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

Report Nos.: 50-424/95-21 and 50-425/95-21

Licensee: Georgia Power Company
P. O. Box 1295
Birmingham, AL 35201

Docket Nos.: 50-424 and 50-425 License Nos.: NPF-68 and NPF-81

Facility Name: Vogtle 1 and 2

Inspection Conducted: August 20 through September 16, 1995

Inspector: FOR R. W. Wright 10/10/95
C. R. Ogle, Senior Resident Inspector Date Signed

FOR R. W. Wright 10/10/95
P. C. Hopkins, Resident Inspector Date Signed

FOR R. W. Wright 10/10/95
M. T. Widmann, Resident Inspector Date Signed

Approved by: B. R. Bonser 10/10/95
B. R. Bonser, Chief (Acting) Date Signed
Reactor Projects Section 3B
Division of Reactor Projects

SUMMARY

Scope: This routine, inspection entailed inspection in the following areas: plant operations, surveillance, maintenance, onsite engineering, plant support, and follow-up. Backshift inspections were performed on August 22-24, and 29, 1995; and on September 3-5, 12, 14, and 16, 1995.

Results: Three non-cited violations and one unresolved item were identified.

Operations:

Two non-cited violations were identified. A non-cited violation involved two examples of mispositioned valves identified by the inspectors during routine walkdowns. Another non-cited violation involved several examples of component labels being changed using a process outside established licensee procedures.

Maintenance:

One non-cited violation was identified. The licensee identified administrative deficiencies associated with the implementation of a wire removal form during replacement of a defective reactor coolant pump potential transformer. Though the errors had minimal safety significance, they may be indicative of a lack of attention to detail on the part of maintenance personnel completing forms.

Engineering:

One unresolved item was identified. Six motor or lube oil coolers for safety related components were discovered with NSCW flows below specified minimums. Subsequent investigation revealed that orifices in the NSCW supply piping to the coolers were partially obstructed. Three similar occurrences of partially obstructed NSCW flowpaths have occurred in the last year. Pending a review of the adequacy of the licensee's previous corrective actions, this item is unresolved.

REPORT DETAILS

1. Persons Contacted

Licensee Employees

*J. Beasley, General Manager Nuclear Plant
S. Bradley, Reactor Engineering Supervisor
*W. Burmeister, Manager Engineering Support
*C. Christiansen, SAER Supervisor
C. Coursey, Maintenance Superintendent
R. Dorman, Manager Training and Emergency Preparedness
*J. Gasser, Assistant General Manager Plant Operations
*M. Griffis, Manager Plant Modifications
T. Hargis, Maintenance Superintendent
M. Hobbs, I&C Superintendent
*K. Holmes, Manager Maintenance
D. Huyck, Manager Nuclear Security
*W. Kitchens, Assistant General Manager Plant Support
I. Kochery, Health Physics Superintendent
*R. LeGrand, Manager Health Physics and Chemistry
G. McCarley, ISEG Supervisor
*R. Odom, Assistant Performance Team Manager Maintenance
T. Parton, Health Physics Superintendent
*M. Sheibani, Nuclear Safety and Compliance Supervisor
*C. Stinespring, Manager Plant Administration
*J. Swartzwelder, Manager Outage and Planning
*C. Tippins, Nuclear Specialist, NSAC
R. Waters, Material Supervisor, Plant Administration

Other licensee employees contacted included technicians, supervisors, engineers, operators, maintenance personnel, quality control inspectors, and office personnel.

Oglethorpe Power Company Representative

J. Sharpe, Site Representative

NRC Inspectors

C. Ogle, Senior Resident Inspector
*P. Hopkins, Resident Inspector
*M. Widmann, Resident Inspector
D. Seymour, Project Engineer, Region II

*Attended Exit Interview

An alphabetical list of abbreviations and acronyms is located in the last paragraph of the inspection report.

