

U.S. NUCLEAR REGULATORY COMMISSION  
Region I

Report No. 84-20  
Docket No. 50-219  
License No. DPR-16 Priority -- Category C  
Licensee: GPU Nuclear Corporation  
100 Interpace Parkway  
Parsippany, New Jersey 07054

Facility Name: Oyster Creek Nuclear Generating Station

Inspection At: Forked River, New Jersey

Inspection Conducted: July 1 - August 3, 1984

Inspectors:

E L Conner for  
C. Cowgill, Senior Resident Inspector

12/20/84  
date

W. Baunack  
W. Baunack, Project Engineer, DPRP

12/20/84  
date

E L Conner for  
F. Young, Resident Inspector (TMI)

12/20/84  
date

E L Conner for  
J. Wechselberger, Resident Inspector

12/20/84  
date

Approved By:

E L Conner  
E. L. Conner, Chief, Reactor Projects  
Section 1B, DPRP

12/20/84  
date

Inspection Summary: Routine inspection by the Resident Inspectors which included follow-up of previous inspection findings, review of plant operations, log and record review, plant tours, physical security, radiation protection, maintenance and surveillance observations, and review of periodic reports. A team inspection was conducted to review aspects of the maintenance program. A technical meeting was held between NRR, Region I and the licensee to discuss inadvertent repositioning of primary containment valves. The inspection identified one violation of technical specifications; failure to follow Station Procedure 105, Conduct of maintenance, Detail 7.

The inspection totaled 187 inspector hours.

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## DETAILS

### 1. Persons Contacted

T. Brownridge, Maintenance and Construction Jobs Manager  
M. Budaj, Manager, Plans and Programs  
P. Fiedler, Vice President and Director, Oyster Creek  
V. Foglia, Operational M/pm and Surveillance Manager  
E. Growney, Safety Review Manager  
C. Halbfooster, Manager, Plant Chemistry  
M. Laggart, Oyster Creek Licensing Manager  
B. Leavitt, Deputy Manager, Radiological Controls  
D. Long, Plant Security Supervisor, Oyster Creek  
J. Maloney, Manager Plant Materiel  
R. Markowski, QA Oyster Creek Audit Manager  
R. Mc Keon, Manager, Plant Operations  
A. Mills, Supervisor, Safety and Health Nuclear, Oyster Creek  
J. Molnar, Core Manager  
W. Popow, Maintenance and Construction Director, Oyster Creek  
M. Radvansky, Manager, Tech Functions Oyster Creek site  
W. Smith, Plant Engineering Director  
J. Sullivan, Plant Operations Director  
J. Thorpe, Director, Licensing and Regulatory Affairs  
C. Tracy, Manager, Oyster Creek QA MOD/OPS  
D. Turner, Manager, Radiological Controls

The inspectors also interviewed other licensee personnel during the inspection including management, clerical, maintenance, and operations personnel.

### 2. Review of Previous Inspection Findings

(Closed) Violation 83-27-01: Shipping cask drain line and access plugs not verified sealed prior to transport. By letter dated January 31, 1984, GPUN received confirmation from Chem-Nuclear Services, Inc., that the tack-welded drain plug was in place prior to delivery to Oyster Creek and upon receipt of the shipment at the disposal site. Also, the inspector verified Facility Procedure 351.32 was revised to include documentation of inspection of drain plug and lid access plugs prior to shipment.

(Closed) Violation 83-25-02: Monthly reactor coolant composite sample not analyzed for Tritium. The required surveillance has been added to Procedure 832.1, "Chemistry Surveillance Test Program". Supervisor approval of weekly and monthly surveillance verification sheets is required by the procedure. Also, periodic independent in-depth reviews of various aspects of the surveillance programs are being performed.

(Closed) Violation 83-23-01: Failure to maintain a fire watch when required. The inspector verified that the requirements of a proper fire watch was discussed with all GSS's and GOS's by Operations Management.

