



UNITED STATES
NUCLEAR REGULATORY COMMISSION

REGION II
101 MARIETTA ST., N.W.
ATLANTA, GEORGIA 30323

Report No.: 50-424/88-43

Licensee: Georgia Power Company
P. O. Box 4545
Atlanta, GA 30302

Docket No.: 50-424

License No.: NPF-68

Facility Name: Vogtle 1

Inspection Conducted: September 7 - September 30, 1988

Inspectors: J. F. Rogge
J. F. Rogge, Senior Resident Inspector

10/5/88
Date Signed

Accompanied: R. F. Aiello, Resident Inspector

Approved By: M. V. Sinkule
M. V. Sinkule, Section Chief
Division of Reactor Projects

10/5/88
Date Signed

SUMMARY

Scope: This routine, unannounced inspection entailed resident inspection in the following areas: plant operations, radiological controls, maintenance, surveillance, fire protection, security, and quality programs and administrative controls affecting quality.

Results: Two violations were identified in which no notice was issued. One in the area of maintenance - Failure to properly implement a MWO on the containment spray system. One in the area of quality programs - Failure of the PRB to perform a review of a FSAR change.

REPORT DETAILS

1. Persons Contacted

Licensee Employees

- *G. Bockhold, Jr., General Manager Nuclear Operations
- *R. M. Bellamy, Plant Manager
- *T. V. Greene, Plant Support Manager
- *J. E. Swartzwelder, Nuclear Safety & Compliance Manager
- *W. F. Kitchens, Manager Operations
 - W. N. Marsh, Deputy Operations Manager
- *C. F. Wreath, Superintendent Nuclear Operations
- *H. A. Jaynes, Assistant Maintenance Manager
 - M. A. Griffis, Maintenance Superintendent
- *C. C. Echert, Manager Chemistry and Health Physics
- *A. L. Mosbaugh, Assistant Plant Support Manager
 - H. M. Handfinger, Assistant Plant Support Manager
 - F. R. Timmons, Nuclear Security Manager
- *R. E. Lide, Engineering Support Supervisor
- *C. Garrett, Operations Engineer
- *J. F. Bledsoe, Independent Safety Engineer Group Engineer
 - G. A. McCarley, ISEG Supervisor
 - E. M. Dannemiller, Technical Assistant to General Manager
 - C. W. Hayes, Vogtle Quality Assurance Manager
- *G. R. Frederick, Quality Assurance Site Manager - Operations
 - W. E. Mundy, Quality Assurance Audit Supervisor
 - R. M. Odom, Plant Engineering Supervisor
- *W. T. Nicklin, Regulatory Compliance Supervisor
 - K. Pointer, Regulatory Specialist
 - S. F. Goff, Regulatory Specialist

Other licensee employees contacted included craftsmen, technicians, supervision, engineers, operations, maintenance, chemistry, QC inspectors, and office personnel.

*Attended Exit Interview

2. Licensee Action on Previous Enforcement Matters - (92702)

(Closed) VIO 50-424/88-31-01, "Failure To Implement MWC 18803134 Flooding Hazard Prevention Procedure Provisions." The inspector reviewed the licensee response dated September 12, 1988. The stated corrective measures were verified complete following the identification of the violation. The inspector has no further questions.

3. Operational Safety Verification - (71707)(93702)

The plant began this inspection period in Power Operation (Mode 1) near 100% reactor power. On September 15, the unit began a power coastdown by maintaining a constant boron concentration and reducing power to maintain criticality.

4. a. Control Room Activities

Control Room tours and observations were performed to verify that facility operations were being safely conducted within regulatory requirements. These inspections consisted of one or more of the following attributes as appropriate at the time of the inspection.

