

August 22, 2001

Mr. John K. Wood  
Vice President - Nuclear  
FirstEnergy Nuclear Operating Company  
P. O. Box 97, A200  
Perry, OH 44081

SUBJECT: PERRY NUCLEAR POWER PLANT  
NRC INSPECTION REPORT 50-440/01-11(DRP)

Dear Mr. Wood:

On July 26, 2001, the NRC completed a team inspection at the Perry Nuclear Power Station. The enclosed report documents the inspection findings which were discussed on July 26, 2001, with you 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, compliance with the Commission's rules and regulations, and with the conditions of your operating license. Within these areas, the inspection involved selected examination of procedures and representative records, observations of activities, and interviews with personnel.

On the basis of the samples selected for review, there were no findings of significance identified during this inspection. The team concluded that problems were properly identified, evaluated, and resolved within the problem identification and resolution programs.

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,

Original signed by  
Christine Lipa, Chief

Christine Lipa, Chief  
Branch 4  
Division of Reactor Projects

Docket No. 50-440  
License No. NPF-58

Enclosure: Inspection Report 50-440/01-11(DRP)

See Attached Distribution

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J. Wood

-2-

cc w/encl: B. Saunders, President - FENOC  
N. Bonner, Director, Nuclear  
Maintenance Department  
G. Dunn, Manager, Regulatory Affairs  
K. Ostrowski, Director, Nuclear  
Services Department  
T. Rausch, Director, Nuclear  
Engineering Department  
R. Schrauder, General Manager,  
Nuclear Power Plant Department  
A. Schriber, Chairman, Ohio Public  
Utilities Commission  
Ohio State Liaison Officer  
R. Owen, Ohio Department of Health

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U. S. NUCLEAR REGULATORY COMMISSION

REGION III

Docket No: 50-440  
License No: NPF-58

Report No: 50-440/01-11(DRP)

Licensee: FirstEnergy Nuclear Operating Company (FENOC)

Facility: Perry Nuclear Power Plant, Unit 1

Location: P.O. Box 97 A200  
Perry, OH 44081

Dates: July 9 through July 26, 2001

Inspectors: K. Zellers, Team Leader, SRI, Davis-Besse  
C. Lipa, SRI, Perry  
W. Scott, Reactor Inspector

Approved by: Christine Lipa, Chief  
Branch 4  
Division of Reactor Projects

## SUMMARY OF FINDINGS

IR 05000440-01-11(DRP); on 07/09/01-07/26/01; FirstEnergy Nuclear Operating Company; Perry Nuclear Power Plant; identification and resolution of problems.

The inspection was conducted by two resident inspectors and one region-based inspector. The significance of most findings is indicated by their color (Green, White, Yellow, Red) using NRC Inspection Manual Chapter 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>.

### **Identification and Resolution of Problems**

The team concluded that the licensee effectively identified, evaluated, and corrected plant problems. Problem identification was determined to be effective based on a low condition report initiation threshold. Licensee audits and assessments identified issues similar to NRC observations. Formal root cause evaluations were thorough. Corrective actions specified were appropriate based on the identified causes and were effective in preventing recurrence of significant conditions adverse to quality. Plant staff willingness to identify safety issues and a low threshold for initiating condition reports supported a safety conscious work environment. However, room for improvement in the areas of evaluation of issues and corrective actions still exists. Some evaluations could have been more rigorous. Extent of condition reviews could be broader in scope. Several equipment failure problems could have been assigned a more in-depth evaluation method. A few equipment related condition reports were not immediately reviewed by licensed operators. Operators could benefit from Generic Letter 91-18 operability guidance training to ensure accurate operability determinations.

## Report Details

### **4. OTHER ACTIVITIES (OA)**

#### 4OA2 Problem Identification and Resolution

##### a. Effectiveness of Problem Identification

###### (1) Inspection Scope

The inspectors reviewed inspection reports issued over the last year, various condition reports (CR) and corrective action documents, industry operating experience documents, audits, and self-assessments in order to determine if problems were being identified at the proper threshold and entered into the corrective action process. The inspectors focused on corrective action documents relating to three risk significant systems: Emergency Diesel Generators, Reactor Core Isolation Cooling, and Emergency Service Water. The documents reviewed are listed in Attachment 1.

