

U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Report No. 50-295/93014(DRP); 50-304/93014(DRP)

Docket Nos. 50-295; 50-304

License Nos. DPR-39; DPR-48

Licensee: Commonwealth Edison Company
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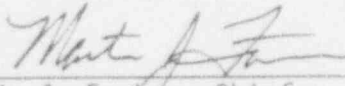
Facility Name: Zion Nuclear Power Station, Units 1 and 2

Inspection At: Zion, IL

Inspection Conducted: June 10 through July 20, 1993

Inspectors: J. D. Smith
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Reactor Projects Section 1A

8/5/93
Date

Inspection Summary

Inspection from June 10 through July 20, 1993 (Report No. 50-295/304-93014(DRP))

Areas Inspected: This was a routine resident and regional inspection of licensee action on previous inspection findings, summary of operations, operational safety verification and engineered safety feature (ESF) system walkdown, maintenance and surveillance observation, engineering and technical support observations, safety assessment and quality verification, and followup to the April 16, 1993 enforcement conference.

Results: One non-cited violation was identified concerning a containment flooding environmental qualification issue (paragraph 2). One unresolved item was identified, concerning the implementation of corrective actions for problems with the technical support center ventilation system (paragraph 4).

Plant Operations

Operation's response to the Unit 1 reactor trip on July 7, 1993 was good. However, the operators could have been more proactive in requesting engineering assistance to identify the cause of dropping condenser vacuum that resulted from a high pressure heater rupture disk failure. Although the operators are generally attentive to submitting operation feedback reports (OFR) for procedure deficiencies, one example of an OFR not being submitted for a non-safety system was identified.

Maintenance and Surveillance

In response to the Unit 1 forced outage, maintenance accomplished significant tasks in a minimal time. These accomplishments were due to an improved forced outage list, excellent interdepartmental coordination and craft personnel who were assigned jobs through completion. Although still not meeting licensee management expectations, improvements were seen in the writing of problem identification forms (PIFS) by maintenance personnel.

Engineering and Technical Support

Engineering's initial response to troubleshooting the cause of the reactor trip was good; however, the focus was on what was thought to be the root cause and did not, at first, consider other possibilities. The troubleshooting, however, did lead to the identification of the root cause of the equipment failure that caused the trip. However, an independent technical review of the engineer's root cause conclusions would have more quickly identified the equipment failure.

Safety Assessment and Quality Verification

Management overview of plant activities continue to improve. The technical audit performed by the Quality Verification group during this period was very good.

DETAILS

1. Persons Contacted

R. Tuetken, Vice President, Zion Station
A. Broccolo, Acting Station Manager
M. Lohmann, Site Engineer & Construction Manager
*P. LeBlond, Executive Assistant
*S. Kaplan, Regulatory Assurance Supervisor
*D. Wozniak, Technical Services Superintendent
*L. Simon, Maintenance Supervisor
J. LaFontaine, Outage Management Manger
T. Printz, Assistant Superintendent of Operations
R. Cascarano, Services Director
W. Stone, Performance Improvement Director
R. Chrzanowski, Technical Staff Supervisor
R. Milne, Security Administrator
*R. Whittier, Quality Verification
*K. Hansing, Operating Engineer
*K. Dickerson, Regulatory Assurance - NRC Coordinator

* Indicates those present at the exit interview on July 20, 1993.

The inspectors also contacted other licensee personnel including members of the operating, maintenance, security, and engineering staff.

