January 14, 2004

Mr. Thomas Coutu
Site Vice President
Kewaunee Nuclear Power Plant
Nuclear Management Company, LLC
N490 State Highway 42
Kewaunee, WI 54216-9511

SUBJECT: KEWAUNEE NUCLEAR POWER PLANT
NRC PROBLEM IDENTIFICATION AND RESOLUTION INSPECTION REPORT
NO. 05000305/2003010(DRP)

Dear Mr. Coutu:

On December 12, 2003, the U.S. Nuclear Regulatory Commission (NRC) completed a team inspection at your Kewaunee Nuclear Power Plant. The enclosed inspection report documents the inspection findings which were discussed on December 16, 2003, with members of your staff.

This 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 activities, and interviews with personnel.

On the basis of the sample selected for review, the team concluded that, in general, problems were properly identified, evaluated, and corrected. There were three findings of very low safety significance (Green) identified during this inspection. The first finding concerned ineffective corrective actions taken to address the implementation of your Boric Acid Leakage Inspection and Tracking Program. The second finding concerned ineffective corrective actions in the area of Emergency Preparedness, which resulted in the failure to make a timely notification to the county and state authorities for an actual Unusual Event declaration on February 26, 2003. These findings were determined to be violations of NRC requirements. However, because of the very low safety significance and because the issues have been entered into your corrective action program, the NRC is treating these findings as Non-Cited Violations in accordance with Section VI.A.1 of the NRC's Enforcement Policy.

An additional third finding, not associated with a violation of NRC requirements, was identified for the failure to take timely corrective actions to prevent recurrence for a September 2000 White Finding associated with Emergency Response Organization Augmentation.

Regarding the ineffectiveness of the Boric Acid Leakage and Tracking Program, we found this finding to be of particular concern in light of the significant industry experience regarding boric acid control. An NRC Generic communication was issued, to which you responded affirming that effective programmatic controls were in place. Clearly, this finding indicates that further attention is warranted in this area.

The second and third findings involving the Emergency Preparedness Program illustrated that long standing issues with this program had yet to be fully corrected. Furthermore, the implementation of the corrective action program in this area was not as effective as in other station organizations.

If you contest the subject or severity of a 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 U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555-0001; with copies to the Regional Administrator, U.S. Nuclear Regulatory Commission, Region III, 801 Warrenville Road, Lisle, IL 60532-4351; the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001; and the NRC Resident Inspector Office at the Kewaunee Nuclear Power Plant.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be made available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records (PARS) component of 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 /

Patrick L. Louden, Chief
Branch 5
Division of Reactor Projects

Docket No. 50-305
License No. DPR-43

Enclosure: Inspection Report 05000305/2003010
w/Attachment: Supplemental Information

cc w/encl: D. Graham, Director, Bureau of Field Operations
Chairman, Wisconsin Public Service Commission
State Liaison Officer

See Attached Concurrence

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U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Docket No:	50-305
License No:	DPR-43
Report No:	05000305/2003010
Licensee:	Nuclear Management Company, LLC
Facility:	Kewaunee Nuclear Power Plant
Location:	N 490 Highway 42 Kewaunee, WI 54216
Dates:	December 1 through December 12, 2003
Inspectors:	R. Krsek, Senior Resident Inspector D. Karjala, Resident Inspector, Prairie Island D. Jones, Reactor Engineer B. Jorgensen, NRC Contractor
Approved By:	Patrick L. Louden, Chief Branch 5 Division of Reactor Projects

Enclosure

SUMMARY OF FINDINGS

IR 05000282/2003010(DRP); 12/01/2003 - 12/12/2003; Kewaunee Nuclear Power Plant; Problem Identification and Resolution.

The inspection was conducted by a senior resident inspector, a resident inspector, a region-based inspector, and a contractor. Two Green findings, which also were associated with Non-Cited Violations, were identified. In addition, a third Green finding was identified which was not associated with a violation of regulatory requirements. 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," Revision 3, dated July 2000.

Identification and Resolution of Problems

The team concluded that the licensee was generally effective in identifying and appropriately characterizing problems. The corrective action program and prescribed processes were also noted to be generally effective. The licensee's effectiveness at problem identification was demonstrated through the increasing numbers of condition reports initiated by the licensee since 1999.

In most instances, the licensee appropriately classified and prioritized items entered into the corrective action program into one of four significance levels (A, B, C, or D), with the more safety significant issues being given a higher significance classification and higher priority for completion. The inspectors identified one area of concern regarding the licensee's significance classification of issues, in that, a majority of the NRC-identified Green findings reviewed, which were conditions adverse to quality, were classified as a significance level 'C.' A significance level 'C' was not an appropriate significance level in the licensee's corrective action program for a condition adverse to quality. Even though some of the NRC-identified Green findings were inappropriately classified, the team concluded that none of the findings had recurred.

The team concluded that the quality of level 'A' root cause evaluations and level 'B' apparent cause evaluations had generally improved from 2001 to 2003. However, the team noted, and recent licensee self-assessments documented, that the quality of the licensee's analyses needs continued improvement. The team also noted that weaknesses in the trending program had been self-identified and improvements were being implemented by the licensee. Finally, the team noted that, in general, the quality of extent of condition reviews conducted for root cause and apparent cause analyses were inconsistent and mainly focused on internal operating experience.

For the large majority of samples reviewed by the team, appropriate corrective actions were taken in a timely manner for items entered into the corrective action program; however, the team identified two findings which demonstrated that the corrective action program was not effective in resolving longstanding or repetitive issues. In addition, the team identified a third finding in which corrective actions to prevent recurrence for a September 2000 NRC White Finding were not timely. The team noted that for 2001 through 2003, the implementation of the

corrective action program in the area of emergency preparedness was not as effective as in other licensee organizations.

A. Inspector-Identified and Self-Revealed Findings

Cornerstone: Mitigating Systems

- Green. The team identified a finding of very low significance associated with a Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," for the failure to assure that actions were promptly taken to correct deficiencies in the implementation of the boric acid leakage inspection and tracking program for boric acid residue on safety-related components, a condition adverse to quality. Since 2001, approximately 12 condition reports had been initiated concerning the adequacy of the implementation of the licensee's boric acid leakage inspection and tracking program. During the inspection, the team identified approximately 14 safety-related components with various degrees of boric acid, which the licensee had not identified and evaluated in accordance with the boric acid leakage inspection and tracking program.

  The team concluded that the licensee's failure to correct previous issues associated with the implementation of the boric acid leak log on safety-related components was greater than minor because if left uncorrected, the issue could become a more significant safety concern. The team evaluated the finding utilizing Inspection Manual Chapter 0609, "Significance Determination Process," Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," Phase 1 screening and determined the finding was of very low significance. (Section .3 c. i.)

Cornerstone: Emergency Preparedness

- Green. The team identified a finding of very low significance associated with a Non-Cited Violation of 10 CFR Part 50.54(q) and the licensee's Emergency Plan for the failure to notify the state and local governmental agencies within 15 minutes after the declaration of an actual Unusual Event on February 26, 2003. The team concluded this failure was caused by the licensee's ineffective corrective actions for previously identified weaknesses and problems in the area of Emergency Preparedness.

  The team determined that this issue was more than minor because this was an actual event implementation problem and affected the emergency preparedness cornerstone objective of implementing adequate measures to protect the health and safety of the public in the event of a radiological emergency. The team evaluated the finding utilizing Inspection Manual Chapter 0609, Appendix B, "Emergency Preparedness Significance Determination Process," Emergency Preparedness Significance Determination Process Sheet 2, dated March 6, 2003, and determined the finding was of very low significance. (Section .3 c. ii.)

- Green. The team identified a Green finding for the failure to take timely corrective actions to prevent recurrence for a White Finding initially identified in September 2000, associated with Emergency Response Organization Augmentation. While the team determined that corrective actions to date have been effective, as evidenced by only one

augmentation drill failure since 2001, three of the eight corrective actions had not been completed.

The team determined that this issue was more than minor because if left uncorrected, the issue could become a more significant safety concern. In addition, the team concluded that the issue affected the emergency preparedness cornerstone performance attribute associated with the emergency response organization augmentation system and emergency response augmentation testing and the objective of implementing adequate measures to protect the health and safety of the public in the event of a radiological emergency. The team evaluated the finding utilizing Inspection Manual Chapter 0609, Appendix B, "Emergency Preparedness Significance Determination Process," Section 5.0, "Corrective Actions," dated March 6, 2003, and determined the finding was of very low significance. (Section .3 c. ii.)

B. Licensee-Identified Violations

No findings of significance were identified.

REPORT DETAILS

4. OTHER ACTIVITIES (OA)

4OA2 Identification and Resolution of Problems (71152)

.1 Effectiveness of Problem Identification

a. Inspection Scope

The team conducted a review of the Kewaunee process for identifying and correcting problems at the plant. Specifically, the team reviewed previous licensee and NRC inspector identified issues related to the seven cornerstones of safety to determine if problems were appropriately identified, characterized, and entered into the corrective action program. The problem identification program and the effectiveness of the program were evaluated by reviewing issues identified in previous NRC inspections, selected corrective action program documents and records, and discussions of the program with licensee personnel.

The team reviewed documents associated with the corrective action program for a period covering July 2001 through November 2003 to determine if problems were being identified at the appropriate threshold and entered into the corrective action process. With respect to the Emergency Preparedness Program and the Emergency Diesel Generator Systems, the team reviewed issues identified by the licensee and NRC for the period covering July 1998 through November 2003. The documents reviewed included previous NRC inspection reports, corrective action program forms (CAPs), and corrective action program work order forms (KAPs).

In addition, in order to identify the presence of longstanding unresolved issues the team reviewed a list of all Work Orders and CAPs issued during the last two refueling outages, as well as a licensee list of test failures since 2001 and maintenance rule program documentation. The team also reviewed the licensee's efforts to capture industry operating experience (OE) issues in the corrective action program. Documents reviewed included industry operating event reports, NRC Information Notices, and NRC bulletins.

