

September 28, 2001

EA-01-228

Mr. Robert J. Barrett
Vice President Operations, IP3
Entergy Nuclear Northeast
Indian Point 3 Nuclear Power Plant
P. O. Box 308
Buchanan, NY 10511

SUBJECT: NRC'S INDIAN POINT 3 NUCLEAR POWER STATION INSPECTION REPORT
NO. 50-286/2001-003

Dear Mr. Barrett:

On August 17, 2001, the NRC completed a team inspection at the Indian Point 3 Nuclear Power Station. The enclosed report presents the results of that inspection. The results were discussed on August 17, 2001, with you, Mr. L. Olivier, and other members of your staff.

This 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 this area, the inspection involved selected examination of procedures and representative records, observations of activities, and interviews with personnel.

On the basis of the sample selected for review, the team concluded that the overall implementation of the corrective action program at Indian Point 3 was adequate. In general, problems were properly identified, evaluated and resolved. However, the team identified two Green findings associated with problem identification. One of the Green findings related to a modification that was installed to preserve main condenser availability for a postulated steam generator tube rupture. Although our inspectors identified a finding related to this modification, we want to acknowledge your efforts to preserve, maintain condenser availability. These findings are also violations of NRC requirements. Due to the very low safety significance of these findings, which were entered into your corrective action program, the NRC is treating these issues as Non-cited violations, in accordance with the NRC's Enforcement Policy. If you deny these Non-cited violations, you should provide a response with the basis for your denial, within 30 days of the date of this inspection report, to the Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555-001; with copies to the Regional Administrator, Region I; the Director, Office of Enforcement, United States Nuclear Regulatory Commission, Washington, DC 20555-001; and the NRC Resident Inspector at the Indian Point Unit 3 Nuclear Power Station.

Mr. Robert J. Barrett

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Sincerely,

/RA/

David C. Lew, Chief
Performance Evaluation Branch
Division of Reactor Safety

Docket Nos.: 50-286
License Nos.: DPR-64

Enclosure: Inspection Report 50-286/2001-003

cc w/encl:

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Mr. Robert J. Barrett

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U.S. NUCLEAR REGULATORY COMMISSION

REGION I

Docket Nos: 50-286
License No: DPR-64

Report No.: 50-286/2001-003

Licensee: Entergy Nuclear Northeast

Facility: Indian Point 3 Nuclear Power Plant

Location: P.O. Box 308
Buchanan, New York 10511

Dates: July 30 - August 17, 2001

Inspectors: E. H. Gray, Division of Reactor Safety (DRS), Team leader
J. Yerokun, DRS, Sr. Reactor Inspector
L. James, Division of Reactor Projects, Resident Inspector

Approved by: David C. Lew, Chief
Performance Evaluation Branch
Division of Reactor Safety

SUMMARY OF FINDINGS

Indian Point 3 Nuclear Power Plant NRC Inspection Reports 50-286/2001-003

IR 05000286/2001003, on 07/30-08/17/2001; Entergy Nuclear Northeast; Indian Point 3 Nuclear Power Plant; annual baseline inspection of the identification and resolution of problems.

This inspection was conducted by two regional inspectors and one resident inspector. The inspection identified two Green findings which were non-cited violations. The significance of most findings is indicated by their color (Green, White, Yellow, Red) using Inspection Manual Chapter 0609, "Significance Determination Process" (SDP). Findings for which the SDP does not apply are indicated by "No Color" or by the severity of the applicable violation. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described at its Reactor Oversight Process website at <http://www.nrc.gov/NRR/OVERSIGHT/index.html>.

A. Inspector Identified Findings

Identification and Resolutions of Problems

The team concluded that, based on the sample reviewed, the overall implementation of the corrective action program at Indian Point 3 was adequate. In general, problems were properly identified, evaluated and corrected. Problems were entered into the corrective action program at an appropriate threshold. The licensee adequately prioritized and evaluated issues, and their evaluations were of adequate depth to identify the causes and appropriately broad in considering the extent of condition. The corrective actions were reasonable and adequately implemented. The team noted that licensee initiatives were successful in reducing the significant human performance errors. However, the team identified instances where the licensee missed opportunities to identify problems. Consequently, these problems were not considered for entry into the corrective action process. These issues resulted in two Green findings that were also non-cited violations.

