

Southern Nuclear Operating Company
Post Office Box 1295
Birmingham, Alabama 35201
Telephone (205) 868-5131



Dave Morey
Vice President
Farley Project

Southern Nuclear Operating Company
October 13, 1993
the southern electric system

Docket No.: 50-364

U. S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, DC 20555

Joseph M. Farley Nuclear Plant
Reply to a Notice of Violation (NOV)
NRC Inspection Report Nos. 50-348/93-19 and 50-364/93-19

Gentlemen:

This letter responds to the violation (NOV-50-364/93-19-02) as cited in the subject NRC inspection report. The violation therein states:

Technical Specification 6.8.1 requires that applicable written procedures recommended in Appendix A of Regulatory Guide (RG) 1.33, Revision 2, 1978, shall be established, implemented and maintained.

Contrary to the above, on August 5, 1993, with Unit 2 at power, a plant systems operator and a licensed shift foreman erroneously isolated Component Cooling Water (CCW) to secondary heat exchanger loads on the miscellaneous CCW header during "switch-over" operations from the "A" train CCW header to the "B" train CCW header. Both operators failed to correctly read posted CCW valve identification numbers and, in turn, failed to properly perform the action steps contained in the written and approved CCW system operating procedure.

This is a Severity Level IV violation (Supplement 1)

The Southern Nuclear Operating Company (SNC) response to this notice of violation (NOV) is provided in Attachment 1.

180063
9310190123 931013
PDR ADOCK 05000364
G PDR

TEO/
11

In the cover letter that forwarded the above NOV , you stated that the NRC is particularly concerned about this violation because it appeared to be a continuation of wrong train/wrong unit events. SNC shares your concern about the recurrence of this type of event. The two individuals involved in this violation did not pay proper attention to detail in reading the valve labels and failed to properly review their actions for mistakes. As a result of this event the importance of proper self-checking has been re-emphasized to plant personnel.

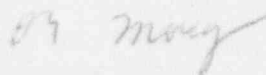
In your cover letter you also emphasize the need for SNC to review our system for "independent verifications." In this event the valve mispositioning errors were made prior to the independent verification of the as-left valve positions. The independent verification must be performed after the initial alignment and thus is not a mechanism to prevent events like this from occurring.

Confirmation

I affirm that the response is true and complete to the best of my knowledge, information and belief.

Respectfully submitted,

SOUTHERN NUCLEAR OPERATING COMPANY



D. N. Morey

BHW:maf 93-19.doc

Attachment

cc: Mr. S. D. Ebnetter
Mr. T. A. Reed
Mr. M. J. Morgan

bc: Mr. J. D. Woodard
Mr. R. D. Hill
Mr. K. W. McCracken
Mr. J. W. McGowan
Commitment Tracking System (2)
Document Control RTYPE A.454

Attachment 1

Admission or Denial

The above violation occurred as described in the subject report.

Reason for Violation

This event resulted due to personnel error as a result of a lack of proper self-checking. The SO and SFO did not completely read the component numbers for two valves that were operated by the SO. When the SO found valve positions opposite of what he expected (already open), he did not discuss this unexpected condition with the control room or supervision. When the SO noticed a change in flow noise at a point in the procedure where this would not have been expected, he did not bring this unexpected system response to the attention of the SFO.

Corrective Action Taken and Results Achieved

The control room operators were alerted to the erroneous isolation of the CCW miscellaneous header by annunciator alarms. Actions were taken by the SFO and SO to restore proper flow to the miscellaneous header.

Corrective Steps to Avoid Further Violations

The following corrective actions were taken to prevent recurrence:

The SO and SFO have been disciplined.

All plant personnel have had the importance of self-verification and the STAR Program (Stop, Think, Act and Review Program, which has been described in previous communications) reemphasized to them with special importance being placed on checking the entire component identification number. Additionally the questioning and discussing of unexpected responses with supervision or co-workers has been stressed. This was accomplished via a Training Advisory Notice issued 9-8-93.

