

October 31, 2000

Mr. Oliver D. Kingsley  
President, Nuclear Generation Group  
Commonwealth Edison Company  
ATTN: Regulatory Services  
Executive Towers West III  
1400 Opus Place, Suite 500  
Downers Grove, IL 60515

SUBJECT: QUAD CITIES INSPECTION REPORT 50-254/00-14(DRP); 50-265/00-14(DRP)

Dear Mr. Kingsley:

On September 30, 2000, the NRC completed an inspection at your Quad Cities Units 1 and 2 reactor facilities. The results were discussed with Mr. Dimmette and other members of your staff. The enclosed report presents the results of that inspection.

The inspection was an examination of activities conducted under your license as they relate to safety and to compliance with the Commission's rules and regulations and with the conditions of your license. Within these areas the inspection consisted of a selective examination of procedures and representative records, observations of activities, and interviews with personnel. Specifically, this inspection focused on resident inspection activities and security plan review.

Based on the results of this inspection, NRC identified three issues which were categorized as being of very low risk significance (GREEN). Of the three issues, two were determined to involve violations of NRC requirements, but because of the low safety significance, the violations are not cited. These issues involved failure to take timely corrective action for an identified condition adverse to quality involving the Unit 1 and Unit 2 high pressure coolant injection systems, as well as failure to follow fire protection procedure requirements to maintain fire barriers protecting safety-related equipment. These issues are listed in the summary of findings and are discussed in the body of the attached inspection report.

If you deny the non-cited violations, you should provide a response with the basis for your denial within 30 days of the date of this inspection report, to the Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington DC 20555-001, with a copy to the Regional Administrator, Region III, Resident Inspector and the Director, Office of Enforcement, United States Nuclear Regulatory Commission, Washington, DC 20555-001.

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Sincerely,

/RA/

Mark A. Ring, Chief  
Reactor Projects Branch 1

Docket Nos. 50-254; 50-265  
License Nos. DPR-29; DPR-30

Enclosure: Inspection Report 50-254/00-14(DRP);  
50-265/00-14(DRP)

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U. S. NUCLEAR REGULATORY COMMISSION

REGION III

Docket Nos: 50-254; 50-265  
License Nos: DPR-29; DPR-30

Report No: 50-254/00-14(DRP); 50-265/00-14(DRP)

Licensee: Commonwealth Edison Company (ComEd)

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

Location: 22710 206th Avenue North  
Cordova, IL 61242

Dates: August 15 through September 30, 2000

Inspectors: C. Miller, Senior Resident Inspector  
P. Prescott, Senior Resident Inspector, Duane Arnold  
M. Kurth, Resident Inspector, Duane Arnold  
K. Walton, Resident Inspector  
J. Adams, Resident Inspector  
T. Madeda, Physical Security Inspector

Approved by: Mark Ring, Chief  
Reactor Projects Branch 1  
Division of Reactor Projects

## NRC's REVISED REACTOR OVERSIGHT PROCESS

The federal Nuclear Regulatory Commission (NRC) recently revamped its inspection, assessment, and enforcement programs for commercial nuclear power plants. The new process takes into account improvements in the performance of the nuclear industry over the past 25 years and improved approaches of inspecting and assessing safety performance at NRC licensed plants.

The new process monitors licensee performance in three broad areas (called strategic performance areas): reactor safety (avoiding accidents and reducing the consequences of accidents if they occur), radiation safety (protecting plant employees and the public during routine operations), and safeguards (protecting the plant against sabotage or other security threats). The process focuses on licensee performance within each of seven cornerstones of safety in the three areas:

Reactor Safety	Radiation Safety	Safeguards
<ul style="list-style-type: none"><li>• Initiating Events</li><li>• Mitigating Systems</li><li>• Barrier Integrity</li><li>• Emergency Preparedness</li></ul>	<ul style="list-style-type: none"><li>• Occupational</li><li>• Public</li></ul>	<ul style="list-style-type: none"><li>• Physical Protection</li></ul>

To monitor these seven cornerstones of safety, the NRC uses two processes that generate information about the safety significance of plant operations: inspections and performance indicators. Inspection findings will be evaluated according to their potential significance for safety, using the Significance Determination Process, and assigned colors of GREEN, WHITE, YELLOW or RED. GREEN findings are indicative of issues that, while they may not be desirable, represent very low safety significance. WHITE findings indicate issues that are of low to moderate safety significance. YELLOW findings are issues that are of substantial safety significance. RED findings represent issues that are of high safety significance with a significant reduction in safety margin.

