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

Report Nos.: 50-335/94-18 and 50-389/94-18

Licensee: Florida Power & Light Co
9250 West Flagler Street
Miami, FL 33102

Docket Nos.: 50-335 and 50-389 License Nos.: DPR-67 and NPF-16

Facility Name: St. Lucie 1 and 2

Inspection Conducted: July 31 - August 27, 1994

Inspectors: K.D. Landis 8-31-94
for S. A. Elrod, Senior Resident Inspector Date Signed

K.D. Landis 8-31-94
for M. S. Miller, Resident Inspector Date Signed

K.D. Landis 8-31-94
for R. S. Baldwin, Reactor Inspector Date Signed

Approved by: K. D. Landis 8/31/94
for K. D. Landis, Chief Date Signed
Reactor Projects Section 2B
Division of Reactor Projects

SUMMARY

Scope: This routine resident inspection was conducted onsite in the areas of plant operations review, maintenance observations, surveillance observations, plant support observations, and followup of previous inspection findings.

Backshift inspection was performed on August 20 and 21.

Results: Plant operations area:

Operations this period continued to be conducted in a safe and professional manner. New fuel movement was performed very well; however, a lack of grappling tool drawings was identified.

Maintenance and Surveillance area:

Maintenance observed during this period was conducted in a competent fashion. Good teamwork was noted in the licensee's response to the failure of the 2B EDG output breaker to close. Surveillance testing was performed well, with good communication and attention to detail.

Plant Support area:

The licensee's plant support functions continue to be effective.

In the areas inspected, violations or deviations were not identified.

REPORT DETAILS

1. Persons Contacted

Licensee Employees

D. Sager, St. Lucie Plant Vice President
C. Burton, St. Lucie Plant General Manager
* J. Scarola, Operations Manager and Acting Plant General Manager
R. Ball, Mechanical Maintenance Department Head
W. Bladow, Site Quality Manager
L. Bossinger, Electrical Maintenance Department Head
H. Buchanan, Health Physics Supervisor
* R. Church, Independent Safety Engineering Group Chairman
* R. Dawson, Maintenance Manager
* D. Denver, Site Engineering Manager
* J. Dyer, Maintenance Quality Control Supervisor
H. Fagley, Construction Services Manager
P. Fincher, Training Manager
R. Frechette, Chemistry Supervisor
K. Heffelfinger, Protection Services Supervisor
* J. Holt, Plant Licensing Engineer
* L. McLaughlin, Licensing Manager
G. Madden, Plant Licensing Engineer
K. Mohindroo, Site Engineering Supervisor
* C. Pell, Site Services Manager
* L. Rogers, Instrument and Control Maintenance Department Head
C. Scott, Outage Manager
J. Spodick, Operations Training Supervisor
D. West, Technical Manager
* J. West, Operations Supervisor
W. White, Security Supervisor
* W. Parks, Reactor Engineering Supervisor

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

NRC Personnel

* S. Elrod, Senior Resident Inspector
* R. Prevatte, Senior Resident Inspector
* M. Miller, Resident Inspector
* R. Baldwin, Regional Inspector, NRC Region II

Attended exit interview

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

2. Plant Status and Activities

a. Unit 1

Unit 1 began the inspection period at 100 percent power and remained at power throughout the period. Power was reduced at times due to condenser backpressure and the unit was reduced to 80% power on August 10 due to a DEH leak. The leak was repaired and the unit returned to 100% power on August 23. Unit 1 ended the inspection period in day 75 of power operation since being started up on June 8 and placed on-line June 11.

b. Unit 2

Unit 2 began the inspection period at 100 percent power and remained at power throughout the period. Power was reduced at times for condenser waterbox cleaning and turbine valve testing. Unit 2 ended the inspection period in day 42 of power operation since being started up on July 15.

c. NRC Activity

During this period, R. S. Baldwin of the Division of Reactor Safety, NRC Region II, was on-site from August 22 through 26. He performed routine resident inspections which are reported in this report.

