UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
245 PEACHTREE CENTER AVENUE NE, SUITE 1200
ATLANTA, GEORGIA 30303-1257

March 11, 2011

Mr. R. M. Krich
Vice President, Nuclear Licensing
Tennessee Valley Authority
3R Lookout Place
1101 Market Street
Chattanooga, TN 37402-2801

SUBJECT: WATTS BAR NUCLEAR PLANT, UNIT 1 – NRC PROBLEM IDENTIFICATION AND RESOLUTION INSPECTION REPORT 05000390/2011008

Dear Mr. Krich:

On January 28, 2011, the U. S. Nuclear Regulatory Commission (NRC) completed an inspection at your Watts Bar Nuclear Plant, Unit 1. The enclosed report documents the inspection findings, which were discussed on January 28, 2011, with Mr. Greg Boerschig 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.

The inspectors concluded that problems were properly identified, evaluated, and resolved within the corrective action program. However, the NRC has determined that one Severity Level IV violation of NRC requirements occurred. Because this issue was of very low safety significance, was not repetitive or willful, and because it was entered into your corrective action program, the NRC is treating this as a non-cited violation consistent with Section 2.3.2 of the NRC Enforcement Policy. If you wish to contest this non-cited violation, you should provide a response within 30 days of the date of this inspection report, with the basis for your denial, to the Nuclear Regulatory Commission, ATTN.: Document Control Desk, Washington DC 20555-001; 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 Senior Resident Inspector at the Watts Bar Nuclear Plant, Unit 1.

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/

George T. Hopper, Chief
Reactor Projects Branch 7
Division of Reactor Projects

Docket No.: 50-390
License No.: NPF-90

Enclosure: Inspection Report 05000390/2011008
w/Attachment: Supplemental Information

cc w/encl.: (see page 3)

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Conservation
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Ann Harris
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Letter to R. M. Krich from George T. Hopper dated March 11, 2011

SUBJECT: WATTS BAR NUCLEAR PLANT, UNIT 1 – NRC PROBLEM IDENTIFICATION AND RESOLUTION INSPECTION REPORT 05000390/2011008

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U.S. NUCLEAR REGULATORY COMMISSION

REGION II

Docket No.:	50-390
License No.:	NPF-90
Report No.:	05000390/2011008
Licensee:	Tennessee Valley Authority (TVA)
Facility:	Watts Bar Nuclear Plant, Unit 1
Location:	Spring City, TN
Dates:	January 10-28, 2011
Inspectors:	R. Clagg, Resident Inspector (Team Leader) P. Lessard, Resident Inspector M. Schwieg, Resident Inspector R. Williams, Reactor Inspector
Approved by:	George T. Hopper, Chief Reactor Projects Branch 7 Division of Reactor Projects

Enclosure

SUMMARY OF FINDINGS

IR 05000390/2011008; January 10 – 28, 2011; Watts Bar Nuclear Plant, Unit 1; biennial inspection of the identification and resolution of problems.

The inspection was conducted by three resident inspectors and one reactor inspector. One NRC-identified finding of very low safety significance (Severity Level IV) was identified. The significance of most findings is indicated by their color (Green, White, Yellow, Red) using Inspection Manual Chapter (IMC) 0609, "Significance Determination Process" (SDP). Findings for which the SDP does not apply may be Green or be assigned a severity level after NRC management review. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process."

Identification and Resolution of Problems

The inspectors concluded that, in general, problems were properly 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.

The inspectors 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.

Cornerstone: Miscellaneous

- SL-IV. The inspectors identified a Severity Level IV, non-cited violation (NCV) of 10 CFR 50.73(a)(2)(i)(B) for the licensee's failure to submit a Licensee Event Report (LER) within 60 days for a condition which was prohibited by Technical Specifications (TS). On June 22, 2009 the licensee failed to recognize that they exceeded the limiting condition for operation (LCO) action time of TS 3.0.3 when both trains of the Essential Raw Cooling Water (ERCW) system were made inoperable when a cross connect valve was inadvertently opened and remained in that position for more than nine hours. Subsequent to this, the condition was discovered, TS 3.0.3 was entered, the valve was shut, and TS 3.0.3 was exited. The licensee's initial reportability evaluation concluded that the event was not reportable because the ERCW system would have been able to perform its safety function.

