

ENCLOSURE

U.S. NUCLEAR REGULATORY COMMISSION
REGION IV

Docket No.: 50-416
License No.: NPF-29
Report No.: 50-416/98-11
Licensee: Entergy Operations, Inc.
Facility: Grand Gulf Nuclear Station
Location: Waterloo Road
Port Gibson, Mississippi 39150
Dates: August 9 through September 19, 1998
Inspectors: Jennifer Dixon-Herrity, Senior Resident Inspector
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Approved By: Joseph Tapia, Chief, Project Branch A
Attachment: Supplemental Information

EXECUTIVE SUMMARY

Grand Gulf Nuclear Station NRC Inspection Report 50-416/98-11

This inspection included aspects of licensee operations, maintenance, engineering, and plant support. The report covers a 6-week period of resident inspection.

Operations

- Control room operator performance during normal operations and during a minor event was very good. Operations personnel exhibited good oversight and effective communications. The immediate response to the air leakage event of reducing power to 80 percent was acknowledged as a conservative decision that effectively used lessons learned from industry events. The observation made by the reactor operator of the change in trend of the air pressure in the drywell was identified as good attention to detail and an example of a good questioning attitude (Section O1.4).
- Equipment availability, material condition, and housekeeping were found to be very good during plant tours. The inspectors identified an example where attention to detail on the part of operators on tour could be improved, in that operators had not identified indicating lights that were out on the local emergency diesel control panels on two separate occasions (Section O2.1).

Maintenance

- The eight maintenance and testing activities observed were properly performed with one exception. The licensee conducted repairs on the safeguards switchgear and battery room air handling unit sheave twice after finding it failed before repairing the equipment properly. The inspectors identified an example where the vendor manuals did not contain guidance for equipment repair and the licensee's work package did not provide sufficient detailed guidance to perform the task (Section M1.4).
- Train B of the residual heat removal system was properly maintained and aligned to satisfy Technical Specification requirements (Section M2.1).

Engineering

- The engineering evaluation conducted in response to a 10 CFR Part 21 Notification on potential inoperability of the diesel engines was thorough and well performed (Section E4.1).

Plant Support

- Observed activities involving radiological controls and security were performed in a professional manner (Sections R1.1 and S1).

- During the third quarter emergency preparedness training drill, licensee staff demonstrated good performance in the control room simulator, improved performance in the technical support center, and improved communications between the control room, the technical support center, and the operations support center (Section P4.1).
- The third quarter emergency preparedness training drill showed noticeable improvement over the second quarter training drill with respect to licensee's self-critique process. Personnel were self-critical and identified a number of programmatic and performance problems (Section P4.2).

Report Details

Summary of Plant Status

The plant operated at 100 percent power until September 12, 1998, when the licensee lowered power to 50 percent to repair a seal on main circulating water Pump B. The licensee returned the plant to 100 percent power on September 13, 1998. The plant operated at 100 percent power until September 14, 1998, when the licensee lowered power to 5 percent in response to increasing pressure in the drywell as a result of an instrument air leak. The licensee conducted repairs and returned the plant to 100 percent power on September 18, 1998, and remained there through the end of the inspection period.

I. Operations

O1 Conduct of Operations

O1.1 Control Room Observations

a. Inspection Scope (71707)

The inspectors routinely observed the conduct of operations in the control room. Frequent reviews of control board status, observations of operator performance, and reviews of control room logs and documentation were performed.

b. Observations and Findings

During routine observations and interviews, the inspectors determined that the control room operators were continually aware of existing plant conditions. Operators responded to annunciator alarms in accordance with approved procedures and demonstrated good three-way communications. Operations shift turnovers were thorough and conducted professionally. Operators were knowledgeable of the status of equipment, and applicable Technical Specification limiting conditions for operations were appropriately documented. The control room operators controlled ongoing surveillance activities well. The inspectors verified that safety-related systems were aligned in accordance with Technical Specification requirements.

