

U. S. NUCLEAR REGULATORY COMMISSION

REGION III

Report No. 50-440/89002(DRP)

Docket No. 50-440

License No. NPF-58

Licensee: Cleveland Electric Illuminating Company
Post Office Box 5000
Cleveland, OH 44101

Facility Name: Perry Nuclear Power Plant, Unit 1

Inspection At: Perry Site, Perry, Ohio

Inspection Conducted: January 24 through March 9, 1989

Inspectors: P. L. Hiland
G. F. O'Dwyer
R. W. Cooper
J. W. McCormick-Barger

Approved By: M. A. Ring, Chief *M. A. Ring*
Reactor Projects Section 3B

4/3/89
Date

Inspection Summary

Inspection on January 24 through March 9, 1989 (Report No. 50-440/89002(DRP))

Areas Inspected: Routine, unannounced safety inspection by resident inspectors of licensee action on previous inspection findings; refueling activities; operational safety verification; monthly surveillance observation; monthly maintenance observation; of licensee QA program evaluation; QA self assessment evaluation; onsite followup of events; and plant status meeting.

Results: Of the nine areas inspected, one violation was identified in the area of onsite followup of events (Paragraph 9.b.1). That violation concerned inadequate implementation of a surveillance procedure. In addition, one "licensee-identified violation" for which a Notice of Violation was not issued was identified in the area of operational safety verification (Paragraph 4.c). That licensee-identified violation concerned an inadequate tag-out instruction which resulted in the loss of shutdown cooling. One unresolved item was identified in the area of onsite followup of events (Paragraph 9.b.3) which concerned the discovery of inadequate torque on the drywell hold down bolts. All of the above items were receiving management attention.

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DETAILS

1. Persons Contacted

a. Cleveland Electric Illuminating Company (CEI)

- +L. C. Phillips, President, C.E.I.
- +A. Kaplan, Vice President, Nuclear Group
- *M. D. Lyster, General Manager, Perry Plant Operations Department (PPOD)
- *R. A. Stratman, Director, Nuclear Engineering Department (NED)
- +V. K. Higaki, Manager, Outage Planning Section (PPOD)
- *F. R. Stead, Director, Nuclear Support Department (NSD)
- W. R. Kanda, Manager, Instrumentation and Controls Section (PPTD)
- *+S. F. Kensicki, Director, Perry Plant Technical Department (PPTD)
- L. L. Vanderhorst, Radiation Protection Section (PPTD)
- *+R. A. Newkirk, Manager, Licensing and Compliance Section (NSD)
- K. Pech, Manager, Technical Section (PPTD)
- +E. Riley, Director, Nuclear Quality Assurance Department (NQAD)
- G. R. Dunn, Compliance Engineer (NSD)
- T. A. Boss, Supervisor, Quality Audit Unit (NQAD)
- D. J. Takas, Manager, Mechanical Maintenance Quality Section (NQAD)
- +J. G. Cantlin, Refueling Planning Supervisor (PPOD)
- W. Coleman, Manager, Operations Quality Section (NQAD)
- M. W. Gmyrek, Manager, Operations Section (PPOD)

b. U. S. Nuclear Regulatory Commission

- +A. B. Davis, Regional Administrator, RIII
- +E. G. Greenman, Director, Division of Reactor Projects, RIII
- +R. L. Spessard, Director, AEOD
- +R. W. Cooper, II, Chief, Projects Section 3B, RIII
- +S. D. Rubin, Chief, Diagnostic Branch, AEOD
- +T. G. Colburn, Project Manager, NRR
- *+P. L. Hiland, Senior Resident Inspector, RIII
- * G. F. O'Dwyer, Resident Inspector
- J. W. McCormick-Barger, Technical Assistant, RIII

* Denotes those attending the exit meeting held on March 9, 1989.

+ Denotes those attending the February 7, 1989 plant status meeting.

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

Open Items listed below have been closed during this inspection period based on a directive by the Division Director, Division of Reactor Safety, Region III. The decision to close these items was based on the length of time the item had been in existence and the recognition of limited safety significance.

Unit 1
50-440

a. Maintenance and Outage Section Items No.

