UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
SAM NUNN ATLANTA FEDERAL CENTER
61 FORSYTH STREET SW SUITE 23T85
ATLANTA, GEORGIA 30303-8931

February 23, 2001

Tennessee Valley Authority
ATTN: Mr. J. A. Scalice
Chief Nuclear Officer and
Executive Vice President
6A Lookout Place
1101 Market Street
Chattanooga, TN 37402-2801

SUBJECT: BROWNS FERRY NUCLEAR PLANT - NRC INSPECTION REPORT 50-259/00-07, 50-260/00-07, AND 50-296/00-07

Dear Mr. Scalice:

On January 26, 2001, the NRC completed an inspection at your Browns Ferry Nuclear facility. The enclosed report presents the results of that inspection. The results were discussed on January 26, 2001, with Mr. A. Bhatnagar and other members of your staff.

The inspection was an examination of activities conducted under your license as they relate to the identification and resolution of problems, and compliance with the Commission's rules and regulations and with the conditions of your operating license. Within these areas, the inspection consisted of a selective examination of procedures and representative records, observations of activities, and interviews with personnel. On the basis of the sample selected for review, there were no findings of significance identified during this inspection. The inspectors concluded that overall, problems were properly identified, evaluated, and resolved within the Browns Ferry problem identification and resolution programs.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosure 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

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Sincerely,

//RA//

Paul E. Fredrickson, Chief
Reactor Projects Branch 6
Division of Reactor Projects

Docket Nos. 50-259, 50-260, 50-296
License Nos. DPR-33, DPR-52, DPR-68

Enclosure: NRC Inspection Report
Nos. 50-259/00-07, 50-260/00-07, 50-296/00-07

Attachment: List of Documents Reviewed

cc w/encl:
Karl W. Singer
Senior Vice President
Nuclear Operations
Tennessee Valley Authority
Electronic Mail Distribution

Jack A. Bailey, Vice President
Engineering and Technical Services
Tennessee Valley Authority
Electronic Mail Distribution

Karl W. Singer
Site Vice President
Browns Ferry Nuclear Plant
Tennessee Valley Authority
Electronic Mail Distribution

General Counsel
Tennessee Valley Authority
Electronic Mail Distribution

cc w/encl: continued see page 3

cc w/encl: Continued
Robert J. Adney, General Manager
Nuclear Assurance
Tennessee Valley Authority
Electronic Mail Distribution

Ashok S. Bhatnagar, Plant Manager
Browns Ferry Nuclear Plant
Tennessee Valley Authority
Electronic Mail Distribution

Mark J. Burzynski, Manager
Nuclear Licensing
Tennessee Valley Authority
Electronic Mail Distribution

Timothy E. Abney, Manager
Licensing and Industry Affairs
Browns Ferry Nuclear Plant
Tennessee Valley Authority
Electronic Mail Distribution

State Health Officer
Alabama Dept. of Public Health
RSA Tower - Administration
Suite 1552
P. O. Box 303017
Montgomery, AL 36130-3017

Chairman
Limestone County Commission
310 West Washington Street
Athens, AL 35611

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U.S. NUCLEAR REGULATORY COMMISSION

REGION II

Docket Nos:	50-259, 50-260, 50-296
License Nos:	DPR-33, DPR-52, DPR-68
Report Nos:	50-259/2000-07, 50-260/2000-07, 50-296/2000-07
Licensee:	Tennessee Valley Authority (TVA)
Facility:	Browns Ferry Nuclear Plant, Units 1, 2, & 3
Location:	Corner of Shaw and Browns Ferry Roads Athens, AL 35611
Dates:	January 8 through January 26, 2001
Inspectors:	J. Bartley, Senior Resident Inspector, Watts Bar, Lead Inspector J. Starefos, Resident Inspector, Browns Ferry P. Fillion, Reactor Inspector, Region II
Approved by:	P. Fredrickson, Chief Reactor Projects Branch 6 Division of Reactor Projects

Enclosure

SUMMARY OF FINDINGS

IR 05000259-00-07,05000260-00-07, 05000296-00-07; on January 8 -26, 2001; Tennessee Valley Authority (TVA); Browns Ferry Units 1, 2, and 3; annual baseline inspection of the identification and resolution of problems.

