



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

Report Nos.: 50-280/91-06 and 50-281/91-06

Licensee: Virginia Electric and Power Company
5000 Dominion Boulevard
Glen Allen, VA 23060

Docket Nos.: 50-280 and 50-281

License Nos.: DPR-32 and DPR-37

Facility Name: Surry 1 and 2

Inspection Conducted: February 24 through March 30, 1991

Inspectors:

W. E. Holland Senior Resident Inspector 4/12/91
Date Signed

J. W. York Resident Inspector 4/12/91
Date Signed

S. G. Tingen Resident Inspector 4/12/91
Date Signed

Approved by:

P. E. Fredrickson Section Chief 4/12/91
Division of Reactor Projects Date Signed

SUMMARY

Scope:

This routine resident inspection was conducted on site in the areas of plant operations, plant maintenance, plant surveillance, plant procedures, ESF system walkdown, and review of licensee self-assessment capabilities. During the performance of this inspection, the resident inspectors conducted review of the licensee's backshift or weekend operations on February 24, 26, March 1, 3, 6, 15, 19, 21, 22, 24, and 30.

Results:

In the safety assessment/quality verification functional area, a violation was identified for failure to take adequate corrective action for untimely performances of periodic tests (paragraph 5).

A review of the status of the Procedure Upgrade Program for Administrative Procedures indicated that the program implementation appears to be progressing in accordance with the current schedule and is providing for a better understanding of administrative requirements. However, the licensee's Quality Assurance organization determined that new procedures were being implemented at a pace which did not allow for adequate training prior to implementation. The

licensee was addressing these issues with additional training during this period. A review of the status of implementation of the Technical Procedures Upgrade Program indicated that the program would provide for better technical procedures with accurate, verifiable results. The implementation schedule was progressing satisfactorily in all departments with the exception of the maintenance instrumentation and control activity. The inspectors consider that implementation of this program in the instrumentation and control area needs continuing management and supervisory attention and involvement. Also, additional review of the current procedures in the instrument and control area is warranted (paragraph 7).

In the safety assessment/quality verification functional area, the failure to update the Updated Final Safety Analysis Report was identified as NCV 50-280, 281/91-06-02 (paragraph 8).

In the safety assessment/quality verification functional area, the use of the Local Performance Annunciator Panels for self-assessment was identified as a strength (paragraph 8).

REPORT DETAILS

1. Persons Contacted

Licensee Employees

- R. Allen, Supervisor, Shift Operations
- * W. Benthall, Supervisor, Licensing
- R. Bilyeu, Licensing Engineer
- * D. Christian, Assistant Station Manager, Operations and Maintenance
- * J. Downs, Superintendent, Outage and Planning
- D. Erickson, Superintendent, Radiological Protection
- * R. Gwaltney, Superintendent, Maintenance
- M. Kansler, Station Manager
- T. Kendzia, Supervisor, Safety Engineering
- * J. McCarthy, Superintendent, Operations
- * A. Price, Assistant Station Manager, Nuclear Safety and Licensing
- * E. Smith, Site Quality Assurance Manager
- * T. Sowers, Superintendent, Station Engineering

NRC Personnel

- W. Holland, Senior Resident Inspector
- * S. Tingen, Resident Inspector
- * J. York, Resident Inspector

* Attended exit interview.

Other licensee employees contacted included control room operators, shift technical advisors, shift supervisors and other plant personnel.

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

2. Plant Status

Unit 1 began the reporting period in power operation. The unit operated at power for the duration of the inspection period.

Unit 2 began the reporting period in power operation. The unit operated at 90% power until March 3, when the unit began a normal coastdown in power. The unit commenced a normal shutdown from 73% power on March 29 to conduct a scheduled refueling/maintenance outage. The unit was at an intermediate shutdown condition when the inspection period ended.

