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

Report Nos.: 50-259/93-28, 50-260/93-28, and 50-296/93-28

Licensee: Tennessee Valley Authority
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1101 Market Street
Chattanooga, TN 37402-2801

Docket Nos.: 50-259, 50-260, and 50-296

License Nos.: DPR-33, DPR-52, and DPR-68

Facility Name: Browns Ferry Units 1, 2, and 3

Inspection at Browns Ferry Site near Decatur, Alabama

Inspection Conducted: July 17 - August 20, 1993

Inspector: C. A. Patterson, Senior Resident Inspector — Date Signed 9/3/93

Accompanied by: J. Munday, Resident Inspector
R. Musser, Resident Inspector
G. Schnebli, Resident Inspector

Approved by: Paul J. Kellogg, Chief, Reactor Projects, Section 4A, Division of Reactor Projects — Date Signed 9/3/93

SUMMARY

Scope: This routine resident inspection included surveillance observation, maintenance observation, operational safety verification, measuring and test equipment, Unit 3 restart activities, reportable occurrences, action on previous inspection findings, and site organization.

One hour of backshift coverage was routinely worked during the work week. Deep backshift inspections were conducted on July 25, 1993, and August 8, 1993.

Results: One violation was identified by an NRC inspector for failure to control measuring and test equipment, paragraph 5. Four examples were identified of equipment not being tracked as required by plant procedures. The licensee conducted an inventory and identified an additional 73 items not properly tracked. A similar violation, 92-21-03, was identified for failure to adequately disposition nonconforming measuring and test equipment. The site quality assurance organization has had several findings in this area over the past several years but deficiencies continue to exist.

One violation was identified by a NRC inspector for failure to control transient combustible material required by the Fire Protection Program, paragraph 4. Six electrical cable reels were moved into the Unit 2 reactor building without the required permit and a fire watch. This violation is similar to a violation in inspection report 92-37.

One noncited violation was identified by the licensee for failure to have an operable radiation monitor during a radioactive release, paragraph 3. The monitor was unknowingly inoperable because the monitor probe was not properly reinstalled after a surveillance procedure. The licensee conducted an incident investigation of the event with comprehensive corrective action.

REPORT DETAILS

1. Persons Contacted

Licensee Employees:

*O. Zeringue, Vice President
*J. Scalice, Plant Manager
J. Rupert, Engineering and Modifications Manager
*R. Baron, Quality and Licensing Manager
D. Nye, Recovery Manager
M. Herrell, Operations Manager
J. Maddox, Engineering Manager
*M. Bajestani, Technical Support Manager
A. Sorrell, Chemistry and Radiological Controls Manager
C. Crane, Maintenance Manager
P. Salas, Licensing Manager
*R. Wells, Compliance Manager
J. Corey, Radiological Control Manager
J. Brazell, Site Security Manager

Other licensee employees or contractors contacted included licensed reactor operators, auxiliary operators, craftsmen, technicians, and public safety officers; and quality assurance, design, and engineering personnel.

NRC Personnel:

P. Kellogg, Section Chief
*C. Patterson, Senior Resident Inspector
*J. Munday, Resident Inspector
*R. Musser, Resident Inspector
*G. Schnebli, Resident Inspector

*Attended exit interview

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

2. Surveillance Observation (61726)

The inspectors observed and/or reviewed the performance of required SIs. The inspections included reviews of the SIs for technical adequacy and conformance to TS, verification of test instrument calibration, observations of the conduct of testing, confirmation of proper removal from service and return to service of systems, and reviews of test data. The inspectors also verified that LCOs were met, testing was accomplished by qualified personnel, and the SIs were completed within the required frequency. The following SIs were reviewed during this reporting period:

a. SLC Operability Surveillance

On July 19, 1993 the inspector witnessed portions of the performance of 2-SI-4.4.A.1, Standby Liquid Control Functional Test. This test verifies the operability of the SLC pumps in conformance with the requirements specified in TS 4.4.A.1, 4.4.B.1, and 4.6.G.1. The results of the surveillance indicated that the flow rate of pump B fell outside the acceptable range of 43.7 - 50.0 gpm. The flow rate of the pump was measured using two different methods, one using an ultrasonic flow meter and the other by measuring the level decrease over time in the tank the pump takes suction on. The flow meter indicated a flow rate of 52.0 gpm while the calculated flow indicated 51.7 gpm. The inspector questioned the system engineer about the increased capacity of the pump since the last surveillance. He stated that the pump had been re-built during the outage and new baseline data obtained during the performance of the surveillance following the maintenance. He indicated that he suspects the capacity had not actually changed since the last surveillance but could not positively confirm this. Based on positive verification of flow by two methods on July 19, 1993, and no reason to suspect pump degradation, the licensee again calculated a new acceptable range for flow, 48.6 - 52.7 gpm. Based on the new flow requirement the B pump was acceptable and the SI was completed satisfactory. The inspector referenced ASME Section XI Subsection IWP-3000 and verified this method of establishing baseline data was acceptable. No other deficiencies were noted.

b. Core Spray Sparger Break Detector Surveillance

On July 19, 1993 the inspector witnessed portions of the performance of 2-SI-4.2.B-24(I), Core Spray Sparger To Reactor Pressure Vessel Differential Pressure Calibration 2-PDIS-75-28. This instruction partially satisfies the requirements of TS 3.2.B and 4.2.B. The surveillance channel checks points on the gauge with a test gauge as pressure is increased to full range and then again as pressure is decreased. The surveillance has two ranges that the points must fall within, one verifies TS operability and the other ensures the point is adjusted as close as possible to the center of the band and is known as "leave as is." The data taken was within the acceptable range to verify operability but was not in the range to leave the instrument as found. Attempts were made to adjust the meter to within the "leave as is" but were unsuccessful. Engineering was contacted and decided to revise the procedure to expand the acceptable "leave as is" range. The procedure was revised, the instrument calibrated to within the appropriate tolerances, and the surveillance completed satisfactorily. The inspector reviewed the safety analysis for the procedure revision as well as the vendor manual and noted no discrepancies. No other exceptions to the surveillance were noted.

No violations or deviations were identified in the Surveillance Observation area.

3. Maintenance Observation (62703)

Plant maintenance activities were observed and/or reviewed for selected safety-related systems and components to ascertain that they were conducted in accordance with requirements. The following items were considered during these reviews: LCOs maintained, use of approved procedures, functional testing and/or calibrations were performed prior to returning components or systems to service, QC records maintained, activities accomplished by qualified personnel, use of properly certified parts and materials, proper use of clearance procedures, and implementation of radiological controls as required.

Work documents were reviewed to determine the status of outstanding jobs and to assure that priority was assigned to safety-related equipment maintenance which might affect plant safety. The inspectors observed the following maintenance activities during this reporting period:

a. MSIV Limit Switch Failure

On July 25, 1993, at approximately 4:55 a.m., the Unit 2 operating shift noted that the valve position indicating lights for the 'D' outboard MSIV were both lit. At the time of the discovery Unit 2 was operating at 100 percent power with steam flow being equally distributed among the four steam lines. Because steam flow in the 'D' line was approximately the same as the other three steam lines, the operators felt assured that 'D' outboard MSIV was still in the full open position. Additionally, the operating crew verified that the RPS relays associated with the involved MSIV were in their normal energized state which further lended credence to the valve having not changed position. A malfunctioning limit switch was thought to be the cause of the double light indication.

The MSIVs were tested on July 24, 1993, in accordance with procedure 2-SI-4.1.A-11(I), MSIV Closure-RPS Trip Functional Test. This test "slow closes" each MSIV approximately 10 percent and ensures that the RPS relays associated with the valve de-energize and that the valve position indicating lights demonstrate valve movement. No deficiencies were noted during this surveillance related to valve position lights.