- Proper Control Room staffing
- Control Room access and operator behavior
- Adherence to approved procedures for activities in progress
- Adherence to TS LCOs
- Observance of instruments and recorder traces of safety related and important to safety systems for abnormalities
- Review of annunciators alarmed and action in progress to correct
- Control Board walkdowns
- Safety parameter display and the plant safety monitoring system operability status
- Discussions and interviews with the OSOSs, SSs, ROs, and the STAs (when stationed) to determine the plant status, plans, and to assess operator knowledge
- Review of the operator logs, unit log and shift turnover sheets

On September 23, during a control room tour the inspector questioned the illuminated status of the SSMP "B" train charging system. The inspector was informed that the associated Boric Acid Pump Motor handswitch had been placed in the Stop position to preclude an automatic start. A recent engineering evaluation had concluded that since these pumps had a common miniflow line that possible pump damage would result if no discharge path was provided. To preclude damage, engineering reviewed FSAR section 9.3.4.1.2.5.2 and noted that the description states that one pump is normally aligned to supply boric acid to the suction header of the charging pumps while the second serves as a standby and that manual or automatic initiation of the reactor coolant makeup system will start one pump. Engineering review of the elementary wiring diagram (1X3D-BD-COIF) concluded that to preclude both pumps from starting simultaneously that one handswitch would have to be in the stop position. This same diagram depicts that the stop position would illuminate the SSMP. Procedure 13701-1 was subsequently revised to implement this operation. Operation personnel subsequently submitted a request for engineering review (NO 88-0565) to resolve the illumination problem. The inspector determined that no compensatory action was established for the SSMP. FSAR Section 7.5.5 discusses SSMP design and operation. This section states that the

requirements of RG 1.47 are met for system level indication of a bypassed or inoperable system. When a monitored component is not in a required position, the corresponding light illuminates. Manual illumination capability is also provided to allow the operators under administrative control to illuminate the panel when unmonitored components render the system inoperable. The inspector addressed the concern to both operations and engineering management that this operating procedure removes the ability of the SSMP to monitor one train of CVCS and this issue should be resolved to restore SSMP monitoring capability. In the interim, operations personnel are placing the handswitch to the auto position and are verifying that the SSMP light extinguishes. Resolution of this item is considered an IFI and is identified as:

IFI 50-424/88-43-01 "Verify resolution of restoring the SSMP to a condition to correctly indicate the operability status"

No violations or deviations were identified.

b. Facility Activities

Facility tours and observations were performed to assess the effectiveness of the administrative controls established by direct observation of plant activities, interviews and discussions with licensee personnel, independent verification of safety systems status and LCOs, licensee meetings and facility records. During these inspections the following objectives are achieved:

- (1) Safety System Status (71710) - Confirmation of system operability was obtained by verification that flowpath valve alignment, control and power supply alignments, component conditions, and support systems for the accessible portions of the ESF trains were proper. The inaccessible portions are confirmed as availability permits. Additional indepth inspection of the containment cooling system was performed to review the system lineup procedure with the plant drawings and as-built configurations, and compare valve/damper remote and local indications. The inspector reviewed the ambient operating temperature profile to verify that temperature measurements inside containment are representative of actual conditions. This activity was performed to complete NRC temporary instruction 2515/98. The inspector concluded that the temperatures inside containment are routinely maintained below the environmental qualification limit of 120°F.
- (2) Plant Housekeeping Conditions - Storage of material and components and cleanliness conditions of various areas throughout the facility were observed to determine whether safety and/or fire hazards existed.

- (3) Fire Protection - Fire protection activities, staffing and equipment were observed to verify that fire brigade staffing was appropriate and that fire alarms, extinguishing equipment, actuating controls, fire fighting equipment, emergency equipment, and fire barriers were operable.
- (4) Radiation Protection - Radiation protection activities, staffing and equipment were observed to verify proper program implementation. The inspection included review of the plant program effectiveness. Radiation work permits and personnel compliance were reviewed during the daily plant tours. RCAs were observed to verify proper identification and implementation.
- (5) Security - Security controls were observed to verify that security barriers were intact, guard forces were on duty, and access to the Protected Area was controlled in accordance with the facility security plan. Personnel were observed to verify proper display of badges and that personnel requiring escort were properly escorted. Personnel within Vital Area were observed to ensure proper authorization for the area. Equipment operability or proper compensatory activities were verified on a periodic basis.
- (6) Surveillance (61726)(61700) - Surveillance tests were observed to verify that approved procedures were being used; qualified personnel were conducting the tests; tests were adequate to verify equipment operability; calibrated equipment was utilized; and TS requirements were followed. The inspectors observed portions of the following surveillances and reviewed completed data against acceptance criteria:

<u>Surveillance No.</u>	<u>Title</u>
14780, Revision 3	Accumulator Tank #4 Pressure Loop (1P-966) Channel Calibration
14495, Revision 2	AFW System Flowpath Verification
14980, Revision 12T	EDG Monthly Operability Test
14825, Revision 3	Quarterly Inservice Valve Testing a). RCS b). NSCW Train "B"
14545, Revision 3	Monthly Staggard Train "A" AFW Pump Operability Test.
14430, Revision 2	Monthly NSCWS Cooling Tower Fan Test

- (7) Maintenance Activities (62703) - The inspector observed maintenance activities to verify that correct equipment clearances were in effect; work requests and fire prevention work permits, as required, were issued and being followed; quality control personnel were available for inspection activities as required; retesting and return of systems to service was prompt and correct; TS requirements were being followed. MWO backlog was reviewed. Maintenance was observed and MWO packages were reviewed for the following maintenance activities:

<u>MWO No.</u>	<u>Work Description</u>
18710229	Replace Gasket On Outboard CCW Bearing Housing And Add Oil As Required
18805645	Replace Existing Containment Spray Globe Type Valve For Valve 1-1206-44-007 With A New Gate Type Valve in accordance With DCP 88-VIN-0053-0-0
18803679	MOVATS Testing On Containment Spray Additive System
18806684	Correct Flow Element 1-FE-929 Direction Which Was Incorrectly Installed During MWO 18805643.

While observing MWO 18805645, the inspector noted that the licensee had cut the wrong weld. Weld Number W106 was cut in lieu of W103 as directed by the MWO. The root cause was due to the fact that the welder failed to review the MWO on station prior to commencing the cutting operation. A deficiency card was written upon discovery by the welding foreman and the MWO was subsequently modified to satisfactorily complete the work. The procedure violation did not result in a TS LCO violation, however it was representative of a failure to implement a procedure required by TS 6.7.1. This item represents a violation of NRC requirement which meet the criteria for non citation.

LIV 50-424/88-40-01, "Failure to Implement MWO 18805645 Procedure Required by TS 6.7.1"

During the morning OSOS briefing on September 26, the inspector learned that MWO 18806684 was planned for accomplishment to correct the installation of flow element 1-FE-929. As a result of inservice testing being conducted to obtain new baseline data following MWO 18805643, engineering determined that the flow

element was installed backwards. A DC was written to document the deficiency. The inspector requested a further description of how the situation had occurred in light of the NRC violation 50-425/88-12-01. This violation should have alerted the licensee, and appropriate controls should have been established on Unit 1 to preclude improper installation. On September 29, the inspector was informed that maintenance would be performing a root cause determination. Pending completion of the licensee's review this item is considered to be an IFI and is tracked 50-424/88-43-02 IFI "Review Licensee Corrective Action For Correct Installation Of Flow Elements."

5. Review of Licensee Reports (90712)(90713)(92700)

a. In-Office Review of Periodic and Special Reports

This inspection consisted of reviewing the below listed reports to determine whether the information reported by the licensee was technically adequate and consistent with the inspector knowledge of the material contained within the report. Selected material within the report was questioned randomly to verify accuracy and to provide a reasonable assurance that other NRC personnel have an appropriate document for their activities.

Snubber Functional Test Sample Plan - The letter dated September 20, 1988 was reviewed. The inspector had no comments.

b. Licensee Event Reports and Deficiency Cards

LERs and DCs were reviewed for potential generic impact, to detect trends, and to determine whether corrective actions appeared appropriate. Events which were reported pursuant to 10 CFR 50.72, were reviewed as they occurred to determine if the technical specifications and other regulatory requirements were satisfied. In-office review of LERs may result in further followup to verify that the stated corrective actions have been completed, or to identify violations in addition to those described in the LER. Each LER is reviewed for enforcement action in accordance with 10 CFR Part 2, Appendix C. Review of DCs was performed to maintain a realtime status of deficiencies, determine regulatory compliance, follow the licensee corrective actions, and assist as a basis for closure of the LER when reviewed. Due to the numerous DCs processed only those DCs which result in enforcement action or further inspector followup with the licensee at the end of the inspection are listed below. The LERs and DCs denoted with an asterisk indicates that a reactive inspection occurred at the time of the event prior to receipt of the written report.

