

U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Report Nos. 50-454/92012(DRP); 50-455/92012(DRP)

Docket Nos. 50-454; 50-455

License Nos. NPF-37; NPF-66

Licensee: Commonwealth Edison Company
Onus West III
1400 Opus Place
Downers Grove, IL 60515

Facility Name: Byron Station, Units 1 and 2

Inspection At: Byron Site, Byron, Illinois

Inspection Conducted: June 13, 1992 through August 3, 1992

Inspectors: W. J. Kropp
C. H. Brown
D. E. Jones

Approved By: C. P. Patel
C. P. Patel, Acting Chief
Reactor Projects Section 1A

8-6-92
Date

Inspection Summary

Inspection from June 13, 1992 through August 3, 1992 (Report Nos. 50-454/92012(DRP); 50-455/92012(DRP)).

Areas Inspected: Routine, unannounced safety inspection by the resident inspectors of action on previous inspection findings, operational safety verification, onsite event followup, current material condition, housekeeping and plant cleanliness, radiological controls, security, regional requests, licensee event report followup, onsite nuclear safety, maintenance activities, surveillance activities, engineering & technical support, and report review.

Results: Of the fourteen areas inspected, no violations were identified. One unresolved item pertaining to the control of work activities (paragraph 6.a) and two open items pertaining to the planning of surveillances (paragraph 6.b) and the identification of design deficiencies (paragraph 7) were identified. The following is a summary of the licensee's performance during this inspection period.

Plant Operations

The licensee's actions for the hydrogen leak on the Unit 2 Main Generator, and the leaking pressurizer spray valve were considered thorough and conservative. The identification of low level contamination in a vehicle during a site entry

radiological survey was also considered good. Housekeeping and material condition continues to be good for both units. The material condition of the common (Unit 0) equipment has steadily improved. The licensee's performance during this inspection period was considered good.

Safety Assessment/Quality Verification

The LERs reviewed appeared adequate to have appropriate corrective actions to preclude similar events. The shutdown risk assessment performed by the Onsite Nuclear Safety Group was considered good. The licensee's performance in this area continues to be good.

Maintenance and Surveillance

The licensee's performance in the maintenance area continues to be good. The inspectors did identify a concern with the control of work activities. The inspectors identified a concern with the surveillance procedures pertaining to the control room ventilation system. The procedures did not have steps to restore the system after the surveillance. The licensee revised the procedures prior to the conclusion of this inspection to include restoration steps. The inspectors also identified that ineffective planning of surveillances resulted in unnecessary actuation of the control room ventilation system. The generator differential trip of the emergency diesel generator (EDG) that will not be bypassed during an emergency start of the EDG, had not been periodically tested. The relay associated with the trip had been periodically tested to verify the trip of the EDG 4kV trip breaker but not the EDG. In response to the inspectors' concerns in the surveillance area, the licensee has established a procedure usage task force. The licensee's performance in the surveillance area during this inspection was considered good.

Engineering and Technical Support

The licensee's performance in this area during the inspection period was considered good. The licensee's corporate ENC department has initiated steps to implement a program to identify and resolve conditions adverse to quality in the area of engineering and design activities.

DETAILS

1. Persons Contacted

Commonwealth Edison Company (CECo)

- *R. Pleniewicz, Station Manager
- *K. Schwartz, Production Superintendent
- *M. Burgess, Technical Superintendent
- *J. Kudalis, Services Director
- *T. Gierich, Planning
- *D. Brindle, Regulatory Assurance Supervisor
- *J. R. Van Laere, Assistant Technical Staff Supervisor
- *D. Johnson, Instrument Maintenance
- *E. Cremens, Mechanical Maintenance
- *E. Zittle, NRC Coordinator
- *D. Milroy, Engineering Projects
- *R. Bastor, Nuclear Quality Programs
- *D. Hatton, Maintenance Staff
- *W. Dean, Nuclear Safety
- *R. Crosby, Electrical Maintenance

*Denotes those attending the exit interview conducted on August 3, 1992.

The inspectors also had discussions with other licensee employees, including members of the technical and engineering staffs, reactor and auxiliary operators, shift engineers and foremen, and electrical, mechanical and instrument maintenance personnel, and contract security personnel.

