March 19, 1999

Southern Nuclear Operating Company, Inc.
ATTN: Mr. H. L. Sumner, Jr.
Vice President - Hatch
P. O. Box 1295
Birmingham, AL 35201-1295

SUBJECT: PLANT PERFORMANCE REVIEW (PPR) - HATCH

Dear Mr. Sumner:

On February 2, 1999, the NRC staff completed a Plant Performance Review (PPR) of Hatch. The staff conducts these reviews for all operating nuclear power plants to develop an integrated understanding of safety performance. The results are used by NRC management to facilitate planning and allocation of inspection resources. PPRs provide NRC management with a current summary of licensee performance and serve as inputs to the NRC's senior management meeting (SMM) reviews. PPRs examine information since the last assessment of licensee performance to evaluate long term trends, but emphasize the last six months to ensure that the assessments reflect current performance. The PPR for Hatch involved the participation of all technical divisions in evaluating inspection results and safety performance information for the period February 1997 to January 1999. The NRC's most recent summary of licensee performance was provided in a letter of April 4, 1997, and was discussed in a public meeting with you on April 22, 1997.

As discussed in the NRC's Administrative Letter 98-07 of October 2, 1998, the PPRs provide an assessment of licensee performance during an interim period that the NRC has suspended its Systematic Assessment of Licensee Performance (SALP) program. The NRC suspended its SALP program to complete a review of its processes for assessing performance at nuclear power plants. At the end of the review, the NRC will decide whether to resume the SALP program or terminate it in favor of an improved process.

During the last six months, Unit 1 operated near or at 100 percent power. Power was reduced three times to implement corrective maintenance for equipment problems. Unit 2 entered the assessment period at 100 percent power. Power was decreased six times to complete corrective maintenance activities for equipment problems. Unit 2 completed a scheduled refueling outage which commenced in September and tied to the grid on November 10. Following the outage, the unit operated well until January 28, when the unit was manually shutdown to repair an electrical ground on safety related equipment.

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Performance at Hatch was acceptable. No plant scrams or unplanned transients occurred during this period. Operator communications and peer checks have continued to improve. In the Maintenance area, plant material condition has been maintained at an acceptable level. Housekeeping has been recognized by the licensee as an area which needs improvement although no equipment issues directly related to housekeeping have been identified. Engineering continued to be effective. Root cause analyses for equipment problems have been thorough. Although engineering support to operations was good, some engineering analyses have relied heavily on "engineering judgement" without thorough supporting documentation. Security, Emergency Preparedness, and Fire Protection have continued to be acceptable. Late in the assessment period, more emphasis was observed being placed on the As Low As Reasonably Achievable program and personnel contaminations. However, additional improvement is warranted. First line supervisors do not always clearly communicate or enforce management expectations.

In the operations area, performance was consistent. The operators continued to perform with a high level of competency during both normal and abnormal operations. Operations management w[illegible]ctively involved in the daily operation of the plant, provided a strong safety focus and exhibited conservative decision making. Improvement was observed in operations communications. Although procedure usage errors were not observed to be problematic during this period, deficiencies were identified in several existing procedures. The licensee has implemented actions to identify and resolve procedure deficiencies. Early during this assessment period Operations personnel exhibited a high threshold for documenting discrepant conditions such that deficiencies of minor significance were not being corrected. An example of this was an alarm on service water radiation monitor which was not pursued as a discrepant condition. Toward the end of the assessment period this had improved, however, more improvement is warranted. The licensed operator requalification program continued to be effectively implemented. Operations performance during this assessment period does not warrant any additional inspection effort above the NRC core program, although some increased emphasis will be placed on the areas identified above.

In the maintenance area, performance was consistent. Corrective maintenance activities were generally performed well. Inservice inspection activities were generally well planned and conducted in accordance with the required codes, standards, and documented commitments exhibiting an improving trend. In addition to the normal NRC core inspections, a regional initiative inspection is planned to review generic issues associated with jet pump cracking and flow-assisted corrosion. Regional initiative inspections will be associated with the construction and testing of the independent spent fuel storage facility installation.

In the engineering area, performance was consistent. Design control, implementation of major modifications, and the modification readiness review program were identified as program strengths. Field engineering support for implementation of design changes was effective. Audits in the area of the 10 CFR 50.59 program were thorough and detailed. A regional initiative inspection will be conducted to close open issues associated with circuit breaker maintenance.

In the plant support area, performance was consistent. The Emergency Preparedness program was maintained in a state of operational readiness. Security equipment remained operable and in good condition with management support dedicated to providing a quality physical security program. Internal and external personnel radiation exposures continued to be below regulatory limits. The number of personnel contamination events declined and radiological housekeeping improved compared to the previous assessment period. Quality Assurance audits in the radiological controls area appropriately identified deficiencies for corrective actions. Performance in the Plant Support area during this assessment period does not warrant any additional inspection effort above the NRC core inspection program.

Enclosure 1 contains a historical listing of plant issues, referred to as the Plant Issues Matrix (PIM), that were considered during this PPR process to arrive at an integrated view of licensee performance trends. The PIM includes items summarized from inspection reports or other docketed correspondence between the NRC and Southern Nuclear Company. The NRC does not attempt to document all aspects of licensee programs and performance that may be functioning appropriately. Rather, the NRC only documents issues that the NRC believes warrant management attention or represent noteworthy aspects of performance.

This letter advises you of our planned inspection effort resulting from the Hatch PPR review. It is provided to minimize the resource impact on your staff and to allow for scheduling conflicts and personnel availability to be resolved in advance of inspector arrival onsite. Enclosure 2 details our inspection plan for the next 8 months. The rationale or basis for each inspection outside the core inspection program is provided so that you are aware of the reason for emphasis in these program areas. Resident inspections are not listed due to their ongoing and continuous nature.

We will inform you of any changes to the inspection plan. If you have any questions, please contact me at (404) 562-4520.