(1) DC reviews:

DC 1-88-2513 "Containment Ventilation Isolation Actuation." On September 7 at 1:57 p.m., with the unit at 100% power an inadvertent shorting of a vital 120 VAC power supply resulted in an ESF actuation. Personnel were in the process of removing a temporary modification to restore the fuel handling building monitors to service. The power transient which occurred resulted in Monitor 1RE-003 being affected. Monitor 1RE-003 provides the actuation of the Containment Ventilation Isolation. All components required to respond actuated properly. This item will receive further review when submitted as a LER pursuant to 10 CFR 50.73(a)(2)(iv).

DC 1-88-2574 "Loss Of Offsite ENS Communications." On September 15, the NRC resident requested the SS verify ENS operability. The Shift Supervisor responded and made a proper notification to the NRC operations center and provided instructions to the Duty Officer on how to call the control room.

DC 1-88-2649 "DG 1B Trip On High Lube Oil Temperature." On September 23, 1B tripped on high lube oil temperature. Lube oil temperature at the time of the trip indicated 169°F. The trip setpoint of 200°F was not exceeded. This item was discovered during the performance of surveillance 14980-1. During retest, no unusual/abnormal indications were noted. Lube oil temperatures were taken at 10 minute intervals using installed temperature gages and contact pyrometers. This item will receive further followup when submitted as a 30 day special report per TS 4.8.1.1.3.

DC 1-88-2680 "Security Violation Due To No Compensatory Post Being Established When The AFW Missile Shield Was Removed (Between The AFW Building And Control Building) For AFW System Maintenance." On September 26, the licensee discovered that the AFW Missile shields had been removed to perform maintenance on an apparent steam leak. The removal occurred on September 12 when operations personnel thought a steam leak existed in the trench. Upon removal of insulation, it was determined that rain water was the source of steam. The insulation was being replaced when a plant engineer questioned the lack of security. Shortly thereafter, engineering determined that the missile shields need replacement. Maintenance replaced the shields within the six hour requirement of TS 3.7.1.2 action a. Further engineering review concluded that removal of these missile shields can be allowed provided reinstallation measures are taken during a Tornado Watch. The NRC inspector expressed concern over the licensee's program for ensuring that the plant hazard features are properly maintained or compensated for during maintenance. A

review of how these features are pragmatically controlled for hazards such as flood, radiation, fire, and missile will be conducted in a subsequent inspection. This item is identified as: 50-424/88-43-03 IFI "Review Licensees Program For Enduring Hazard Protection Is Assured."

- (2) The following LERs were reviewed and are ready for closure pending verification that the licensee's stated corrective actions have been completed.
- (a) 50-424/88-23, Revision 0 "Inadequate Design Leads To Condition Prohibited By Technical Specification." On July 29, LER 88-020-00 was issued, identifying that several electrical penetrations may not have been provided with adequate redundant overload protection. As a result of the interpretation for reportability of the event, two previously identified deficiencies have been reevaluated for reportability. As a result of the reevaluation, an event that was discovered on August 14, 1987 was determined to be reportable on July 28, 1987. The other event was discovered on July 7, 1987 and determined to be reportable on August 11, 1987. It was determined that for each event, redundant overload protection may not have been adequate for the entire range of protection as required by RG 1.63. TS 3.8.4.1 requires that electrical penetration overload protection may not have been provided for several penetrations, and Unit 1 may have been operating in a condition prohibited by TS until the event was discovered. For each event the Limiting Condition for Operation action statement TS 3.8.4.1 was implemented on the event discovery dates of July 7, 1987 and August 14, 1987. The event on August 14, 1987 involved electrical penetrations No. 12 and No. 69, concerning the #12 and #14 AWG conductors. The other event on July 7, 1987 involved penetrations No. 03, 14, 34, 41, 60, and 61, concerning #10 AWG conductors. The inadequate overload protection was discovered during a broadness review for Unit 2 by the designer, Bechtel Power Corporation. The corrective action has been completed for the event of August 14, 1987. The corrective action for the event of July 7, 1987, requires an outage and has been scheduled during the upcoming refueling outage. This action is scheduled to be completed by November 15, 1988. This item will remain open pending completion of the corrective work.
- (3) The following LERs were reviewed and closed.
- (a)*50-424/88-08, Revision 0 "Reactor Trip Caused By Stator

Cooling System Valve Controller Failure." On April 7, the unit tripped from 100% power when stator cooling water temperature control valve, TCV-6800, failed in the heat exchanger bypass position. In this condition temperature became elevated and actuated a turbine trip. This event was reviewed during NRC Report 50-424/88-20. Maintenance to correct the failure was reviewed. This LER identified that AFW valve 1HV-5139A breaker tripped open as operators attempted to throttle flow to SG #1. This failure appears to be identical to the failure discussed in LER 87-20. The LER does not specifically state that the handswitch was replaced nor does it link this LER with the previous LER. The work order which repaired the AFW switch was reviewed to verify proper work completion. LER 50-424/87-20 is also closed. The inspector has no further questions.