To assess equipment trending, maintenance rule implementation, and to verify that work orders written to address safety-related equipment problems were appropriately entered into the corrective action program, the team reviewed the past performance of four risk significant systems which had a high-importance-to-safety ranking. The systems selected were the emergency diesel generator, auxiliary feedwater, service water, and component cooling water systems. As part of this assessment, the team interviewed system engineers, reviewed CAPs, work requests and work orders, and completed partial system walkdowns of those systems.

The team also reviewed records of internal audits and self-assessments associated with the Kewaunee corrective action program. Several CAPs written by licensee personnel on audit and assessment findings were reviewed to verify that adequate corrective

actions had been taken or were planned. The team reviewed other selected licensee audits and self-assessments performed since 2001. The team conducted the review to determine whether the audit and self-assessment programs were effectively managed, adequately covered the subject areas, and to determine whether the associated findings were appropriately captured in condition reports.

b. Assessment

There were no findings identified in this area during this inspection. The team concluded that the licensee was generally effective in identifying and appropriately characterizing problems. During the equipment walkdowns, the team identified one minor issue associated with the storage of wrenches near the emergency diesel generator lube oil coolers. The licensee initiated condition report CAP19104,"Diesel Generator Service Water Valve Chain/Wrench Interaction with Adjacent Equipment," to address the issue and took prompt corrective actions to resolve the issue. The team also identified during equipment walkdowns examples of dried boric acid on safety-related components which were not previously identified in the licensee's boric acid leakage and tracking system. This issue is discussed further in Section .3 c. i. of this report. Issues raised by the team during the inspection were entered into the corrective action program in a timely manner, consistent with the licensee's procedures for initiation of condition reports.

The team concluded that plant personnel effectively identified and entered problems into the corrective action program using corrective action program forms. The significance threshold for entering issues into the program was appropriate. The team also determined that the licensee continued to demonstrate improvement in this area as evidenced by the following data:

- In 1999, licensee personnel initiated 1,306 CAPs;
- In 2000, licensee personnel initiated 2,001 CAPs;
- In 2001, licensee personnel initiated 4,230 CAPs (Refueling Outage year);
- In 2002, licensee personnel initiated 3,709 CAPs (non-Refueling Outage year); and
- In 2003, at the time of the inspection, licensee personnel initiated approximately 4,300 CAPS.

The licensee regularly analyzed CAPs for site-wide and department-specific adverse trends using three different methods. Site-wide trending was performed using Corrective Action Program Performance Indicator data and "Hot Buttons", and department trending was performed using the Quarterly Effectiveness Review process. "Hot Buttons" were established for selected issues, and CAPs that were related to a selected issue are assigned to the respective "Hot Button." When the number of CAPs for a selected "Hot Button" exceeds a trigger value, the issue was evaluated for a potential trend. Potential adverse trend evaluations were documented in a Root Cause Evaluation (RCE), Apparent Cause Evaluation (ACE), or Condition Evaluation (CE), as appropriate.

The team independently reviewed a sample of trend CAPs and evaluations generated between January 2001 and November 2003. Weaknesses in the trending program were self-identified and improvements were being implemented by the licensee. Equipment and human performance trend issues were identified in 2001 and 2002, and the team noted the trends were addressed in 2003. The team concluded that the licensee's process was functioning at an adequate level.

The team concluded that the licensee's audits and assessments of the corrective action program were of appropriate depth and scope, and findings and recommendations were appropriately captured. The licensee's audits and self-assessments were consistent with the inspection team's results.

c. Findings

No findings of significance were identified.

.2 Prioritization and Evaluation of Issues

a. Inspection Scope

The team reviewed the licensee's significance classification and evaluation of a selected sample of CAPs. The team's assessment included a review of the following attributes of individual licensee initiated CAPs: significance category assigned to a CAP; the adequacy of operability and reportability determinations, if applicable; the extent of condition evaluations, if applicable; causal investigations, including root cause evaluations, apparent cause evaluations, and condition evaluations; and the appropriateness of the assigned corrective actions. The team also assessed licensee evaluations for previously issued NRC Non-Cited Violations (NCVs).

The team members also attended daily management meetings and plan of the day meetings to observe licensee management discussions of condition reports recently initiated and verify the assignment of CAP significance categories for current issues. In addition, the team attended a licensee corrective action review board to assess the licensee's program for reviewing and assessing root cause evaluations.

The team used the inspection guidance contained in NRC Inspection Procedure 95001 as an aid in assessing the root cause analyses reviewed during the inspections.

b. Assessment

The team determined that, in general, the licensee appropriately classified items entered into the corrective action program into one of four significance levels (A, B, C, or D), with the more safety significant issues being given a higher significance classification. Issues classified at the 'A' or 'B' level were generally designated to receive a root cause or an apparent cause evaluation. Issues classified at the 'C' or 'D' level, were not considered conditions adverse to quality, and consistent with the licensee's program did not receive a root or apparent cause evaluation, but were evaluated using a condition evaluation or closing the issue to trending.

The team identified one area of concern regarding the licensee's significance classification of issues. The team determined that while several NRC-identified issues were classified at the appropriate level, a majority of the NRC identified findings, which were conditions adverse to quality documented in 2001 and 2002 NRC Inspection Reports, were classified as a significance level 'C.' The licensee's current implementing procedure indicated that Conditions Adverse to Quality should be assigned a minimum of significance level 'B.' The team also noted that the licensee's guide for assigning issue significance stated that Green Non-Cited Violations should be classified as level 'C,' which conflicted with the procedure guidance. The licensee revised the guide for assigning issue significance at the end of the inspection.

The team identified a second area of concern related to the evaluation and assignment of corrective actions, which was inconsistent with Fleet Procedure, FP-PA-ARP-01, "Action Request Process." The fleet procedure prescribed a designation of 'CA' for any corrective actions related to conditions adverse to quality, and 'OTH' for a designation of corrective actions taken for all other activities. The team also noted that the Kewaunee site specific implementing procedure did not prescribe these parameters and that the Fleet Procedure, which was accepted at Kewaunee without any notable exceptions, was the site implementing procedure until June 2003. The team concluded that although the licensee utilized these two designations interchangeably, the licensee treated both 'OTH' and 'CA' activities the same in the corrective program and consequently there were no adverse affects. However, the team concluded that by not implementing the fleet procedure the licensee lost the opportunity to clearly delineate the difference between corrective actions taken for conditions adverse to quality and those for other activities.

In general, root cause and apparent cause evaluations performed in 2001 and 2002 lacked thorough, detailed evaluations of the issues. The licensee recognized these weaknesses during this timeframe through self-assessments and implemented corrective actions to address these issues. The team noted that from 2001 until 2003, root cause and apparent cause evaluations improved across most site organizations. The most notable improvements were evident with respect to root cause evaluations performed in 2003. For 2003, the team also noted that the corrective action review board rejected approximately one-third of the root causes reviewed. The team concluded that licensee efforts to improve the quality of evaluations, in particular root cause evaluations, were successful in continued improvement of evaluation quality.

The team determined that, in general, extent of condition reviews conducted in root cause and apparent cause evaluations were not consistent. Specifically, the team noted that the extent of condition reviews tended to focus on internal issues, and did not thoroughly evaluate externally identified issues of the same nature. In addition, the team noted that apparent cause evaluation extent of conditions typically consisted of one or two sentences and did not thoroughly evaluate extent of conditions. The team concluded that extent of condition evaluations was an area for continued licensee improvement.

Finally, the team independently reviewed a sample of operating experience CAPs and evaluations generated between January 2001 and November 2003. During the course

of system and programmatic reviews the team discussed the operating experience program activities with licensee personnel. The team concluded that the external operating experience program was conducted in accordance with the Fleet procedure and was adequately implemented. The team also noted that recent licensee self-assessments had identified areas for continued improvement.

As stated previously, licensee audits and self assessments of the corrective action program have also identified issues concerning the quality of root and apparent cause evaluations, the quality of extent of condition reviews and areas for improvement with respect to the operating experience program.

c. Findings

No findings of significance were identified.

.3 Effectiveness of Corrective Actions

a. Inspection Scope

The team reviewed selected CAPs and associated corrective actions to evaluate the effectiveness of the licensee's corrective actions taken for issues. The team reviewed condition evaluations, apparent cause evaluations, root cause evaluations, and operability determinations to verify that corrective actions, commensurate with the significance of an issue, were identified and implemented in a timely manner, including corrective actions to address long-standing or repetitive issues.

The team also verified the continued implementation of a sample of completed corrective actions. The samples that were selected for review were based, in part, on the safety and risk significance of the issues pertaining to the reactor safety and emergency preparedness strategic areas.

Finally, the team reviewed a sample of corrective action effectiveness reviews completed by the licensee.

b. Assessment

For the large majority of samples reviewed by the team, appropriate corrective actions were taken for items entered into the corrective action program. However, the team identified that in some instances, the corrective action program was not effective in resolving longstanding or repetitive issues. Specifically, issues associated with the implementation of the boric acid leakage tracking program and the Emergency Preparedness program which are discussed further in Sections .3 c. i., .3 c. ii., and .3 c. iii. of this report.

The team also identified some minor examples of ineffective corrective actions taken for issues and examples of condition reports closed without the appropriate corrective actions initiated. The following is an example which demonstrates this weakness:

The team reviewed the following Condition Reports related to Operations Department Instructions written from 2001 through 2003:

- CAP1675, Weaknesses Identified Concerning Night Orders, and Operating Department Instructions;
- CAP2270, Missing Night Order;
- CAP2388, Operations Superintendent Operating Instructions Review;
- CAP7716, Control of Operations Department Instructions Book Information;
- CAP14216, Operations Department Instructions Do Not Address Previous NRC Concerns for Adverse Weather; and.
- CAP18678, Operations Instructions Book Being Used for Information that Other Staff Needs to Know.

