ENCLOSURE 2

U.S. NUCLEAR REGULATORY COMMISSION
REGION IV

Docket No.:	50-482
License No.:	NPF-42
Report No.:	50-482/96-23
Licensee:	Wolf Creek Nuclear Operating Corporation
Facility:	Wolf Creek Generating Station
Location:	1550 Oxen Lane, NE Burlington, Kansas
Dates:	October 20 through November 30, 1996
Inspectors:	J. F. Ringwald, Senior Resident Inspector M. S. Freeman, Reactor Engineer
Approved By:	W. D. Johnson, Chief, Reactor Projects Branch B

Attachment: Supplemental Information

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EXECUTIVE SUMMARY

Wolf Creek Generating Station
NRC Inspection Report 50-482/96-23

Executive Summary

Operations:

- The management decision to reduce power to repair damage to main feedwater pump wiring was appropriate and conservative (Section O1.1).

- The inspector identified two examples where the shift supervisor inadequately documented the basis for operability determinations (Section O1.2).

Maintenance:

- Operators identified and properly responded to an inadvertent dilution as a result of deficiencies in the restoration section of an instrumentation and control calibration procedure for the letdown radiation monitor. During the review of this deficiency, the licensee identified that the procedure also failed to restore the monitor to service. These deficiencies were identified as a noncited violation (Section M3.1).

- A poor maintenance turnover and weak training caused a spill of spent fuel pool water from an improperly tightened mechanical seal on the spent fuel pool cooling water pump (Section M4.1).

Engineering:

- The inspector concluded that the licensee violated 10 CFR Part 50, Appendix B, Criterion V, when an operability determination failed to comply with the licensee's procedure on operability determinations, by relying on an engineering evaluation which failed to properly identify the leaking component in the turbine-driven auxiliary feedwater pump governor oil system. This example and examples from previous inspection reports indicated a declining trend in the performance of operability determinations (Section E2.1).

Plant Support:

- The decision to perform corrective maintenance on the diesel fire pump instead of reducing the acceptance requirements was appropriate and showed conservative management decision making (Section F1.1).

- The inspector identified a violation of Technical Specification 6.8.1.h associated with concerns on diesel fire pump testing which suggested a lack of thoroughness in preparing and implementing the test procedure and lack of adherence to the fire protection program (Section F1.1).

Report Details

Summary of Plant Status

The plant operated at 100 percent power until October 25, 1996, when operators reduced power to 60 percent to repair main feedwater pump wiring. Operators returned the plant to 100 percent power on October 26, 1996, where it remained throughout the inspection period.

I. Operations

O1 Conduct of Operations

O1.1 Downpower for Main Feedwater Pump Repair

a. Inspection Scope (71707)

The inspector reviewed the downpower evolution to repair main feedwater pump wiring.

b. Observations and Findings

On October 25, 1996, following an extensive troubleshooting effort, the licensee reduced power to approximately 60 percent power to repair wiring for Main Feedwater Pump A. The troubleshooting identified damaged vendor wiring with deteriorated insulation. With the pump out of service, the repairs were completed without difficulty.

As a result of the downpower evolution, the ensuing xenon transient resulted in a quadrant power tilt ratio which exceeded 1.02. Operators entered the action statement for Technical Specification 3.2.4 and reduced power to below 50 percent power. After evaluating the condition, consulting with reactor engineering personnel, and evaluating the technical specification requirements, operators concluded that they understood the cause of the condition, and were certain that it was not the result of misaligned rods or other reactivity anomaly. They then increased power above 50 percent power. At approximately 90 percent power, the quadrant power tilt ratio returned to below 1.02. At approximately 96 percent power, operators performed a calorimetric power measurement, verified that the quadrant power tilt ratio was below 1.02, and exited all action statements associated with Technical Specification 3.2.4.

c. Conclusions

The decision to reduce power to repair the main feedwater pump was a good conservative management decision. The licensee's actions with regard to quadrant power tilt ratio were appropriate.

O1.2 Inadequately Supported Operability Determinations

a. Inspection Scope (71707)

The inspector reviewed every operability determination documented in the shift supervisor's log during the inspection period.

b. Observations and Findings

On two occasions, the shift supervisor did not adequately document the basis for the operability determinations performed. In each of these cases, the operability determination themselves appeared to appropriate.

