September 7, 2001

Mr. Ted C. Feigenbaum
Executive Vice President and Chief Nuclear Officer
Seabrook Station
North Atlantic Energy Service Corporation
c/o Mr. James M. Peschel
P.O. Box 300
Seabrook, NH 03874

SUBJECT: SEABROOK STATION - NRC INSPECTION REPORT 50-443/01-08

Dear Mr. Feigenbaum:

On August 18, 2001, the NRC completed an inspection at the Seabrook nuclear power station. The enclosed report documents the inspection findings which were discussed on August 23, 2001, with Mr G. St. Pierre 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.

No findings of significance were identified.

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Sincerely,

/RA/

Curtis J. Cowgill, Chief
Projects Branch 6
Division of Reactor Projects

Docket No. 50-443
License No: NPF-86

Enclosure: NRC Inspection Report No. 50-443/01-08
Attachment 1: Supplemental Information
cc w/encl: B. D. Kenyon, President and Chief Executive Officer

J. M. Peschel, Manager - Regulatory Programs
G. F. St. Pierre, Station Director - Seabrook Station
D. G. Roy, Nuclear Training Manager - Seabrook Station
D. E. Carriere, Director, Production Services
W. J. Quinlan, Esquire, Assistant General Counsel
W. Fogg, Director, New Hampshire Office of Emergency Management
D. McElhinney, RAC Chairman, FEMA RI, Boston, Mass
R. Backus, Esquire, Backus, Meyer and Solomon, New Hampshire
D. Brown-Couture, Director, Nuclear Safety, Massachusetts Emergency Management Agency
F. W. Getman, Jr., Vice President/Chief Executive Office, BayCorp Holdings, LTD
R. Hallisey, Director, Dept. of Public Health, Commonwealth of Massachusetts
M. Metcalf, Seacoast Anti-Pollution League
D. Tefft, Administrator, Bureau of Radiological Health, State of New Hampshire
S. Comley, Executive Director, We the People of the United States
W. Meinert, Nuclear Engineer
S. Allen, Polestar Applied Technology, Incorporated
R. Shadis, New England Coalition Staff

Dist w/encl:
(VIA E-MAIL) H. Miller, RA/J. Wiggins, DRA
D. Loveless, RI EDO Coordinator
E. Adensam, NRR (ridsnrrdlpmlpdi)
G. Wunder, PM, NRR
C. Cowgill, DRP
R. Summers, DRP
K. Jenison, DRP
T. Haverkamp, DRP
J. Brand, RI - Seabrook
Region I Docket Room (with concurrences)

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REGION I

Docket No.:	50-443
License No.:	NPF-86
Report No.:	50-443/01-08
Licensee:	North Atlantic Energy Service Corporation
Facility:	Seabrook Generating Station, Unit 1
Location:	Post Office Box 300 Seabrook, New Hampshire 03874
Dates:	July 1, 2001 through August 18, 2001
Inspectors:	Glenn Dentel, Senior Resident Inspector Javier Brand, Resident Inspector
Approved by:	Curtis J. Cowgill, Chief Projects Branch 6 Division of Reactor Projects

SUMMARY OF FINDINGS

IR 05000443-01-08, on 7/01- 8/18/2001; North Atlantic Energy Service Corporation; Seabrook Station; Unit 1. Resident Inspection Report.

The inspection was conducted by the resident inspectors. The inspection identified no significant findings. The significance of most findings is indicated by their color (Green, White, Yellow, Red) using IMC 0609 “Significance Determination Process” (SDP). Findings for which the SDP does not apply are indicated by “no color” or by the severity level of the applicable violation. The NRC’s program for overseeing the safe operation of commercial nuclear power reactors is described at its Reactor Oversight Process website http://www.nrc.gov/NRR/OVERSIGHT/index.html.

A. Inspector Identified Findings

No findings of significance were identified.

B. Licensee Identified Violations

There were no violations identified by the licensee during this inspection.

