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

August 22, 2003

Carolina Power & Light Company
ATTN: Mr. James Scarola
Vice President - Harris Plant
Shearon Harris Nuclear Power Plant
P. O. Box 165, Mail Code: Zone 1
New Hill, NC 27562-0165

SUBJECT: SHEARON HARRIS NUCLEAR POWER PLANT - NRC PROBLEM IDENTIFICATION AND RESOLUTION INSPECTION REPORT 05000400/2003005

Dear Mr. Scarola:

On July 25, 2003, the Nuclear Regulatory Commission (NRC) completed an inspection at the Shearon Harris Nuclear Power Plant. The enclosed report documents the inspection results, which were discussed on July 25, 2003, with Mr. R. Duncan 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 selected examination of procedures and representative records, observations of 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 inspectors concluded that problems were properly identified, evaluated and resolved within the problem identification and resolution programs. However, during the inspection, several minor problems were identified related to thoroughness and effectiveness of corrective action.

In accordance with 10 CFR 2.790 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 Publically Available Records (PARS) component of NRC's document system (ADAMS).

ADAMS is accessible from the NRC Web-site at http://www.nrc.gov/NRC/ADAMS/index.html (the Public Electronic Reading Room).

Sincerely,

/RA/

Paul E. Fredrickson, Chief
Reactor Projects Branch 4
Division of Reactor Projects

Docket No.: 50-400
License No.: NPF-63

Enclosure: NRC Inspection Report No. 05000400/2003005
w/Attachment: Supplemental Information

cc w/encl:
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Regulatory Affairs CPB 9
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PUBLIC DOCUMENT (circle one): YES NO

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U. S. NUCLEAR REGULATORY COMMISSION

REGION II

Docket No:	50-400
License No:	NPF-63
Report No:	05000400/2003005
Licensee:	Carolina Power & Light Company (CP&L)
Facility:	Shearon Harris Nuclear Power Plant, Unit 1
Location:	5413 Shearon Harris Road New Hill, NC 27562
Dates:	July 7 - 11 and 20 - 25, 2003
Inspectors:	J. Zeiler, Senior Resident Inspector, Vogtle Electric Generating Plant (Lead Inspector) R. Cortes, Reactor Inspector, Division of Reactor Safety R. Hagar, Resident Inspector, Harris
Approved by:	P. Fredrickson, Chief Reactor Projects Branch 4 Division of Reactor Projects

Enclosure

SUMMARY OF ISSUES

IR 05000400/2003-005; 07/07-25/2003; Shearon Harris Nuclear Power Plant, Unit 1; Biennial baseline inspection of the identification and resolution of problems.

The inspection was conducted by a senior resident inspector, a resident inspector, and a Region II reactor inspector. No findings of significance were identified. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process," Revision 3, dated July 2000.

Identification and Resolution of Problems

The licensee was effective at identifying problems at a low threshold and entering them into the corrective action program. The licensee properly prioritized issues and routinely performed adequate evaluations that were technically accurate and of sufficient depth. Formal root cause evaluations for significant conditions adverse to quality were especially thorough and detailed. Corrective actions developed and implemented for problems were timely and effective, commensurate with the safety-significance of the issue. The licensee's self-assessments and audits were effective in identifying deficiencies in the corrective action program. Based on discussions conducted with plant employees from various departments the inspectors did not identify any reluctance to report safety concerns. However, several minor problems were identified related to thoroughness and effectiveness of corrective action, and equipment deficiencies not properly entered into the corrective action program.

REPORT DETAILS

4. OTHER ACTIVITIES (OA)

4OA2 Problem Identification and Resolution

a. Effectiveness of Problem Identification

(1) Inspection Scope

The inspectors reviewed Procedure CAP-NGGC-0200, Corrective Action Program, Revision (Rev.) 7, which describes the administrative process for initiating and resolving problems. A nuclear condition report (NCR) is initiated to document problems that are significant conditions adverse to quality (Priority 1), conditions adverse to quality (Priority 2), or improvement items (Priority 5).

