



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

Report No.: 50-395/94-10

Licensee: South Carolina Electric & Gas Company  
 Columbia, SC 29218

Docket No.: 50-395

License No.: NPF-12

Facility Name: Virgil C. Summer Nuclear Station

Inspection Conducted: April 1-30, 1994

Inspectors:	<u>For</u> <u>R. W. Wright</u>	<u>5/17/94</u>
	R. C. Haag, Senior Resident Inspector	Date Signed
	<u>For</u> <u>R. W. Wright</u>	<u>5/17/94</u>
	T. R. Farnholtz, Resident Inspector	Date Signed

Accompanying Inspector: M. T. Widmann, Regional Inspector  
 (April 18-22, 1994)

Approved by:	<u>Floyd S. Cantrell</u>	<u>5/17/94</u>
	Floyd S. Cantrell, Chief	Date Signed
	Reactor Projects Section 1B	
	Division of Reactor Projects	

SUMMARY

Scope:

This routine inspection was conducted by the resident inspectors onsite in the areas of monthly surveillance observations, monthly maintenance observations, operational safety verification, installation and testing of modifications, review of licensee self-assessment capability, and action on previous inspection findings. Selected tours were conducted on backshift or weekends. These tours were conducted on four occasions.

Results: (Summarized by SALP functional area)

Operations

The licensee identified a potential single failure scenario that would stop high head safety injection flow. This is identified as an unresolved item (paragraph 5.b). An unresolved item was identified concerning the practice of maintaining an auxiliary building rollup door open for extended periods of time (paragraph 5.c). The overall condition, operation and appearance of the plant continues to be excellent.

### Maintenance and Surveillance

A poor work practice was observed involving signoffs being completed in a maintenance document before the work was actually performed. While no specific procedural guidance was found on the timeframe for completing signoffs the inspector considered it a fundamental and basis work practice to complete signoffs after the work is performed. Maintenance and surveillance activities were performed using good work practices and procedures.

### Engineering and Technical Support

A NRC Information Notice involving inoperable safety-related circuit breakers received a poor technical review. This resulted in an incorrect determination that no further action was required in response to this potential problem with breaker operation. No discrepancies were identified in the licensee's evaluation of other Information Notices.

### Plant Support

A non-cited violation was identified for failure of hourly roving fire watches to fulfill all the procedural requirements during patrols in the cable spreading rooms (paragraph 8).

## REPORT DETAILS

### 1. Persons Contacted

#### Licensee Employees

- W. Baehr, Manager, Health Physics
- \*C. Bowman, Manager, Maintenance Services
- \*M. Browne, Manager, Design Engineering
- L. Faltus, Acting Manager, Chemistry
- \*M. Fowlkes, Manager, Nuclear Licensing & Operating Experience
- S. Furstenberg, Associate Manager, Operations
- \*D. Gentry, Supervisor, Nuclear Security
- \*L. Hipp, Manager, Materials and Procurement
- \*S. Hunt, Manager, Quality Systems
- D. Lavigne, General Manager, Nuclear Safety
- \*J. Nesbitt, Acting Manager, Technical Services
- \*K. Nettles, General Manager, Station Support
- \*H. O'Quinn, Manager, Nuclear Protection Services
- \*M. Quinton, General Manager, Engineering Services
- \*J. Skolds, Senior Vice President, Nuclear Operations
- \*G. Taylor, General Manager, Nuclear Plant Operations
- \*G. Walker, Supervisor, Craft/Technical Training
- \*R. White, Nuclear Coordinator, S.C. Public Service Authority
- \*B. Williams, Manager, Operations

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

\*Attended exit interview

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

### 2. Plant Status

The plant operated at 65 percent power from the beginning of the inspection period until April 13, 1994, when a power increase was initiated. Reactor power was stabilized at 72 percent and remained at that level for the remainder of the inspection period. The reduced power levels were for the purpose of fuel conservation. The power increase to 72 percent enabled the plant to operate more efficiently.