The inspection was conducted by a senior resident inspector from Watts Bar, the Browns Ferry resident inspector, and a regional reactor inspector. No findings of significance were identified.

Identification and Resolution of Problems:

The licensee was effective at identifying problems and placing them into the corrective action program. The licensee's effectiveness at problem identification was evident by the relatively few deficiencies identified by external organizations, including the NRC, that had not been previously identified by the licensee. The licensee appropriately evaluated individual problems based on risk significance when establishing schedules for implementing corrective actions. Corrective actions were generally implemented in a timely manner.

Licensee audits and assessments were found to be effective with an improving trend noted in the quality of problem reporting and root cause evaluations. Findings and problems identified by the audits and assessments were consistent with the inspectors' observations. The interviews of plant personnel indicated that they felt free to input safety issues and conditions adverse to quality into the corrective action program. A safety conscious work environment was evident at Browns Ferry. The inspectors identified several minor instances where conditions adverse to quality related to personnel contamination events were being handled outside the corrective action program, minor deficiencies with root cause evaluations for human performance events, and some minor corrective action documentation deficiencies.

REPORT DETAILS

4. OTHER ACTIVITIES (OA)

4OA2 Problem Identification and Resolution

.1 Effectiveness of Problem Identification

a. Inspection Scope

The inspectors reviewed items selected across the seven cornerstones of safety and high risk systems to verify that problems were being properly identified, appropriately characterized, and entered into the corrective action program for evaluation and resolution. Specifically, the inspectors selected 86 problem evaluation reports (PERs) from the 1,944 which had been issued during calender year 2000 (CY2000). The inspectors reviewed 13 PERs initiated in 1998 and 1999 that were still open at the start of the inspection. In addition the inspectors reviewed the PERs using various computer sorts to determine if any crosscutting issues existed and had been resolved. A list of the specific PERs and sorts reviewed is included in the Attachment to this report. The inspectors also reviewed selected PERs for five risk-significant systems, security equipment, and electrical distribution.

The inspectors reviewed the licensee's Operations Procedure Change Request Program and the personnel contamination events (PCE) tracking database for 2000 to verify that identified problems were not bypassing authorized corrective action programs.

The inspectors reviewed audits and assessments relating to problem identification and resolution. A listing of the specific documents reviewed is included in the Attachment. The inspectors compared the findings and problems identified by the audits and assessments with the findings and observations of the inspectors.

The inspectors reviewed the licensee's evaluation for a sample of operating experience items including reports submitted pursuant to 10 CFR 21, vendor letters, NRC information notices and letters from the nuclear steam supply system (NSSS) supplier. The evaluations reviewed were documented in the selected Nuclear Experience Review (NER) documents listed in the Attachment.

The inspectors walked down the following systems to determine the licensee's effectiveness in identifying deficient conditions. The inspectors selected the systems based on risk significance.

- Division II emergency core cooling system analog trip unit inverter unit
- 480 V reactor motor operated valve board 3A
- 480 V shutdown board 3B
- 5 kV switchgear 3EC
- 250 V shutdown board battery 3EB and associated charger
- Emergency diesel generator (EDG) 3A
- Units 2 and 3 residual heat removal pumps and selected heat exchanger rooms

- Units 2 and 3 high pressure coolant injection system pump rooms
- Units 2 and 3 reactor core isolation cooling system pump areas
- Units 1, 2, and 3 residual heat removal service water (RHRSW) and emergency equipment cooling water pumps

b. Issues and Findings

No findings of significance were identified. Based on a review of the CY2000 PERs, audits, self-assessments, NRC identified findings, and system walkdowns, the inspectors determined that the licensee was identifying problems at the appropriate level and entering them into the corrective action program. This was supported by the few deficiencies identified by external organizations during the last year that were not already identified by the licensee through Nuclear Assurance audits, self-assessments, or the licensee staff's questioning attitude. The licensee's self-assessments were thorough and self-critical and were consistent with the inspectors' observations. The threshold for documenting conditions adverse to quality was at an acceptable level.

