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

Report Nos.: 50-325/95-22 and 50-324/95-22

Licensee: Carolina Power and Light Company
P. O. Box 1551
Raleigh, NC 27602

Docket Nos.: 50-325 and 50-324 License Nos.: DPR-71 and DPR-62

Facility Name: Brunswick 1 and 2

Inspection Conducted: October 1 - November 3, 1995

Lead Inspector: MB Shymlock for 12-1-95
C. A. Patterson, Senior Resident Inspector Date Signed

Other Inspectors: P. M. Byron, Resident Inspector
M. T. Janus, Resident Inspector

Approved By: MB Shymlock 12-1-95
M. B. Shymlock, Chief Date Signed
Reactor Projects Branch 4
Division of Reactor Projects

SUMMARY

Scope:

This routine resident inspection included the areas of operations, maintenance and surveillance, engineering, and plant support.

Results:

In the Maintenance and Surveillance area, an unresolved item was identified concerning problems with the control building ventilation system, paragraph three. Test results indicated a negative pressure when a positive pressure was required. The licensee concluded that the system was operable with compensatory measures. A task force was assigned to review the problem and a recent battery room ventilation modification which may have affected the system.

In the Engineering area, an inspector followup item was identified concerning the unsuccessful attempt to replace the Unit 2 diesel generator governor with a newer model, paragraph four. This same modification was made at another facility without problems. The unloaded governor response was not as expected and the old governor was reinstalled. The licensee has returned the new governor to the vendor for testing.

In the Plant Support area, inconsistent personnel monitoring practices were observed for personnel exiting the radiological control areas, paragraph five. Management assigned action to resolve the issue. The inspector questioned the controls for exceeding the allowable combustible load equivalent for painting in the battery rooms. The licensee took action to strengthen the controls. The annual exercise was conducted on October 31, 1995, with good communications and realism.

REPORT DETAILS

1. Persons Contacted

Licensee Employees

*W. Campbell, Vice President, Brunswick Nuclear Plant
*G. Barnes, Manager, Training
A. Brittain, Manager, Security
N. Gannon, Manager, Maintenance
J. Gawron, Manager, Environmental & Radiological Control
R. Lopriore, General Plant Manager
*G. Gibbs, Manager, Brunswick Engineering Support Section
G. Honma, Supervisor, Licensing
W. Levis, Director, Site Operations
*J. Lyash, Manager, Operations
*D. Hicks, Manager, Regulatory Affairs
M. Marano, Acting Manager, Site Support Services
J. Thompson, Acting Manager, Nuclear Assessment
M. Turkal, Supervisor, Regulatory Compliance

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

NRC Personnel

*C. Patterson, Senior Resident Inspector
*P. Byron, Resident Inspector
M. Janus, Resident Inspector

*Attended exit meeting

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

2. Operations

a. Operational Safety Verification (71707)

Unit Status

Unit 1 was shutdown at the start of this inspection period following a reactor trip that occurred on September 30, 1995. This trip occurred due to on-line maintenance of a conductivity cell. Air in-leakage occurred resulting in vapor binding of the condensate pumps. Loss of this pump caused feedwaters perturbations and the reactor tripped on low water level. The trip was discussed in NRC IR 95-20 and LER 1-95-18. The unit was restarted on November 2, 1995, without any significant problems. At the end of the inspection period the unit had been on-line 32 days.

Unit 2 operated continuously during this inspection period and had been on-line 490 days.

Spent Fuel Pool

The inspector reviewed the FSAR to determine if the licensee's refueling practices were described in the FSAR. Brunswick normally conducts a partial fuel offload during a refueling outage but has on occasion offloaded all fuel assemblies. A full offload was conducted for the extended outage that included the shroud repair. FSAR section 9.1.2 discusses the design basis, safety evaluation, and thermal analysis for the spent fuel pool. The Brunswick spent fuel pools have the capability to store the following amounts of BWR fuel assemblies from Units 1 and 2 and PWR spent fuel assemblies from the H.B. Robinson plant.

