UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
101 MARIETTA STREET, N.W., SUITE 2900
ATLANTA, GEORGIA 30323-0199

Report No.: 50-261/94-03

Licensee: Carolina Power and Light Company
P. O. Box 1551
Raleigh, NC 27602

Docket No.: 50-261 License No.: DPR-23

Facility Name: H. B. Robinson Unit 2

Inspection Conducted: December 26, 1993 - January 22, 1994

Lead Inspector: J. Starefos for 2-17-94
W. T. Orders, Senior Resident Inspector Date Signed

Other Inspectors: C. R. Ogle, Resident Inspector
P. A. Balmain, Resident Inspector, Vogtle
P. Byron, Resident Inspector, Brunswick
C. W. Rapp, Region II Inspector
M. N. Miller, Region II Inspector
J. L. Starefos, Project Engineer

Accompanying Personnel: E. Wang, Reactor Engineer (Intern)

Approved by: 2/18/94
H. O. Christensen, Chief Date Signed
Reactor Projects Section 1B
Division of Reactor Projects

SUMMARY

Scope:

This routine, unannounced inspection was conducted in the areas of operational safety verification, surveillance observation, maintenance observation, engineered safety feature system walkdown, plant safety review committee activities, followup of previously identified items and verification of the completion of Confirmation of Action Letter commitments.

Results:

A non-cited violation was identified which involved the failure to make timely NRC notification of licensed operator termination and failure to respond to a notice of violation within specified time, paragraph 3; a violation was identified which involved inadequate debris intrusion control measures employed during maintenance, paragraph 4; a second violation was identified involving the licensee's failure to post the response to a radiological working condition violation, paragraph 6.

REPORT DETAILS

1. Persons Contacted

*G. Attarian, Chief Electrical Engineer
*R. Barnett, Manager, Projects Management
C. Baucom, Shift Outage Manager
*D. Bauer, Regulatory Compliance Coordinator, Regulatory Compliance
J. Benjamin, Shift Outage Manager, Outages and Modifications
S. Billings, Technical Aide, Regulatory Compliance
*B. Clark, Manager, Maintenance
*T. Cleary, Manager, Technical Support
D. Crook, Senior Specialist, Regulatory Compliance
*C. Dietz, Vice President, Robinson Nuclear Project
*W. Dorman, Acting Manager, Regulatory Affairs
R. Downey, Shift Supervisor, Operations
J. Eaddy, Manager, Environmental and Radiation Support
S. Farmer, Manager, Engineering Programs, Technical Support
B. Harward, Manager, Engineering Site Support, Nuclear Engineering Department
*M. Herrell, Manager, Training
*S. Hinnant, Director, Site Operations
P. Jenny, Manager, Emergency Preparedness
D. Knight, Shift Supervisor, Operations
E. Lee, Shift Outage Manager, Outages and Modifications
A. McCauley, Manager, Electrical Systems, Technical Support
R. Moore, Acting Operations Manager
D. Morrison, Shift Supervisor, Operations
*M. Page, Manager, RESS Mechanical
D. Nelson, Shift Outage Manager, Outages and Modifications
*C. Olexik, Robinson Assessment Section
A. Padgett, Manager, Environmental and Radiation Control
*M. Pearson, Plant General Manager
D. Seagle, Shift Supervisor, Operations
M. Scott, Manager, Reactor Systems, Technical Support
E. Shoemaker, Manager, Mechanical Systems, Technical Support
W. Stover, Shift Supervisor, Operations
D. Winters, Shift Supervisor, Operations

Other licensee employees contacted included technicians, operators, engineers, mechanics, security force members, and office personnel.

Acronyms and initialisms used throughout this report are listed in the last paragraph.

2. Plant Status

The Unit began the report period continuing the forced outage which began on November 17. The Unit remained shutdown throughout the report period while the licensee implementing corrective actions to equipment and personnel deficiencies identified during the forced outage and as required by an NRC Confirmation of Action Letter issued on November 19, 1993.

