

U. S. NUCLEAR REGULATORY COMMISSION

REGION III

Reports No. 50-254/85017(DRP); 50-265/019(DRP)

Docket Nos. 50-254; 50-265

Licenses No. DPR-29; DPR-30

Licensee: Commonwealth Edison Company  
Post Office Box 767  
Chicago, IL 60690

Facility Name: Quad Cities Nuclear Power Station, Units 1 and 2

Inspection Conducted: June 1 through July 31, 1985

Inspectors: A. L. Madison

A. D. Morrongiello

Approved By: *for John F. Sullivan*  
G. C. Wright, Chief  
Reactor Projects Section 2C

*8/20/85*  
Date

Inspection Summary:

Inspection on June 1 through July 31, 1985 (Reports No. 50-254/85017(DRP); 50-265/85019(DRP))

Areas Inspected: Routine, unannounced inspection by the resident inspectors of actions on previous inspections findings; operations; radiological controls; maintenance/modifications; surveillance; housekeeping procedures, fire protection; emergency preparedness; security; quality assurance; quality control; administration; routine reports; LER review; TMI items; Review and Audits including Site Review Committee; Receipt, storage and handling of Equipment Program; Spent Fuel Pool Activities; and independent inspection. The inspection involved a total of 391 inspector-hours onsite by two NRC inspectors, including 80 inspector-hours onsite during off-shifts.

Results: Two violations were identified. The first involved inadequate shift turnover and the second lack of proper protective covers for safety related items in storage. Additionally, an item of concern relating to safety system challenges was identified in the maintenance area. Overall, the licensee's performance has remained steady.

## DETAILS

### 1. Persons Contacted

\*N. Kalivianakis, Superintendent  
\*D. Bax, Assistant Superintendent for Maintenance  
T. Lihou, Technical Staff Supervisor  
R. Roby, Senior Operating Engineer  
\*N. Griser, Senior Quality Assurance Specialist

The inspectors also interviewed several other licensee employees, including shift engineers and foremen, reactor operators, technical staff personnel, and quality control personnel.

\*Denotes those present at the exit interview on July 31, 1985.

### 2. Routine Inspection

The resident inspectors, through direct observation, discussions with licensee personnel, and review of applicable records and logs, examined the areas stated in the inspection summary and accomplished the following inspection modules.

37700	Design Changes and Modifications
38702	Receipt, Storage and Handling of Equipment Program
40700	Review and Audits, including State Review Committee
42700	Plant Procedures
61726	Monthly maintenance observations
62703	Monthly maintenance observations
71707	Operational safety verification
71710	ESF system walkdown
86700	Spent Fuel Pool Activities
90713	Review of periodic and special reports
92700	Onsite review of LERs
92701	TMI Action Items
92706	Independent inspection
93702	Onsite followup of events

The inspectors verified that activities were accomplished in a timely manner using approved procedures and drawings and were inspected/reviewed as applicable; procedures, procedure revisions and routine reports were in accordance with Technical Specifications, regulatory guides, and industry codes or standards; approvals were obtained prior to initiating any work; activities were accomplished by qualified personnel; the limiting conditions for operation were met during normal operation and while components or systems were removed from service; functional testing and/or calibrations were performed prior to returning components or systems to service; independent verification of equipment lineup and

review of test results were accomplished; quality control records and logs were properly maintained and reviewed; parts, materials, and equipment were properly certified, calibrated, stored, and or maintained as applicable; and adverse plant conditions including equipment malfunctions, potential fire hazards, radiological hazards, fluid leaks, excessive vibrations, and personnel errors were addressed in a timely manner with sufficient and proper corrective actions and reviewed by appropriate management personnel.

Further, additional observations were made in the following areas:

a. Action on Previous Inspection Findings

(Closed) Open Item 254/85007-01 and 265/85007-02: Install 48V Battery Seismic - side Spacing Problems. This item was used to track completion of modifications to the station 48V batteries to correct side spacing problems. It was determined by the licensee that adjustments could be made to the existing battery supports and, therefore, no modifications were required. Proper adjustments were made. No further actions are required.

(Closed) Open Item 265/85004-01: No Procedures For Dropped or Otherwise Damaged Fuel Bundle. This item addressed concerns with the adequacy of the licensee's refueling procedures and identified the following weaknesses:

- (1) No procedures for the refueling crew in the event of a dropped or otherwise damaged fuel bundle.
- (2) No requirements to ensure adequate radiation monitoring during fuel movement.
- (3) No guidance given in the event of a loss of water level during refueling operations.

