

U.S. NUCLEAR REGULATORY COMMISSION

REGION I

REPORT NO. 50-322/84-50

DOCKET NO. 50-322

LICENSE NO. NPF-19

LICENSEE: Long Island Lighting Company
P. O. Box 618
Shoreham Nuclear Power Station
Wading River, New York 11792

INSPECTION AT: Shoreham, New York

INSPECTION CONDUCTED: December 15, 1984 - January 31, 1985

INSPECTOR: *P. W. Eselgroth* 2/1/85
P. W. Eselgroth, Senior Resident Inspector Date Signed

APPROVED BY: *Jack Strosnider* 2/1/85
J. R. Strosnider, Reactor Projects Sect. 1C Date Signed

SUMMARY: The inspector reviewed control of plant operations, Independent Safety Engineering Group activities, Shift turnover and log reviews, management involvement in plant operations, plant management/shift personnel communications and shift advisor examinations. The Quality Assurance deficiency reporting and follow-up system was reviewed. Previous inspection items related to HPCI system spurious isolation and Bahnsor Co. HVAC units were also reviewed.

The inspector closed one previous inspection item, opened one new unresolved item and identified two apparent violation.

This report involved 163 hours of inspection by the resident inspector and 36 hours by a region-based inspector.

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DETAILS

1.0 Persons Contacted

R. Kubinak, Director, OA, Safety & Compliance (L)
A. Muller, OC Division Manager (L)
J. Leonard, Vice President - Nuclear (L)
J. Scalice, Operating Division Manager (L)
W. Steiger, Plant Manager (L)
D. Terry, Maintenance Division Manager (L)

L - Long Island Lighting Company

The inspector also held discussions with other licensee and contractor personnel during the course of the inspection.

2.0 Status of Previous Inspection Items

2.1 (closed) Unresolved Item (84-32-01): High Pressure Coolant Injection System (HPCI) Spurious Isolation.

This item was identified during a previous inspection and the licensee had provided the following information: On August 16, 1984 HPCI outboard steam warmup valve (1E41*MOV-048) spuriously closed during the Integrated Electrical Test (PT397.002-3), stopping the opening of HPCI motor operated valve 1E41*MOV-042 which was intended to initiate a loss of coolant accident signal to the emergency diesel generators. This condition occurred twice. Both times, it happened approximately eight seconds into the test, which immediately followed emergency AC bus re-energization. The source of the spurious isolation signal was found to be the Riley Temperature Monitors located in the B21-Steam Leak Detection System. These modules randomly provide an artificial momentary (less than .25 seconds) trip signal upon re-energization. This trip signal may be of sufficient duration to cause an isolation of the monitored system (e.g., RCIC or HPCI).

During this inspection period, the licensee indicated that this item was ready for closure and provided the following information: Station Modification SM-84-099, E&DCR L-0437, FDDR KS1-2295, and MWR-84-6283 were initiated to replace existing RCIC and HPCI timers E51-M602 A & B and M603 A & B, located in panel 1H11*PNL-614 (with a range of 0-150 minutes), with four Eagle 0-5 minute range timers. The purpose of the timers is to interrupt the artificial momentary false isolation signals which may occur when electric power is restored following a loss of same. The RCIC timers were replaced in order to maintain circuit and parts similarity. The licensee indicates that since the RCIC circuits are powered from an uninterruptable power supply spurious isolation of the RCIC System will not occur. The RCIC timers were therefore set at zero.

After evaluating the time delay required to correct the isolation problem on the HPCI system, the licensee determined that a "1 second time delay" was long enough to prevent the problem and short enough to protect against overheating the area and possibly subjecting Class 1E equipment to

environmental failure. For this reason, the licensee states that the 0-5 minute timers that replaced the 0-150 minute timers were not adequate since their minimum setting was 9.5 seconds. Due to the inadequacy of the 0-5 minute timers, E&DCR's L-0437 A & B and GE FDDR KS1-2295 Rev. 1 were issued by the licensee. The HPCI timers were set at zero seconds and the HPCI isolation activation HMA relays B21B-K32A, B were replaced with Class 1E Agastat time delay relays model No. E7014AA (with a range of .2-2 seconds). The new Agastat relays bear the same equipment tag number as the relays they replaced and they were set at 1 second. These additional changes were incorporated into Station Modification SM-84-099 and implemented as part of MWR 84-6283. A Low Voltage Control Circuit Checkout Test (SP.87.001.06) was performed to verify that the one second time delay of the HPCI isolation is sufficient to prevent spurious isolations.