2. Plant Operations (71707)

a. General

The inspection staff reviewed plant operations throughout the reporting period to verify conformance with regulatory requirements, TSs, and administrative controls. Control logs, shift supervisors' logs, shift relief records, LCO status logs, night orders, standing orders, and clearance logs were routinely reviewed. Discussions were conducted with plant operations, maintenance, chemistry, health physics, engineering support and technical support personnel. Daily plant status meetings were routinely attended.

Activities within the control room were monitored during shifts and shift changes. Actions observed were conducted as required by the licensee's procedures. The complement of licensed personnel on each shift met or exceeded the minimum required by TS. Direct observations were conducted of control room panels, instrumentation and recorder traces important to safety. Operating parameters were verified to be within TS limits.

Plant tours were taken during the reporting period on a routine basis. They included, but were not limited to the auxiliary building, control building, electrical equipment rooms, cable spreading rooms, NSCW towers, DG buildings, AFW buildings, MSIV rooms, turbine building and the low voltage switchyard. During plant tours housekeeping and equipment status were observed.

b. Unit 1 Summary

The unit operated at full power throughout the inspection period.

c. Unit 2 Summary

The unit operated at full power throughout the inspection period.

d. Mispositioned Valves

On August 28, 1995, during a walkdown of the Unit 1 Train A DG fuel storage tank room, the inspectors identified valve 1-2403-U4-066, DG 1A Fuel Oil Storage Tank Pump 1 Discharge Filter Drain Isolation Valve, in the open position with the cap installed. Normally, the valve is closed and capped. An operator dispatched by the control room verified the inspectors' observation and then closed the valve. On September 14, during a walkdown of the control room, the inspectors identified valve 1HV-8820, RCS Hot Leg PASS Sample Isolation Valve, in the open position. This is a normally closed containment isolation valve whose position is indicated on the main control board. Following identification to control room personnel, the valve was shut without incident using the control room handswitch.

In response to the fuel oil mispositioned valve, the inspectors reviewed the work package and clearance associated with the system maintenance and walked down a portion of the normal fuel oil system lineup. The inspectors also discussed clearance and removal procedures with operators and Operations management. In response to the PASS sample mispositioned valve, the inspectors reviewed MWOs, completed surveillances, and chemistry sampling procedures to determine how the valve came to be mispositioned.

Based upon this review, the inspectors were unable to conclusively determine how valve 1-2403-U4-066 became mispositioned. However, the inspectors determined that the valve was last manipulated on August 26, during the performance of clearance 19500506. This clearance was initiated to support MWO 19501746 to changeout the fuel oil storage tank pump #1 discharge line filter. Initially, the valve was opened to verify that the discharge line was properly drained and vented prior to work starting. After completion of the work activity, restoration of clearance 19500506 required that the valve be closed and capped, prior to the system being returned to service. During review of the completed clearance, the inspectors noted that two operators signed for the valve being shut on August 26, 1995. The inspectors independently verified that the remaining portions of clearance 19500506 were released in accordance with the system valve and equipment lineup requirements. No further discrepancies were noted. Given that the cap was installed, the inspectors concluded that the impact of the mispositioned valve was minimal. The licensee performed a limited review of the as found condition and was unable to identify a cause.

The inspectors were advised that valve 1HV-8220 may have been inadvertently opened on September 12, 1995, during performance of the Unit 1 RCS leak rate calculation. During this procedure, 14905-1, RCS Leakage Calculation (Inventory Balance), containment isolation valves on the RCS Hot Leg sample line are closed, then reopened, potentially causing a pressure transient in the downstream piping. The licensee theorized that the pressure increase may have caused 1HV-8220 to open partially. A review of the valve's elementary diagram indicated that if the valve became partially open, then the valve would receive a signal to go full open. The inspectors were advised by operations personnel that the valve had been noted to open during performance of the RCS leak rate calculation on previous occasions prior to the September 14 observation by the inspectors. However, no procedural guidance had been implemented to ensure that the valve was shut if this occurred. The licensee was able to recreate the valve opening during a subsequent RCS leak rate calculations performed after September 14. The licensee plans to replace this valve with one of a different design during the next refueling outage.

