



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

Report Nos.: 50-280/92-13 and 50-281/92-13

Licensee: Virginia Electric and Power Company
5000 Dominion Boulevard
Glen Allen, VA 23060

Docket Nos.: 50-280 and 50-281

License Nos.: DPR-32 and DPR-37

Facility Name: Surry 1 and 2

Inspection Conducted: May 10 through June 6, 1992

Inspectors:

A. Ruff For 7/1/92
M. W. Branch, Senior Resident Inspector Date Signed

A. Ruff For 7/1/92
J. W. York, Resident Inspector Date Signed

A. Ruff For 7/1/92
S. G. Tingen, Resident Inspector Date Signed

Approved by:

M. V. Sunkala 7/1/92
P. E. Fredrickson, Section Chief Date Signed
Division of Reactor Projects

SUMMARY

Scope:

This routine resident inspection was conducted on site in the areas of operations, maintenance, surveillance, licensee event review, action on previous inspection items, and safety assessment and quality verification.

During the performance of this inspection, the resident inspectors conducted review of the licensee's backshift or weekend operations on May 22, 28, and June 3, 1992.

Results:

In the maintenance/surveillance area, the following items were noted:

Management oversight and controls associated with replacement of the No. 1 emergency diesel generator governor reflected the implementation of improvements as a result of corrective action for previous weaknesses in this area (paragraph 4.a).

The emergency diesel generator procedure for adjusting scribe marks appeared to need strengthening to eliminate confusion (paragraph 5.a).

In the safety assessment/quality verification area, the following items were noted:

The failure to perform safety evaluations for procedures that were used to operate plant systems differently than that described in the Updated Final Safety Analysis Report was identified as Violation 280,281/92-13-01 (paragraph 7).

The Management Safety Review Committee meeting was thorough and the discussion of issues were detailed to make decisions/recommendations (paragraph 8).

REPORT DETAILS

1. Persons Contacted

Licensee Employees

- R. Allen, Superintendent of Operations (Acting)
- *W. Benthall, Supervisor, Licensing
- R. Bilyeu, Licensing Engineer
- *H. Blake, Superintendent of Site Services
- *R. Blount, Superintendent of Engineering
- *D. Christian, Assistant Station Manager
- *J. Demease, Nuclear Oversight Board
- J. Downs, Superintendent of Outage and Planning
- *R. Gwaltney, Superintendent of Maintenance
- *W. Hartley, Nuclear Oversight Board
- *M. Holdsworth, Supervisor, Security
- M. Kansler, Station Manager
- *A. Keagy, Superintendent of Materials
- *J. McCarthy, Assistant Station Manager (Acting)
- *A. Meekins, Supervisor, Administrative Services
- *D. Modlin, Supervisor, Shift Operations (Acting)
- *J. O'Hanlon, Vice President-Nuclear, Corporate
- *E. Smith, Site Quality Assurance Manager
- *R. Wells, Supervisor, Maintenance

NRC Personnel

- M. Branch, Senior Resident Inspector
- *S. Tingen, Resident Inspector
- *J. York, Resident Inspector

* Attended exit interview.

Other licensee employees contacted included control room operators, shift technical advisors, shift supervisors and other plant personnel.

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

2. Plant Status

Unit 1 began the reporting period in power operation. The unit was at power at the end of the inspection period, day 31 of continuous operation.

Unit 2 began the reporting period in power operation. The unit was at power at the end of the inspection period, day 171 of continuous operation.

