



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

October 31, 2003

Southern Nuclear Operating Company, Inc.
ATTN: Mr. J. B. Beasley, Jr.
Vice President
P. O. Box 1295
Birmingham, AL 35201-1295

**SUBJECT: JOSEPH M. FARLEY NUCLEAR PLANT - NRC PROBLEM IDENTIFICATION
AND RESOLUTION INSPECTION REPORT 050000348/2003007 AND
05000364/2003007**

Dear Mr. Beasley:

On October 3, 2003, the U. S. Nuclear Regulatory Commission (NRC) completed an inspection at your Farley Nuclear Plant, Units 1 and 2. The enclosed inspection report documents the inspection findings, which were discussed on October 3, 2003, with Mr. Randy Johnson and other members of your staff during an exit meeting.

The inspection examined 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 license. The inspectors reviewed selected procedures and records, conducted plant observations, and interviewed personnel.

On the basis of the sample selected for review, the team concluded that, in general, problems were properly identified, evaluated, and corrected. There were two Green findings identified involving a long standing plant equipment deficiency which had not been resolved, and a repetitive deficiency which had not been properly evaluated for corrective action via the corrective action program. These two findings were determined to be violations of NRC requirements. However, because of their very low safety significance and because they were entered into your corrective action program, the NRC is treating these two violations as non-cited violations (NCVs) in accordance with Section VI.A.1 of the NRC's Enforcement Policy. If you deny these NCVs you should provide a response with the basis for your denial, within 30 days of the date of this inspection report, 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 Farley Nuclear Plant.

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In accordance with 10 CFR 2.790 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 the NRC's document system (ADAMS). ADAMS is accessible from the NRC Web site at <http://www.nrc.gov/reading-rm.html> (the Electronic Reading Room).

Sincerely,

/RA/

Brian R. Bonser, Chief
Reactor Projects Branch 2
Division of Reactor Projects

Docket Nos. 50-348 and 50-364
License Nos. NPF-2 and NPF-8

Enclosure: Inspection Report 05000348/2003007
and 05000364/2003007
w/Attachment: Supplemental Information

cc w/encl: (see page 3)

SNC

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cc w/encl:

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U. S. NUCLEAR REGULATORY COMMISSION

REGION II

Docket Nos.: 50-348, 50-364

License Nos.: NPF-2, NPF-8

Report Nos.: 05000348/2003007 and 05000364/2003007

Licensee: Southern Nuclear Operating Company, Inc. (SNC)

Facility: Farley Nuclear Plant

Location: 7388 N. State Highway 95
Columbia, AL 36319

Dates: September 15 to October 3, 2003

Inspectors: K. Van Doorn, Senior Reactor Inspector, Lead Inspector
C. Rapp, Senior Project Engineer
B. Bearden, Senior Resident Inspector
M. King, Resident Inspector
R. Taylor, Reactor Inspector

Approved by: Brian R. Bonser, Chief
Reactor Projects Branch 2
Division of Reactor Projects

Enclosure

SUMMARY OF FINDINGS

IR 05000348/2003007, 05000364/2003007; 09/15/2003 - 10/03/2003; Farley Nuclear Plant, Units 1 & 2; Identification and Resolution of Problems.

The inspection was conducted by a senior reactor inspector, a senior project engineer, a senior resident inspector, a resident inspector, and a Region II reactor inspector. Two Green findings of very low safety significance were identified during this inspection and were classified as non-cited violations (NCVs). 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 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.

Identification and Resolution of Problems

The licensee was generally effective at identifying problems at a low threshold and entering them into the corrective action program. One exception was noted regarding the failure to utilize the corrective action program (CAP) for a repetitive problem involving Motor Driven Auxiliary Feedwater Pumps (MDAFWPs) lubricating oil which did not meet requirements. The licensee properly prioritized issues and routinely performed adequate evaluations that were technically accurate and of sufficient depth. Formal root cause evaluations for significant conditions adverse to quality were normally thorough and detailed although the CAP program as written allowed a less than formal disciplined process to be utilized for root cause evaluations. Historically, corrective actions developed and implemented for problems had not always been timely and effective, however, this inspection showed marked improvement in this area, with one exception involving untimely corrective action for safety-related Loss of Off-Site Power relays. The licensee's self-assessments and audits were effective in identifying deficiencies in the corrective action program. Based on discussions conducted with plant employees from various departments the inspectors did not identify any reluctance to report safety concerns.