At the time of the inspectors' observation on September 14, the control room handswitch was in the automatic position. (The handswitch is designed to spring return to automatic from open when the valve is opened.) Based on a review of the valve's electrical elementary diagram, the inspectors concluded that the valve remained operable despite being mispositioned. The containment isolation function of 1HV-8220 would not have been impacted.

The inspectors concluded that the valves identified above were not in the proper positions as required by the licensee's procedures. These mispositioned valves constitute two examples of a violation of minor significance which will be treated as a Non-Cited Violation, consistent with section IV of the NRC Enforcement Policy. This is identified as NCV 50-424/95-21-01, Mispositioned Fuel Oil Storage Tank Drain Valve and RCS Hot Leg PASS Sample Valve.

e. Unlabeled Handswitches

On September 6, 1995, during a routine control room tour, the inspectors noted that the labeling of the PRT nitrogen supply valves hand switches, 2HV-8047 and 2HV-8033, were inconsistent with the labels for the same valves on Unit 1. Specifically, the Unit 2 valves had the "Auto" position for the handswitch annotated in pencil on the main control board. Licensee management was informed and the discrepancy was corrected. During walkdowns on September 14 and 15, 1995, the inspectors found several other examples, in the control room and auxiliary building, of components with temporary changes made to the labels. Again, the discrepancies were discussed with licensee management and the labels were corrected. The licensee advised the inspectors that they were performing a review of components and hand switches labeling to ensure consistency with established procedures. The control room review is complete and the licensee is correcting the discrepancies identified. A plant review is in progress and should be complete by the end of October.

The inspectors concluded that the observed examples of temporarily annotating component labels was of minor safety significance, but was contrary to the requirements of licensee procedure 10000-C, Component Identification. This failure constitutes a violation of minor significance and is being treated as a Non-Cited Violation, consistent with section IV of the NRC Enforcement Policy. This is identified as NCV 50-424,425/95-21-02, Component Labeling Not In Accordance With Licensee Procedures

Two non-cited violations were identified.

3. Surveillance Observation (61726)

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

The inspectors witnessed or reviewed the following surveillance activities:

SURVEILLANCE NO.	TITLE
14410-1	Control Rod Operability Test
14490-1	Containment Cooling System Operability Test
14607-1	SSPS Slave Relay K618 Train B Test, Safety Injection
14611-2	SSPS Slave Relay K602 Train B Test, Safety Injection
14613-2	SSPS Slave Relay K603 Train B Test, Safety Injection
14802-1	NSCW Pumps and Discharge Check Valves Inservice Test
14980-2	DG Operability Test
24511-1	Steam Blowdown Pipe Break Room Protection 1T-15216D ACOT and Channel Calibration
24700-1	Nuclear Instrumentation System Power Range Channel IN41 Channel Calibration

The inspectors did not identify any problems or concerns during the observation of these surveillance activities.

No violations or deviations were identified.

4. Maintenance Observation (62703)

a. General

Maintenance activities were observed or reviewed during the reporting period to verify that work was conducted in accordance

with approved procedures, TSs, and applicable industry codes and standards. Activities, procedures, and work orders were examined to verify proper authorization to begin work, fire hazard provisions, cleanliness, exposure controls, proper return of equipment to service, and adherence to limiting conditions for operation.

