

U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Report No. 50-266/90016(DRP); 50-301/90016(DRP)

Docket No. 50-266; 50-301

License No. DPR-24; DPR-27

Licensee: Wisconsin Electric Company
231 West Michigan
Milwaukee, WI 53201

Facility Name: Point Beach Units 1 and 2

Inspection At: Two Rivers, Wisconsin

Dates: August 1 through September 4, 1990

Inspectors: C. L. Vanderniet
J. Gadzala
A. Dunlop
P. Castleman

Approved By: *I. N. Jackiw*
I. N. Jackiw, Chief
Reactor Projects Section 3A

9-7-90
Date

Inspection Summary

Inspection from August 1 through September 4, 1990, (Reports No. 50-266/90016 (DRP); No. 50-301/90016(DRP))

Areas Inspected: Routine, unannounced inspection by resident inspectors of outstanding items; operational safety; radiological controls; maintenance and surveillance; emergency preparedness; security; engineering and technical support; and safety assessment/quality verification.

Results: During this inspection period, Unit 1 experienced three brief power reductions due to a faulty turbine control circuit card (3.c). Unit 2 operated at full power with only requested load following power reductions. Issues addressed in this inspection report include: Dual Train Single Failure Potential (3.e.); Operator and Technician Overtime Hours (3.f.); Utility Data Institute Report (3.g.); Testing and Maintenance of Check Valves (5.c.); Vital Area Boundary Degradation (7.a.); Security Field Drill (7.b.); Containment Spray Operability (8.a.); and Plant Management Changes (9.c.). One non-cited violation (NCV) was identified and reviewed during this inspection period; excessive use of overtime for operators and technicians without proper authorization (3.f).

9511090078 900907
PDR ADDOCK 05000266
Q PDR

The authorization of overtime in excess of NRC guidelines for operators and technicians engaged in safety related work has shown recent increases. Additionally, control of the authorization process appears to have weakened. The plant has outlined actions it will be taking to reverse any negative trend which may be forming in this area.

A review of the utility's safety related check valve inservice testing and preventive maintenance programs was performed with satisfactory results. The scope of these check valve programs appear to meet the guidance of Generic Letter 89-04.

The licensee determined that containment spray pumps would not have adequate net positive suction head to operate in the containment sump recirculation mode. The licensee's position was that these pumps remained operable but the emergency operating procedures required revision to restrict pump operation while in recirculation mode. The procedure changes were promptly made. The licensee determined that an emergency notification of this event to the NRC was not required, however, a licensee event report will be issued.

DETAILS

1. Persons Contacted (30703)

- *J. W. Boston, President, Wisconsin Electric
- *G. J. Maxfield, Plant Manager
- *T. J. Koehler, General Superintendent - Maintenance
- J. C. Reisenbuechler, Superintendent - Operations
- M. E. Crouch, Superintendent - Maintenance (acting)
- N. L. Hoefert, Superintendent - Instrument & Controls
- W. J. Herrman, Superintendent - Technical Services
- T. L. Fredrichs, Superintendent - Chemistry
- J. J. Bevelacqua, Superintendent - Health Physics
- M. L. Mervine, Superintendent - Training
- *R. D. Seizert, Superintendent - Regulatory & Support Services

Other licensee employees were also contacted including members of the technical and engineering staffs, and reactor and auxiliary operators.

*Denotes the personnel attending the management exit interview for summation of preliminary findings.

2. Licensee Action on Previous Inspection Findings (92701) (92702)

- a. (Closed) Unresolved Item (266/90010-01; 301/90010-01): Inadequate Procedures for Solid Plant Operations.

On May 12, 1990, Unit 1 experienced a low temperature overpressure (LTOP) actuation due to improper filling of the safety injection accumulators. There was no procedure available for filling of accumulators so the evolution was done under the guidance of a job performance measure, a document used in training operators for specific evolutions. This document, however, was written under the premise of normal power operations. It did not address the solid plant condition which existed at the time of this incident.

The licensee has since issued procedure OI-100, "Filling and Draining the SI Accumulators", to provide guidance for the proper filling and draining of these accumulators. The new procedure contains a precaution against filling accumulators while the plant is solid. The initial conditions and main body of the procedure also contain steps to preclude filling accumulators under solid plant conditions. The inspector's review of this procedure produced no further concerns. This item is closed.

