

March 18, 2002

Mr. J. Alan Price, Vice President -  
Nuclear Technical Services/Millstone  
c/o Mr. D. A. Smith, Manager - Regulatory Affairs  
Dominion Nuclear Connecticut, Inc.  
Rope Ferry Road  
Waterford, Connecticut 06385

SUBJECT: MILLSTONE UNITS 2 AND 3 - NRC TEAM INSPECTION REPORT 50-336/01-015 AND 50-423/01-015

Dear Mr. Price:

On February 1, 2002, the NRC completed a team inspection at your Millstone Units 2 & 3 reactor facilities. The enclosed report documents the inspection findings which were discussed with you and other members of your staff.

This inspection was an examination related to the identification and resolution of problems, and compliance with the Commission's rules and regulations and the conditions of your operating license. Within these areas, 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 Millstone Units 2 and 3 was adequate. Problems were generally properly identified, evaluated, and corrected. However, the team identified some instances where the evaluation of some lower level problems were not of sufficient detail.

Two Green findings were identified during the inspection regarding Unit 2 atmospheric dump valves and a Unit 3 emergency diesel air start system check valve. These green findings were determined to be a violations of NRC requirements. However, because of their very low safety significance and because the issues are being addressed within your corrective action process, the NRC is treating these as non-cited violations, in accordance with Section VI.A.1 of 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, Region I; the Director, Office of Enforcement, United States Nuclear Regulatory Commission, Washington, D.C. 20555-0001; and the NRC Resident Inspector at the Millstone facility.

Mr. J. Alan Price

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Sincerely,

*/RA/*

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

Docket Nos.: 50-336, 50-423  
License Nos.: DPR-65, NPF-49

Enclosures:

(1) NRC Combined Inspection Report 50-336/01-015 and 50-423/01-015

cc w/encl:

D. A. Christian, Senior Vice President - Nuclear Operations and Chief Nuclear Officer  
W. R. Matthews, Vice President and Senior Nuclear Executive - Millstone  
J. A. Price, Vice President - Nuclear Technical Services - Millstone  
C. J. Schwarz, Director, Nuclear Operations and Chemistry  
P. J. Parulis, Manager, Nuclear Oversight  
D. A. Smith, Manager, Regulatory Affairs  
L. M. Cuoco, Senior Nuclear Counsel  
N. Burton, Esquire  
V. Juliano, Waterford Library  
S. Comley, We The People  
J. Buckingham, Department of Public Utility Control  
E. Wilds, Director, State of Connecticut SLO Designee  
First Selectmen, Town of Waterford  
D. Katz, Citizens Awareness Network (CAN)  
R. Bassilakis, CAN  
J. M. Block, Attorney, CAN  
J. Besade, Fish Unlimited  
G. Winslow, Citizens Regulatory Commission (CRC)  
E. Woollacott, Co-Chair, NEAC  
R. Shadis, New England Coalition Staff

Mr. J. Alan Price

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**ENCLOSURE 1**

**U.S. NUCLEAR REGULATORY COMMISSION  
REGION I**

Docket No.: 50-336, 50-423

License No.: DPR-65, NPF-49

Report No.: 50-336/01-015, 50-423/01-015

Licensee: Dominion Nuclear Connecticut, Inc.

Facility: Millstone Power Station, Units 2 and 3

Location: P. O. Box 128  
Waterford, CT 06385

Dates: January 14 through February 1, 2002

Inspectors: J. Carrasco, Reactor Inspector, Division of Reactor Safety (DRS)  
P. Cataldo, Acting Senior Resident Inspector, Unit 2  
A. Della Greca, Senior Reactor Inspector, DRS  
M. Gray, Reactor Inspector, DRS  
A. Lohmeier, Reactor Inspector, DRS (one-week)  
L. Privity, Senior Reactor Inspector, DRS (one-week)  
W. Schmidt, Senior Reactor Inspector, DRS (lead)  
B. Sienel, Resident Inspector, Unit 3

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

## SUMMARY OF FINDINGS

IR 05000336/01-015, 05000423/01-015; on 01/14-02/01/02; Dominion Nuclear Connecticut, Inc., Millstone Power Station; Units 2 and 3; biennial baseline inspection of identification and resolution of problems, corrective action program. Two violations were identified regarding the failure to promptly identify and correct conditions adverse to quality.

