

U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Report No. 50-255/94004(DRP)

Docket No. 50-255

License Nos. DPR-20

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

Facility Name: Palisades Nuclear Generating Facility

Inspection At: Palisades Site, Covert, Michigan

Inspection Conducted: January 29, 1994, through March 14, 1994.

Inspectors: M. E. Parker
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Approved By: W. J. Kropp
W. J. Kropp, Chief
Reactor Projects Section 2A

3/29/94
Date

Inspection Summary

Inspection from January 29, 1994, through March 14, 1994
Report No. 50-255/94004(DRP).

Areas Inspected: Routine, unannounced safety inspection by the resident inspectors of actions on previous inspection findings, operational safety verification, engineered safety feature systems, onsite event follow-up, current material condition, housekeeping and plant cleanliness, radiological controls, safety assessment and quality verification, maintenance, surveillance, fuel handling, and review of licensee reports.

Results: Within the eleven areas inspected, no violations, or deviations were identified. One unresolved item was identified that pertained to missing separation barriers for reactor protection system (RPS) channels 1 and 3 located in the same cable tray (paragraph 3.c).

The following is a summary of the licensee's performance during this inspection period:

Plant Operations

A management change occurred with Michael G. Morris becoming the President and CEO of Consumers Power Company. Robert A. Fenech was named the new Vice President of Nuclear Operations. Thomas J. Palmisano was named acting Plant General Manager.

An operator inadvertently started a containment spray pump during a surveillance test. No spray actuation occurred and the operator responded appropriately. Operators also responded appropriately to an unexpected closure of a main turbine governor valve. The plant was shut down without incident to repair a leaking check valve downstream from the recirculation sump. Operators performed well during the spent fuel inspection activities.

Safety Assessment/Quality Verification

The NPAD organization has undergone some organizational changes. Operations and Engineering team leaders have been filled with senior team leaders to provide a stronger focus on these two weak areas. An independent Management Safety Review Board (MSRB) with several non-licensee members is being formulated. The kickoff meeting was scheduled for March 17 and 18, 1994.

Maintenance and Surveillance

In general, maintenance was effectively accomplished. There were no major equipment deficiencies. Some long-standing material condition deficiencies were identified. Examples included the "A" air start motor for Emergency Diesel Generator (EDG) 1-2, and a problem annunciator associated with lube oil level switch LS 1487 on EDG 1-2.

Engineering and Technical Support

Good work planning and technical discussions were observed during troubleshooting activities on the main governor valve; however, difficulties in restoring the valve back into service indicated the licensee does not have a sound understanding of main generator digital electro-hydraulic control system operation. Fuel handling activities were conducted in a controlled and careful manner. Spent fuel inspections to date have found five leaking fuel rods that are subject to further evaluation and may not be placed into dry storage. A weakness was identified in the licensee's follow-up of a cable separation issue for instrument and control cables in the Reactor Protection System.

DETAILS

1. Persons Contacted

Consumer Company

- *R. A. Fenech, Vice President, Nuclear Operations
- *T. J. Palmisano, Acting Plant General Manager
- R. D. Orosz, Nuclear Engineering & Construction Manager
- R. M. Rice, Director, NPAD
- *D. D. Hice, Nuclear Training Manager
- S. Y. Wawro, Acting Operations Manager
- D. W. Rogers, Safety & Licensing Director
- *R. B. Kasper, Maintenance Manager
- K. E. Osborne, System Engineering Manager
- *H. M. Esch, Acting Administrative Manager
- J. C. Griggs, Human Resource Director
- *H. A. Heavin, Controller
- *D. G. Malone, Shift Operations Superintendent
- *D. J. Malone, Acting Radiological Services Manager
- J. H. Kuemin, Licensing Administrator

Nuclear Regulatory Commission (NRC)

- *M. E. Parker, Senior Resident Inspector
- *D. G. Passehl, Resident Inspector

*Denotes those attending the exit interview conducted on March 14, 1994.