These CAPs were written to document weaknesses in the Operations Department Instruction (ODI) binder. The issues documented that guidance related to plant operations and outdated information had been available in this book without sufficient periodic review or administrative controls, or inadequacies associated with the data in the instructions. In reviewing corrective actions taken, the team noted that corrective action OTH1004 was signed as complete with revisions to the Nuclear Administrative Directives to require a closure date for ODIs in the binder. The team identified that this corrective action had never been implemented.

In conducting a review of the current ODIs, the team noted that of the 28 ODIs, which dated back to 1998, approximately 30 percent of the items were “Conduct of Operations” type issues, which had not been included in the licensee’s conduct of operations procedure. In addition, two ODIs were on a fourth revision and were written in the format of a plant procedure. The team also identified numerous other minor inconsistencies in the implementation of the ODI program.

The team concluded that this issue was minor, in that the operability of equipment was not affected; however, the issue was an example of ineffective corrective actions coincident with incomplete corrective actions for a closed condition report. The licensee entered this minor issue into the corrective action system as CAP19150.

The team also reviewed corrective actions associated with NRC findings and Non-Cited Violations. The team concluded that, in general, the licensee’s proposed corrective actions were completed in a timely manner, and the corrective actions taken were adequate.

Finally, the team reviewed a sample of corrective actions associated with licensee self-assessments, nuclear oversight identified issues, and issues associated with operating experience. The team concluded that in general, corrective actions were adequate and completed in a timely manner, commensurate with the safety significance of the issue.

c. Findings

i. Ineffective Corrective Actions Taken to Address the Implementation of the Boric Acid Leakage Inspection and Tracking Program

Introduction

The team identified a Green finding associated with a Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," for the failure to assure that actions were promptly identified and corrected to address deficiencies in the implementation of the boric acid leakage inspection and tracking program for boric acid residue on safety-related components, a condition adverse to quality.

Description

The team reviewed the following condition reports related to the implementation of the licensee's boric acid leakage inspection and tracking program:

- KAP 01697 - This condition report was written in January 2001, when the NRC Region III Regional Administrator identified several boric acid leak indications on safety-related equipment which were not included in the boric acid tracking program;
- CAP2497 - This condition report was written in February 2001 and documented that the process for identifying boric acid leaks needed to be evaluated, as the log book currently used was not kept current or reviewed on a regular basis. The description also stated, "the program has lacked ownership and appears broke.";
- CAP8299; - This condition report was written in August 2001 and documented the NRC identification of several boric acid leaks, and noted that no entries had been made since April 2001;
- ACE1158; - This apparent cause evaluation documented that the issue concerning the boric acid log being up to date was again raised in the 2001 Problem Identification and Resolution Inspection;
- CAP12392; - This industry operating experience condition report documented the failure to implement the Boric Acid Control Program in 2002 at the Point Beach Plant, and was evaluated and closed by the licensee at Kewaunee noting that Kewaunee's program was adequately implemented;
- CAP15417; - This condition report was written in March 2003 and documented that the program development for reactor vessel integrity and boric acid corrosion control was unsatisfactory;
- CAP16760; - This condition report written in June 2003 documented that the maintenance walkdowns of components listed in the boric acid leakage log had not been completed in a timely manner;
- CAP16881; - This condition report was written in June 2003 when the NRC resident inspectors identified in May 2003 that the maintenance reviews of the boric acid leak log had not been performed since April 2003;
- CAP17594; - This condition report was written in August 2003 by Operations staff noting that the maintenance reviews of the boric acid leak log required by

Procedure GNP-08.02.06, “Auxiliary Building Boric Acid, NaOH, and Component Cooling Water Leakage Inspection and Tracking,” had not been performed for the past 2 months; and

- CAP17812; - This condition report was entitled, “Boric Acid Leak Log Outdated and Ineffective,” and documented in August 2003 that the current revision of Procedure GNP-08.02.06 was not in the boric acid leak log book and that the process is ineffective.

The team also reviewed additional condition reports, not listed above, related to the boric acid leak log. The team determined that all the condition reports reviewed concerning the boric acid leak log since January 2001 were assigned either a significance level ‘C’ or ‘D,’ which are not considered conditions adverse to quality and do not require apparent cause evaluations or extent of condition reviews. The team also noted that this apparent ‘trend’ of ineffectiveness with regard to the implementation of the boric acid leak log since January 2001, did not result in the generation of a trend condition report for this issue, or the evaluation of more recent condition reports at a higher significance level.

In order to assess the effectiveness of the previous corrective actions for this issue, the team obtained a December 6, 2003, copy of the boric acid leak log and then performed an auxiliary building walkdown for boric acid on safety-related components. Without entering the Residual Heat Removal Heat Exchanger Rooms or Residual Heat Removal Valve Gallery, the team identified approximately 14 components with various degrees of dried boric acid which were not included on the December 6, 2003, boric acid leak log. The licensee agreed that the dried boric acid found on the components by the team met the Procedure GNP-08.02.06 criteria for being entered into the log. Condition Report CAP19116, “Dried Boric Acid on Components in the Auxiliary Building,” was initiated by the licensee.

The team also discussed the boric acid inspection and tracking program with the licensee’s program engineers and noted that a recent external self-assessment identified the need to revise the boric acid program. This issue was captured in CAP17930, “Issue New Boric Acid Program by December 31,2003.” The licensee stated the implementation of the new program was delayed until the first quarter of 2004, and the team noted that implementation of this new program was similar to the previous program.

Analysis

The team determined that the failure of previous licensee corrective actions to adequately address implementation of the boric acid leak log through the identification and characterization of boric acid leaks on safety-related equipment in the plant was a licensee performance deficiency warranting a significance evaluation. This inspector-identified issue was greater than minor because if left uncorrected, the issue could become a more significant safety concern. In addition, the team concluded that the failure to correct previous issues associated with the implementation of the boric acid leak log on safety-related components affected the mitigating systems attributes of equipment performance reliability and human performance, with respect to the

implementation of the boric acid leak log for safety-related components. Finally, the issue affected the mitigating systems cornerstone objective of ensuring the reliability of systems that respond to initiating events to prevent undesirable consequences.

The team evaluated the finding using Inspection Manual Chapter 0609, "Significance Determination Process," Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," Phase 1 screening, and determined that based on the boric acid identified by the team on the safety-related components, the finding:

- was not a design or qualification deficiency;
- did not represent an actual loss of safety function of a system;
- did not represent an actual loss of a safety function of a single train for greater than Technical Specification outage time;
- did not represent an actual loss of a safety function of one or more Non-Technical Specification trains of equipment designated as risk significant; and
- did not screen as potentially risk significant due to a seismic, flooding, or severe weather initiating event.

Therefore, the finding was determined to be of very low safety significance (Green).

The team also determined that the finding affected the cross-cutting area of Human Performance, because the implementation of the boric acid leak log relied on licensee personnel to identify and characterize boric acid leaks on safety-related components during the course of normal duties, which was not implemented effectively.

Enforcement

10 CFR 50, App. B, Criterion XVI requires, in part that measures shall be established to assure that conditions adverse to quality, such as failures, malfunctions, deficiencies, deviations, and nonconformances are promptly identified and corrected. Contrary to this requirement, the licensee failed to promptly identify and correct issues associated with the implementation of the boric acid leak log to identify and characterize boric acid on safety-related components, as evidenced by the trend of condition reports associated with the implementation of the log and the team's identification of boric acid on safety-related components. Therefore, the team determined this finding was a violation of 10 CFR Part 50, Appendix B, Criterion XVI. Because this violation was of very low safety significance (Green) and was documented in the licensee's corrective action program as CAP19364, "NRC PI&R Finding - Ineffective Corrective Actions - Boric Acid Leak Log," this finding is being treated as an Non-Cited Violation, consistent with Section VI.A of the NRC Enforcement Policy. (NCV 05000305/2003010-01)

ii Ineffective Corrective Actions in the Area of Emergency Preparedness Which Resulted in the Failure to Make a Timely Notification to the County and State for an Actual Declared Unusual Event on February 26, 2003

Introduction

The team identified a Green finding associated with a Non-Cited Violation of 10 CFR Part 50.54(q) and the licensee's Emergency Plan for the failure to notify the state and local governmental agencies within 15 minutes after the declaration of an actual Unusual Event on February 26, 2003. The team concluded the failure was caused by the licensee's failure to implement effective corrective actions for previously identified weaknesses and problems in the area of Emergency Preparedness.

Description

On February 26, 2003, at 00:26 hours, the licensee declared an Unusual Event when both trains of Emergency Diesel Generators were determined to be inoperable. The emergency notification form was not completed by the Emergency Director until 00:31 hours due to complications from the meteorological towers being out of service and the emergency plan implementing procedures. In addition, due to issues associated with the phone systems, the notifications to the state and local government agencies containing information about the class of the emergency were not initiated until 00:46 hours, 20 minutes following the Unusual Event Declaration.

The team reviewed Root Cause Evaluation RCE605, "Plant Response to KNPP Unusual Event," which evaluated four issues that arose during the Emergency Response Organization's event response:

- Pagers for Directors and select Emergency Response Organization staff members were activated, with reports that some pagers did not activate (CAP14955);
- The requirement to initiate state and local notifications of emergency declaration within 15 minutes was not met (CAP14942);
- The phone number used for drill messages indicated there was no Kewaunee test or emergency, only notification of an earlier Point Beach Nuclear Plant Augmentation Drill (CAP14956); and
- an on-call Emergency Director did not report to the site (CAP14961).