###### (2) Issues and Findings

The team determined that the licensee was effective at identifying problems and entering them into the corrective action system. This was evidenced by the relatively few deficiencies identified by external organizations (including the NRC) that had not been previously identified by the licensee during the review period. Licensee audits and assessments were of good depth and identified issues similar to those that were self-revealing or raised during previous NRC inspections. Also, during this inspection no instances where conditions adverse to quality were being handled outside the corrective action program were identified.

##### b. Prioritization and Evaluation of Issues

###### (1) Inspection Scope

The inspectors conducted an independent assessment of the prioritization and evaluation of a selected sample of CRs. The assessment included a review of the category assigned, operability and reportability determinations, extent of condition evaluations, cause investigations, and the appropriateness and effectiveness of the assigned corrective actions. The inspectors focused on corrective action documents relating to three risk significant systems: Emergency Diesel Generators, Reactor Core Isolation Cooling, and Emergency Service Water. The documents reviewed are listed in Attachment 1.

The inspectors attended several daily management meetings and a restart readiness meeting to observe the assignment of CR categories for current issues and the review of root cause analyses and corrective actions.

(2) Issues and Findings

The team identified that the significance of issues was properly assigned and that root cause evaluations were performed as required by the corrective action program. Formal root cause evaluations were thorough. In general, operability and reportability determinations were technically justified. Actions that were assigned to correct a problem were consistent with the specified causes.

The team noted that several equipment failures could have been designated to receive a more thorough investigation option to prevent recurrence and to determine any generic concerns. For example, CR 01-2658 described a condition where a hydrogen analyzer heater terminal board was found deteriorated and falling apart. The CR indicated that this had happened before and that previous corrective actions may have not been adequate. This CR was designated as requiring an “apparent cause analysis” evaluation method, which is the least in-depth evaluation method that could have been assigned. Because this was an equipment related problem, this issue could have been designated to receive the “basic cause analysis” evaluation method, which required a more rigorous methodology. The inspectors had other examples (CR 01-1983, Motor Feedpump Minimum Flow Valve, and CR 01-3433, Pinhole Leak on ESW Piping) where the “basic cause analysis” evaluation method could have been used, particularly for equipment related problems.

The inspectors observed that extent of condition evaluations were not always prescribed during the CR process and were not always as broad in scope as they could have been. For example, the root cause for degraded condenser vacuum following a turbine trip (CR 01-1982) was that moisture separator reheater drain tank manways had not been hot-torqued. Although other manways were hot torque checked prior to startup, other hot torquing applications, such as hot torquing of body-to-bonnet valves were not evaluated as part of a generic condition evaluation. In another example, non-essential circuit breaker F2B17 had a trip value of 53 ounces, which was greater than the maximum of 50 ounces (CR 00-3683), and no extent of condition evaluation was performed to determine whether other similar circuit breakers had the same problem. Additionally, a pinhole leak was detected on emergency service water piping (CR 00-3433), but there was no documented evidence that an extent of condition review was performed. Thorough extent of condition reviews can discover latent problems with the same root cause that exist with plant equipment, or plant processes, and allow the licensee to act in a pro-active instead of a reactive mode towards identifying and resolving plant problems.

The inspectors noted several examples where the CR evaluation could have been more rigorous. CR 01-0018 described a problem where an improper motor operator stem-nut lubricant caused motor-operated valve (MOV) performance to be less predictable and was causing abnormal wear of the stem-nut. The extent of condition evaluation determined that all MOVs were currently operable but recommended that all MOV stem lubricant be replaced within two refueling outages. The CR did not provide a basis for determining that MOVs would remain operable up to the time of stem-nut lubricant replacement, and therefore did not provide a corrective action due date that could not be changed by the work management organization. Therefore, the evaluation did not provide a positive measure to ensure that MOVs would remain operable until the