- (b) 50-424/88-09, Revision 0 "Inadequate Health/Physics Controls Allows Shipment Of Check Source." On April 6, the licensee was informed by Westinghouse that an In-vent radiation monitor had been shipped to their Baltimore, MD facility with a radioactive source installed without the appropriate shipping papers and labels. As indicated in NRC Report 50-424/88-17, this item was referred to the Regional Radiation Specialists for followup during the next routine inspection. This item is closed based on the review conducted by regional inspection, NRC Report 50-424/88-28.
- (c) 50-424/88-11, Revision 0 "Inadequate Control Of Effluent Monitor Alarm Setpoint Leads To Technical Specification Violation." On April 11, the alert alarm and high alarm setpoints for the turbine building drain effluent monitor 1RE-0848 were found to be set too high. This condition existed since March 9 when the monitor was restored to operable status. TS 3.3.3.9 requires that this instrument be operable with alarm setpoints determined with the methodology and parameters in the Off-site Dose Calculation Manual. Instead of using the correct setpoint, a temporary setpoint was verified during the return to service on March 9. This item was reviewed in NRC Report 50-424/88-20 for enforcement. The inspector reviewed the summary of corrective action dated April 21, 1988. Changes to Procedure 34226-C were reviewed. The inspector has no further questions.
- (d)*50-424/88-13, Revision 0 "Manual Reactor Trip Due To Failure Of MFIV" On April 24, 1988, at 0922 CDT, a manually initiated reactor trip occurred with the reactor plant at approximately 100% of rated thermal power. The Loop 4 MFIV had failed closed and would not respond to an open signal.

The manual trip was initiated in anticipation of receiving a SG low level setpoint automatic reactor trip. The direct cause of the event was No. 4 MFIV failed closed. The root cause was that an intermittent failure of an air solenoid valve coil led to the closure of No. 4 MFIV. Corrective actions included replacing each component, which reasonably could have caused the valve to fail closed. The components consisted of two electrically operated air solenoids, four electrical relays and two timer relays (agastats). The components were replaced prior to the restart of the unit. The removed parts were energized in the maintenance shop in a configuration which simulated the installation in the plant. All parts initially functioned as designed. After one intermittent failure, one of the air solenoids failed permanently. The third action in the report indicated that an engineering evaluation of the control circuit was in progress. The design change, DCR 89-023, was reviewed with the responsible engineering supervisor. While the design is to be implemented in a future outage, the inspector determined that this is a plant enhancement item and not necessarily corrective action for the event described in the LER. The inspector has no further questions regarding this issue.

- (e) *50-424/88-14, Revision 0 "Missed Surveillance Due To Personnel Error And Inadequate Communications." On April 25, the licensee discovered that a Technical Specification surveillance test had not been performed within the required time interval. In accordance with TS 4.0.5, the surveillance for the containment air radioactivity monitor inlet valves, HV-12975 and HV-12976, and outlet valves, HV-12977 and HV-12978 was required to be performed no later than April 25, 1988, at 0902 CDT. As soon as the USS was informed it had been missed, the surveillance was performed immediately and satisfactory. On May 13, at approximately 1400 CDT, it was identified that the plant should have entered TS 3.0.3 on April 25, since both isolation valves for the two penetrations were inoperable and a 1 hour report was made to the NRC. This event occurred because the USS failed to utilize the scheduling document. Also, the OSOs was aware of the surveillance and when it was due, but failed to inform the USS. The TS 3.0.3 entry was not performed because the USS and the OSOS failed to perform an adequate technical review of the system condition. Corrective actions includes instructing appropriate personnel on the use of the surveillance scheduling documents. These documents will be used during shift relief to improve communication and awareness. This item was previously reviewed in NRC Report 50-424/88-25 for

enforcement. This inspection reviewed the documents utilized to instruct operators dated June 10, 1988. The inspector has no further questions.