## 3. Monthly Surveillance Observation (61726)

The inspectors observed surveillance activities of safety related systems and components listed below to ascertain that these activities were conducted in accordance with license requirements. The inspectors verified that required administrative approvals were obtained prior to initiating the test, testing was accomplished by qualified personnel in accordance with an approved test procedure, test instrumentation was calibrated, and limiting conditions for operation were met. Upon completion of the test, the inspectors verified that test results conformed with technical specifications and procedure requirements, any deficiencies identified during the testing were properly reviewed and resolved and the systems were properly returned to service. Specifically, the inspectors witnessed/reviewed portions of the following test activities:

- a. Quarterly test of "B" reactor building spray pump (STP 212.002). All measured parameters and surveillance criteria were met during the performance of the test.
- b. Monthly operational test of pressurizer pressure transmitter, IPT00457 (STP 302.006). This test was conducted to verify operability of the pressurizer instrument signal processing equipment, alarm and trip setpoint per TS surveillance requirements 4.3.1.1 and 4.3.2.1. The system functioned as designed.
- c. Testing 480 VAC switchgear breaker XSW-1B3 03B (STP 502.002). The surveillance is performed once per 60 months. The purpose of the surveillance test was to demonstrate that the 480 VAC circuit breaker used for containment penetration overcurrent protection is operable per TS 4.8.4.1.a.2 by overcurrent trip testing of the breakers and to insure that the 60 month PM is performed per TS 4.8.4.1.b. No discrepancies were noted. All acceptance criteria were met during the performance of the test.
- d. Emergency diesel generator "A" operability test (STP 125.002). This was a monthly surveillance test which satisfies the requirements of TS 4.8.1.1.2.a. The diesel came up to speed and carried the full electrical load as required.
- e. Emergency diesel generator "A" support system pump and valve test (STP 225.001). This test required the installation of a temporary transmitter to indicate diesel fuel oil day tank level. For this purpose, a length of plastic tubing is normally kept attached to the drain connection on the tank. The tubing is then coiled and stored in a drip pan located beneath the drain connection. The drip pan contains granules of absorbent material to soak up any spilled fuel oil. When connecting the transmitter, the free end of the tubing is removed from the drip pan and is attached to the transmitter. The inspector noted that no cap or plug is used to

reduce the possibility of absorbent granules from entering the tubing and subsequently the transmitter. The licensee was notified of this observation.

- f. Train "A" solid state protection system surveillance test (STP 345.037). No discrepancies were noted.

All observed test were performed in accordance with procedural requirements and demonstrated acceptable results. Test personnel were knowledgeable of the test activities.

#### 4. Monthly Maintenance Observation (62703)

Station maintenance activities for the safety-related systems and components listed below were observed to ascertain that they were conducted in accordance with approved procedures, regulatory guides, and industry codes or standards and in conformance with TS.

The following items were considered during this review: that limiting conditions for operation were met while components or systems were removed from service, approvals were obtained prior to initiating the work, activities were accomplished using approved procedures and were inspected as applicable, functional testing and/or calibrations were performed prior to returning components or systems to service, activities were accomplished by qualified personnel, parts and materials used were properly certified, and radiological and fire prevention controls were implemented. Work requests were reviewed to determine the status of outstanding jobs and to ensure that priority was assigned to safety-related equipment maintenance that may affect system performance. The following maintenance activities were observed:

- a. Troubleshooting and repair of the high vibration on "D" feedwater booster pump (MWR 9403505). The high vibration was caused by excessive grease in the motor/pump coupling. The licensee contacted the coupling manufacturer, who recommended that the coupling be packed with two pounds of grease. Previously four pounds of grease had been installed based on the specification in the lube oil manual. After performing the recommended maintenance the coupling was reassembled. The FW Booster Pump was measured for high vibration subsequent to the maintenance activity. The recorded vibrations met the acceptance criteria for the FW Booster Pump operation.
- b. Preventive maintenance task to calibrate meters on the local panel for "B" EDG (PMTS P0176531). The voltage, amperes, and kilowatt meters were included in this calibration activity that is performed every three years. The inspector also reviewed the maintenance history records for the EDG meters located in the control room which are used for data gathering during EDG surveillance testing. These meters are also periodically calibrated.