Sincerely,

(Original signed by
Pierce H. Skinner)

Pierce H. Skinner, Chief
Reactor Projects Branch 2
Division of Reactor Projects

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

Enclosures: 1. Plant Issues Matrix
2. Inspection Plan

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OFFICE	RII:DRP		RII:DRS:MB		RII:DRS:EB		RII:DRS:OLHPB		RII:DRS:PSB					
SIGNATURE														
NAME	BLHolbrook:dka*		GBelisle*		KLandis*		HChristensen*		KBarr*					
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NAME	BLHolbrook:dka*		CBelisle		KLandis		HChristensen		KBarr					
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SIGNATURE							
NAME	BLHolbrook:dka	GBelisle	KLandis	HChristensen	KBarr		
DATE	2/ 1 /99	2/ /99	2/ /99	2/ /99	2/ /99	2/ /99	2/ /99
COPY?	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO

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PLANT ISSUE MATRIX

By Primary Functional Area

Region II
HATCH

Date	Source	Functional Area	ID	Type	Template Codes	Item Description
12/29/1998	1998007	**Pri:** OPS **Sec:** **Ter:**	NRC	POS	**Pri:** 1B **Sec:** 3A **Ter:**	Operations preplanning, the prompt direction provided by operations supervision to decrease power, and the immediate response of the operating crew effectively mitigated a decreasing condenser vacuum transient that had the potential to cause a Unit 2 scram from a low condenser vacuum turbine trip. (O1.3).
12/29/1998	1998007	**Pri:** OPS **Sec:** ENG **Ter:**	NRC	POS	**Pri:** 3A **Sec:** 5B **Ter:**	Personnel response to Residual Heat Removal and Plant Service Water system flow perturbations due to suspected flow blockage was appropriate. The root cause investigation was thorough and detailed and the results of the root cause investigation were logical. The problem was believed to be leaves and other debris in the pump suction pit. Management provided a focused attention to the issue for resolution (O2.3).
12/29/1998	1998007	**Pri:** OPS **Sec:** PLTSUP **Ter:**	NRC	POS	**Pri:** 1C **Sec:** 3A **Ter:**	Operators responded appropriately to plant transients and equipment failures as part of the emergency preparedeness exercise. Event classification, plant status, and follow-up activities were correctly communicated and coordinated with the Technical Support Center. Initial notifications were prompt and operators responded using appropriate procedures. All exercise objectives were met (P4.1).
10/31/1998	1998006	**Pri:** OPS **Sec:** MAINT **Ter:**	NRC	POS	**Pri:** 2A **Sec:** 5A **Ter:** 3A	Operations management demonstrated conservative decision making to reduce reactor power and remove the turbine/generator from service to troubleshoot and implement corrective maintenance for a plugged Stator Cooling Water system "Y" strainer. Maintenance identified the specific component causing the problem. The strainer was becoming clogged with copper oxide. Operations demonstrated conservative decision making to reduct Unit 2 power during maintenance troubleshooting activities for a turbine combined intermediate valve test circuit problem. Troubleshooting identified the cause of the problem as a blown fuse in the test circuit. (IR 98-02, 5/2/98) Operations management took immediate and appropriate corrective actions to troubleshoot, repair, and recalibrate an erroneous diesel generator fuel oil tank level indication. Management displayed conservative and cautious approaches for verifying level by having each shift log tank level indications. (IR 98-05, 9/10/98) Operations management demonstrated conservative decision making by reducing unit power to troubleshoot and repair the 2B circulation water pump shaft bearing sleeve that worked loose. The plant operator's questioning attitude about the location and appearance of the sleeve resulted in prompt identification of the problem. The cause was a set screw that was not countersunk. (IR 98-04, 6/21/98)
09/19/1998	1998005	**Pri:** OPS **Sec:** **Ter:**	NRC	POS	**Pri:** 3A **Sec:** 1B **Ter:** 5B	Control room operators demonstrated correct procedure usage, proper annunciator response, three-part communications, the phonetic alphabet, and peer checks during power changes on Unit 2. Pre-job briefs were detailed and attended by appropriate personnel. (IRs 98-01, O2.4, 98-02, O4.1, 98-03, O3.1, 98-04, O1.2, 98-05, O4.1) Operators demonstrated system awareness and correct procedure usage when they immediately identified and restored a loss of shutdown cooling on Unit 2. A valve unexpectedly went closed during a surveillance due to a procedure lineup deficiency for a switch located on the remote shutdown panel. (IR 98-06, O2.4).
09/19/1998	1998005	**Pri:** OPS **Sec:** ENG **Ter:**	NRC	NEG	**Pri:** 3A **Sec:** **Ter:**	Operator inattention to detail using the Unit 2 outage safety assessment procedure resulted in the failure to promply identify a condition of increased risk. The operators failed to recognize that a Core Spray system was not available for core cooling as identified in the outage assessment due to safety relief valves being removed for maintenance. Operators failed to complete a detailed review of available systems, plant conditions, and ongoing maintenance activities that affected system availability for core cooling.