Date of Full Compliance

September 22, 1993



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

SEP 13 1993

Docket Nos.: 50-348 and 50-364
License Nos.: NPF-2 and NPF-8

Southern Nuclear Operating Company, Inc.
ATTN: Mr. D.N. Morey
Vice President
Farley Project
P. O. Box 1295
Birmingham, AL 35201-1295

Gentlemen:

SUBJECT: NOTICE OF VIOLATION
(NRC INSPECTION REPORT NOS. 50-348/93-19 AND 50-364/93-19)

This refers to an inspection conducted by M.J. Morgan of this office on July 30 through August 30, 1993. The inspection included a review of activities authorized for your Farley facility. At the conclusion of the inspection, and at various times during the inspection, the findings were discussed with those members of your staff identified in the enclosed report.

Areas examined during the inspection are identified in the report. Within these areas, the inspection consisted of selective examinations of procedures and representative records, interviews with personnel, and observation of activities in progress.

Based on the results of this inspection, certain of your activities appeared to be in violation of NRC requirements as specified in the enclosed Notice of Violation (Notice). We are particularly concerned about this violation because it appears to be a continuation of previously identified problems involving wrong unit/wrong train, and in this case, the additional failure of your independent verification system to prevent this type of problem involving important plant equipment.

During management meetings on September 23, 1992 and July 15, 1993, to discuss corrective actions to prevent recurrence of previous violations, you described your program for team building, counseling, root cause analysis and the "STAR" self-verification program. Although these actions have achieved improvement, additional corrective actions are necessary. In particular, please review your system for "independent verifications" to determine what enhancements are necessary.

In addition, the enclosed Inspection Report identifies activities that violate NRC requirements that will not be subject to enforcement action because the licensee's efforts in identifying and correcting the violation meet the criteria specified in Section VII.B of the Enforcement Policy.

SEP 13 1993

Southern Nuclear Operating
Company, Inc.

2

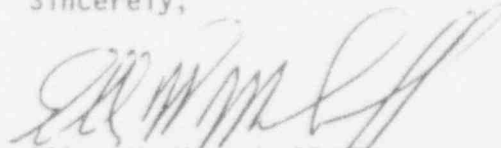
You are required to respond to this letter and should follow the instructions specified in the enclosed Notice when preparing your response. In your response, you should document the specific actions taken and any additional actions you plan to prevent recurrence. You should also address the generic and programmatic aspects of this issue. After reviewing your response to this Notice, including your proposed corrective actions and the results of any future inspections, the NRC will determine whether further NRC enforcement action is necessary to ensure compliance with NRC regulatory requirements.

In accordance with Section 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosures will be placed in the NRC Public Document Room.

The responses directed by this letter and the enclosed Notice are not subject to the clearance procedures of the Office of Management and Budget as required by the Paper Work Reduction Act of 1980, Pub. L. No. 96-511.

Should you have any questions concerning this letter, please contact us.

Sincerely,



Ellis W. Merschoff, Director
Division of Reactor Projects

Enclosures:

1. Notice of Violation
2. NRC Inspection Report

cc w/encls:

B. L. Moore
Licensing Manager
Southern Nuclear Operating
Company, Inc.
P. O. Box 1295
Birmingham, AL 35201-1295

R. D. Hill, Jr.
General Manager, Farley Plant
Southern Nuclear Operating
Company, Inc.
P. O. Box 470
Ashford, AL 36312

(cc w/encls cont'd - See page 3)

SEP 13 1993

Southern Nuclear Operating
Company, Inc.

3

(cc w/encls)
W. R. Bayne, Supervisor
Safety Audit and Engineering Review
Farley Nuclear Plant
P. O. Box 470
Ashford, AL 36312

State Health Officer
Alabama Department of Public Health
434 Monroe Street
Montgomery, AL 36130-1701

James H. Miller, III, Esq.
Balch and Bingham
P. O. Box 306
1710 Sixth Avenue North
Birmingham, AL 35201

Chairman
Houston County Commission
P. O. Box 6406
Dothan, AL 36302

ENCLOSURE 1

NOTICE OF VIOLATION

Southern Nuclear Operating Company
Farley Nuclear Plant

Docket No.: 50-364
License No.: NPF 8

During the Nuclear Regulatory Commission (NRC) inspection conducted on July 30 through August 30, 1993, a violation of NRC requirements was identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," 10 CFR Part 2, Appendix C, the violation is listed below:

Technical Specification 6.8.1 requires that applicable written procedures recommended in Appendix A of Regulatory Guide (RG) 1.33, Revision 2, 1978, shall be established, implemented and maintained.

