



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

Report Nos.: 50-269/88-33, 50-270/88-33, and 50-287/88-33

Licensee: Duke Power Company
 422 South Church Street
 Charlotte, NC 28242

Docket Nos.: 50-269, 50-270,
 and 50-287

License Nos.: DPR-38, DPR-47, and
 DPR-55

Facility Name: Oconee 1, 2, and 3

Inspection Conducted: October 15 - November 15, 1988

Inspectors: *P. H. Skinner* 11/23/88
 P. H. Skinner, Senior Resident Inspector Date Signed

L. D. Wert 11/23/88
 L. D. Wert, Resident Inspector Date Signed

Approved by: *T. A. Peebles* 11-23-88
 T. A. Peebles, Section Chief Date Signed
 Division of Reactor Projects

SUMMARY

Scope: This routine, unannounced inspection involved resident inspection on-site in the areas of operations, surveillance testing, maintenance activities, safeguards and radiation protection, and inspection of open items.

Results: A weakness was identified in the licensee's program to assure all sliding links were in their proper configuration, paragraph 5.b.

Within the areas inspected, the following unresolved items* were identified:

- Lee Station 100 kv transmission system potential inadequate design, paragraph 3.c.
- Potential inadequate configuration control of sliding links, paragraph 5.b.

*Unresolved items are matters about which more information is required to determine whether they are acceptable or may involve violations or deviations.

REPORT DETAILS

1. Persons Contacted

Licensee Employees

- *M. Tuckman, Station Manager
- *C. Boyd, Site Design Engineer Representative
- J. Brackett, Senior QA Manager
- M. Carter, Site Design Engineer Representative
- *J. Davis, Technical Services Superintendent
- *W. Foster, Maintenance Superintendent
- T. Glenn, Instrument and Electrical Support Engineer
- *D. Havice, Instrument & Electrical Engineer
- *P. Guill, Nuclear Licensing Engineer
- C. Harlin, Compliance Engineer
- D. Hubbard, Performance Engineer
- H. Lowery, Chairman, Oconee Safety Review Group
- J. McIntosh, Administrative Services Superintendent
- *F. Owens, Assistant Engineer, Compliance
- *G. Rothenberger, Integrated Scheduling Superintendent
- *R. Sweigart, Operations Superintendent

Other licensee employees contacted included technicians, operators, mechanics, security force members, and staff engineers.

NRC Resident Inspectors

- *P. H. Skinner
- *L. D. Wert

*Attended exit interview

2. Licensee Action on Previous Enforcement Matters (92702)

- a. (Closed) Violation 287/88-28-03: Operation With Degraded Reactor Reactor Building Cooling Units (RBCUs). This item was identified in report 88-28 as being under consideration for escalated enforcement action. An enforcement conference was held on October 6, 1988 and documented in correspondence dated November 4, 1988. This correspondence identified that this item will not be cited as a violation since it resulted from matters not within the control of the licensee. Since no Notice of Violation was issued, no additional actions are required in response to this reported item. However, LER 287/88-03 also addresses this issue. The inspectors will continue to follow the licensees progress on this issue.

- b. (Open) Unresolved Item 269,270,287/88-13-06: Configuration Control Inadequacies In The ES and RPS Cabinets

Electrical wiring discrepancies were identified in Paragraph 4.e of NRC Report 50-269, 270, 287/88-13 dated August 3, 1988. These items are associated with the Reactor Protection System and the Engineered Safeguards Logic. As a result of this inspection, the licensee performed a sample inspection of approximately 30,000 wires/terminations which identified numerous minor discrepancies with the connection drawings.

The inspectors reviewed the extent of the licensee inspection and determined that it had addressed all systems required to be operational in an emergency situation. The program included the physical examination of the wires/terminations, licensee evaluations of drawing and wiring concerns, configuration control of electrical connection drawings, elementary wiring diagrams and schematics, and vendor drawings.

In general, the discrepancies, the licensee's evaluation of the discrepancies, the configuration control inadequacies, and the necessary corrective action indicates no existing safety concern. One specific problem was identified and is discussed in the following paragraphs. Different types of electrical drawings are relied upon during the various phases of the facilities existence. The connection drawings are used more during the construction phase to provide interconnection requirements between components and the panels. The discrepancies identified were with the connection drawings. Elementary wiring diagrams and schematic drawings are used more during operation and testing of the facility. During plant operation, the connection drawings are used as the basis for modifications. Therefore, the need still exists for accurate connection drawings.

