

U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Reports No. 50-266/90010(DRP); 50-301/90010(DRP)

Docket Nos. 50-266; 50-301

Licenses No. DPR-24; DPR-27

Licensee: Wisconsin Electric Company
231 West Michigan
Milwaukee, WI 53201

Facility Name: Point Beach Units 1 and 2

Inspection At: Two Rivers, Wisconsin

Inspection Conducted: May 1 through June 15, 1990

Inspectors: C. L. Vanderniet
J. Gadzala

Approved By: *I. N. Jackiw*
I. N. Jackiw, Chief
Reactor Projects Section 3A

6/26/90
Date

Inspection Summary

Inspection from May 1 through June 15, 1990 (Reports No. 50-266/90010(DRP);
No. 50-301/90010(DRP))

Areas Inspected: Routine, unannounced inspection by resident inspectors of outstanding items; operational safety; radiological controls; maintenance and surveillance; emergency preparedness; security; engineering and technical support; safety assessment/quality verification; and Temporary Instruction 2500/103.

Results: During this inspection period, Unit 2 operated at full power with only requested load following power reductions. Unit 1 began this reporting period in a maintenance and refueling outage, it was returned to operation on May 19, 1990 and has remained in full power operation since. Issues addressed in this inspection report include: Inadvertent Reactor Protection System Actuation (Paragraph 3.e); Low Temperature Overpressure (LTOP) Actuation (Paragraph 3.f); Post Refueling Startup (Paragraph 8.a); Reactor Coolant Pump Motor Cubicle Cover Blocks (Paragraph 8.b); Control Board Human Factors Design (Paragraph 8.c); Emergency Diesel Generator (EDG) Load Sequencing (Paragraph 8.d); Corporate Management Personnel Change (Paragraph 9.a); Self Assessment Capability (Paragraph 9.b); Offsite Review Committee (OSRC) Meeting (Paragraph 9.c); and Temporary Instruction 2515/103 Loss of Decay Heat Removal Program Enhancements Review (Paragraph 10). Two new issues which remain unresolved were identified during this period, they include: Low Temperature Overpressure (LTOP) Actuation (Paragraph 3.f); and Emergency Diesel Generator (EDG) Load Sequencing (Paragraph 8.d).

The utility continued to exercise good control over work activities during the remainder of the Unit 1 outage. Unit 1 reactor startup was handled in a professional manner with no problems encountered. Operation of Unit 2 continued in a safe and professional manner during this inspection period.

DETAILS

1. Persons Contacted (30703) [(30702)]

- *J. J. Zach, Plant Manager
- T. J. Koehler, General Superintendent - Maintenance
- G. J. Maxfield, General Superintendent - Operations
- J. C. Reisenbuechler, Superintendent - Operations
- W. J. Herrman, Superintendent - Maintenance
- N. L. Hocfert, Superintendent - Instrument & Controls
- R. J. Bruno, Superintendent - Technical Services
- T. L. Fredrichs, Superintendent - Chemistry
- J. J. Bevelacqua, Superintendent - Health Physics
- R. C. Zyduck, Superintendent - Training
- R. D. Seizert, Regulatory Engineer
- D. R. Stevens, Nuclear Specialist
- *F. A. Flentje, Administrative Specialist

Other licensee employees were also contacted including members of the technical and engineering staffs, and reactor and auxiliary operators.

*Denotes the personnel attending the management exit interview for summation of preliminary findings.

2. Licensee Action on Previous Inspection Findings (92701)

- a. (Closed) Unresolved Item (301/90005-01): Inadvertent Auxiliary Feedwater (AFW) Actuation.

Wisconsin Electric issued Licensee Event Report (LER) 301/90-001 describing this event and their proposed corrective actions. The LER will be used to continue tracking corrective actions for the incident, therefore, this item is closed.

- b. (Open) Violation (266/89033-02; 301/89033-02): Failure to comply with 10 CFR 50 Appendix B, Criterion XVI - Corrective Actions.

On May 15, Wisconsin Electric acknowledged their lack of timeliness in correcting identified deficiencies as stated in the citation and paid the proposed civil penalty. The company has initiated a series of corrective actions to improve their performance in this area.

The principal corrective action is an increase in personnel to aid in resolving the backlog of open issues. The company has committed to increase its staff size by 16% with an addition of 68 people. The first group is to be hired by July 1, 1990 (approximately 50% of the positions filled by the end of 1990) and the rest by July 1, 1991.