Contrary to the above, on August 5, 1993, with Unit 2 at power, a plant systems operator and a licensed shift foreman erroneously isolated Component Cooling Water (CCW) to secondary heat exchanger loads on the miscellaneous CCW header during "switch-over" operations from the "A" train CCW header to the "B" train CCW header. Both operators failed to correctly read posted CCW valve identification numbers and, in turn, failed to properly perform the action steps contained in the written and approved CCW system operating procedure.

This is a Severity Level IV violation (Supplement 1).

Pursuant to the provision of 10 CFR 2.201, Southern Nuclear Operating Company is hereby required to submit a written statement or explanation to the Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555, with a copy to the Regional Administrator, Region II, and a copy to the NRC Resident Inspector, at the facility that is the subject of this Notice, within 30 days of the date of the letter transmitting this Notice of Violation (Notice). This reply should be clearly marked as a "Reply to the Notice of Violation" and should include for each violation: (1) the reason for the violation, or, if contested, the basis for disputing the violation. (2) the corrective steps that have been taken and the results achieved, (3) the corrective steps that will be taken to avoid further violations, and (4) the date when full compliance will be achieved. If an adequate reply is not received within the time specified in this Notice, an order or demand for information may be issued to show cause as to why the license should not be modified, suspended, or revoked, or why such other action as may be proper should not be taken. Where good cause is shown, consideration will be given to extending the response time.

THE NUCLEAR REGULATORY COMMISSION

Dated at Atlanta, Georgia
this 13th day of September 1993

9309280194
1P



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

***Report Nos.: 50-348/93-19 and 50-364/93-19

Licensee: Southern Nuclear Operating Company, Inc.
P.O. Box 1295
Birmingham, AL 35201-1295

Docket Nos.: 50-348 and 50-364

License Nos.: NPF-2 and NPF-8

Facility name: Farley 1 and 2

Inspection Conducted: July 30 - August 30, 1993

Inspectors: Michael J. Morgan
Michael J. Morgan, Acting Senior Resident Inspector

9/13/93
Date Signed

Michael A. Scott
Michael A. Scott, Resident Inspector

9/13/93
Date Signed

Accompanying Personnel: T. M. Ross, Senior Project Manager, NRR

Approved by: Floyd S. Cantrell
Floyd S. Cantrell, Chief
Reactor Projects Section 1B
Division of Reactor Projects

9/13/93
Date Signed

SUMMARY

Scope:

This routine, resident inspection involved on-site inspection of operations, maintenance, surveillance, follow-up of facility events and an evaluation of licensee self-assessment. Deep backshifts were performed August 17 and 24, 1993.

Results:

On August 18, 1993, during surveillance testing, operations personnel observed a low suction pressure condition on the Unit 2 turbine-driven auxiliary feedwater pump. Extensive testing did not identify the cause, paragraph 3.a. A systems operator during the filling of a pump room sump, operated an engineered safety feature valve without permission from the shift supervisor. A non-cited violation was issued for this event, paragraph 3.b. On August 5, a systems operator and shift foreman, during switch-over operations of component cooling water headers, erroneously isolated water to the miscellaneous header. A violation was issued for this event, paragraph 3.c. On August 19, during performance of load testing activities, a 75-ton boom crane contacted a non-safety related 12 Killovolt power line outside the protected area, paragraph 4.b. On August 11, the inspectors attended a

9309280197 1/p.

meeting of the plant operations review committee, paragraph 6. Also on August 11, the inspectors observed plant personnel and a vendor representative unloading new fuel assemblies, paragraph 7. Licensee action was taken on previous inspection findings, paragraph 8.

One violation and one non-cited violation were identified. Results of this inspection indicate that actions by management, operations, maintenance and other site personnel were adequate.