The licensee initiated changes to appropriate procedures to address these weaknesses prior to refueling operations on Unit 2. The inspectors reviewed these changes and found them adequate. No further actions are required.

(Closed) Open Item 254/85012-02 and 265/85013-02: Station Battery Surveillance and Maintenance Procedure Changes. This item was used to track procedure changes to address the following two concerns:

- (1) No post-maintenance testing following cell jumpering or replacement.
- (2) No requirement for float charge as part of initial conditions for weekly and quarterly surveillances.

Changes to appropriate procedures have been accomplished and reviewed by the inspectors. No further actions are required.

No violations or deviations were identified.

b. Operations

Unit 1 was in operation at the beginning of the report period. On June 8, 1985, a Residual Heat Removal Services Water (RHRSW) pump was found to have a broken seal cooling water line. This placed the Unit in a 30 day Limiting Condition for Operation (LCO). During testing of equipment required by the LCO, it was discovered that the Torus Spray Valve would not open. Since the requirements of the LCO could not be met, an Unusual Event was declared and a shutdown was initiated. Subsequently, the RHRSW pump and valve were repaired and returned to service and the Unusual Event and the shutdown were terminated.

On June 17, 1985, a vent line on 1 C RHRSW pump ruptured, spraying water on 1 B RHRSW pump and the 1/2 Diesel Generator service water (DGSW) pump. This placed Unit 1 in an Unusual Event and an orderly shutdown was initiated. Several hours later the leak was stopped and the 1 B RHRSW pump and 1/2 DGSW pump were returned to service. The Unusual Event and the shutdown were then terminated.

On July 11, during panel checks for shift turnover on Unit 1, it was found that the High Pressure Coolant Injection (HPCI) controller had been left in the manual position instead of automatic following testing. This was the second shift change to occur following completion of testing. The controller was set to 100% so HPCI would have injected adequate cooling water upon an initiation signal. However, QAP 300-7: "Shift Change Nuclear Station Operators", requires that both the offgoing and oncoming operators check the control room panels pursuant to QOS 005-2: "Normal Control Room Inspection and Shift Turnover Panel Check". QOS 005-2 requires the HPCI flow controller to be in automatic.

The initiating cause was an inadequate test procedure which did not require the controller to be returned to automatic. Personnel error on the part of the offgoing and oncoming operators in not performing an adequate shift turnover allowed the controller to remain in that condition. This is a violation (254/85019-01(DRP)).

On July 25, 1985, the licensee declared an Unusual Event when it was determined that the room cooler for one RHR corner room was inoperable. This made two RHR pumps inoperable and a third was already out of service for repair purposes. Therefore, with three out of four RHR pumps inoperable, an orderly shutdown was commenced. Several hours later the room cooler was repaired and the Unusual Event and Shutdown were terminated. Unit 1 remained at full power at the close of the report period.

Unit 2 was shut down for a maintenance and refueling outage at the beginning of the report period. On June 5, 1985, the unit returned to power and, except for minor reductions for testing and load

dispatcher requirements, remained at power throughout the remainder of the report period. The smooth startup and relatively trouble free operation of Unit 2 are evidence of an effective maintenance program.

During plant tours of Units 1 and 2, the inspectors walked down the accessible portions of the Standby Liquid Control Systems, the Standby Gas Treatment Systems, and the Reactor Core Isolation Cooling Systems and performed the applicable portions of Inspection Procedure 71710 "ESF System Walkdown".

No other violations or deviations were identified.

c. Radiological Controls

On July 24, 1985, the licensee confirmed that a pipe used to transfer processed water from the liquid radwaste treatment facility to the Condensate Storage Tanks (CST) had developed a leak. The pipe is five feet below ground and covered by the radwaste concrete floor. Discovery was made due to water seepage through the floor. The licensee has isolated the pipe and intends to replace it with above ground piping.

Initial on-site sampling and observations by the licensee indicate that no off-site releases have occurred. The concentration of activity in the CST based on a gamma isotopic analysis is below the maximum permissible concentration for unrestricted release. The licensee and Region III are continuing to investigate this matter. Final resolution will be tracked as an Open Item (254/85017-02(DRP) and 265/85019-01(DRP)).