The licensee's initial root cause was determined to be:

"...deficiencies in change management and configuration management controls in the Emergency Preparedness Organization. Changes and revisions were made to procedures, processes, and facilities without the adequate consideration of the impact on other plant groups or facilities. Changes were not sufficiently reviewed and communicated to the stakeholders."

With respect to the failure to make the timely notification, the licensee identified that the major contributing causes were the following:

- Temporary procedure change sheets were attached to procedures which created confusion during the implementation of the Emergency Plan Implementing Procedures and contributed to the length of time needed to complete the notification form and to perform the actual event notification; and
- Equipment used to gather meteorological data was out of service for an extended period of time and contributed to the length of time needed to complete the emergency notification form.

As part of this inspection activity, the team reviewed condition reports related to emergency preparedness initiated in 2001 through 2003. The team determined that the condition reports initiated, evaluated, and corrected regarding emergency preparedness issues prior to the February 2003 event, identified the same or similar issues which were the major contributors to all aspects of the licensee's failure to make the timely emergency class notification in February 2003.

Specifically, the team noted the following examples of condition reports which pertained to the first contributing cause regarding the confusion during implementation of the Emergency Plan Implementing Procedures. The root cause evaluation documented that the procedures created confusion by being too prescriptive and restrictive, in addition recent changes to the procedures were not well communicated or understood by the response organization. The team determined the most notable examples included the following:

- Root Cause Evaluation RCE584 (CAP12075), "Emergency Preparedness Personnel Not Responding in a Timely Manner to Identified Drill Deficiencies," was completed in July 2002 in response to an emergency preparedness self-assessment conducted in March 2002 which identified this issue. The evaluation determined that the root cause for this issue was that emergency preparedness staff did not adequately communicate with the emergency response organization.

  The team noted that the corrective actions to prevent recurrence for the first root cause was to develop and implement a method for the timely communication of process and procedure changes to the emergency response organization and this activity was completed in October 2002. In addition, the inspectors noted that this condition report was closed out as complete in January 2003 and no effectiveness review was scheduled or performed;

- Condition Reports CAP11547, "Meteorological Data on Event Notice Form Not the Same as Described in the Drill Scenario," and CAP11589, "Awareness of Temporary Changes," were written following an April 2003 emergency preparedness drill during which the response organization had difficulty in responding in the scenario due to the temporary changes recently made to the emergency plan implementing procedures. The description of the first condition report stated, "it was apparent during the course of the drill that the read and sign issued on this temporary change had not been read by all of the appropriate ERO members....In addition, there was no tagout on the plant process computer indicating the met tower data should not be used."

The team noted that corrective actions were taken and completed by the Fall of 2002 to address the issues identified in this condition report; and

- Condition Report CAP3985, "Status Control or Temporary Procedure Changes not Initiated When Required," was initiated in April 2002 as a result of a Nuclear Oversight Assessment. Operating experience from the Fort Calhoun Plant associated with errors in wind direction calculations for emergency preparedness calculations and activities was deemed to be applicable to Kewaunee due to the meteorological tower and plant process computer calculation problems.

  The team noted that corrective actions for this condition report were taken and completed in 2002.

Next, the team noted that the Condition Report CAP12969, "Invalid Meteorological Data for Event Notifications and Protective Action Recommendations," was written in September 2002, in response to an NRC Inspector identified Green finding documented in NRC Inspection Report 050000305//2002005-04. The issues identified in this condition report pertained to the second contributing cause concerning the meteorological tower being out of service for an extended period.

The team noted that Root Cause Evaluation RCE589 completed on January 8, 2003, for CAP12969 documented that the interim corrective actions taken for this issue were, "effective and completed in a timely manner to address this condition." The interim corrective actions included using 'Danger Cards' to highlight that the meteorological towers were out of service to the plant operators and response organization; issuing procedure temporary changes to two surveillance procedures and two emergency plan implementing procedures; issuance of a night order to plant operators which gave guidance to plant operators when meteorological data was invalid; and repairs to correct the meteorological tower issues. However, the team concluded that the corrective actions taken to address the invalid September 2002 meteorological data were not effective, based on the same issues recurring in February 2003 and which contributed to the untimely event notification.

Finally, the team identified when reviewing Emergency Preparedness condition reports that numerous issues were written to address untimely notifications and ineffective corrective actions in licensee emergency response drills conducted in 2001 and 2002. The team determined that the most notable examples in the corrective action system included the following:

- Root Cause Evaluation RCE01-063 (KAP WO 01-013500), "2001 Graded Emergency Exercise Performance," determined that one of the Emergency Exercise Objectives which had not been met in 2001 included demonstrating the ability of the control room personnel to send the initial emergency notification messages within 15 minutes of event classification with the appropriate protective action recommendations to appropriate governmental organizations. The team noted that the corrective actions to prevent recurrence for this root cause evaluation had been closed out and completed by September 2002. In

addition, the team concluded that the effectiveness review, also conducted in September 2002, was not effective, in that the review was completed prior to having sufficient time to assess the long term corrective actions to prevent recurrence;

- Root Cause Evaluation RCE577 (CAP11650), "Emergency Preparedness Group Implementation of the Corrective Action Program," was initiated and evaluated in response to a May 2002 Kewaunee Nuclear Oversight significant quality assurance finding. One of the examples cited by Nuclear Oversight included a review of Condition Report CAP3492, "February Drill Offsite Notification Timeliness," which was closed and completed without any evaluation of the weaknesses and issues addressed in the condition report description. The Nuclear Oversight finding also documented that: 1) ineffective evaluations performed on emergency preparedness related issues led to significant issues remaining open and recurring; 2) ineffective corrective actions for previously identified issues which allowed significant concerns in emergency preparedness to remain; and 3) corrective actions were not performed in a timely manner.

  The team noted that all the corrective actions, including the corrective actions to prevent recurrence, had been completed and closed by September 2002. In addition, the team concluded that the effectiveness review for this root cause evaluation was ineffective, as the review was completed in July 2002, 2 months prior to the completion of all the corrective actions;

- Condition Report CAP11548, "Missed Performance Opportunity, Late Offsite Notification," was initiated following an April 2002 emergency preparedness drill in which the notifications to the state and local government agencies exceeded the 15-minute requirement. The team noted that all the corrective actions for this condition report had been completed in prior to the February 2003 Unusual Event; and

- Condition Report CAP14130, "December 17, 2002, Drill Offsite Notifications not Accurate," was initiated following the December 2002 emergency preparedness drill, in which event notifications to the state and local government agencies exceeded the 15-minute requirement. Interim corrective actions for this condition report were also taken prior to the February 2003 Unusual Event.

The team concluded that ineffective corrective actions for emergency preparedness issues identified and corrected in the licensee's corrective actions system prior to February 2003, as specifically evidenced by the examples listed above and discussed during the inspection, resulted in the untimely event notification for the Unusual Event which occurred on February 26, 2003.

Analysis

The team concluded that the ineffective corrective actions taken with respect to the Emergency Preparedness Program which resulted in the failure to make a timely notification to the state and local government for an actual event was a licensee performance deficiency warranting a significance evaluation. While the team determined that previously ineffective corrective actions led to this performance deficiency, the team assessed the significance and enforcement aspect of this finding with respect to the actual Unusual Event declared on February 26, 2003.

The team determined that the issue was associated with an actual event implementation problem and affected the emergency preparedness cornerstone, specifically, the response organization performance attribute. In addition, the issue affected the Emergency Preparedness cornerstone objective of implementing adequate measures to protect the health and safety of the public in the event of a radiological emergency. Therefore, the issue was determined to be more than minor.

The significance of the finding was assessed using Manual Chapter 0609, Appendix B, "Emergency Preparedness Significance Determination Process (SDP)," dated March 6, 2003. Using the Emergency Preparedness SDP Sheet 2, "Actual Event Implementation Problem," the team determined that the actual event was an Unusual Event.

Enforcement

10 CFR 50.54(q) requires, in part, that a licensee authorized to possess and operate a nuclear power reactor follow and maintain in effect emergency plans which meet the standards in 10CFR 50.47(b) and the requirements in Appendix E of 10 CFR Part 50. The Kewaunee Nuclear Plant Emergency Plan, Section 4.1.1, "Unusual Event," requires, in part, that for an Unusual Event, Off-Site Authorities be informed of the change in emergency status as specified in the Emergency Plan Implementing Procedures. Emergency Plan Implementing Procedure EPIP-AD-07, "Initial Emergency Notification," Section 3.1, requires, in part that once a classification has been declared, notification must be initiated and in progress to the State and County Agencies within 15 minutes of event classification. Contrary to the above on February 26, 2003, the licensee declared the Unusual Event emergency action level at 00:26 hours, and the licensee notified the State and County Agencies at 00:46 hours, which failed to meet the 15 minute notification required by the licensee's Emergency Plan and 10 CFR 50.54(q).

Therefore, the team determined this finding was a violation of 10 CFR 50.54(q) and the licensee's Emergency Plan. Because this violation was of very low safety significance (Green) and was documented in the licensee's corrective action program as CAP14942, "Unusual Event Untimely Notification," and CAP19364, "NRC PI&R Finding - Ineffective Corrective Actions - Notification of Unusual Event," this finding is being treated as an Non-Cited Violation, consistent with Section VI.A of the NRC Enforcement Policy. (NCV 05000305/2003010-02)

iii. Failure to Take Timely Corrective Actions to Prevent Recurrence of a White Finding Issued in 2000 Associated with Emergency Response Organization Augmentation

Introduction

The team identified a Green finding for the failure to take timely corrective actions to prevent recurrence of a White Finding initially identified in September 2000, associated with Emergency Response Organization Augmentation. While the team determined that corrective actions to date have been effective as evidenced by only one augmentation drill failure since 2001, three of the eight corrective actions had not been completed.

