

U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Reports No. 50-254/86009(DRP); 50-265/86008(DRP)

Docket Nos. 50-254, 50-265

Licenses No. DPR-29; DPR-30

Licensee: Commonwealth Edison Company  
Post Office Box 767  
Chicago, IL 60690

Facility Name: Quad Cities Nuclear Power Station, Units 1 and 2

Inspection At: Quad Cities Site, Cordova, IL

Inspection Conducted: April 13 through June 7, 1986

Inspectors: A. L. Madison

A. D. Morrongiello

Approved By: *D. C. Boyd*  
D. C. Boyd, Chief  
Reactor Projects Section 2D

*6-24-86*  
Date

Inspection Summary

Inspection on April 13 through June 7, 1986 (Reports No. 254/86009(DRP); 50-265/86008(DRP))

Areas Inspected: Routine, unannounced inspection by the resident inspectors of actions on previous inspections findings; operations; radiological controls; emergency preparedness; security; refueling/outages; quality assurance; quality control; administration; routine reports; LER review; regional requests; training; and independent inspection.

Results: No violations or deviations were identified.

## DETAILS

### 1. Persons Contacted

R. Bax, Station Manager  
\*T. Tamlyn, Production Superintendent  
T. Lihou, Technical Staff Supervisor  
\*R. Robey, Technical Services Superintendent  
\*M. Kooi, Compliance Coordinator

\*Denotes those present at the exit interview on June 6, 1986.

The inspectors, through direct observation, discussions with licensee personnel, and review of applicable records and logs, examined the areas stated in the inspection summary and accomplished the following inspection modules.

37700	Design Changes and Modifications
61726	Monthly Surveillance Observations
62703	Monthly Maintenance Observations
71707	Operational Safety Verification
71710	ESF System Walkdown
90713	Review of Periodic and Special Reports
92700	Onsite Review of LERs
92701	Followup on Inspector Identified Problems and Unresolved Items
92703	Generic Letter Followup
92705	Followup - Regional Requests
92706	Independent Inspection
93702	Onsite Followup of Events

The inspectors verified that activities were accomplished in a timely manner using approved procedures and drawings and were inspected/reviewed as applicable; procedures, procedure revisions and routine reports were in accordance with Technical Specifications, regulatory guides, and industry codes or standards; approvals were obtained prior to initiating any work; activities were accomplished by qualified personnel; the limiting conditions for operation were met during normal operation and while components or systems were removed from service; functional testing and/or calibrations were performed prior to returning components or systems to service; independent verification of equipment lineup and review of test results were accomplished; quality control records and logs were properly maintained and reviewed; parts, materials and equipment were properly certified, calibrated, stored, and or maintained as applicable; and adverse plant conditions including equipment malfunctions, potential fire hazards, radiological hazards, fluid leaks, excessive vibrations, and personnel errors were addressed in a timely manner with sufficient and proper corrective actions and reviewed by appropriate management personnel.

Further, additional observations were made in the following areas:

a. Action on Previous Inspection Findings

- (1) (Closed) Open Item (254/85027-03; 265/85030-03 (DRP)). Establish A Monitoring Program for Low Level Radwaste Storage Facility.

The licensee has established a monitoring program to monitor airborne contamination in all areas of the overall monitoring program. The inspectors reviewed the program and determined that it was adequate. No further actions are required.

- (2) (Closed) Open Item (254/85027-12; 265/85030-12 (DRP)). Revise Breaker Surveillance Procedures to Include Checks for Loose Controls.

The inspectors verified that applicable breaker surveillance included requirements to check for loose electrical connections. No further actions are required.

- (3) (Closed) Unresolved Item (254/85027-11; 265/85030-11 (DRP)). Standby Liquid Control Tank Air Sparger Adequacy.

A concern was identified at the LaSalle Station and referred to the inspectors by regional personnel that the preoperational testing of air sparger mixing may not be adequate. The inspectors verified that the preoperational tests at Quad Cities were similar to those called in question at LaSalle and requested the licensee to determine if present practices were adequate to ensure proper mixing of the sodium pentaborate solution.

The licensee performed testing to verify adequate mixing with current practices and these tests were reviewed by the inspectors. No problems were identified. No further actions are required.

b. Operations

- (1) Unit 1

At the beginning of the inspection period Unit 1 was at full power. At various times during this period the unit operated on Economic Generation Control (EGC).

From May 15 to the 18, the unit was shutdown for a planned maintenance outage.

For the remainder of the report period the unit remained in operation either at full power or on EGC.



