

U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Report No. 50-255/85027(DRP)

Docket No. 50-255

License No. DPR-20

Licensee: Consumers Power Company
212 West Michigan Avenue
Jackson, MI 49201

Facility Name: Palisades Nuclear Generating Plant

Inspection At: Palisades Site, Covert, MI

Inspection Conducted: October 16 through November 18, 1985

Inspectors: E. R. Swanson

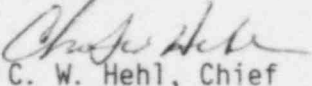
B. L. Jorgensen

J. K. Heller

C. D. Anderson

D. L. Williams

M. L. McCormick-Barger

Approved By: 
C. W. Hehl, Chief
Reactor Projects Section 2A

12/18/85
Date

Inspection Summary

Inspection on October 16 through November 18, 1985(Report No. 50-255/85027(DRP))

Areas Inspected: Routine, unannounced inspection by resident inspector of previous inspection findings; operational safety; maintenance; surveillance; engineered safety feature walkdown; reportable events; cold weather preparations; receipt of new fuel; and the October 24, 1985, management meeting. The inspection involved a total of 123 inspector-hours onsite by six NRC inspectors including 14 inspector-hours on site during off-shifts.

Results: Three violations were identified during this inspection. The first was a result of the failure to install environmentally qualified temperature switches for the cooler fan in the safeguards pump room. The second reflects a breakdown of several aspects of the corrective action system which resulted

8512310297 851223
PDR ADOCK 05000255
PDR
G

in untimely correction of a Technical Specification violation. The third violation relates to a situation where both licensed Senior Reactor Operators were absent from the control room simultaneously. One Unresolved Item described in Paragraph 3.g involves the continuing equipment problems which result in inoperable Safety Injection Tanks and the operators' failure to recognize that plant conditions were not allowed by the Technical Specifications. An additional concern relates to the maintenance controls during replacement of a Shutdown Cooling System (SDC) valve control switch that resulted in a loss of SDC for sixty-five minutes. The two open items were identified to track completion of specific licensee corrective actions.

DETAILS

1. Persons Contacted

Consumers Power Company (CPCo)

#J. W. Reynolds, Executive Vice President, Energy Supply
#R. B. DeWitt, Vice President, Nuclear Operations
#*J. F. Firlit, General Manager, Palisades Plant
*J. G. Lewis, Plant Technical Director
#*R. D. Orosz, Engineering and Maintenance Manager
*R. M. Rice, Plant Operations Manager
*H. M. Esch, Plant Administrative Manager
*W. M. Hodge, Property Protection Supervisor
*R. A. Fenech, Technical Engineer
*D. L. Fitzgibbon, Licensing Engineer
*D. G. Malone, Licensing Engineer
*R. A. Vincent, Plant Safety Engineering Administrator
*R. P. Margol, Quality Assurance Administrator

Michigan Public Service Commission

#R. Fischer, Chief of Staff
#J. Padgett, Supervisor Engineering Section of Electrical Division

U. S. Nuclear Regulatory Commission (NRC RIII)

#J. G. Keppler, Regional Administrator
#C. E. Norelius, Director, Division of Reactor Projects
#C. W. Hehl, Chief, Reactor Projects Section 2A
#J. K. Heller, Resident Inspector

*Denotes those present at the Management Interview on November 19, 1985

#Denotes those present at the Management Meeting on October 24, 1985

Numerous other members of the plant Operations, Maintenance, Engineering, Health Physics staffs, and Security forces were also contacted briefly.

2. Followup on Previous Inspection Findings

(Closed) Unresolved Item 255/85021-05: An unplanned Safety Injection System (SIS) actuation occurred while shutdown during a maintenance evolution as a result of inadequate work instructions. The engineer who wrote the instructions overlooked a daisy-chained power supply which led to the removal of a SIS block during maintenance. The instructions were written for use at power when the block relay would not be energized. A similar event had occurred earlier in the operating cycle. Weak work procedures were considered to be a contributor, but no violation of controls or requirements was identified. This item was discussed at the management interview on November 19, 1985, with respect to the adequacy of their procedural controls and corrective actions. This item is closed.