The inspectors also had discussions with other licensee employees, including members of the technical and engineering staffs, reactor and auxiliary operators, shift engineers and electrical, mechanical and instrument maintenance personnel, and contract security personnel.

2. Action on Previous Inspection Findings (92701)

- a. (Closed) Severity level IV violation (255/86032-02(DRS))

Inadequacies in licensees equipment qualification files concerning maintenance, replacement, surveillance tests, and inspections to preserve the environmental qualification of equipment. This violation and unresolved item 255/86032-02 were closed in inspection report 255/92004. The licensee failed to revise periodic activity sheets for lubrication analysis and gearing inspection for 2400 volt motors for which violation 50-255/92004-01 was issued. Violation 86032-02 and unresolved item 86032-02 are considered closed.

- b. (Closed) Severity level IV violation (255/88020-04(DRS))

Failure to establish measures to inform the document control center about changes to drawings by modifications to hardware.

The inspectors reviewed revisions to procedures 9.03 "Facility Change", Revision 7, May 10, 1989 and procedure 10.44, "Design Document Control and Distribution", Revision 6, May 30, 1989. These procedure revisions provide adequate controls to assure that changes are posted to plant drawings. This violation is closed.

c. (Closed) Unresolved Item (255/88020-07(DRS))

Different fuse ratings shown on schematics for emergency diesel generator 1 and 2 for the same control circuit, 5 FU. Calculations for the worst case loading of the circuit show a maximum load of 10.6 amps. Therefore, either a 15 amp or a 20 amp fuse is acceptable for this application. This item is considered resolved.

d. (Closed) Unresolved Item (255/88020-02(DRS))

Eight terminal block links were left open on TB-8 in the remote shutdown panel. These terminal block links are spares so their position has no safety significance. The licensee has various controls over terminal links in active circuits such as tagging, work orders, procedures and temporary modifications. This item is resolved.

e. (Closed) Unresolved Item (255/91002-01(DRS))

Surveillance test and maintenance procedures not developed or implemented for ATWS. The inspectors verified that the licensee has developed and implemented procedures for surveillance, test and maintenance of the ATWS. Procedures implemented are PPS-1-7, "Anticipated Transient Without Scram (ATWS) Calibration/Functional Test", Revision 0, November 11, 1991 and RPS-1-1, "Anticipated Transient Without Scram (ATWS) End to End Functional Test, Revision 0, December 5, 1991. This item is resolved.

f. (Closed) Inspection Followup Item (255/93032-01(DRP))

Review the licensee's evaluation to determine the level of vacuum actually obtained during vacuum drying of the dry fuel casks. The inspector identified a concern whereby the allowable tolerance range for the instrument used to measure the vacuum pressure for the Palisades' dry fuel storage casks appeared excessive for use at the low pressure values being measured. Pressure in the Ventilated Storage Casks (VSCs) may have been as high as 0.1125 psia, almost twice as high as the procedure limit of 0.06 psia.

Although the exact level of vacuum obtained was not known, the condition was bounded by an engineering analysis assuming a minimum level of vacuum of 0.15 psia. The results found the potential fuel oxidation to be negligible, several orders of magnitude below the 0.5 percent fuel failure limit used as the thermal design basis of the VSC. This IFS item is closed.

No violations, deviations, unresolved, or inspection followup items were identified in this area.

3. Plant Operations (71707, 71710, 93702)

Throughout the most of the period the plant has operated at nearly full power. A forced outage was entered late this evaluation period due to through wall leakage from a containment sump outlet check valve. Otherwise, Palisades experienced a fairly successful operating run since starting up from the extended refueling outage on November 8, 1993.

