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

March 27, 2009

Mr. Tom E. Tynan
Vice President - Vogtle
Southern Nuclear Operating Company, Inc.
Vogtle Electric Generating Plant
7821 River Road
Waynesboro, GA 30830

SUBJECT: VOGTLE ELECTRIC GENERATING PLANT - NRC PROBLEM IDENTIFICATION AND RESOLUTION INSPECTION REPORT 05000424/2009006 AND 05000425/2009006

Dear Mr. Tynan:

On February 27, 2009, the U. S. Nuclear Regulatory Commission (NRC) completed an inspection at your Vogtle Electric Generating Plant Units 1 and 2. The enclosed report documents the inspection findings, which were discussed on February 27, 2009, with you and members of your staff.

The inspection was an examination of activities conducted under your license as they relate to the identification and resolution of problems, and compliance with the Commission's rules and regulations and with the conditions of your operating license. Within these areas, the inspection involved examination of selected procedures and representative records, observations of plant equipment and activities, and interviews with personnel.

On the basis of the samples selected for review, there were no findings of significance identified during this inspection. The team concluded that problems were properly identified, evaluated, and resolved within the problem identification and resolution (PI&R) program. However, the team identified examples of minor problems, including closing of a corrective action prior to completion and closing of a corrective action without clear documentation of what was performed.

In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your response, if any, will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records (PARS) component of the NRC's document system (ADAMS). ADAMS is accessible from the NRC Web site at http://www.nrc.gov/reading-rm/adams.html (the Public Electronic Reading Room).

Sincerely,

/RA/

Steven J. Vias, Chief
Reactor Projects Branch 7
Division of Reactor Projects

Docket Nos.: 50-424, 50-425
License Nos.: NPF-68, NPF-81

Enclosure: Inspection Report 05000424/2009006 and 05000425/2009006
w/Attachment: Supplemental Information

cc w/encl. (See next page)

In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your response, if any, will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records (PARS) component of the NRC's document system (ADAMS). ADAMS is accessible from the NRC Web site at http://www.nrc.gov/reading-rm/adams.html (the Public Electronic Reading Room).

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DATE	03/25/2009	03/25/2009	03/25/2009	03/25/2009	03/25/2009	03/26/2009	
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Letter to Tom E. Tynan from Steven J. Vias dated March 27, 2009

SUBJECT: VOGTLE ELECTRIC GENERATING PLANT - NRC PROBLEM IDENTIFICATION AND RESOLUTION INSPECTION REPORT 05000424/2009006 AND 05000425/2009006

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U. S. NUCLEAR REGULATORY COMMISSION

REGION II

Docket Nos.:	50-424, 50-425
License Nos.:	NPF-68, NPF-81
Report Nos.:	05000424/2009006 and 05000425/2009006
Licensee:	Southern Nuclear Operating Company, Inc.
Facility:	Vogtle Electric Generating Plant, Units 1 and 2
Location:	Waynesboro, GA 30830
Dates:	February 09 - 13, 2009 February 23 - 27, 2009
Inspectors:	S. Atwater, Senior Project Inspector, Team Leader R. Taylor, Senior Project Inspector T. Chandler, Resident Inspector, Vogtle T. Lighty, Project Engineer
Accompanied By:	C. Smith-Standberry, Construction Inspector Trainee
Approved by:	Steven J. Vias, Chief Reactor Projects Branch 7 Division of Reactor Projects

Enclosure

SUMMARY OF ISSUES

IR 05000424/2009006, 05000425/2009006; 02/09/2009 – 02/27/2009; Vogtle Electric Generating Plant, Units 1 and 2; biennial inspection of the identification and resolution of problems.

The inspection was conducted by two senior project inspectors, a resident inspector, a project engineer, and a construction inspector trainee. No findings of significance were identified. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process," Revision 4, dated December 2006.

Identification and Resolution of Problems

The team concluded that, in general, problems were identified, evaluated, prioritized, and corrected. The licensee was effective at identifying problems and entering them into the corrective action program (CAP) for resolution, as evidenced by the relatively few deficiencies identified by external organizations (including the NRC) that had not been previously identified by the licensee, during the review period. Generally, prioritization and evaluation of issues were adequate, formal root cause evaluations for significant problems were adequate, and corrective actions specified for problems were acceptable. Overall, corrective actions developed and implemented for issues were generally effective and implemented in a timely manner. However, the team identified examples of minor problems, including closing of a corrective action prior to completion and closing of a corrective action without clear documentation of what was performed.