(Closed) Unresolved Item 255/85021-03: Environmental Equipment Qualification (EEQ), required for the Safeguards pump room cooler temperature switches was not completed by March 31, 1985 as required by 10 CFR 50.49. No extension beyond the March 31, 1985 10 CFR 50.49 dead line was granted for the subject temperature switches. A Notice of Violation is being issued in the Appendix as closure of this unresolved item (255/85027-01).

One violation and no deviations were identified in this area.

3. Operational Safety

- a. The inspectors observed control room activities, discussed these activities with plant operators, and reviewed various logs and other operations records throughout the inspection. Control room indicators and alarms, log sheets, turnover sheets, and equipment status boards were routinely checked against operating requirements. Pump and valve controls were verified proper for applicable plant conditions. On several occasions, the inspectors observed shift turnover activities and shift briefing meetings.

Tours were conducted in the turbine and auxiliary buildings, and security stations to observe work activities and testing in progress and to observe plant equipment condition, cleanliness, fire safety, health physics and security measures, and adherence to procedural and regulatory requirements.

The inspectors made observations concerning radiological safety practices in the radiation controlled areas including: verification of proper posting; accuracy and currentness of area status sheets; verification of selected Radiation Work Permit (RWP) compliance; and implementation of proper personnel survey (frisking) and contamination control (step-off-pad) practices. Health Physics logs and dose records were routinely reviewed.

The inspectors observed physical security activities at various access control points, including proper personnel identification and search, and toured security barriers to verify maintenance of integrity. Access control activities for vehicles and packages were occasionally observed. Activities in the Central Alarm Station were observed.

An ongoing review of all licensee corrective action program items at the Event Report level was performed.

- b. During a corporate Quality Assurance Department fire protection audit conducted September 30 through October 4, 1985, it was determined that monthly valve position checks and annual valve exercising of one fire suppression water system valve had not been done, apparently since plant licensing. Subsequent licensee review identified several other valves for which surveillance tests had not been performed. The Surveillance tests were rewritten and

performed on November 1, 1985, with the exception of three valves which supply stand pipes inside containment. The licensee is pursuing an exemption for the testing of these service water valves which cannot be stroked during operation without adverse consequences. The Limiting Condition for Operation (3.22.3.1) does not require any remedial action for system inoperability aside from reporting their plans and corrective action to the Commission. Licensee procedures require immediate corrective action to be taken for violation of Technical Specification in surveillance requirements (Procedure 9.23). This was not done until November 1, 1985. Deviation Report written on October 4, 1985, was not transmitted to the appropriate parties for 3 weeks although the violation was identified at the audit exit meeting on October 4, 1985. The Deviation Report should have received management attention and action within five days as procedures require. Additionally potential violations of the Technical Specifications should be categorized as Event Reports and receive even more expeditious processing. The handling of this Deviation Report and the use of a Deviation Report instead of an Event Report conflict with the guidance provided in licensee procedure NODS-Q01. The month long delay in verifying the operability and correct position of the firewater system valve does not constitute timely corrective actions and is, therefore, cited as a violation of corrective action requirements as set forth in the Appendix (255/85027-02).

- c. While at full power on October 15, 1985, at 1230 hours the licensee calculated a Primary Coolant System (PCS) leakrate of 1.39 gpm. Technical Specification 3.1.5 requires a plant shutdown to hot shutdown within 12 hours and then to cold shutdown within 24 hours if unidentified PCS leakage exceeds one gpm. An Unusual Event was declared and power reduction commenced. At 1430 hours a tour of containment showed valves MO-3015 (shutdown cooling isolation) and CV 1059 (pressurizer spray) to have significant packing leaks. The licensee was able to reduce the leakage on CV-1059 and quantify the leakage of MO-3015 at 0.66 gpm. At 2210 hours a leakrate calculation showed 1.6 gpm total and 0.81 gpm unidentified which is within the Technical Specification requirements. The Unusual Event was terminated and power escalation commenced from about 30% reactor power.

