



UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
101 MARIETTA STREET, N.W., SUITE 2900
ATLANTA, GEORGIA 30323-0198

Report Nos. 50-369/95-25 and 50-370/95-25

Licensee: Duke Power Company
422 South Church Street

Docket Nos.: 50-369 and 50-370

License Nos.: NPF-9 and NPF-17

Facility Name: McGuire Nuclear Station 1 and 2

Inspection Conducted: October 8, 1995 - November 11, 1995

Inspectors: S. B. Rudisail 11/16/95
for George F. Maxwell, Sr. Resident Inspector Date Signed
per telcon 11/16/95
Garry A. Harris, Resident Inspector
Marvin D. Sykes, Resident Inspector
Herbert L. Whitener, Reactor Inspector

Approved by: R. V. Crlenjak 11/20/95
R. V. Crlenjak, Chief, Branch 1 Date Signed
Division of Reactor Projects

SUMMARY

Scope: This routine resident inspection was conducted in the areas of plant operations, maintenance, engineering, and plant support. Some of the inspections were conducted during backshift hours. Backshift inspections were conducted on October 13, 20, 27, and November 6, 7 and 8.

Results: In the area of operations:
A Unit 1 pre-outage self-assessment was determined to be detailed and thorough. The assessment team provided useful recommendations to management (paragraph 3.a).

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In the area of maintenance:

Maintenance activities for on-line leak repairs were well implemented and controlled (paragraph 4.b). Inspection and repair of the fuel transfer system was well coordinated (paragraph 4.c).

In the area of engineering:

The Spent Fuel Pool Cooling System was evaluated for both units and verified to meet design basis requirements to keep spent fuel assemblies adequately cooled and covered by water during all storage conditions (paragraph 5.a).

In the area of plant support:

A station emergency preparedness training exercise was challenging and each of the various station teams demonstrated sound knowledge of their responsibilities and duties (paragraph 6).

REPORT DETAILS

1. PERSONS CONTACTED

Licensee Employees

- *M. Cash, Reactor Engineering
- *K. Crane, Regulatory Compliance
- *R. Cross, Compliance Specialist
- T. Curtis, System Engineering Manager
- R. Deese, Safety Review Group
- *B. Dolan, Safety Assurance Manager
- *E. Geddie, Station Manager
- *M. Hatley, Component Engineering
- *P. Herran, Engineering Manager
- *M. Horne, Maintenance Manager
- *D. Jamil, Electrical System Engineering Manager
- R. Jones, Superintendent of Operations
- *P. McHale, I&E Training, Director
- *T. McMeekin, Station Vice President
- M. Nazar, Maintenance Superintendent
- *J. Silver, Operations Staff Manager
- *J. Snyder, Regulatory Compliance Manager
- *K. Thomas, Work Integration Manager
- *J. Thrasher, Modifications Manager
- B. Travis, Component Engineering Manager

Other licensee employees contacted included craftsmen, technicians, operators, mechanics, security force members, and office personnel.

NRC Resident Inspectors

- G. Maxwell, SRI
- *G. Harris, RI
- *H. Sykes, RI

*Attended exit interview

Acronyms and abbreviations used throughout this report are listed in the last paragraph.

2. PLANT STATUS

a. Unit 1

Unit 1 operated at essentially 100 percent power throughout the reporting period.

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b. Unit 2

Unit 2 operated at essentially 100 percent power throughout the reporting period.

c. Inspections and Items of Interest

During this period, an assigned Region II inspector assisted the resident staff during the observation of routine maintenance activities.