However, with the 2A and 2B header cross connected, the system did not meet TS 3.7.8 requirements and was inoperable. This evaluation failed to identify that operating for nine hours with the system inoperable exceeded the TS 3.0.3 LCO action time and thus placed the unit in a condition prohibited by TS, which is a reportable event. The licensee entered this issue into their Corrective Action Program as Problem Evaluation Report 314950.

The inspectors determined that this issue was subject to Traditional Enforcement because it had the potential to impact the NRC's ability to perform its regulatory function and was not suitable for evaluation using the significance determination process. This Violation matched example nine in Section 6.9.d of the NRC Enforcement Policy and was, therefore, determined to be more than minor and a SL-IV Violation. Cross cutting aspects are not assigned to violations being dispositioned through the traditional enforcement process. (Section 4OA2.3)

REPORT DETAILS

4. OTHER ACTIVITIES

4OA2 Problem Identification and Resolution

.1 Assessment of the Corrective Action Program

a. Inspection Scope

The inspectors reviewed the licensee's Corrective Action Program (CAP) procedures which described the administrative process for initiating and resolving problems, primarily through the use of Problem Evaluation Reports (PERs). To verify that problems were being properly identified, appropriately characterized, and entered into the CAP, the inspectors reviewed PERS that had been issued between June 2009 and January 2011, including a detailed review of selected PERs associated with the following risk-significant systems: Auxiliary Feedwater, Essential Raw Cooling Water, safety related Ventilation, and 6.9kV Shutdown Power. 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. The inspectors selected a representative number of PERs that were identified and assigned to the major plant departments, including operations, maintenance, engineering, health physics, chemistry, and security. These PERs 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 PERs, verified corrective actions were implemented, and attended meetings where PERs 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 PERs, 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 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.

Walkdowns were also performed to assess Operator Workarounds, Operator Burdens and main control room (MCR) deficiencies to ascertain if they were entered into the CAP. Work schedules, screenings, and aggregate impact reports were reviewed, and the inspectors verified compensatory measures for deficient equipment were being implemented in the field.

The inspectors conducted a detailed review of selected PERs 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 PERs and the guidance in licensee procedure NPG-SPP-03.1.6, "Root Cause Analysis", Rev. 0 and NPG-SPP-03.1.5, "Apparent Cause Evaluations", Rev. 0. 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 inspectors 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 inspectors 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 PER screening meetings, Department Corrective Action Review Board (D-CARB), and the Corrective Action Review Board (CARB).

Documents reviewed are listed in the Attachment.

b. Assessment

Identification of Issues

The inspectors determined that the licensee was generally effective in identifying problems and entering them into the CAP and there was an appropriately low threshold for entering issues into the CAP. This conclusion was based on a review of the requirements for initiating PERs as described in licensee procedure NPG-SPP-01.14, "Service Request Initiation", Rev. 1, management's expectation that employees were encouraged to initiate PERs for any reason, and the fact that inspectors identified relatively few deficiencies during plant walkdowns not already entered 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.

Based on reviews and walkdowns of accessible portions of the selected systems, the inspectors determined that system deficiencies generally were being identified and placed in the CAP. However, the inspectors identified five instances, all of which were evaluated and determined to be minor, where issues had not been identified and entered into the CAP. The following issues were identified:

- PER 313086, AFW B-Train Discharge Piping Support Inadequacy
- PER 310445, Oily Rags Improperly Stored in Oil Cleanup Supply Barrels in Both ERCW Pump Rooms
- PER 314407, Manpower and Time Requirements Specified in AOI-7.01 have not been Validated
- SR 313832, Floor Buffer Restrained to Safety Related Instrumentation Panel
- PER 314956, Evaluate the Potential Need for a Spare ERCW Strainer Tool used in Emergency and Fire Procedures

Prioritization and Evaluation of Issues

Based on the review of PERs sampled by the inspection team during the onsite period, the inspectors concluded that problems were generally prioritized and evaluated in accordance with the licensee's CAP procedures as described in the PER significance determination guidance in NPG-SPP-03.1, "Corrective Action Program", Rev. 1. Each PER was assigned a priority level at the PER screening meeting, and adequate consideration was given to system or component operability and associated plant risk.