No violations or deviations were identified.

d. Maintenance

The following activities were observed/reviewed:

- (1) Observed repair work and installation of 1B Turbine oil cooler.
- (2) Observed mechanical repair work on 2A Recirculation Motor Generator.
- (3) Observed mechanical repair work on 1A Diesel fire pump.
- (4) Observed electrical repair work on 1B Service Water motor.
- (5) Reviewed replacement of 1B Residual Heat Removal Pump.
- (6) Reviewed repairs to Unit 2 Scram Discharge Volume Instrumentation.



On July 29, 1985, Unit 2A Fuel Pool monitor tripped spuriously causing an automatic initiation of Standby Gas Treatment. All systems responded as required. This is not a significant safety issue. However, a large number of spurious trips have occurred in the recent past as documented in LER 85005, 85012, and 85014 for Unit 1, and this has resulted in excessive challenges to plant safety systems. Also normal corrective maintenance does not appear effective in preventing these spurious actuations. This is an item of concern and will be tracked as an Unresolved Item (254/85017-03 (DRP) and 265/85019-02(DRP)).

The licensee has been requested to respond in writing identifying what actions are intended to eliminate any further spurious actuations and the schedule for completion of these actions.

No violations or deviations were identified.

e. Surveillance

The following activities were observed/reviewed:

- (1) Observed High Pressure Coolant Injection overspeed test for Unit 2.
- (2) Observed hot scram timing for Unit 2.
- (3) Observed Unit 1 Power Operation Functional Test (QIS - 60).
- (4) Observed Unit 2 Reactor High Pressure Automatic Blowdown Calibration.
- (5) Observed Unit 2 Main Steam line Radiation Scram and Isolation testing (QIS - 31).
- (6) Observed magnetic particle testing of lift piers for turbine strongback.
- (7) Observed Unit 2 Vessel level instrument calibration checks.
- (8) Observed Unit 1 Local Power Range Monitor calibration and associated Transverse Incore Probe operations.
- (9) Reviewed Operability testing of Unit 2 Reactor Core Isolation Cooling system.

No violations or deviations were identified.

f. Procedures Reviewed

The following procedures were reviewed:

<u>QIS 34-1</u>	Rev. 7	Reactor Building Ventilation Monitoring Calibration
<u>QIS 34-2</u>	Rev. 6	Reactor Building Ventilation Monitoring Functional Test
<u>QOA 4100-2</u>	Rev. 2	Fire Protection System Failure
<u>QOA 1700-5</u>	Rev. 3	Main Steam Line High Radiation
<u>QOA 5450-6</u>	Rev. 6	Off-Gas Recombination at a Location Other Than the Recombiner
<u>QOP 020-1</u>	Rev. 3	Sealing a Penetration in Secondary Containment
<u>QMP 100-12</u>	Rev. 5	Electrical Maintenance of Safety-Related and Non-Safety-Related Motor Operated Valves
<u>QMP 100-2</u>	Rev. 4	Control and Handling of Welding Electrodes and Bare Wire
<u>QMP 300-5</u>	Rev. 6	Steam Separator Removal
<u>QRP 1210-2</u>	Rev. 2	Film/TLD Badge Issuance and Completion of Occupational External Radiation Exposure History Form (NRC)
<u>QIS 27-1</u>	Rev. 6	HPCI Turbine Area High Temperature Isolation Calibration
<u>QIS 45-1</u>	Rev. 2	Primary Containment CAM Radiation Monitor Source Calibration Check
<u>QMS 200-S3</u>	Rev. 5	Diesel Inspection - Monthly
<u>QMS 7500-1</u>	Rev. 4	Standby Gas Treatment Automatic Start
<u>QOS 005-2</u>	Rev. 8	Normal Control Room Inspection and Shift Turnover Panel Check
<u>QOS 500-1</u>	Rev. 6	Mode Switch in Shutdown; Scram Instrumentation Functional Test
<u>QRP 1170-1</u>	Rev. 1	Administrative Controls for Health Physics Instrumentation
<u>QRP 1610-S4</u>	Rev. 5	Access Control Point Checklist
<u>QOP 1900-19</u>	Rev. 1	Discharging Fuel Pool Cooling into the RHR Injection Loop
<u>QOP 201-4</u>	Rev. 1	Draining Reactor Cavity to the Suppression Chamber
<u>QTP 500-6</u>	Rev. 3	Guidelines for Development of Tests for Modifications
<u>QTP 500-11</u>	Rev. 23	Safety-Related, Code-Related, and Engineering Assisted Modifications
<u>QTP 500-12</u>	Rev. 19	Non Safety-Related, Non Code-Related Non Engineering Assisted Modifications
<u>QDM-11</u>	Rev. 12	Drawing and VETI Control for Work Requests, Procedures, and Plant Modifications
<u>QDM-11-T1</u>	Rev. 3	Central File Document Update Notice
<u>QDM-14</u>	Rev. 1	Processing of Controlled Vendor Equipment Technical Information (VETI) Document
<u>QOP 6900-1</u>	Rev. 5	250 VDC Electrical System
<u>QOP 6900-2</u>	Rev. 5	125 VDC Electrical
<u>QOP 6900-3</u>	Rev. 6	48/24 VDC Electrical System
<u>QOS 6900-1</u>	Rev. 10	Station Battery Weekly Surveillance
<u>QOS 6900-2</u>	Rev. 8	Station Battery Quarterly Surveillance
<u>QOS 6900-4</u>	Rev. 2	Station Battery Monthly Surveillance
<u>QOS 6900-S1</u>	Rev. 11	Station Batteries (Weekly)

