April 20, 2001

EA-01-089

Mr. J. Sorensen
Site Vice-President
Prairie Island Nuclear Generating Plant
Nuclear Management Company, LLC
1717 Wakonade Drive East
Welch, MN 55089

SUBJECT: PRAIRIE ISLAND NUCLEAR GENERATING PLANT
NRC INSPECTION REPORT 50-282/01-06(DRP); 50-306/01-06(DRP)

Dear Mr. Sorensen:

On March 31, 2001, the NRC completed an inspection at your Prairie Island Nuclear Generating Plant. The enclosed report documents the inspection findings which were discussed on April 6, 2001, with Mr. M. Werner and other members of your staff.

This inspection examined activities conducted under your license as they relate to safety and compliance with the Commission's rules and regulations and with the conditions of your license. The inspectors reviewed selected procedures and records, observed activities, and interviewed personnel.

We have determined during this inspection that performance indicator data with significant errors were submitted to the NRC. As you are aware, Prairie Island was a pilot plant for the revised oversight process and we identified significant problems with your submittal of performance indicator data early in the pilot process. As a result of this finding you took corrective action for the underlying root causes of the inaccurate submittals. We are concerned that these corrective actions were not fully effective. However, discretion is being exercised pursuant to Section VII.B.6 of the NRC Enforcement Policy to not cite the violation because the errors were not willful and the inaccurate information was submitted during the period that the Enforcement Policy afforded discretion for the non-willful submittal of inaccurate performance indicator information.

If you deny the violation, you should provide a response with the basis for your denial, within 30 days of the date of this inspection report, to the Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington DC 20555-0001; with copies to the Regional Administrator, Region III; the Director, Office of Enforcement, United States Nuclear Regulatory Commission, Washington DC 20555-0001; and the NRC Resident Inspector at the Prairie Island facility.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records (PARS) component of NRC's document system (ADAMS). ADAMS is accessible from the NRC Web site at http://www.nrc.gov/NRC/ADAMS/index.html (the Public Electronic Reading Room).

Sincerely,

/RA/

Roger D. Lanksbury, Chief
Projects Branch 5
Division of Reactor Projects

Docket Nos. 50-282; 50-306
License Nos. DPR-42; DPR-60

Enclosure: Inspection Report 50-282/01-06(DRP); 50-306/01-06(DRP)

cc w/encl: Plant Manager, Prairie Island
M. Wadley, Chief Nuclear Officer
Site Licensing Manager
Nuclear Asset Manager
J. Malcolm, Commissioner, Minnesota
Department of Health
State Liaison Officer, State of Wisconsin
Tribal Council, Prairie Island Indian Community
J. Silberg, Esquire
Shawn, Pittman, Potts, and Trowbridge
A. Neblett, Assistant Attorney General
Office of the Attorney General
S. Bloom, Administrator
Goodhue County Courthouse
Commissioner, Minnesota Department
of Commerce

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U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Docket Nos:	50-282, 50-306
License Nos:	DPR-42, DPR-60
Report No:	50-282/01-06(DRP); 50-306/01-06(DRP)
Licensee:	Nuclear Management Company, LLC
Facility:	Prairie Island Nuclear Generating Plant
Location:	1717 Wakonade Drive East Welch, MN 55089
Dates:	February 23 through March 31, 2001
Inspectors:	S. Ray, Senior Resident Inspector S. Thomas, Resident Inspector D. Kimble, Resident Inspector, Monticello
Approved by:	Roger D. Lanksbury, Chief Projects Branch 5 Division of Reactor Projects

SUMMARY OF FINDINGS

IR 05000282-01-06(DRP); 05000306-01-06(DRP), on 2/23 - 3/31/2001; Nuclear Management Company, Prairie Island Nuclear Generating Plant, Units 1 & 2. Performance indicator verification.

The inspection was conducted by resident inspectors. The inspection identified one No Color finding which was also a violation of NRC requirements for which enforcement discretion was exercised not to issue a Notice of Violation. The significance of most findings is indicated by their color (Green, White, Yellow, Red) using IMC 0609, "Significance Determination Process" (SDP). The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described at its Reactor Oversight Process website at http://www.nrc.gov/NRR/OVERSIGHT/index.html. Findings for which the SDP does not apply are indicated by "No Color" or by the severity level of the applicable violation.

