

**U.S. NUCLEAR REGULATORY COMMISSION**

**REGION III**

**Report No. 50-305/97003**

**FACILITY**

**Kewaunee Nuclear Power Plant  
Docket No. 50-305 License No. DPR-43**

**LICENSEE**

**Wisconsin Public Service Corporation  
700 North Adams  
Post Office Box 19002  
Green Bay, WI 54307-9002**

**DATES**

**January 3 through February 15, 1997**

**INSPECTORS**

**J. K. Heller, Senior Resident Inspector  
J. F. Lara, Acting Senior Resident Inspector  
J. Gadzala, Resident Inspector**

**APPROVED BY**

**M. J. Jordan, Chief  
Reactor Projects Branch 6**

## **EXECUTIVE SUMMARY**

### **Kewaunee Nuclear Power Plant NRC Inspection Report 50-305/97003**

This report includes results of the routine, unannounced inspection by resident inspectors of plant operations, maintenance, engineering, and plant support.

#### **Operations**

- The conduct of operations in general was professional and safety conscious. (section O1)
- An alert operator discovered that a safeguards breaker position indicating flag had become loose and created the potential for falling into the breaker mechanism. Electricians implemented prompt and appropriate corrective action. (section O1.2)
- The Plant Operations Review Committee's proceedings were considered effective. (section O7.1)

#### **Maintenance**

- Performance of maintenance activities, in general, was professional and thorough. Technicians were experienced and knowledgeable of their assigned tasks. Particularly noteworthy was the proficiency demonstrated by I&C technicians. (sections M1.1, M1.2)
- Insufficient control was implemented to ensure that a piece of string securing the A reactor trip breaker's actuating arm was removed upon completion of a troubleshooting evolution. This is a violation of NRC requirements. However, other administrative controls were in place and prevented this condition from escaping undetected. Therefore, the safety significance of this event was minor. (section M1.4)
- The licensee conservatively decided to install a new style petcock seal on the emergency diesels to ensure that the vent holes were fully exposed. (section M8.1)

#### **Engineering**

- The welds in several newly repaired steam generator tubes had failed, possibly during post weld heat treatment. These tubes had previously been evaluated as acceptable for service. This condition resulted in an indefinite extension of the plant's refueling outage. (section E1.2)

- On February 16, a contractor performing steam generator tube removal work became incapacitated inside the A steam generator. The individual had apparently collapsed due to a known medical condition. The rescue effort was effectively coordinated and carried out. Personnel responded in a composed and competent manner. No radiological exposure or contamination limits were exceeded. (section E1.3)
- Plant engineers evaluated an operability concern with the containment fan coolers as discussed in Generic Letter 96-06. Modifications were made to this system and the licensee considers the containment coolers to be operable. The inspectors will review the licensee's operability evaluation. (section E8.1)
- The licensee determined that a failure of diesel generator A to load as designed during surveillance testing was due to an improperly positioned breaker follower switch linkage rod. This condition was not initially discovered because the post modification test for installation of the new breaker was not sufficiently adequate to verify proper functioning of the specific contact which caused the breaker to reopen during the subsequent surveillance test. This is a violation of NRC requirements. (section E8.3).

#### Plant Support

- Portions of the security plan were not audited annually as required. However, this violation is not being cited because the criteria specified in Section VII.B of the "General Statement of Policy and Procedure for NRC Enforcement Actions," NUREG-1600, were satisfied. (section S7.1)

## REPORT DETAILS

### Summary of Plant Status

The unit remained in refueling shutdown during this period. Difficulties encountered in the repair of steam generator sleeved tubes extended the originally planned outage duration.

### I. Operations

#### **O1 Conduct of Operations (71707)**

##### **O1.1 General Comments**

NRC Inspection Procedure 71707 was used in the performance of an inspection of plant operations.

During observation of control room operations, the inspectors ascertained that the staff was knowledgeable of plant conditions, responded properly to alarms, adhered to procedures and applicable administrative controls, and that proper control room staffing existed. Access to the control room was restricted and operations personnel carried out their assigned duties in an effective manner. The inspectors noted professionalism in observed facets of control room operation.

During facility tours, inspectors noticed few signs of leakage and that all equipment appears to be in good operating condition. Overall, plant cleanliness has remained good.

##### **O1.2 Alert Operator Discovers Loose Component Inside Electrical Breaker**

###### **a. Observations and Findings**

While performing a routine check of safety injection pump breaker A on February 6, an alert operator noted that the position indicating flag on the 4160 VAC breaker was loose. Further investigation by electricians revealed that its fastening bolt had backed out about 2 turns.