3. Operational Safety Verification (71707)

a. General

The inspectors evaluated licensee activities to confirm that the facility was being operated safely and in conformance with regulatory requirements. These activities were confirmed by direct observation, facility tours, interviews and discussions with licensee personnel and management, verification of safety system status, and review of facility records.

The inspectors reviewed shift logs, Operation's records, data sheets, instrument traces, and records of equipment malfunctions to verify equipment operability and compliance with TS. The inspectors verified that the staff was knowledgeable of plant conditions, responded properly to alarms, adhered to procedures and applicable administrative controls, were cognizant of in-progress surveillance and maintenance activities, and were aware of inoperable equipment status through work observations and discussions with Operations staff members. The inspectors performed channel verifications and reviewed component status and safety-related parameters to verify conformance with TS. Shift changes were routinely observed, verifying that system status continuity was maintained and that proper control room staffing existed. Access to the control room was controlled and operations personnel carried out their assigned duties in an effective manner. Control room demeanor and communications were appropriate.

Plant tours were conducted to verify equipment operability, assess the general condition of plant equipment, and to verify that radiological controls, fire protection controls, physical protection controls, and equipment tagging procedures were properly implemented.

b. Notification Of Unusual Event Due To Both EDGs Being Inoperable

At 3:12 p.m. on January 17, 1994, the licensee declared an Unusual Event when it was concluded that both EDGs were inoperable. The A EDG was declared inoperable when the licensee found water dripping onto the diesel's control cabinet and current transformer cubicles. The B EDG had previously been removed from service to support maintenance and modification work. The licensee suspended work on the B EDG and removed the clearance. The Unusual Event was exited at 5:13 p.m. that day, following restoration and successful testing of the B EDG.

The inspectors were notified of the event, reported to the site, and witnessed the licensee's event response. In general the inspectors concluded the response was satisfactory. The

inspectors also verified that appropriate notifications were performed in accordance with regulatory requirements.

The licensee determined the source of the water leaking onto the diesel to be coming from valve EV-6646, an EAC 2 Solenoid Valve. Service water was spraying from the body to bonnet joint on the valve, into the air intake enclosure of EAC-2. A portion of this spray entered a normally open damper which penetrates the A EDG room immediately above the current transformer and generator control cubicles.

The licensee theorized that the valve failure occurred as a result of freezing conditions experienced in the EAC air intake enclosure. It was also noted that the air intake dampers on the EAC were not properly closing which probably exacerbated the situation.

The inspectors witnessed the satisfactory testing of B EDG in accordance with procedure OP-604, Diesel Generators A and B, and the system's return to service.

c. Failure To Make Timely NRC Notifications

On December 28, 1993, the licensee informed the resident staff that a notification to the NRC concerning the status of a licensed operator as well as a violation response, were not made within the prescribed timeframes.

The late notification involved a licensed operator who terminated his employment effective October 29, 1993. The required written notification to the NRC concerning the status change was not made until December 24, 1993, which exceeded the allowed 30-day reporting requirement specified in 10 CFR 50.74.

The late violation response involved the licensee's written response to a violation documented in NRC Inspection Report 50-261/93-26. The licensee's response was dispatched on December 29, 1993. In as much as the Notice of Violation was dated November 26, 1993, the response exceeded the allowed 30-day response timeframe of 10 CFR 2.201.

An Adverse Condition Report was generated by the licensee in response to these incidents. The inspectors were informed that these events were reviewed with the cognizant individuals and that a generic checklist/scheduling aid to track the timeliness of NOV responses and LERs would be generated.

Additionally, the licensee stated that a process to allow track of required correspondence to the NRC on issues related to licensed operators would be developed.

The failure to communicate the notification and violation response in accordance within the specified timeframes is a violation. This violation will not be subject to enforcement action however, because the licensee's effort in identifying and correcting the violation meet the criteria specified in Section VII.B of the Enforcement Policy.