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

- a. (Closed) Open Item 454/91024-03; 455/91024-03: System notebook for the AFW system did not contain all necessary information to ascertain the status of the AFW system from day to day. Based on the inspectors concern with the AFW system notebook, the licensee initiated a task force to evaluate the intent, expectations, and effectiveness of the system notebooks. The system notebooks were structured to provide a centralized source of information with detailed instructions on how to access and obtain important information for understanding and controlling the operation of the system. Expectations of enhancements to make the notebooks more effective have been reflected in Tech Staff Memo 900-4. Training has been conducted and will be part of the Tech Staff training program. Continued monitoring of notebook effectiveness will be conducted by Tech Staff supervision. The inspectors have no further concerns in this area.
- b. (Closed) Open Item 454/91026-01; 455/91026-01: Unavailability of the system engineer to perform an inspection of a lube oil cooler resulted in increased outage time of approximately 3 hours for the

2A AFW pump. The inspectors reviewed the following licensee actions:

- The essential service water (SX) system engineer signature has been added to the SSP outage forms which involve Generic Letter 89-13 work. This will give the SX system engineer a full description of all the work being performed and a better idea of when the inspection will take place. The SX engineer will also be included in the post outage review write up for the work. This will be done for the duration of heat exchanger inspections.
- The work will be included on the Tech Staff plan of the day as a priority for that day. This will bring more attention to the outage work.
- The actual versus estimated duration has been reviewed after each outage to identify adverse trends. This review has been included on the SSP form and reasons for prolonged duration noted.

Based on the above actions, the inspectors have no further concerns in this matter.

- c. (Closed) Open Item 454/91029-01: Overpressurization of regenerative waste drain tank (RWDT). The inspectors reviewed Deviation Report 1-92-001 which documented the causes of the event and corrective actions. The licensee identified two causes of the event: (1) an annunciator procedure that did not provide the necessary steps to isolate the RWDT when filling with the release tank pumps, and (2) an RWDT level transmitter out of calibration. The corrective actions included calibration of the RWDT level transmitter and revising the appropriate annunciator procedure to ensure that the RWDT is properly isolated on high tank levels.
- d. (Closed) Open Item 454/91029-02: Slow starting of the 1B diesel driven auxiliary feedwater (AFW) pump. The licensee's troubleshooting identified the problem as a pinhole leak in a fuel line that resulted in a lack of sufficient prime to the fuel injectors. The fuel line was replaced and the 1B AFW pump has started on the first crank for the past several monthly surveillances. The inspectors have no further concerns in this area.
- e. (Closed) Open Item 454/92002-01; 455/92002-01: Would the failure of emergency diesel generator (EDG) essential service (SX) water valves 1(2) SX169A(B) to open be considered a EDG failure per Technical Specification (TS) table 4.8.1? The inspectors reviewed the licensee's response to this question, dated January 9, 1992. The licensee stated that if the EDG SX cooling valve, 1(2) SX 169A(B) failed to open, the surveillance would be failed and the

EDG declared inoperable. If the SX cooling valve can be failed open then the surveillance would be continued providing that acceptance criteria were met. Procedure, BEP.0, "Reactor Trip on Safety Injection", step 15, has an operator dispatched when the EDG starts to verify EDG operability and that the SX 169 valve has opened. Also, a low cooling flow local alarm would actuate if the valve had not opened and appropriate action could be taken by the operator. The UFSAR also states that the EDG has been shop tested under load with the closed cycle cooling functioning but without service water. The EDG was started from a warm standby condition and operated for 20 minutes at an average load of 4000 kW without reaching temperature alarm setpoints. Based on the licensee's response, the inspectors have no further concerns in this area.