Report Details

Summary of Plant Status: The plant was operated at approximately 100% power since the beginning of the period until July 12, when power was reduced to 95% to remove a circulating water pump from service for maintenance. On July 13, operators returned the unit to 100% power. The plant was operated at approximately 100% power until August 12, when power was reduced to 50% power to repair a through wall leak on an extraction steam line. The unit was returned to 100% power on August 14, after successful completion of extraction steam line repair activities.

1. REACTOR SAFETY
Cornerstones: Initiating Events, Mitigating Systems, Barrier Integrity

1R01 Adverse Weather Protection

a. Inspection Scope

On August 9, the inspectors reviewed the effects on plant equipment and the station's response to increased ambient temperatures. The inspectors reviewed condition report (CR) 01-08068, which documented several alarms caused by the increased ambient temperature, and verified that the effect on the plant was of minor significance and properly captured in the corrective action program.

The inspectors also performed partial walkdowns of the affected areas and the control room, and interviewed control room operators to assess their understanding of the effect of the heat wave on plant equipment and associated alarms. The following challenges were documented and evaluated by the station.

- Battery rooms "A", "B", and "C" high temperature alarms
- Main generator collector air temperature high
- Emergency feedwater pump house high temperature
- Spray additive tank high level alarm
- Condensate storage tank heater inlet temperature high alarm

b. Findings

No findings of significance were identified.

1R04 Equipment Alignments

a. Inspection Scope

On August 8, the inspectors performed a partial system walkdown of the boration system, while the "A" boric acid tank (BAT) was isolated to allow repairs of a pipe flange leak (CS-FE-9428), and a scheduled preventive maintenance activity to replace the diaphragms for valves CS-V-407 and V-408. The inspectors verified that the redundant "B" BAT and associated piping were properly aligned in accordance with the tagging order and system drawing (1-CS-B20729). The inspectorsobserved whether any

material conditions were present that could challenge the operability of the remaining BAT and components.

On August 26, the inspectors performed a partial system walkdown of the cooling tower portion of the "A" service water system. The inspection was completed during the "B" cooling tower pump replacement. The inspectors reviewed the system alignment as described on plant procedure, OS1016.01, "Service Water System Fill and Vent," Rev. 9 and performed field verification of major equipment alignment.

b. Findings

No findings of significance were identified.

1R05 Fire Protection

a. Inspection Scope

The inspectors reviewed the fire protection analyses and examined the following risk significant areas:

- Enclosure building and air handling area (primary building 25' elevation).
- "A" and "B" Trains emergency core cooling systems (ECCS) equipment vaults, in the primary auxiliary building (PAB).
- Fire Pump house

Specific fire protection conditions examined included control of transient combustibles, material condition of fire protection equipment and installed fire barriers/seals, and the adequacy of any fire impairments and compensatory measures. The inspectors also reviewed the pre-fire strategies for the areas, and CRs 01-00272 and 01-04256 which evaluated a degraded fire seal in the PAB (PB-021-EV101-7504), previously identified by the licensee.

The inspectors verified that actions to repair the degraded fire seal were in place.

b. Findings

No findings of significance were identified.

1R06 Flood Protection Measures

a. Inspection Scope

The inspectors reviewed the Updated Final Safety Analysis Report, the Individual Plant Examination, and Individual Plant Examination of External Events, to evaluate the design basis and risk significance for internal and external floods. The inspectors also examined the probable maximum precipitation and the risk impact on the station. The inspectors performed walkdowns of the service water pump house and roof based on postulated heavy rains and/or floods impacting the area.

b. Findings

No findings of significance were identified.

