August 12, 1999

Carolina Power & Light Company
ATTN: Mr. James Scarola
Vice President - Harris Plant
Shearon Harris Nuclear Power Plant
P. O. Box 165, Mail Code: Zone 1
New Hill, NC 27562-0165

SUBJECT: NRC INTEGRATED INSPECTION REPORT 50-400/99-04

Dear Mr. Scarola:

On July 17, 1999, the NRC completed an inspection at your Shearon Harris facility. The enclosed report presents the results of that inspection. The results of the inspection were discussed with you and other members of your staff on July 21, 1999.

The inspection was an examination of activities conducted under your license as they relate to safety and compliance with the Commission's rules and regulations and with the conditions of your license. The inspection consisted of a selective examination of procedures and representative records, observations of activities, and interviews with personnel.

Based on the results of this inspection, three previously identified issues were evaluated under the risk significance determination process and were determined to be of low risk significance, although regulatory requirements were violated. Therefore, three non-cited violations were identified. These issues are listed in the summary of findings and are discussed in the report. If you contest these non-cited violations, you should provide a response within 30 days of the date of this inspection report, with the basis for your denial, to the Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555-0001, with copies to the Regional Administrator, Region II; the NRC Resident Inspector at Shearon Harris Nuclear Power Plant, and the Director, Office of Enforcement, United States Nuclear Regulatory Commission, Washington, DC 20555-0001.

The NRC has noted that your first quarter 1999 performance indicator (PI) data showed a WHITE PI for emergency response organization drill participation under the emergency preparedness cornerstone. The PI threshold for increased regulatory response is less than 80 percent, while the threshold for required regulatory response is less than 60 percent. Discussions with your regulatory affairs personnel revealed that this performance indicator turned WHITE because drill participation was 77.6 percent, and that the majority of the 26 drill nonparticipants were assigned to the main control room emergency communicator position. Training completed in June and July resulted in the second quarter data for this PI to be 82.9 percent which returned it to the GREEN category. No further followup of this issue by the NRC is planned.

CP&L

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be placed in the NRC Public Document Room (PDR).

Sincerely,

(Original signed by B. R. Bonser)

Brian R. Bonser, Chief
Reactor Projects Branch 4
Division of Reactor Projects

Docket No. 50-400
License No. NPF-63

Enclosure: NRC Inspection Report

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U. S. NUCLEAR REGULATORY COMMISSION

REGION II

Docket No:	50-400
License No:	NPF-63
Report No:	50-400/99-04
Licensee:	Carolina Power & Light (CP&L)
Facility:	Shearon Harris Nuclear Power Plant, Unit 1
Location:	5413 Shearon Harris Road New Hill, NC 27562
Dates:	May 30 - July 17, 1999
Inspectors:	J. Brady, Senior Resident Inspector R. Hagar, Resident Inspector
Approved by:	B. Bonser, Chief, Projects Branch 4 Division of Reactor Projects

Enclosure

SUMMARY OF FINDINGS

Shearon Harris Nuclear Power Plant, Unit 1
NRC Inspection Report 50-400/99-04

The report covers a seven-week period of resident inspection.

Inspection findings were assessed according to potential risk significance, and were assigned colors of GREEN, WHITE, YELLOW, or RED. GREEN findings are indicative of issues that, while not necessarily desirable, represent little risk to safety. WHITE findings would indicate issues with some increased risk to safety, and which may require additional NRC inspections. YELLOW findings would be indicative of more serious issues with higher potential risk to safe performance and would require the NRC to take additional actions. RED findings represent an unacceptable loss of margin to safety and would result in the NRC taking significant actions that could include ordering the plant shut down. No individual finding by itself would be indicative of either acceptable or unacceptable performance. The findings, considered in total with other inspection findings and performance indicators, will be used to determined overall plant performance.

Cornerstone: Barrier Integrity

- Green. For approximately 11 days, the licensee operated the unit with an inoperable component cooling water system containment-isolation valve (1CC-176). The subject valve isolates component cooling water flow to the reactor coolant drain tank heat exchanger and the excess letdown heat exchanger (Section 4OA4).

  The following non-cited violations were associated with this finding:

  (1) Operating the unit with valve 1CC-176 inoperable and taking no action to comply with Technical Specification (TS) Action requirements during the period from November 24, 1998, through December 6, 1998, was a violation of TS 3.6.3, Containment Systems.

