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

Report Nos.: 50-424/96-01 and 50-425/96-01

Licensee: Georgia Power Company
P. O. Box 1295
Birmingham, AL 35201

Docket Nos.: 50-424 and 50-425 License Nos.: NPF-68 and NPF-81

Facility Name: Vogtle 1 and 2

Inspection Conducted: January 28 through March 2, 1996

Inspector: For R W. Wright 3/28/96
C. R. Ogle, Senior Resident Inspector Date Signed

for Robert K Caldwell 3-28-96
M. T. Widmann, Resident Inspector Date Signed

Approved by: 3/28/96
P. H. Skinner, Chief Date Signed
Reactor Projects Branch 2
Division of Reactor Projects

SUMMARY

Scope: This routine inspection entailed inspection in the following areas: plant operations, surveillance, maintenance, onsite engineering, plant support, and follow-up. Backshift inspections were performed on February 1, 4-6, 17, 18, 23, 28, and 29; and on March 2, 1996.

Results: Two non-cited violations were identified.

Plant Operations

- In general, performance in the operations area was satisfactory.

- A non-cited violation was identified for the failure of the Unit 1 operators to properly verify that the MDAFW pump A was operable following a surveillance test. As a result, a

surveillance on the MDAFW pump B was performed with an inoperable MDAFW pump A thereby resulting in both pumps being inoperable for approximately 10 minutes (paragraph 2.3).

- The licensee's response to cracks discovered in the discharge piping for the Unit 1 NSCW pumps was consistent with their established procedures for operability determinations. Once the cracks were evaluated and the pumps declared inoperable, Technical Specification LCOs were declared and complied with. The inspectors concluded that while competing concerns existed, the licensee's examination of the other Unit 1 pumps following the initial discovery of the first crack, could have been more expeditious (paragraph 2.4).

Maintenance

- In general, performance in the maintenance area was satisfactory.

- A non-cited violation was identified for a failure to perform an adequate functional test on the Unit 1 hydrogen recombiners following wiring changes (paragraph 3.6).

- Maintenance to replace a faulty mode selector switch in SSPS was conducted in a safe and effective manner (paragraph 3.2).

- Several minor discrepancies were identified during an oil change on a RHR pump motor (paragraph 3.3).

Engineering

- In general, performance in the engineering area was satisfactory.

Plant Support

- In general, performance in the plant support area was satisfactory.

REPORT DETAILS

1.0 Persons Contacted

Licensee Employees

*Beasley, J., General Manager Nuclear Plant
Bradley, S., Reactor Engineering Supervisor
*Brown, R., Manager Training and Emergency Preparedness
*Burmeister, W., Manager Engineering Support
*Christiansen, C., SAER Supervisor
*Gasser, J., Assistant General Manager Plant Operations
*Griffis, M., Manager Plant Modifications & Maintenance Support
*Holmes, K., Manager Maintenance
*Huyck, D., Manager Nuclear Security
*Kitchens, W., Assistant General Manager Plant Support
Kochery, I., Health Physics Superintendent
*LeGrand, R., Manager Health Physics and Chemistry
Odom, R., Assistant Performance Team Manager Maintenance
Parton, T., Chemistry Superintendent
*Rushton, P., Manager Operations
*Sheibani, M., Nuclear Safety and Compliance Supervisor
*Slivka, M., ISEG Engineering Group Supervisor
*Stinespring, C., Manager Plant Administration
*Swartzwelder, J., Manager Outage and Planning
*Tippins, C., Nuclear Specialist, NSAC
Waters, R., Material Supervisor, Plant Administration

Other licensee employees contacted included technicians, supervisors, engineers, operators, maintenance personnel, quality control inspectors, and office personnel.

Oglethorpe Power Company Representative

Sharpe, J., Site Representative

NRC Inspectors

*Ogle, C., Senior Resident Inspector
*Widmann, M., Resident Inspector

*Attended Exit Interview on March 7, 1996

An alphabetical list of abbreviations and acronyms is located in the last paragraph of the inspection report.