(2) Unit 2

At the beginning of the inspection period the unit was at full power. At various times during this period the unit operated on Economic Generation Control (EGC)

On May 25, an Unusual Event was declared when both the 2A Core Spray pump and the unit diesel generator were declared inoperable. The sequence of events was as follows: During his rounds an Equipment Attendant noticed the 2A Core Spray Room cooler belts were broken rendering the 2A Core Spray out of service. During compensatory equipment testing, the unit diesel generator output breaker tripped rendering the diesel inoperable. With both pieces of equipment out of service, the unit began a shutdown. Prior to completing the shutdown, the Core Spray Room cooler belts were replaced and the room cooler was satisfactorily tested. The Unusual Event was terminated. The apparent cause of the damaged belts was the belt tensioner becoming loose. The diesel generator was tested several times and the output breaker worked correctly each time. The station has requested the assistance of the Operating Analysis Division in analyzing the output breaker's performance.

On May 30, the unit shutdown for a planned maintenance outage. The unit resumed power operation on June 5.

Except for the above events, the unit was either at full power or on EGC.

(3) Both Units

On April 16, the licensee restricted access to the turbine building in order to reduce the number of unnecessary personnel contaminations due to an offgas leak problem. The source of the leak was difficult to determine due to its intermittent nature. After much investigative work the source of the leak was tracked down to a worn gasket on a filter element in the sparge air system (a line used for purging the offgas system). After repairing the filter, no further incidences of offgas problems occurred.

During plant tours of Units 1 and 2, the inspectors walked down the accessible portions of the Standby Liquid Control (SBLC) and the High Pressure Core Spray (HPCI) Systems and performed the applicable portions of Inspection Procedure 71710 "ESF System Walkdown."

It should also be noted that for this reporting period, there were no personnel errors.

c. Maintenance

The following maintenance activities were observed/reviewed:

- (1) Observed the installation of bearings on the Unit 1 condensate booster pump.
- (2) Observed the aligning of a Residual Heat Removal Service Water Pump.
- (3) Reviewed workpackage for mainsteam line low pressure relay on Unit 1.

d. Surveillance

The following surveillance activities were observed/reviewed:

- (1) Observed portions of the Unit 1 Standby Liquid Control System test.
- (2) Observed portions of High Pressure Core Spray test for Unit 2.
- (3) Observed portions of Unit 2 startup on June 5.

e. Outages

(1) Unit 1

On May 15 the unit shutdown for a planned weekend maintenance outage. Activities conducted during the outage consisted of Intermediate Range Monitor replacement, the repair of Electrohydraulic Control oil leaks, and repacking various other valves. The unit returned to service on May 18.

(2) Unit 2

On May 30 the unit shutdown for a planned maintenance outage. Activities conducted during the outage consisted of Intermediate Range Monitor repairs, checking for main condensor tube leaks, repair of one outboard Mainsteam Isolation Valve (to restore valve to Technical Specification closure time), head vent valve repair, and repairing steam leaks in the heater bay area.

Both outages were accomplished without incident.

f. Review of Routine and Special Reports

The inspectors reviewed the monthly performance report for the months of March and April 1986. No violations or deviations were identified.

g. LER Review

(1) Unit 1

- (a) (Closed) LER 84008, Revision 00: Inadequate Design Review of 125 VDC Station Batteries.

This issue was also tracked under Unresolved Item (254/84004-01, 265/84004-01 (DRP) and as such was closed in Inspection Report Nos. 254/86002; 265/86002. No further actions are required.

- (b) (Closed) LER 86004, Revision 00: ATWS - ARI Initiation and Reactor Scram while Draining the Reactor Vessel.

This LER remained open pending a procedure revision to QOP 201-1 "Draining the Reactor Vessel and Recirculation Loops" to add a prerequisite to prevent recurrence. This revision has been accomplished and reviewed by the inspectors. No further actions are required.

- (c) (Closed) LER 86006, Revision 00: Inadvertent Isolation of Reactor Building Vents Due to Personnel Error.

This event was fully discussed in Inspection Report Nos. 254/86002; 265/86002 and was an example of failure to follow procedures and a violation was cited (254/86002-03). Therefore actions associated with this event will be tracked with the violation.

- (d) (Open) LER 86007, Revision 00: Spurious Lock Out of 1/2 Emergency Diesel Generator.