This is identified as a non-cited violation, NCV: 94-03-01, Failure To Make Timely NRC Notification Of Licensed Operator Termination And Failure To Respond To A Notice Of Violation Within Specified Timeframe.

d. Confirmation of Action Letter Followup Efforts

On November 18, 1993, CP&L management made the decision to place Robinson Unit 2 in cold shutdown due to a concern with a mis-configured core reload. Confirmation of Action Letter (CAL) was issued documenting the licensee's planned actions to identify the root cause of the mis-configuration, determine the cause of detected nuclear instrumentation anomalies, evaluate operator performance, and assess the status of not only Robinson's organization, but also plant equipment, to determine if the facility was ready for restart.

The Resident Inspection Staff, assisted by Region II inspectors, conducted independent reviews of the licensee's actions. The issues inspected during this report period are detailed below.

i) General Plan For Restart Readiness

The inspectors reviewed procedure PLP-059, Plan For Restart Readiness And Startup and Power Ascension, Rev. 4. The procedure delineates the licensee's program designed to complete a self-assessment for readiness to safely startup and operate Robinson Nuclear Plant following the forced outage which began on November 17, 1993. Completion of this self-assessment is based upon verification of the successful completion of the "Startup Required Actions", specified in the NRC Confirmation Action Letter dated November 19, 1993, as well as a review of system readiness, organizational readiness, operational readiness and verification of core configuration.

The Plant Manager was responsible for determining whether improvement items identified during these reviews were required to be completed before unit startup or long term issues. The review of Systems Readiness augmented the requirements of procedure PLP-027, System Startup Readiness

Determination, to include affirmations by the responsible Systems Engineers that their respective systems were ready to support safe, reliable operation. The affirmations were based on reviews of system conditions that may have changed since completion of PLP-027 reviews following Refueling Outage 15, completion of "Startup Required Actions" and verification that required activities are included in the Startup And Power Ascension Schedule.

The review of Organizational Readiness performed by each Unit Manager and the Plant Manager, required each Unit Manager to affirm that their organizations and personnel were prepared to support plant operation and to demonstrate this preparation to the Site Vice President.

Finally, the review of Operational Readiness was performed to ensure each shift supervisor and operating crew were satisfied with the plant material condition and were prepared to operate the plant safely. A collective evaluation was performed which led to the Plant Manager's recommendation to the Vice President that plant heatup activities commence.

ii) Action Item: Barriers To Prevent Repeating Industry Events

The licensee addressed this issue with both long and short term corrective actions. The short term actions were listed as Corrective Action #5 in the Nuclear Instrumentation Incident Evaluation Team's (NIIET), Recommended Corrective Actions Prior to Restart memo to C.R. Dietz dated November 24, 1993. The team recommended that Operations Management ensure that Operations personnel do not develop tunnel vision by concentrating only on Reactivity Management. It was recommended that Operations Management revisit the March 24, 1993, letter from Kenneth Strahm to R. A. Watson of CP&L which highlights the need to maintain control of key primary plant parameters. The inspectors reviewed the March 24, 1993, Strahm letter which contains descriptions of six events which occurred during the previous 12 months. Each of the events related to operator inattention during restart.

The inspectors also reviewed the December 18, 1993, memo from the Acting Operations Manager to the Operations Staff listing his expectations. The listed expectations appeared to be adequate, addressing all aspects of the operators' duties and responsibilities.

In addition, the inspectors reviewed the Pearson to Dietz January 6, 1994, memo which documents the close out of

Corrective Action No. 5. The inspectors also reviewed the January 7, 1994, memo (RAP/94-0060) from the Plant Manager to Operation shift crew members which documents his discussions with them.

Long term corrective actions were listed as Corrective Action No. 14 for ACR 93-284. The corrective actions include the following:

- Communicate the importance of incorporating industry operating experience to enhance the equipment and personnel performance at Robinson.

- Use the power range NI indication event as a case study to reinforce the importance of barriers in the event and compare with the operating experience from a similar 1989 event at HNP, in series of employee information meetings for all site employees.

- Have one or more of the Investigation Team members participate in the employee meeting presentations.