3. Operational Safety Verification (71707,42700)

The inspectors conducted frequent tours of the control room to verify proper staffing, operator attentiveness and adherence to approved procedures. The inspectors attended plant status meetings and reviewed operator logs on a daily basis to verify operations safety and compliance with TSs and to maintain awareness of the overall operation of the facility. Instrumentation and ECCS lineups were periodically reviewed from control room indication to assess operability. Frequent plant tours were conducted to observe equipment status, fire protection programs, radiological work practices, plant security programs and housekeeping. Deviation reports were reviewed to assure that potential safety concerns were properly addressed and reported.

a. Licensee 10 CFR 72 Reports

On May 11, the licensee made a 10 CFR 50.72 report concerning operation of Unit 1 since the startup on May 1, 1992, in non-compliance with the requirements of TS 3.3.B.2 (Safety Injection System) for alignment of the CH/HHSI pumps. The control switches for the CH/HHSI pumps were aligned such that the A CH/HHSI pump would trip on an undervoltage condition. This CH/HHSI pump configuration was identical to the condition that resulted in escalated enforcement action in September, 1991. This event is covered in detail in IR 280,281/92-12.

b. Troubleshooting Motor Driven Fire Pump

While securing the motor driven fire pump on June 3, the breaker for the pump cycled twice and tripped. The diesel driven fire pump then automatically started but was secured when the operator observed air coming out of a vent on the pump's casing. Deviation report No. S-92-0977 was written and work request No. 800386 was issued.

The licensee declared both fire pumps inoperable and initiated a one hour clock to establish a continuous fire watch with backup suppression equipment for Unit 1 and 2 cable vault and tunnels as required by TS 3.21.B.3. A 24 hour LCO was initiated to establish a backup fire suppression water system in accordance with TS 3.21.B.2.b. The plant fire truck was designated as the backup fire suppression water system and it was verified as operable.

The inspectors observed operation personnel coordinating with the system engineer in the filling and venting of the system and evaluating the problem. It was concluded that a check valve between a hydropneumatic tank and both fire pumps caused the problem. The failure of this check valve allowed the pressure to be lowered in the tank and the air to migrate to the two pumps causing cavitation. After filling and venting, the pressure was returned to normal in the hydropneumatic tank. The check valve

appears to be performing normally and an annunciator in the control room would indicate any return of this problem.

Within the areas inspected, no violations were identified.

4. Maintenance Inspections (62703, 42700,)

During the reporting period, the inspectors reviewed maintenance activities to assure compliance with the appropriate procedures.

The following maintenance activities were reviewed.

a. No. 1 EDG Governor Replacement

On May 19, the No. 1 EDG did not start during a post maintenance test and the problem was later attributed to a failed governor. The EDG was operated on the previous shift; therefore, the EDG governor failure was quickly identified. The inspectors observed portions of the maintenance to replace the No. 1 EDG governor: Procedure O-MCM-0705-01, Emergency Diesel Injector Rack, Governor Compensation, and Speed Limit Switch Adjustments, dated February 13, 1992, and WO 3800127359 were used to accomplish this maintenance. The governor was removed and replaced with a spare governor.

Prior to installing the new governor it was sent to a local test facility. The governor was adjusted and tested. The test facility was not on the licensee's QA approved vendor list. The inspectors reviewed ENAP-0004, Procurement Technical Evaluation, dated May 4, 1992 which allows the use of non-qualified vendors provided Virginia Power's QA program is extended to cover the vendor. During the test, the licensee's QA program was extended to cover the vendor with the presence of a corporate QA inspector who monitored the test activities. In addition, an SNSOC approved procedure was used for adjustments and testing of the governor. This procedure was incorporated into procedure O-MCM-0705-01.

The inspectors reviewed the PMT requirements for this maintenance and did not identify any discrepancies. An EDG fast speed start was required. The inspectors also reviewed O-MCM-0705-01 and did not identify any deficiencies. The inspectors concluded that management oversight and control functions related to the governor replacement were successful in satisfactorily accomplishing this maintenance. For example, a formal maintenance procedure was utilized that specifically addressed governor replacement, correct PMT requirements were specified, procedures were followed, and communications between operation, maintenance, and engineering were good.

b. Mechanical Equipment Bolting

During the walkdowns of plant areas, the inspectors noted a questionable condition regarding the mounting of several safety-related and nonsafety-related pumps, motors, and engines. Specifically, the jacking bolts which are normally used only to align the foundation bolts prior to tightening were found to be contacting the foundation of the equipment and had not been backed off. This condition could mask equipment vibration problems and did not appear to be addressed by the licensee maintenance procedures.