REPORT DETAILS

1. Persons Contacted

Licensee Employees

W. Bayne, Supervisor, Safety Audit and Engineering Review
C. Buck, Technical Manager
R. Coleman, Modification Manager
P. Crone, Superintendent, Operations Support
L. Enfinger, Administrative Manager
*R. Hill, General Manager - Farley Nuclear Plant
*W. Jaasma, Senior Engineer, Safety Audit and Engineering Review
M. Mitchell, Superintendent, Health Physics and Radwaste
*C. Nesbitt, Operations Manager
*J. Osterholtz, Assistant General Manager - Plant Support
J. Powell, Unit Supervisor - Plant Operations
*L. Stinson, Assistant General Manager - Plant Operations
J. Thomas, Maintenance Manager

*Attended the exit interview

Other licensee employees contacted included, technicians, operations, security, maintenance, I&C and office personnel.

On August 30, 1993, M. A. Scott reported to Farley as Resident Inspector.

From August 9 to August 13, T. Ross, Senior Project Manager, NRR, assisted the resident inspectors.

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

2. Plant Status

a. Units 1 and 2 Status

Units 1 & 2 operated at full power during reporting period.

b. NRC/Licensee Meetings and Inspections

During the week of August 23, Region II security personnel conducted a routine inspection of FNP site. (Report 50-348, 364/93-20).

During the week of August 16, Region II personnel from the Division of Reactor Safety conducted the initial phase of an operational performance inspection of the FNP's service water system.

3. Operational Safety Verification (71707)

The inspectors conducted routine tours to verify license requirements are being met. Tours included review of site documentation, interviews with plant personnel and an on-going evaluation of licensee self-assessment.

a. Turbine-Driven Auxiliary Feedwater Pump (TDAFWP) Low Suction Pressure Event - Unit 2

On August 18, during post-maintenance performance of surveillance test, STP-22.16, operations personnel observed a low suction pressure condition on the Unit 2 TDAFWP. Concurrently, security and operations personnel heard metallic noises in the area of the Unit 2 condensate storage tank (CST). The TDAFWP was immediately secured and the FNP personnel investigated system components for cause.

On August 19, a FNP management meeting was held to develop an event investigation plan. TDAFWP suction components/valves were disassembled. Radiography of system piping and other valves was also performed. On August 20, the CST bladder was cut open and divers conducted a visual inspection of the inside of the tank. No problems were found in the tank. The pump suction and suction line components were vented and the pump was run for about three minutes. The low TDAFWP suction pressure anomaly did not reappear. FNP management decided to further examine the system using fiber optics. Nothing unusual was observed. At about 9:00 a.m., a conference call was held between FNP, SNC, NRR, and Region II personnel to discuss the event and FNP's plan. FNP theorized that the metallic sounds heard in the vicinity of the CST were due to thermal expansion/contraction of the tank and piping upon recirculation of "cooler" liquid through hot piping. After discussions with the Region II and NRR staff, the licensee decided to rerun STP-22.16 and also surveillance STP-22.19, which used the TDAFW pump to feed directly to the steam generators. The TDAFWP was run for about 85 minutes and the motor-driven AFW pumps were also tested. Personnel were stationed in the area of the CST. The surveillance tests were satisfactory and no unusual sounds were noted near the CST.

On August 21, with the pump secured, the pump suction piping pressure transmitter sensing lines were vented in an attempt to reproduce the original low suction pressure; however, the problem did not reappear. The CST bladder was repaired, system components were inspected and restored to operable conditions and the TDAFWP and overall system was declared operable. The pump and associated system equipment are scheduled to be inspected in the upcoming September - October Unit 2 refueling outage.

b. Unauthorized and Inappropriate Auxiliary Feedwater (AFW) System Drain Valve Operation - Unit 2

On July 21, a systems operator (SO), during filling operations of the turbine-driven AFW (TDAFW) pump room sump, operated an ESF valve without first obtaining proper authorization from the unit shift supervisor (See Inspection Report 50-348,364/93-17 paragraph 3.b.) This item was identified as unresolved item 50-364/93-17-01, Unauthorized AFW system drain valve operation. This UNR is now identified as a non-cited violation (NCV) 50-364/93-19-01. The AFW system remained operable throughout the incident. This violation will not be subject to enforcement action because the licensee's efforts in identifying and correcting the violation meet the criteria specified in Section VII.B of the Enforcement Policy. This item is closed.