A. NRC Identified and Self-Revealing Findings

Cornerstone: Mitigating Systems

- Green: An NCV of 10 CFR 50, Appendix B, Criterion XVI, Corrective Action, for failure to utilize the corrective action program for repetitive problems with MDAFWP bearing oil which did not meet acceptance criteria.

This finding is associated with the Mitigating Systems cornerstone and affected the objective of equipment reliability. This finding is of very low safety significance because it did not result in actual inoperability of the MDAFWP. (Section 4A02.a)

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- Green: An NCV of 10 CFR 50, Appendix B, Criterion XVI, Corrective Action, for failure to take timely corrective action for repetitive out-of-calibration conditions on safety-related relays associated with Loss of Off-Site Power (LOSP) sequencers.

This finding is associated with the Mitigating Systems cornerstone and affected the objective of equipment reliability. This finding is of very low safety significance because the system was not inoperable for greater than the time allowed by plant Technical Specifications. (Section 4AO2.c)

B. Licensee-Identified Violations

None.

REPORT DETAILS

4. OTHER ACTIVITIES (OA)

4OA2 Problem Identification and Resolution

a. Effectiveness of Problem Identification

(1) Inspection Scope

The inspectors reviewed procedures associated with the CAP which described the administrative process for initiating and resolving problems via Condition Reports (CRs). The inspectors selected CRs for review covering various cornerstones, severity levels, and site departments. The inspectors also conducted a detailed review of CRs for five risk significant systems. These systems were also selected based on equipment performance history and Maintenance Rule (MR) considerations. These systems included the Auxiliary Feedwater System (AFW), the Vital DC and AC electrical systems, Component Cooling Water System (CCW), and the Service Water System (SW). The inspectors also reviewed maintenance history and selected completed Work Orders (WOs) for the five systems and reviewed associated system health reports. Additional CRs were selected associated with MR evaluations and problems previously identified by NRC. The inspectors also reviewed NRC inspection results of CRs documented in NRC reports over the last two-year time period. These reviews were performed to verify that problems were being properly identified, appropriately characterized, and entered into the CAP.

The inspectors also conducted plant walkdowns of equipment associated with the five selected systems to assess the material condition and to look for any deficiencies that had not been entered into the CAP.

The inspectors reviewed selected industry operating experience items associated with the five systems, including NRC generic communications, to verify that these were appropriately evaluated for applicability and whether issues identified through these reviews were entered into the CAP.

The inspectors reviewed licensee audits and self-assessments including those which focused on problem identification and resolution to verify that findings were entered into the CAP and to verify that these findings were consistent with the NRC's assessment of the licensee's CAP.

The inspectors also attended various plant meetings to observe management and oversight functions of the corrective action process. These included morning meetings, a Human Performance Review Board (HPRB) meeting, a Corrective Action Review Board (CARB) meeting, Corrective Action Program Coordinator (CAPCO) meetings, and the daily 3:30 p.m. plant performance telephone conference. The inspectors also held discussions with various personnel to evaluate their threshold for identifying issues and entering them into the CAP.

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Documents reviewed are listed in the Attachment.

(2) Assessment

The inspectors determined that the licensee was generally effective in identifying problems and entering them into the CAP. CRs normally provided complete and accurate characterization of the subject issues with only minor exceptions noted. In general, the threshold for initiating CRs was low and employees were encouraged by management to initiate CRs. Equipment performance issues were generally being identified at an appropriate level and entered into the CAP. One exception is described in Section (3).

The licensee was effective in evaluating internal and external industry operating experience items for applicability and entering issues into the CAP.

Department self-assessments were particularly self-critical and, along with audits, were effective in identifying value-added issues which were entered into the CAP where appropriate. Site management was actively involved in the CAP process and focused appropriate attention on significant plant issues. The HPRB, CARB, and CAPCO meetings provided valuable insights and oversight of the CAP process. The establishment of the CAPCO type concept for departmental ownership of the process was considered a recent significant positive change in the program.