- b. (Closed) Unresolved Item (266/90014-01; 301/90014-01): Error in Emergency Core Cooling System (ECCS) Decay Heat Model. On July 12, 1990, Wisconsin Electric was notified by their fuel vendor of an error in the ECCS decay heat model, indicating a potential for failure to comply with the 2200 deg F. peak cladding temperature (PCT) acceptance limit specified in 10 CFR 50.46. Subsequent calculations showed that the PCT acceptance limit would be met by reducing the heat flux peaking factor (F(q)) to 2.40. As short term corrective action, the plant adopted this lower value of F(q) as an

administrative limit. Further calculations by the vendor demonstrated that for the remainder of the current Unit 1 and 2 operating cycles, $F(q)$ will not exceed 2.32 under the existing technical specification band for axial flux offset and rod insertion limits.

Wisconsin Electric issued licensee event report 266/301/90-007, "Error in ECCS Decay Heat Model", describing this issue on August 13, 1990. Their intent is to refine the calculations to allow resumption of the current technical specification limit for $F(q)$ of 2.5. This is necessary to support currently planned future core design changes. The fuel vendor plans to submit the revised calculations to the NRC for review October 15, 1990. This issue will be tracked by LER 266/301/90-007, therefore, this item is closed.

- c. (Closed) Unresolved Item (266/89006-02; 301/89006-02): Emergency Diesel Generator Inspection Procedure and QA Status Inadequacies. During inspection of an emergency diesel generator (EDG), the inspector found a broken bolt on the EDG turbocharger exhaust duct. Further evaluation revealed that this area was not part of scheduled maintenance activities nor were many of the EDG replacement parts considered quality assurance (QA) material.

As part of the licensee's long term QA program upgrade, all EDG replacement parts were designated as QA material and are currently controlled under the QA program. An issue involving use of a different type washer on one of the six turbocharger bolts is under investigation by the licensee under their APL control tracking system. The diesel annual inspection procedure (RMP 43) was changed to include inspection of the turbocharger exhaust duct bolts. The inspector reviewed the revised procedure and discussed the revised quality assurance procedures with the licensee. No further concerns were identified and this item is closed.

- d. (Closed) Open Item (266/89028-01; 301/89027-01): Verification that Previous Commitments Under Confirmatory Orders Have Not Been Unknowingly Compromised. In their response to an NRC request that the licensee address the effectiveness of their commitment tracking system, Wisconsin Electric noted that confirmatory orders without accompanying safety evaluation reports (SERs), such as some of those issued in response to NUREG 0737, may not be effectively tracked. The licensee agreed to review such confirmatory orders to ensure that previous commitments have not been unknowingly compromised.

The licensee has since commenced an upgrade of their commitment tracking program. All commitments which were not accompanied by SERs were reviewed for inclusion in the new tracking program. Additionally, steps in various procedures which were generated as a result of a commitment will be identified as such in the procedure to prevent their inadvertent deletion or alteration during a

procedure change. The inspector requested a brief on the licensee's progress in this area and was informed that all commitments which had not been previously tracked formally, were identified and were being complied with. The inspector was satisfied with the licensee's progress and this item is closed.

3. Plant Operations (71707) (93702)

a. Control Room Observation (71707)

The inspector observed control room operations, reviewed applicable logs and conducted discussions with control room operators during the inspection period. During these discussions and observations, the inspectors ascertained that the operators were alert, cognizant of current plant conditions, attentive to changes in those conditions and took prompt action when appropriate. The inspectors noted that a high degree of professionalism attended all facets of control room operation and that both unit control boards were generally in a 'black board' condition (no non-testing annunciators in alarm condition). A recent exception to this condition is the fuel oil tank level alarm being in the alarm condition due to the temporary controls imposed on the system while the licensee evaluates a seismic modification. Several shift turnovers were also observed and appeared to be handled in a thorough manner.

The inspectors performed walkdowns of the control boards to verify the operability of selected emergency systems, reviewed tagout records and verified proper return to service of affected components.

Wisconsin Electric has formed a committee from their human resources department to review monetary compensation levels for nuclear power department personnel. The committee will attempt to determine how salaries at Point Beach compare with the nuclear industry in general. This committee has also been tasked with reviewing the issue of personnel retention at the plant. This is viewed as a positive first step in addressing recently identified concerns regarding the plant's personnel retention.

b. Facility Tours (71707)

Tours of the primary auxiliary building, turbine hall, gas turbine building, service water building, unit facades, and radioactive waste treatment area were conducted to observe plant equipment conditions, including plant housekeeping/cleanliness conditions, status of fire protection equipment, fluid leaks and excessive vibrations and to verify that maintenance requests had been initiated for equipment in need of maintenance.