The inspectors reviewed 153 NCRs from approximately 6300 that had been initiated by the licensee since July 2001 (coinciding with the last NRC baseline problem identification and resolution inspection) to verify that problems were being properly identified, appropriately characterized, and entered into the corrective action program (CAP). The reviews primarily focused on issues associated with five risk significant plant safety systems: emergency diesel generator (EDG), emergency service water (ESW), high head safety injection (HHSI), 125 volt DC, and 6.9 Kilovolt AC Distribution. In addition to the system reviews, the inspectors selected a representative number of NCRs that were identified and assigned to the major plant departments which included operations, maintenance, engineering, security, chemistry, health physics, and emergency preparedness.

The inspectors reviewed completed maintenance work orders (WOs), system health reports, and the Maintenance Rule database for the five risk significant systems to verify that equipment deficiencies were being appropriately entered into the corrective action and Maintenance Rule programs. The inspectors conducted plant walkdowns of equipment associated with the EDG and ESW systems to assess the material condition and to look for any deficiencies that had not been entered into the CAP. The inspectors reviewed control room operator logs for January to February 2003 to verify that equipment deficiencies, especially those involving the five safety systems selected for the focused review, were entered in the CAP.

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

The inspectors reviewed licensee audits and self-assessments (focusing primarily on problem identification and resolution) to verify that findings were entered into the CAP and to verify that these findings were consistent with the NRC's assessment of the licensee's CAP.

The inspectors attended several plant daily status and unit evaluator meetings to observe management and unit evaluator oversight functions in the corrective action process. The inspectors also interviewed personnel from operations, maintenance, engineering, security, health physics, chemistry, and emergency preparedness to evaluate their threshold for identifying issues and entering them into the CAP.

Documents reviewed to support the inspection are listed in the Attachment.

(2) Assessment

The inspectors determined that the licensee was effective in identifying problems and entering them into the CAP. NCRs normally provided complete and accurate characterization of the subject issues. In general, the threshold for initiating NCRs was low and employees were encouraged by management to initiate NCRs. Equipment performance issues involving maintenance effectiveness such as maintenance errors, poor maintenance work practices, and inadequate risk assessments were being identified at an appropriate level and entered into the CAP. However, the inspectors noted instances where NCRs were not always being initiated for Maintenance Rule equipment deficiencies when a maintenance work request was also opened. This could result in loss of equipment performance trending information and not provide a complete and timely recognition of equipment reliability problems.

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

Department self-assessments and audits performed by the Nuclear Assessment Section (NAS) and the Performance Evaluation Support Section were effective in identifying issues and these deficiencies were entered into the CAP. NAS audits were particularly self-critical and identified substantive issues or directed attention to areas that needed improvement. Site management was actively involved in the CAP and focused appropriate attention on significant plant issues.

b. Prioritization and Evaluation of Issues

(1) Inspection Scope

The inspectors evaluated the same 153 NCRs and operating experience items discussed in Section 4OA2.a to verify that the licensee appropriately prioritized and evaluated problems in accordance with Procedure CAP-NGGC-0200. While the majority of NCRs reviewed were classified as Priority 2, the sample also included a representative number of Priority 1 and Priority 5 NCRs. The inspectors' review was also intended to verify that the licensee adequately determined the cause of the problems and adequately addressed operability, reportability, common cause, generic concerns, and extent of condition. For significant conditions adverse to quality, the review was also to verify that the licensee adequately addressed the root and contributing causes and appropriately identified corrective actions to prevent recurrence. The inspectors also reviewed a sample of voided NCRs to verify they were voided for the appropriate reasons.

(2) Assessment

The inspectors determined that the licensee properly prioritized issues entered into the CAP in accordance with Procedure CAP-NGGC-0200. Generally, the licensee performed adequate evaluations that were technically accurate and of sufficient depth. Formal root cause evaluations for Priority 1 NCRs were especially thorough and detailed. The inspectors did not identify any risk significant issues that had not been appropriately prioritized and evaluated. However, the inspectors identified several minor problems involving NCRs that lacked thorough investigations and minor documentation discrepancies. These issues included the following:

- NCR 60174, "A" EDG circuit breaker tripped during light bulb replacement: This NCR addressed the tripping of DC control power to the EDG while an operator was attempting to replace a light bulb for the "operational" light indication on the diesel panel. The NCR stated that the cause of the condition was known to be a result of inadvertent operator action. However, the NCR was closed as "No Further Investigation Required," without providing any details regarding what the "inadvertent action" was or how this implied human performance error was addressed. Upon discussing the NCR with the EDG system engineer, the inspectors learned that a similar problem occurred five months after the first incident involving the same light indication socket. The licensee's investigation into the second incident identified a generic problem with the light socket design. The inspectors determined that the licensee missed an opportunity to identify the real problem earlier due to lack of a thorough investigation. The licensee considered this another example of similar problems that had previously been identified and were addressing as part of NCR 47417.

