

U. S. NUCLEAR REGULATORY COMMISSION

REGION III

Reports No. 50-282/92011(DRP); 50-306/92011(DRP)

Docket Nos. 50-282; 50-306

License Nos. DPR-42; DPR-60

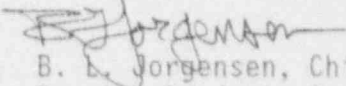
Licensee: Northern States Power Company
414 Nicollet Mall
Minneapolis, MN 55401

Facility Name: Prairie Island Nuclear Generating Plant

Inspection At: Prairie Island Site, Red Wing, MN

Inspection Conducted: May 27 through July 20, 1992

Inspectors: M. L. Dapas D. C. Kosloff R. Bywater
 S. P. Ray J. Holmes Z. Falevits

Approved By:  B. L. Jorgensen, Chief
Reactor Projects Section 2A

8-3-92
Date

Inspection Summary

Inspection on May 27 through July 20, 1992 (Reports No. 50-282/92011(DRP); 50-306/92011(DRP))

Areas Inspected: Routine unannounced inspection by resident and regional inspectors of operational safety including onsite followup of events, maintenance, surveillance, licensee event reports, engineered safety feature system walkdown, spent fuel pool activities, and licensee action on previous inspection findings.

Results: One violation of NRC requirements and one unresolved item were identified in the areas inspected.

Operations: No new strengths or weaknesses were identified. The decision to test equipment from the hot shutdown panel is an example of conservative operating philosophy, since there is no regulatory requirement to conduct this testing (paragraph 3.e).

Maintenance and Surveillance: No new strengths or weaknesses were identified. One violation was identified for failure to perform required auxiliary feedwater system testing (paragraph 3.g.).

Engineering and Technical Support: No new strengths or weaknesses were identified. One unresolved item was identified involving Appendix R "hot short" conditions (paragraph 3.f.). The engineering review process broke down where the violation (involving failure to perform required AFW system testing) was concerned. The licensee did not recognize the significance of the missed testing in terms of an operability question (paragraph 3.g.).

Safety Assessment/Quality Verification: No new strengths or weaknesses were identified. The review function of the onsite review committee also broke down in that the committee also did not recognize the significance of the failure to perform required AFW system testing (paragraph 3.g.).

DETAILS

1. Persons Contacted

E. Watzl, General Manager, Prairie Island
M. Sellman, Plant Manager
*K. Albrecht, General Superintendent, Engineering
*M. Wadley, General Superintendent, Operations
G. Lenertz, General Superintendent, Maintenance
*R. Lindsey, Assistant to the Plant Manager
*D. Schuelke, Superintendent, Radiation Protection and Chemistry
G. Miller, Superintendent, Technical Support
*M. Reddemann, General Superintendent, Electrical and Instrumentation Systems
*M. Klee, Superintendent, Quality Engineering
E. Eckhoft, Nuclear Support Services
J. Leville, Nuclear Support Services
*A. Hunstad, Staff Engineer
J. Maki, Superintendent, Electrical Systems
*M. Werner, Site Safety/Fire Protection Administrator
*G. Goering, Manager, Nuclear Projects
*G. Aandahl, Superintendent, Design Standards
*J. McDonald, Superintendent, Site QA
S. Hiedeman, System Engineer
G. Thoraldson, System Engineer
*G. Rolfson, Nuclear Projects Department, General Superintendent
*B. Jorgensen, Nuclear Regulatory Commission
*M. Dapas, Nuclear Regulatory Commission
*D. Kosloff, Nuclear Regulatory Commission
#Z. Falevits, Nuclear Regulatory Commission
#J. Holmes, Nuclear Regulatory Commission

#Denotes those present at the interim management interview of June 25, 1992.

*Denotes those present at the management interview of July 23, 1992.

2. Operational Safety Verification (37700, 71707, 92701, 93702)

Both units operated at full power throughout the inspection period except as noted below.

Unit 1 was reduced in power for load-following on July 4, 5, and 6. Unit 2 power was reduced on June 14, July 11, and 12, for load-following, and power was reduced to about 20 percent on June 15 to allow replacement of a failed control signal converter in the feedwater valve control system. Unit 2 was restored to full power the same day.

The inspectors observed control room operations, reviewed applicable logs, conducted discussions with control room operators, and observed shift turnovers. The inspectors verified operability of selected emergency systems, reviewed equipment control records, verified the

proper return to service of affected components, conducted tours of the auxiliary building, turbine building and external areas of the plant to observe plant equipment conditions, including potential fire hazards, and to verify that maintenance work requests had been initiated for equipment in need of repairs.