Description

In September 2000, during a baseline NRC inspection, documented in NRC Inspection Report 050000305/2000015, the inspectors identified a preliminary White Finding concerning the licensee's unannounced, off-hours emergency response augmentation drills. On February 28, 2001, the NRC determined the final significance of the finding was of low to moderate safety significance (White). The finding involved the failure to correct self-identified deficiencies disclosed through emergency response staffing drills during the second, third, and fourth quarters of 1999, and the second quarter of 2000. In 16 of 18 drills, the licensee failed to demonstrate that sufficient staff would respond to the site in a timely fashion, as required for emergency response.

In March 2001, the NRC completed a Supplemental Inspection for the White Finding, documented in NRC Inspection Report 050000305/01-07, which reviewed the licensee's root cause and proposed corrective actions. The inspection report documented that the root cause evaluation was systematic and conducted at the appropriate depth, and concluded the long-term corrective actions to prevent recurrence were adequate to address the root causes identified in the evaluation. The inspection report also documented that, while the corrective actions were scheduled to be completed by April 2001, certain actions would be extended due to the resources necessary to accomplish the task.

Root Cause Evaluation RCE-01-002, "Plant Pager Test Failures Root Cause Evaluation," documented that the there were two root cause associated with the White finding:

- Management had not effectively acted to provide increased depth and flexibility in the emergency response organization following a reduction in staffing several years ago; and
- Management had accepted an adverse trend of drill failures without requiring investigation into the root causes.

The team reviewed and assessed the eight individual corrective actions to prevent recurrence as part of this inspection. The team determined that the initiating Condition Report CAP2900, "A 'White' Program Finding in Emergency Preparedness Program," written in August 2000, was shown as completed and closed as of March 19, 2003.

The corrective actions to prevent recurrence were separated into two major headings to address the two root causes:

- Establish an emergency response organization focused on providing shift augmentation for the NUREG-0654, Table B-1 positions. This corrective action prescribed five specific actions; and
- Improve the review of drill and test data for key responders to ensure that test success or failure is accurately determined and verified. This corrective action prescribed three specific actions.

The team noted that three of the five corrective actions to address the first root cause had been adequately completed and closed.

However, the team determined that Corrective Action CA2525, "Provide Key Responders with Pagers or Use Other Notification Methods that Ensure Successful Notification in all Conditions, Including Late Night," was closed out to action OTH9923, "KNPP Emergency Response Pagers Out of Service - Implementation of Dialogics Due in 2003," which was opened on January 8, 2003, as a result of Condition Report CAP13775, "KNPP ERO Pagers Out of Service." The team determined through discussions with the current Emergency Preparedness staff that implementation of the new pager system and the Dialogics system was not currently scheduled for completion until the end of the first quarter in 2004.

The team searched the licensee's corrective action database and identified approximately 30 condition reports that had been written since 2001 documenting continued problems with the site paging system used for emergency response augmentation. In addition, Condition Report CAP14955 was initiated following the failure of some licensee pagers to activate during the February 2003 Unusual Event and was included in Root Cause Evaluation RCE605, discussed in the previous section of this report. The team concluded that, as of this inspection, this corrective action to prevent recurrence for the 2000 White Finding had not been implemented, and emergency response organization members continued to have issues associated with the licensee's pagers for emergency response.

In addition, the team verified completion of Corrective Action CA2532, "Determine if an actual response drill is desired, and if so, when to conduct and at what frequency," which was also associated with the corrective action to prevent recurrence for the first root cause. The team determined this corrective action was closed in December 2001 to the following statement:

> "An actual response drill is desired, but management has decided not to perform one in the year 2001 due to other activities. An actual response drill will be conducted in 2002. A frequency has not been committed to as there is no regulation currently requiring this."

The team determined through discussions with the current Emergency Preparedness staff that an actual response drill had not been conducted in 2002 or 2003, as discussed in this corrective action. Therefore, the team determined that to date, this corrective action to prevent recurrence for the 2000 White Finding had not been implemented.

Also the team noted that, following the White Finding, the licensee developed a 'Call Tree' as a 'backup' method for shift augmentation when a pager system outage occurs or in the case of a large failure. However, in discussions with the current Emergency Preparedness staff, the licensee has not tested the ability of the 'Call Tree' to notify the members of the response organization in a timely manner. The licensee initiated Condition Report CAP19278, "Testing Emergency Response Organization Call Tree," to test this backup method.

The team determined that two of the three corrective actions to prevent recurrence for the second Root Cause identified in RCE 01-002 were completed. However, Corrective Action CA2533 was written to develop lessons learned from any test failures, provide these to responders and incorporate them as appropriate into the retraining program. After reviewing corrective action data and discussing the corrective action with current Emergency Preparedness staff, the team concluded that this corrective action to prevent recurrence for the second Root Cause had not been completed.

The team reviewed the licensee's effectiveness review which was completed in May 2002, prior to the completion of all the corrective actions to prevent recurrence. The effectiveness review documented the need for Kewaunee to proceed with the implementation of the Dialogics callout system in 2002 and the need to continue the effort to obtain a common pager system for the entire emergency response organization.

Finally, the team determined that the most recent Root Cause Evaluation conducted in Emergency Preparedness (RCE605) identified the following two investigation findings relevant to current shift augmentation problems at the site:

- "Pager reliability has been scrutinized and it is recommended that Dialogics be implemented as soon as possible. Implementation was set for July 2003, but purchase order discrepancies will delay implementation."; and
- "Plant and Emergency Preparedness management must take an aggressive approach to correct Emergency Response Organization Augmentation and ensure members are held accountable."

The team determined that the licensee's most recent investigation findings continued to highlight the difficulties the licensee has regarding augmentation processes and hardware issues which were first identified in September 2000 as a result of the NRC White Finding for shift augmentation.

In order to assess the adequacy of the five corrective actions to prevent recurrence which were implemented, the team reviewed the licensee's drill augmentation data for 2001 through 2003. The team noted that while the 2003 augmentation data was readily available, the licensee had difficulty in obtaining the compiled results for 2001 and 2002. Since 2001, the licensee had experienced only one augmentation drill failure, which occurred in November 2002 for one response organization position. However, the team also determined through data provided by the emergency preparedness staff, that approximately 70 percent of the response organization personnel responded to pager augmentation drills conducted in 2001, while approximately 60 percent of the response

organization personnel responded to pager augmentation drills conducted in 2002 and 2003.

The team concluded that the corrective actions taken since September 2000 appear to have been effective, as evidenced by only one augmentation drill failure since 2001. However, the team also concluded that the corrective actions to prevent recurrence have not been timely, most notably with the implementation of a common paging system for the response organization and implementation of the Dialogics callout system.

Analysis

The team determined that the failure to take timely corrective actions to prevent recurrence for a 2001 White Finding associated with Emergency Response Organization Augmentation was a licensee performance deficiency warranting a significance evaluation.

The team determined this issue was greater than minor because if left uncorrected, the issue could become a more significant safety concern. In addition, the issue affected the emergency preparedness cornerstone, specifically, the emergency response organization readiness performance attribute associated with the emergency response organization augmentation system and emergency response augmentation testing. In addition, the issue affected the Emergency Preparedness cornerstone objective of implementing adequate measures to protect the health and safety of the public in the event of a radiological emergency.

The significance of the finding was assessed using Manual Chapter 0609, Appendix B, "Emergency Preparedness Significance Determination Process (SDP)," dated March 6, 2003. Using the Emergency Preparedness SDP, Section 4.2, "10CFR 50.47(b)(2)," the team concluded that the licensee's process for timely augmentation of on-shift staff was a planning standard function. In addition, the team determined that since there was only one instance of an augmentation drill failure since the 2001 White Finding for Emergency Response Augmentation the finding was not of low to moderate safety significance (White) as in 2001. However, using the guidance contained in Section 5.0, "Corrective Actions," specifically, Section 5.2, "Timeliness," the team concluded that since the corrective actions to prevent recurrence for the 2001 White Finding had not been completed within 180 days of identification, and in addition, had not been completed within the next evaluated biennial exercise cycle (the second biennial emergency preparedness exercise since the White Finding was documented in NRC Inspection Report 05000305/2003007, dated October 27, 2003) the team concluded that the licensee's corrective actions to prevent recurrence were not timely. In accordance with Section 5.2.1 of the Emergency Preparedness SDP, since the finding involves untimely corrective actions for a problem which is not related to a risk significant planning standard, the finding is considered to be of very low significance (Green).

This finding was entered into the licensee's corrective action system as CAP19366, "NRC PI&R Finding - Untimely Corrective Actions for Emergency Preparedness Staff Augmentation." (FIN 05000305/2003010-03)

Enforcement

No violation of regulatory requirements occurred.

.4 Assessment of Safety-Conscious Work Environment

a. Inspection Scope

The team interviewed several members of the plant staff, representing several different work groups at various levels, to assess the establishment of a safety conscious work environment. The interviews typically included questions similar to those listed in Appendix 1 to NRC Inspection Procedure 71152, "Suggested Questions for Use in Discussions with Licensee Individuals Concerning PI&R Issues."

During the conduct of interviews, document reviews and observations of activities, the team looked for evidence that suggested plant employees may be reluctant to raise safety concerns. The team also discussed the implementation of the Employee Concerns Program at Kewaunee and discussed the implementation of the program with the program owner.

b. Assessment

The team concluded, based on the activities performed, that there was no evidence to support that management did not foster an environment where workers felt free to raise safety issues.

c. Findings

No findings of significance were identified.

40A5 Other

(Closed) Unresolved Item (URI) 05000305/2003006-03: Licensee Evaluation of Circumstances Surrounding Event Notification 39816, dated May 1, 2003. The URI was opened pending the licensee's evaluation of the circumstances surrounding Event Notification 39816 and the consequences of the Self-Contained Particulate, Iodine, and Noble Gas Monitoring (SPING) Units being out of service long-term. In August 2003, the licensee initiated Condition Report CAP018205 after the resident inspectors inquired about an evaluation and condition report concerning the May 1, 2003, notification. The team reviewed the licensee's evaluation, which determined that the SPING units were not inoperable for an extended period as was initially reported.