3. **OPERATIONS** (NRC Inspection Procedure 71707, 40500 and 92901)

Throughout the inspection period, inspectors conducted facility tours to observe operations and maintenance activities in progress. The tours included entries into the protected area and radiologically controlled areas of the plant. During these inspections, discussions were held with operators, radiation protection technicians, instrument and electrical technicians, mechanics, security personnel, engineers, supervisors, and plant management. Some operations and maintenance activity observations were conducted during backshift inspections. The inspectors attended licensee meetings to observe planning and management activities. The inspections confirmed Duke Power Company's compliance with 10 CFR, Technical Specifications (TS), License Conditions, and Administrative Procedures.

a. Unit 1 Pre-outage Self-Assessment

The inspectors evaluated a pre-outage self-assessment that was conducted by an independent review team for the next Unit 1 scheduled refueling outage, IEOC10. The inspectors noted that the self-assessment was performed in accordance with the controlling requirements of the Nuclear Site Directive 403 and the McGuire Site Directive 403.

The inspectors observed that the review team identified strengths in scheduling, outage risk periods, and made recommendations to station management. The strengths included recognition that the schedule did not rely on the steam generators to supply decay heat removal and did not allow any work to be conducted on either train of spent fuel pool cooling during the outage. The risk periods were identified as those times during reactor coolant system (RCS) reduced inventory, RCS solid operations, fuel movement, zero power physics testing, and during the addition of boron to the RCS or the spent fuel pool.

The team recommended that the number of non-shift operations personnel in the control room should be minimized during RCS reduced inventory and solid operations, core alterations, and zero power physics testing. The team also recommended that work

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control not allow RCS power operated relief valve work to be scheduled until an RCS vent path has been established and that all vital instrumentation and control work be scheduled for completion during Mode 5 or No Mode.

The inspectors agreed with the team findings and concluded that the outage self-assessment was detailed and the team provided useful recommendations to management.

- b. (CLOSED) LER 50-369/94-09: Boron Dilution of the Unit 1 Volume Control Tank Due to Procedural Deficiencies Caused by Inadequate Self-Checking

(CLOSED) VIO 50-369,370/94-25-02: Reactivity Addition Caused by Valve Mispositioning

On November 25, 1994, while Unit 1 operated at 100% power, reactor operators noticed an unexpected increase in the reactor coolant system temperature. The operators attempted to borate the RCS via the normal and emergency flow paths from the boric acid storage tank but the attempts were unsuccessful. The operators subsequently inserted control rods to achieve the appropriate RCS temperature. Troubleshooting investigations were conducted and valve lineups were performed. Operators discovered that the manual outlet valve from the A (Unit 1) boric acid storage tank, INV381, had been closed by Chemistry personnel while performing CP/O/A/8400/10, Boric Acid Addition to the Boric Acid Storage Tanks. The valve was immediately returned to the correct position and boric acid flow was reestablished. The inspectors determined that the core thermal power limit was not violated.

The licensee determined and the inspectors agreed, that procedure CP/O/A/8400/10 incorrectly required that INV381 be closed thereby isolating the A Boric Acid Tank. The procedure had recently been revised and reissued without proper validation and verification.

To prevent recurrence, the licensee has developed a list of Chemistry procedures requiring cross-disciplinary Operations review and implemented a new process for validation and verification of procedures. The inspectors reviewed and verified the licensee's corrective actions as described in the DuPont Power Company Letter dated January 27, 1995, in response to the Violation. The corrective actions were complete and adequate to prevent recurrence. This violation and the related LER are closed.

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- c. (CLOSED) VIO 50-369,370/94-25-03: Mispositioned Valve Caused by Failure to Follow Procedure

The inspectors noted during the past year that several valves important to plant safety were mispositioned due to failure to follow procedures. The valves involved various safety related systems and components. The corrective actions for the violations included procedure revisions and process evaluation. In addition, site management implemented cross-discipline management meetings, system alignment verifications and improved trending and configuration control schemes. The inspectors noted that there has been a reduction in the number of significant events related to mispositioned components at the station. Based on the inspectors' verification of the completed corrective actions identified in the Duke Power Company Letter to the NRC dated January 27, 1995, this item is closed.