Performance indicator data will be compared to established criteria for measuring licensee performance in terms of potential safety. Based on prescribed thresholds, the indicators will be classified by color representing varying levels of performance and incremental degradation in safety: GREEN, WHITE, YELLOW, and RED. GREEN indicators represent performance at a level requiring no additional NRC oversight beyond the baseline inspections. WHITE corresponds to performance that may result in increased NRC oversight. YELLOW represents performance that minimally reduces safety margin and requires even more NRC oversight. And RED indicates performance that represents a significant reduction in safety margin but still provides adequate protection to public health and safety.

The assessment process integrates performance indicators and inspection so the agency can reach objective conclusions regarding overall plant performance. The agency will use an Action Matrix to determine in a systematic, predictable manner which regulatory actions should be taken based on a licensee's performance. The NRC's actions in response to the significance (as represented by the color) of issues will be the same for performance indicators as for inspection findings. As a licensee's safety performance degrades, the NRC will take more and increasingly significant action, which can include shutting down a plant, as described in the Action Matrix.

More information can be found at: <http://www.nrc.gov/NRR/OVERSIGHT/index.html>.

## SUMMARY OF FINDINGS

NRC Inspection Report 50-254-00-14(DRP), 50-265-00-14(DRP) on 08/15 - 09/30/2000, ComEd, Quad Cities Nuclear Power Station, Units 1 & 2, Fire Protection, and Operability Evaluations.

The inspection was conducted by resident inspectors and a regional security specialist. This inspection identified three GREEN issues, which involved two non-cited violations. The significance of the three issues is indicated by their color (GREEN) and was determined by the Significance Determination Process.

### Cornerstone: Mitigating Systems

- GREEN. On September 15, the inspectors determined that the bottom latch in the inactive leaf of door 128, a 3-hour rated fire door, was not properly latched. The fire protection engineer determined that the degraded door also resulted in the inoperability of the emergency diesel generator room carbon dioxide fire suppression system. This finding constituted a violation of Quad Cities Operating Licensee DPR-29. This violation is being treated as a **Non-Cited Violation (50-265/00-14-01)**, consistent with Section VI.A.1 of the May 1, 2000, Enforcement Policy (Section 1R05).

The inspectors evaluated the degraded condition of fire door 128 using the fire protection Significance Determination Process, and evaluation techniques discussed with Senior Risk Analysts and Fire Protection Engineers in Region III and NRR. Since the degradation of the fire door was minimal, and the area of the turbine building directly in front of the door (within 15 to 20 feet) was relatively free of combustibles and cables, the inspectors determined that the possibility of a fire in the Unit 2 emergency diesel generator room spreading to damage the shared emergency diesel generator was not credible. Therefore the significance of this finding was considered very low (GREEN).

- GREEN. The inspectors found that the July 3 and August 23, 2000 supporting operability documentation forms for Problem Identification Form Q2000-2372, regarding a design deficiency for Units 1 and 2 high pressure coolant injection motor speed changers, did not adequately support the operability of the system.

Inspectors reviewed the risk significance of the motor speed changer being inoperable and found the risk to be very low (GREEN) since the change to core damage frequency was less than E-6/year. In addition, operators were briefed on the potential problems with the system, and the licensee installed design changes to correct the problem on both units (Section 1R15).

- GREEN. Inspectors found that the licensee failed to implement modifications to correct a previously identified design deficiency which could have made the motor speed changer inoperable in accident situations. The failure to implement corrective actions for this condition was a violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action." This violation is being treated as a **Non-Cited Violation (50-254/00-14-02); 50-265/00-14-02**, consistent with Section VI.A.1 of the May 1, 2000, Enforcement Policy.

