



**UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
SAM NUNN ATLANTA FEDERAL CENTER
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ATLANTA, GEORGIA 30303-8931**

April 19, 2004

Virginia Electric and Power Company
ATTN: Mr. David A. Christian
Sr. Vice President and
Chief Nuclear Officer
Innsbrook Technical Center - 2SW
5000 Dominion Boulevard
Glen Allen, VA 23060-6711

**SUBJECT: SURRY POWER STATION - NRC INTEGRATED INSPECTION REPORT NOS.
05000280/2004002 AND 05000281/2004002**

Dear Mr. Christian:

On March 27, 2004, the United States Nuclear Regulatory Commission (NRC) completed an inspection at your Surry Power Station, Units 1 and 2. The enclosed integrated inspection report documents the inspection findings which were discussed on April 19, 2004, with Mr. Blount and other members of your staff.

The inspection examined 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 inspectors reviewed selected procedures and records, observed activities, and interviewed personnel.

Based on the results of this inspection, no findings of significance were identified. However two licensee-identified violations which were determined to be of very low safety significance are listed in Section 4OA7 of this 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 United States Nuclear Regulatory Commission, ATTN.: Document Control Desk, Washington DC 20555-0001; with copies to the Regional Administrator, Region II; the Director, Office of Enforcement, United States Nuclear Regulatory Commission, Washington, DC 20555-0001; and the NRC Resident Inspector at the Surry Power Station.

In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your response (if any) will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records (PARS) component of

NRC's document system (ADAMS). ADAMS is accessible from the NRC Web site at <http://www.nrc.gov/reading-rm/adams.html> (the Public Electronic Reading Room).

Sincerely,

/RA/

Kerry D. Landis, Chief
Reactor Projects Branch 5
Division of Reactor Projects

Docket Nos.: 50-280, 50-281
License Nos.: DPR-32, DPR-37

Enclosure: Integrated Inspection Report 05000280, 281/2004002
w/Attachment: Supplemental Information

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U.S. NUCLEAR REGULATORY COMMISSION

REGION II

Docket Nos.: 50-280, 50-281

License Nos.: DPR-32, DPR-37

Report Nos.: 05000280/2004002, 05000281/2004002

Licensee: Virginia Electric and Power Company (VEPCO)

Facility: Surry Power Station, Units 1 & 2

Location: 5850 Hog Island Road
Surry, VA 23883

Dates: December 28, 2003 - March 27, 2004

Inspectors: G. McCoy, Senior Resident Inspector
D. Arnett, Resident Inspector
L. Garner, Senior Project Engineer (Sections 4OA3 and 4OA7)

Approved by: K. Landis, Chief, Reactor Projects Branch 5
Division of Reactor Projects

Enclosure

SUMMARY OF FINDINGS

IR 05000280/2004002, IR 05000281/2004002: 12/28/2003 - 3/27/2004; Surry Power Station, Units 1 & 2; Routine Integrated Report.

The report covered a three month period of inspection by resident inspectors and an announced inspection by a regional senior project engineer. No findings of significance were identified. The significance of most findings is indicated by their color (Green, White, Yellow, Red) using IMC 0609, "Significance Determination Process," (SDP). Findings for which the SDP does not apply may be Green or be assigned a severity level after NRC management review. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process, Revision 3, dated July 2000.

A. NRC-Identified and Self-Revealing Findings

No findings of significance were identified.

B. Licensee-Identified Violations

Violations of very low safety significance, which were identified by the licensee, have been reviewed by the inspectors. Corrective actions taken or planned by the licensee have been entered into the licensee's corrective action program. These violations and corrective action tracking numbers are listed in Section 4OA7 of this report.

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REPORT DETAILS

Summary of Plant Status

Unit 1 and Unit 2 operated at power the entire reporting period. On March 3, 2004, Unit 1 power was reduced to 75% due to problems with the feedwater heater level control system. On March 5, 2004, Unit 1 was returned to 100 percent power.