The inspector reviewed the test records and has no further comment. This item is resolved.

2.2 (open) Unresolved Item 84-29-01: Bahnson Co. HVAC Units.

Inspection Report 84-29 discussed a February 9, 1984 Board Notification (84-006) relative to possible quality control problems with HVAC units manufactured by the Bahnson Co., Winston Salem, North Carolina. Board Notification 84-006 indicated that Bahnson had provided HVAC units for safety-related applications at a number of nuclear reactor facilities including Shoreham and Inspection Report 84-29 requested the licensee to identify these applications. This problem was also the subject of Information Notice 84-30.

There are four Bahnson HVAC units in safety-related applications and the licensee has inspected each of these units to determine if the units conform to specification and drawing requirements. Two of these units are used in the control room air conditioning system and the other two are used in the relay room air conditioning system.

During this report period a region based inspector reviewed the seven LDR's listed in last month's report that the licensee has issued principally on welding and fastener deficiencies on these units. The inspector also desired to review seismic calculations for several of the welds in question. However, the licensee was unable to obtain this information from the consultant who performed the calculations during the inspector's visit to the site.

This item will remain unresolved until the requested seismic calculations have been reviewed by the NRC.

2.3 (open) Unresolved Item 84-45-01: Control of Plant Operations.

On November 2, 1984, preparations were made by the licensee to drain water from the reactor vessel to support the inspection of reactor vessel internals by the licensee's Reactor Engineer. As discussed in the resident inspector's

previous report, several thousand gallons of this water were spilled onto the drywell floor in the process of draining the reactor vessel. On November 5, 1984, the reactor vessel water level was once again lowered in support of a different inspection and drywell flooding was once again experienced, although to a lesser extent.

The cause of these occurrences was determined by the licensee to be a mispositioned vent valve on the Drywell Equipment Drain Tank. The individual assigned to investigate the November 2 flooding occurrence had determined the cause prior to the November 5 occurrence, however, as stated in the Incident Report "feedback to the Operations personnel was not completed". The licensee found during its investigation of these occurrences that an unapproved valve lineup sheet, showing vent valve 1G11-02V-3533 as shut, was in the official valve lineup file. This was contrary to the open position shown for this valve in Station Procedure 23.702.02. Also, a drywell drain tank level recorder in the control room, which could have contributed to earlier identification of the drain path error, was found to be out of service.

The previous month's inspection report stated that the inspector's review of these occurrences to date had resulted in the following concerns relative to the control of plant operations and the timely response to abnormal occurrences:

- . In the event of abnormal occurrences, what steps will be taken to preclude a repetition of the problem prior to completion of the review/corrective action process.
- . Some steps appear warranted to ensure that the controls associated with performing evolutions in a safe and orderly manner are actually implemented such as maintaining accurate approved plant status files, using procedures and checking the availability of system instrumentation including backups.

The resident inspector reviewed the Incident Report, issued by the Operations Department on January 3, 1985, and plant management documented comments on the report. In total, the report and management comments called for the following corrective actions:

- . Presentation of a training lecture to operators using this incident as a basis for emphasizing the ease with which abnormal events occur and the complexity of the problem that can occur from a single error. Emphasis will also be given to the necessity for correct communications and transmitting instructions between on-shift personnel.

- . All records, log books, and materials maintained in the Main Control Room will be reviewed again to insure that only controlled documents are utilized to conduct plant operations.
- . Drawing discrepancies will be pursued vigorously and resolved as quickly as possible.
- . The separation of high and low conductivity fluids is of significant importance to Radwaste processing requirements and will be brought to the attention of all plant personnel.
- . Plant management has set a goal of five working days for issuance of all incident reports.