The inspectors determined that station personnel had conducted root cause and apparent cause analyses in compliance with the licensee's CAP procedures and assigned cause determinations were appropriate, considering the significance of the issues being evaluated. A variety of formal causal-analysis techniques were used depending on the type and complexity of the issue consistent with NPG-SPP-03.1.5, "Apparent Cause Evaluations", Rev. 0 and NPG-SPP-03.1.6, "Root Cause Analysis", Rev. 0.

Effectiveness of Corrective Actions

Based on a review of corrective action documents, interviews with licensee staff, and verification of completed corrective actions, the inspectors 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, PERs, 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.

c. Findings

Introduction: An NRC-identified Severity Level IV, non-cited violation (NCV) of 10 CFR 50.73(a)(2)(i)(B) was identified for the licensee's failure to submit a Licensee Event Report (LER) within 60 days for a condition prohibited by Technical Specifications (TS).

Description: TS Surveillance Requirement 3.7.8.1 requires the licensee to verify the correct alignment of manual, power operated and automatic valves in the ERCW system. The procedure the licensee uses to meet this requirement is 1-SI-67-1, ERCW Valves Servicing Safety Equipment Position Verification. While performing 1-SI-67-1 on June 22, 2009, the licensee discovered that both the Primary ERCW Supply Valve (2-FCV-67-66) and the Backup ERCW Supply Valve (2-FCV-67-68) to the 2A-A Emergency Diesel Generator (EDG) heat exchanger were open. Under normal operating conditions, 2FCV-67-66 is open and 2FCV-67-68 is required to be closed.

When both 2-FCV-67-66 and 2-FCV-67-68 are open, both trains of ERCW are cross connected; the system is rendered inoperable, thus requiring entry into TS 3.0.3. TS 3.0.3 required the licensee to place the plant in Mode 3 within seven hours. The licensee entered TS 3.0.3 at the time of discovery, 2130, and subsequently exited TS 3.0.3 at 2137 when the licensee closed 2-FCV-67-68 in accordance with procedure 1-SI-67-1.

Subsequent investigation by the licensee determined that 2-FCV-67-68 was inadvertently opened when a painter working in the area bumped the valve's push button control at 1225 on June 22, 2009. The licensee's evaluation of this event determined that it was not reportable because the ERCW system was still able to provide its safety function with both 2-FCV-67-66 and 2-FCV-67-68 open. However, with the 2A and 2B header cross connected, the system did not meet TS 3.7.8 requirements and was inoperable. This evaluation failed to identify that operating for nine hours with the system inoperable exceeded the TS 3.0.3 LCO action time and thus placed the unit in a condition prohibited by TS, which is a reportable event. An LER is required if a condition existed for a time longer than permitted by the TS even if the condition was not discovered until after the allowable time had elapsed and the condition was rectified immediately upon discovery. Consequently, the licensee failed to submit an LER within 60 days as required by 10 CFR 50.73. The licensee has entered this issue into their CAP as PER 314950.

Analysis: The inspectors determined that the licensee's failure to submit an LER as required by 10 CFR 50.73 was a violation. The inspectors determined that this issue was subject to Traditional Enforcement because it had the potential to impact the NRC's ability to perform its regulatory function and was not suitable for evaluation using the significance determination process. This Violation matched example nine in Section 6.9.d of the NRC Enforcement Policy and was, therefore, determined to be more than minor and a SL-IV Violation. Cross cutting aspects are not assigned to violations being dispositioned through the traditional enforcement process.

Enforcement: 10 CFR 50.73 requires, in part, that licensees submit an LER for any operation or condition which was prohibited by TS within 60 days of discovering the event. Contrary to this, the licensee failed to submit a report within 60 days of June 22, 2009, when the event associated with inadvertently cross connecting both trains of ERCW was discovered. This violation had no actual or potential safety consequences and the licensee took immediate corrective action to conduct another reportability evaluation. Because this violation was of very low safety significance, was not repetitive or willful, and was entered into the licensee's CAP as PER 314950, this violation is being treated as an NCV, consistent with Section 2.3.2 of the NRC Enforcement Policy, and is designated as NCV 05000390/2011008-01: "Failure to Submit a Licensee Event Report for a Condition Prohibited by Technical Specifications Associated with the Essential Raw Cooling Water System."