87016-06 87025-01 87025-02 87025-03 87025-04 87025-05

b. Operational Programs Section Items No.

87005-01 87005-03 87005-04 87005-05

c. Materials and Processes Section Items No.

88900-01

d. Plant Systems Section Items No.

86024-01 87013-01 87013-02 87013-04 87013-06

Unit 2
50-441

e. Maintenance and Outage Section Items No.

82008-04 83024-02 83030-07 83030-08 84999-01

f. Operational Programs Section Items No.

81019-11 83003-BB 85002-EE 85007-EE

g. Materials and Processes Section Items No.

79010-EE 79014-1B 79014-2B 79014-3B 79014-BB 80008-BB
80008-EE 83025-EE 84001-EE 84021-EE 84049-EE 85022-EE

h. Plant Systems Section Items No.

79001-1B 79001-2B 79001-3B 79001-BB 80001-CC 80006-BB
80016-BB 81002-EE 81013-CC 81019-19 82003-PP 82008-10
83001-PP 83002-PP 83006-01 83007-01 83013-EE 83015-EE
83023-EE 83025-01 83028-01 83030-01 83035-01 83035-02
83035-03 84002-BB 84008-01 84007-06 84009-EE 84025-03
84027-EE 84028-EE 84030-EE 84036-PP 84014-EE 84044-EE
85003-EE 85004-EE 85005-EE 85009-EE 85010-EE 85017-EE

No violations or deviations were identified.

3. Refueling Activities (60710)

During the report period, the licensee commenced the first refueling outage. The inspectors observed several of the activities conducted during the refueling effort. In particular, the inspectors observed fuel movements from the containment refuel bridge and noted that refuel operations were being performed in accordance with an approved fuel movement check sheet, status of fuel movement was being maintained in the control room, and the SRO in charge of refuel operations was in continuous communication with the main control room.

The inspectors noted that the SROs in charge of refueling were approved to work 12 hour shifts through the duration of refueling activities. While the overtime approval was granted by the appropriate level of plant supervision, the inspectors requested the licensee to reevaluate the extended use of overtime when delays in initial fuel movement extended the scheduled duration. At the conclusion of the report period the licensee was qualifying additional SROs to supplement their refuel personnel and reduce the amount of required overtime.

No violations or deviations were identified.

4. Operational Safety Verification (71707)

The inspectors observed control room operations, reviewed applicable logs, and conducted discussions with control room operators during the inspection period. The inspectors verified the operability of selected emergency systems, reviewed tag-out records and verified tracking of Limiting Conditions for Operation associated with affected components. Tours of the intermediate, auxiliary, reactor, and turbine buildings 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 certain pieces of equipment in need of maintenance. The inspectors observed plant housekeeping/cleanliness conditions and verified implementation of radiation protection controls. These reviews and observations were conducted to verify that facility operations were in conformance with the requirements of Plant Technical Specifications, 10 CFR, and administrative procedures.

During the inspection period an NRC Diagnostic Evaluation Team performed a detailed review of plant activities to provide information to senior NRC management to supplement Systematic Assessment of Licensee Performance (SALP) evaluation, NRC Performance Indicators, and other assessment data. The Team evaluated actions and involvement of licensee management and staff in safe plant operation, the effectiveness of licensee safety improvement programs, and the licensee's determination of root cause(s) of safety performance problems. A detailed report of the Team's findings will be issued by separate correspondence.

- a. On February 2, 1989, at about 6:30 a.m. plant operators responded to radiation alarms in the plant's Off-Gas Building. Upon receipt of an "Alert Alarm" from the Iodine and Gaseous radiation monitors in the Off-Gas Building, plant operators entered Off-Normal Instruction (ONI-D17), "High Radiation Levels Within Plant." At 6:55 a.m., the Shift Supervisor directed that the Turbine Building, Off-Gas Building, and Turbine Power Complex Building be evacuated of unnecessary personnel until the cause for the "Alert Alarms" was identified and appropriate corrective action taken. -

The Shift Supervisor received assistance from additional plant personnel to evaluate the cause for increasing radiation levels. The inspectors monitored support activities being conducted from the Technical Support Center. At about 7:45 a.m. a hold-up line loop seal was discovered to have a low water level. The loop seal was refilled and at about 8:00 a.m. the radiation levels were observed by the inspectors to be decreasing which indicated the low water level in the hold-up line loop seal was the cause for the increased radiation levels. At about 3:00 p.m. normal access was restored to the Turbine Building, Off-Gas Building, and Turbine Power Complex.