The licensee is also planning to form a Safety Evaluation Group whose functions will include the performance of 50.59 reviews and screening of open items to identify those of potential safety significance. This group is expected to be operational by the end

of 1990. In the interim, the task of reducing action items has been assigned to an ad hoc Action Team, which was approved on January 18, 1990. This team was responsible for allowing the licensee to reduce its open item list by 50% since the start of the year. This team is currently developing a new open item prioritization procedure which is expected to be fully implemented by September 1, 1990.

The licensee is revising Quality Assurance Instruction QAI 18.2, which defines the process to identify delinquent corrective actions and escalate them to appropriate management levels consistent with their significance. Additionally, three of the open item tracking lists are scheduled for consolidation to provide a single tracking tool for the various work efforts.

The inspector will continue to follow the licensee's progress in this area and this item will remain open pending staffing of a majority of the newly defined billets and completion of the remaining corrective actions.

No violations or deviations were identified.

3. Plant Operations (71707) (93702) (60710)

a. Control Room Observation (71707)

The inspector observed control room operations, reviewed applicable logs and conducted discussions with control room operators during the inspection period. During these discussions and observations, the inspectors ascertained that the operators were alert, cognizant of current plant conditions, attentive to changes in those conditions and took prompt action when appropriate. The inspectors noted that a high degree of professionalism attended all facets of control room operation and that both unit control boards were generally in a 'black board' condition (no non-testing annunciators in alarm condition). Several shift turnovers were also observed and appeared to be handled in a thorough manner.

The inspectors performed walkdowns of the control boards to verify the operability of selected emergency systems, reviewed tagout records and verified proper return to service of affected components.

Plant Management personnel were observed making tours of the control room and the plant. The Vice President, Nuclear, and the new President of Wisconsin Electric were also observed touring the plant.

b. Facility Tours (71707) (60710)

Tours of the Primary Auxiliary Building, Turbine Building, and Unit 1 Containment, were conducted to observe plant equipment conditions, including plant housekeeping/cleanliness conditions, status of fire

protection equipment, fluid leaks and excessive vibrations and to verify that maintenance requests had been initiated for equipment in need of maintenance.

The inspector conducted a detailed tour of Unit 1 containment prior to reactor startup. Inspection emphasis was placed on stowage of temporary equipment used during the outage and the cleanliness of the area surrounding the containment recirculation sump. Portable equipment was noted to be properly stowed. Temporary storage barrels were individually chained to support stanchions to prevent movement under accident conditions. The area around the containment recirculation sump was free of debris and the sump grating was properly installed. The inspector noted some minor stowage and cleanliness deficiencies which could have contributed to debris washing up against the sump grating under accident conditions. This was brought to the plant's attention and corrected.

During facility tours, inspectors noticed only occasional signs of leakage and that all equipment appears to be in good operating condition. Overall, plant cleanliness is adequate.

c. Unit 1 Operational Status (93702) (60710)

Refueling outage 17 was completed and criticality achieved May 17. The unit was placed on line on May 20 and remained there for the remainder of this period with only requested load following power reductions.

d. Unit 2 Operational Status (93702)

The unit continued to operate at full power during this period with only requested load following power reductions.

e. Inadvertent Reactor Protection System Actuation (93702)

On May 10, the licensee notified the NRC via the Emergency Notification System (ENS) regarding an inadvertent reactor trip signal and Emergency Safeguards Features (ESF) actuation on Unit 1 while in cold shutdown. The initiating signals were caused by a low-low level in both steam generators.

The steam generators were in a drained condition for routine maintenance. This condition results in an expected reactor trip signal due to steam generator level being below the trip setpoint. In preparation for cold rod drop timing tests, this trip signal was cleared by inserting artificial level test signals into the steam generator level circuitry to prevent the system from sensing the low level condition. The test signal generator was powered from a receptacle via two extension cords. These cords were labeled with tags warning against unplugging both at the end inserted into the wall receptacle and at the signal generator end. There was no tag at the connection between the two extension cords.

A technician performing unrelated work, unaware of what the extension cords supplied, unplugged the untagged connection between the two extension cords for use in another application. This cut power to the steam generator level test signal generator, thereby allowing the level circuitry to sense actual level. Since actual level was below the trip setpoints, protective action was initiated. The auxiliary feedwater (AFW) system did not initiate on the low steam generator level because in the shutdown condition, the main feed pump control switches are in pullout, defeating AFW activation. Since the scram breakers were already open, no protective action resulted from the reactor trip signal.