2. Licensee Actions on Previous Inspection Findings (92701, 92702)

- a. (Closed) Unresolved Item (295/90013-03; 304/90015-01 (DRP)):
"Incorrect Containment Flood Level Specified in the UFSAR."
During an individual plant evaluation, the licensee identified an incorrect containment flood level as specified in the updated final safety analysis report (UFSAR). The revised containment flood level affected equipment environmental qualification. This is considered a non-cited violation as it meets the criteria specified in Section VII.B.2 of the Enforcement Policy (10 CFR Part 2, Appendix C). Corrective actions, identified in Licensee Event Report (LER) 90-015-00, were accomplished in a prompt manner. The licensee has also identified the need for a long term modification which is scheduled for refueling outage 14 on both units. The completion of this modification (M22-1(2)-91-027) is considered an inspection followup item (295/304-93014-01(DRP)). The unresolved item is closed.
- b. (Closed) Unresolved Item (295/90030-08 DRP)): "Section XI Testing Deficiencies." In inspection report 295/92014 it was noted that on April 22, 1992, the 2C service water (SW) pump performed above the +3 percent acceptance band on the pump head curve. It was also noted that the curve used was the original pre-operational curve, rather than a revised curve reflecting a previous impeller change. The inspector reviewed the licensee's actions which were to provide computer generated pump head curves in place of the

original pre-operational curves. The curves were provided and the inspector had no concerns. No violations were identified. This item is closed.

- c. (Closed) Open Item (304/91004-03(DRP)): "Significant Training Deficiencies." The licensee provided on-shift crew training which included valve description, operation training, and a walk-through of the resetting procedure. Equipment attendants were then evaluated by qualified personnel during the resetting of the deluge valve. The inspector reviewed the licensee's actions and found them to be adequate to resolve the concerns. This item is closed.
- d. (Closed) Unresolved Item (295/91010-05(DRP)): "Inadvertent Discharge of Diesel Fire Pump Starting Batteries." The inspector reviewed the licensee's corrective actions and found them to be acceptable. No violations were identified. This item is closed.

One non-cited violation was identified.

3. Summary of Operations

Unit 1

The unit operated at power levels up to 100 percent throughout the report period except as noted below:

On July 7, Unit 1 tripped from 100 percent power. The operators' response was good, and the plant performed as expected with the exception of a failed high pressure heater rupture disk. The cause of the trip was an invalid loop stop isolation valve closure signal on one train in conjunction with periodic testing of the reactor protection circuitry on another train. The invalid signal was caused by a shorted lug on the valve limit switch. The short was from the insulation wearing away due to high temperatures, vibration, and the close contact of the two cables for the closed indication. The combination of the invalid signal and the test signal caused the reactor coolant pump to trip, which, in turn, caused the reactor to trip. It had been over 600 days since the last reactor trip.

In parallel with determining the root cause of the trip, the scope of the forced outage was determined. The station created and maintained a forced outage work request list in order to scope outage work more efficiently. This was the first time the list was used. Based on the unit restart on July 9, the list proved helpful.

The unit was taken off line on the morning of July 10 to replace a ruptured heater drain tank rupture disk and was returned to power shortly after midnight. Although the rupture disk may have been weakened or even ruptured during the trip, once the unit was shut down, it could not be detected.

Unit 2

The unit operated in the load-following mode at power levels up to 100 percent the entire report period.

No violations or deviations were identified.

4. Operational Safety Verification and Engineered Safety Features System Walkdown (71707 & 71710)

The inspectors verified that the facility was operated in conformance with its licenses along with regulatory requirements. The inspectors confirmed that the licensee's management control system was effectively carrying out its responsibilities for safe operation. During tours of accessible areas of the plant, the inspectors made note of general plant and equipment conditions, including control of activities in progress.

On a sampling basis, the inspectors observed control room staffing and coordination of plant activities; observed operator adherence with procedures and technical specifications (TS); monitored control room indications for abnormalities; verified that electrical power was available; and observed the frequency of plant and control room visits by management. The inspectors also monitored various administrative and operating records.

a. Engineered Safety Features (ESF) Systems

Accessible portions of ESF systems and their support systems components were inspected to verify operability through observation of instrumentation and proper valve and electrical power alignment. The inspectors also visually inspected components for material conditions.

System walkdowns were performed on the auxiliary feedwater (AFW) system and the safety injection (SI) system. During the AFW walkdowns the inspector identified minor valve labelling deficiencies: on the 2A turbine driven AFW pump, two valves were not labeled, while two others were mislabeled. These valves were included in the AFW valve lineup procedure (SOI 10 Appendix 1).