- b. On February 14, 1989, the licensee received high radiation alarms in the Turbine Building and Off-Gas Building exhaust system. From monitoring the condenser off-gas loop seal level switches located in the reactor control room, the operators determined that all loop seal water levels appeared to be adequate. However, flows on the condenser off-gas system had lowered about 85 cubic feet per minute (CFM) at the time of the high radiation alarms. Within about one hour of the initial alarms, the prefilter loop seal low level alarm was received and the operator in the field noticed no level on the associated level switch. The operators closed the loop seal isolation valve and condenser off-gas flow returned to normal and area radiation levels began to decrease. The effected buildings were evacuated and the loop seal that had lost its water seal was refilled. The licensee reported that the building airborne contamination levels had not reached levels that would have required respiratory protection and that calculated doses at the site boundary, as a result of the loop seal failure, did not exceed Technical Specification (TS) limits (calculated at less than 2 mrems per year versus a TS limit of 500 mrems per year).

Inspection Report 50-440/88017, Paragraph 4, also discussed loop seal failures at the Perry plant that occurred on and before December 21, 1988, and corrective actions the licensee had taken to resolve those failures. The inspectors noted that the two recent failures were different than the previous failures in that the recent events appeared to have been due to failure of loop seal drain valves to adequately seal resulting in the drain down of the water seals. The previous events had been due to pressure buildup in the system during the switchover from one dessicant dryer bank to the other and associated improper valve operations resulting in the loss of the water seals. As mentioned earlier, Inspection Report

50-440/88017 identified the licensee's corrective actions for the dryer switchover problems.

The licensee informed the inspectors that a work order had been generated to perform maintenance on the loop seal drain valves and the licensee was reviewing the level instrumentation associated with the level switches to determine if more reliable instrumentation could be found to replace the existing equipment.

- c. On March 1, 1989, the licensee experienced a loss of shutdown cooling during the performance of a tag-out. While removing fuses for an approved system tag-out (Tag-Out No. 1-89-557-R2), Residual Heat Removal (RHR) Pump "A" tripped. At the time of occurrence, RHR-A was operating in a shutdown cooling lineup with RHR-B available as the second shutdown cooling mode loop as required by Technical Specification 3.9.11.2.

The tag-out being performed was on the Reactor Core Isolation Cooling System in order to allow commencement of planned work activities during the licensee's refuel outage. Tag-Out No. 1-89-557-R2 instructed that fuses E12-F49 and E12-F50 be removed. When those fuses were removed, RHR-A tripped. The licensee initiated Condition Report (CR) 89-079 to identify the root cause of the inadequate tag-out and to provide corrective actions. Failure of the licensee to provide adequate instructions while performing Tag-Out No. 1-89-557-R2 is a Violation (440/89002-01) of 10 CFR 50, Appendix B, Criterion V which requires in part that activities affecting quality shall be prescribed by documented instructions of a type appropriate to the circumstances. However, based on the prompt identification and appropriate corrective actions taken by the control room operators as discussed below, the inspectors considered this to be a "licensee identified violation" for which a Notice of Violation will not be issued.

Upon loss of the operating RHR-A pump, control room operators directed that fuses E12-F49 and F50 be reinstalled. RHR-A was restored to a shutdown cooling mode lineup about 12 minutes after initial pump trip. The observed temperature rise during that 12 minute interval was about 6 degrees fahrenheit. The inspectors review of actions taken by plant operators and discussion with the on-duty Shift Supervisor indicated that plant operators had followed Off-Normal Instruction (ONI) E12-2, "Loss of Shutdown Cooling;" plant operators were aware of the ongoing tag-out effort which facilitated prompt restoration of RHR-A to a shutdown cooling lineup; the redundant RHR-B pump was available for service as required by Technical Specifications; and ACTION "a." of Technical Specification 3.9.11.2 was complied with (i.e. RHR-A was restored to an operable status within 1 hour). In addition, the inspectors review of ONI-E12-2 noted that instructions had been provided in paragraph 4.2 which detailed the licensee's Alternate Shutdown Cooling methods.