1R11 Licensed Operator Requalification

a. Inspection Scope

The inspectors observed operator training focusing on human performance of time critical tasks. The inspectors reviewed the operators ability to correctly evaluate the training scenario and implement the emergency plan. The inspectors also evaluated whether deficiencies were identified and discussed during critiques.

b. Findings

No findings of significance were identified

1R12 Maintenance Rule Implementation

a. Inspection Scope

The inspectors evaluated Maintenance Rule (MR) implementation for the charging and safety injection systems. The inspectors examined the last six months of CRs associated with these systems, and reviewed in detail a selected sample of these CRs and determined whether the issues should have been classified as maintenance preventable functional failures. Specific attributes reviewed included MR scoping, characterization of failed structures, systems, and components (SSCs), MR risk categorization of SSCs, SSC performance criteria or goals and appropriateness of corrective actions.

b. Findings

No findings of significance were identified.

1R13 Maintenance Risk Assessment and Emergent Work Control

a. Inspection Scope

The inspectors reviewed the scheduling and control of maintenance activities in order to evaluate the effect on plant risk. The inspectors reviewed the routine planned maintenance and emergent work for the following equipment removed from service:

- On August 1, the inspectors observed the testing and replacement of the “B” emergency diesel generator turbo charger bolting, performed per work request (WR) 01W001832

- On August 17, the inspectors observed the troubleshooting and repairs, performed per WR 01W00824, to a leaking steam admission valve (MS-V-393) for the turbine driven emergency feedwater pump.

- On July 19, the inspectors observed maintenance activities, performed per WR 01W000971 and design change request (DCR 92-033), to change the input resistors for the reactor coolant system (RCS) Thot loop 2 channels, to dampen the effects of an upper head anomaly event.

b. Findings

No findings of significance were identified.

1R14 Personnel Performance During Non-routine Plant Evolutions

a. Inspection Scope

On August 8, the inspectors reviewed operators and maintenance technicians performance during the implementation of a non-routine freeze seal to support the following maintenance activities:

- Installation of a new flange gasket to repair a reoccurring leak at a boration system flange (CS-FE-9428) joint.

- Replacement of the associated diaphragms for two boration system valves (CS-V-407 and V-408).

The inspectors also reviewed CR 01-07959, which was issued by health physics personnel to evaluate the maintenance technicians' use of protective clothing and notification of health physics personnel prior to breaching a potentially contaminated system boundary.

In addition, the inspectorsreviewed CR 01-08239, which documented a condition identified by the inspector, regarding the process to control staging of compressed gas bottles in plant areas where temperatures caused by harsh environment conditions may exceed the bottle temperature limits.

The inspectors interviewed operators, health physics, and maintenance technicians, and performed field walkdowns. The inspectorsreviewed the issues described in the CRs listed to ensure that the identified conditions did not adversely affect system operability or plant safety, and to verify that corrective actions taken were adequate to prevent recurrence.

b. Findings

No findings of significance were identified.

1R15 Operability Evaluations

a. Inspection Scope

The inspectors reviewed operability determinations (ODs) and other issues, in order to determine that the identified conditions did not adversely affect safety system operability

or plant safety. In addition, where a component was determined to be inoperable, the inspectors verified the TS limiting condition for operation implications were properly addressed. The inspectors reviewed the following items:

- OD 01-01536, Foreign solvent material found in the actuators internals for the main feedwater system isolation valves (1-FW-V-30, 39, 48, 57).

- Anomaly detected by the loose parts monitoring system. The inspectors examined the alarm response procedure and the action plan developed to track, evaluate, and address the potential indication of a loose part at the bottom of the reactor vessel.

- Preventive maintenance (PM) repetitive tasks that were overdue (greater than 25% past their recommended completion date). The inspectors reviewed the evaluations of the impact of the overdue PMs and actions to resolve the issues. The PM coordinator initiated several condition reports (01-07603, 01-07674, 01-07675, and 01-07677) to address deficiencies identified.