The team determined that overall audits and self-assessments were adequate in identifying deficiencies and areas for improvement in the CAP, and appropriate corrective actions were developed to address the issues identified. Operating experience usage was found to be generally acceptable and integrated into the licensee's processes for performing and managing work, and plant operations.

Based on discussions and interviews conducted with plant employees from various departments, the inspectors determined that personnel at the site felt free to raise safety concerns to management and use the CAP to resolve those concerns.

A. NRC Identified and Self-Revealing Findings

None

B. Licensee Identified Violations

None

REPORT DETAILS

4. OTHER ACTIVITIES

4OA2 Problem Identification and Resolution

a. Assessment of the Corrective Action Program

(1) Inspection Scope

The inspectors reviewed the licensee's CAP procedures which described the administrative process for initiating and resolving problems primarily through the use of condition reports (CRs). To verify that problems were being properly identified, appropriately characterized, and entered into the CAP, the inspectors reviewed CRs that had been issued between January 2007 and December 2008, including a detailed review of selected CRs associated with the Main Steam System, Standby Power System, Reactor Coolant System, 125 VDC System, and 480 VAC System. Where possible, the inspectors independently verified that the corrective actions were implemented as intended. The inspectors also reviewed selected common causes and generic concerns associated with root cause evaluations to determine if they had been appropriately addressed. To help ensure that samples were reviewed across all cornerstones of safety identified in the NRC's Reactor Oversight Process (ROP), the team selected a representative number of CRs that were identified and assigned to the major plant departments, including operations, maintenance, engineering, health physics, chemistry, and security. These CRs were reviewed to assess each department's threshold for identifying and documenting plant problems, thoroughness of evaluations, and adequacy of corrective actions. The inspectors reviewed selected CRs, verified corrective actions were implemented, and attended meetings where CRs were screened for significance to determine whether the licensee was identifying, accurately characterizing, and entering problems into the CAP at an appropriate threshold.

The inspectors reviewed CRs, Action Items (AI), work orders, and health reports for the systems selected. These reviews were performed to verify that problems were being properly identified, appropriately characterized, and entered into the CAP. Items reviewed generally covered a two-year period of time; however, in accordance with the inspection procedure, a five-year review was performed for selected systems for age-dependent issues.

The team conducted a detailed review of selected CRs to assess the adequacy of the root cause and apparent cause evaluations of the problems identified. The inspectors assessed if the licensee had adequately determined the cause(s) of identified problems, and had adequately addressed operability, reportability, common cause, generic concerns, extent-of-condition, and extent-of-cause. The review also assessed if the licensee had appropriately identified and prioritized corrective actions to prevent recurrence.

The team reviewed selected industry operating experience items, including NRC generic communications, to verify that they had been appropriately evaluated for applicability and that issues identified through these reviews had been entered into the CAP.

The team reviewed site trend reports, to determine if the licensee effectively trended identified issues and initiated appropriate corrective actions when adverse trends were identified.

The inspectors attended various plant meetings to observe management oversight functions of the corrective action process. These included the Corrective Action Program Coordinator (CAPCO) meetings, Management Review Meetings (MRM), Corrective Action Review Board (CARB) meetings and Plant Review Board (PRB) meetings.

The documents reviewed are listed in the Attachment.

(2) Assessment

Identification of Issues

The team determined that the licensee was generally effective in identifying problems and entering them into the CAP. There was a low threshold for entering issues into the CAP as evidenced by a CR generation rate of approximately 1,000 per month. The management expectation was for employees to initiate CRs for all deficiencies. Trending was generally effective in monitoring equipment performance and the team did not identify any deficiencies not previously entered into the CAP. Site management was actively involved in the CAP and focused appropriate attention on significant plant issues.

Prioritization and Evaluation of Issues

Based on the review of CRs, work orders, and health reports for the systems selected and audits conducted by the licensee, the team concluded that problems were generally prioritized and evaluated in accordance with the licensee's CAP procedures. Each CR was assigned a severity level, the type of cause determination, and a responsible department by the Corrective Action Program Coordinators (CAPCOs). Management reviewed the CAPCO decisions at the Management Review Meeting (MRM). Management reviews were thorough, and adequate consideration was given to system or component operability and associated plant risk.