On July 26, 1993, the licensee issued WO 93-09611-00 to cycle the 'D' outboard MSIV in accordance with applicable portions of 2-SI-4.1.A-11(I). This effort was to be performed in order to hopefully "free up" what was thought to be a stuck or malfunctioning limit switch. Prior to the performance of the evolution, the ASOS briefed the involved personnel to ensure that the evolution was thoroughly understood. The operators "slow closed" the 'D' outboard MSIV for approximately 30 seconds (approximately equal to 10 percent closed). As expected, the

associated RPS relays de-energized during the valves closure and re-energized as the valve was returned to the full open position. However, the position indicating lights never changed state throughout the entire evolution. The valve's position indicating limit switch is thought to be malfunctioning and will be repaired or replaced during a future power reduction/forced outage.

b. Inoperable Liquid Radwaste Effluent Radiation Monitor

On July 13, 1993, the contents of the Floor Drain Sample Tank were released to the Tennessee River while the radiation monitor for this release path, 0-RM-90-130, was inoperable. On July 12, 1993, the detector was removed from service for a setpoint adjustment in accordance with WO 93-09182-00. Following completion of this work, 0-SI-4.2.D.1, Liquid Radwaste Monitor Calibration/Functional Test, was performed satisfactorily as post maintenance testing. Operations declared the monitor operable at 0230 on July 13, 1993. At 2200 on July 13, 1993, the floor drain sample tank was released via this pathway; however, following the release, it was discovered that the detector had not been reinstalled in the detector housing during performance of the setpoint adjustment, as required. With the detector not installed in the detector housing the release path would not have automatically isolated in the event the radiation levels of the release were to increase to the trip setpoint. With the monitor out of service, TS Table 3.2.D, allows radwaste discharges to be made via this pathway, provided two independent samples of the tank are analyzed in accordance with the sampling and analysis program specified in the REM and two qualified station personnel independently verify the release rate calculations and valve lineup before the discharge. Because the monitor was thought to be operable, these compensatory actions were not performed. However, the release was not unmonitored, 0-SI-4.8.A.1-1, Release Procedure - Liquid Effluents, was performed in conjunction with the release and serves to verify that the MPC limits required by TS 3.8.A.1, are not exceeded. Upon discovery of this condition, the detector was reinstalled and the surveillance re-performed. Failure to place the detector back into the detector housing during the performance of the surveillance is a violation but will not be subject to enforcement because the licensee's effort in identifying and correcting the violation met the criteria specified in Section VII.B of the Enforcement Policy. This matter is identified as NCV 259, 260, 296/93-28-01, Inoperable Radwaste Effluent Radiation Monitor.

One noncited violation was identified in the Maintenance Observation area.

4. Operational Safety Verification (71707)

The NRC inspectors followed the overall plant status and any significant safety matters related to plant operations. Daily discussions were held with plant management and various members of the plant operating staff.

The inspectors made routine visits to the control rooms. Inspection observations included instrument readings, setpoints and recordings, status of operating systems, status and alignments of emergency standby systems, verification of onsite and offsite power supplies, emergency power sources available for automatic operation, the purpose of temporary tags on equipment controls and switches, annunciator alarm status, adherence to procedures, adherence to LCOs, nuclear instruments operability, temporary alterations in effect, daily journals and logs, stack monitor recorder traces, and control room manning. This inspection activity also included numerous informal discussions with operators and supervisors.

General plant tours were conducted. Portions of the turbine buildings, each reactor building, and general plant areas were visited. Observations included valve position and system alignment, snubber and hanger conditions, containment isolation alignments, instrument readings, housekeeping, power supply and breaker alignments, radiation and contaminated area controls, tag controls on equipment, work activities in progress, and radiological protection controls. Informal discussions were held with selected plant personnel in their functional areas during these tours.

a. Unit Status

Unit 2 operated continuously at power during this period without any significant problems. The unit was online for 78 days at the end of the period.