- "B" emergency diesel generator (EDG) engine vibration high alarms received on July 25, 2001, during a scheduled 4 hour surveillance test run (CR 01-07312). Investigations performed by the system engineer determined that one turbo charger support bracket bolt was loose and one other bolt was broken. The inspectors reviewed the effect that the loose and broken bolts had on the EDG operability, and the actions taken by the system engineer to resolve the issue. The inspectors also performed visual inspections of both EDGs, conducted interviews with the system engineer, and reviewed long term action plans developed by the system engineer to address this repeat bolting problem.

In addition, the inspectors reviewed preliminary OD 01-07774. This OD evaluated a severe deformation of a safety related pipe support (4609-SG-10), that carries dead weight, thermal, and seismic loads for the "D" steam generator feedwater supply piping. The pipe support is anchored to an embed plate in the west wall of the pipe chase and by a vertical leg on the east side of the frame. The upper east corner of the frame was pushed north causing a twist in the lower horizontal member. The embed plate is bowed outwards with evident separation from the wall along the embed plate concrete interface. Additionally, a small crack was identified at the support's bottom saddle weld. No damage to the 18 inch pipe was identified.

The inspectors performed several independent visual inspections of the damaged pipe support and other similar pipe supports associated with all four steam generators feedwater supply piping, visually inspected other systems pipe supports in the general area within both pipe chases and associated piping, reviewed historical data for in-service inspections performed on these pipe supports, interviewed the system and structural engineers, and conducted a conference calls with the NRC regional office and the licensee.

The preliminary OD determined that the support was damaged due to binding between the pipe and the bottom support saddle, preventing the pipe to slide freely on the saddle, during expected thermal expansion of the pipe. The inspectorsverified that there were no indications that the damage was caused by water hammer.

b. Findings

No findings of significance were identified.

1R17 Permanent Plant Modifications

a. Inspection Scope

The inspectors reviewed a design change request (DCR 00-0024), which increased the EDGs jacket water and lubricating oil keepwarm temperatures as corrective actions to the "B" EDG failure of November 1, 2000. These changes were made to bring temperatures within the engine closer to operating temperatures, in order to reduce the possibility of non-uniform growth of the piston skirts which could result in liner rub or damage. The inspectors performed visual inspections of the EDGs, and interviewed the EDG system engineer. The inspectors also reviewed CR 01-06871, which evaluated periodically decrease of the jacket water temperatures below the new administrative limit of 135 degrees Fahrenheit to ensure that operability of the engine was not adversely impacted.

b. Findings

No findings of significance were identified.

1R19 Post-Maintenance Testing

a. Inspection Scope

The inspectors reviewed and/or observed several post-maintenance test (PMTs) activities to ensure: 1) the PMT was appropriate for the scope of the maintenance work completed; 2) the acceptance criteria were clear and demonstrated operability of the component; and 3) the PMT was performed in accordance with procedures.

The inspectors attended some of the pre-evolution briefings, performed system or component and control room walkdowns, observed operators and technicians perform test evolutions, reviewed some of the applicable on-line maintenance assessment forms, and reviewed applicable component performance parameters. The following PMTs were observed and/or reviewed:

- On July 18, OX0443.02, "Electric Fire Pump Weekly Test," Rev. 7, following bearing lubrication and minor oil leak repairs on pump P-21.

- On July 25, OX1406.02, "Containment Spray Pump and Valve Quarterly Operability, 18 Month Position Indication and Comprehensive Pump Testing," Rev. 9, following repair of minor oil reservoir leaks.

- On July 26, OX1456.81, "Operability Testing of IST Valves," Rev. 5, following inspection of limitorque operator, and thermal overload protection relay replacement and calibration for the "B" SI pump suction isolation valve CBS-V-51.

- On July 28, OX1416.05, “Service Water Cooling Tower Pumps Quarterly and 2 Year Comprehensive Test,” Rev. 7, following replacement of the “B” cooling tower pump.

b. Findings

No findings of significance were identified.