One "licensee identified violation" was identified.

5. Monthly Surveillance Observation (61726)

For the below listed surveillance activities the inspectors verified one or more of the following: testing was performed in accordance with procedures; test instrumentation was calibrated; limiting conditions for operation were met; removal and restoration of the affected components were properly accomplished; 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.

<u>Surveillance Test No.</u>	<u>Activity</u>
SVI-G43-T1307	"Suppression Pool Makeup Timer Channel B Functional/Calibration for 1G43-K2"
SVI-R45-T1326	"Division 3 Diesel Generator Day Tank Fuel Oil Water Test"
SVI-M17-T2001	"Containment Vacuum Instrument Isolation Valve Operability Test"
SVI-C41-T2001	"Standby Liquid Control Pump Valve Operability Test"

In addition to the above reviews, the NRC Diagnostic Evaluation Team reviewed several other surveillance instructions and the surveillance program during this inspection period. These reviews will be documented in the Team's report due out later this year.

No violations or deviations were identified.

6. Monthly Maintenance Observation (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.

One or more of 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 was assigned to safety related equipment maintenance which may affect system performance.

Portions of the following maintenance activities were observed/reviewed:

- a. On February 15, 1989, preventive maintenance of valve G41-F360 on the Fuel Pool Cooling and Cleanup System was performed. The preventive maintenance was performed as documented on Work Order 88-008199. The work package included a controlled copy of Preventive Maintenance Instruction (PMI) 0030, "Maintenance of Limitorque Valve Operators."
- b. On February 17, 1989, corrective maintenance of reactor containment inner personnel airlock door ball valves was performed. The work was performed as documented on Work Order 89-0000853.
- c. On February 24, 1989, corrective maintenance on valve OP42-F0380A on the Emergency Closed Cooling System was performed to adjust the limit switches for the full closed position. The work was performed as documented on work order 89-000732.

In addition to the work observations identified above, the NRC Diagnostic Evaluation Team observed several maintenance activities during this inspection period including the replacement of relief valves on the Division I Emergency Diesel Generator starting air system, repair of the diesel generator ventilation vent louver seals, replacement of the reactor containment inner personnel airlock door seal, and the attempted repair of the main steam leak off valve. The results of the Diagnostic Evaluations reviews will be documented in a report to be issued later this year.

7. Evaluation of Licensee Quality Assurance Program Implementation (35502)

In preparation for the onsite observation portion of the NRC's Diagnostic Evaluation Team (DET) inspection conducted February 13 through March 10, 1989, the Quality Programs evaluator performed an in-office evaluation of previous NRC inspection reports, SALP reports, licensee corrective actions for NRC inspection findings and Licensee Event

Reports. The evaluator determined that based on the above review, no significant Quality Assurance related deficiencies were apparent. However, due to poor operational performance during early 1988, and numerous equipment failures and/or problems, the DET was conducted and included an onsite review of the licensee's Quality Programs as part of its overall licensee's performance evaluation. That evaluation will be documented in an NRC Headquarters report and made available to the licensee and the public at a later date. The in-office review of information described above meets the requirements of NRC Inspection Manual 35502, "Evaluation of Licensee Quality Assurance Program Implementation."

No violation of NRC requirements was identified.

8. Quality Assurance Self Assessment (40500)

During the report period, the inspector reviewed the licensee's January 31, 1989, draft report on the Quarterly Assessment of Quality Program Effectiveness for the fourth quarter of 1988. The inspector also observed the deliberations of the group charged with the assessment of each functional area and the process by which the ratings are assigned.