On November 14, 1996, a security guard noted a halon system pipe hanger contacting an electrical junction box labeled as containing Train A safety-related cabling. Operations and engineering personnel identified that the pipe support contacted a junction box containing cabling for GT RT-32, containment atmosphere process radiation monitor. The log entry stated that this condition did not affect operability, noted that the junction box had no damage or sign of rubbing with the hanger barely touching it, and that the operability of the halon system was not affected. While this log entry did provide some basis for the conclusion in the as-found static condition, it failed to consider the potential effects of a seismic event or other condition that could exacerbate the condition.

On November 15, 1996, the turbine building watch identified a grounding cable in contact with a safety-related cable. The ground cable stuffing tube insulation was loose, and there appeared to be excessive slack in the ground cable. The log entry described the condition and stated that this was not an operability concern. No basis for the operability concern was documented.

The operations manager, plant manager, and chief operating officer all stated that these log entries did not meet management expectations. The operations manager indicated that they are considering changing their method for documenting operability determinations.

c. Conclusions

On two occasions shift supervisors failed to meet management expectations by inadequately documenting the basis for operability determinations.

II. Maintenance

M1 Conduct of Maintenance

M1.1 General Comments on Maintenance Activities

a. Inspection Scope (62707)

The inspector observed all or portions of the following work activities.

105797	Task 1	Brickwork on normal charging pump room wall
110097	Task 1	Mechanical cleaning of Safety Injection Room Cooler Coil Train A
RNM C-0570	Revision 2	Undervoltage relay dropout voltage and time response test
STN FP-450	Revision 4	Fire damper inspection and drop test
STN IC-265A	Revision 9	Calibration of Emergency Fuel Oil Storage Tank A level loop

b. Observation and Findings

Except as noted in Sections M2, M3, and M4, the inspectors found no concerns with the maintenance observed.

c. Conclusions

Except as noted in Sections M2, M3, and M4, the inspectors concluded that the maintenance activities were being performed as required.

M1.2 General Comments on Surveillance Activities

a. Inspection Scope (61726)

The inspectors observed all or portions of the following surveillance activities.

STS AB-201D, Revision 2	Atmospheric relief valve inservice test
STS BG-210, Revision 10	Chemical and volume control system inservice check valve test

b. Observations and Findings

The inspectors found no concerns with the surveillances observed.

c. Conclusions

The inspectors concluded that the surveillance tests were being performed as required.

M2 Maintenance and Material Condition of Facilities and Equipment

M2.1 Breaker Test Device Storage Without Seismic Analysis

a. Inspection Scope (62707)

The inspector reviewed licensee actions in response to the discovery that electricians stored breaker test devices in spare switchgear cubicles without a supporting seismic analysis.

b. Observations and Findings

On October 18, 1996, the inspector questioned the licensee regarding differing indications on the spare switchgear cubicles in the safety-related 4160 volt AC cubicles. During the discussions, the system engineer explained that the indications were for the 86 lockout relays for the spare cubicles only, and differing indications had no impact on any safety-related equipment. Subsequent to these discussions, operators reset the tripped relay to make the indications consistent.

The inspector asked the electrical maintenance superintendent what was located in the spare cubicles. In answering that the cubicles contained breaker test devices, the superintendent recognized that these devices may not have had seismic analyses to support their storage in the safety-related cubicles. After confirming this concern, the superintendent coordinated with the shift supervisor to have the devices removed from the cubicles, and directed electricians to initiate Performance Improvement Request (PIR) 96-2662.

Subsequent reviews by engineering personnel concluded that, while no seismic analysis addressed the storage of these test devices in the cubicle, the analysis for storing a racked down breaker in a cubicle would bound the storage of a test device. Engineering personnel completed this engineering disposition based on PIR 96-2662 on November 27, 1996.

c. Conclusions

While the licensee ultimately demonstrated that it was acceptable to store breaker test devices in the spare safety-related cubicles, discussions with the inspectors resulted in the licensee identifying that these devices had been stored without an evaluation demonstrating the acceptability of this practice.