Plant electricians expressed concern that the loose metallic flag could fall out and adversely effect breaker operation. They promptly initiated a work request and tightened the loose indicator that same day.

The inspector discussed this concern with plant engineers. The inspector also independently examined the breaker. Electricians performed an inspection on other similar breakers and found a slightly loose flag on the B diesel generator breaker. Although the bolt in this case was snug, electricians were able to tighten it ½ turn using an appropriate torque wrench. The flags on all other breakers were found to be appropriately secured.

Both of the loose flags were found on newly installed 4160 VAC vacuum breakers. Plant engineers believe that these bolts were loose when the breakers were initially installed.

b. Conclusions

An appropriate questioning attitude displayed by the operator enabled him to discover that the breaker position indicating flag on the A safety injection pump breaker was loose. Electricians responded promptly to this concern and investigated all other similar breakers. Corrective actions taken were proper.

**07 Quality Assurance in Operations (40500)**

**07.1 Plant Operations Review Committee Meeting Observations**

The inspector observed sessions of the Plant Operations Review Committee. Issues discussed included steam generator tube plugging, station blackout testing, and vacuum filling of the reactor coolant system. Committee members asked probing questions and candidly discussed various aspects of the issues. The inspector considered the committee's proceedings to have been effective.

**08 Miscellaneous Operations Issues (92901, 90712, 92700)**

**08.1 (Closed) LER 305/96-012: RHR Pump Flow Instrument Not Checked in Accordance with Technical Specifications**

This report documents the licensee's discovery that the shutdown operations shift logsheet did not require logging of residual heat removal (RHR) flow while the plant was shutdown. Details are contained in Inspection Report 305/96014. The operations logsheet was subsequently revised to incorporate this requirement.

**II. Maintenance**

**M1 Conduct of Maintenance (61726, 62707)**

**M1.1 General Comments**

a. Inspection Scope

NRC Inspection Procedures 62707 and 61726 were used in the performance of an inspection of plant maintenance and surveillance activities.

The inspectors observed and reviewed selected portions of the following maintenance and test activities:

- MWR 209605, Perform 'A' DG Air Leak Checks
- MWR 211117, Valve SA-2010A-1 repair (air supply to diesel service water control valve)

- MWR 211299, Replace 'A' DG Hand Hole Cover
- MWR 211346, Cut Service Water Line and Install Flange Connection
- MWR 211376, Replace 'A' DG Cylinder Test Valve Packing Nuts and Packing Seals
- MWR 211389, Verify and Adjust Breaker Switch Linkage
- PMP 2-7 (Revision G), Service Water Pumps Bearing Lube H<sub>2</sub>O Branch Lines Cleaning and Flush
- PMP 42-03, (Revision J), Train A Auto Sequencing Test With Diesel A in Pullout
- PMP 47-03 (Original), Reactor Control and Protection QA-1 Reactor Trip Breaker Cubicle Maintenance
- RT-DGM-10-TSC (Revision P), Technical Support Center Diesel Generator
- SP 33-098 (Revision AL), Safety Injection Pump and Valve Test-IST
- SP 23-100 (Revision AC), Containment Spray Pump and Valve Test-IST
- SP 33-110 (Revision X), Diesel Generator Automatic Test
- SP 33-110 (Revision Y), Diesel Generator Automatic Test
- SP 42-312A (Revision E), Diesel Generator A Availability Test
- SP 42-312B (Revision D), Diesel Generator B Availability Test
- SP 47-062A (Revision E), Reactor Protection Logic Train A Monthly Test
- GIP 100-NC44K/XA (Original), NC44K/XA Replacement
- Repair of seal around A diesel starting air bank leaking plug

b. Observations and Findings

The work performed under these activities was professional and thorough. Technicians were experienced and knowledgeable of their assigned tasks.

Particularly noteworthy was the proficiency demonstrated by I&C technicians. During replacement activities for a failed negative rate trip relay, the inspector observed a comprehensive pre-evolution brief and close coverage by quality control personnel. Communications between the technicians performing this activity and reactor operators were effective.

M1.2 Diesel Generator Testing Appropriately Conducted

a. Observations and Findings

The inspector observed that procedures were evident and in use during testing activities. Operators were knowledgeable of the activity and closely monitored diesel operation. Communications between the diesel room and control room were effective.