2.0 PLANT OPERATIONS (71707)

2.1 Plant Status

On February 6, a Unit 1 power reduction to 42% power was performed to repair a stator cooling water leak on the main generator rectifier number 4. On February 10, the unit was returned to full power and remained there until February 14 when the Unit 1 coastdown commenced for refueling outage 1R6. On the evening of March 2, the unit commenced a shutdown to begin 1R6.

Unit 2 operated at full power throughout the inspection period.

2.2 General

The inspection staff reviewed plant operations throughout the reporting period to verify conformance with regulatory requirements, TSs, and administrative controls. Control logs, shift supervisors' logs, shift relief records, LCO status logs, night orders, standing orders, and clearance logs were routinely reviewed. Discussions were conducted with plant operations, maintenance, chemistry, health physics, engineering support and technical support personnel. Daily plant status meetings were routinely attended.

Activities within the control room were monitored during shifts and shift changes. Actions observed were conducted as required by the licensee's procedures. The complement of licensed personnel on each shift met or exceeded the minimum required by TS. Direct observations were conducted of control room panels, instrumentation, and recorder traces important to safety. Operating parameters were verified to be within TS limits.

Plant tours were taken during the reporting period on a routine basis. They included, but were not limited to the auxiliary building, control building, electrical equipment rooms, cable spreading rooms, NSCW towers, DG buildings, AFW buildings, MSIV rooms, turbine building and the low voltage switchyard. During plant tours, housekeeping and equipment status were observed. During a routine review of control room documentation, the inspectors identified minor administrative shortcomings in the LCO tracking sheets maintained for some inoperable incore thermocouples. These observations were identified to on-shift personnel for resolution.

2.3 Two Trains of MDAFW Pumps Rendered Inoperable

On February 8, 1996, both Unit 1 MDAFW pumps were inadvertently removed from service for approximately 10 minutes as a result of errors made during surveillance testing. This resulted in an unplanned entry into TS 3.7.1.2.a., Auxiliary Feedwater System. This TS requires that the unit be placed in hot standby within 6 hours and in hot shutdown within the following 6 hours if both MDAFW pumps are inoperable. When the discrepant condition was detected by on-shift personnel, the TS was

declared. The TS was exited shortly thereafter when the MDAFW pump B was returned to service.

In response to this event, the inspectors reviewed MDAFW systems drawings; electrical diagrams on the pump handswitch and 4160V alarm circuitry; elementary diagrams on the system status monitor panel; sequence of events log sheet; SOP 13601; surveillance procedures 14640, Train A K640 Slave Relay Test, and 14641; TS 3.7.1.2; FSAR Section 10.4.9, Auxiliary Feedwater System, commitments; the DC generated as a result of the event; and a shift briefing detailing the event. Additionally, the inspectors also interviewed operations shift personnel involved in the event and appropriate management as to their review of the event.

On February 8, surveillances 14640, Train A K640 Slave Relay Test, and 14641, Train B K640 Slave Relay Test, were accomplished. The train A surveillance was performed first. As required by Step 5.10 of procedure 14640, the operator attempted to place the MDAFW pump A handswitch in the PTL position to stop and prevent restart of the running AFW pump. However, while placing the control board handswitch in the PTL position, the handswitch momentarily spring returned to the auto position before it was finally placed in PTL. A review of the sequence of events log sheet revealed that this resulted in an attempt to restart the motor prior to it coming to rest. It was subsequently determined that this resulted in the 4160V breaker tripping on overcurrent and the activation of the associated breaker lockout relay. Coincident with this, the associated control room breaker trouble annunciator alarmed and the control board handswitch amber trouble light illuminated. Both these indications cleared when the handswitch was placed in PTL, however, the cause of these alarms was not understood by the on-shift personnel. The remaining steps of the surveillance were completed and the MDAFW Pump A handswitch was restored to the automatic position. The operators failed to detect an indicator light on the SSMP which illuminated when the MDAFW Pump A handswitch was returned to the automatic position. (The corresponding main control board annunciator warning of the SSMP indicator was already illuminated due to a previous SSMP indicator being received.)