On June 29, 1992, a licensee fire watch recognized that he had missed a portion of his fire watch patrol. The patrol was being performed as compensatory action for Thermo-Lag fire barriers in response to NRC Bulletin 92-01. The fire watch had not patrolled the Unit 2 Auxiliary Feedwater Pump Room, which had one terminal box protected with a Thermo-Lag fire barrier. The inspectors verified that the terminal box was the only item in the room protected by a Thermo-Lag fire barrier. The inspectors verified that the licensee's corrective actions were appropriate to prevent other missed fire watch patrols. At the end of the inspection period the licensee had not completed its evaluation of the necessity of maintaining a fire watch patrol for the terminal box. The evaluation will determine whether the Thermo-Lag on the terminal box is an acceptable fire barrier, and whether there is any regulatory requirement to protect the wiring in the terminal box. The inspectors will review the licensee's evaluation in a future inspection.

No violations, deviations, open items or unresolved items were identified.

3. Licensee Action on Previous Inspection Findings (37700, 92701, 92702)

- a. (Closed) Violation (50-282/89017-01(DRP)): Failure to sample the emergency diesel generator (EDG) fuel storage tank on a monthly basis as required by Technical Specification (TS) 4.6.A.1.c.

TS 4.6.A.1.c requires the licensee to obtain a sample from the fuel storage tank for each EDG at least once a month and to verify that viscosity, water, and sediment are within acceptable limits as specified in Table 1 of ASTM D975-68. It had been the licensee's practice to obtain these samples from each EDG day tank. The inspectors' original concern was that with four fuel storage tanks capable of providing fuel to each of the two day tanks, a fuel sample from the day tanks would not be a representative sample of fuel in the storage tanks. The inspectors verified that surveillance procedure (SP) 1190, "Emergency Diesel Generator Oil Storage Tanks Sampling Procedure," was revised and that fuel samples are now obtained directly from each fuel storage tank via the associated fuel oil transfer pump discharge sample connection.

In the original response to this violation, dated July 20, 1989, the licensee indicated that in addition to sampling the fuel storage tanks directly, it would continue to sample the day tanks. When SP 1190 was revised to include direct sampling of the fuel storage tank, reference to day tank sampling was deleted. As a result, the licensee stopped sampling the day tanks. The

inspectors discussed with the licensee this apparent deviation from the original commitment made in response to the violation. The licensee stated that SP 1190 would be further revised to require sampling from both the day tanks as well as individual fuel storage tanks. This violation is closed.

b. Additional Fuel Oil Testing Issues

During review of the violation discussed above, the inspectors also reviewed the requirements and licensee practices for sampling fuel from other safety-related diesel engines onsite. Number 12 and 22 diesel-driven cooling water pumps do not have a TS requirement for fuel sampling. However, the licensee samples the fuel for these engines on a quarterly schedule and tests for viscosity, water, and sediment. The inspectors consider this a good practice.

TS 4.16.B.1.e requires sampling of the diesel-driven fire pump fuel storage tank every three months to verify that viscosity, water, and sediment are within acceptable limits. The licensee currently obtains this sample from the associated day tank, a practice similar to the one for which the violation was issued. The literal requirement of the TS is not being followed in that fuel samples are obtained from the day tank rather than the fuel storage tank. There is no safety concern regarding this practice since one fuel storage tank supplies the one day tank, resulting in a representative fuel sample. The licensee stated that it preferred to sample the day tank rather than directly sample the fuel storage tank due to the system configuration. The licensee intends to submit a TS change request to reflect the current sampling practice for the diesel-driven fire pump.

c. (Closed) Violation (50-282/89023-02(DRP)): Failure to perform monthly testing of the logic associated with safeguards bus 26 as required by TS 4.1.A.

Procedure SP 1093.2, "D1 Diesel Generator Manual Test - Bus 26," was not performed during the month of August 1989. By mistake, Procedure SP 1093.1, "D1 Diesel Generator Manual Test - Bus 15," was performed instead. Procedures SP 1093.1 and SP 1093.2 respectively test the loss of voltage logic associated with the 4kV safeguards buses 15 and 26, as required by TS 4.1.A. Upon discovery of this missed surveillance, the surveillance was conducted and successfully completed.