The licensee concluded that with the exception of the normal out-of-service time while the SPING units were calibrated, the units were not inoperable or incapable of providing data to support emergency plan emergency classification requirements. Therefore, the licensee's initial notification to the NRC was conservative based on the information available at the time, and the licensee subsequently concluded that the SPING units were capable of monitoring the radioactivity of gases monitored to support emergency

plan classifications. The team verified that the licensee's evaluation addressed the circumstances surrounding the event notification and that the equipment was capable of fulfilling the emergency plan needs. Therefore, the team considered this unresolved item closed.

40A6 Exit Meeting

The team presented the inspection results to Mr. K. Hoops and other members of licensee management in an exit meeting on December 16, 2003. Licensee management acknowledged the findings presented and indicated that no proprietary information was provided to the team.

ATTACHMENT: SUPPLEMENTAL INFORMATION

SUPPLEMENTAL INFORMATION

KEY POINTS OF CONTACT

Licensee

K. Hoops, Site Director
K. Davison, Plant Manager
L. Armstrong, Engineering Director
S. Baker, Manager, Radiation Protection
T. Breene, Site Assessment Manager
L. Gerner, Acting Regulatory Affairs Manager
G. Harrington, Licensing
R. Nicolai, Performance Improvement Manager
B. Presl, NMC Security Consultant
S. Putman, Assistant Plant Manager, Maintenance
R. Repshas, Manager, Site Services
J. Riste, Licensing Supervisor
J. Stafford, Superintendent, Operations

Nuclear Regulatory Commission

J. Lamb, Project Manager

LIST OF ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

05000305/2003010-01	NCV	Green 10 CFR 50, Appendix B, Criterion XVI NCV for Ineffective Corrective Actions Taken to Address the Implementation of the Boric Acid Leakage Inspection and Tracking Program (Section .3 c. i.)
05000305/2003010-02	NCV	Green 10 CFR 50.54(q) and Emergency Plan NCV for Ineffective Corrective Actions in 2002 Which Resulted in the Failure to Make Timely Notifications for an Actual Unusual Event in February 2003 (Section .3 c. ii.)
05000305/2003010-03	FIN	Green Finding for the Failure to Take Timely Corrective Actions to Prevent Recurrence for a 2001 White Finding Associated with Emergency Response Organization Augmentation (Section .3 c. iii.)

Closed

05000305/2003010-01	NCV	Green 10 CFR 50, Appendix B, Criterion XVI NCV for Ineffective Corrective Actions Taken to Address the Implementation of the Boric Acid Leakage Inspection and Tracking Program (Section .3 c. i.)
05000305/2003010-02	NCV	Green 10 CFR 50.54(q) and Emergency Plan NCV for Ineffective Corrective Actions in 2002 Which Resulted in the Failure to Make Timely Notifications for an Actual Unusual Event in February 2003 (Section .3 c. ii.)
05000305/2003010-03	FIN	Green Finding for the Failure to Take Timely Corrective Actions to Prevent Recurrence for a 2001 White Finding Associated with Emergency Response Organization Augmentation (Section .3 c. iii.)
05000305/2003006-03	URI	Licensee Evaluation of Circumstances Surrounding Event Notification 39816, dated May 1, 2003 (Section 4OA5)

LIST OF DOCUMENTS REVIEWED

Procedures

CP 0021; Rev. 2; Employee Concerns Program

FP-EC-ECP-01; Rev. 1; Employee Concerns Program
FP-PA-ARP-01; Rev. 1; Action Request Process
FP-PA-ARP-01; Rev. 2; Action Request Process
FP-PA-ARP-01; Rev. 3; Action Request Process
FP-PA-OE-01; Rev. 0; External Operating Experience

GNP 08.02.06; Rev. C; Auxiliary Building Boric Acid, NaOH, and CCW Leakage Inspection and Tracking
GNP-08.06.01; Rev. A; Boric Acid Corrosion Control Inspection and Evaluation
GNP 11.08.01; Rev. K; Action Request Process
GNP-11.08.02; Rev. C; Action Request Process Trending

NAD-01.40; Rev. C; Self-Assessment Program
NAD-12.06; Rev. B; Operations Instructions
NAD-12.08; Rev. C; Superintendent - Plant Operations Night Orders
NAD-14.01; Rev. C; Operating Experience Assessment Process
NAD-14.01; Rev. D; Operating Experience Process

NEP-14.13; Rev. C; Operating Experience Assessment Procedure
NEP-14.13; Rev. D; Operating Experience Procedure

NMC Focused Self-Assessment Handbook, Rev. 0, 6/14/02

Self-Assessment Program - Event Investigation Guide
Self-Assessment Program; Quarterly Effectiveness Review Guideline; May 23, 2001

Surveillance Procedures SP-42-219A and B; Diesel Generator A (and B) Operability Test; Revision K

CAPs Reviewed

CAP000049; CAP ADMIN
CAP000074; CAPADMIN (CCW pump runout)
CAP000156; CAPADMIN (CCW pumps in parallel)
CAP000168; EP Exercise Performance Issues
CAP000192; CCW Pump 1B Heats Up during Two Pump Operation
CAP000205; During SP-42-312B Synchronizer Dial Was 6.2
CAP001208; CAP ADMIN
CAP001323; Late Evaluation of Shift Augmentation Drills
CAP001536; Evaluate Potential SFP Heat Exchanger Contingencies or if any are Required

CAP001675; Weaknesses Identified Concerning Night Orders, Operating Depart Instructions
CAP001680; EP Exercise Performance Issues
CAP001829; 7/23/01; SW-903C Fail to Fully Close
CAP002059; During the “E” Series of O-LRQ-C14Y1, there were 2 Crew Failures and 2 Individual Failures
CAP002270; CAP ADMIN
CAP002388; Sup - PO Operating Instructions Review
CAP002477; Heat Detectors in “A” AFW Pump Room
CAP002497; Boric Acid Leaks in the RCA
CAP002740; JOSRC Concern on KAP Process
CAP002900; A “White” Program Finding In Emergency Preparedness Program
CAP002918; CAPADMIN (flow in excess of design flow)
CAP003009; 2/1/02; SW-903D Fail to Indicate Close
CAP003069; OEA 2002-023 (OE 13020)
CAP003504; Timeliness and Accuracy of PARs
CAP003975; Pre-Job Briefing Areas for Improvement
CAP003977; Wrong Pushbutton Actuated During SP 55-155A
CAP004007; EP Self-Assessment Recommendations
CAP005705; DG 1B Governor Synchronizer Setting Problem Identified
CAP007716; Control of Operation’s Instructions Book Information
CAP007971; Shift Augmentation Test Response Problem During August Test
CAP008299; Administrative Concern about Log Keeping Related to Minor Leaks in the Plant
CAP009032; March Pager Test Performance Decline
CAP009096; 50.54(q) Process Not Followed
CAP009150; Miscommunication Results in Missed Data During SP55-155B
CAP009162; US-NRC Inspection - CASP Instrument Testing
CAP009187; Westinghouse Emergency Contact
CAP009190; QA Record Incomplete
CAP009724; D/G “B” Synchronizer Dial
CAP009811; CAP ADMIN
CAP009829; IRP’s Potentially Calibrated with Tech Inadequate Procedure
CAP009949; Diesel Generator “B” Synchronizer Dial Setting at 7.4 When D/G B Shutdown
CAP010477; Failure to Meet Shift Augmentation Goals for 8/2000 Pager Test
CAP011577; AFW2B not Responding Properly
CAP011650; Significant QA Finding - EP Implementation of the Corrective Action Program
CAP011881; Auxiliary Feedwater System (Terry) Turbine Driven Pump & Trip Throttle Valve
CAP011894; Turbine Driven Auxiliary Feedwater Pump Spurious Overspeed Trips
CAP011904; Inadequate Evaluation of as Found and as Left Condition
CAP011926; SW Pump 1A1 Operability Question
CAP011933; June 2002 Shift Augmentation Drill
CAP011937; Significant QA Finding - Measuring and Test Equipment
CAP011938; SW Pump 1A1 Technical Specification LCO

CAP012075; EP Personnel Not Responding in a Timely Manner to Identified Deficiencies
CAP012269; Auxiliary Feedwater System (Terry) Turbine Driven Pump & Trip Throttle Valve
CAP012271; OEA 2002-179 (OE 13727)
CAP012392; PB Level A Issue - Failure to Fully Implement the Boric Acid Control Program
CAP012454; 8/1/02; SW-903D Fail to Close
CAP012457; 8/1/02; SW-903C-1 Fail to Full Open
CAP012564; Wrong Button Depressed During SP 55-155A
CAP012597; Contamination Control Practice Does Not Meet Expectations
CAP012675; Unsealed Penetrations Found in Appendix R Wall
CAP012730; M&TE Range or Type and Due Date Not Required by PMP 36-04
CAP012769; Inoperable Appendix R Fire Barrier Identified by NRC Resident
CAP012969; Delinquent Initiation of an Action Request (AR)
CAP013048; OEA 2002-248 (OE 13481)
CAP013169; Incoming Radioactive Shipment Exceeds External Contamination Limits
CAP013318; 10/16/02; SW-914B Open too Quick
CAP013374; Invalid TD AFW Pump Start
CAP013380; Suspected Water Hammer Following TDAFW Pump Start
CAP013414; Missed OD Following Water Hammer in AFW System
CAP013418; 10/23/02; SW-914D Open too Quick
CAP013427; NRC Questioned Why IST Vibration Data on CCW Pumps does not Include Axial Readings
CAP013531; Lack of Calculation Indexing
CAP013532; Review Recent Calculation Errors and Discrepancies for Common Issues
CAP013550; AMS-3 Air Monitor Readouts to Eberline RMS / Radserv / Plant Computer Incorrect
CAP013562; Old ALARA Concerns Apparently Not Acted Upon
CAP013576; Hot Button “Human Performance” Exceeds Trigger Number
CAP013611; Significant QA Finding - Implementation of Corrective Action Program
CAP013657; Wrong Button Depressed During SP 55-155A
CAP013685; ERO Augmentation
CAP013752; Steps Performed Out of Sequence During SP-55-155B
CAP013769; “Human Performance” Hot Button Has Exceeded the Trigger Value
CAP013976; NRC Regulatory Issue Summary 2002-21
CAP014069; Improper Operation of Pushbutton During SP-55-155A
CAP014082; Track Completion of Human Performance Improvement Plan Items
CAP014216; Operations Instructions Do Not Address Previous NRC Concerns for Adverse Weather
CAP014241; Hot Button Has Exceeded the Trigger Value for Third Straight Month
CAP014242; Hot Button Has Exceeded the Trigger Value for Third Straight Month
CAP014265; NRC Resident Inspector Noted Foreign Material on Safeguards Battery B
CAP014321; Unclear Logging Requirements in A-CP-46
CAP014328; Apparent Violation of Technical Specifications
CAP014522; Fleet Procedure Allows Closure of WO before Completion of Work
CAP014597; Evidence of an Active Boric Acid Leak from Safety Injection Pump “A” Inboard Bearing