1R22 Surveillance Testing

a. Inspection Scope

The inspectors observed portions of several surveillance testing activities of safety related systems to verify that the system and components were capable of performing their intended safety function, to verify operational readiness, and to ensure compliance with required Technical Specifications (TS) and surveillance procedures.

The inspectors attended some of the pre-evolution briefings, performed system and control room walkdowns, observed operators and technicians perform test evolutions, reviewed system parameters, and interviewed the system engineers and field operators. The following surveillance procedures were reviewed.

- On July 12, OX1416.04, “Service Water Quarterly Pump and Discharge Valve Test and Comprehensive Pump Test”, Rev. 9.

- On July 16, OX1436.03, “Electric Driven Emergency Feedwater Pump Quarterly, 18 Month/30 Days Cold Shutdown and Comprehensive Pump Tests, and Monthly Valve Verification Surveillance,” Rev. 8 and OX1456.49, “Train B ESFAS Slave Relay K615 Quarterly Go Test,” Rev. 7. The inspectors also reviewed operator’s response and corrective actions to an operator error (CR 01-06918).

- On July 26, OX1423.33, “Control Room Air Conditioning System Annual EPS Surveillance,” Rev. 0. The inspectors also reviewed operator’s response to the failure of this surveillance test and the engineering evaluation of the test data.

b. Findings

No findings of significance were identified.

1R23 Temporary Plant Modifications

a. Inspection Scope

The inspectors reviewed temporary modifications (TM) 01-0009 and 01-0014, and associated implementing documents to verify the plant’s design basis and affected system or component operability were maintained. Maintenance Manual, MA 4.3A, “Temporary Modifications,” Rev. 16, specified requirements for development and installation of TMs.

On July 13, the inspectors observed activities to repair a minor body to bonnet steam leak on the “D” steam generator main feed water isolation valve 1-LV-4240. On August 13, the inspectors observed activities to repair a through wall leak on an extraction steam line. The inspectors performed field walkdowns of the proposed seal injections in the turbine building prior to implementation and attended the pre-evolution brief. Using NRC inspection manual chapter 9900 as guidance, the inspectors reviewed the work package, the 10 CFR 50.59 safety screening evaluation, on-line maintenance assessment, applicable procedures, and the temporary modification package to ensure that the licensee had implemented adequate engineering controls and analyses.

The inspectors also interviewed personnel, observed portions of the work activities, and reviewed two condition reports initiated to address licensee identified issues during the seal application. The CRs reviewed were:

- CR 01-06858, which documented that the final torque setting changed during application of required bolt torqing, and

- CR 01-06899, which documented that minor leakage remained after application of the sealant, and that the leak had shifted from the body to bonnet joint to the body to bonnet bolts.

b. Findings

No findings of significance were identified.

4. OTHER ACTIVITIES

4OA1 Performance Indicator Verification

.1 High Head Safety Injection (HHSI) and Residual Heat Removal (RHR) Systems Unavailability

a. Inspection Scope

The inspectors selectively examined records used by the licensee to identify safety systems unavailability, which are used to monitor the readiness of important safety systems to perform their intended safety functions in response to off-normal events or accidents.

The inspectors reviewed the performance indicators (PIs) for the HHSI and RHR systems for the time period from July 1, 2000 to June 30, 2001 against the applicable criteria specified in Nuclear Energy Institute (NEI) 99-02, Regulatory Assessment Performance Indicator Guideline, Revision 1, to verify that all conditions that met the NEI criteria were recognized and identified as performance indicators. The inspectors reviewed records included quality assurance surveillance reports, corrective action program records, control room operators logs, and PI data summary reports.

b. Findings

The inspectors determined that for the 1st quarter of 2001, additional unavailability and required hours were incorrectly counted for the HHSI/charging system during the reactor shutdown continuing through January 2001. The engineer, assigned to account the unavailability hours, assumed the TS required boration flow path during refueling was required for the performance indicator. The function required per NEI 99-02 is "the ability of a high pressure safety injection train to take a suction from the primary water source ... and inject into the reactor coolant system at rated flow and pressure." The TS for emergency core cooling systems addresses this function and is required for modes 1 to 4 and not for modes 5 and 6 (refueling). Based on the TS bases, the function of the TS for boration flow path is to "ensure that negative reactivity control is available during each mode of facility operation." Although this function is important and governed by TS, the performance indicator does not track these unavailability and required hours. The licensee concluded that the 1st quarter of 2001 hours were incorrectly submitted and issued CR 01-08604.