During facility tours, inspectors noticed some occasional signs of leakage. All equipment appears to be in good operating condition.

Plant cleanliness appears to be improving from a recent downturn although the radioactive waste treatment area remains marginal.

c. Unit 1 Operational Status (93702)

The unit continued to operate at full power for most of this period with only requested load following power reductions and three brief power reductions resulting from a turbine control system malfunction as discussed below.

On August 16, at 1907, unit 1 experienced an instantaneous load reduction from full power to approximately 85% power. This was immediately followed by an instantaneous power increase of 40MW. After this increase, the turbine control system shifted from automatic to manual control. Operators brought the unit back to full power at 2054 and returned the turbine control system to automatic. Following a review of control room indicators and strip chart recorders, operators felt that the problem was in the turbine electro-hydraulic control (EHC) system. Instrumentation and control (I&C) technicians were called in to troubleshoot.

At 2130 a second instantaneous power reduction to approximately 87% power occurred. Operators quickly responded by taking manual control of the turbine and stopping the reduction. The unit was again returned to full power at 2320. This time, however, the turbine control system was left in manual. I&C personnel evaluated the operation of the turbine control system and verified that the malfunction was in the EHC system. The system was left in manual until August 26, which was the next scheduled power reduction for stop valve testing. The turbine was then taken off line for one and a half hours, the faulty circuit cards were replaced, and the control system was returned to automatic without further incident.

d. Unit 2 Operational Status (93702)

The unit continued to operate at full power during this period with only requested load following power reductions.

e. Dual Train Single Failure Potential (71707)

On August 9, the inspector noted a possibility that both trains of safety injection circuitry feed into a common node at the isolation reset switches for the feedwater regulating valve bypass valve. Such a condition could potentially allow both trains of safety injection to fail with only a single fault occurring. The reset switch is a Westinghouse type OT-2 switch. At the inspector's request, the licensee conducted an evaluation of this concern.

The licensee's evaluation determined that the two electrical trains are wired through separate poles which are physically located on opposite sides of the reset switch. This was done in accordance with an alternate wiring plan provided by the switch vendor in lieu of providing separate reset switches for each train. This physical separation is intended to prevent the possibility of an electrical

fault on one train from affecting the other train. The licensee also has surveillance procedures in place which determine the correct position of the switch, including its electrical contacts, periodically and whenever the switch is used. This is intended to assure that the switch returns to its correct position after use and does not fail in mid position. The inspector had no further concerns on this issue.

f. Operator and Technician Overtime Hours (71707)

The inspector conducted a review of hours worked by various operators and technicians to verify compliance with NRC guidelines and procedure PBNP 3.4.4. "Safety Related Work Duration Restrictions". During the current SALP cycle which started April 1, 1989, there were 115 documented approvals for personnel to exceed the 72 hours per 7 days guideline. Most of these occurrences were during maintenance outages.

Several deficiencies were noted in the control of excessive overtime. One individual was found to have exceeded the 24 hours per 48 hours limit during two successive periods without authorization. Five individuals were noted to have exceeded the 72 hours per 7 days limit without authorization. One person was apparently improperly authorized to work 19 hours in a single day. Nine authorization forms for personnel to exceed the 7 day limit were completed after these limits were already exceeded. The forms also never received approval signatures. These deficiencies are contrary to the requirements of procedure PBNP 3.4.4. Additionally, it appears that among the more recent authorization forms, the frequency of blanket authorizations for groups of people to exceed overtime limits has increased. This practice tends to go against the intent of the overtime control procedure. The inspector was concerned about this violation because excessive overtime can lead to fatigue of the personnel involved and a consequent derogatory impact on their performance in safely operating or maintaining the plant.

The inspector presented these findings to the licensee for correction. The plant commenced a review of recent excessive overtime authorizations to determine if an undesirable trend is starting, and if so, to remedy the situation. All forms which were missing approval signatures were presented to the plant manager for belated approval. A memo was drafted to be circulated among the group heads to reemphasize the procedural requirements for control of overtime. The inspector was satisfied with the initial corrective action and the licensee's proposals, therefore, the violation is not being cited because the criteria in Section V.A of the Enforcement Policy were satisfied (266/90016-01; 301/90016-01). This item is closed.

g. Utility Data Institute Report (71707)

Electric industry figures from the Utility Data Institute released in June, show that Point Beach Nuclear Plant (PBNP) was the fourth

lowest cost producer of electricity during 1989 among US nuclear plants. PBNP's cost was 1.23 cents per kilowatt hour.