With the Train A surveillance completed and believing the Train A MDAFW A pump was operable, the operators began the corresponding surveillance on the Train B MDAFW pump. During this surveillance, the MDAFW pump B was also rendered inoperable for approximately 10 minutes. At the completion of the Train B surveillance, an operator noticed that the Train A MDAFW SSMP light was still illuminated. An operator dispatched to the 4160V switchgear, discovered the tripped breaker for the MDAFW pump A. At this point, the LCO for two inoperable MDAFW pumps was declared. The LCO was exited when the MDAFW pump B was returned to service.

Licensee corrective actions taken in response to this event included a review of the alarm and relay wiring interlocks. The 4160V breaker annunciator alarm circuit and control board handswitch amber light circuit were evaluated to determine if a modification was possible to allow the 4160V annunciator and the handswitch amber light to illuminate when the 186 lockout relay was actuated and the pump handswitch removed from the PTL position. A second corrective action was a change in philosophy in the writing of clearances to tag out pumps differently so that the clearance will not adversely impact the SSMP alarm function.

The inspectors concluded that the operators complied with the appropriate TS requirements for AFW pump operability. But, they failed to ensure that the MDAFW pump A was operable prior to the performance of the Train B surveillance. This is contrary to the requirements of Procedure 14641-1. However, consistent with Section VII of the NRC Enforcement Policy, this is identified as NCV 50-424/96-01-01, Failure to Properly Verify MDAFW Train A Operable After Surveillance Testing.

2.4 TS 3.0.3 Entry Due to NSCW Pump Discharge Piping Cracks

On February 20, 1996, Unit 1 NSCW Trains A and B were declared inoperable after the licensee completed an engineering evaluation of cracks found in the discharge piping of the pumps. This evaluation concluded that several of the pumps could potentially be unable to perform their safety function following a seismic event. Given that less than two pumps per train remained operable, both trains were declared inoperable and TS 3.0.3, LCO Applicability, was entered at 10:25 p.m.. This LCO was exited at 10:42 p.m. when sufficient repairs had been completed to restore NSCW pumps number 1 and 3, and hence NSCW Train A, to service. Train B was restored to service at 4:15 a.m., on February 22, 1996, following repairs to two pumps in that train.

The NSCW system cools safety related ECCS equipment and serves as the ultimate heat sink. Each unit is provided with two redundant trains with three pumps per train. Train A consists of pumps 1, 3, and 5 while train B includes pumps 2, 4, and 6. TS 3.7.4, NSCW System, requires two independent NSCW trains to be operable with at least two pumps per train, otherwise the unit is placed in a 72-hour LCO.

In response to this issue, the inspectors reviewed NSCW system drawings; engineering evaluations; TS 3.7.4 requirements; FSAR section 9.2.1., NSCW System, commitments; MWO 19600436 (provided instruction for the weld repairs); a four-hour NRC notification made pursuant to 10 CFR 50.72; and the resulting DCs. The inspectors also interviewed appropriate operations and engineering personnel, as well as licensee management.

On February 17, Unit 1 NSCW pump 1 was declared inoperable following the discovery of a crack in the pump discharge piping, near the weld for the four-inch fill line connection. This condition was identified during testing following pump and motor removal and replacement for

refurbishment. The inspectors were informed by the licensee that the crack was probably the result of fatigue style failure associated with movement of the slow fill line during pump starts.

Weld repairs on NSCW pump 1 were initiated on February 19. Examinations of the other two train A pumps that same day identified similarly located, but less severe cracks in the discharge piping for Unit 1 NSCW pumps 3 and 5. An evaluation of the operability of the system was begun by the licensee following the discovery of these additional cracks. Following the completion of the weld repair to NSCW pump 1, pump 3 was removed from service for repair. On the afternoon of February 20, the licensee examined the Unit 1, train B NSCW pumps and identified similar indications of cracking in all the Unit 1 train B pumps.