O1.2 Scheduled Downpower to Repair Main Circulating Water Pump Seal

a. Inspection Scope (71707)

On September 12, 1998, the plant conducted a downpower for a planned control rod pattern exchange, control rod scram time testing, corrective maintenance to steam plant components, and repairs to the seal on main circulating water Pump B. The inspectors observed the downpower evolution in the control room.

b. Observations and Findings

The control room supervision maintained positive control of all planned evolutions and conducted pre-evolution briefs before all major activities. Periodic briefs were used to keep the operating crew aware of plant status and maintenance activities. Operations crew personnel conducted all activities according to plan using approved procedures, specific guidance, and support from reactor engineering. All reactivity control evolutions were performed using peer review and self-checking techniques. All control rod activities were directly supervised by the plant supervisor and verified by a second licensed operator.

O1.3 Unexpected Pressure Increase in the Drywell

a. Inspection Scope (71707)

The inspector observed the actions taken in the control room and the troubleshooting and mitigation efforts conducted by the licensee in response to an unexpected pressure increase in the drywell.

b. Observations and Findings

On September 14, 1998, while conducting rounds, a licensed operator identified that the drywell pressure was slowly increasing. The drywell pressure was normally stable at approximately 0.1 psig and was noted to have slowly increased to 0.3 psig. The operator discussed the concern with control room supervision and power was lowered to 80 percent. The operators were concerned that the increase in drywell pressure was due to leaking instrument air and could result in the closure of the main steam isolation valves. Operations personnel in the control room immediately assumed the positions that would be taken during an emergency response until the suspected cause of the drywell pressure increase was identified. Through evaluation of a computer trend, personnel noted that the instrument air supply pressure indicated a drop at the same time that the pressure in the drywell started increasing. The drywell was vented to the containment which was then vented through filters to the atmosphere. The operators performed this task approximately every 35 minutes as the drywell pressure approached .5 psig (the plant was designed to automatically shut down at 1.23 psig drywell pressure) as a compensatory action until the root cause of the problem could be identified and repaired.

Engineering personnel reported immediately to the control room to assist with the troubleshooting effort. After identifying the instrument air supply lines to the drywell, the licensee conducted a meeting to determine an action plan to identify and repair the leak. After entering containment, personnel were able to verify that the leak was in the drywell due to the increased flow on an air regulator on the line going into containment. The indicated flow was 270 scfm rather than the normal 120 to 180 scfm that had been trended in the past.

Operations personnel lowered power to approximately 5 percent in a controlled manner to allow entry into the drywell. The team found that the solder had failed on a 90 degree elbow in the supply line to the inboard drywell purge isolation valve. The elbow and the attached line had been forced up away from the fitting. Maintenance personnel took pictures of the failed area and replaced the elbow. Prior to exiting the drywell, licensee personnel completed the tour of the drywell to verify that there were no additional air leaks. Operations personnel returned the plant to 100 percent power.

The licensee plans to conduct a root cause analysis of the failure. The elbow had been installed in the plant since construction and was oblongated on the side that failed. The licensee observed that the flow through the regulator, which measured instrument air flow into the drywell, decreased to below 10 scfm after the repair. This indicated that the elbow had been leaking since before the regulator was installed in 1995.

O1.4 Conclusions to Conduct of Operations

Control room operator performance during normal operations and during a minor event was very good. Operations personnel exhibited good oversight and effective communications. The immediate response to the air leakage event of reducing power to 80 percent was acknowledged as a conservative decision that effectively used lessons learned from industry events. The observation made by the reactor operator of the change in trend of the air pressure in the drywell was identified as good attention to detail and an example of a good questioning attitude. With the exception of the discussion in Section R1.1, all activities involved with the troubleshooting effort were well planned and conducted in accordance with the plan.

O2 **Operational Status of Facilities and Equipment**

O2.1 Plant Tours

a. Inspection Scope (71707)

The inspectors routinely toured the accessible portions of the plant containing safety and risk significant structures, systems, and components. The inspectors performed a general walkdown of the Train C reactor core isolation cooling and residual heat removal systems.

b. Observations and Findings

The inspectors found that plant equipment was maintained in very good material condition. Plant housekeeping and area lighting were good. The systems reviewed during the general walkdown were correctly aligned and in good condition. During a tour of the diesel rooms on August 17, 1998, the inspectors noted that the indicating lights were out for lockout relays on the local diesel control panels for both Division I and II diesels. The inspectors discussed whether the lights should be lit with the shift superintendent who then had auxiliary operators check the panels. The operators found that the indication lights for two lockout relays and one compressor were burned out.