UNIT	BWR	PWR
1	1803	160 (Max)
2	1839	144 (Max)

The thermal analysis for the SFP cooling system indicates that it will maintain the SFP bulk temperature at or below 150 degrees F following a partial refueling. The analysis further indicates that the RHR system alone or in conjunction with the SFP cooling system will maintain the SFP bulk temperature at or below 150 degrees F following a full core offload. In the past few years the licensee has used the supplemental FPC system to assist in cooling which allows RHR to be taken out of service sooner during an outage. In conclusion, the licensee's design basis accounts for all refueling practices.

b. Followup - Operations (92901)

(CLOSED) LER 1-95-01, Two Inoperable Control Rod Accumulators Result In Entry Into Technical Specification 3.0.3.

On January 6, 1995, Unit 1 was operating at 100% power when the licensee entered T.S. 3.0.3, at 1:26 a.m., due to a second HCU being inoperable. Earlier in the evening, HCU 18-23 had been declared inoperable due to low nitrogen accumulator pressure. The HCU declared inoperable was HCU 06-39, also due to low nitrogen accumulator pressure. Both of these HCUs had been previously recharged, and WR/JOs had been initiated to replace the C11-111, gas side isolation valves on each unit. On entry into T.S. 3.0.3, work on replacing the C11-111 valves was expedited, the HCUs were recharged, and returned to operable status. The licensee exited T.S. 3.0.3, at 3:52 a.m., when it had declared both HCUs operable.

The licensee investigation into the root cause of the repetitive failures of the C11-111 valves determined that the problem was caused by the degradation of the valve body O-rings. Analysis of the O-rings by the vendor, at the licensee's request, determined that the O-rings were slightly undersized or had been chemically contaminated, resulting in the potential for increased leakage.

The licensee's initial corrective actions included: the prompt replacement of the failed HCU C11-111 valves; and initiation of a root cause investigation. The event was originally reported in an LER dated February 2, 1995 and following the completion of the root cause determinations a Supplemental LER was issued on June 22, 1995. Supplemental corrective actions included: stopping all scheduled periodic bulk replacement programs for these valves; and continuation of ongoing discussions with the vendor on a long term resolution to the O-ring deficiencies observed. The inspector has reviewed the event, the corrective actions completed to date and finds them acceptable for the closure of this item.

No violations or deviations were identified.

3. Maintenance and Surveillance

a. Maintenance Observation (62703)

RHR Service Water Flow Control Valve Refurbishment

On October 14, 1995, the licensee conducted maintenance and repair activities on 1-E11-F068 A, Unit 1 RHR Service Water Flow Control Valve. Problems associated with the same valve on the other loop and in the other unit were previously discussed in NRC IR 95-20. During that inspection period two of the valves had failed to properly stroke during a quarterly test. The valve failures were caused by the valve plug becoming stuck in the basket assembly. The cause of this problem was determined to be galling of the mating surface. This galling was caused by the plug and basket assemblies being made of the same Inconel material. The Inconel baskets had been previously installed to combat erosion problems experienced with the original Ni-Al-Bronze assemblies.

Maintenance records indicated that this valve had a new Inconel basket installed, but had not experienced problems as seen in the two other valves which had failed. This maintenance activity was to inspect the valve internals and determine if scoring and galling were evident between the Inconel basket and plug assembly. The license planned to replace the Inconel plug assembly with a new plug assembly

with a hardened face which would prevent the galling. The hardened plug face and redesigned seating surfaces were design changes recommended by the vendor to prevent galling between the two surfaces.

The inspector observed the conduct of maintenance activities and was present when the valve body was opened for inspection. On inspection of the valve internals, scoring and evidence of galling were found. The score marks were present in several locations around the valve assembly, and traveled the full length of the valve stroke. This basket and plug assembly were removed and replaced with a refurbished Inconel basket and hardened Inconel plug assemblies. The inspector observed that the maintenance activity was well planned and conducted in an expeditious, professional manner and completed within the 8 hour secondary containment LCO time limit. The valve was successfully stroke tested following the completion of the maintenance activities. This issue continues to be tracked by EEI 325,324/95-20-03, Design Review Renders RHRSW Valves Inoperable.