The inspectors witnessed or reviewed the following maintenance activities:

MWO NOS.	WORK DESCRIPTION
19501697	Limitorque Operator Perform PM
19502178	1A DG Voltage Regulator #2 Power Drive Potentiometer Replacement
19502277	Revise the Alarm and Trip Set Points for the SG Blowdown and CVCS Letdown Line
19502428	1A/1B DG - Inspection of Air Start Pressure Gauges For Moisture
29501477	Repair/Replace Spent Fuel Pool Heat Exchanger and Pump Room Equipment
29502167	2A/2B DG - Inspection of Air Start Pressure Gauges For Moisture
29502212	CCW Surge Tanks Level Indicator and Transmitter

The inspectors did not identify any problems or concerns during the observation of these maintenance activities.

b. Defective RCP Number 4 Potential Transformer

At 8:42 p.m., on August 27, 1995, Unit 2 received a RCP Bus 2, Channel 4 UV annunciator and an UV RCP Bus Alert alarm. At 2:06 a.m. the next morning, the RCP Number 4 UV and UF leads in SSPS Train A and B were lifted to trip the associated bistables and comply with the requirements of T.S. 3.3.1. Troubleshooting revealed a defective potential transformer in the RCP Number 4 switchgear. The transformer was replaced and the RCP UV and UF leads in SSPS were restored to normal at 12:15 p.m. on August 28, 1995.

In response to this issue, the inspectors witnessed a portion of the maintenance effort. The inspectors also reviewed the maintenance work order package and pertinent log entries in the control operators log. Based on this review, the inspectors concluded that the licensee satisfactorily complied with the requirements of TS. The maintenance witnessed by the inspectors was satisfactory.

During the conduct of the maintenance activity, Operations personnel detected an error in the documentation of lifted leads by maintenance personnel. While lifting the leads associated with the potential transformer, the technician inadvertently initialed the lifted lead form indicating he had restored the SSPS leads. Furthermore, the inspectors were also advised that during the lead lift for the potential transformer, the performer and independent verifier inadvertently initialled in the incorrect blocks. While none of these errors was particularly significant, the inspectors noted that the lifted lead form is relatively straightforward and as such would not readily lend itself to error. Given the basic nature of the lifted lead form, these errors indicate that additional management attention to maintenance personnel activities, while performing wire lifts, may be necessary.

Overall, the inspectors concluded that the failure to properly complete the lifted wire form was contrary to the requirements of licensee procedure 20429-C, Short-Term Documentation of Temporary Jumpers and Lifted Wires. This failure constitutes a violation of minor significance and is being treated as a Non-Cited Violation, consistent with Section IV of the NRC Enforcement Policy. This is identified as NCV 50-424,425/95-21-03, Wire Removal Form Procedures Not Adequately Implemented.

One non-cited violation was identified.

5. Onsite Engineering (37550) (37551)

General

During the inspection period, the inspectors assessed the effectiveness of onsite engineering processes by reviewing engineering evaluations, root cause determinations, modifications, and engineering testing. The inspectors also reviewed DCs to determine whether the licensee was appropriately documenting problems and implementing corrective actions.

No violations or deviations were identified.

6. Plant Support (71750)

General

Plant support activities were observed and reviewed to ensure that licensee programs were implemented in conformance with facility policies

and procedures and in compliance with regulatory requirements. Activities reviewed included radiological controls, physical security, emergency preparedness, and fire protection.

No violations or deviations were identified.

7. Follow-up (92700)

The following items were reviewed using licensee reports, inspections, record reviews, and discussions with licensee personnel, as appropriate:

a. Degraded NSCW System Flow on Safety Related Pump Motors and Lube Oil Coolers Due To Foreign Material

On August 26, 1995, in response to elevated component temperatures, the licensee measured NSCW flow through the Unit 1 CCP Train B lube oil cooler at between 3.5 and 4.5 gpm. Since calculation REA 94-VAA020 specifies between 11.4 and 20 gpm of NSCW flow for this cooler, the pump was removed from service on August 28, 1995, and the NSCW inlet piping and flow orifice were inspected. A piece of debris, similar to a small piece of concrete was removed from the orifice plate contained in the inlet NSCW piping to the cooler. Following restoration to service, normal NSCW flow rates were measured to the charging pump. Subsequent flow measurements of NSCW flows to other NSCW cooled pumps and motors, equipped with similarly sized orifices, revealed five more motor or lube oil coolers with less than the minimum required NSCW flow. These included the following components: safety injection pump 1B motor cooler, containment spray pump 1B motor cooler, safety injection pump 2B motor cooler and lube oil cooler, and containment spray pump 2A motor cooler. In each case, the NSCW piping and orifice were inspected and flow restricting debris was found and removed. Normal NSCW flows were restored to all affected components. A subsequent, preliminary evaluation performed by the licensee prior to the end of the inspection period concluded that the impacted components remained operable despite NSCW flows below specified minimums. This evaluation was based, in part, on data obtained from running several of the components with the degraded NSCW flows.