The lights provided an indication function only and did not affect diesel operability. On August 25, 1998, the inspectors noted that the light for one lockout relay and two lights on the compressor control panel were out and notified the control room. Operators verified that the bulbs were burned out and changed the bulbs. The inspector discussed why operators had not identified these burned out lights during operator rounds with the shift superintendent and the operations superintendent. Operations supervision provided training to the auxiliary operators on the need to check the lights and initiated Condition Report 1998-0927 to identify the high burnout rate for this type of bulb.

c. Conclusions

Equipment availability, material condition, and housekeeping were found to be very good during plant tours. The inspectors identified an example where attention to detail on the part of operators on tour could be improved, in that operators had not identified indicating lights that were burned out on the local emergency diesel control panels on two separate occasions.

07 Quality Assurance in Operations

07.1 Licensee Self-Assessment Activities (71707)

During the inspection period, the inspectors reviewed multiple licensee self-assessment activities. Three plant safety review committee meetings and the condition reports generated during the inspection period were included. The inspectors determined that the effects on plant safety and reportability were correctly evaluated and that the need for a root cause determination was identified where required by procedures. The inspectors reviewed several closed condition reports and noted that the corrective actions effectively addressed the concerns. The three plant safety review committee meetings were held to address revisions to safety-related procedures and the corrective action plan for the repair of the instrument air line in the drywell. The committee members exhibited a good understanding of the concerns addressed and asked pertinent questions about the changes and the actions being taken with regard to the Updated Final Safety Analysis Report (UFSAR) and the Technical Specifications. The inspectors concluded that the self-assessment activities reviewed were effective.

08 Miscellaneous Operations Issues (92901)

08.1 (Closed) Violation 50-416/9805-02: Failure to follow Diesel System Operating Procedure. This item involved the inspectors finding the Division 1 standby diesel generator local control cabinet doors open and unattended, causing the diesel to be technically inoperable. The licensee identified the apparent cause as a failure to comply with the system operating instruction. The long-term corrective action was to reinforce the need to ensure the doors were closed with the auxiliary operators. To further enforce the training, the operator rounds were revised to specifically check the cabinet doors, rather than relying on the general area checks that called for this action previously. The inspectors determined that the corrective actions addressed the concerns.

O8.2 (Closed) Licensee Event Report 98-002: Failure to maintain standby diesel generator seismically qualified as required by Technical Specifications. This item was discussed in Section O8.1.

II. Maintenance

M1 Conduct of Maintenance

M1.1 General Maintenance Comments

a. Inspection Scope (62707)

The inspectors observed portions of maintenance activities, as specified by the following work orders:

- 209735 High pressure core spray jockey pump coupling preventive maintenance
- 202138 High pressure core spray motor oil sample and change
- 212470 Replacement/troubleshooting of reactor protection system Train B fuse
- 212474 High pressure core spray pump breaker stab receptacle replacement
- 212445 Safeguards switchgear and battery room air handling unit sheave replacement

b. Observations and Findings

All work observed was well performed and conducted in accordance with the instructions and procedures provided in the work packages. With the exception of the concern discussed in Section M1.3, the technicians performing the tasks were knowledgeable of the equipment and used good work practices. The inspectors observed that the technicians adhered to electrical safety precautions and that the interiors of cabinets were clean and in good condition.

M1.2 General Surveillance Comments

a. Inspection Scope (61726)

The inspectors observed the performance of portions of the following tests and surveillances:

- Surveillance 06-OP-1C71-Q-0001-TEMP1, "MSIV Closure Functional Test"
- Surveillance 06-OP-1T48-M-0002, "Standby Gas Treatment B Operability"
- TSTI 1P73-98-006-O-N, "Injection of Oxygen into Offgas System"

b. Observations and Findings

The inspectors noted that the test procedures provided clear guidance and properly implemented Technical Specification requirements. Measuring and test equipment was verified to be within its current calibration cycle. Instrumentation was properly removed and returned to service. The operators and technicians were knowledgeable and qualified. As-found test data was within the tolerance established for the equipment. Personnel involved demonstrated good communications and attention to detail.