<u>QOS 6900-S2</u>	Rev. 10	250 VDC Station and Computer UPS Batteries (Quarterly)
<u>QOS 6900-S3</u>	Rev. 8	125 VDC Station Batteries (Quarterly)
<u>QOS 6900-S4</u>	Rev. 9	24/84 VDC Station Batteries (Quarterly)
<u>QOS 6900-S6</u>	Rev. 3	Station Batteries (Monthly)

g. Review of Routine and Special Reports

- (1) The inspectors reviewed the monthly performance report for Units 1 and 2 for the months of May and June, 1985.
- (2) The inspectors reviewed a special report detailing the actions connected with finding that the recombiner for Unit 1 was not put on the line prior to reactor pressure reaching 900 psig as required by the Technical Specifications.

On May 17, 1985, Unit 1 was in the STARTUP mode at less than 1 percent thermal power. Control rods were being pulled and Reactor pressure was increasing. During this time, difficulty was experienced with condenser vacuum. This difficulty led to the belief that a possible vacuum leak had developed, and therefore, efforts were concentrated on locating the leak. Because of this preoccupation with the potential vacuum leak, a Recombiner was not put on-line when Reactor pressure reached 700 psig as required by the Normal Startup Procedure. A Recombiner is required to be in operation whenever Reactor pressure is above 900 psig in accordance with Technical Specification 3.8.A.5.a. However, Technical Specification 3.8.A.5.b allows the Recombiner to be made inoperable for 48 hours. In this case, Reactor pressure reached 900 psig at approximately 3 a.m. on May 17, but the 1A Recombiner was not put on-line until approximately 8 a.m. on May 17 when Unit 1 was operating at 458 MWt. No equipment failures were involved, therefore, no action was required to prevent a recurrence of equipment failures, and the 1A Recombiner was put on-line using normal procedure.

The immediate corrective action upon discovery was to put the 1A Recombiner on-line. Because the Shift Engineer has the ultimate responsibility of seeing that plant operation is in compliance with the plant's operating license and operating procedures, a discussion with all Shift Engineers regarding this deviation was conducted by Station management. This was the first time that Recombiner operation was inadvertently overlooked since the new Technical Specification requirement to have a Recombiner in operation when Reactor pressure exceeds 900 psig took effect in December 1984. Also, the Deviation Report was included in the Required Reading book for all NSO's and SCRE's.

Because this error was identified by the licensee and prompt, effective corrective actions were taken and because of the relative safety significance of this event, no violation was issued.

No violations or deviations were identified.



h. LER Review

- (1) (Closed) LER 85002, Revision 0: Unit 1 #4 Tip Ball Valve

On May 9, 1985, while performing TIP system power operated Valve Stroke Testing, #3 TIP Ball Valve failed to close following testing. The unit was shut down and did not require Secondary Containment at the time. The cause of the stuck ball valve was a loss of lubrication. The valve was cleaned and lubricated and returned to service on May 11, 1985. No further actions are required.