  (2) Failure to perform an adequate cycling test and verify the isolation time of valve 1CC-176 and failure to verify the isolation time of valve 1CC-202 prior to entering Mode 4 on November 24, 1998, and the subsequent entry into Mode 4, was a violation of surveillance requirement TS 4.6.3.1 and TS 4.0.4.

  (3) Failure to promptly identify and correct a test deficiency during a surveillance test on November 22, 1998, and failure to correct the causes of the failure of valve 1CC-176 to shut during a surveillance test on December 6, 1998, were two examples of a violation of 10 CFR 50, Appendix B, Criterion XVI, Corrective Action.

Report Details

The unit was at essentially 100% power for the entire period.

1. Reactor Safety

Cornerstones: Initiating Events, Mitigating Systems, Barrier Integrity

1R03 Emergent Work

a. Inspection Scope

The inspectors reviewed the following emergent items:

WR/JO	Title
99-AEYI1	AH-4B breaker failure
99-AFAZ1	NI-41 drawer digital meter replacement
99-AFHN1	Jockey fire pump problems
99-AFLT1	“C” cold leg accumulator pressure transmitter drift

b. Observations and Findings

No findings were identified and documented through this inspection.

1R04 Equipment Alignment

a. Inspection Scope

The inspectors performed a detailed review of the auxiliary feedwater system.

b. Observations and Findings

No findings were identified and documented through this inspection.

1R05 Fire Protection

a. Inspection Scope

The inspectors reviewed the high fire risk areas which included four fire zones that did not screen out using the Fire Induced Vulnerability Evaluation methodology in the Individual Plant Examination for External Events (IPEEE). Two zones contained the control room envelope and the other two contained the two switchgear rooms.

b. Observations and Findings

No findings were identified and documented through this inspection.

1R06 Flood Protection Measures

a. Inspection Scope

The inspectors reviewed the IPEEE, the Final Safety Analysis Report (FSAR), and flooding calculations in relation to both internal and external flooding.

b. Observations and Findings

No findings were identified and documented through this inspection.

1R07 Heat Sink Performance

a. Inspection Scope

The inspectors reviewed the inspections that were performed on the A and C Charging Safety Injection Pump oil coolers in accordance with EPT-163, “Generic Letter 89-13 Inspections,” Revision 9.

b. Observations and Findings

No findings were identified and documented through this inspection.

1R09 Inservice Testing (IST) of Pumps and Valves

a. Inspection Scope

The inspectors reviewed the performance of the following IST tests:

OST-1007, “CVCS/SI System Operability Train A Quarterly Interval Mode 1-4,” Revision 17

OST-1062, “Sampling, Chemical Addition and Main Steam Drain Systems ISI Valve Test and Remote Position Indication Test 2 Year Interval Modes 1, 2, 3 and 4,” Revision 8

b. Observations and Findings

No findings were identified and documented through this inspection.

1R11 Licensed Operator Requalification

a. Inspection Scope

The inspectors observed licensed operator requalification simulator examinations for Crew E.

b. Observations and Findings

No findings were identified and documented through this inspection.

1R12 Maintenance Rule Implementation

a. Inspection Scope

The inspectors reviewed the licensee's implementation of the Maintenance Rule (10 CFR 50.65) with respect to the equipment issues described in the following Condition Reports (CRs):

CR 99-01108 Emergency Service Water Intake Structure Exhaust Fan E-88-B Failure to Start

CR 99-01651 Containment Fan Cooler AH-4B-SB tripped while securing from OST-1010.

b. Observations and Findings

No findings were identified and documented through this inspection.

1R15 Operability Evaluations

a. Inspection Scope

The inspectors reviewed the following operability evaluations:

ESR 9900126 "A" Motor-Driven Auxiliary Feedwater Pump Pressure-Control Valve Response, Revision 0

ESR 9900143 Emergency Service Water Intake Structure Exhaust Fan E-88-B Failure to Auto Start, Revision 0

ESR 9900262 Turbine Driven Auxiliary Feedwater Pump, Oil Seal Evaluation, Revision 0

b. Observations and Findings

No findings were identified and documented through this inspection.

1R16 Operator Workarounds

a. Inspection Scope

The inspectors reviewed the following operator work-arounds:

- Essential services chilled water cross-connect valves do not isolate as needed.
- Main feedwater isolation valve actuator temperature required to be maintained greater than 60 degrees F.
- C cold leg accumulator requires frequent feed and bleed to maintain operability due to leak-by of 1SI-258.

b. Observations and Findings

No findings were identified and documented through this inspection.

