

REPORT NO. 50-322/85-39

DOCKET NO. 50-322

LICENSE NO. NPF-36

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

INSPECTION AT: Wading River, New York

INSPECTION CONDUCTED: October 1 - 31, 1985

INSPECTORS: for Jack Strosnider
A. Berry, Senior Resident Inspector

11/14/85
Date Signed

for Jack Strosnider
E. L. Conner, Project Engineer, Section 1B

11/14/85
Date Signed

APPROVED: Jack Strosnider
J. R. Strosnider, Chief
Reactor Projects Section 1B, DRP

11/14/85
Date Signed

SUMMARY: During the inspection period, October 1, 1985 - October 31, 1985, the inspectors observed plant activities related to the completion of the 5% Power Ascension Test Program, and the beginning of the Maintenance/Modification outage. The inspectors observed various activities conducted during the outage, including replacement of sources in the reactor vessel and other refuel floor activities. In addition, the inspectors followed up a Part 21 notification from American Air Filter related to the Transamerica Delaval Diesel Generators, reviewed handling of changes to Station Procedures and completion of Maintenance Work Request.

No unacceptable conditions were identified. As a result of this inspection, two previously unresolved items were closed, and three new items were opened (One related to the Part 21 Diesel Generator notification).

This inspection involved 143 hours of inspection by the Senior Resident Inspector and a Region-based Project Engineer.

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DETAILS1. Persons Contacted

H. Carter, Operating Engineer
 N. DiMascio, Health Physics Engineer
 R. Grunseich, Operational Compliance Engineer
 R. Gutman, Modifications Engineer
 W. Hunt, Outage Engineer
 L. Lewin, Outage and Modifications Division Manager
 J. Nataro, QA Department Manager
 A. Peters, Plant Administrative Coordinator
 P. Pizzariello, Maintenance Engineer
 G. Rhoades, Lead Compliance Engineer - Impell Corporation
 J. Scalice, Operations Division Manager
 J. Schmitt, Radiological Controls Division Manager
 C. Seaman, Quality Controls Division Manager
 W. Steiger, Plant Manager
 C. Swenson, Modification Engineer
 D. Terry, Maintenance Division Manager

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

2. Status of Previous Inspection Item2.1 (Closed 80-02-01, 80-02-02 MSIV Leakage Control System and Primary Containment Atmospheric Control System.2.1.1 Main Steam Isolation Valve (MSIV) Leakage Control System

NRC Inspection Report 50-322/80-02 identified three concerns associated with the MSIV Leakage Control System. The licensee's action on these three concerns were subsequently reviewed in NRC Inspection Report 50-322/85-26. The concerns were: physical separation, post-accident discharge, and operating procedures.

Inspection Report 50-322/85-26 detailed the closure of the concerns regarding Physical Separation and Operating Procedures. The concern regarding Post-Accident Discharge was left open pending completion of the licensee's review and revision (as necessary) of specific procedures detailing operation of the MSIV-LCS to address:

- symptoms oriented guidance in the procedures to determine the need to operate the inboard subsystem;
- including appropriate levels of approval (i.e., Emergency Director) prior to start of inboard subsystem;

- correction of a precautionary statement in procedure SP23.406.01 relative to MSIV-LCS discharge location and the potential for contaminating the reactor building atmosphere.

The licensee's actions in this matter have been reviewed by the inspector. Station Procedure Change Notice No. 85-1310 was written to revise Procedure SP23.406.01, 'MSIV Leakage Control System' as follows:

- A new limitation (6.2) was added to Section 6.0 of the procedure which establishes the order of priority for system operation (outboard system prior to inboard), and requires Watch Engineer approval prior to operation.
- The limitation requires approval of the Emergency Director prior to the operation of the inboard system.
- Precaution Statement 4.1 was revised to state that the flow path from the MSIV-LCS is to the Reactor Building Standby Ventilation System, to the outside.

Symptomatic guidance which governs the initiation of the MSIV-LCS is incorporated already in SP29.023.03, 'Containment Control'. This procedure requires the operator to initiate the Leakage Control System if necessary, when primary containment pressure is high. The inspector found that the procedure change was approved by the Review of Operations Committee on October 21, 1985. The inspector's review determined that all concerns have been satisfactorily resolved. This item is closed.