While monitoring the diesel testing, the inspector identified two discrepancies on the B diesel. The duplex fuel filter was leaking slightly and the screws attaching the governor speed changing motor to its base were loose. Licensee personnel documented the filter leak in the maintenance work request system. Mechanics initiated a work request and tightened the hold down screws on the speed changing motor. This condition was also documented in the corrective action system for

evaluation. Inspection of the other governor motor indicated it was securely fastened.

While monitoring A diesel testing, the inspector noted that service water manual isolation valve SW-300A was leaking slightly past its seat. Licensee personnel documented this discrepancy in the maintenance tracking system for correction.

b. Conclusions

The inspector determined that the identified discrepancies were minor and did not affect the test. Diesel generator testing was appropriately controlled and successfully conducted.

M1.3 Industrial Safety Weaknesses During Service Water Pump Maintenance

a. Observations and Findings

The inspector considered the industrial safety practices observed during performance of maintenance on service water pump B2 to be adequate. Plastic tubing used to supply low pressure air for blowing out residual water was snaked across a passageway and presented a tripping hazard. An open container of muriatic acid being used to remove flow blockage was covered only with a rubber glove and a paper towel scrawled with the word "acid." Mechanics occasionally left the area unattended; however, this maintenance activity was completed by the end of the day and all extraneous material was properly removed. The inspector discussed these concerns with plant management.

While monitoring this activity, the inspector noted that the sight glass flapper in a bearing lubrication supply line was missing. Discussions with maintenance personnel revealed they had also discovered this deficiency. They had subsequently expanded the work package scope to include replacement of the sight glass.

b. Conclusions

The inspector considered the industrial safety precautions to be adequate.

M1.4 Reactor Trip Breaker Test Failure due to Actuating Arm Being Restrained

a. Observations and Findings

On January 23, technicians were performing a routine test of the reactor protection system. The A reactor trip breaker unexpectedly failed to open during the undervoltage phase of this test. An investigation revealed that the undervoltage coil actuating arm in the trip breaker was restrained by a piece of string. This string prevented the undervoltage trip mechanism from actuating the breaker. The reactor was shutdown at the time and this system was not required to be operable.

The inspector reviewed the circumstances surrounding this event and observed that administrative control tags (Danger Tags) were attached to the reactor trip and bypass breakers. These tags, which had been placed January 15, specified that the breakers required post maintenance testing prior to being restored to operability. Maintenance on these breakers had been performed earlier and the reactor protection system test that was being conducted was part of the post maintenance test.

The breaker maintenance procedure requires a visual inspection of the breaker upon completion of maintenance to ensure any foreign material is removed. The inspector's discussion with the electricians involved revealed that they had performed this inspection. However, shortly after their inspection was performed, a DC bus ground occurred due to an unrelated maintenance activity. The troubleshooting process for this ground, covered by work request WR 211228, involved the electrician restraining the trip breaker's undervoltage coil from actuating. He did this by tying its actuating arm with a piece of string.

The ground was successfully located and corrected, but the electrician forgot to remove the string from the breaker. Although the breaker remained administratively controlled out of service by the Danger Tags, no additional control was implemented specifically to ensure removal of the string. Consequently, the breaker did not operate as expected during subsequent testing.

Instructions in the work request did not describe restraining of the reactor trip breaker's undervoltage coil as part of the specified troubleshooting activity. Nor was this facet of the activity documented on the completed work request. Consequently, the post maintenance test developed for this activity did not consider such a condition.

As corrective action, the licensee evaluated specific training to address improvements in work request instruction writing. These included guidance on the use of additional controls (such as administrative tags) when a required activity affects equipment configuration and is not explicitly described in the work instructions. A matrix on troubleshooting techniques was also being developed and was planned for inclusion in the training process.

The string was removed from the trip breaker and the reactor protection system test was completed without further incident.

b. Conclusions

Control of troubleshooting activities was insufficient to ensure that the piece of string securing the trip breaker's actuating arm was removed upon completion of the evolution. This is a violation of NRC requirements (305/97003-01).



**M7 Quality Assurance in Maintenance Activities (40500)**

**07.1 Observations of Quality Assurance Group's Maintenance Audit**

The inspector observed the February 6 exit meeting of the quality assurance group's maintenance audit. Issues discussed included a lowering of the initiation threshold for corrective action documents, requirements for post maintenance testing, documentation of evaluations, and completeness of work request documents. The auditors findings resulted in a candid and spirited discussion of various aspects of these issues. Although maintenance personnel took exception to some of the findings, the inspector considered those findings to be well supported. Quality assurance personnel demonstrated independence from plant staff by appropriately supporting their conclusions. The inspector considered the maintenance audit to have been effective.