This event is nearly identical to one which occurred during the Unit 2 refueling outage November 15, 1989. In that event, power to the signal generator was lost when the electrical outlet was deenergized. The licensee has documented this current event in Licensee Event Report 266/90-005.

f. Low Temperature Overpressure (LTOP) Actuation (93702)

On May 12, the licensee notified the NRC via the ENS regarding an actuation of the LTOP protection system while attempting to fill safety injection accumulators on Unit 1. The plant was shutdown and solid with primary pressure at approximately 380 psi. The accumulators were at 700 psi pressure and isolated from the primary.

A safety injection pump was started in preparation for adding water to the accumulators. The operator then opened an accumulator cross connect valve in preparation for directing water from the safety injection pump to the accumulator. Opening of this valve also provided a flow path from the accumulator to the primary, which caused the overpressure event. The maximum pressure reached was approximately 405 psi, which was below the allowable maximum limit for existent plant conditions. LTOP functioned as designed.

There was no procedure available for filling of accumulators so the evolution was done under the guidance of a job performance measure (JPM), a document used in training operators for specific evolutions. This document, however, was written under the premise of normal power operations. A formal procedure to fill accumulators was in the draft stage at the time of this incident. The new procedure does not allow filling of accumulators with the plant in a solid condition.

When asked to perform the fill operation, the shift supervisor indicated that it should be done later, meaning after plant conditions changed. The requesting technician thought the shift supervisor meant later during the shift. When the technician returned, the shift supervisor was not in the control room so he asked the control operator to perform the fill operation. The control operator was not aware of the shift supervisor's intention and opted to proceed with filling.

The evolution was terminated immediately after the LTOP actuation and the system lineup restored to normal. The plant conducted an investigation of this incident and made appropriate changes to the new accumulator fill procedure (OI-100). The licensee determined that had LTOP malfunctioned, the maximum pressure that the primary could have been exposed to would have been the same as accumulator pressure, approximately 700 psi. This pressure was still below that allowed under existent conditions at the time of this event. Further review of this event will be conducted by the resident staff to determine the adequateness of the licensee's guidance to operators while in a solid plant condition. This item will be tracked as an unresolved item (266/90010-01; 301/90010-01(DRP)).

These reviews and observations were conducted to verify that facility operations were conducted safely and in conformance with requirements established under technical specifications, federal regulations, and administrative procedures. No violations or deviations were identified.

4. Radiological Controls (71707)

The inspectors routinely observed the licensee's radiological controls and practices during normal plant tours and the inspection of work activities. Inspection in this area includes direct observation of the use of Radiation Work Permits (RWPs); normal work practices inside contaminated barriers; maintenance of radiological barriers and signs; and health physics (HP) activities regarding monitoring, sampling, and surveying. The inspector also observed portions of the radioactive waste system controls associated with radwaste processing.

From a radiological standpoint the plant is in good condition, allowing access to most sections of the facility. During tours of the facility, the inspectors noted that barriers and signs also were in good condition. When minor discrepancies were identified, the HP staff quickly responded to correct any problems.

All activities were conducted in a satisfactory manner during this inspection period. No violations or deviations were identified.

5. Maintenance/Surveillance Observation (62703) (61726)

a. Maintenance (62703)

Station maintenance activities of safety related systems and components listed below were observed/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 considered during this review: the limiting conditions for operation were met while components or systems were removed from service; approvals were obtained prior to initiating the work; activities were accomplished using approved procedures and were inspected as applicable; functional testing

and/or calibrations were performed prior to returning components or systems to service; quality control records were maintained; activities were accomplished by qualified personnel; parts and materials used were properly certified; radiological controls were implemented; and fire prevention controls were implemented.

Work requests were reviewed to determine status of outstanding jobs and to assure that priority is assigned to safety-related equipment maintenance which may affect system performance.

Portions of the following maintenance activities were observed/reviewed:

- Reactor vessel head bolt cleaning and lubricating.
- Control rod drive mechanism (D-4) replacement.
- Control rod drive mechanism (D-4) seal weld repair.
- 1P2B charging pump controller, instrument air supply regulator replacement.
- DYOB Inverter annual testing and repair.

The technician performing this work was well qualified and knowledgeable about the job. The equipment technical manual, engineering drawings, the tagout permit, and the work procedure were all at the job site and frequently referred to.

b. Surveillance (61726)

The inspector observed surveillance testing and verified that testing was performed in accordance with adequate procedures; that test instrumentation was calibrated; that limiting conditions for operation were met; that removal and restoration of the affected components were accomplished; that test results conformed with technical specifications and procedure requirements and were reviewed by personnel other than the individual directing the test; and that any deficiencies identified during the testing were properly reviewed and resolved by appropriate management personnel.