The individual responsible for the improper termination of the fire watch has terminated his employment at the facility. Also, routine inspections have not identified any other instances where fire watches were not properly posted.

### 3. Plant Operations Review

#### 3.1 Shift Logs and Operating Records

Shift logs and operating records were reviewed to verify that they were properly filled out and signed and had received proper supervisory reviews. The inspector verified that entries involving abnormal conditions provided sufficient details to communicate equipment status and follow-up actions. Logs were compared to equipment control records to verify that equipment removed from or returned to service were properly noted in operating logs when required. Operating memos and orders were reviewed to insure that they did not conflict with Technical Specification requirements. The logs and records were compared to the requirements of Procedure 106, "Conduct of Operations", and Procedure 108, "Equipment Control". The following were reviewed:

- Control Room and Group Shift Supervisor's Logs, all entries;
- Technical Specification Log;
- Control Room, and Shift Supervisor's Turnover Check Lists;
- Reactor Building and Turbine Building Tour Sheets;
- Equipment Control Logs;
- Standing Orders;
- Operational Memos and Directives.

#### 3.2 Facility Tours

The inspector frequently toured the following areas:

- Control Room (daily)
- Reactor Building
- Turbine Building
- Augmented Off-Gas Building
- Rad-Waste Buildings

- Cooling Water Intake and Dilution Plant Structure
- Monitor and Change area
- 4160 Volt Switchgear, 460 Volt Switchgear, and Cable Spreading Room
- Diesel Generator Building
- Battery Rooms
- Maintenance Work Areas
- Yard Areas (including Area Perimeter)

The following were observed:

3.2.1 During daily control room tours, the inspector verified that the control room manning requirements of 10 CFR 50.54 (K), Technical Specifications, and the licensee's conduct of operations procedure were met. Shift turnovers were observed for adequacy. Selected control room instrumentation needed to support the cold shutdown, conditions was verified to be operable and indicated parameters within normal expected limits. Recorders were examined for evidence of abnormal or unexplained transients. The inspector verified compliance with Technical Specification Limiting Conditions for Operation (LCO's) applicable to the cold shutdown condition and refueling activities, including those relating to secondary containment integrity, and fire protection systems. The inspector closely monitored outage activities and verified that operators and supervisors were aware of work in progress and complied with applicable Technical Specification requirements.

No unacceptable conditions were identified.

3.2.2 The inspector reviewed the lighted annunciator windows with respect to plant operating conditions. During this review the inspector verified the validity of the annunciators with the control operators and Procedure 2000 RAP - 3024.01, NSSS Annunciator Response Procedures.

No unacceptable conditions were identified.

3.2.3 The inspector examined plant housekeeping conditions including general cleanliness, control of material to prevent fire hazards, maintenance of fire barriers, storage and maintenance of fire fighting equipment, and radiological housekeeping. During routine plant tours, the inspector noted continued effort to improve housekeeping conditions throughout the period.

No unacceptable conditions were identified.

- 3.2.4 Equipment control procedures were examined for proper implementation by verifying that tags were properly filled out, posted, and removed, as required, that jumpers were properly installed and removed, and that equipment control logs and records were completed. Selected active tagouts were independently verified by the inspector. Selected cleared tagouts were reviewed to determine that system alignments had been properly restored and safety systems returned to service had been properly tested. Selected locked valves were examined for proper position and installation of locking devices. The inspector monitored outage related activities including erection of scaffold and work platforms, installation of temporary hoses and cables, and the setup of radiological control barriers, to ensure that these activities did not block or otherwise impair the operability of components important to safety, and were controlled in accordance with the equipment control procedures when required.

No unacceptable conditions were identified.

3.2.5 Technical Specification Review

The inspector reviewed the control room copy of the licensee's Technical Specifications (TS) by comparison with a copy from the authority file in Bethesda, Maryland. This was to determine if the licensee's controlled copies were accurate and current. The inspector noted the following minor discrepancies in GPUN's control room copy:

1. Page 4.10-1a concerning ECCS core limit basis was missing;
2. Page 2.2-2 was in the GPUN copy concerning RCS pressure basis in TS although it does not exist in authority file copy; and
3. NRR copy had Appendix B, Section 5 concerning administrative controls.