2.1.2 Primary Containment Atmosphere Control System (PCAC)

NRC Inspection Report 50-322/80-02 also identified a concern associated with the Primary Containment Atmosphere Control System. The concern involved the discharge of the PCAC System into the secondary Containment. Subsequently, NRC Inspection Report 50-322/85-26 detailed NRC's review of the licensee's actions on this concern. This item was left open pending completion of the licensee's review and revision (as necessary) of specific procedures detailing operation of the PCAC system to address the following:

- development of symptoms oriented procedural guidance based on review of appropriate parameters to determine the need to initiate the system,

- specification of appropriate levels of approval (i.e., Emergency Director) prior to initiation of the system,
- upgrading of precautionary statements relating to discharge of radioactivity into secondary containment atmosphere.

The licensee's actions in this matter have been reviewed by the inspector. Station Procedure Change Notice No. 85-1311 was written to revise procedure 23.402.01, "Primary Containment Post LOCA Hydrogen and Oxygen Recombination" as follows:

- . Caution statements were added to the procedure to require Emergency Director/Watch Engineer approval prior to initiating venting, and
- . The licensee noted that procedural guidance already exists within SP29.023.03, "Containment Control" regarding sampling and parameter verification prior to venting.

The inspector verified that the procedure change was approved by the Review of Operations Committee on October 21, 1985. The inspectors review determined that all concerns have been satisfactorily resolved. This item is closed.

2.2 (Open) 50-322/85-36-01 Fitness for Duty Training Records

In the referenced inspection report, twenty (20) supervisory personnel who should have the fitness for duty training were not listed on the computer printout received from the training department. Two of this group told the inspector they had taken the required training.

During this inspection, the inspector attempted to resolve this open item. A training department representative indicated that the data for one of the individuals who said he had taken the training had been improperly entered in the computer. This has been corrected. He said the remaining computer record was correct and that it indicated the remaining 19 supervisors apparently had not taken the subject training. The remaining 19 supervisors names not on the computer listing maintained by the training department as having received the training was communicated to the licensee's compliance organization for resolution. The inspector also questioned why the computer report doesn't have the names of individuals that should receive the training. A response to the above will be reviewed at a later date.

3. Review of Facility Operations

3.1 Plant Status Summary

During the inspection period, the licensee completed testing under the 5% Power Ascension Test Program, and began a maintenance and modification outage that is expected to last approximately 60 - 70 days.

The 5% testing program concluded on October 8, 1985. Prior to conclusion of the test program, the licensee conducted an initial roll of the turbine generator on October 6, 1985. The turbine achieved synchronous speed at 7:45 p.m. The roll was initiated from 4.2% power, with one bypass valve half open. Response of reactor power, pressure and bypass valves were normal. At 10:20 p.m. the turbine was tripped due to high vibration. On October 7, 1985 the turbine was again rolled to synchronous speed, and additional vibration monitoring took place. No problems were noted. The licensee had planned to synchronize the Main Generator to the grid as part of the 5% testing program, but did not do so due to generator stator water cooling leaks. The Maintenance and Modification outage commenced on October 8, 1985 with shutdown and cooldown of the reactor. Major items scheduled to be accomplished during the outage include:

- Source replacement activities,
- Environmental Qualification modifications,
- Electrical System modifications
- Fire detections installation
- Control rod drive inspection/modification, and
- HPCI/RCIC Maintenance/Modifications.

The replacement of the startup sources involved the removal and replacement of five antimony-beryllium sources in the reactor vessel. This work began on October 21, 1985 with the beginning of the first replacement sequence. The replacement of all sources was completed on October 26, 1985.

Maintenance and modification work continued throughout the inspection period. Control Rod Blade 22-35 was removed from the core on October 28, 1985 for inspection. Inspection by maintenance and GE personnel indicated that the blade needed to be replaced. Spare rods were on site, and at the end of the inspection period, the licensee was planning to complete installation of the spare blade. (See Section 9.0 for further discussion of the Maintenance/Modification Outage Activities.)