1R19 Post Maintenance Testing

a. Inspection Scope

The inspectors reviewed the following post-maintenance tests:

Number	Test Procedure Title	Related maintenance task
MST-E0006	"480/240 VAC Molded Case Circuit Breaker Test," Revision 9	WR/JO99-AEYI1, AH-4B breaker replacement
MST I0044	"Nuclear Instrumentation System Power Range N41 Calibration," Revision 15	WR/JO 99-AFAX1, NI-41 digital meter replacement
OST-1131	"Control Room Area HVAC ISI Test Quarterly Interval All Modes," Revision 8	PM-M0014, Limitorque Inspection and Lubrication, Revision 16, and PM-E0009, 480 VAC Motor Preventive Maintenance, Revision 5
OST-1411	"Auxiliary Feedwater Pump 1X-SAB and 1AF-68, 1AF-106, 1AF-87 Forward Flow Operability Test Quarterly Interval Modes 1-3," Revision 11	PM-M0057, Terry Turbine Annual Bolt Retorquing, Revision 6
OST-1010	"Containment Cooling System Operability Test Monthly Interval	WR/JO 99-AEYI-1, fan cooler fan AH-4-1B Trip

Modes 1-4," Revision 10

b. Observations and Findings

No findings were identified and documented through this inspection.

1R22 Surveillance Testing

a. Inspection Scope

The inspectors reviewed the following surveillance tests:

OST 1122, "Train A 6.9 KV Emergency Bus Under Voltage Trip Actuating Device Operation," Revision 1

OST 1118, "Containment Spray Operability Train A Quarterly Interval," Revision 12

MST-I0078, "Residual Heat Exchanger A Bypass Flow (F-0605A) Calibration," Revision 7

b. Observations and Findings

No findings were identified and documented through this inspection.

4 Other Activities

4OA3 Event Follow-up

(Closed) LER 50-400/1999-06-00, Containment-Isolation Valve Technical Specification Noncompliance. The event described in this LER is described in section 4OA4 of this report. No new issues were revealed by this LER.

4OA4 Other

(Closed) URI 50-400/99-02-02, failure of a containment-isolation valve to close in response to a slave-relay signal.

This unresolved item (URI) was opened in NRC Inspection Report (IR) 50-400/99-02, and was discussed in IR 50-400/99-03. The inspectors identified three non-cited violations that had relatively low risk significance:

- Operating the unit with an inoperable containment isolation valve, and not adhering to TS Action requirements.

- Failure to perform an adequate cycling test on one containment isolation valve, and failure to verify the isolation time of two containment isolation valves.

· Failure to promptly identify and correct a test deficiency, and failure to adequately investigate the failure of a containment isolation valve.

This URI involved the following sequence of events:

Date	Event
11/98	During the last refueling outage, the licensee performed preventive maintenance (PM) on the actuators of many safety-related valves. On November 11, 1998, the licensee performed PM on containment-isolation valve 1CC-176, which automatically isolates component cooling water (CCW) flow to the reactor coolant drain tank heat exchanger and excess letdown heat exchanger. Subsequent events indicated that this PM left the valve inoperable with respect to automatic actuation. Following the PM on 1CC-176, the licensee performed a post-maintenance test (PMT) on the valve which consisted of cycling the valve twice, using the handswitch on the main control board (MCB). Subsequent events indicated that this PMT did not reveal the inoperability of the valve with respect to automatic actuation.
11/22/98	During completion of surveillance test OST-1825, “Safety Injection Actuation Switch Test 18 Month Interval Modes 5, 6 or Defueled,” Revision 1, the test coordinator noted that computer records indicated that valve 1CC-176 failed to shut in response to a slave relay signal. The test coordinator mistakenly determined that the valve had actually shut, and thus concluded that the computer records were in error. However, the test coordinator did not identify any test deficiency in the licensee’s corrective action program.
11/24/98	At the end of the refueling outage, the unit entered Mode 4.
12/6/98	During completion of surveillance test OST-1045, “ESFAS Train B Slave Relay Test Quarterly Interval Modes 1-4," Revision 14, test personnel noted that 1CC-176 failed to stroke closed in response to a signal from its slave relay. The licensee entered this failure into the corrective action program as CR 98-03211, and initiated action to determine the cause of the failure and repair the valve. Those actions revealed that in the valve’s actuator, a contact was misaligned and a connector was loose. After the licensee realigned the subject contact and tightened the subject connector, the valve operated properly. Subsequent investigation revealed that the misaligned contact was in the circuit that causes the valve to respond to a signal from the slave relay.