The inspection was conducted by six region-based inspector and two resident inspectors. Two Green findings of very low safety significance were identified during this inspection and were classified as non-cited violations. The findings were evaluated using the significance determination process. 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/reactors/operating/oversight.html>.

### Identification and Resolution of Problems

Overall the licensee identified problems at an appropriate threshold and entering them into the CAP for resolution. The identification of repetitive trends appeared proper. However, the use of trend cause codes to identify possible precursor trends was limited. No deficiencies were identified in completed operability determinations. The significance level 1 root cause evaluations reviewed during the inspection sufficiently identified likely causal factors and corrective actions. The significance level 2 apparent cause evaluations generally appeared appropriate. The selected effectiveness reviews were of good quality.

Several instances were identified where the evaluation of problems documented in significance level 2 and level "N" condition reports were either not adequately evaluated or prioritized for completion, or were not completed in sufficient detail to provide for timely and effective corrective actions. Two instances involving Unit 2 atmospheric steam dump valves and a Unit 3 emergency diesel air start check valve were determined to be green findings.

Corrective actions appeared appropriate. The effectiveness reviews selected were of good quality, including several where the reviewer appropriately identified inadequate corrective actions. Some safety-related pump bearing oil problems concerns continue to occur, but previous corrective actions may not have had time to correct existing issues.

### **Cornerstone: Mitigating Systems**

- Green. A non-cited violation of 10 CFR 50 Appendix B, Criteria V, for failure to perform an operability determination in accordance with procedures for the potential to pressurize the Unit 2 atmospheric dump valves (ADV) actuators greater than their design limit.

However, the failure to perform on operability determination was considered to have a very low safety significance because, a subsequently performed license operability determination provided a reasonable basis for concluding that when the final evaluation is complete, the ADVs will be shown to be capable of performing their safety function in the existing configuration (Section 40A2.2).

- Green. A non-cited violation of 10 CFR 50 Appendix B, Criteria XVI, for failure to promptly identify and correct a condition adverse to quality regarding two instances where a safety related check valve in the Unit 3 emergency diesel “A” air start system failed to prevent a pressure decrease in the associated air receiver tank.

However, the failure to identify and evaluate this problem is considered to have a very low safety significance because of the redundant air receivers and compressors, and remote monitoring of air receiver pressure. (Section 4OA2.2).

## Report Details

### **4. OTHER ACTIVITIES [OA]**

#### 4OA2 Identification and Resolution of Problems

##### .1 Effectiveness of Problem Identification

###### a. Inspection Scope

The team reviewed the process for identifying and resolving problems within the licensee's corrective action program (CAP); items entered into this process are referred to as condition reports (CRs). The team reviewed CRs and other documents, identified in Attachment 1, to determine the licensee's threshold for identifying problems and entering them into the CAP.

The team reviewed items from the licensee's operating, maintenance, and quality assessment processes to determine if personnel initiated CRs after identifying problems. The team also reviewed a sample of work requests (WR), control room deficiencies, system health reports, surveillance test results, and completed preventive maintenance tasks, and operating experience information.

The team attended the licensee's daily CR screening meeting (CRT) to assess the type of issues identified during the inspection. The team also conducted a plant walk-down of safety-related, risk significant areas to verify that observable system equipment and plant material adverse conditions were entered into the CAP. Additionally, the team interviewed plant personnel to discuss technical issues and the use of the CAP.

The inspectors reviewed quality assurance (QA) audit surveillance reports, departmental self-assessments, and an internal analysis of the corrective action program. The review was to determine if assessment findings were entered into the licensee's corrective action program, and to determine if corrective actions were completed to resolve identified program deficiencies.

###### b. Issues and Findings

Overall the team concluded the licensee is identifying problems at an appropriate threshold and entering them into the CAP for resolution. The identification of repetitive trends appeared proper.

##### .2 Prioritization and Evaluation of Issues

###### a. Inspection Scope

The team screened CRs issued since the previous problem identification and resolution inspection and selected those listed in Attachment 1 of this report for detailed review to determine whether the issues were properly evaluated and resolved. The CR process requires that each CR be assigned a significance level; level 1 issues, are the most significant and receive a root cause determination; level 2 issues receive an apparent

cause determination; and level “N” issues are the least significant and require only correcting the condition. For selected CRs, the team reviewed the licensee reportability and operability assessment; the assignment of significance and priority; the technical adequacy, scope, and depth of the root or apparent cause evaluation; and the timeliness of resolution. The CRs documented issues in risk significant systems, including auxiliary feed water (AFW), service water (SW), instrument air, alternating current (AC) and direct current (DC) electrical systems and several issues related to non-cited violations (NCVs) and Licensee Event Reports (LERs).