The inspectors determined that the reduction in the unavailability and required hours would not change the significance (color) of the reported values for the performance indicator. The licensee planned to include the updated unavailability and required hours in the next quarterly update of the performance indicators.

.2 Auxiliary Feedwater Safety System Unavailability

a. Inspection Scope

The inspectors reviewed the performance indicators for the emergency feedwater (EFW) system. The inspectors verified accuracy of the reported data through reviews of performance indicators for the time period from July 1, 2000 to June 30, 2001 against the applicable criteria specified in NEI 99-02 to verify that all conditions that met the NEI criteria were recognized and identified as performance indicators. The reviewed records included quality assurance surveillance reports, corrective action program records, control room operators logs, and PI data summary reports.

b. Findings

On March 5, the turbine driven emergency feedwater (TDEFW) pump failed to run during a partial loss of off-site power event. The recorded PI fault exposure time for the TDEFW pump was zero hours. The inspectors questioned whether the fault exposure time should be 2 ½ days as assumed in NRC Special Team Inspection Report 0500443/2001-005, dated May 7, 2001.

The licensee determined that the TDEFW pump remained recoverable following the failure to run. The resolution of this item is pending a response from NRC headquarters. Therefore, it is identified as unresolved item (**URI 50-443/01-08-01**). The licensee planned to submit a frequently asked question (FAQ) to address this issue.

.3 Emergency AC Power (Emergency Diesel Generators) System Unavailability

a. Inspection Scope

The inspectors reviewed the performance indicators for the EDGs. The inspectors verified the accuracy of the reported data through reviews of performance indicators for the time period from July 1, 2000 to June 30, 2001 against the applicable criteria specified in NEI 99-02 to verify that all conditions that met the NEI criteria were recognized and identified as performance indicators. The reviewed records included corrective action program records, control room operators logs, and PI data summary reports.

b. Findings

On November 1, 2000, during a 24-hour surveillance test run, the “B” EDG experienced a catastrophic failure requiring extensive repairs and a complete re-built. The recorded PI fault exposure time for this EDG was zero hours. The inspectors questioned whether the fault exposure time should be 3 days (72 hours) as documented in NRC Inspection Report 0500443/2000-011, and in NRC correspondence EA-01-032, “Final Determination For a White Finding and Notice Of Violation At Seabrook, dated June 29, 2001.

The Seabrook staff concluded that the "B" EDG failed during the outage while the plant was shutdown and only one emergency diesel was required to be operational. The licensee planned to submit a FAQ to address this issue. The inspectors determined that this issue requires further clarification and interpretation in regards to the current version of the NEI 99-02 guidance. The resolution of this item is pending a response from NRC headquarters. Therefore, it is identified as unresolved item (**URI 50-443/01-08-02**).

.4 Emergency Preparedness: Drill and Exercise Performance

a. Inspection Scope

As part of the licensed operator requalification inspection, the inspectors reviewed the classifications and notifications completed and the collection of this data for the NRC performance indicator, drill and exercise performance. The inspectors reviewed the licensee's guidance, "Emergency Preparedness Performance Indicators (EPDP-03)," Rev. 5 against the NEI 99-02 guidance.

b. Findings

The licensee guidance in EPDP-03 specified that classification should be within 15 minutes after conditions/data are available and notification within 15 minutes following classification. However, the guidance continues that longer than 15 minutes for either classifications or notifications may be acceptable if the control or emergency response organization staff was performing safety related activities meant to protect the public health and safety. The NEI 99-02 guidance states that timely "offsite notifications are initiated within 15 minutes of event classification." This is consistent with 10 CFR 50, Appendix E requirements of 15 minutes for notifications. In each case, there was not an allowance to exceed the 15 minutes. The licensee agreed with this assessment and have revised their guidance for notifications. The inspectors noted that the licensee's emergency response manual maintained a strict 15 minute requirement for notifications. This manual would have been the guidance used by the operators in an actual event rather than the licensee's PI guidance.