- c. Inspection and calibration of "3" EDG jacket water (JW) temperature switch ITS15436B and lube oil (LO) temperature switch ITS15410B (MWRs 9403452 and 9403451). In response to the burnt contacts for the JW and LO heaters (see below) the temperature switches which provide the input signals for energizing and de-energizing the heaters were checked. The LO temperature switch was within the tolerance setting while the JW temperature switch close setting error was +2.4°F (tolerance plus or minus 2.2°F). This resulted in a 3.1°F deadband between the switch close and open settings. A 5°F deadband is desired. The close switch setting was readjusted.
- d. Internal inspection and cleaning of the blades on service water building supply fan XFN0080A (PMTS P0176431).
- e. Service water to "A" EDG relief valve overhaul (MWR 9403286). Testing of this valve in the as found condition indicated that it lifted at 68 psig while the setpoint pressure was 64 plus/minus 2 psig. This out-of-tolerance condition was documented in a nonconformance notice (NCN #4929). The valve was disassembled, reworked, reassembled, and adjusted within tolerance. No discrepancies were noted.
- f. Fire service system flow test (PMTS P0177914). This functional test was done to gather data after sections of the preaction sprinkler system were cleaned due to a low flow condition (see NRC Inspection Report 50-395/94-03).
- g. Maintenance run on the "A" EDG to check the operation of the diesel fuel oil day tank level switch (MWR 9413081). During the surveillance run of the "A" EDG on April 26, 1994, the fuel oil transfer pump failed to turn off when the day tank level reached the high level setpoint. This resulted in the day tank overflowing back to the underground storage tank. The EDG fuel oil transfer system is designed to allow excessive fuel oil in the day tank to return to the storage tank without a loss of fuel oil inventory. The transfer pumps are controlled by the day tank level switch. The purpose of the maintenance run was to observe the operation of the level switch and attempt to duplicate the problem. This appears to be a continuation of problems that led to replacement and testing of switches in this application as discussed in Inspection Report 395/94-07, paragraph 7. The inspector observed the run and noted that both the lead and standby fuel oil transfer pumps operated as required. The initial problem could not be duplicated. The licensee intends to repeat the transfer pump tests the next time the "A" diesel generator is run for its normal monthly surveillance test to verify proper operation of the day tank level switch.

- h. Preventive maintenance task to test molded case circuit breaker XMC1DB2Y 08EH (feed for "A" charging pump miniflow isolation valve) (PMTS P0165267).
- i. Replacement of starter contactors M1 and M3 in the "B" EDG auxiliary electrical panel (MWR 94E3057). These contactors control the starting and stopping functions for the jacket water heaters and the lube oil heaters. An earlier inspection identified signs of excessive arcing on the 480 VAC contacts. As part of the corrective action the control temperature switches were calibrated. The licensee has not completed their final review of this issue.

The maintenance activities observed were performed using good work practices and per the applicable procedural instructions.

5. Operational Safety Verification (71707)

a. Plant Tour and Observations

The inspectors conducted daily inspections in the following areas: control room staffing, access, and operator behavior; operator adherence to approved procedures, TS, and limiting conditions for operations; and review of control room operator logs, operating orders, plant deviation reports, tagout logs, and tags on components to verify compliance with approved procedures.

The inspectors conducted weekly inspections for the operability verification of selected ESF systems by valve alignment, breaker positions, condition of equipment or component(s), and operability of instrumentation and support items essential to system actuation or performance. The emergency feedwater and the emergency borate portion of the reactor water makeup systems were included in these inspections.