stem-nut lubricant was replaced. The licensee generated CR 01-2901 to document this observation. Another example of an evaluation that could have used more rigor was CR 01-2181 where foreign material was found in a motor feedwater pump (MFP) minimum recirculation line. After consultation with the pump manufacturer it was assumed that the foreign material was not from a newly installed MFP because of the relatively high radioactivity of the foreign material and because the MFP vibration and flow characteristics were normal. A more conservative assumption would have been to assume the material came from the pump until proven otherwise. Subsequently, more foreign material became lodged in the minimum recirculation valve. The pump manufacturer then recommended pump disassembly. The licensee shut the plant down, disassembled the pump and that the source of the foreign material was from 9 diffuser vane tips that were missing. This less that rigorous evaluation resulted in an undesired cycle on the plant.

The inspectors determined that operability evaluation training for operators could be improved. This was determined upon review of CR 01-0430, where an emergency core cooling (ECC) train temperature controller was left in manual. Operators performing initial and subsequent operability reviews of the condition did not determine that the system had been inoperable. Generic Letter (GL) 91-18 references NRC Inspection Manual Part 9900 guidance, "Operable/Operability: Ensuring the Functional Capability of a System or Component." Section 6.7 provides guidance for being able to take credit for manual versus automatic actions:

...The licensee should have written procedures in place and *training* accomplished on those procedures before substitution of any manual action for the loss of an automatic action.

The assignment of a dedicated operator for manual action is not acceptable without written procedures and a *full consideration of all pertinent differences...*

After reviewing the above guidance the inspectors determined that the ECC train had been inoperable. One reason was that a full consideration of all pertinent differences between automatic and manual was not done before taking credit for operability. A second reason was that requisite operator training had not been performed for operating the controller in manual. After the licensee reviewed the circumstances and the GL 91-18 guidance with the inspectors, they agreed that the ECC train had been inoperable. The inspectors then determined that operators were not being trained to GL 91-18 guidance. Thereafter, the licensee generated two condition reports (CRs 01-2794 and 01-2795) to obtain operator training on GL 91-18 guidance and to evaluate procedural guidance for equipment operability determinations.

c. Effectiveness of Corrective Action

(1) Inspection Scope

The inspectors reviewed selected CRs and associated corrective actions to evaluate the effectiveness of corrective actions. The inspectors focused on corrective action documents relating to three risk significant systems: Emergency Diesel Generators, Reactor Core Isolation Cooling, and Emergency Service Water. The documents reviewed are listed in Attachment 1.

(2) Issues and Findings

No significant findings were identified in the area of corrective action effectiveness. Root cause evaluations clearly specified the corrective actions which were intended to prevent recurrence of the problem. In all cases reviewed, these actions matched the identified causes and were completed by the required due dates. The inspectors did not identify any significant repetitive problems which would indicate that corrective actions to prevent recurrence had been ineffective.

The inspectors evaluated corrective actions for not performing immediate reviews of some condition reports which was an NRC identified non-cited violation (NCV 2000-009-01, CR 00-2337, CR 00-2258). The root cause was that the program, processes and management expectations did not provide clear guidance to condition report initiators to forward these items to the SRO for review. The licensee changed the program to list the conditions that require that senior reactor operator (SRO) reviews be done and included the list within the condition report software so that SRO reviews would be forced if any condition of the list was met. Despite the change in program requirements, the inspectors found several instances where the SRO review block was improperly checked no. None of these examples constituted a problem that was more than minor in nature because no operability or reportability issues were determined with the particular examples. These examples were indications of implementation problems not related to the previous programmatic problem. The licensee agreed and generated CRs to address the observations.

The inspectors determined that control of the maintenance procedure change backlog did not consistently include positive actions to ensure out of date procedures would not be used. About 200 procedure change requests were identified as needing to be implemented before the next use of the applicable procedure. However, no formal administrative controls were used to prevent the applicable procedures from being used prior to the implementation of the change. The licensee agreed that corrective actions were necessary to address the inconsistent use of administrative controls for procedures needing revision and generated CR 01-2923 to resolve the issue.

d. Assessment of Safety-Conscious Work Environment

(1) Inspection Scope

During the inspection, the inspectors asked plant staff the type of questions that might indicate any unwillingness to raise safety questions. The types of questions that were asked are listed in Appendix 1 to Inspection Procedure 71152, "Suggested Questions for Use in Discussions with Licensee Individuals Concerning PI&R Issues." The inspectors also discussed the implementation of the Employee Concerns Program with the plant's Ombudsman.