1. REACTOR SAFETY

Cornerstones: Initiating Events, Mitigating Systems, Barrier Integrity

1R04 Equipment Alignment

a. Inspection Scope

For the three systems identified below, the inspectors reviewed plant documents to determine correct system lineup, and observed equipment to verify that the system was correctly aligned:

- Unit 2 auxiliary feedwater system while the B auxiliary feedwater pump (2-FW-P-3B) was tagged out for maintenance,
- Unit 2 safety injection system while the B low head safety injection pump (2-SI-P-1B) was tagged out for maintenance, and
- Number 2 emergency diesel generator (EDG) during a performance test of the number 1 EDG.

b. Findings

No findings of significance were identified.

1R05 Fire Protection

a. Inspection Scope

The inspectors conducted tours of the following eight areas to assess the adequacy of the fire protection program implementation. The inspectors checked for the control of transient combustibles and the condition of the fire detection and fire suppression systems (using "SPS Appendix R Report") in the following areas:

- Auxiliary building,
- Turbine building,
- Units 1 and 2 normal switchgear rooms,
- Number 1 emergency diesel generator room,
- Unit 2 safeguards building,
- Unit 2 main steam valve house,
- Emergency service water pump room and oil tank room, and
- Unit 2 emergency switchgear room.

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b. Findings

No findings of significance were identified.

1R11 Licensed Operator Requalification Programa. Inspection Scope

The inspectors observed licensed operator performance during simulator training session RQ-04.1-ST-1 & 2 to determine whether the operators:

- were familiar with and could successfully implement the procedures associated with recognizing and recovering from containment sump blockage and the proper application of abnormal procedures;
- recognized the high-risk actions in those procedures; and,
- were familiar with related industry operating experiences.

b. Findings

No findings of significance were identified.

1R12 Maintenance Effectivenessa. Inspection Scope

For the two equipment issues described in the plant issues listed below, the inspectors evaluated the licensee's effectiveness of the corresponding preventive and corrective maintenance. For each selected item below, the inspectors performed a detailed review of the problem history and surrounding circumstances, evaluated the extent of condition reviews as required, and reviewed the generic implications of the equipment and/or work practice problem. Inspectors performed walkdown of the accessible portions of the system, performed in-office reviews of procedures and evaluations, and held discussions with system engineers. Inspectors compared the licensee's actions with the requirements of the Maintenance Rule (10 CFR 50.65), VPAP 0815, "Maintenance Rule Program," and the Surry Maintenance Rule Scoping and Performance Criteria Matrix.

- Oil leakage issues on the Unit 1 and Unit 2 service air compressors (1-SA-C-1 and 2-SA-C-1) (Plant Issues S-2002-3499, S-2002-3834, S-2003-0933, and S-2003-5154), and
- A clogged Y-strainer on the A control room chiller (1-VS-E-4A) (Plant Issue S-2003-4291).

b. Findings

No findings of significance were identified.

1R13 Maintenance Risk Assessments and Emergent Work Control

a. Inspection Scope

The inspectors reviewed the licensee's risk assessments and the risk management actions used to manage risk for the plant configurations associated with the five activities listed below. The inspectors verified that the licensee performed adequate risk assessments, and implemented appropriate risk management actions when required by 10 CFR 50.65(a)(4). For emergent work, the inspectors also verified that any increase in risk was promptly assessed, and that appropriate risk management actions were promptly implemented.

- The B component cooling heat exchanger (1-CC-E-1B), and the Unit 2 A charging pump (2-CH-P-1A) out of service for maintenance and the motor driven fire pump (1-FP-P-1) failed a performance test;
- The blackout diesel out of service for maintenance with the Unit 1 AMSAC system, D component cooling heat exchanger (1-CC-E-1D), and the A control room chiller (1-VS-E-4A) out of service for maintenance;
- Work in the 230 KV switchyard with the B control room chiller (1-VS-E-4B) and the C component cooling heat exchanger (1-CC-E-1C) out of service for maintenance;
- Failure of the 2A2 battery charger (2-EP-UPS-2A-2) during the semi-annual station battery test while the Unit 2 C charging pump (2-CH-P-1C) was out of service for maintenance; and
- Performance of the number 3 emergency diesel generator start sequence test (0-OPT-EG-008) with maintenance activity in the 230 KV switchyard.

b. Findings

No findings of significance were identified.