Control Building Ventilation Problems

On October 25, 1995, during testing of the control building ventilation system to obtain data necessary to support a proposed TS change, an abnormally was observed. During performance of AI-117, Guidance for Trouble Shooting Safety Related Equipment, the starting of a CBEAF unit caused a negative pressure in the control room. Control Room pressure was required to be positive to prevent in-leakage of radiation during an accident condition. TS 4.7.2.d.4 surveillance requires an 18 month test to verify that positive pressure can be maintained. The licensee performs OPT 46.4, Control Building HVAC AUTO Initiation, to satisfy this requirement. The test was last performed in November 1994 with satisfactory results. The results of AI-117 surveillance are listed below:

Control Room Pressure

	CBEAF	Normal System Lineup
1. Last PT 46.4 results (11/94)	+0.06" (B)	+0.055"(A)
2. CR pressure prior to performing AI-117		+0.03"

(cont'd)

	CBEAF	Normal System Lineup
3. Placed 2A CBEAF in service	-0.04"	
4. Secured 1 radwaste fan	-0.03"	
5. Secured 1st U/1 Batt Rm Fan	-0.01"	
6. Secured 2nd U/1 Batt Rm Fan	+0.01"	
7. Secured 1st U/2 Batt Rm Fan	+0.02"	
8. Secured 2nd U/2 Batt Rm Fan	+0.04"	
9. Started 1A and 2A Batt Rm Fan 1B and 2B Fans Secured	+0.01"	
10. Returned to normal CBHVAC alignment		+0.09"

The licensee determined based on the surveillance data that certain fan configuration could maintain correct control room pressures. The system was determined to be operable in all modes with compensatory measures should the CBEAF operate in the radiation or smoke protection mode. An operability evaluation per OI-4, LCO Evaluation and Followup, was performed to analyze the situation and documented in ESR 9501649. The inspector reviewed the ESR and concluded it addressed all know problems with operation of the system. Operator training was conducted for all operating crews on the compensatory measures. The inspector observed some of this training in the control room.

On October 30, 1995, the inspector questioned why the licensee did not report the situation as a condition outside the design basis of the plant which would require a 4-hour report. The licensee stated that the analyses was not complete although the TS requirement for positive pressure had not been maintained.

The inspector discussed with the licensee what had changed since the acceptable surveillance test of November 1994. Two things had occurred both of which were thought to have improved the positive pressure in the control room, One was sealing of penetrations, conduits, etc. The second was a modification made to the battery room ventilation system that was completed in February 1995.

The inspector reviewed the battery room HVAC modifications PM 92-051 for Unit 1 and PM 92-052 for Unit 2. The battery room HVAC Project was initiated to find the root cause for the inability to calibrate the ventilation system to design specifications and to resolve conditions causing spurious alarm annunciations in the control room. The original design of the battery room ventilation

system was to maintain a negative room pressure which promoted hydrogen gas removal. Due to temperature control problems and other maintenance problems, such as ventilation duct damper cycling when the door opened to the battery room, the design was changed with the modification. The negative pressure control was determined not to be needed and the system changed to a temperature control design. Thermostats now control the inlet and outlet dampers to balance flow thorough the room. The licensee stated this should have improved the positive pressure in the control room since less air would be drawn out of the control room.

The inspector reviewed field revision four of the modification and noted the following statements:

> "Field Revision 4 is written to provide a clear definition of acceptable flow ranges for the Battery Room Supply and Exhaust fan subsystems. The need for this clarification stems from three factors. The first is that the present design as reflected in this project summary section does not provide adequate basis for or documentation of the required flow rates. Second, changes in required flow rates have been identified as a result of the Design Basis Reconstitution Program (since the issuance of Rev. 0 of the modification). Third, actual flow testing as documented in TCF 95-005 and TCF 95-013 demonstrates that flow rates other than those stated in the current design documents are possible within the CBHVAC system."