3. Operational Safety Verification (71707 & 42700)

a. Daily Inspections

The inspectors conducted daily inspections in the following areas: control room staffing, access, and operator behavior; operator adherence to approved procedures, TS, and LCOs; examination of panels containing instrumentation and other reactor protection system elements to determine that required channels are operable; and review of control room operator logs, operating orders, plant deviation reports, tagout logs, temporary modification logs, and tags on components to verify compliance with approved procedures. The inspectors also routinely accompanied station management on plant tours and observed the effectiveness of their influence on activities being performed by plant personnel.

b. Weekly Inspections

The inspectors conducted weekly inspections in the following areas: operability verification of selected ESF systems by valve alignment, breaker positions, condition of equipment or component, and operability of instrumentation and support items essential to system actuation or performance. Plant tours were conducted which included observation of general plant/equipment conditions, fire protection and preventative measures, control of activities in progress, radiation protection controls, physical security controls, missile hazards, and plant housekeeping conditions/cleanliness. The inspectors routinely noted the temperature of the AFW pump discharge piping to ensure increases in temperature were being properly monitored and evaluated by the licensee.

c. Biweekly Inspections

The inspectors conducted biweekly inspections in the following areas: verification review and walkdown of safety-related tagouts in effect; review of sampling program (e.g., primary and secondary coolant samples, boric acid tank samples, plant liquid and gaseous samples); observation of control room shift turnover; review of implementation of the plant problem identification system; verification of selected portions of containment isolation lineups; and verification that notices to workers are posted as required by 10CFR19.

d. Other Inspection Activities

Inspections included areas in the Units 1 and 2 cable vaults, vital battery rooms, steam safeguards areas, emergency switchgear rooms, diesel generator rooms, control room, auxiliary building, cable penetration areas, independent spent fuel storage facility, low level intake structure, and the safeguards valve pit and pump pit areas. RCS leak rates were reviewed to ensure that detected or suspected leakage from the system was recorded, investigated, and evaluated; and that appropriate actions were taken, if required. The inspectors routinely independently calculated RCS leak rates using the NRC Independent Measurements Leak Rate Program (RCSLK9). On a regular basis, RWPs were reviewed, and specific work activities were

monitored to assure they were being conducted per the RWPs. Selected radiation protection instruments were periodically checked, and equipment operability and calibration frequency were verified.

During this inspection period, a problem was identified involving improper operation of a pressure switch in the containment spray system for Unit 1. This pressure switch provided a close signal to one of two parallel caustic (NaOH) supply valves from the chemical addition tank to the suction of the B CS pump. The close signal would be generated in the event the CS pump failed to develop adequate discharge pressure during accident conditions. Testing results determined that the pressure switch affecting the parallel valve for the B train was also inoperable. Unit 1 B train CS system was declared inoperable and a 24 hour LCO was entered. An engineering evaluation of this condition was conducted and it was concluded that closure of the caustic supply valves was not required during accident conditions. A JCO was prepared with an attached safety evaluation to allow for verifying open the associated CS valves and removing power from the same. These actions were accomplished within the 24 hour action a statement timeframe and the LCO was exited. Further testing determined that the Unit 1 A train and the Unit 2 A and B train pressure switches were operable.

The inspectors were advised of the above condition after licensee identification of the problem during SNSOC review of a deviation report for closeout. The deviation report, which was written in November 1990, was reviewed prior to Unit 1 restart from refueling and was determined not to be a startup issue at that time. The inspectors monitored licensee actions after identification of the problem including licensee discussions with NRC management on immediate actions, entry and exit into the LCO condition, safety committee review of the JCO and safety evaluation, and operator actions in implementation of JCO requirements. The licensee conducted a root cause evaluation as to why this issue was not identified as requiring resolution prior to startup. The inspectors reviewed the preliminary conclusions of the evaluation with the licensee and noted the following:

- Switch calibrations were performed during refueling outages; however, preventative maintenance actions were not adequately addressed in a program.
- The deviation report was not included in the startup assessment review list due to the identification of a work order on the same. The work order was discussed during startup assessment; however, the work order was identified as a preventative maintenance work order and did not receive proper attention due to this status.
- CS train A remained operable during the timeframe from unit restart until identification and correction of the deficiency.