These reviews and observations were conducted to verify that facility operations were conducted safely and in conformance with requirements established under technical specifications, federal regulations, and administrative procedures.

4. Radiological Controls (71707)

The inspectors routinely observed the licensee's radiological controls and practices during normal plant tours and the inspection of work activities. Inspection in this area includes direct observation of the use of Radiation Work Permits (RWPs); normal work practices inside contaminated barriers; maintenance of radiological barriers and signs; and health physics (HP) activities regarding monitoring, sampling, and surveying. The inspector also observed portions of the radioactive waste system controls associated with radwaste processing.

From a radiological standpoint the plant is in good condition, allowing access to most sections of the facility. During tours of the facility, the inspectors noted that barriers and signs also were in good condition. When minor discrepancies were identified, the HP staff quickly responded to correct any problems.

All activities were conducted in a satisfactory manner during this inspection period.

5. Maintenance/Surveillance Observation (62703) (61726) (73756)

a. Maintenance (62703)

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.

Portions of the following maintenance activities were observed/reviewed:

- 1DY01 instrument bus inverter inspection/refurbishment (RMP 36)
- 2P2C charging pump brush inspection
- G02 emergency diesel generator annual inspection (RMP 43)

b. Surveillance (61726)

The inspector observed surveillance testing 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.

The inspector witnessed and reviewed the following test activities:

- RMP 110 (Revision 1) G01 Redundant Systems Check

No discrepancies were noted during the observance of any of the above tests.

c. Testing and Maintenance of Check Valves (73756)

The inspector evaluated the licensee's program for testing and maintaining check valves in safety related systems per E. G. Greenman memorandum dated April 9, 1990. The purpose was to: (1) evaluate the licensee's program in order to identify early indication of programmatic weaknesses, poor test and maintenance histories, and general assessment of the check valve operability and reliability program; and (2) provide early notification to the Region and Headquarters of program weaknesses which may warrant special inspections.

The licensee's present 10 year inservice testing (IST) interval expires at the end of 1990. The program is being updated and is expected to be submitted to the NRC later this year. The program will incorporate the guidance issued in Generic Letter 89-04, "Guidance on Developing Acceptable Inservice Testing Programs." The licensee is reviewing their present program to verify that it agrees with the guidance positions in Generic Letter (GL) 89-04 for the testing of check valves or determine what aspects of the program need revision. The licensee also intends to look at other valves not included in the present IST program to determine if they should be included. GL 89-04 guidance positions include full flow testing, disassembly and inspection with partial flow testing, pressure isolation valve testing, and seat leak testing.

The inspector reviewed a draft of the licensee's review process for updating the IST program. Check valves included in the present IST program were identified and the following information obtained for each valve: system, valve number, manufacturer, valve type and size, design flow rate, required accident flow rate, valve function, normal and safety related positions, effect on valve leakage, flow and valve position indication (if available), existing and required testing, and proposed changes or additional actions. These valves are from the following system: residual heat removal, safety injection, containment spray, auxiliary feedwater, service water, instrument air, diesel air start, component cooling, chemical and volume control, reactor coolant, service air, and main steam.

The inspector reviewed several test procedures that are used to verify full flow, partial flow, and seat leak testing. Some of these procedures were considered adequate as written, but others require changes to include required flow rate specifications for flow testing and acceptable leak rates for seat leak testing. These changes will ensure that acceptance criteria are verified during full flow and seat leakage testing.

The licensee is pursuing implementation of a comprehensive check valve preventive maintenance (CVPM) program. Aspects of the program include: measurement and evaluation of wearing parts, nonintrusive monitoring, periodic disassembly and inspection, a check valve data base, valve specific procedures, and trending of measurement data. Some aspects have been routinely performed in the past and others are now being incorporated into the program. The licensee will maintain this information in a computer data base. This information will be incorporated into their data retrieval "CHAMPS" system. The licensee also does root cause analysis on check valve failures in order to prevent their recurrence. This process has identified some cases where valve designs changes were needed to improve performance.