A. Inspector-Identified Findings

Performance Indicator Verification

- No Color. The inspectors identified a violation in that the licensee had failed to report 51.9 hours of Unit 2 residual heat removal system unavailability performance indicator data during the 2nd quarter of 2000.

  The finding had the potential for impacting the NRC's ability to perform its regulatory function because the additional unavailable hours caused the Unit 2 residual heat removal system unavailability performance indicator to change from Green to White in the 4th quarter of 2000. Discretion pursuant to Section VII.B.6 of the Enforcement Policy was exercised not to cite the violation (Section 4OA1).

B. Licensee-Identified Findings

No findings of significance were identified.

Report Details

Summary of Plant Status:

Unit 1 was in a refueling outage until it was started up on February 24, 2001. Unit 1 was placed on the grid on February 25 and reached full power on February 28. Unit 1 remained at or near full power for the remainder of the inspection period. Unit 2 was operated at or near full power for the entire inspection period except that power was briefly reduced to about 45 percent of full power on March 28-29, for turbine valve testing.

1. REACTOR SAFETY

Cornerstones: Initiating Events, Mitigating Systems, and Barrier Integrity

1R04 Equipment Alignment

a. Inspection Scope

The inspectors performed a partial walkdown of the 122 safeguards chilled water train to verify that critical portions of the redundant train were in the correct lineup during the time when the 121 safeguards chilled water train was out-of-service. This system was selected because it provides cooling to emergency core cooling equipment.

As part of this inspection, the inspectors reviewed System Prestart Checklist C37.11-1, "Chilled Water Safeguards System," Revision 11.

b. Findings

No findings of significance were identified.

1R05 Fire Protection

a. Inspection Scope

The inspectors conducted fire protection walkdowns which were focused on availability, accessibility, and condition of fire fighting equipment and on the condition and operating status of installed fire barriers. The inspectors selected the following fire areas for inspection based on their overall contribution to internal fire risk, as documented in the Individual Plant Examination of External Events (IPEEE):

- Fire Area 25, D1 Room;
- Fire Area 113, 21 D5 Fuel Oil Day Tank Room;
- Fire Area 115, 21 D5 Lube Oil Makeup Tank Room; and
- Fire Area 119, 21 High Temperature/Low Temperature Coolant Makeup Tank Pump Room.

As part of these inspections, the inspectors reviewed the following documents:

- IPEEE, NSPLMI-96001, Appendix B, “Internal Fires Analysis,” Revision 1; and
- Plant Safety Procedure F5 Appendix F, “Fire Hazard Analysis,” Revision 12.

b. Findings

No findings of significance were identified.

1R06 Flood Protection

a. Inspection Scope

The inspectors reviewed the Updated Safety Analysis Report (USAR) and related flood analysis documents to identify those safety-related areas that can be affected by external seasonal flooding. This inspection included a review of licensee documentation of flood levels for areas containing safety-related equipment and a review of problem reports and corrective actions for past flooding events. Some specific areas which warranted special attention included:

- sealing of electrical conduits located below the floodline;
- holes or unsealed penetrations in floors and walls between flood areas;
- adequacy of watertight doors between flood areas;
- operable sump pumps and level alarm circuits; and
- underground bunkers/manholes subject to flooding.

The inspectors specifically reviewed the load carrying capability of the roof of the D5/D6 fuel oil storage vaults because they were located outside of the flood protection boundaries and were important for maintaining safe conditions during a long term design basis flood situation.

For areas where operator actions were credited to mitigate the affects of external flooding, the inspectors reviewed the procedures utilized for coping with flooding to verify that they could be reasonably used to achieve the desired result, including whether the flooding event could limit or preclude the required operator action.

The inspectors reviewed the following documents during this inspection:

- Surveillance Procedure 1293, “Flood Preparation Flood Control Panel Inspection/Installation,” Revision 7 (completed on 5/22/00);
- Abnormal Procedure AB-4, “Flood,” Revision 17;
- National Weather Service Flood Prediction for Red Wing, Minnesota (dated 3/9/01);
- Site Engineering Manual, Section 2.1.12, “Civil Hydraulics and Flood Protection,” Revision 1;
- USAR, Section 2.4.3.5, “Floods,” Revision 21;
- USAR, Appendix F, “Probable Maximum Flood Study, Mississippi River at Prairie Island, Minnesota,” Revision 4;

- Calculation Number S-379-SG-002, “Evaluation of D5/D6 Fuel Oil Storage Vault Roof Slab for Design Flood Loading Capabilities,” Revision 1, Addendum 1;
- Design Basis Document DBD-TOP-05, “Hazards,” Revision 2; and
- IPEEE, NSPLMI-96001, Appendix C, “Other External Events,” Revision 0.

b. Findings

No findings of significance were identified.