Some significant licensee personnel changes occurred this period:

- On January 18, 1994, the President and Chief Executive Officer of Consumers Power Company, Fredrick W. Buckman, resigned to become CEO of Pacificorp in Oregon. Michael G. Morris, formerly Chief Operating Officer, was elected President and CEO.
- On February 22, 1994, Consumers Power Company President Michael G. Morris announced the resignation of David P. Hoffman, Vice President of Nuclear Operations. The new Vice President, Robert A. Fenech, was named February 25, 1994, to replace Mr. Hoffman. Mr. Morris also announced that Plant General Manager Gerald B. Slade has been reassigned to another position within Consumers Power Company. Thomas J. Palmisano, Palisades Operations Manager, was named acting Plant General Manager until a permanent replacement is named.

a. Operational Safety Verification (71707)

The inspectors verified that the facility was being operated in conformance with the license and regulatory requirements, and that the licensee's management control system was effective in ensuring safe operation of the plant.

On a sampling basis the inspectors verified proper control room staffing and coordination of plant activities; verified operator adherence with procedures and technical specifications; monitored control room indications for abnormalities; verified that electrical power was available; and observed the frequency of plant and control room visits by station management. The inspectors reviewed applicable logs and conducted discussions with control room operators throughout the inspection period. The inspectors observed a number of control room shift turnovers. The turnovers were conducted in a professional manner and included log reviews, panel walkdowns, discussions of maintenance and surveillance activities in progress or planned, and associated LCO time restraints, as applicable.

b. Engineered Safety Feature (ESF) Systems (71710)

During the inspection, the inspectors selected accessible portions of several ESF systems to verify status. Consideration was given to the plant mode, applicable Technical Specifications, Limiting Conditions for Operation requirements, and other applicable requirements.

Various observations, where applicable, were made of hangers and supports; housekeeping; whether freeze protection, if required, was installed and operational; valve position and conditions; potential ignition sources; major component labeling, lubrication, cooling, etc.; whether instrumentation was properly installed and functioning and significant process parameter values were consistent with expected values; whether instrumentation was calibrated; whether necessary support systems were operational; and whether locally and remotely indicated breaker and valve positions agreed.

During the inspection, the accessible portions of the following ESF systems were walked down:

- Low Pressure Safety Injection
- High Pressure Safety Injection
- Auxiliary Feedwater
- Service Water
- Containment Spray
- Emergency Diesel Generator

The inspector noted a drawing error in the air start system for the emergency diesel generators (EDGs). The two solenoid valves that supply air to the EDG's air start motors, SV-1479 and SV-1480, are shown normally open on system drawing No. M214 SHT1. The valves actually are normally closed. The system engineer agreed with the observation and initiated a drawing change.

c. Onsite Event Follow-up (93702)

During the inspection period, the licensee experienced several events, some of which required prompt notification of the NRC pursuant to 10 CFR 50.72. The inspectors pursued the events onsite with licensee and/or other NRC officials. In each case, the inspectors verified that any required notification was correct and timely. The inspectors also verified that the licensee initiated prompt and appropriate actions.

January 26, 1994: During the performance of a surveillance test QO-1, "Safety Injection System," Rev.34, the control room operator was verifying the position of equipment actuated by the simulated safety injection actuation signal (SIAS), and inadvertently started containment spray pump P-54B. The operator immediately observed the pump start and stopped the pump within about one

second. No spray flow occurred since containment spray admission valves CV-3001 and CV-3002 remained closed during the test. No damage occurred to valves CV-3001 and CV-3002 since these two valves were satisfactorily cycled and timed during other surveillance tests performed during the present cold shutdown condition.

During performance of the procedure at step 5.2.9, the control operator verifies the white standby lights are on for the containment spray pumps P-54A and P-54B. During this particular test, the control operator placed a portion of his finger on the light during the verification of the white lights being lit. The operator apparently depressed the light too hard and the pump started.

Procedure Q0-1 did not address the white light/pushbutton start feature for P-54B when the white light was illuminated. At no point in the procedure were operators directed to depress the white light/pushbutton. Further, the control operator and shift engineer performing Q0-1 were not aware that P-54B would start if the white light/pushbutton was depressed. This start feature was unique to the containment spray pumps.