Management oversight was evident in all aspects of the program. Performance trending was extensive and informative with an appropriate focus on human performance. The inspectors identified minor instances where conditions adverse to quality related to personnel contamination events were being handled outside the corrective action program. However, the inspectors determined that the conditions were being promptly identified and corrected and therefore, this issue was considered to be minor in nature. The licensee initiated PER 01-000847-000 to resolve the issue. The inspectors also identified one instance where a PER was not generated to document a functional failure of a radiation monitor. The inspectors considered this a minor issue because the licensee took all the Maintenance Rule (MR) required actions and no additional corrective actions would have resulted by writing a PER. The licensee generated PER 01-000830-000 to address the corrective action aspects of this issue.

.2 Prioritization and Evaluation of Issues

a. Inspection Scope

The inspectors reviewed the licensee's prioritization and evaluation of NRC violations, audit and self-assessment findings, industry operating experience, and self-identified deficiencies. The industry operating experience review consisted of a sample of operating reports submitted pursuant to 10 CFR 21, vendor letters, NRC information notices, and letters from the NSSS supplier. A listing of the specific documents reviewed is included in the Attachment. The inspectors also reviewed the sampling of PERs listed in the Attachment to evaluate the licensee's efforts in establishing the scope of problems and the cause determination. Additionally, the inspectors reviewed the root cause evaluations for fifteen PERs.

b. Issues and Findings

No findings of significance were identified. The inspectors determined that the licensee was effective in prioritizing and evaluating issues commensurate with their safety significance. The majority of the 1,944 PERs generated during CY2000 were level C (1,358) and level D (344), with level A being the highest priority and D the lowest. The PERs reviewed were assigned the appropriate priority level. In addition, the inspectors concluded that the licensee's reviews for extent of condition, generic implications, common cause failure modes, and previous occurrences were effective. Operability and reportability issues were appropriately evaluated and resolved. Significant conditions adverse to quality were evaluated and resolved in a timely manner. Root cause evaluations were typically effective in identifying the root and contributing causes for significant conditions. The inspectors noted minor deficiencies with root cause evaluations for human performance events which were consistent with the findings of the licensee's root cause evaluation self-assessments. The inspectors did not identify any cases where the deficiencies resulted in inadequate corrective actions. The licensee instituted a program to improve the quality of root cause evaluation which assigns a root cause expert in each organization and the root cause evaluations are graded for quality.

.3 Effectiveness of Corrective Actions

a. Inspection Scope

The inspectors reviewed the sampling of 99 PERs listed in the Attachment, to verify that the licensee had identified and implemented corrective actions commensurate with issue safety-significance, and where possible, evaluated the effectiveness of the actions taken. Program requirements such as criteria and conditions necessary for closing a PER were also reviewed. Six of the sixty-seven PERs which were greater than one year old were reviewed to verify that appropriate immediate corrective actions were taken to correct or compensate for the identified problem. The inspectors also reviewed four non-cited violations and three licensee event reports to evaluate the adequacy of corrective actions and to verify that the identified corrective actions were completed. Corrective actions resulting from the audits and assessments were evaluated for appropriateness to the circumstances.

Correction of plant equipment problems was evaluated in order to verify that the cause analyses of conditions adverse to quality were adequately performed. The inspectors specifically reviewed the licensee's corrective actions for two functional failures associated with an EDG, and a radiation monitor. The inspectors also selected for review three PERs, 00-002341-000, 00-000670-000, and 00-003657-000, which the licensee had determined to be preventable functional failures. These PERs were reviewed to assess several aspects, including the problem statement, immediate action, priority, regulatory reporting, cause, corrective action, and timeliness. The inspectors reviewed fifteen of the root cause analysis determinations which were performed in CY2000 to evaluate the effectiveness of the corrective actions in preventing recurrence of the conditions.

b. Issues and Findings

The inspectors determined that, with one exception, the licensee's corrective actions were appropriately focused to correct the problem and, for significant conditions adverse to quality, adequate to prevent recurrence. Corrective actions developed and implemented for plant equipment problems were generally effective in correcting the equipment deficiencies. The apparent cause determination was generally correct in identifying why the equipment problems occurred and the licensee was thorough in completing corrective actions. The licensee identified appropriate PERs for consideration as generic concerns and evaluation of common causes. The inspectors identified some minor corrective action deficiencies associated with corrective action documentation which were provided to the licensee for resolution. The deficiencies were consistent with findings from the licensee's self-assessments. The licensee generated PERs 01-000708-000 and 01-000717-000 to resolve these deficiencies.