- Emphasize, during these employee meeting presentations, the expectation that managers and employees should consider how lessons learned from industry experience can be most beneficial or can be related to experience at Robinson.

C. R. Dietz documented the closure of this item in his January 21, 1994, memo to W. Dorman, Corrective Action Program Manager. The licensee has assembled a notebook of Operating Experiences for Plant Startup and plans to have the onshift crews review it and have related discussions prior to commencing selected major evolutions.

The inspectors concluded from their review and discussions with licensee personnel that the licensee has completed both the long and short term corrective actions.

iii) Action Item: Independent System Walkdowns

Between January 4 and January 11, 1994, the inspectors conducted detailed walkdowns of portions of the AFW, SI, and A EDG systems. They were performed as an independent review of the material condition of the systems as well as a check on the thoroughness of the system engineer/SRO walkdowns conducted as part of the PLP 27/59 process.

During the walkdowns, the inspectors observed a number of deficiencies on each of the systems which had not been detected by the system engineer/SRO walkdowns. The deficiencies were identified to the system engineers for disposition. Although the deficiencies were minor and did not impact the operability of the systems, the number and ease of discovery of the deficiencies, concerned the inspectors about the thoroughness of the remainder of the PLP 27/59 walkdowns. During discussions with licensee management about these concerns, the inspectors became aware of two factors that may have contributed to the lack of walkdown thoroughness observed by the inspectors. One factor was that plant management's initial expectations for the performance of the walkdowns were not adequately communicated to site personnel. This was recognized by management during the walkdown process and further guidance was provided. Additionally, all Engineering Tech Support Management was not uniformly performing verifications of the walkdowns. Following the discussions between licensee management and the inspectors on this point, Engineering Technical Support Management performed a series of intensive verifications of the plant walkdowns. The inspectors were informed that these walkdowns revealed additional deficiencies, none of which however, impacted system operability.

Overall, the inspectors concluded that the system walkdowns were an enhancement in the licensee's system readiness evaluation process. Although the walkdowns were sufficient to determine system operability, they lacked the thoroughness to identify all readily apparent system deficiencies. Weak management oversight contributed to this deficiency.

During the walkdowns, the inspectors noted that a number of limit switch cover bolts were missing for actuators on the following valves: SI-866A (1 bolt missing); SI-867A (1 bolt missing); and SI-867B (2 bolts missing). The inspectors questioned the impact of these missing cover bolts on the EQ qualification of these motor operated valves. The inspectors were provided documentation by the licensee that demonstrated that the missing cover bolts did not impact valve operability. The inspection also reviewed completed maintenance work requests on these valves during RFO-15. The packages required that the limit switch covers be installed following maintenance. These observations were discussed with the cognizant supervisor and the maintenance manager. The inspectors were informed that based on these observations, the licensee was in the process of conducting a walkdown of readily accessible MOVS. Approximately 25 percent of the accessible MOV population was subsequently

inspected and only one other case of a missing cover bolt had been detected.

During the EDG A walkdown, the inspectors observed that the EDG A configuration did not match the controlled drawings. Similarly drawing/system configuration errors were observed during the AFW system walkdown. While none of the deficiencies were significant, each was easily recognizable by comparing the drawing to the system. While following up on this deficiency the inspectors were informed by plant management that it was not an explicit expectation that drawing be used during the system engineer/SRO walkdowns. The inspectors were also informed that the EDG A walkdown was "preliminary" and that the PLP 27/59 for this system was being held in abeyance pending the results of troubleshooting on the EDG B.