4. **MAINTENANCE** (NRC Inspection Procedures 62703, 61726 and 92902)

- a. Surveillance Testing

The inspectors witnessed selected surveillance tests to verify that approved procedures were available and in use, test equipment in use was calibrated, test prerequisites were met, system restoration was completed, and acceptance criteria were met.

The selected tests listed below were reviewed and/or witnessed in detail:

<u>Procedure/Work Order</u>	<u>Equipment/Test</u>
PT/2/A/4350/02A and 02B	EDG 2A and 2B Operability Test
MP/0/B/7650/124	Fuel Transfer System 5 Year Inspection and Maintenance
CP/0/A/8400/10	Boric Acid Addition to the Boric Acid Storage Tanks
OP/0/A/6550/14	Filling and Draining Spent Fuel Pool Transfer Canal and Cask Area
PT/0/A/4150/02A	Core Power Distribution and Incore/NIS Correlation Check
AP/1/A/5500/40	Loss of Refueling Canal Level
OP/1/A/6200/05	Spent Fuel Cooling System

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The inspectors concluded that the above tests were conducted in accordance with the procedures. No violations or deviations were identified.

b. Maintenance Activities

The maintenance activities listed below were witnessed in detail by the inspectors:

1. On-Line Steam Leak Repair Of 1A Feedwater Pump High Pressure Stop Valve (ISP-15) Flange.
Work Order Task 95029378-10.
Procedures: MP/O/A/7700/05, On-Line Leak Sealing
Reinjection
USSI-NP-4-Rev 2, Wire Wrap-Injection Washers
2. On-Line Steam Leak Repair Of 1B Condenser Steam Air Ejector Flange (1ZJAE0002).
Minor Modification MGMM-7591
Work Order Task 95015255-03.
Procedures: MP/O/A/7650/77, On-Line Leak Sealing Initial
Injection
USSI-14-Rev 1, Full Face Flange-Injection
Washers

During observations of the above maintenance activities, the inspectors determined the following:

- Pre-job briefings were conducted and operations was advised of the process and consented.
- Approved procedures were compared to the latest revision and verified correct.
- System design classification, temperature and pressure were correctly transferred from system drawings to procedures.
- Procedures were present at the job-site and were followed.
- Equipment that had the potential to cause plant operation or safety problems was identified and precautions implemented.
- Pressure gauge on the injection tool was calibrated.
- Acceptability of sealing material was verified by both site personnel and vendor, Utilities Support Specialist, Inc. (USSI) representatives.
- Vendor crew was knowledgeable on leak sealing processes and plant procedures and controls.

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- Coordination between vendor crew members was good.
- Control of tools and materials at the job-site was good.
- Housekeeping in the work area was good.

The inspectors concluded that the above maintenance activities were well implemented and controlled. No violations or deviations were identified.

- c. (CLOSED) LER 50-369/94-05: Boron Dilution of the Unit 1 Spent Fuel Pool During Drain Down and Decontamination of the Transfer Canal.

To determine the adequacy of the licensee's corrective actions in response to LER 50-369/94-05, the inspectors witnessed portions of the maintenance activities associated with WO #95074397. The maintenance activities involved draining the fuel transfer canal and performing visual inspections of the fuel transfer system and making necessary repairs. A pre-job briefing was held. Representatives from Operations, Engineering, Maintenance, Chemistry, and Radiation Protection were present. Foreign material exclusion control was emphasized and contingency actions were identified.

Prior to the maintenance activity, the fuel transfer canal was drained in accordance with OP/O/A/6550/14, Filling and Draining Spent Fuel Pool (SFP) Transfer Canal and Cask Area. To minimize the potential for airborne contamination, the canal walls were sprayed periodically with demineralized water. A flow totalizer was used to monitor demineralized water additions to the canal area. To ensure adequate mixing in the SFP, the fuel pool cooling and cleanup (KF) system was operated whenever demineralized water was pumped from the canal to the spent fuel pool. To reduce the probability of diluting the SFP below the 2000 ppm TS limit, the SFP boron concentration was increased to 2270 ppm. Calculations were also performed to determine the maximum quantity of demineralized water that could be added to the pool prior to requiring a new boron sample.

