



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

Licensee: Duke Power Company
 P.O. Box 1007
 Charlotte, N.C. 28201-1007

Docket Nos.: 50-413 and 50-414

License Nos.: NPF-35 and NPF-52

Facility Name: Catawba Nuclear Station Units 1 and 2

Inspection Conducted: March 8, 1992 - April 4, 1992

Inspectors: W. T. Orders, Senior Resident Inspector

5-4-92
 Date Signed

P. C. Hopkins, Resident Inspector

5-4-92
 Date Signed

J. Zeiler, Resident Inspector

5-4-92
 Date Signed

Approved by: George A. Belisle, Chief
 Projects Section 3A
 Division of Reactor Projects

5/4/92
 Date Signed

SUMMARY

Scope: This routine, resident inspection was conducted in the areas of review of plant operations; surveillance observations; and, maintenance observations.

Results: Two violations and two Non-Cited Violations (NCVs) were identified. One violation involved a failure to follow station procedures that had the potential to result in a personnel overexposure (Paragraph 6). The other violation involved a failure to follow procedures and inadequate procedures, resulting in the operation of a Nuclear Service Water pump approximately 40 minutes without minimum flow protection, ultimately resulting in both units entering Technical Specification 3.0.3 (Paragraph 8). One NCV involved a single-failure design deficiency in the control circuitry of the Auxiliary Feedwater System (Paragraph 7), and the other NCV was the result of an inadequate performance of a Technical Specification surveillance (Paragraph 9).

REPORT DETAILS

1. Persons Contacted

Licensee Employees

- S. Bradshaw, Shift Operations Manager
- * Forbes, Engineering Manager
- S., Operations Support Manager
- *R. Futrell, Regulatory Compliance Manager
- E. Geddie, Operations Superintendent
- *T. Harrall, Safety Assurance Manager
- *J. Lowery, Compliance
- W. McCollum, Station Manager
- *S. Mode, Safety
- K. Seasely, Compliance
- M. Tuckman, Catawba Site Vice-President

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

NRC Resident Inspectors

- W. Orders
- *P. Hopkins
- J. Zeiler

*Attended exit interview.

2. Plant Status

a. Unit 1 Summary

Unit 1 began the report period operating at 85 percent power, having reduced power on March 5 to effect repairs of a Main Turbine Stop Valve which had failed to stroke properly, and to cleanup the Main Turbine Hydraulic Oil System which had been contaminated with waste oil and water. On March 10, following these repair activities, the unit returned to 100 percent power. The unit operated at virtually full power for the remainder of the report period.

b. Unit 2 Summary

Unit 2 operated for the entire report period at or near 100 percent power.

3. Plant Operations Review (71707 and 71710)

The inspectors reviewed plant operations throughout the report period to verify conformance with regulatory requirements, Technical Specifications (TS) and administrative controls. Control Room logs, the Technical Specification Action Item Log, and the Removal and Restoration (R&R) log were routinely reviewed. Shift turnovers were observed to verify that they were conducted in accordance with approved procedures. The complement of licensed personnel on each shift inspected, met or exceeded the requirements of Technical Specifications. Further, daily plant status meetings were routinely attended.

Plant tours were performed on a routine basis. The areas toured included but were not limited to the following:

- Turbine Buildings
- Auxiliary Building
- Units 1 and 2 Diesel Generator Rooms
- Units 1 and 2 Vital Switchgear Rooms
- Units 1 and 2 Vital Battery Rooms
- Standby Shutdown Facility

During the plant tours, the inspectors verified by observation and interviews that measures taken to assure physical protection of the facility met current requirements. Areas inspected included the security organization, the establishment and maintenance of gates, doors, and isolation zones in the proper conditions, and that access control badging were proper and procedures followed.

In addition, the areas toured were observed for fire prevention and protection activities and radiological control practices. The inspectors also reviewed Problem Investigation Reports (PIRs) to determine if the licensee was appropriately documenting problems and implementing corrective actions.