.2 <u>Assessment of the Use of Operating Experience (OE)</u>

a. <u>Inspection Scope</u>

The inspectors examined licensee programs for reviewing Operating Experience (OE) issues and evaluations as required by licensee procedure NPG-SPP-02.3, "Operating Experience Program", Rev. 1. In addition, the inspectors selected OE documents, such as NRC Information Notices, Bulletins, and Generic Letters; Part 21; and industry and vendor letters, which had been issued since June 2009 to verify whether the licensee had appropriately evaluated each notification for applicability and whether issues identified through these reviews were entered into the CAP. Documents reviewed are listed in the Attachment.

b. <u>Assessment</u>

Based on a review of selected documentation related to operating experience issues, the inspectors 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 the 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 all apparent cause and root cause evaluations in accordance with licensee procedure NPG-SPP-03.1 "Corrective Action Program", Rev. 1.

c. <u>Findings</u>

No findings were identified.

.3 <u>Assessment of Self-Assessments and Audits</u>

a. <u>Inspection Scope</u>

The inspectors 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 NPG-SPP-02.1, "Self-Assessment and Benchmark Program", Rev. 0. Documents reviewed are listed in the Attachment.

b. Assessment

The inspectors determined that the scopes of assessments and audits were adequate. Self-assessments were generally detailed and critical, as evidenced by findings consistent with the inspectors' independent review. The inspectors verified that PERs were created to document 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 PERs reviewed that were initiated as a result of adverse trends.

c. Findings

No findings were identified.

.4 Assessment of Safety-Conscious Work Environment

a. Inspection Scope

The inspectors randomly interviewed 20 on-site workers regarding their knowledge of the corrective action program at Watts Bar Unit 1 and their willingness to write PERs or 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 ECP 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. Documents reviewed are listed in the Attachment.

b. Assessment

Based on the interviews conducted and the PERs reviewed, the inspectors 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.

c. Findings

No findings were identified.

4OA6 Exit

Exit Meeting Summary

On January 28, 2011, the inspectors presented the inspection results to Mr. Greg Boerschig, Plant Manager, and other members of licensee management. The inspectors confirmed that proprietary information was not provided or examined during the inspection.

ATTACHMENT: SUPPLEMENTAL INFORMATION

KEY POINTS OF CONTACT

Licensee personnel:
G. Boerschig, Plant Manager
J. Bushnell, Licensing Engineer
T. Carter, Director, Safety and Licensing
R. Cole, CAP Manager, Engineering
H. Cusick, Site Employee Concerns Program Specialist
J. Deal, Manager, Quality Assurance
T. Detchemendy, Manager, Emergency Preparedness
S. Duncan, Manager, Performance Improvement
K. Dutton, Director Engineering
S. Ferrell, CAP Analyst
M. McFadden, Manager, Operations
D. Murphy, Manager, Maintenance
C. Riedl, Manager, Site Licensing
C. Woolson, Maintenance Rule Program Manager

NRC personnel:
R. Monk, Senior Resident Inspector

LIST OF ITEMS OPENED, CLOSED, AND DISCUSSED

Opened and Closed

05000390/2011008-01	NCV	Failure to Submit a Licensee Event Report for a Condition Prohibited by Technical Specifications Associated with the Essential Raw Cooling Water System (Section 4OA2.3)

LIST OF DOCUMENTS REVIEWED

Procedures

0-PI-OPS-14.0, "Staged Emergency Operating Procedure Items", Rev. 8
1-SI-67-1, "Essential Raw Cooling Water Valves Servicing Safety Equipment Position Verification", Rev. 3
AOI-7.1, "Maximum Probable Flood", Rev. 16
MI-17.021, "Installation of Spool Pieces between Essential Raw Cooling Water System and Component Cooling System", Rev. 6
MI-57.006, "6900 Volt Circuit Breaker Overhaul Inspection", Rev. 9
MI-57.001, "6900 Volt Circuit Breaker Inspection", Rev. 34
NEDP-22, "Functional Evaluations", Rev. 9
NPG-SPP-01.0, "Organization and Administration", Rev. 0
NPG-SPP-1.6, "Self-Assessment and Benchmarking Program", Rev. 17
NPG-SPP-01.14, "Service Request Initiation", Rev. 1
NPG-SPP-02.1, "NPG Self-Assessment and Benchmarking Program", Rev. 0
NPG-SPP-02.3, "Operating Experience Program", Rev. 1