Cornerstone: Mitigating Systems

- Green. A Non-cited violation (NCV) of 10 CFR 50.59, failure to adequately evaluate a modification to the service water system and address the effect of a failure of a non-seismic pipe on the safety related service water system.

This finding was determined to be of very low safety significance (Green) by the Safety Determination Process (SDP), Phase 1, because even though the system was degraded, the service water system was determined to have been capable of performing its safety function. (Section 40A2)

- Green. A Non-cited (NCV) violation of 10 CFR 50 Appendix B, Criterion XVI, to promptly identify and correct a condition adverse to quality in regard to the improper installation of the Trico oiler on component cooling water system pump #33.

This finding was determined to be of very low safety significance (Green) by the Safety Determination Process (SDP), Phase 1, because even though the oiler was degraded, the component cooling water pump was determined to have been capable of performing its safety function. (Section 40A2)

Report Details

OTHER ACTIVITIES (OA)

4OA2 Identification and Resolution of Problems (IP 71152)

.1 Effectiveness of Problem Identification

a. Inspection Scope

The team reviewed items selected from various licensee processes and activities to determine if the licensee was properly identifying, characterizing and entering problems into the corrective action process for evaluation and resolution. The licensee's primary process for identifying and resolving problems was the Deviation and Event Report (DER) process; items entered into this process are referred to as DERs. The team reviewed DERs identified in Attachment 1 to determine the licensee's threshold for identifying problems and entering them into the corrective action process.

The team also reviewed items from the licensee's operating, maintenance and quality assessment processes to determine if personnel were appropriately initiating DERs when problems were identified via these processes. The team reviewed a sample of control room surveillance logs, operator work-around and control room deficiencies, temporary modifications, system status reports, problem identification tags (PIDs), emergency preparedness items, Quality Assurance (QA) audits, self assessments, operating experience information, and minutes from the plant operating review committee (PORC) and the safety review committee (SRC) meetings. The team also performed plant walkdowns and conducted interviews with plant personnel to determine if problems were appropriately identified.

b. Issues and Findings

When licensee personnel identified issues through other processes, they initiated DERs at a proper threshold to document and evaluate the problem. The team did not identify instances where other processes were incorrectly used in place of the DER process. However, the team identified some instances in which the licensee missed opportunities to identify problems and issues.

- Service Water System Modification

A Non-cited violation of 10 CFR 50.59, failure to fully evaluate the potential credible effects of a service water system (SWS) alignment change, was determined to be of very low safety significance (Green) by the significance determination process (SDP).

The team identified that safety evaluation 01-03-019, for a service water system alignment change to supply cool water to the circulating water pumps from essential SWS, did not properly assess the potential effects of a seismic event on essential SWS operability. The alignment change was desired to allow the circulating water pumps to receive cooling water and remain running to maintain condenser vacuum following a loss of non-essential service water. The team identified that since June 4, 2001, when the revised alignment was implemented, the SWS system was operated outside of its seismic design basis. Specifically, the safety evaluation improperly assessed the impact on SWS operability of a potential failure of a section of 8-inch piping that was not

previously qualified or evaluated for use following a seismic event. The safety evaluation assumed that the failure of the 8-inch pipe was bounded by a previously analyzed failure of a 10-inch non-seismically qualified piping section. However, the team identified that the analysis should have accounted for the combined affects of the failure of both the 10-inch and 8-inch sections following a seismic event. The team further concluded that the licensee missed opportunities during multiple reviews of the safety evaluation to identify this problem.

On August 2, following NRC identification of this condition, the licensee re-aligned the SWS to its previously analyzed condition. During the inspection the licensee completed calculation IP3-CALC-SWS-03523, "Evaluation of 8-inch Seismic Class III piping Inside the Intake Structure," which concluded that the 8-inch section of piping would remain intact following a seismic event. In this review the licensee identified a section of 2-inch piping, connected to the 8-inch section, that could be damaged following an earthquake. The calculation determined that the combined flow from a failure of the 10-inch and the 2-inch sections would not affect the SWS operability.