The team determined that the station had conducted root cause and apparent cause analyses in compliance with the licensee's CAP procedures, and the assigned cause determinations were appropriate considering the significance of the issues being evaluated. The following causal-analysis techniques were used depending on the type and complexity of the issue:

- Event and Causal Factors Chart
- "Why" Staircase Analysis
- Management Oversight and Risk Tree (MORT Analysis)
- Kepner Tregoe

The team determined that generally, the licensee had performed evaluations that were technically accurate and of sufficient depth. The licensee has substantially improved the quality of their root cause analyses since the last PI&R inspection.

The team further determined that operability, reportability, and degraded or non-conforming condition determinations had been completed consistent with the CAP program procedures.

Effectiveness of Corrective Actions

Based on a review of corrective action documents, interviews with licensee staff, and verification of completed corrective actions, the team determined that overall, corrective actions were timely, commensurate with the safety significance of the issues, and effective, in that conditions adverse to quality were corrected and non-recurring. A review of performance indicators, all CRs, and effectiveness reviews demonstrated that the significant conditions adverse to quality had not recurred. Effectiveness reviews for corrective actions to prevent recurrence (CAPRs) were sufficient to ensure corrective actions were properly implemented and were effective. However, the team identified the following two examples in which corrective actions had been closed improperly. The first corrective action had been closed prior to completion and the second corrective action had been closed without proper documentation.

- CR 2008102153, "Clearance & Tagging Errors"

  The root cause evaluation identified ineffective management oversight and inadequate use of Human Error Tools as root causes for this event. AI 2008205802 was generated to enhance management oversight through bi-monthly observations in the area of clearance development and review.

  As of the first week of inspection, the team determined that the management observations had not yet been established and AI 2008205802 had been closed. When notified of this condition, the licensee immediately generated CR 2009101479 to investigate. The licensee revised procedure 10000-C to formally establish a management observation policy and generated an action item to establish a recurring task. At the close of the inspection, management had conducted their first observation.

  Previous clearance and tagging CRs along with misposition CRs were reviewed to determine if a common caused existed. The team determined that an adverse trend existed in which similar root causes were identified in previous analysis reports associated with clearance and tagging deficiencies. The licensee has not yet completed all of the programmatic corrective actions to address the clearance and tagging issues.

- CR 2007101757, "Engineering Qualifications Not Valid"

  AI 2007201138 was an effectiveness review that found the actions taken to address the root causes to be ineffective. AI 2007201138 had been closed with no follow-up action identified. Investigation under CR 2009101505 found the questionable qualifications were based on an incorrect qualification

standard. Once the correct standard was referenced, the qualifications were valid. This was an error in documentation only, in that the original effectiveness review was not corrected prior to closure.

(3) Findings

No findings of significance were identified.

b. Assessment of the Use of Operating Experience (OE)

(1) Inspection Scope

The team examined licensee programs for reviewing industry operating experience, reviewed the licensee's operating experience database, and interviewed the OE Coordinator, to assess the effectiveness of how external and internal operating experience data was handled at the plant. In addition, the team selected operating experience documents (e.g., INPO OE, NRC Regulatory Information Summaries (RIS), Information Notices (IN), Generic Letters, Part 21 vendor notifications, licensee event reports, and plant internal operating experience items, etc.), which had been issued since January 1, 2007, to verify whether the licensee had appropriately evaluated each notification for applicability to the Vogtle plant, and whether issues identified through these reviews were entered into the CAP. Procedure NMP-GM-008, "Operating Experience Program," was reviewed to verify that the requirements delineated in the program were being implemented at the station.

(2) Assessment

Based on interviews with the OE coordinator, a sample of relevant OE, and a review of documentation related to the review of operating experience issues, the team determined that the licensee was generally effective in screening operating experience for applicability to the plant. Industry OE was evaluated at either the corporate or plant level depending on the source and type of document. Relevant information was then forwarded to the applicable department for further action or informational purposes. OE issues requiring action were entered into the CAP for tracking and closure.

The inspectors determined that significant operating experience such as INPO Significant Event Notifications (SEN) and Significant Operating Experience Reports (SOER), NRC Generic letters (GL), Regulatory Information Summaries (RIS), and Information Notices (IN), and Part 21 vendor notifications was regularly used to prevent events from occurring and to address events or near-misses. OE was regularly included in System Health Reports and in CRs associated with station events as part of the causal investigations and corrective action development.

