



**UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
REGION IV  
611 RYAN PLAZA DRIVE, SUITE 400  
ARLINGTON, TEXAS 76011-8064**

April 17, 2000

Craig Anderson, Vice President  
Operations  
Arkansas Nuclear One  
Entergy Operations, Inc.  
1448 S.R. 333  
Russellville, Arkansas 72801-0967

SUBJECT: NRC INSPECTION REPORT NO. 50-313/00-003; 50-368/00-003

Dear Mr. Anderson:

This refers to the inspection conducted on February 6 through April 1, 2000, at the Arkansas Nuclear One, Units 1 and 2, facility. The enclosed report presents the results of this inspection.

During the 8-week period covered by this inspection, your conduct of activities at the Arkansas Nuclear One facility was generally characterized by safety-conscious operations, sound engineering and maintenance practices, and careful radiological controls.

Based on the results of this inspection, the NRC has determined that three Severity Level IV violations of NRC requirements occurred. These violations are being treated as noncited violations (NCVs), consistent with Section VII.B.1.a of the NRC Enforcement Policy. These NCVs are described in the subject inspection report. If you contest the violations or severity level of these NCVs, you should provide a response within 30 days of the date of this inspection report, with the basis for your denial, to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555-0001, with copies to the Regional Administrator, U.S. Nuclear Regulatory Commission, Region IV, 611 Ryan Plaza Drive, Suite 400, Arlington, Texas 76011; the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001; and the NRC Resident Inspector at the Arkansas Nuclear One, Units 1 and 2, facility.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your response, if requested, will be placed in the NRC Public Document Room (PDR).

Entergy Operations, Inc.

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Should you have any questions concerning this inspection, we will be pleased to discuss them with you.

Sincerely,

*/RA/*

P. Harrell, Chief  
Project Branch D  
Division of Reactor Projects

Docket Nos.: 50-313  
50-368  
License Nos.: DPR-51  
NPF-6

Enclosure:  
NRC Inspection Report No.  
50-313/00-03; 50-368/00-03

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**ENCLOSURE**

U.S. NUCLEAR REGULATORY COMMISSION  
REGION IV

Docket Nos.: 50-313; 50-368

License Nos.: DPR-51; NPF-6

Report No.: 50-313/00-03, 50-368/00-03

Licensee: Entergy Operations, Inc.

Facility: Arkansas Nuclear One, Units 1 and 2

Location: 1448 S. R. 333  
Russellville, Arkansas 72801

Dates: February 6 through April 1, 2000

Inspectors: R. Bywater, Senior Resident Inspector  
K. Weaver, Senior Resident Inspector  
J. Russell, Resident Inspector  
J. Keeton, Resident Inspector

Approved by: P. Harrell, Chief, Project Branch D  
Division of Reactor Projects

Attachment: Supplemental Information

## EXECUTIVE SUMMARY

### Arkansas Nuclear One, Units 1 and 2 NRC Inspection Report 50-313/00-03; 50-368/00-03

This routine announced inspection included aspects of licensee operations, engineering, maintenance, and plant support. The report covers an 8-week period of resident inspection.

#### Operations

- A violation of Technical Specification 6.2.2 was identified for not meeting minimum shift crew composition on 11 occasions in 1998. This event was reported as Licensee Event Report 50-368/98-07. This violation is being treated as a noncited violation consistent with Section VII.B.1.a of the NRC Enforcement Policy. This violation was placed in the licensee's corrective action program as Condition Report 2-1998-0377 (Section O8.1).

#### Maintenance

- Instrument and control technicians demonstrated poor skill of the craft by not successfully repairing a main turbine electrohydraulic control system leak. The leak was noticed during a main turbine startup and was worked on but not adequately corrected. During subsequent main turbine operation at approximately 40 percent power, a transient power change down to approximately 10 percent became necessary when the leak occurred again (Section M1.1).
- Failure to test door interlocks for each containment air lock to verify that the outer door could not be opened with the inner door open within the required testing interval was identified as a violation of Technical Specification 4.6.1.3.2. This event was reported as Licensee Event Report 50-368/98-01. This Severity Level IV violation is being treated as a noncited violation consistent with Section VII.B.1.a of the NRC Enforcement Policy. Corrective actions for this violation have been completed and documented in Condition Report 2-1998-0098 (Section M8.1).