- f. (Closed) Unresolved Item 454/92002-02: Inspectors had concerns with control room log entries. Review of log entries since March 1992 have noted no problems. The inspectors have no further concerns in this area.
- g. (Closed) Unresolved Item 454/92006-03: Surveillance procedure 1BIS 6.4.1-003 did not adequately verify operability of check valve, IPS 231A. The licensee was requested to respond in writing to discuss the methods utilized to verify operability of other check valves in systems with air as the process medium opened to the containment atmosphere. The licensee's May 29, 1992 response stated that check valves 1/2 PR002G, H, and 1/2 PR032 receive IST operability tests. None of these valves have a safety function in the open direction that would require a full flow test, such as the one performed for the 1/2 PS231A(B) valves in surveillance 1/2 BIS 6.4.1-002(3). The only IST operability tests required for the 1/2 PR002G,H and 1/2 PR032 valves were backflow and seat leakage tests. Based on the licensee's response, the inspectors have no further concerns in this area.
- h. (Closed) Violation 455/91008-01: Failure to perform a non-routine surveillance resulting from ineffective corrective action from a previous occurrence. The inspectors reviewed the licensee's response to the violation dated June 13, 1991. The licensee's actions included a review of the non-routine surveillance program by the Onsite Nuclear Safety Group. The inspectors have no further concerns in this area.
- i. (Closed) Unresolved Item 455/92002-03: Work packages were not at work site. The licensee planned to revise the appropriate administrative procedures to establish criteria for the control of work packages for maintenance activities performed in containment areas. The inspectors reviewed Maintenance Memo 700-06, Revision 0, "Policy in Work Package Presence at the Job Site" which clearly delineates management's expectations for work packages in a radiologically contaminated area. The inspectors have no further concerns in this area.

- j. (Closed) Open Item 455/92002-04: The Limitations and Actions (L&A) section of surveillance procedure 2BOS 3.2.1-805 needed to be reviewed to ensure that statement 6 in the L&A section was clear as to what operator actions would be required if a component fails to actuate during a surveillance. The inspectors reviewed a proposed revision to statement 6 of the L&A section of procedure 2BOS 3.2.1-805. The proposed revision clarified actions that include the determination of the actual position of slave relay contacts by voltage or resistance readings. Since numerous surveillance procedures that test slave relay operability have the same generic statement as found in procedure 2BOS 3.2.1-805, the licensee plans to have the revised generic statement in applicable procedures prior to the next refueling outage. Based on the revised L&A statement and the licensee's plans in revising the applicable procedures by the next refueling outage, the inspectors have no further concerns in this area.
- k. (Closed) Unresolved Item 455/92006-01: Work was performed outside the scope of surveillance procedure 2BOS 3.2.1.1.a-1. To recover a screw an electrician disconnected contactor lugs from a thermal overload block. After recovering the screw, the electrician failed to reconnect the forward contactor leads. As a result the high head injection valve 2SI 8801A would not open when the Volume Control Tank was attempted to be placed on a float through valve 2SI8801A several days later. The licensee counseled the electrician on proper work scope activities that included disciplinary action and remedial training. The event was also discussed at an Electrical Maintenance Department meeting on March 6, 1992. Based on the licensee's actions the inspectors have no further questions concerning this matter.
- l. (Closed) Unresolved Item 455/92006-02: The replacement of a pressurizer pressure transmitter involved removing a Unistrut without the required torque values for the cap screws in the applicable surveillance procedure, 2BIS 3.1.1-206. The licensee was requested to respond in writing with the results of a review of work performed not addressed by station documents, such as, NWRs or surveillance procedures. The inspectors have reviewed the licensee's May 29, 1992 response. The licensee identified other procedures that were revised to include torquing requirements for conduit supports. The inspectors have no further questions concerning this matter.
- m. (Closed) Open Item 455/92011-03: Review of data of post modification testing on the 2A AFW pump. The licensee had added needle valves to the actuator instrument air supply tubing for valves 2AF004A/B. The suction pressure decreased below the stated acceptance criteria in the post modification test. The residents reviewed the test results and the impact of the suction pressure decrease on potential operability concerns for the 2AFW pump. Based on this review, the inspectors have no further questions in this matter.

3. Plant Operations

Unit 1 operated at power levels up to 100% in the load following mode since January 30, 1992.

Unit 2 operated at power levels up to 100% in the load following mode from June 14, 1992, when the unit was returned to service after a forced outage to repair check valve 2FW079C, to July 18, 1992 when the unit was shut down for a 8 day maintenance outage. The major work during the outage was the repair of the hydrogen leak on the main generator and the repair of pressurizer spray valve, 2RY455C. On July 25, 1992, the unit was returned to service and has operated since in the load following mode up to 100% power.

a. Operational Safety Verification (71707)

The inspectors verified that the facility was being operated in conformance with the licenses and regulatory requirements, and that the licensee's management control system was effectively carrying out its responsibilities for safe operation.

