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

March 16, 2001

EA-01-067

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

SUBJECT: HATCH NUCLEAR PLANT - NRC PROBLEM IDENTIFICATION AND RESOLUTION INSPECTION REPORT NOS. 50-321/01-02, 50-366/01-02 AND NOTICE OF VIOLATION

Dear Mr. Sumner:

On February 16, 2001, the NRC completed an inspection at your Hatch Units 1 and 2 reactor facilities. The enclosed report presents the inspection findings which were discussed on February 16, 2001, with Mr. P. Wells and other 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 the conditions of your operating license. Within these areas, the inspection involved selected examination of procedures and representative records, observations of activities, and interviews with personnel.

On the basis of the sample selected for review, we concluded that in general, problems were properly identified, evaluated, and corrected. However, minor problems were noted involving corrective actions not being documented within the corrective action program, timeliness of evaluations and documentation of repetitive problems, timeliness of corrective actions, corrective actions which were unclear or incomplete, and severity level classification of condition reports.

There was one no-color finding during this inspection associated with your failure to document issues as required by 10 CFR 50.73. A Licensee Event Report did not identify or document the significant complications encountered with the Reactor Core Isolation Cooling (RCIC) system during an event. This violation was originally identified as a non-cited violation of 10 CFR 50.73 in NRC Inspection Report Nos. 50-321/00-02 and 50-366/00-02, issued on May 1, 2000. This violation is now being cited in the enclosed Notice of Violation based on our determination that your staff failed to restore compliance within a reasonable time after the original violation was identified. This is consistent with Section VI.A.1 of the "General Statement of Policy and Procedure for NRC Enforcement Actions - May 1, 2000," NUREG-1600, as amended on

November 3, 2000 (65 Federal Register 59274) (Enforcement Policy). This section of the Enforcement Policy states that restoration of compliance within a reasonable time after the violation was identified is one of the criteria that must be satisfied for a Severity Level IV violation to be dispositioned as a non-cited violation. In addition, as discussed in the Enforcement Policy, violations involving reporting issues are dispositioned in accordance with the Policy Supplements, rather than being assessed by the Significance Determination Process, as these violations could impact the regulatory process. Based on this, the NRC has determined that this cited violation should be characterized at Severity Level IV. For tracking purposes, the NRC will administratively retract the previous non-cited violation.

Please note that you are required to respond to this letter and should follow the instructions specified in the enclosed Notice when preparing your response. Your response should address the cause and corrective actions for both the inadequate Licensee Event Report and the failure of your corrective action process to ensure compliance was restored prior to final disposition of the condition report. The NRC will use your response, in part, to determine whether further enforcement action is necessary to ensure compliance with regulatory requirements.

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).

Should you have any questions concerning this letter, please contact us.

Sincerely,

/RA/

Victor M. McCree
Deputy Director
Division of Reactor Projects

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

Enclosures: 1. Notice of Violation
2. NRC Inspection Report 50-321, 366 /01-02

cc w/encls:
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Distribution w/encls:
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RIDSNRRDIPMLIPB
PUBLIC

NOTICE OF VIOLATION

Southern Nuclear Operating Company, Inc
Hatch Unit 1

Docket No. 50-321
License No. DPR-57
EA-01-067

During the NRC inspection conducted on February 5, 2001 through February 16, 2001, a violation of NRC requirements was identified. In accordance with the "General Statement of Policy and Procedures for NRC Enforcement Actions," NUREG-1600, the violation is listed below:

> 10 CFR 50.73.b requires, in part, that Licensee Event Reports (LER) shall contain a brief abstract describing the major occurrences during the event, including all component or system failures that contributed to the event and significant corrective action taken to prevent recurrence. In addition, the LER shall contain a narrative description of the cause of each component or system failure, the effect of each failed component, and operator actions that affected the course of the event, including procedural deficiencies that contributed to the event.
>
> Contrary to the above, on February 16, 2001, Licensee Event Report (LER) 50-321/00-02: Reduction in Reactor Feedwater Flow Results in Automatic Reactor Shutdown on Low Water Level, dated February 25, 2000, did not contain all information as required by 10 CFR 50.73.b. Specifically, the LER did not contain the significant complications encountered with the Reactor Core Isolation Cooling (RCIC) system failure, the cause of the RCIC system failure, or the effect of the RCIC system failure on the event. The LER did not identify several unsuccessful attempts to restart the RCIC system after the RCIC turbine tripped on high reactor water level following a reactor trip. The LER also did not document certain operator actions that affected the course of the event involving the RCIC system, including an operating procedure that allowed the operator to restart the RCIC system turbine by opening the Trip and Throttle valve with the steam supply valve full open and the turbine control system demanding maximum speed. This method of restarting the tripped RCIC system contributed to repetitive overspeed trips of the RCIC turbine during the event. In addition, the LER did not contain a description of the significant corrective actions taken or planned to prevent recurrence of the RCIC system failure.

This is a Severity Level IV Violation (Supplement 1).

Pursuant to the provisions of 10 CFR 2.201, Southern Nuclear Operating Company, Inc., is hereby required to submit a written statement or explanation to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, D.C. 20555, with a copy to the Regional Administrator, Region II, and a copy to the NRC Resident Inspector, Hatch Nuclear Plant, within 30 days of the date of the letter transmitting this Notice of Violation (Notice). This reply should be clearly marked as a "Reply to a Notice of Violation" and should include for each violation: (1) the reason for the violation, or, if contested, the basis for disputing the violation or severity level, (2) the corrective steps that have been taken and the results achieved, (3) the corrective steps that will be taken to avoid further violations, and (4) the date when full

compliance will be achieved. Your response may reference or include previous docketed correspondence, if the correspondence adequately addresses the required response. If an adequate reply is not received within the time specified in this Notice, an Order or Demand for Information may be issued as to why the license should not be modified, suspended, or revoked, or why such other action as may be proper should not be taken. Where good cause is shown, consideration will be given to extending the response time.

If you contest this enforcement action, you should also provide a copy of your response to the Director, Office of Enforcement, United States Nuclear Regulatory Commission, Washington, DC 20555-0001.

Because your response will be placed in the NRC Public Document Room (PDR), to the extent possible, it should not include any personal privacy, proprietary, or safeguards information so that it can be placed in the PDR without redaction. However, if you find it necessary to include such information, you should clearly indicate the specific information that you desire not to be placed in the PDR, and provide the legal basis to support your request for withholding the information from the public.

Dated at Atlanta, Georgia
this 16th day of March, 2001

U.S. NUCLEAR REGULATORY COMMISSION

REGION II

Docket Nos:	50-321, 50-366
License Nos:	DPR-57, NPF-5
Report Nos:	50-321/01-02, 50-366/01-02
Licensee:	Southern Nuclear Operating Company (SNC), Inc.
Facility:	E. I. Hatch Nuclear Power Plant, Units 1 & 2
Location:	P. O. Box 2010 Baxley, Georgia 31515
Dates:	February 5 through 16, 2001
Inspectors:	P. Van Doorn, Senior Reactor Inspector (Lead) B. Holbrook, Senior Project Engineer J. Starefos, Resident Inspector D. Thompson, Security Inspector
Approved by:	Victor M. McCree Deputy Director Division of Reactor Projects

Summary of Findings

Adams Template:

IR 05000321-01-02, IR 05000366-01-02, on 02/5-16/2001, Southern Nuclear Operating Company, Inc., Edwin I. Hatch Nuclear Power Plant, Units 1 & 2, annual baseline inspection of the identification and resolution of problems.

The inspection was conducted by a Region II Senior Reactor Inspector, a Browns Ferry Resident Inspector, and a Region II Senior Project Engineer. No findings of significance were identified. One finding with no color was identified: a cited violation was identified due to the failure to restore compliance or develop corrective actions to prevent recurrence for a previously identified violation for failure to document a problem in a Licensee Event Report.