#### Engineering

- Failure to perform control element assembly surveillance testing for position indication maximum deviation for one group due to inadequate verification of a computer software change was identified as a violation of Technical Specification 4.1.3.1.1. This event was reported as Licensee Event Report 50-368/98-03. This Severity Level IV violation is being treated as a noncited violation consistent with Section VII.B.1.a of the NRC Enforcement Policy. Corrective actions for this violation have been completed and documented in Condition Report 2-1998-0216 (Section E8.1).

## Report Details

### Summary of Plant Status

At the beginning of this inspection period, Unit 1 was shut down in a maintenance outage for repairs to Low Pressure Injection/Decay Heat Removal Pumps P-34A and P-34B and repairs to the Reactor Coolant Pump P-32D antirotational device. The unit remained shut down until March 12, 2000. On March 12, following completion of the maintenance activities, Unit 1 operators made the reactor critical and commenced a power increase to approximately 12 percent. On March 13, the main generator was placed in service and the Unit 1 operators commenced a power increase. On March 14, Unit 1 operators manually tripped the reactor from approximately 82 percent power due to a failure of the main turbine electrohydraulic control (EHC) system. On March 14, Unit 1 operators commenced a reactor startup following repairs to the main turbine EHC system. On March 16, Unit 1 achieved 100 percent power and continued to operate at or near 100 percent power at the end of this inspection period.

At the beginning of this inspection period, Unit 2 was at 100 percent power. On February 6, 2000, Unit 2 operators reduced reactor power to approximately 82 percent in response to a malfunction of Main Feedwater Pump A, which was caused by a failed circuit card in its EHC system. On February 8, Unit 2 operators returned the unit to 100 percent power following replacement of the failed circuit card. On February 25, Unit 2 operators reduced power to approximately 95 percent to perform quarterly turbine valve testing and returned power to 100 percent the same day. Unit 2 was at or near 100 percent power at the end of this inspection period.

## I. Operations

### **O1 Conduct of Operations**

#### O1.1 General Comments (71707)

The inspectors observed various aspects of plant operations, including shift manning, to verify compliance with Technical Specifications (TS), plant procedures, and the Updated Safety Analysis Report. The inspectors also observed the effectiveness of communications, management oversight, proper system configuration and configuration control, housekeeping, and operator performance during routine plant operations and surveillance testing.

The conduct of operations was professional. Evolutions were generally well controlled and performed according to procedures. Shift turnover briefs were comprehensive. Housekeeping was generally good and discrepancies were promptly corrected. Safety systems were found properly aligned. Specific events and noteworthy observations are detailed below.

#### O1.2 Unit 1 - Reactor Coolant System Hot Leg Level Instrument Nozzle Weld Cracks

On February 15, 2000, while Unit 1 was shut down, the licensee found a primary system leak located at a weld on one of the reactor coolant system hot leg level instrumentation nozzles. After further investigation, the licensee also identified cracked welds on six

other hot leg level instrumentation nozzles. The licensee determined these hot leg instrumentation nozzle weld cracks were caused by primary water stress corrosion cracking. The licensee replaced six of the nozzles in accordance with the ASME Code. The licensee repaired the seventh nozzle using alternate repair criteria, which was verbally approved by the NRC Office of Nuclear Reactor Regulation on February 29, 2000. The licensee submitted Licensee Event Report (LER) 50-313/2000-003 in accordance with 10 CFR 50.73(a)(2)(ii) on March 16, 2000. Further NRC review and evaluation of the risk significance associated with this issue will be conducted during closure of the LER.