At 0445 hours on October 16, 1985, the licensee calculated a 3.66 gpm unidentified leakrate and at 0500 hours declared an Unusual Event and commenced a shutdown from 55% reactor power. The plant reached hot shutdown at 1135 hours and was placed on shutdown cooling at about 2000 hours on October 16, 1985, to permit work on MO-3015. While shutdown the licensee's repair efforts included replacement of the hand switches for valve MO-3015. This was done as part of the generic corrective action in response to a failure of a similar switch. During switch replacement, the technician procured and installed an incorrect switch. As a result of this error, when the control power was restored the shutdown cooling isolation valve went closed and isolated the suction of the operating pump (P67A). This was not noticed by the operator for about 15 minutes. Restoration of shutdown cooling with the redundant pump (P67B) was accomplished approximately 50 minutes later. Pump P67A was subsequently tested and found to

be operating satisfactorily. The loss of cooling did not result in any adverse consequences to the primary coolant system. No Technical Specification operability requirements are applicable to the Shutdown Cooling System when the reactor is not critical, therefore, no violation occurred.

The licensee repacked the leaking valve (MO 3015) and capped the lantern seal leakoff line since it could not be replaced. During subsequent stroke testing of the valve the Limitorque motor operator overheated. Apparently the valve had been backseated manually which resulted in binding the valve in the open position. The motor operator was replaced and the valve was satisfactorily stroke tested.

While preparing to start up on October 19, 1985, a PCS leakrate of 1.3 gpm was calculated at 1410 hours. An Unusual Event was declared until 1747 hours when a subsequent calculation, with PCS letdown to the Chemical Volume Control System (CVCS) isolated, showed the leakage to be well within limits. A relief valve was found to have a flange leak. Torquing of the valve flange reduced leakage to acceptable limits. Unidentified leakage was reduced to approximately 0.3 gpm and the plant was returned to service at 1143 hours on October 20, 1985.

At 2035 hours on October 20, 1985, the licensee calculated an unidentified PCS leakrate of 1.27 gpm. An Unusual Event was declared. When the plant was stabilized without charging or letdown flow, an unidentified leakrate of essentially zero gpm was calculated at 0115 hours on October 21, 1985. Restoration of charging and letdown flow did not result in an increased leakrate, thus the previously identified excessive leakrate was attributed to computational error. The licensee attributed the error to calculating the leakrate when plant conditions were not stable, i.e. while increasing power, which requires considerable letdown and charging flow.

- d. On October 15, 1985, the licensee discovered that a conduit seal was missing from pressurizer pressure transmitter PT-0105b. This rendered the transmitter non-environmentally qualified. This transmitter provides input to the Saturation Margin Monitor (SMM) (one of two channels) and the Low Temperature Overpressure Protection (LTOP) system. The licensee made a four-hour report at 1615 hours. No actions were taken since LTOP is not required at normal operating temperature and pressure and the SMM has redundant features of which only one channel must be operable. During the shutdown on October 16 through 20, 1985, the pressure seal was replaced.
- e. On October 17, 1985, the licensee discovered that the primary coolant system Low Temperature Overpressure Protection (LTOP) System may not provide adequate protection from overpressure transients. This discovery was promptly reported to the NRC at 1730 hours. Evaluation by the licensee had found that due to vessel fluence increasing at a more rapid rate than expected, the pressure temperature limits are exceeded by the design basis pressure transient (inadvertent High

Pressure Safety Injection (HPSI) Pump Start or Primary Coolant Pump (PCP) Start). To compensate for this the licensee has modified plant procedures to disable both HPSI pumps by removing fuses when below 1400 psig, and provide additional limitations on PCP starting and primary to secondary temperature equalization.