Identification and Resolution of Problems:

The inspectors determined that, in general, problems were properly identified, evaluated, and corrected. A very low threshold for self-identification was demonstrated. Significant problems were adequately addressed. Minor problems were noted involving corrective actions not being documented within the corrective action program, timeliness of evaluations and documentation of repetitive problems, timeliness of corrective actions, corrective actions which were unclear or incomplete, and severity level classification of condition reports.

The inspectors identified one no-color finding during this inspection associated with the failure to document issues required by 10 CFR 50.73 . A Licensee Event Report did not identify that the operating procedure for the Reactor Core Isolation Cooling system turbine allowed the operator to attempt to restart the Reactor Core Isolation Cooling system by opening the Trip and Throttle valve with the steam supply valve full open and the turbine control system demanding maximum speed. This method of restarting the tripped Reactor Core Isolation Cooling system contributed to repetitive overspeed trips during a January 26, 2000, event. This violation was originally documented as a non-cited violation on May 1, 2000. However, at the time of this inspection the licensee had not taken action to restore compliance or develop corrective actions to prevent recurrence. This violation is now being cited in the enclosed Notice of Violation based on the NRC's determination that the licensee failed to restore compliance within a reasonable time after the original violation was identified.

Report Details

4. Other Activities (OA)

4OA2 Problems Identification and Resolution

a. Effectiveness of Problem Identification

(1) Inspection Scope

To assess the effectiveness of the licensee's corrective action program (CAP), the inspectors reviewed corrective action documents for selected risk significant systems and other areas such as solenoid valves, check valves, and human performance issues. Selected systems included the following: High Pressure Coolant Injection (HPCI), Reactor Core Isolation Cooling (RCIC), Residual Heat Removal (RHR), RHR Service Water (RHRSW), Plant Service Water (PSW), and the Diesel Generators (Dgs). The review included examination and evaluation of the Condition Reports (CRs and COs) for problems in each system and samples of associated documentation such as action items and Work Orders. The inspectors also reviewed a list of cooling tower fan condition reports. The review of documents was performed to determine if individual and repeat problems had been captured in the licensee's CAP and to evaluate whether problems were appropriately documented. The inspectors also reviewed the results of the licensee's process for evaluating operating experience items; evaluations concerning Maintenance Rule (MR) component failures; selected self-assessments, audits, trend reports, and management observations for examples of effective problem identification and documentation.

The inspectors reviewed procedures and documents associated with the CAP and self-assessment processes and compared licensee performance to the procedures and document requirements to ensure the requirements were being met.

Procedures and documents reviewed are listed in Attachment 2 of this inspection report.

(2) Findings

The inspectors determined that the licensee was generally effective at identifying problems and initiating corrective action documents. A low threshold for individual problem identification was demonstrated. Some issues identified via self-assessments and management observations were not entered into the CAP. However, licensee management recently initiated improved instructions to enter these types of finding into the CAP.

Condition report trending was primarily the responsibility of the Nuclear Safety and Compliance group (NSAC). The process was being implemented by NSAC personnel without any written guidance. Formal trending was performed every six months. Valuable information and recommendations were initiated from trending data, however, timeliness was lacking. Trend reports were issued three months or more after the end of the trend period. Corrective actions for the most recent trend report, a data period end date of June 2000, had yet to be fully implemented. Near term repetitive equipment issues were only informally trended and not always properly documented. NSAC personnel performed a daily review of CRs to identify recent repetitive equipment

failures and followed this with a review by equipment number with the intent to initiate higher severity level CRs when appropriate. Some examples of this occurring were noted. However, some examples of repetitive issues not being documented were also noted, although corrective actions had been independently initiated. Site personnel, such as engineers, typically relied on NSAC for trending and were not knowledgeable of what a "trend" was or when it was appropriate to initiate a higher level CR for a repetitive issue. Examples of repetitive issues not being documented, although corrective actions had been initiated, include the following:

- Cause evaluation and corrective actions for repetitive failure of cooling tower fans due to shifting of the cooling tower structure.

- Additional corrective actions associated with a failed intrusion detection system described in CR 000002342.