(2) Issues and Findings

No significant findings were identified. Plant staff interviewed indicated a willingness to identify safety issues. The low threshold for initiating CRs, the increasing number of CRs, and management support for using the CR process observed during the daily management meeting also supported a safety conscious work environment.

4OA5 Other

(Closed) URI 50-440/01-09-01. Inability to Automatically Backwash Emergency Service Water Strainer. The inspectors reviewed the licensee's 10 CFR 50.59 screening documentation, the USAR, and the operating procedures. The inspectors determined that there was no violation because the automatic backwashing was not a safety-related feature. The inspectors also determined that the licensee had provided sufficient guidance to operators to address this work-around until the equipment is repaired, which is scheduled for October 2001.

4OA6 Meetings

Exit Meeting

The inspectors presented the inspection results to Mr. J. Wood and other members of licensee management in an exit meeting on July 26, 2001. Licensee management acknowledged the findings presented and indicated that no proprietary information was provided to the inspectors.

## KEY POINTS OF CONTACT

### Licensee

R. Lockwood, Supervisor, Performance Improvement Unit  
J. Hubbart, Performance Improvement Unit  
K. Russell, Regulatory Affairs  
M. Peterson, RCIC System Engineer  
R. Pikus, ESW System Engineer  
R. Boyles, EDG System Engineer  
S. Sayovitz, MOV Program Engineer  
J. Wood, Vice President-Nuclear  
G. Dunn, Manager, Regulatory Affairs  
D. Gudger, Supervisor, Compliance  
T. Lentz, Manager, Design Engineering  
K. Ostrowski, Director, Nuclear Services Department  
T. Rausch, Director, Nuclear Engineering Department  
R. Schrauder, General Manager, Nuclear Power Plant Department

### NRC

L. Collins, Acting Branch Chief, Reactor Projects, Branch 4  
R. Vogt-Lowell, Resident Inspector, Perry

## LIST OF ITEMS OPENED, CLOSED, AND DISCUSSED

### Closed

50-440/01-09-01    URI    Inability to Automatically Backwash ESW B Strainer

## LIST OF ACRONYMS USED

ADAMS	Agencywide Documents Access and Management System
CFR	Code of Federal Regulations
CR	Condition Report
ECC	Emergency Core Cooling
FENOC	FirstEnergy Nuclear Operating Company
GL	Generic Letter
MFP	Main Feedwater Pump
NCV	Non-Cited Violation
NRC	Nuclear Regulatory Commission
NRR	Office of Nuclear Reactor Regulation
PARS	Publicly Available Records
SDP	Significance Determination Process
SRO	Senior Reactor Operator
TS	Technical Specification

## ATTACHMENT 1

### LIST OF DOCUMENTS REVIEWED

The following is a list of licensee documents reviewed during the inspection, including documents prepared by others for the licensee. Inclusion of a document on this list does not imply that NRC inspectors reviewed the entire documents, but, rather that selected sections or portions of the documents were evaluated as part of the overall inspection effort. In addition, inclusion of a document on this list does not imply NRC acceptance of the document, unless specifically stated in the body of the inspection report.