The NSCW system is the ultimate heat sink. NSCW cooling water is pumped from the cooling tower basins, one per train, by two of three NSCW pumps provided in each train to the essential component coolers, through the two main redundant NSCW supply headers. After removing heat from the components, the cooling water is returned to the cooling towers where the heat is rejected to the atmosphere. The NSCW system provides cooling for CCP and SI pump motor and lube oil coolers; CCW, CS, RHR and NSCW motor coolers; DG jacket water heat exchanger; control building ESF chillers and auxiliary air cooling coils; CCW and ACCW heat exchangers; piping penetration area air coolers; and reactor cavity and containment cooling coils. Proper system flow balance is obtained through the

use of appropriately sized orifices in the NSCW piping to the individual components. The NSCW pumps themselves sit in 80 foot deep wells within the NSCW tower structures immediately adjacent to the NSCW basins. These pump wells communicate with the basins through an opening in the well near the bottom of the basin. These openings are equipped with pump suction screens constructed of expanded metal. The inspectors were provided documentation by the licensee that reveals that the openings within this suction screen are a nominal 0.325 inches by 0.875 inches. (This is larger than some downstream orifices.) The pumps are also provided with a grating around the upper portion of the pump where they enter the well. At the time of this event, Unit 1 had solid plates over the major portion of these gratings while the Unit 2 gratings were uncovered.

The inspectors reviewed licensee actions taken in response to this event. This included witnessing measurement of NSCW flows to numerous components as well as follow-up of flushing activities. The inspectors also reviewed historical information related to previous instances of partially obstructed NSCW flow orifices at the site. Additionally, the inspectors reviewed licensee documentation related to the operation of the system including the FSAR, Calculation REA 94-VAA020, and the preliminary evaluation of the as found, degraded NSCW flows.

The licensee actions accomplished or planned in response to the August 26, 1995, event can be categorized into three broad areas: activities to reduce the occurrence of foreign material from entering the basins and pump shaft wells, prevention of any foreign material in the basin from blocking small orifices, and ensuring that testing and inspection are adequate for detecting possible flow blockage. Highlights of this effort include: temporary covers over pump well openings pending permanent cover fabrication and installation, enhanced debris screens and barriers for the basins where appropriate, evaluation of system design to preclude or mitigate obstruction of orifices, and more frequent NSCW flow measurements through small orifices.

The inspectors noted that the licensee's immediate corrective actions taken in August 1995 to measure NSCW flows to the coolers and the follow-on maintenance efforts to remove the restrictions to flow were good. Pumps were appropriately declared out of service, maintenance well executed, and flushed debris captured. The inspectors noted from their independent examination of the captured debris, that it consisted of a mix of materials. It included pieces of concrete and stone material, wire and plastic, as well as unidentified debris. Numerous pieces were removed with dimensions larger than the downstream orifice.

The inspectors reviewed historical documentation related to three prior instances of partially blocked NSCW flow orifices. These three instances were: blockage of NSCW flow to the CCP 2B lube oil

cooler due to a concrete spall detected on September 1, 1994; a reduction in Unit 2 NSCW Pump 4 motor cooler flow due to an unidentified object detected on January 25, 1995; and a reduction in NSCW flow to Unit 2 CCW Pump 5 motor cooler due to a plastic pen top on January 31, 1995. The corrective actions taken in response to these events, particularly the January 1995 occurrences were significantly narrower in scope and failed to include interim measures to reduce the likelihood of debris introduction.

