ENCLOSURE 2

U.S. NUCLEAR REGULATORY COMMISSION

REGION IV

Docket No: 50-285
License No: DPR-40

Report No: 50-285/97-18

Licensee: Omaha Public Power District
Fort Calhoun Station FC-2-4 Adm.
P.O. Box 399, Hwy. 75 - North of Fort Calhoun
Fort Calhoun, Nebraska

Facility: Fort Calhoun, Nebraska

Location: Blair, Nebraska

Dates: September 14 through October 25, 1997

Inspectors: W. Walker, Senior Resident Inspector
V. Gaddy, Resident Inspector

Approved: W. D. Johnson, Chief, Project Branch B

Attachment: Supplemental Information

EXECUTIVE SUMMARY

Fort Calhoun Station
NRC Inspection Report 50-275/97-18

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

Operations

- In general, the conduct of operations was professional and safety-conscious. The inspectors noted marked improvement in the clarity and the thoroughness of shift turnovers (Section 01).

- Reactor operators failed to perform necessary contingency actions in response to a low lube oil level alarm on Reactor Coolant Pump 3B (Section O2.1).

- Utlization of a Technical Specification interpretation in December 1995 allowed all charging pumps to be inoperable for approximately 10 hours (Section 08.2).

Maintenance

- Licensee personnel failed to obtain the required approval prior to deferring preventive maintenance on the spent fuel pool heat exchanger (Section O2.2)

- Electrical maintenance personnel and the diesel generator system engineer were aggressive and timely in their efforts to identify and replace a degraded diode in the diesel generator field flashing circuit with a higher amperage rated diode (Section M1.2).

- In August 1996, maintenance personnel failed to implement the instructions of a maintenance work order which directed them to verify that correct components were installed in the discharge accumulator of the charging pump (Section M1.3)

- Implementation of a test monitor for safety related surveillance activities was characterized by strict control to ensure that procedures were completed exactly as written and that any changes needed to ensure the accuracy of the procedures were identified for revision (Section M1.5).

Engineering

- The licensee changed plant drawings to allow an incorrect charging pump bladder configuration (Section M1.3).

- The licensee analysis regarding availability of the diesel driven auxiliary feedwater pump was conservative in that the pump's performance was bounded by the risk analysis assumptions for both demand and run failures (Section E1.2).

Plant Support

- Plant workers exhibited good rad tion protection practices. Especially notable was performance of plant personnel d ing the replacement of Purification Filter CH-17B. Workers exhibited good knowledge of the requirements of their radiation work permit (Section R1.1).

Report Details

Summary of Plant Status

The Fort Calhoun Station began this inspection period with a power ascension in progress following a shutdown to repair a condenser tube leak. On September 19, 1997, the plant attained 100 percent power and operated at that level throughout the remainder of the inspection period.

I. Operations

01 Conduct of Operations

01.1 General Comments (71707)

Using Inspection Procedure 71707, the inspectors conducted frequent reviews of ongoing plant operations. In general, the conduct of operations was professional and safety conscious; specific events and noteworthy observations are detailed in the section below. In particular, the inspectors noticed marked improvement in the clarity and the thoroughness of shift turnovers during this inspection period.

02 Operational Status of Facilities and Equipment

02.1 Reactor Coolant Pump-3B Low Lube Oil Level Indication

a. Inspection Scope (71707)

The inspectors followed up on reactor operator actions performed following receipt of a low lube oil level alarm on the lower oil reservoir for Reactor Coolant Pump RC-3B.

b. Observations and Findings

On September 21, 1997, at 1 p.m., the control room operators received a low lube oil level alarm for the lower lube oil reservoir for Reactor Coolant Pump 3B. The reactor operators responded to the alarm by following the instructions provided on an operator note which directed them to contact the shift supervisor and reference Operating Instruction, OI-RC-9, "Response to Degraded RCP Oil Levels," Attachment 9. This operating instruction directed the reactor operators to make a containment entry within 8 hours following receipt and validation of a low lube oil level alarm. The reactor operators did not make a containment entry until 1 p.m. on September 22, 1997. The containment entry identified no fire hazard and the level transmitter for the lower oil level reservoir was declared inoperable.