The following corrective action was promptly taken by GPUN or NRR:

1. Page 4.10-1a was placed in all GPUN controlled TS copies;
2. Page 2.2-2 was removed from all GPUN controlled TS copies; and

3. Appendix B, Section 5 was removed from NRR authority file.

Our review of all above errors in documentation indicate there were no safety related problems. No further action is necessary and this issue is considered closed.

4. Radiation Protection

During entry to and exit from radiation controlled areas (RCA), the inspector verified that proper warning signs were posted, personnel entering were wearing proper dosimetry, that personnel and materials leaving were properly monitored for radioactive contamination and that monitoring instruments were functional and in calibration. Posted extended Radiation Work Permits (RWP's) and survey status boards were reviewed to verify that they were current and accurate. The inspector observed activities in the RCA to verify that personnel complied with the requirements of applicable RWP's and that workers were aware of the radiological conditions in the area.

- f. Physical Security

During daily entry and egress from the protected area, the inspector verified that access controls were in accordance with the security plan and that security posts were properly manned. During facility tours, the inspector verified that protected area gates were locked or guarded and that isolation zones were free of obstructions. The inspector examined vital area access points to verify that they were properly locked or guarded and that access control was in accordance with the security plan.

6. Review of Licensee Event Reports (LER's)

The inspector reviewed LER's submitted to NRC:R1 to verify that the details were clearly reported, including the accuracy of the description and corrective action adequacy. The inspector determined whether further information was required, whether generic implications were indicated, and whether the event warranted onsite follow-up. The following LER's were reviewed:

LER 84-15 HFA relay window fogging with undetermined substance. Window fogging of a number of HFA relays were found. General Electric was notified of this condition and asked to provide Oyster Creek with a solution. GPU Reading Labs were tasked to conduct independent testing of the HFA relays. Investigations continue and any corrective action may include cleaning or replacement prior to startup.

On January 25, 1984, the licensee discovered window fogging on 58 AC century series HFA relays. The relays with date code HW were installed in the Reactor Protection System (RPS) and had developed an unknown oily substance within the enclosed portion of relay. The oily substance had only developed on the energized relays in RPS and not in the other 10 de-energized relays.

GPUN requested General Electric exam the HFA relays to determine the cause of the oily substance. An initial cause was thought to be the cement between the cover and the glass. Two new relays with date code EX were placed into service on June 9, 1984. The new relays had no cement between the relay window and cover, but on June 25, 1984, window fogging was discovered on the new relays.

General Electric and GPUN's Reading lab continue to test the HFA relays to determine the source of the oily substance. Contact resistance measurements are taken to determine if any significant change occurs in contact resistance on the installed relays. The relay testing continues to develop specifics for corrective responses which may necessitate relay replacement. The resident inspectors will continue to follow the problem. (84-20-04)

LER 84-16 Failure to functionally test all excess flow check valves. Eleven excess flow check valves could not be seated during functional tests due to insufficient flow. The excess flow check valves of concern are located in recirculation pump seal pressure transmitter lines and the inner head seal leakage detection system. A piping modification is being evaluated to permit functional testing of excess flow check valves installed in low flow lines. (84-20-01)

The following LER was selected for on-site follow-up. The inspector verified that reporting requirements had been met, the appropriate corrective action had been taken, and that the event was reviewed by the licensee as required by facility procedures. The following details specifics associated with the review of this LER.

LER 84-17 Inadvertent repositioning of primary containment valves.

-- Plant Condition during the Event

The plant was shutdown for a long outage for repairs and modifications.