**M8 Miscellaneous Maintenance Issues (92902, 90712, 92700)**

**M8.1 (Closed) Inspector Followup Item 305/96010-C4: Recessed Vent Holes on Emergency Diesel Petcocks**

The inspector had expressed concern that the recessed vent holes on the emergency diesel petcocks could restrict flow out the vent. Plant engineers discussed this concern with the diesel vendor who determined that sufficient clearance existed to provide an adequate vent path even with the vent holes recessed. Nevertheless, the licensee conservatively decided to install a new style petcock seal which would ensure that the vent holes are fully exposed.

The inspector observed installation of the seals and subsequent diesel testing. No further concerns were noted.

**M8.2 (Closed) LER 305/96-011: Safety Injection System Leakage Test Not Performed in Verbatim Compliance with the Technical Specifications**

This report documents a failure to shut the isolation valves nearest the reactor coolant system during inservice testing. A violation for this condition was cited in Inspection Report 305/96014.

**III. Engineering**

**E1 Conduct of Engineering (37551)**

**E1.1 General Comments**

NRC Inspection Procedure 37551 was used in the performance of an inspection of engineering support.

## **E1.2 Steam Generator Laser Weld Repair Failures**

### **a. Inspection Scope**

On February 5, the licensee notified the NRC via the emergency notification system that the welds in several steam generator tubes had failed. These tubes had previously been evaluated as being acceptable for service. Additional details appear in Inspection Report 305/96011.

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

During the current refueling outage, about 1900 sleeved tubes total in the two steam generators were repaired using a laser weld repair technology. The adequacy of each weld was evaluated using ultrasonic testing. Following ultrasonic testing, the tubes were heat treated to relieve any residual stress incurred during welding. Tube integrity was then evaluated using eddy current testing.

After completion of this repair process, the B steam generator secondary side was filled with water on January 29. The A steam generator secondary was filled two days later. The following day, moisture was found at the base of the primary side of 76 tubes in the steam generators. Chemical analysis verified that secondary side water was leaking through the weld repaired tubes.

Subsequent ultrasonic testing indicated that several of the welds had failed, possibly during the heat treat process.

The eddy current testing that was performed after welding would not have identified the failed welds because it is only sensitive to flaws internal to the tube and sleeve walls. Qualification testing performed by the weld process vendor indicated that the heat treat process should not have produced enough stress to damage the welds. Consequently, no ultrasonic testing was conducted after the heat treatment.

The NRC had been evaluating the acceptability of the laser weld repair technology at the time of this event. A specialist from NRC Region III, who was onsite evaluating this process, was still in the process of reviewing the acceptability of certain aspects of this activity.

The licensee was evaluating this issue and was in the process of removing five additional tubes from steam generator A to further study this phenomena. A root cause determination was being prepared. The Region III specialist was continuing to follow this activity as of the close of this inspection period.

### **E1.3 Worker Incapacitated Inside Steam Generator**

#### **a. Inspection Scope**

On Sunday morning, February 16, a contractor performing tube removal in steam generator A became incapacitated inside the primary side bowl.

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

Shortly after entering the A steam generator hot leg to install a tube pulling tool, the contractor was observed to fall away from tool. A manager overseeing the evolution on a video monitor observed the man show signs of distress and heard him having trouble breathing.

An engineer that was outside the steam generator bowl was directed to enter the steam generator and remove the injured man. A health physics technician remained outside the steam generator to assist in the removal. The injured man was removed from the steam generator within five minutes.

The injured man's condition improved shortly afterwards, but he was taken to a local hospital for observation. Some minor skin contamination was removed from the individual prior to his being transported. The man had apparently collapsed due to a medical condition he was known to have. He was able to return to work the next day.

This event was captured on the video recorders being used to monitor the steam generator tube pulling evolution. The inspector was notified of the event and responded to the site, interviewed the personnel involved, and reviewed the video of the event.

The inspector's review of the video revealed that the manager overseeing the activity took control of the situation in an aggressive manner. He directed the on-scene rescue effort, implored participants to remain calm, notified the control room, and requested offsite medical assistance.

#### **c. Conclusions**

The rescue effort was effectively coordinated and carried out. Personnel responded in a composed and competent manner. No radiological exposure or contamination limits were exceeded.