Based on the above information, the inspector concluded that the licensee was focusing on event causes in a proper manner and after completion of the evaluation and presentation of findings to management, appropriate corrective actions should be implemented. The licensee will issue a LER on the failure of the CS pump discharge pressure switch. Corrective actions will be further evaluated upon inspector closeout of this LER.

e. Physical Security Program Inspections

In the course of monthly activities, the inspectors included a review of the licensee's physical security program. The performance of various shifts of the security force was observed in the conduct of daily activities to include: protected and vital areas access controls; searching of personnel, packages and vehicles; badge issuance and retrieval; escorting of visitors; and patrols and compensatory posts. No discrepancies were noted.

Within the areas inspected, no violations were identified.

4. Maintenance Inspections (62703 & 42700)

During the reporting period, the inspectors reviewed maintenance activities to assure compliance with the appropriate procedures.

The following maintenance activity was reviewed:

a. Motor Driven AFW Pump 1-FW-P-3B

On March 4, the inspectors witnessed the performance of periodic test 1-PT-15.1B, Motor Driven Auxiliary Feedwater Pump 1-FW-P-3B, dated February 14, 1991. During this test, the flow showed an increase on the recirculation flow instrumentation without any adjustment of the valve positions. Visual examination of the instrumentation (annubar) revealed a leak at the interface between a threaded connection and a flange. The periodic test was discontinued and work request no. 3800108756 was issued. The craft tightened the fitting and periodic test was performed again on March 6. Again after a short run on the pump, the flow indication began to increase without any valve adjustment. Once again leakage was detected at the same fitting interface.

An analysis of the fitting showed a circumferential crack and distortion of the threads, probably caused by overtightening. The system engineer stated that the fitting was a schedule 40 and in the future would be replaced with a thicker schedule 80 fitting. This flow instrumentation is on the recirculation line and is only used for testing purposes. On March 7, the periodic test was successfully performed. No discrepancies were identified.

b. Pressure Switch 1-CS-PS-103A Calibration

On March 6, the inspectors witnessed the calibration of pressure switch 1-CS-PS-103A. The purpose of this pressure switch is to detect the discharge pressure of containment spray pump 1-CS-P-1B, and on low pressure provide an automatic closure signal to the containment spray system CAT suction valve 1-CS-MOV-103A. The operation of the pressure switch, suction valve, and spray pump is discussed in more detail in paragraph 3.d. EWO 3800108879 and procedure IMP-C-G-35, Pressure Switch Checkout, dated November 27, 1988, were used to accomplish this maintenance. The inspectors attended the prejob brief, walked down the job with the technicians, observed portions of the pressure switch calibration, reviewed the procedure at the job site, reviewed the completed work package, and reviewed the applicable portions of procedure 1-DRP-005, Instrument Setpoints, dated July 24, 1990. While attempting to obtain the as-found setpoint, the pressure switch did not actuate. After the technician agitated the pressure switch, it properly actuated at the correct setpoint. Because the pressure switch did not initially operate, it was determined to be inoperable. The resulting corrective action is discussed in paragraph 3.d. With the exception of the pressure switch setpoints contained in 1-DRP-005, no deficiencies were noted.

Procedure IMP-C-G-35 is a generic procedure that provides instructions to calibrate pressure switches throughout the plant. The procedure does not provide pressure switch setpoints. The technicians are required to obtain pressure switch setpoints preferably from the setpoint document, or if not in the setpoint document, obtain the setpoints from the instrument's history folder. Review of the setpoint documents, 1-DRP-005 and 2-DRP-005, and instrument history folders for the Units 1 and 2 containment spray pumps' pressure switches, revealed that conflicting information was provided. The Unit 1 setpoint document specified a 60 psig setpoint while the Unit 2 setpoint document specified a 70 psig setpoint. The instruments' history folders specified both 60 and 70 psig setpoints. The Unit 2 setpoint document provided a pressure switch span while the Unit 1 setpoint document did not provide a span. The pressure switch's span is required in order to calculate the setpoint tolerance. Since the function of the containment spray pump discharge pressure switches was eliminated as discussed in paragraph 3.d, the conflicting information specified in the setpoint documents and instrument history folders are not a safety concern. However, the inspectors are concerned that the setpoint documents and instrument history folders may contain other discrepancies. This issue will be further reviewed during subsequent inspection periods.