On February 20, at 5:59 p.m. the licensee declared pump 4 inoperable in order to commence weld repairs. At 6:10 p.m. the licensee declared pump 2 inoperable based on preliminary results of an engineering evaluation. The licensee's evaluation concluded that the pump would potentially be unable to perform its safety function following a seismic event. The licensee entered LCO 1-96-035, 72-hour LCO, due to the pump 4 weld repair in progress and pump 2 being potentially inoperable following a seismic event. At 10:25 p.m. the licensee completed its engineering evaluation on the operability of all Unit 1 NSCW pumps. The licensee determined that NSCW pumps 5 and 6 would also potentially not be able to perform their safety function during a seismic event and immediately declared the affected pumps inoperable. TS 3.0.3 was entered due to both NSCW trains being inoperable. At this time, the NSCW train A pump 3 weld repair was in progress and pump 5 was considered potentially inoperable due to the engineering evaluation. Likewise, for train B, the pump 4 weld repair was in progress and pumps 2 and 6 were considered potentially inoperable due to the same analysis. Shortly after the entry into 3.0.3, the licensee completed weld repairs to NSCW pump 3 and therefore exited TS 3.0.3 based on pumps 1 and 3 being operable and hence NSCW train A being operable. Train B remained in the 72-hour LCO due to repairs in progress. This LCO was exited on February 22 when the weld repairs to pumps 2 and 4 were completed.

On February 21, the corresponding Unit 2 NSCW pump discharge piping was examined. No indications of cracks in the discharge piping were discovered. The physical arrangement of the discharge piping between the two Units is different which may have contributed to the lack of cracking on Unit 2.

The inspectors concluded that the licensee's evaluation process for determining NSCW pump operability during this issue was consistent with their procedures. Furthermore, once the licensee determined that pumps were inoperable, the appropriate TS LCOs were declared and complied with. However, the inspectors were concerned that approximately two and half days elapsed from the discovery of the initial indication on the Unit 1 NSCW pump 1 discharge piping until the examination of the same piping on the other Unit 1 pumps. This concern was discussed with the plant general manager following the event. The plant general manager

reviewed with the inspectors the licensee's basic approach to this issue and some competing concerns which delayed an immediate identification of the other cracks. Overall, the inspectors concluded that while the licensee's approach did not violate regulatory requirements, the examination of the other Unit 1 pumps could have been more expeditious.

The inspectors will monitor the licensee's long term resolution of this issue.

2.5 Walkdown of Clearances

During the inspection period the inspectors walked down the following clearances:

19600043 NSCW Pump Train A - Remove Pump for Rebuild and Pit Inspection

19600088 CCW Pump Motor Train A - Motor, Coupling, Breaker, and Check Valve PM

29600042 NSCW Pump Train A - Motor Cooler Flush

The inspectors did not identify any problems or concerns during the walkdown of these clearances.

3.0 MAINTENANCE AND SURVEILLANCE (62703, 61726, 90712, AND 92902)

3.1 Maintenance - General

Maintenance activities were observed or reviewed during the reporting period to verify that work was conducted in accordance with approved procedures, TSs, and applicable industry codes and standards. Activities, procedures, and work orders were examined to verify proper authorization to begin work, fire hazard provisions, cleanliness, exposure controls, proper return of equipment to service, and adherence to limiting conditions for operation were met.

The inspectors witnessed or reviewed the following maintenance activities:

MWO NOS.	WORK DESCRIPTION
19501048	Change Oil For RHR Pump 1A Motor
19600436	Weld Repair on NSCW Pump 1A Bypass Slow Fill Line (off of Discharge Header)
29500537	DG 2B Air Receiver #2 Dew Point Check
29600067	Replace Optical Isolator on DG 2B Control Panel

The inspectors did not identify any significant problems or concerns during the observation of these maintenance activities.

3.2 Replacement of SSPS Mode Selector Switch

On February 8, during performance of surveillance procedure 14420, SSPS and Reactor Trip Breaker Train A Operability Test, the continuity of the output relays at the relay test panel could not be verified as required by the surveillance procedure. In response, I&C personnel suspended the surveillance and initiated troubleshooting. The mode selector switch used to test the SSPS actuation logic, master relays, and SI reset circuit was determined to be faulty. On February 12, 1996, the switch was replaced and surveillance procedure 14420 was successfully accomplished.