1R11 Licensed Operator Requalification

a. Inspection Scope

The inspectors observed an operating crew on the simulator during requalification testing activities. The inspectors observed crew performance in the areas of:

- clarity and formality of communications;
- ability to take timely corrective actions in the safe direction;
- prioritization, interpretation, and verification of alarms;
- procedure use;
- control board manipulations;
- oversight and direction from supervisors; and
- group dynamics.

The inspectors also observed the performance of the examination evaluators and their critique of the crew’s performance. Additionally, the inspectors reviewed simulator configuration compared to the actual control room. The scenario involved a loss of bus duct cooling, a loss of safety injection accumulator pressure, a dropped control rod, the failure of the automatic protection system, and a station blackout. As part of this inspection, the inspectors reviewed Simulator Exercise Guide SQ-10, “Cycle Evaluation 10,” Revision 3.

b. Findings

No findings of significance were identified.

1R12 Maintenance Rule Implementation

a. Inspection Scope

The inspectors evaluated the licensee’s implementation of the maintenance rule for structures, systems, or components (SSCs) with performance problems. This evaluation included the following aspects:

- whether the SSC was scoped in accordance with 10 CFR 50.65;
- whether the performance problem constituted a maintenance rule functional failure;
- safety significance classification;

- the proper 10 CFR 50.65(a)(1) or (a)(2) classification for the SSC; and
- the appropriateness of the performance criteria for SSCs classified as (a)(2) or the appropriateness of goals and corrective actions for SSCs classified as (a)(1).

The inspectors reviewed the licensee's implementation of the maintenance rule requirements for the following SSCs:

- D1 emergency diesel generator;
- D2 emergency diesel generator; and
- safeguards screenhouse ventilation

As part of these inspections, the inspectors reviewed the 1999 Annual and First Quarter Equipment Performance Report, dated May 2, 2000, Second Quarter Equipment Performance Report, dated July 28, 2000, Third Quarter Equipment Performance Report, dated October 26, 2000, Fourth Quarter Equipment Performance Report, dated January 23, 2001, Prairie Island Maintenance Rule System Basis Document, as well as the following procedures, work orders (WOs), and condition reports (CRs):

<u>D1 and D2 Emergency Diesel Generators</u>

- CR 20001153, "During the Performance of SP [surveillance procedure] 1093 Operator Failed to Shutdown Exciter - Control Room Operator Failed to Question Indication";
- CR 20003465, "Evaluate the Increased Maintenance Required on D1 and D2 Standby Coolant Recirculation Pumps - 6 WOs in 18 Months";
- CR 20004999, "D1 and D2 Jacket Coolant Chromate Specification Not In Accordance With Electrical Power Research Institute Closed Cooling Water Guidelines";
- CR 20010377, "Consider Changing Performance Criteria for D1 and D2 - What Effect Will Increasing the Out-of-Service Hours to Match D5 and D6 Have on Probabilistic Risk Assessment";
- CR 20011048, "D1 and D2 Coolant Sample Points Are Not Easily Accessible";
- CR 20012100, "SP 1093 Interrupted Due to Smoke from Penetration 472 - Flamemastic on Asbestos Insulation Smoldering Due to Exhaust Heat";
- WO 0000544, "Install New Motors on Spare Jacket Coolant Pumps";
- WO 0000557, "D2 Standby Coolant Recirculation Pump Has Seal Leak";
- WO 0000947, "D1 Jacket Coolant Leak at Water Jumper";
- WO 0000952, "D1 #4 Cylinder Thermocouple Reading Incorrectly";
- WO 0000953, "Standby Jacket Coolant Pump Seal Leak";
- WO 0001442, "D2 Standby Jacket Coolant Pump Seal Leaks";
- WO 0003228, "D2 Stack Temperature Switch Junction Box Loose";
- WO 0003956, "Standby Jacket Coolant Pump Motor Tripped";
- WO 0004385, "Packing Leak from D1 Standby Coolant Circulating Pump";
- WO 0007175, "D1 Standby Coolant Circulating Pump";
- WO 0007844, "Recalibrate Timer";
- WO 0007959, "D1 Standby Coolant Circulating Water Pump Seal Leak";
- WO 0008454, "D1 Standby Jacket Coolant Pump Seal Leak";
- WO 0008496, "D1 Oil Heater Coupling - Minor Leak";