- Evaluation of repetitive trips of the 2A DG lube oil pump.

- Cause evaluation and additional inspections for a wiring error on DG 1A identified on CO0006251.

- Evaluations of cause for a PSW pump trip identified on CR2000010872.

- Actions being performed to replace a HPCI relief valve described by CR9902738

Audits and self-assessments of the CAP resulted in beneficial identification of problems. Two recent audit comments noted problems which had each been described on three separate condition reports that were yet to be corrected. Specifically, these were a temporary cable which did not meet fire codes near a HPCI pump identified on CO9705539, CO9901888, and CO9901896 which were documented between 1997 and 1999. For this example, each of the CRs were closed without adequate corrective action. The second example involved an inoperable telephone required at the hazardous material storage facility identified on CO0000360, CO0005394, and CO0009842. A new CR was initiated for each as a result of the audit comment (CR2000010838 and CR2000010836) but each of these was only assigned a Severity Level (SL) 4 and the audit report stated that each of the issues "seemed to be an isolated event." These issues could have been addressed at a higher level to evaluate program implications and why these had to be identified several times over an extended period. In addition, a very thorough self-assessment of the CAP was conducted on July 10-14, 2000, which identified many programmatic issues, but some corrective actions remained to be implemented.

A line organization self-assessment program was established via procedure AG-MGR-63-0598N. A number of self-assessments were not performed in year 2000 which did not meet procedural goals, although these were not requirements. Only narrowly focused self-assessments were conducted in some areas. However, overall self-assessment efforts were effective in identifying issues.

The current CAP procedure (10AC-MGR-004-0S) lacked detail in some respects, provided conflicting information, and did not describe some aspects of the program.

Trend guidance was minimal. Guidance for severity level classification was minimal and two forms of guidance were provided, one based on risk and one based on the need for a cause determination. According to licensee management, their expectation for a SL5 CR was to perform an immediate fix for the problem or the issue could be something which did not need corrective action. However, the procedure stated that a SL5 CR "does not require corrective action." The inspectors identified some SL 5 CRs that did require corrective action.

Licensee management expectations regarding apparent cause determination were not well understood at all levels. Some personnel indicated that an apparent cause required the same rigor and documentation as a formal root cause. However, licensee management indicated that documentation was not required and the level of rigor could be less, dependent on the issue.

Corrective actions were tracked using an action item tracking program separate from the CAP. The tracking item document usually defined what corrective actions were planned; but no procedural tie from the CAP to the action item tracking system and vice versa existed. Although there was no requirement for a procedural tie, the lack of integration made tracking licensee corrective actions cumbersome. A daily management review of CRs was not described in the procedure, but did routinely occur.

b. Prioritization and Evaluation of Issues

(1) Inspection Scope

Selected corrective action documents were reviewed to determine if there was agreement with the severity classification level and thoroughness of evaluations including root cause and apparent root cause evaluations described in licensee procedures. The licensee's CAP classification requirements were reviewed for clarity and consistency. The inspectors attended licensee management meetings which were held to determine if the ownership assignment and selection of severity classification levels for emerging CRs met licensee procedure requirements and licensee management expectations. The inspectors also observed a Human Performance Board Meeting.

(2) Findings

Most issues were properly characterized, classified, and entered into the CAP. The inspectors did not find any risk significant issues that had not been appropriately prioritized and evaluated. The highest level issues were thoroughly evaluated, although not always thoroughly documented within the CAP as described in Section 4AO2a. The daily management review of new CRs effectively emphasized ownership of the issues. The Human Performance Board provided a thorough review of selected issues and set good standards for personnel.

The inspectors identified examples where more timely evaluations could have been performed and in some cases could have prevented the same problem from recurring or getting identified repeatedly. One example was the failure to use the proper torque on a RHRSW pump due to a failure to update a procedure described on CO0007177. The

same problem had occurred previously (CO0000928) but the procedure had not been corrected prior to the second occurrence. Another example was an action to improve procedures for a reactor cooldown described on CR2000000197 dated 7/21/2000 which would help prevent exceeding Technical Specification requirements. Although, the licensee had previously experienced difficulty maintaining limits in this area, corrective actions were not planned until 6/29/2001. Other examples of repetitive condition reports are described in Section 4AO2a.