1R14 Operator Performance During Non-Routine Evolutions and Events

a. Inspection scope

Inspectors observed operations in the control room when the Unit 1 B feedwater regulating valve (1-FW-FCV-1488) was placed on the jack in accordance with procedure 1-MOP-FW-015. The inspectors reviewed operator logs, plant computer data, and strip charts to determine the operator's response and to verify the evolution was performed in accordance with plant procedures.

b. Findings

No findings of significance were identified.

1R15 Operability Evaluations

a. Inspection Scope

The inspectors evaluated the technical adequacy of five operability evaluations to ensure that operability was properly justified and the subject component or system remained available such that no unrecognized increase in risk occurred. The operability evaluations were described in the engineering transmittal (ET) and plant issues listed below:

- ET S-03-0202 Rev 0 & 1, "Evaluation of Unit 1 computer enhanced rod position indication (CERPI) M-10 spiking;"
- ET S-04-0019 Rev 0 & 1, "Repair of degraded shaft on 02-CH-P-1C;"
- Plant Issue S-2004-0931, "Steam trap found cold and needed to be bypassed during 1-OPT-FW-003 (1-FW-P-2);"
- Plant Issue S-2004-0030, "1-FP-P-1 failed during 0-OPT-FP-008;" and
- Plant Issue S-2004-0245, "Failed compression test on the B emergency service water pump (1-SW-P-1B)."

b. Findings

No findings of significance were identified.

1R19 Post Maintenance Testing

a. Inspection Scope

The inspectors reviewed five post maintenance test procedures and activities associated with the repair or replacement of the following components to determine whether the procedures and test activities were adequate to verify operability and functional capability following maintenance of the following equipment:

- Work order (WO) 504075-2, "Overhaul emergency service water pump 1B diesel engine (01-SW-P-1B);"
- WO 494148-01, "Valve exercise test of containment spray pump B suction (01-CS-MOV-100B);"
- WO 503002-05, "Replace SI logic cabinet test switch;"
- WO 509794-01, "Weld repair of 1-SI-P-1B discharge flow element;" and
- WO 502151-01, "Air entrained in the oil of Unit 2 A charging pump (2-CH-P-1A)."

b. Findings

No findings of significance were identified.

1R22 Surveillance Testinga. Inspection Scope

For the seven surveillance tests listed below, the inspectors examined the test procedure and either witnessed the testing and/or reviewed test records to determine whether the scope of testing adequately demonstrated that the affected equipment was functional and operable:

- 2-PT-1.2, "Power range nuclear instrument trip channel test," on N-41;
- 0-EPT-0104-01, "Semi-annual station battery test;"
- 1-OPT-FW-003, "Turbine driven auxiliary feedwater pump 1-FW-P-2;"
- 0-ST-VS-004, "Integrated tracer gas test of control room envelope;"
- 0-ST-VS-005, "Main control room emergency fan unfiltered inleakage testing;"
- 0-OP-AAC-001, "AAC diesel generator operation;" and
- 1-PT-8.1, "Reactor protection system logic (for normal operations)."

b. Findings

No findings of significance were identified.

Cornerstone: Emergency Preparedness1EP6 Drill Evaluationa. Inspection Scope

The inspectors observed an emergency response training drill conducted on January 6, 2004 in the technical support center to assess the licensee's performance in emergency classification, notification, and protective action recommendation development.

b. Findings

No findings of significance were identified.

4. OTHER ACTIVITIES4OA1 Performance Indicator VerificationUnplanned Scrams per 7000 critical hours Performance Indicatora. Inspection Scope

The inspectors performed a periodic review of the Unplanned Scrams per 7000 critical hours performance indicator for Units 1 and 2. Specifically, the inspectors reviewed this performance indicator from the first quarter of 2003 through the fourth quarter of 2003. Inspectors evaluated whether the performance indicator was calculated in accordance

with the guidance contained in NEI 99-02. Documents reviewed included applicable monthly operating reports, licensee event reports and operator logs.

b. Findings

No findings of significance were identified.