During the reporting period, the inspectors conducted a detailed walkdown of the ECCS portion of the Unit 1 Chemical and Volume Control (NV) System. Accessible portions of the system were reviewed against plant drawings to ensure that the as-built system reflected the current system configuration. Using the licensee's system lineup procedures, OP/1/A/6200/01 and OP/1/A/6200/06, the inspectors verified that main system flowpath valves and assorted drain and vent valves were in their correct positions. This lineup verification was accomplished using the control room board indication as well as comparing local valve indication where possible.

Selected valves in the flowpath were examined to ensure that they were installed correctly, with no bent stems, missing handwheels, or improper labeling. Outstanding work requests on components in the flowpath were

examined to ensure that there was no major outstanding maintenance which could affect system performance. Selected process instrumentation was examined to ensure proper installation, function, calibration, and indication.

The inspectors also reviewed the past year of in-service tests on the NV pumps to ensure that the pump operating parameters, such as differential pressure, flowrate, vibration, and bearing temperature were properly measured and were within acceptable performance ranges.

No major discrepancies were identified from the NV system walkdown and related inspections. Minor problems were discussed with operations personnel for resolution.

No violations or deviations were identified.

4. Temporary Waiver of Compliance - Units 1 and 2 (71707)

On March 16, the licensee requested a waiver of compliance from the requirements of TS 3.6.5.5 in order to radiograph both unit's Pressurizer Power Operated Relief (PORV) block valves. The waiver was necessary because the licensee estimated that the pressurizer hatch, which would provide entry for the radiographers and equipment, would have to be open greater than the one hour allowed by TS. The licensee requested the pressurizer hatch to be open for up to six hours on each unit to perform the radiography. The waiver was granted by the NRC on March 17, following review and approval of the proposed waiver by the licensee's Nuclear Safety Review Board.

On March 23, the licensee radiographed the Unit 2 PORV block valves and closed the pressurizer hatch within the six hours. Two of the three valves were verified to be in their proper position (open) based on the results of the radiography. The results for block valve 2NC-31B were inconclusive. Valve 2NC-31B specifications (size, thickness, manufacturer) were different than the other pressurizer block valves. It required different radiography techniques. These differences were known by engineering personnel, but apparently were not communicated to the radiography personnel. In order to radiograph this valve again, the licensee requested that the original waiver be amended. The amendment would allow for an additional six hours to radiograph valve 2NC-31B again. The amendment to the waiver was granted by the NRC and on March 24 and the licensee radiographed the valve. The results of the radiography determined that the valve was open. The inspectors noted better planning and control of the radiography activities for 2NC-31B valve. The radiography film was expedited from the containment to the film developers located outside containment and direct communication between the radiographers and film analyzers was established to more quickly determine the acceptability of the results. Prior to closing the hatch, it was ensured that conclusive results were obtained. The waiver was considered closed for Unit 2.

On March 25, the licensee opened the Unit 1 pressurizer hatch and radiographed the PORV block valves. Prior to closing the hatch, the licensee analyzed the results of the radiography which determined that the valves were open. The hatch was closed within the time constraints of the waiver and the waiver was considered closed.

No violations or deviations were identified.

5. Ice Condenser Inlet Door Degradation at Sequoyah Nuclear Plant (71707)

On March 17, the Tennessee Valley Authority (TVA) informed the NRC of a problem at their Sequoyah Nuclear Station involving the upheaval and cracking of the top layer of concrete comprising the ice condenser floor. This resulted in mechanical interference with the bottoms of a number of lower ice condenser inlet doors in both units. The interferences increased the opening force beyond the TS required limit of 675 inch-pounds resulting in the doors being inoperable.