The inspectors observed the switch replacement as well as the pre-job briefing. The inspectors noted that the licensee's review prior to the commencement of the switch replacement was thorough and addressed the appropriate concerns. Overall, the inspectors concluded that the maintenance was conducted in a safe and effective manner.

3.3 RHR Pump Motor Oil Change

On February 13, 1996, the inspectors witnessed performance of MWO 19501048, Change Oil For RHR Pump 1A Motor. During this observation, the inspectors noted several minor discrepancies. These included: attempts by the maintenance technician to disassemble the upper bearing oil sightglass when he was unable to locate the drain plug referenced in the procedure; the use of the same funnel to drain the used oil and add new oil; the lack of fall protection; and the failure of the technician to question the difference between the oil removed (approximately 2 cups) and the motor capacity specified in the lubrication guide (approximately 3 quarts). These discrepancies did not rise to the level of regulatory non-compliance. However, they were discussed with the appropriate maintenance department supervisory personnel for resolution. Overall the performance of the maintenance was adequate.

3.4 Surveillance - General

Surveillance tests were reviewed by the inspectors to verify procedural and performance adequacy. The completed tests were examined for necessary test prerequisites, instructions, acceptance criteria, technical content, data collection, independent verification where required, handling of deficiencies, and review of completed work. The tests witnessed, in whole or in part, were inspected to determine that approved procedures were available, equipment was calibrated, prerequisites were met, tests were conducted according to procedure, test results were acceptable, and system restoration was completed.

The inspectors witnessed or reviewed the following surveillance activities:

SURVEILLANCE NO.	TITLE
14030-1	Power Range Calorimetric Channel Calibration
14410-1	Control Rod Operability Test
14420-2	SSPS and Reactor Trip Breaker Train A Operability Test
14825-1	Steam Generator #4 ARVs 3000A and 3030A Quarterly IST
14980-2	DG 2A Operability Test
14980-2	DG 2B Operability Test
28719-1/2	RHR Check Valve Torque Surveillance

The inspectors did not identify any problems or concerns during the observation of these surveillance activities.

3.5 Higher Than Normal Dew Point Results on Unit 2 DG Train A Air Receiver Tank

On February 20, during performance of surveillance SCL00166, Diesel Generator Air Start Maintenance, the Unit 2 DG Train A air receiver tank, 2-2403-G4001-K02, dew point was determined to be approximately 48.1 degrees F. This result was within the surveillance acceptance criteria of 32 to 50 degrees F. However, moisture was identified in the dew point sample line (i.e., the tubing between the air receiver tank and the local air receiver pressure gauge). The technicians performing the surveillance disassembled the tubing and identified approximately four to five drops of water inside this tubing. It was also noted during performance of the surveillance that the refrigerant suction pressure on the internal compressor in the air dryer was higher than normal. An I&C technician advised the inspectors that the higher pressure could allow some moisture to pass through the dryer. On February 21, maintenance personnel recharged the compressor's freon system which resulted in the suction pressure being returned in the normal range. No further maintenance was performed on the DG Train A number 2 air compressor. Operations performed daily surveillances to verify air contained in the receiver tanks was moisture free. A review of operator daily surveillance sheets noted no adverse conditions identified on February 21 or 22.

A review of dew point results from previously completed surveillance task sheets by the inspectors identified a very minor upward trend in measured dew point temperatures for the Unit 2, K02 air receiver tank during the last two months. Further, it was also noted by the inspector that the previous six months results captured as a part of the surveillance SCL00166 indicated that the K02 air receiver average dew point results were slightly higher than the average dryer performance for the other three DGs. However, the inspectors noted that neither of these trends was particularly significant. Overall, the inspectors concluded that the higher than normal dew point result of February 20 in and of itself was not significant, but could be noteworthy for trending the performance of the system.