The inspectors identified examples where corrective actions were unclear or incomplete. Corrective actions associated with a cause determination were not always developed. These included the following:

- CO0007177: This issue described above involved a failure to update a procedure. Corrective actions were only to revise the procedure based upon the second occurrence versus addressing why the procedure had not been revised.

- CR2000007523: Documentation identified that the wrong resistor may have been used for a HPCI controller. No followup action was documented to determine if this was the case or how to prevent recurrence.

- CO0000523 and 567: A functional failure of a Unit 1 PSW check valve was identified, but documentation for root cause and broadness review was not found.

- CR2001000133: This CR involving a possible design question for the circulation water dilution pump and PSW dilution pump which was closed without the design question being addressed by engineering.

- CR2000010519: This CR involved the failure to take a chemistry sample for the RHRSW heat exchanger. Extra sampling had been implemented due to a contamination problem. Corrective action included only an e-mail to the operations shift.

- CR2000010915: This CR involved a mispositioned backwash control switch due to a failure to follow procedure. No corrective action to specifically address this cause was documented.

- CR2000010945: This CR involved flooding in the computer room and noted that the room drains were plugged. No evaluation of the acceptability of the plugged drains had been performed.

Some condition reports may have been more appropriately classified at a higher SL. These included CRs 2000010836 and 10838 described in Section 4OA2 and the following:

- CR2001000891: This CR documented a control rod mispositioning which was classified as SL3, however, procedural examples suggested a different SL.

- CR2000003535: This issue involved RHR discharge pressure being high. The CR was classified as SL4; extensive assessment and testing had been performed but not documented.

c. Effectiveness of Corrective Actions

(1) Inspection Scope

The inspectors reviewed selected CAP documents to evaluate the effectiveness of corrective actions. The inspectors reviewed a sample of human performance CRs attributed to procedure compliance problems, which was the most common licensee performance problem area. The inspectors also held discussions with licensee personnel concerning their perceptions as to the effectiveness of their CAP. In addition, the inspectors reviewed the corrective actions associated with selected Non-cited violations (NCVs) and Licensee Event Reports (LERs) to ensure licensee procedure and regulatory requirements were met.

(2) Findings

Based on the discussion with licensee personnel and sample of condition reports selected for review, the inspectors found that, for the most part, the licensee's corrective actions on significant issues were effective. As described previously, some examples of repetitive issues of lesser significance were observed. As noted in Section 4AO2b, preventive corrective actions occasionally lacked thoroughness or were not initiated in some cases.

Although licensee trend reports indicated human performance issues continued at a high rate, this was well recognized by site management and some good initiatives were noted. These included the Human Performance Board which provided a high level review of selected performance issues, a Human Performance Improvement Team, which was a management review of weekly human performance issues, a Human Performance Analysis Program, human performance indicators, and a human performance champion.

However, the inspectors determined that the corrective actions were not completed for a NCV regarding incomplete LER documentation for an event that resulted in a unit trip. As discussed in LER 50-321/00-02: Reduction in Reactor Feedwater Flow Results in Automatic Reactor Shutdown on Low Water Level, issued on February 25, 2000, Unit 1 automatically tripped on January 26, 2000, when an unexpected closure of a feedwater heater inlet valve occurred and reduced the feedwater flow to the reactor. During the event, some systems including RCIC, malfunctioned or responded in a way that was not completely understood at the time. However, the LER did not identify or document the significant complications encountered with the RCIC system during the event. There were several unsuccessful attempts, early in the recovery, to restart the RCIC system after it tripped on high reactor water level. The licensee's Event Review Team identified that the RCIC system operating procedure allowed the operator to attempt to restart the RCIC turbine by opening the Trip and Throttle (T&T) valve with the steam supply valve full open and the turbine control system demanding maximum speed. This method of

restarting the tripped RCIC turbine contributed to repetitive overspeed trips during the event.