M1.3 Safeguards Switchgear and Battery Room Air Handling Unit Failure

The inspectors observed as the sheave and belts on the safeguards switchgear and battery room air handling Unit 2Z77B001B were replaced on August 26, 1998. The work was completed in accordance with procedures. The inspectors reviewed the history of the failure and learned that on August 19, 1998, maintenance personnel discovered that the belts and sheave on the air handling unit had failed. Maintenance personnel replaced the sheave and belts on August 21, 1998. After returning the unit to service, the belts were found broken on August 22, 1998, and replaced. On August 25, 1998, personnel found the sheave and belts broken again.

The inspectors reviewed the work instructions documented in the work package for the two sheave replacements. During the first sheave replacement, the directions provided were to replace the sheave (no further details were provided) and to check the fan speed and vibration after the work was complete. During the second sheave replacement, the licensee had contacted the vendor. The instructions used were detailed instructions provided with the sheave. Guidance was also provided for performing vibration and alignment checks immediately after the work was complete, after 8 hours of run time and, again, after 24 hours of run time. The licensee initiated Condition Report 1998-0893 on August 19, 1998, to document the initial failure and conduct a root cause analysis. The inspectors reviewed the vendor manual and found that it did not contain guidance for replacing the sheave or for conducting any type of overhaul activity.

The inspectors discussed the activity with a mechanical maintenance supervisor. The supervisor explained that the licensee had discovered that the sheave originally installed in the air handling unit was not the same size as that in the other three trains. As a result, the fan turned at a slower speed. In April 1998, the licensee replaced the original sheave with the same type sheave used in the other trains. No further work or adjustments were made at the time, beyond verifying the fan speed and checking for vibration. The supervisor identified a number of potential root causes that would be reviewed, including the setpoints for the temperature switches which turn the unit on and off, the original sheave change out, and the maintenance practices used to replace the

sheaves. The supervisor explained that this was the first time that they had performed anything more than preventive maintenance on the units.

M1.4 Conclusions on Conduct of Maintenance

The eight maintenance and testing activities observed were properly performed, with one exception. The licensee conducted repairs on the safeguards switchgear and battery room air handling unit sheave twice after finding it failed before repairing the equipment properly. The vendor manual did not contain guidance for equipment repair and the licensee's work package did not provide sufficient detailed guidance to perform the task.

M2 Maintenance and Material Condition of Facilities and Equipment

M2.1 Engineered Safety Feature System Walkdown

a. Inspection Scope (71707)

The inspectors performed detailed system walkdowns of the accessible portions of the Train B Residual Heat Removal system. The inspectors verified proper valve, control board, remote shutdown panel, and electrical alignment in accordance with System Operating Procedure 04-1-01-E12-1 and Piping and Instrument Diagrams (P&ID) M-1085A & B.

b. Observations and Findings

The inspectors found that the system was properly aligned to assure system operability in accordance with the applicable procedure and P&IDs and that the alignment satisfied Technical Specification and UFSAR requirements. Major components were properly labeled, lubricated, and free of identifiable leakage.

The inspectors identified minor discrepancies in the system manual valve lineup checksheet. The actual valve location and locked valve status that did not agree with the P&ID. The discrepancies were reported to the operations department for correction.

c. Conclusions

Train B of the residual heat removal system was properly maintained and aligned to satisfy Technical Specification requirements.

III. Engineering

E4 Engineering Staff Knowledge and Performance

E4.1 Standby Diesel Generator Operability

a. Inspection Scope (37551)

The inspectors reviewed the engineering operability evaluation conducted in response to a 10 CFR Part 21 Notification titled "Enterprise DSR-4 and DSRV-4 Emergency Diesel Generator Starting Air Pressure Switch."

b. Observations and Findings

The notification described the potential for nonessential automatic safety shutdowns to be reactivated after an emergency start if the starting air tank pressure fell below the pressure switch low pressure limit. The licensee immediately initiated Condition Report 1998-0910 to document the concern. The system engineer reviewed the logic and found that the identified concern did not apply. The inspectors reviewed the licensee's evaluation, the Class 1E start circuit logic diagram for the diesels, and the information provided in the notification. The inspectors noted that the pressure switch that would open upon sensing low pressure in the air start tanks was not in line with the solenoid that deactivated the nonessential automatic safety shutdowns.