2/24/99 The licensee issued an "Apparent Cause Report" for CR 98-03211, indicating that the investigation of the December 6, 1998, failure was complete. The report said that the cause of the condition was an inadequate PM procedure, and recommended that the procedure be changed. An action item was initiated to change the PM procedure as recommended in the report.

3/99 During a routine equipment-alignment inspection of the CCW system, the inspectors reviewed with the CCW system engineer a sample of CRs associated with CCW components. That sample included CR 98-03211. The inspectors noted that the Apparent Cause Report for that CR said that "it is believed" that the November 11, 1998, PM task had caused valve 1CC-176 to be inoperable, and that the PM procedure contained insufficient detail. The inspectors considered that this conclusion implied the PMT performed on valve 1CC-176 had not been adequate to reveal that the valve was inoperable.

The inspectors considered that the failure of a safety-related valve due to a routine PM task had generic implications that were potentially risk-significant, in that:

- The PM task that apparently made valve 1CC-176 inoperable had been performed on approximately 150 other safety-related valves in multiple safety-related systems,

- The PM task may have made other safety-related valves inoperable, and

- Since the PMT on 1CC-176 had not revealed that valve's inoperability, the same PMT on other safety-related valves would not have revealed those valves' inoperability.

The inspectors thus considered that the inoperability of valve 1CC-176 due to a routine PM task and the subsequent failure of the PMT to reveal that inoperability rendered indeterminate the operability of multiple safety-related systems.

3/31/99 In response to the inspectors' concerns, the licensee initiated CR 99-00976. The licensee's subsequent investigation revealed that:

- All of the safety-related valves which had been subjected to the same PM task as 1CC-176 (except 1CC-176) had been demonstrated operable through scheduled surveillance testing, before the unit entered Mode 4.

- For approximately 50 safety-related valves, the PMT that had been used to demonstrate operability following routine PM tasks was in fact not adequate to demonstrate operability. This was because although some valves are configured such that manual actuation and automatic actuation are accomplished through different circuits in the actuator, and other valves are configured such that manual and automatic actuation are accomplished through the same circuit, the PMT did not distinguish between the two types. Consequently, while the PMT was adequate to demonstrate operability for valves that are configured such that manual and automatic actuation are accomplished through the same circuit, the PMT was not adequate to demonstrate operability for valves with the other configuration. (Valve 1CC-176 was configured such that manual actuation and automatic actuation are accomplished through different circuits in the actuator.)

5/6/99 The licensee determined that during the November 22, 1998, surveillance test described above, a test deficiency had occurred and had not been entered into the corrective-action program. The licensee initiated CR 99-01316 to document that determination.

The 11/22/98 test deficiency was firm evidence that valve 1CC-176 had been inoperable when the unit entered Mode 4. The licensee consequently began preparation of a corresponding Licensee Event Report (LER).

5/21/99 The licensee initiated CR 99-01440, which stated that the initial investigation into the 1CC-176 failure, as described in the Apparent Cause Report associated with CR 98-03211, was not adequate.

5/28/99 The licensee determined that the Technical Specification (TS) 4.6.3.1 surveillance requirement to verify actuation time after maintenance work is performed on a containment-isolation valve's actuator and before placing the valve in service had not been satisfied for containment-isolation valve 1CC-202. The licensee initiated CR 99-01501 to address the issue.

6/4/99 The licensee submitted LER 1999-006-00, which reported that the requirements of TS 4.6.3.1 had not been performed on valves 1CC-176 and 1CC-202 before the unit entered Mode 4, and that, contrary to the requirements of TS 3.6.3, valve 1CC-176 had been inoperable when the unit entered Mode 4. The LER also reported that valve 1CC-176 had been restored to compliance with both TS 3.6.3 and TS 4.6.3.1 on December 6, 1998, and that valve 1CC-202 had been restored to compliance with TS 4.6.3.1 on December 22, 1998.