4OA2 Problem Identification and Resolution

.1 Daily Review of Plant Issues

a. Inspection Scope

As required by Inspection Procedure 71152, "Identification and Resolution of Problems," and in order to help identify repetitive equipment failures or specific human performance issues for follow-up, the inspectors performed a daily screening of items entered into the licensee's corrective action program. This review was accomplished by reviewing hard copies of each condition report and attending the daily Plant Issue Review Team meetings.

b. Findings

No findings of significance were identified.

.2 Semi-Annual Review of Plant Issues

a. Inspection Scope

The inspectors performed a semi-annual review of the licensee's corrective action program to identify trends that might indicate the existence of more significant safety issues. This semi-annual review included a review of the licensee's system health reports, self-assessment reports, and the plant issue database.

b. Findings

No findings of significance were identified.

.3 Detailed Review of Individual Issues

a. Inspection Scope

The inspectors performed an in-depth review of the failure of the A control room chiller chilled water pump (1-VS-P-2A) to achieve the required minimum flowrate of 250 gpm. This issue was documented in the corrective action program by Plant Issues: S-2003-1059, S-2003-3072, S-2003-3982, S-2004-0106, S-2004-0187, S-2004-0190, S-2004-0191, S-2004-0217 and S-2004-0241. The plant issues were reviewed to ensure that the full extent of the issue was identified, an appropriate evaluation was performed, and

appropriate corrective actions were specified and prioritized. The inspectors evaluated the plant issues against the requirements of the licensee's corrective action program as delineated in Station Administrative Procedure VPAP-1601, "Corrective Action," and 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action."

b. Findings and Observations

No findings of significance were identified. The inspectors observed that the licensee failed to adequately determine the causes for the chilled water pump not meeting performance acceptance criteria during sequential quarterly tests. For each of three quarterly tests, the licensee took limited corrective actions, such as changing the pump lift, to address the test failure. In January 2004, after another quarterly performance test failure, extensive troubleshooting was performed on the chilled water system. As a result, the pump impeller was replaced, the discharge globe valve was replaced with a gate valve and a suction strainer was removed. After this work, the pump easily achieved the post maintenance testing requirements and was returned to service. Failure to take adequate corrective action is a violation of 10 CFR 50 Appendix B Criterion XVI. This violation is minor because this is one of five available chillers and despite the degraded chilled water pump, the chiller would still be able to provide some cooling to the control room air handlers.

4OA3 Event Followup

.1 (Closed) LER 05000280/2002001-00 Inadvertent Auxiliary Feedwater Pumps Autostart Due to Relay Failure

On December 31, 2002, the Unit 1 A Motor Driven Auxiliary Feedwater Pump automatically started due to a relay failure. During the relay replacement, the Steam Driven Auxiliary Feedwater Pump automatically started twice due to intermittent continuity of a temporary jumper. The inspectors reviewed the LER and associated plant issues and identified no findings of significance. The licensee identified the relay failure and auxiliary feedwater pump automatic starts in their corrective action program as Plant Issues S-2002-4071 and S-2002-4075, respectively.

.2 (Closed) LER 05000281/2002001-00 Residual Heat Removal Piping Corrosion Through-wall Leak

On April 13, 2002, the licensee identified a small through-wall leak on a Unit 2 Residual Heat Removal (RHR) 3/4-inch pipe which rendered both trains of the RHR system inoperable due to a non-conformance with the American Society of Mechanical Engineers (ASME) Code. However, the RHR system remained capable of performing its design function. With both trains of RHR inoperable and with two reactor coolant system loops out of service during plant heatup, the conditions of Technical Specification 3.1.A1.d.1 were not met. The licensee took appropriate immediate actions and subsequently replaced the RHR piping section. Engineering determined that the leak had not compromised the structural integrity of the pipe. A visual inspection on Unit 1 revealed no similar problem. No new findings were identified by the inspectors'

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review. This failure to comply with Technical Specifications constitutes a violation of minor significance that is not subject to enforcement action in accordance with Section IV of the NRC's Enforcement Policy. The problem is documented in the licensee's corrective action program as Plant Issue S-2002-1390.