M3 Maintenance Procedures and Documentation

M3.1 Inadvertent Dilution Due to an Inadequate Procedure

a. Inspection Scope (62707)

The inspector reviewed the circumstances surrounding an inadvertent dilution following a radiation monitor surveillance.

b. Observations and Findings

On November 18, 1996, after completion of Procedure STN IC-480, "Channel Calibration CVCS Letdown Radiation Monitor SJ RE01," Revision 5, operators questioned the reading of Radiation Monitor SJ RE01, letdown radiation monitor, and initiated a purge. Approximately 20 minutes later, the operators noted that the purge light was still illuminated, and the volume control tank level had increased approximately one percent. Reactor power began to increase, and operators took actions to limit the increase to below the license limit. Operators subsequently initiated PIR 96-2998.

During troubleshooting, operators determined that Procedure STN IC-480 changed the purge time from the normal value of 2 minutes, to 60 minutes, and failed to change it back to 2 minutes. This nominal one gpm flow from the reactor makeup water tank through the radiation monitor into the volume control tank continued beyond the normal 2 minutes causing the inadvertent dilution.

The licensee made two significant revisions to Procedure STN IC-480 since the last performance of the procedure. While Revision 4 incorporated lessons learned from Revision 3, Revision 5 failed to capture appropriate restoration steps which had been present in Revision 4. One of these omitted restoration steps was the resetting of the purge time. On November 20, 1996, instrumentation and controls technicians identified another restoration step that Revision 5 omitted. The procedure directed operators to shut Valve SJ-V733, letdown radiation monitor sample isolation valve, but failed to direct them to open it during restoration. After discovering the procedure omission, the technicians notified the shift supervisor. Operators immediately checked and found Valve SJ-V733 shut. Consequently, Radiation Monitor SJ-RE01 was not restored to service on November 18, 1996, at the completion of Procedure STN IC-480, and remained out of service until November 20, 1996. Technicians subsequently initiated PIR 96-3012.

c. Conclusions

Operators identified and properly responded to an inadvertent dilution. The failure of Procedure STN IC-480, to properly restore the radiation monitor to service, and reset the purge time, was a violation of Technical Specification 6.8.1.a, in that the procedure was not adequate. This licensee-identified and corrected violation is

being treated as a noncited violation, consistent with Section VII of the NRC Enforcement Policy.

M4 Maintenance Staff Knowledge and Performance

M4.1 Spent Fuel Pool Cooling Pump Seal Leak

a. Inspection Scope (62707)

The inspector reviewed the licensee's response to seal leakage from the Train A spent fuel pool cooling pump.

b. Observations and Findings

On October 25, 1996, while performing a fill and vent of the Train A spent fuel pool cooling pump, the nuclear station operator noted excessive water leaking from the seal of the pump. After stopping the fill and vent evolution and obtaining assistance from radiation protection personnel, the licensee initiated PIR 96-2756 to document and evaluate this issue. No personnel contaminations occurred, and radiation protection personnel appropriately posted the newly created contaminated area.

During the subsequent investigation, the licensee discovered that the mechanic who replaced the mechanical seal elected to only tighten the seal finger tight and planned to tighten the seal further after the pump alignment. Due to a poor turnover, this information was not conveyed to the oncoming crew and the seal was never completely tightened prior to the fill and vent evolution. Management disciplined the master mechanic who provided the poor turnover to the oncoming crew.

The licensee also identified two approaches for tightening mechanical seals. The first approach tightened the seal upon installation, the second delayed the tightening until after pump alignment. Management decided upon the standard practice for the shop to tighten the seal prior to alignment and attempted to convey this during a recent training class. During the PIR investigation, the licensee determined that this message was not clearly understood by several individuals who attended this training. As a result, management directed the training department to enhance future training on this topic.

c. Conclusions

A poor maintenance turnover and weak training caused the seal leakage. The licensee responded very effectively to the event in limiting the spread of contamination, and in identifying and implementing effective corrective action.

III. Engineering

E2 Engineering Support of Facilities and Equipment

E2.1 Erroneous Operability Determination

a. Inspection Scope (37551)

The inspector reviewed every operability determination requiring engineering support made during the inspection period.

b. Observations and Findings

On November 11, 1996, the turbine building operator identified an oil leak on the governor oil system of the turbine-driven auxiliary feedwater pump. The shift supervisor made an immediate operability determination based on an estimated leak rate evaluation. Later that day, the system engineer provided an operability recommendation after evaluating the leak, its impact on the system, and after discussing the impact of the leak with the call superintendent, a system engineering supervisor, the operations superintendent, and other personnel. The next day, the inspector discussed the leak with the system engineer. When the inspector asked the system engineer what the leaking component was, the system engineer incorrectly identified the leaking component. Oil leaked from fittings on the auxiliary lube oil sump, yet the system engineer referred to the leaking component as the electronic governor, a governor component that sensed the turbine speed and provided an oil pressure error signal to the governor valve controller.