Plant tours included observation of general plant/equipment conditions, fire protection and preventative measures, control of activities in progress, radiation protection controls, physical security controls, plant housekeeping conditions/cleanliness, and missile hazards. Reactor coolant system leak rates were reviewed to ensure that detected or suspected leakage from the system was recorded, investigated, and evaluated; and that appropriate actions were taken if required. Selected tours were conducted on backshifts or weekends.

The overall condition, operation and appearance of the plant continues to be excellent.

b. Potential Unresolved Single Failure Condition

The licensee identified a concern with two charging/high head safety injection (HHSI) pump cross-connect motor operated valves, XVG-8133A and XVG-8133B, not having a "power lockout" feature.

The concern involves a potential single failure of either XVG-8133A or XVG-8133B, when the "C" HHSI pump is aligned to the "B" train which would result in the termination of all HHSI flow. Both these valves are required to be open during normal operations. The single failure of concern involves a "hot short" in the control circuitry for the valves which would cause a valve to close unexpectedly. A "power lockout" feature, when activated, would prevent the valve from changing positions in response to either inadvertent operator action or invalid (hot short) signal. Application of a power lockout can include an electrical switching device or the removal of power from the component.

During licensing of the plant, motor operated valves were evaluated for "power lockout" consideration. A list was generated by the licensee of valves that would be controlled as "power lockout" valves, however, these two valves were not included. Section 6.3.2.20 of the FSAR references Branch Technical Position EICSB 18, "Application of the Single Failure Criterion to Manually-Controlled Electrically-Operated Valves" for the selection of valves requiring power lockouts. Valves XVG-8133A and XVG-8133B are not referenced in the FSAR, Section 6.3.2.20, which describes the twelve valves that have power lockout features.

Based on the inspector's review of Branch Technical Position EICSB 18, valves XVG-8133A and XVG-8133B appear to meet the criteria for requiring power lockout consideration. The licensee's current view is that Section 6.3.2.20 of the FSAR (involving valves that require power lockout features) is a "Licensing Basis" issue and does not constitute part of the plant's "Design Basis". In addition the licensee believes that no long term action is required to address the power lockout concern for XVG-8133A and XVG-8133B due to the low probability of this single failure event ever occurring. To resolve this issue the licensee plans to submit to the NRC a letter documenting their position. The inspector will continue to followup on the licensee's actions for this issue.

To address this potential problem until the final resolution is obtained, engineering provided guidance to avoid operating the "C" HHSI pump on "B" train. If plant conditions require the operation of "C" HHSI pump on "B" train then the supply breakers for both XVG-8133A and XVG-8133B should be de-energized and locked open with the valves in the open position. Station Order, SO-94-16, addresses this current unresolved situation and provided the above guidance to the operators on the precautions for system alignment when operating "C" pump on "B" train. A caution tag was also placed on "C" pump control switch. The licensed operators on each shift reviewed SO-94-16 prior to their shift's work and initial



that the orders have been reviewed. Based on the inspector's review of this issue and a review of SO-94-16 the licensee's initial actions are adequate to ensure operability of the high head safety injection system. This item is considered unresolved (URI 94-10-03, HHSI X-connect valves need for power lockout) pending resolution of power lockout concern by NRR.

c. Openings in The Auxiliary Building Wall

The inspector questioned the licensee on the appropriateness of maintaining the auxiliary building rollup door in the open position for extended periods of time. The door is located on the north wall of the auxiliary building, elevation 436', and has an approximate size of 14'(width) x 16'(height). The licensee's practice was to open the door during favorable outside ambient conditions such that the air flow into the building would enhance the comfort level in the auxiliary building. These conditions generally occur during the fall, spring, and summer time periods.