**O1.3 Unit 1 - Plant Trip (71707, 93702)**

Unit 1 operators manually tripped the reactor at 12:05 a.m. on March 14, 2000, following a failure of the main turbine governor valve EHC system. The operators were performing a power escalation following the Unit 1 outage and power was at approximately 82 percent when the trip occurred. A reactor operator made a downward adjustment to the turbine governor valve position limiter setting on the turbine EHC control panel, and the valve position limiter setting unexpectedly continued to decrease without further operator action. This resulted in the inadvertent closure of the turbine governor valves. Operators manually tripped the reactor prior to exceeding any automatic reactor trip setpoints.

The inspectors observed portions of the posttrip plant response. Operator and plant response were typical for a reactor trip with minor complications. One of the two 6.9-kV busses that provide power to the reactor coolant pumps had a slow transfer from the unit auxiliary transformer to Startup Transformer 1. This resulted in the loss of two reactor coolant pumps. The licensee's performance in response to the trip was acceptable.

**O8 Miscellaneous Operations Issues (92700)**

**O8.1 (Closed) LER 50-368/98-07: Minimum Shift Composition was not Maintained as Required By TS when a Biennial Requalification Examination Failure by a Licensed Operator was not Promptly Detected**

The licensee determined that the biennial requalification examination for one senior reactor operator was misgraded. The corrected exam score was less than the minimum for passing and resulted in the individual not meeting requirements for maintaining an active license. Between completion of the exam and discovery of the correct score, the individual stood watch on 11 occasions. This resulted in not maintaining minimum shift crew composition as required by TS.

A violation of TS 6.2.2 was identified for not meeting minimum shift crew composition as identified in TS Table 6.2-1 on 11 occasions in 1998. This violation is being treated as a noncited violation (NCV), consistent with Section VII.B.1.a of the NRC Enforcement Policy (50-368/0003-01). This violation was placed in the licensee's corrective action program as Condition Report (CR) 2-1998-0377.

## **II. Maintenance**

### **M1 Conduct of Maintenance**

#### **M1.1 Unit 1 - EHC System Leak Repair**

##### **a. Inspection Scope (62707)**

On March 15, 2000, the inspectors observed instrument and control technicians repairing a Unit 1 main turbine EHC system hydraulic fluid leak. The inspectors reviewed Maintenance Action Item 19404, which provided the work instructions for the maintenance, and CR 1-2000-0162, which described a leak from the same location on March 13, 2000.

##### **b. Observations and Findings**

On March 13, during main turbine startup, a hydraulic fluid leak occurred at the actuator for Valve CV-6829, Main Turbine Intercept Valve D. In response, the operators tripped the main turbine. Approximately 3 gallons of hydraulic fluid had leaked from the actuator. Instrument and control technicians replaced an O-ring that was suspected of leaking. The 1/4-inch O-ring sealed solenoid-operated Test Valve SV-8543 to the bottom of the Valve CV-6829 actuator. On March 13, the generator was synchronized to the grid and, on March 14, power was raised to approximately 82 percent. The reactor was then manually tripped following inadvertent closure of all main turbine governor valves caused by an unrelated component failure and is documented in Section O1.3 of this report. On March 14, a reactor startup was performed, and the generator was synchronized to the grid on March 15. On March 15, with the reactor at approximately 40 percent power, operators received annunciation for low electrohydraulic fluid tank level and an operator on the turbine deck reported a hydraulic fluid leak from the actuator for Valve CV-6829. Operators reduced power to approximately 10 percent and the main turbine was tripped.