The licensee intended to revise procedure Q0-1 to alert operators that the containment spray pumps will start if the white light/pushbutton is illuminated. One other recommended action was to examine the light/push button to determine whether replacement, adjustment, or repair was appropriate.

The inspector concluded the event was due to a procedure weakness and operator error. In addition, a training improvement item was identified regarding the white light/pushbutton operation for the containment spray pumps. Several operators admitted that they did not know that depressing the white light during the surveillance test would start the containment spray pumps. The inspector will assess the adequacy of the licensee's corrective actions when the licensee event report is issued for this event.

January 28, 1994: With the plant at 100 percent power, the number 2 governor valve on the main turbine (CV-0572) unexpectedly drifted closed. Operators stabilized the plant at approximately 90 percent power using procedure ONP-1, "Loss of Load," Rev.5. No safety systems actuated.

The licensee worked with the vendor during troubleshooting and repair efforts. The root cause was found to be a malfunctioned main valve positioner card in the turbine digital electro-hydraulic system (DEH). The card was replaced, and after some valve adjustments, the plant was returned to full power on February 2, 1994.

February 1, 1994: The licensee reported a potential problem identified by an NRC Service Water Inspection Team regarding seismically qualified instrument lines associated with the component cooling water heat exchangers. The sensing lines were used for indicating differential pressure and did not appear to be supported within the support spacing requirements or constructed in accordance with the design specifications.

Subsequent engineering analyses found the tubing was built to design specifications and, therefore, met the appropriate operability criteria. The licensee retracted the report to the NRC.

February 9, 1994: An NRC Service Water Inspection Team identified two potential single active failures for certain service water and component cooling water configurations that supply lubrication and cooling to the seals on the engineered safeguards pumps. The details are addressed in NRC Inspection Report 255/94002(DRS). The inspector will assess the adequacy of the licensee's corrective actions when the licensee event report is issued for this event.

February 10, 1994: During a walkdown of cable trays in the cable spreading room and the IC switchgear room, the licensee discovered that separation barriers were missing for reactor protection system (RPS) channels 1 and 3 for cables located in the same cable tray. The Final Safety Analysis Report Section 8.5.3.2 requires that if channel 1 circuits are routed in the same raceways as channel 3 circuits, then the circuits must be separated by a barrier between them.

The licensee performed an immediate operability determination and found no operability problem existed based upon reference of an IEEE paper on cable separation issues (reference IEEE 90 WM 254-3 EC) and other internal "engineering aid" documents. The licensee used those documents to justify operability. The documents included discussions on low voltage instrument and control cables similar to those in question. The licensee found that under a postulated electrical fault the amount of heat generated would not be enough to affect adjacent cables not separated by a barrier.

As followup of this issue, the inspector reviewed the licensee's documentation and discussed the licensee's operability determination. In addressing the inspector's concerns, the licensee found that the operability determination may have been incorrect. Although the reasons cited for low voltage instrument and control cabling may have been correct for some configurations, the IEEE document referenced above and used as a basis for the operability determination did not state that the amount of heat generated would not affect adjacent cables under an electrical fault. The effect on the cables due to heat is currently unknown, and the licensee is currently performing an evaluation to

determine this effect. The document also indicates separation may be required.

The inspector concluded the licensee's initial analysis was weak, as the licensee is now exploring the possibility that the RPS channels may have been inoperable with the unit at power. Pending the completion of the licensee's analysis, this issue is considered an Unresolved Item (No. 255/94004-01(DRP)).