The team also assessed the backlog of corrective actions to determine if any, individually or collectively, represented an increased risk due to the delay in implementation. Additionally, the team attended the CRT to observe the review process and the basis for assigning significance levels.

b. Issues and Findings

The team concluded the CRT assigned initial significance levels adequately to problems and identified appropriate departments responsible for resolution. From an evaluation standpoint, the majority of issues were properly prioritized (i.e., proper significance levels) to provide an appropriate level of evaluation. The team reviewed several existing operability determinations (OD), including several that were performed during the inspection, and did not identify any issues.

The significance level 1 root cause evaluations reviewed by the team sufficiently identified likely causal factors and corrective actions. The significance level 2 apparent cause evaluations generally appeared appropriate. Significance level “N” causal coding was generally not being done, as allowed by the process limiting the use of these codes to identify possible precursor trends. The team noted that while the use of the cause code information appeared unclear, CRT discussions observed during the inspection indicated the licensee recognized the need for training of department CR coordinators to achieve consistency in trending significance level 2 and “N” CRs. The CAP staff indicated that they intended to conduct such training soon.

Notwithstanding, the team identified instances where the licensee’s evaluation of problems documented in significance level 2 and level “N” condition reports were either not timely or completed in sufficient detail. Two issues involving steam atmospheric dump valves (ADV) and an emergency diesel generator (EDG) air start check valve were determined to be findings. The additional examples were minor issues when characterized using the group 1 and 2 questions (Appendix B of NRC Manual Chapter 0610\*) and therefore the SDP was not applied.

Atmospheric Steam Dump Valve Actuators - Unit 2

Green. A non-cited violation of 10 CFR 50 Appendix B, Criteria V, for failure to perform an operability determination in accordance with procedures for the potential to pressurize the Unit 2 atmospheric dump valves (ADV) actuators greater than their design limit.

The ADVs are safety related, air operated valves that open when required to “dump” clean secondary side steam to the atmosphere, and thereby cool the primary side

reactor coolant system (RCS) when the non-safety condenser is unavailable. Operation of the ADVs also helps preclude opening of the spring loaded code safety valves. The ADVs are designed to fail closed, and, in accordance with the technical specification bases, be capable of operation remotely from the control room or manually using the valve handwheel.

In May 2000, the licensee determined the vendor specified that the air supply pressure to the ADV actuators should not exceed 100 psig to avoid component damage. The licensee further identified that the air supply to the ADVs does not include an air regulator. Since the instrument air compressors unload at setpoints between 108 psig and 115 psig, the licensee concluded there is a potential that the ADV actuators may be pressurized greater than their design limit during a full open signal.

The licensee initiated significance level "N" CR M2-00-1523 and closed it without further action, concluding that a supply line regulator may inhibit the ADV "quick opening function" during a full open signal. The licensee concluded the ADVs remained operable since there was not a history of ADV diaphragm failures. Additionally, the licensee noted that based on informal vendor observations during diaphragm leakage tests up to 125 psig, the actuators were not noted to distort and prevent ADV closure on spring action or subsequent manual operation.

The licensee reconsidered this issue in November 2001 (level "N" CR-01-11261), since they concluded that a properly selected air regulator may not inhibit the ADV "quick opening function," and the potential remained to challenge the ADV actuator beyond the design limits. The licensee further indicated that the air supply at the ADV actuators had been measured to be 105 psig during unrelated air operator diagnostic testing. The CR reiterated the previous operability discussion and tracked a corrective action to initiate a purchase order by November 2002 to authorize the valve vendor to perform a weak link analysis and identify the actuator design margin.

The team concluded the licensee had not completed an evaluation of the ADV actuator design margin, or alternatively modified the air supply to ensure air supply pressure remains below the actuator design limit. In response to the teams conclusions, the licensee initiated CR-02-00882 to re-evaluate the problem. The licensee performed an OD after the inspection that concluded the ADVs remained operable based on their performance history and vendor observations, and reconsidered the priority of corrective actions to complete a vendor analysis of ADV design margins.