3. Plant Operations (71707)

a. Plant Tours

The inspectors periodically conducted plant tours to verify that monitoring equipment was recording as required, equipment was properly tagged, operations personnel were aware of plant conditions, and plant housekeeping efforts were adequate. The inspectors also determined that appropriate radiation controls were properly established, critical clean areas were being controlled in accordance with procedures, excess equipment or material was stored properly, and combustible materials and debris were disposed of expeditiously. During tours, the inspectors looked for the existence of unusual fluid leaks, piping vibrations, pipe hanger and seismic restraint settings, various valve and breaker positions, equipment caution and danger tags, component positions, adequacy of fire fighting equipment, and instrument calibration dates. Some tours were conducted on backshifts. The frequency of plant tours and control room visits by site management was noted.

The inspectors routinely conducted partial walkdowns of ESF, ECCS, and support systems. Valve, breaker, and switch lineups as well as equipment conditions were randomly verified both locally and in the control room. The following accessible-area ESF system and area walkdowns were made to verify that system lineups were in accordance

with licensee requirements for operability and equipment material conditions were satisfactory:

- Unit 1 Auxiliary Feedwater System,
- Unit 1 Charging Pumps,
- Unit 2 Charging Pumps, and
- Unit 2 EDG Fuel Oil Transfer System.

b. Plant Operations Review

The inspectors periodically reviewed shift logs and operations records, including data sheets, instrument traces, and records of equipment malfunctions. This review included control room logs and auxiliary logs, operating orders, standing orders, jumper logs, and equipment tagout records. The inspectors routinely observed operator alertness and demeanor during plant tours. They observed and evaluated control room staffing, control room access, and operator performance during routine operations. The inspectors conducted random off-hours inspections to ensure that operations and security performance remained at acceptable levels. Shift turnovers were observed to verify that they were conducted in accordance with approved licensee procedures. Control room annunciator status was verified. Except as noted below, no deficiencies were observed.

(1). The inspector observed the operators shifting Unit 2 swing bus alignment and ICW/CCW C pump alignment per:

- OP 2-091023, Rev 6, "Transfer Electrical Alignment on the 4160V 2AB & 480V Load Center 2AB Busses."

- OP 2-0960020, Rev 16, "125 V DC Class 1E Power System Normal Operation."

Equipment operators performed valve manipulations properly in the correct order. The Nuclear Watch Engineer independently verified the alignments. The electrical alignments were properly made from the control room.

(2). The inspectors observed various aspects of the licensee receiving new Siemens fuel for the fall, 1994, Unit 1 refueling. Attributes inspected included physical condition of the truck and canisters; organization and control of receiving team activities and interface coordination between operations, reactor engineering, maintenance, health physics, and the fuel vendor representative; handling of canisters; opening canisters; initial inspections and unloading activities; use of the new fuel crane; proper fuel storage in the dry storage cells; and fuel inspection by the vendor and the reactor engineering group.

Fuel receipt was conducted per OP 1610020, Rev 14, "Receipt and Handling of New Fuel and CEAs." The prerequisite steps

provided centralized control of required preparations and preventive maintenances. Often this procedure directed performance of a preventive maintenance per another specific procedure. The inspectors considered this centralized control to be a strength. In addition to the prerequisite steps and the performance steps, the procedure provided data sheets to record inspections of the shipping containers, individual fuel assemblies, or CEAs; and for recording the disposition of anomalies found.

The inspectors witnessed the licensee unloading several shipping containers including containers 6455 and 6445. Fuel bundle movements observed included moving bundle S7 from the cask to cell B7 and moving bundle S6 from the cask to cell B8. The plant staff unloading the fuel was experienced and competent. They handled the fuel with great care and accurately positioned the bundles for insertion into the dry storage cells. During the unloading activities, the inspector had several specific observations.

- Several studs securing the strongback in a shipping container had metal "filings" adhering to the threads.