An unresolved item (URI) was identified related to MR implementation and corrective action involving numerous RHRSW room sump pump failures. The inspectors reviewed PER 00-005304-000, which described a repetitive failure trend for RHRSW room C sump pump A caused by blown fuses on four different occasions. This PER was initiated on May 23, 2000. Between September 1998 and September 2000, the licensee experienced six failures of this sump pump. Each of the six failures were documented by separate work orders (WOs). The first three failures were corrected by replacement of the control power fuse. The fourth failure was corrected by replacement of the control power fuse and troubleshooting which failed to identify any causes. Fuses were replaced for the fifth and sixth failures along with the replacement of the coil and starter parts. In October 2000, the licensee initiated WO 00-010196-001 to replace the complete motor starter in the 480V electrical board compartment. As of January 26, 2001, this WO remained open in a materials restraint (ordered) status. The inspectors determined that the actual cause of the numerous RHRSW room sump pump failures, as indicated by the continuing fuse replacements, had not been promptly identified and corrected.

As part of the corrective action review of the sump pump issue, the inspectors reviewed the licensee's implementation of the MR as it related to the RHRSW room sump pump failures. Procedure SPP-6.6, Maintenance Rule Performance Indicator Monitoring, Trending, and Reporting 10CFR50.65, Revision 5 implements the requirements of 10 CFR 50.65. Procedure 0-TI-346, Maintenance Rule Performance Indicator Monitoring, Trending, and Reporting 10CFR50.65, Revision 15, Attachment 5, Section 2 identifies the MR performance criteria for components being monitored under the MR.

Procedure SPP-6.6 states that if the cause determination reveals that the corrective actions associated with events or conditions contributing to exceeding a function's performance criteria (functional failure, train or component reliability, or condition) are determined inadequate to correct deficiencies then the function is placed in a(1). Two cause determination evaluations (CDEs) were written that addressed the RHRSW room sump pump failures. The MR expert panel met on two occasions to discuss the failures. On May 18, 2000, the MR expert panel only assessed two of the four failures that had previously occurred because the system engineer was unaware of two of the failures. On November 2, 2000, the MR expert panel assessed the six sump pump failures discussed above and concluded that there was not sufficient evidence that the sump pump problem had been identified since one of the sump pumps had failed six times

and was currently awaiting a starter. The MR expert panel also concluded that they were not prepared to make a judgement on whether to keep the system in a(2) or to go to a(1) status until the root cause of the problem was identified and clearly understood. In addition, the MR expert panel considered that the function provided by the RHRSW room sump pumps was not risk-significant, that only one sump pump was exhibiting reliability concerns, and that no functional failures (loss of decay heat removal capability) had occurred.

Procedure SPP-6.6 also states that after the function is placed in a(1), a goal is set for the function being monitored, that a PER shall be initiated in accordance with SPP-3.1, Corrective Action Program, and that the PER shall be classified as a Level A or B and shall require formal root cause techniques. The inspectors determined that had the MR process been followed, a Level B PER, requiring a root cause evaluation, would have been generated. Thus, a more prompt identification and correction of the actual sump pump failure condition adverse to quality, may have occurred. Due to this issue having interrelated corrective action and MR aspects, further NRC review of the corrective actions related to this issue and also the licensee's not placing the RHRSW room sump pumps in MR a(1) is necessary. Pending completion of this review, this issue is identified as Unresolved Item (URI) 259,260,296/2001-007-01, RHRSW Room Sump Pump Failures.