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08/01/1998	1998004	**Pri:** OPS **Sec:**	NRC	NEG	**Pri:** 3B **Sec:** **Ter:**	The overall performance grade for some licensed operators was a combination of observations of the Shift Technical Advisor and the licensed operator position into one grade.
08/01/1998	1998004	**Pri:** OPS **Sec:**	NRC	STR	**Pri:** 3B **Sec:** **Ter:**	For the licensed operator requalification process, the sample plan and the reviewed licensed operator written examinations were satisfactory. The development of the Probabilistic Safety Assessment matrix was noted as a program strength. The licensee had performed an analysis of the training/testable items versus the Probabilistic Safety Assessment data and identified which important events, equipment operability and operator actions were significant core damage frequency contributors. The licensee then ensured that all significant contributors were included in operator requalification training.
05/02/1998	1998002	**Pri:** OPS **Sec:**	NRC	NEG	**Pri:** 5A **Sec:** 4B **Ter:**	Operations personnel demonstrated a lack of sensitivity for changing unclear steps in the Reactor Core Isolation Cooling surveillance procedure. The procedure required operators to make independent verifications that could not be made and required operators to take actions that were not specifically identified in the procedure. The Emergency Diesel Generator (EDG) procedure precuatuions contained ambiguity related to running the EDG unloaded or at low load. This contributed to a small fire on EDG insulation. (IR 97-12, 2/7/98)
05/02/1998	1998002	**Pri:** OPS **Sec:** ENG	NRC	POS	**Pri:** **Sec:** **Ter:**	The Plant Review Board (PRB) met the requirements specified in Section 1 of the Hatch Quality Assurance Manual and Section 17 of the Updated Final Safety Analysis Report for the number of members, departments represented, timeliness, and scope of review. The PRB members conducted a detailed and thorough review of the 10 CFR 50.59 evaluations completed for procedure revision. (Also see IR 97-12, 2/7/98)
05/02/1998	1998002	**Pri:** OPS **Sec:** MAINT	NRC	POS	**Pri:** 2A **Sec:** 2B **Ter:** 1C	Operations supervision was actively involved in the Unit 2 High Pressure Coolant Injection maintenance and testing activities and provided continuous oversight and direction. Operators correctly used procedures, displayed an attentiveness to detail, and effectivley monitored system critical parameters. Technical Specifications and surveillance testing acceptance criteria were met. Maintenance and engineering support to operations was evident for the planning and work activities.
03/10/1998	1997012-02	**Pri:** OPS **Sec:** MAINT	NRC	VIO IV	**Pri:** 3A **Sec:** 2B **Ter:**	The Nitrogen Supply system for the Containment Atmospheric Dilution System (CAD) was not well maintained. Although the system remained operable, pressure control valves were leaking, insulation was not in place per drawings, ice had formed on piping and valves, and some valves were not in the required testing program. Procedures were not followed to change setpoints based upon operating history. (Also VIO 97-12-06).
02/07/1998	1997012	**Pri:** OPS **Sec:** MAINT	NRC	POS	**Pri:** 3A **Sec:** **Ter:**	Operators quickly detected and immediately extinguished a small fire on Emergency Diesel Generator (EDG) insulation. Maintenance provided support to operations to evaluate the cause of the fire and provided recommendations to change the surveillance testing procedure. The problem was caused by running the EDG unloaded or at low loads for an extended time during surveillance and post maintenance testing which allowed lube oil to accumulate in the exhaust.
02/07/1998	1997012	**Pri:** OPS **Sec:** MAINT	NRC	POS	**Pri:** 5B **Sec:** 5C **Ter:**	Site equipment reliability and corrective action meetings were effectively focused. Management demonstarated effective priortization and focus for risk and safety significant equipment.

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Date	Source	Functional Area	ID	Type	Template Codes	Item Description
01/23/1998	1997011-03	**Pri:** OPS **Sec:** OTHER	NRC	VIO IV	**Pri:** 1A **Sec:** 3A **Ter:**	Opereators failed to make the required 4-hour report that the Drywell pneumatic system had isolated. Operators failed to identify that the closing of the valves was a safety system actuation. The previous corrective actions failed to prevent four late 10 CFR 4-hour reports that occurred within the past two years. (Also VIO 97-11-02, LER 321/97-07)
12/27/1997	1997011	**Pri:** OPS **Sec:**	NRC	STR	**Pri:** 1B **Sec:** 3A **Ter:**	Operator response to a transient and manual scram resulting from the Unit 2 condensate booster pump check valve problems was good in that power was reduced, a manual scram was initiated, and plant procedures were correctly and promptly used. A condensate booster pump check valve failed to seat and resulted in a overpressure and failure of a metal suction bellows. (LER 366/97-10)
12/27/1997	1997011	**Pri:** OPS **Sec:** MAINT	NRC	POS	**Pri:** 2A **Sec:** 2B **Ter:** 4B	Management was actively involved and provided oversight and direction for system walkdowns and damage assessment, shutting down the reactor for repairs, and ensuring personnel safety following a damaged Unit 2 condensate check valve and ruptured suction bellows. The check valve stuck open causing overpressure and damage of the suction bellows.
12/27/1997	1997011	**Pri:** OPS **Sec:** MAINT	NRC	STR	**Pri:** 1B **Sec:** 3A **Ter:**	Operator actions to immediately identify and verify by instrumentation that the Unit 2 Recirculation pump speed had increased were appropriate and in accordance with procedures and expectations. Operator actions were timely with reactor power reduced to rated after about 2 minutes. Engineering and maintenance provided support to investigate and repair the stuck controller pushbutton that caused the problem.
11/15/1997	1997010	**Pri:** OPS **Sec:**	NRC	STR	**Pri:** 3A **Sec:** 3B **Ter:** 1A	Operator performance prevented a potential Scram on Unit 1 due to a loss of condenser vacuum. Operators identified the problem, reduced power, and restored a valve being manipulated during equipment clearance activities to the original position. The problem was a valve on the standby steam jet air ejector that had seat leakage. Operator performance during refueleing and fuel movement was identified as a strength. This was the fourth refueling outage completed without operator or fuel movement error.
11/15/1997	1997010	**Pri:** OPS **Sec:** MAINT	NRC	POS	**Pri:** 2A **Sec:** 2B **Ter:**	Decay heat removal systems were in good operational condition prior to and during the refueling outage. Management, supervisors, and operators demonstrated a good safety attitude about work activities that could affect core cooling and the removal of systems from service that would decrease emergency system availability. Operators prevented work activities in and around control room panels where emergency core cooling system switches were located.
11/15/1997	1997010	**Pri:** OPS **Sec:** MAINT	NRC	POS	**Pri:** 2A **Sec:** 3A **Ter:**	For the Unit 1 Drywell closeout following the refueling outage, the material conditions and general housekeeping were good. The licensee correctly installed the new reactor vessel insulation as part of the new insulation upgrade program. No system or component leakage was observed. The Unit 2 Torus was closed out in accordance with procedure requirements. The licensee demonstrated a safety focus toward equipment and system operability prior to closeout activities. (Also IR 98-06)
11/15/1997	1997010	**Pri:** OPS **Sec:** MAINT	NRC	POS	**Pri:** 2B **Sec:** 3A **Ter:**	Operations and maintenance interfaced effectively during an infrequent main transformer backfeed activity. Good overall planning was observed. Operations provided good oversight and direction for equipment clearances to remove the 1D startup transformer from service. Overall work activities were well planned, detailed, and precise.