- The inspectors found that the risk significance for internal and external events was very low (GREEN) since unavailability of the high pressure coolant injection system resulted in a change to core damage frequency of less than E-6/year. The licensee implemented modifications on both units to correct the design deficiency (Section 1R15).

## Report Details

### **1. REACTOR SAFETY**

#### Plant Status

Operators maintained Unit 1 at or near full power operations during the period, except for minor power decreases for turbine testing and/or control rod positioning.

Operators maintained Unit 2 at or near full power operations until September 22 when reactor power was decreased to about 35 percent in order to improve risk conditions for a repair of three Unit 2 emergency diesel generator control switches. Power was restored to 100 percent on September 23. Operators reduced Unit 2 power to 95 percent on September 30 to troubleshoot a problem with the Number 3 turbine control valve. The unit remained at 95 percent power for the remainder of the period.

#### 1R04 Equipment Alignments (71111-04)

##### a. Inspection Scope

The inspectors verified the system alignments of the accessible portions of the listed systems. During the walkdown, the inspectors verified the system lineup and system operating parameters (i.e., temperature, pressure, flow, etc.). In addition, the inspectors reviewed design and licensing information, and discussed system performance with licensee personnel. The inspectors reviewed system alignments related to the Mitigating Systems Cornerstone for the following risk important systems:

- Unit 1 "A" residual heat removal train during the unavailability of the "B" residual heat removal train;
- Unit 1 emergency diesel generator during the unavailability of the ½ emergency diesel generator; and
- Unit 2 emergency diesel generator during the unavailability of the ½ emergency diesel generator.

##### b. Issues and Findings

There were no findings identified.

**1R05 Fire Protection (71111-05)**

**Unit 2 Battery Room and Units 1 and 2 Emergency Diesel Generator and Day Tank Rooms Fire Protection Walkdowns**

a. **Inspection Scope**

The inspectors conducted fire protection walkdowns of the Unit 2 battery room related to the Mitigating System Cornerstone and walkdowns of the Units 1 and 2 emergency diesel generator and day tank rooms, fire zones 9.1 and 9.2, respectively. During the walkdowns, the inspectors verified that transient combustibles and ignition sources were properly controlled; that material condition, operational lineups, and operational effectiveness of fire detection systems, fire suppression systems, and fire protection equipment were maintained; and that material condition and operational status of fire barriers were maintained. The inspectors discussed issues associated with the fire zones with the fire marshal, fire protection engineer, and licensee management. The inspectors reviewed the following documents:

- Quad Cities Units 1 and 2 Updated Fire Hazards Analysis, Section 9.1, "Unit 1 Diesel Generator Room," Revision 97-02;
- Quad Cities Units 1 and 2 Updated Fire Hazards Analysis, Section 9.2, "Unit 2 Diesel Generator Room," Revision 97-02;
- Quad Cities Administrative Procedure 1500-01, "Administrative Requirements Fire Protection," Revision 14;
- Quad Cities Mechanical Maintenance Surveillance Procedure 4100-61, "Fire Door Inspection," Revision 5;
- Condition Reports Q2000-03472 and Q2000-03428;
- Action Request Number 990108305.

b. **Issues and Findings**

On September 15, the inspectors determined that the bottom latch in the inactive leaf of door 128, a 3-hour rated fire door, located between the Unit 2 emergency diesel generator room and the turbine building was not properly latched. The inspectors notified the station's fire protection engineer. The fire protection engineer assessed the door's condition and confirmed that the fire door was degraded. In addition, the fire protection engineer determined that the degraded condition of the fire door also resulted in the inoperability of the emergency diesel generator room carbon dioxide fire suppression system. The degraded door was entered into the licensee's corrective actions program with Condition Report Q2000-03472 and Action Request 990108305. The inspectors verified that compensatory actions were promptly initiated.