.3 (Closed) LER 05000281/2002002-00 Low Head Safety Injection System Inoperable Due To Partially Closed Valve

On October 30, 2002, the licensee identified that the outlet valve for the Unit 2 A Low Head Safety Injection (LHSI) pump seal cooler was 90 percent closed, which rendered the pump inoperable. The valve was re-opened approximately 20 minutes later. Operating procedure 2-OP-SI-001A, "Safety System Alignment," required the valve to be full open. This finding is more than minor because inadequate seal cooling could result in the loss of the outboard seal. The finding effects the Mitigating Systems and Barrier Integrity Cornerstones. If one assumes that the pump was unable to perform its safety function, the other LHSI pump was capable of performing the system's function. If the outboard seal was to fail, the inboard seal was not affected by the condition and precluded an open pathway from containment. Thus, in accordance with the Significance Determine Process phase I screening worksheet, the finding is determined to be of very low safety significance (green). This licensee-identified finding is a violation of Technical Specification 6.4, "Unit Operating Procedures." Enforcement aspects of the violation are addressed in Section 4OA7 of this report. The finding is documented in the licensee's corrective action program as Plant Issue S-2002-3408.

.4 (Closed) LER 0500281/2002003-00 Reactor Trip Due To Turbine Electro-Hydraulic Control Circuitry Failure

On November 23, 2002, Unit 2 reactor tripped due to circuit card failures in the turbine electro-hydraulic control circuitry. The cards were replaced and the failed cards were sent to an offsite vendor for failure analysis. The inspectors reviewed the LER and associated plant issue and identified no findings of significance. The licensee documented the equipment failures in their corrective action program as Plant Issue S-2002-3678.

.5 (Closed) LER 05000281/2002004-00 Turbine Trip Fuses Removed Resulting in Condition Prohibited by Tech Specs

On November 23, 2002, both trains of the Unit 2 turbine trip logic were defeated when circuit fuses were removed in accordance with a post maintenance test procedure. Technical Specification Table 3.7-3 does not allow both trains to be inoperable when the unit is in Hot Shutdown. The inadequate test procedure was revised. The turbine trip function was effectively fulfilled since the associated turbine valves were already closed. The inspectors reviewed the LER and associated plant issue and identified no new findings. This failure to comply with Technical Specifications constitutes a violation of minor significance that is not subject to enforcement action in accordance with Section IV of the NRC's Enforcement Policy. The problem was documented in the licensee's corrective action program as Plant Issue S-2002-3688.

.6 (Closed) LER 05000281/2003002-00 Inside Recirculation Spray Pump Breaker Failed to Close Due to Mechanical Binding

On September 23, 2003, during surveillance testing, the Unit 2 B inside recirculation spray pump failed to start due to mechanical binding in the pump's electrical breaker. The probable failure mode indicates that the mechanical binding occurred when the pump was secured from its last operation on April 3, 2002. The breaker was replaced and actions were taken to address this condition on other similar safety-related breakers. The condition which affected the Mitigating Systems Cornerstone is more than minor due to the duration the pump, i.e., subsystem, was inoperable. Because there was no licensee performance deficiency, this finding is not suitable for Significance Determination Process evaluation, but has been reviewed by NRC management and is determined to be a green finding of very low safety significance. The management review determination included consideration that if a Significance Determination Process evaluation was performed, the evaluation result would be green due to the availability of the other three recirculation spray subsystems and other mitigating equipment. This licensee-identified finding is a violation of Technical Specification 3.4, "Spray Systems." Enforcement aspects of the violation are addressed in Section 4OA7 of this report. The finding is documented in the licensee's corrective action program as Plant Issues S-2003-4251 and S-2003-4275.

