UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
101 MARIETTA STREET, N.W., SUITE 2900
ATLANTA, GEORGIA 30323-0199

Report Nos.: 50-269/95-17, 50-270/95-17 and 50-287/95-17

Licensee: Duke Power Company
422 South Church Street
Charlotte, NC 28242-0001

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

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

Facility Name: Oconee Units 1, 2 and 3

Inspection Conducted: June 25 - July 29, 1995

Inspectors: R E Carroll for 8/18/95
P. E. Harmon, Senior Resident Inspector Date Signed

W. K. Poertner, Resident Inspector
L. A. Keller, Resident Inspector
P. G. Humphrey, Resident Inspector
R. Freudenberger, Senior Resident Inspector, Catawba
R. Carroll, Project Engineer

Approved by: R. V. Crlenjak 8/18/95
R. V. Crlenjak, Chief Date Signed
Reactor Projects Branch 3

SUMMARY

Scope: This routine, resident inspection was conducted in the areas of plant operations, maintenance and surveillance testing, onsite engineering, and plant support. It included an inspection of open items and licensee event reports.

Results: In the operations area, control room operators alertly identified and controlled a reactor coolant leak while the plant was at hot shutdown conditions. The leak necessitated a unit cooldown and depressurization as described in paragraph 2.c.

In the maintenance area, all activities observed were performed in an acceptable manner using proper procedural controls.

In the plant support area, the inspectors completed an inspection of the licensee's fire protection program. No discrepancies were identified.

ENCLOSURE

REPORT DETAILS

1. Persons Contacted

Licensee Employees

B. Peele, Station Manager
*E. Burchfield, Regulatory Compliance Manager
D. Coyle, Systems Engineering Manager
J. Davis, Engineering Manager
T. Coutu, Operations Support Manager
*W. Foster, Safety Assurance Manager
*J. Hampton, Vice President, Oconee Site
D. Hubbard, Maintenance Superintendent
*C. Little, Electrical Systems/Equipment Manager
*J. Smith, Regulatory Compliance
*G. Rothenberger, Operations Superintendent
*R. Sweigart, Work Control Superintendent

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

*Attended exit interview.

2. Plant Operations (71707 and 40500)

a. General

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, temporary modification log, and equipment removal and restoration records were reviewed routinely. Discussions were conducted with plant operations, maintenance, chemistry, health physics, instrument & electrical (I&E), and engineering personnel.

Activities within the control rooms were monitored on an almost daily basis. Inspections were conducted on day and night shifts, during weekdays and on weekends. Inspectors attended some shift changes 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 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. During the plant tours, ongoing activities, housekeeping, security, equipment status, and radiation control practices were observed.

b. Plant Status

Unit 1 operated at full power throughout the reporting period.

Unit 2 operated at full power throughout the reporting period.

Unit 3 completed a scheduled refueling outage and returned to power on July 23, 1995.

c. Leak On Unit 3 Pressurizer Spray Valve

On July 18, 1995, a leak occurred on the Unit 3 Pressurizer Spray Block Valve, 3RC-3, while establishing conditions for low power physics testing. The 3RC-3 valve was being throttled when the operator noticed that the inventory in the letdown storage tank (LDST) was dropping and the reactor building sump level was increasing. The operator focused the reactor building camera on the pressurizer cavity (B cavity) and observed steam rising from that area.

The leak occurred at approximately 6:00 a.m., and was determined to be at a rate of 36 gpm. Unit 3 was being restarted after completing the End of Cycle-15 (EOC-15) refueling outage, and was in a hot standby condition with Reactor Coolant System (RCS) temperature at 540 degrees F and pressure at approximately 2200 psig (no load temperature and pressure). The leak rate dropped to a calculated 7 gpm when operators closed Pressurizer Spray Valve, 3RC-1 and 3RC-3. At that time, Abnormal Procedure AP/3/A/1700/02, Excessive RCS Leakage, was entered. The licensee made a Notice Of Unusual Event (NOUE) at 6:52 a.m.

The inspector was present in the control room when the event began, and determined that the operators alertly detected, diagnosed and controlled the leak. As a result, the unit was shutdown in a safe and timely manner. The NOUE was exited that evening at 10:43 p.m., when the unit was taken to cold shutdown.