On March 15, instrument and control technicians removed Valve SV-8543 from the bottom of the actuator and removed a cylindrical base plate that contained the O-ring. The base plate was designed to be maintained flush to the base of the actuator. The inspectors noted that an alignment pin, mounted on the bottom of the actuator, had been flattened. The pin aligns the cylindrical plate and the actuator base. The flattened pin provided for a slight gap between the cylindrical plate and the actuator, which enabled the hydraulic fluid to leak past the O-ring. This alignment pin was either damaged during the previous corrective maintenance on March 13, when a leak occurred at the same location, or was damaged at some point prior to March 13 and the damage was not noticed or corrected at that time. The inspectors found that the technicians demonstrated poor skill of the craft in either causing the flattened alignment pin or not noticing and correcting the flattened alignment pin on March 13. This poor skill of the craft resulted in the unit transient on March 15 from approximately 40 percent reactor power to approximately 10 percent reactor power.

The instrument and control technicians subsequently removed the damaged alignment pin, installed a new pin, and corrected the hydraulic leak.

c. Conclusions

Instrument and control technicians demonstrated poor skill of the craft by not successfully repairing a main turbine EHC system leak. The leak was noticed during a main turbine startup and was worked on but not adequately corrected. During subsequent main turbine operation at approximately 40 percent power, a transient power change down to approximately 10 percent became necessary when the leak occurred again.

M1.2 Unit 2 - Red Train Battery 2D11 Cell 14 Replacement

a. Inspection Scope (62707, 71707)

On February 15, 2000, the inspectors observed the prejob briefing performed in preparation for the Red Train Battery 2D11 Cell 14 replacement.

b. Observations and Findings

The inspectors observed that the prejob briefing included Units 1 and 2 operations, engineering, and maintenance personnel. The prejob briefing covered all contingencies and required actions taken in order to reduce the risk involved with the evolution. The inspectors observed that prior to removing Battery 2D11 from service, operations personnel appropriately entered the required TS limiting condition for operation. The inspectors observed good communications between Units 1 and 2 operators and maintenance craft personnel. The maintenance activities were performed in an expedient manner which limited the amount of time that Unit 2 was in a high risk configuration.

c. Conclusions

The prejob briefing conducted prior to removing Red Train Safety Related Battery 2D11 from service was thorough and included additional precautions and contingencies taken to reduce the risk from the evolution. Operations personnel demonstrated good control of the evolution and equipment while the maintenance activities were in progress.

M1.3 General Comments on Surveillance Activities

a. Inspection Scope (61726)

The inspectors observed all or portions of the following surveillance activities:

- Procedure 2106.006, Revision 49, "Emergency Feedwater Pump System Operations," performed on March 13 (Unit 2).

- Procedure 2104.036, Revision 43, "Emergency Diesel Generator Operations," performed on March 1 (Unit 2).

b. Observations and Findings

The inspectors noted that these surveillance activities were performed in accordance with the approved procedures. All equipment functioned as required and no problems were observed.

**M8 Miscellaneous Maintenance Issues (92700)**

- M8.1 (Closed) LER 50-368/98-01: Surveillance Testing of Containment Building Personnel and Escape Air Lock Door Interlocks did not Verify Operability of each Interlock Function as Required by TS due to Inappropriate Interpretation of Requirements

The licensee discovered that the containment building personnel and escape air lock door interlock surveillance test had not satisfied requirements of TS. The surveillance tests had been performed by a method that verified the inner door would not open when the outer door was open, but did not verify that the outer door would not open when the inner door was open. This test method had been used since before initial plant operation. The licensee determined that the root cause was an inadequate interpretation of TS requirements.

Failure to test door interlocks for each containment air lock to verify that the outer door could not be opened with the inner door open within the required testing interval was identified as a violation of TS 4.6.1.3.2. This Severity Level IV violation is being treated as an NCV consistent with Section VII.B.1.a of the NRC Enforcement Policy (50-368/0003-02). Corrective actions for this violation have been completed and documented in CR 2-1998-0098.

- M8.2 (Closed) LER 50-368/98-05: Surveillance Test of One Sodium Hydroxide Addition Pump was not Performed in Accordance with the Literal Requirements of TS due to Procedure Deficiencies

This equipment is no longer required by Unit 2 TS; therefore, this event is not considered to be safety significant.