To preclude the wrong surveillance procedure from being used by mistake, the licensee revised the subject surveillance procedures for both emergency diesel generators. The inspectors verified that SP 1093, "D1 Diesel Generator Slow Start and Train A Auto Load Sequencer Test," Revision 49, now tests the logic associated with Bus 15 and Bus 26 and that SP 2093, "D2 Diesel Generator Slow Start and Train B Auto Load Sequencer Test," Revision 50, now

tests the logic associated with Bus 16 and Bus 25. This violation is closed.

- d. (Closed) Violation (50-282/89026-01; 50-306/89026-01(DRP)): Two examples of failure to follow written procedures as required by Technical Specifications.

On October 24, 1989, plant personnel erroneously removed 2R22, the Unit 2 shield building vent gas monitor, from service. On October 25, 1989, a plant operator incorrectly de-energized 1R37, the Unit 1 auxiliary building gas monitor A. These actions violated requirements of applicable plant procedures. The licensee took corrective action for each violation example and for a general concern regarding inadequate attention to detail. The inspectors verified that labeling had been improved for the gas monitors.

The inspectors also verified that the licensee had developed an awareness program to help individual workers self-check their own work activities. The licensee's Error Reduction Task Force reviews events involving personnel error to identify root causes and adverse trends. After an apparent improvement in the number of personnel errors related to attention to detail, the licensee noted an adverse trend during the last quarter of 1990. Attention to detail related incidents were occurring at a rate considered unacceptable by the licensee. In response to this concern, the licensee adopted various methods aimed at teaching workers how to maintain as well as improve their level of attention to detail. The licensee's evaluation and trending efforts to monitor for instances of poor attention to detail, and its recognition that fresh approaches are needed to maintain an increased level of awareness for attention to detail, should minimize related personnel errors. The inspectors will continue to monitor the licensee's efforts to reduce personnel errors. This violation is closed.

- e. (Closed) Unresolved Item (282/90002-01; 306/90002-01(DRP)): Testing of Hot Shutdown Panel Remote Controls.

The inspectors noted that the licensee had developed procedures to test the operation of equipment from the Hot Shutdown Panels. This is considered an example of a conservative operating philosophy. Since the NRC has established no specific interval for such testing, the licensee should use good engineering practice to establish testing intervals. This item is closed.

- f. (Closed) Open Item (282/92004-01(DRP); 306/92004-01(DRP)): The NRC was informed that during a Design Basis Reconstitution evaluation of 10 CFR 50 Appendix R requirements, the licensee identified three potential "hot short" electrical fault conditions that may exist during a fire in the control room. This could adversely affect the ability to safely shut down the reactor. In one scenario, a hot short in the control room could result in the

loss of 125Vdc control power to all 4.16kV breaker control circuits for an entire safety related bus, which was contrary to the licensee's approved safe shutdown methodology. In the second scenario a hot short in No. 12 diesel driven cooling water pump circuitry could result in the loss of cooling flow for safe shutdown equipment. The third scenario consisted of a hot short opening the reactor coolant system head vent solenoid valves resulting in the loss of reactor coolant.

The inspectors examined the licensee's compensatory measures and long term corrective action plans to address the concerns regarding electrical isolation for Appendix R type scenarios. The inspectors also attempted to ascertain whether these were isolated conditions. As part of this inspection, the inspectors reviewed applicable Appendix R related schematic and wiring diagrams, fuse coordination curves, modifications, design calculations, and procedures, and interviewed plant technical and operations staff. In addition, a field inspection of installed electrical components was performed to determine the adequacy of Appendix R related circuits and components.

The inspectors determined that the licensee's short term and long term compensatory actions appeared adequate (Note: permanent hot shutdown repairs, including fuse pulling, require a granted exemption from NRR which the licensee has not yet requested); however, the inspectors made the following observations:

1. Several wiring discrepancies were noted between 4.16KV bus 15, cubicle 1, "Safety Injection Pump" drawing NF-40155-1, Revision J and installed components. The inspectors determined that the drawings contained errors.
2. Licensee's Safety Evaluation SE 024, incorrectly stated on page 3, item e, that the trip/close control circuits for all nine 4.16kV safety related breakers were protected by redundant 30A fuses. The inspectors noted, however, that only two breakers were protected by double fuses. The licensee revised the Safety Evaluation.
3. A list of components required for electrical operation from outside the control room and which must have redundant fusing was not readily available for review.
4. The licensee failed to recognize, during the original Appendix R reviews performed in the early 1980's, the recently identified circuit failure modes that could have adversely affected the ability to maintain a hot shutdown status during a control room fire. The inspectors were informed that the ongoing Appendix R Reconstitution review program will be completed in the Fall of 1992. In addition,

the licensee is confident, based on the completed Appendix R reviews, that additional significant concerns should not exist.