On February 3, 1986, Unit One was in the SHUTDOWN mode with the unit in a refueling outage. At 1047 hours a 1/2 Diesel Generator (DG) Relay Trip alarm was received in the control room. The "A" phase Differential Current Relay on Bus 13-1 had tripped and actuated the lockout relay. The relays were reset approximately 5 minutes after the trip. On February 13, 1986, the "A" phase Differential Current Relay again tripped at 1538 hours. The trip was reset at 1603 hours. The root cause of the trips was not positively identified. The probable cause is believed to be spurious actuation due to vibration. This type of relay, General Electric model 12CFD12B1A, is sensitive to vibration and shock. A modification has been initiated to replace these relays with a type that is less sensitive to vibration. This LER will remain open pending completion of the modification.

- (e) (Closed) LER 86008, Revision 00: Inadvertant Auto Start of 1/2 Emergency Diesel Generator.



Unit One was shutdown and in the REFUEL mode on March 25, 1986, when the 1/2 Diesel Generator received an auto-start signal. The diesel generator started and ran unloaded. Electrical Maintenance personnel were putting a block on a Core Spray logic relay to prevent starting the 1/2 Diesel Generator during the performance of a modification test. While installing the block the relay was inadvertently contacted causing the 1/2 Diesel Generator to start. The root cause of the occurrence is personnel error. A contributing factor was the cramped quarters and the sensitivity of the relay involved. The event is considered an isolated incident and no further action is required.

- (f) (Closed) LER 86015, Revision 00: Scram Discharge Volume High Level Scram While Switching RPS Bus.

This LER remained open pending a procedure revision to QOP 7000-1 "Reactor Protection System MG Sets to add a precaution to prevent recurrence. This revision has been accomplished and reviewed by the inspectors. No further actions are required.

- (g) (Closed) LER 86016, Revision 00: Inadvertent Unit One Emergency Diesel Generator Start.

On March 17, 1986, Unit One was in the SHUTDOWN mode for a scheduled refueling outage. At 1658 hours the Unit One diesel Generator auto-started and ran unloaded. Electrical Maintenance personnel had just completed the action steps of the Core Spray Logic Functional Test, QMS 700-5. A portion of the test was repeated in an attempt to duplicate the event but the auto-start could not be repeated. Probable cause is believed to be inadvertent physical contact with one of two contact sensitive relays which could have started the diesel generator without producing additional alarms or system actuations. The event is considered an isolated incident and no further corrective action is deemed necessary.

- (h) (Closed) LER 86017, Revision 00: Isolation of Instrument Root Valves due to Personnel Error.

On March 18, 1986, Unit 1 was in the REFUEL mode during a refueling and maintenance outage. At 1349 hours an Anticipated Transient Without Scram (ATWS) trip was received from a Division I reactor low water signal. The trip was reset at 1404 hours. At 1425 hours a Channel "B" Reactor Protection System (RPS) trip occurred from reactor low water level signal. It was then observed that the reactor water level indicator 1-263-100A did not agree with other control room level indication. While

backfilling the level instrument lines trying to correct the problem, a second ATWS trip was received at 1715 hours. At 1900 hours it was discovered that instrument root valves 1-263-12A and 14A at drywell penetration X-49 were isolated. These root valves isolated the reactor variable leg and the reference leg instrument lines that feed instrumentation on the 2201-5 rack. It was not known immediately when the valves were closed. An investigation determined that the valves were closed between 0300 and 0330 hours on 3-18-86. A valve checklist was in progress at that time and it is believed the root valves were inadvertently closed during performance of the checklist. The cause of the initial ATWS trip and Channel "B" RPS trip is believed to be the result of the isolated instrument lines.

This event is considered another example of personnel errors discussed in the previous report (254/86002) and as such, actions related to this event will be tracked with the licensee's response to the cover letter request.

- (i) (Closed) LER 86018, Revision 00: Reactor Scram During Surveillance Due to Coincidental IRM Spikes.

On March 20, 1986, Unit One was in the REFUEL mode during a refueling and maintenance outage. At 0215 hours a reactor scram occurred. The 4KV Bus 13-1 Undervoltage Functional Test (QOS 6500-1) was in progress and a channel "A" Reactor Protection System (RPS) trip was expected as part of the test. A Channel "B" RPS trip occurred just prior to the test which resulted in a full scram. The Channel "B" trip was caused by spiking of Intermediate Range Monitors (IRM) 15 and 18. The exact cause of the spiking was not determined, however IRM 15 was found to have a worn and cracked cable which was replaced. No abnormalities were found on IRM 18 until Unit 1 was started up following the outage. During startup IRM 18 detector failed. The detector is scheduled to be replaced during an outage. No further actions are required.