The NEI 99-02 guidance also states timely "classifications are made consistent with the goal of 15 minutes once available plant parameters reach an emergency action level. ... the 15 minute goal is a reasonable period of time for assessing and classifying an emergency once indications are available to control room operators that an emergency action level has been exceeded." The inspectors questioned whether the guidance would permit exceeding the 15 minutes under any circumstance. The licensee interpreted the word "goal" as allowing judgement for those instances where the 15 minutes was exceeded. The licensee planned to submit a FAQ to address this issue. This will remain an unresolved item (**URI 50-443/01-08-03**) pending resolution of the FAQ.

The licensee determined that the emergency preparedness drill and performance indicator would not change since during drills the 15 minute limit was not exceeded for classifications or notifications. The issues were documented in CR 01-07079.

4OA6 Meetings, including Exit

.1 Exit Meeting Summary

The inspectors presented the inspection results to Mr. Gene St. Pierre and other members of licensee management following the conclusion of the inspection on August 23, 2001. The licensee acknowledged the findings presented.

The licensee did not indicate that any of the information presented at the exit meeting was proprietary.

ATTACHMENT 1

SUPPLEMENTAL INFORMATION

a. Key Points of Contact

P. Freeman	Manager, Nuclear Design Engineering (Electrical)
J. Grillo	Assistant Station Director
R. LeGrand	Manager, Work Control and Outages
W. Leland	Manager, Chemistry/Health Physics
T. Nichols	Manager, Plant Engineering
J. Peschel	Manager, Regulatory Programs
B. Plummer	Manager, Operations
D. Roy	Manager, Nuclear Training
R. Sherwin	Manager, Maintenance
G. St. Pierre	Station Director
J. Vargas	Director, Engineering
R. White	Manager, Nuclear Design Engineering (Mechanical)

b. List of Items Opened, Closed and Discussed

Opened:

50-443/01-08-01	URI	Auxiliary Feedwater System Unavailability Performance Indication - Evaluating the TDEFW pump failure to run fault exposure time.
50-443/01-08-02	URI	Emergency AC Power (Emergency Diesel Generators) System Unavailability Performance Indication - Evaluating the “B” EDG failure fault exposure time.
50-443/01-08-03	URI	Emergency Preparedness Performance Indication - Evaluating Exceeding the 15 Minutes for Classifications

c. List of Acronyms Used

BAT	Boric Acid Tank
CR	Condition Report
DCR	Design Change Request
DRPI	Digital Rod Position Indication
EDG	Emergency Diesel Generator
ECCS	Emergency Core Cooling System
EFW	Emergency Feedwater
EPDP	Emergency Preparedness Performance Indicator
FAQ	Frequently Asked Question
HHSI	High Head Safety Injection
NEI	Nuclear Energy Institute
NRC	Nuclear Regulatory Commission
MR	Maintenance Rule
OD	Operability Determination
PAB	Primary Auxiliary Building
PI	Performance Indicator
PM	Preventive Maintenance
PMT	Post Maintenance Testing
RCS	Reactor Coolant System
RHR	Residual Heat Removal System
SDP	Significance Determination Process
SSC	Structure, System, or Component
TDEFW	Turbine Driven Emergency Feedwater
TM	Temporary Modification
TS	Technical Specifications
URI	Unresolved Item
WR	Work Request