This issue was originally identified as a non-cited violation of 10 CFR 50.73 in NRC Inspection Report Nos. 50-321/00-02 and 50-366/00-02, issued on May 1, 2000. In response to this NCV, the licensee entered the NCV into their corrective action program as CR CO0003312.

Although the licensee had dissenting comments at the inspection exit meeting, the cover letter to NRC Inspection Report Nos. 50-321/00-02 and 50-366/00-02 afforded the licensee the formal opportunity to contest the violation or its severity level by providing a written response to the NRC within 30 days of the date of the inspection report. The licensee did not provide a written response to the NRC that contested the violation or its severity level.

During this inspection, the inspectors identified that the licensee had closed CR CO0003312 without restoring compliance or developing corrective actions. The licensee's basis for disposition and closure of the CR was, in part, that "the restart of RCIC was a routine post event reactor water level evolution and not part of the mitigation of the event. Based on this it is the opinion of management that this condition did not meet the requirements of 10 CFR 50.73 for inclusion into the LER. This was communicated during the respective NRC exit as a dissenting comment. This was a subjective call by the resident inspector which was not shared by licensee management. The RCIC condition was captured in the plant's corrective action program and has been handled as required with no further action necessary regarding change to the LER."

10 CFR 50.73.b requires, in part, that LER shall contain a brief abstract describing the major occurrences during the event, including all component or system failures that contributed to the event and significant corrective action taken to prevent recurrence. In addition, the LER shall contain a narrative description of the cause of each component or system failure, the effect of each failed component, and operator actions that affected the course of the event, including procedural deficiencies that contributed to the event. The LER shall also contain a description of the significant corrective action taken or planned to prevent recurrence.

Based on the results of this inspection, the NRC again determined that LER 50-321/00-02 did not contain all information as required by 10 CFR 50.73.b. Specifically, the LER did not document the significant complications encountered with the RCIC system failure, the cause of the RCIC system failure, or the effect of the RCIC system failure on the event. The LER did not document several unsuccessful attempts to restart the RCIC system after the RCIC turbine tripped on high reactor water level following a reactor trip. The LER also did not document certain operator actions that affected the course of the event involving the RCIC system, including an operating procedure that allowed the operator to restart the RCIC system turbine by opening the Trip and Throttle valve with the steam supply valve full open and the turbine control system demanding maximum speed. This method of restarting the tripped RCIC system contributed to repetitive overspeed trips of the RCIC turbine during the event. Finally, the LER did not contain a description of the significant corrective actions taken or planned to prevent recurrence of the RCIC system failure. Since the licensee did not

implement corrective actions to supplement the LER and rectify these omissions, compliance with 10 CFR 50.73.b had not been restored.

This violation is now being cited in the enclosed Notice of Violation based on the determination that licensee personnel failed to restore compliance within a reasonable time after the original violation was identified. This is consistent with Section VI.A.1 of the "General Statement of Policy and Procedure for NRC Enforcement Actions - May 1, 2000," NUREG-1600, as amended on November 3, 2000 (65 Federal Register 59274) (Enforcement Policy). This section of the Enforcement Policy states that restoration of compliance within a reasonable time after the violation was identified is one of the criteria that must be satisfied for a Severity Level IV violation to be dispositioned as a non-cited violation. In addition, as discussed in the Enforcement Policy, the significance of violations involving reporting issues are dispositioned in accordance with the Enforcement Policy Supplements, as these violations could impact the regulatory process. Based on this, the NRC has determined that this cited violation should be characterized at Severity Level IV. The inspectors identified this as Violation 50-321/01-02-01: Failure To Document Issues Required by 10 CFR 50.73. For tracking purposes, the NRC will administratively retract the previous non-cited violation.