After the unit was cooled down and depressurized, 3RC-3 was disassembled and inspected. The inspection revealed that a piece of old packing had been left in the stuffing box from a previous packing activity. This was suspected of contributing to the failure of the new packing rings when they were torqued down.

During the EOC-15 refueling outage, 3RC-3 had been repacked and stroke tested. The valve is located in an area with limited access and visibility to the bonnet; thereby causing difficulties during packing installation. Unlike that which was done during the refueling outage, the operator and hanger were removed from the valve to enhance the post-leak repacking effort. The valve was subsequently repacked with a more resilient type packing material.

d. Unit 3 Mid-loop

Following the Unit 3 refueling, the licensee reduced Reactor Coolant System (RCS) inventory and reached the mid-loop RCS level on July 7, 1995. This mid-loop evolution was for removal of nozzle dams in the steam generators. The inspectors reviewed the licensee's program prior to the reduction of RCS inventory and verified that the requirements were met while operating at the reduced inventory levels as specified in Operations Procedure OP/3/A/1103/11, Draining and Nitrogen Purging of RC System, Enclosure 3.6, Requirements for Reducing RXV Level to < 50" on LT-5. This procedure stipulated the sequence and steps required for reduction of RCS inventory and mid-loop operation.

Step 1 of Enclosure 3.6 specifically addressed the ability to establish containment closure. The licensee implemented a Shutdown Protection Plan for the outage which required containment closure to be maintained except as necessary to bring materials and tools in and out of the reactor building. The plan further required that penetrations be closed, except for those with temporary cables installed, as necessary for outage activities such as steam generator tube testing and maintenance.

The inspector verified that the requirement for two independent trains of RCS level monitoring was met while at reduced inventory. This was accomplished by the use of two permanently installed instruments (LT-5A and LT-5B) and two temporary ultrasonic instruments. Level indications were displayed in the control room on the LT-5A and LT-5B indicators, the Inadequate Core Cooling Monitor, and on the Operations Aid Computer.

The inspector verified that two trains of core exit thermocouples were available and utilized while at reduced inventory, as well as two sources of inventory makeup and cooling were available for operation.

The unit was at reduced inventory for approximately 11 hours. This was the shortest time to date for the licensee to complete a mid-loop evolution. During the time that Unit 3 was in a reduced inventory status, the licensee implemented and maintained the requirements specified by procedure. Operation at reduced inventory was accomplished without incident. The inspector concluded that this reduced inventory evolution was well coordinated and controlled.

e. Control Room Instrumentation

The inspectors reviewed the Unit 3 control room instruments that were out of service at the completion the refueling outage. A total of 7 instruments were out of service. At the beginning of

the outage, 42 Unit 3 instruments were out of service. The instruments included in the count were indicators, annunciators and computer points.

The licensee has been increasing efforts to reduce the number of out of service instruments for all three Oconee units. A total of 59 instruments were out of service for the three units as of July 26, 1995. Of the 59 out of service, approximately one-half require a unit outage for repair. Efforts are in progress to return those remaining to service.

The licensee's efforts in this area have been effective in reducing the number of out of service control room instruments.

f. Spent Fuel Pool and Fuel Transfer Canal Water Clarity

In the last Systematic Assessment of Licensee Performance (SALP) report (NRC Inspection Report 50-269,270,287/94-99), a concern was identified regarding poor spent fuel pool water clarity. During the Unit 3 outage (U3EOC13) the inspectors observed portions of the fuel offload into the spent fuel pool and portions of the fuel reload into the reactor vessel. The inspectors noted that water clarity and underwater lighting for both the Unit 3 Spent Fuel Pool and Fuel Transfer Canal had improved significantly from that observed during previous outages. The inspectors concluded that water clarity and lighting were adequate for fuel movement during this outage.

Within the areas reviewed, violations or deviations were not identified. Operators effectively identified and controlled a primary system leak (paragraph 2.c) and efforts to reduce the number of out of service control room instruments are effective (paragraph 2.e).

3. Maintenance and Surveillance Testing (62703 and 61726)

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 adequately described work that was not within the skill of the craft. Activities, procedures and work orders (WO) were examined to verify that proper authorization and clearance to begin work was given, cleanliness was maintained, exposure was controlled, equipment was properly returned to service, and limiting conditions for operation were met.