The licensee's evaluation of the September 1, 1994, event concluded that the blockage was the result of a concrete spall most likely from the NSCW tower itself which became entrained in the NSCW system. Though a licensee walkdown discovered spalling in the towers, the event was considered to be isolated. No corrective actions, other than removal of the obstruction were identified. The inspectors were advised that this was the first documented case of an obstructed flow orifice in the system. The inspectors independently reviewed the maintenance work history and determined that no prior instances of maintenance in response to obstructed flow orifices were documented.

The January 25 and 31, 1995, flow reduction events, though on separate NSCW supplied component coolers, were detected by Surveillance 83308-C, Performance Testing/Monitoring of Safety-Related Pump Motor, Lube Oil and Pipe Penetration Area Air Coolers. The evaluation performed in response to these events concluded that the pump well grating and covers did not provide adequate protection from foreign material entry. As corrective action, the evaluation recommended that the pump well covers be provided for Unit 2 and that the existing Unit 1 covers be enhanced to provide more complete coverage. Though these modifications were planned, no field work was initiated prior to the flow reductions detected in August 1995.

The inspectors were advised that as a result of a small piece of sheet metal being dropped into the NSCW basin 1A on December 27, 1994, the licensee had planned additional corrective actions which when implemented could reduce the likelihood of NSCW system flow orifices becoming obstructed with entrained debris. The first was a planned inspection and cleaning of the bottom of the Unit 1A NSCW tower basin in an effort to locate and remove the dropped sheet metal. The licensee advised the inspectors that if this planned inspection had revealed a debris problem in the Unit 1A basin, then it is likely to have resulted in similar inspections in the other basins. The second planned corrective action was a planned modification to install screens in the Unit 1 NSCW tower air side to reduce the amount of air entrained debris which could be deposited into the basins. These screens already existed in the Unit 2 NSCW towers.

The inspectors were also advised that the licensee did not take any interim corrective actions in response to the January 1995 events. Hence, no measures designed to reduce the likelihood of debris intrusion into the system were planned until the activities outlined above were completed. Along these lines, the inspectors considered it particularly noteworthy that during an inspector walkdown of the NSCW towers shortly after the August 28, 1995, event, numerous small pieces of debris were found on, in, and near the NSCW pump wells and their covers. While the inspectors did not attempt to quantify this material or analyze the likelihood of it being transported if introduced into the pump well or basin, some of the items found were similar in size to those recovered from the NSCW system orifices. Shortly thereafter, the licensee installed temporary covers over the pump wells and permanent covers were installed prior to the end of the inspection period. Hence, there is limited evidence to suggest that a basic heightened sense of susceptibility to foreign object intrusion did not exist following the January 1995 events. On September 14 and 15, 1995, the inspectors observed a continued lack of sensitivity on the part of the licensee to in-process material in and around the NSCW tower pumps. Pending further NRC review of the adequacy of previous licensee corrective actions, this is identified as an Unresolved Item, URI 50-424,425/95-21-04, NSCW Debris Obstructs System Orifices.

b. (Closed) VIO 50-424,425/94-22-02, Failure To Follow Protected Area Entry/Exit Procedure with Regard To Designated Vehicles

This violation dealt with two examples of designated vehicles inside the protected area being left unattended with the keys in the ignition.

This item is closed. The corrective actions for this violation will be reviewed with the corrective actions taken by the licensee in response to similar occurrences documented in VIO 50-424,425/95-06-03, Inadequate Corrective Actions for Unsecured Designated Vehicles Inside the Protected Area.

c. (Closed) LER 50-425/94-01, Automatic Reactor Trip Due To Turbine Trip Resulting From Trip of Switchyard Breakers

This LER dealt with the reactor automatic trip as a result of a high voltage switchyard differential relay failure on a shunt reactor resulting in a trip of two 500 KV air blast circuit breakers on low air pressure. The low air pressure condition was a result of compressed air refill pressure switch failure to operate properly and maintain adequate air pressure. Based on the inspector's review of the licensee's corrective actions, this LER is closed.