#### Condition Reports

- 01-0381 RCIC Oil Level Indicator
- 00-0150 During Div 2 EDG Surveillance Start, Annunciators Came in for Crankcase Pressure High Trip, Lube Oil Pressure Low Trip, and Jacket Water Outlet Temp High Trip
- 00-0202 Upon Starting Div-3 EDG for its Monthly SVI Run, Output Voltage Was Slow to Respond
- 00-1320 Failure to Establish Proper Administrative Controls over Containment Isolation Valves
- 00-1370 The M43 Div 3 EDG Dampers Did Not Stroke When the Associated Controller Was Taken to Manual
- 00-0559 Evaluation of in 2000-01 Operational Issues Identified in Boiling Water Reactor Trip and Transient
- 00-1478 During Maintenance Run of the Div 3 EDG, One of the Two Fuel Oil Transfer Pumps Failed to Automatically Shut off on High Fuel Oil Day Tank Level.
- 00-1549 An Unexpected Half (½) Main Steam Line Isolation Signal from Div-2
- 00-1549 During Normal Operation of the Power Plant, Received an Unexpected Half (½) Mn Steam Line Isolation Signal from the Division 2 Lead Detection System.
- 00-2151 RCIC Turbine Trip Throttle Valve Tripped for Apparent Reason
- 00-1439 The Control Room Was Not Able to Raise or Lower the Generator Output Voltage During the Second Maintenance Run of the Div 3 EDG
- 00-2337 Control Room Review of CRs
- 00-2358 MOV Corrective Actions Untimely
- 00-2397 Discovered the Fuse Replaced 8/8/00 on the Transformed, Located North of the Technical Bldg., Had Failed Again
- 00-2538 Inadequate Evaluation of MOV Test Data
- 00-2768 The DIV 2 EDG Starting Air Compressor 2B Has Evidence of Water in the Oil.
- 00-2243 Maintenance Performed on Non-safety Valve May Have Affected ESW System

- 00-3185 Audit 00-14 Review of the Collective Significance Review Committee
- 00-3363 Failure to Promptly Address Extended Inoperability of the Control Room CO2 System
- 00-3418 Failure to Update Procedure ONI-054 in a Timely Manner to Include Information Used to Alert Operators about Potential Fire Impacts upon RHR Valves
- 00-3433 Pinhole Leak on ESW Piping
- 00-3529 Foreign Material Found in Lube Oil Sump Tank, 1R47A0001B
- 00-3530 Foreign Material Found in Main Bearing Lube Oil Sump of Division 2 EDG
- 00-3560 Foreign Material Found Wedged in Heat Exchanger Tube
- 00-3634 Division 3 Emergency Diesel Generator Monthly Run, the Voltage Regulator Did Not Respond as Expected
- 00-3683 Breaker F2B17 Had Trip Value of 53 Ounces Instead of <50 Ounces.
- 00-3709 EDG Fuel Oil Strainer Differential Pressure Switch
- 00-3901 Inadequate Test Procedure for SRV Logic
- 01-0018 MOV Test Data for 1E12F0064A Did Not Meet FTI-F0016 Criteria
- 01-0049 Motor Operated Valve Program Issues Related to 1E12F064A
- 01-0209 Recommendations Associated with Site Trending Report SA 232-QAS-2000
- 00-2959 Emergency Operating Procedure Was Not Correct
- 01-0430 ECC A Controller Found in Manual
- 01-0530 Div 1 EDG Fuel Transfer Pump 2 Running Alarm with Pump-2 Not Running
- 01-0667 Technical Specification Locked High Radiation Areas Had an Inadequate Barrier (Two Examples, in Violation of Technical Specification 5.7.2
- 01-0699 Limitorque Actuator Gear Box Grease
- 01-0880 PM Tasks Deterred 3rd Time
- 01-0900 FME in Div-1 EDG
- 01-0921 Review of Corrective Action Program Sub-processes for Effectiveness
- 01-0923 As Found MOV Diagnostic Test Data for 1E51F0063 Were Unsat
- 01-1099 Div 1 EDG Reverse Power Trip
- 01-1230 Technical Specification Locked High Radiation Areas Had an Inadequate Barrier (Two Examples, in Violation of Technical Specification 5.7.2
- 01-1248 Information Notice Evaluation of Potential Loss of Safety Related Equipment Due to Lack of HELB
- 01-1299 Div 3 EDG Had Been Run with Fuel Oil System Not in the Standby Condition.
- 01-1323 1E51F064 Leaked Excessively During Performance of LLRT

01-1406 ESW Valve Failed PMT

01-1473 Collective Significance of Configuration Control Issues

01-1493 Refuel Floor Closure Walkdown

01-1646 Foreign Material Found in Drier Skid

01-1695 Altercation Between MOVATS Contract Employees During RF08

01-1700 MOV CR

01-1700 Collective Significance for Motor Operated Valve Stem Lubrication Issues.