- (f) 50-424/88-15, Rev 0 "Missed Surveillance Due To Personnel Error." On May 24, the licensee discovered that the monthly Analog Channel Operational Test surveillance for the Containment Radiation Level monitors, IRE-0005 and IRE-0006, had not been performed since August 1987. An investigation revealed this TS surveillance (4.3.3.1) was linked to another TS surveillance (4.3.2.1) with the same requirement. Due to a TS change in August 1987, the TS 4.3.2.1 surveillance was deleted without realizing that TS 4.3.3.1 surveillance was no longer to be addressed. This event was caused by personnel error when an inadequate review of the TS changes was performed to determine the necessary changes to the surveillance data base. The procedure did not provide for data base revisions. Corrective actions include review of previous TS revisions to determine if other surveillance data base changes were needed. The procedure has been revised to require a two-party review for data base changes and will not allow "linking" between the TS surveillance items. The surveillance for monitor IRE-0005 was performed satisfactorily on May 24, but on May 25, monitor IRE-0006 failed the surveillance. Since only one operable monitor is required, the action statement was no longer applicable. This item was reviewed for enforcement in NRC Report 50-424/88-25. The change to Procedure 80012-C was verified to have the revision and the data change was reviewed.
- (g) 50-424/88-17, Revision 0 "Inadequate Procedure And Procedure Violation Leads To Missed Surveillance." On June 5, 1988 at approximately 1520 CDT it was discovered that a liquid release was being performed prior to completing a source check of the radiation monitor IRE-0018. The source check is a Technical Specification requirement prior to a release. The radwaste operator was notified and the release was stopped at approximately 1525 CDT. This event was caused by an inadequate procedure. The procedure which administratively controls the release of liquid radioactive waste did not require the source check to be performed. Two separate procedure violations, one by a chemistry technician and another by a radwaste operator, also contributed to the event. Corrective actions include a revision to the procedure to require a source check to be performed and counseling of the involved personnel on the importance of following the procedures. This item was reviewed for enforcement in NRC Report 50-424/88-31. The inspector

verified that counseling had occurred and reviewed the procedure changes.

- (h) 50-424/88-18, Revision 0 "Inadequate Work Instructions Lead To Technical Specification Violation." On June 6, 1988 at 0959 CDT, it was determined that Unit 1 had been operated in a condition prohibited by the TS. On June 5, 1988 at approximately 1530 CDT, work was performed on a particulate radiation monitor IRE-2562A. Due to the system alignment, when the coverplate was removed from IRE-2562A, the sample flow to monitor IRE-2562C was such it was also rendered inoperable. On June 6, 1988 at approximately 0028 CDT, the Containment Normal Sump Level was declared inoperable. At 0954 CDT on June 6, 1988, it was determined that IRE-2562C should have been declared inoperable when the coverplate for the A channel was removed and a six hour Hot Standby action statement should have been initiated, when the Containment Normal Sump Level was inoperable. This event occurred because of inadequate work instructions to the maintenance crew. Work planning will contact chemistry for input to TS related work orders for the Plant Effluent Radiation Monitor System, prior to being issued to the field. Maintenance will receive training and will contact the chemistry foreman prior to removing any monitor from service. This item was reviewed for enforcement in NRC Report 50-424/88-31. The inspector reviewed the June 20, 1988 letter discussing work order handling processes between chemistry and maintenance. The inspector has no further questions.
- (i) 50-424/88-25, Revision 0 "Reactor Trip Due To Lightning Strike." On July 31, lightning struck the Containment building and a reactor trip occurred. An investigation revealed that the electrical surge from the lightning strike shutdown the output of the CRDM power supplies allowing the rods to drop into the core, as designed. Several other plant systems were affected by the lightning strike, but these had no major impact on plant operations. The electrical surge from the lightning strike had caused the CRDM positive 24 volt DC and negative 24 volt DC power supplies to automatically shut down. All power supplies in the CRDM power supply cabinets were reset. Loss of these power supplies had caused power interruption to the CRDM thyristors, allowing the rods to drop into the core. This item was reviewed in NRC Report 50-424/88-31 listed as DC 1-88-2125. The inspector has no further questions.