The elementary wiring diagrams and schematics provide the necessary information for design, training, troubleshooting, functional understanding of the circuits, and testing during the plant operations phase. In no instance were the elementary wiring diagrams or the electrical schematic drawings found to be in error or the circuits to be electrically incorrect. For all the discrepancies identified, the problems were with the connection drawings and in several instances with vendor drawings concerning internal panel wiring.

During the licensee's inspection of Unit 3, an overload bypass contact for Engineered Safeguard (ES) Channel 6 was found not connected (missing jumper). In the motor control circuit for Reactor Building Cooling Unit Fan 3B, Relay 3CR-70, contact 4Fa, the bypass contact was not connected as required by the elementary wiring diagram and schematic No. OEE-338-18, Low Pressure Service Water

System - Reactor Building Cooling Unit Fan "3B". This constitutes a failure to meet the requirements in 10 CFR 50, Appendix B, Criteria V, Instructions, Procedures, and Drawings. Criteria V states, in part, activities affecting quality shall be prescribed by drawings and shall be accomplished in accordance with these drawings. This apparent violation was discussed with the resident inspectors, and Regional personnel and since all the requirements specified in 10 CFR Part 2, appendix C, Section V, were satisfied, this violation is not cited.

The licensee replaced the missing jumper and performed an Operability Evaluation per Problem Investigation Report 3-088-0197, dated September 2, 1988. The Operability Evaluation stated that the worst case scenario has ES Channel 5 out of service during an accident condition. Channel 5 controls fan A&B and Channel 6 controls fans B&C. Fan A would stop running and would have to be started manually in accordance with emergency procedure EP/3/A/1800.1, Section ES 505, in low speed. Fan C would run in low speed with the overloads bypassed. Fan B would fail if an overload condition occurred.

The inspector discussed and reviewed the corrective action already completed or planned to be taken by the licensee. The licensee stated that the wiring/termination discrepancies would be corrected by either changing the wiring/terminations in the panels to agree with the drawings or by revising the drawings to agree with the as-built configuration. Either method would be acceptable.

3. Plant Operations (71707)

- a. The inspectors reviewed plant operations throughout the reporting period to verify conformance with regulatory requirements, technical specifications (TS), and administrative controls. Control room logs, shift turnover records, and equipment removal and restoration records were reviewed routinely. Discussions were conducted with plant operations, maintenance, chemistry, health physics, instrument & electrical (I&E), and performance personnel.

Activities within the control rooms were monitored on an almost daily basis. Inspections were conducted on day and on night shifts, during week days and on weekends. Some inspections were made during shift change in order to evaluate shift turnover performance. Actions observed were conducted as required by the licensee's Administrative Procedures. The complement of licensed personnel on each shift inspected met or exceeded the requirements of Technical Specifications (TS). Operators were responsive to plant annunciator alarms and were cognizant of plant conditions.

Plant tours were taken throughout the reporting period on a routine basis. The areas toured included the following:

Turbine Building
 Auxiliary Building
 Units 1, 2, and 3 Electrical Equipment Rooms
 Units 1, 2, and 3 Cable Spreading Rooms
 Station Yard Zone within the Protected Area
 Standby Shutdown Facility
 Units 1/2 Spent Fuel Pool Room

During the plant tours, ongoing activities, housekeeping, security, equipment status, and radiation control practices were observed.

All three Oconee units operated at 100% power for the entire report period with the exception of Unit 3 which tripped twice on November 14, 1988 due to turbine trips (See paragraph 3.b). Unit 3 was returned to operation on November 15, 1988.

On November 2, 1988, Senator Ernest Hollings toured the Oconee site. The Senator spent about one and a half hours onsite and met briefly with the resident inspector during the course of the tour.

b. Reactor Trips - Unit Three

On November 14, 1988, at 7:27 a.m., Unit 3 reactor tripped from 100% power. The trip was caused by an anticipatory reactor trip on main turbine trip. The operators reduced secondary side pressure to about 950 psig to cause one of the main steam relief valves to fully seat. No other problems occurred. An investigation could not determine the cause of the turbine trip and the unit was returned to criticality at 11:54 a.m. and power escalation commenced. At 5:37 p.m. the power level had been increased to 39% when the main turbine tripped again. This caused a reactor runback but the reactor tripped on high reactor coolant system pressure although this transient should not have caused a reactor trip. The trip of the main turbine was caused by a circuit identified as the Main Turbine Customer Trip. Several independent signals feed this trip and the problem was isolated to a partial ground on a high steam generator level circuit for the 2A once thru steam generator. The faulty sensing module was replaced and the circuit tested satisfactorily.