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Date	Source	Functional Area	ID	Type	Template Codes	Item Description
11/15/1997	1997010	**Pri:** OPS **Sec:** OTHER	NRC	POS	**Pri:** 5A **Sec:** 5C **Ter:**	All significant occurrence reports reviewed were correctly classified and were being actively tracked for resolution. The recommended schedule for determining root cause and subsequent corrective actions were appropriate for the situation. The occurrence reports were receiving senior and department level management attention and review.
11/15/1997	1997010-02	**Pri:** OPS **Sec:** MAINT	NRC	VIO IV	**Pri:** **Sec:** **Ter:**	Unit 1 was in cold shutdown when operators withdrew a control rod with accumulator pressure less than that specified by Technical Specifications. Several accumulators had been discharged in preparation for maintenance activities and operators were attempting to time the control rods at the same time the accumulators were discharged. (LER 321/97-05)
11/03/1997	1997009-01	**Pri:** OPS **Sec:** MAINT	NRC	VIO IV	**Pri:** 3A **Sec:** 3C **Ter:**	Operations demonstrated poor oversight and coordination of a battery charger transfer activity. A plant equipment operator failed to follow (use) procedures governing continuous activities that affected the operability of Emergency Diesel Generators (EDG) and their battery chargers. The battery chargers for EDG 2A and 2C were rendered inoperable due to an incorrect breaker alignment. (LER 366/97-09) Operations supervision failed to follow procedures to correctly generate a Maintenance Work Order package for a Reactor Manual Control system relay replacement. Operations supervision authorized work and maintenance personnel performed working using a work package that did not contain work instructions or post maintenance testing information. A required VT-1 inspection was not completed following work on the 2B feedwater check valve hinge pin. (VIO 97-09-01)
10/04/1997	1997009	**Pri:** OPS **Sec:**	NRC	WK	**Pri:** 1B **Sec:** 3A **Ter:**	The operating crew's performance on Unit 2 resulted in additional challenges during a normal manual scram. Operators slow response to control level and reset the Scram allowed reactor level to increase. This resulted in manual closing of the Main Steam Isolation Valves to prevent flooding the lines and using Reactor Core Isolation Cooling for pressure control.
12/29/1998	1998007-04	**Pri:** MAINT **Sec:** OPS	NRC	NCV	**Pri:** 1A **Sec:** 2B **Ter:**	A lack of administrative controls resulted in an inappropriate surveillance frequency and a missed Technical Specification surveillance test on the Unit 2 Reactor Building Exhaust Radiation Monitoring system. The licensee's immediate corrective actions were timely and comprehensive (M3.2).
09/19/1998	1998005	**Pri:** MAINT **Sec:**	NRC	POS	**Pri:** **Sec:** **Ter:**	Unit 2 Inservice Inspection activities were conducted in accordance with procedures, licensee commitments, and regulatory requirements. Underwater welding related to emergency core cooling equipment suction strainers was accomplished by qualified and certified welders using certified fill material.
06/20/1998	1998003	**Pri:** MAINT **Sec:**	NRC	POS	**Pri:** 5B **Sec:** 5C **Ter:**	Actions to identify and correct total in-leakage was satisfactory. Licensee management was kept informed of the total amount of radwaste in-leakage which was indicative of component and system leaks. Leakage was routinely assessed and leakage reduction was often identified as a priority. Although management goals for total site radwaste in-leakage were generally not met, the amount of in-leakage for 1998 to date, was improved from the values recorded in 1997.

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06/20/1998	1998003	**Pri:** MAINT **Sec:** ENG	NRC	NEG	**Pri:** 5A **Sec:** 4B **Ter:** 4C	Maintenance and engineering personnel failed to recognize and expeditiously correct mechanical system and component deficiencies. For two months, maintenance and engineering personnel failed to recognize the root cause of problems associated with the Unit 1 Core Spray jockey pump. The significance of the tolerances for the impeller clearances and flatness of the casing wear plate was not identified.
06/20/1998	1998003	**Pri:** MAINT **Sec:** ENG	NRC	POS	**Pri:** 5A **Sec:** 2A **Ter:** 4B	Maintenance and engineering personnel took prompt and prudent action in conducting an assessment and inspection of the bearing condition for the 1A Emergency Diesel Generator after an analysis indicated a wear particle concentration increase. The inspection revealed that the wear increase was due to normal wear-in for a new bearing and a replacement bearing was not necessary.
06/20/1998	1998003	**Pri:** MAINT **Sec:** OPS	NRC	POS	**Pri:** 1A **Sec:** 3A **Ter:**	Operator performance for the Unit 1 Control Rod Drive system testing and corrective maintenance for Balance of Plant leaks was excellent as evidenced by correct procedure usage, clear and concise communications, peer checks, and careful switch manipulation. Supervisors were present to provide support and direction and to make on-the-spot decisions.
05/02/1998	1998002-08	**Pri:** MAINT **Sec:**	NRC	NCV	**Pri:** 3A **Sec:** 2B **Ter:**	The Technical Specifications (TS) requirements for a Unit 1 Reactor Building Ventilation Radiation monitor setpoint was not met. A technician left the setpoint greater than the TS allowable value. A supervisory review of the completed procedure failed to identify the error.
04/21/1998	1998001-02	**Pri:** MAINT **Sec:**	NRC	VIO IV	**Pri:** 3A **Sec:** **Ter:**	Maintenance personnel failed to follow procedures and work was performed on the Unit 2 Standby Liquid Control system that was not specified on the maintenance work order and was outside the approved clearance boundary. This rendered both trains of the system inoperable when a pipe was cut to remove a valve.
03/21/1998	1998001	**Pri:** MAINT **Sec:**	NRC	POS	**Pri:** 2B **Sec:** **Ter:**	For maintenance rule (a) (2) systems, structures and components (SSCs), performance criteria had been established, suitable trending had been performed, and corrective actions were taken when SSCs failed to meet performance criteria or experienced failures. Industry wide operating experience had been considered.
03/21/1998	1998001	**Pri:** MAINT **Sec:**	NRC	WK	**Pri:** 2A **Sec:** 2B **Ter:**	Several weaknesses were identified in the periodic assessment procedure for the Maintenance Rule. For example, the procedure did not adequately address review of goals, performance, effectiveness of corrective actions, and optimizing availability and reliability.
03/21/1998	1998001	**Pri:** MAINT **Sec:** OPS	NRC	POS	**Pri:** 3A **Sec:** **Ter:**	Personnel performance during routine surveillance activities between 10/97 and 3/98 was satisfactory. Procedures were consistently used, communications were generally three-part, clear, concise and met the requirements of the communications procedure. Supervisors observed some work activities and provided direction and assistance when needed. (Also IR 97-09, 97-10, 97-11)
03/20/1998	1998008	**Pri:** MAINT **Sec:**	NRC	NEG	**Pri:** 2B **Sec:** **Ter:**	Some manufacturer recommended steps and good industry practices were not incorporated into circuit breaker maintenance procedures. Examples included the following: reduced voltage functional test, check of the anti-pump circuit, breaker operating time check, and clearance check between tripping trigger, trip latch roller, and closing trigger.