Field revision 4 was dated February 3, 1995. The inspector concluded that there was much confusion surrounding the HVAC modification. The inspector questioned if the effect of the battery room ventilation system modifications were tested to determine the overall ventilation of the control building and control room. No testing had been performed. The inspector reviewed the testing requirements for the modification and they were only for the battery room ventilation system.

The licensee formed a task force of up to 50 engineers to support resolution of the issue. This included flow balancing of the entire control building ventilation system and collection of the test data. An analysis of the situation will continue. On November 2, 1995, after completion of flow balancing of the four battery rooms, AI-117 was performed again. Little improvement in negative pressure in the control room was noted. Finally, on November 3, 1995, the licensee made a one-hour notification to the NRC of the problem. This issue will be tracked as URI 325,324/95-22-01, Control Building Ventilation Problems, pending further review.

b. Followup - Maintenance (92902)

(CLOSED) LER 2-95-02, The High Pressure Cooling Injection System Failed to Operate As Required During the Performance of the HPCI Periodic Test.

On May 10, 1995, the Unit 2 HPCI system failed to operate during the performance a routine periodic test. The unit was operating at 100% power at the time of the event, and the Automatic Depressurization System and the Low Pressure Cooling Injection Systems were operable at the time of the event. During the performance of the test, the oil operated steam supply valves E-41-V8 and E-41-V9 were opened at the start of the test by operating the auxiliary oil pump. During the test, however the V-9 valve unexpectedly closed, causing HPCI pump to stop. The licensee investigated the cause of the valve failure and determined that a resistor in the HPCI power supply to governor speed control circuit had failed. The resistor was replaced, the system successfully retested and returned to service. Subsequent investigation determined that the resistor failure was caused by end of life burnout. The licensee verified the three other installations of this resistor in the Unit 1 HPCI system and the Units 1 and 2 Reactor Core Isolation Cooling systems were in operation at the normal temperatures.

As a corrective action, the licensee contacted the vendor of the resistor to determine if a preventive maintenance program should be required for these resistors. The vendor did not recommend any program for the resistors. Additionally, the licensee initiated an ESR to review the use of dropping resistors in these applications. Engineering determined that based on problems experienced with the existing power supply and its interaction with the upgraded flow controllers on Unit 1, that the power supplies would be replaced with an isolated DC to DC power supply, thus removing the drooping resistors all together. ESR 95-987 implemented the replacement on Unit 1 RCIC, ESR 95-1012 will implement it on Unit 1 HPCI, and Plant Modification 92-80 will implement this change on both the Unit 2 HPCI and RCIC systems during the February 1996 refueling outage. The inspector reviewed the licensee's corrective actions and finds them acceptable for the closure of this item.

No violations or deviations were identified

4. Engineering

a. On Site Engineering (37551)

<u>DG Governor Modification</u>

On October 16, 1995, at 5:00 a.m., both Brunswick Units 1 and 2 entered a seven day LCO to support replacement of the

number 2 DG governor. Plant Modification 94-17, was designed to replace the existing Woodward governors with a newer Woodward model. The governors were scheduled to be replaced because they had become obsolete, and the vendor would no longer provide parts and service. The obsolete governors consisted of Woodward model EGA and EGB-35P controllers, and will be upgraded to Woodward model 2301A and EGB-35C controllers. The modification was scheduled to be implemented first on DG 2. This same governor replacement was successfully performed at the McGuire station which utilizes the same Nordberg DG sets as Brunswick.

The schedule for the removal and replacement of the DG governor was planned to be completed within 5 of 7 days allowed by the TS LCO. The plan included a contingency for re-installation of the existing governor should problems arise. A decision point was scheduled at the 3 day point, if problems should arise, 12 hours would be allowed for troubleshooting, if a success path could not be determined, the contingency plan would be initiated to restore the DG to an operable status within the allowed time. The inspector reviewed the work schedule and associated contingency plan and noted that it was well developed and organized to either complete the activity or return an operable DG to service prior to the 7 day LCO expiring. The inspector observed that the availability of a scheduled contingency plan and decision hold point facilitated quick turn around and recovery following the unexpected performance of the new governor.