Maintenance activities observed or reviewed in whole or in part are as follows:

(1) Reactor Protection System (RPS) Channel D Flow Instrumentation Calibration, WO 94096787

The residents observed calibration of 'D' feedwater flow transmitter on Unit 3. The activity was performed per IP/3/A/0305/0011, Reactor Protection System Channel 'D' RC Flow Instrumentation Calibration. The documentation was complete for the steps performed and calibration instruments were logged as required.

The activity was determined to have been performed to acceptable standards.

(2) Install MARBO Plug Next to 2LPS-133, WO 95018743, Task 03

The inspectors observed activities in progress to remove a MARBO plug that had been installed in the Low Pressure Service Water (LPSW) piping located adjacent to valve 2LPS-133. The plug was installed to isolate Unit 3 during the refueling outage from Units 1 and 2, which were operating at power. The plug removal, observed on June 26 thru June 28, 1995, was difficult because it had become detached from the stem and had moved away from the pipe nozzle that had been installed to utilize the MARBO system. Removal was further complicated because the plug was in the crossover piping between the units and the LPSW system was in service as required to support the operation of Units 1 and 2. The problems encountered involved attaching cables to the plug with the system at operating pressure to pull the plug back into position and remove it from the piping at the nozzle provided.

The activity was determined to have been satisfactorily performed.

(3) Power Range NI Calibration, WO 95045717

The inspectors observed calibration of the Unit 3 power range nuclear instrumentation on July 23, 1995. The activity was performed in accordance with IP/0/A/0301/003T, Reactor Protection System Power Range Calibration at Power Instrument Procedure, which utilizes the reactor thermal power level as indicated by heat balance for the calibration.

The instrumentation was removed and returned to service as required by IP/0/A/0305/015, Nuclear Instrumentation RPS Removal From and Return to Service for Channels A,B,C and D. The work effort was performed according to the applicable procedures and to acceptable standards.

b. The inspectors observed surveillance activities to ensure they were conducted with approved procedures and in accordance with

site directives. The inspectors reviewed surveillance performance, as well as system alignments and restorations. The inspectors assessed the licensee's disposition of any discrepancies which were identified during the surveillance.

Surveillance activities observed or reviewed in whole or in part are as follows:

(1) Unit 3 Turbine Driven Emergency Feedwater (TDEFW) Pump Test, PT/3/A/0600/12

On July 20, 1995, the inspector observed an operability test of the Unit 3 TDEFW Pump. The test was performed in accordance with procedures and all test acceptance criteria were met.

(2) Unit 3 Engineered Safeguards System Logic Subsystem 1 Functional Test, IP/0/A/0310/007A

The inspector observed the test on July 11, 1995. The purpose of the test is to functionally test the Engineered Safeguards (ES) devices in Logic Channel 1. Functions tested included High Pressure Injection start and reactor building isolation. All devices tested operated as expected. All activities observed were satisfactory.

(3) Control Rod Drive Trip Time Testing, PT/0/A/0300/01

On July 17, 1995, the licensee performed control rod drive trip time testing while at hot shutdown. The test consisted of manually tripping the control rods and determining rod drop times using the operator aid computer and the events recorder. TS require a trip time of 1.66 seconds or less. The inspector noted that all rods dropped within the required time with the slowest rod dropping in 1.279 seconds. All activities observed were satisfactory.

Within the areas reviewed, licensee activities were satisfactory.

4. Onsite Engineering (37551)

During the inspection period, the inspectors assessed the effectiveness of the onsite design and engineering processes by reviewing engineering evaluations, operability determinations, modification packages and other areas involving the Engineering Department.

The inspectors reviewed the Engineering Evaluations supporting the MARBO plug removal discussed in Paragraph 3.a.(2), and several System Operability Evaluations. All evaluations were complete and properly documented. Additionally, the inspectors verified that the Unit 3 vital

inverters were replaced during the Unit 3 refueling outage. The inspectors observed portions of the replacement activity in the field and verified that post modification testing demonstrated acceptable performance.

Within the areas reviewed, licensee activities were satisfactory.