The inspectors discussed this condition with the Maintenance Manager and a walkdown by the licensee indicated that approximately 30 percent of the equipment inspected had the same condition (i.e. jacking bolt tight against the equipment foundation). The licensee indicated that, although the procedures do not detail the need to loosen the jacking bolts after equipment alignment, discussion with mechanics involved with equipment mounting revealed that they were aware of the need to loosen the jacking bolts after alignment.

The inspectors did not identify any cases where excessive equipment vibration was being dampened by the use of the jacking bolts. However, the licensee was reluctant to just loosen the jacking bolts with out measuring the resultant equipment vibration. The licensee agreed to verify proper equipment vibration with the jacking bolts loosened during the scheduled predictive maintenance vibration measurement. The licensee proposed resolution of the inspectors concern in this area appears to be acceptable when combined with the evaluation of possible procedure enhancements as well.

Within the area inspected, no violations were identified.

5. Surveillance Inspections (61726, 42700)

During the reporting period, the inspectors reviewed surveillance activities to assure compliance with the appropriate procedure and TS requirements.

The following surveillance activity was reviewed:

a. No. 1 EDG Post Maintenance Testing

On May 20, the inspectors witnessed the testing of the No. 1 EDG following the replacement of the governor. The testing was accomplished in accordance with 1-OPT-EG-004, Number 1 Emergency Diesel Generator Quarterly Fast Start Exercise Test, dated April 16, 1992. The inspectors attended the pre-job briefing, witnessed portions of the test, and reviewed the completed test procedure. The EDG was initially started in slow speed in accordance with

step 5.2.17 of operating procedure 1-OP-EG-001, Number 1 Emergency Diesel Generator, dated April 16, 1992. The engine increased in speed and stabilized at approximately 420 rpm versus the desired 470 to 490 rpm value stated in the procedure. A slow speed adjustment was made in accordance with the procedure.

The inspectors' review of the above operating procedure identified an area that needed strengthening by the licensee. Specifically, step 5.3 of 1-OP-EG-001 which was used to shutdown the EDG from the main control room contained confusing instructions associated with verification of governor speed control scribe marks after engine shutdown. The governor speed control knob and gears had been scribed with a distinct marking on all three EDG following the August 1991 EDG failure as part of the corrective actions. Procedures were developed to require verification that these scribe marks were in alignment locally to ensure that the EDG would achieve rated speed during emergency starting. The confusing instructions were contained in steps 5.3.11 and its preceding note and 5.3.12. Step 5.3.11 required that the alignment of scribe marks on the gears and the speed control knob be verified. However, the preceding note stated that, if the scribe marks are found not aligned during the verification, no alignment should be attempted. Step 5.3.12 states that if the scribe marks are not in alignment then notify the shift supervisor. It was not clear as to whether alignment of the scribe marks were an option or whether the operator was not to make the adjustments and the shift supervisor would recognize the need to have maintenance adjust the scribe marks. The potential for leaving an EDG in an unknown inoperable condition was further complicated in that there was no other mention of verifying the scribe marks prior to declaring the EDG fully operable per the note after step 5.3.19 of the procedure.

The inspectors discussed the above concerns with station management who indicated that a procedure revision would be considered to resolve the confusion.

Within the areas inspected, no violations were identified.

6. Licensee Event Review (92700)

The inspectors reviewed the LERs listed below and evaluated the adequacy of corrective action. The inspector's review also included followup on the licensee's implementation of corrective action.