(3) Findings

Introduction: A Green NCV of 10 CFR 50, Appendix B, Criterion XVI was identified for failure to implement timely corrective actions for recurring problems with the 1A MDAFWP inboard and outboard bearing oil.

Description: The inspectors reviewed the oil analysis, which is performed once every three months, for the 1A MDAFWP outboard and inboard pump bearings. The oil analysis noted high particulate count levels for several oil samples dating back to September 20, 2001. During this time period eight of nine oil samples from the 1A MDAFWP outboard bearing and three of nine oil samples from the 1A MDAFWP inboard bearing were found to have particulate count levels in the Marginal and Unacceptable range. Upon discussion with maintenance personnel it was understood that the threshold for writing a CR was believed to be a high particulate count coincident with elevated metal content in the oil, which would indicate bearing wear. In addition, General Maintenance Procedure for the Lubrication Analysis Program (FNP-0-GMP-30.1 Rev. 3.0) stated, "Marginal or Unacceptable items require a Condition Report." During the time period reviewed the licensee failed to write a CR for the Marginal and Unacceptable particulate levels identified in the inboard and outboard bearing oil analyses.

Analysis: The inspectors determined that this finding was associated with the Mitigating Systems cornerstone and potentially affected the objective of equipment reliability. This finding was more than minor because the condition represented degradation of a safety

system that had the potential for affecting system operability. This example also illustrated a deficiency in the licensee's corrective action program such that recurring system deficiencies were not identified and corrected in timely manner. This issue is of very low safety significance because it did not actually result in the system being inoperable.

Enforcement: 10 CFR 50, Appendix B, Criteria XVI, Corrective Actions, requires in part, that measures be established to assure that conditions adverse to quality are promptly identified and corrected. Further, in the case of significant conditions adverse to quality, the measures shall assure that the cause of the condition is determined and corrective action taken to preclude repetition. Contrary to the above, licensee corrective actions affecting the safety-related AFW system were inadequate in that a recurring problem related to this system existed from January 2001 to present. This problem was high particulate counts in the inboard and outboard bearing oil. Since this violation is of very low safety significance, as it did not result in the safety-related system being inoperable, and has been entered into the corrective action program as CR 2003002554 and CR 2003002459, this violation is being treated as an NCV in accordance with Section VI.A.1 of the NRC Enforcement Policy: NCV 05000348, 364/2003007-01, Failure to Adequately Evaluate and Correct a Recurring Auxiliary Feedwater Pump Bearing Oil Out-of-Specification Condition.

b. Prioritization and Evaluation of Issues

(1) Inspection Scope

The inspectors reviewed site and department trend reports along with the inspections discussed in Section 4OA2.a to verify that the licensee appropriately prioritized and evaluated problems in accordance with their risk significance. The inspectors' review was also intended to verify that the licensee adequately determined the cause(s) of the problems, including root cause where appropriate, and adequately addressed operability, reportability, common cause, generic concerns, extent of condition, and extent of cause. The review was also to verify that the licensee appropriately identified corrective actions to prevent recurrence and these actions had been appropriately prioritized.

(2) Assessment

The inspectors determined that the licensee properly prioritized issues entered into the CAP. Generally, the licensee performed adequate evaluations that were technically accurate and of sufficient depth. Formal root cause evaluations sometimes lacked detail. An example was the relay issue described in 4AO2.c below. The cause had not been fully determined and the evaluation technique listed was "Pencil and Paper Narrative." The licensee's program as written allowed this informal evaluation process to be used as a stand alone root cause methodology, even though the procedure further described this technique as primarily an information gathering technique. This was the technique credited on a number of root cause evaluations reviewed by the inspectors. This was considered a negative observation regarding the CAP root cause process.

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The licensee indicated that this technique should not be used as a stand alone method and that they would initiate corrective actions for this issue. The inspectors determined that site and department trend reports were thorough and a low threshold was established for evaluation of potential trends.

