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

Report Nos.: 50-280/94-27 and 50-281/94-27

Licensee: Virginia Electric and Power Company
Innsbrook Technical Center
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: September 3 through October 1, 1994

Inspectors:

RW Haware For — 10-21-94
M. W. Branch, Senior Resident Inspector — Date Signed

RW Haware For — 10-21-94
S. G. Tingen, Resident Inspector — Date Signed

RW Haware For — 10-21-94
D. M. Kern, Resident Inspector — Date Signed

Accompanying Personnel: D. M. Tamai, NRC Intern

Approved by: G. A. Belisle — 10/24/94
G. A. Belisle, Chief — Date Signed
Reactor Projects Section 2A
Division of Reactor Projects

SUMMARY

Scope:

This routine resident inspection was conducted on site in the areas of plant status, operational safety verification, maintenance and surveillance inspections, onsite engineering review, annual emergency exercise, Licensee Event Report followup and action on previous inspection items. Inspections of backshift activities were conducted on September 6, 12, 19, 26 and 29, 1994.

Results:

When cleaning a component cooling water heat exchanger, personnel were very sensitive to foreign material exclusion controls. However, inadequate heat exchanger draining during maintenance activities resulted in rework (paragraph 4.1).

The maintenance associated with 1-SW-PCV-100A was satisfactorily accomplished, the mechanics performing the maintenance were well trained and procedures were followed. Scheduling and planning for all maintenance activities associated with the A main control room chiller were good (paragraph 4.2).

An operator entered a quarterly containment spray pump test at a place other than he had been instructed. This weakness was considered as an isolated occurrence (paragraph 4.3).

Operators demonstrated detailed knowledge of emergency diesel generator (EDG) procedures and system design during required periodic testing. Procedures were generally of high quality. The decision to secure the EDG prior to troubleshooting a bound breaker control switch demonstrated a conservative safety perspective. Operations, engineering, and maintenance personnel effectively coordinated their efforts to minimize the time that the number 2 EDG was unavailable (paragraph 4.4).

Maintenance activities associated with repairing fuel oil transfer pump 1-EE-P-1E were satisfactorily accomplished. Maintenance transmittals and skill of the craft were utilized to perform the majority of this maintenance (paragraph 4.4).

The safety evaluation associated with injecting leak sealant into the Unit 1 C steam generator lower handhold cover gasket area addressed the appropriate issues. The Station Nuclear Safety And Operating Committee's safety evaluation review was good (paragraph 5).

Operators properly responded to the drill scenario presented by the annual emergency exercise. Drill emergency classifications were properly made. Emergency facilities were properly staffed and communications were good. The recently installed radio system improved drill communications. The licensee was very critical when evaluating the conduct of the exercise. Concerns identified during the exercise were listed in the emergency exercise critique results (paragraph 6).

REPORT DETAILS

1. Persons Contacted

1.1 Licensee Employees

*W. Benthall, Supervisor, Licensing
*H. Blake, Jr., Superintendent of Nuclear Site Services
*R. Blount, Superintendent of Maintenance
D. Boone, Quality Assurance
*D. Christian, Station Manager
*J. Costello, Station Coordinator, Emergency Preparedness
*J. Downs, Superintendent of Outage and Planning
*D. Erickson, Superintendent of Radiation Protection
*B. Garber, Licensing
B. Hayes, Supervisor, Quality Assurance
*D. Hayes, Superintendent of Administrative Services
*A. Keagy, Nuclear Materials
*C. Luffman, Superintendent, Security
*J. McCarthy, Assistant Station Manager
*G. Miller, Corporate Licensing
A. Price, Assistant Station Manager
*S. Sarver, Superintendent of Operations
*R. Saunders, Vice President, Nuclear Operations
K. Sloane, Operations
*E. Smith, Site Quality Assurance Manager
*D. Sommers, Corporate Licensing
*T. Sowers, Superintendent of Engineering
*B. Stanley, Supervisor, Station Procedures
*J. Swientoniewski, Supervisor, Station Nuclear Safety
G. Thompson, Supervisor, Maintenance Engineering
E. Turko, Engineering
G. Woodzell, Nuclear Training

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

1.2 NRC Personnel

*M. Branch, Senior Resident Inspector
*D. Kern, Resident Inspector
D. Tamai, Intern
*S. Tingen, Resident Inspector

*Attended Exit Interview

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

2. Plant Status

Units 1 and 2 operated at power for the entire inspection period.