- NCR 63108, EDG self-assessment weakness, and NCR 71959, Maintenance Rule functional failure on EDG starting air compressor: These NCRs described instances where the licensee failed to classify several spurious EDG starting air compressor circuit breaker trips as Maintenance Rule functional failures. While the cause was identified as incorrect Maintenance Rule database entries by the system engineer, corrective actions were limited to replacing the circuit breaker and updating the Maintenance Rule database to reflect the proper classifications. The inspectors noted that there was no other discussions regarding why the system engineer failed to properly classify the failures or address corrective actions for this causal factor. This issue was entered into the CAP as NCR 99414.

c. Effectiveness of Corrective Actions

(1) Inspection Scope

The inspectors evaluated the same 153 NCRs and operating experience items discussed in Section 4OA2.a to verify that the licensee had identified and implemented timely and appropriate corrective actions to address problems. The inspectors verified that the corrective actions were properly documented, assigned, and tracked to ensure completion. Where possible, the inspectors independently verified that corrective actions were implemented as intended. For significant conditions adverse to quality,

the review was to verify that effectiveness reviews were adequately performed as required by Procedure CAP-NGGC-0200. The review was also to verify the adequacy of corrective actions to address equipment deficiencies and Maintenance Rule functional failures of the five risk significant plant safety systems that were selected for the focused review as discussed in Section 4OA2.a.

(2) Assessment

Overall, corrective actions developed and implemented for problems were timely and effective, commensurate with the safety significance of the issues. However, several minor problems were identified related to corrective action effectiveness. These issues included the following:

- NCR 91818, Entry into AOP-14: This Priority 1 NCR documented a component cooling water (CCW) system surge tank pressure transient. One of numerous corrective actions identified was to revise the CCW system operation lineup procedure to change the sequence of valve manipulations during normal operations in order to minimize the potential for pressure transients in the CCW surge tank. The inspectors identified that the licensee failed to enter a tracking assignment (CORR) for this item. As a result, the procedure change had not been initiated. The inspectors considered this a minor issue since the procedure change was determined to be an enhancement item. The primary corrective actions, which included system design changes, were implemented to address the initial problem. Also, the inspectors noted that the licensee's effectiveness review had not been completed yet for this NCR and one of the expected review items was to verify that assignment tracking items were initiated for corrective actions. The licensee initiated NCR 99784 to address the assignment tracking error.

- NCR 51865, High air particulate release from equipment hatch: This NCR described a release of radioactive particulate material which caused the annual goal for such releases to be exceeded. The investigation identified three apparent causes, and the corresponding report listed three corrective actions. The report indicated that all three corrective actions were complete, but did not identify the assignment type or responsible group for any action. The inspectors learned that the listed actions were in fact not completed; instead, the licensee completed an alternative to one of the listed actions, and did not complete either of the other actions because they had determined that one was inappropriate and the other was unnecessary. The inspectors considered that the alternative corrective action was adequate to address the adverse condition, without the uncompleted actions. The licensee addressed this issue in NCR 99608 as one example of inadequate documentation of completed corrective actions.