**E8      Miscellaneous Engineering Issues (92903)**

**E8.1    (Open) Unresolved Item (305/96010-05):    Containment Fan Cooler Operability  
(Generic Letter 96-06)**

This issue concerns operability of the containment fan coolers due to a potential for development of two phase flow during a loss of coolant accident coincident with a loss of offsite power. The licensee determined that the service water piping system supplying the containment fan coolers could potentially become degraded under certain conditions.

On January 24, the NRC staff issued guidance on this concern reiterating the provisions contained in Generic Letter 91-18. In particular, the staff's guidance stated that licensees are not precluded from starting up from an outage with degraded conditions as long as the affected systems and components are operable.

Plant engineers initiated a modification to reinforce one section of the service water piping that was most susceptible to degradation under the postulated conditions. Additionally, resizing the orifices in the downstream piping was being evaluated and their location was moved further downstream to improve modeling of consequences that could result from any two phase flow which might develop.

Based on these actions, the licensee considered the containment coolers to be operable. The inspectors will review the licensee's operability evaluation.

**E8.2    (Closed) Violation (305/96006-03):    Improper Acceptance Criteria for Safety  
Injection Flow Test**

Inspectors found that procedure SP 33-191, "Safety Injection Flow Test," specified a 50 gpm acceptance criteria for cold leg injection flow differential. The USAR specified a more restrictive 30 gpm maximum. The licensee's investigation determined that the procedure was improperly revised in 1985.

The inspector reviewed past test results and determined that actual measured flow differential was within the more restrictive 30 gpm requirement. The procedure was subsequently revised with the appropriate acceptance criteria. The inspector reviewed the revised procedure and had no further concerns.

**E8.3    (Closed) Inspector Followup Item (305/96014-03):    Diesel Output Breaker Auxiliary  
Switch Linkage Rod Length**

**a.      Observations and Findings**

On December 19, diesel generator A failed to load as designed during surveillance testing. The cause was due to improper adjustment of the linkage rod attached to the breaker follower switch. This caused the diesel output breaker to reopen immediately after closing.

The output breaker had been replaced during the current refueling outage as part of a modification to upgrade 4160 VAC safety related breakers (Design Change 2618). In the case of diesel generator A, the lower lever arm for the breaker position follower switch did not properly align with the actuating lever on the new breaker. This required the rod's lower mounting bracket to be moved about ½ inch. However, this was not factored into the adjusted length of the linkage rod, which consequently caused it to undershoot the desired location when positioning the follower switch.

The undershoot was insufficient to fully position the switch; instead, it was left in a condition where its individual contacts were susceptible to "chatter" from vibration or other mechanical agitation.

The licensee's root cause evaluation also determined that the design change procedure writers and reviewers did not fully understand the switch contacts' characteristics. Consequently, neither the installation procedure, nor the post modification test, were sufficiently adequate to ensure proper adjustment of the follower switch linkage and verify the switch's proper functioning.

Additional details about this condition are contained in Inspection Report 305/97002.

In response to this condition, the licensee initiated lessons learned on a modification installation procedure. In addition, the licensee conducted an inspection of other newly replaced 4160 VAC breakers to verify the status of their respective switch arrangements. One breaker on the tertiary aux transformer was found with a similar condition. The linkage rod was subsequently adjusted on this breaker. The inspector reviewed these actions, monitored selected portions of the linkage verification process, and determined they were appropriate. The subsequent surveillance test of the emergency diesels verified that their output breakers were operating properly.

b. Conclusions

The licensee determined that the diesel generator's failure to load was due to the breaker's follower switch linkage rod being incorrectly adjusted during breaker modification activities. The condition was not initially discovered because the post modification test was not sufficiently adequate. This is a violation of NRC requirements (305/97003-02).

#### IV. Plant Support

R1 Radiological Protection and Chemistry Controls (71750)

NRC Inspection Procedure 71750 was used in the performance of an inspection of the plant support area.

From a radiological standpoint the plant is in good condition, allowing access to most sections of the facility. During tours of the facility, the inspectors noted that barriers and signs also were in good condition.

**S1 Security (71750)**

The inspectors, by direct observation and interview, verified that portions of the physical security program were being implemented in accordance with the station security plan. The inspectors also monitored any compensatory measures that may have been enacted by the plant.

All observed activities were conducted in a satisfactory manner during this inspection period.