The licensee performed a quarterly self assessment of the implementation, adequacy, and effectiveness of the Quality Assurance Program. The evaluation process attempted to provide an objective, comprehensive, and consistent assessment of all aspects of Perry Plant Operations related to safety and reliability and covers the same functional areas as the NRC's Systematic Assessment of Licensee Performance (SALP). Ratings assigned to each functional area were based on performance information and observations compiled over the quarter, such as Monthly Performance Report Indicators, Quality Assurance audits and surveillances, Independent Safety Engineering Group (SEG) assessments, Licensee Event Reports (LERs), Condition Reports (CRs), evaluations and findings from outside organizations, etc. Ratings were both qualitative and quantitative judgments and could have been either Excellent, Good, or Satisfactory. A rating of Excellent indicated superior performance; a rating of Good indicated that performance was adequate; a rating of Satisfactory indicated that performance improvement was needed.

As of the third quarter of 1988, the licensee revised the assessment process to align the program functional areas to those of the NRC's SALP program. In addition, the licensee's Nuclear Quality Assurance Department had recently reorganized to provide QA supervisors, each of whose groups was responsible for audit and surveillance activities in one of the QA assessment functional areas. In this manner, all functional areas were to have a dedicated QA staff to ensure that continuous coverage of each functional area is maintained. These two recent changes caused the QA quarterly assessment program to be in a transitory state. Notwithstanding, the inspector had the following observations relative to the overall process for arriving at functional area ratings:

- ° The draft Quarterly Assessment report listed factual performance information pertinent to each functional area for the particular quarter being assessed. There was no attempt to assimilate the information before the group deliberations occurred to provide an understanding of the relative and overall significance that the information had on the performance in a given functional area. The lack of utilization of assessment criteria caused the deliberations to be unfocused and resulted in inconsistent approaches to arriving at functional area ratings.
- ° The lack of procedural guidance to characterize and categorize items into particular functional areas caused extended discussions relative to the assignment of certain activities to particular functional areas.
- ° Because the assessments were performed on a quarterly basis, a sufficient amount of information relative to the elements that

define each functional area may not have been available, causing the basis for a rating to be shallow.

For example, the performance elements that described the Engineering and Technical Support area included engineering and technical support for operations, outages, maintenance, testing and surveillance. Although this was a significant element by which performance in this area should have been judged, there was no information accrued over the quarter that related to this element. Thus, the rating given to this functional area may not have been truly representative of the performance of the engineering and technical support organization in the significant facet of support to plant organizations.

Another example of this problem concerned the Operations functional area. Information regarding operator performance in responding to alarms/annunciators, compliance with procedures, communications between Operations and other plant organizations, effectiveness of management policy and direction to operators, and differential crew performance was not available for the fourth quarter 1988 and, thus, was not considered in the determination of the rating in that functional area.

The licensee believed that the recent realignment of the Operations Quality Assurance organization to dedicate specific groups to monitoring and assessing performance in each functional area will result in an improvement in the attainment of significant performance information over each quarterly period such that the basis for making rating determinations will be more representative of actual functional area performance.

No violations or deviations were identified.

9. Onsite Followup of Events at Operating Power Reactors (93702)

a. General

The inspectors performed onsite followup activities for events which occurred during the inspection period. Followup inspection included one or more of the following: reviews of operating logs, procedures, condition reports; direct observation of licensee actions; and interviews of licensee personnel. For each event, the inspectors reviewed one or more of the following: the sequence of actions; the functioning of safety systems required by plant conditions; licensee actions to verify consistency with plant procedures and license conditions; and verification of the nature of the event. Additionally, in some cases, the inspectors verified that licensee investigation had identified root causes of equipment malfunctions and/or personnel errors and were taking or had taken appropriate corrective actions. Details of the events and licensee corrective actions noted during the inspectors' followup are provided in paragraph b. below.

b. Details

(1) Reactor Core Isolation Cooling System Containment Isolation (Event # 14513)

On January 16, 1989, at 9:05 p.m. the licensee experienced an unexpected containment isolation of the Reactor Core Isolation Cooling (RCIC) system. The cause of this event was a procedural deficiency in Surveillance Instruction (SVI) E31-T5395A, "Residual Heat Removal (RHR)/RCIC Channel Functional For 1E31-N684A." At the time of this event, the reactor plant was in Operational Condition 1 at 70 percent power.