During interviews of I&C personnel, the inspectors learned of a previous occurrence of moisture being identified in the same location on a previous surveillance. Based on statements from the I&C technicians on February 22, 1996, the checklist performed sometime late in 1995 failed the surveillance acceptance criteria for the initial dew point measurement. A second dew point measurement, with the tubing removed, met the acceptance criteria. Examination of the instrument air tubing identified water drops in the tubing. No documentation could be found by the inspectors or the licensee to document the failure of the dew point surveillance conducted in late 1995 or the moisture identified inside the instrument tubing. The technicians stated that they remember discussing the failure and the discovery of the moisture with their supervision and documenting it in the MWO. The supervisor acknowledged this discussion. The inspectors concluded the lack of documentation on the Unit 2 air receiver tank surveillance failure was a missed opportunity by the licensee to track and trend a potential deficiency in the system.

3.6 Follow-up Maintenance/Surveillance

The following items were reviewed using licensee reports, inspections, record reviews, and discussions with licensee personnel, as appropriate:

(Closed) URI 50-424/95-28-02 and LER 50-424/95-07, Hydrogen Recombiner Inadequate Post-Maintenance Functional Test

Inspection Report 50-424,425/95-28 (paragraph 4.c) documents the inspectors' review of an issue involving inadequate post-maintenance functional testing for the Unit 1 hydrogen recombiners. In this instance, the recombiner units were restored to an operable status following wiring changes, based on continuity and megger checks but without performing a functional test. Pending further review, URI 50-424/95-28-02 was opened. On January 8, 1996, the licensee promulgated LER 50-424/95-07 documenting this issue and their planned corrective actions.

Based on their review, the inspectors have determined that this issue resulted from the failure of the maintenance work request to specify an adequate functional test for the intended maintenance. The inspectors reviewed the planned corrective actions identified in the LER and determined that they were adequate.

The failure to specify an adequate post-maintenance functional test was contrary to the requirements of Procedure 29401, Maintenance Work Order Functional Tests. However, consistent with Section VII of the NRC Enforcement Policy, this is identified as NCV 50-424/96-01-02, Inadequate Hydrogen Recombiner Post-Maintenance Functional Test.

These items are closed.

4.0 ONSITE ENGINEERING (37551)

4.1 General

During the inspection period, the inspectors assessed the effectiveness of onsite engineering processes by reviewing engineering evaluations, root cause determinations, modifications, and engineering testing. The inspectors also reviewed DCs to determine whether the licensee was appropriately documenting problems and implementing corrective actions.

5.0 PLANT SUPPORT (71750 AND 92904)

5.1 General

Plant support activities were observed and reviewed to ensure that licensee programs were implemented in conformance with facility policies and procedures and in compliance with regulatory requirements. Activities reviewed included radiological controls, physical security, emergency preparedness, and fire protection.

5.2 PLANT SUPPORT FOLLOW-UP

a. (Closed) VIO 50-424, 425/95-24-03, Failure to Follow Protected Area Entry/Exit Procedure with Regard to PA Designated Vehicles

This violation identified one example of a designated vehicle left unattended in the protected area near the Unit 2 NSCW tower with the keys in the ignition.

This item is administratively closed. The corrective actions for this violation will be reviewed with the corrective actions taken by the licensee in response to a similar occurrence documented in VIO 50-424, 425/95-28-03, Designated Vehicle Left Unattended In Protected Area With Engine Running.

b. (Closed) VIO 95-424, 425/95-06-03, Inadequate Corrective Actions for Unsecured Designated Vehicles Inside the Protected Area

This violation dealt with inadequate corrective actions for two examples of designated vehicles inside the protected area being left unattended with the keys in the ignition. The two examples are documented in inspection report 50-424, 425/94-22.

This item is administratively closed. The corrective actions for this violation will be reviewed with the corrective actions taken by the licensee in response to a similar occurrence documented in VIO 50-424, 425/95-28-03, Designated Vehicle Left Unattended In Protected Area With Engine Running.