b. Transient Combustibles

On July 29, 1993, the inspector identified six partial reels of electrical cable located in the unit 2 reactor building without the required transient combustible permit and continuous fire watch. The inspector contacted the Fire Protection group who posted a continuous fire watch. They stated they had not been informed that cable was placed in the building. The cable was used to implement DCN W7728A. TS 6.8.1.1.f, requires that written procedures be established, implemented, and maintained covering implementation of the Fire Protection Program. Section I-C of the Fire Protection Report Volume 2, step 5.1.1, states that in critical areas, any combustible material that is not permanently installed shall be designated as a transient combustible. Furthermore, a transient combustible permit shall be initiated and compensatory measures taken as required. Failure to initiate the required transient combustible permit and post a continuous fire watch is a violation of these requirements and is identified as VIO 259, 260, 296/93-28-02, Failure To Control Transient Combustibles. A similar violation was issued November 27, 1992, in IR 92-37, for failure to adequately control transient combustibles.

One violation was identified in the Operational Safety Verification area.

5. Measuring and Test Equipment

On July 27, 1993, the inspector noted an instrument cart containing electrical test equipment left unattended in the 1A DG room. On July 28, 1993, the inspector noted another cart containing electrical test equipment left unattended in the Unit 3 DG building. The equipment on both of the carts was controlled under the Measuring and Test Equipment program. The licensee determined the equipment belonged to the Customer Group and was used during DG testing. The inspector reviewed the M&TE usage logs for the equipment which indicated it had been checked back into the control area. The inspector questioned the licensee about maintaining positive control of the equipment and storing the equipment in a suitable environment, as required by the M&TE program. While the DG buildings are not the designated control areas for this equipment, the licensee stated that occasionally it will be left there if the equipment is to be used to test more than one DG. The licensee moved the equipment to the designated control area. The inspector reviewed the vendor documents describing the environment the equipment was to be stored in and verified the DG building was suitable. Further discussion with the licensee concerning the environment of the storage facility indicated that while the environmental conditions required for each piece of M&TE was not specifically verified they believe that no problems exist in this area. This is based on the room being kept at a controlled temperature and low humidity which the licensee stated is generally the limiting factor for storage of equipment. The inspector randomly selected various M&TE and verified this was accurate.

On August 4, 1993, the inspector noted a thermometer, labelled E10120, being used in the plant which was under the control of the M&TE program. The procedure for which the thermometer was needed, listed this thermometer as well as another, labelled 542968, as being used to support the procedure. The inspector questioned the M&TE issue personnel about the status of these two thermometers. E10120 was identified in the usage log as having been checked out on May 8, 1993, but did not indicate when it would be returned. However, the inspector was later informed that the log was wrong and that the thermometer had actually been lost. The inspector informed the M&TE coordinator of the location of the thermometer and it was retrieved and dispositioned. The usage log indicated that thermometer 542968 had been returned to the control area but could not be immediately located; however, it was found in the control area some time later. In addition, the inspector also noted three other instruments, E10258, E10595, and E10647, had been checked out for long term use without indicating the dates they would be returned. The M&TE coordinator later informed the inspector that while two of the instruments were still being used, E10595 was actually located in the control area. The usage logs for these instruments were also corrected and the discrepancy dispositioned. In addition, the licensee performed an inventory of all the M&TE and out of approximately four thousand items, seventy-three could not be accounted for. The

licensee intends to generate out-of-tolerance investigations for these items.

SSP-6.7, Control of Measuring and Test Equipment, section 3.9, states that M&TE is allowed to be checked out on a shift by shift basis. If the equipment is needed for a longer period of time it can be kept longer but the user must provide an expected return date on the usage log. Section 3.11 states that the user of M&TE shall provide the work document the equipment will be used for, the organization responsible for the equipment, the expected duration of use, and information concerning each individual use of the equipment. It further states that control of the M&TE will be maintained while it is being used. If the equipment will be left unattended it must be tagged to identify the controlling document and the responsible individuals. When the equipment is returned, the procedure states that all usages shall be documented on the usage log. Contrary to these requirements, electrical M&TE was found in the plant which was left unattended and not tagged as such and was kept for greater than one shift without the proper documentation. In addition, the usage log identified this equipment as having been returned to the control area. Four pieces of M&TE were checked out and kept for periods of one to three months without the proper documentation. Of these four, one of the items was also identified as lost and one was actually found in the control area. The lost M&TE was found by the inspector and secured by the licensee. 10 CFR 50, Appendix B, Criteria XII requires that measures shall be established to ensure that tools, gauges, instruments, and other measuring and test devices used in activities affecting quality are properly controlled, calculated, and adjusted to maintain accuracy within specified limits. SSP-6.7, Control of Measuring and Test Equipment implements these requirements. Collectively, these items indicate a lack of control of M&TE and is identified as VIO 259, 260, 296/ 93-28-03, Failure to Control M&TE.