- Several shims at the top of the fuel bundles were made of galvanized steel. They were not covered by an inert material such as plastic but were separated from the bundle by a thick plywood shim. The sequence of shim removal was discovered to be important in prevention of contact between the galvanizing material and the fuel assembly. When the plywood shim was removed, some of the steel shims fell over onto the end of a bundle. In this case, the galvanizing material did not touch the fuel pins. Subsequent licensee review found that the vendor instructions addressed the sequence of removing shims.

- The grapple tool used to pick up the new fuel bundles had a safety sleeve intended to prevent the tool from rotating and unlatching during use. The inspector found that a missing pin (1/4 inch cap bolt) would no longer positively position the safety sleeve with respect to the grapple and prevent the grapple from rotating. Closer inspection found the grapple fingers slightly spread such that the safety sleeve fit tightly and could not be rotated by hand when engaged, somewhat mitigating the lack of a pin.

  Certain quality verifications had been conducted prior to the inspector identifying that the alignment pin was missing. Because of QC questioning, the grapple had recently been designated as a special lifting device, clearly identified, weight tested, and placed in that control program. Procedure step 8.1.5 had not yet been changed to require only a visual examination per the

special lifting device program. Procedure step 8.1.5 currently required a dye penetrant inspection of the grapple welds, but the missing pin was not recognized because a visual inspection was not required. Additionally, there was not a design drawing to compare the grapple to. Apparently, the grapple had been manufactured on site a number of years ago and successfully used since then.

At the end of the inspection, the licensee was obtaining drawings and, if necessary, associated engineering analyses and standards for the various grapples on site. The licensee plans to also change OP 1610020 to require visual inspection per the drawing. With regard to the missing anti-rotation pin, the licensee stopped the fuel receipt activities in progress at the time and replaced it prior to restarting.

During this inspection period, the inspectors reviewed the following clearance:

- 2-94-08-066

The posting of required notices to workers was reviewed.

c. Technical Specification Compliance

Licensee compliance with selected TS LCOs was verified. This included the review of selected surveillance test results. These verifications were accomplished by direct observation of monitoring instrumentation, valve positions, and switch positions, and by review of completed logs and records. Instrumentation and recorder traces were observed for abnormalities. The licensee's compliance with LCO action statements was reviewed on selected occurrences as they happened. The inspectors verified that related plant procedures in use were adequate, complete, and included the most recent revisions.

d. Management Changes

On August 5, the licensee announced the following management changes, effective September 1:

- C. A. Pell was named Outage Manager, reporting to the Site Vice President. Mr. Pell was formerly the Services Manager.
- J. A. West was named Services Manager. Mr. West was formerly the Operations Supervisor.
- C. H. Wood was named Operations Supervisor. Mr. Wood was formally Assistant Operations Supervisor.

- R. E. Dawson was named Licensing Manager. Mr. Dawson was formally Maintenance Manger.

- J. Marchese was named Maintenance Manager. Mr. Marchese was formally Construction Services Manager at Turkey Point.

In conclusion, operations this period continued to be conducted in a safe and professional manner. New fuel movement was performed very well; however, a lack of grappling tool drawings was identified.

4. Maintenance and Surveillance (62703, 61726)

a. Maintenance Observations

Station maintenance activities involving selected safety-related systems and components were observed/reviewed to ascertain that they were conducted in accordance with requirements. The following items were considered during this review: LCOs were met; activities were accomplished using approved procedures; functional tests and/or calibrations were performed prior to returning components or systems to service; quality control records were maintained; activities were accomplished by qualified personnel; parts and materials used were properly certified; and radiological controls were implemented as required. Work requests were reviewed to determine the status of outstanding jobs and to ensure that priority was assigned to safety-related equipment. Portions of the following maintenance activities were observed:

(1). NPWO 3505, Eddy Current Inspection of Unit 1 Replacement Reactor Vessel Studs