On a sampling basis the inspectors verified proper control room staffing and coordination of plant activities; verified operator adherence with procedures and technical specifications; monitored control room indications for abnormalities; verified that electrical power was available; and observed the frequency of plant and control room visits by station management.

b. Onsite Event Follow-up (93702)

Since the end of the Unit 2 refueling outage on April 30, 1992, main generator hydrogen consumption had been steadily increasing. The licensee performed an investigation and determined that the cause of the leakage was either the hydrogen seals on the exciter end of the main generator and/or the seal's mounting hardware in the generator. The main generator vendor (Westinghouse) was onsite to verify the station's investigation conclusions. To ensure continued safe operation until Unit 2 was shut down on July 18, to repair the leak, the licensee initiated the following steps:

- Or, a two hour frequency, non-licensed operators would monitor seal oil operating parameters to identify any adverse trends. The data was reviewed by the station's system engineers on a routine basis. One of the parameters monitored was the seal oil vapor extractor suction pressure. The excessive hydrogen leakage was located at the exciter

end bearing cavity where the vapor extractor's suction was located. The excessive hydrogen was removed by the vapor extractor to the outside atmosphere through a flame arrestor.

- As compensatory action in case the vapor extractor became inoperable, air movers were placed at the main generator exciter to ensure that hydrogen did not concentrate at an unacceptable level prior to the station taking appropriate action for the inoperable vapor extractor.

c. Current Material Condition (71707)

The inspectors performed general plant as well as selected system and component walkdowns to assess the general and specific material condition of the plant, to verify that Nuclear Work Requests (NWRs) had been initiated for identified equipment problems, and to evaluate housekeeping. Walkdowns included an assessment of the buildings, components, and systems for proper identification and tagging, accessibility, fire and security door integrity, scaffolding, radiological controls, and any unusual conditions. Unusual conditions included but were not limited to water, oil, or other liquids on the floor or equipment; indications of leakage through ceiling, walls or floors; loose insulation; corrosion; excessive noise; unusual temperatures; and abnormal ventilation and lighting. The material condition of both units were considered good based on a low backlog of corrective maintenance and normally dark main control board annunciators.

d. Housekeeping and Plant Cleanliness

The inspectors monitored the status of housekeeping and plant cleanliness for fire protection and protection of safety-related equipment from intrusion of foreign matter. Housekeeping and plant cleanliness was considered very good during this inspection period.

e. Radiological Controls (71707)

The inspectors verified that personnel were following health physics procedures for dosimetry, protective clothing, frisking, posting, etc. and randomly examined radiation protection instrumentation for use, operability, and calibration. A Radiation Occurrence Report was issued by the licensee, on July 20, 1992, as a result of a contaminated van. A contractor van containing equipment for surveying burnable poison rod assemblies for consolidation was found to have low levels (2-3K smearable, and 5K fixed) of contamination during a site entry radiological survey. The van and its contents were decontaminated and released.

f. Security

Each week during routine activities or tours, the inspectors monitored the licensee's security program to ensure that observed actions were being implemented according to the approved security plan. The inspectors noted that persons within the protected area displayed proper photo-identification badges and those individuals requiring escorts were properly escorted. The inspectors also verified that checked vital areas were locked and alarmed. Additionally, the inspectors also observed that personnel and packages entering the protected area were searched by appropriate equipment or by hand.

No violations or deviations were identified.

4. Regional Request (92701)

a. Spent Fuel Pool Storage Control

The inspectors reviewed the licensee's program for the control of storage of equipment or components, other than fuel assemblies, in the spent fuel pool (SFP). The inspectors determined that there was no procedure which governs the storage of items other than fuel assemblies or fuel handling tools in the SFP. However, three procedures pertained to activities in and around the SFP; operation of the fuel handling overhead crane (BFP-FH-20), fuel handling cleanliness zone requirements (BFP-FH-31), and administrative controls during refueling (BAP 370-3). Procedure BAP 370-3 has a relevant statement that prohibits the long term storage of irradiated or activated materials that would pose a radiation hazard above the level of the top of the spent fuel racks. Material stored in the SFP has been placed into containers inside the racks or in the spent fuel cask loading area.