As discussed above, the units should be capable of the loss of a main turbine from this power level without sustaining a reactor trip. A review of the plant parameters and data associated with the trip indicate that the trip may have been caused by a combination of high xenon levels in the core which caused the rod insertion to decrease reactor power at a slower than expected rate in conjunction with rapidly decreasing feedwater flow. The integrated control system (ICS) cross limit circuits should have more closely matched reactor power and feedwater flow decreases to reduce the rate of change which would have reduced the pressure surge allowing the plant to sustain the turbine trip without a reactor trip. The licensee is continuing

the investigation of the ICS to determine if the system performed as expected. The reactor was returned to criticality at 3:25 a.m. on November 15, 1988. The inspectors are continuing to follow the licensee's actions.

c. Inadequate Voltage Levels on Standby Bus When Powered From Lee Station Gas Turbines

On October 17, 1988, Design Engineering (DE) completed preliminary calculations of the Oconee Standby Bus Voltage profile when the bus is being fed by a Lee gas turbine. The results of the calculations indicated that a less than adequate voltage level could exist at the standby bus if all three units transfer to the standby bus simultaneously in the event of a complete loss of offsite power (LOOP) or if the loss of coolant accident (LOCA) loads of one unit transfer to the standby bus followed by the transfer of LOOP loads of two units in the event of a LOCA/LOOP. This calculation was generated in response to a finding identified in a Safety System Functional Inspection (SSFI) conducted at Oconee Nuclear Station in June 1986. The licensee responded to the NRC in correspondence dated October 1, 1986, which stated that calculations had been performed less formally for modifications that occurred six or seven years prior to the SSFI and that these design basis documents were being completed and filed. The response also included a commitment that if significant calculations were found to be not retrievable, then system capability would be verified by regenerating the analysis, testing, operating experience, or documented design reviews. In Duke Power Company internal correspondence dated August 11, 1986, the Lee Combustion Turbine Feed system to the ONS transformer CT5, was identified (as followup to the SSFI) as requiring design analysis to be performed.

Subsequent to the notification to operations personnel by Design Engineering (DE), the Station 100 kv system was declared inoperable. A review was conducted to determine if the station has previously operated outside of TS requirements. The results of this review indicated that both Keowee units are removed from service 1) once per year for approximately 30 minutes to perform a flow test, 2) once every three years for less than 24 hours for turbine inspections, and 3) have been removed twice since 1979 for re-wedge of the generators which requires less than 72 hours. As a result of the finding that the Lee Station 100 kv system would not perform its design function for all postulated accidents, the licensee reported as required by 50.72 (b)(2)(iii)(D) and 50.73 (a)(2)(v)(D). The inadequacy of the Lee Station to perform its design function is identified as an Unresolved Item 269,270,287/88-33-01: Lee Station 100 KV Transmission System Inadequate Design, pending additional review by NRC management.

d. SRO In The Control Room Exited Assigned Area

On October 28, 1988, with both Units 1 and 2 operating at 100 percent full power, the Senior Reactor Operator (SRO) who was designated as the "SRO in the Control Room" on Units 1 and 2 mistakenly left that control room for a period of about 3 minutes. This was a violation of Oconee Nuclear Station Operations Management Procedure (OMP) 2-1 "Duties and Responsibilities of Reactor Operators, non licensed operators and the SRO in the Control Room" which requires the "SRO in the Control Room" to be within the boundaries of that control room (inside the CAD key doors) any time the unit is above cold shutdown. Additionally it requires that the SRO shall ensure he is properly relieved prior to crossing the boundary. Technical Specification (TS) 6.1.1.3 requires that an SRO shall be in the control room from which a unit is operated whenever the unit is above cold shutdown. This TS was not violated since throughout the period that the "SRO in the Control Room" was not in the control room, the Shift Supervisor (an active SRO) and the Shift Technical Advisor (STA) were both within the boundaries of the control room.