The licensee has obtained sufficient spare reactor vessel studs to allow refurbishment and testing be performed between refueling outages, rather than during the refueling schedule critical path. The eddy current inspection was being performed in the Unit 2 fuel receipt bay by the licensee's NDE team from the materials laboratory in West Palm Beach. The studs were stored vertically in a 20-stud carrier rack. Since this was a wet process, the carbon steel studs quickly developed surface rust in the thread area. Mechanical maintenance persons were on hand to represerve the studs when the inspection of that group was complete. Inspection attributes included stud preservation, thread protection using sleeves, care by the eddy current operator stationed on top of the studs, and radiological control activities by mechanics. The activities observed were being performed in a competent manner.

(2). NPWO 66/0060, 2B EDG Output Breaker Failure to Close

The inspector witnessed portions of the troubleshooting effort for the 2B EDG output breaker. The breaker, a Westinghouse Model 50DHP250, failed to close during a surveillance test of

the 2B EDG on August 24. Work was performed per MP 920069, revision 2, "Troubleshooting 4KV/6.9KV Breaker Failures." The inspector noted a methodical approach to the problem, with electricians and engineers working well together to ensure that all available electrical checks were performed prior to racking the breaker out for testing.

Electrical continuity and resistance checks indicated that no control circuitry failures existed. Upon removing the breaker from the cubicle, a pair of loose connections were identified and corrected, however the breaker had been successfully cycled several times following removal from the cubicle prior to the identification, indicating that the loose connections were not the root cause of the problem.

The breaker was returned to its racked-in position and the EDG was started. The breaker again failed to close; however, engineers observing the breaker locally noted that contacts on a Westinghouse model CVE synchronism check relay failed to change state, thus prohibiting breaker operation. The relay had been tested during the troubleshooting evolution and was found to be slightly out of tolerance on pickup voltage (100V vs. 94 +/- 4) and time delay (3.55 seconds vs. 2.8 seconds +/- 10%). Both parameters were returned to acceptable values. Indications were that the EDG and the B ECCS bus were not in an acceptable band of synchronism for a long enough period to allow the relay to make up a permissive signal for breaker closure before the phase angle differential exceeded the relay's 20 degree closing angle setpoint. Operators tried again to close the breaker, with the incoming and running phases more closely matched, and the breaker was successfully closed.

The inspector concluded that a combination of CVE relay setpoints and operator action was responsible for the failure of the breaker to close on previous attempts. The time delay of the CVE relay, coupled with its closing angle, required very close synchronism between off-site power and the 2B EDG. While the as-found conditions of the relay may have hampered attempts to close the breaker prior to the troubleshooting effort, the two closing attempts after the evolution, the first unsuccessful and the second successful, indicated that operators had failed to match frequencies closely enough prior to attempting to close the output breaker.

The inspector found the evolution to be well-coordinated between Operations, Electrical Maintenance, and Protection and Control. Ample engineering support to the troubleshooting effort was available. Those involved in the troubleshooting effort were methodical and took care to examine all possible evidence before removing the breaker from its cubicle.

(3). NPWO 0446, Nitrogen Fill of 2B Charging Pump Pulsation Dampeners.

On August 23, the inspector observed the maintenance action of filling the suction and discharge pulsation dampeners (accumulators) on the 2B Charging pump. Maintenance personnel completed this task without the procedure present at the job location. The inspector reviewed the procedure and verified that the procedure was completed without error. It was necessary to fill only the discharge pulsation dampener.

Upon review of the NPWO, the inspector noted that the NPWO contained a document called the Training Qualification Information (TQI) sheet which did not include the name of the principle maintenance person performing this task. However, the other maintenance person involved in the task was listed on the TQI sheet. Their supervisor was questioned about this apparent discrepancy. The supervisor stated that this form was to be used for information only and was not inclusive. Given that the TQI did not include all maintenance personnel qualified to perform the task required of the NPWO, the inspector found its usefulness questionable.