- M8.3 (Closed) LER 50-368/98-06: Automatic Removal of Operating Bypasses for Logarithmic Power High Trip and Core Protection Calculator Trips of Local Power Density and Departure from Nucleate Boiling Ratio not within Required Values Due to Inaccurate Wording in Original TS with Respect to Plant Design

The licensee determined that the root cause of this condition was inaccurate wording in the original TS with respect to plant design. The licensee submitted a TS change to establish setpoint requirements consistent with the plant design and safety analysis. NRC issued Amendment 196 to the Unit 2 facility operating license by letter, dated December 31, 1998, to correct this TS deficiency.

- M8.4 (Closed) Violation 50-313/9808-02: Failure to incorporate acceptance limits into surveillance procedure.

The inspectors reviewed this violation and determined that no further action is required. The violation has been entered into the licensee's corrective action program as CR C-1998-0171.

- M8.5 (Closed) Inspection Followup Item (IFI) 50-313;368/9708-01: Untimely preventive maintenance updates to 480- and 4160-volt breakers

The inspectors reviewed the IFI and determined that no further action is required.

- M8.6 (Closed) IFI 50-313/9908-01: Further review of certain engineered safety feature equipment and the equipment location

The inspectors reviewed the IFI and determined that no further action is required.

### **III. Engineering**

#### **E8 Miscellaneous Engineering Issues (92700)**

- E8.1 (Closed) LER 50-368/98-003: Surveillance Testing of Control Element Assembly (CEA) Position Indication Maximum Deviation was not Performed for One Group as Required by TS

On May 20, 1998, errors in developing and implementing a software change for calculated CEA position verification resulted in Group P deviations not being determined for all CEAs within that group. TS 4.1.3.1.1 requires that each CEA position be determined to be within 7 inches of all other CEAs in its group at least once every 12 hours. Failure to perform the CEA surveillance testing for position indication maximum deviation for one group due to inadequate verification of a computer software change was identified as a violation of TS 4.1.3.1.1. This Severity Level IV violation is being treated as an NCV consistent with Section VII.B.1.a of the NRC Enforcement Policy (50-368/0003-03). Corrective actions for this violation have been completed and documented in CR 2-1998-0216.

- E8.2 (Closed) IFI 50-313/9713-03: Review and assessment of 10 CFR 50.59 evaluation, including supporting documentation regarding discrepancy between Final Safety Analysis Report and plant configuration

This item involved the NRC review of the pending 10 CFR 50.59 evaluation of the differences between the Unit 1 configuration and the Final Safety Analysis Report, which was documented in Engineering Report 97-R-1002-01, dated February 21, 1997. The review determined that no further NRC action was required.

#### **IV. Plant Support**

##### **R1 Radiological Protection and Chemistry Controls**

###### **R1.1 General Comments**

###### **a. Inspection Scope (71750)**

The inspectors routinely observed the licensee's radiological controls to verify conformance with TS and procedures.

###### **b. Observations and Findings**

During routine tours of the plant and observations of plant activities, the inspectors found that health physics personnel provided good support and personnel demonstrated proper radiological work practices during maintenance activities. Areas in the plant were properly posted and personnel were observed demonstrating good ALARA (as low as reasonably achievable) work practices.

###### **c. Conclusions**

Health physics personnel provided good support and personnel demonstrated proper radiological work practices during maintenance activities. Areas in the plant were properly posted and personnel were observed demonstrating good ALARA work practices.

#### **V. Management Meetings**

##### **X1 Exit Meeting Summary**

The inspectors presented the inspection results to members of the licensee's staff on April 5, 2000. The licensee acknowledged the findings presented.

The inspectors asked the licensee whether any material examined during the inspection should be considered proprietary. No proprietary information was identified.