c. Erroneous Isolation of the Component Cooling Water (CCW) System Miscellaneous Header - Unit 2

On August 5, with Unit 2 at power during "switch-over" operations from the "A" train CCW header to the "B" train CCW header, a plant SO and a licensed shift foreman (SFO), erroneously isolated CCW to the miscellaneous CCW header. Their action resulted in the control room receiving a "low CCW flow to the RCP heat exchanger" alarm and indications that RCS letdown (L/D) flow was being diverted around the RCS L/D demineralizers. Automatic bypassing of the demineralizers occurs when higher-than-expected (~130 degrees F) outlet temperatures are experienced from the L/D heat exchanger. Isolation of this header also isolated CCW to the RCP seal packages, and the gross failed fuel monitor and sampling system heat exchangers. Upon receiving directions from control room operators, the SO immediately restored cooling from the "A" train CCW supply by reopening the "A" train valves. Control room personnel verified that CCW flow had been reestablished. Event duration was about 75 seconds.

In accordance with the procedure, SOP-23.0B, the following steps are required to be performance and independently verified. The "B" train CCW supply header cross-connect valves, "Q2P17V009A" & "Q2P17V009B", are required to be opened prior to the closing of the "A" train CCW supply header cross-connect valves, "Q2P17V009C" & "Q2P17V009D". Both the SO and SFO failed to follow the procedural steps contained in SOP-23.0B. Instead, the SO erroneously verified open, the "2A" & "2B" CCW pump suction valves, "Q2P17V109A" & "Q2P17V109B". The resident inspectors, during follow-up activities performed for this event, determined that the personnel involved failed to properly identify valves prior to their operation. Both the SO and SFO misread the attached valve identification (ID) numbers, (i.e., they attempted to

identify valves by simply reading the last three identifiers - the "09A" and "09B" designations - rather than the whole valve ID number).

Both operators failed to correctly read posted CCW valve ID numbers and as a result the SO failed to properly perform the action steps contained in the written and approved CCW system operating procedure. The SFO failed to properly identify all valves to be operated prior to their operation by the SO. The SFO also failed to coordinate these local CCW valve realignment activities. As part of the licensee's immediate corrective actions, both operators were "counseled", the specifics of self-verification techniques were discussed, other operations personnel were notified of the event "specifics" and a formal "root cause" analysis, was begun. Further enhancements to the CCW operating procedure are being considered. FNP continues to emphasize self-verification techniques to their operations personnel. This includes a check of the whole valve ID number.

At the time of the event, FNP personnel were in the process of hanging tags as part of an improved labeling program. These "new" labels include the noun name of the component, clearer ID numbers, universal coding and a color coding for the appropriate unit, (i.e.; yellow bordering for Unit 1; green for Unit 2). FNP management was also evaluating various methods for better identification of chain-operated valves.

The isolation of the Unit 2 miscellaneous CCW header is an example of personnel error and operators failing to thoroughly and accurately follow established procedural action steps. This event is a violation, (NOV) 50-364/93-19-02, Erroneous CCW valve operation due to a failure to adhere to approved written procedures.

No other violations or deviations were identified in this area. Results of inspections in the operation's area indicate that operations personnel conducted other assigned activities in accordance with applicable procedures.

4. Monthly Maintenance Observation (62703)

The inspectors reviewed various FNP preventative/corrective maintenance activities, to determine conformance with facility procedures, vendor technical manuals, work requests and NRC regulatory requirements.

a. Portions of the following activities were observed/reviewed:

- MWR-253215; Unit 2 Containment spray pump room sump pump - verify and reset overload adjustment

The inspector reviewed documentation for the associated adjustment efforts and noted that a proper release of the component was

obtained from the SS. The inspector noted that the pump overload was properly adjusted from the previous 100 percent condition to a desired 115 percent to allow for pump room ambient conditions. Work performed appeared to be satisfactory and in accordance with guidance contained in the MWR and the sump pump technical manual.

- MWR-274500; Service water to the Unit 2 TDAFWP isolation valve - perform radiography on the valve.