Surveillance Instruction E31-T5395A had been revised in December 1988, in order to allow the conduct of the surveillance activity without placing the RCIC system in a secured status. That surveillance instruction was revised to direct the temporary lifting of wires to prevent the actuation of associated isolation valves during test activities. However, due to personnel error during the revision process, the incorrect wires were designated in the revised instruction. As a result of that error, when the surveillance was performed, initiation of the test signal closed the RCIC outboard isolation valve.

The licensee initiated Condition Report (CR) 89-026 to provide documentation of the root cause for this event and to provide corrective action. During the inspectors review of the event and discussions with the licensee, it was noted that control room operators had not identified the RCIC isolation in a timely manner. When the isolation occurred at 9:05 p.m., an "RCIC Out of Service" annunciator was alarmed in the control room. The control room operators had not recognized that alarm until the shift turnover panel walkdown at 10:45 p.m. Technical Specification 6.8.1.a. requires that written procedures shall be established, implemented, and maintained covering surveillance testing (ref.: Regulatory Guide 1.33, Revision 2, dated February 1978, paragraph 8.b.(2)(b)). Failure of the licensee to provide adequate surveillance instructions to perform the Division 1 leak detection isolation logic for high steam flow is a Violation (440/89002-02(DRP)).

The licensee's corrective action for this event was documented in Licensee Event Report 440/89003-00, dated February 10, 1989. As stated in that report, the licensee reviewed six additional RCIC surveillance procedures that had been revised in the same time frame. One additional surveillance (SVI-E31-T0123A) was found to be deficient and it was corrected prior to initial use. The personnel involved in revising the surveillance procedures were counseled regarding the importance of attention to detail. The operating crews were counseled regarding their responsibilities for attention to plant status. As part of the

licensee's Regualification Training Program, this event was to be reviewed by all plant operators with emphasis on verifying system status during conduct of surveillance activities.

Based on the licensee's identification of the root cause for this violation (personnel error); the corrective action completed (both deficient surveillance instructions were properly corrected), and the corrective action taken to prevent recurrence, the inspectors have no further questions on this violation; therefore, a written response to the violation was not required. This item is closed.

(2) Reactor Water Cleanup (RWCU) System Isolation (ENS #14634)

On February 3, 1989, at 1:26 p.m., while reactor power was at 98%, the licensee experienced an unexpected containment isolation (Divisions 1 and 2, outboard and inboard respectively) of the RWCU system due to high differential temperature in the RWCU pump rooms. The high temperature appeared to have resulted from the failure of an ASCO solenoid valve which caused the discharge damper for the "A" exhaust fan of the Intermediate Building Ventilation System (M38) to have failed in an intermediate position and thereby prevented the "A" and "B" exhaust fans from removing enough air out of the pump rooms to maintain a sufficient cooling flow. Operations personnel failed the "A" discharge damper in the closed position which allowed the "B" exhaust fan to re-establish all system flows to normal levels. A plant operator verified locally that there was no leakage in the RWCU pump room. The operators verified that all valves had stroked closed except for the RWCU outboard containment isolation valve, G33-F004, because both of its position indication lights had de-energized. Investigation showed that a small fuse which only fed control room indication had blown. That fuse was replaced and it blew again immediately. The Unit Supervisor ordered the inboard RWCU containment isolation valve, G33-F001, closed and de-energized as required by Technical Specification 3.6.4. The inspectors will review the licensee's root cause analysis and corrective actions as documented in Licensee Event Report 440/89-004.

(3) Drywell Head Bolts Torqued Below Expected Value (ENS# 14849)

On February 24, 1989, with the plant in Operational Condition 4 (COLD SHUTDOWN) and while making preparations for entry into Operational Condition 5 (REFUELING), the licensee discovered the drywell head bolts torqued to a value less than the required 450 to 500 ft.-lbs.

In a Mark III containment design, the drywell is surrounded by the containment structure. During plant operation the drywell head is bolted to the drywell structure and is designed for a maximum internal pressure of 30 psig. The containment structure is designed for a maximum internal pressure of

15 psig. A pressure transient within the drywell is suppressed by the "suppression pool" located in the containment structure and connected to the drywell through horizontal vent piping.

