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

December 4, 2009

Mr. Dennis R. Madison
Vice President
Southern Nuclear Operating Company, Inc.
Edwin I. Hatch Nuclear Plant
11030 Hatch Parkway North
Baxley, GA 31513

SUBJECT: EDWIN I. HATCH NUCLEAR PLANT - NRC IDENTIFICATION AND RESOLUTION OF PROBLEMS INSPECTION REPORT 05000321/2009007 AND 05000366/2009007

Dear Mr. Madison:

On November 5, 2009, the U. S. Nuclear Regulatory Commission (NRC) completed a team inspection at your Edwin I. Hatch Nuclear Plant, Units 1 and 2. The enclosed report documents the inspection findings, which were discussed on November 5, 2009, with yourself and other members of your staff.

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

On the basis of the sample selected for review, there were no findings of significance identified during this inspection. The team concluded that in general, problems were properly identified, evaluated, and corrected. However, during the inspection, some examples of minor problems were identified, including conditions adverse to quality that were not being entered into the corrective action program, narrowly focused condition report evaluations, and corrective actions that were ineffectively tracked or had not occurred.

In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records (PARS) component of 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/

Daniel J. Merzke, Acting Chief
Reactor Projects Branch 7
Division of Reactor Projects

Docket Nos.: 50-321 and 50-366
License Nos.: DPR-57 and NPF-5

Enclosure: Inspection Report 05000321/2009007 and 05000366/2009007
w/Attachment: Supplemental Information

cc w/encl. (See next page)

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Letter to Dennis R. Madison from Daniel J. Merzke December 4, 2009

SUBJECT: EDWIN I. HATCH NUCLEAR PLANT - NRC IDENTIFICATION AND RESOLUTION OF PROBLEMS INSPECTION REPORT 05000321/2009007 AND 05000366/2009007

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U.S. NUCLEAR REGULATORY COMMISSION

REGION II

Docket Nos:	50-321, 50-366
License Nos:	DPR-57, NPF-5
Report No:	05000321/2009007 and 05000366/2009007
Licensee:	Southern Nuclear Operating Company, Inc.
Facility:	Edwin I. Hatch Nuclear Plant, Units 1 & 2
Location:	11030 Hatch Pkwy N Baxley, Georgia 31513
Dates:	October 19, 2009 through November 5, 2009
Inspectors:	M. King, Senior Project Engineer (Team Leader) E. Morris, Hatch Senior Resident Inspector G. Kolcum, Brunswick Resident Inspector D. Arnett, Project Engineer
Approved by:	Daniel J. Merzke, Acting Chief Reactor Projects Branch 7 Division of Reactor Projects

Enclosure

SUMMARY OF FINDINGS

IR 05000321/2009-007, 05000366/2009-007; 10/19/2009 - 11/05/2009; Hatch Nuclear Plant, Units 1 & 2; Biennial Baseline Identification and Resolution of Problems Inspection.

The inspection was conducted by a senior project engineer, a senior resident inspector, a project engineer and a resident inspector. 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 properly identified, evaluated, prioritized, and corrected. Generally, the threshold for initiating condition reports (CRs) was appropriately low, as evidenced by the types of problems identified and the large number of CRs entered annually into the Corrective Action Program (CAP). Employees were encouraged by management to initiate CRs. However, the team did identify some examples where plant issues were not appropriately entered into the CAP.

Generally, prioritization and evaluation of issues were consistent with the licensee's CAP guidance, 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 timely, effective, and commensurate with the safety significance of the issues.

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. The licensee's operating experience (OE) usage was found to be generally acceptable and integrated into the licensee's processes for performing and managing work, and plant operations. However, the team did identify two examples where the licensee did not evaluate the need to release external OE when defects in vendor supplied qualified components were identified.

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 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 August 2007 and October 2009, including a detailed review of selected CRs associated with the following risk-significant systems: residual heat removal (RHR), RHR service water, station auxiliary DC power system, and reactor building heating, ventilation, air conditioning (HVAC). 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, Emergency Preparedness, 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 conducted plant walkdowns of equipment associated with the selected systems and other plant areas to assess the material condition and to look for any deficiencies that had not been previously entered into the CAP. The inspectors reviewed CRs, maintenance history, completed work orders (WOs) for the systems, and reviewed associated system health reports. These reviews were performed to verify that problems were being properly identified, appropriately characterized, and entered into the CAP. Items reviewed generally covered a 26-month period of time; however, in accordance with the inspection procedure, a 5-year review was performed for selected systems for age-dependent issues.