Draft copies of the CVPM program and the General Inspection of Swing and Tilting Disc Check Valve procedure were reviewed. The licensee appears to be on schedule for implementing a good program for check valve maintenance. The inspector also reviewed several maintenance work orders for valve inspection and part replacement and a root cause analysis. The licensee appears to be implementing the aspects of the program reviewed by the inspector.

The scope of the licensee's updated IST and CVPM programs for check valves appears to meet the guidance established by GL 89-04, although their review and approval of these programs is not yet complete. The inspector concluded that the proposed programs are adequate. Further inspection in this area is not deemed warranted until after the programs have been fully implemented and the plant has settled into the routine of operating under the guidance of these new programs.

6. Emergency Preparedness (71707)

An inspection of emergency preparedness activities was performed to assess the licensee's implementation of the site emergency plan and implementing procedures. The inspection included monthly review and tour of emergency facilities and equipment, discussions with licensee staff, and a review of selected procedures.

All activities were conducted in a satisfactory manner during this inspection period.

7. Security (71707)

The inspector, by direct observation and interview, verified that physical security activities were being conducted in accordance with the station security plan. This included checks that identification badges were properly displayed, vital areas were locked and alarmed, and personnel and packages entering the protected area were appropriately searched. The inspector also monitored any compensatory measures that may have been enacted by the licensee.

a. Vital Area Boundary Degradation (71707)

On August 11, the licensee notified the NRC via the Emergency Notification System that a loose piece of sheet metal could have potentially allowed access to a vital area. No adverse consequences occurred as a result of this degradation. The area was compensated upon its discovery, and the problem was subsequently corrected. The inspector observed the area in question and discussed the corrective actions with the licensee. No further concerns were noted.

b. Security Field Drill (71707)

The site conducted a security field drill on August 18 in conjunction with the Manitowoc County Sheriff Department and the state office of the FBI. This exercise, which was unannounced to the site participants, was directed and evaluated by the licensee and monitored by the inspector. The exercise objectives were met and the inspector had no concerns.

All other activities were conducted in a satisfactory manner during this inspection period.

8. Engineering and Technical Support (71707)

The inspector evaluated licensee engineering and technical support activities to determine their involvement and support of facility operations. This was accomplished during the course of routine evaluation of facility events and concerns through direct observation of activities and discussions with engineering personnel.

a. Containment Spray Operability (71707)

On August 29, while evaluating a minor degradation in Residual Heat Removal (RHR) pump discharge head that was observed during testing in May 1990, the licensee discovered that the containment spray (CS) pumps did not have adequate net positive suction head (NPSH) to operate while in the containment sump recirculation mode. In this mode, the RHR pumps take a suction on the containment sump and discharge to the suction of both the CS pumps and the high head safety injection (SI) pumps. With both CS and SI pumps running, the RHR pumps supply inadequate NPSH for the CS pumps unless containment pressure is greater than 50 psig. If only the CS pumps are running, containment pressure must still be greater than 10 psig for the RHR pumps to supply adequate NPSH. The SI pumps are of a different type and have adequate NPSH under all anticipated conditions. The CS pumps have adequate NPSH to operate only during the injection phase, when refueling water storage tank level is greater than 6%. During the recirculation phase, the higher temperature of the water being pumped coupled with the large head losses incurred in the piping between the RHR and CS pumps, deprive the CS pumps of adequate NPSH.

The licensee performed an operability evaluation and determined that the CS pumps are operable, but the emergency operation procedures (EOPs) required change to prevent damage to these pumps. The EOPs have always called for operation of the CS pumps following a large break loss of coolant accident (LOCA) during the injection phase. The operators were previously given the option of running the CS pumps as necessary during the recirculation phase. The licensee's evaluation shows that once sump recirculation mode is called for, containment heat removal can be adequately accomplished by running two of the four containment accident fans. Also, sufficient NaOH is sprayed into containment during the injection phase for elemental iodine absorption considerations. Therefore, the CS pumps are not needed after completion of the injection phase.

The licensee issued an emergency night order alerting operators to this condition and directing that CS pumps not be operated during sump recirculation mode unless containment pressure is greater than 10 psig or 50 psig as appropriate for the existent equipment lineup. Two EOPs (1.3 & 1.4) were subsequently changed to prevent operation of the CS pumps in the recirculation mode unless containment pressure conditions warranted/allowed such operation. Since the CS pumps remain capable of fulfilling their safety functions, the licensee determined that they remained operable.