- WO 0010949, “D1 Emergency Generator Oil Line to Turbocharger Leak”;
- WO 0010968, “Union Leaking Near 2 DG-4-4”;
- WO 0011147, “D1 Jacket Coolant Pump Seal Leaks”;
- WO 0013102, “Faulty Reading on Position 10 of Engine Pyrometer”;
- WO 0013526, “D1 Generator Stator Temperature Reads 20 Degrees Celsius High”;
- WO 0013926, “D2 Jacket Coolant Pump Has a Seal Leak”; and
- WO 0100462, “Fuel Oil Leak from Hand Pump.”

Safeguards Screenhouse Ventilation

- WO 0000433, “Air Leaking from Regulator Weep Hole for CD-34136”;
- WO 9811321, “21 Scavenging and Combustion Air Control Damper Air Regulator Leaking”;
- WO 0006724, “P3548-15-11, 11 Screenhouse Exhaust Fan 3 Year Inspection”;
- WO 0006725, “P3548-15-21, 21 Screenhouse Exhaust Fan 3 Year Inspection”;
- WO 9912530, “Replace Safeguards Screenhouse Roof Exhaust Fan Auxiliary Relay (52x/111c-25)”;
- WO 0013717, “Very Small Reset Band on Control for Screenhouse Safeguards Exhaust Fan”; and
- CR 20005329, “Screenhouse Safeguards Exhaust Fan Cycles Every 3 Minutes, Verify This Is Within the Motor Duty Cycle.”

b. Findings

No findings of significance were identified.

1R13 Maintenance Risk Assessments and Emergent Work Control

a. Inspection Scope

The inspectors reviewed the licensee’s management of plant risk during maintenance activities and its control of emergent work activities. The inspectors also reviewed the licensee’s evaluation, planning, control, and performance of the work to determine if it was done in a manner to reduce risk where practical, and that contingency plans were in place where appropriate. The activities were selected based on the component’s contribution to risk or the probability of the work resulting in an initiating event. The following activities were inspected:

- troubleshooting and repair of the 21 inverter (supplies Unit 2 instrument Bus II) which was bypassed and would not reset;
- troubleshooting and recalibration of the spurious Unit 2 rod withdrawal limit alarm; and
- performance of preventive maintenance on the 12 diesel-driven cooling water pump during a time when the 121 motor-driven cooling water pump was inoperable.

As part of these inspections, the inspectors reviewed the following additional documents:

- WO 0103736, “Replace Fuse for 21 Inverter”;
- WO 0103723, “21 Inverter Bypassed - In Synch Light Not Lit”;
- CR 20012594, “21 Inverter Bypassed on 3/15/01 at 408. In Synch Light Not Lit Preventing Returning Inverter to Supplying the Load”;
- Abnormal Operating Procedure 2C20.8 AOP1, “Abnormal Operation, Instrument AC Inverters,” Revision 6;
- WO 0101620, “Rod Withdrawal Limit Alarm Came in With No Rod Motion”;
- WO 0014350, “P3002-2-12 12 Diesel Cooling Water Pump Annual Inspection”;
- WO 0014351, “P300203012 12 Diesel-Driven Cooling Water Pump Annual Electrical Inspection”;
- WO 0100208, “12 Diesel Cooling Water Pump Instruments 12 Month Calibration”; and
- Daily At-Power Risk Report for 8:00 3/20/2001.

b. Findings

No findings of significance were identified.