Additional examples for failure to adequately control M&TE include, a QA audit conducted in July, 1991, which identified examples of M&TE usages that were not logged in the usage logs. This was documented as CAQR BFSCA910168107. In November, 1991, additional examples were identified and the CAQR was revised to include them. In June 1992 a violation was issued for failure to adequately disposition M&TE found to be out of tolerance.

6. Unit 3 Restart Activities (30702, 37828, 61726, 62703, 71707)

The inspector reviewed and observed the licensee's activities involved with the Unit 3 restart. This included reviews of procedures, post-job activities, and completed field work; observation of pre-job field work, in-progress field work, and QA/QC activities; attendance at restart craft level, progress meetings, restart program meetings, and management meetings; and periodic discussions with both TVA and contractor personnel, skilled craftsmen, supervisors, managers and executives.

The licensee is still working on the Unit 3 Recovery Schedule which should be finalized this month with a meeting scheduled on September 7, 1993, between licensee and NRC management to discuss the schedule and long range plans. The inspectors will continue to follow the progress of the schedule. Currently, the work is being scheduled and tracked by a Summer Semester Schedule which provides a three month look ahead for both maintenance and modifications. Progress on the three month schedule will be used as input to more accurately project work duration on the long range schedule.

Construction activities continue to increase with the completion of the Unit 2 cycle 6 refueling outage. Major activities in progress include: CRDR work in the control room panels; fire protection systems; seismic upgrades; and pipe supports.

7. Reportable Occurrences (92700)

The LERs listed below were reviewed to determine if the information provided met NRC requirements. The determinations included the verification of compliance with TS and regulatory requirements, and addressed the adequacy of the event description, the corrective actions taken, the existence of potential generic problems, compliance with reporting requirements, and the relative safety significance of each event. Additional in-plant reviews and discussions with plant personnel, as appropriate, were conducted.

a. (CLOSED) LER 259/91-06, Unplanned Engineered Safety Feature Actuation During Maintenance Activities Due to Proximity of Components.

On May 7, 1991, an initiation of the CREV system occurred when maintenance personnel performing work in panel 25-165 inadvertently bumped relay CR-A, which is associated with radiation monitor 0-RM-90-259. The bumping of the relay caused its contacts to close and initiate the CREV system and a high radiation alarm in the main control room.

In response to this event, the licensee evaluated the need for a design change to relocate the components in panel 25-165 and to provide a cover for the CR-A relay. Since this matter was an isolated event, the licensee determined that no design change nor any covers would be provided for the CR-A relay. A second proposed corrective action involved adding a caution statement to the System Instrument Maintenance Index, 0-SIMI-31B, to inform personnel of the potential ESF actuation in the event that the relays are bumped. This action was performed. The final proposed corrective action was that of labeling the involved relays. This action was verified by the inspector.

b. (CLOSED) LER 50-296/92-004, Chemical Release In Unit 3 Reactor Building Forced An Evacuation Of Compensatory Action Fire Watches Leading To A Violation Of Technical Specifications.

On November 4, 1992, all compensatory fire watches, required by TS, were evacuated from the Unit 3 reactor building due to a chemical release. The release was caused by an unexpected exothermic reaction from an epoxy grout compound. Following removal of the remaining grout and ventilating the area, the fire watches were returned to their posts.

