

ENCLOSURE

U.S. NUCLEAR REGULATORY COMMISSION
REGION IV

Docket No.: 50-483
License No.: NPF-30
Report No.: 50-483/98-22
Licensee: Union Electric Company
Facility: Callaway Plant
Location: Junction Highway CC and Highway O
Fulton, Missouri
Dates: September 27 through November 14, 1998
Inspectors: D. G. Passehl, Senior Resident Inspector
F. L. Brush, Resident Inspector
Approved By: David N. Graves, Acting Chief, Project Branch B

ATTACHMENT: Supplemental Information

EXECUTIVE SUMMARY

Callaway Plant NRC Inspection Report 50-483/98-22

Operations

- In violation of Technical Specification 6.8.1.a, a reactor operator failed to properly implement the procedure for raising pressure in safety injection accumulator Tank C. As a result, the accumulator was inoperable for approximately 15 minutes. The licensee discussed the event with the operator, identified procedure and labeling enhancements, and proposed additional corrective actions. This nonrepetitive, licensee-identified and corrected violation is being treated as a noncited violation, consistent with Section VII.B.1 of the NRC Enforcement Policy (Section O4.1).

Maintenance

- Overall, observed material condition and housekeeping were very good. The licensee corrected a material condition concern regarding high temperature on a main transformer bushing. No significant material condition concerns arose during the plant power reduction and subsequent increase. The licensee also identified a material condition deficiency regarding degradation of essential service water Pump A and initiated appropriate corrective actions (Section M2.1).
- The licensee's actions and justification for performing partial testing of the emergency diesel generator load shed and emergency load sequencer circuit in Mode 1 versus "At least once per 18 months, during shutdown" were appropriate. This closes Unresolved Item 50-483/97015-01. The licensee also reported the failure to perform adequate testing within the required time in Licensee Event Report 50-483/97005-02. This report will be reviewed during a future inspection (Section M8.1).
- There were multiple examples of a violation of Technical Specification surveillance requirements as a result of surveillances conducted while on-line instead of "At least once per 18 months during shutdown" and subsequent plant mode changes made while relying on those surveillances. The licensee failed to perform these surveillances while shut down as a result of an incorrect surveillance data base. This nonrepetitive, licensee-identified and corrected violation is being treated as a noncited violation, consistent with Section VII.B.1 of the NRC Enforcement Policy (Section M8.2).

Engineering

- The licensee aggressively monitored and pursued solutions for the axial offset anomaly. The licensee formed a task team to address options to improve axial offset and conserve shutdown margin (Section E1.1).

Plant Support

- Observations of radiation worker radiological protections practices indicated good adherence to established practices, although radiological survey maps were not posted outside some rooms in the radwaste building, contrary to licensee management expectations (Section R1.1).

Report Details

Summary of Plant Status

The plant began the report period September 27, 1998, at 100 percent power. On October 22, 1998, operators reduced reactor power to 90 percent because of degradation of the main transformer Phase B neutral ground bushing. On October 23, 1998, operators reduced reactor power to 7 percent to allow workers to repair the bushing. By October 25, 1998, workers successfully completed repairs and operators returned the reactor to 100 percent power.

I. Operations

O1 Conduct of Operations

O1.1 General Comments (71707)

The inspectors conducted frequent reviews of ongoing plant operations. In general, the conduct of operations was professional and safety-conscious. Plant status, operating problems, and work plans were appropriately addressed during daily turnover and plan-of-the-day meetings. Plant testing and maintenance requiring control room coordination were properly controlled. The inspectors observed several shift turnovers. No problems were noted.

O2 Operational Status of Facilities and Equipment

O2.1 Review of Equipment Tagouts (71707)

The inspectors walked down the following tagouts:

- Workman's Protection Assurance 28397 - Residual Heat Removal Pump B,
- Workman's Protection Assurance 27872 - Safeguards Transformer B, and
- Workman's Protection Assurances 28491, 28493, and 28498 - Emergency Diesel Generator B.

The inspectors did not identify any discrepancies. The tagouts were properly prepared and authorized. All tags were on the correct devices and the devices were in the position prescribed by the tags.