However, the team identified one significant OE that had not been entered into the CAP, as required by procedure. RIS 2008-22 contained safeguards information and was therefore correctly processed through security protocols, rather than through the corrective action process. This was a minor issue in that the OE procedure did not address handling of safeguards information. The licensee generated CR 2009101910 to address the procedure gap.

c. Assessment of Self-Assessments and Audits

(1) Inspection Scope

The team reviewed audit reports and self-assessment reports, including those which focused on problem identification and resolution, to assess the thoroughness and self-criticism of the licensee's audits and self assessments, and to verify that problems identified through those activities were appropriately prioritized and entered into the CAP for resolution.

(2) Assessment

The team determined that the scope of assessments and audits was adequate. Self-assessments were generally detailed and critical, as evidenced by observations consistent with the team's independent review. CRs were created to document a summary of the results and associated recommendations from the final reports. The team verified that all recommendations from self-assessments reviewed had been entered into the CAP, and verified that actions had been completed consistent with those recommendations. Generally, the licensee performed evaluations that were technically accurate. The team concluded that the self-assessments and audits were an effective tool to identify adverse trends.

(3) Findings

No findings of significance were identified.

d. Assessment of Safety-Conscious Work Environment

(1) Inspection Scope

The team randomly interviewed 20 on-site workers regarding their knowledge of the corrective action program at Vogtle and their willingness to write CRs or to raise safety concerns. 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 conducted to determine if any conditions existed that would cause employees to be reluctant to raise safety concerns. The inspectors reviewed the licensee's Employee Concerns Program (ECP) and interviewed the Concerns Coordinator. Additionally, the inspectors reviewed a sample of completed ECP reports 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 the interviews conducted and the CRs reviewed, the team determined that licensee management emphasized the need for all employees to identify and report problems using the appropriate methods established within the administrative programs, including the CAP and ECP. These methods were readily accessible to all employees. Based on discussions conducted with a sample of plant employees from various departments, the inspectors determined that employees felt free to raise issues, and that management encouraged employees to place issues into the CAP

for resolution. The inspectors did not identify any reluctance on the part of the licensee staff to report safety concerns.

The investigations conducted by the ECP were thorough and complete, and recommended corrective actions were appropriately focused to address actions needed to resolve individual concerns. The team noted one exception in which the licensee failed to formally enter a concern into the concerns resolution process due to lapses in ECP staffing caused by illness and turnover. However, the licensee had taken actions to acknowledge and address the employee concern.

(3) Findings

No findings of significance were identified.

4OA6 Meetings, Including Exit

On February 27, 2009, the inspectors presented the inspection results to Mr. Tom Tynan and members of the site staff. The inspectors confirmed that proprietary information was not provided or examined during the inspection.

ATTACHMENT: SUPPPLEMENTAL INFORMATION

SUPPLEMENTAL INFORMATION

KEY POINTS OF CONTACT

Licensee Personnel

J. Agcaoilli, Engineering
M. Agcaoilli, 125 VDC System Engineer
R. Brigdon, Nuclear Operation Training Supervisor
C. Buck, Chemistry Manager
W. Copeland, Performance Improvement Supervisor
R. Dedrickson, Plant Manager
K. Dyer, Security Manager
J. Ealick, Fleet Oversight Supervisor
M. Hickox, Principal Licensing Engineer
D. Hill, Root Cause Analyst
D. Holt, Performance Improvement Engineer
P. Hurst, Concerns Program Manager
M. Johnson, Health Physics Support Supervisor
N. Johnson, Standby Power System Engineer
I. Kochney, Health Physics
D. Lambert, Site Design Manager
L. Mansfield, Engineering Support Manager
J. Martin, 480 VAC System Engineer
D. McCary, Maintenance Manager
T. Morgan, Human Resources Business Consultant
T. Parton, Operations Support Superintendent
S. Phillips, Maintenance Superintendent
T. Reeves III, Health Physics Specialist
A. Rivera, Main Steam System Engineer
J. Robinson, Technical Services Manager
M. Sharma, Nuclear Specialist
R. Shepherd, Performance Improvement Nuclear Specialist
E. Sweat, RCS System Engineer
T. Tynan, Site Vice President
R. Vaught, Outage and Scheduling Manager
D. Vineyard, Operations Manager
A. Whaley, Corrective Action Program Supervisor
J. Williams, Site Support Manager
D. Wilson, Human Resource Business Partner
M. Wilson, Fleet Oversight
T. Youngblood, Engineering Director

NRC

S. Vias, Branch Chief, Reactor Projects Branch 7

LIST OF ITEMS OPENED, CLOSED, AND DISCUSSED

Opened and Closed

None

Closed

None

Discussed

None.