- a. (Closed) LER 280,281/90-20, Startup and Power Operation With One Train of Containment Spray System Inoperable Due to Improper Deletion of Pressure Switch Repair From Outage Work Scope. This issue involved the failure of limit switches 1-CS-PS-103A and 1-CS-PS-103C. This issue and immediate corrective actions were previously discussed in IR 280,281/91-06. Long term corrective actions involved performing a CFE on the failed limit switches,

performing an engineering study to evaluate the removal of the switches, performing a root cause evaluation, review of test records to determine if other systems may have the same type of switches, upgrade I&C PM program, and strengthen the startup assessment process. A CFE has not been performed for the failed limit switches; however, this item is being tracked by CTS No. 1212 until completion. The MOVs that automatically operated in response to actuation of these limits switches were failed opened, control power was removed, and stem locking devices were installed as described in IR 280,281/91-06. The inspectors walked down the system and verified the installation of stem locking devices and that the control room indication for the MOVs were deenergized. The root cause evaluation was performed and is discussed in IR 280,281/91-06. The startup assessment process was enhanced by requiring corrective actions, in response to station deviations which are initiated during a RFO, be tracked and have SNSOC concurrence if corrective measures were not implemented before startup of the unit. In addition, a representative from the Outage & Planning Department is required to attend SNSOC meeting during review of station deviations to ensure that outage related station deviations are scheduled to be worked during the outage. The I&C PM program was enhanced by incorporating it into the station PM program which requires written approval to defer a PM. In addition, deferred PMs are tracked monthly by the PM coordinator and are reviewed by the MRB during restart assessments. The inspectors consider that the corrective actions were properly implemented or were being properly tracked.

- b. (Closed) LER 280,281/91-17, Diesel Generator Rendered Inoperable Due to Personnel Error in Adjusting the Governor. This issue involved the No. 3 EDG being inoperable for a period of time greater than allowed by TSs due to an improperly adjusted governor speed control dial. Violation 280,281/91-24-01, Failure to Comply With the Requirements of TS 3.16.B.1 with the No. 3 EDG Inoperable, was issued as a result of this event. The corrective actions for this LER and the violation are the same and are discussed below..

Within the areas inspected, no violations were identified.

7. Action On Previous Inspection Items (92701,92702)

- a. (Closed) Violation 280,281/90-36-01, Low SW Flow Through the RSHXs. This issue involved inoperable RSHXs in both units due to reduced SW flow rates. The reduced SW flow rates were caused by macrofouling of the RSHXs. Short term corrective actions involving inspection, cleaning, testing, alternating SW BC supply headers, and placement of RSHXs SW supply headers in partial wet-layup were discussed in IR 280,281/90-36. The licensee responded to this violation in a letter dated March 14, 1991. In that letter, the licensee stated that the following long term corrective actions would be implemented: (1) chemically treat the

48 inch SW headers to the RSHXS in order to control hydroid growth; (2) monitor 48 inch SW supply headers for temperature, salinity, PH, conductivity, dissolved oxygen, chlorine and ammonia and correlate results with visual inspections; (3) perform flow testing and post test inspection on a RS SW subsystem and perform as-found inspection on the remaining RS SW subsystem during the 1991 Unit 2 RFO and 1992 Unit 1 RFO; (4) initiate an ecosystem study to support a long-term biological control strategy; and (5) clean, inspect, repair and epoxy coat RSHX supply piping.

