inspector determined whether further information was required from the licensee, whether generic implications were indicated, and whether the event warranted onsite followup. The following LERs were reviewed:

- LER 82-54/03L * Continuous chlorination of Circulating Water System in excess of ETS limits.
- LER 82-59/03L * ASME XI test frequency not met for Auxiliary Feed Pump.

* Denotes those reports selected for onsite followup.

10. Onsite LER Followup

The inspector reviewed the licensee's actions for the following LERs:

LER: 82-54: Environmental Technical Specifications 2.3.1, Biocides-(Chlorine), was exceeded on September 23, 1982, when the Circulating Water System was continuously chlorinated over a seven hour period. This exceeded the maximum permitted cumulative period of 2 hours per day. The environmental impact was minimized because maximum free chlorine residual, measured at 0.45 mg/l, did not exceed the ETS daily concentration limit of 0.50 mg/l. This event was not reported to the NRC until December 6, 1982. ETS 5.4 and 5.6.2 require that an LCO violation be reported within 24 hours by telephone, followed within 15 days by a written report. Through discussions with the Chemistry Department and the Shift Technical Advisory Group (responsible for LER investigation), the inspector could not determine that adequate corrective actions had been undertaken addressing ETS reportability requirements. This item remains unresolved (83-01-03) pending review of licensee corrective actions.

LER: 82-59: The B auxiliary feedwater pump failed to meet ASME Section XI acceptance criteria (delta pressure) during performance of its monthly surveillance test on November 8, 1982, placing the pump on a double frequency test schedule. The licensee discovered the missed surveillance test when the pump was due for its next regular monthly test on December 8, 1982. The high delta pressure data was determined to be due to a partially plugged instrument line and the pump was always able to perform its safety function (it was never placed in "pull-to-lock").

The failure to conduct increased frequency ASME Section XI testing, is due to the same root cause reported in LER 82-55, as discussed in NRC Inspection Report No. 50-334/82-29. Since it occurred within the time frame as the previous LER and could not have reasonably been expected to be identified and corrected until actions for LER 82-55 were formulated and put into effect, it is not considered an example of a repetitive problem due to inadequate corrective actions. This item meets the new NRC enforcement guidelines and is considered a licensee identified violation.

Follow up inspector review of this area confirmed implementation of adequate corrective actions whereby the increased ASME testing requirements are being properly logged and scheduled. The licensee is now in compliance with the ASME Section XI Testing Program.

11. Unresolved Items

Unresolved items are matters about which more information is required to determine whether they are acceptable, items of noncompliance or deviations. Two new unresolved items were identified and are discussed in details 3.b and 10. Followup on several previous unresolved items are discussed in Section 2.

12. Exit Interview

Meetings were held with senior facility management periodically during the course of this inspection to discuss the inspection scope and findings. A summary of inspection findings were also provided to the licensee at the conclusion of the report period.