In addition to the above information the resident inspector reviewed other recent plant occurrences and has the following comments:

- . The drywell flooding report details the events which apparently led to an unofficial valve lineup being placed in the official valve lineup file and noted that the report "tentatively ascribed" this problem to (1) the incorrect process by which the valve lineup was placed in the file and (2) the failure to monitor the official valve lineup file for incorrect data. After some followup on how the official valve lineup file is controlled administratively, the inspector found that a procedure covering this area entitled "Operations System Valve Lineups to Support Plant Startup" (TP No. 21.036.01) was cancelled on October 5, 1984. The inspector brought this matter to the attention of plant management and was subsequently informed that this administrative procedure will be updated and reissued. The inspector also noted that the report does not identify corrective action for the problem identified by the report as "failure to monitor the official valve lineup file for incorrect data".
- . Plant management has emphasized the importance to operations personnel of prompt incident evaluation and feedback to involved personnel. Also, the inspector notes that in the case of the January 8, 1985 inadvertant scram caused by an I&C Technician assigned to transfer of the channel B Source Range Monitor (SRM) from the Fuel Load Chamber detector to the in-core SRM detector, there was rapid review and followup by plant personnel. Specifically, the associated review and procedural corrective actions were taken prior to proceeding with similar work on the other SRM detectors. The inspector's concern documented in the previous monthly report relative to taking adequate steps to preclude a repetition of problems prior to completion of review/corrective actions is considered resolved.

- . The November 2, 1984 drywell flooding, the December 18, 1984 improper movement of a control rod blade guide and the January 8, 1984 inadvertant scram incidents were associated with evolutions which can all be categorized as infrequently performed operations which were conducted without an explicit procedure. The licensee should consider review of this apparent trend by one of the established operations overview groups.
- . In the drywell flooding incident report, there are several references to problems with the Drywell Equipment Drain Tank (DWEDT) and Drywell Floor Drain Tank (DWFDT) level recording instruments in the Control Room. Specifically the report states the following in various places: "The DWEDT and DWFDT levels are displayed on a recorder on the 602 panel in the control room. On November 2 the blue pen of the recorder, DWEDT Level, was downscale and MWR 84-6174 tag had been placed on the unit." "The draining of the vessel continued with the operator monitoring the DWEDT level on a Control Room recorder. This recorder normally also displays Drywell Floor Drain Tank (DWFDT) level, but this indication was out of service at the time." "The control room operators were hindered by their lack of level indication on the DWEDT, but a duplicate recorder in the Radwaste Control room was operating properly."

From the inspectors review of plant records it appears that MWR 84-6174 was written on the DWFDT level instrumentation in the control room; however, the report appears to be contradictory on what level instrumentation was out of service. Also, the important matter of operations personnel review of the availability of necessary instrumentation - including those peripheral or associated systems, in this case the DWFDT Level, which might first detect abnormal operations - was not addressed by the incident report.

- . The drywell flooding incident report describes the events leading up to the discovery of the flooding problem and states the following with regard to the initial indications of the problem: "Both during, and after the shift turnover, the Drywell humidity was observed and commented upon. Other parameters and indications were checked, and as part of the shift assignments the 12-8 Watch Engineer assigned an operator to check the Drywell as part of his Reactor Building rounds. The Watch Engineer did not feel that the problem was likely to be real or serious, based on previous experience with erratic behavior of this parameter. (A week earlier, with similar behavior, no problem could be found in the Drywell). Therefore he did not direct the operator to go directly there. Since the operator was not sent directly to the Drywell, it was 2 a.m. before the operator, having made an investigation, called the control room and asked the Nuclear Station Operator (NSO) for assistance." Watch personnel's confidence in plant instrumentation is an important factor in the proper control of plant operations.