Removal of the original governor was performed ensuring that all as found conditions were documented so the governor could be easily re-installed if needed. A Woodward Governor field representative was onsite to assist in the installation and testing of the new governors. The inspector observed the removal/installation activities on several occasions and noted the care the technicians were taking in removing equipment, and documenting its as found conditions. The job was worked around the clock to support the schedule, and the removal and installation of the new governor was completed ahead of schedule.

Following the installation of the new governor, the DG was ready to start modification acceptance testing early in the morning on October 18. Testing was performed in accordance with Special Procedure 1-SP-PM94017-01, PM 94-017 Acceptance Test Emergency Diesel Generator #2. Testing included: unloaded DG runs for tuning and response testing of the governor; loaded DG runs; loss of load DG runs; and finally, a fully loaded DG run with a LOCA load shed and resequence of loads. These tests were designed to ensure that the

governor response was capable of meeting all design basis criteria for the DG prior to being declared operable.

Initial unloaded DG testing on October 18 revealed unexpected governor responses, causing the licensee to stop testing and enter the 12 hour troubleshooting activity at 6:00 a.m.. The governor response to the induced overspeed transient during the unloaded runs was not what the engineers expected to observe. The observed results fell outside of the criteria specified in the test procedure. The test results indicated that the governor slowed down at the same constant rate irrespective of changes to controller settings. Based on subsequent conference calls with Woodward Governor, the licensee attempted several different adjustments to the governor controllers without any noticeable affect on observed governor response. These additional tests indicated that the governor response to an overspeed event during unloaded runs was the same irrespective of governor gain and reset settings. Neither the Woodward field representative nor the engineers in the corporate office could explain the observed responses or offer possible solutions.

Based on the inability to resolve the questions regarding governor response and inadequate time to continue these troubleshooting activities, plant management made the decision to re-install the old governor late that afternoon. At the licensee's request, an additional Woodward field representative familiar with the old style governor was dispatched to the site to assist with re-installation and testing activities. The removal of the new governor and the re-installation of the old governor proceeded according to schedule with no problems encountered. The DG was successfully tested and declared operable with the old governor re-installed at 3:05 a.m. on October 20, 1995. The replacement governor was preserved and will be sent back to Woodward for subsequent testing and analysis. The licensee plans to send an engineer and technician with the governor to observe the testing.

The licensee's troubleshooting activities raised many questions regarding the licensee's preparation for this modification. The inspector questioned whether the vendor's representative was the same one involved in the installation of these governors at McGuire. The inspector was informed that the vendor representative was not the same, and that the representative was not familiar with a Nordberg DG set. Looking at the unexpected response curve of the new governor, the inspector asked to see the response curve for the old governor. The inspector was informed that the same response had not been measured and recorded for the old governor. The inspector then questioned the basis for the criteria in the special test procedure as this parameter was not previously evaluated. The licensee informed the

inspector that the engineering product review team had requested specific criteria for expected responses in the procedure and that this criteria was added, based on vendor manual recommendations and assumed DG responses. Subsequent testing of DG 2 with the re-installed governor revealed that the governor responds similarly to the same induced transient in a unloaded condition. The licensee speculates that this response is a result of actual internal interia of the DG motor slowing down in an unloaded condition.

The inspector discussed these observations with licensee management and was informed that they were initiating their own investigation into these problems. Following the completion of activities, the licensee was going to perform a analysis of events and subsequent root cause evaluation. Answers to additional questions are pending the Woodward's analysis and testing of the governor. The inspector will to follow the results of these efforts and track this issue under an Inspector Follow-up Item, IFI 325,324/95-22-02, Problems with DG Governor Modification.