The licensee performed a root cause analysis of this event to determine why the reactor operators failed to make a containment entry within 8 hours of receiving a low lube oil level alarm. The following causes were identified:

- Less than adequate guidance in the operating instruction;

- Poor alternate system engineer and reactor operator awareness of the Safety Analysis for Operability, SAO-97-01, "Reactor Coolant P ımp Lube Oil Collection System";

- Poor turnover practices between the primary system engincer and the alternate system engineer;

- Poor alarm response guidance in that the low lube oil alarm was not specified in the alarm response procedures; and

- Insufficient training for operations personnel or system engineering to ensure proper awareness of SAO-97-01 and the compensatory actions required.

The licensee has implemented the following corrective actions for this event:

- Refresher training on SAO-97-01 was conducted for operating crews.

- The operations manager discussed expectations with all shift supervisors involved in the event and issued a memo to all shift supervisors on the expectation to determine validity of reactor coolant pump lube oil level alarms within 1 hour.

- The operations supervisor issued an action item to all shift supervisors to review active safety analysis for operability evaluations with crews on a quarterly basis.

- System engineering developed and issued an "Away From Work Turnover" sheet.

The inspectors reviewed the licensee's corrective actions and found them to be appropriate.

Failure to follow the required actions in Operating Instruction, OI-RC-9, "Response to Degraded RCP Oil Levels," Attachment 9, and make a containment entry within 8 hours of receipt of a valid low lube oil level alarm is a violation of 10 CFR Part 50, Appendix B, Criterion V, which [redacted] that activities affecting quality will be prescribed by instructions and [redacted] and that these instructions and procedures will be followed.

This licensee identified and corrected violation is being treated as a noncited violation consistent with Section VII.B.1 of the NRC Enforcement Policy (50-285/9718-01).

c. Conclusions

Inadequate procedural guidance and crew unfamiliarity with the requirements of the safety analysis for operability resulted in reactor operators failing to perform necessary contingency actions in response to a low lube oil level alarm on Reactor Coolant Pump 3B.

02.2 Engineered Safety Feature System Walkdown

a. Inspection Scope (71707)

The inspectors used Inspection Module 71707 to walk down portions of the spent fuel pool cooling system. The system was walked down using the following drawing and procedure:

- Operating Instruction OI-SFP-1, "Spent Fuel Pooling Cooling," and
- Drawing 11405-M-11, "Spent Fuel Pool System Flow Diagram."

b. Observations and Findings

During the walkdown, the inspectors noted that the material condition of the equipment was good. All supports and seismic restraints were properly anchored and in good condition. Valves were verified to be in their correct positions as required by the operating instruction.

The inspectors asked to see copies of eddy current data and data from the last cleaning of the spent fuel pool heat exchanger. The licensee informed the inspectors that the spent fuel pool heat exchanger had never been cleaned or eddy current tested. The inspectors reviewed a copy of Preventive Maintenance Order 9603504. The preventive maintenance order required that the spent fuel pool heat exchanger be eddy current tested and cleaned on November 2, 1996. The inspectors asked why this work was not performed. Engineering personnel stated that performing the maintenance required a component cooling water outage and required an alternate spent fuel pool cooling system be installed. Since the preventive maintenance order was not performed, the inspectors asked if the licensee had completed the proper documentation that authorized deferring the preventive maintenance order as required by the preventive maintenance program. The licensee stated that this had not been done. Failing to properly defer the preventive maintenance order is a violation of Standing Order SO-M-2, "Preventive Maintenance Program," (50-285/9718-02). The inspectors reviewed the most recent performance data for the heat exchanger. Performance tests had been performed every refueling outage. The inspectors verified that the flow through the heat exchanger was sufficient to ensure that it could perform its design function.

The licensee determined that other outage related preventive maintenance orders that were not completed had not been flagged for deferral or administrative closure. At the conclusion of the inspection period, the licensee was identifying preventive maintenance orders that were not performed during the last refueling outage.

c. Conclusions

A lack of understanding of the preventive maintenance program requirements resulted in engineering personnel not obtaining the required approval prior to deferring the preventive maintenance order to clean and eddy current test the spent fuel pool heat exchanger.

02.3 Review of Equipment Tagouts (71707)

The inspectors reviewed the following tagouts:

- Serial Number 97-1020, Minor Repairs to Charging Pump CH-1B
- Serial Numbers 97-1031 and 97-1039, Raw Water/Component Cooling Water Heat Exchanger Inspection and Cleaning

The inspectors found that all tags were on the proper components and that components were in the required tagged position. Plant material condition and housekeeping were observed to be good.