3. Operational Safety Verification (71707)

3.1 Biweekly ESF Inspections

3.1.1 Unit 1 CS System

The inspectors walked down the Unit 1 CS system in the safeguards building and the RWST and CAT in the RCA. Grading work in the RCA required maintenance to dig in the area surrounding the RWST and CAT. The inspectors observed that maintenance personnel were taking appropriate caution to prevent damage to exposed piping and electrical conduit. Correct valve alignments, control room indications and breaker positions, and proper housekeeping and labeling were verified. Overall equipment condition was adequate.

3.1.2 Unit 2 AFW System

The inspectors walked down the three AFW pumps located in the safeguards building following maintenance on TDAFW pump 2-FW-P-2. Proper valve and breaker alignments were verified, and control room indications were observed to be proper. The equipment appeared to be in good overall condition and housekeeping was adequate.

Within the areas inspected, no violations or deviations were identified.

4. Maintenance and Surveillance Inspections (62703, 61726)

Maintenance and surveillance activities were observed and reviewed to verified that activities were conducted in accordance with TSs and approved procedures and licensee commitments to regulatory guides, industry codes and standards.

4.1 CC Heat Exchanger Cleaning

On September 8 and 9, the inspectors observed personnel performing O-MCM-0812-01, BC and CC Heat Exchanger Cleaning, revision 0, for heat exchanger 1-CC-E-1D. FME and tag out records were reviewed. In accordance with the work order, the tube scrapers (purple Goodway scrapers) were counted before and after the cleaning. All the Goodway scrapers were accounted for. After the cleaning, 37 green Conco scrapers were also found. The extra scrapers were attributed to being left in the heat exchanger during previous cleanings prior to positive FME controls being established. DR S-94-1726 was initiated to address the event. The inspectors noted that the previous cleaning occurred near the time FME violation 50-280, 281/94-17-02 was issued.

During the cleaning, the inspectors verified the tag out. The SW outlet valve was required closed by the tag out but was partially open. When the inspectors questioned the tagout, they were informed that it was a generic tagout for several jobs and that a partial clearance was always performed to open the valve for drainage. However, the outlet valve was not opened enough for sufficient drainage to remove the sludge lancing debris. This debris settled out and plugged the tubes in the bottom portion of the heat exchanger. These tubes were required to be recleaned.

During the CC heat exchanger cleaning, personnel were very sensitive to FME control. However, inadequate draining of the heat exchanger during the maintenance activities resulted in rework. This issue was discussed with the supervisor.

4.2 1-SW-PCV-100A Diaphragm Inspection

On September 13 and 14 the inspectors witnessed PM on the air operator for the 4A chiller condenser SW outlet PCV 1-SW-PCV-100A. The PM was performed in accordance with WO 295530-01, procedure 0-MCM-0414-03, Copes-Vulcan Model D-100-40, D-100-60 and D-100-100 Control Valve Overhaul, revision 1, and ICP-1-SW-V-100, Service Water Pressure Control Valves 100A, 100B, 100C, 101A, 101B and 101C, revision 2. The inspectors witnessed removal, inspection and reinstallation of the air operator's diaphragm, valve stroke adjustment, air-operator spring adjustment and packing adjustment. The inspectors reviewed the PMT requirements which required that the valve be stroke time tested in accordance with 0-OPT-VS-001, Control Room Air Conditioning System Pump and Valve Inservice Test, revision 8. The inspectors reviewed the results of procedure 0-OPT-VS-001, that was performed on September 15, and verified that 1-SW-PCV-100A was satisfactorily stroke tested following the maintenance. The inspectors concluded that the maintenance associated with 1-SW-PCV-100A was satisfactorily accomplished, mechanics performing the maintenance were well trained, and procedures were followed.