TVA determined that the upper concrete pad, called the wear slab, had been raised several inches in certain ice condenser bay areas. The raised floor caused the metal flashing at the bottom of the door to interfere with the door as it opened. Preliminary evaluation indicated that the cause of the degradation was from water, which had seeped under the wear slab, and upon freezing, had caused the wear slab to raise up.

On March 18, discussions were held between the NRC and Duke Power Company (DPC) management to determine the possibility of a similar situation at Catawba or McGuire. It was noted that, unlike Sequoyah, neither Catawba nor McGuire have defrosted the ice condenser floor area, nor is the ice condenser temperature allowed to rise above freezing during outage activities. In addition, water is not allowed to accumulate during ice condenser cleaning and wall defrosting activities. Based on the determination that the combination of construction/design deficiencies and adverse maintenance practices created the problem at Sequoyah, it was concluded that the potential for a similar problem at Catawba or McGuire was remote.

The licensee indicated that either during the upcoming refueling outages or forced outage, the ice condensers in both units would be inspected to ensure the absence of water intrusion under the ice condenser floor area. The inspectors will monitor the licensee's subsequent inspections and evaluations of the ice condensers.

No violations or deviations were identified.

6. Hot Particle Event (71707)

On April 1, 1992, at 8:15 a.m., two Safety personnel entered the Radiation Control Area (RCA) to perform procedures PT/O/A/4400/01I, Annual Maintenance and Inspection of Portable Fire Extinguishers, and PT/O/A/4400/01M, Monthly Visual Inspection of Fire Hose Stations on fire protection equipment located in the Auxiliary Building.

An RP technician reviewed the proposed activities with the personnel and told them to use Standing Radiation Work Permit (SRWP) 92-20, Column B, for entry into Room 217. A copy of the SRWP was provided to the Safety personnel for review. The lead Safety person was issued dosimetry and the keys to Room 217.

The two safety personnel then proceeded to perform their fire protection equipment inspections, leaving Room 217 for last. In preparation for entering Room 217, the lead Safety person returned to the clean change room to obtain protective clothing. He did not obtain adequate protective clothing, in that, he neglected to obtain a hood, as required by the SRWP. Additionally, he did not review SRWP 92-20 to determine the specific protective clothing requirements.

Ultimately, the lead safety person entered Room 217 at 10:26 a.m. During the inspection, the RP issued dosimetry alarmed and the "Low Battery" light came on. He stated that he finished the inspection without weighing the fire extinguisher in the room, even though a marker was used to initial and date the inspection tag on the fire extinguisher. The marker and the scales that were to have been used to weigh the fire extinguisher were not wrapped by the Safety personnel when they were removed from the contaminated room.

The two personnel performed a hand and foot frisk on elevation 543' and proceeded to the RP office to return the dosimetry and the room key. A whole body monitor which is required by Station Directive 3.8.3, Enclosure 6.8, was not performed.

The personnel exited the RCA at the Material Access Point (MAP). During the whole body monitor, the lead Safety person was found to be contaminated on the left thigh. He performed a second whole body monitor and a second alarm was received because he had attempted to perform a recount prior to the monitor completing a background count. According to the personnel, the second count indicated no contamination.

Hand held items (paperwork, scales, etc.) were frisked for contamination by the second Safety person prior to RCA exit. He was distracted during the frisking by the above mentioned alarms and did not perform an adequate survey. (The exit from the RCA at the MAP was video taped.)

The two Safety personnel performed additional fire protection inspections in the Waste Solidification Building. Hand held items were again frisked prior to exit from that building, although, hand and foot frisks were not performed. The Safety personnel did not return to the MAP area for a whole body monitor. Additional fire protection equipment inspections were performed in the Turbine Buildings.

After performing additional fire protection inspections in other areas, at approximately 5:15 p.m., the lead Safety person prepared to leave the site. When the individual passed through the exit portal monitor, it alarmed indicating contamination. The monitor was reset and a second attempt was performed. A second alarm was received and RP personnel were contacted.