The inspector witnessed and reviewed the following test activities:

- ICP 2.3 (Revision 4) I&C Surveillance Test, Reactor Protection System Logic (Long)
- RESP 3.1 (Revision 2) Primary System Tests
- IT 7 (Revision 14) Inservice Testing of Service Water Pumps and Valves

No discrepancies were noted during the observance of any of the above tests.

No violations or deviations were identified.

6. Emergency Preparedness (71707)

An inspection of emergency preparedness activities was performed to assess the licensee's implementation of the site emergency plan and implementing procedures. The inspection included monthly review and tour of emergency facilities and equipment, discussions with licensee staff, and a review of selected procedures.

All activities were conducted in a satisfactory manner during this inspection period. No violations or deviations were identified.

7. Security (71707)

The inspectors, by direct observation and interview, verified that portions of the physical security plan were being implemented in accordance with the station security plan. The inspectors also continued to monitor compensatory measures that have been enacted by the licensee.

- Security System Degradation (71707)

On May 19, the licensee notified the NRC via the ENS regarding a security system degradation involving a partial loss of intrusion monitoring capability. The degraded area was compensated upon discovery and the plant area searched. No evidence of unauthorized entry was found. The inspector discussed the event and subsequent corrective actions with the licensee and was satisfied.

All activities were conducted in a satisfactory manner during this inspection period. No violations or deviations were identified.

8. Engineering and Technical Support (71707) (71711)

The inspector evaluated licensee engineering and technical support activities to determine their involvement and support of facility operations. This was accomplished during the course of routine evaluation of facility events and concerns through direct observation of activities and discussions with engineering personnel.

a. Post Refueling Startup (71711)

The inspector observed Unit 1 reactor startup and startup testing following completion of the refueling outage. Portions of the nuclear instrumentation system and emergency power system were walked down prior to the startup to determine their readiness to support restart and were found to be acceptable. The control rod worth table (ROD 3.1) was prepared and approved for Unit 1 cycle 18.

The precritical checklist was properly completed before commencing control rod pulls. The inspector reviewed and observed portions of procedure RESP 4.1 (revision 3), 'Initial Criticality and ARO Physics Tests' and had no concerns. Startup activities were performed in accordance with Technical Specification requirements.

b. Reactor Coolant Pump Motor Cubicle Cover Blocks (71707)

During original plant construction, Wisconsin Electric had Bechtel provide blocks covering the reactor coolant pump motor cubicles to provide additional space for temporary equipment storage during outages. Although it was not originally intended to leave these blocks in place during operation, that intent was lost over time and the blocks were left over the cubicles during operation. In a recent evaluation, the utility discovered that a design basis loss of coolant accident (LOCA) could sufficiently raise pressure in the pump cubicle to lift the 10,000 lb. concrete blocks off their seats.

Consequently, the plant decided to store the blocks adjacent to the pump cubicles in accordance with the original design. The company analyzed this arrangement to verify that it was acceptable under accident conditions or during a seismic event. The analysis determined that the blocks would not shift during a seismic event, nor would they tip over if not stacked more than four high. This was immediately done on Unit 1 since it was in an outage.

The utility analyzed operation of Unit 2 with the blocks in place until the next refueling outage and wrote a justification for continued operation. This justification was based on the low probability of an accident and the likelihood that a LOCA would involve a leak before break vice an instantaneous pipe break. The leak before break condition results in a smaller pressure transient, which would be insufficient to lift the blocks. Based on this, the licensee determined that they could continue to operate indefinitely with the blocks in place. The plant has not yet decided whether to store the Unit 2 blocks adjacent to their pump cubicles after the next outage or leave them in place. The configuration of Unit 2 containment is slightly different from Unit 1 and could make storage of the blocks adjacent to the pump cubicles difficult.

The inspector discussed this issue with the licensee and observed the block storage in Unit 1 containment.

c. Control Board Human Factors Design (71707)

The inspector noted that several valve controllers on both unit control boards are inconsistently labeled. These controllers have a linear scale graduated from 0 to 100 to indicate valve position. On most, the 0 position corresponds to the valve being fully shut while the 100 position corresponds to the valve being fully open. There are several, however, where this convention is reversed. This creates the potential to confuse the operator and cause improper valve positioning.