During the preparations for removing the drywell head, the licensee discovered that the 144 head bolts were not torqued to the required value. The licensee initiated Condition Report (CR) 89-065 to document the identified condition and to track the root cause investigation. The licensee notified the NRC operations center of this event via the ENS on February 24, in accordance with 10 CFR 50.72.

At the conclusion of the report period the licensee had not completed their investigation into the root cause of this event. As required by 10 CFR 50.73, the licensee was planning to submit Licensee Event Report 440/89-005 which was to provide the results of their investigation. The subject of drywell head bolt torquing will remain an Unresolved Item (440/89002-03) pending the inspectors review of the licensees' investigation as to the root cause of this event.

(4) Main Steam Isolation Valves Exceed Technical Specification Allowable Leakage Rates (ENS# 14851, 14852 & 14864)

On February 24, 26, and March 3, 1989, with the reactor plant in Operational Condition 4 (COLD SHUTDOWN), the licensee identified excessive leakage through their Main Steam Isolation Valves (MSIV). The test actually checks a group of 4 valves around and including the MSIVs. While performing a required Local Leak Rate Test, the licensee identified that the leakage rates through all 4 Main Steam Lines exceeded the test acceptance criteria of less than 11.8 Standard Liters per Minute (SLM). Repairs to the Main Steam Lines were planned to be performed during the current Refueling outage. The inspectors will review the licensee's root cause investigation and the corrective actions taken.

(5) Initiation Of Control Room Ventilation In the Emergency Recirc Mode

On March 1, 1989, with the reactor plant in Operational Condition 5 (REFUELING), the licensee experienced an unexpected ESF actuation when Train "A" of the control room ventilation system shifted to its emergency recirc mode during restoration from a routine surveillance activity. While performing the restoration steps of Surveillance Instruction (SVI) D17-T0257, "Auto Initiation Of Emergency Recirc," plant technicians depressed an alarm acknowledge button in accordance with the surveillance instruction. That action apparently caused a momentary initiation signal to start the control room ventilation train "A" in the recirc mode. Plant operators restored the control room ventilation system to a normal lineup. The licensee initiated Condition Report (CR) 89-077 to document the event and to track the root cause investigation.

As required by 10 CFR 50.72, the licensee informed the NRC operations center of this event via the ENS on March 1, 1989. The inspectors will review the licensee's investigation into the root cause of this event following their submittal of a Licensee Event Report.

10. Plant Status Meetings (30702)

On February 7, 1989, NRC management met with CEI management at the NRC Regional Office to discuss the current status of the plant, recent events, Refueling Outage preparation and licensee initiatives to improve the quality of plant operating and maintenance activities. These meetings were being held on a periodic (initially monthly) basis.

The licensee discussed plant operations to date and summarized significant events. Included in their discussion, the licensee presented their plans for the first refueling outage that commenced on February 22, and was scheduled to last 89 days.

NRC (RIII) management acknowledged the licensee's status and plans.

11. Unresolved Items

Unresolved items are matters about which more information is required in order to ascertain whether it is an acceptable item, a violation or a deviation. An unresolved item is identified in Paragraph 9.b.3).

12. Violations For Which A "Notice of Violation" Will Not Be Issued

The NRC uses the Notice of Violation as a standard method for formalizing the existence of a violation of a legally binding requirement. However, because the NRC wants to encourage and support licensee's initiatives for self-identification and correction of problems, the NRC will not generally issue a Notice of Violation for a violation that meets the tests of 10 CFR 2, Appendix C, Section V.G. These tests are: (1) the violation was identified by the licensee; (2) the violation would be categorized as Severity Level IV or V; (3) the violation was reported to the NRC, if required; (4) the violation will be corrected, including measures to prevent recurrence, within a reasonable time period; and (5) it was not a violation that could reasonably be expected to have been prevented by the licensee's corrective action for a previous violation. A violation of regulatory requirements identified during the inspection for which a Notice of Violation will not be issued were discussed in Paragraph 4.c.

13. Exit Interviews (30703)

The inspectors met with the licensee representatives denoted in Paragraph 1. throughout the inspection period and on March 9, 1989. The inspectors summarized the scope and results of the inspection and discussed the likely content of the inspection report. The licensee did not indicate that any of the information disclosed during the inspection could be considered proprietary in nature.