.4 Assessment of Safety Conscious Work Environment

a. Inspection Scope

The inspectors interviewed plant personnel and developed a general view of the safety culture at Browns Ferry in terms of willingness to report problems, and attitudes toward maintaining safety margins and defense in depth. The inspectors also attended Management Review Committee meetings to develop insights into management's expectations for identifying and resolving problems.

b. Issues and Findings

No findings of significance were identified. The inspectors concluded that licensee management was pro-active in fostering a work environment that encouraged employees to identify problems and initiate PERs. Employees felt free to identify concerns to either supervision or the employees concern program. The Management Review Committee was quick to encourage employee's to initiate PERs when the number of PERs being generated was seen to be dropping off.

4OA6 Management Meetings

The inspectors presented the inspection results to Mr. A. Bhatnagar and other members of licensee management at the conclusion of the inspection on January 26, 2001. 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

T. Achorn, Site Licensing
T. Abney, Licensing Manager
S. Armstrong, Performance Analysis
A. Bhatnagar, Site Support Manager
P. Chadwell, Operations Support Supervisor
R. Coleman, Radcon Manager
J. Corey, Radiation Protection and Chemistry Manager
J. Grafton, Site Quality Assurance Manager
E. Hollis, Outage Scheduling
R. Jones, Site Support Manager
G. Little, Operations Manager
R. Moll, System Engineering Manager
T. Niessen, Assistant Plant Manager
L. Parvin, Performance Analysis
M. Scaggs, Maintenance and Modifications Manager
J. Wallace, Site Licensing Engineer
R. Wiggall, Site Engineering Manager

ITEMS OPENED

259,260,296/2001-007-01	URI	RHRSW Room Sump Pump Failures (Section 4OA2.3).

ATTACHMENT

LIST OF DOCUMENTS REVIEWED

Problem Evaluation Reports

RCA - root cause analysis was specified by the licensee and reviewed by the inspectors
* - reviewed only for timeliness of corrective actions and extensions

PER #	Level
98-006431-000	C
98-007420-000	C
98-013383-000	A RCA
99-010011-000	C
99-011560-000	C
99-012645-000	C
99-012678-000	C
99-012679-000	C
99-012680-000	C
99-012681-000	C
99-012682-000	C
99-012730-000	C
99-013025-000	C
00-000060-000	C
00-000135-000	C
00-000212-000	B RCA
00-000227-000	B RCA
00-000442-000	D
00-000621-000	C
00-000628-000	C
00-000644-000	C
00-000670-000	B
00-000787-000	D
00-000926-000	C
00-000999-000	C
00-001027-000	N/A
00-001266-000	N/A
00-001270-000	C
00-001366-000	C
00-001382-000	C
00-001386-000	B
00-001455-000	C
00-001787-000	D
00-001829-000	C
00-001909-000	D
00-002091-000	C
00-002107-000	N/A
00-002112-000	N/A
00-002176-000	B RCA
00-002340-000	B RCA
00-002341-000	C
00-002398-000	C
00-002402-000	N/A
00-002548-000	B RCA
00-002553-000	C
00-002617-000	C *
00-003145-000	N/A
00-003195-000	D
00-003298-000	C
00-003306-000	C
00-003317-000	N/A
00-003549-000	C
00-003572-000	B RCA
00-003657-000	A
00-003879-000	C *
00-003901-000	B
00-004014-000	B RCA
00-004051-000	C *
00-004164-000	C
00-004248-000	B RCA
00-004401-000	C
00-004702-000	B RCA
00-004799-000	C
00-005175-000	C
00-005304-000	C
00-005318-000	C
00-005333-000	C
00-005782-000	C
00-005891-000	C
00-006103-000	N/A
00-006175-000	C
00-006242-000	C
00-006371-000	C
00-006452-000	C
00-006662-000	C
00-006682-000	B
00-007074-000	B
00-007180-000	D
00-007416-000	D
00-007446-000	C *
00-007456-000	C *
00-007459-000	C
00-007486-000	C
00-007488-000	C
00-007618-000	C *
00-007697-000	C
00-007700-000	B RCA
00-008001-000	C
00-009757-000	C
00-009997-000	B
00-010328-000	C
00-010666-000	C
00-010796-000	B RCA
00-011186-000	C
00-011461-000	D
00-011605-000	B
00-012167-000	B RCA
00-012615-000	B RCA
00-012783-000	B