The inspector discussed this issue with the Mechanical Maintenance Supervisor, who stated that the TQI form had been superceded by a database which was maintained by the Training Department. He further stated that the TQI form was produced automatically by the computer program which generated NPWOs and that changes to the program were pending. The inspector reviewed ADM 0010432, rev 71, "Nuclear Plant Work Orders," which stated that the Training Department's list of qualified personnel was to be used as the source of qualification information. The Mechanical Maintenance Supervisor stated that he would provide additional guidance to maintenance planners regarding the use and inclusion of TQIs in work package preparation.

The Mechanical Maintenance Supervisor stated that work on the charging pump accumulators was not covered in pump maintenance training as the accumulators were not integral to the pumps. Thus, the status of the workers' qualifications with respect to pumps should not be of issue. The inspector agreed and found that the level of detail contained in the NPWO was sufficient for journeymen maintenance personnel.

b. Surveillance Observations

Various plant operations were verified to comply with selected TS requirements. Typical of these were confirmation of TS compliance for reactor coolant chemistry, RWT conditions, containment pressure, control room ventilation, and AC and DC electrical sources. The inspectors verified that testing was performed in accordance with

adequate procedures, test instrumentation was calibrated, LCOs were met, removal and restoration of the affected components were accomplished properly, test results met requirements and were reviewed by personnel other than the individual directing the test, and that any deficiencies identified during the testing were properly reviewed and resolved by appropriate management personnel. The following surveillance tests were observed:

(1). Containment Anomalies Inspection

On August 23, the inspector accompanied HP and Operations personnel during a containment anomalies inspection conducted in accordance with AP 2-0010125, revision 50, "Schedule of Periodic Tests, Checks, and Calibrations." HP coverage, including pre-job briefing and surveys in containment was good. Inspections performed were thorough and were successful in identifying a minor seat leak in V-2475, a drain valve for PDIS-2216. Boron deposits and accumulated water indicated that the leak was minor in nature, with only one drop observed in approximately 5 minutes of observation. The operator performing the inspection was able to effect minor movement in the valve stem while checking the valve shut. The valve was noted for a followup check during the next containment entry.

(2). OP 2-2200050B, Rev 11, "2B Emergency Diesel Generator Periodic Test and General Operating Instructions"

The inspectors witnessed portions of this surveillance test, performed August 24. The test incorporated a retest of the EDG following the installation of a permanent integrated ESF test connection per PC/M 217.293. The connection served to allow a non-intrusive method of connecting EDG voltage and frequency strip chart recorders and a start-signal-to-breaker-close-in timer to the EDG to obtain data during the 18 month integrated safeguards test performed each outage to satisfy TS surveillance requirement 4.8.1.1.2.e. Prior to the implementation of this PC/M, the licensee installed jumpers within the EDG and other electrical cabinets and routed them to the instrumentation.

The inspector reviewed the retest procedure and found it to be adequate to verify proper PC/M implementation. The electrical maintenance engineer and electricians performing the test were familiar with their required actions and had coordinated the evolution with the SNPO performing the actual EDG surveillance test to ensure compatibility of actions.

The inspector accompanied the SNPO during pre-start checks and found that the SNPO did a thorough job in completing the required checks without error. The SNPO noted that step 8.1.(4)(2)b required logging of governor oil sight glass levels when the EDG was running at 900 rpm. The SNPO made a note on

the procedure to direct him back to this step when the EDG was at 900 rpm. As written, the procedure did not direct the SNPO back to step 8.1.(4)(2)b to obtain the required information. During the test, the EDG started and accelerated properly, operating parameters assumed normal values, and the instrumentation fed from the newly-installed test connection functioned as expected. When control room operators attempted to synchronize the EDG with the grid, the output breaker failed to close. Six attempts were made without success. Ultimately, the EDG was shut down without satisfactorily performing the surveillance. Troubleshooting of the subject breaker was performed (see paragraph 4.a.(2)) and the surveillance was satisfactorily completed later that evening.