08 Miscellaneous Operations Issues

08.1 (Closed) Violation 50-285/9711-01: failure to follow procedures during approach to criticality. Operating Procedure OP-2A, "Plant Startup," Revision 19, did not provide guidance to reactor operators concerning actions to take if, while withdrawing control rods during a startup, a situation is reached where all rods are out and criticality has not been achieved. During the May 12 startup, the reactor operators reached the all rods out position without the reactor being critical and they did not initiate a procedure change prior to continuing the approach to criticality. Operating Procedure OP-2A was revised to include specific guidance on reactor operator actions during a plant startup and approach to criticality prior to reaching the all rods out position. The inspectors reviewed the licensee's corrective actions and found them to be appropriate.

08.2 (Closed) LER 50-285/96004: all charging pumps inoperable due to inadequate administrative controls. In September 1996, during a review of selected Technical Specification Interpretations, a reviewer noted that Technical Specification Interpretation 96-02 and its predecessor, Technical Specification Interpretation 94-06, contained errors that specified an incorrect Technical Specification limiting condition for operation for a particular combination of inoperable components. While researching this interpretation, the licensee

identified that on December 18, 1995, this Technical Specification Interpretation had allowed all charging pumps to be inoperable for about 10 hours. The charging pumps were inoperable as a result of a surveillance being performed on one of the pumps and maintenance that disabled the diesel generator that provided emergency power to the other two pumps. This violated Technical Specification 2.2 for the charging system. Failing to meet the conditions of Technical Specification 2.2 is a violation. 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 (50-285/9718-03).

As corrective actions, the licensee performed an expert technical panel review of all open Technical Specification Interpretations to assess their adequacy relative to Technical Specifications and their bases; strengthened the Technical Specification Interpretation program to more clearly define its scope, limitations, and the technical review process; and performed a detailed technical review of all existing Technical Specifications Interpretations against design basis information to ensure their technical accuracy. The inspectors verified that these actions had been performed. The inspectors concluded that the licensee's corrective actions had been appropriate.

II. Maintenance

M1 Conduct of Maintenance

M1.1 General Comments

a. Inspection Scope (62707)

The inspectors observed all or portions of the following activities:

- Repair of Raw Water Relief Valve RW-222;
- Troubleshooting of a governor limit switch on Diesel Generator 1;
- Repair of a terminal strip inside a halon control panel; and
- Cleaning raw water/component cooling water Heat Exchanger AC-1A.

b. Observations and Findings

The inspectors found the work performed under these activities to be professional and thorough. All work observed was performed with the work package present and in active use. Maintenance technicians were experienced and knowledgeable of their assigned tasks. The inspectors frequently observed supervisors and system engineers monitoring job progress, and quality control personnel were present when required by procedure.

In addition, see the specific discussions of maintenance observed in Sections M1.2 and M1.3.

M1.2 Diesel Generator Field Flash Circuit Diode Replacement

a. Inspection Scope (62707 and 61726)

The inspectors observed partial performance of Surveillance Test OP-ST-DG-0001, "Diesel Generator 1 Check," Revision 22, and followed up on maintenance to replace a diode in the field flashing circuit for the diesel.

b. Observations and Findings

On September 17, 1997, the inspectors observed a normal start test of Diesel Generator 1. During the test, the electrical field for the generator field failed to flash. The reactor operators backed out of the test, and electrical maintenance technicians with the assistance of the diesel generator system engineer started a troubleshooting effort. The electrical maintenance technicians identified that a diode in the field flashing circuit was degraded. The diode is used as an isolation device between the 125Vdc bus and the field flashing circuit in the event of a fault on the dc bus. During normal operation the diode passes current from the dc bus to the primary generator field winding to flash the field at the initiation of the diesel generator start signal. The electrical maintenance technicians replaced the diode and the surveillance was performed successfully.

The system engineer inspected the degraded diode and identified some indications that the diode may have experienced elevated temperature conditions while in service. Additionally, the system engineer and electrical maintenance technicians verified that a similar condition did not exist on Diesel Generator 2. Based on inspection and voltage readings, a determination was made that the diode in the field flashing circuit for Diesel Generator 2 was functional.