The issue is more than minor and had a credible impact on safety because there was the potential to pressurize both ADVs greater than the vendor specified design limit, possibly causing actuator damage. This issue affects the mitigating systems cornerstone because the reliability of ADVs to remove heat from the RCS was affected. However, the failure to perform an OD was considered to have a very low safety significance in accordance with the Phase 1 of the NRC's significance determination process (SDP) because, when performed, the OD provided a reasonable basis for concluding the ADV would remain capable of being operated manually, and because in the past the ADV had not failed due to diaphragm overpressurization. Therefore this design deficiency does not result in a loss of ADV safety function.

10 CFR 50 Appendix B, Criterion V, requires, in part, that activities affecting quality be prescribed by documented procedures and be accomplished in accordance with these procedures. The licensee's procedures MP-16-CAP-FAP01.1, step 2.1.6 requires that an OD be performed for conditions that have an actual or potential effect on system or component operability. Licensee procedure RP 5, Section 1.1., likewise, requires an OD be performed when a condition affects the design or qualification of a safety related component. Contrary to this, the licensee failed to perform an OD in November 2001 when it was identified that the ADV actuators could be pressurized beyond their design limit during a full open signal. However, because of the very low safety significance, and because the issue was entered into the licensee's corrective action program in CR-02-00882, it is being treated as a non-cited violation, consistent with Section VI.A.1 of the NRC Enforcement Policy (**NCV 50-336/2001-15-01**).

### Emergency Diesel Generator Air Start System - Unit 3

Green. A non-cited violation of 10 CFR 50 Appendix B, Criteria XVI, for failure to promptly identify and correct a condition adverse to quality regarding two instances where a safety related check valve in the Unit 3 "A" EDG air start system failed to close to prevent a pressure decrease in the associated air receiver tank.

The team reviewed two significant level "N" condition reports, (CR-01-09415 and CR-01-09486) that documented two instances in September 2001 where non-safety condensate traps remained open, causing control room alarms as pressure decreased in air receiver tank 3EGA\*TK1A. The licensee entered the applicable technical specification action statement, cross-tied the redundant air receiver in accordance with procedures, and exited the action statement. The licensee initiated work requests, completed repairs to the traps, and closed the condition reports.

In reviewing these CRs, the team determined that safety related check valve (3EGA\*V004), located between the condensate traps and the air receiver tank, did not close to perform its safety function to isolate the air receiver tank when a trap remained open. The team reviewed the quarterly inservice testing results for this check valve, and determined leakage tests completed before and subsequent to the trap failures demonstrated that the check valve performed as required against the maximum system differential pressure. Additionally, subsequent to the failures, this valve was opened and visually inspected in January 2002 as part of normal scheduled maintenance. Some wear was noted on the valve disc and arm, and these components were replaced.

The team concluded that the licensee missed two opportunities in September 2001 to identify that check valve 3EGA\*V004 failed to perform its safety function. Consequently, the licensee did not determine why the valve passed quarterly inservice tests, but did not prevent loss of air receiver pressure when system condensate traps remained open. This issue is more than minor and had a credible impact on safety, because the failure to recognize and determine the cause of this condition could result in additional instances of air receiver pressure decreasing under similar conditions. Additionally, the extent of this condition was not addressed.

This issue affects the mitigating systems cornerstone because the reliability of the EDG air start system was affected. However, the failure to identify and evaluate this problem was considered to have a very low safety significance in accordance with the Phase 1 of the NRC's SDP, because redundant air receivers and compressors were provided for each EDG, and receiver pressure was monitored remotely. Consequently, there was no loss of the EDG air start safety function. The licensee initiated CR 02-00876 to address this issue.

10 CFR 50 Appendix B, Criterion XVI, requires, in part, that measures be established to assure that conditions adverse to quality, such as equipment failures, be promptly identified and corrected. Contrary to this, the licensee failed to promptly identify a condition adverse to quality regarding two instances where safety related check valve 3EGA\*V004 failed to close to prevent a pressure decrease in the associated air receiver tank. However, because of the very low safety significance, and because the issue was entered into the licensee's corrective action program in CR-02-00876, it is being treated as a non-cited violation, consistent with Section VI.A.1 of the NRC Enforcement Policy **(NCV 50-423/2001-15-02)**.