c. Overview of the Maintenance Trending and CFE Programs Implementation

In January 1990, the licensee implemented maintenance trending and CFE programs in order to enhance maintenance effectiveness. VPAP-1501, Station Deviation Reports, and VPAP-1601, Corrective Action, establish the requirements for the programs. The inspectors reviewed VPAP-1501, VPAP-1601, results of QA audits S90-07, dated April 27, 1990, and S90-14, dated November 7, 1990, Station Deviation Trend Report For October - December, 1990, and discussed the programs with the cognizant licensing and maintenance supervisors.

The inspectors concluded that the programs have been adequately implemented, however new program type problems have been experienced. The QA audits identified that issuance of trending reports was not timely and that there was a large backlog of CDEs. Discussion with the cognizant maintenance supervisor indicated that there was also a large backlog of CFEs. The inspectors concluded that the licensee was aggressively pursuing these new program problems. VPAP-1501 and VPAP-1601 have been revised to streamline program processes, CDE backlog numbers have been reduced, and maintenance engineering is in the process of adding two more engineers to help reduce the backlog of CFEs.

Within the areas inspected, no violations were identified.

5. Surveillance Inspections (61726 & 42700)

During the reporting period, the inspectors reviewed various surveillance activities to assure compliance with the appropriate procedures as follows:

- Test prerequisites were met.
- Tests were performed in accordance with approved procedures.
- Test procedures appeared to perform their intended function.
- Adequate coordination existed among personnel involved in the test.
- Test data was properly collected and recorded.

The following surveillances were either reviewed or observed:

a. Motor Driven Auxiliary Feedwater Pump Testing

On March 4 and 6, the inspectors witnessed the performance of periodic test 1-PT-15.1B, Motor Driven Auxiliary Feedwater Pump 1-FW-P-3B, dated February 14, 1991. The purpose of this test is to demonstrate operability of 1-FW-P-3B. Both of the tests were discontinued because a leak caused an inaccurate flow indication (see

par. 4.a). The inspectors noted that when a periodic test is discontinued, the partially completed documentation is made a part of the permanent records. On March 7, after repair of the leak, the periodic test was successfully completed. The results of the test were reviewed by the inspectors and no discrepancies were noted.

b. Review of Surveillance Testing

During the inspection period, the licensee identified two instances where PTs were not performed within the TS required time intervals. On March 7, DR S-91-0280 was issued as a result of not performing 2-PT-18.6I, Pressurizer Block Valve Stroke Test, within the TS quarterly time interval. On March 11, DR S-91-0286 was issued as a result of not performing PT 53.3, High Energy Line Inspection, within the TS weekly time interval.

The inspectors reviewed the 1990 and 1991 DRs that have been issued against PTs which were not performed within their scheduled time intervals. Including the DRs discussed in the previous paragraph, there were nine DRs issued as a result of not performing PTs within their scheduled time intervals. Three of the nine DRs identified the failure to perform surveillance testing within TS specified time intervals.

The licensee's administrative procedures require that corrective action be assigned to DRs. The inspectors reviewed the corrective actions assigned to the 1990 and 1991 DRs issued prior to March 1991, documenting PTs that were not performed within their scheduled dates. DR 2-90-0219, dated March 28, 1990, identified that a new procedure, 2-PT-18.8A, Charging Pump Component Cooling Performance, was issued but not performed during the scheduled time interval. Corrective action for this DR involved revising administrative procedures to require that the Test Group, which is the group responsible for identifying when PTs are required to be performed, be notified when new PTs were issued and schedule the PT accordingly. DR 1-90-0875, dated June 28, 1990, identified that PT 24.38, HVAC Fire Damper Operability, was not performed within its scheduled dates. NCV 280/90-26-01 was issued as a result of the failure to perform this PT. Also, the licensee reported this problem in LER 280/90-07. Corrective action involved issuance of PT tracking schedules that would identify when quarterly or longer surveillances approached the end of their grace period. Also, enhancement of administrative procedures was accomplished to highlight the process for timely identification of overdue PTs. Corrective actions for the remaining 1990 and 1991 DRs focused on the particular PT that was not performed during the scheduled dates and on how to prevent it from reoccurring for that PT.