The system engineer contacted the vendor for the diode and discussed the degraded diode and the specifications for the diode. The degraded diode was rated at a maximum continuous current rating of 7.5 amps. Because of the overheating effects observed on the degraded diode, the system engineer determined that a test of the field flashing circuitry would be necessary. During the monthly surveillance test on Diesel Generator 2, the system engineer monitored the current through the field flashing circuitry and discovered that for approximately 1.2 seconds during field flashing the diode exceeds its continuous maximum current by 4.5 amps. The system engineer determined that the cumulative effect on the diode over several years of operations would be a shortening of the service life of the diode.

An operability evaluation was performed to ensure that Diesel Generator 1 was operable with the lower amperage diode which had been previously installed. A decision was made, after consultation with the vendor, to install diodes rated at

25 amps in both diesel generators. This work was approved and the 25 amp diodes were installed on both diesels under substitute replacement item Engineering Change Notice 97-307. At the end of this inspection period, questions regarding the maintenance history and the design application of the diesel generator field flashing circuit diodes remained open. This will be an inspection followup item (50-285/9718-04)

M1.3 Charging Pump Accumulator Configuration Discrepancies

a. Inspection Scope (62707)

The inspectors followed up on an unauthorized change to the discharge accumulator of the charging pump and the failure of the licensee to recognize the unauthorized change.

b. Observations and Findings

On September 21, 1997, operations personnel tagged Charging Pump CH-1C out of service so the bladder of the discharge accumulator (CH-22) could be replaced. Maintenance Work Request 973516 authorized the repair of the accumulator.

During disassembly of the accumulator, maintenance personnel noticed a difference in the configuration of the installed bladder compared to the new bladder. The installed bladder appeared to have been modified. The valve stem and the top portion of the gas valve assembly were missing. Due to the differences in configuration, maintenance personnel stopped work and sought assistance.

System engineering personnel determined that the bladder was most likely changed in January 1987 when the gas bag assembly was replaced. Spacers had been fabricated for the gas valve. The licensee could not find any documentation authorizing the change.

The inspectors asked if any maintenance had been performed on the accumulator since 1987 that should have identified the difference in configuration. The licensee determined that on August 12, 1996, maintenance personnel disassembled the accumulator to replace the bladder. Maintenance personnel noticed a difference between the old bladder and the replacement bladder. Maintenance personnel assumed that the replacement bladder was incorrect, reinstalled the old bladder, and informed engineering personnel.

System engineering personnel also assumed the new bladder was incorrect and initiated Engineering Change Notice 96-460 to revise the component drawings to reflect the as-found condition of the bladder. System engineering personnel did not perform an investigation to determine why the bladders were different. The condition report (199601005) that documented the differences also acknowledged the difference between the old bladder and the vendor's manual.

The inspectors reviewed the maintenance work order (951239) used to disassemble the accumulator and inspect the bladder in August 1996. The maintenance work order stated that it appeared that the incorrect bladder may be installed in the accumulator. The maintenance work order directed maintenance personnel to verify that the appropriate bladder was installed. If an incorrect bladder was installed, maintenance personnel were directed to replace the bladder. During this inspection, maintenance personnel did not verify the correct bladder was installed and reinstalled the incorrect bladder. Failing to perform the action specified by the maintenance work order is a violation. This licensee-identified and corrected violation is being treated as a noncited violation consistent with Section VII.B.1 of the NRC Enforcement Policy (50-285/9718-05). By failing to verify the correct bladder was installed in the accumulator, maintenance and engineering personnel allowed an unauthorized configuration change to continue for over a year. In addition to the work performed on the accumulator in August 1996, Maintenance Work Order 951239 indicated that the pump had been tagged out in August 1995 and April 1996. Although records of any work performed at those times were not located, these were possible additional opportunities to verify the correct component was installed.

The inspectors asked about the configuration of the other charging pump accumulators. The licensee stated that the other accumulators would be inspected at the next opportunity.

M1.4. Conclusions on Conduct of Maintenance

Maintenance and engineering personnel failed to aggressively pursue resolution of configuration changes to plant equipment in August 1996. In addition, in August 1996, the licensee changed plant drawings to allow the incorrect charging pump accumulator bladder configuration.

Electrical maintenance personnel and the diesel generator system engineer were aggressive in their efforts to identify a degraded diode in the diesel generator field flashing circuit and make a determination that a diode of higher amperage rating was necessary.