Administrative Procedure ADM 02-024, "Technical Specification Operability," Revision 3, Step 5.3.2, required the licensee to perform a number of actions associated with the operability determination to ensure sufficient scope of review. This step required the licensee to determine what equipment was degraded or potentially nonconforming, the safety functions performed by the equipment, and the circumstances of the potential nonconformance including the possible failure mechanism. Without properly identifying the leaking component, the inspector concluded that these requirements could not have been met.

The inspector determined that the operability evaluation performed by the licensee failed to include all the required actions, in that the licensee did not properly identify the affected component and, therefore, did not determine the impact of the leak on this component. This is a violation of 10 CFR Part 50, Appendix B, Criterion V (482/9623-01).

NRC Inspection Reports 50-482/96-12, -96-11, and -96-09 identified several previous examples where the NRC inspectors identified weakly supported operability determinations. The inspector determined that while the previous examples of weakly supported operability evaluations were not identified as violations of

requirements, they indicated a declining trend in performance. The violation identified in this paragraph was determined to be more significant than the previous examples, in that the licensee performed an operability evaluation without properly identifying the affected component.

c. Conclusions

The inspector concluded that the licensee violated 10 CFR Part 50, Appendix B, Criterion V, when an operability determination failed to comply with the licensee's procedure on operability determinations, in that it failed to properly identify the affected equipment. This example and previous examples identified by NRC inspectors indicated a declining trend in the performance of operability determinations onshift.

E2.2 Review of Updated Safety Analysis Report (USAR) Commitments

A recent discovery of a licensee operating their facility in a manner contrary to the USAR description highlighted the need for a special focused review that compares plant practices, procedures and/or parameters to the USAR descriptions. While performing the inspections discussed in this report, the inspectors reviewed the applicable portions of the USAR that related to the areas inspected. The inspectors verified that the USAR wording was consistent with the observed plant practices, procedures, and/or parameters.

E8 Miscellaneous Engineering Issues (92903)

E8.1 (Closed) Inspection Followup Item 50-482/9302-06: Pressure Locking and Thermal Binding of Safety-Related Power-Operated Gate Valves. This item involved the licensee's efforts to complete reviews of its Generic Letter 89-10 motor-operated valve population for susceptibility to pressure locking and thermal binding and to take corrective actions, where necessary, to ensure valve operability. Subsequently, the NRC issued Generic Letter 95-07, "Pressure Locking and Thermal Binding of Safety-Related Power-Operated Gate Valves." The licensee's response to this generic letter is currently under review by the NRC Office of Nuclear Reactor Regulation. This issue will be fully resolved under Generic Letter 95-07; therefore, this item has been closed.

IV. Plant Support

P1 Conduct of Emergency Planning Activities

P1.1 Emergency Planning Drill

a. Inspection Scope (71750)

The inspectors observed the unannounced off-hours emergency drill of October 30, 1996. The drill was unsuccessful due to late staffing of the technical support center. The licensee issued PIR 96-2258 to address this. This matter will be reviewed during a future inspection as an inspection followup item (482/9623-02).

The inspector observed the operators in the simulator during the drill and noted they used the correct emergency procedures for the situation, paid attention to detail, and maintained a questioning attitude while recovering from the scenario. The inspector noted the operators were concerned with the condition of the plant during the scenario. They were concerned that, because of continued emergency core cooling system operation and as a result of the procedural requirement for the 269°F subcooling prior to returning to normal charging, that pressurizer level would increase until the pressurizer went solid. This would have increased the leak rate through the tube rupture. As a result of previous concerns, the licensee began investigating possible changes to Emergency Procedures EMG C-31, "SGTR With Loss of Reactor Coolant - Subcooled Recovery Desired", and EMG C-32, "SGTR With Loss of Reactor Coolant - Saturated Recovery Desired." The licensee issued Document Revision Requests 96-2449 and 96-2450 to track these changes. The inspector concluded this would adequately address the concern described here.