- (j) (Closed) LER 86019, Revision 00: Anticipated Transient Without Scram Caused by Contractors During Shutdown.

On March 17, 1986, during a Unit One refueling outage, an Anticipated Transient Without Scram (ATWS)/Alternate Rod Insertion (ARI) System trip occurred at 1815 hours. The Scram Discharge Volume (SDV) vent and drain valves closed and the control rod drive scram valves opened as designed. The trip was reset within 30 seconds. Investigation revealed that scaffolding erected to install fire protection modifications was in contact with instrument sensing lines for the ATWS instruments at the 2201-5 rack. Probable



cause was personnel working in the area which disturbed the sensing lines enough to cause the ATWS reactor level instruments to trip, although it was not determined who was in the area at the time. Corrective action was to rearrange scaffolding so it would not disturb the instrument rack. The scaffolding in close proximity to the rack was subsequently removed prior to Unit 1 startup. No further actions are required.

- (k) (Closed) LER 86020, Revision 00: Spurious Group I Isolation.

This event was discussed fully in Inspection Report Nos. 254/86002; 265/86002. No further actions are required.

- (1) (Open) LER 86021, Revision 00: Reactor Scram Due to Low Water Level.

On April 5, 1986, with a startup in progress, Unit 1 Reactor was operating in the STARTUP mode at 3 percent of rated thermal power. Reactor pressure was approximately 300 psig and one and one-half turbine bypass valves were open due to the Reactor Core Isolation Cooling (RCIC) System Turbine Overspeed Test having been completed earlier. Water was being supplied to the reactor vessel by the condensate system through the Low Flow Feedwater Regulator Valve. At 0820 hours, the 1B Reactor Feed Pump (RFP) was started and reactor water level began to increase. At 0825 hours, a HI REACTOR WATER LEVEL alarm was received.

The operator closed the reactor feedwater inlet valves to terminate the reactor water level increase before the reactor feed pumps tripped. The level was rising because the low flow feedwater regulator valve was not controlling reactor level due to excessive leakage. The reactor water level increase was stopped and as the level then began to decrease, the operator tried to re-open the reactor feedwater inlet valves. The valves traveled to dual indication but no feedwater flow was obtained. A second reactor feed pump was started with no impact on feedwater flow. The reactor water level continued to decrease and Unit 1 subsequently scrammed due to low reactor water level at 0836 hours.

After completing the scram recovery unit startup commenced at 1056 hours on April 5, 1986, with the low flow feedwater regulator valve manually isolated. Reactor water level was controlled by manual operation of one main feedwater regulator valve. The low flow feedwater regulator valve was overhauled during the May 15 through 18 maintenance outage.

Work requests have been written to inspect and regrease the valve operators and inspect the torque switch settings. A supplemental report will be issued detailing further cause and corrective actions at that time. This LER will remain open pending receipt of that report.

- (m) (Open) LER 86022, Revision 00: CAM Line Not Meeting Code Stress Allowables.

On May 1, 1986, Quad Cities Station was notified by the Station Nuclear Engineering Department that certain Unit One and Unit Two Containment Atmosphere Monitoring (CAM) system piping did not meet NUREG-0661 acceptance criteria for Mark I containment structures and piping. The affected lines were 1-2402A(B)-1/2"-HB and 2-2402A-1/2"-HB. An operability assessment based on General Electric's functional capability criteria for essential Mark II piping indicated that all lines were operable with 5 percent damping except line 1-2402A-1/2"-HB.

A modification was performed in 1984 to the CAM system which resulted in the lines not meeting the NUREG-0661 requirements. The modification was designed using the original system drawings instead of the updated Mark I containment drawings. The root cause of the event was inadequate drawing and design control by the two Architect Engineering firms involved and the Station Nuclear Engineering Department. Unit One lines have been modified to meet Mark I criteria, and the Unit Two line will be modified during the fall 1986 refuel outage. An Action Item Record has been issued by the licensee to resolve the design drawing control problem.

This LER will remain open pending completion of the above modification and resolution of the Action Item Record.

- (n) (Open) LER 86023, Revision 00: RCIC Inoperable Due to Spurious Overspeed Trips.