LIST OF DOCUMENTS REVIEWED

Procedures

Concerns Program Procedure, Rev 9.0
NMP-AD-012 Operability Determinations and Functionality Assessments, Version 6
NMP-AD-012-F01 Prompt Determination of Operability, Version 1
NMP-AD-012-GL01 Prompt Determination of Operability Guideline, Version 1
NMP-ES-001 Equipment Reliability Process Description, Version 7
NMP-ES-001-GL01 Equipment Reliability Event Free Clock Reset Criteria, Version 2
NMP-GM-002, Corrective Action Program, Rev 7
NMP-GM-002-001, Corrective Action Program Instructions, Rev 11
NMP-GM-002-002, Effectiveness Review Instructions, Rev 1
NMP-GM-002-GL03, Cause Determination Guidelines, Rev 12
NMP-GM-002-GL05, Data Configuration Guideline, Rev 14
NMP-GM-002-GL09, CAP Training and Qualification Plan, Rev 1
NMP-GM-013, Integrated Performance Assessment, Rev 1
NMP-GM-008, Operating Experience Program Version 6
NMP-MA-006, Rework Program, Version 2.0
50028-C, AI SSC Classification/Monthly Status Report, Rev 15.1
14986-C, Security Diesel Generator Load Test, Rev 17

Condition Reports

2000001929	2003001597	2003002176	2003002197	2003002389	2004000184
2004001501	2004001978	2004002504	2004002989	2004003621	2004151063
2004151123	2005100835	2005101787	2005104478	2005107369	2005110364
2005111257	2006102359	2006102721	2006103594	2006109712	2006109952
2006109953	2006111712	2006112084	2006112783	2007100039	2007100078
2007100188	2007100096	2007100237	2007100259	2007100262	2007100491
2007101109	2007101311	2007101355	2007101666	2007101748	2007101757
2007101900	2007102014	2007102161	2007102211	2007102400	2007102428
2007102520	2007102522	2007102638	2007102919	2007102989	2007103387
2007103546	2007103580	2007103718	2007103840	2007103883	2007103925
2007104053	2007104084	2007104186	2007104260	2007104602	2007104604
2007104694	2007105019	2007105288	2007105452	2007105476	2007105584
2007105619	2007105689	2007105693	2007105809	2007105890	2007105979
2007106228	2007107600	2007107713	2007108319	2007108415	2007108560

Condition Reports (cont.)

2007108614	2007108615	2007108616	2007108618	2007108619	2007108621
2007108715	2007108962	2007109053	2007109839	2007110110	2007110792
2007111591	2007111799	2007111805	2007111974	2007112543	2007112446
2007112728	2007112742	2007112760	2007112890	2007113060	2008100087
2008100319	2008100556	2008101609	2008101772	2008101975	2008102153
2008102330	2008102873	2008102874	2008102875	2008102904	2008103103
2008103330	2008103509	2008103734	2008104000	2008104207	2008104821
2008104834	2008104931	2008104991	2008105088	2008105207	2008105645
2008105652	2008105969	2008106118	2008106265	2008106692	2008106726
2008106729	2008106920	2008107201	2008107256	2008107362	2008107375
2008107505	2008107540	2008107796	2008107825	2008107854	2008108003
2008108021	2008108178	2008108190	2008108357	2008108893	2008109022
2008109091	2008109267	2008109383	2008109859	2008110052	2008110104
2008110119	2008110440	2008110488	2008110791	2008110805	2008110848
2008110870	2008110907	2008110947	2008110969	2008110970	2008110971
2008110973	2008111359	2008111485	2008112064	2008112092	2008112392
2008112654	2008112988	2008113428	2009101073	2009100074	2009100352
2009100769	2009100970	2009101000	2009101166	2009101474	2009101478
2009101479	2009100487	2009101505	2009101726	2009101752	2009101765
2009101861	2009101862	2009101910			

Action Items

2004200405	2004200408	2005204639	2006201122	2006202343	2006202512
2006204734	2006205103	2006205303	2006205313	2007200298	2007200745
2007200901	2007200902	2007200903	2007201008	2007201139	2007201336
2007201709	2007201712	2007201731	2007201820	2007201821	2007202419
2007202875	2007202877	2007204121	2007204141	2007204143	2007204152
2007204215	2007205176	2008109269	2008200840	2008200841	2008202144
2008203171	2008203288	2008203908	2008204801	2008204836	2008204937
2008204938	2008205252	2008205735	2008205778	2008206528	2008206534
2008206798	2008206800	2008206802			