The inspectors noted that this maintenance required that the A MCR chiller be isolated and that the appropriate TS LCO was entered. Numerous other maintenance activities associated with the A chiller were also performed during this period. The SW condenser side of the chiller was rodded out and cleaned, SW check valve 1-SW-316 was replaced, a thermostat in the chiller control circuit was replaced and the diaphragm on PCV 1-SW-PCV-101A was also replaced. Scheduling and planing for the maintenance activities associated with the A MCR chiller were good, in that, all related maintenance activities associated with this component were accomplished in the same component outage.

4.3 Unit 2 Containment Spray Quarterly Test

On September 19, the inspectors witnessed the quarterly performance testing of the CS pumps and system MOVs in accordance with 2-OPT-CS-002, Containment Spray System Test, revision 0 and 2-PT-19.1, RWST Chemical Addition Tank and Containment Spray System MOVs, revision 5. The CS spray test was also used to return pump, 2-CS-P-1B, to service after maintenance. While performing 2-OPT-CS-002 for the 1B pump, the inspectors noticed that four earlier steps had not been performed. Four valves had to be opened or verified open. One valve 2-CS-18, RWST recirculation inlet header, required a change of position. When questioned, the operator checked the procedure and realized that he had entered the procedure at a different place than he had been instructed. He returned the lineup to the original condition and performed the steps. If this valve had not been opened, the CS pump recirculation flow path to the RWST would have been through a 1.5-inch line instead of both the 4-inch and 1.5-inch line. The inspectors concluded it was an operator error and informed the shift supervisor. The shift supervisor indicated that the operator would be counseled. On September 27, DR S-94-1811 was submitted. The inspectors reviewed the DR and determined that appropriate corrective actions were taken. The inspectors considered this weakness as an isolated occurrence.

4.4 Emergency Diesel Generator Surveillance Testing

The licensee performed surveillance tests 2-OPT-EG-001, Number 2 EDG Monthly Start Exercise Test, revision 5, 2-OPT-EG-005, Number 2 EDG Fuel Oil System Tests, revision 4, and 2-OSP-EG-6.1, Number 2 EDG Lube Oil and Cooling Water Sampling, revision 1, to demonstrate operability of the number 2 EDG and supporting components as required by TS. The inspectors observed the pre-evolution briefing, equipment lineup verifications, and portions of the surveillance tests to assess the licensee's knowledge and conduct of EDG testing. Test precautions were appropriately highlighted during the pre-evolution brief. The inspectors discussed methods of EDG performance verification and the purpose of selected procedural steps with operators during performance of the surveillance. Operators demonstrated detailed knowledge of the test procedures and EDG system design.

The EDG room operator noted that cooling water expansion tank level stabilized slightly below the normal operating band following the EDG start. The operator promptly inspected the EDG room, identified no visible indication of coolant leakage, and notified the control room of this abnormal condition. Lube oil and EDG component temperatures remained normal. The Unit 2 SRO contacted the EDG system engineer for assistance. The system engineer verified that recent oil analysis did not indicate the presence of water intrusion and that coolant chemistry was adequate to support a direct addition of water to the expansion

tank. The inspectors noted that the licensee did not have a procedure to restore expansion tank level during EDG operation. However, the Unit 2 SRO and system engineer coordinated effectively to assure proper cooling water quality and personnel safety were maintained during restoration of expansion tank level. The inspectors independently confirmed that the post addition coolant water chemistry was within specification as documented in procedure 2-OSP-EG-6.1.

The inspectors reviewed the above listed surveillance procedures and noted them to be of generally high quality. The inspectors questioned whether operators have sufficient guidance available for prompt restoration of EDG cooling water expansion tank level during occasions when the system engineer is not available for consultation. This item and minor procedure inconsistencies were discussed with the system engineer and operations personnel. The licensee agreed to review and revise procedures as necessary.