In particular, instrumentation should be maintained to the point where operators will believe their instrumentation and not have to factor a history of instrumentation problems into their decision/response process. The previously discussed Drywell drain tank level instrumentation problem and this reference to the humidity instrumentation problem clearly indicate that instrumentation operability played a role in this incident. However, the report does not define any followup on the level of operability of plant instrumentation in the recommendations/corrective actions.

- . On January 25, 1985, at approximately 7:30 p.m., while an Equipment Operator was performing a valve line-up to restore fuel pool clean-up operation, fuel storage pool water was inadvertently drained into the reactor cavity via valve 06V-073. At the completion of a previous evolution, reactor cavity cleanup, this valve was supposed to have been returned to the locked shut position, however, it was apparently left open. At approximately 9:30 p.m. on January 25, 1985, according to the Watch Engineer, a Radwaste Operator failed to observe a procedural caution statement with regard to closing the inlet valves to the Recovery Sample Tank (RST) during the valve lineup for fuel pool cleanup and consequently drained fuel storage pool water into the B RST. These occurrences further illustrate the need for improvement in the area of valve lineups.

In summary, this item is considered unresolved until the licensee takes specific actions, or indicates that none is considered necessary, relative to the following items:

- . Resolution of administrative controls over the official valve lineup file in the Control Room, including periodic monitoring for incorrect data.
- . Plant review group operations trend analysis.
- . Clarification of the incident report on instrumentation problems experienced during the drywell flooding problem and actions to remind operators of the importance of reviewing the availability of all necessary instrumentation prior to commencing plant evolutions.
- . Assessment of the need to improve the on line availability of plant instrumentation.

3.0 Independent Safety Engineering Group Utilization

During this report period, the inspector reviewed the current work assignments of the Independent Safety Engineering Group (ISEG) with the ISEG Supervisor. The function of the ISEG, as defined by the Shoreham Technical Specifications, is to examine unit operating characteristics, NRC issuances, industry advisories, Licensee Event Reports, and other sources of unit design and operating experience information, including units of similar design, which may indicate areas for improving unit safety. The inspector found that the ISEG is spending about 40% of its time reviewing industry nuclear reactor information, about 40% of its

time updating Shoreham plant system descriptions and 20% of its time overseeing Shoreham plant operations.

The inspector asked the ISEG Supervisor if the ISEG had identified any current notable trends in plant operations and was informed that they had not. The inspector questioned the relatively low percentage of time spent on overseeing plant operations and the significantly larger percentage of time being spent updating and reviewing plant system descriptions. The ISEG Supervisor indicated that the system description work is preventing the ISEG from spending more time overseeing Shoreham plant operations. The ISEG Supervisor also stated, when asked what other groups were involved, that fulfillment of LILCO's agreement with Suffolk County on updating of the plant system descriptions seems to be falling largely to the ISEG. It should be added that the ISEG Supervisor was not attempting to use the inspector as a means of workload adjustment, but responding candidly to the inspectors probing line of questions.

The above mentioned agreement is contained in "Resolution of Suffolk County Contention 19-Human Factors, Procedures: which states, in part, the following:

"LILCO agrees that, prior to Shoreham's second refueling outage, it will (i) perform a review of all system descriptions, operating procedures and lesson plans to ensure that there is consistency in nomenclature, descriptions and instructions, and (ii) make whatever modifications to procedures and/or lesson plans that may be necessary to achieve such consistency. This review will be conducted by the Shoreham Operations Staff in conjunction with the Independent Safety Engineering Group (ISEG). The results of such review will be provided to SC."

The inspector found that the ISEG is not only reviewing plant system descriptions for final accuracy, but is having to do updating work on the descriptions, too. This situation was discussed with the Director of Quality Assurance, Safety and Compliance (QASC) to whom the ISEG Supervisor reports. The inspector expressed his concern that the involvement of the ISEG in the plant system description updating process goes beyond the requirements of the agreement with Suffolk County and that the current level of involvement is significantly diverting the efforts of the ISEG from overseeing Shoreham plant operations. The Director, QASC, stated that he would look into this.