Control room walkdowns were also performed to assess the main control room (MCR) deficiency list and to ascertain if deficiencies were entered into the CAP. Operator Workarounds and Operator Burden screenings were reviewed, and the inspectors verified compensatory measures for deficient equipment which were being implemented in the field.

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 reviewed these evaluations against the descriptions of the problem described in the CRs and the guidance in the licensee's procedure, NMP-GM-002-GL03, "Cause Determination Guideline." 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 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 corrective action program coordinators (CAPCO) meetings and the Management Review Meeting (MRM).

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 and there was a low threshold for entering issues into the CAP. This conclusion was based on a review of the requirements for initiating CRs as described in licensee procedure NMP-GM-002, "Corrective Action Program," management expectation that employees were encouraged to initiate CRs for any reason, a review of system health reports, the types of problems identified, and the large number of CRs entered annually into the CAP. Trending was generally effective in monitoring equipment performance. Site management was actively involved in the CAP and focused appropriate attention on significant plant issues. However, the team did identify the following examples of minor performance deficiencies where conditions adverse to quality were not entered into the CAP, contrary to procedure NMP-GM-002, "Corrective Action Program." However, the inspectors determined these performance deficiencies were not findings of significance and not subject to enforcement action in accordance with the NRC's Enforcement Policy:

- The inspector's review of control room logs identified that on November 4, 2007, a Unit 1 RHR pump discharge check valve, 1E11-F031C, failed to reseat following a surveillance of the Unit 1 'C' RHR pump. The licensee failed to initiate a CR to document this failure. The operability of the RHR system was maintained when the operators briefly started the Unit 1 "A" RHR pump which successfully seated the 1E11-F031C check valve. Inspectors noted that the failure of this check valve to seat had been identified and documented in a previous CR and the repair was scheduled to occur the next day. The licensee initiated CR 2009110928 to address this issue.

- Inspectors identified that work to inspect and repair a Unit 1 RHR pump discharge check valve, 1E11-FO31A, which occurred on September 13, 2008, documented a condition where the disc size was different than expected and required vendor support to resolve. The licensee failed to initiate a CR to document the parts discrepancy. The licensee initiated CR 2009110561 to address this issue. This issue had no impact on the operability of the RHR system.
- Inspectors identified that several CR's had been written which documented electrolyte leakage from battery cells, 1A and 2B station service batteries and the 1A, 1B, 1C, and 2C diesel generator batteries, manufactured by C&D Technologies. The licensee recognized the extent of the condition in the system health report; however, the licensee failed to initiate a CR to document the widespread condition as an adverse trend in the CAP. The licensee initiated CR 209110573 to address this issue. This issue had no impact on the operability of the station service batteries or the diesel generator batteries.

Prioritization and Evaluation of Issues

Based on the review of audits conducted by the licensee and the assessment conducted by the inspection team during the onsite period, the team concluded that the licensee was generally effective in the prioritization and evaluation of identified problems. Problems were generally prioritized and evaluated in accordance with the licensee's CAP procedures as described in the CR severity level determination guidance in NMP-GM-002, "Corrective Action Program." Each CR written was assigned a severity level at the CAPCO meeting, and adequate consideration was given to system or component operability and associated plant risk.

The team determined that the licensee had conducted root cause and apparent cause analyses in compliance with the site CAP procedures, and assigned cause determinations were appropriate considering the significance of the issues being evaluated. A variety of causal-analysis techniques were used depending on the type and complexity of the issue consistent with licensee procedure NMP-GM-002-GL03, "Cause Determination Guideline." The licensee had performed evaluations that were technically accurate and of sufficient depth. The team further determined that operability, reportability, and degraded or non-conforming condition determinations had been completed consistent with the guidance contained in NMP-AD-012, "Operability Determinations and Functionality Assessments for Resolution of Degraded and Nonconforming Conditions." However, the team did make the following observation in the area of prioritization and evaluation of issues:

- CR 2007107101 was initiated on July 24, 2007, for failure of the Unit 1 'C' RHR pump discharge check valve, 1E11-FO31C, to seat. The operability information documented in the CR concluded the valve was operable after corrective action was taken to reseat the valve and vent the system; however, the CR did not document that the system had become inoperable before the operators performed those corrective actions. By site CAP procedures, a determination of inoperability and entry into the associated technical specification action statement is a key factor in determining the appropriate severity level (SL) for CR's. In this case, the

inspectors determined that, although the inoperability aspect was not considered in assigning a SL to this CR, the SL of the CR would not have changed and the licensee conducted the appropriate evaluation of the degraded condition. Inspectors also noted that compensatory actions which were put into place by Operations as a result of this degraded condition were performed outside of the CAP process (i.e., were not documented and tracked by the CR). The licensee initiated CR 2009110566 to address this issue.