- f. During a tour of the control room on October 22, 1985, it was noted that indicator FI 302A for containment spray flow was reading 2000 gpm with no flow in the system. When pointed out to the operators, a work request was initiated to correct the deficiency.
- g. On November 8, 1985, at 0805 hours, licensee personnel were alerted by a high level alarm for the T-82B Safety Injection Tank (SIT) caused by in-leakage from the Primary Coolant System (PCS). It had been determined a day earlier that a PCS isolation check valve had not fully reseated after a test. The level was restored by draining the tank to within the Technical Specification (T.S.) limit by 0810 hours. A sample of the SIT for concentration at 0907 hours showed that it was below the Technical Specification limit of 1720 ppm boron (1708 ppm). A subsequent fill and drain of the SIT resulted in a boron concentration sample of 1548 ppm at 0941 hours. This sample apparently was diluted by leakage into the sample path. Numerous fill and drain evolutions followed which exceeded the upper level and lower level limits for the tank. The required minimum concentration was finally obtained at 1315 hours.

Technical Specification 3.3 allows one SIT to be inoperable for one hour and if not restored within that hour requires that the plant be taken to hot shutdown within 12 hours. Between 1007 and 1315 hours the licensee considered themselves to be in this action statement and had declared an Unusual Event and initiated a plant shutdown. They later realized that the P-67A Low Pressure Safety Injection Pump (LPSI) was concurrently inoperable, having been tagged out at 0737 hours and returned to service at 1150 hours on the same day. This condition was in excess of the limiting condition allowed by Technical Specification 3.3.2. Had the operators recognized this, action to shut the plant down would have been initiated when the SIT was inoperable due to a high level from 0805 to 0810 hours and later when the concentration was found to be low at 0907 hours. Due to the circumstances, the licensee did commence the plant shutdown at approximately the same time they would have if they had correctly discerned the situation in the first place. T.S. 3.0.3 allows one hour to take action to place the plant in hot standby within the next six hours, and hot shutdown within the following six hours. T.S. 3.3 allows one hour for the SIT to be inoperable and then requires shutdown to hot shutdown within the next 12 hours.

The safety evaluation accompanying Amendment 74 to the Palisades Technical Specifications evaluated the reduction of one SIT's boron concentration to that of the primary coolant system. This one time exemption (Amendment 74) found this situation not to constitute a significant safety hazard. Nevertheless, the circumstances surrounding this event raise the following concerns.

Issues of concern include:

- With known leakage into the SITs and a history of prior problems, no action was taken to anticipate the amount of dilution which could be tolerated before the concentration of boron fell below the T. S. limit (the PCS boron concentration was at 94 ppm).
- The level indicator and administrative alarms for the SIT were not functional and did not warn the operator he was approaching a T.S. limit. Inoperability of these indicators and alarms have been contributors to prior events of SIT inoperability.
- The operators conducted feed and bleed operations to increase the concentration, but after the first cycle the SIT concentration dropped from 1708 to 1548 ppm.
- The operators did not recognize that they already had an Emergency Core Cooling Component inoperable and conducted feed and bleed by filling above the high level limit and draining below the low level limit which was in violation of the Technical Specifications.
- The Shift Supervisor and Shift Engineer did not recognize that a condition existed which exceeded the allowable conditions of their T.S. until about four hours into the event.
- Corrective maintenance completed during the previous outage was not successful in preventing loop check, fill and drain and pressure control valve leakages.

Further review of this event will be conducted to resolve the above concerns and will be tracked as an Unresolved Item (255/85027-03).

- h. At 0143 hours on November 15, 1985, the licensee was alerted to inleakage in the T82-B Safety Injection Tank (SIT) from the Primary Coolant System (PCS). At 0348 hours sample results showed the concentration to be less than the Technical Specification minimum. Attempts to restore the concentration were thwarted by further PCS inleakage during the feed and bleed process and at 0445 hours an Unusual Event was declared and a unit shutdown from 97% power commenced. Technical Specification 3.3.2 requires a shutdown to hot shutdown in 12 hours. At 0720 the concentration was restored to above the Technical Specification minimum and the Unusual Event was terminated. The unit returned to power from 89% power. Inleakage through the PCS check valves is at a rate of about 0.3 gpm, well within the Technical Specification limit of 1.0 gpm. PCS boron concentration is about 75 ppm and the make up water concentration is about 1850 ppm. The minimum concentration for the SIT is 1720 ppm.
- i. While at power at 2035 hours on November 15, 1985, and at 2030 hours on November 16, 1985, Unusual Events were declared when the 24 hour PCS unidentified leakrates were found to be in excess of the Technical