The epoxy is supplied as a 30 pound kit with premixed parts and mixing only part of the kit was not recommended by the manufacturer. The craft performing the work mixed the entire kit but put the unused portion in a closed container which prevented heat dissipation and caused the release of smoke and vapor. The licensee determined the root cause of the event to be inadequate warning information and proper instructions from the manufacturer. Corrective actions included the manufacturer of the grout providing hands-on training to the personnel using it. Additionally, following this training, MMI-172, Chemical Grouting To Fill Voids To Rotating And Stationary Equipment Base Plates, was revised to include a precaution concerning epoxy grouts and a requirement to contact the manufacturer for instructions for handling when instructions are not adequately provided.

c. (CLOSED) LER 50-259/93-003, Engineered Safety Feature Actuation Caused By A Sudden Pressure Relay Being Struck By Tool.

On April 19, 1992, during the Unit 2 refueling outage, the Athens 161 kV offsite power supply was deenergized when a dropped tool struck a sudden pressure relay causing it to close. This loss of power initiated auto-starts of diesel generators C, D, 3A, and 3B, the CREV System, and the Standby Gas Treatment System. The root cause was failure to provide adequate barriers to prevent dropped items from contacting sensitive plant equipment. Corrective actions included discussing this event with both management and field personnel stressing the importance of identifying sensitive equipment located in the work area and methods to avoid disturbing them.

In addition, SSP-9.3, Modification and Design Change Control, was revised to require a walkdown by Operations for work occurring in the 3C Relay Room to ensure sensitive equipment is adequately protected. The inspector questioned the licensee about what controls exist to ensure employees other than those working on modifications do not disturb sensitive equipment. The licensee provided a copy of the maintenance planners guide which contains information pertinent to this concern and stated that the guide was in the process of being further enhanced. In addition, caution signs exist throughout the plant to indicate areas containing sensitive equipment.

d. (CLOSED) LER 260/93-05, ESF Actuation Resulting From a Lifted Neutral Lead on a MSIV Solenoid Circuit.

On May 20, 1993, an electrician lifted a jumper and the neutral lead of the power supply to an ammeter for the MSIV solenoid circuit. The neutral lead was installed in series configuration which caused several Division 1 circuits to open when the lead was lifted. This resulted in a PCIS Division 1 actuation which controls Group 1, 2, 3, 6, and 8 valves. All systems and components functioned as expected. The licensee determined the root cause for this event was personnel error for failing to recognize the impact of lifting the neutral lead when preparing and reviewing the work plan. The work plan writer and the independent reviewer did not consider that a procedural precaution for lifting the neutral lead from the power supply was necessary for the plant configuration at the time of the event. The licensee took the following corrective actions to prevent recurrence: 1) Work plan writers and independent reviewers were trained on the individual's responsibilities pertaining to the requirements of the site standard practice for proper review criteria for modifications work plans and the circumstances of this event; 2) the Modifications Training Handbook was revised; and 3) the responsible personnel were trained on the need to include necessary precautions in future work plans. The inspectors reviewed the licensee's corrective actions and found them to be adequate.

8. Action on Previous Inspection Findings (92701, 92702)

a. (CLOSED) URI 260/93-18-01, Loss of Primary Pressure Control.

During the performance of two infrequent surveillance procedures, the pressure indicator used to control pressure was isolated. The NRC conducted a human performance study report - Browns Ferry Unit 2 (5/11/93) of this event. The licensee conducted an incident investigation, ATWS/ARI/RPT Trip Due to Reactor Overpressure, of the event. The inspector reviewed each of these reports and concluded that the problem focused on miscommunication between the control room operator and the technician. Procedure enhancements were made to help prevent recurrence. A digital pressure indicator was the primary display because other displays lacked the proper scales necessary to control pressure within the required band for the hydro test, 2-SI-3.3.1.A, ASME Section XI System Leakage Test. However, the Marotta valve test, SI-4.7.D.1.d-1, 2, 3, Functional Test of Instrument Line Flow Check Valves, required the digital display be taken out of service without written direction on what alternative pressure indication to use.