The Quad Cities Operating Licensee DPR-29, License Condition h.3.F stated that the Commonwealth Edison Company shall implement and maintain in effect all provisions of the approved fire protection program as described in the Updated Final Safety Analysis Report. The Updated Final Safety Analysis Report, Section 9.5.1, referenced the requirement for administrative procedures defining the fire protection program, administrative technical requirements, and surveillance requirements. Quad Cities Administrative Procedure 1500-01, "Administrative Requirements Fire Protection," Section D.8.a.(1), required that fire barriers protecting safety-related or safe shutdown areas shall be intact at all times. The inspectors determined that Section D.8.a.(1), of Quad Cities Administrative Procedure 1500-01 had not been properly implemented, constituting a violation of Quad Cities Operating Licensee DPR-29, License Condition h.3.F. This violation is being treated as a **Non-Cited Violation (50-265/00-14-01)**, consistent with Section VI.A.1 of the May 1, 2000, Enforcement Policy.

The inspectors evaluated the degraded condition of fire door 128 using the fire protection Significance Determination Process, and evaluation techniques discussed with Senior Risk Analysts and Fire Protection Engineers in Region III and NRR. Since the degradation of the fire door was minimal, and the area of the turbine building directly in front of the door (within 15 to 20 feet) was relatively free of combustibles and cables, the inspectors determined that the possibility of a fire in the Unit 2 emergency diesel generator room spreading to damage the shared emergency diesel generator was not credible. Therefore the significance of this finding was considered very low (GREEN.)

In addition, the inspectors noted that discrepancies existed between the actual as-built condition of the 3-hour fire barriers surrounding the Unit 1 and Unit 2 emergency diesel generator rooms and the descriptions of the 3-hour fire barriers contained in the fire hazards analysis. The inspectors observed one additional fire door in each of the 3-hour fire barriers that was not described in the fire hazards analysis description of fire zone 9.1 (Unit 1 emergency diesel generator and day tank rooms) and fire zone 9.2 (Unit 2 emergency diesel generator and day tank rooms). The inspectors verified that the doors were being maintained and inspected by the licensee as 3-hour fire doors. The fire marshal entered the conditions into the corrective action program with Condition Report Q2000-03428.

#### 1R12 Maintenance Rule Implementation (71111-12)

##### a. Inspection Scope

The inspectors reviewed the licensee's implementation of the maintenance rule requirements, including a review of scoping, goal setting, performance monitoring, short-term and long-term corrective actions, and current equipment performance status.

The inspectors reviewed the following condition reports for proper maintenance rule classifications:

Initiating Events Cornerstone

- Condition Report Q2000-03159 Momentary Secondary Containment Breech - Reactor Building Interlock

Mitigating Systems Cornerstone

- Condition Reports Q2000-02604, Q2000-02692, and Q2000-02869 Control Room Toxic Gas Analyzer

b. Issues and Findings

There were no issues or findings associated with this inspection activity.

1R13 Maintenance Risk and Emergent Work (71111-13)

a. Inspection Scope

The inspectors reviewed the licensee's evaluation of plant risk and equipment configuration associated with the performance of planned and emergent maintenance activities. The inspectors evaluated risk considerations for planned and emergent work on the following systems:

Initiating Events Cornerstone

- Emergent work to replace lexan control switches for the Unit 2 emergency diesel generator control switch, voltage regulator switch and governor switch
- Planned work on Unit 2 emergency diesel generator with line 15504 out of service

Mitigating Systems Cornerstone

- Emergent work on residual heat removal service water valve 1-1001-5A

Containment Systems Cornerstone

- Unit 2 motor control center 28-1B trip

b. Issues and Findings

There were no findings identified and documented during this inspection.