(3). AP 2-0420050, Rev. 36, "Containment Spray and Iodine removal System - Periodic Test", Unit 2 B Containment Spray pump.

The inspector witnessed portions of this surveillance test, performed on August 23. This was a retest to validate the results of a previously run surveillance in which the 2B Containment Spray pump was placed in a ASME Section XI, Alert status. The Alert status was based upon discharge pressure which was 1 psig above the allowed tolerance value. As a result of the Alert status, the licensee is required, by section IWP-3230 of the ASME Boiler and Pressure Vessel Code, to double the normal frequency of testing (normally once per quarter) until the cause of the condition is determined and the condition corrected.

The SNPO conducted the surveillance with Technical Staff engineers observing. The SNPO followed the procedure which required slowly opening the inlet to the discharge pressure gage in order to obtain the discharge pressure reading. The discharge pressure gage had a significant oscillation which required the SNPO to throttle the gage isolation valve in order to dampen the pressure oscillation. The discharge pressure was once again in the upper band of the acceptance criteria. The pump was left in the Section XI Alert status and will be retested in approximately 5 weeks.

While touring the area, the inspector observed boron crystals on the packing of valve V07132, 2B Containment Recirculation Isolation valve. Unit 2 control room operators were notified of this condition. The inspector will follow subsequent code runs of this pump.

(4). AP 1-0010125A, Rev. 35, "Surveillance Data Sheets" 1 HPSI Valve Stroke Times

The inspector witnessed portions of this surveillance test performed on August 23. Data sheets #33 and 8B were used. Local operation of HCV-3626 was observed. Valve HCV-3626 moved

freely and without apparent binding. The SNPO entered a contaminated area in order to observe movement of valves HCV-3626 and HCV-3636. In doing so, the SNPO used the required radiological controls in entering the contaminated area. The test resulted in satisfactory valve performance.

(5). OP 1-0110050, Rev. 29, Control Element Assembly Periodic Exercise

The inspector witnessed portions of this surveillance test performed on Unit 1 on August 25. The procedure was adequate in exercising the control element assembly during the periodic exercise. Communications between the control room operator and an I&C technician obtaining data in the cable spreading room was considered to be good. The RCO methodically moved each CEA and then signed each step prior to advancing to the next CEA.

In conclusion, maintenance observed during this period was conducted in a competent fashion. Good teamwork was noted in the licensee's response to the failure of the 2B EDG output breaker to close. Surveillance testing was performed well, with good communication and attention to detail.

5. Plant Support (71750)

a. Fire Protection

During the course of their normal tours, the inspectors routinely examined facets of the Fire Protection Program. The inspectors reviewed transient fire loads, flammable materials storage, housekeeping, control hazardous chemicals, ignition source/fire risk reduction efforts, and fire barriers.

b. Physical Protection

The inspectors verified by observation during routine activities that security program plans were being implemented as evidenced by: proper display of picture badges; searching of packages and personnel at the plant entrance; and vital area portals being locked and alarmed.

c. Radiological Protection

Radiation protection control activities were observed to verify that these activities were in conformance with the facility policies and procedures, and in compliance with regulatory requirements. These observations included:

- Entry to and exit from contaminated areas, including step-off pad conditions and disposal of contaminated clothing;
- Area postings and controls;
- Work activity within radiation, high radiation, and contaminated areas;

- Radiation Control Area (RCA) exiting practices; and,
- Proper wearing of personnel monitoring equipment, protective clothing, and respiratory equipment.

The inspector reviewed HPP-3, revision 1, "High Radiation Areas," and verified that locked high radiation area key control was being accomplished in accordance with the procedure. No deficiencies were identified.

In summary, the licensee's plant support functions continue to be effective.