-- Description of the Event

On June 27, 1984, licensee's Startup and Test crew performed a test of computer index point 2401.4 in accordance with Test Procedure TP 416/4. Part of this procedural step required that the maintenance and construction crew complete a modification involving tie-in of computer wiring to existing plant circuitry. Fuse 6F8, in panel 11F, was removed and terminal TB7-10/11F was loosened to permit TB66-11 tie-in to a panel 11F neutral string. During this tie-in, a number of containment isolation valves changed position. The list of valves and their new positions are listed below:

<u>Valve Number</u>	<u>New Position</u>	<u>Description</u>
V-22-1	Closed	Equipment Sump Isolation Valve
V-22-28	Closed	DW FLR Sump Iso. Valve
V-24-29	Opened	Recir. Loop Sample Valve
V-24-30	Opened	Recir. Loop Sample Valve
V-26-16	Closed	Supp. Chamber Vac Relieve Valves
V-26-18	Closed	Supp. Chamber Vac Relief Valves
V-27-3	Opened	DW Purge Iso. Valve
V-27-4	Opened	DW Purge Iso. Valve
V-28-17	Opened	Torus Vent Valve
V-28-18	Opened	Torus Vent Valve
V-28-47	Opened	Torus Vent Valve
NSO 3A	Opened	Main Stream Isolation Valve (MSIV)
NSO 3B	Opened	MSIV
NSO 4A	Opened	MSIV
NSO 4B	Opened	MSIV

Also, the plant experienced a half scram at about the same time that the above valves changed position.

The Group Shift Supervisor (GSS) was notified, the wire terminal was tightened, and fuse 6F8 re-installed. The MSIV's were then shut by operator action.

The step was attempted a second time, this time with fuse 6F8 installed, and the results were the same except that no half scram occurred.

The licensee believes that the half scram during the first attempt may have been caused by a spike on the Intermediate Range Monitor (IRM). The GSS had the IRM ranged up scale prior to the second attempt to prevent a half scram. Since the IRM circuits are independent of the containment isolation circuits, it is thought the occurrence of a half scram was merely a coincidence.

-- Licensee Evaluation of the Event

Subsequent to the event, the licensee researched the circuits involved to determine the cause of the event. However, the cause has not been positively determined so far. The only explanation to date is that the containment isolation relays in panel 10F, which actuates the valves, somehow became energized and caused the valves to change position.

Licensee believes that when TB 7-10/11F was loosened, the neutral feed from panel 11F to panel 10F was interrupted and became floating while Panel 11F continued to have its grounded neutral. Through normally closed contacts of the control closed contacts of the control switches, the containment isolation relays and solenoids (three devices in series) had an applied voltage of 120 VAC which the licensee believes is sufficient to energize the relays. The licensee plans to substantiate this explanation by further testing.

NRC Meeting with the Licensee

A technical meeting between NRR, Region 1, and the licensee was held on July 6, 1984, to study the cause and generic implications of the event and to determine licensee follow-up actions. The results of the meeting are as follows:

- The licensee's only explanation of the cause of the event is as discussed above;
- The licensee will continue their evaluation and testing to determine the cause of the event and an outside organization should also be involved in the evaluation for independently determining the cause;
- The licensee was requested to evaluate the Single Failure Criterion with respect to the containment isolation circuits;
- The licensee and NRC are to further determine potential generic implications of the event;
- The licensee is to prepare plans and procedures for testing the circuit;

- The licensee will submit a report on the event to the NRC within approximately 3 weeks; and
- The licensee must complete all actions before the plant restart in August 1984.

It was determined that this type of event is not likely to occur with a concurrent primary containment isolation signal and, therefore, the containment isolation will occur in a real accident condition. However, the event has to be further evaluated for any potential safety concerns. (84-20-02)

## 7. Maintenance

The inspector observed maintenance activities to verify that activities were properly approved, operations personnel were cognizant of activities in progress, proper procedural controls were in effect, redundant systems and components were available when required, test instrumentation was calibrated, activities were performed in an acceptable manner by appropriately qualified personnel, and appropriate radiological precautions were taken. Portions of the following activities were observed.