3.2 Operational Safety Verification

The inspector toured the control room daily to verify proper shift manning, use of and adherence to approved procedures, and compliance with Technical Specification Limiting Conditions for Operation. Control panel instrumentation and recorder traces were observed and the

status of annunciators was reviewed. Nuclear instrumentation and reactor protection system status were examined. Radiation monitoring instrumentation, including in-plant Area Radiation monitors and effluent monitors were verified to be within allowable limits, and observed for indications of trends. Electrical distribution panels were examined for verification of proper lineups of backup and emergency electrical power sources as required by the Technical Specifications.

The inspector reviewed Watch Engineer and Nuclear Station Operator logs for adequacy of review by oncoming watchstanders, and for proper entries. A periodic review of Night Orders, Maintenance Work Requests, Technical Specification LCO Log, and other control room logs and records was made. Shift turnovers were observed on a periodic basis.

The inspector also observed and reviewed the adequacy of access controls to the Main Control Room and verified that no loitering by unauthorized personnel in the Control Room Area was permitted. The inspector observed the conduct of Shift personnel to ensure adherence to Shoreham Procedures 21.001.01, "Shift Operations" and 21.004.01, "Main Control Room - Conduct of Personnel".

The inspector noted that on-shift personnel conducted themselves in a dedicated and professional manner, and that watchstanding personnel were fully aware of plant status and ongoing activities. The inspector also noted that the physical layout of the control room, and presence of the security console in the control room are factors which sometimes lead to excessive noise and congestion, but that Shift supervisory personnel and watchstanders do an effective job of minimizing disruption in the control room.

No unacceptable conditions were identified.

3.3 Plant and Site Tours

The inspector conducted periodic tours of accessible areas of plant and site throughout the inspection period. These included: the Turbine and Reactor Buildings, the Rad Waste Building, the Control Building, the Screenwell Structure, the Fire Pump House, the Security Building, and the Colt Diesel Generator Building.

During these tours, the following specific items were evaluated:

- Fire Equipment - Operability and evidence of periodic inspection of fire suppression equipment;
- Housekeeping - Maintenance of required cleanliness levels;
- Equipment Preservation - Maintenance of special precautionary measures for installed equipment, as applicable;

- QA/QC Surveillance - Pertinent activities were being surveilled on a sampling basis by qualified QA/QC personnel;
- Component Tagging - Implementation of appropriate equipment tagging for safety, equipment protection, and jurisdiction.
- Personnel adherence to Radiological Controlled Area rules, including proper Personnel frisking upon RCA exit.
- Access control to the Protected Area, including search activities, escorting and badging, and vehicle access control.
- Integrity of the Protected Area boundary.

No unacceptable conditions were identified.

3.4 Administrative Matters

3.4.1 Review of Operations Committee (ROC)

Several Review of Operations Committee Meetings were attended by the inspector during the inspection period. During these meetings, the inspector verified the required Technical Specification composition and quorum for the committee. The inspector also verified that appropriate reviews of safety evaluations and issues were presented.

No unacceptable conditions were identified.

3.4.2 Plant Organizational Changes

During the inspection period, the licensee made the following changes in personnel who have frequently interfaced with the Nuclear Regulatory Commission.

- . Mr. C. Seaman was named Division Manager of the Quality Controls Division. He replaced Mr. A. Muller, who became Division Manager of the Quality Assurance Division.
- . Mr. R. Grunseich was named Operational Compliance Engineer replacing Mr. G. Rhoades (Impell Corporation) who has left the site.
- . Mr. G. Gisonda was named Supervisor, Nuclear Licensing, replacing Mr. R. Grunseich.
- . Mr. J. Wynne was named Supervisor of Licensed Operator Training and Requalification, replacing Mr. K. Rottkamp who was named Supervisor, Shoreham Simulator Project.