Significance Determination

The inspectors determined that in this sequence of events, the most risk significance was associated with the finding that the licensee had operated the unit for 11 days (from November 24, 1998, through December 12, 1998) with containment-isolation valve 1CC-176 inoperable. With the assistance of an NRC Senior Reactor Analyst, the inspectors assessed the risk significance of this finding, based on the following:

- In response to a Phase-A containment isolation signal, valve 1CC-176 automatically isolates component cooling water flow to the reactor coolant drain tank heat exchanger and excess letdown heat exchanger.

- The component cooling water piping isolated by valve 1CC-176 is a closed loop that is neither part of the reactor coolant pressure boundary nor connected directly to the containment atmosphere. In addition, the line is neither a high-energy line nor a bypass leakage path.

- The failure of valve 1CC-176 to shut in response to a slave-relay signal would be indicated in the main control room.

- In a scenario in which valve 1CC-176 would be required to shut in response to a slave-relay signal, emergency procedures require control-room operators to verify that all containment-isolation valves are shut, and to manually shut any that are open.

- During the subject period, valve 1CC-176 could be shut from a manual handswitch on the main control board.

The NRC postulated a scenario that would require valve 1CC-176 to shut in order to contain a release of radioactive materials from the containment atmosphere, and estimated that the frequency of that scenario would be on the order of E-14/year. Because that frequency was several orders of magnitude smaller than the threshold between the “green” and “white” licensee performance bands, the NRC concluded that operating the unit for 11 days with valve 1CC-176 not capable of being automatically shut had relatively low risk significance, and was a “green” inspection finding.

Enforcement

The inspectors determined that during this sequence of events, the following violations of NRC requirements occurred:

(1) TS 3.6.3, Containment Isolation Valves, is applicable in Modes 1-4, and requires, in part, that each containment-isolation valve shall be operable. With one or more containment-isolation valve(s) inoperable, TS 3.6.3 provides a choice of several action requirements that must be satisfied within 4 hours. Otherwise, TS 3.6.3 requires the unit to be in hot standby within the next 6 hours, and in cold shutdown within the following 30 hours. Within 4 hours after the unit entered Mode 4, the licensee satisfied none of those action requirements.

Operating the unit with valve 1CC-176 inoperable during the period from November 24, 1998, through December 6, 1998, was a violation of TS 3.6.3. This violation is being treated as a Non-Cited Violation, consistent with Appendix F of the NRC Enforcement Policy. This violation is in the licensee’s corrective action

program as CR 99-01316. The inspectors have designated this violation as NCV 50-400/99-04-01, Mode 4 entry and subsequent unit operation with an inoperable containment isolation valve.

(2) TS 4.6.3.1 is applicable in Modes 1-4, and requires, in part, that each containment-isolation valve shall be demonstrated operable prior to returning the valve to service after maintenance, repair or replacement work is performed on the valve or its associated actuator, control or power circuit by performance of a cycling test, and verification of isolation time. TS 4.0.4 is applicable in all modes, and requires, in part, that entry into an operational mode shall not be made unless the Surveillance Requirement(s) associated with the Limiting Condition for Operation has been performed within the stated surveillance interval. After maintenance was performed on valve 1CC-176 prior to November 24, 1998, the licensee failed to perform an adequate cycling test and verify the valve's isolation time before the unit entered Mode 4 on November 24, 1998. After maintenance was performed on valve 1CC-202 prior to November 24, 1998, the licensee failed to verify the valve's isolation time before the unit entered Mode 4 on November 24, 1998. As a result, the unit entered Mode 4 without the Surveillance Requirements described in TS 4.6.3.1 for valves 1CC-176 and 1CC-202 having been performed.

Failure to perform an adequate cycling test and verify the isolation time of valve 1CC-176 and failure to verify the isolation time of valve 1CC-202 prior to entering Mode 4 on November 24, 1998, and the subsequent entry into Mode 4, was a violation of TS 4.6.3.1 and TS 4.0.4. This violation is being treated as a Non-Cited Violation, consistent with Appendix F of the NRC Enforcement Policy. This violation is in the licensee's corrective action program as CRs 99-01316 and 99-01501. The inspectors have designated this violation as NCV 50-400/99-04-02, failure to demonstrate the operability of containment-isolation valves prior to entering Mode 4.