Section 9.4.2, Auxiliary and Radwaste Area Ventilation System, of the FSAR provides only limited information on the design basis of the ventilation system. Paragraph 9.4.2.1(5) addresses the air pressure in the auxiliary building with the following statement, "Maintenance of a negative auxiliary building pressure ensures that exfiltration from the auxiliary building does not occur. The FSAR does not address the auxiliary building rollup door nor any other potential air flow opening in the auxiliary building enclosure. In response to the inspector's questions, the licensee stated that it was their belief that opening the rollup door would not have a negative impact on the operation of the auxiliary building. However, there was no written evaluation or review to document the licensee's position regarding the rollup door. The licensee plans a complete written evaluation to support their views on the acceptability of opening the auxiliary building rollup door. This issue is identified as unresolved item 50-395/94-10-01, pending review of the licensee's evaluation and review of the practice of maintaining the door open without prior completion of a written evaluation to support this decision.

6. Installation and Testing of Modifications (37828)

Removal and replacement of turbine building sump liquid radiation monitor, RM-L0008, was accomplished per MRF 22177. The radiation monitor was replaced with a new model that has a reduced potential for clogging from sump debris and reduce the amount of maintenance associated with cleaning the monitor. Compensatory measures were being implemented by health physics taking and analyzing grab samples of the sump every six hours. The inspector reviewed the GTP-702, Attachment VI.Q tracking sheet and verified that the turbine building sump was being sampled every six hours.

The inspector identified a concern with modification personnel completing signoffs in the data sheet prior to the actual work being performed. The applicable work steps that were signed off prior to accomplishing the work related to the reassembly of two piping flanged connections (i.e. installation of proper fasteners and gaskets, and proper torquing requirements). The QC inspection signoffs that was also related to this work had not been signed off. The inspector informed licensee management of this observation concerning signoffs. The inspector reviewed SAP-300, Conduct of Maintenance, to determine the level of guidance provided for completion of signoffs. While no specific guidance was found, the inspector considered the practice of completing signoffs after performing the applicable work a fundamental and basis attribute of a work control process. The inspector will followup on any licensee actions in response to this observation.

No other problems or discrepancies were identified based on a review of maintenance and modification group work packages, or work activities being performed in the field.

7. Review of Licensee Self-Assessment Capability (40500)

a. Evaluation of Licensee's Review of Information Notice 94-02

The inspector reviewed the licensee's assessment of NRC Information Notice (IN) 94-02, Inoperability of General Electric Magne-Blast Breaker Because of Misalignment of Close-Latch Spring. The IN described a GE Magne-Blast breaker that was discovered to be inoperable due to the closing springs being discharged. Misalignment of the close-latch spring prevented the close-latch monitoring switch from actuating which is a required signal for the charging motor to recharge the closing springs. The spring misalignment allowed the coils of the spring to catch on the switch mounting plate which restricted movement of the switch. Only local breaker indication was available to display the condition of the closing spring.

The IN stated that only tension style close-latch springs may be susceptible to misalignment problems. A newer design close-latch "torsion-style" spring which surrounds the close-latch shaft will prevent the spring from catching on the switch mounting plate.

After reviewing the licensee's assessment for the IN, the inspector concluded that the assessment was of limited scope and did not address several key issues. This conclusion was based on:

- In the licensee's assessment description of the IN, the following statement was included, "This condition gave local, but not remote indication of springs not fully charged. It was the practice of the plant where this event occurred to rely on remote breaker indication". However, the IN did not discuss the practices of this plant in regard to reliance on remote breaker indication nor did it provide enough information to

support this statement in the licensee's assessment. This conclusion was used by the licensee to support their position that no action was needed.

- The assessment also stated that, "SAP-201, Danger Tagging requires that upon removal of Red Tags, that breakers which are racked in be energized and that all local indications be checked at that time". The only similar statement in SAP-201, identified by the inspector, dealt with paragraph 5.5.3 that pertained to a danger tagger's responsibilities and that they ensure components operate properly during repositioning. No requirements were specified in SAP-201 on verification of local breaker indications.
- The IN makes reference to two different types of close-latch springs. A torsional style spring is not susceptible to the misalignment problem while a tension style spring is susceptible. In the licensee's initial assessment no mention was made to the type of close-latch springs installed in the 7.2 kV breakers at V. C. Summer. For the initial assessment, the evaluator did not visually inspect any breakers to obtain a better understanding of this potential problem. In a later revision of the licensee's assessment, it was mistakenly concluded that torsion styles were installed.
- The assessment focused only on breaker racking operations for opportunities to have a misaligned spring that could affect breaker operability. The assessment failed to recognize that this condition could occur during subsequent operation of the breaker.