4. Licensee Reports4.1 In Office Review of Licensee Event Reports

The inspector reviewed Licensee Event Reports (LERs) submitted to the NRC to verify that details were clearly reported, including accuracy of the cause description and adequacy of corrective action. The inspector determined whether further information was required from the licensee, whether generic implications were involved, and whether the event warranted onsite follow-up. The following LERs were reviewed.

<u>LER NUMBER</u>	<u>TITLE</u>
*** 85-036-00	Reactor Water Cleanup Inboard Isolations While Adjusting Blowdown Flow.
85-037-00	RPS Actuation due to valving in of instrument connected to variable leg.
* 85-038-00	"B" RPV Reference Leg Failed High.
** 85-039-00	CRAC Initiation due to low Reactor Building differential pressure.
** 85-040-00	CRAC/RBSVS initiation due to voltage dip caused by thunderstorm.
85-041-00	Bomb Threat.
85-042-00	Mechanical Disturbances on variable leg causes low level trip.
85-043-00	RPS Actuation due to valving in instrument stand to variable leg.
85-044-00	RWCU Isolation due to technician error.
85-046-00	ESF Actuations and Suspended Fire Watches due to Hurricane "Gloria".
85-047-00	Auto-start of Emergency Diesel Generator 103 due to operator error.

No unacceptable conditions were identified.

*Details on this event may be found in section 6.0 of NRC inspection report 50-322/85-36.

**Details on these events may be found in section 8.0 of NRC inspection report 50-322/85-36.

***Further discussed in Section 4.2.1.

4.2 Onsite Followup of Licensee Event Reports

For those LERs selected for onsite follow-up (denoted by triple asterisks in detail 4.1), the inspector verified; the reporting requirements of 10 CFR 50.73 and Technical Specifications had been met, that prompt and effective corrective action had been taken, that the licensee had reviewed the event to determine ways to prevent future occurrence, and determined whether follow-up action is required.

4.2.1 LER 85-036-00, " Reactor Water Cleanup Inboard Isolations While Adjusting Blowdown Flow."

Within the period September 3, 1985 - October 1, 1985, four inboard isolations of the Reactor Water Cleanup system occurred due to high delta-flow trips. Each of these four isolations occurred while operators were adjusting blowdown flow to the Main Condenser. All four occurrences were due to problems with the sensitivity of the flow sensing circuitry in the RWCU system.

The Reactor Water Cleanup system is used during reactor startup and heatup to maintain proper reactor vessel level. In this mode, the Blowdown Flow Control Valve (HCV-004) is used to adjust a desired flowrate of reactor water back to either the Main Condenser or the Rad Waste system. This flow is controlled by a controller in the main control room which has manual control only.

The reactor water cleanup system has a leak detection system which will isolate the system upon detection of; RWCU area high temperature, RWCU delta flow high, or low-low reactor water level. The delta flow high portion of this logic compares the RWCU inlet flow to the sum of the return flow and blowdown flow. If this differential exceeds 44 gallons per minute for greater than 45 seconds, an isolation will occur. The purpose of the time delay is to allow isolation signal override during system startup.

In each of the four isolations which occurred, the inboard isolation valve (MOV-033) closed, the RWCU pump tripped, and a RWCU Inboard Leakage High Isolation alarm was received as the operator was adjusting blowdown flow. Immediate actions, in all four instances, verified that no leakage had occurred. The system was returned to normal, and blowdown operations continued.

The licensee has attributed the cause of the problem to problems in the flow sensing circuitry of the RWCU system. Three flow transmitters provide signals to the isolation logic. One transmitter (FT-011) is located on the discharge line from the RWCU pumps, one (FT-012) is located on the return line to the vessel, and one (FT-013) is located on the blowdown line. These three flow transmitters input to a summer which compares the values and provides a delta flow value. The licensee is calibrating all of the individual components in the RWCU flow sensing circuitry to determine the exact cause of the problem. The licensee will submit a supplemental report when corrective actions are complete and the definite cause has been identified. A review of that supplemental report will be detailed in a future inspection. Until that time this is designated Unresolved Item 50-322/85-39-01.