- NCR 88091, Equipment deficiency leads to dilution event: This NCR described a reactor coolant system dilution event that resulted from inadequate maintenance performed on a reach rod for a chemical and volume control system diaphragm valve. The primary corrective action developed was to include a preventive maintenance checklist activity in the planning of any work orders involving corrective maintenance on reach rod operated diaphragm valves. The

inspectors noted that the manner in which the new checklist was added to the work planning database would not ensure that the person planning the valve work would know to include the checklist. The licensee addressed this issue by reopening NCR 88091 and providing more specific work planner instructions for ensuring the checklist would be included in future corrective WOs. The inspectors considered this an example where corrective actions were not completely effective.

d. Assessment of Safety-Conscious Work Environment

(1) Inspection Scope

During technical discussions with members of the plant staff, to include operations, maintenance, engineering, chemistry, health physics, emergency preparedness, and security personnel, the inspectors conducted interviews to develop a general perspective of the safety-conscious work environment at the site. The interviews were also to determine if any conditions existed that would cause employees to be reluctant to raise safety concerns. The inspectors also reviewed the licensee's employee concerns program (ECP) which provides an alternate method to the C for employees to raise concerns and remain anonymous. The inspectors interviewed the ECP Coordinator and reviewed a select number of ECP reports completed since July 2001 to verify that concerns were being properly reviewed and identified deficiencies were being resolved in accordance with Procedure REG-NGGC–0001, Employee Concerns Program.

(2) Assessment

The inspectors concluded that licensee management emphasized the need for all employees to identify and report problems using the appropriate methods established within the administrative programs. All of the predominant methods established by the licensee, including the CAP, the WO system, and the ECP, were readily accessible to all employees. Licensee management encouraged all employees to promptly identify nonconforming conditions. Based on discussions conducted with plant employees from various departments, the inspectors did not identify any reluctance to report safety concerns.

4OA6 Management Meetings

The inspectors presented the inspection results to Mr. R. Duncan, and other members of licensee management at the conclusion of the inspection on July 25, 2003. The inspectors confirmed that proprietary information was not provided or examined during the inspection.

SUPPLEMENTAL INFORMATION

KEY POINTS OF CONTACT

Licensee personnel

J. Caves, Supervisor - Licensing/Regulatory Programs
F. Diya, Superintendent - Systems Engineering
R. Duncan, Director - Site Operations
W. Gurganious, Manager - Nuclear Assessment
A. Khanpour, Manager - Harris Engineering
S. Larson, Quality Control
E. McCartney, Training Manager
G. Miller, Maintenance Manager
T. Morton, Manager - Support Services
T. Natale, Manager - Outage and Scheduling
T. Pilo, Supervisor - Emergency Preparedness
J. Scarola, Vice President Harris Plant
G. Simmons, Superintendent - Radiation Control
B. Waldrep, General Manager Harris Plant
E. Wills, Operations Manager
M. Wallace, Licensing Specialist

NRC personnel

R. Musser, Senior Resident Inspector, Harris
L. Plisco, Director, Division of Reactor Projects, RII

LIST OF ITEMS OPENED, CLOSED AND DISCUSSED

None.

Attachment

LIST OF DOCUMENTS REVIEWED

Procedures

ADM-NGGC-0101, Maintenance Rule Program, Rev. 15
ADM-NGGC-0104, Work Management Process, Rev. 20
ADM-NGGC-0200, Passport Action Tracking, Rev. 1
AP-013, Plant Nuclear Safety Committee, Rev. 27
AP-617, Reportability Determinations and Notification, Rev. 19
AP-618, Operability Determinations, Rev. 13
AP-925, Significant Adverse Condition Investigations, Rev. 2
AP-930, Plant Observation Program, Rev. 3
CAP-NGGC-0200, Corrective Action Program, Rev. 7
CAP-NGGC-0201, Self-Assessment Program, Rev. 6
CAP-NGGC-0202, Operating Experience Program, Rev. 4
CAP-NGGC-0205, Significant Adverse Condition Investigations, Rev. 0
EGR-NGGC-0008, Engineering Programs, Rev. 3
REG-NGGC–0001, Employee Concerns Program, Rev. 11