1R15 Operability Evaluations (71111-15)

a. Inspection Scope

The inspectors reviewed operability evaluations associated with the following mitigating systems:

- Unit 1 high pressure coolant injection motor speed design changer deficiency (July 3, 2000, and August 23, 2000, versions), Problem Identification Form Q2000-2372;
- Unit 1 reactor recirculation jet pump cracking; and
- Unit 1 environmental qualification of control cable 12867 for the "B" reactor recirculation loop suction valve, 1-202-5B.

b. Issues and Findings

- .1 The inspectors found that the July 3 and August 23, 2000, supporting operability documentation forms for Problem Identification Form Q2000-2372 regarding Units 1 and 2 high pressure coolant injection motor speed changer design deficiencies did not adequately support the licensee's determination that the system was operable. Inspectors reviewed the risk significance of the motor speed changer being inoperable and found the risk to be very low. In addition, operators were briefed on the potential problems with the system, and the licensee installed design changes to correct the problem on both units.

The operability documentation assumed that a single start of the system would be sufficient to meet system design requirements, but failed to show that only one start was needed. In addition, the form did not detail manual operator actions taken for transient scenarios and how those actions might affect system operation with a degraded motor speed changer; lacked detail to conclude that manual actions were sufficient to replace automatic design features used to control reactor vessel level as described in the updated final safety analysis; and failed to show how system response for design functions using manual control, such as anticipated transients without scram, would not be adversely affected by a degraded motor speed changer. The inspectors found that the operability documentation did not address system performance if the system was inadvertently or purposefully shut off by operator action, or by any one of several trip signals for the system.

Further conversations with lead system and design engineers indicated that the reason the operability documentation justified that only one start was necessary, was that the 10 CFR 50.46 LOCA analysis could show that no core damage would occur even if no high pressure coolant injection would occur. Inspectors pointed out that the overall plant design for a single train safety system such as high pressure coolant injection was that core damage would not result if the system failed. Therefore the claim that the system was operable because the degradation of the motor speed changer would not have led to core damage was not sufficient justification for determining that the system was operable.

This issue was previously discussed in Inspection Report 50-254/00-007; 50-265/00-007 and the risk was assessed as GREEN for internal events, even if the system was conservatively considered not available under all conditions because of the motor speed changer. Inspectors reviewed the risk considerations for external events (fire) because the high pressure coolant injection systems were credited in the external events risk model. Since the issuance of inspection report 50-254/00-007; 50-265/00-007, the licensee had modified the risk achievement worth for the system from 1.03 to 1.01 based on the cutsets in the model where the system was credited.

Inspectors and licensee analysts used the risk achievement worth (RAW) to find the change in core damage frequency ( $\Delta$ CDF) using the following calculation:

$$\Delta \text{CDF} = (\text{Base fire CDF}) \times (\text{RAW}-1) \times (\text{time of exposure})$$

For Unit 1 with exposure time of 1 year (maximum):  $6.6\text{E-}5/\text{year} \times (1.01-1) \times 1 = 0.66\text{E-}6/\text{year}$ .

For Unit 2 with exposure time of 1 year (maximum):  $7.13\text{E-}5/\text{year} \times (1.01-1) \times 1 = 0.71\text{E-}6/\text{year}$ .

These values were both below the WHITE threshold value of E-6/year, and thus resulted in very low risk (GREEN).

- .2 (Closed) Unresolved Item (50-254/2000007-02): Motor Speed Changer Design Deficiencies. Inspectors found that the licensee failed to implement modifications to correct a previously identified design deficiency which could have made the motor speed changer inoperable in accident situations. The failure to implement corrective actions for this condition was a violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action." This violation is being treated as a **Non-Cited Violation (50-254/00-14-02; 50-265/00-14-02)**, consistent with Section VI.A.1 of the May 1, 2000, Enforcement Policy. The inspectors found that the risk significance for internal and external events was very low (GREEN). See the risk assessment in Section .1 above. The licensee implemented modifications on both units to correct the design deficiency. This item is closed.
- .3 (Closed) Unresolved Item (50-254/2000007-03): High Pressure Coolant Injection Level Control Design Deficiency. This issue was discussed in Inspection Report 50-254/00-007; 50-265/00-007. Inspectors reviewed additional licensee documentation which indicated that the automatic control of the system between 44 and 48 inches reactor vessel level would not have caused an excessive battery drain. As a result, the inspectors found that the risk significance for internal and external events was very low. The licensee implemented modifications on both units to correct the design deficiency. This item is closed.