- Cable tray installation
- Cable spreading project tunnel erection
- Control Room alarm panel modification
- Emergency diesel
- Cask shipment
- Condensate and fuel system
- Torus pitting repair
- Control Rod Drive return line modification
- Condensate and Feed System
- Dilution Pump overhaul
- Shutdown cooling system valve replacement
- Post Accident Sampling Modification
- IRM/SRM dry tube replacement
- Isolation condenser pipe repairs

A. Maintenance Program Review

A detailed inspection was conducted of the licensee's maintenance practices to verify (1) Equipment Failures are evaluated for frequency and root cause (2) Maintenance errors are detected, evaluated, and corrected, including root cause, and (3) Licensee record systems are organized to support the above evaluations.

Licensee Procedures 105, "Conduct of Maintenance", 118, "Preventive Maintenance Administrative Procedure", and 101, "Organization and Responsibility" were reviewed. Portions of the procedures which directly apply to the subject of this review were identified and the licensee's adherence to these procedural requirements verified. In addition, discussions were held with Plant Material, Maintenance and Construction, and Plant Engineering personnel to gain insight into their involvement with the evaluation of maintenance activities.

The facility procedures were found to be detailed, in compliance with the requirements of ANSI 18.7-1976 and adequate to provide a thorough review and evaluation of maintenance along with complete documentation of the maintenance activities. Daily work planning meetings, post-job critiques, maintenance of equipment history cards, equipment failure trending, major outage post-work reviews, and a preventive maintenance program are among the procedural requirements.

The following are the results of a review of documentation and discussions with personnel.

- (1) Maintenance and Construction (M & C) Short Forms - Most maintenance work is performed in accordance with M & C Short Forms. This form essentially provides the complete review and documentation associated with a maintenance task. A random sampling of several hundred completed M & C Short Forms was conducted. Among the items reviewed were evidence of repeat failures or failures on first retests. No significant problems were noted. Discussions with personnel indicate that repeat failure or test failures do occasionally occur and that these are identified and corrected during procedurally required Short Form reviews or the procedurally required post-job reviews which are conducted with personnel involved in the job. The Post Job review is conducted to "Evaluate work Methods, Practices, Procedures, and significant or unexplained experiences for feedback and improvement of similar future jobs".

Overall the M & C Short Forms were generally well prepared. However, the inspectors did note the following deficiencies associated with the completed forms.

- On some forms, more attention should have been given to completing the block which describes the work performed.

- In some instances, up to a year was taken from the time the work was performed and the M & C Short Form returned to Plant Material for recording equipment history and trending. This had been noted by the licensee and a Quality Deficiency Report was issued by the Plant Material Department on April 13, 1984.
- A significant number of older maintenance requests (issued prior to the current short form) where work had been performed, in some instances years ago, are only now being signed off. In general, a substantial improvement was noted in the documentation of maintenance since the major changes to the administrative organization at the site. This inspection focused primarily on the evaluation of how maintenance is currently performed.
- Station Procedure 105, Conduct of Maintenance, Appendix A, Paragraph 13, requires the Group Maintenance Supervisor or Job Supervisor to complete the Malfunction/Cause section of the Short Form to identify the cause of the failure or problem. This information is to be used for failure analysis equipment history, and will be supplied to the Nuclear Plant Reliability Data System.
- Also, Appendix A, Paragraph 2.4 requires the Department Manager/Supervisor to indicate on the Short Form if the problem or work request involves work which is Important-to Safety as defined in the CPUN Operational Quality Assurance Plan and Appendix B of the Conduct of Maintenance Procedure. During the review of completed M & C Short Forms a number of instances were identified in which the Malfunction/Cause section of the form was not completed. Also, some instances were noted where tasks obviously important to safety were incorrectly classified.

Examples of M&C Short Forms in which the Malfunction/Cause section of the form was not completed.