(3) Findings

No findings of significance were identified.

c. Effectiveness of Corrective Actions

(1) Inspection Scope

The inspectors reviewed the open CR list and a sample of the open CRs, reviewed the open Action Item (AI) list and a sample of the open AIs, reviewed selected licensee effectiveness reviews, and confirmed implementation of selected AIs associated with CRs reviewed, along with the inspections discussed in Section 4OA2.a and b, to verify that the licensee had identified and implemented timely and appropriate corrective actions to address problems. The inspectors verified that the corrective actions were properly documented, assigned, and tracked to ensure completion. The review was also to verify the adequacy of corrective actions to address equipment deficiencies and MR functional failures of risk significant plant safety systems.

(2) Assessment

In general, corrective actions developed and implemented for problems were timely and effective, commensurate with the safety significance of the issues. The reviews of plant inspection history and equipment issues showed that the licensee had sometimes been slow to correct equipment problems. However, a marked improvement was noted during this inspection regarding management emphasis on correcting problems and most problems had causes identified and corrections scheduled, although a number of corrections were yet to be completed. One exception was noted and is described below.

(3) Findings

Introduction: A Green NCV of 10 CFR 50, Appendix B, Criterion XVI, was identified for failure to take timely corrective actions for repetitive out-of-calibration conditions on safety-related relays associated with the Loss of Off-Site Power (LOSP) sequencers.

Description: On September 24, 2002, the licensee wrote CR 2002002291 Severity Level (SL) 4 to document several LOSP relays that did not meet the as-found acceptance criteria in surveillance procedures FNP-2-STP 933.1 and FNP-2-STP-934.1. The licensee conducted a review of WOs for LOSP relay calibration since March 1994 and found that certain relays had a high failure rate. The corrective actions identified were to replace the relays identified during the WO review, revise FNP-2-STP 933.1 and FNP-2-STP-934.1 to require replacement of any relay that did not meet the as-found

acceptance criteria, and acquire additional spare relays. The licensee initiated WOs to replace the relays; however, no spare relays were available. The licensee also issued a purchase order for four Class 1E relays, but the order was canceled when a lower cost relay was located. However, the lower cost relays were not Class 1E and had to be certified through the commercial grade dedication (CGD) process. The licensee was completing the CGD process and expected the spare relays to be available in December 2003. Although there was a historical record of these relays not meeting the as-found acceptance criteria, the licensee failed to identify this condition adverse to quality until September 2002. Also, spare relays will not be available until December 2003 although the need to replace these relays was identified in September 2002.

On March 17 and 18, 2003, the licensee again found LOSP relays that did not meet the as-found acceptance criteria. These failures were documented in CRs 2003000570 and 2003000576. The corrective actions for both CRs were the same as for CR 2002002291. These two failures were considered functional failures and resulted in the Unit 1 B1G sequencer being classified as MR category a(1). On June 3, 2003, the licensee wrote CR 2003001332 (SL2) to document the MR category a(1) classification. This CR required a formal root cause evaluation; however, no rigorous root cause methodology was used and the evaluation provided no new information than that previously documented in CR 2002002291. The significant corrective actions for this CR were to implement the WOs initiated in CR 2002002291 and identify a replacement relay that could meet the Technical Specification calibration requirements. Engineering evaluations for relays that could meet the TS calibration requirements were not expected to be completed until early 2004.

Analysis: The inspectors determined this finding was associated with the Mitigating Systems cornerstone and affected the objective of equipment reliability. The licensee failed to promptly identify repetitive calibration failures that had occurred since 1994 until September 2002. Also, the licensee failed to implement corrective actions in that, as of October 2003, relays identified to be replaced in September 2002 had not been replaced. This resulted in additional calibration failures in March 2003. Further, the corrective actions were inadequate in that it was not identified until June 2003 that the existing relay was not suitable for the application. This finding is of very low safety significance because the system was not inoperable for greater than the time allowed by plant Technical Specifications.