CAP014893; KNPP Six Year Drill Objective Matrix
CAP014904; “B” D/G Synchro Dial Was Set to an Acceptable Value IAW SP-42-291B and PCR 2810
CAP014931; Diesel Generator “B” Synchronizer Dial Outside 5.2-6.0 Band, at 7
CAP014941; January Augmentation Drill
CAP014955; Unusual Event Staff Augmentation 2/26/03
CAP015040; 3/3/03; SW-901C-1 Open too slow
CAP015192; Hot Button “Trend” Exceeds Trigger Value
CAP015365; GNP-8.2.6 Does not List Records Generated in the Records Section of the Procedure
CAP015373; AFW-2A/B Limit Switch Wiring Not Wired Per Logic W/D
CAP015374; Missed Timing Verification During SP 55-155B
CAP015417; Program Development for Vessel Integrity and BA Corrosion Control is Unsatisfactory
CAP015530; RHR System Leak near RHR-500B
CAP015546; Diesel Generator “B” Synchronizer Dial
CAP015578; Lack of Timely EP Group Notification to the Control Room about Siren Status
CAP015746; NRC Review of Calculation C11470 Identified Some Discrepancies
CAP015780; High Rad Area Boundary Controls Missing
CAP015808; 4/16/03; CC-652 Setpoint
CAP016046; R-16 and R-20 Setpoints
CAP016062; Receipt Contamination Survey on Inside of Laundry Trailer
CAP016090; 4/26/03; CC-611A Setpoint
CAP016092; 4/26/03; CC-611B Setpoint
CAP016163; “A” DG Did Not Start on Primary Air Start Motors
CAP016215; Untimely Corrective Actions Associated with M&TE Tracking
CAP016311; 5/6/03; SW-903C Fail to Full Close
CAP016533; Welding Electrode Segregation
CAP016576; NRC DEP PI
CAP016595; AFW-2A & AFW-2B Limit Switch Issue
CAP016721; SOER Recommendation 3 - Diesel Generator “B” Synchronizer Dial Mispositioned
CAP016760; Boric Acid Leaks in the Aux Building
CAP016767; Radiological Boundary Violation at Old CCWHX Outside Storage Location
CAP016881; Maintenance Review of Boric Acid Leak Tracking Program Deficiencies
CAP016902; Repetitive Boric Acid Leaks in the Auxiliary Building
CAP016932; Human Performance Issues Identified During the Outage
CAP016963; Boric Acid Corrosion Improvements Needed
CAP017084; Drill June 18, 2003 SCR-1 Untimely
CAP017594; GNP-08.02.06 Is Not Being Fully Implemented
CAP017659; High Range Rad Monitors R-40 and R-41 Affecting Dose Assessment and Dose Projection
CAP017794; Use of Trending to Improve Station Performance
CAP017812; Boric Acid Leak Log Outdated and Ineffective
CAP017855; Screening Process Effectiveness
CAP017856; Use of Barrier Analysis as a Tool for Evaluations is Low
CAP017858; Use of CE’s for Resolution in t-Track

CAP017859; Level of Support and Time for RCE
CAP017861; Corrective Action Items Having Inappropriate Priorities
CAP017862; Understanding of CAP Trending/t-Track Capabilities is Low
CAP017865; Lack of Equipment Trending
CAP017866; Operability Determination Documentation
CAP017867; Work Control - CAP Interface (CAP)
CAP017868; Process Issue/Timeliness of Doing CAs
CAP017870; Trend Codes Applied to 1466 CAP's Missing Significant Information
CAP017915; CAPs Associated with Technical Specifications Section 3.10
CAP017930; Issue New Boric Acid Program by 12/31/03
CAP017976; Request Common Cause Analysis of Mispositioning Errors in 2002 and 2003
CAP018196; Work Order Instructions Out of Date - Procedure Revised
CAP018261; Recurring Leak on FW SW Filter/Strainer
CAP018278; OEA 2003-253 (OE 15897)
CAP018321; EP Training Effectiveness Self-Assessment Not Distributed
CAP018400; Electronic Dosimeter Issued Past Due Date
CAP018428; NRC Observed Issues During Inverter Maintenance
CAP018549; Personnel Pager Response During Pager Test Augmentation Drills is Poor
CAP018678; Operations Instruction Book Being Used for Information that Staff Needs to Know
CAP018773; Hot Button "Human Performance" Exceeds Trigger Value of 15
CAP019106; Shortfalls in KPB Human Perf. Improvement Plan and Implementation
CAP019116; Dried Boric Acid on Components in Aux Building
CAP019139; Maintenance Group to Provide an Evaluation of Human Performance Data
CAP019138; Engineering Design Group to Provide an Evaluation of Human Performance Data
CAP019157; Outstanding Night Order Probably Should Be Closed

Root Cause Evaluations

RCE000002; Root Cause Evaluation, CCW pump heatup
RCE000013; Service Water Flow Analysis
RCE000019; EP Exercise Performance Issues
RCE000053; EP Inspection a "White" Level Finding was Identified in the Area of Shift Augmentation
RCE000057; Appendix R Requirements not met in Fire Zone TU-95B
RCE000576; CCW Hx A Tube Leaks (5/4/02)
RCE000577; Significant QA Finding - EP Implementation of the Corrective Action Program
RCE000584; EP Staff Does not Adequately Follow Up on Drill Identified Deficiencies
RCE000589; Invalid Meteorological Data for Event Notifications and Protective Action Recommendations
RCE000590;Vendor Equipment Technical Information Program Incomplete/Ineffective Corrective Actions
RCE000592; Invalid TD AFW Pump Start
RCE000601; Logging of Axial Flux Difference Not Performed as Required by Technical Specifications

RCE000605; Plant Response to KNPP Unusual Event
RCE000954; Common Cause Evaluation for Calculation Issues Identified During Preparation for CCW SSDI Inspection
RCE010002; Plant Pager Test Failures
RCE010063; 2001 Graded Emergency Exercise Performance
RCE010081; AFW Valves Inappropriately Throttled

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Apparent Cause Evaluations

ACE000249; Late Evaluation of Shift Augmentation Drills
ACE000345; Weaknesses Identified Concerning Night Orders, Operating Depart Instructions
ACE000611; Heat Detectors in "A" AFW Pump Room
ACE000765; Wrong Pushbutton Actuated During SP 55-155A
ACE001087; Shift Augmentation Test Response Problem During August Test
ACE001158; Administrative Concern about Log Keeping Related to Minor Leaks in the Plant
ACE001325; On March 24 a Pager Drill Was Conducted
ACE001350; Improve Shift Augmentation Response by the ERO
ACE001366; Miscommunication Results in Missed Data During SP55-155B
ACE001589; Diesel Generator B Synchronizer Dial Setting at 7.4 When D/G B Shutdown
ACE001878; Wrong Button Depressed During SP 55-155A
ACE001887; Unsealed Penetrations Found in Appendix R Wall
ACE001893; Inoperable Appendix R Fire Barrier Identified by NRC Resident
ACE002005; Suspected Water Hammer Following TDAFW Pump Start
ACE002011; Missed OD Following Water Hammer in AFW System
ACE002048; Hot Button "Human Performance" Exceeds Trigger Number
ACE002056; Invalid TD AFW Pump Start
ACE002061; Wrong Button Depressed During SP 55-155A
ACE002081; Steps Performed Out of Sequence During SP-55-155B
ACE002095; Hot Button has exceeded the trigger value for the third straight month
ACE002103; Improper Operation of Pushbutton During SP-55-155A
ACE002169; KNPP Six Year Drill Objectives Matrix
ACE002336; Human Performance Issues Identified During the Outage
ACE002408; MD(R)-109 Discovered Closed by NAO
ACE002410; Request Common Cause Analysis of Mispositioning Errors in 2002 and 2003
ACE002468; Personnel Pager Response During Pager Test Augmentation Drills is Poor