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02/07/1998	1997012-03	Pri: MAINT Sec:	NRC	NCV	Pri: 3A Sec: Ter:	Due to a lack of attention to detail, surveillance schedulers failed to submit a surveillance procedure frequency change form and the required weekly test frequency was not met for the Reactor Protection System channel switches.
02/07/1998	1997012	Pri: MAINT Sec: ENG	NRC	POS	Pri: 3A Sec: 4B Ter:	Maintenance and engineering personnel provided support for the troubleshooting and repair of the 2C Emergency Diesel Generator (EDG) following a failure to start. Procedures were correctly used and supervisors were present to provide oversight and direction during troubleshooting. The activities identified that the governor shutdown solenoid was the problem.
02/07/1998	1997012	Pri: MAINT Sec: OPS	NRC	POS	Pri: 3A Sec: Ter:	Maintenance personnel and plant equipment operators exhibited procedural familiarity for the isolation of the instrument air supply outside the power block tt.] was leaking due to corrosion and was being replaced. Performance was demonstrated by actions to close proper valves to correctly isolate the air headers, placing temporary air hoses to maintain component operation, and establishing a correct clearance boundary. Appropriate fire actions were taken for a blocked open fire door.
12/27/1997	1997011	Pri: MAINT Sec:	Self	NEG	Pri: 3A Sec: Ter:	Poor maintenance work practices resulted in a leak from the nitrogen supply line to the Unit 1 "B" inboard Main Steam Isolation Valve. "O" rings were not installed properly and nitrogen leaks occurred that required a unit shutdown for rework activities. (LER 321/97-07)
12/27/1997	1997011	Pri: MAINT Sec:	NRC	STR	Pri: 3A Sec: 2B Ter:	Routine maintenance activities between 12/15/97 and 10/04/97 were generally completed in a thorough and correct manner. Workers consistently used procedures, and followed work instructions of work packages. Documentation of work performed and as-found conditions of equipment was detailed and accurate. Supervisors observed work activities and provided direction and oversight during the work. (IRs 97-09, 97-10, 97-11)
12/27/1997	1997011	Pri: MAINT Sec: MAINT	NRC	WK	Pri: 3B Sec: 3C Ter:	Poor supervisory oversight of loaned personnel during the Unit 1 refueling outage was identified. Loaned personnel from another site removed insulation from safety related equipment to remove snubbers. The removed insulation was not documented, tracked or replaced.
11/15/1997	1997010-03	Pri: MAINT Sec: OPS	Self	NCV	Pri: 3A Sec: Ter:	Operators lack of attention to detail during testing on Unit 1 resulted in an Engineered Safety Feature actuation. During local leak rate testing, two operators placed jumpers in an incorrect panel causing the actuation. Operator peer checks and independent verifications failed to prevent the error.
10/04/1997	1997009	Pri: MAINT Sec: ENG	NRC	POS	Pri: 2A Sec: 4B Ter:	Maintenance and engineering support to operations following the 1A Emergency Diesel Generator (EDG) failure to start on September 4 was excellent as evidenced by troubleshooting and history reviews. The review identified that a fuel oil check valve failure caused the problem. The review of past performance and repair history of the failed fuel oil check valve replacements for all EDGs demonstrated conservative decision making. The licensee altered the preventative maintenance schedule for the valves.
10/04/1997	1997009	Pri: MAINT Sec: ENG	NRC	POS	Pri: 3A Sec: 4B Ter:	Maintenance personnel's attention to detail during a system walkdown led to the discovery of broken pieces of the Unit 2 High Pressure Coolant Injection pump flange bushing. The bushing was replaced and the bearing was repaired. The pump vendor suspected that slight shaft movement occurred causing the bushing to be damaged. (LER 366/97-08)