Ultimately, a hot particle was located on the person's head, above the left ear. Initial frisker readings of the hot particle indicated 35,000 corrected counts per minute (ccpm). The particle was removed per HP/O/B/1004/06, Personnel Decontamination.

Isotopic analysis of the hot particle revealed that the particle was comprised of Cobalt-60 (Co-60) and Manganese-54 (Mn-54). Due to the fact that the exact time that the person came into contact with the hot particle could not be determined, the most conservative exposure time was used by RP. The exposure time frame used was from time of entry into the RCA (8:15 a.m.) until the time that the hot particle was removed (5:50 p.m.). The decay corrected activity of the Co-60 was determined to be 6.958E-01 microcuries (uCi) and the decay corrected activity of the Mn-54 was 5.739E-02 uCi. This would result in an estimated exposure of 29.855 Rem to the skin of the individual.

Station Directive 3.8.3, Contamination Prevention, Control, and Decontamination Responsibilities, delineates the responsibility of personnel in the prevention and the control of contamination; provides information and direction concerning decontamination of personnel, work areas and equipment; directs personnel on the proper use of monitoring devices used to detect contamination; and states the exit requirements from the RCA and Radiation Control Zones (RCZs).

Section 4.4 and Enclosure 6.8 of the above station directive specify the requirements for exiting contaminated areas. Personnel exiting contaminated areas are required to perform a hand and foot contamination monitor with a hand held frisker prior to leaving the local area and then proceed to the contaminated side of the change room to perform a whole body monitor, without hard hat.

Station Directive 3.8.8, Radiological Work Practices, describes methods used in controlling work practices dealing with radiation areas and radioactive material. Section 2.1.3 of this directive states that all employees are responsible for reading and complying with posted Standing Radiation Work Permits (SRWPs). Section 4.4.2 instructs personnel who have been in contaminated areas to wrap or bag materials removed from the

contaminated area. Section 5.3.2 of the directive instructs employees on where to locate copies of RWP/SRWPs.

Procedure PT/O/A/4400/011, Annual Maintenance and Inspection of Portable Fire Extinguishers, is performed in April of each year to verify the condition of station fire extinguishers. PT/O/A/4400/01M, Monthly Visual Inspection of Fire Hose Stations, is performed to verify that fire hose stations are capable of rendering effective performance. Each of these PTs contains a statement in the Limits and Precautions section instructing personnel to perform inspections within RCZs in such a manner so as to insure that listed precautions on the SRWP/RWP are adhered to.

Contrary to the above procedures;

The two Safety personnel failed to properly utilize monitoring equipment provided and failed to inform HP of the alarms received from the whole body monitor at the MAP.

The two Safety personnel failed to read the SRWP as required.

The two Safety personnel failed to properly wrap or bag materials removed from a contaminated area, and

The two Safety Personnel failed to follow the instructions of PT/O/A/4400/011 in that the extinguisher in Room 217 was not weighed as required.

Technical Specification 6.8.1. requires, in part, that adequate written procedures be established, implemented and maintained. The above litany of inadequacies is considered a violation of the requirements of Technical Specification 6.8.1. and specifically the implementation of the applicable station directives. This issue is identified as Violation 413, 414/92-09-01: Multiple Examples of Failure to Follow Procedures That Led to the Spread of Contamination and Personnel Overexposure.

7. Auxiliary Feedwater (CA) System Design Problem (71707)

On January 10, 1992, a Problem Investigation Report (PIR), O-C92-0014 was initiated concerning Final Safety Analysis Review (FSAR) Accident Analysis Section 15.2.8, Feedwater System Pipe Break. The concern involved the amount of time required to develop full CA System flow after receiving a CA start signal. It was discovered that up to 35 additional seconds is required to allow for operation of the isolation valves initiated by the flow optimization circuit.