<u>Work Request No.</u>	<u>Date</u>	<u>Description of Work</u>
16287	4/ 4/84	Repair leaky scram valve diaphragms on HCV's 42-47 and 42-43
16266	3/23/84	Air leaks on Scram Valves
14372	3/20/84	Replace Shem Pin on CDPS locking mechanism

14617	4/8/84	Investigate and repair burnt wires inside old fire alarm panel
10027	3/20/84	"B" fuel pool pump check valve doesn't hold. "B" pump runs backward when "A" pump is running

Examples of M & C Short Forms in which the task was incorrectly classified with regard to Important-to-Safety are:

<u>Work Request No.</u>	<u>Date</u>	<u>Description of Work</u>
19505	2/13/84	MS HI FLO RE22F
18456	3/15/84	RE02A Low Low Level Switch
16194	11/29/83	Off Gas Radiation Monitor Ch. 1
15999	1/19/84	AOG Vent Monitor

The failure to complete the forms in accordance with requirements of Procedure 105, Conduct of Maintenance, is considered to be a violation of TS 6.8.1 (84-20-03).

Discussions with personnel regarding the forms in which Important-to-Safety was incorrectly classified indicates that since the QCL/QASL block was checked "yes" the work was in fact correctly performed.

A licensee representative stated that training sessions had recently been given to Maintenance and Construction Department personnel which included instructions for the proper completion of M & C Short Forms.

- 2) Plant System/Equipment History Record - During the review of M & C Short Forms the work performed on 13 pieces of equipment was noted and subsequently the equipment history cards for this equipment reviewed. In each instance the work performed was recorded on the equipment history card.

Prior to 1982, little attention appears to have been given to the recording of equipment history as evidenced by many history cards having few or no entries prior to 1982 with many entries subsequent to 1982. The period through which the cards have been reviewed for trend is indicated. The cards examined had been reviewed for trends through the second quarter of 1984. Equipment History Cards are being maintained and reviewed as required by Procedures 105 and 118.

- (3) Causes of Malfunctions - ANSI 18.7 - 1976 requires that causes of malfunctions be promptly determined, evaluated and recorded. The M & C Short Form records the cause and corrective actions taken relative to equipment malfunctions. Daily Short Form reviews and Work Planning Meetings are conducted by applicable representatives from Operations, Plant Material, Radiological Controls, QA/QC, Plant Engineering, etc. During these reviews, redundant components that may be affected and cases where failures appear frequent or otherwise are significant would be identified. Also, Post Job critiques and deviation reports are mechanisms by which malfunctions are evaluated. The requirement to promptly evaluate malfunctions appears to be satisfied.
- (4) Failure Trending - Procedure 105, Conduct or Maintenance, and 118, Preventive Maintenance Administrative Procedure, require that reviews for failure trending be performed. Among the documentation to be reviewed are Short Forms and History Cards. The inspectors verified Plant Material Mechanical Trending and Electrical/I&C Failure Trending Reports are being prepared. The reports provide a statistical listing of problems and provide recommendations were appropriate. A comprehensive vibration monitoring program for various pieces of rotating equipment other than that covered by the IST program is also being conducted. Licensee representatives indicated additional effort in the area of failure trending is being considered.
- (5) Preventive Maintenance - Procedure 118, preventive maintenance administrative procedure details the preventive maintenance program at the site. Preventive maintenance (PM) appears to be conducted in accordance with these procedural requirements. The PM is being conducted in accordance with PM procedures and/or Short Forms. Preventive Maintenance is being recorded on history cards. Significant effort was noted to have been expended on the snubber and oil sample PM programs.
- (6) Post Job Reviews - Procedure 105, Conduct of Maintenance, requires that major maintenance jobs be followed by formal post-job critiques involving all parties (QA, Radiological Controls, Plant Engineering, Operations, Plant Material, Maintenance and Construction) who were part of the job effort. Post-job reviews conducted for Low Pressure Turbine Inspections, Condenser Isolation Valve Repacking 1978 and 1980, Recirculation Valve Repacking 1978 and 1980, MSIV Inspection 1978, 1980, and 1983, and Control Room Recorder Replacement were reviewed. In general, post-job reviews are good and recommendations are carried out where appropriate. Also, incident critiques are held during a job if a problem arises. A schedule has been setup for post-job reviews for major maintenance recently performed.