The team considered this issue to be more than minor, because the licensee failed to properly analyze, in accordance with 10 CFR 50.59, the credible impact of a seismic event on the mitigating function of the essential SW piping, prior to aligning the system to cool the circulating water pumps. The team reviewed the licensee's completed calculation which indicated that although the SWS was degraded and outside its seismic design basis, the system would have been able to perform its design basis function following a seismic event. Therefore, in accordance with the SDP, Phase 1 Screening, the team determined that this issue was of very low safety significance (Green). The NRC identified this issue and the licensee incorporated it into their corrective action process as DER 01-03116, Plant Operation Outside Analyzed Condition. This violation of 10CFR 50.59 is being treated as a Non-cited violation. **(NCV 50-286/2001-003-01)**

- Trico Safety Related Pump Bearing Oilers

A Non-cited (NCV) violation of 10 CFR 50 Appendix B, Criterion XVI, failure to promptly identify a condition adverse to quality in regard to Trico oilers, was found and determined to be of very low safety significance (Green) by the Safety Determination Process (SDP).

The team identified that the licensee did not take timely corrective action, when presented with multiple opportunities to address a problem with the Trico oilers. In September 2000, the licensee received an operating experience (OE) input regarding the susceptibility for Trico oilers to be rendered inoperable as a result of maintenance practices. In addition, information on additional examples of problems with the oilers was received by the plant in January, February, and March 2001. Adequate action was not taken to verify the presence or absence of the problem, and no Action and Commitment Tracking (ACT) item or work request (WR) were generated prior to this inspection. Based on questions posed by the team, the licensee investigated and determined that the 33 component cooling water (CCW) pump Trico oiler had a partially blocked oil supply due to the same condition presented in the four OE inputs.

The team considered this issue to be more than minor, because the actual degradation of the oil supply to the 33 CCW pump, a mitigating system train, was not identified despite numerous known problems with Trico oilers. The improper installation of Trico oilers can have a credible impact on safety. The team determined this issue to be of very low safety significance (Green) in accordance with Phase 1 Screening of the SDP, because the 33 CCW pump remained operable with reduced oil flow, and as such it did not represent an actual loss of safety function of the single train of the CCW system. The NRC identified this issue and the licensee incorporated it into their corrective action program as DER 01-03113. This violation of 10CFR 50, Appendix B, Criterion XVI is being treated as a Non-cited violation. **(NCV 50-286/2001-003-02)**

- Discrepancy between UFSAR Description of a Steam Generator Tube Rupture Response and the Emergency Operating Procedure (EOP) Response

A minor violation of 10 CFR 50, Appendix B, Criterion III, "Design Control," involving failure to identify a discrepancy between the UFSAR Chapter 14 Accident Analysis and EOP E-0, "Plant Trip/Safety Injection", was found. The Updated Final Safety Analysis Report (UFSAR) Chapter 14 Accident Analysis described the plant's and operator's response to a steam generator tube rupture (SGTR) with offsite power available as: dumping steam from the steam generators to the condenser to contain the radioactivity introduced to the steam generators by the tube rupture within the secondary side of the plant. However, the EOPs and Temporary Procedure Change (TPC) as of the end of the inspection period, and the EOPs prior to June 4, 2001, instructed the operators to close the main steam isolation valves (MSIVs), thus isolating the condenser and requiring the use of the atmospheric dump valves to cool the plant.

The licensee failed to identify the discrepancy between the UFSAR Chapter 14 analysis and the EOPs despite past opportunities, including the 10 CFR 50.54f Design Basis review, the 10 CFR 50.59 Safety Analysis performed in conjunction with the SW modification described above, and the TPC performed in August 2001 for closure of the MSIVs and isolation of the condenser in response to a SGTR or a safety injection signal.

The discrepancy between the UFSAR Chapter 14 Accident Analysis and the Emergency Operating Procedures was determined to be minor because it did not have a credible impact on safety. It did not affect any equipment operability nor an actual loss of a safety function. This issue impacted the availability of the condenser, during a postulated SGTR with offsite power available. Isolating the condenser early in a SGTR event would require the use of atmospheric dump valves during the SGTR even though offsite power would be available. However, maximum postulated dose the public could receive is bounded by the SGTR without offsite power analysis. This issue was entered into the licensee's corrective action program as DER 01-03207.