The system engineer identified a potential for the diesels to trip if starting air decreased to less than 40 psig due to loss of pneumatic control. The engineer detailed compensatory actions already in place to address this potential concern. The described event would require the failure of a trip parameter, the failure of the motor-driven air compressor, and the failure of operators to respond to alarm response instructions. In this case, an alarm would sound in the control room when the tank pressure decreased below 200 psig and existing procedures would require operators to start the diesel driven air compressor. The diesel driven air compressor would return the air storage tanks to the correct pressure and prevent the diesels from tripping. The engineer stated that the condition report would remain open to allow further review of the latter issue and the identification of additional potential corrective actions.

c. Conclusions

The engineering evaluation conducted in response to a 10 CFR Part 21 Notification on potential inoperability of the diesel engines was thorough and well performed.

E8 Miscellaneous Engineering Issues (92903)

E8.1 (Closed) Inspection Followup Item 50-416/9809-01: Design basis for control room air conditioning. This item was opened to review the difference between the description of the control room air conditioning system in the UFSAR and procedure changes that resulted from a design problem identified with the system in July 1989. As a result of

the design problem, personnel are required to align a manual valve in the standby service water system to allow the system to perform its design function following a loss of instrument air or a loss of offsite power coincident with a loss of a coolant accident. The UFSAR description does not include manual action outside of the control room. The inspector discussed the concern with licensing personnel responsible for updating the UFSAR who explained that the engineers were not aware that the UFSAR contained the statement that all instrumentation and controls for the heating, ventilation, and air conditioning system are designed for automatic operation with manual starting of the fans and that the alarms and manual controls for the fans are located in the control room. As a result, the UFSAR was not changed in 1989. The inspectors considered that the current off-normal procedure for loss of instrument air provides adequate direction to assure proper system operation, and that the licensee currently plans to modify the system to eliminate the operator workaround.

IV. Plant Support

R1 Radiological Protection and Chemistry Controls

R1.1 General Comments (71750)

The inspectors made frequent tours of the radiological controlled area and observed radiological postings and worker adherence to protective clothing requirements. Locked high radiation doors were properly controlled, high radiation and contamination areas were properly posted, and personnel were following procedures. The inspectors observed that survey maps reviewed were posted and up-to-date. Observed activities involving radiological controls were performed in a professional manner.

R4 Staff Knowledge and Performance in Radiological Protection and Chemistry Controls

R4.1 Use of Neutron Monitor

a. Inspection Scope (71750)

The inspectors discussed the radiation concerns and the radiation protection plans developed in response to the required entry into the drywell and followed up on licensee identified concerns involving the surveys conducted in response to the plans.

b. Observations and Findings

The licensee identified that the technician using a neutron monitor to conduct the survey prior to entry into the drywell had the monitor in the incorrect setting during a portion of the survey. The monitor was inadvertently changed to the dose setting rather than the dose rate setting. As a result of this error, the technician identified a dose rate of 1 to 2 mrem per hour rather than the actual 800 mrem per hour. Both the incorrect dose rate and historical dose rates encountered in the areas were used during prejob briefings to inform workers of the radiological hazards in the job area. During a later

entry, radiation protection technicians using the same monitor recognized the error that had been made and assessed the situation. The total dose received by personnel as a result of the error was less than the prejob estimations, and there were no overexposures. The licensee documented the event in Condition Report 1998-0962, voluntarily reported the event to Region IV NRC personnel, and planned to conduct a root cause determination for the incident. This issue, which may represent a violation of NRC requirements, will remain open for a reasonable time to allow the licensee to develop its corrective actions (EEI 50-416/9811-01).

c. Conclusions

The licensee identified that a radiation protection technician incorrectly used a neutron monitor during a radiological survey of the drywell, resulting in providing incorrect dose information to radiation workers during prejob briefings. Although this had the potential to allow workers to accrue more dose than expected or allowed, no negative consequence resulted.