O2.2 Engineered Safety Feature System Walkdowns (71707)

The inspectors walked down accessible portions of the following engineered safety features and vital systems:

- Auxiliary Feedwater System Trains A, B, and T and
- Emergency Diesel Generators A and B.

Equipment operability, material condition, and housekeeping were acceptable.

O4 Operator Knowledge and Performance

O4.1 Safety Injection Accumulator Tank C Pressure Decreased Below Minimum Technical Specification Value

a. Inspection Scope (71707)

On October 8, 1998, a reactor operator inadvertently opened a valve that caused pressure in safety injection accumulator Tank C to decrease below the minimum required value. The inspectors reviewed:

- Suggestion-Occurrence-Solution Report 98-3588, and
- Normal Operating Procedure OTN-EP-00001, "Accumulator Safety Injection System," Revision 13.

b. Observations and Findings

The reactor operator was using Section 4.4 of Procedure OTN-EP-00001 to raise pressure in safety injection accumulator Tank C. While intending to open the safety injection accumulator Tank C nitrogen supply control Valve EPHV8875C, the operator incorrectly opened safety injection accumulator Tank C fill line isolation Valve EPHV8878C. The error was not apparent until the operator opened safety injection accumulator tanks' nitrogen supply control Valve EPHV8880. Pressure did not increase as expected. Procedure OTN-EP-00001, Step 4.4, stated to open Valve EPHV8875C prior to opening Valve EPHV8880.

Valve EPHV8880 supplies nitrogen to all four accumulator tanks. This supply branches into four parallel supply paths, one for each accumulator tank. Valve EPHV8875C controls the nitrogen supply to accumulator Tank C. The safety injection pumps supply borated water to fill the accumulator tanks through a similar piping arrangement. Valve EPHV8878C controls the borated water supply to accumulator Tank C.

Upon noting no pressure increase, the reactor operator closed Valve EPHV8880. The operator reviewed previous actions and identified the opening of Valve EPHV8878C instead of Valve EPHV8875C. The operator closed Valve EPHV8878C, reviewed the procedure, and noted a caution at Step 4.4.4. The caution stated that the relief valve on the main nitrogen supply line will lift if the individual accumulator supply valve (Valve EPHV8875C) is closed before Valve EPHV8880 is closed. The operator believed that the caution did not apply since Valve EPHV8875C was not yet opened.

The operator resumed the procedure and opened Valve EPHV8875C and then Valve EPHV8880. The operator displayed a computer point for pressure in accumulator Tank C and identified a decreasing trend. The operator closed Valve EPHV8880 and Valve EPHV8875C. Pressure in accumulator Tank C became stable at 597 psig. The minimum value required by Technical Specification 3.5.1 was 602 psig. The licensee declared the accumulator inoperable.

The oncoming senior reactor operator crew discussed the event with the reactor operator. The group determined the cause of the pressure decrease to be the lifting of the safety injection accumulator tanks' nitrogen supply header pressure relief Valve EP8857. This valve is located downstream of Valve EPHV8880 in the main nitrogen supply flow path. The licensee determined that accumulator Tank C pressure was vented out the relief valve. The licensee determined that the valve lifted with Valve EPHV8880 open and Valve EPHV8875C closed. The opening of Valve EPHV8875C allowed the accumulator nitrogen to vent through the relief valve. The relief valve subsequently closed.

Following discussions, the crew successfully pressurized the accumulator tank and declared the accumulator operable. The licensee determined the accumulator to be inoperable for 15 minutes. The allowed outage time was 24 hours. The licensee initiated an investigation of the event using Suggestion-Occurrence-Solution Report 98-3588.

The licensee identified the cause to be personnel error and discussed the error with the reactor operator. In addition, the licensee identified the following corrective actions:

- Using temporary "stop/think" covers around switches operated to pressurize accumulator tanks,
- Adding a note to Procedure OTN-EP-00001 stating to use a peer check to verify correct lineup,
- Evaluating a different color scheme (possibly green) on the main control board for valves controlling the nitrogen supply,
- Evaluating piping configuration and controller setpoints for the nitrogen supply flowpath, and
- Evaluating improvements to the leak tightness of the system.