.2 Prioritization and Evaluation of Issues

a. Inspection Scope

The team reviewed items selected from the licensee's corrective action processes to determine whether the issues were properly evaluated and resolved. The review included the appropriateness of the assigned significance, the timeliness of resolutions, and the scope and depth of the root cause evaluations (or apparent cause evaluation). The samples included those designated as significant and covered the seven cornerstones. The team screened Problem Identification Tags (PIDs) and Deviation & Event Reports (DERs) in the licensee's corrective action process and selected those listed in Attachment 1 of this report for detailed review.

b. Issues and Findings

From the samples reviewed, the team concluded that the licensee adequately prioritized and evaluated issues entered in the DER process. The licensee's evaluations were of adequate depth to identify the causes and appropriately broad in considering the extent of condition. The licensee's assessments properly considered operability and reportability requirements. However, the team identified one instance associated with the 33 emergency diesel generator (EDG) governor where the licensee did not promptly evaluate a small puddle of oil found below the governor oil gauge.

Emergency Diesel Generator Governor Oil Leak

A minor violation of 10 CFR 50, Appendix B, Criterion XVI, involving failure to promptly evaluate a small puddle of oil that was found below the 33 EDG governor oil gauge was identified. On July 31, 2001, the team noted a PID (# 3892) on the 33 EDG governor gauge indicating oil leakage from the governor. The team also noted a small puddle (approximately two ounces) of oil under the gauge. The licensee had identified this leakage in May 2001 and hung the PID tag on the governor but was unaware of the puddle of oil under the gauge and had not assessed the significance of the leakage. There was no DER initiated to address the origin of the leak and evaluate the impact of the leakage on the governor, hence the emergency diesel generator, functionality. The team determined that this constituted a failure to perform timely evaluation and take corrective actions for an identified problem as required by 10 CFR 50 Appendix B Criterion XVI.

This issue was subsequently entered into the licensee's corrective action program as DER 01-03222, EDG Governor Oil Overfill. This violation was determined to be minor because the issue had no credible impact on safety. The puddle of oil was determined to be from spill associated with improper addition of oil to the governor. The governor, as well as the diesel, was not degraded as a result of the oil puddle. The EDG was capable of performing its safety function. Subsequent inspection revealed no actual leakage from the governor.

.3 Effectiveness of Corrective Actions

a. Inspection Scope

The team reviewed the corrective actions associated with selected DERs to determine whether the corrective actions addressed the identified causes and were completed or scheduled to be completed in a timely fashion.

The team reviewed DERs for repetitive problems to determine whether previous corrective actions were effective. The team also reviewed the backlog of corrective actions to determine if there were items that individually or collectively represented an adverse effect on plant risk or an adverse trend in the implementation of the corrective action program.

b. Issues and Findings

Overall, the team concluded the licensee developed and implemented corrective actions that appeared reasonable to address the identified problems. Based on the sample reviewed, the team determined that the corrective actions were completed or scheduled to be completed in a timely manner. The team noted that the licensee had implemented various initiatives over the past year to make improvements in the area of human performance. These improvements were successful in reducing the significance of the human performance errors.

.4 Safety Conscious Work Environment

a. Inspection Scope

The team reviewed the licensee's Safety Conscious Work Environment program implementation (Employee Speak Out Program) and considered during interviews with plant personnel if conditions were apparent or existed that would challenge the establishment of a safety conscious work environment at the Indian Point Unit 3 plant.

b. Issues and Findings

There were no findings identified during this part of the inspection.

4OA6 Management Meetings

.1 Exit Meeting Summary

The team presented the inspection results to Messrs. R. Barrett, L. Olivier, and other members of the Indian Point 3 staff during an exit meeting on August 17, 2001. The licensee acknowledged the findings presented. No information examined or reviewed during the inspection was considered to be proprietary.