Material and equipment have not been suspended from ropes or cables above the level of the racks; even temporarily. The station utilizes the cleanliness zone long term storage log to track items, other than fuel assemblies, stored in the SFP. The latest log dated July 9, 1992, indicated that there were no items, other than refueling tools, that weighed more than 250 pounds. Refueling tools were stored in holders designed for tool storage. The inspectors toured the SFP area and noted no discrepancies between the log and items presently stored in the SFP.

b. Emergency Diesel Generator (EDG) Unavailability

The inspectors were requested to collect data on EDG unavailability from June 1990 through May 1992. The data furnished to the Region identified the out of service (OOS) date for each of the four EDGs onsite, the status of the unit at the

time of the OOS, the duration of each OOS, the reason for the OOS (preventive maintenance, corrective maintenance or test), and a brief explanation of the work on the EDG.

c. Plant Information

To facilitate compiling information on plants for the purpose of discussion among NRC management, the inspectors were requested to send simplified drawings of major reactor plant systems to the region. The drawings the licensee utilizes in training manuals were transmitted to the Region.

5. Safety Assessment/Quality Verification (40500, 90712, 92700)

a. Licensee Event Report (LER) Follow-up (90712, 92700)

Through direct observations, discussions with licensee personnel, and review of records, the following event reports were reviewed to determine that reportability requirements were fulfilled, that immediate corrective action was accomplished, and that corrective action to prevent recurrence had been or would be accomplished in accordance with Technical Specifications (TS):

(Closed) 454/92003-LL: On May 30, 1992, the licensee identified that a sample was missed which was required with the circulation water blowdown monitor, OPR010J, inoperable. The cause of the missed sample was a cognitive personnel error by a chemistry technician when a sample was obtained from radiation monitor OPR41J, which was operable, instead of OPR010J. The inspectors have reviewed the licensee's corrective actions which appeared appropriate for the cause of the event.

(Closed) 455/92003-LL: Due to the "C" steam generator's feedwater regulating valve, 2FW530, failing close, a manual reactor trip was initiated by the Unit 2 Nuclear Station Operator. The licensee determined that the root cause of the 2FW530 regulating valve closure was the failure of the operator diaphragm due to bolt hole elongation with insufficient clamping forces on the diaphragm in the diaphragm casing. The insufficient clamping force may have been due to insufficient torquing of the bonnet bolts and/or the use of a room temperature vulcanization (RTV) sealant (Permatex 6B) on the sealing surface of the diaphragm. The Permatex had been applied on the diaphragm sealing surface to prevent air leakage from the bonnet. The application of the Permatex was beyond the work instructions used by the maintenance worker. The use of Permatex is further discussed in paragraph 5.b of this report.

The licensee initiated a root cause investigation team (HPES 92-08) and a supplemental LER will be issued by August 25, 1992. The supplemental LER will include the final recommendations for corrective actions from the HPES team. The supplemental LER will

be reviewed by the inspectors for adequate long term corrective action. Immediate corrective actions by the licensee included repairing 2FW530, and increasing the diaphragm casing bolt torquing to 40 foot pounds on all four Unit 2 feedwater regulating valves. Based on the inspections of the Unit 1 valves, no increase in torque values were deemed necessary, since no Permatex sealant was found on the edge of the exposed diaphragms

(Closed) 454/92004-LL: The licensee received an operability assessment from corporate engineering regarding the Boron Dilution Protection System (BDPS). Certain conditions were identified where the BDPS may not be capable of performing the as design safety function. Special Operating Order 92-019 was revised to implement the conditions needed to maintain operability of the BDPS.

(Closed) 455/92004-LL: Unit 2 tripped on a source range high flux on Channel N32 which the suspected caused was noise due to lightning. At the time of the trip, the shutdown banks were withdrawn and the operators were preparing to pull the control banks to criticality.

b. Onsite Nuclear Safety (ONS)

The inspectors reviewed ONS's post outage shutdown risk assessment report for the recent Unit 2 refueling outage that concluded on April 30, 1992. The report was a good assessment of the station's performance during the refueling outage. The report identified enhancements the station initiated during the outage as well as recommendations for the station to consider for future outages. The overall quality of the ONS's assessment of the Unit 2 outage was considered very good. The station's management continues to support and seek enhancements to continue to reduce shutdown risk. The ONS and station's performance in shutdown risk continues to be very good and pro-active.