1R15 Operability Evaluations

a. Inspection Scope

The inspectors reviewed a sampling of operability evaluations for safety significant systems and conditions to determine that operability was justified, that availability was assured, and that no unrecognized increase in risk had occurred. The following evaluations were reviewed:

- CR 20012100, “SP 1093 Interrupted Due to Smoke from Penetration 472 - Flamemastic on Asbestos Insulation Smoldering Due to Exhaust Heat,” and CR 20012101, “Flamemastic Sealant Used on D1 Exhaust Started to Smolder While Running SP 1093”; and
- CR 20012683, “High Range Radiation Monitors (1R-48, 1R-49, 2R-48, 2R-49); Evaluate High Voltage Readings That Were Low.”

b. Findings

No findings of significance were identified.

1R16 Operator Workarounds

a. Inspection Scope

The inspectors reviewed newly identified operator workarounds (OWAs) to verify that the functional capability of the system, human reliability in responding to an initiating

event, or the ability of operators to implement abnormal or emergency operating procedures was not significantly affected. The following OWAs were reviewed:

- OWA 20011995, "High Vibration Problem With 12 and 13 Containment Fan Cooler Units (CFCUs) Restrict Fast Speed Operation of the CFCUs"; and
- OWA 20012221, "Auxiliary Building Steam Exclusion Actuates Every Time Auxiliary Building Special Ventilation is Run During the Winter Months Due to Temperature Control Valves That Leak By."

b. Findings

No findings of significance were identified.

1R19 Post-Maintenance Testing

a. Inspection Scope

The inspectors reviewed post-maintenance testing activities to ensure that the testing adequately verified system operability and functional capability. The post-maintenance testing activities were selected based on the respective system's importance to mitigating core damage or protecting barrier integrity.

The inspectors observed post-maintenance testing associated with the following work:

- testing of the 11 turbine-driven auxiliary feedwater (AFW) pump following replacement of the steam inlet valve actuator and other refueling outage work in accordance with Preventive Maintenance Procedure PM 3132-1-11, "11 Turbine-Driven Aux Feed Pump Refueling Inspection," Revision 42; and
- testing of the 121 control room chiller following maintenance performed in accordance with Preventative Maintenance Procedure PM 3138-2, "121 Control Room Chiller Annual Inspection (075-011)," Revision 21.

As part of these inspections, the inspectors reviewed the following additional documents:

- SP 1330, "11 Turbine-Driven AFW Turbine/Pump Bearing Temperature Test," Revision 9;
- SP 1376, "AFW Flow Path Verification Test After Each Cold Shutdown," Revision 6;
- SP 1102, "11 Turbine-Driven AFW Pump Monthly Test," Revision 72; and
- Periodic Test Procedure 1678, "121 Control Room Chiller Inspection," Revision 4.

b. Findings

No findings of significance were identified.

1R20 Refueling and Outage Activities

a. Inspection Scope

The inspectors observed activities associated with the Unit 1 refueling outage that began on January 20, 2001. The inspectors reviewed configuration management, clearance activities, reactivity control, containment closure, heatup, and startup activities for management of risk, conformance to applicable procedures, and compliance with Technical Specifications. The activities were chosen based on their probability of resulting in an initiating event or their importance for maintaining barrier integrity. The following major activities were observed:

- reactor coolant system heatup to normal operating temperature and pressure;
- preparations for reactor startup to criticality;
- transition to power operations mode and starting of the main feedwater system;
- initial rolling of the turbine; and
- portions of core physics testing.

As part of this inspection, the inspectors also reviewed Operating Procedure 1C1.2, "Unit 1 Startup Procedure," Revision 23;

b. Findings

No findings of significance were identified.

1R22 Surveillance Testing

a. Inspection Scope

The inspectors witnessed selected surveillance testing and reviewed test data to verify that the equipment tested by the SPs met Technical Specifications, the Updated Safety Analysis Report, Design Basis Documents, and licensee procedural requirements, and demonstrated that the equipment was capable of performing its intended safety functions. The activities were selected based on their importance in verifying barrier integrity or mitigating systems capability. The following tests were evaluated:

- SP 1116, "Monthly Power Distribution Map, Unit 1," Revision 27;
- SP 1112, "Steam Exclusion Monthly Damper Test," Revision 39; and
- SP 1094, "Bus 15 Load Sequencer Test," Revision 13.