Attachment 1

PARTIAL LIST OF PERSONNEL CONTACTED

- * P. Asendorf, Security Manager
- H. Bain, General Security Supervisor
- * J. Barnes, Acting Director of Engineering (System Eng. Manager)
- * R. Barrett, Vice President, Operations-IP3
- * F. Bieise, Acting Manager Design & Analysis
- * C. Bristol, Maintenance
- * J. Bubniak, Mechanical Eng Supervisor, Design & Analysis
- * R. Buckley, Self-Assessment Coordinator, Corrective Action & Analysis
- * R. Burroni, I&C Manager
- B. Christman, Assistance Operations Manager
- * J. Comiotes, Director Safety Assurance
- * V. Coulehan, Operating Experience Coordinator, Corrective Action & Analysis
- * L. Danko, Nuclear Licensing Engineer
- * B. Deschamps, Radiation Protection Manager, RES
- J. DeRoy, GM, Plant Operations
- * M. Devlin, Site Planning & Scheduling
- * A. DiCesaro, System Engineering
- J. Donnelly, Licensing Manager
- M. Garofalo, QA Supervisor
- * J. Gillen, Sr QA Engineer
- * M. Kerns, Chem Gen. Supv.
- * R. Lee, Sr. Mech Engr-Design&Analysis
- * L. Lee, System Engineer
- J. LePere, Waste Maintenance Supervisor, RES
- M. Licitra, Project Management
- * S. Manzione, Supervisor Components Engineering
- D. Mayer, Manager Health Physics/Chemistry
- D. Moody, Procurement and Contracts Manager
- N. Nilsen, Construction Services Manager
- * L. Olivier, Sr. Vice President & Site Nuclear Executive
- * J. Perrotta, Quality Assurance Manager
- K. Peters, Corrective Action & Analysis Manager
- S. Petrosi, Design & Analysis Manager
- * S. Prussman, Senior Licensing Engineer
- * Z. Rafla, Structural Engineer
- * B. Sullivan, Asst. Ops Mgr/Ops
- * B. Taggart, Speakout Employee Concerns/Safety Review Committee
- * B. Thomas, Shift Manager Operations
- * M. Troy, Procurement Engineering Supervisor
- * A. Vitale, Manager-Maintenance
- D. Weaver, Emergency Plan Planner

* Indicates attended Exit Meeting on August 17, 2001

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened/closed

- NCV 50-286/2001-003-001 Failure to perform an adequate safety evaluation for a modification to the service water system per 10 CFR 50.59. (Section 4OA2.1)
- NCV 50-286/2001-003-002 Failure to promptly identify a condition adverse to quality in regard to Trico oilers per 10 CFR 50 Appendix B(Section 4OA2.1)

LIST OF ACRONYMS USED

ACT	Action and Commitment Tacking
CFR	Code of Federal Regulations
CCW	component cooling water
CWS	circulating water system
DER	deviation and event report
DRS	Division of Reactor Safety
EDG	emergency diesel generator
EOP	emergency operating procedure
EP	emergency planning
FCU	fan cooler unit
LER	licensee event report
MSIV	main steam isolation valve
NCV	Non-cited violation
OA	Other Activities
OE	operating experience
PID	problem identification tags
PORC	plant operating review committee
QA	quality assurance
SDP	significance determination process
SGTR	steam generator tube rupture
SRC	safety review committee
SSC	systems, structures and components
SWS	service water system
TPC	temporary procedure change
UFSAR	Updated Final Safety Analysis Report
WR	work request

List of Documents Reviewed for Inspection 50- 286/2001-003

Background Information

AP-8, Deviation and Event Report Initiation, Revision 40, 1/24/01
 AP-8.2, Deviation and Event Analysis, Revision 10
 AP-8.3, DER Operability and Reportability Review by Operations, Revision 4.
 AP-8.5, Screening and Assignment of DERs, Revision 1, 5/19/00
 AP-8.8, Revision 0, Feedback of Operating Experience
 AP-37.4, Action and Commitment Tracking System, Revision 6, 3/26/01
 CAA-SD-01, Self Assessment Process, Revision 0, 4/19/01
 E-0, Reactor Trip or Safety Injection, Revision 16, 8/6/01
 E-0 DEV, Reactor Trip or Safety Injection, Revision 15, 2/13/01
 E-0 DEV, Reactor Trip or Safety Injection, Revision 16, 8/6/01
 SPO-SD-01, Work Control Process, Revision 10/4/16/01
 SPO-SD-05, FIN (FIX-IT-NOW), Revision 2, 6/10/98
 UFSAR Section 14.2.4 Steam Generator Tube Rupture

Deviation/Event Reports

DER 01-03302	DER 01-03116	DER 98-00549	DER 00-02624
DER 01-01399	DER 01-00225	DER 01-01339	DER 01-02606
DER 01-02526	DER 01-02151	DER 01-02077	DER 01-01873
DER 01-02220	DER 01-02194	DER 00-02702	DER 01-00155
DER 01-00390	DER 00-01183	DER 00-01343	DER 00-01448
DER 00-02603	DER 00-02781	DER 01-00123	DER 01-00205
DER 01-00211	DER 01-00225	DER 01-00395	DER 01-00496
DER 01-00721	DER 01-01339	DER 01-02554	DER 01-02573
DER 01-02608	DER 01-02666	DER 01-02707	DER 01-02994
DER 01-03113	DER 01-03116	DER 01-03177	DER 01-03222
DER 01-00103	DER 01-00266	DER 01-00534	DER 01-00945
DER 01-01182	DER 01-01664	DER 01-01724	DER 01-01957
DER 01-01182	DER 01-01724	DER 01-00225	DER 01-00514
DER 00-3249	DER 01-00254	DER 01-00300	DER 01-00431
DER 01-00598	DER 01-00605	DER 01-01749	DER 00-3331
DER 00-3332	DER 00-3247	DER 00-3248	