Failure Analysis of Scram Discharge Vent Valve

The licensee conducted a root cause analysis of the scram discharge outboard vent valve 1-C11-V139. The valve failed to stroke closed during stroke tests on September 26, 1996, and September 27, 1995. These failures were discussed in NRC IR 95-20. The inspector reviewed CR 95-02388. The cause of the event occurred as a result of increased frictional force on the valve stem. The increased force was noted during valve operation and resulted from intrusion of valve/piping corrosion products, packing degradation, and uneven loading of the packing. Four corrective actions to prevent recurrence were identified for completion in the next several months. These included review of alternate packing materials, periodic changeout of the packing, and review of other similar valves in the plant. The inspector concluded the root cause was thorough and with completion of the corrective actions should prevent recurrence.

b. Self Assessment (40500)

The inspector concluded the DG governor modification was another example of the licensee's continuing difficulty to conduct quality modification work. In this case the PRG was added as part of the corrective action for escalated enforcement related to EA-166 concerning HPCI and RCIC modifications and testing. However, the recommendations for an expected unloaded DG governor response were made without a good technical basis. Furthermore, this modification work was performed without success while a limited stop work directive was in effect for modification work as discussed in NRC IR 95-20. This modification had been successfully performed at another facility with the same make of DGs.

No violations or deviations were identified.

5. Plant Support (71750)

a. Radiological Controls (71750)

On October 31, 1995, after entering the control building for a tour of the control room, the inspector noticed a worker not using the personnel monitor but instead using the frisker. The inspector inquired about the use of the frisker and was told by the worker that he could never pass the monitor do to the fuel leaks causing gases in the turbine building breezeway. The only instructions provided at the monitors was a sign to instruct people to cover contaminated areas with protective clothing and contact radiological controls. The inspector inquired from plant management about the practice and received varying answers about the accepted practice. Management did assign action to resolve the issue and provide clear instructions to workers. This issue will be inspected by a Region II specialist during the nest scheduled inspection.

b. Fire Protection (64704)

Transient Combustible Material

On October 11, 1995, during a routine tour of the control building the inspector reviewed two transient combustible material load evaluations for painting in the 1A and 1B battery rooms. One evaluation was for the fire retardant plywood used over the 250 volt DC batteries. The CLE was 1500. The other evaluation was for the list of painting material the painters would be bringing into the room. This CLE was 1075. However, noted on the second evaluation form was that this exceeded the ACLE by 320. No explanation was provided as why this was acceptable. The inspector reviewed procedures OFPP-013, Weekly Fire Inspection, and OFPP-014, Control of Combustibles, Transient Fire Loads, and Ignition Sources. Each building on the site such as the control building have ACLE limits. The limit for the battery room was 2255. Thus, the CLE of 1075 and 1500 was 2575 which exceeded 2255 by 320.

The inspector discussed these issues with the LPU supervisor. The LPU took out fire impairments to track the condition of the CLEs exceeding the limit. This practice was allowed by procedure. The compensatory measure for the rooms was to verify that the detection equipment in the areas was operable. The licensee felt the actions taken were conservative since the load evaluations performed for the materials was the maximum expected. For example 50 paint brushes were listed, but it was not expected that there would be 50 paint brushes in the room. Also, the combustible loading calculation yielded a fire severity time of 1.9 hours well

below 3 hours.

The inspector questioned these practices since to prevent or limit a possible fire the amount of material brought into the room could be limited. This room contained the 250 volt DC battery that supplied safety equipment. Further discussions with the licensee revealed that the proposed list of painting equipment for the job was reduced. Procedure OFPP-014 was revised to require approval of the LPU supervisor anytime any ACLE would be exceeded.

c. Emergency Preparedness

Annual Exercise

On October 31, 1995, the licensee conducted their annual exercise. The inspector toured the TSC, OSC, and EOF during the drill. The inspector reviewed activation of the TSC and emergency classifications made early in the drill. Once the TSC was activated good communications were observed and briefings by the Site Emergency Coordinator. Equipment out of service was tracked with uniformity between the TSC,OSC, and EOF. The inspector reviewed the computer terminal in the EOF to review the status of sirens in Brunswick and New Hanover counties. Although the drill did not have NRC participation the realism displayed was similar to the last full NRC participation drill.