Work Orders

1053871504	1062237701	1070278101	1070566001	1070886401	1080449101
1081133901	1081159701	1081263101	1081306201	1081746201	1081859301
2040257501	2070050401	2070386101	2070503501	2070714801	2070793001
2070840501	2071336601	2071527101	2072151201	2080714101	2080721201
2080751601	2081218401	2081511401	2081570101	2081638501	2081689901
2081690501	2081697001	2081701201	2081853601		

Self Assessments

Fleet Oversight Quarterly Self Assessment Report, 3rd Quarter 2008
Fleet Oversight Quarterly Self Assessment Report, 4rd Quarter 2008
V-CAP-2008-1, QA Audit of the Corrective Action Program (CAP), March 2008
V-ENG-2007, QA Audit of Engineering Activities (ENG), August 2007
SNC Fleet Assessment, Foreign Material Exclusion Programs, Spring 2007
Nuclear Safety Culture Self Assessment, December 2007

Other Documents:

Operability Determinations
- OD 1-07-002 NSCW PSVs
- OD 1-07-005 Sequencer Termination Units
- OD 1-07-003 Rev 0 ECCS Sump Suction Valves
- OD 2-07-002 TDAFW
- OD 2-07-003 MSIV 3016B
- OD 2-07-004 Sequencer Termination Units
- OD 2-07-005 Press Code Safety restraints
- OD 2-07-008 DG2A water in Oil
- OD 2-07-009 SGBD Sample Pipe Hanger

System Health Reports from the 2nd Quarter of 2007 through the 4th Quarter of 2008, and Current Maintenance Rule a(1) Action Plans for the:
- Standby Power System
- 125 VDC System
- 480 VAC System

NCVs

NCV 2007202 (Sept 07). "Potential Security Vulnerability"

CR 2007109656	AI 2007205044	AI 2007205191	AI 2007205910
AI 2008203119			

NCV 2007401 (June 07) "Security Manual Search Process"

CR 2007106645	AI 2007202705	AI 2007203116

NCV 2008003 (April 08) "White Residue Inside Containment"

CR 2008104461	AI 2008203461	AI 2008203462	AI 2008203463
AI 2008203464	AI 2008203465	AI 2008203466	AI 2008203467
AI 2008203468	AI 2008203469	AI 2008203470	AI 2008203471
AI 2008203472	AI 2008203473	AI 2008203474	AI 2008203475
AI 2008203476	AI 2008203477	AI 2008203478	AI 2008203479
AI 2008203485	AI 2008203486	AI 2008203487	AI 2008206773

NCV 2007006-01 "Material Condition of EDG MCCs"

CR 2007108171	AI 2007205393	AI 2007205394	AI 2007205395
AI 2008203117			

LER 1-2008-001 (June 08) "Group A PZR Heaters Inoperable During Mode Change"

CR 2008104834	AI 2008203404	AI 2008203405	AI 2008203406
AI 2008203407	AI 2008203408	AI 2008203409	AI 2008203410
AI 2008203411	AI 2008203412	AI 2008203413	AI 2008203414
AI 2008203415	AI 2008203416	AI 2008203417	AI 2008203418
AI 2008203419	AI 2008203420	AI 2008203422	AI 2008203423
AI 2008203424	AI 2008203425	AI 2008203426	AI 2008203579

NRC Generic Communications

GL2008-01 Managing Gas Accumulation in Emergency Core Cooling, Decay Heat Removal, and Containment Spray Systems

GL2007-01 Inaccessible or Underground Power Cable Failures that Disable Accident Mitigation Systems or Cause Plant Transients.

IN2008-13 Main Feedwater System Issues and Related 2007 Reactor Trip Data

IN2008-04 Counterfeit Parts Supplied to Nuclear Power Plants

IN2008-21 Impact of Non-Safety Electrical Support System Vulnerabilities On Safety Systems

RIS2008-02 Actions to Increase the Security of High Activity Radioactive Sources

RIS2008-22 Notification of Licensees Regarding Aircraft Threats

Part 21 Vendor Notifications

2008-16-00 – Part 21 Replacement Diaphragm Failures Due Inadequate Cure and Operation Over Maximum Pressure

2008-27-00 - Tyco Electronics - Part 21 Transfer of Information; CII-012 Relays