(3) 10 CFR 50, Appendix B, Criterion XVI, Corrective Action, requires, in part, that measures shall be established to assure that conditions adverse to quality, such as failures, are promptly identified and corrected. The failure of valve 1CC-176 to shut in response to a slave-relay signal during a surveillance test on November 22, 1998, was a condition adverse to quality, and the licensee's failure to promptly identify and correct that failure was a violation of 10 CFR 50, Appendix B, Criterion XVI. This violation is being treated as a Non-Cited Violation, consistent with Appendix F of the NRC Enforcement Policy. This violation is in the licensee's corrective action program as CR 99-01316. The inspectors have designated this violation as example 1 of NCV 50-400/99-04-03, failure to identify and correct conditions adverse to quality.

(4) 10 CFR 50, Appendix B, Criterion XVI, Corrective Action, requires, in part, that measures shall be established to assure that conditions adverse to quality, such as failures, are promptly identified and corrected. In the case of significant conditions adverse to quality, this criterion requires that the measures shall assure that the

cause of the condition is determined and corrective action taken to preclude repetition.

CR 98-03211 identified as an adverse condition the December 6, 1998, failure of valve 1CC-176 to shut in response to a slave-relay signal. The failure of valve 1CC-176 to shut in response to a slave-relay signal was a significant condition adverse to quality. Therefore, 10 CFR 50, Appendix B, Criterion XVI, required the licensee to assure that the cause of the condition was determined and corrective action was taken to preclude repetition. However, the licensee failed to determine the cause of the condition and take action to preclude repetition, in that:

- The Apparent Cause Report associated with CR 98-03211 identified an inadequate preventive-maintenance procedure as the likely cause of the December 6, 1998, failure. However, subsequent investigation revealed that the preventive-maintenance procedure was not inadequate.

- The licensee subsequently determined that the causes of that condition included preventive-maintenance practices that left the valve inoperable, a post-maintenance test that was not adequate to reveal the valve's inoperability, and a surveillance test in which the valve's failure to shut was noted but not addressed. The licensee's investigation into that failure, as documented in the Apparent Cause Report associated with CR 98-03211, did not address and thus did not correct any of those causes.

The licensee's failure to correct the causes of the failure of valve 1CC-176 to shut in response to a slave-relay signal was a violation of 10 CFR 50, Appendix B, Criterion XVI. This violation is being treated as a Non-Cited Violation, consistent with Appendix F of the NRC Enforcement Policy. This violation is in the licensee's corrective action program as CR 99-01440. The inspectors have designated this violation as example 2 of NCV 50-400/99-04-03, failure to identify and correct conditions adverse to quality.

4OA5 Management Meetings

Exit Meeting Summary

The inspectors presented the inspection results to members of licensee management at the conclusion of the inspection on July 21, 1999. The licensee acknowledged the findings presented.

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

PARTIAL LIST OF PERSONS CONTACTED

Licensee

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D. Braund, Superintendent, Security
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NRC

B. Bonser, Chief, Reactor Projects Branch 4
R. Laufer, Harris Project Manager, NRR

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

50-400/99-04-01	NCV	Mode 4 Entry and Subsequent Unit Operation With an Inoperable Containment Isolation Valve. (Section 40A4)
50-400/99-04-02	NCV	Failure to Demonstrate the Operability of Containment-Isolation Valves Prior to Entering Mode 4. (Section 40A4)
50-400/99-04-03	NCV	Failure to Identify and Correct Conditions Adverse to Quality (2 examples) (Sections 40A4 and 40A4)

Closed

50-400/1999-06-00	LER	Containment-Isolation Valve Technical Specification Noncompliance (Section 40A3)
50-400/99-02-02	URI	Failure of a Containment-Isolation Valve to Close in Response to a Slave-Relay Signal (Section 40A4)
50-400/99-04-01	NCV	Mode 4 Entry and Subsequent Unit Operation With An Inoperable Containment Isolation Valve. (Section 40A4)
50-400/99-04-02	NCV	Failure to Demonstrate the Operability of Containment-Isolation Valves Prior to Entering Mode 4. (Section 40A4)
50-400/99-04-03	NCV	Failure to Identify a Condition Adverse to Quality (2 examples) (Sections 40A4 and 40A4)

LIST OF BASELINE INSPECTIONS PERFORMED

The following inspectable-area procedures were used to perform inspections during the report period. Documented findings are contained in the body of the report.

Inspection Procedure		Report Section
Number	Title	
71111-03	Emergent Work	1R03
71111-04	Equipment Alignment	1R04
71111-05	Fire Protection	1R05
71111-06	Flood Protection Measures	1R06
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