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Condition Evaluations

CE000183; During SP-42-312B Synchronizer Dial Was 6.2
CE000983; CAP ADMIN

CE001847; Boric Acid Leaks in the RCA
CE002329; OEA 2002-023 (OE 13020)
CE002730; Timeliness and Accuracy of PARs
CE003113; EP Self-Assessment Recommendations
CE006771; Control of Operation's Instructions Book Information
CE007882; US-NRC Inspection - CASP Instrument Testing
CE008271; Problems were within Planning Standard 10 CFR 50.47(b)(6), "Emergency Communication"
CE008283; IRP's Potentially Calibrated with Tech Inadequate Procedure
CE008363; Diesel Generator B Synchronizer Dial Setting at 7.4 When D/G B Shutdown
CE0010022; Auxiliary Feedwater System (Terry) Turbine Driven Pump & Trip Throttle Valve
CE010033; Turbine Driven Auxiliary Feedwater Pump Spurious Overspeed Trips
CE010069; June 2002 Shift Augmentation Drill
CE010313; Auxiliary Feedwater System (Terry) Turbine Driven Pump & Trip Throttle Valve
CE010320; OEA 2002-179 (OE 13727)
CE010385; PB Level A Issue - Failure to Fully Implement the Boric Acid Program
CE010823; OEA 2002-248 (OE 13481)
CE011381; Track Completion of Human Performance Improvement Plan Items
CE011469; Operations Instructions Do Not Address Previous NRC Concerns for Adverse Weather
CE011490; Hot Button Has Exceeded the Trigger Value for Third Straight Month
CE011491; Hot Button Has Exceeded the Trigger Value for Third Straight Month
CE011924; January Augmentation Drill
CE012075; Hot Button "Trend" Exceeds Trigger Value
CE012171; AFW-2A/B Limit Switch Wiring Not Wired Per Logic W/D
CE012172; Missed Timing Verification During SP 55-155B
CE012197; Program Development for Vessel Integrity and BA Corrosion Control is Unsatisfactory
CE012281; Diesel Gen "B" Synchronizer Dial
CE012686; A DG Did Not Start on Primary Air Start Motors
CE012980; NRC DEP PI
CE012990; AFW-2A & AFW-2B Limit Switch Issue
CE013049; SOER Recommendation 3 - Diesel Gen B Synchronizer Dial Mispositioned
CE013080; Boric Acid Leaks in the Aux Building
CE013128; Maintenance Review of Boric Acid Leak Tracking Program Deficiencies
CE013140; Repetitive Boric Acid Leaks In the Auxiliary Building
CE013581; Trend Codes Applied to 1466 CAP's Missing Significant Information
CE013728; OEA 2003-253 (OE 15897)
CE013871; Hot Button "Human Performance" Exceeds Trigger Value of 15

Corrective Actions

CA002525; Obtain an ERO Notification System
CA002532; Determine if an Actual Response Drill is Desired
CA002533; Develop Lessons Learned from any Test Failures
CA006604; Develop 50.54q Procedure

CA006605; Revise KNPP EP so that It may be Performed by Either the TSC or the EOF
CA008500; EP Staff Does not Adequately Follow Up on Drill Identified Deficiencies
CA008501; EP Staff Does not Adequately Follow Up on Drill Identified Deficiencies
CA013333; Corrective Action Program - Feedback to Initiators
CA013376; CAPs Associated with Technical Specifications Section 3.10

Miscellaneous

EFR008185; Significant QA Finding - EP Implementation of the Corrective Action Program
EFR010682; Perform an Effectiveness Review
Event Notification 39816, 5/1/03; Loss of Radiation Level Indications in the Auxiliary Building and Containment Vent Stacks

ICC-03-LP002; 2003 Pre-Refueling Training

KAP01-19960; Use of Operating Experience in Pre-Job Briefs Needs Improvement

M-MD-LP 2.1.9; Tube and Fitting
MRE 001649; Unsealed

NMC 2002 Employee Concerns Program; Self-Assessment Report of Palisades, DAEC, Monticello, Prairie Island, and Kewaunee/Point Beach Nuclear Generating Plants
NMC Help Guide, Rev. 0; Action Request Process

OBD000047; Aux Bldg Mezzanine FCU B has a Maximum Allowable SW Inlet Temp of 79° F
OTH001004; Perform a Thorough Review of Operations Instructions and Night Orders, Removing or Updating Any Out of Date Material
OTH001008; Incorporate “Facility Command” Demonstration Requirements in Qualification for ED/ERO
OTH001009; Establish Regularly Scheduled Periodic Drills in the Emergency Response Facility
OTH001010; Revise the Emergency Preparedness Training Program to Require Satisfactory Drill
OTH001011; Conduct a Focused Self-Assessment of the Kewaunee EP Training
OTH002527; Conduct an Effectiveness Review on the KNPP ERO Shift Augmentation (RCE 01-002) OTH010384; Review I&C Surveillance Procedures - TS 3.10.b.13 RCE000601
OTH008020; Significant QA Finding - EP Implementation of the Corrective Action Program
OTH008113; Significant QA Finding - EP Implementation of the Corrective Action Program
OTH008821; Procedure Review/Revision Recommendation
OTH009137; Significant QA Finding - EP Implementation of the Corrective Action Program
OTH009138; Significant QA Finding - EP Implementation of the Corrective Action Program

OTH009885; Track Completion of Human Performance Improvement Plan Items
OTH009886; Track Completion of Human Performance Improvement Plan Items
OTH009923; KNPP ERO Pagers Out of Service - Implementation of Dialogics, Due in 2003
OTH010295; Address Remaining Concerns in ODI on Cold Weather Operation
OTH010353; Review Operations Dept Procedures for Impact-Tech Spec 3.10.b.13
OTH010878; KNPP Six Year Drill Objectives Matrix
OTH011495; Program Development for Vessel Integrity Program
OTH011496; Program Development for Boric Acid Corrosion Control
OTH012270; Boric Acid Corrosion Improvements Needed

PCR000739; Revise EPMP 02.06
PCR002524; Improve the Review of Drill and Test Data for Key Responders to that Test Success or Failure is Accurately Determined and Verified
PCR006860; Develop and Incorporate into EPIPs a Method for Manual Backup to the ERO Radio Paging System
PCR009904; Admin Controls for Invalid Data
PCR010611; Procedure Revisions to Reflect Axial Flux Logging Requirements
PCR010940; January Augmentation Drill
PCR010967; GNP-8.2.6 Does not List Records Generated in the Records Section of the Procedure

RFT010356; Review Training Material for Impact-Tech Spec 3.10.b.13
RFT010683; Change Simulator Grading Criteria

SA000378; KNPP Corrective Action Program (CAP) Self-Assessment, KSA-AE-03-01
SA000573; KNPP Emergency Preparedness NRC Readiness Self-Assessment
SA000599; KNPP EP CAP Implementation, KSA-EP-03-02

WO010269; Evidence of an Active Boric Acid Leak from Safety Injection Pump “A” Inboard Bearing
WO012034; Boric Acid Leaks in the Aux Building

NRC Identified Issues During the Inspection

CAP019104; DG SW Valve Chain/Wrench Interaction with Adjacent Equip
CAP019107; FME Tailpipes on Relief Valves
CAP019113; SW-1340B not Fully Closed
CAP019116; Dried Boric Acid on Components in Aux Building
CAP019126; 25 percent Grace Applied to Activities Beyond TS Section 4.0 Surveillance
CAP019143; Leakage at SFP HX Inlet Flange
CAP019150; Questions Raised by the Senior Resident Inspector Concerning ODI/Night Orders
CAP019178; Cover Sheet for NMC Fleet Procedure
CAP019278; Testing ERO Call Tree
CAP019283; NRC PI&R Inspection Identifies Difference in Fleet Procedure and Plant Procedure
CAP019364; NRC PI&R Finding - Ineffective Corrective Actions - Boric Acid Leak Log

CAP019365; NRC PI&R Finding - Ineffective Corrective Actions - Notification of UE
CAP019366; NRC PI&R Finding - Untimely Corrective Actions - EP Staff Augmentation

NRC Documents

Generic Letter 88-05; Boric Acid Corrosion of Carbon Steel Reactor Pressure Boundary Components in PWR Plants and Kewaunee Response to Generic Letter 88-05

Information Notices

NRC IN 2003-22; Degraded Bearing Surfaces in GM/EMD Emergency Diesel Generators

NRC Inspection Reports (IR)

Kewaunee Nuclear Plant IR 05000305/99011
Kewaunee Nuclear Plant IR 05000305/2000015
Kewaunee Nuclear Plant IR 05000305/2001002
Kewaunee Nuclear Plant IR 05000305/2001004
Kewaunee Nuclear Plant IR 05000305/2001005
Kewaunee Nuclear Plant IR 05000305/2001006
Kewaunee Nuclear Plant IR 05000305/2001007
Kewaunee Nuclear Plant IR 05000305/2001009
Kewaunee Nuclear Plant IR 05000305/2001011
Kewaunee Nuclear Plant IR 05000305/2001012
Kewaunee Nuclear Plant IR 05000305/2001013
Kewaunee Nuclear Plant IR 05000305/2001014
Kewaunee Nuclear Plant IR 05000305/2001017
Kewaunee Nuclear Plant IR 05000305/2002003
Kewaunee Nuclear Plant IR 05000305/2002005
Kewaunee Nuclear Plant IR 05000305/2002006
Kewaunee Nuclear Plant IR 05000305/2002007
Kewaunee Nuclear Plant IR 05000305/2003002
Kewaunee Nuclear Plant IR 05000305/2003004
Kewaunee Nuclear Plant IR 05000305/2003006

LIST OF ACRONYMS USED

ACE	Apparent Cause Evaluation
CAP	Corrective Action Program
CE	Condition Evaluation
DRP	Division of Reactor Projects
IMC	Inspection Manual Chapter
IR	Inspection Report
KAP	Corrective Action Work Order Forms
NCV	Non-Cited Violation
NRC	Nuclear Regulatory Commission
ODI	Operations Department Instruction
OE	Operating Experience
PARS	publicly available records
RCE	Root Cause Evaluation
SDP	Significance Determination Process
SPING	Self-Contained Particulate, Iodine, and Noble Gas Monitor
URI	Unresolved Item