During their review of this LER, the inspector noted that the licensee provided a closure package that had a documented

corrective action closure date after the commitment date stated in the LER. A review of further documentation revealed that the item was addressed before the date stated in the LER, but the licensee had failed to close the item administratively on time.

d. (Closed) VIO 50-424/95-03-01, Degraded Decay Heat Removal Via Natural Circulation (Reference paragraph 7.e for closeout)

e. (Closed) LER 50-424/94-09, Degraded Standby Decay Heat Removal Capability Via Natural Circulation.

VIO 50-424/95-03-01 and LER 424/94-09-01 dealt with degraded standby decay heat removal capability using natural circulation on September 16, 1994. This degradation occurred when the RCS was vented and level reduced, thereby making adequate natural circulation flow questionable.

The inspectors reviewed the licensees corrective actions and concluded they are adequate. These items are closed.

No violations or deviations were identified.

8. Exit Meeting

The inspection scope and findings were summarized on September 18 with those persons indicated in paragraph 1. The inspector 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 the inspection.

Item No.	Status	Description and Reference
NCV 50-424/ 95-21-01	Closed	Mispositioned Fuel Oil Storage Tank Drain Valve and RCS Hot Leg PASS Sample Valve (paragraph 2.d)
NCV 50-424,425/ 95-21-02	Closed	Component Labeling Not In Accordance With Licensee Procedures (paragraph 2.e)
NCV 50-424,425/ 95-21-03	Closed	Wire Removal Form Procedures Not Adequately Implemented (paragraph 4.b)
URI 50-424,425/ 95-21-04	Open	NSCW Debris Obstructs System Orifices (paragraph 7.a)
VIO 50-424/ 95-03-01	Closed	Degraded Decay Heat Removal Via Natural Circulation (paragraph 7.d)

VIO 50-424,425/ 94-22-02	Closed	Failure To Follow Protected Area Entry/Exit Procedure with Regard To Designated Vehicles (paragraph 7.b)
LER 50-424/ 94-09	Closed	Degraded Standby Decay Heat Removal Capability Via Natural Circulation (paragraph 7.e)
LER 50-425/ 94-01	Closed	Automatic Reactor Trip Due To TurbineTrip Resulting From Trip of Switchyard Breakers (paragraph 7.c)

No violations or deviations were identified.

8. Abbreviations

ACCW - Auxiliary Component Cooling Water
ACOT - Analog Channel Operational Test
AFW - Auxiliary Feedwater System
CCP - Centrifugal Charging Pump
CCW - Component Cooling Water
CS - Containment Spray
CVCS - Chemical and Volume Control System
DC - Deficiency Card
DG - Diesel Generator
ESF - Engineered Safety Feature
FSAR - Final Safety Analysis Report
I&C - Instrumentation and Controls
ISEG - Independent Safety Engineering Group
KV - Kilovolts
LCO - Limiting Condition for Operation
LER - Licensee Event Report
MSIV - Main Steam Isolation Valve
MWO - Maintenance Work Order
NCV - Non-Cited Violation
NPF - Nuclear Power Facility
NRC - Nuclear Regulatory Commission
NSAC - Nuclear Safety and Compliance
NSCW - Nuclear Service Cooling Water System
PASS - Post Accident Sampling System
PM - Preventive Maintenance
RCP - Reactor Coolant Pump
RCS - Reactor Coolant System
REA - Request for Engineering Assistance
RHR - Residual Heat Removal System
SAER - Safety Audit And Engineering Review
SG - Steam Generator
SSPS - Solid State Protection System
TS - Technical Specifications
UF - Under Frequency
URI - Unresolved Item
UV - Under Voltage
VIO - Violation