Non-cited Violations

NCV 2000-007-01, Tech. Specs., Quadrant Power Tilt Ratio (DER 00-02781)
 NCV 2000-007-02, Tech. Specs., Containment Spray System Additive Tank (DER 00-02603)
 NCV 2000-009-01, AFW System Valve Mis-positioning (DER 01-00496)

Temporary Modifications

970477800, CCR Intake Structure/Traveling Screen
 980417200, Check Valves MW-682, 683 Internals.

Self Assessments

Self-Assessment, Auxiliary Cooling Water Chemistry Control, 6/15/01
 Radiological Event Reports (RER) Summary - 1st Quarter 2001
 Radiological and Environmental Services Department, Annual Self-Assessment Report, July 2000 To July 2001.
 Instrument & Controls Maintenance Department Self Assessment Year 2000, May 2000
 Instrument & Controls Maintenance Department 2nd Quarter Self Assessment - R-11 Outage Critique
 Maintenance Department Self Assessment Effectiveness of Troubleshooting, 4/12/01
 Maintenance Department Self Assessment Report July 1999-August 2000

Work Requests

WR 00-01111-00, CCRAC System PM
 WR 00-01109-00, 31 BATP Prejob Briefing
 WR 99-04249-00, Inspection of Cat 1 and Cat 2 M Plant Ventilation Fans
 WR 00-00164-00, 31 Static Inverter Filter Indicating Light Socket Replacement
 WR 00-03242-00, Westinghouse 480V MCC Inspection
 WR 00-00027, Minor Maintenance Baseline Eddy Current Inspection of Hydrogen Coolers
 WR 99-05093-00, Instrument Air Dryer System Inspection and PM

Operating Experience Items

Event 37885, 10 CFR 21 Notification, R-11 Monitor (ACT 01-57594)
 Event 37703, Broken Cap Screws, Turbine Driven AFW Pump (ACT 01-54715)
 Event 37709, 10 CFR 21 Notification, Rosemount Conduit Seal (ACT 01-54548)
 10 CFR 21 Notification, Calculation of Minimum Critical Power Ration
 IN 2001-006, Centrifugal Charging Pump Thrust Bearing Damage Not Detected Due to Inadequate Assessment of Oil Analysis Results and Selection of Pump Surveillance Points (ACT 01-57780)
 IN 2001-07, Unrestricted Access (ACTs 01-57145, 01-57206)
 IN 2001-10, Failure of Central Sprinkler Co. Sprinkler Heads (ACT 01-57540)
 IN 2001-21, Detached Check Valve (ACT 01-53539)

Quality Assurance Audit Reports

A00-16I, IP3 Access Authorization/PADs
 A00-06I, IP3 Emergency Planning Program
 A00-12I, IP3 Security/Fitness for Duty
 QA Audit Report A00-081, Corrective Action Program

Quality Assurance Job Observations

2001-0102, Replace Reactor Protection and SI Logic Relays In Accordance With DCP 00-3-064
 2001-0134, Installation of Instrument Port Conoseal Assemblies
 2001-0149, Disassemble Valve CH-1151A, inspection internals, repair/replace parts as required and reassemble IAW VLV-029-GEN
 2001-0151, Perform PM inspection on valve WD-AOV-1723 per PM Procedure VLV-013-GEN

Problem Identification (PID)Tags

00627	01398	03015	03016	03017	03401	03776
63376	63377	63378	00400	03014	03141	03142
03143	03500	63371	63372	63373	63374	00346
00347	00348	03013	03105	03180	63369	63370
00218	00827	00828	03147	03148	03426	03585
03662	03781	63390	63391	63392	00318	00338
00339	00340	00341	00342	00343	00344	01797
01911	01912	01913	03422	03425	03580	03584
63385	63387	00314	01083	01804	01909	03150
03182						