The inspector was subsequently informed by the ISEG Supervisor that steps had been taken to reduce the ISEG involvement with plant system description updating from 40% to 20%. The inspector's understanding is that the level of effort by the ISEG in this area has been and continues to be a management decision above the ISEG Supervisor level. The inspector inquired of the ISEG Supervisor whether this revised level of effort

involved only review of descriptions updated by others or updating and review work. The ISEG Supervisor stated that system description updating work was still to be performed by the ISEG, in addition to review of the descriptions for final accuracy. The NRC inspector considers that the updating of system descriptions by the ISEG is outside the ISEG charter defined by the Shoreham Technical Specifications and outside the agreements reached with Suffolk County on Contention 19. The inspector considers that this diversion of ISEG resources from its safety overview role defined in the Shoreham Technical Specifications should be discontinued. The Director, QASC, was appraised of the resident inspectors assessment of current licensee guidelines on ISEG utilization on January 22, 1985.

Resolution of this issue is unresolved item 84-50-1.

4.0 Shift Turnover and Log Reviews

During this inspection period, the resident inspector reviewed the following logs on numerous occasions:

- . Watch Engineer's Log
- . Report of Abnormal Condition Log
- . Temporary Procedure Changes Log
- . Lifted Leads & Jumper Log
- . Maintenance Work Request Log
- . Radiation Work Permit File
- . Station Equipment Clearance Permit Log
- . Standing Orders
- . Night Orders
- . Outstanding LCO's

The inspector found the logs to be neat, legible and accurate records of plant status. The inspector also followed up on temporary procedure changes to see if they were being approved by the Review of Operations Committee and the Plant Manager within fourteen days of implementation, as required by the Shoreham Technical Specifications, Paragraph 6.8.3.C. The inspector reviewed the plant records in this area one month after the effective date of the Operating License, December 7, 1984, and found no discrepancies.

The inspector also overviewed watch engineer shift turnovers on many occasions. The inspector checked for proper review by the on-coming and off-going watch engineer of the status of plant conditions, plant equipment maintenance and test status, logs and current directives. The inspector sometimes performed this inspection in conjunction with looking into other items in the control room. In all cases, the inspector found the shift turnovers to be conducted very well.

No violations were identified.

5.0 Management Involvement in Plant Operations

During this report period, which includes the initiation and completion of fuel loading into the reactor, the inspector has paid particular attention to the level of management involvement in shift activities. During preparations for fuel load and throughout the fuel loading process members of the plant management staff have been visibly involved interfacing with and overseeing shift activities in the plant, particularly in the control room and on the refueling floor. This management presence has been evident during backshift and weekend hours, as well as during the day shift. During fuel loading whenever problems arose, whether these were equipment or personnel related, licensee management consistently took the time necessary to carefully assess these situations before proceeding and has consistently taken a safety conservative approach to their resolution. In summary, plant management involvement to date with plant operations, as observed by the resident inspector, has been excellent.

No violations were identified.

6.0 Plant Management/Shift Personnel Communications

Plant Management's close communication with shift personnel has been evident not only from their visible presence in the plant but also from entries in the Watch Engineer's Log which document many instances when a member of plant management was contacted by telephone to report on significant activities during backshift and weekend hours when a member of management did not happen to be present on shift. The resident inspector has also noted several instances where aspects of managements communications with shift personnel needed improvement as follows:

- a. On January 4, 1985, in accordance with Startup Test Procedure No. 3, the mid-shift watch engineer cleared personnel from the 175 foot refueling level in preparation for a partial shutdown margin test following the placement of the 144th fuel assembly into the reactor. This action, unbeknown to the watch engineer, was in conflict with the fire watches implemented in these areas in accordance with licensee letter SNRC-1122 dated December 7, 1984. The inspector found in a discussion with the watch engineer that he had not been informed of the management commitment to the NRC to maintain supplementary fire detection capabilities in these areas.
- b. Station Procedure No. 21.008.01, Operations Standing Orders, requires that written directives to operations personnel of continuing applicability be approved by the Chief Operating Engineer, or in his absence the Chief Technical Engineer. On January 10, 1985 the resident inspector found typewritten directives approved only by the Operating Engineer, in a binder entitled "Operations Administrative Directives", in the control room covering the following types of activities:

- . Maintaining Systems Operability Status
- . Annunciator Status and Response
- . Operation of Radwaste Systems
- . Surveillance Test Program

This is a Severity Level V Violation (Supplement I).