5. Monthly Surveillance and Maintenance Observation

5.1 Surveillance Activities

The inspector observed the performance of various surveillance tests to verify that; the surveillance procedure conformed to technical specification requirements, administrative approvals and tagging requirements were reviewed and approved prior to test initiation, testing was accomplished by qualified personnel, current approved procedures were used, test instrumentation was currently calibrated, limiting conditions for operation were met, test data was accurately and completely recorded, removal and restoration of affected components was properly accomplished, and tests were completed within the required Technical Specification frequency.

Observations of the following Surveillance Activities were made:

- . SP 24.608.01 Refuel Interlocks Test
- . SP 24.602.01 IRM Functional Test
- . SP 24.121.03 LPCI Valve Lineup Verification
- . SP 24.008.01 Refuel Bridge Surveillance

No unacceptable conditions were identified.

5.2 Maintenance Activities

The inspector observed the conduct of various maintenance activities throughout the inspection period. During this observation, the inspector verified that; maintenance activities were conducted within the requirements of the plant's administrative procedures and technical specifications, proper radiological controls were implemented and observed, proper safety precautions were observed, and that activities which have the potential to impact plant operations are properly coordinated with the control room.

The following activities were observed:

- . Reactor Building Fire Detector installation
- . Refuel floor activities
- . Division 3 electrical work
- . Screenwell and Service Water Pump work

No unacceptable conditions were identified.

6. Review and Followup of IE Notices, Bulletins and Generic Letters

6.1 IE Notices

The inspector reviewed notices issued by the Office of Inspection and Enforcement during the inspection period. Review was to determine; if the subject of the notice was applicable to the Shoreham Nuclear Power Station, and if follow-up of the licensee's action was required by the inspector.

Three IE Notices, (85-17 - Supplement 1, 85-80, and 85-82) were received and reviewed during this inspection period.

Notice No. 85-17, Supplement I relates to the possible sticking of ASCO Solenoid Valves. The inspector verified that Shoreham does not have ASCO Solenoid Valve Model HTX 8323-20V, the subject of the notice, and therefore the notice does not apply.

Notice No. 85-80 relates to Timely Declaration of an Emergency Class, Implementation of an Emergency Plan, and Emergency Notifications. This notice was informational in nature, and therefore no follow-up is required.

Notice No. 85-82 relates to Diesel Generator Differential Protection Relays not being Seismically Qualified. The notice describes a potentially significant safety problem involving a General Electric Model 12 CFD relay that is not seismically qualified for Class IE service when in the de-energized state of operation. The inspector verified that Shoreham uses three GE Model 12 CFD relays for the Transamerica Delaval Diesel Generators (EDG 101, 102 and 103). The licensee is reviewing this information, and is considering what action(s) to take. The follow-up of this I&E Notice will be the subject of a future inspection report (50-322/85-39-02).

7. Part 21 Notification - American Air Filter

The NRC received a Part 21 notification dated September 3, 1985 from American Air Filter (AAF) which stated that Intake Silencers supplied by AAF to Transamerica Delaval (TDI) for use on Standby Diesel Generators may have an internal part which is not welded in place. AAF stated that if the part is not welded in place, as required by design, it is possible for it to be ingested into the engine upon startup.

Shoreham was one of the facilities mentioned in the AAF notification. NRC contact with TDI indicated that they had notified affected facilities. The inspector verified that Shoreham's Diesel Generator Air Silencers are AAF Model FTDM-30-8-4R, which is one of the two models cited by AAF in their letter as having the potential flaw. The inspector then contacted the Maintenance Division Manager, the QA Division Manager, the QA Department Manager, and the Nuclear Operations Support Division to verify that Shoreham had responded to the concerns of the Part 21 report. Investigation by these individuals determined that LILCO had received no notification from Transamerica Delaval or American Air Filter regarding the Intake Silencers. The inspector obtained a copy of the Part 21 notification from the NRR Licensing Project Manager and provided it to the QA Division Manager. The licensee contacted Transamerica Delaval to determine why no notification was made to them.