As discussed in inspection report 50-282/92004(DRP); 50-306/92004(DRP) which identified the subject open item, the original Appendix R inspection conducted in April 1987 identified a deficiency with the licensee's control room evacuation safe shutdown procedure in that the licensee's method of control for the power operated relief valve (PORV) high/low pressure interface valves was by procedural action prior to evacuation of the control room. In response to this concern, the licensee revised the control room evacuation safe shutdown procedures to secure the pressurizer PORVs from outside of the control room. The revised procedure resulted in closing the item. The licensee's position was that the present arrangement of manually closing the PORV block valves prior to exiting the control room has already been accepted based on the previous NRC Appendix R inspection and followup inspection at this site.

The licensee also indicated that the use of operator actions in the control room (shutting the PORV block valves) followed immediately by alternative actions taken outside the control room (pulling PORV fuses) has been previously accepted by the NRC in SERs at other nuclear plants. In addition, the short time between evacuating the control room and taking alternative actions from outside the control room has not had to be considered when performing analyses for compliance with Appendix R III.L performance criteria (i.e. pressurizer level on-scale).

The licensee has not conducted a bounding analysis (as discussed in Generic Letter 86-10) to determine if sufficient time is available for the operator to shut the PORVs from outside the control room by pulling fuses, to stop the loss of reactor coolant and maintain pressurizer level within the indicating range (assuming a hot short causes the PORVs to open initially and no credit is given for shutting the PORV block valves from the control room prior to evacuation). During this inspection, the licensee performed a rough calculation regarding the loss of reactor coolant with one PORV block valve open and a hot short causing a PORV to open. The licensee calculated that in approximately 6 minutes with one open PORV that the level of the reactor coolant would be at the bottom of the pressurizer. It is the inspectors' understanding that operators will take all the necessary actions to mitigate the consequences of a control room fire including closing of the PORV block valves. However, (based on Generic Letter 86-10) credit is given only for "tripping" the reactor in

the control room, and credit for other control room actions would require a granted exemption request. It is the inspectors' concern that the operators may not close the PORV block valves due to the fire (effects of heat and smoke on the operators and/or damage to the PORV block valve switches/wiring) and may be required to exit the control room before this task could be accomplished. The licensee's position is that this issue was reviewed and accepted by the NRC during a previous inspection. Due to the lack of a granted exemption or bounding analysis, the potential safety significance, and generic implications of this event, this item is being referred to NRR for resolution. This issue is considered an Unresolved Item (282/92011-01(DRS); 306/92011-01(DRS)).

- g. (Closed) Unresolved Item (282/92008-01(DRP)): Deficiencies in auxiliary feedwater (AFW) system testing. Licensee Event Report (LER) 50-282/92004 reported a failure to perform Technical Specification (TS) required annual full flow testing of the turbine driven AFW pumps at the required frequency. As corrective action for the LER, the licensee conducted a review of AFW system testing. On June 2 and 3, 1992, the inspectors discussed the results of the test review with licensee engineering personnel. TS 4.8.A.8 requires verification, at 18 month intervals, that each AFW pump starts automatically upon receipt of each AFW actuation test signal. Each pump has the following actuation signals:
- Safety injection
 - Low level in A Steam Generator
 - Low level in B Steam Generator
 - Open breaker for both feedwater (FW) pumps (loss of FW).

Actuation test signals are provided to each AFW pump by both associated steam generator low water level circuits. The licensee had never tested the AFW pumps to verify that each pump would start automatically upon receiving an actuation signal from 1) each associated steam generator low water level circuit, or 2) the circuitry that senses that both associated main FW pump breakers are open. This is a violation (282/92011-02(DRP); 306/92011-02(DRP)) of TS 4.8.A.8.