Specification limit of 1 gpm (1.645 and 1.61 gpm, respectively). In both cases two hour leakrate calculations were subsequently done, resulting in unidentified leakrates of 0.42 and 0.4 gpm, respectively, thus terminating the Unusual Events at 2250 hours on November 15, 1985 and at 2205 hours on November 16, 1985. The licensee's Technical Specifications do not allow for an evaluation period upon discovery of an indicated high leakrate so the Unusual Events are declared immediately. A Technical Specification change request has been submitted by the licensee to correct this situation.

When large volumes of water are moved such as during dilutions and diversions, the daily PCS leakrates can lead to inaccurate results due to the cumulative error in determining diversion flow. This situation was discussed with the licensee at the management interview on November 19, 1985, and the licensee agreed to review their leakrate procedure to look for ways to improve the accuracy during times of excessive charging and letdown flow.

One violation and one Unresolved Item were identified in this area.

4. Maintenance

The inspector reviewed and/or observed selected work activities and verified appropriate procedures were in effect controlling removal from and return to service, hold points, verification testing, fire prevention/protection, and cleanliness. For the work involving design changes, the scope of the work and safety evaluations were reviewed for adequacy. The following activities were inspected.

- a. RPS 24503057 Nuclear Instrument Channel C troubleshooting intermittent pre trip light
- b. SWS 24504023 HFA relay replacement under SC-84-6.1-5 to comply with commitments under IEB 84-02
- c. RSW 24505029 Modification of control circuit for Safeguards pump room sump pumps (FC-661) - a TMI commitment

No violations or deviations were identified.

5. Surveillance

The inspector reviewed surveillance activities to ascertain compliance with scheduling requirements and to verify compliance with requirements relating to procedures, removal from and return to service, personnel qualifications, and documentation. The following test activities were inspected:

- a. Daily Control Room Surveillance - Test D/WO-1
- b. Safeguards Boron Samples, Safety Injection Tanks (For the B tank only) - Test MC-11B

- c. Nuclear Instrument Trip Checks - Test MI-01
- d. Emergency Diesel 1-1 monthly test - Test M07A1

No violations or deviations were identified.

6. Engineered Safety Features Walkdown

The inspector performed a walkdown of the 1-1 Diesel Generator and verified: That each valve in the subsystem flowpaths was in its required position and operable, that power was aligned for components that activate on an initiation signal, that essential instrumentation was operable, and that no conditions existed which would adversely affect system operation of the Diesel Generator 1-1 systems.

Licensee checklist 22.1 was reviewed and minor discrepancies were identified such as the checklist not reflecting the caps on vent or drain valves and not reflecting the administrative seals which were in place.

No violations or deviations were identified in this area.

7. Licensee Event Reports

Through direct observations, discussions with licensee personnel, and review of records, the following reportable events were examined to determine that reportability requirements were met, immediate corrective action was accomplished as appropriate, and corrective action to prevent recurrence has been accomplished per Technical Specification.

(Closed) LER 255/84-005: While shutdown, an Engineered Safety Features Actuation occurred due to the out of sequence reinstallation of fuses during work associated with the replacement of HFA relays. The necessary procedures, which were inadequate since they did not specify the sequence, have been revised to prevent recurrence. This LER is considered closed.

(Closed) LER 255/84-023 Revision 3: The reactor trip setpoint for three pump flow was found to have been set nonconservatively. Although three pump operation had not been used and is now prevented by the existing setpoint, the licensee had planned to input a setpoint that would allow this mode of operation by September 30, 1985. Delays in obtaining an analysis from the fuel vendor have precluded timely accomplishment of this change. Therefore, this revision was submitted to retract their commitment, while confirming that the more conservative setpoints will be maintained until the desired setpoints can be implemented. This item is closed.