M1.5 Surveillance Activities

a. Inspection Scope

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

- OP-ST-DG-0001, "Diesel Generator 1 Check," Revision 22;
- OP-ST-FO-3001, "Diesel Generator 1 Fuel Oil System Pump Inservice Test," Revision 11;

- OP-ST-ESF-0009, "Channel A Safety Injection, Containment Spray and Recirculation Actuation Signal Test," Revision 28;
- EM-ST-FP-0059, "Visual and Functional Test of Cable Spread Room Halon Fire Protection System," Revision 3;
- EM-ST-FP-0058, "Visual and Functional Test of Control Room Walk-In Cabinet Halon Fire Protection System," Revision 5; and
- OP-ST-CH-3003, "Chemical and Volume Control System Pump Check Valve Inservice Test," Revision 18.

b. Observations and Findings

The inspectors noted that the surveillances were performed in accordance with procedures. The surveillance procedures were present and in use during the observations. The inspectors also observed enhancements to the surveillance program as follows:

- Annunciators which were expected to alarm during surveillance testing were identified with red flags before starting the surveillance;
- A test monitor program in which the shift technical advisor ensures that steps in a surveillance procedure are completed exactly as written was implemented; and
- Plastic labels were used to identify switches which were out of normal position during the performance of a surveillance activity.

c. Conclusions

Surveillance activities were generally completed thoroughly and professionally. The inspectors noted that in all of the safety-related surveillances observed a test monitor was present and actively involved in ensuring that procedures were completed exactly as written and that any changes needed to ensure accuracy of the procedures were identified for revision.

M8 Miscellaneous Maintenance Issues

M8.1 (Closed) Violation 50-285/9604-02: inadvertent dilution of the volume control tank. The licensee identified the following contributing causes:

- General lack of knowledge of the postaccident sampling system by plant personnel;
- Inadequate cross-disciplinary review of the procedure change;

- Inadequate procedure review; and
- Insufficient awareness of reactivity issues by the individuals involved in the procedure change.

The licensee corrected the procedure to remove the demineralized water flow path to the volume control tank and revised the procedure change request form to include a checkoff for whether or not a cross-disciplinary review was required. In addition, the licensee provided postaccident sampling system training to engineering, operations, and maintenance personnel. The licensee also assessed the reactivity management training already provided to plant personnel to determine whether the staff was adequately sensitized on the importance of reactivity management.

The actions taken by the licensee were adequate to address the identified deficiencies.

III. Engineering

E1 Conduct of Engineering

E1.2 Diesel Driven Auxiliary Feedwater Pump

a. Inspection Scope (37551)

The inspectors followed up on the October 1, 1997, diesel-driven auxiliary feedwater pump failure to start.

b. Observations and Findings

On October 1, 1997, during the normal monthly surveillance test for the diesel-driven auxiliary feedwater pump, the licensee identified that a faulty fuel solenoid valve resulted in the diesel failing to start.

The inspectors reviewed past performance data for the pump to make an assessment of the pump's reliability. Although the pump is not safety related or part of plant Technical Specifications, it is credited in probability risk assessments and is referenced in the plant emergency operating procedures for accident mitigation. The licensee's risk assessment assumed the fail to run and fail to start frequencies were 1.82E-2 per hour and 4.1E-2 per demand, respectively. The recent pump performance data supplied by the licensee supported these assumptions.

The system engineer determined that the failure of the fuel solenoid was caused by excessive vibration. The licensee has approved a modification to remount the

engine using flexible couplings to eliminate the excessive vibration. Additionally, a modification has been approved to mount the fuel solenoid off the engine to remove the possibility of vibration induced failure.

c. Conclusion

The licensee's analysis regarding availability of the diesel-driven auxiliary feedwater pump was conservative in that the pump's performance was bounded by the risk analysis assumptions for both demand and run failures.

IV. Plant Support

R1 Radiological Protection and Chemistry Controls

R1.1 Tours of Radiologically Controlled Area

a. Inspection Scope (71750)

The inspectors performed routine tours of the radiologically controlled area and observed radiation work practices of plant personnel.

b. Observations and Findings

During this report period, the inspectors observed radiation protection personnel perform their assigned duties. These duties were performed in a professional manner and in accordance with licensee procedure and management's expectations. The inspectors performed surveys throughout the radiologically controlled area. All areas surveyed had been properly posted by the licensee.