The inspectors discussed the TS surveillances that were missed in March 1991, with licensee personnel. The inspectors concluded that 2-PT-18.6I was not accomplished when required for two reasons.

Corrective action taken in March 1990, to ensure that new PTs are properly scheduled for performance was not adequate because one year later 2-PT-18.6I, a new PT, was issued without being properly scheduled for performance. The second reason this PT was not performed is the tracking process for PTs that are approaching the end of their grace period is ineffective. After the performance of a PT, it takes approximately two to three weeks for the Test Group to receive the completed PT and update records that the PT was completed. During this two to three week period, PTs are listed on PT tracking lists as not completed. As a result, the PT tracking lists are lengthy and personnel do not adequately review this list because user perception is that many of the PTs listed were performed within the required timeframe; however, records were not updated in a timely manner by the Test Group. The inspectors concluded that corrective action taken in June 1990, to provide identification that a PT was approaching its grace period end date was not effectively implemented. The inspectors also concluded that PT-53.3 was not performed when required because corrective actions for previously missed PTs did not provide adequate checks and balances to assure performance of all PTs.

The inspectors consider that the licensee's corrective actions taken in response to past problems associated with untimely performance of PTs to be inadequate. Corrective actions involving identification of new PTs, notification that PTs were approaching the end of their grace period, and highlighting overdue PTs did not prevent missing two PTs in March 1991. 10CFR50, Appendix B, Criterion XVI states, in part, that measures shall be established to assure that conditions adverse to quality, such as deficiencies, deviations, and nonconformances be promptly identified and corrected. Failure to take adequate corrective action for missed PTs is identified as Violation 280,281/91-06-01.

Within the areas inspected, one violation was identified.

6. Plant Procedures (42700)

During this inspection period, the inspectors continued with a review of the licensee's Procedure Upgrade Program. Discussions were held with corporate and station management and supervision responsible for the program. Additional discussions and reviews were conducted with supervision and personnel responsible for implementation of the program. The following conclusions were determined during these discussions.

The Procedure Upgrade Program for Administrative Procedures at the Surry Power Station was approximately 60% completed when reviewed during this inspection period. The project completion date for this program is December, 1992. During the last 6 months, the licensee's QA organization determined that new procedures were being implemented at a pace which did not allow for adequate training prior to implementation. The implementation schedule was reviewed and adjusted to address this concern.

The program implementation appears to be progressing in accordance with the current schedule and is providing for a better understanding of administrative requirements.

The inspectors reviewed a licensee technical procedures assessment report which provided an overall evaluation of Surry's Technical Procedures Upgrade Program and noted that the I&C area of the maintenance department had completed the fewest upgrade reviews during 1990. Based on this progress, the inspectors reviewed the method of procedure upgrade with the procedure writers group I&C section. During this review, the inspectors noted the following:

- The procedure upgrade program will provide better, more uniform technical procedures. However, very few procedures had been through the full verification and validation process. The inspector was informed that some procedures had been provided to the I&C shop for verification; however, shop progress in this area was minimal.
- The process for procedure upgrade requires that setpoint data be identified and verified as being accurate. Information in the shop in many cases did not provide assurance of validity. This condition required detailed records searches to assure that data was accurate. This effort was being accomplished by the procedure writers who requested engineering support when necessary. The inspectors noted that current procedures which were being used for loop calibration or other functional checks contained several PARs and that setpoint data information was based in many cases on the shop instrument history files.
- The inspectors also questioned procedure writers about available information to upgrade procedures and concluded that some information needed additional clarification or revision. Setpoint document discrepancies are also discussed in paragraph 4.b.