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. For significant conditions adverse to quality, the corrective actions directly addressed the cause and effectively prevented recurrence in that 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 were sufficient to ensure corrective actions were properly implemented and were effective. However, the team did make the following observations in the area of effectiveness of corrective actions:

- Inspectors identified that CR 2008102274 contained three action items which established specific effectiveness review criteria as documented in the effectiveness review plan section of the root cause analysis. The three action items were subsequently consolidated into a single action item; however, one of the planned effectiveness review criteria of “no event recurrence" was not retained or conducted. This omission of recommended effectiveness review criteria represented a missed opportunity to ensure the intent of the root cause corrective action plan was met. The licensee initiated CR 2009110171 to address this issue.
- A review of tagout records revealed that a corrective action for CR 2008102274 requiring tagout preparers to explicitly document assumptions on tagout cover sheets was not being implemented in practice. Inspectors did not identify any examples where the ineffective implementation of tagout preparation guidance significantly impacted operations or maintenance activities; however, this issue represented a missed opportunity for the licensee to identify an ineffective corrective action. The licensee initiated CR 2009111080 to address this issue.

(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 and reviewed licensee procedure NMP-GM-008, “Operating Experience Program,” 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., NRC generic communications, 10 CFR Part 21 reports, licensee event reports, vendor notifications, and plant internal operating experience items, etc.), which had been issued since August 2007 to verify whether the licensee had appropriately evaluated each notification for applicability to the Hatch plant, and whether issues identified through these reviews were entered into the CAP. Documents reviewed are listed in the Attachment.

(2) Assessment

Based on a review of documentation related to the review of OE issues, the team determined that the licensee was generally effective in screening OE for applicability to the plant. The inspectors verified for selected issues that 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. In addition, operating experience was included in each root cause evaluation reviewed by the inspectors in accordance with licensee procedure NMP-GM-002-GL03, “Cause Determination Guideline.” However, the team did make the following observation regarding the licensee’s use of OE:

- The inspectors identified two examples where the licensee missed an opportunity to evaluate the need to generate external OE when vendor supplied qualified components were determined to be deficient. The first example was a manufacturing defect associated with the lid-to-jar seal for the 1A and 2B station service batteries and the 1A, 1B, 1C, and 2C diesel generator batteries. The second example was a manufacturing defect affecting RHR pump discharge check valve seat tolerances. The licensee initiated CR 209110573 and CR 2009110603 to address this issue. Subsequent screening by the licensee concluded that neither of the issues above could have created a substantial safety hazard.

(3) Findings

No findings of significance were identified.

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 in accordance with licensee procedure NMP-GM-003, “Self Assessment.”

(2) Assessment

The team determined that the scopes of assessments and audits were adequate. Self-assessments were generally detailed and critical, as evidenced by findings consistent with the team's independent review. The team verified that CRs were created to document all areas for improvement and findings resulting from the self-assessments, and verified that actions had been completed consistent with those recommendations. Generally, the licensee performed evaluations that were technically accurate. Site trend reports were thorough and a low threshold was established for evaluation of potential trends, as evidenced by the CRs reviewed that were initiated as a result of adverse trends.

(3) Findings

No findings of significance were identified.

d. Assessment of Safety-Conscious Work Environment

(1) Inspection Scope

During normal interactions with plant employees during the course of this inspection, the inspectors informally interviewed plant personnel regarding their knowledge of the CAP at Hatch and their willingness to write CRs or raise safety concerns. The inspectors conducted interviews to develop a general perspective of the safety-conscious work environment at the site to determine if any conditions existed that would cause employees to be reluctant to raise safety concerns. The inspectors reviewed the licensee's Concerns Program Procedure and interviewed the Concerns Coordinator. Additionally, the inspectors reviewed a sample of employee concern issues which had been entered into the CAP to verify concerns were being properly reviewed and deficiencies were being resolved.

(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 concerns program. These methods were readily accessible to all employees. Based on discussions conducted with a sample of plant employees from various departments, the inspectors concluded 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.

(3) Findings

No findings of significance were identified.