On March 2, 1992, Design Engineering (DE) notified the station of the operability question involving the CA System and its flow optimization circuitry which had arisen during their work on the PIR. At 8:40 p.m.,

that evening, the motor driven CA pumps for both units were declared inoperable and compensatory actions were developed to keep both units operable.

At 1:30 a.m. the next morning, the motor driven CA pumps were declared operable upon implementation of compensatory actions. These compensatory actions required that dedicated licensed operators be stationed to mitigate single failure scenarios by initiation of manual flow optimization operation.

DE determined that the signal which enables the Train B CA flow optimization circuit would fail if the Train A CA motor driven pump control circuit lost power. The flow optimization circuit ensures that the minimum CA flow (490 gpm) is delivered to the two non-faulted S/Gs in the event of a feedwater line break. Under these conditions, the CA System would not provide the required minimum flow to two intact steam generators during a feedwater line break without operator action.

The CA flow optimization circuits have since been modified to insure proper control circuit separation and operation.

The initial review of the CA system design appeared inadequate in that the operational functions of the flow optimization circuit were not known. 10 CFR 50, Appendix A, Section III, Protection and Reactivity Control Systems, Criterion 20, System Functions states the following: the protection system shall be designed, (1) to initiate automatically the operation of appropriate systems, and (2) to sense accident conditions and to initiate the operation of systems and components important to safety.

Based upon review of the circumstances and the licensee's positive and in-depth actions associated with this issue, the inspectors determined that this event constitutes a licensee identified violation, and as such, will not be cited in that the criteria specified in section VII.B of the Enforcement Policy were satisfied. This is documented as a non-cited violation (NCV) 413, 414/92-09-02: Failure to Perform Adequate Design Review.

8. Nuclear Service Water System Inoperability (71707)

On March 12, 1992, Operations personnel planned the block tagout for isolating and draining of the Nuclear Service Water (RN) side of the 1B Component Cooling Water (KC) Heat Exchanger and Diesel Generator Jacket Water Heat Exchanger as well as the RN Train B return header to allow the cleaning of the heat exchanger tubes and associated valve maintenance.

On March 16, 1992, Unit 1 and 2 Work Lists were issued for the RN tagout and drain evolution. These Work Lists provided direction for the RN tagout/drain process, but, only the Unit 1 Work List contained a caution statement emphasizing the need to align the 1A and 2A Containment Spray (NS) Heat Exchangers for minimum flow protection for the Unit 2 Train A RN pump, which would be operating during the activities. The RN block

tagout, R&R 02-556, which was essentially the controlling procedure for the RN evolutions, did not provide steps or cautions to ensure that the NS Heat Exchangers were aligned for minimum flow protection.

During normal operation, the heat loads provided with RN System cooling water will normally provide the operating RN pump minimum flow requirements, but should this not be the case, one of the non-operating KC Heat Exchangers is used to provide a minimum flow path. If the KC Heat Exchangers are not available, an NS Heat Exchanger can be configured to provide a minimum flow path; however, this is not a normal configuration.

After the Work Lists were issued, the Unit 1 SRO held a tailgate meeting with the Unit 1 Operator at the Controls (OATC) on the tagout/drain evolution. A tailgate meeting was then held involving only the Shift Supervisor, Control Room SRO, Unit 1 SRO and an extra Reactor Operator (RO). Neither the Unit 2 SRO nor ROs were in attendance at the tailgate meetings, although, the RN maintenance activities affected both units. At the meetings, the Unit 1 SRO was made aware of the NS miniflow requirement, but he failed to notify the Unit 1 ROs of the need for the NS alignment. In addition, the Unit 2 ROs were not instructed to align the 2A NS Heat Exchanger for RN minimum flow protection.

On March 16 at 10:30 p.m., the RN tagout/drain evolution was initiated. The following morning, at 12:50 a.m., the extra RO closed the RN crossover valves 1RN-47A and 2RN-47A per the specified R&R. Closing these valves isolated the non-operating KC Heat Exchangers being used for RN Train A minimum flow protection, and since neither the 1A or 2A NS Heat Exchangers had been aligned for RN minimum flow protection, a minimum flow path did not exist for the operating 2A RN Pump.