The licensee's assessment of the IN was that no further action was needed. The inspectors review of the IN concluded that the 7.2 kv onsite could be susceptible to the same failure mechanism noted in the IN. Based on the inspectors comments, the licensee is reviewing this issue again to determine if further action is needed.

b. Additional Review of IN Technical Evaluation Packages

The inspector reviewed five IN evaluation packages performed by the Nuclear Licensing & Operating Experience (NL&OE) group. The licensee conducts reviews of generic communications as routine function of the NL&OE group. Of the packages reviewed by the inspector, two of the five IN evaluation packages lacked adequate documentation to understand the licensee's position and why the issue was closed out.

The evaluation package for IN 93-84, which dealt with the failure of the number one seal on the reactor coolant pump (RCP) and subsequent operator actions was left as an open issue. The recommendations of Westinghouse to upgrade the measured RCP seal

leakoff flow were not feasible to implement at the time of the review according to the licensee's documentation. No followup by the NL&OE group, the system engineer, operations or training was apparent to the inspector for the IN 93-84 evaluation package other than the issue is to remain open. Subsequent discussions with the licensee determined that the issue has been reviewed and addressed by the system engineer, although not documented. RCP operating procedures and the corresponding operator actions are based on seal number one leakoff flow and are more conservative than the recommended Westinghouse actions of Technical Bulletin 93-01-R0.

Evaluation package IN 94-10, which dealt with motor operated valves (MOV) pinion gear keys becoming dislodged or being sheared also contained incomplete documentation. The issue of deficient material being installed for motor pinion keys (i.e., American Iron and Steel Institute (AISI) 1018 in lieu of 4140 material) was not addressed in the evaluation package. Following subsequent discussions with the NL&OE personnel, a Technical Work Record (a permanent document filed in the evaluation package record), was generated to address the material aspect of IN 94-10.

Information Notice Evaluation Packages Reviewed:

IN 93-84,	Determination of Westinghouse Reactor Coolant Pump Seal Failure
IN 93-87,	Fuse Problems with Westinghouse 7300 Printed Circuit Cards
IN 94-05,	Potential Failure of Steam Generator Tubes with Kinetically Welded Sleeves
IN 94-10,	Failure of MOV Due to Sheared/Dislodged Motor Pinion Gear Key
IN 94-20,	Common Cause Failures Due to Inadequate Design and Dedication

During the inspector's review of INs 93-87, 94-05, and 94-20 evaluation packages no discrepancies were identified and adequate reviews were performed by the NL&OE group.

8. Action on Previous Inspection Findings (92701)

(Closed) Unresolved Item 50-395/94-07-04, Limited Roving Fire Watch (RFW) Patrols

The inspector had identified that RFW patrols in the two cable spreading rooms, elevations 425 and 448, were being performed in short time durations. The hourly roving fire watch patrol had been previously established due to the separation criteria of 10 CFR 50, Appendix R not being satisfied for cabling routed through the rooms. Specifically, on

February 7, 1994, the inspector observed that a RFW in the 448' elevation cable spreading room only stepped in the front entrance way to the room and did not patrol through the remaining portions of the room. The total duration of the RFW's patrol in the room was 24 seconds. (The approximate size of the room is 4700 square feet.)

Additionally, the inspector obtained security access records for cable spreading rooms, elevations 425 and 448, for the time period February 7 - 9, 1994. Review of the 142 hourly RFW records revealed the following observations: 79 patrol durations were less than or equal to 20 seconds; 12 patrol durations were less than or equal to 10 seconds (the shortest duration was 6 seconds); and only 2 patrol durations were greater than 40 seconds.