#### Emergency Diesel Generator Fuel Transfer System - Unit 3

The team determined that the licensee did not document the operability basis for a Unit 3 EDG "follow" fuel transfer pump day tank level switch that was out of calibration. The licensee initiated significance level "N" CR-01-10263 in October 2001 to identify that the follow pump started at a day tank level of approximately 270 gallons versus the setpoint value of 322 gallons. The CR initiated a work order to re-calibrate the level switch, which had not been completed at the time of the inspection. The team observed that while the diesel generator technical specification bases discuss the primary and follow fuel transfer pump start setpoints in the context of maintaining at least the minimum required day tank volume of 278 gallons, the CR did not document the basis for determining there was not an operability issue. The team concluded that the out-of-calibration level switch to start the follow fuel pump did not affect system operability because the minimum required day tank volume during standby was maintained and monthly diesel generator testing verified that both the primary and follow fuel pumps automatically transfer sufficient fuel to the day tank to supply the EDG and refill the tank. The licensee initiated CR-02-00876 to address the inadequately documented operability basis and CR-02-00873 to review the technical specification bases.

#### Direct Current Circuit Breaker Preventive Maintenance Interval - Unit 3

The team reviewed significance level 2 CR-01-00432, initiated by the licensee to evaluate the Unit 3 refueling outage preventive maintenance (PM) schedule for 125 volt direct current (DC) breakers. The licensee intended to increase the Unit 3 DC breaker preventive maintenance frequency from two to three years. In reviewing the issue, the team determined that 25% of the breaker pole tests had previously failed to meet the test acceptance criteria. These tests verified that the breaker tripping characteristics were within the specified limits. Considering these failure rates, the team concluded the evaluation did not provide an adequate basis for increasing the breaker preventative

maintenance frequency. The licensee initiated CR-02-00822 to re-evaluate the breaker test acceptance criteria, failure rate data, and the PM interval.

#### Degraded Grid Relay Setpoints - Unit 2

In reviewing significance level 2 CR-M2-00-2653, initiated in September 2000, the team determined that the licensee had not completed a revised degraded grid voltage relay calculation after concluding that calculation may not have identified the design basis scenario where the highest electrical loading would occur. Consequently, the safety-related AC busses may separate from offsite power while the offsite source was still available and unnecessarily rely on emergency diesel operation. The licensee evaluated the issue and determined that the calculation included sufficient margins to offset the potentially higher electrical loads present during other plant conditions.

#### Seismic Evaluation of Conduit Running Between Buildings - Unit 2

The team concluded the licensee did not document an adequate analysis of six Unit 2 safety-related rigid conduits that traversed the open space between the Auxiliary and Containment Buildings without flex connections to accommodate potential seismically generated relative displacements between buildings. The licensee evaluated this condition via Technical Evaluation M2-EV-00-0063 completed in 2000. The technical evaluation used non-specific engineering judgement to justify the seismic acceptability of these conduits, but recommended that the six conduits be analyzed. The technical evaluation was completed as a result of two similar conduits identified in 1996 (CR M2-96-0925). The original two conduits were evaluated and dispositioned satisfactorily by calculation 97-ENG-1539C2, Rev. 0. During the inspection the licensee had not completed an analysis and had not determined what the potential effects of a conduit failure would have been following a seismic event. Following identification by the team, the licensee completed a bounding analysis and documented the issue in CR-02-00859.

### .3 Effectiveness of Corrective Actions

#### a. Inspection Scope

The team reviewed the corrective actions associated with selected CRs to determine whether the identified causes were addressed and completed or scheduled to be completed in a timely fashion. The team reviewed CRs for repetitive problems to determine whether previous corrective actions were effective. The team also reviewed the removal of the instrument air system from the Maintenance Rule enhanced monitoring status. The team reviewed the CR backlog reduction initiative 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 CAP. The team reviewed several effectiveness reviews completed for level 1 CRs.

The team reviewed corrective actions for issues dealing with bearing oil in safety-related pumps, including the use of contaminated oil in a Unit 3 recirculation spray system pump (CR-01-00499), bearing failure of Unit 3 charging cooling pump CCE\*P1A (CR-01-09938), and the use of the wrong oil in the Unit 2 turbine driven AFW (TDAFW) pump (CR-01-11574). The team also reviewed the technical evaluations supporting

that the high pressure injection (HPI) safety system unavailability (SSU) performance indicator was not impacted by the December 2001 empty bearing oil bubbler on CCE\*P1A (CRs 01-12085 and 02-00135).

b. Issues and Findings

Corrective actions for level 1 and 2 issues appeared appropriate. The effectiveness reviews selected were appropriate, including several where the reviewer identified inadequate corrective actions.