The inspectors agreed with the licensee's findings. The inspectors also determined that the reactor operator did not discuss the initial failure to raise pressure with the control room supervisor. This did not meet management expectations.

Technical Specification 6.8.1.a requires, in part, that written procedures shall be established, implemented, and maintained covering the applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978. Regulatory Guide 1.33, Section 3.d, includes procedures for the emergency core cooling system. The inspectors considered the failure to properly implement Procedure OTN-EP-00001, by opening Valve EPHV8875C prior to Valve EPHV8880, a violation of Technical Specification 6.8.1.a. This nonrepetitive, licensee-identified and corrected violation is being treated as a noncited violation, consistent with Section VII.B.1 of the NRC Enforcement Policy (50-483/98022-01).

c. Conclusions

In violation of Technical Specification 6.8.1.a, a reactor operator failed to properly implement the procedure for raising pressure in safety injection accumulator Tank C. As a result, the accumulator was inoperable for approximately 15 minutes. The licensee discussed the event with the operator, identified procedure and labeling enhancements, and proposed additional corrective actions. This nonrepetitive, licensee-identified and corrected violation is being treated as a noncited violation, consistent with Section VII.B.1 of the NRC Enforcement Policy.

O4.2 Tagout of Safeguards Transformer B

a. Inspection Scope (71707)

The inspectors attended the prejob briefing and observed equipment operators performing portions of Special Operating Procedure OTS-MD-0003, "Fast Transfer of XNB01 Power Supply at Power," Revision 1. This was for a worker protection tagout in preparation for planned maintenance on safeguards Transformer B.

b. Observations and Findings

The inspectors observed the licensee transfer the power supply for vital bus Transformer XNB01 from the normal to an alternate source. Transformer XNB01 was the normal power supply for 4.160 kV vital Bus NB01 and alternate power supply for 4.160 kV vital Bus NB02.

The inspectors observed that the prejob briefing was thorough. Plant and personnel safety were discussed as well as the requirements of Procedure OTS-MD-0003. All personnel involved in the job attended and participated in the briefing.

The inspectors also observed equipment operators opening switchyard breakers and a disconnect switch in accordance with Procedure OTS-MD-0003 and the tagout instructions. The operators exhibited good coordination and communications with the plant control room and took the appropriate safety precautions. The inspectors did not observe any problems during the power transfer.

II. Maintenance

M1 Conduct of Maintenance

M1.1 General Comments - Maintenance

a. Inspection Scope (62707)

The inspectors observed or reviewed portions of the following work activities:

- Work Authorization P602931 - Inspect and Clean Emergency Diesel Generator B Lube Oil Cooler,
- Work Authorization P515345 - Service Limitorque Operator on Essential Service Water Train B to Ultimate Heat Sink Valve EFHV0038, and
- Work Authorization P626688 and Chemistry Procedure CTP-EF-06102 - ESW Piping Chemical Addition, Revision 5.

b. Observations and Findings

The inspectors identified no substantive concerns. All work observed was performed with the work packages present and in active use. The inspectors frequently observed supervisors and system engineers monitoring job progress, and quality control personnel were present when required.

M1.2 General Comments - Surveillance

a. Inspection Scope (61726)

The inspectors observed or reviewed all or portions of the following test activities:

- Test Procedure ISL-NF-NB02A, "Loop-Misc; NB02A Degraded and Undervoltage to LSELS," Revision 14,
- Test Procedure ISL-NF-NB02B, "Loop-Misc; NB02B Degraded and UV to LSELS," Revision 13,
- Test Procedure OSP-NE-0001B, "Standby Diesel Generator "B" Periodic Tests," Revision 3, and
- Test Procedure OSP-JE-P001B, "Emergency Fuel Oil Pump B In-Service Test," Revision 20.

b. Observations and Findings

The surveillance testing was conducted satisfactorily and was in accordance with the licensee's approved programs and the Technical Specifications.

M2 Maintenance and Material Condition of Facilities and Equipment

M2.1 Review of Material Condition

a. Inspection Scope (62707)

The inspectors performed plant tours and reviewed licensee documents to evaluate plant material condition.

b. Observations and Findings

The inspectors observed that material condition and housekeeping were good. The inspectors identified a few minor discrepancies during plant tours. The licensee documented these discrepancies and initiated corrective action.