The inspectors walked down the SW system and verified installation of equipment utilized to chemically treat the 48 inch SW headers to the RSHXs. Additionally, the inspectors reviewed procedures 1,2-OP-49.1, Startup and Shutdown of the SW System and Chemical Injection of Headers, dated August 22, 1991, 1,2-OP-49.7, Draining RSHX SW Piping in Wet Lay-UP, dated May 31, 1991, and 1,2-OSP-SW-001, Maintenance and Sampling of RSHX SW Piping in Wet Lay-up, dated April 23, 1992. These procedures are utilized to add chemicals, fill, and sample the system. The inspectors also reviewed the the monthly PT schedule and verified that the SW BC headers are alternated on a weekly basis. During the Unit 1 1992 RFO, the inspectors inspected internal portions of the 48 inch SW piping and considered the program effective in minimizing hydroid growth. During the previous Units 1 and 2 RFOs, the inspectors monitored flow testing of the RSHXs and inspected the RSHXs following the tests. Results of these inspections also indicated that corrective actions have been effective. IRs 280,281/91-10 and 92-07 discussed these inspections. The Virginia Institute of Marine Science monitors hydroid growth and makes recommendations to the licensee for long term control. This item is being tracked by CTS No. 220 until completion. Approximately 80% of the Unit 1 and 50% of the Unit 2 RSHX SW supply piping has been coated with epoxy. Completion of epoxy coating is scheduled during the upcoming RFOs and is being tracked by CTS No. 1180. At the end of the inspection period, the licensee was evaluating the need to routinely flow test the SW piping to the RSHXs. The inspectors consider that the corrective actions were properly implemented.

- b. (Closed) UNR 280,281/91-33-01, Safety Evaluations for Changes in the Facility. This issue involved three examples in which the licensee had operated plant systems in a different manner than described in the UFSAR but had not first prepared written safety evaluations pursuant to 10CFR 50.59. Based on guidance from Part 9900 of the NRC Inspection Manual and NSAC-125, the inspectors concluded that a safety evaluation should have been done for each example. The licensee disagreed. Because of this disagreement, the NRC further reviewed this issue and concluded that the licensee should have recognized these configurations as changes to procedures described in the FSAR and therefore, should have performed safety evaluations to justify these changes. The basis for this conclusion is that the UFSAR's description of the operation of a plant system, including its alignment or

configuration, constitutes a procedure as described in 10 CFR 50.59. Thus, proposed procedures for operating a plant system in a different manner than described in the UFSAR should be evaluated pursuant to 10 CFR 50.59. 10 CFR 50.59(b)(1) requires records of changes in procedures as described in the safety analysis report to include written safety evaluations which provide the basis for the determination that the procedure changes do not involve unreviewed safety questions. The failure to perform safety evaluations for the procedures that were used to operate plant systems differently than that described in the UFSAR was identified as Violation 280,281/92-13-01. Examples of procedures that operated plant systems differently than described in the UFSAR were OP 52.2.1, Administrative Control of 1-FP-36, dated October 27, 1989, 2-OP-49.7, Filling and Draining RSHX Service Water Supply Piping, dated September 18, 1991, and OP 6.2.3, Administrative Control of 1-EG-15, 2-EG-15 or 3-EG-15, dated January 20, 1990.

- c. (Closed) IFI 280,281/90-30-01, Followup on Licensee Corrective Action and Testing Deficiencies Identified During RSHX SW Flow Testing. This issue involved reduced RSHX SW flow rates and incorrect indication of control room RSHX SW flow identified during testing accomplished in Unit 1 during the 1990 RFO. Violation 280,281/90-36-01 was issued as a result of reduced SW flow rates which was discussed in the previous paragraph. During the Unit 1 1992 RFO, new RSHX SW flow instrumentation was installed in Unit 1 and satisfactorily tested. Testing of the new flow instrumentation was discussed in IR 280,281/92-07. Installation of new RSHX SW flow instrumentation in Unit 2 is scheduled for the 1993 RFO.
- d. (Closed) VIO 280,281/91-24-01, Failure to comply with the requirements of TS 3.16.B.1 with the No. 3 EDG inoperable. This issue involved the No. 3 EDG being inoperable for a period of time greater than allowed by TSs due to an improperly adjusted governor speed control dial. Immediate corrective actions required to restore the EDG to an operable status are discussed in IR 280,281/91-24. The licensee responded to this violation in letters dated November 20, and December 20, 1991. In these responses, the licensee stated that the following long term corrective actions would be implemented: (1) scribe the governor gearing and speed knobs at the 900 rpm setting and install a see-through cover plate on each governor limit switch enclosure so the the scribed match marks may be observed without cover removal (2) revise operator logs to verify that match marks are properly aligned on each shift, (3) revise PMT requirements to specify that fast start testing requirements following any governor maintenance, upgrade procedures for governor maintenance and fast start operation, (4) train select station personnel with vendor participation on EDG governors in order to increase overall knowledge level, (5) establish special task teams to review root causes and review EDG governor and control circuits to ensure