February 17, 1994: The plant commenced a shutdown from full power to repair a through wall leak found on the recirculation containment sump outlet check valve, CK-ES-3166. The licensee entered Technical Specification 3.0.3 and declared an Unusual Event in accordance with the emergency plan. Following cooldown of the primary system to less than 325 degrees F., the licensee exited from the Unusual Event and Technical Specification 3.0.3. The plant ended this inspection report period in Cold Shutdown with plans in progress to repair the leaking check valve. The inspector will assess the adequacy of the licensee's corrective actions when the licensee event report is issued for this event.

d. Current Material Condition (71707)

The inspectors performed general plant as well as selected system and component walkdowns to assess the general and specific material condition of the plant, to verify that work requests had been initiated for identified equipment problems, and to evaluate housekeeping. Walkdowns included an assessment of the buildings, components, and systems for proper identification and tagging, accessibility, fire and security door integrity, scaffolding, radiological controls, and any unusual conditions. Unusual conditions included but were not limited to water, oil, or other liquids on the floor or equipment; indications of leakage through ceiling, walls or floors; loose insulation; corrosion; excessive noise; unusual temperatures; and abnormal ventilation and lighting.

Some improvement was noted in overall plant material condition. The licensee began to address lower priority work in the emergency diesel generator and service pump rooms. Also, some improvement was noted in cleaning up the boric acid in the spent fuel pool heat exchanger room, although additional attention is required and planned. Boric acid and contamination in and around the engineered safeguards pump skids were a concern. Other specific items noted included:

- Two longstanding maintenance items were observed for Emergency Diesel Generator (EDG) 1-2 that are examples of missed opportunities to correct the deficiencies:

- (1) A work order was written dated April 18, 1993, to replace the "A" air start motor as a preventive

measure against excessive starting times of the EDG. The system engineer stated that a spare motor was scheduled to be installed on the EDG during the last refueling outage, but the opportunity was missed because an o-ring was not available. The system engineer stated that the motor would be replaced during the next EDG outage this summer. No operability concern exists with the EDG.

(2) A work order was written dated September 28, 1992, to address a problem annunciator associated with lube oil level switch LS 1487. Initial resolution of the problem resided with the Instrument and Control (I&C) technicians, who had difficulty in repairing the switch, but did not seek outside assistance from the I&C system engineer until about one month ago. The cognizant I&C engineer stated he had a plan to troubleshoot the problem, which involves checking the wiring configuration, during the next monthly surveillance test on the EDG. No operability concern exists since operators check lube oil level using the dipstick at least daily.

- Water seepage was observed in the west engineered safeguards room. The seepage was determined to be ground water based on chemistry analysis. The licensee generated a work request and issued a deficiency report to address this item.
- A white precipitate buildup was observed in the auxiliary feedwater pump P-8A catch tray beneath the outboard pump bearing. The licensee had earlier noted this phenomenon on both auxiliary feedwater pumps P-8A and P-8B and sent a sample to the Jackson, MI laboratory for chemical analysis. The material was found to be composed of about 98 percent lead, and was identified with the pump packing. The licensee concluded the precipitate was caused by packing wear products mixing with the water around the pump shaft. The precipitate has caused no operability concern since no known performance problems exist that are attributable to this precipitate material.
- Instrument tubing for a pressure gauge for auxiliary feedwater pump P-8C in the west safeguards room was bent. The licensee generated a work request to repair or replace the bent tubing.
- Standing water on the floor in various areas of the turbine building was noted. The licensee responded by mopping the areas or roping off and posting the areas, as appropriate.

e. Housekeeping and Plant Cleanliness (71707)

The inspectors monitored the status of housekeeping and plant cleanliness for fire protection and protection of safety-related equipment from intrusion of foreign matter.

Observations communicated to the licensee included a spare circuit breaker in the IC switchgear room not secured and yellow plastic bags and other material on the floor in the east and west engineered safeguards pump rooms not properly stored.

f. Radiological Controls (71707)

The inspectors verified that personnel were following health physics procedures for dosimetry, protective clothing, frisking, posting, etc. and randomly examined radiation protection instrumentation for use, operability, and calibration.