During discussion of the tests that had not been done, the inspectors questioned the operability of all four AFW pumps. On June 4, 1992, at 10:55 a.m., after further review of the test requirements of TS 4.8.A.8, the licensee declared all four AFW pumps inoperable and entered TS Limiting Condition for Operation (LCO) 3.0.C for both units, which provided one hour to prepare for shutdown and six additional hours to achieve hot shutdown. The licensee requested a temporary waiver of compliance (TWOC) to allow 24 hours to complete required testing. The time requested was consistent with guidance included in Generic Letter 87-09. The inspectors observed successful testing of No. 22 AFW pump. This pump was declared operable at 12:32 p.m. while discussion of

the TWOC was in progress. Unit 2 was then in a 72 hour LCO action statement instead of a six hour action statement, obviating the need for a TWOC for Unit 2. At 1 p.m. Region III verbally granted a TWOC for Unit 1. Successful testing of the No. 11 AFW pump was completed and it was declared operable at 1:45 p.m. This placed Unit 1 in a 72 hour LCO action statement and the TWOC was terminated. The inspectors verified that the remaining required testing was completed within the LCO action statement 72 hour time limit.

The inspectors evaluated the history of licensee reviews of AFW system testing. During review of NRC Information Notice No. 88-83, "Inadequate Testing of Relay Contacts in Safety-Related Logic Systems", licensee engineers noted that the low level and loss of FW actuation signals were not being tested. Corrective action was begun to test the low level actuation signals, but the lack of testing was not recognized as an operability concern. In March, 1992, a system engineer completed another review of AFW system testing. This review, which identified the same testing deficiencies, was provided to the onsite safety review committee (Operations Committee), but lack of testing was not recognized as an operability concern by the engineer or the Operations Committee (OC). A more thorough evaluation of the testing deficiencies by the licensee could have resolved the operability concern sooner.

One violation and one unresolved item were identified, no deviations or open items were identified.

4. Maintenance Observation (71707, 37700, 62703)

Routine preventive and corrective maintenance activities were observed to ascertain that they were conducted in accordance with approved procedures, regulatory guides, industry codes or standards, and in conformance with Technical Specifications. The following items were considered during this review: adherence to Limiting Conditions for Operation 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, radiological controls were implemented, and fire prevention controls were implemented.

Portions of the following maintenance activities were observed or reviewed during the inspection period:

- Bus Duct Cooling System Solenoid Modification: During the Unit 2 refueling outage, electricians had incorrectly wired the operators for the duct fan dampers. The inspectors verified the adequacy of the corrective actions recommended by the licensee's Error Reduction Task Force.

- Replacement of motor operator for valve MV 32017, main steam to No. 11 auxiliary feedwater pump.
- Repair of an oil seal leak on No. 11 steam generator blowdown pump.
- Repair of emergency diesel generator (EDG) fuel oil storage tank (FOST) transfer pumps.
- Cleaning of EDG FOST.

No violations, deviations, unresolved or open items were identified.

5. Surveillance (37700, 61726, 71707, 92701)

The inspectors reviewed Technical Specification required surveillance testing as described below, and verified that testing was performed in accordance with adequate procedures, test instrumentation was calibrated, and Limiting Conditions for Operation were met. The inspectors further verified that the removal and restoration of affected components were properly accomplished, test results conformed with Technical Specifications and procedure requirements, test results were reviewed by personnel other than the individual directing the test, and deficiencies identified during the testing were properly reviewed and resolved by appropriate management personnel.

Portions of the following test activities were observed or reviewed:

- SP 1088, Safety Injection Pumps Test
- SP 1315, Spent Fuel Pool Enclosure Inspection
- SP 1321, CVCS Pump Operation from Hot Shutdown Panels
- SP 2008, Safety Injection Pumps Test
- SP 2321, CVCS Pump Operation From Hot Shutdown Panels
- SP 1554, Containment at Power Inspection. The inspectors observed the licensee conduct its monthly containment inspection. The inspectors noted that appropriate radiological controls were followed by involved personnel to minimize exposure and prevent personnel contamination. During the conduct of SP 1554, the inspectors observed the licensee install a mechanical sealing device on a hydrogen control system test connection, manual isolation valve (HC-5-5). The licensee attempted to install a sealing device on a similar isolation valve (HC-5-6) but was unsuccessful due to the valve configuration. The inspectors questioned the licensee regarding administrative controls for containment isolation valves and associated test connections for containment leak rate testing. The inspectors also discussed this issue with selected Region III personnel and researched available NRC correspondence to identify relevant guidance. Inspection report 50-282/88016; 50-306/88016 (routine inspection of activities associated with containment integrated leak rate test) discussed acceptable administrative controls for test connections associated with containment leak rate testing. Specifically, the report states that test connections must be administratively controlled to ensure their leak tightness or otherwise be subject to Type C testing. The report further states that one way to

ensure leak tightness is to cap the test connection with a good seal after its use. The inspectors verified that valves HC-5-5 and HC-5-6 are capped.