As part of these inspections, the inspectors also reviewed the following documents:

- Core Operating Limits Report, Unit 1, Cycle 21, Revision 1;
- CR 20012133, "Error in Manual Calculation of FΔH [Nuclear Enthalpy Rise Hot Channel Factor] During SP 1116";
- Foxboro Instrument Manual 16-551, dated June 1993;
- Calibration Card for Measuring and Test Equipment I&C 4-03, 11111.1 Ohm Decade Box;

- SP 1338, “Bus 15 Sequencer Software Verification,” Revision 5
- SP 1119, “Unit 1 Refueling Outage Load Sequencer Test,” Revision 3;
- Spectrum Technologies Instruction Manual XH-2713-21 for Load Sequencer; and
- CR 20012644, “Repeat Problems With Maintaining Log of Use of Load Sequencer Safety-Related Software, Interfacing Computer, and Programmable Logic Controller-5 Keys.”

b. Findings

No findings of significance were identified.

1R23 Temporary Plant Modifications

a. Inspection Scope

The inspectors reviewed the design and safety evaluation screening for planned Temporary Modification 01T081, “Blank Off Control Room Humidifier Ducts for Humidifier Removal.” This temporary modification was selected because of the potential effect on control room habitability.

In addition to the draft temporary modification package, the inspectors reviewed the following documents:

- USAR Section 10.3.3.2, “Control Room Ventilation System,” Revision 22; and
- USAR Appendix I, Section 4.2, “Steam Exclusion Boundaries,” Revision 22.

b. Findings

No findings of significance were identified.

4. OTHER ACTIVITIES

4OA1 Performance Indicator Verification

a. Inspection Scope

The inspectors reviewed the performance indicator data, submitted by the licensee, for completeness and accuracy for the safety system unavailability performance indicator for the residual heat removal (RHR) system in the mitigating systems cornerstone. Control room logs and computerized limiting condition for operation (LCO) logs were reviewed for January 2000 through December 2000 to verify that the licensee had reported all unavailability for those four quarters. In addition, the inspectors reviewed the following documents:

- WO 9706969, “PE-211J-11, 21 RHR Heat Exchanger Component Cooling Water Inlet MV-32128 Breaker PM [preventive maintenance]”;
- WO 9807624, “PE-211J-5, Breaker Electrical 5-Year PM-MV-32129”;

- WO 9911228, “P3117-1-22, 22 SI [safety injection] Pump Refueling Inspection PM”;
- WO 9911693, “P32208, RHR to 21 SI Pump D70 Inspection”;
- WO 9911694, “P32209, RHR to 22 SI Pump D70 Inspection”; and
- WO 9912292, “PE-211J-19, Breaker Electrical 5-Year PM-MV-32208.”

b. Findings

A No-Color finding and non-cited violation were identified when inspectors noted errors in the PI data submitted to the NRC. The inspectors identified that the licensee had failed to report 51.9 hours of unavailability for the Unit 2 RHR system during the 2nd quarter of 2000. Had the additional hours been reported they would have resulted in the performance indicator crossing from Green to White in the 4th quarter of 2000.

While reviewing data for Unit 2 RHR system unavailability, the inspectors identified that the Unit 2, Train 2, (22) SI train and the Unit 2, Train 2, (22) RHR train were simultaneously removed from service for preventive maintenance on April 16, 2000, at 9:10 p.m., and returned to service on April 17, 2000, at 5:13 p.m.. This resulted in unavailability of both the 22 SI and 22 RHR trains for about 20 hours. However, in its 2nd quarter performance indicator data, the licensee only reported this period of planned unavailability for the 22 SI train, not the 22 RHR train. Similarly, the inspectors identified that the Unit 2, Train 1, (21) SI train and the Unit 2, Train 1, (21) RHR train were simultaneously removed from service for preventive maintenance on April 18, 2000, at 6:54 a.m., and returned to service on April 19, 2000, at 2:46 p.m. This resulted in about 31.9 hours of unavailability for both trains. However, in its 2nd quarter performance indicator data, the licensee only reported this period of planned unavailability for the 21 SI train, not the 21 RHR train. The errors appeared to be caused by the fact that the computerized LCO log only allowed an entry to be associated with one system code and the operator picked the SI system. When collecting the unavailability data for the performance indicator, licensee personnel apparently did not adequately review the LCO log text, the Unit 2 control room log, or the associated preventive maintenance WOs, to note that the conditions affected both the SI and RHR systems.