6. Followup of Unresolved Items (Units 1 and 2) (92901)

(Closed - Units 1 & 2) URI 94-14-01, Use of N/A by Operators in Procedural Steps

This item was opened when the inspector noted that a surveillance test, required by plant procedures, could not be performed due to equipment inoperability. As a result of the inoperability, Operations management directed, via Night Order, that the procedure directing the surveillance be modified via TC to remove the surveillance requirement. The inspector found that the procedure had not been modified and that operators had been annotating the applicable portion of the procedure as "N/A" and recording the reason. When questioned as to the propriety of "N/A-ing" procedure steps, operators stated that, while they could not cite written management guidance allowing the practice, it was an established practice. The inspector found that this practice ran counter to the requirements of ADM 0010120, revision 61, "Conduct of Operations," which stated in part that "If a procedure in use can NOT be complied with due to a technical inaccuracy, system status, inoperative components of other reasons, a temporary change shall be initiated..."

In continuing to review the issue, the inspector found that ADM 0010129 Appendix P, "Surveillance Testing," step 3 stated that "If a step is NOT completed in the test procedure for any reason, the reason shall be recorded on the procedure." The inspector found that, in the case of the surveillance test described in this URI, operator action was consistent with the allowance of Appendix P of ADM 0010129; however, operators appeared to be unaware of the allowance.

The inspector discussed the issue with Operations management; particularly the concern that, if operators were unaware of allowances afforded for not performing procedural steps, they may not be aware of when such allowances do not apply. Operations management acknowledged that there may be a lack of consistency from operator to operator as to when a procedural step may be "N/A'd." By the end of the inspection period, ADM 0010120 had received a TC which provided guidance on when "N/A" may be used in performing procedural steps.

Inspection determined that the guidance for the use of "N/A" was adequate, and revealed that operators did not violate ADM 0010129 in the

use of "N/A" with accompanying comments. This item is closed. The inspector will continue to follow the licensee's actions with regard to employing guidelines for the use of "N/A" in non-surveillance procedures.

7. Followup of Corrective Actions for Violations and Deviations (92901)

(Closed Unit 1) VIO 50-335/93-301-02, Failure to follow procedure which stated the requirement to follow procedural writing criteria.

The inspector reviewed the change to procedure 1-0030135, Rev. 19, "Control Room Inaccessibility", Appendix J, and Emergency Operating Procedure 99, Appendix U, "Manual Operation of the Atmospheric Dump Valves." The procedural changes to address local operation of the Atmospheric Dump Valves adequately followed the procedural writing criteria.

Upon further review of 1-0030135, Rev. 19, "Control Room Inaccessibility", Appendix A, step H is first stated on page 13 and is repeated on page 14. This typographical error was pointed out to the Operations Supervisor.

8. Exit Interview

The inspection scope and findings were summarized on August 25, 1994, with those persons indicated in paragraph 1 above. The inspector described the areas inspected and discussed in detail the inspection results listed below. Proprietary material is not contained in this report. Dissenting comments were not received from the licensee.

ITEM NUMBER	STATUS	TYPE	DESCRIPTION and REFERENCE
335/93-301-02	CLOSED	VIO	Failure to Follow Procedural Writing Criteria (para 7)
335,389/94-14-01	CLOSED	URI	Use of N/A by Operators in Procedural Steps (para 6)

9. Abbreviations, Acronyms, and Initialisms

ADM	Administrative Procedure
CCW	Component Cooling Water
CEA	Control Element Assembly
DEH	Digital Electro-Hydraulic (turbine control system)
ECCS	Emergency Core Cooling System
EDG	Emergency Diesel Generator
ESF	Engineered Safety Feature
HCV	Hydraulic Control Valve
ICW	Intake Cooling Water
LCO	TS Limiting Condition for Operation
NPWO	Nuclear Plant Work Order
NRC	Nuclear Regulatory Commission

RCO	Reactor Control Operator
RWT	Refueling Water Tank
SNPO	Senior Nuclear Plant [unlicensed] Operator
TC	Temporary Change
TQI	Training Qualification Information
URI	[NRC] Unresolved Item
VIO	Violation (of NRC requirements)