Enforcement: 10 CFR 50, Appendix B, Criteria XVI, Corrective Actions, requires in part, that measures be established to assure that conditions adverse to quality are promptly identified and corrected. Contrary to the above, the licensee failed to promptly identify repetitive safety-related calibration failures that had occurred since 1994 until September 2002. Also, the licensee failed to implement corrective actions in that, as of October 2003, relays identified to be replaced in September 2002, had not been replaced, resulting in additional calibration failures in March 2003. Since this violation is of very low safety significance and the licensee has entered it into the corrective action program as CR 2003002443, this violation is being treated as an NCV in accordance with Section VI.A.1 of the NRC Enforcement Policy: NCV 05000348, 364/2003007-02,

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Failure to Promptly Identify and Correct Multiple Loss of Off-Site Power Sequencer Relay Out of Calibration Conditions.

d. Assessment of Safety-Conscious Work Environment

(1) Inspection Scope

During technical discussions with members of the plant staff the inspectors conducted interviews to develop a general perspective of the safety-conscious work environment at the site. The interviews were also to determine if any conditions existed that would cause employees to be reluctant to raise safety concerns. The inspectors also reviewed the licensee's employee concerns program (ECP) which provides an alternate method to the CAP for employees to raise concerns and remain anonymous. The inspectors interviewed the ECP Coordinator and reviewed a select number of ECP reports completed in 2002 and 2003 to verify that concerns were being properly reviewed and identified deficiencies were being resolved and entered into the CAP when appropriate.

(2) Assessment

Based on this inspection and the CR reviews, the inspectors concluded that licensee management emphasized the need for all employees to promptly identify and report problems using the appropriate methods established within the administrative programs. The inspectors did not identify any reluctance to report safety concerns.

(3) Findings

No findings of significance were identified.

4OA6 Management Meetings

On October 3, 2003 the inspectors presented the inspection results to Mr. R. Johnson, and other members of his staff who acknowledged the findings. The inspectors confirmed that proprietary information was not provided or examined during the inspection.

ATTACHMENT: SUPPLEMENTAL INFORMATION

Enclosure

SUPPLEMENTAL INFORMATION

KEY POINTS OF CONTACT

Licensee personnel

R. V. Badham, Administration Manager
C. L. Buck, Chemistry/Health Physics Manager
C. D. Collins, Assistant General Manager - Plant Support
P. Crone, Licensing Supervisor
J. R. Johnson, Assistant General Manager - Operations
R. R. Martin, Engineering Support Manager
B. L. Moore, Maintenance Manager
C. D. Nesbitt, Training and Emergency Preparedness Manager
W. D. Oldfield, Quality Assurance Supervisor
T. Youngblood, Operations Manager

NRC personnel

T. Johnson, Senior Resident Inspector, Farley
V. McCree, Director, Division of Reactor Projects, RII
C. Patterson, Senior Resident Inspector, Farley

LIST OF ITEMS OPENED, CLOSED, AND DISCUSSED

Opened and Closed

05000348, 364/2003007-01 NCV Failure to Adequately Evaluate and Correct a Recurring Auxiliary Feedwater Pump Bearing Oil Out of Specification Condition (Section 4AO2.a)

05000348, 364/2003007-02 NCV Failure to Promptly Identify and Correct Multiple Loss of Off-site Power Sequencer Relay Out of Calibration Conditions (Section 4AO2.c)

LIST OF DOCUMENTS REVIEWED

Procedures

NMP-GM-002, Corrective Action Program, Version 1.0
NMP-GM-002-GL01, CR Software, Version 1.0
NMP-GM-002-GL02, Corrective Action Program Details and Expectations Guideline, Version 1.0
NMP-GM-002-GL03, Corrective Action Program Root Cause Determination Guideline, Version 1.0
NMP-GM-002-GL04, Corrective Action Program Apparent Cause Determination Guideline, Version 1.0
NMP-GM-002-GL05, Corrective Action Program Trend Coding and Analysis Guideline, Version 1.0

NMP-GM-002-GL06, Corrective Action Review Board Guideline, Version 1.0
 NMP-GM-002-GL07, Corrective Action Program Effectiveness Review Guideline, Version 1.0
 NMP-GM-003, Self-Assessment Procedure, Version 1.0
 NMP-GM-003-GL01, Self-Assessment Guideline, Version 1.0
 FNP-0-AP-30, Preparation and Processing of Condition Reports and Licensee Event Reports, Version 35.0
 FNP-0-ACP-9.0, Root Cause Program, Version 10.0
 FNP-0-ACP-9.1, Root Cause Investigation, Version 9.0
 FNP-0-MP-94.2, Procedure for Component Cooling Water Heat Exchanger Tube Plugging, Version 1.0