ATTACHMENT

PARTIAL LIST OF PERSONS CONTACTED

Licensee

C. Anderson, General Manager, Plant Operations  
G. Ashley, Licensing Supervisor  
V. Bond, Unit 2 System Engineer Supervisor  
R. Carter, Unit 2 Maintenance Superintendent  
R. Carter, Unit 2 Operations Assistant Manager  
E. Christian, Unit 1 Instrumentation and Control Superintendent  
M. Cooper, Licensing Specialist  
F. Daubenheyer, Maintenance Superintendent  
C. Eubanks, Unit 2 Outage Manager  
B. James, Outage, Planning and Scheduling  
D. Lach, Design Engineering Supervisor  
J. Miller, Operations Manager in Training  
K. Nichols, Unit 1 System Engineer Supervisor  
G. Parks, Quality Supervisor  
J. Smith, Jr., Radiation Protection Manager  
J. Vandergrift, Director, Nuclear Safety  
H. Williams, Jr., Superintendent, Plant Security  
C. Zimmerman, Unit 1 Plant Manager

INSPECTION PROCEDURES USED

37551	Onsite Engineering
61726	Surveillance Observations
62707	Maintenance Observations
71707	Plant Operations
71750	Plant Support Activities
92700	Licensee Event Report Followup
93702	Prompt Onsite Response to Events at Operating Power Reactors

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

50/368/0003-01	NCV	Minimum shift composition was not maintained as required by TS when a biennial requalification examination failure by a licensed operator was not promptly detected (Section O8.1)
50-368/0003-02	NCV	Surveillance testing of containment building personnel and escape air lock door interlocks did not verify operability of each interlock function as required by TS due to inappropriate interpretation of requirements (Section M8.1)

50-368/0003-03 NCV Failure to perform CEA surveillance testing as required by TS 4.1.3.1.1 (Section E8.1)

Closed

50-368/98-01 LER Surveillance testing of containment building personnel and escape air lock door interlocks did not verify operability of each interlock function as required by TS due to inappropriate interpretation of requirements (Section M8.1)

50-368/98-03 LER Surveillance testing of CEA position indication maximum deviation was not performed for one group as required by TS position surveillance testing (Section E8.1)

50-368/98-05 LER Surveillance test of one sodium hydroxide addition pump was not performed in accordance with the literal requirements of TS due to procedure deficiencies (Section M8.2)

50-368/98-06 LER Automatic removal of operating bypasses for logarithmic power high trip and core protection calculator trips of local power density and departure from nucleate boiling ratio not within required values due to inaccurate wording in original TS with respect to plant design (Section M8.3)

50-368/98-07 LER Minimum shift composition was not maintained as required by TS when a biennial requalification examination failure by a licensed operator was not promptly detected (Section O8.1)

50-313/9808-02 VIO Failure to incorporate acceptance limits into surveillance procedure (Section M8.4)

50-313/9713-03 IFI Review and assessment of 10 CFR 50.59 evaluation, including supporting documentation regarding discrepancy between Final Safety Analysis Report and plant configuration (Section E8.2)

50-313;368/9708-01 IFI Untimely PM updates to 480- and 160-volt breakers (Section M8.5)

50-313/9908-01 IFI Further review of certain engineered safety feature equipment and the equipment location (Section M8.6)

50-368/0003-01 NCV Minimum shift composition was not maintained as required by TS when a biennial requalification examination failure by a licensed operator was not promptly detected (Section O8.1)

50-368/0003-02 NCV Surveillance testing of containment building personnel and escape air lock door interlocks did not verify operability of each interlock function as required by TS due to inappropriate interpretation of requirements (Section M8.1)

50-368/0003-03      NCV      Failure to perform CEA surveillance testing as required by  
TS 4.1.3.1.1 (Section E8.1)

LIST OF ACRONYMS USED

ALARA	as low as reasonably achievable
CEA	control element assembly
CFR	Code of Federal Regulations
CR	condition report
EHC	electrohydraulic control
IFI	inspection followup item
LER	Licensee Event Report
NCV	noncited violation
NRC	Nuclear Regulatory Commission
TS	Technical Specification
VIO	violation