The inspectors also identified a discrepancy in the lineup procedure: Four Unit 1 valves were listed as being located at the "F-12 standpipe" when, in fact, they were at the F-29 standpipe. The F-12 standpipe was the location of the same valves on Unit 2. These issues were discussed with the licensee and are being corrected.

b. Radiation Protection (RP) Controls

The inspectors verified that workers were following RP procedures and randomly examined RP instrumentation for operability and calibration.

The overall performance of the RP group continues to improve as demonstrated by the reduction in personnel contaminations and exposure. The RP group has been challenged by the spent fuel pool rerack job which has resulted in higher personnel exposures than projected. However, they have demonstrated good performance in handling these unforeseen problems

Spent Fuel Pool Rerack Modification: During this inspection period, an increase was observed in both the actual and expected dose rates for the spent fuel pool rerack modification. The increase was attributed to several factors, including more highly contaminated racks--which required more decontamination time, more involved rigging practices--which increased the time necessary to load used racks into the shipping boxes, and high dose rates being found on the shipping boxes during surveys after the boxes were removed from the trackway. This latter problem resulted in racks being unloaded from the shipping boxes, recleaned, reboxed, and the placement of shielding on the outside of several boxes. Although minor problems continued to appear, steady progress was being made. Job coverage by the radiation protection department was good.

c. Security

During the inspection period, the inspectors monitored the licensee's security program to ensure that observed actions were being implemented according to their approved security plan.

d. Housekeeping and Plant Cleanliness

The inspectors monitored the status of housekeeping and plant cleanliness for fire protection and protection of safety-related equipment from intrusion of foreign matter. The inspectors noted a general decline in housekeeping, due, in part, to preparations for the dual unit outage. For example, condensation on piping due to insulation removal led to an increase in a contaminated area due to water dripping on contaminated surfaces and spreading through the area.

e. Operational Events

2A Auxiliary Feedwater Pump Failure: On June 24, the 2A turbine-driven AFW pump failed its periodic test. The apparent cause of the failure was moisture condensation due to the 2D steam header trap not working. A Level II root cause investigation was initiated because of a comparable problem with the pump during Unit 2 startup from its last refueling outage. The steam trap was repaired, and the AFW pump was successfully retested and returned to operation.

Technical Support Center (TSC) Self-contained Particulate, Iodine, and Noble Gas (SPING) Misalignments: On May 24, the TSC SPING radiation monitor alarmed high due to the presence of naturally occurring radon and was taken out of service. The licensee transferred the ventilation system to the recirculation mode within two hours, in accordance with TS requirements. However, on May 28, it was discovered that the TSC ventilation system was in the normal mode (instead of the recirculation mode) with all control switches in automatic.

On June 7, it was discovered that the Train B emergency makeup air treatment system fan local disconnect switch was in the off position instead of the required on position. This was discovered when an alarm sounded indicating a problem with either the TSC SPING radiation monitor or the TSC ventilation system.

Implementation of corrective actions is considered an unresolved item (295/304-93014-03(DRP)) pending follow-up on procedural reviews.

f. Assessment of Plant Operations

Operations' response to the Unit 1 reactor trip on July 7, 1993, was good. However, the operators could have been more proactive in requesting engineering assistance to identify the cause of dropping condenser vacuum that resulted from a high pressure heater rupture disk failure. Although the operators are generally attentive to submitting operation feedback reports (OFR) for procedure deficiencies, one example of an OFR not being submitted for a non-safety system was identified.

No violations or deviations were identified.

5. Monthly Maintenance and Surveillance (62703 and 61726)

a. Maintenance and Surveillance Activities

Station maintenance and surveillance activities were observed to verify that they were conducted in accordance with approved procedures and TS requirements. The inspectors reviewed work packages to ensure that approvals were obtained prior to initiating the work and testing, that operability requirements were met, and that any discrepancies were resolved prior to returning the component to service. The inspectors also verified that the activities were performed by qualified personnel.