Operators continued the surveillance following restoration of cooling water expansion tank level. When attempting to place an electrical load on the EDG, the control switch for the EDG output breaker bound in the pull-to-lock position. The system engineer informed the Unit 2 SRO that attempts to further manipulate a degraded control switch with the EDG in operation had the potential to place the EDG out-of-phase onto the emergency bus. Operators secured the EDG and initiated a priority one work request to identify and correct the cause of the bound control switch. The licensee's decision to secure the EDG immediately rather than attempt cycling the control switch with the EDG in operation demonstrated a conservative safety perspective.

The inspectors reviewed and discussed the maintenance work order with the electrical maintenance supervisor. The work order provided sufficient flexibility for technicians to identify the cause of the control switch binding and accomplish the repair without necessitating intrusive switch disassembly. Control switch binding was attributed to a degraded switch cover plate. A component failure analysis was in progress at the close of this report period. The cover plate was replaced and operators cycled the switch by hand freely with no indication of further binding. The work order was completed in a timely manner and surveillance 2-OPT-EG-001 was performed successfully as a post maintenance test.

During performance of procedure 2-OPT-EG-005, fuel oil transfer pump 1-EE-P-1E, failed to meet acceptance criteria for adequate pump flow rate. The procedure specified a minimum flow rate of 7.6 GPM. A flow rate of 7.4 GPM was obtained during the test. The pump was declared inoperable and the appropriate TS action statement was entered. The inspectors witnessed the overhaul of the fuel oil transfer pump and also witnessed the installation of

the pump following overhaul. This maintenance was accomplished in accordance with WO 298297, procedure MCM-0134-02, Hydrex II Pump Mechanical Seal Replacement, revision 1, and a maintenance transmittal.

After the pump was disassembled mechanics identified that the internal gear clearances were excessive which resulted in reduced flow output. Components were machined to obtain the correct clearances and the pump was reassembled. The inspectors noted that mechanics used skill of the craft and a maintenance transmittal in lieu of a procedure to overhaul the pump. The inspectors concluded this maintenance activity was satisfactorily accomplished.

The inspectors walked down the EDG fuel oil transfer system when pump 1-EE-P-1E was removed and verified that the system was properly isolated and that FME covers were installed over system openings. The inspectors noted that with the fuel oil transfer pump removed the fuel oil piping was not supported and would easily move when agitated by hand. The suction piping to EDG fuel oil transfer pumps 1-EE-P-1D and F, which were operable, could also be moved. The inspectors concluded that this piping was required to withstand a seismic event and questioned whether the piping met seismic acceptance criteria with 1-EE-P-1E removed. The licensee evaluated this condition via a seismic analysis computer program and concluded that the fuel oil transfer piping was capable of withstanding a seismic event with the pump removed. Following pump reinstallation, the fuel oil transfer piping could not be moved. The pump was tested in accordance with 2-OPT-EG-005 and an acceptable flow rate of 8.3 GPM was obtained.

Operators successfully demonstrated the number 3 EDG operable as required by TS 3.16.B.1 during the period in which the number 2 EDG was inoperable for repair of the fuel oil transfer pump. The number 2 EDG was returned to service at 11:36 pm on September 27. The inspectors concluded that operations, engineering, and maintenance personnel effectively coordinated their efforts to minimize the time that the number 2 EDG was unavailable.

Within the areas inspected, no violations or deviations were identified.

5. Onsite Engineering Review (37551)

Review of SE for Temporary Leak Sealant Repair

On September 6 a steam leak was repaired on the Unit 1 C SG lower handhold cover. Every other bolt securing the handhold cover to the SG was removed one at a time and replaced with a stud and special capnut. The outer portion of the flange was wrapped with wire and a leak sealant compound was injected into the flange area via each stud/capnut assembly. Safety Evaluation 94-166, Leak Seal 1-RC-E-1C Handhold, dated September 1, 1994, concluded that this repair method did not create an

unreviewed safety question. The inspectors reviewed SE 94-166 and attended the SNSOC meeting that approved this SE. The inspectors concluded that the SE addressed the appropriate issues in that stress analysis for the bolting material and wire wrap were performed, amount of compound injected was limited, and the effect of radiation on the leak sealant was analyzed. The SE was approved by SNSOC with no changes. The SNSOC review of the SE was considered good, in that, the method of temporary leak repair was thoroughly evaluated.