d. Followup - Plant Support (92904)

(Closed) URI 325,324/95-15-03, Storage of Material in Contaminated Areas

During a tour of the Unit 2 reactor building on August 11, 1995, the inspector observed rags being stored in green poly bags inside an area designated as contaminated. The licensee has a policy that only "clean" material will be stored in green poly bags and material inside a contamination boundary is considered to be contaminated. The licensee informed the inspector that material inside a radiological barrier could be in a green bag but all contaminated material had to be labeled when it crossed the barrier. They also informed the inspector that material was not to be stored in a contaminated area, but they allowed the decontamination workers to store a sufficient amount of bar towels wetted with a decontamination fluid for a day's cleaning. The bar towels are stored in green poly bags and after use placed in yellow poly bags for removal from the contaminated area.

On December 5, 1995, the licensee plans to revise their training manual to emphasize radwaste reduction by eliminating storage of material inside contaminated areas and the proper method of protecting material in these areas. The inspector reviewed the proposed changes and found them to be adequate. The inspectors reviewed the licensee's decontamination contractor's qualification

program for decontamination workers and found that the contractor adequately addresses protection of and storage of material in a contaminated area. The inspector considers that the licensee adequately addresses this issue and it is considered closed.

No violations or deviations were identified.

6. Exit Interview

The inspection scope and findings were summarized on November 3, 1995, with those persons indicated in paragraph 1. The inspectors described the areas inspected and discussed in detail the inspection findings listed below. The licensee did not identify as proprietary any of the material provided to or reviewed by the inspectors. Dissenting comments were not received from the licensee.

Item Number	Status	Description/Reference Paragraph
325,324/95-22-01	Open	URI, Control Building Ventilation Problems, paragraph 3.
325,324/95-22-02	Open	IFI, Problems with DG Governor Modification, paragraph 4.
1-95-01	Closed	LER, Two Inoperable Control Rod Accumulators Result In Entry Into Technical Specification 3.0.3, paragraph 2.
2-95-02	Closed	LER, The High Pressure Cooling Injection System Failed to Operate As Required During the Performance of the HPCI Periodic Test, paragraph 3.
325,324/95-15-03	Closed	URI, Storage of Material in Contaminated Areas, paragraph 5.

8. Acronyms and Initialisms

ACLE	Allowable Combustible Load Equivalent
BWR	Boiling Water Reactor
CBEAF	Control Building Emergency Air Filtration
CFR	Code of Federal Regulations
CLE	Combustible Load Equivalent
CR	Condition Report
DC	Direct Current
DG	Diesel Generator
EA	Enforcement Action
EOF	Emergency Operations Facility
ESR	Engineering Service Request

FPC	Fuel Pool Cooling
FSAR	Final Safety Analysis Report
HCU	Hydraulic Control Unit
HPCI	High Pressure Coolant Injection
HVAC	Heating Ventilation and Air Conditioning
IFI	Inspector Followup Item
IR	Inspection Report
LER	Licensee Event Report
LCO	Limiting Condition for Operation
LPCI	Low Pressure Coolant Injection
LPU	Loss Prevention Unit
LOCA	Loss of Coolant Accident
MSIV	Main Steam Isolation Valve
NRC	Nuclear Regulatory Commission
OI	Operating Instruction
OSC	Operations Support Center
PM	Plant Modification
PMTR	Post Maintenance Test Requirement
PRG	Product Review Group
PT	Periodic Test
PWR	Pressurized Water Reactor
RCIC	Reactor Core Isolation Cooling
RTGB	Reactor Turbine Generator Board
RHRSW	Residual Heat Removal Service Water
RHR	Residual Heat Removal
SFP	Spent Fuel Pool
SP	Special Procedure
SRO	Senior Reactor Operator
TS	Technical Specification
TSC	Technical Support Center
URI	Unresolved Item
VIO	Violation
WR/JO	Work Request/Job Order