The following maintenance activities were observed during this inspection period:

Z26653 Preventive Maintenance on Air Operated Valve
1FCV-C0129M (Steam Dump Line M Spray Control Valve)

Z23894	Miscellaneous Work on Condensate-Condensate Booster Pump 2D (Bearing replacement and reinstallation of thermocouples)
Z27210	Maintenance of Personnel Monitor IPM-8 AR-34
Z32959	Troubleshoot and Repair Train B Reactor Protection Logic Relays per Technical Staff Direction

The following surveillance activity was observed during this inspection period:

PI-6C-ST Containment Spray Pump Systems Test and Checks

Emergency Lighting: The inspectors identified a number of emergency lighting units that were fully discharged. The units were restored and the licensee found that the circuit breaker powering the units had tripped. Due to previous tripping experiences, the circuit breaker was replaced.

1C Containment Spray Pump: The licensee changed the diesel driven containment spray pump surveillance testing interval from monthly to biweekly due to problems encountered during previous surveillances. On May 13, during the post-maintenance surveillance test the diesel came up to speed, then dropped off. This was similar to its performance during the last two surveillance runs. A second post-maintenance test was run 1½ hours later. This time the diesel cranked on battery 1, but did not start; automatically switched to battery 2, started and came up to speed. No further problems were encountered, and the diesel successfully completed the surveillance run. An as-found surveillance test is planned at the end of July to further investigate the cause of the speed drop-off.

b. Assessment of Maintenance and Surveillance

In response to the Unit 1 forced outage, maintenance accomplished significant tasks in a minimal time. These accomplishments were due to an improved forced outage list, excellent interdepartmental coordination and craft personnel assigned to jobs through completion. Although not meeting licensee management expectations, improvements were seen in the writing of problem identification forms (PIFS) by maintenance personnel.

No violations or deviations were identified.

6. Engineering and Technical Support (37828)

The inspectors evaluated the extent to which engineering principles and evaluations were integrated into daily plant activities. This was accomplished by assessing the technical staff involvement in non-routine

events, outage-related activities, and assigned TS surveillances; observing on-going maintenance work and troubleshooting; and reviewing deviation investigations and root cause determinations.

a. Engineering and Technical Support Events

Erosion Corrosion Ultrasonic Testing: The licensee performed additional ultrasonic testing as a followup to the May 22 steam leak in the Unit 1 high pressure turbine steam line to the moisture separator reheater (discussed in inspection report 93011). The identical elbow on the east side was ultrasonically tested on May 27 and again on June 29. The results were the same from both tests. The licensee will have the corporate testing group perform a follow-up comparison test on July 29.

Design Basis Documentation (DBD) Status: As a result of the SW system design basis and other system weaknesses, the licensee initiated a program to consolidate existing design basis information into system and topical packages. There are a total of 50 design basis document (DBD) packages, of which 21 will be completed by the end of 1993. The remainder of the DBD packages are scheduled for completion by 1997. The licensee is ahead of schedule for meeting the NRC commitments for DBD package consolidations.

Eagle 21 Sporadic Alarms: The Eagle 21 process protection system continued to experience sporadic alarms which cleared before the alarm cause could be identified. This phenomenon was limited to Unit 1 until June 18, when similar alarms occurred on Unit 2. A temporary alteration, used in troubleshooting, was installed in two racks within protection Set III of Unit 1. Trouble shooting progress is limited until an alarm occurs on the specific racks that are being monitored.

On June 21, Unit 1, Protection Set I, alarmed and did not clear. The set could not be reset and the problem was determined to be different than the sporadic alarm problem. The tester subsystem processor card was replaced and the problem was corrected.

Temporary Service Water System: During the upcoming dual unit outage (DUO), the SW and component cooling water (CCW) systems will be taken out of service for replacement of various valves. However, certain functions normally provided by the SW and CCW systems will still be required. Modification M22-1-92-002 will design and install a temporary service water system and a temporary spent fuel pool cooling system. The temporary systems will be connected after both units 1 and 2 reactors are completely defueled and SW and CCW are taken out of service.