4OA6 Meetings, Including Exit

.1 Exit Meeting Summary

On April 19, 2004, the resident inspectors presented the inspection results to Mr. Blount and other members of his staff who acknowledged the findings. The inspectors confirmed that proprietary information was not provided or examined during the inspection.

.2 Annual Assessment Meeting Summary

On April 8, 2004, the NRC Chief of Reactor Projects Branch 5 met with Virginia Electric and Power Company to discuss the NRC's Reactor Oversight Process (ROP) and the Surry Power Station (SPS) annual assessment of safety performance for the period of January 1, 2003 - December 31, 2003. The major topics addressed were the NRC's assessment program and the results of the SPS assessment. Attendees included corporate and SPS site management, site staff, and members of the local news media and the public.

This meeting was open to the public. The presentation material used for the discussion is available from the NRC's document system (ADAMS) as accession number ML041070128. ADAMS is accessible from the NRC Web site at <http://www.nrc.gov/reading-rm/adams.html> (the Public Electronic Reading Room).

4OA7 Licensee-Identified Violations

The following violations of very low safety significance (green) were identified by the licensee and are violations of NRC requirements which meet the criteria of Section IV of the NRC Enforcement Policy, NUREG-1600, for being dispositioned as a Non-Cited violation.

- Technical Specifications 6.4 A and D required procedures for operation of components involving nuclear safety be followed. On October 30, 2002, the licensee determined that the seal cooler outlet valve for the Unit 2 LHSI pump was not open as required by operating procedure 2-OP-SI-001A. This finding was of very low safety significance as discussed in Section 4OA3.3. This issue is addressed in the licensee's corrective action program as Plant Issue S-2002-3408.
- Technical Specification 3.4.B.3 required an inoperable inside recirculation spray subsystem be returned to operable status within 72 hours. Contrary to the above, on September 23, 2003, the Unit 2 B inside recirculation spray subsystem was found to have been inoperable due to mechanical binding of the B inside recirculation spray pump breaker. Based upon the probable failure mode, the pump was inoperable after it was last shutdown on April 3, 2002. This finding was of very low safety significance as discussed in Section 4OA3.6. This issue is addressed in the licensee's corrective action program as Plant Issues S-2003-4251 and S-2003-4275.

ATTACHMENT: SUPPLEMENTAL INFORMATION

SUPPLEMENTAL INFORMATION

KEY POINTS OF CONTACT

Licensee

R. Allen, Manager, Outage and Planning
R. Blount, Site Vice President
M. Gaffney, Director, Nuclear Station Safety and Licensing
B. Garber, Supervisor, Licensing
T. Huber, Manager, Engineering
L. Jones, Manager, Radiation Protection and Chemistry
D. Llewellyn, Manager, Training
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K. Sloane, Director, Nuclear Station Operations and Maintenance
B. Stanley, Manager, Maintenance
J. Swientoniewski, Manager, Operations

NRC

K. Landis, Chief, Branch 5, Division of Reactor Projects, Region II

LIST OF ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

None

Closed

05000280/2002001-00	LER	Inadvertent Auxiliary Feedwater Pumps Autostart Due to Relay Failure (Section 4OA3.1)
05000281/2002001-00	LER	Residual Heat Removal Piping Corrosion Through-wall Leak (Section 4OA3.2)
05000281/2002002-00	LER	Low Head Safety Injection System Inoperable Due To Partially Closed Valve (Section 4OA3.3)
05000281/2002003-00	LER	Reactor Trip Due To Turbine Electro-Hydraulic Control Circuitry Failure (Section 4OA3.4)
05000281/2002004-00	LER	Turbine Trip Fuses Removed Resulting in Condition Prohibited by Tech Specs (Section 4OA3.5)

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05000281/2003002-00

LER

Inside Recirculation Spray Pump Breaker Failed to Close Due to Mechanical binding (Section 4OA3.6)

Discussed

None

Attachment