Work Orders

- 98-010348-000
- 99-001781-000
- 00-002229-000
- 00-005237-000
- 00-006573-000
- 00-010196-000
- 00-11579-000
- 99-004070-001

Audits and Assessments

- Self Assessment Report BFN-SIT-00-003 - Root Cause Analysis for Events Caused by Human Error, February 14 - March 10, 2000
- Corporate Nuclear Assurance Assessment Report NA-CH-00-002 - Corrective Action Program, August 21-25, 2000
- Self Assessment Report BFN-PAG-00-001, Corrective Action Documentation, October 25-29, 2000

Operating Experience Issue Documents

- NER - indicates Nuclear Experience Review program TVA tracking number
- NER 99-1062-001: Licensee's evaluation for Potentially Reportable Condition PRC-99-35 issued by General Electric Company, on Soldering Deficiencies in Woodward EGM Controllers
- NER 00-0002-001: Licensee's evaluation for a Part 21 report issued by the D.C.Cook plant on trip rollers in ABB type HK circuit breakers
- NER 00-0003-001: Licensee's evaluation for a Part 21 report issued by ITT on air operated diaphragm valves
- NER 00-0081-001: Licensee's evaluation for a Part 21 report issued by the Salem plant on GE Model CR2940U301 switches
- NER 00-0161-001: Licensee's evaluation for Potentially Reportable Condition PRC-99-47 issued by General Electric Company, on Minimum Test Voltage for GE Type AK/AKR Circuit Breakers
- NER 00-0546-001:Licensee's evaluation for Power Delivery Services notice PDS-00-01 issued by General Electric Company on Manual Operation of GE AK and AKR Circuit Breakers
- NER 00-0289-001:Licensee's evaluation for NRC Information Notice 00-01, Operational Issues Identified in Boiling Water Reactor Trip and Transient
- NER 00-0379-001:Licensee's evaluation for NRC Information Notice 00-06, Offsite Power Voltage Inadequacies
- NER 00-0439-001: Licensee's evaluation for Services Information Letter SIL No. 617, Rev1, issued by GE Nuclear Energy on GE type AK-15/25 circuit breaker and MVT flux shifter failure to reset
- NER 00-0721-001: Licensee's evaluation for Services Information Letter SIL No. 630 issued by GE Nuclear Energy on Physical separation of circuits for low pressure Emergency Core Cooling Systems

Procedures

- OSIL-90 Processing Operations Procedure Changes, Dated 03/01/97
- RCI-1.1 Field Operations Program Implementation, Revision 87
- SPP-3.1 Corrective Action Program, Revision 2
- BP-236 Event Critique and Root Cause Analysis, Revision 0
- SPP-6.6 Maintenance Rule Performance Indicator Monitoring, Trending, and Reporting 10CFR50.65, Revision 5
- 0-TI-346 Maintenance Rule Performance Indicator Monitoring, Trending, and Reporting 10CFR50.65, Revision 15

Other Documents

- Sort of CY2000 PERs on procedure compliance cause code
- Sort of CY2000 PERs on security and safeguards cause code
- Sort of CY2000 PERs on status management cause code
- Sort of CY2000 PERs on fire protection cause code
- Sort of CY2000 PERs on corrective action cause code
- Sort of CY2000 PERs on configuration control cause code
- Sort of CY2000 PERs requiring a root cause analysis
- Sort of PERs greater than one year old
- Licensee Event Report 50-296/2000004, “Missed Control Rod LCO”
- Data taken during surveillance 0-SR-3.8.6.2(II), “Quarterly Check for Shutdown Board C and D Batteries”on January 9, 2001

Previously Identified NRC Findings

- NCV 50-296/00-03-01, Failure to Meet TS LCO 3.9.4
- NCV 50-260/00-03-02, Inadequate Procedure Renders CREVS Inoperable
- NCV 50-296/00-03-03, Failure to Meet TS LCO 3.3.1.2
- NCV 50-260/00-04-01, Failure to Meet TS SR 3.0.4 for Instrument Channel Checks