Based on these discussions and reviews, the inspectors concluded that implementation of the TPUP would provide for better technical procedures with accurate, verifiable results. The implementation schedule was progressing satisfactorily in all departments with the exception of the maintenance I&C shop. The inspectors consider that implementation of this program in the I&C area needs additional management and supervisory attention and involvement. They further concluded that additional review of the current procedures in the I&C area is warranted. This effort will continue during the next inspection period in conjunction with the I&C maintenance document issue identified in paragraph 4.b.

Within the areas inspected, no violations or deviations were identified.

7. ESF System Walkdown (71710)

During this inspection period, the inspectors performed a detailed walkdown of the accessible portions of the ESF systems listed below. The inspection included, but was not limited to verification that housekeeping was adequate, valves did not exhibit gross packing leakage or improper labeling, and valves appeared to be in correct positions as required by the plant conditions.

Unit 1 - Low Head Safety Injection System

The inspectors specifically walked down the accessible major flowpaths for the low head SI system and noted all components which had outstanding work requests identified. The inspectors then reviewed the status of each identified work request and associated work order to determine status of work. The only discrepancy noted was a lack of attention on the part of the craft in removing the local work request tag when work was completed. No operational concerns were identified.

Safety-Related HVAC System

The inspectors walked down certain portions of the flowpath for the safety-related HVAC with the systems engineer. Also, four individual supports/restraints were inspected to the drawing requirements for configuration, welding, bolting, and dimensions. No operational concerns were identified. The inspectors reviewed Inspection Report 50-280, 281/91-03, which was a followup on the maintenance team inspection, and noted that this report indicated that there were 450 open work orders on the HVAC system at the time of the inspection. The inspectors will continue to follow the licensee's efforts to reduce this large backlog on the HVAC system.

Within the areas inspected, no violations were identified.

8. Evaluation of Licensee Self-assessment Capability (40500)

Self-Assessment Annunciator Panels

The licensee has initiated a self-assessment system that uses annunciator windows (panels) which display various colors to indicate the self-assessment (performance) evaluation of various areas. This performance annunciator panel is divided into three performance areas, personnel performance, equipment performance, and program performance.

Each performance area is represented by panels, e.g. personnel performance has operation, maintenance, radiological protection, engineering etc. The panels for the equipment performance area has plant equipment availability, thermal performance, ESF actuations, reactor trips etc. Each of these panels (windows) has a number of sub-windows or panels that are evaluated on the station level in order to determine the overall evaluation of the panel.

A committee composed of an Assistant Station Manager, Station Quality Manager, Manager of the Corporate Nuclear Safety Group, and Manager of the Industry Operating Events Reporting Group meet quarterly to evaluate the individual windows and select the appropriate color. Numerical values and judgemental evaluations are used for making these selections.

This self-assessment tool is used to evaluate the performance in individual areas and to identify an area that needs additional management attention. For example, when the indicators show either a yellow (potential reduction in the margin of safety or significant operations/maintenance impact) or a red (significant actual reduction in the margin of safety) window or panel, the station superintendent responsible for this area is called before the committee to explain the course of action that will be taken to correct or change the degrading condition.

The Quality Assurance Department Trending Program also uses the annunciator windows method to represent the results of the activities performed by the QA departments at Surry, North Anna, and Corporate. The functional areas that are evaluated are: engineering, operations, maintenance, TS, licensing/programs, records administration, radiological protection, security, procurement/material control, emergency preparedness, fire protection, chemistry, inservice inspection, special processes, nuclear site services, configuration management, fitness for duty, procedures, and nuclear training. These areas are evaluated on a quarterly basis with red, yellow, white, and green used to indicate the status of the quality program and to indicate areas that need more attention from the quality organization. Input to the individual functional windows include audit findings, deviation reports, surveillance findings, NRC findings, and INPO items. The use of these self-assessment tools by the licensee is considered a strength.