(Closed) LER 255/85-013: Spurious reactor trips were caused by Nuclear Instrument (NI) noise. While shutdown on August 23, 26, and 27, 1985, NI noise spikes resulted in unplanned Reactor Protection System actuations which in some cases caused cocked shutdown rods to trip. A high startup rate trip was generated in one of two wide range nuclear instruments

which fed two protective system channels. The reactor trip occurs from a two-out-of-four coincidence logic. All systems actuated as required. The noise spikes were found to be generated by an unused portion of the circuitry which was removed. This event is closed.

(Closed) LER 255/85-014: Plant operators removed all methods of boric acid injection from service while the reactor was shutdown on August 24, 1985. The flowpath through the A charging pump was administratively inoperable since the pump had not been tested after maintenance. Although "inoperable" the pump was operating during the fourteen hour period all other pumps had been removed from service. Subsequent testing determined that the charging pump was operable. Of particular concern to the NRC is the fact that this event spanned three shifts and underwent the scrutiny of two shift turnovers. The adequacy and completion of licensee corrective actions (E-Pal 85-75) will be tracked as an open item (255/85027-04).

(Closed) LER 255/85-015 and revision 1: This Special Report documents the inadvertent actuation of both primary Power Operated Relief Valve (PORV) on August 26 which resulted from a primary coolant system pressure transient. While shutdown with the Low Temperature Over Pressure (LTOP) setpoints in effect, the start of a third primary coolant pump caused the PORVs to open. Review of the event determined that operators had not allowed an adequate margin between the PORV lift setpoint (375 psi) and the primary coolant system pressure (300 psi). The PORVs opened and reclosed properly and system pressure returned to the previous 300 psi. A precaution was added to the operations procedures to ensure that adequate margin will be maintained in the future. This event report is closed.

(Closed) LER 255/85-016: A reactor trip from 47% power was initiated by the Generator Distance Relay on August 30, 1985. No unexpected transients resulted from the trip. The cause of the trip was determined to be a result of improperly disabling the relay's trip function. Operators had instead disabled the relay's potential transformer input, which after a period of decay allowed the trip signal to actuate. Areas being addressed by corrective action include panel labeling, physical arrangement of controls and a review of why the trip relay had not been returned to service prior to start-up. This event is closed.

(Closed) LER 255/85-017: A review of Electrical Environmental Qualification (EEQ) issues on September 9, 1985, determined that the Engineered Safeguards Room cooler temperature control switches were not qualified by March 31, 1985, as required by 10 CFR 50.49(g). This event is also discussed in Paragraph 2 of this report and a citation of the violation is contained in the appendix. This event report is closed.

(Closed) LER 255/85-018: Pressurizer pressure transmitters were found to be calibrated approximately 36 pounds low resulting in conservative low pressure actuation, but in a nonconservative high pressure reactor trip setpoint. This error was later found to be within the assumed error for the high pressurizer pressure trip transient analysis. Root cause of this event was determined to be a scale error in the value assigned to

the weights used for the calibration. Four of the weights were assigned values incorrect by a factor of ten (four pound vs. forty pounds). Completion of corrective actions as outlined in Inspection Report 255/85023, Paragraph 4.d (see E-Pal-85-87) will be tracked as an open item 255/85027-05).

(Closed) LER 255/85-019: On September 30, 1985 with the plant at 97% power, a review of Technical Specification Surveillance Test Procedures identified a deficiency in the test of the containment isolation actuation on a containment high radiation signal. The licensee declared the containment isolation system inoperable and commenced a shutdown at 1745 hours. Remaining portions of the circuitry which had not been tested were verified to be operable at 2124 hours on September 30, 1985, and a return to power was commenced. The licensee's self initiated review of Technical Specification surveillances is credited with the discovery and review determined that appropriate corrective actions were taken. This event is closed.

(Open) LER 255/85-020: Hydrostatic testing of the main steam and feedwater system was not performed as required during the 1983 outage in accordance with inservice inspection requirements. This error was due to a misinterpretation of code requirements which incorrectly identified that the test was due by 1987. The licensee has submitted a relief request to perform it in 1987 or to obtain for permanent relief. This issue remains open pending further review by the NRC.