Normally with both Units 1 and 2 operating at power there are at least three SROs assigned to the Unit 1/2 control room (in addition to the Shift Supervisor and STA) for each shift. Two of the SROs are designated "Unit Supervisors" and the other SRO is designated "the SRO in the Control Room". Unit supervisors are not restricted to the control room boundaries and frequently leave the control room in the course of their duties. The above incident occurred because one of the Unit Supervisors had relieved "the SRO in the Control Room" and then forgot that he was serving in that role and left the control room. He proceeded to the Unit 3 control room area, quickly realized his error and returned to the Unit 1/2 control room. (The other SROs assigned to the Unit 1/2 control room had left the control room previously except the Shift Supervisor and STA).

While no TS violation had occurred and the entire episode was corrected within about three minutes, the licensee realized the significance of this matter, promptly informed the resident inspectors, and expeditiously initiated corrective actions to prevent any reoccurrence. The licensee has enacted an informal program which requires the "SRO in the Control Room" to install a clear plastic sleeve over his CAD key card. The "SRO in the Control Room" would not be able to key out of the control room doors without removing this sleeve. Since there are no other documented similar instances at Oconee in the many years of operation, the inspectors consider this episode to be an isolated case and judge the licensee's corrective action to be sufficient to prevent any reoccurrences in the future.

e. Temporary Removal of a Senior Reactor Operator From Licensed Duties

On October 27, 1988, an Oconee Senior Reactor Operator (SRO) was removed from licensed duties by Operations management. The operator was suspected of being under the influence of alcohol when reporting to work. The SRO was tested for blood alcohol levels by a Duke Power company physician. Results were obtained on October 31, 1988, which indicated positive. The operator received disciplinary action in accordance with Duke policy and has been enrolled in the company's Employee Assistance Program (an extensive rehabilitation program).

f. Reduction in Facility Personnel

On November 9, 1988, as part of a reduction in Duke Power Company personnel, a total of 42 personnel were terminated from various operating departments in the Nuclear Power Production Department. The process used was to have each individual that was terminated escorted by a supervisor throughout the termination process. This was initiated since the individuals access to controlled areas was removed upon notification. In addition to the NPD personnel terminated at Oconee, approximately 90 persons working for the Construction Maintenance Division at the site were also terminated. No adverse operating effects have been observed as a result of this reduction in personnel at this time.

No violations or deviations were identified.

4. Surveillance Testing (61726)

Surveillance tests were reviewed by the inspectors to verify procedural and performance adequacy. The completed tests reviewed were examined for necessary test prerequisites, instructions, acceptance criteria, technical content, authorization to begin work, data collection, independent verification where required, handling of deficiencies noted, and review of completed work. The tests witnessed, in whole or in part, were inspected to determine that approved procedures were available, test equipment was calibrated, prerequisites were met, tests were conducted according to procedure, test results were acceptable and systems restoration was completed.

Surveillances reviewed and witnessed in whole or in part:

IP 3A/0305/3A RPS Channel A On-line Test
 PT 0/A/0400/06 SSF HVAC Service Water Pump Service Water Test
 PT/0/A/0600/15 Control Rod Movement Test (Unit 1)

No violations or deviations were identified.

5. Maintenance Activities (62703)

- a. Maintenance activities were observed and/or reviewed during the reporting period to verify that work was performed by qualified personnel and that approved procedures in use adequately described work that was not within the skill of the trade. Activities, procedures and work requests were examined to verify proper authorization to begin work, provisions for fire, cleanliness, and exposure control, proper return of equipment to service, and that limiting conditions for operation were met.

Maintenance reviewed and witnessed in whole or in part:

WR 051202H	Repair Oil Leak on Hydra-motor on Valve SSF-CCW 277
WR 17710C	Repair Inlet Flange to IMS 93
MP/O/A/2000/4	Doble Testing (Safe Shutdown Facility Breakers)

b. Configuration Control Inadequacies Associated With Sliding Links

On November 1, 1988, the resident inspector was informed by station compliance personnel that Oconee had written a Problem Investigation Report (PIR) to initiate an investigation by the Safety Review Group into sliding links discovered inadvertently open (as the result of an inspection of links being conducted in response to a Catawba PIR on sliding links). The inspector immediately met with the Instrument and Electrical (I&E) personnel tasked with the link inspection. At that time all of the control room boards, the Safe Shutdown Facility boards and most of the cable room boards had been inspected on Unit 3 and the same inspections were in progress on Units 1 and 2 in conjunction with the wiring discrepancy inspections that were being completed (See paragraph 2.b). At this time, while no safety related equipment had been affected by open sliding links, approximately 35 links had been discovered open that should have been shut. Approximately one third of these open links were on shield cables to computer points (these links do not significantly affect the functioning of the computer indications) and many others were located in circuitry to the event recorders. A total of three annunciators were rendered inoperable (inappropriately) by open sliding links. A link had also been found open in the circuitry associated with the Unit 1 'A' High Pressure Injection (HPI) pump. The open link defeated a feature which would automatically restart the 'A' HPI pump and a component cooling pump on a restoration of power following an undervoltage condition on the Main Feeder Busses.