At 12:53 a.m., the RN Pump 2A High RN Discharge Pressure computer alarm was received, as well as, the RN Train B Low Pressure and Train A Low Flow alarm. The Train B Low Pressure alarm was expected and the Train A Low Flow had been alarming spuriously. The Control Room ROs failed to respond adequately to the RN computer/annunciator alarms due to their expectation of nuisance alarms normally received during similar evolutions. However, at 1:35 a.m., the Unit 2 OATC noticed that the 2A RN flow indicated zero GPM flow and immediately aligned it for minimum flow through the 2A NS Heat Exchanger. The 1A NS Heat Exchanger was then aligned for RN minimum flow protection. The 2A RN pump had been running for approximately 40 minutes without adequate minimum flow.

RN Pump 2A was declared inoperable pending successful completion of testing to confirm that no damage had occurred. Train B RN had been rendered inoperable by the RN drain evolution. Having three RN pumps inoperable placed both units outside the RN System Technical Specification action statement requirements (TS 3.7.4). At 3:45 a.m., the licensee entered the action requirements of TS 3.0.3 requiring unit shutdown on both units. Both units exited TS 3.0.3 at 8:55 a.m., after restoring RN Train B to service. That same day, RN Pump 2A was successfully tested with no damage evident.

The inspectors reviewed the circumstances of this event and concluded that there was poor control of work activities and poor communication exhibited between the shift operations management personnel and the reactor operators. Although, shift briefings were conducted, appropriate personnel were not in attendance and adequate information was not disseminated to the appropriate individuals to ensure control of the planned operations evolutions.

Operations Management Procedure (OMP) 2-18, Tagout Removal and Restoration (R&R) Procedure, Section 3.2, requires that the R&R record sheets shall be used by operations personnel to provide information to be used to insure plant conditions are maintained as necessary to safely perform work. The RN block tagout, R&R 02-556, was inadequate in that it failed to provide steps or cautions to ensure the control of the RN maintenance activities.

OMP 1-8, Authority and Responsibilities of Licensed Reactor Operators and Licensed Senior Reactor Operators, requires that the Control Room SRO keep himself and his staff informed of all evolutions that may affect the operation of the plant. The Control Room SRO failed to follow this OMP, in that he did not adequately inform his staff of the necessary plant alignment to support the RN evolutions.

Similarly, OMP 2-5, Operations Work List and Technical Memorandums, provides a means for the Operation Management staff to communicate necessary shift work activities and informational items to the Shift Supervisory staff. The Shift and Unit Supervisors are responsible for communicating all necessary information contained on the Work List to their personnel. The shift operations management staff failed to inform their staff of important information on the Work List to ensure control of the planned RN evolutions.

Technical Specification 6.8.1 requires, in part, that adequate written procedures be established, implemented, and maintained covering safety systems and their operation. This event is considered to be a violation of the requirements of Technical Specification 6.8.1. for failing to follow or provide adequate procedural guidance resulting in the 2A RN Pump being run without adequate minimum flow protection. This issue is identified as Violation 413, 414/92-09-03: Failure to Follow and Inadequate Procedures Resulting in the 2A RN Pump Operation without Adequate Minimum Flow Protection.

9. Inadequate Performance of Technical Specification Surveillance (71707)

On March 1, 1992, at 8:00 p.m., with Unit 2 Mode 1, 100 percent power, Operations night shift personnel began performing surveillance procedure PT/2/A/4600/C2A, Mode 1 Surveillance Item Periodic Test. Enclosure 13.1 of PT/2/A/4600/O2A, Item 11, is performed to meet the surveillance requirements for TS 4.4.6.2.1.b (Monitor the Containment Floor and Equipment sump inventory and discharge at least once every 12 hours). The acceptance criteria for Item 11 is to verify computer point B-4554, Unidentified leakage greater than 1 GPM in Containment, is not in alarm.