Condition Reports (CRs)/Occurrence Reports (ORs)

Maintenance Rule CRs

2001000452, 120 VAC exceeded MR performance criteria
 2002001874, During rescoping effort MR expert panel determined that Unit 1 SGBD isolation valves had exceeded MR performance criteria
 2002001875, During rescoping effort MR expert panel determined that Unit 2A MDAFW pump room cooler had exceeded MR performance criteria
 2002001876, During rescoping effort MR expert panel determined that SW dilution bypass valves had exceeded MR performance criteria
 2002002588, During review MR expert panel determined that DG alarms had exceeded MR performance criteria
 2002002773, MR goal not satisfied for 4160 volt breakers
 2003000258, December 2002 MR periodic assessment recommendations
 2003000303, 1A Condensate Pimp exceeded MR unavailability performance criteria
 2003001333, Unit 1 B SGFP exceeded MR plant level performance criteria
 2003001295, Unit 2 Inverter 2F exceeded MR performance criteria
 2003001296, 7300 Analog Protection System exceeded MR performance criteria

Miscellaneous CRs

2002002508, Control rod B8 sticking
 2003001298, Errors in equipment out of service plant risk calculations
 2002002164, Both trains of control room emergency filtration system inoperable (TS 3.0.3 entry) due to tool pouch work causing door 453 to be inoperable
 2002000258, Radiation monitor RE11, containment air particulate, high alarm set point, warn alarm set point and function switch were incorrectly set
 2002002253, Maintenance performed on the wrong units diesel generator service water valve
 2001000077, Channel III Tavg failed low, 7300 card failures
 2001001098, Conoseal #2 found leaking during cold head inspection
 2001001369, Fast speed breaker for containment cooler fan did not close, inadequate PMT
 2001001535, Reactor trip 6/23/01, after generator neutral auxiliary relay actuated
 2001001556, Handswitch issues affecting breaker operations
 2001001751, DG has been in A1 since 1996 due to repetitive MPFFs of the air dryer ck valves
 2001002669, 1B D/G jacket water leaker into the rocker arm reservoir
 2001002778, Control rods not fully inserting during hot rod drop testing
 2002001020, Unit 1 reactor trip 5/3/02 (and associated licensee-identified NCV reviewed)

2002002081, Database inaccurate for 2B EDG ready to start light, fuses in auto start circuit blew
 2002002529, Rod F-6 dropped to 198 steps after a step insertion, manual reactor trip
 2003000020, Valve actuator broke during quarterly inservice test for 2A RHR discharge valve
 2003001167, 1B SGFP oversped while operating at 100 percent power, no speed control
 2003001952, Incorrect leads lifted, generated all rods at bottom indication
 2002003076, Self-assessment of the Operating Experience Program
 2001002102, Area for improvement regarding root cause evaluations
 2002000065, NRC PI&R finding
 2002001663, Configuration Management negative trend
 2002002701, Self-Assessment improvements needed
 2002002702, Inconsistent corrective action quality
 2003000518, Overflow of 2C D/G FOST
 2003000863, Audit finding regarding extension requests
 2003000869, Audit finding regarding corrective action deadlines
 2003000702, Missing safeguards information procedure
 2003001194, Challenges to CAPCO process
 2003001457, Control Room conduit seals
 2003001556, Burning 12KV breaker
 2003001805, Small bore SW vent/drain failures
 2003001969, Potential adverse trend in clearances