The inspectors reviewed two significant discrepancies identified by the licensee:

- Essential Service Water Pump A

On September 30, 1998, while performing Procedure OSP-EF-P001A, "ESW Train A In-Service Test," Revision 27, essential service water Pump A entered the Alert range based on declining differential pressure data. Because of this, the licensee changed the in-service test periodicity from quarterly to monthly and initiated actions to obtain a replacement pump. The licensee had not yet made a decision on when the new pump would be installed and stated they would make this decision based on future pump performance data. The licensee determined that the present operating condition of the pump did not impact system operability.

The inspectors reviewed the pump performance data and the applicable code requirements. The inspectors identified no concerns with the licensee's actions.

- Main Transformer Phase B Neutral Bushing

On October 21, 1998, while performing routine thermography, the licensee identified high temperature on the main transformer Phase B neutral bushing.

The licensee determined the temperature of the Phase B bushing to be approximately 130°C. The temperatures of the bushings on Phases A and C were approximately 30°C. The temperature rating for the bushing for continuous operation was 105°C. The licensee monitored the Phase B bushing and observed a temperature rise of 8°C over a 24-hour period. On October 24, 1998, the licensee took the main generator off line to make repairs.

The licensee determined the root cause of the heating to be dried grease in the connection for the Phase B bushing. The licensee researched different types of grease and held discussions with offsite transmission personnel. The licensee repaired the bushing by applying new grease. In addition, the licensee inspected and refurbished Phases A and C neutral bushings, as well as the high side bushings on all three phases.

The inspectors determined that the licensee completed repairs to the main transformer bushings safely and without incident. The material condition of plant equipment was demonstrated to be very good based on observations made by the inspectors during the power reduction from 100 percent to 7 percent and the subsequent return to 100 percent power.

c. Conclusions

Overall, observed material condition and housekeeping were very good. The licensee corrected a material condition concern regarding high temperature on a main transformer bushing. No significant material condition concerns arose during the plant power reduction and subsequent increase. The licensee also identified a material condition deficiency regarding degradation of essential service water Pump A and initiated appropriate corrective actions.

M8 Miscellaneous Maintenance Issues (92902)

M8.1 (Closed) Unresolved Item 50-483/97015-01: auto-start signals of certain pumps were not being tested as required by Technical Specification 4.8.1.1.2.g.2.

On September 4, 1997, the licensee discovered that certain contacts in the load shed and emergency load sequencer circuit that inhibit the auto-start signals of certain pumps were not being tested as required by Technical Specification 4.8.1.1.2.g.2. Although subsequent testing performed during Mode 1 demonstrated that the contacts would operate satisfactorily, literal compliance with the Technical Specifications may have required that the testing be performed during shutdown conditions.

Technical Specification 4.8.1.1.2.g stated that the testing be performed "At least once per 18 months, during shutdown." The licensee determined that adequate testing of the contacts could be performed at power without any detrimental effects. Consequently, the licensee developed a testing plan, wrote a safety evaluation, and issued work authorization documents. The licensee justified performing the testing at power because:

- Technical Specification 4.8.1.1.2.g applied to testing of the entire load shed and emergency load sequencer system. The licensee performed testing on a small part of the entire load shed and emergency load sequencer system;
- The basis for Technical Specification 4.8.1.1.2.g stated that the restriction on performing the testing while shutdown was due to perturbations to the electrical distribution systems that could challenge continued steady state operation. The specific testing performed would not lead to perturbations to the electrical distribution systems that could challenge steady state operation; and
- The same testing would be performed with sequencer relays that happened to fail with the reactor at power.

The inspectors concluded that the licensee's actions and justification for performing partial testing of the emergency diesel generator load shed and emergency load sequencer circuit in Mode 1 versus "At least once per 18 months, during shutdown" were appropriate. This closes Unresolved Item 50-483/97015-01. The licensee also reported the failure to perform adequate testing within the required time in Licensee Event Report 50-483/97005-02. This report will be reviewed during a future inspection.

M8.2 (Closed) Licensee Event Report 50-483/96007-00: missed surveillances and literal Technical Specification compliance violations due to personnel oversight.