On May 5, 1986 the Unit One Reactor Core Isolation Cooling (RCIC) System turbine tripped numerous times on mechanical overspeed while attempting to manually start the system for an operability test. The RCIC System was declared inoperable and the High Pressure Coolant Injection (HPCI) System tested satisfactorily as per Technical Specifications. Unit One was operating in the RUN mode at 96 percent power when the event occurred. The cause of the overspeed trips was due to the mechanical overspeed trip linkage being out of adjustment. The linkage was adjusted and a portion of the linkage machined and the system was run satisfactorily and declared operable on May 10. Additional corrective action is being pursued by

Two Action Item Records which address improving the RCIC overspeed trip system. This LER will remain open pending resolution of these Action Item Records.

(2) Unit 2

- (a) (Closed) LER 85020 Revision 00: Unit 2 Condenser 5 Foot Circulating Water Pump Trip Out of Service (OOS).

This LER remained open pending procedure revisions to QOS 030-3, Condenser Pit High Level Alarm and Trip Surveillance to prevent recurrence. These revisions have been accomplished and reviewed by the inspectors. No further actions are required.

- (b) (Closed) LER 86005 Revision 00: Standby Gas Treatment Auto Initiation From Hot Trash on Refuel Floor.

This event was fully discussed in Inspection Report Nos. 254/86002; 265/86002. No further actions are required.

- (c) (Closed) LER 86006 Revision 00: Unit 2 Reactor Building Ventilation Isolation and SBGTS Auto-Initiation Due to 2A Fuel Pool Monitor Trip.

On April 14, 1986, Unit 2 was operating in the RUN mode at 100 percent power when the 2A Fuel Pool Radiation Monitor tripped at 0435 hours causing the isolation of the Reactor Building Ventilation System and the auto-initiation of the Standby Gas Treatment System. The apparent cause of the occurrence is instrument setpoint drift. The monitor was found to trip at 30 mR/hr instead of the normal 100 mR/hr. The monitor was recalibrated to trip at a setpoint of 100 mR/hr.

No further action is required.

- (d) (Closed) LER 86007 Revision 00: Failure of the Unit 2 Core Spray Room Cooler Due to Burned Contacts.

On April 9, 1986, at 2155 hours, Unit 2 was in the RUN mode operating at 100 percent of rated thermal power. It was found that the 2B Core Spray Room Cooler would not run in either the Manual or Automatic mode. The cause of the room cooler failing to run was due to pitting and burning of contacts on the motor control center contactor that supplies power to the room cooler motor. The pitting was most likely due to weak springs on the contacts not making up as designed. This was the first occurrence of this type of contactor failure. The failed contactor was replaced and the room cooler was tested and returned to service May 10, 1986. No further action is required.



h. TMI Action Plan Followup

- (1) (Closed) Item II.B.2.3., "Plant Shielding Equipment Qualification." The modifications required for this item were accomplished as part of the overall Environmental Qualification (E.Q.) Program completed by November 30, 1985. The inspectors reviewed the licensee's actions to ensure compliance with their submittals. No further actions are required.
- (2) (Closed) Item II.B.3.1., "Valve Position Indication: Install Direct Indications of Valve Position (Relief and Safety Valves). The relief valve actuator position is accomplished by environmentally qualified Dresser Electromatic relief valve actuators which contain limit switches. Direct indication of relief and safety valve position is obtained from environmentally qualified acoustic monitors manufactured by General Atomic Corporation. This is in accordance with the licensee's submittals and the overall E. Q. program. No further actions are required.
- (3) (Closed) Item II.K.3.57., "Manual Actuation of ADS." The concern identified by this item was that a source of cooling water be available prior to manual actuation of ADS valves. The licensee has implemented the guidelines established by the BWR owners' group in their Emergency Operating Procedures (in place October 31, 1985). The inspectors have reviewed the procedures for adequacy in this regard. No further actions are required.

i. Headquarters Requests

- (1) Survey of Licensee's Response to Selected Safety Issues (TI 2515/77)

The purpose of the inspection was to determine the actions that the licensee had taken to address selected safety issues identified in I.E. Bulletins, Circulars, and Information Notices and in the Institute of Nuclear Power Operations (INPO) significant operating event reports (SOERs). The inspectors reviewed the following items:

(a) NUREG-0737 (TMI) items:

- (1) II.k.3.13 HPCI and RCIC Initiation Levels.
- (2) II.k.3.15 Isolation of HPCI and RCIC Modification.
- (3) II.k.3.22 RCIC Suction.
- (4) II.k.3.24 Spare Cooling for HPCI/RCIC Modifications.

(b) Generic Letter 83-28.

- (c) SOER 81-13.
- (d) SOER 82-14.
- (e) SOER 84-1.