This circuit is a portion of a Reactor Coolant Pump seal protection feature. The link did not affect the Engineered Safeguards circuitry associated with the pump and also did not affect the manual operation of the pump. The inspector expressed concern that open sliding links were a significant problem and the scope of the proposed inspection

was far too narrow (at that time the inspection was limited to the control room and cable room panels and cabinets being inspected as a result of the wiring discrepancy issue scheduled to be complete by July 1989) to ensure that no safety function were rendered inoperable by open links. During a subsequent conference call with the resident inspector, other Region II personnel and NRR, a commitment was made by the licensee to inspect virtually all safety related and important to safety links by November 7, 1988.

On November 7, that inspection was completed and as of November 10, 1988, the results were being evaluated on several sliding links discovered open. A total of 25 to 30 links were discovered open (out of about 60,000 links inspected) which should have been shut (excluding approximately 25 computer point cable shields and links whose positions were simply not documented properly). No safety related function had been affected by these links. Another control room annunciator and several computer indicators have been found inoperable due to open links. Several other application areas of sliding links were still being inspected and/or evaluated including the Keowee Hydrostation, the 230 kv Switchyard and panels in the Turbine Building. This issue is identified as Unresolved Item (269,270,287/88-33-02): Potential Inadequate Configuration Control Associated With Sliding Links, pending completion of inspection for sliding links and evaluation of all open links. The inspectors will closely follow licensee progress and corrective action on this issue. Preliminary indications appear that some of the open links may be the result of improper control during Nuclear Station Modification work.

During followup discussions with the licensee on this matter the resident inspectors were informed that a partial inspection of control room panels on Unit 3 conducted on August 22, 1988, (initial response to the Catawba finding) had discovered eight open links which should have been shut. The I&E personnel involved with this inspection did not feel at that time that this indicated a significant loss of control of sliding links. As late as November 1, 1988, the licensee's intentions were still to inspect only links in panels in the control rooms and cable rooms although a PIR had been initiated to investigate the issue. The NRC inspectors consider that although no safety related functions have been discovered to be adversely affected by open links, inappropriately open sliding links, whether safety related or not, is a significant issue. The licensee's actions to determine the scope of this issue and resolve it were not carried out in the typical vigorous and expeditious fashion the inspectors would have expected. This concern is considered a weakness and should be reviewed by licensee management.

No violations or deviations were identified

6. Safeguards and Radiological Controls Activities (71707)

In the course of the monthly activities, the Resident Inspectors included review of portions of the licensee's physical security activities. The performance of various shifts of the security force was observed in the conduct of daily activities which included; protected and vital areas access controls, searching of personnel, packages and vehicles, badge issuance and retrieval, escorting of visitors, patrols and compensatory posts. The inspectors observed protected area lighting, and protected and vital areas barrier integrity, and verified interfaces between the security organization and operations or maintenance.

No violations or deviations were identified.

7. Licensed Operator Activities (71707 & 41701)

a. During the weeks of October 3 and October 17, 1988, regional inspectors conducted a modified version of Inspection Module 41701, "Licensed Operator Training", as well as Inspection Requirement 02.05 of Inspection Module 71707, "Operational Safety Verification". The focus of the inspection was to obtain a "snapshot" view of licensed operator training, review the facility's process for integrating licensee events into the training program, inspect their program for tracking active and inactive licenses as described in 10 CFR 55.53(e) and (f) and inspect their program for tracking and evaluating the medical status of the licensed personnel as described in 10 CFR 55 - Subpart C, "Medical Requirements" and ANSI/ANS-3.4-1983, "Medical Certification and Monitoring of Personnel Requiring Operator Licenses for Nuclear Power Plants".

b. No violations or inspector follow-up items were identified. Pertinent comments are as follows:

- (1) Licensed operator simulator training was observed and found to be of meaningful content and well structured. Constructive and insightful feedback was provided by the evaluators and effective use was made of video replays in reviewing the simulator activities. There was significant operations department involvement via the presence of the Operations Superintendent and/or his primary assistant as evaluators.
- (2) The facility's procedure for NRC license maintenance, OMP 1-12, did not provide an adequate mechanism for tracking the 40 hours of parallel watchstanding required to return an inactive licensee to active status. Additionally, the OMP referenced the wrong sections of 10 CFR 55 that define the requirements for license maintenance. The facility committed to resolving these administrative problems.