Section 5.3 of FPP-004, Duties of a Fire Watch, specifies that a RFW patrol through the affected room or area once per hour, look for signs of smoke or fire, and look for items that may create a fire hazard. Based on the inspector's observation, the February 7, 1994, hourly RFW patrol did not satisfy the requirements of FPP-004. Specifically, the RFW was only at the cable spreading room entrance, therefore, the RFW did not patrol through the affected area nor could the RFW look for fire hazard items that may have been in the room. The inspector also questioned the ability of the other short duration RFW patrols to satisfy the requirements of FPP-004 when patrolling large areas such as the cable spreading rooms.

During the followup review of this issue the licensee informed the inspector that the hourly RFW patrols in the cable spreading rooms were not required by the fire protection plan but were implemented as a "defense in depth" measure. The licensee contends that the compensatory action for the lack of adequate cable separation was satisfied by a temporary modification that was performed on the "C" charging pump cooling valve. The inspector reviewed the requirements of 10 CFR 50, Appendix R, for fire protection of safe shutdown capacity, the temporary modification for "C" charging pump, and the operating history for "C" pump during the applicable time period. The inspector concluded that the hourly RFW patrols were not required by the fire protection plan.

The licensee provided the RFWs with additional verbal guidance for the hourly patrols. Currently the RFWs are walking through the areas and spending more time during their patrols. The inspector verified this in discussions with RFWs and a review of recent security access records.

The hourly RFW patrols in the cable spreading rooms failed to comply with all the procedural requirements in FPP-004 and is identified as a violation. Since the RFW patrols were not required by the fire protection plan this violation has only minor safety significance, therefore, it is not being cited because the criteria specified in Section VII.B of the NRC Enforcement Policy were satisfied. This non-cited violation is identified as NCV 94-10-02, Failure to adequately implement the duties of an hourly roving fire watch.

## 9. Exit Interview (30703)

The inspection scope and findings were summarized on May 3, 1994, with those persons indicated in paragraph 1. The inspectors described the areas inspected and discussed the inspection findings.

The licensee did not view the implementation of the roving fire watches in the cable spreading rooms as a failure to follow procedural requirements but as an area that can be improved. The licensee did not identify as proprietary any of the materials provided to or reviewed by the inspectors during the inspection.

<u>Item Number</u>	<u>Description and References</u>
94-10-01	URI - Unevaluated openings of the auxiliary building enclosure.
94-10-02	NCV - Failure to implement the requirements for a hourly roving fire watch.
94-10-03	URI - HHSI X-connect valves need for power lockout

## 10. Acronyms and Initialisms

CVCS	Charging and Volume Control System
EDG	Emergency Diesel Generator
ESF	Engineered Safety Feature
FPP	Fire Protection Procedure
FSAR	Final Safety Analysis Report
FW	Feedwater
GE	General Electric
GTP	General Test Procedure
HHSI	High Head Safety Injection
IN	Information Notice
JW	Jacket Water
kV	Kilovolt
LER	Licensee Event Report
LO	Lube Oil
MOV	Motor Operated Valve
MRF	Modification Request Form
MWR	Maintenance Work Request
NCN	Nonconformance Notice
NL&OE	Nuclear Licensing and Operating Experience
NRC	Nuclear Regulatory Commission
NRR	Nuclear Reactor Regulation
PM	Preventive Maintenance
PMTS	Preventive Maintenance Task Sheet
PSIG	Pounds Per Square Inch Gauge
PTP	Preventive Test Procedure
PZR	Pressurizer
RB	Reactor Building

RCP	Reactor Coolant Pump
RCS	Reactor Coolant System
RFW	Roving Fire Watch
RHR	Residual Heat Removal
RWP	Radiation Work Permit
SAP	Station Administrative Procedure
SI	Safety Injection
SO	Station Order
SPR	Special Report
STP	Surveillance Test Procedure
TS	Technical Specification
VAC	Voltage Alternating Current