reliable operation, and (6) perform a QA assessment on implementation of the PMT program.

The inspectors walked down all three EDGs and verified that the governors' gears were matched, marked, and aligned. The inspectors also verified the installation of see-through cover plates on the EDG governors and that plant logs were revised to require verification of the governor match marks. Procedure No. IA, Plant Log Readings, dated May 28, 1992, was reviewed to verify that governor match marks were checked for alignment on each shift. Review of EDG upgraded procedures and PMT requirements are discussed in paragraphs 4.a and 5.a and were considered adequate. The licensee has not completed the governor training but this item was being tracked by CTS item 1473. Present licensee plans are to train station personnel in September 1992. The inspectors reviewed CFA Report 91-1991, dated December 27, 1991, on EDG governors, and verified that the EDG failure was analyzed and that EDG governor enhancements were investigated. The inspectors reviewed the PMT followup assessment, dated May 27, 1992. This assessment concluded, in general, that the specified PMT assured equipment was operable before return to service. The inspectors consider that the corrective actions in response to the violation were properly implemented or were being properly tracked.

- e. (Closed) VIO 280/90-39-01, Failure to Follow Precaution 4.19 While Performing Continuity Checks During the Performance of Procedure 1-OPT-ZZ-001. This issue involved the inadvertent automatic start of the Nos. 1 and 3 EDGs caused by an electrician improperly performing a continuity check. The licensee responded to this in a letter dated February 25, 1991. In the letter, the licensee stated that the following corrective actions would be implemented; strengthen standards for conducting prejob briefings, include this example in training lesson plans for electricians, and revise ESF test procedures to include precautionary statement alerting workers to the possibility of voltage being present during continuity checks of electrical circuits. The licensee formed a team to develop standards for conducting prejob briefings. Once these standards were developed, the team issued them via a station letter to the different departments. Each department reviewed these standards and incorporated them into the applicable department procedures. The operations department incorporated the new prejob brief criteria in Revision 2 to VPAP-1401, Conduct of Operation. The inspectors reviewed this document and verified that these instructions were added. The engineering department incorporated the new prejob brief criteria into Revision 3 of SUADM-ENG-09, Test Control, and Revision 1 of SUADM-ENG-11, Special Tests. The inspectors reviewed these documents and verified that instructions were added. The inspectors reviewed procedures 1-OPT-ZZ-001, ESF Actuation With Undervoltage and Degraded Voltage 1H-Bus, dated February 27, 1992 and 2-OPT-ZZ-002, ESF Actuation With Delayed Undervoltage 2J-Bus, dated August 29, 1991, and verified that these procedures were revised to provided

a precautionary statement was added to alert workers of the possibility of voltage being present during continuity checks. The inspectors reviewed Revision 2 to the lesson plan titled, Event Training Using Test Equipment, and verified that it covered this event. The inspectors consider that the corrective actions in response to the violation were properly implemented.