This licensee event report was previously discussed in NRC Inspection Report 50-483/97-14, Section M8.1.

On December 11, 1996, the licensee identified that a loop calibration for component cooling water from reactor coolant system outer containment flow Transmitter EGFT0062 had not been performed as required during the Spring 1995 refueling outage. The calibration was initially scheduled to be performed every 18 months as a preventive maintenance task, as opposed to a surveillance task. The licensee subsequently changed the frequency of the calibration to every 36 months based on performance results, which was allowed for preventive maintenance tasks.

The licensee calibrated Transmitter EGFT0062 in the fall of 1993 and again in the fall of 1996. Because this calibration was a surveillance that was required to be performed "at least once per 18 months during shutdown," per Technical Specification 4.7.3.b.1, the change to 36 months was inappropriate. The licensee stated that the as-found values for Transmitter EGFT0062 were within the required tolerance in the fall of 1996.

The inspector reviewed the corrective actions regarding Transmitter EGFT0062. The licensee reclassified the calibration of Transmitter EGFT0062 as a surveillance and changed the surveillance data base to ensure the surveillance is performed every 18 months during refueling outages.

The licensee reviewed other surveillances required to be performed "at least once per 18 months during shutdown." The licensee discovered that some were actually being performed in Mode 1 and had been performed in Mode 1 since initial plant startup. These surveillances were:

- Technical Specification 4.5.2.e - Emergency Core Cooling Subsystems,
- Technical Specification 4.7.1.2.1.c.2 - Auxiliary Feedwater System,
- Technical Specification 4.7.3.c - Component Cooling Water System,
- Technical Specification 4.7.4.b - Essential Service Water System, and
- Technical Specification 4.7.4.c - Essential Service Water System.

The licensee reviewed the above surveillances and found them to be current and technically adequate such that no operability concern existed. The licensee revised the surveillance data base to ensure that these surveillances would be performed every 18 months during refueling outages.

The inspectors reviewed the above surveillances during the time the respective systems were required to be operable following a refueling outage until the time that the surveillances were actually performed. The inspectors determined that all "as-found" values for surveillance on Technical Specification equipment were satisfactory. Although there were no past operability concerns, the failure to perform timely surveillance tests resulted in the above systems exceeding the respective allowed outage times.

Technical Specification 4.04 states, in part, that entry into an operational mode or other specified condition shall not be made unless the surveillance requirement(s) associated with the Limiting Condition for Operation have been performed within the stated surveillance interval.

Technical Specification 4.0.3 states, in part, that the failure to perform a surveillance requirement within the allowed surveillance interval shall constitute noncompliance with the operability requirements for a Limiting Condition for Operation.

Technical Specification Section 3.0.4 requires, in part, that entry into an operational mode shall not be made unless the conditions for the Limiting Conditions for Operation are met without reliance on provisions contained in the action requirements.

Technical Specification 3.7.3 required that at least two independent component cooling water loops be operable in Modes 1, 2, 3, and 4.

Technical Specification 3.5.2 required that two independent emergency core cooling subsystems be operable in Modes 1, 2, and 3.

Technical Specification 3.7.1.2 required that at least three independent steam generator auxiliary feedwater pumps and associated flow paths be operable in Modes 1, 2, and 3.

Technical Specification 3.7.4. required that at least two independent essential service water loops be operable in Modes 1, 2, 3, and 4.

There were multiple examples of a violation of Technical Specification surveillance requirements as a result of surveillances conducted while on-line instead of "At least once per 18 months during shutdown" and subsequent plant mode changes made while relying on those surveillances. The licensee failed to perform these surveillances while shutdown as a result of an incorrect surveillance data base. This nonrepetitive, licensee-identified and corrected violation is being treated as a noncited violation, consistent with Section VII.B.1 of the NRC Enforcement Policy (50-483/98022-02).

III. Engineering

E1 Conduct of Engineering

E1.1 Axial Offset Anomaly

a. Inspection Scope (37551)

The inspectors reviewed the Cycle 10 axial offset data and interviewed licensee personnel.

b. Observations and Findings

The licensee observed a deviation between the predicted and actual axial offset value during the present operating cycle (Cycle 10). The licensee determined that the deviation was the result of boron in the crud layer on previously burned fuel assemblies from Cycle 9 that were loaded in Cycle 10. The reactor vendor adjusted the initial prediction to account for the boron in the crud layer. The vendor assumed that the boron in the crud layer would remain the same for the remainder of the operating cycle (see NRC Inspection Report 50-483/98-11).