5. Plant Support (71750 and 64704)

The inspectors assessed selected activities of licensee programs to ensure conformance with facility policies and regulatory requirements. During the inspection period, the following areas were reviewed:

a. Fire Protection

The inspectors continued their review of the licensee's fire protection program which began during the previous reporting period and was documented in Inspection Report 95-11. The review during this reporting period focused on the requirements for activation, event priorities, methods utilized for combating electrical fires, the criteria for manning the fire brigade and requests for assistance, and annunciation of fires.

During the review, one area of concern was identified where the annunciator for the Units 1 and 2 fire alarm was located on the Unit 1 annunciator panel with only unique labeling to distinguish it from the adjacent alarms. The alarm for Unit 3 was also on the annunciator panel with labeling being the only unique identifier. This was a concern because of the possibility for overlooking a fire alarm during a unit trip or loss of offsite power when many alarms would be in alarm state on the annunciator panel.

The licensee was questioned as to what assurances could be provided that this annunciator would not be overlooked when in alarm at the same time various other annunciators were activated. Their response was that the fire alarm would be detected when the alarms were acknowledged because of the requirement for operators to scan those in alarm when acknowledging. Scanning the alarm panels is an event that is watched closely by the training instructors when the operators are on the simulator. Based on this activity, the training personnel were convinced that the fire alarms would be promptly acknowledged and response would be immediate. However, it was reported to the inspectors that nuclear safety could take precedence over a fire based on the severity of the event.

In addition, the inspectors were informed by operations personnel that the operators would respond from the unit not affected by the accident. The licensee indicated that efforts are in progress to change the applicable procedures to mandate this requirement. It

was further emphasized that since Oconee is a three unit site, there are more personnel available on shift to respond to those events than other sites with less units.

Based on the review by the inspectors, the site was determined to be in compliance with the Selected Licensee Commitments and Site Directives.

Within the areas reviewed, licensee activities were satisfactory.

6. Inspection of Open Items (92901 and 92902)

The following open items were reviewed using licensee reports, inspection record review, and discussions with licensee personnel, as appropriate:

a. (Closed) Inspector Followup Item (IFI) 287/94-11-02, Torque Switch Maintenance

This item concerned the failure of several limitorque motor operated valves (MOVs) to operate, apparently as the result of dirty torque switch contacts. The licensee attributed the dirty torque switch contacts to the inadvertent omission of a step in the maintenance procedure which required their cleaning (IP/0/A/3001/001). Due to the time of the procedure change, this inadvertent preventive maintenance omission only affected Unit 3. As a result there were 56 MOVs that did not receive the recommended torque switch cleaning. When the issue was first identified, the licensee inspected the torque switch contacts on a representative sample (5 Unit 3 MOVs). The inspections did not show a problem with dirty torque switch contacts so the licensee concluded that the remaining population of susceptible MOVs could wait until the next refueling outage for cleaning.

NRC Inspection Report 50-269,270,287/95-01 describes the subsequent failure of another Unit 3 limitorque MOV due to dirty torque switch contacts. Due to this failure, the licensee inspected 25 additional MOVs. The inspections did not reveal any additional problems with dirty torque switches. There were no additional problems experienced with dirty torque switch contacts prior to the latest Unit 3 refueling outage. The inspector verified that the applicable maintenance procedure was revised to include torque switch contact cleaning. Additionally, the inspector verified that the entire population of safety significant Unit 3 limitorque MOVs received torque switch cleaning during the outage.

b. (Closed) Violation 269,270,287/94-07-01: Failure to Follow Procedure Results in Loss of Power

During Main Steam Stop Valve (MSSV) maintenance on January 27, 1994, Unit 3 experienced a 21 second loss of electrical power to its Main Feeder Buses (MFB), with a corresponding loss of spent fuel pool cooling for approximately 4 minutes. At the time of the event, the defueled unit was receiving electrical power to its MFBs by backcharging through its main generator transformer from the 525 KV switchyard via Power Control Breaker-59 (PCB-59). Consequently, when maintenance technicians working in the number 4 MSSV power cabinet inadvertently grounded terminal lugs to the energized loss of load circuit, PCB-59 opened and electrical power was lost.