NPG-SPP-03.1, “Corrective Action Program”, Rev. 1
NPG-SPP-03.1.4, “Corrective Action Program Screening and Oversight”, Rev. 1
NPG-SPP-03.1.5, “Apparent Cause Evaluation”, Rev. 1
NPG-SPP-03.1.6, “Root Cause Analysis”, Rev. 1
NPG-SPP-03.1.7, “PER Actions”, Rev. 1
NPG-SPP-09.1.8, “Qualification Requirements and Training Program”, Rev. 2
NPG-SPP-09.17, “Temporary Equipment Control”, Rev. 0
ODM-15.1, “Operator Workarounds, Burdens, Challenges, Control Room Deficiencies, and AUO Round Deficiencies”, Rev. 2
OPDP-1, “Conduct of Operations”, Rev. 18
PIDP-5, “Apparent Cause Evaluations”, Revision 2
PMTI-52285-06, “120V Vital Inverter 2-II Initial Startup and Testing”, Rev. 2
PMTI-52285-07, “120V Vital Inverter 2-II Initial Startup and Testing”, Rev. 2
TI-126, “Post Maintenance Testing Matrices”, Rev. 11
TI-276, “Temporary Equipment Control”, Rev. 6
TVA-NQA-PLN89-A, “Nuclear Quality Assurance Plan (NQAP) (Quality Assurance Program Description)”, Rev. 24A1
TVA-SPP-11.8.4, “Expressing Concerns and Differing Views”, Rev. 0

Problem Evaluation Reports (PERs)

127222	173115	206831
131960	173213	206832
134944	173325	207208
144618	174704	208212
148716	175086	209617
153787	175160	210159
159721	175700	210282
160227	176026	210796
161225	176604	212903
164765	176675	212905
166545	177278	214718
166665	177441	215224
166855	178261	215374
166891	178453	215542
167323	200223	215554
167617	201381	216245
168839	202362	218076
168916	204050	218797
168925	204159	220478
168975	204962	220676
170028	205430	220754
170294	205651	221018
172256	206237	221591
172301	206581	223677

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244876
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265949
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274593
274760
275372
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313231

Self-Assessments

CRP-CAP-F-10-001, NPG Fleet Corrective Action Program Assessment
QA-WB-09-038, Quality Assurance Assessment of Corrective Action Effectiveness
QA-WB-09-041, Quality Assurance Emergency Preparedness Drill Assessment
QA-WB-10-016, Quality Assurance Assessment of Radiation Protection
T34-100215-002, Quality Assurance Assessment of Emergency Preparedness
WBN-SIT-F-11-004, Site Readiness for the NRC PI&R Inspection
WBN-SIT-S-10-001, PER Cause Analysis and Closure Quality Snapshot
WBN-SIT-S-10-005, 1st Quarter and 2nd Quarter Level B and C PER Closure Quality Assessment

Other Documents

Engineering CAP Health Recovery Plan
Essential Raw Cooling Water System Health Report, 6/1/2010-9/30/2010
July 2010 Nuclear Safety Review Board Review of CAP
N3-3B-4002, Auxiliary Feedwater System, Rev. 15
N3-67-4002, Essential Raw Cooling Water System, System 67, Rev.25
Operations Focus Aggregate Impact Report, 1/20/11
Operations Watchstander Aggregate Impact Report, 9/2010
Outage and Non-Outage Operator Work Around List, 1/13/2011
Outage and Non-Outage Operator Control Room Deficiency List, 1/13/2011
Outage and Non-Outage Operator Burden List, 1/13/2011
Outage and Non-Outage Operator Work Around List, 12/9/2010
Outage and Non-Outage Operator Control Room Deficiency List, 12/9/2010
Outage and Non-Outage Operator Burden List, 12/9/2010
WBN-VTD-G080-2240, General Electric Installation and Adjustment of Early A and B Switcher in Magne-Blast Circuit Breakers