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By Primary Functional Area

Date	Source	Functional Area	ID	Type	Template Codes	Item Description
10/31/1998	1998006	Pri: ENG Sec: MAINT	NRC	POS	Pri: 3A Sec: 4B Ter:	Field engineering support for implementation of design changes on Unit 2 was effective and thorough. The implementation engineers coordinated activities directly with craft foremen and provided direct oversight in resolving installation problems
06/20/1998	1998003	Pri: ENG Sec:	NRC	NEG	Pri: 2B Sec: 4B Ter:	A lack of attention to detail by corporate engineering resulted in undersized wiring and incorrect breaker trip setpoints for a Motor Control Center (MCC) associated with the Turbine Building Chilled Water system. The water system is not safety related but is important to safety. As a result the non-safety related MCC lost power. Operations personnel were required to take compensatory actions to limit loads on the MCC to minimize the impact of the design error.
06/20/1998	1998003	Pri: ENG Sec:	NRC	NEG	Pri: 3A Sec: 4B Ter:	The request for engineering review (RER) process was not rigorously implemented as required by procedure. RERs were not consistently tracked by department. The disposition of RERs was not thoroughly controlled by the engineering departments, nor was the status of RERs communicated to requesting departments. The RERs did not affect safety related equipment.
05/02/1998	1998002	Pri: ENG Sec: OTHER	NRC	POS	Pri: 5A Sec: 4B Ter: 3B	Audits in the area of the 10 CFR 50.59 Evaluation Program were thorough and detailed. The audits were conducted by corporate and site personnel knowledgeable of the safety evaluation program. The response and corrective actions to audit findings were timely and appropriate to ensure program implementation. Site and corporate personnel had received specific training to conduct 10 CFR 50.59 evaluations. The safety evaluation procedure included appropriate and detailed guidance for the preparation and review of 10 CFR 50.59 evaluations.
05/02/1998	1998002-03	Pri: ENG Sec: OPS	NRC	NCV	Pri: 3A Sec: Ter:	The failure to compare and document the closure time of the Unit 2 Reactor Core Isolation Cooling valve, 2E51-F003, to the inservice testing reference time, was identified. The valve cycle time was not revised and monitored following maintenance activities.
04/21/1998	1998001-03	Pri: ENG Sec:	NRC	VIO IV	Pri: 3A Sec: 4B Ter:	Personnel failed to review, approve, and obtain signature authority of the responsible engineer for a pressure test following safety related work on the Unit 2 Standby Liquid Control system. Cut piping was welded, approved, and placed in service without a review from the responsible engineer.
04/21/1998	1998001-08	Pri: ENG Sec:	NRC	EEI	Pri: 3A Sec: 4B Ter: 5C	A missing temperature switch on each train of the Main Control Room Environmental Control system rendered each train incapable of performing a design safety function to protect personnel from radiation. The licensee believed that the switches had been missing since original installation of the systems. NCV 98-02-04 was later issued.
03/20/1998	1998008	Pri: ENG Sec: OTHER	NRC	WK	Pri: 4A Sec: Ter:	Weaknesses were identified in the original calculations of circuit breaker control voltage with respect to design inputs and conclusions. The worst case calculated voltage at the closing coil for Emergency Diesel Generator 1B was below the published minimum operating voltage for the coil.

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02/07/1998	1997012	**Pri:** ENG **Sec:** MAINT	NRC	POS	**Pri:** 5A **Sec:** 5C **Ter:**	Engineering personnel demonstrated excellent observations for problem identifiecation on the Standby Liquid Control (SBLC) and Plant Service Water (PSW) systems. Missing bolts on the SBLC test tank (seismic concern) was identified by the system engineer during a system walkdown. Maintenance replaced the bolts. A small section of piping, 12-15 inches, that did not have missile shielding since initial construction was identifed by a system engineer during a PSW system walkdown. A temporary concrete barrier was immediately placed for corrective actions. Maintannce and engineering support to identify and correct the problems were timely.
02/07/1998	1997012	**Pri:** ENG **Sec:** PLTSUP	NRC	POS	**Pri:** 4B **Sec:** 5A **Ter:**	The problem solving team convened by Nuclear Safety and Compliance conducted a detailed investigation for the root causes of the fission product monitor and commercial grade oxygen analyzer problems. The systems would not operate properly to meet the surveillance requirements. The team determined that the problems with the systems included incorrect operation of the system, vacuum leaks, and degraded components. Previous design changes also contributed to the problems for line routing that allowed moisture buildup to hinder operations.
11/15/1997	1997010-04	**Pri:** ENG **Sec:**	Licensee	DEV	**Pri:** 3A **Sec:** **Ter:**	A missed commitment for Unit 2 Technical Specifications amendment 132 was associated with the alternate leakage path equipment. The licensee identified a missed commitment to treat (test) alternate leakage path equipment (repair/replacement) as ASME code. A code test was not completed before unit startup as required.
11/15/1997	1997010-09	**Pri:** ENG **Sec:**	NRC	NCV	**Pri:** 3A **Sec:** **Ter:**	Engineering personnel failed to identify that a procedure change required a Final Safety Analysis Report (FSAR) change. The issue was for Residual Heat Removal system on-line testing. The FSAR specified that certain testing be conducted with the unit shutdown and the system drained. On-line testing was completed for the system without revising the FSAR.
09/19/1998	1998005	**Pri:** PLTSUP **Sec:**	NRC	NEG	**Pri:** 3A **Sec:** **Ter:**	The As Low As Reasonably Achievable (ALARA) planning was limited in some respects as evidenced by minimal participation by upper management in scheduled plant ALARA committee meetings and by inspector observations of a pre-job briefing that contained inconclusive details.
09/19/1998	1998005	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 2A **Sec:** 1C **Ter:** 3C	Emergency facilities and equipment were maintained in an operational status. The licensee maintained on-shift dose assessment capabilities that were user friendly and required minimal training. The licensee maintained a satisfactory Emergency Preparedeness (EP) training prgram. The EP audits satisfied the requirements of 10 CFR 50.543 (t). Both of the licensee's Notices of Unusual Events since August 1996 were properly classified and notifications were made in a timely manner.
09/19/1998	1998005	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 3A **Sec:** **Ter:**	Actions for a Notice of Unusual Event were correct and timely when two workers fell from a scaffold and were transported to a hospital. The workers were potentially contaminated. Procedures were correctly used and contamination control techniques were correct.
08/01/1998	1998004	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** 2B **Ter:**	Both passive and active barriers of the vehicle barrier system were in place and operable as required by the site security plan and licensee procedures. Frequent adjustments to the airline cable were determined to be caused by environmental conditions and the placement of the cable.