As indicated in the cited violation, the work group responsible for performing the MSSV related work and the operating personnel who approved the work were not aware it was being performed on energized circuits and/or the implications on plant safety of working on these circuits while energized. Accordingly, the licensee took the following actions before resuming the maintenance activity: (1) the related work package was replanned; (2) a pre-job briefing was held and requirements to verify voltage levels prior to beginning work on electrical circuits was emphasized; and (3) the main turbine valves were completely isolated from the generator loss of load circuitry. To preclude similar loss of power events in the future, the licensee committed to revise OP/0/A/1107/05, Backcharging Unit Main and Auxiliary Transformer, to: (1) assure a rapid bus transfer (in lieu of operator action as in this event) if the main transformer loses its power source; and (2) allow the removal of the tie between the main turbine valves and the loss of load circuitry while the main transformer is on backcharge. Having verified that the appropriate procedure changes were made, the inspector considered this item closed.

c. (Closed) Apparent Violation (EEI) 269/94-16-01: Failure To Follow Refueling Procedures (Violation EA 94-104-02014 and 01014)

Similar to three previous violations, this enforcement action concerned two instances of inadequate control over Unit 1 refueling activities in May 1994. The first instance (Violation EA 94-104-02014, Severity Level IV) involved an inadequate procedure for the control of fuel assembly movement. Specifically, the refueling procedure did not contain revised steps to delineate the refueling sequence deviations to support nuclear instrumentation (NI) response testing during core reload. When questioned by the NRC, revised procedural steps were written/approved prior to completing the remainder of the NI response testing. As such, the inspector confirmed that such

testing in the future would require detailed procedures that have been approved by the Reactor Engineering Department.

The second instance (Violation EA 94-104-01014, Severity Level IV assessed a Civil Penalty) involved the failure to implement procedural requirements related to the identification and independent verification of fuel assembly location during movement of fuel from the spent fuel pool to the reactor core. This resulted in a fuel assembly being retrieved from the wrong spent fuel pool location and subsequently placed in the reactor core. Although the use of an independent refueling bridge position spotter was implemented prior to this event (corrective action for similar Violation 50-269/93-03-01 addressed in Inspection Report 95-06), the possible overhearing of the communications to the bridge operator identifying the fuel assembly location compromised the spotter's independence.

In recent months, fuel handling has been recognized as a maintenance responsibility. As such, a new Maintenance Procedure (MP/0/A/1500/009, Defueling Re-Fueling Procedure) was written to direct fuel handling activities using the guidance taken from Refueling Procedures OP/1,2,3/A/1502/007. Accordingly, the inspector confirmed spotter independence was assured by verifying that MP/0/A/1500/009 requires the refueling step number (instead of the fuel assembly location) be communicated to the bridge operator and that the spotter not be involved with the positioning of the bridge. Also confirmed by the inspector was the procedural verification of portable spent fuel pool cameras to visually confirm a fuel assembly's identification number prior to transferring the assembly to the Reactor Building. Utilizing these independent verification enhancements in conjunction with improved spent fuel pool water clarity (see paragraph 2.g of this report), the recent Unit 3 reload was accomplished without any fuel assembly misplacements.

d. (Closed) Violation 269,270,287/94-01-02, Inadequate Procedures for Steam Generator Tube Plugging Activities

During core unloading of Unit 3 in January 1994, eight steam generator tube plugs were found lodged in the fuel assemblies' lower plenums. Subsequent investigation revealed that a total of 14 tube plugs were missing from their installed locations. The licensee later determined that improper rolling had occurred on 33 tube plugs (including the 14 plugs that had become dislodged from their tubes) during the previous Unit 3 refueling outage. The cause of the improper rolling was a combination of inadequate procedures used by the contractor crews, and an error in the software program used in the rolling process.

Immediate corrective actions included locating and retrieving the missing plugs, installing new plugs in the affected tubes, and correcting the software error. Subsequently, procedure changes were made to include a method to ensure proper torquing by the rolling mechanism, and independent review and verification of the rolling process prior to task closeout was implemented.

The inspector reviewed the procedure (B&W Procedure 1154835A, Revision 26) to verify the changes had been incorporated. The inspector also reviewed the results of the corrective re-rolling for the improperly rolled tube plugs. This item is closed.