The inspectors observed plant workers perform work inside the radiologically controlled area and inside contaminated areas. Workers exhibited good radiation protection work practices. Especially notable was the effort of plant workers and radiation protection personnel during the replacement of a purification filter (CH-17B). The planning, the prejob briefing, and the dose reduction efforts for this filter replacement were excellent.

The inspectors questioned some workers on the requirements of their radiation work permit. All workers questioned were aware of these requirements.

c. Conclusion

Plant workers exhibited good radiation protection practices. Especially notable was the performance of plant personnel during the replacement of Purification Filter CH-17B. Workers exhibited good knowledge of the requirements of their radiation work permit.

F8 **Miscellaneous Fire Protection Issues**

F8.1 (Closed) Violation 50-285/97015-04: failure to complete a fire impairment permit and establish a compensatory fire watch in the diesel generator room. Standing Order SO-G-58, "Control of Fire Protection System Impairments, Revision 24, requires that impairments of all fire suppression systems or equipment be identified with a fire impairment permit and that appropriate compensatory measures be established. On July 9, 1997, during painting in Diesel Generator Room 2, scaffolding was erected which blocked the fire suppression system in the room without a fire impairment permit or appropriate compensatory measures being established. A fire impairment permit was generated and appropriate compensatory measures were established immediately upon discovery. Additionally, a plant standdown was conducted addressing the human performance concerns related to the fire protection impairment program. This involved briefings by managers and supervisors at the department level. The topics covered included this specific event, a discussion of the requirements of the fire protection system impairment program, and the control of transient combustible materials. The inspectors reviewed the licensee's corrective actions and found them to be appropriate.

VI. Management Meetings

X1 **Exit Meeting Summary**

The inspectors presented the inspection results to members of licensee management on October 24, 1997. The licensee acknowledged the findings as presented.

The licensee stated that the violation involving maintenance on Charging Pump CH-1C should not be cited. They noted that the issue was one of configuration control which they identified and for which a previous violation had been written and corrective actions implemented. The licensee noted that because of previous corrective actions taken for configuration control issues they were able to identify in September 1997 that a wrong part had been used in the charging pump discharge accumulator and correct it.

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

ATTACHMENT
SUPPLEMENTAL INFORMATION

PARTIAL LIST OF PERSONS CONTACTED

Licensee

M. Bare, System Engineer
D. Bock, Senior Design Engineer
D. Buell, System Engineer
J. Chase, Manager, Fort Calhoun Station
K. Dowdy, Senior Production Planner
D. Dryden, Station Licensing Engineer
M. Ellis, Supervisor, Maintenance Support
C. Fritz, System Engineer
S. Gambhir, Division Manager Engineering and Operations Support
J. Johnson, Special Services Engineer
B. Mierzejewski, System Engineer
C. Ovici, System Engineer
R. Phelps, Manager, Station Engineering
R. Short, Manager, Operations
M. Sweigart, Nuclear Safety Review Specialist

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 92700:	Onsite Followup of Written Reports of Nonroutine Events at Power Reactor Facilities
IP 92901:	Followup - Operations
IP 92902:	Followup - Maintenance
IP 92904:	Followup - Plant Support

ITEMS OPENED AND CLOSED

Opened

50-285/9718-02	VIO	failure to obtain proper authority and document deferral of preventive maintenance on the fuel pool heat exchanger (Section 02.2)
50-285/9718-04	IFI	diesel generator field flashing circuit (Section M1.2)

Closed

50-285/9711-01	VIO	failure to follow procedure during approach to criticality (Section 08.1)
50-285/96004	LER	all charging pumps inoperable due to inadequate administrative ontrols (Section 08.2)
50-285/9604-02	VIO	inadvertent dilution of volume control tank (Section M8.1)
50-285/9715-04	VIO	failure to complete a fire impairment permit (Section F8.1)

Opened and Closed

50-285/9718-01	NCV	failure to follow the operating instruction for low reactor coolant pump lube oil level indication (Section 02.1)
50-285/9718-03	NCV	failure to meet the Technical Specification requirement for charging pump operability (Section 08.2)
50-235/9718-05	NCV	failure to follow maintenance procedures for charging pump bladder installation (Section M1.3)