The licensee determined that the assumption has not remained valid; however, since additional crud has accumulated on the previously burned assemblies. The additional boron has resulted in a deviation from the adjusted initial prediction. Recently, the actual deviation was trending at approximately 4 percent below the adjusted prediction. There was no current impact on routine plant operations due to the axial offset anomaly.

The licensee determined that axial offset may recover (become more positive) if no additional significant amount of crud accumulates on the previously burned assemblies. The licensee determined that this may occur since the power of these assemblies decreases as the cycle progresses, which results in less subcooled boiling and less crud deposition.

If crud begins forming on the new assemblies, the axial offset could become even more negative. The licensee did not expect this to occur since the power in the new assemblies is relatively low compared to previous cycles. The low power assemblies exhibit low subcooled boiling which should prevent the formation of crud on the new assemblies. The licensee determined that, to date, there has not been any indication of the axial offset anomaly on the new assemblies. The licensee formed a task team to address options to improve axial offset and conserve shutdown margin.

c. Conclusions

The licensee aggressively monitored and pursued solutions for the axial offset anomaly. The licensee formed a task team to address options to improve axial offset and conserve shutdown margin.

IV. Plant Support

R1 Radiological Protection and Chemistry Controls

R1.1 General Comments (71750)

- a. The inspectors observed health physics personnel, including supervisors, routinely touring the radiologically controlled areas. Licensee personnel working in radiologically controlled areas exhibited good radiation worker practices.

Except for areas in the radwaste building, contaminated areas and high radiation areas were posted with current survey maps. Although appropriate surveys had been conducted in the radwaste building, the survey maps were not posted outside the respective rooms. The survey maps, however, were available in the radwaste control room survey book. Although not a procedure requirement to post survey maps outside the rooms, management expectations were not met. The licensee initiated Suggestion-Occurrence-Solution Report 98-3609 to document the investigation and corrective actions.

The inspectors checked a sample of doors, required to be locked for the purpose of radiation protection, and found no problems.

b. Conclusions

Observations of radiation worker radiological protection practices indicated good adherence to established practices, although radiological survey maps were not posted outside some rooms in the radwaste building, contrary to licensee management expectations.

V. Management Meetings

X1 Exit Meeting Summary

The exit meeting was conducted on November 12, 1998. The licensee did not express a position on any of the findings in the report.

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

ATTACHMENT

SUPPLEMENTAL INFORMATION

PARTIAL LIST OF PERSONS CONTACTED

Licensee

H. D. Bono, Supervising Engineer, Regulatory Support
J. L. Cunningham, Shift Supervisor, Operations
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R. R. Roselius, Superintendent, Radiation Protection and Chemistry
T. P. Sharkey, Supervising Engineer, Systems
J. R. Scherr, Reactor Operator, Op
W. A. Witt, Superintendent, Systems Engineering

INSPECTION PROCEDURES USED

37551	Onsite Engineering
61726	Surveillance Observations
62707	Maintenance Observations
71707	Plant Operations
71750	Plant Support Activities
92700	Onsite Followup of Written Reports of Nonroutine Events at Power Reactor Facilities
92901	Followup - Plant Operations
92902	Followup - Maintenance

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

98022-01	NCV	Safety injection accumulator tank pressure decrease below Technical Specification limits (Section O4.1).
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98022-02 NCV Missed surveillance and Technical Specification compliance violations (Section M8.2).

Closed

98022-01 NCV Safety injection accumulator tank pressure decrease below Technical Specification limits (Section O4.1).

97015-01 URI Technical Specification required testing missed during shutdown (Section M8.1).

96007-00 LER Missed surveillance and Technical Specification compliance violations (Section M8.2).

98022-02 NCV Missed surveillance and Technical Specification compliance violations (Section M8.2).

Discussed

97005-02 LER Failure to perform Technical Specification required testing (Section M8.1).