In the Part 21 report, AAF states that the likelihood of the presence of the flaw is much lower if the engine has already been in service. The Shoreham TDI Diesel Generators, (EDG 101, 102 and 103) have each accumulated over 1200 hours of running time without any problem being experienced with the silencer. However, the licensee immediately contacted AAF to obtain detailed instructions for silencer inspection, and began planning to accomplish inspection of all three diesel generators during the present outage period.

The potential flaw involves the lack of a weld on each of two end caps of the centerline "bullet" of the silencers. These end caps must be welded to the cylindrical section of the silencer. Absence of the weld allows the sizable part to be held in place solely by friction. Air pressure and vibration which would exist during engine operations could dislodge the part and convey it downstream to the engine's turbocharger.

The results of Shoreham's inspection of the three TDI Diesel Generators will be detailed in a future inspection report. Pending the outcome of those inspections, this is designated Unresolved Item No. 50-322/85-39-03.

8. Emergency Response Exercise

The inspector observed a portion of an internal LILCO Emergency response exercise conducted on October 31, 1985. The inspector found the drill scenario and performance of the plant staff in the Technical Support Center to be acceptable.

No unacceptable conditions were identified.

9. Maintenance and Modification Outage Activities

A maintenance and modification outage, scheduled to last approximately 60-70 days was begun on October 8, 1985. Major activities scheduled to be included in this outage include:

- Replacement of five antimony-beryllium startup neutron sources in the core,
- Environmental Qualification modifications,
- Electrical system/Diesel generator modifications,
- Fire detection installation in the reactor building,
- Control rod drive inspection/modification,
- HPCI/RCIC maintenance and modification, and
- Nuclear Instrumentation repair work.

Drywell head removal was completed on October 10, 1985. An inspection of the bellows area in the reactor cavity indicated some loose paint chips which were cleaned and removed prior to the removal of the reactor vessel head on October 15, 1985. Actual core alterations, the first source sequence exchange, began on October 21, 1985. Each of the five sequences involved removal of the four fuel bundles surrounding the source holder, removal of the source holder from the core, removal of the old source pins from the holder, installation of the new source pins in the source holder, reinstallation of the source holder in the core, and reloading of the four fuel bundles into the core. The start of core alterations was delayed due to required maintenance on the refueling bridge and polar crane following their respective surveillance tests.

In conjunction with core alterations, work continued on; Electrical Division 3, the Auxiliary Boiler, an alternate air supply to the post accident sampling facility, the screenwell bays, suppression pool inspection, and other maintenance/modification work.

The replacement of the five sources was completed on October 26, 1985. Upon completion of source replacement, work on control rod 22-35 began. The licensee had experienced problems with rod 22-35 during the 5% Power Ascension Test Program, specifically, the inability to withdraw the rod to position 48. Removal and inspection of the Control Rod Drive Mechanism and blade was scheduled for this outage to determine the cause of the problem. The CRD and Blade were removed on October 28, 1985. Inspection of the blade by LILCO Maintenance and General Electric personnel indicated that the blade would have to be replaced. A spare blade on site was obtained, and inspection to ensure its acceptability for use was commenced. The blade was scheduled to be installed in the core at the end of the inspection period.

Also during the period, work on Division 3 of the electrical distribution system was completed, and it will be returned to service at the beginning of the next inspection period, at which time Division 1 work will begin.

Environmental Qualification modifications required to be completed by the November 30, 1985 NRC commitment date continued with no major problems experienced. The licensee does not anticipate any problems in meeting the November 30th deadline, but has requested an extension from the Commission beyond the November 30, 1985 date for two items which have the potential for failing to meet the deadline.

The two items that the licensee is requesting an extension for are:

- (1) Hydrogen Recombiners in the Primary Containment Atmosphere Control System, and
- (2) Raymond Mask Damper Actuators in the Reactor Building Standby Ventilation System.

The basis for the request is the potential for minor delays in parts delivery, potential minor and correctable testing difficulties, and slowness in test documentation. The potential for these delays exist due to problems which have occurred with vendor environmental qualification testing and verification. (Ref SNRC-1199, J. D. Leonard, Jr., V.P. Nuclear Operations, LILCO to Chairman N. J. Palladino, et al, U. S. Nuclear Regulatory Commission, "Response to Generic Letter 85-15 Information Relating to the Deadline for Compliance with 10CFR50.49, "Environmental Qualification of Electrical Equipment Important to Safety for Nuclear Power Plant" Shoreham Nuclear Power Station - Unit 1 Docket No. 50-322". As of the end of this inspection period the Commission had not ruled on the licensee's extension request.