F1 Control of Fire Protection Activities

F1.1 Diesel Fire Pump Test

a. Inspection Scope (71750)

The inspector observed the performance of a sequential flow test and investigated the licensing basis requirements for operability of the diesel fire pump.

b. Observations and Findings

The licensee performed the annual test of the diesel fire pump using Procedure STN FP-204, "Fire Protection System Flow and Sequential Pump Start", on October 2, 1996. This test required the pump to produce a minimum flow of 3300 gpm with a residual pressure of 80 psig at the underground interface point. The pump failed the test and was declared inoperable. In deciding how to restore the pump to operability, the licensee investigated the possibility of changing the acceptance requirements and did find adequate margin to lower the flow

requirements. Management decided, however, to leave the acceptance requirements alone and perform corrective maintenance on the pump instead. The licensee installed a temporary diesel fire pump in accordance with the fire protection program and reworked the permanent pump to improve its performance. The postmaintenance test on the permanent diesel fire pump was to perform the annual flow test again. The inspector observed performance of Procedure STN FP-204, Revision 10, October 24, 1996.

License Condition 2.C.5 required a fire protection program as described in the USAR. This was described in USAR Section 9.5.1.7 which referred to Table 9.5.1-3 and the licensee's fire protection program document. USAR Section 9.5.1 further stated the fire protection program was an administrative procedure. Procedure AP 10-100, "Fire Protection", Revision 1, described this fire protection program. Step 6.3.2.2.i required Procedure STN FP-204 to perform a flow test in accordance with Chapter 5, Section 11 of the National Fire Protection Association (NFPA) Fire Protection Handbook, 14th edition. In addition, Technical Specification 6.8.1.h required that procedures be established, implemented, and maintained covering fire protection program implementation. Procedures AP 10-100 and STN FP-204 were required by this Technical Specification.

In comparing the performance of Procedure STN FP-204 against these requirements the inspector found five concerns:

1) The NFPA Fire Protection Handbook provided instructions to take pitot tube readings in the center of the flow stream at a distance equal to one half the diameter of the nozzle opening, in this case one inch.
Procedure STN FP-204 contained no such instructions which resulted in different personnel using different methods to take readings during the test. Early in the test the inspector observed test personnel taking readings with the pitot tube instrument directly against the test nozzle. Later, test personnel took readings with the pitot tube held in the flow stream out away from the nozzle. The licensee later learned the proper method only after consulting with fire protection industry experts. The licensee initiated PIR 96-2809 to evaluate the use of pitot tube readings as a method of determining flow.

2) The NFPA Fire Protection Handbook also provided a caution that pitot tube readings less than 10 psi or greater than 30 psi at any open hydrant should be avoided. Procedure STN FP-204 contained no limits on pitot tube readings and the inspector noted that readings taken on October 24 exceeded 30 psi. The observed readings were not taken on open hydrants, but on a test header. The limits were provided in the handbook because of reduced accuracy at higher pressures. With no limits, it would be possible to have pitot tube pressures high enough to cause data errors such that flow would be indicated to be acceptable when in fact it was not. The licensee initiated PIR 96-3065 to investigate these limits.

3) The inspector observed that Pump Discharge Valve 1FP0005B was throttled closed during the test to raise the system pressure. This was allowed by Procedure STN FP-204, however, it would not accomplish the test objective. of providing adequate loop pressure and flow. The licensee initiated Document Revision Request 96-2418 to request procedure changes to remove this practice.

4) Upon restoration from the test, the inspector observed that the electric fire pump, which had been secured during the test, automatically started when restored to service. This was not prohibited by the test procedure, but it was unexpected because test personnel had made extra efforts to increase header pressure just before closing the breaker in order to keep the pump from starting. Upon investigation, the inspector learned that an automatic start signal was sealed-in due to low header pressure after the diesel pump was stopped. This seal-in feature was due to a time delay which had not elapsed when the electric fire pump breaker was closed. This indicated a lack of understanding of the electric fire pump start logic. The licensee initiated Document Revision Request 96-2418 to review this concern.

5) Fire Protection Program Procedure AP 10-100 required Procedure STN FP-204 to perform a flow test in accordance with the NFPA Fire Protection Handbook. However, Procedure STN FP-204 indicated the requirement came from NFPA Standard 20. This situation gave confusing guidance on which requirements were to be implemented by Procedure STN FP-204. The licensee initiated Document Revision Request 96-2418 to review this concern.

c. Conclusions

The decision to perform corrective maintenance on the diesel fire pump instead of reducing the acceptance requirements was appropriate and showed conservative management decision making.