The inspectors also reviewed an internal licensee memorandum (dated January 15, 1992) that discusses administrative controls for sealing and locking containment test connection isolation valves. The licensee generated this memorandum in response to previous inspector questions regarding the basis for controls on containment penetration connections (not limited to test connections). This memorandum defines test connection manual isolation valves as "sealed closed isolation valves" and states that these valves should be under administrative control to assure that they cannot be inadvertently opened. The memorandum further states that administrative controls include mechanical devices to seal or lock the valve closed. During discussion with the inspectors on this issue, the licensee stated that appropriate administrative controls for test connections associated with containment leak rate testing were a locked or sealed manual isolation valve and a properly installed cap (good seal or compression fitting) to provide leak tightness redundancy. While the as-found condition of test connection manual isolation valves HC-5-5 and HC-5-6 did not conform to the licensee's intended administrative controls for these valves, the inspectors concluded that there was no regulatory issue with the as-found condition of the subject valves. The inspectors consider the licensee's approach on administrative controls for test connections associated with containment leak rate testing as an example of conservative operating practice.

No violations, deviations, unresolved or open items were identified.

6. Engineered Safety System Walkdown (71707, 71710)

The inspectors performed a detailed walkdown of a representative sample of the accessible portions of the Safety Injection System to verify system operability. This included verification that the system lineup procedure is consistent with plant system drawings and the as-built configuration, valve and power supply breaker positions are correct to ensure that plant equipment and instrumentation were properly aligned, major system components are properly labeled, lubricated, cooled, and no leakage exists, local and remote indication of significant process parameters are consistent with normal expected values, and support systems essential to system actuation or performance are operational. Some minor discrepancies were noted with failure to remove work requested tags from specific valves once maintenance had been completed or the original work request had been canceled. The inspectors discussed these discrepancies with the licensee after which the licensee initiated appropriate corrective action.

No violations, deviations, unresolved or open items were identified.

7. Spent Fuel Pool Activities (86700)

The inspectors reviewed the licensee's controls for the storage of items in the spent fuel pool (SFP) in response to a request by the Region III NRC office. The inspectors reviewed applicable procedures governing SFP inventory control and conducted a visual inspection of No. 123 SFP to determine if any items were being stored in the SFP that could impact fuel assemblies in the event they fell. The inspector was not able to visually inspect No. 121 SFP as it was covered by large steel plating. The licensee recently installed a new spent fuel handling crane designed for single failure protection and a new trolley for the Auxiliary Building crane. Before the installation of the new crane and trolley, it had been the licensee's practice to cover the No. 121 SFP with steel plating for heavy load protection in the event of Auxiliary Building crane failure. The licensee informed the inspector that the reactor cavity sipper basket (approximate weight of 250 lbs.), might be stored in No. 121 SFP, and if so would be suspended by a stainless steel cable. The inspector will visually inspect #121 SFP when the licensee removes the SFP covers.

No violations, deviations, unresolved or open items were identified.

8. Licensee Event Report (LER) Follow-up (92700, 92701)

- a. (Closed) LER 282/92004, Rev. 1: Failure to Perform a Full Flow Test of Turbine-Driven Auxiliary Feedwater Pumps Due to Personnel Error. This revision reported that additional testing had not been done, which resulted in a Violation, (282/92011-02(DRP), 306/92011-02(DRP)) discussed in paragraph 3.g. This issue will be followed up during review of the corrective action for the violation. This LER is closed.
- b. (Open) LER 282/92007: Design Basis Reconstitution Effort Identified a Condition Outside the Plant Design Basis. The licensee identified a very small pathway that could allow a tornado-driven missile to reach the No. D1 Emergency Diesel Generator Room. The inspectors verified that the licensee had installed a suitable missile barrier and cleared the immediate area of any potential missiles. This LER will remain open until the inspectors review the licensee's final evaluation of the potential for missile damage and any required corrective actions.

No violations, deviations, unresolved or open items were identified.

9. 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 is discussed in paragraph 3.f.

10. Management Interview (71707)

The inspectors met with the licensee representatives denoted in paragraph 1 at the conclusion of the report period on July 23, 1992. The inspectors discussed the purpose and scope of the inspection and the findings. The inspectors also discussed the likely information content of the inspection report with regard to documents or processes reviewed by the inspector during the inspection. The licensee did not identify any documents or processes as proprietary.