A small primary coolant system (PCS) iodine spike upon plant shutdown indicated the first known presence of a leaking fuel rod in the core. PCS activity had been about 3 percent of the technical specification limit (1.0 microcuries per gram) for dose equivalent iodine (I-131) just prior to plant shutdown.

No violations, deviations, unresolved, or inspection followup items were identified in this area.

4. Safety Assessment/Quality Verification (40500 and 92700)

The inspector reviewed the licensee's deviation reports (DRs) generated during the inspection period. This was done in an effort to monitor the conditions related to plant or personnel performance, potential trends, etc. DRs were also reviewed to ensure that they were generated appropriately and dispositioned in a manner consistent with the applicable procedures.

The NPAD organization has undergone some organizational changes. Operations and Engineering team leaders have been filled with Senior Team Leaders to provide a stronger focus on these two weak areas. An Independent Management Safety Review Board (MSRB) with several non-licensee members is being formulated. The kickoff meeting is scheduled for March 17 and 18, 1994.

No violations, deviations, unresolved, or inspection followup items were identified in this area.

5. Maintenance/Surveillance (62703 & 61726)

a. Maintenance Activities (62703)

Routinely, station maintenance activities were observed and/or reviewed to ascertain that they were conducted in accordance with

approved procedures, regulatory guides and industry codes or standards, and in conformance with technical specifications.

The following items were also considered during this review: limiting conditions for operation were met while components or systems were removed from service; approvals were obtained prior to initiating the work; functional testing and/or calibrations were performed prior to returning components or systems to service; quality control records were maintained; and activities were accomplished by qualified personnel.

Portions of the following maintenance activities were observed and reviewed:

- Troubleshoot and repair the number 2 governor valve on the main turbine (CV-0572).

The inspector observed good work planning and technical discussions among members of the licensee's staff and the Westinghouse vendor. The root cause was found to be a circuit card in the digital electro-hydraulic control system (DEH). The card was tested and satisfactorily replaced; however, the licensee experienced difficulty in returning the governor valve back into service following repairs. The licensee has experienced some problems with the DEH in the past, and this latest problem indicates that the licensee has not yet gained a sound understanding of how the entire system operates.

- Troubleshoot and repair control room alarm chimes.
- Replace Emergency Diesel Generator 1-2 control transformer.

b. Surveillance Activities (61726)

During the inspection period, the inspectors observed technical specification required surveillance testing and verified that testing was performed in accordance with adequate procedures, that test instrumentation was calibrated, that results conformed with technical specifications and procedure requirements and were reviewed, and that any deficiencies identified during the testing were properly resolved.

The inspectors also witnessed or reviewed portions of the following surveillances:

- DWO-13, "LLRT - Local Leak Rate Tests For Inner and Outer Personnel Air Lock Door Seals," Rev.3

The inspector questioned the suitability of the 12 minute test performed on the outer containment door. Although the

licensee complied with all associated technical specification surveillance requirements, the basis document to the procedure stated that "Per ANSI/ANS - 56.8, 1987, Type B pressure decay tests shall have a duration of not less than 15 minutes for each test."

The inspector reviewed the completed procedure with the cognizant system engineer section head and found the test was performed per the procedure and results met the stated acceptance criteria. The individual stated that the 12 minute duration was satisfactory for the small volume and that the procedure basis document would be revised since ANSI/ANS - 56.8, 1987 was used for guidance only and was not endorsed by NRC.

The inspector checked with a Region III specialist and found that indeed ANSI/ANS - 56.8, 1987 is not endorsed by NRC. Further, on the small volume being tested the pressure decay method employed was acceptable (versus using make-up flow) and for this test time was not a critical parameter; 12 minutes was sufficient to calculate a leak rate given initial and final pressure values. The licensee intended to check the other related procedures to ensure the basis document accurately reflects procedure requirements.