During the 1989 Unit 1 outage, such an event occurred. While placing the residual heat removal (RHR) system in service, the operator intended to shut a heat exchanger outlet flow control valve by placing the controller to the 0 position. However, this is one of the controllers where the 0 position corresponds to full open. A brief rapid cooldown ensued, which the operator quickly recognized and corrected.

The controllers the inspector noted as being contrary to convention are:

HC-142, 130, 135, 110 (Chemical & Volume Control System)
HC-624, 625 (RHR heat exchanger outlet flow control)
DTIC-2525 (heater drain tank temperature control)
PC-2273 (low pressure feedwater heater bypass control)
HC-431K (pressurizer pressure control)

This issue will be considered an open item pending its evaluation by the licensee and determination of appropriate corrective action (266/90010-02; 301/90010-02).

d. Emergency Diesel Generator (EDG) Load Sequencing (71707)

The utility discovered that a phrase was omitted from Technical Specification (TS) 15.4.6.A.2 in 1985 during retyping of that page to incorporate an unrelated amendment. The missing phrase is 'less than the time periods listed in'. Without that phrase, the TS implies that EDG load sequencing times must correspond with the times listed in FSAR section 8.2. The licensee interpreted this TS to allow inclusion of an appropriate tolerance band on either side of the time value listed. With the phrase as intended, the meaning changes to require that sequencing times be less than the times listed in the FSAR.

Test data reveals that certain required loads did not always sequence as required by the correct version of the TS, although the longest deficiency is 1.6 seconds for a load required to start within 45 seconds after the initial starting signal. The licensee is evaluating this situation. This issue is considered an unresolved item pending completion of the licensee's evaluation and subsequent review by the NRC (266/90010-03; 301/90010-03).

All activities were conducted in a satisfactory manner during this inspection period. No violations or deviations were identified.

9. Safety Assessment/Quality Verification (40500) (90712) (92700)

The licensee's quality assurance programs were inspected to assess the implementation and effectiveness of programs associated with management control, verification, and oversight activities. Special consideration was given to issues which may be indicative of overall management involvement in quality matters such as self improvement programs, response to regulatory and industry initiatives, the frequency of management plant tours and control room observations, and management personnel's attendance at technical and planning/scheduling meetings.

a. Corporate Management Personnel Change (71707)

On June 2, the Chairman of the Board of Wisconsin Electric left that position to become the President and Chief Operating Officer of Wisconsin Energy Corporation, the holding company for Wisconsin Electric. His position was filled by the former president of

Wisconsin Electric who now holds the dual title of Chairman of the Board and Chief Executive Officer. The vacancy left by this promotion was filled by the Executive Vice President and Chief Operating Officer, who was raised to the new position of President and Chief Operating Officer.

b. Self Assessment Capability (40500)

The inspector evaluated the effectiveness of the licensee's self assessment capability. The evaluation focussed on determining whether the licensee's self assessment programs contribute to the prevention of problems by monitoring and evaluating plant performance, providing assessments and findings, and communicating and following up on corrective action recommendations.

The utility has the necessary review groups in place for effective self assessment. The review groups operate independently and with a critical approach to the review process. There appears to be serious management commitment to safety review, and safety review personnel appear to have the requisite abilities, experience, and authority to do quality technical work.

A weakness in the licensee's program is inadequate follow up of corrective actions for audit findings. This issue has been covered in recent inspection reports, resulting in a notice of violation and a civil penalty. The licensee is initiating a corrective actions program which the inspector will continue to follow. This area will be addressed further in a future inspection report.

c. Off Site Review Committee (OSRC) Meeting (40500)

The inspector observed selected portions of session 43 of the Off Site Review Committee. Issues reviewed included Technical Specification amendments, Licensee Event Reports, steam generator feed ring endurance, and NRC inspection reports. A quorum of the OSRC was present at the session and both the Chief Executive Officer and the President of Wisconsin Electric attended various segments. Also attending was the President of Wisconsin Energy, the parent company. The inspector considered OSRC discussion spirited and candid. The committee suggested a vigorous design basis reconstitution program to obtain the necessary documentation.

d. Licensee Event Report (LER) Review (90712)

The inspector reviewed LERs submitted to the NRC to verify that the details were clearly reported, including accuracy of the description and corrective action taken. The inspector determined whether further information was required, whether generic implications were indicated, and whether the event warranted onsite followup. The following LERs were reviewed and closed:

*266/88-008 Steam Line Break with Continued Feedwater Addition.