Within the areas inspected, no violations or deviations were identified.

6. Annual Emergency Exercise (82301)

The inspectors observed the annual emergency exercise conducted on September 21, and also attended post exercise critiques. Activities in the CRS, TSC, LEOF, OSC and HP area were observed.

The inspectors monitored the beginning of the exercise scenario from the CRS. Operators properly responded to the scenario. The SS/SEM and STA properly classified the scenario as an Alert when conditions warranted. The turnover between SS/SEM and Assistant Station Manger to assume the SEM position was thorough. Although the exercise scenario simulated an event occurring in Unit 1, an individual operator was assigned as the Unit 2 CRO. During the scenario, the third RO assisted the Unit 1 CRO at the control board and the Unit 2 CRO assumed the primary responsibility of the third RO. The inspectors noted that during an actual event, the Unit 2 CRO would not be available to assume the responsibilities of the third RO and an extra licensed operator would be required to fill the position of the third RO. This issue was discussed with the licensee who stated that extra licensed personnel are assigned to each shift in order to provide additional support when required. This issue was listed as a comment on the emergency exercise critique results.

The TSC was promptly staffed and the Site Area and General Emergency event classifications were properly made. Damage control team tasks were prioritized as the TSC staff properly responded to the exercise. The inspectors noted that at one point in the scenario 10 CFR 50.54(x) was invoked when the initial conditions of a procedure could not be met and were waved. The licensee's basis for implementing 10 CFR 50.54(x) was that TSs require that procedures be followed and that deviating from procedural requirements resulted in deviating from TS requirements and therefore, required that 10 CFR 50.54(x) be invoked. The inspectors reviewed 10 CFR 50.54(x) and concluded that the licensee interpretation regarding procedure compliance was extremely conservative. However, when 10 CFR 50.54(x) is implemented, 10 CFR 50.72(b)(i)(B) requires that a one-hour report to the NRC be made. No report was simulated during the exercise. This concern was listed as a comment on the emergency exercise critique results.

Communications between the Recovery Manager and state and local officials in the LEOF were noted to be good. During the scenario, the

wind direction was predicted to change. Personnel in the LEOF were prepared for the change in wind direction and promptly expanded the area that required evacuation/shelter when a change in wind direction occurred.

Operations in OSC were good and well organized. Status updates were held frequently and were communicated to all maintenance personnel. Adequate pre-job and post-job briefs were held for damage control tasks. Proper emphasis was placed on communications with the damage control teams. The operations information link assisted in expediting planning of damage control tasks.

The inspectors attended the post drill critique conducted in the LEOF and OSC. The inspectors also attended the post drill critique conducted by the exercise observers. The inspectors noted that personnel were encouraged to express any problems encountered. Several comments were received. The licensee's exercise observers thoroughly reviewed these comments and identified additional issues and comments pertaining to the drill. The exercise objectives and issues and comments were thoroughly discussed, recorded and presented to management. The inspectors concluded that the licensee was very critical when evaluating the conduct of the emergency exercise.

During the drill, the inspectors observed the licensee utilize the new trunked radio system that was recently installed. Each organizational group (operations, HP, chemistry and maintenance) had communication within its own group and to the main system hub. Each group could not communicate directly with each other on independent channels (i.e. the OSC could not communicate by radio to HP or security). This reduced the amount of unwanted information to all groups and allowed each group to remain focused on their team members. The inspectors observed the use of the new radio system in the OSC. With the exception of the damage control teams assigned to the emergency switchgear rooms, communications with the damage control teams were very good overall. Radio checks were conducted after leaving the OSC and frequent status check-ins were utilized.

At one point in the drill, there were three damage control teams assigned independent tasks in the ESGR. Because of the electrical equipment in the ESGR, radios were not allowed to be used. The inspectors noted that the three damage control teams were communicating with the OSC via one station telephone. The teams were congregating around the telephone to receive further instructions from the OSC. This observation was provided to the licensee and was added as a comment to the emergency exercise critique results.

Within the areas inspected, no violations or deviations were identified.