No violations or deviations were identified.

6. Maintenance/Surveillance (62703 & 61726)

a. Maintenance Activities (62703)

Routinely, station maintenance activities were observed and/or 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 also considered during this review: approvals were obtained prior to initiating the work; functional

testing and/or calibrations were performed prior to returning components or systems to service; quality control records were maintained; and activities were accomplished by qualified personnel.

Portions of the following maintenance activities were observed and reviewed:

- B90000 Relocation of U-0 station air compressor discharge check valve
- B94538 1A MS PORV trouble alarm will not clear

Based on (1) the event described in LER 455/92003 where Permatex was applied to feedwater regulatory valve 2FW530 which was not delineated in the work instruction (paragraph 4.b), (2) the failure of a maintenance worker to reconnect a contactor lug that was lifted outside the scope of the surveillance package which is described in unresolved item 455/92006-01 (paragraph 2.j), and (3) the removal of a Unistrut without the required torque values identified in the surveillance procedure described in Unresolved Item 455/92006-02 (paragraph 2.k), the inspectors are concerned with the performance of work activities during the last Unit 2 refueling outage that were not delineated in a work instruction or procedure. In the case of the removal of the Unistrut, the activity had been pre-planned prior to the activity but the planning had not adequately addressed the removal of the Unistrut to facilitate the replacement of a pressurizer transmitter. The other activities pertaining to the lifting of a contactor lug and the application of the Permatex were not pre-planned. The inspectors will continue to monitor work activities and events to ensure that an adverse trend does not exist in the performance of work activities. This matter is considered an Unresolved Item pending further NRC review (454/92012-01; 455/92012-01(DRP)).

No violations or deviations were identified.

b. Surveillance Activities (61726)

During the inspection period, the inspectors observed Technical Specification required surveillance testing and verified that testing was performed in accordance with adequate procedures, that test instrumentation was calibrated, that results conformed with Technical Specifications and procedure requirements and were reviewed, and that any deficiencies identified during the testing were properly resolved.

The inspectors witnessed or reviewed portions of the following surveillances:

- OBOS 7.6.b-1(2), Rev. 3, "Control Room Ventilation System Train OA(B) Staggered Monthly Surveillance".
- OBVS 3.3.1-4, Rev. 6, "Unit 0 Digital Channel Operational Test of ORE-PRO31B, ORE-PRO32B, ORE-PRO33B, and ORE-PRO34B".
- OBVS 7.6.e.2-1, Rev.4, "Unit 0 Control Room Ventilation System Train A Emergency Makeup System Auto-Start".
- IBVS 0.5-3.CC.1-1, Rev. 12, "ASME Surveillance Requirements For Component Cooling Pump 1CC01PA"
- IBVS 7.1.2.1.a-2, Rev. 11, "Diesel Driven Auxiliary Feedwater Pump Monthly Surveillance"
- 2BOS 8.1.1.2.a-2, Rev. 5, "Unit 2B Diesel Generator Operability Monthly and Semi-Annual Surveillance"

During the review of surveillance procedures OBVS 3.3.1-4 and OBVS 7.6.e.2-1, the inspectors identified the following concerns:

- (1) As a result of simulating a high radiation signal in radiation monitors during surveillance OBVS 3.3.1-4, the control room ventilation (CRV) system realigned to the emergency mode. Prior to the surveillance, one train of CRV is in a normal configuration with the other train shut down. Surveillance procedure OBVS 3.3.1-4 does not have steps to restore the CRV system to the normal configuration upon completion of the testing. Also, a review of surveillance procedures OBOS 7.6.b-1(2), Revision 3, "Control Room Ventilation System Train OA(B) Staggered Monthly Surveillance", identified that there were no restoration steps to place the CRV system in the normal configuration after testing. This surveillance is performed to verify operability of the CRV system by running the system for 10 continuous hours. The licensee revised procedures OBVS 3.3.1-4 and OBOS 7.6.b-1(2) to include restoration steps prior to the conclusion of this inspection.
- (2) Procedure OBVS 3.3.1-4 was a monthly digital channel operability test on radiation monitors that pertained to the CRV system. The surveillance was required by the Technical Specification (TS). TS 4.7.6.b also requires a monthly surveillance of the CRV system to verify that the system operates for at least 10 continuous hours in the emergency mode with the heaters operating. This surveillance is performed by the operations department in accordance with surveillance procedures OBOS 7.6.b-1 (Train A) and OBOS 7.6.b-2 (Train B). Discussion with the licensee determined that surveillances OBOS 7.6.b-1(2) has not been routinely performed immediately following surveillance OBVS 3.3.1-4.