- (2) (Closed) LER 85003, Revision 0: Unit 1 Group II Isolation and 'A' Standby Gas Treatment Failure To Start On May 17, 1985, while Unit 1 was in the RUN mode and Unit 2 was in COLD SHUTDOWN, Unit 2 received an unexpected Group II isolation signal. This signal occurred when the test for a modification tripped Group II Channel B. Group II Channel A was previously tripped due to the removal of the 2A Drywell radiation monitor for maintenance. Upon receipt of the Group II isolation signal, the 'B' Standby Gas Treatment System (SBGTS) (BH) auto-started. The 'A' SBGTS, which was selected as primary, failed to start. When the 'B' SBGTS started it was immediately noticed that the heater did not energize. An Operator was sent to investigate and he discovered that the breaker for the heater was tripped.

The breaker was reset and the normal differential temperature across the heater was established. Repeated attempts were performed to duplicate the 'A' SBGTS failure to start, but in every case the 'A' SBGTS properly served its function. After further investigation, it was postulated that the cause of the 'A' SBGTS failure to start was a degradation of the auto-start relay 595-133. The similar relay on 'B' SBGTS caused an identical failure of 'B' to start on June 5, 1985. The relay failure was intermittent in nature, causing a failure to start in 1 out of 3 cases.

The breaker trip appears to have been caused by a faulty breaker which was replaced after it totally failed on June 12, 1985.

The personnel error and communication problem involved in testing Channel B while a Trip signal was present on Channel A was discussed with the licensee (See Report 254/85012 and 265/85013) and adequate corrective actions were taken. As such, no further actions are required.

- (3) (Closed) LER 85004, Revision 0: Unit 1 Loss of Essential Service System Bus.

On May 23, 1985, the Essential Service System (ESS) Uninterruptible Power Supply (UPS) failed causing a half scram and an auto-start of the 'B' Standby Gas Treatment System. The ESS

Bus transferred to its AC backup. This event occurred again at 10:08 a.m. on June 12, 1985, when the UPS was repaired and the feed was transferred from its reserve feed to the normal feed. The UPS failed due to the failure of two transistors in the Inverter Logic Power Supply. All circuitry was repaired and the UPS was successfully returned to service at 10:08 a.m. on June 12, 1985. No further actions are required.

- (4) (Closed) LER 85005, Revision 0 and Revision 1: Unit 1A Fuel Pool Monitor - Various Trips.

As noted in Section d. of this report, concerns related to this LER and others have been addressed as an Unresolved Item and the Licensee has been requested to respond in writing. Therefore, tracking of this issue will be handled in that manner.

- (5) (Closed) LER 85006, Revision 0: Unit 1 Reactor Scram From Group I Isolation.

On May 30, 1985, while valving in Pressure Transmitter PT 1-5641-2, Instrument Rack 2251-1 began to vibrate. This rack contains pressure switches which actuate a Group I isolation on Main Steam Line low pressure. The vibration on Instrument Rack 2251-1 caused these pressure switches to trip initiating a Group I isolation. The reactor then scrammed from Main Steam Isolation Valve (MSIV) closure. The MSIVs were reopened and the Bypass Valves opened to lower Reactor pressure. Reactor water level decreased rapidly. A Reactor feed pump was started to replace the lost inventory. A second Reactor scram occurred at 6:07 p.m. due to low Reactor water level. A minute later, Reactor water level was restored to normal.

The licensee is investigating possible engineering solutions to reduce the potential for this event. Also, in the future, when valving in on this rack, Instrument Maintenance will pre-pressurize the sensing line to prevent vibration. No further actions are required.

- (6) (Closed) LER 85007, Revision 0: Unit 1A Fuel Pool Monitor Trip.

See Item 4.

- (7) (Closed) LER 85008, Revision 0: 1/2 Diesel Generator Cooling Water Pump and 1B Residual Heat Removal Service Water Pump Out of Service.

On June 17, 1985, a high level alarm was received from the 1B/1C Residual Heat Removal Service Water (RHR) vault sump. The 1C RHR Service Water Pump was immediately tripped and an Equipment Attendant was dispatched to investigate. It was discovered that a broken vent line on the 1C RHR Service Water

Pump existed and that the vault was partially filled with water. As a precautionary measure, the 1B RHR Service Water Pump and the 1/2 Diesel Generator Cooling Water Pump were declared inoperable because they are located in the same room. This action rendered the 1/2 Emergency Diesel Generator inoperable. Electrical integrity tests were performed on all the motors and showed all parameters to be normal. The 1C RHR Service Water Pump was repaired on June 18, 1985. The 1/2 Diesel Generator Cooling Water Pump and the 1B RHR Service Water Pump were also returned to service on June 18, 1985. No further actions are required.