**S7 Quality Assurance in Security and Safeguards Activities (71750)**

**S7.1 Security Plan Audit Interval Not Per Requirements**

**a. Inspection Scope**

On January 10, security personnel identified that their audit schedule contained incorrect periodicity requirements for auditing certain portions of the security plan. Consequently, these sections were being audited every other year vice annually as required.

**b. Observations and Findings**

In 1993, the licensee restructured their audit schedule in an attempt to enhance audit effectiveness. Since most areas only needed auditing on a two year frequency, the audit schedule was changed to audit half the security plan each year. However, 10 CFR 50.54 and 10 CFR 73.55 required several areas within the security plan to be audited annually.

These annual requirements were not recognized when the audit schedule was changed. Consequently, these areas were only audited every other year. Although the NRC has proposed a rule change to increase the periodicity of these requirements to two years (SECY-96-236), the new rule is not yet in effect. This licensee identified violation is not being cited because the criteria specified in Section VII.B of the "General Statement of Policy and Procedure for NRC Enforcement Actions," NUREG-1600, were satisfied (NCV 305-97003-03).

The inspector's discussions with security management revealed that they have identified the sections in need of an annual audit and are making preparations to audit these sections. As documented in KAP 547, these audits will continue to be performed annually until the rule change becomes effective. This issue was also discussed with NRC Region III security specialists.

c. Conclusions

Portions of the security plan were not audited annually as required. However, this violation is not being cited because the licensee identified it and initiated appropriate corrective action.

**V. Management Meetings**

**X1 Exit Meeting Summary**

The inspectors presented a summary of preliminary findings to members of Wisconsin Public Service management at the conclusion of the inspection. The licensee acknowledged the findings presented.

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

**X3 Management Meeting Summary (30702)**

Members of NRC Region III management met with members of plant management and walked down various plant systems on January 30, to discuss items of interest and gather information for the upcoming Kewaunee SALP board.

**PARTIAL LIST OF PERSONS CONTACTED**

Wisconsin Public Service Corporation

C. A. Schrock, Manager, Kewaunee Nuclear Plant  
D. J. Ropson, Manager, Engineering and Technical Support  
K. H. Evers, Manager, Nuclear Support Services  
R. P. Pulec, Superintendent, Nuclear Licensing and Systems  
G. I. Harrington, Plant Licensing Supervisor  
S. F. Putman, Maintenance Engineering Group Leader  
J. J. Hannon, Superintendent, Plant Instrument and Control  
C. S. Smoker, Superintendent, Plant Quality Programs  
D. T. Braun, Superintendent, Plant Operations  
M. T. Reinhart, Superintendent, Radiation Protection  
R. L. Hanson, Operations Supervisor

NRC

J. A. Grobe, Deputy Director, Division of Reactor Projects  
M. N. Leach, Acting Deputy Director, Division of Reactor Safety

## INSPECTION PROCEDURES USED

IP 37551: Onsite Engineering  
IP 40500: Effectiveness of Licensee Controls in Identifying, Resolving, and Preventing Problems  
IP 61726: Surveillance Observations  
IP 62707: Maintenance Observation  
IP 71707: Plant Operations  
IP 71750: Plant Support Activities  
IP 90712: In Office Review of Written Reports of Nonroutine Events at Power Reactor Facilities  
IP 92700: Onsite Followup of Written Reports of Nonroutine Events at Power Reactor Facilities  
IP 92901: Followup - Operations  
IP 92902: Followup - Maintenance  
IP 92903: Followup - Engineering  
IP 92904: Followup - Plant Support  
IP 93702: Prompt Onsite Response to Events at Operating Power Reactors

## ITEMS OPENED, CLOSED, AND DISCUSSED

### Opened

305/97003-01	VIO	Inadequate Control Ground Troubleshooting Activities
305/97003-02	VIO	Improperly Performed Breaker Modification
305/97003-03	NCV	Portions Of The Security Plan Not Audited Annually

### Closed

305/96006-03	VIO	Improper Acceptance Criteria for Safety Injection Flow Test
305/96010-04	IFI	Recessed Vent Holes on Emergency Diesel Petcocks
305/96014-03	IFI	Diesel Output Breaker Auxiliary Switch Linkage Rod Length
305/97003-03	NCV	Portions Of The Security Plan Not Audited Annually
305/96-011	LER	Safety Injection System Leakage Test Not Performed in Verbatim Compliance with the Technical Specifications
305/96-012	LER	RHR Pump Flow Instrument Not Checked in Accordance with Technical Specifications

### Discussed

305/96010-05	URI	Containment Fan Cooler Operability
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