Electrical systems CRs/ORs

2002002291, 2003000570, 2003000576, 2003001332, 2003001574, 2003000560,
 2003000254, 2001002672, 2002000496, 2001002756, 2002002997, 2002001184,
 2001003112, 2002000318, 2002002773, 2002001276, 2002001433, 2002001596,
 2002001978, 2002002602, 2002002879, 2003001178, 2003001196, 2003001505,
 2003001617, 2001002579, 2003001962, 2003001015, 2003001016, 2003000395,
 2003001295, 2003000559, 2003000841, 2003001144, 2003000159, 2003000132,
 2002002417, 2002002754, 2003001532, 2002002417, 2002002533, 2003000028,
 2001002756, 2002000496, 2002001295, 2003000395, 2003000759, 2003001332,
 2003001178, OR's: 2-97-167, 1-99-149

Service Water System CRs

2002001369, 2001001556, 2001001887, 2001002196, 2001002198, 2001002260,
 2001002349, 2001002499, 2001002506, 2001002702, 2001002705, 2001002715,
 2001002716, 2001002736, 2001002945, 2001002955, 2001002967, 2001002970,
 2001002972, 2001003118, 2002000116, 2002000282, 2002000294, 2002000316,
 2002000325, 2002000327, 2002000362, 2002000454, 2002000615, 2002000638,
 2002000759, 2002000825, 2002000985, 2002000996, 2002001050, 2002001057,
 2002001139, 2002001160, 2002001171, 2002001184, 2002001239, 2002001533,
 2002001583, 2002001608, 2002001646, 2002001647, 2002001665, 2002001705,
 2002001770, 2002001787, 2002001792, 2002001828, 2002001840, 2002001843,
 2002001877, 2002001895, 2002001985, 2002002125, 2002002253, 2002002260,
 2002002333, 2002002358, 2002002359, 2002002365, 2002002428, 2002002516,
 2002002791, 2002002800, 2002002846, 2002002864, 2002002879, 2002002893,
 2003000061, 2002000127, 2003000151, 2002000188, 2002000453, 2003000476,
 2003000486, 2003000514, 2003000543, 2003000653, 2003000722, 2003000761,

2003000770, 2003000825, 2003000829, 2003000837, 2003000861, 2003000864,
2003000957, 2003001113, 2003001127, 2003001141, 2003001151, 2003001208,
2003001227, 2003001237, 2002001259, 2003001364, 2003001436, 2003001493,
2003001562, 2003001620, 2003001716, 2003001774, 2003001789, 2003001805,
2003001865

Component Cooling Water System CRs

2001001443, 2001002150, 2001002338, 2002002447, 2002002762, 2001003065,
2002000080, 2002000640, 2002000716, 2002000732, 2002000810, 2002001118,
2002002230, 2002002236, 2002002602, 2002002835, 2002000624, 2002000648,
2003001205, 2003001223, 2003001227, 2003001264, 2003001283, 2003000912,
2003001181, 2003001298, 2003001356, 2003001608, 2003001654, 2003001761,
2003001874, 2003002040

Auxiliary Feedwater System CRs

2003000508, 2001002975, 2003001297, 2001002905, 2002002896, 2001002665,
2003001287, 2003000789, 2002000659, 2002000656, 2003000868, 2002002473,
2002000644, 2003002554, 2003002459

Maintenance Work Orders

Service Water System

M3003820, M1007912, M1007114, M1007137, M1007798, M2004085, M3000729, M3000758,
M0561592, M0554242, M1008842, M1006667, M2004525, M0554256, M0561594, M3003476,
M1007333, M1008650, S2004472, M2003833, M3002230, M3002930, M3002994, M0561744,
M1007233, M1007449, M1007459, M3002278, M3005511, S3000310, M2004989, M2003393,
M1006624, M3000898, M3000912, S3000913, M3000900, M3000911, S2005023, S2005022,
M3000895, M3000894, M3000909, M3000910

Component Cooling Water System

S3000760, M3003591, M1007615, M1007701, M1007654, M1007641, M1007466, M1009247,
M2000421, M2001330, M2001232, M2001230, M2004174, M2004594, M2005910, M2005703,
M2002893, M0557281, W0678140, W0678141, M1009247, W0703130, W0678143,
W0703783, M0554542, M2007438, M2004274, M0557863, M2005726