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Date	Source	Functional Area	ID	Type	Template Codes	Item Description
06/20/1998	1998003	Pri: PLTSUP Sec: 	NRC	NEG	Pri: 3B Sec: 5B Ter:	Although some recent improvements were observed in the quality of personnel contamination reports (PCRs), some were not thorough and detailed and some corrective actions were not identified to other involved departments. Some PCRs did not specifically identify the cause of the problems or make recommendations to prevent repeat problems. The personnel assigned to complete PCR determinations were not trained in root cause and corrective action analysis.
06/20/1998	1998003	Pri: PLTSUP Sec: 	NRC	POS	Pri: 5A Sec: 5C Ter:	The completion of a contamination control self-assessment demonstrated site management's increased sensitivity for contamination control issues and a need for improvement. The self-assessment was thorough and detailed.
05/02/1998	1998002	Pri: PLTSUP Sec: 	NRC	NEG	Pri: 1C Sec: 2B Ter:	The command and control responsibilities of the first responders for emergencies during a medical emergency drill were not clearly delineated or defined. This contributed to a lack of command and control observed during the medical drill conducted in April, 1998. Information communicated to the control room during the drill did not identify that the simulated injured individual was contaminated. Subsequent information relayed to the hospital was incorrect.
05/02/1998	1998002	Pri: PLTSUP Sec: 	NRC	POS	Pri: 3A Sec: Ter:	Plant Health Physics had placed increased emphasis upon area decontamination and the removal of debris from contaminated areas. This was partially accomplished through better house keeping which has generally improved since the last report period.
05/02/1998	1998002	Pri: PLTSUP Sec: 	NRC	POS	Pri: 3A Sec: 5A Ter:	Chemistry's persistence in determining the root cause for the loss of the primary Reactor Coolant system flow to the continuous in-line conductivity cell resulted in a detailed and timely solution to the problem. The problem was determined to be a combination of design and procedural lineup deficiencies.
05/02/1998	1998002	Pri: PLTSUP Sec: OPS 	NRC	POS	Pri: 1C Sec: Ter:	The fire protection personnel provided an effective drill for the fire brigade. Response and coordination objectives were met. Minor deficiencies associated with a failure to initially establish a hydrant operator and sparse followup messages to the fire brigade leader were discussed with the fire drill coordinator. These deficiencies were also discussed in a post drill critique for corrective actions. The fire brigade leader demonstrated good leadership abilities by setting up a command post, using applicable procedures, and providing oversight and direction to fire brigade members during the performance of an unannounced fire drill conducted on March 3, 1998. (IR 98-01, 3/21/1998)
04/21/1998	1998001-04	Pri: PLTSUP Sec: OPS 	NRC	VIO IV	Pri: 3A Sec: 3C Ter:	A failure to conduct adequate surveys to evaluate the extent of radiation levels and potential hazards to workers conducting condensate pump vibration analysis measurements within a High Radiation area in the Unit 1 Turbine Building, was identified. The surveys reviewed failed to identify maximum contact and general area dose rates where specific work activities occurred. (VIO 98-01-04) A failure to follow procedure in accordance with Technical Specification 5.4.1 for entry into a High Radiation Area, was identified. Workers entered the area and failed to notify Health Physics of planned work activities. No overexposures occurred. (VIO 98-01-06)

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Date	Source	Functional Area	ID	Type	Template Codes	Item Description
03/21/1998	1998001	Pri: PLTSUP Sec: Ter:	NRC	NEG	Pri: 3A Sec: Ter:	Numerous examples of poor facility housekeeping, cleanliness and contamination control practices were identified. Examples included, use of protective clothing, cloth and paper coveralls, cloth liners, and rubber gloves that were discarded outside of established collection receptacles. Discarded paper trash was observed. Abandoned tools and equipment that extended across established radiological control boundaries were observed.
03/21/1998	1998001	Pri: PLTSUP Sec: ENG Ter:	NRC	WK	Pri: 4B Sec: 4C Ter:	Brand Industrial Services Company silicone foam penetration seal designs were not supported by available vendor qualification test records. The licensee did not perform engineering evaluations that satisfied the guidance of NRC GL 86-10 for deviations from fire barrier configurations qualified by test results and evaluations.
03/21/1998	1998001	Pri: PLTSUP Sec: OPS Ter:	NRC	NEG	Pri: 3A Sec: 3C Ter:	Poor supervisory oversight of chemistry activities and poor chemistry interface with the operations department contributed to a failure to follow procedure during drywell sampling activities. Technicians completed an incorrect sample analysis that was not questioned or reviewed by chemistry supervision. Procedures were not followed and operations personnel failed to question the sample results.
03/10/1998	1997012-07	Pri: PLTSUP Sec: Ter:	NRC	VIO IV	Pri: 3A Sec: Ter:	A failure to follow procedure was identified for the failure to document release surveys. Also, a failure to dispose of licensed material in accordance with 10 CFR 20.2001 (a) requirements, was identified. (VIO 97-12-07 and 97-12-09)
03/10/1998	1997012-09	Pri: PLTSUP Sec: OPS Ter:	NRC	VIO IV	Pri: 2B Sec: 3A Ter:	Personnel who identified contaminated material in the onsite landfill failed to initiate a deficiency card for the problem. This was not in accordance with site procedures. Operations failed to submit a timely deficiency card for a frozen safety related nitrogen pressure control valve. Discrepant conditions of minor significance were not consistently documented as deficiencies. (IR 98-04, 6/21/98)
03/10/1998	1997012-10	Pri: PLTSUP Sec: OTHER Ter:	NRC	VIO IV	Pri: 3A Sec: Ter:	The licensee failed to maintain decommissioning records in accordance with 10 CFR 50.57 (g) requirements for contaminated material discovered in the onsite landfill.
02/07/1998	1997012	Pri: PLTSUP Sec: Ter:	NRC	POS	Pri: 3A Sec: Ter:	Licensee Health Physics technicians appropriately identified the disposal of licensed material in the onsite landfill as a deficient radiological condition. This concern was identified to supervisiors and licensee management, however, the problem was not considered a deficiency and no deficiency card was completed.
02/07/1998	1997012	Pri: PLTSUP Sec: Ter:	NRC	WK	Pri: 3A Sec: 2B Ter:	Technicians and management interpretations of radiation control procedural requirements were inconsistent with respect to the procedural methods and equipment available for use to frisk material prior to release from a radiological controlled area. The limited use of automated gamma-sensitive equipment to conduct surveys of aggregate Unit 1 Radwaste Building concrete debris released to the onsite landfill was identifed as a program weakness.