During the SI system walkdown, the inspectors observed that no flow existed through the "C" SI pump thrust bearing cooler. Though the pumps were not required in the existing plant configuration, SW flow had existed through the cooler earlier that day. The inspectors were informed by the system engineer and Operations Manager that the SW flow had been throttled to prevent overflowing SW drains. The inspectors were also informed that fluctuations in the SW system pressure due to service water booster pump testing was responsible for this observed change in SW flow.

iv) Action Item: Improve Shift Turnover Briefings

The inspectors reviewed revisions to Procedure OMM-008, Minimum Equipment List and Shift Relief, to determine if the revisions provided additional guidance to ensure sufficient information is turned over for a proper relief. The inspectors reviewed document change form 93-P-2301 and its accompanying 10 CFR 50.59 determination for revision 71 of the procedure. The inspectors noted that procedure OMM-008 had been revised to add new shift relief responsibilities for the Work Control Center Senior Control Operator (Section 5.1.5) and additional turnover checklist for the offgoing Work Control Center Senior Control Operator, Auxiliary Operators, Fire Protection Technical Aide, and Makeup Water Treatment Auxiliary Operator (sections 5.1.5, 5.1.7, and 5.1.9)

The inspectors concluded that procedure OMM-008 had been enhanced and that the additional attachments will improve shift turnovers for several positions in the control room.

v) Action Item: Expectations For Pre-job Briefings

The inspectors reviewed the licensee's restart closeout package 02-13 which included Document Change Form 93-P-2033 with a 10 CFR 50.59 determination for revision 41 of procedure GP-003, Normal Plant Startup From Hot Shutdown To Critical. The inspector verified that procedure GP-003 section 5.2, Instructions For Taking The Reactor Critical contains instruction steps (5.2.1, 5.2.2, and 5.2.3) to require that a Management Designated Monitor (MDM) be assigned and given permission to take the reactor critical. A pre-shift briefing, SWAG/Outage Turnover meeting review and a pre-job briefing checklist are also required to be completed prior to taking the reactor critical.

The inspector also reviewed Document Change Form 93-P-2183 for revision 37 of Procedure GP-005, Power Operation and the revised procedure. The inspector verified that section 5.2, which deals with warming up the secondary was revised to incorporate instruction steps (5.2.1 and 5.2.2) to require MDM permission prior to performing the evolution. A pre-shift briefing, SWAG/Outage Turnover Meeting Review and Pre-job Briefing checklist and also required prior to performing the evolution.

The inspector reviewed revisions to the outage management manual and verified that a format for shift turnover meetings was developed and instructions were incorporated to identify infrequently performed evolutions and notify a MDM prior to the evolution. Procedure PLP-037, Conduct of Infrequently Performed Tests and Evolution Section 5.3.2 provides requirements from the content of pre-job briefings and management expectations for conduct of the evolutions. A pre-Job Briefing Checklist (Attachment T.6) is incorporated into the implementing documents and is required to be performed prior to conducting the evolution.

The inspectors concluded that the above changes enhanced the guidance for the conduct of pre-job briefings.

4. Maintenance Observation (62703)

a. General

The inspectors observed safety-related maintenance activities on systems and components to ascertain that these activities were conducted in accordance with TS, and approved procedures. The

inspectors determined that these activities did not violate LCOs and that required redundant components were operable. The inspectors verified that required administrative, material, testing, radiological, and fire prevention controls were followed. In particular, the inspectors observed/reviewed the maintenance activities detailed below.

WR/JO 94ABHC1	Examine A Diesel Switches/Mag Amps For Water Damage
WR/JO 94AAMN	Remove, Inspect Air Start Check Valves On A EDG

b. Failure To Follow Procedure During Maintenance In Diesel Room

The inspectors witnessed licensee activities to resolve an electrical ground on the A EDG per WR/JO 94-ABHC1. During the conduct of this effort, the inspectors observed steel shot on the floor inside the EDG control cabinet. This observation was confirmed by the I & C supervisor. Additional shot was found elsewhere in the control cubicle; in the current transformer cubicle; in a drip pan beneath the engine blower; and in the generator enclosure itself.

As a result of this discovery, the licensee conducted a boroscope examination of accessible areas in the generator enclosure and vacuumed accessible portions of the generator housing. Examination of the vacuum cleaner's contents following the vacuuming of the generator enclosure and other adjacent areas revealed approximately 35 steel shot.