6. Plant Review Board - (40700)

This inspection consisted of a review of the licensee's Onsite Review committee to determine if any significant safety-related responsibilities of the PRB are not adequately being met. The following requirements, guidance and licensee commitments were utilized as appropriate:

- 10CFR 50.73
- ANSI N18.7-1976
- RG 1.33 Revision 2, 1978
- FSAR section 13.4.1
- Technical Specification

This review included attendance at two PRB meetings and review of selected meeting minutes. The licensee's administrative procedure 00002-C "Plant Review Board - Duties and Responsibilities" was reviewed against appropriate commitments. The review was performed to determine if the PRB is properly fulfilling its function in the following areas:

- Compliance with the composition, duties and responsibilities as described in the TS,
- Review of all reportable events,
- Investigation of all violations of TS including recommendations to prevent future recurrences,
- Review of plant operations to detect potential nuclear safety hazards, and,
- Review of proposals which could affect nuclear safety,

Amendment number 37 to the FSAR apparently was sent to and issued by the NRC with neither the PRB nor General Manager's review. A DC (#1-88-2577) has subsequently been written. Future corrective action is dependent upon the disposition of the DC. Procedure 00402 Rev 8, License Document Change Request, paragraph 3.2.1 specifies that the PRB shall review License Documents as specified by the General Manager. This item represents a violation of NRC requirement which meet the criteria for non citation.

LIV 50-424/88-43-02, "Failure to conduct a review as required by TS 6.4.1.6".

7. Exit Interviews - (30703)

The inspection scope and findings were summarized on September 30, 1988 with those persons indicated in paragraph 1 above. The inspector described the areas inspected and discussed in detail the inspection results. No dissenting comments were received from the licensee. The licensee did not identify as proprietary any of the materials provided to or reviewed by the inspector during this inspection. Region based NRC exit interviews were attended during the inspection period by a resident inspector. This inspection closed one VIO, and ten LERs. The items identified during this inspection were:

IFI 50-424/88-43-01, "Verify resolution of restoring the SSMP to a condition to correctly indicate the operability status" - paragraph 4.a.

IFI 50-424/88-43-02, "Review Licensee Corrective Action for Correct Installation of Flow Elements" - paragraph 4.b.(7)

IFI 50-424/88-43-03, "Review Licensee Program for Ensuring Hazard Protection is Assured" - paragraph 5.a.(1)

LIV 50-424/88-43-01, "Failure to Implement MWO 18805645 Procedure Required by TS 7.7.1" - paragraph 5.a.(1)

LIV 50-424/88-43-02, "Failure to conduct a review as required by TS 6.4.1.6" - paragraph 6

8. Acronyms And Initialisms

AFW	Auxiliary Feedwater System
ANSI	American National Standard Institute
AWG	American Wire Gage
CCW	Component Cooling Water
CDT	Central Daylight Time
CFR	Code of Federal Regulations
CRDM	Control Rod Drive Mechanism
CVCS	Chemical Volume and Control System
DC	Deficiency Cards
DGP	Design Change Package
DCR	Design Change Request
DG	Diesel Generator
ENS	Emergency Notification System
ESF	Engineered Safety Features
FSAR	Final Safety Analysis Report
GM	General Manager
IFI	Inspector Followup Item
ISEG	Independent Safety Engineering Group
LCO	Limiting Conditions for Operations

Acronyms And Initialisms (cont'd)

LD	License Document
LER	Licensee Event Reports
MD	Maryland, State of
MFIV	Main Feedwater Isolation Valve
MOVATS	Motor Operated Valve Actuator Testing System
MWO	Maintenance Work Order
NPF	Nuclear Power Facility
NRC	Nuclear Regulatory Commission
NSCWS	Nuclear Service Cooling Water System
OSOS	On Shift Operations Supervisor
PRB	Plant Review Board
RCA	Radiation Control Areas
RCS	Reactor Coolant System
RG	Regulatory Guide
SG	Steam Generator
SS	Shift Supervisor
SSMP	Safety System Monitor Panel
STA	Shift Technical Advisor
TCV	Temperature Control Valve
TS	Technical Specification
URI	Unresolved Item
USS	Unit Shift Supervisor
VIO	Violation