#### 1R17 Permanent Plant Modifications (71111-17)

##### .1 Modification of Unit 1 High Pressure Coolant Injection System Restart

###### a. Inspection Scope

The inspector reviewed Design Change Package 9800238 for the modification of high pressure coolant injection logic so that the system would restart at an indicated reactor vessel level of negative 59 inches. The inspectors found that the licensee's design review properly evaluated system changes. The inspectors verified that implementation of the modification did not put the plant in an unsafe configuration, met acceptance criteria, and demonstrated system operability.

b. Issues and Findings

There were no findings identified and documented during this inspection.

.2 Unit 1 High Pressure Coolant Injection System Logic Changes for the Auxiliary Oil Pump, Emergency Oil Pump, and Motor Speed Changer

a. Inspection Scope

The inspectors reviewed Design Change Package 9900079 for the modification of high pressure coolant injection logic for the auxiliary oil pump to cause the auxiliary oil pump to run when high pressure coolant injection is running regardless of how long the initiation signal is present, for the emergency oil pump to add a 6-second time delay to prevent spurious starts of the emergency oil pump, and for the motor speed changer to add a limit switch to de-energize it when it reached the high speed stop. The inspectors found that the licensee's design review properly evaluated system changes. The inspectors verified that implementation of the modification did not put the plant in an unsafe configuration, met acceptance criteria, and demonstrated system operability.

b. Issues and Findings

There were no findings identified and documented during this inspection.

1R19 Post Maintenance Testing (71111-19)

a. Inspection Scope

The inspectors reviewed post maintenance testing procedures associated with the Mitigating Systems Cornerstone activity listed below. The inspectors ensured that the test procedure demonstrated proper operation of the component after completion of the maintenance activity.

Quad Cities Electrical Maintenance Surveillance 0250-01, "Limitorque Motor Operated Valve Environmental Qualification Surveillance," Unit 1 Valve 1-1001-5A, residual heat removal heat exchanger service water discharge valve.

b. Issues and Findings

There were no issues or findings identified during the inspection activity.

1R22 Surveillance Testing (71111-22)

a. Inspection Scope

The inspectors reviewed the results of the following testing in the Mitigating Systems Cornerstone:

QCOS 2300-26 "HPCI CCST Suction Valve Closure Test."

b. Issues and Findings

There were no issues or findings identified during the inspection activity.

1R23 Temporary Plant Modifications (71111-23)

.1 Bypass of the Unit 2 Service Platform Rod Block

a. Inspection Scope

The inspectors reviewed temporary plant modification (T-Mod) Package 9900341, "Bypass of the Unit 2 Service Platform Rod Block." The inspectors reviewed the T-Mod installation instruction, wiring diagrams 4E-2411, Revision H and 4E2755C, Revision Y; and verified that the drawings were consistent with instructions. The inspectors reviewed Safety Evaluation Summary, SS-H-00-0048 and 10 CFR 50.59 Safety Evaluation, SE-00-029.

b. Issues and Findings

There were no findings identified and documented during this inspection.

.2 Unit 2 Emergency Diesel Generator Temperature Indication

a. Inspection Scope

The inspectors reviewed Condition Report Q2000-03176 that documented existence of a temporary thermometer in the Unit 2 emergency diesel generator room. The inspectors discussed the purpose and use of the thermometer with operations personnel in order to verify that the emergency diesel generator operability was not based on temperature measurements obtained from the temporary thermometer.

b. Issues and Findings

There were no findings identified and documented during this inspection.

