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February 28, 1984

Docket No. 50-348
Docket No. 50-364

Mr. R. C. Lewis
U. S. Nuclear Regulatory Commission
Region II
101 Marietta Street, N.W.
Suite 3100
Atlanta, GA 30303

SUBJECT: J. M. Farley Nuclear Plant NRC Inspection of December 11, 1983 - January 10, 1984

**RE: Report Numbers 50-348/83-33
50-364/83-31**

Dear Mr. Lewis:

This letter refers to the violations cited in the subject inspection reports which state:

"The following violations were identified during an inspection conducted on December 11, 1983 - January 10, 1984. The Severity Levels were assigned in accordance with the NRC Enforcement Policy (10 CFR Part 2, Appendix C).

1. Technical Specification 6.8.1 requires that written procedures shall be implemented for surveillance test procedures and operating procedures.

   Contrary to the above, the licensee did not implement surveillance and operating procedures as follows:

   a. Although FNP-1-STP-201.6B requires that a sign-off sheet be initialed as each step is completed, such sign-offs were initiated after six steps were performed.

   b. Although FNP-1-SOP-2.6C requires a valve verification, on December 13, 1984, no verification was performed on a checklist that the first man performed on October 22, 1983.

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c. Although FNP-2-STP-256.15 required the removal of a test transmitter on October 18, 1983, the test transmitter was not removed as of December 20, 1983 and no exception was noted during the procedure review on December 14, 1983.

d. Although FNP-2-STP-24.7 requires MOV 536 to be verified open, MOV 536 was not verified open on December 29, 1983. The inspector found MOV 536 shut on December 30, 1983."

Admission or Denial

The above violation occurred as described in the subject reports.

Reason for Violation

1a. - Personnel error. Failure to follow procedure.

1b. - Personnel error. Failure to properly implement system operating procedure.

1c. - Because the 2B charging pump remained on line upon completion of the test, initial and subsequent attempts to disconnect the transmitter were denied. The fact that the transmitter remained connected and not noted on the review sheet was an oversight by the reviewer.

1d. - Personnel error. Failure to follow surveillance procedure.

Corrective Action Taken and Results Achieved

1a. & 1c. The importance of adhering to procedures was discussed during a shop meeting on December 14, 1983 with special emphasis being placed on signing off individual steps to insure proper sequential conduct of the procedure. The importance of a thorough review was stressed to all reviewers in the I & C group with emphasis on the restoration of systems to their original configuration. The personnel directly involved with these incidents have been counseled.

1b. This item of the violation has been discussed with key personnel on each crew with emphasis on procedure adherence and control of procedures.

1d. FNP-1-STP-24.7/FNP-2-STP-24.7 (Service Water Valves Inservice Test) have been revised to require an independent verification of the service water to Diesel Building valve positions: The personnel directly involved have been counseled.

Corrective Steps Taken to Avoid Further Violations

See above. All corrective action was completed by January 4, 1984.

Date of Full Compliance

1a. December 14, 1983
1b. October 25, 1983
1c. December 22, 1983
1d. December 30, 1983

"2. 10 CFR 50, Appendix B, Criterion XVI, as implemented by the licensee's Operational Quality Assurance Manual, requires the licensee to establish measures to assure that, in the case of significant conditions adverse to quality, corrective action is taken to prevent repetition.

Contrary to the above, the licensee failed to establish corrective measures to insure that service water valve MOV 536 remained open to supply train B, Unit 2, service water cooling from the diesel generators. MOV 536 was found inadvertently closed on three occasions: March 31, 1981, September 25, 1983 and December 30, 1983."

Admission or Denial

The above violation occurred as described in the subject reports.

Reason for Violation

Personnel error. The condition of not having main control board indication for one of the two valves was identified on April 1, 1981. At that time FNP-1-STP-24.7/FNP-2-STP-24.7 were revised to require verification of the valve positions and PCR 81-2006 was written to provide main control board indication. The operator failed to follow the procedure.

Corrective Actions Taken and Results Achieved

FNP-1-STP-24.7/FNP-2-STP-24.7 verification requirements have been strengthened and PCN 81-2006 to add the valve indication to the main control board is scheduled to be implemented by June 1, 1984.

Corrective Steps Taken to Avoid Further Violations

See above. All corrective action is scheduled to be completed by June 1, 1984.

Date of Full Compliance

December 30, 1983.

Affirmation

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

The information contained in this letter is not considered to be of a proprietary nature.

Yours very truly,

F. L. Clayton, Jr.

FLCJr/DSM:sam/G-2