No unacceptable conditions were identified.

10. Neutron Source Changeout

The antimony-beryllium neutron sources located in five (5) positions of the core have decayed to the point that the T.S. 4.9.2.c minimum SRM count rate of 0.7 cps may not be met in the near future. These antimony sources are being replaced with stronger (more highly irradiated) sources during the current outage.

An inspector observed the source changeout from the refueling floor and/or the bridge at various times during the operation. During the first observation, late on mid-shift on October 21, 1985, the inspector noted that the maintenance crew was following a GE handwritten method for using the source upending tool that amplified the instructions given in approved procedure, (SP 35.703.05). The inspector questioned the use of such a hand written instruction, and brought the matter to the attention of the SRO overseeing Refuel floor operations. The SRO stopped the job and a Temporary Procedure Change (TPC) was initiated to include the GE method in SP 35.703.05. The remainder of the source changeout went smoothly.

On October 22, 1985, the inspector reviewed the TPC prepared and approved for the source upending tool operation (TPC 85-719). The GE handwritten

method had been typed and attached to the TPC. The stated justification was, "This amplification is needed for detailed instruction for the source handling inverter tool." TPC 85-719 has been sent to the Review of Operations Committee for their review/approval.

Concern was raised by the inspector that this use of a handwritten instruction was a violation of procedural controls. Subsequent investigation and review by the Senior Resident Inspector determined that no violation of procedural controls had occurred for the following reasons:

- . Procedure SPF 31.010.01 provides that "Written instructions may be provided by the Maintenance Engineer to assist in performing the job". The inspector verified that the written instructions provided by General Electric (GE) had been reviewed by the Maintenance Engineer prior to their use by personnel on the refuel floor.
- . A detailed review by the inspector has determined that the instructions were not meant to replace or overrule procedural guidance, but rather were amplification upon already existing, approved procedural steps.
- . The inspector confirmed that personnel using the source upending tool had received training by General Electric Company in the use of the tool and that the written instructions did no more than summarize the techniques taught in the training.
- . The inspector noted that procedures are not meant to detail every step one must take to perform a task, and that the intent of procedures is not to guide an untrained, inexperienced person through a series of actions. Procedures are used by trained, qualified personnel who possess skills appropriate for the work involved.

The inspector verified that on October 24, 1984, the Review of Operations Committee reviewed the Temporary Procedure Change (85-719) which was written at the time of the occurrence of this issued, and noted that the committee did not recommend that the TPC be made a permanent procedure change. The committee did approve its temporary use for 30 days. The inspector had no further questions.

11. Temporary Procedure Changes

As a result of initial follow-up of the TPC detailed in Section 10.0, an inspector met with the Plant Administrative Coordinator (PAC) and his staff to review how procedure changes are controlled. This group had received and processed 25 to 35 requests for procedure changes under the SPCN (Station Procedure Change Notice) or TPCN method with a current backlog of 40. The requests are prioritized by date received or other criteria (such as important to safety). The PAC's TPC Log Book and Chronological Log, required by SP 12.006.01, were reviewed and found up-to-date. There are currently 47 controlled sets of procedures that are kept up by the PAC group. The inspector had no further questions.

12. Unresolved Items

Areas for which more information is required to determine acceptability are considered unresolved. Unresolved items are discussed in Section 4.2.1, 6.1, and 7.

13. 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. Except as detailed in Section 7 no written material was provided to the licensee by the inspector during this inspection. The Senior Resident Inspector met with the Operations Division Manager, in his capacity as Acting Plant Manager, on October 31, 1985 to summarize and review the results of the inspection period.

Based on NRC Region I review of this report, and discussions with licensee representatives, it was determined that this report does not contain information subject to 10 CFR 2.790 restrictions.

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