The inspector reviewed the MWR and the associated test set-up. The RT was performed on the valve body to determine if any of the internals had been damaged. The RT was difficult to read and management decided to discontinue RT efforts and reexamine the AFW lines with fiber optic equipment. Work performed was satisfactory and in accordance with directions contained in the package; however, results of the RT were inconclusive. (Paragraph 3 a.)

b. 75-Ton Crane Contacts the Warehouse 12KV Electrical Feeder Line

On August 19, during performance of load testing activities for the 75-ton crane main and auxiliary hoists, the crane's boom contacted a 12KV power line. The boom was immediately moved and load testing activities were halted. No personnel were injured and the event did not involve the FNP main power block/grid lines or associated system electrical transmission lines. Burn marks were evident on the crane boom jib line, at the point of the arc. The neutral wire of the 12KV warehouse feeder lines was frayed but not broken.

The weights used for testing are at different locations. While the crane was being backed into position for testing, the boom was lifted in order to avoid a dump truck that was in its path. As the crane continued to be moved into the testing area/position, the boom came into contact with the power lines. The associated power line fuses "blew", consequently reenergizing of the power lines was not possible. Causes of the problem included, a lack of a required spotter/flagman and appropriate, approved precautions not being followed by the crane operator. FNP/SNC management, health/safety and maintenance personnel are presently investigating this industrial safety incident and a report will be written. SNC management considers this to be a significant incident. Immediate corrective actions have included, 1) personnel discipline, 2) stressing of the FNP guidelines/procedures for crane operation to appropriate FNP personnel and 3) presentations of this incident at site safety meetings. The inspectors will provide updates of this incident in a future report.

No violations or deviations of NRC requirements were identified in this area. The results of inspections in the maintenance area indicate that both operations and maintenance personnel conducted other assigned activities in accordance with applicable procedures.

5. Monthly Surveillance Observation (61726)

Inspectors witnessed surveillance test activities performed on safety-related systems and components, in order to verify that such activities were performed in accordance with facility procedures and NRC regulatory and licensee technical specification requirements.

The following surveillance activities were observed/reviewed:

- 1-STP-1.0 | Operations Daily/Shift Surveillance Requirements
- 2-STP-1.0 | Modes 1, 2, 3, and 4

The inspectors routinely observed operator activities while parameters were monitored, documented, and evaluated.

- 2-STP-22.16; Turbine-Driven AFW (TDAFW) Pump Inservice Test

The inspectors observed, 1) pump start-up, 2) pump flows using the small recirculation discharge piping, 3) combination discharge flows using both the small and larger recirculation discharge pathways, 4) pump RPMs and 5) TDAFW pump suction pressures and flows. The inservice test was satisfactory and conducted in accordance with the approved plant procedure. (Paragraph 3 a.)

- 2-STP-22.19; Auxiliary Feedwater (AFW) Normal Flow Path Verification

The inspectors observed, 1) start-up of the TDAFW pump and the motor driven pumps, 2) required flows to the appropriate steam generators and 3) restoration of normal system alignment/configuration. Testing flows to the steam generators did not cause a plant transient. Flow path verification and operability was determined to be satisfactory and in accordance with the approved plant procedure. (Paragraph 3 a.)

No violations or deviations were identified in this area. The results of inspections in the surveillance area indicate that personnel conducted assigned activities in accordance with applicable procedures.

6. Evaluation of Licensee Self-Assessment Capability (40500)

The inspectors attended a meeting of the PORC on August 11. The meeting was chaired by the General Manager - Nuclear Plant and a quorum was present as required by Technical Specification 6.5.1. Members were prepared for the discussions, had knowledge of the issues, and discussion among the PORC members was uninhibited and encouraged by the chairman of the committee. The licensee's self-assessment program, specifically PORC activities, are adequate and no violations or deviations were identified.