A note associated with Item 11 states that if computer point D-4554 is out of service, the operators are required to manually calculate the containment floor/sump inventory and discharge using PT/2/B/4150/29, Containment Floor and Equipment Drain Sump Increase Test.

At 8:15 p.m., a Unit 2 operator verified that computer point D-4554 was within acceptable limits and signed off Item 11. However, before PT/2/A/4600/02A was completed, computer point D-4554 started alarming every fifteen minutes. Operations personnel determined that the computer point was giving false alarms and initiated work request 60460 OPS to investigate and repair the computer point. Computer point D-4554 was declared inoperable and placed in the Technical Specification Action Item Logbook (TSAIL) at 10:53 p.m. At this time, the operator voided his signature for Item 11 and entered a procedure discrepancy, indicating that they were "complying with TS" for the inoperable computer point. However, the operator overlooked the note requiring the performance of procedure PT/2/B/4150/29; therefore, manual calculation of the containment floor/sump inventory and discharge was not conducted. The completed PT/2/A/4600/02A, along with the corrective action taken for Item 11 was reviewed and approved by the operator's Unit Supervisor. Both had overlooked the note for Item 11, thus resulting in TS surveillance item (4.4.6.2.1.b) not being performed properly.

The following morning, day shift personnel began performing PT/2/A/4600/02A. During the night, computer point D-4554 had stopped alarming. An operator verified the computer point was within acceptable limits and signed off Item 11. The Unit Supervisor for Unit 2 reviewed the completed procedure, and recognizing that computer point D-4554 was inoperable because of the previous shift entry into TSAIL, had the operator go back and enter a discrepancy for Item 11. The discrepancy indicated that the operators were "complying with TS." However, again the operator and Unit Supervisor overlooked the note for Item 11, and failed to perform the manual calculation using PT/2/B/4150/29.

Later that night, the operations night shift personnel began performing PT/2/A/4600/02A. Again, after reviewing the computer point value, an operator signed off Item 11, and during the Unit Supervisor's review of the test, it was discovered that computer point D-4554 was inoperable based on the TSAIL entry. The operator went back and voided his signature for Item 11 and entered a procedure discrepancy. However, this time, the operator noticed the note for Item 11 and entered "perform PT/2/B/4150/29" under Corrective Action for the discrepancy. PT/2/B/4150/29 was completed at 11:56 p.m., on March 2. The results of the test concluded that sump 2A and sump 2B had 0 gallon increase per minute over the 60 minute test.

The above event is identified as a Violation of the requirements of Technical Specification 6.8.1 for failing to follow the requirements of surveillance procedure PT/2/A/4600/02A. After the inspectors reviewed the event circumstances and the licensee's actions, it was determined that the event constituted a licensee identified violation; appropriate corrective

action was accomplished before the end of the inspection period; and, the violation was not willful. Consequently, this violation will not be cited in that the criteria specified in Section VII.B of NRC Enforcement Policy were satisfied, this issue is identified as NCV 414/92-09-04: Operations Personnel Failure to Follow Surveillance Procedures.

10. Surveillance Observation (61726)

a. General

During the inspection period, the inspectors verified plant operations were in compliance with various TS requirements. Typical of these requirements were confirmation of compliance with the TS for reactivity control systems, reactor coolant systems, safety injection systems, emergency safeguards systems, emergency power systems, containment, and other important plant support systems. The inspectors verified that: surveillance testing was performed in accordance with approved written procedures, test instrumentation was calibrated, limiting conditions for operation were met, appropriate removal and restoration of the affected equipment was accomplished, test results met acceptance criteria and were reviewed by personnel other than the individual directing the test, and any deficiencies identified during the testing were properly reviewed and resolved by appropriate management personnel.