4OA6 Meetings, Including Exit

On November 5, 2009, the inspectors presented the inspection results to Mr. Madison and other 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

S. Bargeron - Plant Manager
T. Beckworth – Employee Concerns Program Coordinator
B. Bowers – System Engineer
S. Brunson – NSSS System Supervisor
C. Clark - Systems Engineer
C. Dixon - Corrective Action Supervisor
J. Dixon - Health Physics Manager
W. Holt - Outage & Scheduling Manager
B. Hulett - Site Design Engineering Manager
G. Johnson - Hatch Engineering Director
D. Madison - Hatch Site Vice President
R. Miller – Outage Scheduling Coordinator
J. Payne – Senior Plant Engineer
S. Soper - Engineering Support Manager
T. Spring - Acting Operations Manager
S. Tipps - Principal Licensing Engineer
K. Underwood - Performance Improvement Supervisor
R. Varnadore - Maintenance Manager
A. Wilcher - Systems Engineer
A. Wolf – Operations Superintendant

LIST OF ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

None

Closed

None

Discussed

None

LIST OF DOCUMENTS REVIEWED

Procedures

Concerns Program Procedure, Versions 8 - 10
NMP-GM-002, Corrective Action Program, Versions 6
NMP-GM-002-001, Corrective Action Program, Versions 3 - 13
NMP-GM-002-002, Effectiveness Review Instruction, Version 1
NMP-GM-002-GL03, Cause Determination Guideline, Version 12
NMP-GM-002-GL09, CAP Training and Qualification Plan, Version 1
NMP-GM-003, Self Assessment, Versions 7 - 14
NMP-GM-006, Work Management, Version 10.0
NMP-GM-008, Operating Experience Program, Versions 4 - 7
NMP-AD-012, Operability Determinations and Functionality Assessments for Resolution of Degraded and Nonconforming Conditions, Versions 2 - 6
NMP-ES-005, Scoping and Importance Determination for Equipment Reliability, Version 6.0

Self-Assessments

Integrated Performance Assessment - Cross Functional Review Results, January 2009
CAP Trend Summary Report, February 2009 through April 2009
Fleet Oversight Audit of the Corrective Action Program, H-CAP-2009-1
Fleet Oversight Quarterly Assessment Report- 4th Qtr 2008
Fleet Oversight Assessment, H-FOA-EOY-2009-1, HNP Assessment of 2008 End of Year Performance Improvement Focus Areas, August 2009
Team OE Self Assessment, August 4-13, 2008
Apparent Cause/Basic Cause Determination Self-Assessment – August 24-September 2, 2009
Security Department Contingency Response Self Assessment, July 20-28, 2009
H-FOA-EP-2009-1, Fleet Oversight Assessment Report, March 16, 2009
H-FOA-PI-2009-1, Security Firing Range Safety, March 26, 2009
H-FOA-EP-2009-2, Emergency Preparedness Drill #1, July 15, 2009
FME Program Focused Self Assessment, February 27-29, 2008
Maintenance Department, Focused Self Assessment on Procedure Use and Adherence, September 15-23, 2008
Operations Work Management Fleet Self Assessment, July 9-18, 2008
System Monitoring Self Assessment, July 29-31, 2008
RP Team Self-Assessment - High Rad Controls, August 20-24, 2007
Engineering Self Assessment - System Engineering Training, March 23-27, 2009
Site Engineering Performance Monitoring Adverse Trend Summary, August 19, 2009

Condition Reports (CRs)

2006104145	2007106065	2007107976	2007108310
2007101917	2007106943	2007108031	2007108421
2007101917	2007106973	2007108052	2007108499
2007102616	2007106973	2007108094	2007108523
2007102619	2007107001	2007108113	2007108693
2007102669	2007107101	2007108141	2007108698
2007103319	2007107325	2007108182	
2007103319	2007107872	2007108207	
2007105289	2007107887	2007108208	
2007106026	2007107960	2007108228	