The team concluded that the licensee continued to have oil lubrication issues on safety-related pumps. The effects of each were found to be of very low safety significance in previous NRC inspection reports. In reviewing the root cause evaluations, the corrective actions taken with respect to controls over oil storage and the required level of oil in bearings may not have had time to correct existing concerns. In one case the effectiveness review scheduled for a Unit 3 level 1 RSS pump wrong oil issue was not completed and pushed off to a subsequent Unit 2 TDAFW pump wrong oil issue. It appeared that, while the root causes for each issue were not specifically similar, if the effectiveness review was completed it would have identified that the corrective actions had not been effective. The team found that corrective actions for CR 01-09991 - Trico Oil Bubbler problems, generally acceptable to prevent recurrence, if they were implemented. However the team noted several intervening issues that developed more in-depth knowledge of bearing oil requirements including the technical evaluation and root cause analysis for the December 2001 lack of oil level in the CCE\*P1 bearing bubbler (CR-01-12085). The team agreed with the licensee that CCE\*P1A was operable in December 2001 with no oil indicated in the bearing bubbler, because of oil that remained in the bearing sump and the limited time that the charging pump, supported by CCE\*P1A, needed to be available for HPI; therefore the HPI SSU was not adversely impacted.

.4 Assessment of Safety-Conscious Work Environment

a. Inspection Scope

The team interviewed plant staff to determine if conditions existed that would result in personnel being hesitant to raise safety concerns to their management and/or the NRC.

b. Issues and Findings

No findings of significance were identified.

4OA6 Meetings, including Exit

Exit Meeting Summary

The inspectors presented the inspection results to Mr. A. Price and other members of licensee management at the conclusion of the inspection. The licensee acknowledged the findings presented.

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

## ATTACHMENT 1 - SUPPLEMENTAL INFORMATION

### a. Partial List of Persons Contacted

Diane Fredericks - Inspection Coordinator - Regulator Affairs  
Brian Sharrow - Regulator Affairs  
Dave Smith - Manager - Regulator Affairs  
Steve Heard - Manager - Performance Improvement  
Vince Wessling - Supervisor - Performance Improvement  
Tom Burns - Maintenance  
Mike Ahern - Manager - Asset Strategy  
Stephen Scafe - Director - Engineering  
Chris Schwarz - Director - Station Operations and Maintenance  
Alan Price - Site Vice President

### b. List of Items Opened, Closed and Discussed

#### Open and Closed

05000336/2001-15-01	NCV	Failure to perform an operability determination on the potential to pressurize the Unit 2 atmospheric dump valves (ADV) actuators greater than their design limit.
05000423/2001-15-02	NCV	Failure to failure to promptly identify and correct a condition adverse to quality regarding two instances where a safety related check valve in the Unit 3 emergency diesel "A" air start system failed to close.

#### Closed

05000423/2001-003	LER	Failure of Containment Air Lock Results in Entry into Technical Specification 3.0.3
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### c. List of Acronyms Used

AC	alternating current
ADV	atmospheric dump valves
AFW	auxiliary feedwater
AWO	automated work order
CAP	corrective action program
CR	condition reports
CRT	condition review team
DC	direct current
EDG	emergency diesel generator
HPI	high pressure injection
LER	licensee event report
NCV	non-cited violation
OD	operability determination
PM	preventive maintenance
RSS	recirculation spray system
SSU	safety system unavailability
SW	service water
TS	technical specification