6.0 OTHER NRC PERSONNEL ON SITE

On February 2, 1996, Mr. J. Johnson, Deputy Director, DRP, and on February 6, 1996, Mr. A. Gibson, Director, DRS, Region II, were on site for a plant tour and to discuss areas of interest with the residents and licensee personnel.

7.0 REVIEW OF UFSAR COMMITMENTS

A recent discovery of a licensee operating their facility in a manner contrary to the Updated Final Safety Analysis Report description highlighted the need for a special focused review that compares plant practices, procedures and/or parameters to the UFSAR description. While performing the inspections discussed in this report, the inspectors reviewed the applicable portions of the UFSAR that related to the areas inspected. The following was noted between the wording of the UFSAR and the plant practices, procedures and/or parameters observed by the inspectors. In IR 95-28, the inspectors documented differences in the FSAR descriptions for the Unit 1 and Unit 2 Spent Fuel Pool design bases. The inspectors concluded that the licensee's actual refueling practices were bounded by FSAR analysis. However, the inspectors were concerned that a full core off-load was not described under a "normal" case for Unit 1. (It was described for Unit 2 as a normal case.) This concern was discussed with licensee management and on March 5, 1996, the FSAR was revised. This revision eliminated differences in the FSAR descriptions between the two units and as a result a full core off-load is now described under a "normal" case.

8.0 EXIT MEETING

The inspection scope and findings were summarized on March 7, with those persons indicated in paragraph 1. The inspector described the areas inspected and discussed in detail the inspection findings. No dissenting comments were received from the licensee. The licensee did not identify as proprietary any of the material provided to or reviewed by the inspectors during the inspection.

Item No.	Status	Description and Reference
NCV 50-424/ 96-01-01	Closed	Failure to Properly Verify MDAFW Train A Operable After Surveillance Testing (paragraph 2.3)
NCV 50-424/ 96-01-02	Closed	Inadequate Hydrogen Recombiner Post-Maintenance Functional Test (paragraph 3.6)
VIO 50-424, 425/ 95-24-03	Closed	Failure to Follow Protected Area Entry/Exit Procedure with Regard to PA Designated Vehicles (paragraph 5.2.a)
VIO 50-424, 425/ 95-06-03	Closed	Inadequate Corrective Actions for Unsecured Designated Vehicles Inside the Protected Area (paragraph 5.2.b)
URI 50-424/ 95-28-02	Closed	Hydrogen Recombiner Inadequate Post Maintenance Functional Test (paragraph 3.6)
LER 50-424/ 95-07	Closed	Hydrogen Recombiner Inadequate Post Maintenance Functional Test (paragraph 3.6)

9.0 ACRONYMS

AFW	- Auxiliary Feedwater System
ARV	- Atmospheric Relief Valve
CCW	- Component Cooling Water
CFR	- Code of Federal Regulations
DC	- Deficiency Card
DG	- Diesel Generator
DRP	- Division of Reactor Projects
DRS	- Division of Reactor Safety
ECCS	- Emergency Core Cooling System
FSAR	- Final Safety Analysis Report
I&C	- Instrumentation and Controls
IR	- Inspection Report
ISEG	- Independent Safety Engineering Group
LCO	- Limiting Condition for Operation

LER	- Licensee Event Report
MDAFW	- Motor Driven Auxiliary Feedwater
MSIV	- Main Steam Isolation Valve
MWO	- Maintenance Work Order
NCV	- Non-Cited Violation
NPF	- Nuclear Power Facility
NRC	- Nuclear Regulatory Commission
NSAC	- Nuclear Safety and Compliance
NSCW	- Nuclear Service Cooling Water System
PA	- Protected Area
PM	- Preventive Maintenance
PTL	- Pull-To-Lock
RHR	- Residual Heat Removal System
SAER	- Safety Audit And Engineering Review
SI	- Safety Injection
SOP	- System Operating Procedure
SSMP	- System Status Monitor Panel
SSPS	- Solid State Protection System
TS	- Technical Specifications
UFSAR	- Updated Final Safety Analysis Report
URI	- Unresolved Item
VIO	- Violation
1R6	- Unit 1 Sixth Refueling Outage