- (7) Major outage Post-Work Reviews - Procedure 105 requires that major outage post-work reviews be documented in a report to the Vice President/Director Oyster Creek from the Manager Plans and Programs. Department contacts have been identified who will assist the Manager Plans and Programs in documenting major outage post-work reviews. This report will be completed following the completion of the outage.
- (8) Plant Engineering Director Responsibilities - Procedure 105, Paragraph 3.4 states the Plant Engineering Director is responsible for "Analyzing Data Relative to Failure Trends and Initiating Appropriate Corrective Action". The Plant Engineering Director does, in fact, not analyze failure trends except as requested by Plant Material. The Licensee stated the procedure would be changed clarifying the Plant Engineering Directors responsibilities concerning failure trends.
- (9) Audits - Periodic audits are performed of the results of actions taken to correct deficiencies occurring in facility equipment, structures, systems or methods of operation that affect nuclear safety. Audits S-OC-83-03B, Maintenance/Plant Material conducted October 20, 1983, to March 5, 1984, and S-OC-83-14, Corrective Action conducted December 1, 1983 to February 24, 1984, were reviewed to determine the general scope of the audits in the area of correcting deficiencies occurring in facility equipment. The required audits are being performed. Also, follow-up audits are done to determine that corrective action, where required, is being taken. The inspector had no further questions in this area.

In general, considerable improvement has been made by the licensee during the last several years in the overall conduct of maintenance including documentation, reviews, and evaluation, and the preventive maintenance program. The general attitude of personnel contacted, who are associated with the conduct of maintenance, is one of constantly trying to improve the overall program. The violation identified which is associated with documentation of M & C Short Forms is the only deficiency noted in an otherwise good program.

#### 8. Surveillance Testing

The inspector reviewed the following surveillance tests to determine if the tests were included on the master surveillance schedule, the test was technically adequate and has been performed at the required frequency.

- 636.4.003 Diesel Generator Load Test Revision 17, 12/21/83
- 645.4.001 Fire Pump Operability Test Revision 17, 6/29/84
- 620.4.005 Source Range Monitor Test and Calibration (Front Panel Test) Revision 8, 4/20/84

No unacceptable conditions were identified.

9. Welding Allegation

The inspector received an allegation from an individual stating that welding to install new valve V-16-133 was improper in that there were bad root passes on all three welds. Valve V-16-133 was installed in the reactor water cleanup system as a part of modifications to facilitate testing in accordance with 10CFR 50, Appendix J. Valve installation involved welding a short piece of pipe onto the valve to be installed in the system and then welding the valve in place. The valve is located on the 55' elevation in the primary containment drywell.

The inspector reviewed the weld history records for weld joints ND1-017-B, ND1-002 BW, and ND1-001-BW. These records showed that each weld in question had been repaired. The inspector noted that the entire weld joint for ND1-017-B was removed, including the heat affected zone, and rewelded. The root pass was radiographed and accepted on October 7, 1983. For weld joint ND1-002-BW, local grind and blend was used to remove flaws and then the joint rewelded and examined. For weld ND1-001 BW the root pass was replaced. Records show that final radiographic examinations were acceptable for all welds.

No unacceptable conditions were identified.

10. Review of Periodic and Special Reports

Upon receipt, periodic and special reports submitted by the licensee pursuant to Technical Specification 6.9.1 were reviewed by the inspector. This review included the following considerations: the report includes the information required to be reported to the NRC; planned corrective actions are adequate for resolution of identified problems; and that the reported information is valid. The following periodic reports were reviewed by the inspector.

-- June Monthly Operating Report

11. Exit Interview

At periodic intervals during the course of this inspection, meetings were held with senior facility management to discuss the inspection scope and findings. A summary of findings was presented to the licensee at the end of this inspection.