This report details the discovery of a design inadequacy involving a postulated main steam line break accident inside containment. If the main feed regulating valve failed to shut during such an accident, containment design pressure could be exceeded due to the addition of feedwater while the main feedwater pumps discharge valves cycle shut. As corrective action, Wisconsin Electric modified their emergency procedures to instruct operators to trip the condensate pumps and heater drain tank pumps if a main feed regulating valve does not shut. A plant modification was then evaluated which provides for automatic tripping of the condensate pumps and heater drain tank pumps on a high containment pressure safety injection signal. The modification eliminates this scenario from consideration as a credible accident. Installation was completed on Unit 2 during the fall 1989 outage and on Unit 1 during the current outage. The inspector discussed the modification with the licensee and had no further concerns.

*266/89-005 Low Temperature Overpressure Protection System Nitrogen Operation Design Inadequacy

This report details a design and as-built inadequacy associated with nitrogen operation of the Low Temperature Overpressure Protection (LTOP) system. During system testing, the plant discovered that the opening stroke times for the relief valve, using the nitrogen backup system, was in excess of the values assumed in the safety evaluation report.

As immediate corrective action, the licensee vented the primary by opening both power operated relief valves on the shutdown unit being tested. The nitrogen supply piping length was then shortened and relief valve spring tension adjusted to meet the required stroke times. The permanent correction consisted of: replacement of the nitrogen supply solenoid valves with higher capacity design models; installing a pressure regulator with higher flow; and increasing the size of the supply tubing. This modification was completed on Unit 2 during the fall 1989 outage and on Unit 1 during the current outage. The inspector reviewed the modification documents, including the post modification test data, and had no further concerns.

*266/90-003 Diesel Generator Fuel Oil Supply

This report describes the condition of the diesel generator fuel oil supply on April 9, 1990, following determination that a portion of the piping was not seismically supported. This condition caused the licensee to request a temporary waiver of compliance from Technical Specification requirements from the NRC, which was granted for 7 days. Wisconsin Electric performed a modification to seismically support the fuel oil piping which was completed within the allotted 7 days on April 15. The inspector checked the modified piping supports and had no further concerns.

*266/90-004 Single Failure Potential in Safeguards Switchgear B03/B04 Tie Breaker

This report describes a potential single failure condition which could cause the B03/B04 bus tie breaker to close. Inadvertent closure of this breaker with both emergency diesel generators (EDG) running could parallel the EDGs out of phase and result in failure of both generators. The bus tie breakers are provided to facilitate maintenance during unit shutdown. As corrective action, the plant removed the DC control power fuses for the B03/B04 tie breaker to prevent inadvertent closure. The breakers are administratively controlled by operations procedure OI-35 and maintenance procedures RMP-23A/B. OI-35 (Common) and RMP-23A (Unit 1) have been revised to further describe authorized use of the breakers and to address installation and removal of the control power fuses. Revision of RMP-23B (Unit 2) is in progress. The inspector reviewed the procedure changes and was satisfied.

e. LER Followup (92700)

The LERs denoted by asterisk above were selected for additional followup. The inspector verified that appropriate corrective action was taken or responsibility was assigned and that continued operation of the facility was conducted in accordance with Technical Specifications and did not constitute an unreviewed safety question as defined in 10 CFR 50.59. Report accuracy, compliance with current reporting requirements and applicability to other site systems and components were also reviewed.

All activities were conducted in a satisfactory manner during this inspection period. No violations or deviations were identified.

10. Temporary Instructions (TI)

(Open) TI 2500/103 Loss of Decay Heat Removal Program
Enhancements Review

Inspection using this Temporary Instruction is being performed in accordance with direction from the regional office, even though an SER has not been issued by NRR. Based on communication with NRR, an SER on this issue will not be written until after the completion of the residents' inspection. Inspection under this TI was initiated because sufficient work has been done by the licensee to warrant an evaluation of the progress of that work in meeting the requirements of Generic Letter 88-17.

No violations or deviations were identified.

11. Outstanding Items (92701)

Open Items

Open items are matters which have been discussed with the licensee, will be reviewed further by the inspector, and involve some action on the part of the NRC, licensee or both. An open item disclosed during the inspection is discussed in paragraph 8.c.

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. Unresolved items disclosed during the inspection are discussed in paragraphs 3.g and 8.d.

12. Exit Interview (30703)

A verbal summary of preliminary findings was provided to the licensee representatives denoted in Section 1 on June 18, 1990, at the conclusion of the inspection. No written inspection material was provided to the licensee during the inspection.

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