The NRC's Reactor Oversight Process and Enforcement Policy rely heavily on the strength and rigor of the licensee's corrective action program to identify and correct problems. In this case, the actions taken did not demonstrate these attributes. In response to this current problem, the licensee entered this violation into their corrective action program as CR 2001001168, dated February 14, 2001.

d. Assessment of Safety-Conscious Work Environment

(1) Inspection Scope

The inspectors reviewed licensee audits and assessments, issues in CAP documents of all levels, and held discussions with various licensee employees to determine if an environment conducive to the identification of issues existed. In addition, the inspectors discussed the employee concerns program (ECP) with the Concerns Coordinator, reviewed issues resulting from the ECP, and reviewed the ECP procedure and promotional materials. The review and discussions were performed to ensure site procedure requirements were met, to determine if personnel used and had confidence in the ECP program, and that a strong safety-conscious work environment existed.

(2) Findings

The licensee exhibited a strong safety-conscious work environment. The threshold for the identification of issues was very low. The ECP was actively communicated and utilized.

e. Management Meetings

.1 Exit Meeting Summary

The inspectors presented the inspection results to Mr. P. Wells, Plant Manager, and other members of licensee management at the conclusion of the inspection on February 16, 2001. The licensee acknowledged the findings presented.

The inspectors asked the licensee if any other materials examined during the inspection should be considered proprietary. No proprietary information was identified.

ITEMS OPENED CLOSED AND DISCUSSED

Opened

50-321/01-02-01	NOV	Failure To Document Issues Required by 10 CFR 50.73 (Section 40A2 [c.2])

Retracted

50-321/00-02-03	NCV	Failure To Document Issues Required by 10 CFR 50.73 (Section 40A2 [c.2])

Attachments: 1. List of Persons Contacted
2. List of Documents Reviewed

LIST OF PERSONS CONTACTED

J. Betsill, Assisstant General Manager-Plant Support
M. Googe, Maintenance Manager
J. Hammonds, Engineering Support Manager
G. Johnson, Safety Audit and Engineering Review Supervisor
D. Madison, Assistant General Manager-Operations
P. Roberts, Outage and Planning Manager
J. Thompson, Nuclear Security Manager
S. Tipps, Nuclear Safety and Compliance Manager
R. Varnadore, Operations Support Superintendent
P. Wells, General Manager

PARTIAL LIST OF DOCUMENTS REVIEWED

Licensee Procedures

10AC-MGR-004-0S, Corrective Action Program, Revisions 14 and 15
10AC-MGR-004-0S, Condition Reporting System, Revision 13
10AC-MGR-005-0S, Corrective Action Program, Revision 11
AG-ADM-11-0283N, Action Item Tracking, Revision 3
AG-MGR-27-0687N, Root Cause and Apparent Cause Analysis, Revision 6
AG-MGR-64-1198N, Condition Report Processing, Revision 3
AG-MGR-63-0598N, Self-Assessment Process, Revision 2
AG-MGR-70-0900N, Human Performance Analysis Program, Revision 0
03RC-CPL-001-0N, Preparation and Processing of Justifications for Non-Reportability, LERs, and Special Reports, Revision 3
00AC-REG-001-0S, Federal and State Reporting and Federal Document Posting Requirements, Revision 6
Concerns Program Procedure, August 11, 1995
SAER-07, Hatch Project Safety Audit and Engineering Review Procedure for SAER Audits, Revision 10

Audits, Self-Assessments, Other Oversight Activities and Associated Documents

Audit Report 00-CA-2, Corrective Action Program
Audit Report 00-CA-1, Corrective Action Program
Corrective Action Program Self-Assessment, July 10-14, 2000
Corrective Action Self-Assessment, January 18-21, 1999
Operation Procedure Usage Self-Assessment, November 5, 1999
Chemistry Self-Assessment, November 15-19, 1999
Clearance Self-Assessment, April, 2000
Preventive Maintenance Deferral Process Self-Assessment, 2000
Maintenance Work Delays/Inefficiencies Self-Assessment, May 10-12, 2000
Condition Report and Significant Occurrence Report Trend Report, 10/04/00
Condition Report and Significant Occurrence Report Trend Report, 5/05/2000
Deficiency and Significant Occurrence Report Trend Report, 11/24/1999
CR 2000008446, 8447, 8448, 8450, 8451, 8452, 8455, 8456, 8458, 9322, 9328, 9329, 9333, 9335, 0360, 5394, 9842, 10836, 10838, 10979, 9901888, 9901896, and 9705539
Action Items: 20000200766, 2000200765, 2000200772 through 783, OP0000005, OP0000003, and 200002000