Nuclear Condition Reports

45164, Information Notice 01-10 Model GB series fire sprinkler head failures
45168, Information Notice 01-12 Hydrogen fire at nuclear power plants
45641, Evaluate results from 10CFR50.54(t) audit at the Robinson Nuclear Plant
47237, Cooper inspection 2001-04 - white finding in emergency planning
47760, Radioactivity in sewage sludge
79757, Adverse trend in secondary chemistry
53374, Reactor coolant pump “C” lift pump plexiglass cover missing
62802, Spent fuel shipping activities
65804, Elevated secondary chemistry during startup
61495, Contamination control practices
62316, Expectations for timely completion of corrective actions and assignments are not being enforced
52541, Potential adverse trend in maintenance rework
56231, High incidence of oil contamination
69225, Relief valve 3CF-106 lifts each time the plant trips
45907, Action-request assignments going overdue
64981, Timeliness of corrective actions taken
58269, Personnel do not attend foreign-material-exclusion training as recommended by INPO
64783, Circulating water debris filter and waterbox corrosion
64881, Rework
65631, Work order 212286 on “C” charging/safety injection pump is considered rework
73209, Lack of/improper tag out for 6.9 KV maintenance
79472, Work performed without work order
55458, 2001 CAP review of electrical equipment failures
54438, Pressure valve seal performance
55551, R10 turbine/generator project quality of work
43580, “B” ESW strainer continuously runs following maintenance

55746, Perform needs analysis on lube oil sampling program
54786, “C” charging/safety injection pump speed increaser high particle count
58948, “Continuous-use” procedures were not consistently implemented to meet standards
48665, Inadequate risk assessment of schedule changes
92940, R11 key safety function availability checklist configuration
48724, Inadequate foreign-material-exclusion controls
53713, Communication of risk-assessment changes
55863, Emerging trend in outage & scheduling human performance
61268, No clear guidelines provide directions on how to protect opposite-train equipment
62132, Risk evaluation of spent fuel movement
51865, High air particulate release from equipment hatch
67375, Increase in steam generator sodium concentration
83490, Steam generator blowdown demineralizers’ performance is degrading
92275, 120-volt alternating-current bus 1DP-1A-SA voltage spike
54982, Safety battery charger high voltage trip
48715, Trip of breaker 1CB for inverter S1
48544, Discharge of 1A 250-volt direct-current battery
90875, 6.9 kilovolt breaker found in incorrect position
87750, 1C component cooling water breaker found in disconnect
51797, “C” component cooling water pump breaker aligned to wrong train
89400, Test relay failure during “A” trip actuating device operational test
32111, Intermittent failure of test relay UVTX/SA during OST-1122
28575, Management expectations for initiating action requests
55742, Chemical control processes were not reviewed prior to the outage
62317, Operating experiences are not being evaluated against HNP programs and processes
59168, AP-929 self-assessment identified weakness
45849, Maintenance self-assessment weakness #1
45850, Maintenance self-assessment weakness #2
68437, Benchmarking improvements for predictive maintenance
56255, Quality of troubleshooting self assessment 28643
45133, Strengthen HNP EP continuing training
45141, Potential training adverse trend in procedure compliance
45251, Overdue AR action items
45703, Failure to initiate a CR
46101, HNP EP drills need to minimize simulation
47426, Uncompensated IDS Zone - One Hour NRC Notification
47590, Incorrect value for peak containment accident pressure
47871, Changes to plant process computers not tracked by simulator
48409, Hanger CE-H-184 was found not supporting the piping
49293, Mislabeled cable terminated in ARP-1A SA
50261, Adverse trend of SW relief valves
51026, "B" ESW strainer tube sheet support rings badly degraded
51455, FSAR description of service water system operation
51812, Pre-entry search discovery of firearm
52399, Inadequate weapon inventories
52488, “C” Loop AF-FW-1, R1
53153, Buildup of debris on 1A-SA CCW motor
54450, "A" chiller inoperable due to 1SW-1055 failure to modulate
54455, EOF ventilation system not meeting minimum differential pressure