- (3) The medical records of six personnel, including several individuals that have medical conditions on their license, were reviewed for compliance with ANS/ANSI-3.4. They were found to meet the applicable requirements. The facility appeared to have an effective tracking system for scheduling biennial medical examinations required by 10 CFR 55.21.

8. Inspection of Open Items (92700)

The following open items are being closed based on review of licensee reports, inspection, record review, and discussions with licensee personnel, as appropriate:

(Open) LER 287/88-03: Potential Degraded Performance of Reactor Building Cooling Units Due to Service Induced Fouling. During this report period the licensee has continued to periodically measure the thermal performance of the RBCUs as discussed in Inspection Reports 269,270,287/88-28 and 88-32 and during an enforcement conference on this matter on October 6, 1988. The frequency of the testing has been set to ensure that fouling will not cause a loss of heat removal capability below that required. While the licensee has made improvements in the accuracy of measured parameters and overall testing methods, the mechanism of fouling and an accurate rate of fouling accumulation remain unresolved. The licensee has not yet been able to confirm that calculations of the thermal performance of the coolers have been yielding values significantly lower than actual thermal performances due to conservative errors in the heat transfer modeling portion of the calculation. The licensee's Nuclear Safety Analysis Section continued to utilize very conservative criteria (discussed in Inspection Report 269,270,287/88-28) to determine overall system heat removal capability in the operability evaluations. The current status of the RBCU testing is as follows:

Unit 1: Latest testing conducted on November 8, 1988, indicate that the RBCUs can support 100 percent full power operation for a period well in excess of the end of cycle scheduled refueling outage. (January 27, 1989). This testing has provided more indications that the .25 percent per day fouling rate utilized in the operability determinations for all three units is conservative and the actual fouling rate seems to be much lower. The licensee has continued to apply the .25 percent per day fouling rate to all operability evaluations.

Unit 2: Most recent test was conducted on October 4, 1988 and indicated that the RBCUs can support full power operation through at least January 3, 1989. More testing is scheduled well in advance of this date.

Unit 3: Latest test conducted on November 1, 1988, indicated that the RBCUs can support full power operation for at least 28 calendar days as of November 1, 1988. Additional testing will be conducted well in advance of this date to ensure both operability and gather additional data to resolve this issue.

The inspectors have continued to closely follow the licensee's actions on this matter. Very conservative assumptions including a lakewater temperature of 80 degrees F and a fouling rate of .25 percent per day continue to be applied to all operability evaluations. The licensee's commitment to resolving this issue has resulted in testing at intervals set by these conservative evaluations instead of lengthening testing intervals by utilizing more realistic but less conservative assumptions. More testing along with the continued seasonal decrease in lakewater temperature should help resolve suspected conservative errors in the heat transfer modeling portion of the thermal performance calculations. The inspectors will continue to monitor the licensee's actions on this matter.

9. Exit Interview (30703)

The inspection scope and findings were summarized on November 15, 1988, with those persons indicated in paragraph 1 above. The following items were discussed in detail:

<u>Item Number</u>	<u>Status</u>	<u>Description/Reference Paragraph</u>
287/88-28-03	Closed	Operation With Degraded Reactor Building Cooling Units, paragraph 2.a
269,270,287/88-13-06	Open	Configuration Control Inadequacies in the ES and RPS Cabinets, paragraph 2.b
269,270,287/88-33-01	Open	Lee Station 100 KV Transmission System Inadequate Design, paragraph 3.c
269,270,287/88-33-02	Open	Potential Inadequate Configuration Control Associated With Sliding Links, paragraph 5.b

<u>Item Number</u> (cont'd)	<u>Status</u>	<u>Description/Reference Paragraph</u>
LER 287/88-03	Open	Potential Degraded Performance of Reactor Building Cooling Units Due to Service Induced Fouling, paragraph 7

The licensee representatives present offered no dissenting comments, nor did they identify as proprietary any of the information reviewed by the inspectors during the course of their inspection.