During the inspection, the licensee determined that the emergency pullout cable shear pin had been damaged. The damaged pin was replaced and was taken to the site test facility for metallurgical analysis. The inspection and repairs were completed in accordance with MP/O/B/7650/124, Fuel Transfer System 5 Year Inspection and Maintenance. The inspectors observed that two way communication was maintained between the maintenance technicians performing the inspection and repair in the fuel transfer canal and the SFP operating deck. Radiation protection personnel frequently

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communicated area dose rate information and stressed the ALARA principle to the workers.

The inspectors concluded that the maintenance activity was well coordinated. No discrepancies were identified. Also, as a result of the inspectors observations and completion of licensee identified corrective actions, LER 50-369/94-05 is closed.

- d. (CLOSED) LER 50-369/94-04: Unit 1 Reactor Trip Occurred Due to Improper Use of Equipment

On May 12, 1994, Unit 1 experienced an automatic reactor trip from 100% power. The trip occurred when a screwdriver rolled off a divider barrier located inside the Unit 1 main control board 1EB5. The screwdriver struck the reverse power circuitry for the Unit 1 main generator causing the generator power circuit breakers to open. A full load rejection occurred, followed by a reactor trip on high negative flux rate. This event was caused by maintenance technicians using a main control board electrical divider barrier as a place to store tools.

The inspectors evaluated the short term and long term corrective actions and concluded that: 1) the affected electrical circuitry and relays were satisfactorily tested prior to the Unit restart; 2) management has directed maintenance technicians not to store tools on or near electrical circuits; and 3) caution statements have been added to controlling maintenance procedures, warning personnel not to store tools on or near electrical circuits or components.

Based on a review of previous and subsequent LERs, the inspectors concluded that this was an isolated event. The inspectors noted that no equipment was damaged by the screwdriver event, the plant was returned to full power without incident, and management actions were prompt and appropriate. This item is closed.

- e. (CLOSED) LER 50-369,370/95-04: Failure to Comply with the Technical Specification Action Statement for Reactor Coolant Leakage Detection Systems Due to Programmatic Deficiencies and Equipment Failure

The inspectors evaluated the circumstances and conditions involved with this event and documented them as a Non-Cited Violation in Inspection Report 50-369,370/95-22. Therefore, this LER is closed.

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- f. (CLOSED) LER 50-369/95-01: Manual Reactor Trip Initiated As A Result Of Equipment Failure

On January 29, 1995, while Unit 1 was operating at 100 percent power, the D steam generator feedwater isolation valve, 1CF26, closed unexpectedly and the control room operator initiated a manual reactor trip. All systems responded as required.

Investigation revealed that the valve closed following a fuse failure in the control circuitry for the valve. The corrective actions that were taken by the licensee included replacing the defective fuse (Bussman Type FNQ) with a more reliable type fuse. The inspectors also noted that similar fuses that were installed in other critical circuits were replaced with the new type fuses. Subsequently, the valve was tested and returned to service. The inspectors determined that the corrective actions outlined in this LER have been completed. This item is closed.

- g. (CLOSED) VIO 50-369,370/94-12-01: Gaseous Vapors In Control Room

On April 7, 1994, maintenance personnel failed to properly evaluate or create a separate task for the removal of glue from the control room ventilation system chiller heat exchanger during corrective maintenance. Subsequently, vapors from a solvent to remove the glue entered the control room complicating routine operations.

The inspectors verified that the licensee's corrective actions identified in the Duke Power Company Letter to the NRC, dated August 5, 1994, were complete. The corrective actions included training maintenance personnel on the actions to take if there is a significant change in the scope of a work activity. The work process manual was also revised to include a description of the actions to take when the scope of work changes. The inspectors verified that the corrective actions were implemented and determined that they were adequate. This item is closed.