- f. (Closed) VIO 280/90-39-02, Failure to Provide Adequate Instructions for Testing, Resulting in the Unintentional Actuation of B Train CLS HI (SI). This issue involved inadequate instructions in an ESF procedure for removal of a test jumper which resulted in the inadvertent initiation of B train CLS HI (SI). The licensee responded to this in a letter dated February 25, 1991. In the letter the licensee stated that the following corrective actions would be implemented; revise the ESF procedure to specify the correct jumper and strengthen administrative controls governing procedure development by requiring an additional technical review for complex procedures that have the potential to cause inadvertent ESF actuations. The inspectors reviewed procedure 1-OPT-ZZ-001 and verified that it was revised to provide adequate instructions for removal of the test jumper. Station Procedure Directive 001, dated February 13, 1991, which was revised, instructed procedure writers of the additional technical review. The inspectors consider that the corrective actions in response to the violation were properly implemented.
- g. (Closed) VIO 280/90-39-03, Inadequate Field Change Resulting in Unreliable Reactor Vessel Level Indication. This issue involved a field change to a DCP that modified the reactor head vent piping. The field change was inadequate because it did not recognize that the standpipe had been turned over to operations for unrestricted use. As a result, the reactor vessel standpipe indication was unreliable while the modification to the reactor head vent piping was being performed. The licensee responded to this violation in a letter dated February 25, 1991. In the letter the licensee stated that the following corrective actions would be implemented; issue a lessons learned memorandum to Design, System and Testing Engineering personnel discussing this issue; issue a memorandum to operations personnel emphasizing that a step may be marked as NA only when specifically authorized in the body of the DCP or EWR and enhance administrative procedures governing field change preparation and technical review processes to ensure notification of shift supervisors and retagging of system boundaries before working on systems returned to operations under a partial technical review. The inspectors reviewed the memorandum to engineering personnel titled, Lessons Learned-DC 86-15-1 Partial Technical Review/Subsequent Field Changes, dated December 4, 1990. This memorandum discussed the event and how to prevent similar occurrences. The inspectors reviewed Operations department memorandum dated January 9, 1991 which explained that steps in EWRs or DCPs may not be marked NA unless specifically allowed by the procedure. The inspectors also reviewed SUADM-ENG-13, DCP/EWR

Implementation and Closeout, dated March 10, 1992 and verified that it contained instructions that shift supervisor notification, retagging of system boundaries and review of initial conditions and precautions are required for continued work or rework on a system previously released under a partial technical review. The inspectors consider that the corrective actions in response to the violation were properly implemented.

- h. (Closed) VIO 280,281/90-41-01, Failure to Correctly Classify SW pumps 1-VS-P-1A, B, and C and CD pumps 1-VS-P-2A, B, and C in Accordance With Regulatory Guide 1.26. This issue involved the improper classification of SW pumps 1-VS-P-1A, B, and C and CD pumps 1-VS-P-2A, B, and C as non Class 3 components and therefore erroneously omitted from the licensee's IST program. The licensee responded to this violation in a letter dated March 22, 1991. In the letter, the licensee stated that the pumps and valves in the control-room-envelope air conditioning system were added to their Section XI program. The inspectors reviewed Revision 4 to the Inservice Testing Program Plan and verified that the pumps and valves in the control room envelope air conditioning system were in the program. The inspectors consider that the corrective actions in response to the violation were properly implemented.

Within the areas inspected, no violations were identified.

8. Safety Assessment and Quality Verification (40500)

The inspectors attended portions of the June 2 MSRC meeting. During that meeting, the plant managers from both stations discussed recent plant performance and regulatory history. Several proposed TS amendments were presented and the inspectors determined that an appropriate level of detailed discussion occurred before approval of amendments. The inspectors also monitored the discussion of the CNS subcommittee report on a new performance monitoring program that was being proposed. The program was only in the development stage and the MSRC members had a lot of discussion over the definition of some of the indicators being monitored. Specifically, there was concern that indicators such as "nuclear safety" needed to be better defined because a declining trend may indicate unacceptable performance to one person but not to another. The CNS subcommittee chairman indicated that the comments would be considered and a new draft would be presented during the next scheduled MSRC meeting. The inspectors considered the MSRC meeting was thorough and that discussion of issues at the appropriate level occurred before decisions/recommendations were made.