Since surveillance procedure OBVS 3.3.1-4 required placing the operating CRV train in the emergency mode, the performance of OBOS 7.6.b-1(2) while the operating CRV train was in the emergency mode would prevent unnecessary starts of ESF equipment. This matter is considered an Open Item pending further review by the NRC (454/92012-02; 455/92012-02(DRP))

The inspectors identified a concern with generator differential trip on the emergency diesel generators (EDG) that would not be bypassed in an emergency start (SI or Loop) of a EDG. The inspectors, through discussion with the licensee, determined that the relay in the generator differential protective circuit has been tested every 18 months to verify the relay would trip the EDG 4 kV output breaker, if the setpoint was exceeded. However, there was no testing on periodic basis to verify the relay would also trip the EDG, as designed. The licensee has revised procedure 1/2BVS 8.1.1.2.f-7 and 1/2 8.1.1.2.f-8 to include the verification through testing that the generator differential relay would trip the EDG.

Inspection Report 454/92008; 455/92008 identified that increased licensee management attention was needed in the surveillance area, based upon surveillance concerns that the inspectors have identified since September 1991. In response to the inspectors' concerns, the licensee had established a procedure usage task force to assess and evaluate all procedures which includes the surveillance procedures.

No violations or deviations were identified.

7. Engineering & Technical Support (37700)

The inspectors reviewed the licensee's Corporate Engineering and Construction (ENC) plan to implement a formal program to identify, track, and resolve conditions adverse to quality. At present ENC does not have such a formal program. The program for full implementation has been scheduled for the end of 1992. The process will include the recording on a Problem Identification Form (PIF) each deviation, noncompliance and discrepancy. The PIF will indicate the condition observed, the date and time of discovery, the apparent cause of the condition and a recommended method of resolving the condition. This program has the following objectives:

- To ensure that all conditions adverse to quality are documented, evaluated and resolved in a timely manner with appropriate management review based on the safety significance of the review.
- To minimize the required resources by taking advantage of existing processes that can be effectively integrated into the program.
- To include a mechanism for tracking issues and ensuring that all required station and NRC notifications are performed.

The inspectors consider ENC's initiative to continually improve performance as a positive step. The implementation, and effectiveness of this program to identify design deficiencies and conditions adverse to quality will be monitored by the NRC as an Open Item (454/92012-03(DRP); 455/92012-05(DRP)).

No violations or deviations were identified.

8. Report Review

During the inspection period, the inspector reviewed the licensee's Monthly Performance Report for June 1992. The inspector confirmed that the information provided met the requirements of Technical Specification 6.9.1.8 and Regulatory Guide 1.16.

The inspector also reviewed the licensee's Monthly Plant Status Report for June 1992.

No violations or deviations were identified.

9. Open Items

Open items are matters which have been discussed with the licensee, which will be reviewed by the inspector and which involve some action on the part of the NRC or licensee or both. Open Items disclosed during the inspection are discussed in Paragraph 6.b and 7.

10. Unresolved Items

Unresolved items are matters about which more information is required in order to ascertain whether they are acceptable items, violations, or deviations. An unresolved item disclosed during the inspection is discussed in paragraph 6.a.

11. Exit Interview (30703)

The inspectors met with the licensee representatives denoted in paragraph 1 during the inspection period and at the conclusion of the inspection on August 3, 1992. The inspectors summarized the scope and results of the inspection and discussed the likely content of this inspection report. The licensee acknowledged the information and did not indicate that any of the information disclosed during the inspection could be considered proprietary in nature.