2007108703	2008102081	2008105696	2009100583
2007108704	2008102081	2008105801	2009100903
2007108705	2008102141	2008106016	2009100911
2007108706	2008102143	2008106041	2009100958
2007108708	2008102237	2008106075	2009100958
2007108709	2008102274	2008106109	2009100999
2007108710	2008102274	2008106111	2009101108
2007108711	2008102315	2008106226	2009101108
2007108712	2008102328	2008106252	2009101161
2007108713	2008102470	2008106515	2009101299
2007108720	2008102534	2008106575	2009101341
2007108721	2008102596	2008106694	2009101411
2007109149	2008102669	2008106861	2009101450
2007109171	2008102678	2008106867	2009101451
2007109560	2008102741	2008106907	2009101597
2007109812	2008102767	2008106907	2009101973
2007109812	2008102783	2008107088	2009102215
2007109991	2008102803	2008107368	2009102385
2007109991	2008102813	2008107562	2009102439
2007110301	2008103067	2008107562	2009102615
2007110370	2008103067	2008107697	2009102712
2007110396	2008103067	2008107709	2009102730
2007111020	2008103413	2008107760	2009102787
2007111034	2008103498	2008107923	2009102825
2007111034	2008103628	2008108069	2009102825
2007111035	2008103741	2008108095	2009103146
2008100154	2008103776	2008108250	2009103239
2008100154	2008104090	2008108546	2009103240
2008100163	2008104152	2008109176	2009103241
2008100410	2008104154	2008109177	2009103264
2008100491	2008104250	2008109206	2009103391
2008100509	2008104275	2008109261	2009103408
2008100632	2008104352	2008109616	2009103531
2008100637	2008104442	2008109697	2009103587
2008100676	2008104519	2008109697	2009103588
2008100681	2008104612	2008109728	2009103950
2008101004	2008104731	2008110421	2009103957
2008101013	2008104840	2008111160	2009104345
2008101376	2008104894	2008111160	2009104405
2008101568	2008104907	2008111727	2009104488
2008101568	2008105108	2008111955	2009104795
2008101568	2008105108	2008111956	2009104795
2008101702	2008105201	2008111957	2009104953
2008101702	2008105219	2009100030	2009104991
2008101703	2008105358	2009100069	2009105006
2008101849	2008105560	2009100173	2009105651
2008101993	2008105696	2009100196	2009105670
2008102081	2008105696	2009100197	2009105763

2009105827	2009107299	2009108801	2009110167
2009105836	2009107511	2009109272	2009110168
2009106103	2009107525	2009110090	2009110180
2009106212	2009107547	2009110164	2009110180
2009106714	2009108179	2009110164	2009110181
2009106880	2009108308	2009110165	2009110181
2009106989	2009108558	2009110165	2009110182
2009107004	2009108558	2009110166	2009110182
2009107290	2009108768	2009110166	

Action Items (AIs)

2007201184	2007205149	2008205143	2009201023
2007201185	2008201673	2009200294	2009201076
2007203159	2008201993	2009200919	2009201116
2007203160	2008202650	2009200920	2009201661
2007203162	2008204319	2009200946	2009203219
2007205144	2008204641	2009200947	2009203665
2007205148	2008204649	2009201022	

Work Orders (WOs):
1052400101
1060705701
1061937202
1091066701
1091068903
1091989601
2070870801

Operating Orders (OOs):
OO-01-0608S
OO-01-0907S
OO-04-0308

System Health Reports:
Station Auxiliary DC Power Systems, 3rd Qtr 2007 – 2nd Qtr 2009
Residual Heat Removal System, 2nd Qtr 2009
Reactor Building HVAC 2nd Qtr 2009
Drywell Cooling 2nd Qtr 2009

Other Documents:
Calculation: 0900269.300 dated March 2, 2009
Allowable Wall loss determination worksheet
Watermark SMNH-08-010 “Heat Exchanger Tube Plugging Criteria
Heat Exchanger Minimum Wall Calculation
HPN-2-FSAR
HPN-1-FSAR
Drawing for Reactor Building Ventilation System Below EL 130’ 0” Sheet No H-26229
Reptask 2E11F031B3

Reptask 2E11F031C1
Reptask 2E11F031D1
Equivalency Determination (ED) 1080147401
As Built Notice (ABN)-H00841, ABN-H01052
Lesson Plan Z41-MCREC-LP-03701
CRs/AIs initiated as a result of inspection:

2006110106	2009110144	2009110190	2009110580
2009110090	2009110164	2009110191	2009110581
2009110091	2009110165	2009110192	2009110603
2009110105	2009110166	2009110194	2009110608
2009110106	2009110167	2009110206	2009110928
2009110106	2009110168	2009110222	2009111080
2009110136	2009110169	2009110267	2009111093
2009110137	2009110171	2009110539	2009204897
2009110138	2009110180	2009110540	
2009110139	2009110180	2009110561	
2009110140	2009110181	2009110566	
2009110142	2009110182	2009110573	