55801, IST post-outage assessment IMC #12
56730, EP - radiological release mitigation strategies
57260, AH-16B repetitive failure
57407, Simulator benchmarking AR 56935-04 followup
57511, EDG fuel oil day tank sizing and setpoint values
57949, Main control room nuisance alarm ALB-23 (3-19)
58536, TDAFW oil particle count above SAE class 4 target
58893, IFMC 5 from PQD self-assessment 56270
59630, Background noise level in the control room
59783, 1X and 2X CTMU traveling screens are corroded
59860, Security procedural enhancement
59992, ERFIS calibration for main and auxiliary reservoir levels
60679, Simulator runback not functioning as expected
60984, RCDT unexplained gradual pressure increase
60991, Thru wall leak on “B” ESW header
61348, Incorrect due date for valve inspection PM
63213, Significant adverse trend (security trainee injuries)
64529, EP procedure compliance
66058, Incomplete corrective action
66681, SAMG qualification
68437, Benchmarking improvements for predictive maintenance
69600, Control of safeguards information (near miss)
70021, Mislabeled oil samples sent to HEEC
70303, Ineffective corrective actions
70312, JPM performance problems under NRC exam conditions
70352, ESW 1A-SA DP limit
74403, IST program check valve testing
74447, IFMC - trending of check valve inspection results
76241, Missing IQR signature
78758, Inappropriate oil selected for large motors
78764, Lube oil selection and sampling basis documentation
78849, EP siren failures due to ice storm
85267, OSC facility briefings
86613, Emergency communications failure to make state/county notifications in 15 minutes
90333, Near miss with generating incorrect product type
90664, Freeze seal jacket hung on ESW without proper seismic evaluation
91818, Entry into AOP-014
92331, Disconnected ESW screen wash pump motor 1A-SA incorrectly
92678, EST-211 reseat information
93059, Erosion/Corrosion of seal area on a ESW booster pump
93066, Test failure of 1CC-129
52336, Valve 1CS-7 failed to close on less than 17% in pressurizer
52469, Reactor makeup water to boric acid blender valve FCV-1148 failure
52623, High radiation swing gate tied open
53186, Technical Specification 3.4.1.3 not met in Mode 4
53945, Alternate dilution failed to stop at desired amount
58700, Technical Specification 3.0.3 entry
59194, Charging safety injection pump venting guidance questioned
59352, Low security of the sources used for emergency preparedness functions

60083, Poor implementation of configuration control practices
60174, “A” EDG circuit breaker tripped during light bulb replacement
60391, Inadequate radiological work planning
62606, “B” EDG overspeed trip would not reset
63108, EDG self-assessment weakness
63105, EDG system notebook not maintained up-to-date
65361, Rework on “C” charging safety injection pump
65802, 250 Volt DC Battery charger tripped
67837, AP-618 log not properly completed for RWST level transmitter issue
68511, EDG overspeed trip valves not replaced within vendor recommended timeframe
71928, Moisture separator reheater tank alternate dump valve opens due to clearance error
71959, Maintenance Rule functional failure on EDG starting air system
72819, Breaker 1E-1A found in the off-normal position
76069, Inadequate corrective action closure
80575, Failure of MUX 54B power supply
81788, Emerging CAP trend in operations procedure use
84673, NAS radiation protection procedure deficiency
84990, Radiation area boundary posting moved
87051, Adverse trend in radiological postings
88091, Equipment deficiency leads to dilution event
88254, CTMU pump control switch found out of position
88433, Reach rod for valve 1CS-65 rework
89570, CAP self-assessment weakness 3: NCRs closed without assignments
92350, Non-qualified radworker enters RCA on incorrect RWP
92389, 1SF-120 found out of position
92399, Clear area contamination from vacuum system
92977, Radiation monitor not source checked
93105, Entry into AOP-025 during OST-1823 performance
94058, Repeat contamination in a clean area

Maintenance Work Orders

391910, Did not receive expected results from the OST-1122 test of the 120-volt AC
403765, Repair 6.9-kilovolt switchgear 1A unit auxiliary transformer supply bus bars
405176, Breaker 501 did not shut while attempting to un-cross-tie the general service bus
100320, Preventive maintenance on a 6.9-kilovolt bus and cubicle
100527, Preventive maintenance on a 6.9-kilovolt 1200/2000 amp air circuit breaker
186719, Preventive maintenance on a 6.9-kilovolt 1200/2000 amp air circuit breaker
179881, Troubleshoot no charge light on the A 125-volt DC battery charger
190806, 1A-SA DC bus voltage reads low on the main control board
197798, Troubleshoot cause of increased noise in the 1A-SA battery charger
233218, Troubleshoot failure of 125-volt DC emergency bus 1A-SA
192910, Perform relay card calibration on the C&D battery charger
100954, Calibration of Pyco temperature indication switch
103968, Inspect internal pipe coating of Train "B" ESW piping
104238, Perform OST-1215 to stroke time valve 1SW-274
104445, Limitorque actuator inspection and lubrication
106683, ESW pump "A" discharge header pressure