- (8) (Open) LER 85011, Revision 0: Unit 1 Scram and Loss of Unit 2 Auxiliary Power.

On May 7, 1985, Unit 1 was in the RUN mode and Unit 2 was in COLD SHUTDOWN. Contractor personnel working on roof repairs were attempting to connect a power cord for a drill to an AC outlet located near the ground below. While lowering the cord from the roof, a sudden 'A' phase to ground fault occurred. This fault opened oil circuit breakers, which caused a loss of normal auxiliary power to Unit 2. Diesel Generator 1/2 auto-started and closed-in to Bus 23-1 on a Bus 23-1 undervoltage signal. Unit 2 remained stable.

The electrical transient in the 345 KV switchyard caused a transient on the Unit 1 electrical system. The transient caused a loss of 'A' Reactor Protection System Bus and a lock-up of a Feedwater Regulating Valve. The locked-up Feedwater Regulating Valve resulted in a high Reactor water level condition which resulted in a Turbine trip, and Reactor scram. Subsequently, a normal scram recovery was performed and all electrical systems were returned to normal. All systems and equipment functioned as designed.

The auxiliary transformer was examined and damaged insulators were found on the 'A' phase lines feeding the transformer. The insulators were replaced and the transformer was returned to service on May 8, 1985. All systems and equipment functioned as designed and no changes were necessary. However, the Station is considering a modification which may prevent losing the feed to the RPS MG Set drive motor for similar faults on the 345 KV system. The modification involves a time delay relay which allows the flywheel to be more effective in performing its intended function.

This LER will remain open pending resolution of this modification.

- (9) (Closed) LER 85014, Revision 0 and Revision 1: Unit 1A Fuel Monitor Trip.

See Item 4

- (10) (Closed) LER 85006, Revision 0 and Revision 1: Unit 2 Main Steam Isolation Valves Failed Local Leak Rate Testing.

The licensee has submitted a supplemental report detailing the amount of leakage and the repairs performed to correct the sealing surface wear. No further actions are required.

- (11) (Closed) LER 85007, Revision 0 and Revision 1: Unit 2 Local Leak Rate Tests Exceeded Limits.

The licensee has submitted a supplemental report detailing the amount of leakage and the repairs performed to correct problems found. No further actions are required.

- (12) (Closed) LER 85008, Revision 0 and Revision 1: Unit 2 Recirculation Pipe Riser Crack.

The licensee has submitted a supplemental report delineating crack indications found and corrective actions taken. No further actions are required.

- (13) (Closed) LER 85012, Revision 0: Unit 2 Group II Isolation.

On May 20, 1985, the main feed breaker to Bus 24-1 tripped during testing by the Operational Analysis Department (OAD). The Unit 2 Diesel Generator was already running for testing and it was feeding Bus 24-1. Because the Diesel Generator was then carrying the full load of Bus 24-1, Diesel Generator load went from 700 KW to 2500 KW. Since the unit operator was not aware of the cause of the breaker trip, the Diesel Generator was tripped. This caused a one/half Group II isolation. The other half of the Group II isolation logic was already satisfied because the 2A High Drywell Radiation Monitor was removed for maintenance. This started the Standby Gas Treatment System (SBGTS).

After it was determined that OAD personnel had tripped the main feed breaker to Bus 24-1, normal power was restored to the Bus. The Group II isolation was reset and the SBGTS was secured. Station Management immediately stopped all OAD work. The following day it was emphasized to OAD that all work performed at the Station must be done under the control of a Work Request. The Work Request that controlled the wiring verification did not allow the movement of any relays. The personnel involved with this incident were cautioned to not operate outside of a Work Request. This prompt action by Station Management should prevent future recurrence. Because of this prompt corrective action and the relative safety significance of the event, no violation will be issued.

- (14) (Closed) LER 85013, Revision 0: Unit 2 loss of Emergency Diesel Generators.