3. **SAFEGUARDS**

**Physical Protection (PP)**

3PP4 Security Plan Changes (IP71130-04)

a. Inspection Scope

The inspector reviewed Revisions 47 and 48 of the Quad Cities Nuclear Station Security Plans, Security Personnel Training and Qualification Plans, and Safeguards Contingency Plans to verify that the changes did not decrease the effectiveness of the submitted plans. The plan revisions were submitted by licensee letter dated June 30, 2000.

b. Issues and Findings

The documents were submitted in a timely manner and the changes did not appear to reduce the effectiveness of the previous plans. However, one unresolved item was identified in Revision 47. In Section 1.7 the licensee added a new limitation regarding the definition of a bullet-resisting structure. NRC review determined that this new limitation is not included in NRC guidance documents and may decrease the effectiveness of the structure if implemented. The licensee's plan change did not result in any modifications to bullet resistant structures, however. This issue was discussed with the licensee on September 27, 2000. The licensee agreed to resubmit a plan change that will eliminate the bullet-resisting height limitation. This is an **unresolved item** until the removal of the height limitation from the security plan (**50-254/00-14-03; 50-265/00-14-03**).

4OA2 Performance Indicator Verification (71151)

a. Inspection Scope

The inspectors reviewed the licensee submitted data for the Emergency Alternating Current Unavailability performance indicator.

b. Issues and Findings

There were no findings identified and documented during this inspection.

4OA3 Event Followup (71153)

(Closed) Licensee Event Report 50-254/00005-00: Emergency Diesel Generator Technical Specification Surveillance Requirement Not Completed Within Allowed Time. The risk significance and enforcement aspects of this event were discussed in Inspection Report 50-254/2000007; 50-265/2000007. The inspectors reviewed the licensee's corrective actions for this event. This item is closed.

4OA4 Management Meetings

The inspectors presented the inspection results to Mr. Dimmette and other members of licensee management following the conclusion of the inspection on October 5, 2000. The licensee acknowledged the findings presented. No proprietary information was identified.

## PARTIAL LIST OF PERSONS CONTACTED

### Licensee

J. Dimmette	Site Vice President
G. Barnes	Station Manager
E. Anderson	Radiation Protection Manager
G. Boerschig	Engineering Manager
R. Chrzanowski	Nuclear Oversight Manager
M. McDowell	Operations Manager
M. Perito	Maintenance Manager

### NRC

M. Ring	Branch Chief, Branch 1
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## ITEMS OPENED, CLOSED, AND DISCUSSED

### Opened

50-265/00-14-01	NCV	Units 1 and 2 Emergency Diesel Generator and Day Tank Rooms Fire Protection Walkdowns
50-254/00-14-02; 50-265/00-14-02	NCV	Motor Speed Changer Design Deficiencies
50-254/00-14-03; 50-265/00-14-03	URI	Security Plan Change

### Closed

50-265/00-14-01	NCV	Units 1 and 2 Emergency Diesel Generator and Day Tank Rooms Fire Protection Walkdowns
50-254/00-14-02; 50-265/00-14-02	NCV	Motor Speed Changer Design Deficiencies
50-254/2000007-02	URI	Motor Speed Changer Design Deficiencies
50-254/2000007-03	URI	High Pressure Coolant Injection Level Control Design Deficiencies
50-254/00005-00	LER	Emergency Diesel Generator Technical Specification Surveillance Requirement not Completed Within Allowed Time

### Discussed

None

## LIST OF BASELINE INSPECTIONS PERFORMED

The following inspectable-area procedures were used to perform inspections during the report period. Documented findings are contained in the body of the report.

<u>Number</u>	<u>Title</u>	<u>Report Section</u>
71111-04	Equipment Alignment	1R04
71111-05	Fire Protection	1R05
71111-13	Maintenance Work Prioritization & Control	1R13
71111-15	Operability Evaluations	1R15
71111-17	Permanent Plant Modifications	1R17
71111-19	Post Maintenance Testing	1R19
71111-22	Surveillance Testing	1R22
71111-23	Temporary Plant Modifications	1R23
71130-04	Security Plan Changes	3PP4
71151	Performance Indicator Verification	4OA2
71153	Event Follow-up	4OA3

## LIST OF ACRONYMS USED

CFR	Code of Federal Regulations
IDNS	Illinois Department of Nuclear Safety
IFI	Inspection Follow-up Item
LER	Licensee Event Report
URI	Unresolved Item
VIO	Violation