116758, ESW booster pump, bearing lubrication, and coupling re-lubrication
147509, Cycle strainer to verify proper operation
150681, Perform lube oil sampling on "A" ESW pump motor
159917, ESW booster pump “A” discharge flow
195275, Inspect valve 1CS-238 actuator for signs of lug damage
197181, Inspect "A" ESW strainer
210642, Shorten travel stop sleeve
176103, No voltage to breaker for EDG lube oil heater
191987, Excessive wear found on breaker for EDG jacket water heater
197709, Valve 1CS-7 failed to shut when pressurizer level decreased
198492, Valve 1SI-381 failed RPI during testing
198511, Valve 1CS-151 failure to open
243300, Starting air compressor for 1A EDG failure to start
245835, 1A EDG annunciator panel failed
331326, Refurbish 1A EDG starting air compressor breaker

Engineering Documents

Engineering Change Request (ECR) 247, New pressure differential switches for emergency service water strainers
ECR 441, Evaluate and approve graphite pressure seals for key feedwater valves
Maintenance Rule Database - functional failures between July 2001 and July 2003; Scoping documents; and Performance Criteria for selected systems

Industry Operating Experience Reports

OE12349, Self-contained breathing apparatus fiber breathing air cylinders
OE12277, Indian Point 3 loss of spent fuel pool cooling
OE16276, Westinghouse 7300 system comparator circuit card failure
OE16524, Rapid increase in emergency diesel generator output
OE16409, Repeat issues with station sensitivity to fire protection standards
OE16213, Main generator breaker unexpectedly opens causing a reactor trip
OE16104, Loss of station air and degradation of control air
OE16061, Centrifugal charging pump low gearbox oil pressure
OE15915, Emergency diesel generator rocker arm lube oil float valve adjustment problem
OE15642, Reactor trip and safety injection caused by scaffold construction activities near a main steam isolation valve
OE15461, Feedwater regulation valve stem wear
OE15172, Emergency diesel generator jacket water intrusion
OE14826, Forced power reduction caused by cooling tower fill material entering condenser
OE14515, Diesel fire pump engine overheated during summer
OE14812, Unplanned release of radioactive gaseous activity
OE14094, Failure of breaker 1SB-B2 to close

Self- Assessments

82896, Radiological Effluent Management Programs
56017, Laboratory Quality Control Practices
56011, Quality of Regulatory Required Reports
[none], AP-929, Procedure Effectiveness, Use, and Compliance
26961, Maintenance Work Practices
55286, Predictive & Preventive Maintenance
21291, ACAD 91-015 Obj. 4, 5, & 6
21294, Complete Comprehensive Evaluation of Operation Training Program Report
25604, Organizational Performance & Safety
27827, SAMG
28637, Corrective Action Program
28642, Prioritization of Engineering Work
28644, Engineering Product Quality
30080, Evaluation of Reduced Drill Impact
27324, Operations Procedure Use and Adherence
55157, Effectiveness of Operations Audit Programs
55163, Clearance Process
26969, Radiation Monitoring Instrumentation
55549, Biennial Self-Assessment of HNP Corrective Action Program

Performance Evaluation Support and Nuclear Assessment Section Assessments

01-05-SW-H, HNP Environmental & Radiological Control (Chemistry) Assessment
H-ERC-02-01, Environmental & Radiation Control Assessment
H-MA-02-01, HNP Maintenance Assessment
H-OUT-01-01, RFO10 Post Outage Assessment
H-EP-02-01, HNP Emergency Preparedness
H-EP-03-01, HNP EP
H-SC-02-01, HNP Security
H-TQ-02-01, HNP Training and Qualification Assessment
H-ES-03-01, HNP Engineering
H-TS/OL-03-01, HNP Technical Specification and Operating License Amendment
H-SP-03-02, RF-11 Abnormal Operating Procedure (AOP-14) Entry Assessment
H-ERC-02-01, Environmental & Chemistry and Radiation Control Assessment
H-RP-03-01, HNP Radiation Protection Assessment