The Division of Reactor Safety, Region III, reviewed the temporary service water modification package (Parts A through E) and determined that the proposed system design is acceptable. The

review of the proposed system included a review of the modification package, the 10 CFR 50.59 safety evaluation, discussions with the cognizant engineer, a review of regulatory documents, and a walkdown of the proposed piping layout.

The temporary SW system provides a means to transfer the spent fuel pool's decay heat to the ultimate heat sink. In the event of a failure of the temporary SW system, the pool would eventually boil if cooling was not restored. This is significant since water level must be maintained above the fuel assemblies. Assuming the peak decay heat load calculated for Zion's DUO, the time-to-boil with a starting temperature of 120° F is 8.5 hours. This provides adequate time to line up existing alternate make-up systems to maintain water level. Make-up systems available include the Unit 1 and Unit 2 refueling water storage tank purification loop, and demineralized water. Additionally, four seismic fire protection hose stations in the fuel building can also provide enough flow to maintain pool temperature below 180° F. Therefore, in the event of an unrecoverable failure of the temporary SW system, other systems and methods are available to remove the irradiated fuel assembly's decay heat.

A complete loss of all cooling to the pool was evaluated and would result in eventual boiling and a loss rate of 107 gpm at the peak decay heat load for the DUO. The integrated whole body doses at the site boundary and at the low population zone were determined (conservatively assuming that the fuel handling building ventilation system was not in operation). These doses were within the guidelines set forth in 10 CFR Part 100 and bounded by the values calculated for the loss of coolant accident evaluated in the plant's UFSAR.

The temporary SW system is designed so that its pressure at the spent fuel pool (SFP) heat exchangers is greater than the SFP cooling system pressure to preclude passing radioactive SFP fluid to the lake. Additionally, a radiation monitor is provided downstream of the temporary SFP cooling heat exchangers. Should these precautions fail, the modification package evaluated a loss of temporary SW pressure and failure of the temporary SFP heat exchangers in order to determine potential off-site doses. The radiological doses which would result from a conservative release of spent fuel pool water into Lake Michigan were bounded by technical specification dose limits and by the fuel handling accident which is evaluated in the UFSAR.

The non-seismic temporary SW system was also reviewed for its potential to impact safety related components or systems. The majority of the temporary SW piping is routed in the turbine building and outdoors where failure of piping or components would not affect safety related components or systems in the plant.

Temporary SW piping in the auxiliary building, the fuel building and in the crib house is routed, and installation is sequenced, so that failure could not impair safety related components or systems.

Barriers to cope with flooding and separation between safe shutdown equipment are not altered during the proposed modification. The safety implication and risk from flooding are significantly reduced during the outage. The temporary SW system is designed to ANSI B31.1 requirements and areas in the plant will be hydrostatically tested prior to operation. Also, the temporary SW system provides for adequate isolation and the pumps can be tripped from the control room.

b. Assessment of Engineering and Technical Support

Engineering's initial response to troubleshooting the cause of the reactor trip was good. However, the focus was on what was thought to be the root cause and not at other possibilities. The troubleshooting, however, did lead to the identification of the root cause of the equipment failure that caused the reactor trip. An independent technical review of the root cause conclusions would have more quickly identified the equipment failure.

No violations or deviations were identified.

7. Safety Assessment and Quality Verification (40500)

The effectiveness of management controls, verification, and oversight activities in the conduct of jobs observed during this inspection was evaluated. Management and supervisory meetings involving plant status were attended to observe the coordination between departments. The results of licensee corrective action programs were routinely monitored by attendance at meetings, discussion with the plant staff, review of deviation reports, and root cause evaluation reports.

a. SAQV Related Events

Surveillance Intervals for Radiation Protection and Chemistry Surveillances: On June 3, a problem identification form (PIF) was written by the operations department to document a possible violation of Technical Specification (TS) 4.3.3.A surveillance requirements. The TS requires either continuous monitoring by radiation detectors (which were abandoned in place), or manual sampling of the containment atmospheres once a shift. The PIF questioned the interpretation of "once a shift" for departments on an 8-hour shift, especially since TS Interpretation 93-03 defined the word "shiftly" to mean "once in a 12-hour period." Additionally, the PIF questioned the amount of latitude the station had regarding "pulling" the sample versus "counting" the sample.