The licensee determined the source of the steel shot to be the use of a paint stripping machine in the A EDG room during the refueling outage. The licensee stated that the machine was only used briefly in the A EDG room in attempt to remove paint from the floor. The inspectors learned that the machine had also been used in the hallway in the auxiliary building and in the charging pump room. On January 19, 1994, the inspectors were informed that approximately 3 steel shot were discovered in the C charging pump motor frame, but none were found in room's electrical cubicles.

Technical Specification 6.5.1.1, Procedures, Tests, and Experiments requires, in part, that written procedures be established, implemented, and maintained covering the activities recommended in Appendix A of Regulatory Guide 1.33, Rev 2., 1978, including general procedures for the control of maintenance. Maintenance Management Manual Procedure, MMM-001, Maintenance Administration Program

requires the use of adequate debris intrusion control measures during the performance of maintenance.

Contrary to the above, inadequate debris intrusion control measures were used on November 15, 1993, during paint stripping efforts on the Emergency Diesel Generator A room floor. As a result, steel shot was introduced into Emergency Diesel Generator A as well as its associated generator control and current transformer cubicles. This is identified as Violation, VIO 94-03-02: Failure To Employ Adequate Debris Intrusion Control Measures.

5. Surveillance Observation (61726)

The inspectors observed certain safety-related surveillance activities on systems and components to ascertain that these activities were conducted in accordance with license requirements. For the surveillance test procedures listed below, the inspectors determined that precautions and LCOs were adhered to, the required administrative approvals and tagouts were obtained prior to test initiation, testing was accomplished by qualified personnel in accordance with an approved test procedure, and test instrumentation was properly calibrated. Upon test completion, the inspectors verified that the systems were properly returned to service. Specifically, the inspectors witnessed/reviewed portions of the following test activities:

SP-1289	B EDG Failure To Start Test
EST-048	Control Rod Drop Test (Refueling Outage)
OP-604	Diesel Generators A and B

No violations or deviations were identified.

6. Plant Support - Radiological Controls (71707)

Failure To Post A Response To A Radiological Working Condition Violation

On January 5, 1994, the inspectors observed that the licensee's response to violation 50-261/93-26-01 and 93-26-03 had not been posted as required by 10 CFR 19.11 (a)(4)(e). These violations involved inadequate control of locked high radiation area keys and improper control of a basket containing an irradiated bolt in the spent fuel pool. The licensee's response was dispatched on December 29, 1993. Hence, the Response was not posted within the 2-day timeframe specified in 10 CFR 19.11 (a)(4)(e). 10 CFR 19.11 requires that the licensee's response to a violation involving radiological working conditions be posted within 2 days of dispatch.

Contrary to the above, on January 5, 1994, the licensee failed to follow 10 CFR 19.11 (a)(4)(e), in that, the response to violations 50-261 93-26-01 and 93-26-03 were not posted within two working days of dispatch.

The inspectors noted that this violation was similar to NCV 92-24-03 documenting the failure to post a violation involving deficiencies associated with contaminated vacuum cleaner servicing in July 1992.

7. Review of Licensee Event Reports (92700)

The below listed LERs were reviewed to determine if the information provided met NRC requirements. The determination included: adequacy of description, verification of compliance with Technical Specifications and regulatory requirements, corrective action taken, existence of potential generic problems, reporting requirements satisfied, and the relative safety significance of each event.

LER 91-002, Reactor Trip Due To Lo-Lo Steam Generator Level.

LER 92-002, Failure To Test All Circuitry Associated With Auxiliary Feedwater Auto Start.

LER 92-015, Seismically Inoperable Service Water System Due To Corroded Piping.

LER-92-022 , Potential For ESF Inoperability Due To Procedure Defect.

LER-92-001, Degraded Condition Due To Inoperability Of Containment Isolation Valve.

The corrective actions for the above LERs have been completed and no violations or deviations were identified. These items are closed.

8. Licensee Action on Previous Findings (92701, 90702) (Followup)

(Closed) IFI 93-28-05, Documentation Of Lead-Lag Controller Accuracy.