7. Transfer and Visual Inspection of New Fuel - Unit 2 (60705)

On August 11, the inspectors observed activities of FNP personnel (i.e., operations, health physics and reactor engineering), and a vendor fuels representative, in the process of unloading, inspecting, and transferring new fuel assemblies from their shipping containers to the storage racks. The assemblies had been recently shipped from the vendor for the upcoming refueling outage. This evolution was conducted in accordance with the FNP fuel handling procedure FHP-3.0, "Receipt and Storage of New Fuel." Site personnel accomplished their duties in a deliberate and methodical manner in accordance with FHP-3.0 and without incident. Radiological surveys and swipes of each new assembly were performed, along with thorough visual inspections using the criteria/guidance contained in Attachment "B" of the procedure. No anomalous mechanical conditions were identified.

8. Action on Previous Inspection Findings (92700)

- a. (Closed) Unit 2 URI 50-364/93-17-01, Unauthorized AFW system drain valve operation. The operator was disciplined for his conduct. The drain valve was immediately closed and the affected pump room areas were cleaned. An incident report and root cause study was prepared by the licensee and the event was discussed with operations personnel. This aspect of operating safety-related equipment without proper authorization, continues to be emphasized in the licensee's SO training program. This item is closed.
- b. (Closed) Unit 1 NOV 50-348/91-17-01, Unit 1 turbine-driven auxiliary feedwater pump not fully operable when plant mode changes were conducted. The violation was caused by procedural inadequacy and personnel error by the SS. The procedure did not have the appropriate sign-off provisions and the SS failed to ensure the proper LCO status sheet was generated. A civil penalty was assessed by the NRC. As indicated in your Reply to the Notice of Violation, dated October 14, 1991, the SS was reprimanded and all plant procedures were reviewed for cases where a group, other than the primary performing group, was required to perform a procedural step. All procedures found to exhibit this "inconsistency" were evaluated for specific secondary group sign-off provisions. New procedures are written to include guidance and specific sign-offs for both primary and secondary group signatures. This item is closed.
- c. (Closed) Unit 1 NOV 50-348/91-17-02, Shift supervisor did not conduct required audits of locked valve and key checkout sheets on Unit 1. This violation was caused by personnel error in that a locked valve audit was not performed weekly. The performance of the locked valve and key checkout log audits by the shift supervisors was emphasized and is a part of their training. This item is closed.

9. Exit Interview

The inspection scope and findings were summarized during management interviews throughout the report period and on September 1, with the facility manager and selected members of his staff. The inspection findings were discussed in detail. The licensee acknowledged the inspection findings and did not identify as proprietary any material reviewed by the inspectors during this inspection. The licensee was informed that the item discussed in paragraph 8 were closed.

<u>ITEM NUMBER</u>	<u>DESCRIPTION AND REFERENCE</u>
50-364/93-19-01 (NCV)	Unauthorized AFW system drain valve operation
50-364/93-19-02 (NOV)	Erroneous CCW valve operation due to a failure to adhere to approved written procedures.

10. Acronyms and Abbreviations

AFW	-	Auxiliary Feedwater
AP	-	Administrative Procedure
CCW	-	Component Cooling Water
CST	-	Condensate Storage Tank
D/G	-	Emergency Diesel Generator
DRP	-	Division of Reactor Projects
ESF	-	Engineered Safety Features
FHP	-	Fuel Handling Procedure
FNP	-	Farley Nuclear Plant
HP	-	Health Physics
ID	-	Identification
I&C	-	Instrumentation and Controls
KV	-	Kilovolts
LCO	-	Limiting Condition for Operation
MDAFW	-	Motor-Driven Auxiliary Feedwater
MOV	-	Motor-Operated Valve
MWR	-	Maintenance Work Request
NCV	-	Non-cited Violation
NOV	-	Notice of Violation
PORC	-	Plant Operations Review Committee
RCP	-	Reactor Coolant Pump
RCS	-	Reactor Coolant System
RPM	-	Revolutions Per Minute
RT	-	Radiography Test
SFO	-	Shift Foreman Operating
S/G	-	Steam Generator
SNC	-	Southern Nuclear Operating Company
SO	-	Systems Operator
SS	-	Shift Supervisor
SNC	-	Southern Nuclear Operating Company

STAR	-	"Stop", "Think", "Act", "Review"
STP	-	Surveillance Test Procedure
SWS	-	Service Water System
TDAFWP-		Turbine-Driven Auxiliary Feedwater Pump