Prior to this PIF being written, the chemistry and radiation protection departments considered "once a shift" to mean any time during a scheduled 8-hour shift. Both departments were informed that the interpretation "once in a 12 hour period" applied to their departments, and radiation protection procedures were revised to clearly delineate the TS requirements.

The inspectors found that the radiation protection and chemistry departments normally obtained and analyzed the manual samples within the same 8-hour shift. However, for the June 3 samples discussed in the PIF, the samples were obtained, but not analyzed, during the 3-11 shift. The practice of pulling and analyzing the samples within the same shift was conservative; TS (Table 3.12-1, Note 6) allowed analysis to be performed within 24 hours of the sample being obtained.

The inspectors concluded that no violation of TS requirements occurred. However, the inspectors found that communications were poor, in that the TS interpretation was not considered before the PIF was written.

Quality Verification Technical Support Audit: On July 16, the licensee's quality verification group completed an audit of the Zion technical support function with a formal exit meeting. The audit looked into a number of areas including the inservice testing program, the check valve program, plant chemistry, emergency preparedness, and the exempt change process, among others. The audit team identified a number of findings and appeared to have conducted a thorough intensive audit. Plant management's response to the findings was appropriate.

b. Assessment of SAQV

Management overview of plant activities continue to improve. The technical audit performed by the quality verification group during this period was very good.

No violations or deviations were identified.

8. Licensee Event Report (LER) Followup (92700)

Through direct observations, discussions with licensee personnel, and review of records, the following LERs were reviewed to determine that reportability requirements were fulfilled, immediate corrective actions were accomplished, and corrective actions to prevent recurrence had been taken in accordance with technical specifications. The LERs listed below are closed, based on the discussion in section 4.e.

<u>LER NO.</u>	<u>DESCRIPTION</u>
295-93005	Radiation Monitor being Out of Service Without the Ventilation System Being in the Proper Position.

295-93006 Train B Emergency Air Treatment System Fan Local Disconnect Switch was Found in the Off Position.

In addition, the inspectors reviewed PIFs generated during the inspection period in order to monitor conditions related to plant or personnel performance for potential trends. The PIFs, and the results of investigations, were also reviewed to ensure that they were generated appropriately and dispositioned in a manner consistent with applicable procedures and the quality assurance manual.

No violations or deviations were identified.

9. Followup to the April 16, 1993 Enforcement Conference

At the enforcement conference, the licensee explained that the auxiliary building ventilation system design was to maintain a nominal one-fourth inch negative pressure on potentially contaminated individual cubicles or pipe chases relative to the general areas of the auxiliary building, and that the design was not to maintain the entire building at a nominal one-quarter inch negative pressure relative to atmosphere as the NRC thought. Subsequently, the inspector determined that ECCS equipment room cubicles are designed to be maintained at one-half inch negative pressure relative to atmosphere. To accomplish this goal, pressure differential control dampers in each area are employed as required and are controlled by a differential pressure gage system.

During a tour of the auxiliary building on April 28, 1993, the inspector followed site procedure TSGP-35, "Cubicle Differential Pressure Surveillance," which is performed by the licensee annually to assure proper pressure differential exist between cubicles and the general areas of the auxiliary building. The inspector found that ten out of seventy gages inspected read "0" and were therefore inoperable. A review of the past licensee surveillances indicated that six out of the ten have been inoperable for approximately six months, one for approximately one year, and one for approximately eighteen months. The failure to take timely corrective action to repair the gages is an additional example of an apparent violation of 10CFR50, App. B, Criterion XVI (50-295/93009-05 (DRP); 50-304/93009-05 (DRP)).