Failure of the licensee to comply with the approval requirements of SP21.008.01 constitutes a violation of 10 CFR 50 Appendix B, Criterion V and Shoreham FSAR Section 17.2.5. requirements. (50-322/84-50-02)

7.0 NRC Resident Inspector Notification

The resident inspector requested that plant management keep the resident informed in a timely manner of significant plant events and activities, particularly those pertaining to safety related equipment. The licensee has been very responsive to this request, often going out of their way to ensure that the inspector is promptly informed of items of significance.

No violations were identified.

8.0 Shift Advisor Examination

The resident inspector sat in on one of the shift advisor oral examinations on January 25, 1985 to assess the adequacy of the examination content and the evaluation of candidate performance made by the oral board. The three member board consisted of the Operations Manager, the Training Division Manager and a Watch Engineer (all Shoreham SRO licensed individuals). The first part of the board consisted of a one and a half hour session, held in the Operations Manager office, during which the candidate was asked twenty-four questions relative to Shoreham plant operations including Technical Specifications. The questions asked called for detailed system operational knowledge (significant design features, trip set points and responses) and included integrated plant operation. The first session of the oral examination was followed by a one hour session in the control room. During the control room session, the Shift Advisor candidate was asked several administrative questions with regard to the duties and responsibilities of the Shift Advisor position, including the location of the various logs and drawings available for reference in the control room. The candidate was then asked to describe what major plant status indications are easily visible on the control panels from the Watch Engineers Office. This was followed by questions on three separate plant upset scenarios. For each of these scenarios the candidate was required to describe, at the panels, the annunciators, alarms and meter indications that would occur and the expected operator actions - including pulling out associated control room procedures. This was followed by a walkdown of the control room panels during which the board members asked questions about individual specific aspects of the panel switches and system lineups.

The resident inspector then met with the board members, immediately following completion of the examination, to ascertain the scores assigned to the candidates performance. The three board members assigned grades of 87%, 87% and 84% to the first session and, on a sat/unsat criteria for the second half, all three members graded the candidate as satisfactory. The inspector found the examination content and the board member's evaluation of the candidate's performance satisfactory in every regard.

No violations were identified.

9.0 Quality Assurance Deficiency System Management Overview

On January 3, 1985, the inspector reviewed the status of followup on LILCO Deficiency Reports with a QA Supervisor. After an LDR is issued to an organization at the plant, that organization then becomes responsible for submitting corrective actions to QA. QA then either approves or disapproves the proposed LDR corrective action. The QA Department tracks those LDR's having no approved corrective action and the subsequent closeout of LDR corrective actions. The inspector reviewed the status of LDR's for which an approved corrective action has not been established. The inspector found that the licensee's program for ensuring that the report findings have corrective actions identified in a timely manner is lacking. Specifically, there are six deficiency reports from 1983 and seventeen from 1984 (more than 90 days old) for which no licensee corrective action has been established. The specific LDR's cover a variety of problems such as improper purchase specifications, a fire pump heat exchanger that was initially brought on site without passing through LILCO stores, use of an out-of-tolerance torque wrench, observation of a service water system relief valve with a broken spindle ball, etc. The inspector expressed to the Director of Quality Assurance, Safety and Compliance, and the Vice President of Nuclear Operations his concern that the existence beyond 90 days of this number of LDR's with no approved corrective action dilutes the credibility of the deficiency corrective action system. They agreed to follow up on this issue and get back to the inspector. The inspector notes that more than half of the LDRs are indicated as pertaining to safety-related equipment. These are LDRs 1840, 1844, 1982, 2092, 2155, 2215, 2324, 2341, 2379, 2403, 2455, 2457, 2466, 2470, 2471, 2472, 2473 and 2488. This is a Severity Level V violation (Supplement I). Failure of the licensee to comply with the 10 CFR 50 Appendix B, Criterion XVI, and Shoreham FSAR Section 17.2.16 requirement that conditions adverse to quality be promptly identified and corrected constitutes a violation. (50-322/84-50-03). The inspector further notes, in connection with this apparent lack of management involvement in the LDR follow-up system, that the QA Department Manager position has been vacant for eight months.