5. **ENGINEERING** (NRC Inspection Procedures 37551 and 92903)

- a. Fuel Pool Cooling System Design Review

The inspectors evaluated the capability of the spent fuel pool cooling and cleanup system to provide sufficient cooling to the stored spent fuel assemblies under design basis accident conditions. The inspectors reviewed process flow diagrams, piping and instrumentation diagrams, system descriptions, and held discussions with cognizant licensee personnel.

The fuel pool cooling portion of the system consists of two closed loops consisting of a full capacity pump and heat exchanger

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combination. The system was designed to maintain the spent fuel pool water temperature within acceptable limits under normal and abnormal heat load conditions. The McGuire Safety Analysis Report (SAR) defines the normal case as a 1/3 core offload with all available storage locations filled with previous discharges from refueling operations except for 193 locations reserved for a full core discharge. The SAR defines the abnormal case as a full core offload resulting in all storage locations being filled. The inspectors verified that the system was designed to maintain the SFP temperature below 140°F for the abnormal maximum case and 120°F for the normal maximum case when both cooling trains are in operation. If single failure criteria is applied, the system has adequate redundancy such that a single failure would not prevent the system from performing its intended function under normal and abnormal conditions. The temperature would be limited to a maximum bulk pool temperature of 140°F for the normal maximum case and saturation for the abnormal maximum case.

The fuel pool has wet storage capacity for 1463 fuel assemblies and the pool water contains at least 2000 ppm boron. As a means of reducing shutdown risk during midloop operation, the licensee operates both trains of fuel pool cooling and performs full core offloads during refueling outages. Operating both trains of fuel pool cooling maximizes cleanup and clarity and maintains pool temperature within acceptable limits. The inspectors evaluated the licensee's current fuel offloading practice and determined that this practice is acceptable.

The licensee's current design analysis stated that boiling of the pool would occur after approximately 13.8 hours for the normal case and approximately 4.7 hours for the abnormal case after a loss of both trains of cooling. The inspectors verified that procedures are available to operators for establishing makeup to the pool from the refueling water storage tank, the reactor makeup water storage tank, and standby nuclear service water pond. The standby nuclear service water pond is the assured source. All means of makeup are manually initiated and terminated.

The inspectors reviewed system performance data and determined that the material condition of the system has been maintained to assure adequate fuel pool cooling capability. The inspectors concluded that the as-built system meets the design bases requirements.

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- b. (CLOSED) LER 50-369/95-03: Failure of the Turbochargers Associated with the Emergency Diesel Generators Due to Design Oversight

On June 12, 1995, the turbocharger on the 2A emergency diesel generator (EDG) failed due to the loss of a blade on the compressor impeller during operability testing. On June 27, prior to confirmation of the results of the root cause analysis for the 2A EDG turbocharger failure, the turbocharger on the 2B EDG failed.

As a result of these two events, a special Region II inspection was conducted. A Violation was identified and documented in Inspection Report 50-369,370/95-19. The Violation is being tracked as Escalated Enforcement Item EA 95-156. Based on the issuance of the Escalated Enforcement Item, this LER is closed.

- c. (CLOSED) DEV 50-369,370/95-13-02: Standby Nuclear Service Water Pond Dam Construction

This Deviation involved a section of the earthen berm at the north abutment of the Standby Nuclear Service Water Pond dam. The inspectors evaluated the Duke Power Company response to this item as outlined in a letter to the NRC dated July 19, 1995. The inspectors noted that a section of the earthen berm was not constructed at the north abutment on the dam.