On May 22, 1985, Unit 2 was in the REFUEL mode. The 1/2 Diesel Generator was out of service while the Electrical Maintenance Department was performing QMS 700-5, "Core Spray Logic Functional Test". In accordance with the test, the Unit 2 Diesel Generator started. The Diesel Generator only ran 30 seconds when it tripped out mechanically on overspeed. A Generating Station Emergency Plan (GSEP) Unusual Event was declared since Unit 2 had no operable Diesel Generator. The 1/2 Diesel Generator was immediately returned to service. The Unit 2 Diesel Generator trip was caused by the governor compensating mechanism being out of adjustment. It was readjusted and the Diesel Generator was returned to service on May 24, 1985.

No further actions are required.

- (15) (Closed) LER 85014, Revision 0: Unit 2 Scram From Surveillance Procedure.

On May 31, 1985, the surveillance QOS 1600-11, "Primary Containment Isolation (PCI) Simulated Automatic Close Initiation Test" was performed. In the course of adhering to the procedure, a full scram was initiated. The cause of the scram was an inadequacy of the procedure. The procedure called for resetting the alarms, but did not require the resetting of a 1/2 scram signal initiated on a previous step. A full scram was, therefore, initiated. The procedure was modified to require resetting of the 1/2 scram signal before tripping the other channel.

No further actions are required.

No violations or deviations were identified.

i. TMI Action Items

- (1) (Closed) Item II.B.3 Post-Accident Sampling

NRR has issued a Safety Evaluation Report (SER) dated July 23, 1985 accepting the licensee's Post-Accident sampling system. The resident inspectors have verified that the licensee's program does correspond to their submittal.

No further actions are required.

- (2) (Open) Item II.F.2 Inadequate Core Cooling Instrumentation.

NRR has issued a SER dated June 5, 1985 accepting the licensee's submittal to comply with this requirement. Actions associated with replacement of mechanical level indication equipment has been accomplished and reviewed by the resident inspectors. Actions to address reference leg overheating are scheduled to be completed sometime in 1988 and will be reviewed at that time.



j. Receipt, Storage and Handling of Equipment Program

The inspectors reviewed the licensee's program for receipt, storage and handling of equipment in accordance with Inspection Procedure 38702 and found it to be acceptable. However, during a tour of the station warehouse two safety related check valves were found to be without protective covers as required by QAP 300-13 (1976): Levels of Storage and Inspection Criteria and ANSI N45.2.13(1976) Quality Assurance Requirements for Control of Procurement of Items and Services for Nuclear Power Plants which refers to ANSI 45.2.2 (1972) Packaging, Shipping, Receiving, Storage and Handling of Items for Nuclear Power Plants for additional requirements. This is a violation (254/85017-04(DRP) and 265/85019-03(DRP)).

When notified, the licensee placed protective covers on the valves.

No other violations or deviations were identified.

k. Design Changes and Modifications (40% complete)

The following modifications were reviewed and found to be in conformance with the requirements of Technical Specifications and 10 CFR 50.59:

M-4-2-84-20 Indicating lights for Control Valve Test Switches  
M-4-2-84-30 Outer Bellows on Core Spray Penetration X-16B  
M-4-2-85-20 Feedwater check valve pivot pin modification  
M-4-1-85-1 SBLC swing pump - (This modification is still in progress)  
M-4-2-85-23 Fabricate sleeve for 2ARHR Pump Motor  
M-4-2-85-13 Limitorgue Motor Operator - EQ Modifications

No violations or deviations were identified.

4. Regulatory Improvement Program Meeting

On July 16, 1985, a meeting was conducted between CECo and Region III management. The purpose of the meeting was to discuss additional aspects of the licensee's Regulatory Improvement Program (RIP) which were identified during the June 24, 1985 RIP meeting. This meeting was part of the continuing series of management meetings aimed at improving licensee regulatory performance and enhancing communications between the NRC and CECo.

5. Open Items

Open items are matters which have been discussed with the licensee, which will be reviewed further by the inspectors, and which involve some action on the part of the NRC or licensee or both. The open item disclosed during the inspection is discussed in Paragraph 2c.

6. Unresolved Items

Unresolved items are matters about which more information is required in order to ascertain whether they are acceptable items, items of noncompliance, or deviations. The unresolved item disclosed during the inspection is discussed in Paragraph 2d.

7. Exit Interview

The inspectors met with licensee representatives (denoted in Paragraph 1) throughout the month and at the conclusion of the inspection on July 31, 1985, and summarized the scope and findings of the inspection activities.

The inspectors also discussed the likely informational content of the inspection report with regard to documents or processes reviewed by the inspectors during the inspection. The licensee did not identify any such documents/processes as proprietary.