Safety Committee Meetings

The inspectors attended the on-site safety committee, SNSOC, meeting on March 26 and 28 in order to evaluate the licensee's onsite program for continuing review of the operational and safety aspects of the nuclear facility as required by TS 6.1.C. The inspectors observed the committee reviewing several new procedures, an engineering work request for the replacement and modification of the containment sump in Unit 2, the temporary modification logs for both units, and the root cause evaluation for a problem encountered with the containment spray discharge pressure switches.

The licensee has established SNSOC ad hoc subcommittees within the last month. These subcommittees can approve nonintent procedure changes and revisions, and routine changes to engineering work requests and design changes. The inspectors noted that the SNSOC continues to function well and in a coordinated manner.

Updating UFSAR

The inspectors discussed Deviation Report No. S-91-0269, dated February 26, 1991, with the licensee. This deviation identified the fact that a backlog greater than six months old exists for the submittal of UFSAR changes. The requirements of 10 CFR 50.71.e.4 are that revisions to the UFSAR shall be filed no less frequently than annually and shall reflect all changes up to a maximum of six months prior to the date of filing. For Surry there were 15 changes to be filed for updating the UFSAR that were greater than 18 months old, 16 changes less than 18 months but greater than 12 months old, and 39 changes greater than 6 months but less than 12 months old. An accurate UFSAR has particular importance for input to safety evaluations required by 10 CFR 50.59 and for some of the inputs to the TS. This condition was also identified for North Anna (ref. Inspection Report 50-338,339/91-02).

In a memorandum to M. Bowling dated February 19, 1991, some of the following reasons for the backlog were identified: failure to clearly identify an administrative control, inefficient processing of change packages, lack of management attention, etc. This same memorandum contained recommendations for reduction of the backlog.

This licensee identified condition is identified as NCV 50-280,281/91-06-03, Failure to maintain UFSAR updated. This licensee identified violation is not being cited because the criteria specified in Section V.G.1 of the NRC Enforcement Policy were satisfied.

Within the areas inspected, one NCV was identified.

9. Exit Interview

The inspection scope and results were summarized on April 1, 1991 with those individuals identified by an asterisk in paragraph 1. The following summary of inspection activity was discussed by the inspectors during this exit.

<u>Item Number</u>	<u>Description and Reference</u>
VIO 50-280,281/91-06-01	Failure to take adequate corrective action for missed PTs.
NCV 50-280,281/91-06-02	Failure to update the UFSAR.

The licensee acknowledged the inspection conclusions with no dissenting comments. The licensee did not identify as proprietary any of the materials provided to or reviewed by the inspectors during this inspection.

10. Index of Acronyms and Initialisms

AFW	-	AUXILIARY FEEDWATER
CAT	-	CHEMICAL ADDITION TANK
CFR	-	CODE OF FEDERAL REGULATIONS
CDE	-	CAUSE DETERMINATION EVALUATION
CFE	-	COMPONENT FAILURE EVALUATION
CS	-	COOLANT SYSTEM
DR	-	DEVIATION REPORT
ESF	-	ENGINEERED SAFETY FEATURE
EWO	-	ENGINEERING WORK ORDER
GPM	-	GALLONS PER MINUTE
HVAC	-	HEATING, VENTILATION, AIR CONDITIONING
I&C	-	INSTRUMENTATION AND CONTROL
ISI	-	INSERVICE INSPECTION
JCO	-	JUSTIFICATION FOR CONTINUED OPERATION
LER	-	LICENSEE EVENT REPORT
LCO	-	LIMITING CONDITIONS OF OPERATION
NCV	-	NON-CITED VIOLATION
NRC	-	NUCLEAR REGULATORY COMMISSION
PT	-	PERIODIC TEST
RCS	-	REACTOR COOLANT SYSTEM
RWP	-	RADIATION WORK PERMIT
SI	-	SAFETY INJECTION
SNSOC	-	STATION NUCLEAR SAFETY AND OPERATING COMMITTEE
TS	-	TECHNICAL SPECIFICATIONS
URI	-	UNRESOLVED ITEM
UFSAR	-	UPDATED FINAL SAFETY ANALYSIS REPORT
VIO	-	VIOLATION
VPAP	-	VIRGINIA POWER ADMINISTRATIVE PROCEDURES