Operating Experience Evaluation Packages Reviewed

General Electric Service Information Letter (GE SIL) 217, 229, 624, 629, and 631
MOVATS Technical Bulletin, 2000-01
BWR Owners Group Bulletin, FN-03, Revision 0

CRANS Service Bulletin, CSB-VTS-2000-01
INPO Significant Event Notification, SEN 217
WANO SER 2000-03
IN 2000-01 and 2000-08

Human Performance Documents

Human Performance Indicators, Fourth Quarter 2000
Human Performance Improvement Team Report, August 22, 2000
Summary of Human Performance Conditions by Week, 2/06/2001
Human Performance Board Standards
CO0005611, 6032, 6190, 6208, 6412, 7177, 7382, 7749, 8277, 8299, 8350, 8531, 8580, 8912, 9793, 9928, 10022, 10427, 6989, 5571, 5627, 5630, 5632, 5648, 5652, 5662, 5747, 5751, 5765, 5890, 5949, 6242, 6911, 6929, 6943, 6987, 7013, 7017, 7156, 7740, 8135, CR2000009418 and 6144

HPCI Documents

Unit 1 HPCI CRs: 2000000009, 2000000675, 2000005669, 2000006735, 2000006864, 2000006937, 2000007523, 2000009013, 2000009722, 2000009786, 2000009885, 2000009993, and 2000010897. CO9900198 and 9902738

Unit 2 HPCI CR2000000274, 2000001490, 2000001494, 2000001506, 2000006491, 2000001866, and CO9900198

RCIC Documents

Unit 1 RCIC CR2000000596, 2000003312 and 2000010683. CO9900194, 9902020, 9903779, and 9601109

Unit 2 RCIC CR2001000124, 2000000596, 2000006523, 2000009617, and 2000010058

PSW Documents
CO0003755 and 0007614. CR2000003636, 2000010915, 2000010945, 2000011094, 2000011567, 2000010872, 2000003684, 2000005000, and 2001000133

RHR and RHRSW Documents

CO0000695, CO00006599, CO9805418, and CO9900632. CR2000010519, 2000011283, 2000000515, 2000007875, 2000007874, 2000011539, 2000007601, 2000003535, 2000004241, and 2000006862

Diesel Generator Documents

DG System Health Report, 2000 Fourth Quarter
CR2000004301; CO0002479, 4660, 4714, 6188, 5613, and 6251

Check Valve Documents

CR 2000010941, 2000010995. CO0000567, CO0000523, CO98002891, CO9706120 (Partial Review)

Solenoid Documents

CR2000009650

Security Documents

CR2000000836, 1090, 1227, 1617, 1622, 1716, 2342, 2344, 2346, 3747, 3819, 4126, 4401, 5211, 6432, 6738, 6935, 7369, 7376, 7387, 7394, 7399, and 7400

Non-Cited Violations (NCV), LERs and Associated Documents

NCVs Reviewed: 50-321/99-11-0, 50-321, 366/00-02-02, and 50-321/00-02-03
LERs Reviewed: 50-321/2000-001, 50-321/2000-002, 30-321/2000-004, 50-321/2000-005, 50-321/2000-007, 50-366/2000-001, 50-366/2000-003, and 50-366/1993-008
Event Review Reports: 0000001, 0005754, and 0000161
Significant Occurrence Report 9903779
Lesson Plan EC-LP-00101-00

Miscellaneous Condition Reports Reviewed:

CR2001000891, 2000000070, 2000000161, 2000000197, 2000000596, 2000000607, 2000002095, 2000002564, 2000002732, and 9800299