7. Licensee Event Report Followup (92700)

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

7.1 (Closed) LER 50-280, 281/93-007-00, Portions of the Turbine Trip Inputs to the Reactor Protection System Were Performed Outside the TS Required Time Frames During Previous Outages. TS table 4.1-1, item 28 requires that turbine trip inputs to reactor protection be functionally tested prior to each startup. During a review of TS surveillance implementation, the licensee identified that this testing was being accomplished after a unit was on line in lieu of prior to each startup. As corrective action, procedure 1/2 IPT-RP-TM-001, Turbine Trip Signal Input to Reactor Protection System Functional Test, was developed to provide instructions for testing these components prior to startup. The inspectors reviewed performance copies of 1/2-IPT-RP-TM-001 dated March 22, May 12 and June 22, 1994, and verified that the turbine trip inputs to reactor protection were functionally tested prior to each Unit 1 and 2 startup performed in 1994.

7.2 (Closed) LER 50-280, 281/93-007-01, Missed Surveillance Due to Failure to Test One Contact of the Auxiliary Feedwater Pump Low-Low Steam Generator Auto Start Logic. TS table 4.1-1, item 32.a requires that the SG water low-low level instrumentation channels for AFW pump auto-start be calibrated during each RFO. During a review of TS surveillance implementation, the licensee identified that Unit 2 procedures did not test the A/C SG level combination. As a result, a contact in the start matrix was not being tested. Unit 1 procedures fully tested the channel. As immediate corrective action a 24-hour LCO was entered and exited after the circuit was properly tested. The inspectors reviewed 2-OPT-FW-012, SG Low-Low Level Test, revision 0, and verified that the procedure was updated to provide instructions for testing the SG low-low A/C combination that opens the steam admission valves to the TDAFW pump. The inspectors also discussed this issue with the supervisor of station procedures who now is required to review all procedure changes on a daily basis to ensure that procedure changes for one unit are evaluated and implemented for the other unit when required.

7.3 (Closed) LER 50-280, 281/93-007-02, Missed Surveillance Due to Not Performing Auxiliary Feed Water Channel Check Prior to Certain Startups. TS table 4.1-2, item 1, requires that the AFW flow rate channels be checked prior to each startup if not done within the previous week. During a review of TS surveillance implementation, the licensee identified that AFW flow channel checks were not performed prior to startup when the unit was not initially in a cold shutdown condition. When this condition was identified, Unit 1 was in cold shutdown and Unit 2 was in hot shutdown so no immediate corrective action was required. The inspectors reviewed

1/2-GOP-1.4, Unit Startup from Hot Shutdown to 2% Power, revision 10, for Unit 1 and revision 9 for Unit 2, and verified that the procedures were revised to require AFW flow instrument channel checks be performed prior to startup.

The three LERs discussed above were identified by the licensee during their corrective action review of TS surveillance testing. This project was discussed in NRC Inspection Report Nos. 50-280/94-24 and 50-281/94-24.

Within the areas inspected, no violations or deviations were identified.

8. Action on Previous Inspection Items (92702)

(Closed) URI 50-280, 281/92-15-01, Lack of Formal UFSAR Update Process for Non-Plant Type Modifications or Changes That Occur On or Around The Facility. This item resulted from the NRC's review of the licensee's evaluation of environmental changes around the site (TI 2515/112). The following items were reviewed:

The adequacy of the licensee's program in evaluating health and safety issues resulting from changes in population distribution, industrial facilities, military activity, or transportation hazards that arise on or near the site.

Documentation of changes in population distribution, industrial facilities, military activity, or transportation hazards that occur on or near the site in updates to the UFSAR.

The results of that inspection determined that the licensee had no formal program to routinely review changing population distribution or new hazards created by demographic changes around the facility. The licensee also did not routinely update site information contained in chapter 2 of the UFSAR. The inspection also identified two hazards that were not adequately addressed in the UFSAR.