Section (a) of 10 CFR 50.9, “Completeness and Accuracy of Information,” required, in part, that information provided to the NRC by a licensee be complete and accurate in all material respects. Contrary to this, on July 21, 2000, the licensee submitted performance indicator information to the NRC, pursuant to NEI 99-02, Revision 0, “Regulatory Assessment Performance Indicator Guideline,” that was not accurate. Specifically, the licensee failed to report approximately 31.9 hours of safety system unavailability for the Unit 2, Train 1, residual heat removal system and approximately 20 hours of safety system unavailability for the Unit 2, Train 2, residual heat removal system. These periods of unavailability occurred between April 16 and April 19, 2000. This information was material because the additional unavailability time would have caused the Unit 2 safety system unavailability performance indicator for the residual heat removal system to change from Green to White performance in the 4th quarter of 2000 and could have resulted in a change to the NRC’s actions in regard to assessing the licensee performance. However, because these errors were not willful and the inaccurate information was submitted during the period when the Enforcement Policy

afforded discretion for the non-willful submittal of performance indicator data, discretion was exercised, pursuant to Section VII.B.6 of the Enforcement Policy, not to issue a Notice of Violation. This issue was placed in the licensee's corrective action program as Condition Report 20012326.

The unreported 51.9 hours of RHR planned unavailability would have resulted in the Unit 2 RHR system unavailability performance indicator crossing from the Green to White performance band in the 4th quarter of 2000. Because the errors had the potential for impacting the NRC's ability to perform its regulatory function, the issue is considered a finding with no color assigned to Unit 2.

4OA3 Event Follow-up

Cornerstones: Initiating Events and Mitigating Systems

.1 (Closed) Licensee Event Report (LER) 50-306/00-02-01 (2-00-02, Supplement 1): "Discovery that PORV [Power Operated Relief Valve]/Block Valve Cable in Containment Does Not Meet Appendix R Separation Criteria."

This supplement simply reported that the condition, originally identified on Unit 2, did not exist on Unit 1. The Unit 2 issue was previously discussed in Inspection Report 50-282/00-05(DRP); 50-306/00-05(DRP), and closed in Inspection Report 50-282/00-08(DRP); 50-306/00-08(DRP).

.2 (Closed) LER 50-282/00-04-00 (1-00-04, Original) and (Open) LER 50-282/00-04-01 (1-00-04, Revision 1): "Inoperability of Safeguards Cooling Water (Essential Service Water) Pumps Caused by Unqualified Lubricating Water Supply to the Pump Shaft Bearings."

This revision updated some of the information in this LER. The issue was previously discussed in Inspection Report 50-282/00-13(DRS); 50-306/00-13(DRS), and will be reviewed in a future supplemental inspection.

4OA6 Meetings

Exit Meeting

The inspectors presented the inspection results to Mr. M. Werner and other members of licensee management on April 6, 2001. The licensee acknowledged the findings presented. The inspectors asked the licensee whether any materials examined during the inspection should be considered proprietary. No proprietary information was identified.

PARTIAL LIST OF PERSONS CONTACTED

Licensee

T. Allen, General Superintendent Engineering, Nuclear Generation Services
T. Amundson, General Superintendent Engineering
T. Breene, Manager Nuclear Performance Assessment
L. Gard, General Superintendent Plant Maintenance
A. Johnson, General Superintendent Radiation Protection and Chemistry
T. Silverberg, General Superintendent Plant Operations
M. Sleigh, Superintendent Security
J. Sorensen, Site Vice President
M. Werner, Plant Manager

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened and Closed

None

Closed

50-306/00-02-01 (2-00-02, Supplement 1)	LER	Discovery That PORV/Block Valve Cable in Containment Does Not Meet Appendix R Separation Criteria (Section 4OA3.1)
50-282/00-04-00 (1-00-04, Original)	LER	Inoperability of Safeguards Cooling Water (Essential Service Water) Pumps Caused by Unqualified Lubricating Water Supply to the Pump Shaft Bearings (Section 4OA3.2)

Discussed

50-282/00-04-01 (1-00-04, Revision 1)	LER	Inoperability of Safeguards Cooling Water (Essential Service Water) Pumps Caused by Unqualified Lubricating Water Supply to the Pump Shaft Bearings (Section 4OA3.2)