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Date	Source	Functional Area	ID	Type	Template Codes	Item Description
02/07/1998	1997012-08	**Pri:** PLTSUP **Sec:** MAINT	NRC	NCV	**Pri:** 3A **Sec:** 2B **Ter:**	Fission product monitoring troubleshooting activities led by chemistry, with maintenance and operations personnel support was not well planned or coordinated. As a result, personnel error led to a breach of primary containment integrity when a manual valve that was required to be closed was opened.
12/27/1997	1997011	**Pri:** PLTSUP **Sec:** ENG	NRC	STR	**Pri:** 1C **Sec:** 5B **Ter:**	The licensee's root cause analysis to identify causes of an increasing trend in worker contaminations and corrective action recommendations was appropriate. The analysis identifed that the structure of the new maintenance performance teams recently implemented blurred the responsibilities for the radiation and contamination control programs, diluted worker accountability, and created a false sense of security among team workers. The licensee reorganized the teams.
12/27/1997	1997011	**Pri:** PLTSUP **Sec:** OPS	NRC	POS	**Pri:** 3A **Sec:** 1C **Ter:**	Proficiency of chemistry technicians and radwaste operators during the conduct of a Unit 2 liquid floor drain sample tank effluent release was demonstrated by correct procedural usage and attention to detail.
11/15/1997	1997010	**Pri:** PLTSUP **Sec:**	NRC	STR	**Pri:** 1C **Sec:** **Ter:**	Review of protected and vital area requirements from 12/15/97 to 03/10/98 revealed that personnel, vehicle, and package searches were correctly made. Procedures were correctly used for these activities. Vehicles were searched, escorted and secured as described in applicable procedures. Perimeter fences were intact and not compromised by erosion or disrepair. (IRs 97-09, 97-10, 97-11, 97-12)
11/15/1997	1997010-07	**Pri:** PLTSUP **Sec:**	NRC	NCV	**Pri:** 1C **Sec:** 2B **Ter:**	Failure to have adequate surveillance procedures to meet Containment High Range Monitors calibration requirements specified in NUREG- 0737, was identified. Only four of the six range decades above 10 Roentgens per hour were calibrated properly.

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PLANT ISSUE MATRIX

By Primary Functional Area

Legend

Type Codes:

BU	Bulletin
CDR	Construction
DEV	Deviation
EEI	Escalated Enforcement Item
IFI	Inspector follow-up item
LER	Licensee Event Report
LIC	Licensing Issue
MISC	Miscellaneous
MV	Minor Violation
NCV	NonCited Violation
NEG	Negative
NOED	Notice of Enforcement Discretion
NON	Notice of Non-Conformance
P21	Part 21
POS	Positive
SGI	Safeguard Event Report
STR	Strength
URI	Unresolved item
VIO	Violation
WK	Weakness

Template Codes:

1A	Normal Operations
1B	Operations During Transients
1C	Programs and Processes
2A	Equipment Condition
2B	Programs and Processes
3A	Work Performance
3B	KSA
3C	Work Environment
4A	Design
4B	Engineering Support
4C	Programs and Processes
5A	Identification
5B	Analysis
5C	Resolution

ID Codes:

NRC	NRC
Self	Self-Revealed
Licensee	Licensee

Functional Areas:

OPS	Operations
MAINT	Maintenance
ENG	Engineering
PLTSUP	Plant Support
OTHER	Other

EEIs are apparent violations of NRC Requirements that are being considered for escalated enforcement action in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Action" (Enforcement Policy), NUREG-1600. However, the NRC has not reached its final enforcement decision on the issues identified by the EEIs and the PIM entries may be modified when the final decisions are made.

URIs are unresolved items about which more information is required to determine whether the issue in question is an acceptable item, a deviation, a nonconformance, or a violation. A URI may also be a potential violation that is not likely to be considered for escalated enforcement action. However, the NRC has not reached its final conclusions on the issues, and the PIM entries may be modified when the final conclusions are made.

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INSPECTION PLAN

INSPECTION PROCEDURE/ TEMPORARY INSTRUCTION	TITLE/PROGRAM AREA	NUMBER OF INSPECTORS	PLANNED INSPECTION DATES	TYPE OF INSPECTION - COMMENTS
73753/92902	In service Inspection	1	April 1999	Core
73743/92902	In service Inspection	1	April 1999	Regional Initiative - Generic Concerns - UT on Jet Pumps - FAR Inspection
92903	Engineering Followup	1	April 1999	Regional Initiative to close previously opened electrical items
83750	Radiation Protection	1	April 1999	Core
81700	Security	1	May 1999	Core
84750/86750	HP & Chemistry	1	June 1999	Core
93809	Safety System Engineering Inspection	4	June 1999	Core
83750	Radiation Protection	1	July 1999	Core
NUREG-1201	Initial Examinations	3	October 1999	Initial Exams for 12 candidates
84750/86750	HP & Chemistry	1	October 1999	Core
81700	Security	1	October 1999	Core
82301/82302	EP Exercise	3	October 1999	Core
40500	Corrective Actions	3	October 1999	Core
Cask Storage Facility Inspection				
80853	Concrete Pour	1	April 1999	Regional Initiative
60853	Crane Modifications	1	June 1999	Regional Initiative

Enclosure 2

INSPECTION PROCEDURE/ TEMPORARY INSTRUCTION	TITLE/PROGRAM AREA	NUMBER OF INSPECTORS	PLANNED INSPECTION DATES	TYPE OF INSPECTION - COMMENTS
60853	Review Onsite Construction	1	July 1999	Regional Initiative
81001	Review Security Upgrades	1	October 1999	Regional Initiative
60854	Observe Dry Run Activities	Team	October 1999	Regional Initiative
60855	Observe Loading Activities	1	November 1999	Regional Initiative