Electrical Systems

M3003313, M3000518, M2007242, M2006000, M3000192, M3000375, M695358, M2007625,
M700293, M3001594, M3005087, M3005089, M3005090, M3005091, M3005092, M3005093,
M3001082, M2000035, M3005501, M3004706, M2007690, M2006675, M2004841, M2004850,
M2003305, M2003306, M2000801, M1007973, M1009155, M2006000, M2001226, M2002629,
M3000341, M3000682, M2001327, M1007651, M682191, M682217, M561202, M561203,
M561204, M561325

Operating Experience (OE) Items

Information Notices: 2002-01, 2002-32, 2002-04, 1998-83, 2002-02
Westinghouse NSAL-03-06
SOERs 98-2, 03-2, and 02-4
SENs 189 and 201

OEs 11501, 12418, 12528, 13080, 13772, 13789, 14003, 14138, 14698, 14723, 15618, 16312, and 16337

Self- Assessments

Corrective Action Audit No. 2003-CAR/19-1
 Corrective Action Audit No. 2002-CAR/19-2
 Operations Self-Assessment, Conduct of Operations dated July 21-25, 2003
 Corrective Action Self-Assessment dated September 29, 2003
 Annual Audit of Plant Farley Concerns Program-2002
 Level 5 Condition Report Classifications, CR 2001002721
 Adverse Trends in Rad Protection Events, CR 2003001507
 Equipment Reliability, CR 2002000453
 OE Self-Assessment, CR 2002003076
 Rx Engineering and I&C Systems, CR 2003000564
 Maintenance Adherence to Standards, CR 2003002156
 Focused Self-Assessment of Root Cause Program, CR 2002003077
 Engineering Support Self-Assessment, CR 2003000564
 Operations Clearance and Tagging Self-Assessment, CR 2003000125
 Health Physics Focused Self-Assessment, CR 2003001901

Backlogged Action Items

2000202036, NRC Information Notice 97-014 commitment to install redundant spent fuel temperature indicators and control room alarms
 2002203075, replace service water strainer bypass line
 2000250023, Limatorque maintenance update 98-02
 2000250252, increase actuator capability for 8 of 40 MOVs with negative margin capability
 2002203404, EOP related setpoint evaluations
 2003291229, component cooling water thermal barrier piping cracking
 2003201192, problems with one simulator crew's ability to transfer to cold leg recirculation in timely manner
 2003201193, annual simulator evaluation results, training issues
 2003200338, RER 03-0055 Unit 2 main steam interference reconciliation / pipe stress calculations
 2003201497, fire induced failures could cause inadvertent drain down of the RWST to the sump
 2000201618, letdown flow rates in dose analysis, currently awaiting NRC approval
 2003202119, on-shift crew awareness for increased surveillance of service water pond level with one train of raw water out of service
 2003201220, recent failures of the thermal barrier inlet and outlet piping on both units - an enhanced monitoring and long term plan to be established

Miscellaneous Documents

System Health Reports: 2nd quarter 2003 for Batteries, AC Distribution Cabinets, Auxiliary Feedwater System, Service Water System, and Component Cooling Water System
 July 2003 Maintenance Rule Report dated 9/10/2003
 A1 SSC Monthly Status Reports for Service Water System
 July 2003 Maintenance Rule Report and summary letter, FNP-03-0149-ES dated 9/10/03
 Farley Nuclear Plant Quarterly Trend Reports for May, June, July 2003; February, March, April, 2003; and November, December, January, 2002-2003

Quarterly Department Trend Analysis Reports, 2nd Quarter, 2003 for Operations, Maintenance,
Health Physics/Chemistry, and Engineering Support
Potential Adverse Trend Condition Report list for 2003
Monthly Summary Report, August 2003
Outstanding Minor Departures
Work-Around Lists dated 09/07/2003
Farley Nuclear Plant Major Issues Status Report, dated 9/17/03
Farley Nuclear Plant Equipment Reliability List and Closed Equipment Issues list including
ERHL Action Plans for open issues and closed issues
Overdue Condition Report Summary Report for 10/2/03
Condition Report Summary Report of Level 1, 2 and 3 CRs
Condition Report Summary Report for Maintenance Preventable Functional Failures, 2001-
2003
Open Condition Report List dated 08/13/2003
Open Action Item List dated 08/13/2003