b. Surveillance Activities Reviewed

The inspectors witnessed or reviewed the following surveillances:

PT/0/A/4200/17	Standby Shutdown Facility Diesel Test
PT/1/B/4250/02A	Main Turbine Weekly Trip Test
PT/1/A/4400/02C	Nuclear Service Water Valve Verification
PT/1/A/4450/03A	Annulus Ventilation System Train 1A Operability Test
PT/1/A/4600/02A	Mode 1 Periodic Surveillance Items
PT/2/A/4600/02A	Mode 1 Periodic Surveillance Items
PT/1/A/6350/02	Diesel Generator Startup and Shutdown from the Diesel Generator Room
PT/2/A/4200/18	Safety Injection System Power Disconnect Test
IP/0/B/3710/22	Exide Batteries Periodic Inspection
IP/1/B/3121/11A	Calibration Procedure for Reactor Coolant Systems Instrumentation
IP/1/A/3121/04	Calibration Procedure Reactor Coolant System (NC) Pressurizer Instrumentation

No major discrepancies were identified from the inspection activities in this area.

No violations or deviations were identified.

11. Maintenance Observations (62703)

a. General

Station maintenance activities of selected systems and components were observed/reviewed to ensure that they were conducted in accordance with the applicable requirements. The inspectors verified licensee conformance to the requirements in the following areas of inspection: activities were accomplished using approved procedures, and functional testing and/or calibrations were performed prior to returning components or systems to service; quality control records were maintained; activities performed were accomplished by qualified personnel; and materials used were properly certified. Work requests were reviewed to determine the status of outstanding jobs and to assure that priority was assigned to safety-related equipment maintenance which may affect system performance.

b. Maintenance Activities Reviewed

The inspectors witnessed or reviewed the following maintenance activities under the Work Request Nos. or maintenance procedures listed:

92013771-01	Replace Internals of Check Valve 2Ni-114
92014970-01	Modification of Train B Auxiliary Feedwater Pump Optimization Circuitry
005714 MES	Inspect Power Elements of KD Thermostatic Valve
MP/O/A/7400/33	Diesel Engine Temperature Regulating Valve Corrective Maintenance
057085051-01	Repair Diesel Fuel Oil Fitting on 1A DG Leaks during operational run.
MP/O/A/7400/29	Diesel Engine Fuel Injector Removal and Replacement
MP/O/A/7400/20	Diesel Engine Fuel Oil Filter and Strainer Removal/Replacement
007553 MNT	Inspect and Replace 1A DG IL04 Regulator
91064542-01	Perform SSF Diesel Inspection
922001003-01	SSF 125VDG Battery Bank Monthly Check Out
91019115-01	Calibrate NC Hotleg Lo-Range Pressure Switches
91019073-01	Calibrate Pressurizer Pressure Instrumentation Valve

No major discrepancies were identified from the inspection activities in this area.

No violations or deviations were identified.

12. Exit Interview

The inspection scope and findings were summarized on April 8, 1992, with those persons indicated in paragraph 1. The inspector described the areas inspected and discussed in detail the inspection findings listed below. No dissenting comments were received from the licensee. The licensee did not identify as proprietary any of the materials provided to or reviewed by the inspectors during this inspection.

<u>Item Number</u>	<u>Description and Reference</u>
VIO 413, 414/92-09-01	Failure to Follow Procedures which had the Potential to Result in an Overexposure of a Plant Employee (Paragraph 6).
NCV 413, 414/92-09-02	Failure to Perform Adequate Design Review of the Auxiliary Feedwater System (Paragraph 7).
VIO 413, 414/92-09-03	Failure to Follow or Inadequate Procedures Resulting in the 2A RN Pump Operation without Minimum Flow Protection (Paragraph 8).
NCV 414/92-09-04	Operations Personnel Failure to Follow Surveillance Procedures (Paragraph 9).