10.0 Colt Diesel Generator Building

As of January 30, 1985, construction of the Colt Diesel Generator Building is proceeding on schedule and is approximately 95% complete. The remaining construction work consists of items such as: completing the installation of personnel walkways and platforms, painting, completion of the security system

and roofing work that must be done in the Spring 1985. All remaining construction work is essentially on hold due to engine test program activities.

Colt engine test program status is as follows: The 901 engine is nearing completion of the remaining initial calibration and circuit checks. All 901 engine flood system flushes have been completed. System flushing and some circuit and component checkouts are in progress on the 903 engine. The initial engine run-in is scheduled to commence on February 8, 1985. Completion of the last engine run-in is scheduled for the end of April. At the present time, the licensee plans to terminate Colt engine testing at the end of April 1985 to allow completion of the above mentioned construction items. The Colt engine test program schedule beyond this point is not firm.

11.0 Site Tours

Site tours were conducted routinely during the inspection period to observe activities and verify compliance with regulatory and administrative requirements. Tours of accessible areas included the main control room, relay and switchgear rooms, turbine building, reactor building, TDI emergency diesel generator rooms, auxiliary boiler room, recirculation MG set room, EMD temporary diesels, 20 MW and 50 MW gas turbines, reserve and normal service station transformers, site grounds and the Colt diesel building. Main control room staffing was reviewed for conformance with the requirements of the Technical Specification and during these tours the following additional items were evaluated:

- Fire Protection - Compliance with the compensating fire watch measures implemented as a result of the December 7, 1984 agreements reached with the NRC Fire Protection Inspection Team was inspected. Evidence of periodic inspection of fire suppression equipment was also checked.
- Security - Selected aspects of plant physical security were reviewed during regular and backshift hours to verify that controls were in accordance with the physical security plan and approved procedures. This review included the following security measures: guard staffing; random observations of the secondary alarm station; verification of physical barrier integrity in the protected and vital areas; and, implementation of access controls, including identification, authorization, badging, escorting, and personnel and vehicle searches. The actions taken by the security force during the security alert conditions that were declared on January 23, 1985 in response to a bomb threat against the Shoreham plant. A search of the site, with assistance from the Suffolk County Police Department using dogs, produced negative results. Two Region I physical security inspectors were on site and also observed the licensee's actions in response to the event.

No violations were identified.

- Housekeeping - Maintenance of required cleanliness levels was observed on plant tours in general. Also on one occasion, the inspector and plant manager toured areas of the reactor building together with particular emphasis on cleanliness. Cleanliness was observed to be excellent overall. The only cleanliness deficiency noted was one cigarette butt in a remote area of the drywell floor crawl space underneath the A loop recirculation pump.
- Equipment Preservation - Maintenance of special precautionary measures for installed equipment, as applicable.
- Component Tagging - Implementation of appropriate equipment tagging for safety, equipment protection, and jurisdiction.

General site/plant tour areas observed were satisfactory except where otherwise noted in this report.

12.0 Unresolved Items

Areas for which more information is required to determine acceptability are considered unresolved. Unresolved items are contained in paragraphs 2.2, 2.3, 3.0, 6.0 and 9.0.

13.0 Management Meetings

At periodic intervals during the course of this inspection, meetings were held with licensee management to discuss the scope and findings of this inspection. Based on the NRC Region I review of this report and discussions held with licensee representatives on February 1, 1985, it was determined that this report does not contain information subject to 10 CFR 2.790 restrictions.

The resident inspector also attended the entrance and exit meetings for inspections conducted by region-based inspectors during the period.