Since identification of the above items by the NRC, Virginia Power has developed a formal program to perform periodic reviews of UFSAR sections that are not routinely changed by plant modifications. Procedure VPAP-2803, Safety Analysis Report (SAR) Management, revision 0, was developed and contains instructions in section 6.2.6 to perform the section reviews. The inspectors reviewed this procedure and held discussions with project management as to details of these periodic reviews. The inspectors were provided a Level II schedule for the UFSAR Improvement Project. This project has completed the review and update of UFSAR chapter 2 which was reissued in revision 22, dated April 1994. The inspectors reviewed this revised chapter and determined it adequately resolved the two hazards identified in the URI associated with air traffic and the onsite combustion turbines. Remaining reviews and overall project completion is currently being scheduled and

personnel are being assigned. The licensee elected to have the corporate licensing group maintain the UFSAR with engineering assistance being requested as needed.

Within the areas inspected, no violations or deviations were identified.

9. Exit Interview

The inspection scope and findings were summarized on October 5, 1994, with those persons indicated in paragraph 1. The inspectors described the areas inspected and discussed in detail the inspection results addressed in the Summary section and those listed below.

Item Number	Status	Description/(Paragraph No.)
LER 50-280, 281/93-007-00	Closed	Portions of the Turbine Trip Inputs to the Reactor Protection System Were Performed Outside the TS Required Time Frames During Previous Outages (paragraph 7.1).
LER 50-280, 281/93-007-01	Closed	Missed Surveillance Due to Failure to Test One Contact of the Auxiliary Feedwater Pump Low-Low Steam Generator Auto Start Logic (paragraph 7.2).
LER 50-280, 281/93-007-02	Closed	Missed Surveillance Due to Not Performing Auxiliary Feed Water Channel Check Prior to Certain Startups (paragraph 7.3).
URI 50-280, 281/92-15-01	Closed	Lack of Formal UFSAR Update Process for Non-Plant Type Modifications or Changes That Occur On or Around The Facility (paragraph 8).

Proprietary information is not contained in this report. Dissenting comments were not received from the licensee.

10. Index of Acronyms and Initialisms

AFW	AUXILIARY FEEDWATER
BC	BEARING COOLING
CAT	CHEMICAL ADDITION TANK
CC	COMPONENT COOLING
CFR	CODE OF FEDERAL REGULATIONS
CRO	CONTROL ROOM OPERATOR

CRS	CONTROL ROOM SIMULATOR
CS	CONTAINMENT SPRAY
DR	DEVIATION REPORT
EDG	EMERGENCY DIESEL GENERATOR
ESGR	EMERGENCY SWITCHGEAR ROOM
ESF	ENGINEERED SAFETY FEATURE
FME	FOREIGN MATERIAL EXCLUSION
GPM	GALLONS PER MINUTE
HP	HEALTH PHYSICS
LCO	LIMITING CONDITION OF OPERATION
LEOF	LOCAL EMERGENCY OPERATIONS FACILITY
LER	LICENSEE EVENT REPORT
MCR	MAIN CONTROL ROOM
MOV	MOTOR OPERATED VALVE
NRC	NUCLEAR REGULATORY COMMISSION
OSC	OPERATIONAL SUPPORT CENTER
PCV	PRESSURE CONTROL VALVE
PM	PREVENTIVE MAINTENANCE
PMT	POST MAINTENANCE TEST
RFO	REFUELING OUTAGE
RCA	RADIOLOGICAL CONTROL AREA
RO	REACTOR OPERATOR
RWST	REFUELING WATER STORAGE TANK
SE	SAFETY EVALUATION
SEM	STATION EMERGENCY MANAGER
SG	STEAM GENERATOR
SNSOC	STATION NUCLEAR SAFETY AND OPERATING COMMITTEE
SRO	SENIOR REACTOR OPERATOR
SS	SHIFT SUPERVISOR
STA	SHIFT TECHNICAL ADVISOR
SW	SERVICE WATER
TDAFW	TURBINE DRIVEN AUXILIARY FEEDWATER
TI	TEMPORARY INSTRUCTION
TS	TECHNICAL SPECIFICATION
TSC	TECHNICAL SUPPORT CENTER
UFSAR	UPDATED FINAL SAFETY ANALYSIS REPORT
URI	UNRESOLVED ITEM
WO	WORK ORDER