- QO-20, "Inservice Test Procedure - Safety Injection Pumps," Rev.5
- QO-1, "Safety Injection System," Rev.34
- MO-33, "Control Room Ventilation Emergency Operation," Rev.3.

No violations, deviations, unresolved, or inspection followup items were identified in this area.

6. Fuel Handling (42700, 86700)

The inspector monitored the licensee's inspection of fuel assemblies in the spent fuel pool following commencement of activities for this year's dry fuel storage project. On January 10, 1994, fuel inspections began to confirm the identity and verify the integrity of fuel assemblies designated for dry fuel storage. As a conservative measure, the licensee has chosen to perform ultrasound examinations (UTs) of spent fuel in addition to visual inspections (VTs). The UTs are not required by the Certificate of Compliance for storage of the spent fuel.

The licensee completed VTs on 101 of about 300 scheduled spent fuel assemblies, and UTs on 259 of about 355 scheduled spent fuel assemblies to date. The VTs are performed in-house by the licensee (CPCo) and UTs are performed by Siemens Power Corp (SPC). The results of these inspections identified 6 failed rods, 5 fuel rods and 1 poison rod, in

assemblies that are subject to further evaluation prior to a final decision on whether they will be placed into dry storage. Those failed rods characterized as "gross failures" are not intended to be placed into dry storage. In addition, 15 VTs identified suspect indications that will undergo further evaluation. The UTs are scheduled to be complete March 25, 1994, with the VTs on April 22, 1994. The actual loading of the dry fuel storage casks is set to begin on May 16, 1994.

The inspector attended several daily pre-job briefings and the post-job summaries. These briefings were well attended. The lead project engineer covered the details of the planned activities, discussed the precautions, potential problems, and contingencies. The task responsibilities and expectations were fully addressed. There were healthy discussions of procedures, questions, and exchanges of ideas.

The inspector examined the procedures, inspection results, and reviewed selected videotapes of VTs performed on fuel assemblies. The inspector evaluated the fuel handling crew's detection methods for failed fuel rods and damaged spacers. Specific fuel assemblies examined included A-35, H-50, H-41, I-29, I-67, and I-68.

The inspector performed a random inspection and review of several videos of the inspection of fuel assemblies. The inspector independently noted several apparent defects, either of the fuel rods or associated segments, such as bent cap screws, questionable lock wire or even a bent rod. The licensee had previously identified these apparent defects, and plan to perform a careful evaluation of the assemblies prior to assigning them for dry storage.

The inspector noted good correlation between what the licensee's fuel handling crew identified as questionable defects and subsequent verification by the reactor engineer by reviewing the video tape. The video tape documented the scanning of peripheral rods and the spacers. The potential for a failed fuel rod being missed by the fuel handling (inspecting) crew during the inspection appeared very slight. However, the licensee's plans to conduct subsequent UT testing of all the used fuel assemblies in the spent fuel pool which would significantly reduce the potential of a failed fuel to be missed.

No violations, deviations, unresolved, or inspection followup items were identified in this area.

7. Report Review

During the inspection period, the inspectors reviewed the licensee's monthly operating report for December, 1993, and January, 1994. The inspectors confirmed that the information provided met the reporting requirements of TS 6.9.1.C and Regulatory Guide 1.16, "Reporting of Operating information."

No violations, deviations, unresolved, or inspection followup items were identified in this area.

8. 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.c.

9. Meetings and Other Activities (30703)

a. Management Meetings (30702)

On February 7, 1994, and on February 24-25, 1994, the NRC section chief assigned to Palisades toured the Palisades plant and met with licensee management to discuss plant performance and plant material condition.

b. Exit Interview (30703)

The inspectors met with the licensee representatives denoted in paragraph 1 during the inspection period and at the conclusion of the inspection on March 14, 1994. The inspectors summarized the scope and results of the inspection and discussed the likely content of this inspection report. The licensee acknowledged the information and did not indicate that any of the information disclosed during the inspection could be considered proprietary in nature.