(Closed) LER 255/85-021: At 1610 hours on October 9, 1985, with the plant at 98% power, miscommunication between the two assigned Senior Reactor Operators (SRO) resulted in them both leaving the Control Room for approximately five minutes. The event was discovered by the first individual to return to the Control Room when he could not find the other SRO there. A licensed Reactor Operator (RO) was at the controls at all times. One SRO was in the adjacent Technical Support Center and one was in the Auxiliary Operator office during the subject time frame. Both locations are accessible by the paging system and are less than 20 yards from the control room. Normally, the two SROs and ROs communicate their intentions of leaving and their return to the other individual to ensure compliance with 10 CFR 50.54 (m)(2)(iii). The SRO who first returned noted that the other SRO was not present and notified plant management of the violation. The lack of a previous history of problems in this area and good administrative controls do not indicate a serious problem with compliance with the requirements. A violation is being issued to document the violation and emphasize the potentially serious consequences of an operator not being at his required station (255/85027-06).

(Closed) LER 255/85-022: Excessive primary coolant system leakage was identified which resulted in a plant shutdown to make repairs. This event is discussed in more detail in Paragraph 3.c of this report and is considered closed.

(Open) LER 255/85-023: Low temperature overpressure limits were found not to be conservative with respect to changes in vessel fluence. This event is discussed in more detail in Paragraph 3.e and remains open.

No violations or deviations were identified.

8. Cold Weather Preparations

In preparation for the upcoming cold weather, the inspector verified that the licensee had taken steps to deal with the possible adverse effects due to the cold. The inspector reviewed the licensee's completed cold weather checklists and had no concerns. The licensee has had no history of cold weather problems.

No violations or deviations were identified.

9. Receipt of New Fuel

The inspector verified prior to receipt of new fuel that technically adequate, approved procedures were available covering the receipt, inspection, and storage of new fuel; observed receipt inspections and storage of new fuel elements and verified these activities were performed in accordance with the licensee's procedures; and, followed up resolutions of deficiencies if found during new fuel inspections.

No violations or deviations were identified.

10. Management Meeting

A management meeting to discuss the licensee's regulatory performance was held at the Palisades Plant Site on October 24, 1985. Attendance was noted in Paragraph 1. The licensee agenda included the following topics: Surveillance Testing; engineering and field operations repairmen; administrative procedure and Q. A. program requirements training; health physics practices; annual emergency exercise; housekeeping; the number and definition of control room deficiencies; backlog of maintenance orders; and preplanning for the 1985 refueling outage. The Regional Administrator discussed the impact of surveillance and maintenance problems at other sites (Turkey Point and Davis-Besse). Mr. Keppler expressed concern for the number of outstanding maintenance orders and informed the licensee that a Confirmatory Action Letter (CAL) would be issued documenting steps to reduce the backlog. The wording of the CAL was briefly discussed. After the meeting the licensee conducted a tour of the auxiliary building, control room and turbine building.

On October 30, 1985, the CAL was issued confirming commitments the licensee had made to: qualitatively and quantitatively improve the backlog of maintenance work orders, especially those affecting the deficiencies in the control room; improve trending in the maintenance area; augment the assigned maintenance workforce; and to make periodic reports of the status of the backlog reduction. In addition, the licensee agreed not to startup from the upcoming (December 1, 1985 - February 1986) outage until the Regional Administrator agrees that the completeness and adequacy of the licensee's actions are satisfactory.

11. Unresolved Items

Unresolved Items are matters about which more information is required in order to ascertain whether they are acceptable items, violations or deviations. An Unresolved Item disclosed during the inspection is discussed in Paragraph 3.g.

12. Open Items

Open Items are matters which have been discussed with the licensee, which will be reviewed further by the inspector, and which involve some action on the part of the NRC, or licensee or both. Two Open Items disclosed during the inspection are discussed in Paragraph 7.

13. Management Interview

A management interview (attended as indicated in Paragraph 1) was conducted on November 19, 1985, following the inspection. The scope and findings of the inspection were discussed. The inspector also discussed the likely informational content of the inspection report with regard to documents or processes reviewed by the inspector during the inspection. The licensee did not identify any such documents/processes as proprietary.