Upon notification, site engineering personnel immediately conducted a survey to assure that dam elevation data was available. Also, they completed an operability evaluation for the service water pond. The pond was found to be past and present operable. The inspectors observed that the licensee has satisfactorily implemented a modification to the dam, extending an earthen berm on the northern abutment. The inspectors noted that the applicable Final Safety Analysis Report drawings have been revised to show the final as-built condition of the dam. The inspectors found that the corrective actions have been satisfactorily completed for this deviation. Therefore, this item is closed.

- d. (CLOSED) LER 50-369,370/95-02: Train A Of The Control Room Ventilation System Was Judged Technically Past Inoperable Because Of Inadequate Review Of The Cumulative Effects Of Field Changes During The Design Process

This inadequate design review concern was also addressed in Violation 50-369,370/95-13-01. Therefore, this LER is closed and the corrective actions will be tracked as part of the followup inspections associated with the Violation.

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the corrective actions will be tracked as part of the followup inspections associated with the Violation.

- e. (CLOSED) IFI 50-369,370/95-01-02: Unidentified Reactor Coolant System Leakage

Following a review of recent McGuire Unit 1 RCS unidentified leakage data, the inspectors determined that the reliability of the RCS leakage calculation had improved. The inspectors discussed actions that had been completed and those planned to be completed during the next Unit 1 outage, currently scheduled for December 1995. The actions that have been taken and those scheduled to be completed during the LEOC10 outage, were determined to be adequate to further improve the reliability of the RCS leakage data and therefore, IFI 50-369/95-01-02 is closed.

- f. (CLOSED) VIO 50-369,370/94-08-01: Non-Conservative Leakage Calculation

The licensee identified that on several occasions prior to December 7, 1993, while in Modes 1, 2, 3, and 4, unidentified leakage had exceeded the Technical Specification requirement of 1 gpm. The RCS leakage calculation did not account for inputs from other systems to the reactor coolant system drain tank (NCDT) and pressurizer relief tank (PRT). The failure to recognize these potential inputs caused the calculation to become non-conservative. The corrective actions performed included implementation of a temporary modification to quantify and eliminate inputs to the NCDT drain header that were not RCS related and improve calculation reliability. The inspectors verified that the corrective actions identified in the Duke Power Company Letter to the NRC dated June 1, 1994, and the supplemental responses dated August 17 and December 15, 1994, had been implemented. Based on the inspectors' review and evaluation, this item is closed.

- g. (CLOSED) VIO 50-369,370/94-25-01: Mechanical Restriction on Main Feedwater Regulating Valve 2CF20

On October 12, 1994, the licensee discovered that main feedwater regulating valve 2CF20 was mechanically restricted and therefore may not have fully closed on a main feedwater isolation signal. Upon discovery, immediate corrective action was taken to fully retract the handwheel gag to ensure full closure of the valve. Maintenance personnel performed visual inspections of each of the main feedwater regulating valves and verified that the handwheel mechanical restrictors were in the fully retracted position. In addition, the licensee revised maintenance procedure IP/O/A/3222/01, Copes Vulcan D-100-160 Valve Actuator Corrective Maintenance, to require that the handwheel gag position be

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verified before and after valve maintenance. The inspectors reviewed the corrective actions identified in the Duke Power Company Letter dated January 27, 1995, and determined that they have been completed. This item is closed.

6. **PLANT SUPPORT (NRC Inspection Procedures 71750)**

Station Emergency Preparedness Training Exercise

On October 11, 1995, a station emergency preparedness training exercise was conducted. The training scenario began with a simulated truck fire followed by a chlorine cylinder rupture that resulted in a crane falling onto the top of the Unit 1 refueling water storage tank spilling approximately 130,000 gallons of water from the tank. A simulated Alert was declared and eventually conditions deteriorated to the point that a General Emergency was declared.