The concerns on diesel fire pump testing suggest a lack of thoroughness in preparing and implementing Procedure STN FP-204 and lack of adherence to the fire protection program. This failure of the licensee to adequately establish and maintain Procedure STN FP-204 as required by the fire protection program is a violation of Technical Specification 6.8.1.h (482/9623-03).

F2 Status of Fire Protection Facilities and Equipment

F2.1 Reactor Coolant Pump Oil Collection System

a. Inspection Scope (71750)

The inspector reviewed the licensee's response to NRC Information Notice 94-58, "Reactor Coolant Pump Lube Oil Fire."

b. Observations and Findings

The licensee initiated Industry Technical Information Program Report 02805 in response to NRC Information Notice 94-58. This report concluded that major leaks would be collected appropriately and directed to the oil collection system, but that minor leaks, such as those identified during Refueling Outage VII from the resistance temperature detector terminal box, could occur. The evaluation further concluded that these minor leaks were essentially negligible, and that no additional actions were necessary. However, the report also recommended that reactor coolant pumps be inspected each outage, and if leaks continued to occur, it recommended the addition of drip pans with the leakage conveniently routed to the oil collection system.

The licensee did not track this recommendation and initiated PIR 96-3133 on December 2, 1996, to address this concern. In addition, engineering personnel used PIR 96-3133 to track the initiation of Industry Technical Information Program Report 03547 associated with the containment fire at Arkansas Nuclear One as described in INPO Operating Plant Experiences 8123, "Fire in Containment Building During Heatup Following Refueling Outage," November 18, 1996, and Licensee Event Report 50-313/96-009.

The inspector asked the system engineer how they met the requirements of 10 CFR Part 50, Appendix R, given the leakage identified during Refueling Outage VII. The engineer responded that 10 CFR Part 50, Appendix R refers to flanges and fittings, and any leakage from these are collected and routed to the oil collection system. Leakage from the terminal box they viewed as beyond the scope of 10 CFR Part 50, Appendix R.

c. Conclusions

The inspector will review this issue during a future inspection after PIR 96-3133 and Industry Technical Information Program Report 03547 are closed. This will be tracked as an inspection followup item (482/9623-04).

V. Management Meetings

X1 Exit Meeting Summary

The inspectors presented the inspection results to members of licensee management at the conclusion of the inspection on December 3, 1996. The licensee acknowledged the findings presented. Some licensee staff members expressed disagreement with the violation associated with the operability determination for the turbine-driven auxiliary feedwater pump discussed in Section E2.1 of this report. The licensee asserted that since the actual operability determination was correct, and the engineer properly identified that the leak was on the governor oil system, it was not necessary to correctly identify the actual subcomponent in order to comply with Procedure ADM 02-024. The licensee also stated that the small size of the leak made proper identification of the location irrelevant.

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

ATTACHMENT 1

SUPPLEMENTAL INFORMATION

PARTIAL LIST OF PERSONS CONTACTED

Licensee

G. D. Boyer, Director of Site Support
N. S. Carns, President and Chief Executive Officer
C. W. Fowler, Manager, Integrated Plant Scheduling
O. L. Maynard, Chief Administrative Officer
B. T. McKinney, Plant Manager
R. Muench, Vice President Engineering
W. B. Norton, Manager, Performance Improvement and Assessment
C. C. Warren, Chief Operating Officer

ITEMS OPENED, CLOSED, AND DISCUSSED

INSPECTION PROCEDURES USED

IP 37551	Onsite Engineering
IP 61726	Surveillance Observations
IP 62707	Maintenance Observations
IP 71707	Plant Operations
IP 71750	Plant Support Activities
IP 92903	Followup - Engineering

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

9623-01	VIO	Erroneous operability determination (Section E2.1)
9623-02	IFI	Emergency planning exercise (Section P1.1)
9623-03	VIO	Diesel fire pump test (Section F1.1)
9623-04	IFI	Reactor coolant pump oil collection system (Section F2.1)

Opened and Closed

50-482/9623-05	NCV	Inadvertent dilution due to an inadequate procedure (Section M3.1)

Closed

50-482/9302-06	IFI	Pressure locking and thermal binding on safety-related power-operated gate valves (Section E8.1)