The RHR pump degradation which led to this finding is within the allowable tolerance in the safety analysis. The RHR pumps were therefore also determined to be operable.

The inspector monitored and reviewed the licensee's evaluation of this event, and reviewed the emergency orders and changes to the EOPs. No further concerns were identified. The licensee will update the Final Safety Analysis Report to reflect this condition.

The licensee chose not to make an emergency notification of this event, deciding instead to only issue an event report discussing it. The inspector discussed the rationale for this decision with the licensee.

Two NRC Information Notices (IN 87-63 & IN 88-74) on this topic were previously issued because of similar events at other plants. Wisconsin Electric received both notices and is still in the process of evaluating them. The utility recently completed development of computer code to model flow characteristics in piping systems. It was this model that identified the CS NPSH problem while being used to evaluate the RHR pump head degradation. The company plans to use this model to reanalyze the remainder of the emergency core cooling system thereby completing their evaluation of the above information notices.

All activities were conducted in a satisfactory manner during this inspection period.

9. Safety Assessment/Quality Verification (71707) (90712) (92700)

The licensee's quality assurance programs were inspected to assess the implementation and effectiveness of programs associated with management control, verification, and oversight activities. Special consideration was given to issues which may be indicative of overall management involvement in quality matters such as self improvement programs, response to regulatory and industry initiatives, the frequency of management plant tours and control room observations, and management personnel's attendance at technical and planning/scheduling meetings.

a. Licensee Event Report (LER) Review (90712)

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

*266/90-005 Steam Generator Low-Low Level Reactor Trip During Cold Shutdown

On May 10, 1990, an automatic reactor trip signal was generated on Unit 1 during preparations for cold rod drop testing. The reactor was shutdown at the time so no protective actuations occurred. The trip signal occurred when a test cart supplying a dummy test signal to the steam generator level circuitry was inadvertently deenergized. This event is covered in detail in inspection report (266/90010; 301/90010). The licensee has since designed and fabricated a small test module which will plug directly into the test jacks for the instrument channel to be simulated. It is powered by the instrument loop itself, thereby requiring no external power supply. This test module will replace the test cart whose use

is being discontinued. The inspector observed the final stages of bench testing the new test module and discussed its operation and use with the licensee.

*266/90-008 Reactor Coolant System Leakage

This report describes the detection and repair of Unit 1 reactor coolant leaks at the canopy seal weld on control rod drive mechanism I-3 and the upstream weld of the A steam generator drain line isolation valve. The initial leak was first noted July 5, 1990. The plant was shutdown to repair the leak on July 20. During the ensuing containment entry, the leak on the steam generator drain line valve was found. Both leaks were repaired and the unit was brought back on line July 29. This event is covered in detail in inspection report (266/90014; 301/90014). No further concerns were identified during review of the event report.

*266/90-009 Intermediate Range Trip Signal

On July 23, 1990, an automatic reactor trip signal was generated on Unit 1 during routine intermediate range nuclear instrumentation testing. The reactor was shutdown at the time so no protective actuations occurred. The trip signal occurred when a control power fuse for the IRNI circuit failed. The cause of the fuse failure could not be ascertained but was suspected due to age degradation. Details of this event are described in inspection report (266/90014; 301/90014). No further concerns were identified during review of the event report.

b. LER Followup (92700)

The LERs denoted by asterisk above were selected for additional followup. The inspector verified that appropriate corrective action was taken or responsibility was assigned and that continued operation of the facility was conducted in accordance with Technical Specifications and did not constitute an unreviewed safety question as defined in 10 CFR 50.59. Report accuracy, compliance with current reporting requirements and applicability to other site systems and components were also reviewed.

c. Plant Management Changes (71707)

Effective August 1, the superintendent of maintenance was transferred to technical services as the superintendent of that group. The former maintenance assistant, a highly experienced individual, became the acting superintendent of maintenance.

All activities were conducted in a satisfactory manner during this inspection period.

10. Exit Interview (30703)

A verbal summary of preliminary findings was provided to the licensee representatives denoted in Section 1 on September 4, 1990, at the conclusion of the inspection. No written inspection material was provided to the licensee during the inspection.

The likely informational content of the inspection report with regard to documents or processes reviewed during the inspection was also discussed. The licensee did not identify any documents or processes as proprietary.