During a review of procedure TSGP-35, the inspector identified that the procedure had a high pressure acceptance criteria of "0" inches water. This does not meet the design intent expressed in the UFSAR to maintain the cubicles either at a one-quarter inch negative pressure with respect to the general areas of the auxiliary building or one-half inch negative pressure with respect to atmosphere. By specifying inadequate acceptance criteria, 43 out of 70 cubicles inspected were not meeting their design intent without being identified and corrected in a timely manner, and therefore the auxiliary building ventilation system was not meeting its design intent as expressed by the licensee during the

enforcement conference. The failure to translate appropriate acceptance criteria into a surveillance procedure is an additional example of an apparent violation of 10CFR50, App. B, Criterion III (50-295/93009 (DRP); 50-304/93009 (DRF)).

Because many pressure gages appeared not to be functioning properly for some time, the inspector questioned if there were any instrument calibration requirements on these differential pressure gage circuits. The licensee provided the inspector a computer printout off of the General Surveillance Instruments (GSIN) tracking data base which tracks instrument calibration frequencies. The printout indicated that the gage circuits are only calibrated on request via procedure TSGP-35 results, or by system engineer walkdowns. The printout only documented times when the whole differential pressure gage loop was calibrated. If only a portion of the loop was worked on it would be reflected in the work request file history and not in the GSIN database. The printout indicated that five gages (system loops) have not been calibrated since 1978. The failure to have established calibration and adjustment frequencies to maintain accuracy of the gages within necessary limits is an apparent violation of 10CFR, App. B, Criterion XII (50-295/93009-06 (DRP); 50-304/93009-06 (DRP)).

During the enforcement conference, the licensee presented information that a work request was opened when the missile door operator broke and therefore they did not need to generate a PIF in accordance with ZAP 700-08. Upon further review, it was determined that the missile door and its actuator were not safety related and thus a PIF was not required to be generated per ZAP 700-08, and a work request was sufficient. This closed apparent violation (50-295/93009-04A (DRP); 50-304/93009-04A (DRP)). However, the door is an integral part of the auxiliary building's Seismic Class I concrete outer envelope, and is necessary to control the spread of contamination by allowing the required vacuum to be maintained in the building. Consequently, the licensee's quality assurance (QA) program was not applied to the maintenance activities associated with the broken door opener. It was further identified during a followup inspection in June that the individual cubicle differential pressure gages and their associated circuitry also are not safety related and thus do not get the attention they should have when they become inoperable. The failure to identify components to be covered by the licensee's QA program, which are essential to the control of the spread of contamination, is an apparent violation of 10CFR50, App. B, Criterion II (50-295/93009-07 (DRP); 50-304/93009-07 (DRP)).

10. Inspection Followup Items

Inspection followup 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. An Inspection followup item disclosed during this inspection is discussed in paragraph 2.

11. 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. One unresolved item disclosed during this inspection is discussed in paragraph 4.

12. Licensee Identified Violations

The NRC uses the Notice of Violation as a standard method for formalizing the existence of a violation of a legally binding requirement. However, because the NRC wants to encourage and support licensee's initiatives for self-identification and correction of problems, the NRC will not generally issue a Notice of Violation for a violation that meets the tests of 10 CFR 2, Appendix C, Section VII.B.(2). These tests are:

- (1) the violation was identified by the licensee;
- (2) it was not a violation that could reasonably be expected to have been prevented by the licensee's corrective action for a previous violation;
- (3) the violation was or will be corrected, including measures to prevent recurrence, within a reasonable time; and
- (4) it was not a willful violation.

A violation of regulatory requirements identified during this inspection for which a Notice of Violation will not be issued is discussed in paragraph 2.

13. Exit Interview (30703)

The inspectors met with licensee representatives (denoted in section 1) throughout the inspection period and at the conclusion of the inspection on July 20 to summarize the scope and findings of the inspection activities. The licensee acknowledged the inspectors' comments. 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 or processes as proprietary.