7. Review of Licensee Event Reports (92700)

The below listed Licensee Event Reports (LERs) were reviewed to determine if the information provided met NRC requirements. The determination included: adequacy of description, compliance with Technical Specification and regulatory requirements, corrective actions taken, existence of potential generic problems, reporting requirements satisfied, and the relative safety significance of each event. The following LERs are closed:

a. (Closed) LER 269/93-10, Equipment Failure Causes Low Steam Generator Water Level Resulting in Manual Reactor Trip

A Unit 1 transient occurred on November 3, 1993, which resulted in the reactor operator manually tripping the reactor. The transient resulted from a momentary circuit interruption due to a broken wire termination lug in a terminal box that caused Main Steam Stop Valve (MSSV) 2 to partially close. The other three MSSVs on Unit 1 then closed due to an interlock in the system. When the circuit interruption cleared, two of the closed MSSVs (MSSV 3 and 4) associated with the 'A' Main Steam line failed to reopen as required due to stuck solenoid valves.

The reactor operator noticed that the turbine by-pass valves on the 'A' steam line were open at the beginning of the transient and attempted to close the valves. However, the operator had not noticed that the MSSVs had closed. Levels in the steam generators began to vary. When the level in the 'B' steam generator dropped below 15 percent, the unit was tripped as required per Emergency Operating Procedure EP/1/A/1800/001. The unit responded as required, but a high flow to the 'B' steam generator was noted.

Although the broken wire lug caused the initial closure of the MSSVs, the failure of the test solenoid valves on MSSVs 3 and 4 was attributed to those MSSVs not reopening. It was further determined that these test solenoids had failed as a result of inadequate maintenance.

The corrective actions taken by the licensee included: (1) inspection of all MSSVs, control valves, and intermediate and intercept stop valves wiring cabinets periodically; (2) evaluating the need to add the solenoid valves to the preventative maintenance program; (3) evaluating the metallurgy of the broken lug, which resulted in the replacement of the lugs; (4) evaluating the need to require a manual reactor trip on low steam generator pressure; (5) evaluating the need to train operators for this event on the simulator; and (6) evaluating for generic applicability.

The inspectors reviewed the corrective actions taken by the licensee and determined them to be adequate with the exception of the solenoid valves. The solenoid valves were not considered as safety-related by the licensee and not maintained as safety-related. This has been identified as a Deviation in NRC Inspection Report 50-269,270,287/95-09, Item 95-09-02.

Based on the licensee's corrective actions and the previously identified Deviation, this item is closed.

b. (Closed) LER 270-93-07, Inappropriate Action, Deficient Procedure and Low Flow Spike Result in Reactor Trip

On October 24, 1993, Unit 2 tripped from 100 percent power on a Flux/Flow/Imbalance trip from the Reactor Protection System. The trip occurred when RCS flow transmitters on two separate channels experienced simultaneous low flow spikes due to channel noise. The licensee also discovered a calibration error in the instrument channel which reduced the margin to the trip setpoint. If the calibration had been properly set, minor spiking would not have resulted in a trip. The calibration error involved both a procedural deficiency and an error by the technicians performing the calibration.

The corrective actions for this event included correcting the procedure (IP/0/A/305/04, Reactor Protective System Flow Check), properly calibrating the channels on both Unit 2 and Unit 3, and providing training to all calibration crews on the previous error.

The inspector reviewed the revised procedure and confirmed that crew training had been completed. This item is closed.

8. Exit Interview

The inspection scope and findings were summarized on August 1, 1995, with those persons indicated in paragraph 1 above. The inspectors described the areas inspected and discussed in detail the inspection findings. No dissenting comments were received from the licensee. The

licensee did not identify as proprietary any of the material provided to or reviewed by the inspectors during this inspection.

Item Number	Status	Description/Reference Paragraph
IFI 287/94-11-02	Closed	Torque Switch Maintenance (paragraph 6.a)
Violation 269,270,287/94-07-01	Closed	Failure to Follow Procedure Resultsin Loss of Power (paragraph 6.b)
EEI 269/94-16-01 (Violation EA 94-104-02014 and 01014)	Closed	Failure to Follow Refuelling Procedures (paragraph 6.c)
Violation 269,270,287/94-01-02	Closed	Inadequate Procedures for Steam Generator Tube Plugging Activities (paragraph 6.d)
LER 269/93-10	Closed	Equipment Failure Causes Low Steam Generator Water Level Resulting in Manual Reactor Trip
LER 270/93-07	Closed	Inappropriate Action, Deficient Procedure and Low Flow Spike Result in Reactor Trip