P4 Staff Knowledge and Performance in Emergency Preparedness

P4.1 Third Quarter Training Drill

a. Inspection Scope (71750)

On August 26, 1998, the inspectors observed and evaluated the control room and technical support center staffs as they performed tasks necessary for response during the third quarter training drill. These tasks included staffing and activation, accident assessment and mitigation strategies, event classification, facility management and control, internal and external communications, assistance and support to other emergency response facilities, and prioritization of response activities for accident mitigation. The inspectors reviewed applicable emergency plan sections, checklists, and logs.

b. Observations and Findings

The personnel in the technical support center and the control room met all of the objectives the licensee identified for the observed drill. The inspectors noted that personnel were aware of their responsibilities and carried out those responsibilities well. The controllers in this drill were noted to be more involved in the training aspect of the drill and in ensuring that the scenario went according to plan. The inspectors observed as controllers stepped in unobtrusively to provide guidance to players on their job responsibilities and on the scenario when things went wrong. The inspectors noted that the licensee had provided the controllers and evaluators for the drill with training on the licensee's expectations and their responsibilities before the drill began.

The inspectors noted several concerns that were not addressed during the licensee's self-critique. The control room simulator was not prepared to provide the trainees with all of the information that would normally be available in that charts used in the control

room, such as the Technical Specification tracking board, had been left blank. In addition, the inspectors noted that the players immediately staged themselves in the positions they would take during response to an accident before the drill began. During the drill, the control room simulator crew operated residual heat removal Pump A on minimum flow for approximately 3 1/2 hours while waiting for the failed closed low pressure coolant injection valve to be manually opened. This was in conflict with System Operating Procedure 04-1-01-E12-1, "Residual Heat Removal System," Revision 107, Precaution 3.2.1, to "limit the time an RHR pump runs on minimum flow as much as possible, normally not to exceed one hour" and with Emergency Procedure 05-S-01-EP-3, "Containment Control," Revision 25, direction to operate all available Suppression Pool Cooling using those RHR pumps not available for or required to assure adequate core cooling when suppression pool temperature is above 95°F.

c. Conclusions

During the third quarter emergency preparedness training drill, licensee staff demonstrated good performance in the control room simulator, improved performance in the technical support center, and improved communications between the control room, the technical support center, and the operations support center.

P4.2 Licensee Self-Critique

a. Inspection Scope

The inspectors observed and evaluated the licensee's end-of-drill facility critique in the control room, the technical support center, as well as the controller and evaluator critique on August 27, 1998, to determine whether the process would identify and characterize weak or deficient areas in need of corrective action.

b. Observations and Findings

The end-of-drill critiques in the TSC and simulator were open and self-critical; a number of good issues were discussed. The controller and evaluator critique demonstrated improved performance over the second quarter training drill. The discussions were open and self-critical, identifying several areas for improvement for all of the emergency preparedness facilities. These included areas for improvement in tracking the repair team activities in the control room, in communications between the different facilities, and in the use of engineering in the different facilities.

c. Conclusions

The third quarter emergency preparedness training drill showed noticeable improvement over the second quarter training drill with respect to the licensee's self-critique process. Personnel were self-critical and identified a number of programmatic and performance problems.

S1 Conduct of Security and Safeguards Activities

S1.1 General Comments (71750)

On a daily basis, the inspectors observed the practices of security personnel and the condition of security equipment. Protected and vital area barriers were in good condition. The isolation zones were free of obstructions and the protected area illumination levels were good. The inspectors concluded that the daily security activities were conducted in a professional manner.

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 September 23, 1998. The licensee acknowledged the findings presented.

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

ATTACHMENT

PARTIAL LIST OF PERSONS CONTACTED

C. Bottemiller, Superintendent, Plant Licensing
W. Cade, Assistant, Operations
W. Eaton, Vice President of Operations
C. Ellsaesser, Manager, Performance and System Engineering
C. Lambert, Director, Nuclear Plant Engineering
C. Morgan, Manager, Emergency Planning
J. Roberts, Director, Quality Programs
C. Stafford, Acting Manager, Plant Operations
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INSPECTION PROCEDURES USED

IP 37551: Onsite Engineering
IP 61726: Surveillance Observations
IP 62707: Maintenance Observation
IP 71707: Plant Operations
IP 71750: Plant Support Activities
IP 92901: Followup - Plant Operations
IP 92903: Followup - Engineering

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

50-416/98811-01 EEI Incorrect use of Neutron Monitor (Section R4.1)

Closed

50-416/9805-02 VIO Failure to follow Diesel System Operating Procedure (Section O8.1)

50-416/98-002 LER Failure to maintain standby diesel generator seismically qualified as required by Technical Specifications (Section O8.2)

50-416/9809-01 IFI Design Basis for Control Room Air Conditioning (Section E8.1)