9. Exit Interview

The inspection scope and results were summarized on, June 9, with those individuals identified by an asterisk in paragraph 1. The following summary of inspection activity was discussed by the inspectors during this exit.

Item Number	Status	Description and Reference
VIO 280,281/92-13-01	Open	Failure to perform safety evaluations for procedures that were used to operate plant systems differently than that described in the UFSAR.
VIO 280, 281/91-24-01	Closed	Failure to comply with the requirements of TS 3.16.B.1 with the No. 3 EDG inoperable.
VIO 280/90-39-01	Closed	Failure to Follow Precaution 4.19 while performing continuity checks during the performance of procedure 1-OPT-ZZ-001.
VIO 280/90-39-02	Closed	Failure to provide adequate instructions for testing, resulting in the unintentional actuation of B Train CLS HI (SI).
VIO 280/90-39-03	Closed	Inadequate field change resulting in unreliable reactor vessel level indication.
VIO 280,281/90-36-01	Closed	Low SW flow through the RSHXs.
VIO 280,281/90-41-01	Closed	Failure to correctly classify SW pumps 1-VS-P-1A, B, and C and CD pumps 1-VS-P-2A, B, and C in accordance with Regulatory Guide 1.26.
UNR 280,281/91-33-01	Closed	Safety evaluations for changes in the facility.
IFI 280,281/90-30-01	Closed	Followup on licensee corrective action and testing deficiencies identified during RSHX SW flow testing.

LER 280,281/90-20	Closed	Startup and power operation with one train of containment spray system inoperable due to improper deletion of pressure switch repair from outage work scope.
LER 280,281/91-17	Closed	Diesel Generator Rendered Inoperable Due to Personnel Error in Adjusting the Governor.

10. Index of Acronyms and Initialisms

BC	-	BEARING COOLING
CFA	-	COMPONENT FAILURE ANALYSIS
CFE	-	COMPONENT FAILURE EVALUATION
CLS	-	CONSEQUENCES LIMITING SAFEGUARD
CFR	-	CODE OF FEDERAL REGULATIONS
CNS	-	CORPORATE NUCLEAR SAFETY
CTS	-	COMMITMENT TRACKING SYSTEM
DCP	-	DESIGN CHANGE PACKAGE
ECCS	-	EMERGENCY CORE COOLING SYSTEM
EDG	-	EMERGENCY DIESEL GENERATOR
ESF	-	ENGINEERED SAFETY FEATURE
EWR	-	ENGINEERING WORK REQUEST
FSAR	-	FINAL SAFETY ANALYSIS REPORT
HHSI	-	HIGH HEAD SAFETY INJECTION
IFI	-	INSPECTOR FOLLOWUP ITEM
I&C	-	INSTRUMENTATION AND CONTROLS
IR	-	INSPECTION REPORT
IST	-	INSERVICE TEST
LER	-	LICENSEE EVENT REPORT
LCO	-	LIMITING CONDITIONS OF OPERATION
MOV	-	MOTOR OPERATED VALVE
MRB	-	MANAGEMENT REVIEW BOARD
NRC	-	NUCLEAR REGULATORY COMMISSION
MSRC	-	MANAGEMENT SAFETY REVIEW COMMITTEE
OP	-	OPERATING PROCEDURE
PM	-	PREVENTIVE MAINTENANCE
PMT	-	POST MAINTENANCE TEST
PT	-	PERIODIC TEST
QA	-	QUALITY ASSURANCE
RS	-	RECIRCULATION SPRAY
RSHX	-	RECIRCULATION SPRAY HEAT EXCHANGER
SNSOC	-	STATION NUCLEAR SAFETY AND OPERATING COMMITTEE
SW	-	SERVICE WATER
TS	-	TECHNICAL SPECIFICATION
UFSAR	-	UPDATED FINAL SAFETY ANALYSIS REPORT
UNR	-	UNRESOLVED ITEM
VIO	-	VIOLATION
WO	-	WORK ORDER