The inspector reviewed revision six of SI 4.7.D.1.d-1, 2, 3 dated July 30, 1993 and revision three of 2-SI-3.3.1.A dated July 16, 1993. Procedural steps were added for use of alternate

instrumentation to monitor vessel pressure when the digital display is removed from service with appropriate cross reference between the two procedures.

b. (CLOSED) VIO 50-259, 260, 296/93-07-02, Failure to Comply With Radiation Protection Procedures

This violation was identified for three specific examples of failure to comply with radiation protection procedures. These examples were identified by the inspectors during routine tours of the plant during a single day. The first example involved an individual handling the fuel support piece lifting tool without being signed on to the appropriate RWP and without wearing a face shield. The second example dealt with an individual removing his anti-c hood and surgeons cap while still within the contamination zone. The final example involved an individual donning an anti-c hood which had been lying on a steam line within a contamination zone.

Corrective actions for these matters involved issuing radiological awareness reports 93-026 and 93-028 on the incidents. The second and third examples of the violation were combined into one RAR due to the incidents occurring within a close proximity and similar time frame. Secondly, all involved personnel were counseled on the importance of following radiological work instructions. In addition, these matters have been incorporated into initial radiological controls GET and Radiological Controls GET retraining. Based on the inspector's review of these corrective actions, this matter is considered closed.

9. Site Organization

On July 27, 1993, J. Brazell, Acting Site Security Manager, became the permanent Site Security Manager.

Effective July 26, 1993, Raul Baron, Site Manager of Nuclear Assurance and Licensing, became the corporate General Manager of Nuclear Assurance reporting to Mark Medford, Vice President of Technical Support.

John Maciejewski, General Manager of Nuclear Assurance will become General Manager of Operations Services reporting to Dr. Medford. Mr. Maciejewski will be responsible for Nuclear Training, Operations, and Maintenance.

10. Exit Interview (30703)

The inspection scope and findings were summarized on August 20, 1993, with those persons indicated in paragraph 1 above. The inspectors described the areas inspected and discussed in detail the inspection findings listed below. The licensee did not identify as proprietary any of the material provided to or reviewed by the inspectors during this inspection. Dissenting comments were not received from the licensee.

Item Number	Description and Reference
259, 260, 296/93-28-01	NCV, Inoperable Radwaste Effluent Radiation Monitor, paragraph 3.
259, 260, 296/93-28-02	VIO, Failure to Control Transient Combustible Material, paragraph 4.
259, 260, 296/93-28-03	VIO, Failure to Control M&TE, paragraph 5.

Licensee management was informed that 4 LERs, 1 URI, and 1 VIO were closed.

11. Acronyms and Initialisms

ARI	Alternate Rod Injection
ASME	American Society of Mechanical Engineers
ASOS	Assistant Shift Operations Supervisor
ATWS	Anticipated Transient Without Scram
CAQR	Condition Adverse to Quality Report
CFR	Code of Federal Regulations
CRDR	Control Room Design Review
CREV	Control Room Ventilation System
DCN	Design Change Notice
DG	Diesel Generator
ESF	Engineered Safety Feature
GET	General Employee Training
GPM	Gallons Per Minute
IR	Inspection Report
LCO	Limiting Condition for Operation
LER	Licensee Event Report
MPC	Maximum Permissible Concentration
MSIV	Main Steam Isolation Valve
M&TE	Measuring and Test Equipment
NCV	Noncited Violation
NRC	Nuclear Regulatory Commission
PCIS	Primary Containment Isolation System
QC	Quality Control
REM	Radiological Effluent Manual
RPS	Reactor Protection System
RPT	Recirculation Pump Trip
RWP	Radiological Work Permit
SI	Surveillance Instruction
SIMI	System Instrument Maintenance Index
SLC	Standby Liquid Control
SSP	Site Standard Practice
TS	Technical Specification
URI	Unresolved Item
VIO	Violation
WO	Work Order