**2001 CRs  
Reviewed**

01-00216	01-01443	01-04306	01-06817	01-10516
01-00230	01-01524	01-04320	01-06825	01-10596
01-00250	01-01533	01-04323	01-07025	01-10792
01-00257	01-01649	01-04555	01-07097	01-10854
01-00274	01-01711	01-04676	01-07132	01-10869
01-00315	01-01753	01-04804	01-07210	01-10935
01-00316	01-01878	01-04910	01-07239	01-10961
01-00329	01-02004	01-04996	01-07245	01-10986
01-00383	01-02018	01-05062	01-07601	01-11085
01-00384	01-02055	01-05117	01-07742	01-11233
01-00395	01-02172	01-05162	01-07777	01-11261
01-00396	01-02175	01-05220	01-07974	01-11325
01-00401	01-02194	01-05238	01-08019	01-11452
01-00403	01-02196	01-05256	01-08165	01-11486
01-00403	01-02243	01-05301	01-08248	01-11499
01-00403	01-02288	01-05364	01-08424	01-11574
01-00406	01-02473	01-05371	01-08460	01-11597
01-00413	01-02484	01-05427	01-08514	01-11680
01-00427	01-02619	01-05452	01-08526	01-11709
01-00432	01-02653	01-05460	01-08544	01-11903
01-00438	01-02737	01-05485	01-08552	01-11957
01-00499	01-02824	01-05524	01-08665	01-12011
01-00503	01-02827	01-05547	01-08816	01-12027
01-00506	01-02827	01-05612	01-08835	01-12032
01-00549	01-02873	01-05629	01-09255	01-12058
01-00630	01-02881	01-05629	01-09255	01-12058
01-00659	01-02907	01-05708	01-09328	01-12059
01-00729	01-02971	01-05880	01-09415	01-12109
01-00783	01-03015	01-05906	01-09474	01-12214
01-00846	01-03070	01-05943	01-09486	01-12225
01-00848	01-03081	01-05944	01-09555	01-12228
01-00873	01-03178	01-05946	01-09593	01-12229
01-00926	01-03301	01-05959	01-09613	01-12349
01-00934	01-03434	01-06023	01-09647	01-12411
01-01000	01-03534	01-06127	01-09862	02-00058
01-01158	01-03558	01-06128	01-09941	02-00135
01-01243	01-03610	01-06186	01-09965	02-00144
01-01270	01-03617	01-06270	01-09991	02-00422
01-01284	01-03617	01-06270	01-09991	02-00422
01-01325	01-03841	01-06324	01-10262	02-00514
01-01345	01-03863	01-06336	01-10263	02-00786
01-01405	01-03879	01-06364	01-10308	02-00782
01-01415	01-04029	01-06459	01-10310	02-00718
01-01431	01-04076	01-06487	01-10318	02-00666
01-01435	01-04098	01-06510	01-10330	02-00860
	01-04127	01-06569	01-10336	02-00876
	01-04175	01-06638	01-10376	02-00882
	01-04225	01-06804	01-10466	
	01-04284			

<b>Earlier CRs Reviewed</b>	11870	M2-98-1331	M3-96-0585	M3-96-1357
	11252	M3 -01-0159	M3-96-0655	M3-97-0119
	M2-00-1523	M3-00-0124	M3-96-0685	M3-97-1217
02508	M2-00-2653	M3-00-1655	M3-96-1018	M3-97-1502
07902	M2-96-0344	M3-00-2340	M3-96-1018	M3-97-1541
07962	M2-96-0925	M3-01-0176	M3-96-1165	M3-99-3671
11110	M2-97-10600	M3-96-0520	M3-96-1170	

**ARs**

99010098, AR 99012527-15, 01006734, 96005261

**EWRs**

M2-96123, M2-970109, M2-97149, M2-98023, M2-98029, M2-98039, M298083, M2-98087, M2-99018, M2-99019, M2-99034, M2-99059, M2-99089, M3-00058, M2-00096, M2-01-007

**AWO**

M2-98-04358, M2-002604, M2-01-11420, M2-01-11851, M2-01-12282, M2-01-12340, M2-01-12475, M2-01-12476, M2-01-12478 M2-00-02605, M2-0015943, M2-01-07955, M2-01-02099, M2-01-07804, M2-01-08868,, M2-01-12479, M2-01-12481, M2-01-12482, M3-9712245, M3-97-12247

**Design Change Notices**

DM3-00-0008-01                      Revise Setpoint for All C&D Battery Chargers at MP3

**Calculations**

97-ENG-01774E2                      Battery 201A & Charger, Associated Cable & Device Electrical Verification Calculation

**Technical Evaluations**

M3-EV-01-0013                      Containment Recirculation Past Operability with Containment Bearing Oil in 3RSS\*P1B during Post LOCA Long Term Cooling

M3-EV-02-0001                      Charging Pump Mission Time for NEI 99-02

M3-EV-02-0003                      Charging Pump Seal Cooling Pump Empty Bubbler