01-1749 MOV CR

01-1801 EDG Damper Linkages Fail/crack Following Modification

01-1978 Stator Water Cooling Leak

01-1979 ECCS Signal - Invalid

01-1980 ECCS Signal - Invalid

01-1982 Loss of Condenser Vacuum

01-1983 Motor Feedpump Min Flow Valve

01-1984 Turbine Bypass Valve Failed to Close

01-1985 ECCS Signal - Invalid

01-1986 Manual Reactor Scram

01-1989 Overall Forced Outage Review

01-1993 RCIC Test Return Valve Failure

01-2008 Extent of Condition Evaluation for Loose MSR Manways Described in CR 01-1982

01-2010 Low-Low Set Logic Initiated During Scram Event

01-2017 RFPT Trip on Low Condenser Vacuum

01-2181 FME in Valve 1N27-F0170

01-2505 Stored Equipment Resting on RHR Piping

01-2651 Div 3 D/g Failed to Start

01-2658 H2 Analyzer Heater Term Board Found Deteriorated and Falling Apart

99-1177 During Div 3 LOOP/LOCA Test, EDG Failed to Load the Bus. EDG Output Breaker Closed but EDG Did Not Load.

99-1279 Technical Specification Locked High Radiation Areas Had an Inadequate Barrier (Two Examples, in Violation of Technical Specification 5.7.2

99-1721 Upon Start of Div-2 Dg Annunciator "Fuel Pumps/os Drive Failure" Was Received and Locked In.

99-2219 RFA to Allow Loctite Instead of Staking Screw for RCIC Emergency Weight

Adjusting Screw

- 99-2221 Some Personnel Are Reluctant to Report Human Performance Issues.
- 99-2365 During Preparation to Correct a Loose Bolt on Division 2 Diesel Generator, the Mechanic Found a Broken Bolt on the Tie Plate Between the Turbo chargers.
- 99-2454 Storage of Equipment in Cages, Where Items May Be Close to Safety-related Equipment
- 99-2510 Calculation E51-5 Rev 2 Discrepancies

CRs Initiated During the Inspection

<b>CR#</b>	<b>Description</b>
01-2902	Motor Operated Valve Stem Lubrication Issues from NRC Inspection.
01-2923	Weakness in Control of Procedures During Changes.
01-2936	PI&R Inspection Recommendation for Expanded Use of Effectiveness Reviews.
01-2937	Additional PI&R Identified CRs That Did Not Receive a Control Room Review.
01-2892	Apparent Procedure Weakness in Implementing USAR Requirement
01-2855	RCIC Room Aux 574' Under grating Housekeeping
01-2852	CR 01-1982 Did Not Receive a Control Room Review
01-2854	CR 01-2181 Did Not Receive a Control Room Review
01-2794	RFA Request for Operator Training on Generic Letter 91-18
01-2795	Evaluate Procedural Guidance for Operability of Equipment

NCVs and URI's

2000-009-01	Control room review of CRs
2000-009-02	MOV corrective actions untimely
2000-010-01a	Failure to update procedure ONI-054 in a timely manner to include information used to alert operators about potential fire impacts upon RHR valves
2000-010-01b	Failure to promptly address extended inoperability of the Control Room CO2 system
2000-014-02	Inadequate test procedure for SRV logic
2001-06-01	Technical Specification locked high radiation areas had an inadequate barrier (two examples, in violation of Technical Specification 5.7.2
2001-06-01	Technical Specification locked high radiation areas had an inadequate



2001-06-01 barrier (two examples, in violation of Technical Specification 5.7.2  
 Technical Specification locked high radiation areas had an inadequate barrier (two examples, in violation of Technical Specification 5.7.2

URI 2001-08-01 EDG damper linkages fail/crack following modification

URI 2000-14-01 Inadequate Evaluation of MOV test data

Self Assessments and QA Audits

PA 01-02 Refuel Outage/In-Service Inspection Program and Activities/Special Nuclear Material Controls