The inspectors witnessed portions of the exercise. The inspectors also evaluated the drill objectives and the licensee's self-assessment of the performance of station personnel during the exercise. The inspectors observed that the emergency management team demonstrated clear understanding of the procedural requirements for emergency classification, proper notification of offsite agencies, staffing requirements, the control and transfer of responsibilities, accounting for station personnel, monitoring and controlling emergency worker radiation exposure, and monitoring both onsite and offsite airborne radioiodine concentrations. The inspectors observed that the fire brigade promptly responded to the truck fire and demonstrated good fire fighting practices. The site security team quickly responded to the location of the fire and provided support for the fire brigade. Plant operations personnel demonstrated their ability to assess the incident and provide mitigation strategies.

The inspectors determined that the exercise was challenging and that each of the various station teams demonstrated thorough knowledge of their responsibilities and duties. The inspectors observed that the licensee conducted a self-assessment of personnel performance during the exercise. The inspectors evaluated the self-assessment and determined that the assessment was accurate and that it provided useful recommendations for improving overall performance during future exercises.

7. **EXIT INTERVIEW**

The inspection scope and findings identified below were summarized on November 9, 1995, with those persons listed in paragraph 1. The inspectors described the areas inspected and discussed in detail the inspection findings in the Summary and listed below. The licensee did not identify as proprietary any of the material provided to or reviewed

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by the inspectors during this inspection. The following items were discussed in detail:

<u>Item Number</u>	<u>Status</u>	<u>Description and Reference</u>
LER 50-369/94-09	CLOSED	Boron Dilution of the Unit 1 Volume Control Tank Due to Procedural Deficiencies Caused by Inadequate Self-Checking (paragraph 3.b)
VIO 50-369,370/94-25-02	CLOSED	Reactivity Addition Caused by Valve Mispositioning (paragraph 3.b)
VIO 50-369,370/94-25-03	CLOSED	Mispositioned Valve Caused by Failure to Follow Procedure (paragraph 3.c)
LER 50-369/94-05	CLOSED	Boron Dilution of the Unit 1 Spent Fuel Pool During Drain Down and Decontamination of the Transfer Canal (paragraph 4.c)
LER 50-369/94-04	CLOSED	Unit 1 Reactor Trip Occurred Due to Improper Use of Equipment (paragraph 4.d)
LER 50-369,370/95-04	CLOSED	Failure to Comply with the Technical Specification Action Statement for Reactor Coolant Leakage Detection Systems Due to Programmatic Deficiencies and Equipment Failure (paragraph 4.e)
LER 50-369/95-01	CLOSED	Manual Reactor Trip Initiated As A Result Of Equipment Failure (paragraph 4.f)
VIO 50-369,370/94-12-01	CLOSED	Gaseous Vapors In Control Room (paragraph 4.g)

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LER 50-369/95-03	CLOSED	Failure of the Turbochargers Associated with the Emergency Diesel Generators Due to Design Oversight (paragraph 5.b)
DEV 50-369,370/95-13-02	CLOSED	Standby Nuclear Service Water Pond Dam Construction. (paragraph 5.c)
LER 50-369/95-02	CLOSED	Train A Of The Control Room Ventilation System Was Judged Technically Past Inoperable Because Of Inadequate Review Of The Cumulative Effects Of Field Changes During The Design Process (paragraph 5.d)
IFI 50-369,370/95-01-02	CLOSED	Unidentified Reactor Coolant System Leakage (paragraph 5.e)
VIO 50-369,370/94-08-01	CLOSED	Non-Conservative Leakage Calculation (paragraph 5.f)
VIO 50-369,370/94-25-01	CLOSED	Mechanical Restriction on Main Feedwater Regulating Valve 2CF20 (paragraph 5.g)

8. Acronyms and Abbreviations

ALARA	-	As Low As Reasonably Achievable
EDG	-	Emergency Diesel Generator
LER	-	Licensee Event Report
PRT	-	Pressurizer Relief Tank
RCS	-	Reactor Coolant System
SFP	-	Spent Fuel Pool
VCT	-	Volume Control Tank

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