Inspection Report 93-28 documents IFI 923-28-05, regarding an inspector request for documentation to support the lead-lag controller accuracy used in an error analysis of the pressurizer pressure instrumentation. The lead-lag controller accuracy used in the analysis was one percent instead of the two percent specified in MMM-006, Calibration Program.

On January 17, 1994, the inspectors were provided a copy of Engineering Evaluation, EE 94-012. This evaluation reviewed sixty-six calibration of lead/lag units. Based on this review, the engineering evaluation concluded that assigning a one percent calibration tolerance to the lead-lag controllers was acceptable.

Based on the information presented in the EE, the inspectors have no further questions. This item is closed.

(Closed) DEV 93-33-02, Failure To Install RHR Pump Suction Pressure Instrumentation As Committed To In Response To Generic Letter 88-17. The licensee performed an evaluation for Modification 1011, "Instrumentation for Mid-Loop Operation" and determined that the monitoring of RHR pump discharge pressure would be more appropriate. The monitoring was implemented as required during Refueling Outage 13 (Spring, 1991). This item is closed.

(Closed) VIO-92-28-02, SI-895K Valve Open When Safety Injection System Is In Standby Mode. Due to personnel error, open position was indicated in OP-202. The licensee has revised OP-202. The inspector reviewed the latest revision of OP-202, Revision 32, and found the position of SI-895K to be in the correct position of CLOSED. In addition, the individual involved has been counseled. This item is closed.

(Closed) VIO-92-31-01, The Contaminated Process Equipment Area (CPEA) Posting For The Charging Pump Room Entrance Door Was Removed. The corrective action includes revising The Lesson Plans For Contracted Health Physics Technicians to emphasize that, although CPEA designation is not standard to the industry, it is used at HB Robinson as part of the Contamination Control Program. This item is closed.

(Closed) VIO 92-02-01, Failure to Follow The Procedure When Stroke Timing The Primary Sampling System Containment Isolation Valve. The inspector reviewed OST-701, Inservice Inspection Valve Test, Revision 26, the latest revision. Changes have been made to reflect the current testing method. In addition, Valve Data Sheet in OST-701 has been revised to eliminate any inconsistencies discovered between the test data sheet and the test acceptance criteria. This item is closed.

9. Exit Interview (71701)

The inspection scope and findings were summarized on January 28, 1994, with those persons indicated in paragraph 1. The inspectors described the areas inspected and discussed in detail the inspection findings listed below and in the summary. Dissenting comments were not received from the licensee. The licensee did not identify as proprietary any of the materials provided to or reviewed by the inspectors during this inspection.

Item Number	Description/Reference Paragraph
NCV 94-03-01	Failure To Make Timely Notifications To The NRC Relative To Operator Termination And Response To A Violation
VIO 94-03-02	Failure To Employ Adequate Debris Intrusion Control Measures
VIO 94-03-03	Failure To Post Response To Radiological Working Conditions Violation

10. List of Acronyms and Initialisms

ACR	Adverse Condition Report
CCW	Component Cooling Water
CFR	Code of Federal Regulation
CPEA	Contaminated Process Equipment Area
DEV	Deviation
DG	Diesel Generator
EAC	Evaporative Air Conditioner
EDG	Emergency Diesel Generator
EE	Engineering Evaluation
ESF	Engineered Safety Features
GP	General Procedure
HNP	Harris Nuclear Plant
INPO	Institute of Nuclear Power Operations
LER	Licensee Event Report
MDAFW	Motor Driven Auxiliary Feedwater
MST	Maintenance Surveillance Test
NCV	Non-cited Violation
NI	Nuclear Instrumentation
NOV	Notice of Violation
OMM	Operations Management Manual
OP	Operating Procedure
OST	Operations Surveillance Test
PI	Pressure Indicator
PLP	Plant Program
RNP	Robinson Nuclear Project
SI	Safety Injection
TS	Technical Specification
URI	Unresolved Item
VIO	Violation