232-QAS-2000 Self Assessment Report - 2nd Quarter 2000 Site Trend Report  
 Perry Nuclear Power Plant Business Plan Monthly Performance Report

216-QAS-2000 INPO Corrective Action Program Principles GAP Analysis March 1 through July 31. 2000

270QAS2000 Effectiveness of Operating Experience

PA 00-14 Effectiveness of Corrective Action Audit

Procedures

PAP 0205	Operability of Plant Systems	9
NOP-LP-2001	Condition Report Process	1
NOP-LP-2001	Perry CR Reference Guide	June 28, 2001
SOI-P45/P49	System Operating Instruction for ESW system	Rev 2
ARI	Annunciator Response Procedures for ESW	
NOP-LP-2003	Employee Concerns/Ombudsman Program	Rev 1

Miscellaneous Documents

PAAR 00-023 Full consideration of all pertinent differences Performance Analysis and Action Report (PAAR) EDG starting air compressor oil analysis

PAAR 01-006 Reactor recirculation pump oil analysis

PAAR 00-008 RCIC Turbine degraded lubricant

PAAR 00-011 Steam bypass and pressure regulation pump vibration levels

PAAR 01-011 Reactor water cleanup pump motor vibration levels

PAAR 01-010 Main feedwater pump vibration levels

PAAR 00-002 MCC F1F04 feed to breaker 0P50C0001B high resistance

PAAR 00-001 Distribution panel F1G05 feed to 0P55B0035E high resistance

PNPP 2001-1	PNPP System Health Report
PNPP 2000-4	PNPP System Health Report Corrective Action Review Board Charter Dated 11/22/99  PES CR Binning Report 01/01/2000 Thru 01/06/2000 Investigation Report - "Unexpected ESF, SRV, and RRCS Actuations Following Scram 01-002" Dated 05/24/01
PIU 01-00002	Collective Significance Review Report 01-2001 Dated 6/26/01
OSCR 2000-0222	Outage Scope Change Request (OSCR) for ESW work items
Board meeting 2001-0002	Outage Review Board Meeting Minutes regarding ESW work items
PY1-P45-0020	10 CFR 50.59 Screen for tagout on ESW strainer, dated July 3, 2001
USAR 9.2	Emergency Service Water System
IN 98-07 Response	Offsite power reliability challenges from industry deregulation
IN 97-84 Response	Rupture in extraction stem piping as a result of flow-accelerated corrosion.
IN 98-24 Response	Stem binding in turbine governor valves in reactor core isolation cooling (RCIC) and auxiliary feedwater.  CR Survey Question Averages dated 7/26/01 Printout of online corrective maintenance backlog dated 7/24/01 Printout of online minor maintenance backlog dated 7/24/01 Manager's Communication s and Teamwork Meeting Package for 7/12/01 Manager's Communication s and Teamwork Meeting Package for 7/10/01 System Health Report 2000-4
Letter	Bob Saunders Letter dated 11/28/00 Regarding Safety Conscious Work Environment
IN 97-45 Response	Containment Radiation Monitor Qualification Concerns  Manager's Communications and Teamwork Meeting Package for 6/27/01
Memo	Memo From Kearney Dated 2/9/01, Control of CAFs for Work in the Plant

List of Requested Items Prior to On-site Inspection

Corrective Action Program Procedures  
Trending Program Procedures

QA Audit Procedure  
Self-assessment Program Procedures  
Copy of Most Recent Audit of Corrective Action Program  
Copy of Most Recent Self-assessment of Corrective Action Program  
Employee Concerns Program Procedure  
List of Maintenance Rule A-1 from June 2000  
List Ranking of Significant Systems  
List of QA Audits since June 2000  
List of Self-assessments since June 2000  
List of Operability Determinations  
List of Root Cause Evaluations since June 2000  
List of Test Failures since June 2000  
List of EOP Changes  
List of Performance Indicators for Corrective Action Program  
CRs by Ranking since June 2000  
CRs Documenting Ineffective Corrective Action since June 2000  
CRs Identifying Trends Adverse to Quality since June 2000