No deficiencies were identified except for SOER 84-1. Recommendation 4 dealt with procedures and training to address operator actions if significant heat exchanger performance degradation as a result of fouling is detected. No actions had been taken by the licensee to address this concern. The licensee has agreed to review this area and provide training and procedure revisions as deemed applicable. These actions will be tracked as an Open Item (254/86009-01; 265/86008-01(DRP)).

j. 10 CFR Part 21 Reports

Region III received a Part 21 report from Magentrol International concerning their Model 402 Series Level control used for safety-related applications. Investigations at Browns Ferry revealed that a torque check on the enclosing tube nut had not been performed. Without the proper torque, the enclosing tube nut could loosen during a seismic event causing a leak; or, loss of pressure of process fluid.

Ten of the subject models had been shipped to Quad Cities for use in the Scram Discharge Volume (SDV) modifications. However, a design revision had eliminated their use in this application and they were processed back into spare parts for use in non-safety related applications only. As such, they are no longer an item of concern and this Part 21 report is considered closed.

k. Generic Letters

- (1) In general, no specific licensee administrative procedure addresses actions to take with regard to Generic Letters. Each letter is handled individually and any appropriate actions are taken by those groups responsible for that area. However, in some cases, adequate measures are not taken to ensure continuing complete compliance with Generic Letters. For example; Generic Letter 85-14: Commercial Storage at Power Reactor Sites of Low-Level Radioactive Waste Not Generated By the Utility was issued August 1, 1985. The licensee immediately reviewed this letter and determined that, at that time, they would not store radioactive waste from other facilities. However, no provisions were made to ensure that the requirements of the generic letter were met should this position be revised. When this issue was raised with the licensee, the licensee committed to include generic letters in the tracking system to be developed for the Compliance Coordinator. This will be tracked as part of that Open Item (254/86009-02; 265/86008-02(DRP)).

- (2) (a) (Open) Generic Letter 84-23: Reactor Vessel Water Level Instrumentation in BWRs.

The licensee responded to this letter on December 4, 1984, detailing the actions they would take. The replacement of mechanical level indication equipment delineated in this response has been accomplished and has been reviewed by the inspectors and found acceptable. The schedule for accomplishing a design change to prevent reference leg overheating as stated in the December 4, 1984 letter will be completed during each units' refueling outage beginning after December 1, 1987. This item will remain open pending satisfactory completion of this design change.

- (b) (Closed) Generic Letter 85-13: Transmittal of NUREG-1154 Regarding the Davis-Besse loss of Main and Auxiliary Feedwater Event.

The resident inspector determined that the information was reviewed for applicability to Quad Cities Station and that the information was made available to the plant staff through their training program. This generic letter is considered closed and no further action is required.

- (c) (Open) Generic Letter 85-14: Commercial Storage at Power Reactor Sites of Low-Level Radioactive Waste Not Generated By the Utility.

As discussed above, to ensure continued compliance the licensee must provide some tracking mechanism or procedural requirement referencing the actions in the letter. The licensee has agreed to do this. This letter will remain open pending such actions.

- (d) (Closed) Generic Letter 8602: Technical Resolution of Generic Issue B-19 Thermal Hydraulic Stability.

The licensee had reviewed core reload data for both units and determined that they have had sufficient margin. Future core reloads will also be examined to demonstrate compliance with general design criteria 10 and 12. This Generic Letter is considered closed and no further action is planned.

- (e) (Open) Generic Letter 85-06: Quality Assurance Guidance for ATWS Equipment That is Not Safety-Related.

This letter provided explicit QA Guidance required by 10 CFR 50.62 for ATWS Equipment that has not been designated safety-related. In accordance with the licensee's letter of October 10, 1985, the schedule for complete compliance with the 10 CFR 50.62 ATWS rule is



Spring 1987 for Unit 1 and Fall 1986 for Unit 2. After discussions with licensee personnel, the inspectors have determined that no program is in place to date to address non safety-related ATWS equipment as required. The licensee's Q.A. organization has issued a Finding to this effect during a recent inspection prompted by the resident inspector's inquiries.

2. Open Items

Open items are matters which have been discussed with the licensee, which will be reviewed further by the inspectors, and which involve some action on the part of the NRC or licensee or both. The open items disclosed during the inspection are discussed in Paragraphs 1.i. and 1.k.

3. Exit Interview

The inspectors met with licensee representatives (denoted in Paragraph 1) throughout the inspection period and at the conclusion of the inspection on June 5, 1986, and summarized the scope and findings of the inspection activities.

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/processes as proprietary.