



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

October 17, 2001

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

**SUBJECT: EDWIN I. HATCH NUCLEAR POWER PLANT - NRC INTEGRATED
INSPECTION REPORT 50-321/01-05, 50-366/01-05, and 72-36/01-02**

Dear Mr. Sumner:

On September 29, 2001, the Nuclear Regulatory Commission (NRC) completed an inspection at your Hatch Nuclear Reactor facility. The 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. The enclosed report documents the inspection findings which were discussed on October 10, 2001, with Mr. P. Wells and other members of your staff.

Based on the results of this inspection, the inspectors identified three findings of very low safety significance (Green). One finding was determined to involve a violation of NRC Requirements. However, because of its very low safety significance and because it has been entered into your corrective action program, the NRC is treating this issue as a non-cited violation, in accordance with Section VI.A.1 of the NRC's Enforcement Policy. If you deny this non-cited violation, you should provide a response with the basis for your denial, within 30 days of the date of this report, to the Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington DC 20555-0001; with copies to the Regional Administrator, Region II; the Director, Office of Enforcement, United States Nuclear Regulatory Commission, Washington, DC 20555-0001; and the NRC Resident Inspector at the Edwin I. Hatch Nuclear Power Plant.

Since September 11, 2001, your staff has assumed a heightened level of security based on a series of threat advisories issued by the NRC. Although the NRC is not aware of any specific threat against nuclear facilities, the heightened level of security was recommended for all nuclear power plants and is being maintained due to the uncertainty about the possibility of additional terrorist attacks. The steps recommended by the NRC include increased patrols, augmented security forces and capabilities, additional security posts, heightened coordination with local law enforcement and military authorities, and limited access of personnel and vehicles to the site.

The NRC continues to interact with the Intelligence Community and to communicate information to you and your staff. In addition, the NRC has monitored maintenance and other activities which could relate to the site's security posture.

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In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosures will be publicly available in the NRC Public Document Room or from the Publicly Available Records (PARS) component of the NRC's document system (ADAMS).

ADAMS is accessible from the NRC Web site at <http://www.nrc.gov/NRC/ADAMS/index.html> (the Public Electronic Reading Room).

Sincerely,

/RA/

Stephen J. Cahill , Chief
Reactor Projects Branch 2
Division of Reactor Projects

Docket Nos.: 50-321, 50-366, 72-36

License Nos.: DPR-57, NPF-5

Enclosure: Integrated Inspection Report
50-321/01-05, 50-366/01-05, 72-36/01-02
w/Attachment

cc w/encl: (See page 3)

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cc w/encl:
J. D. Woodard
Executive Vice President
Southern Nuclear Operating Company, Inc.
Electronic Mail Distribution

Charles A. Patrizia, Esq.
Paul, Hastings, Janofsky & Walker
10th Floor
1299 Pennsylvania Avenue
Washington, D. C. 20004-9500

P. H. Wells
General Manager, Plant Hatch
Southern Nuclear Operating Company, Inc.
Electronic Mail Distribution

Senior Engineer - Power Supply
Municipal Electric Authority
of Georgia
Electronic Mail Distribution

D. M. Crowe
Manager Licensing - Hatch
Southern Nuclear Operating Company, Inc.
Electronic Mail Distribution

Ernest L. Blake, Esq.
Shaw, Pittman, Potts and
Trowbridge
2300 N Street, NW
Washington, D. C. 20037

Office of Planning and Budget
Room 610
270 Washington Street, SW
Atlanta, GA 30334

Director
Department of Natural Resources
205 Butler Street, SE, Suite 1252
Atlanta, GA 30334

Manager, Radioactive Materials Program
Department of Natural Resources
Electronic Mail Distribution

Chairman
Appling County Commissioners
County Courthouse
Baxley, GA 31513

Resident Manager
Oglethorpe Power Corporation
Edwin I. Hatch Nuclear Plant
Electronic Mail Distribution

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U. S. NUCLEAR REGULATORY COMMISSION

REGION II

Docket Nos: 50-321, 50-366, 72-36

License Nos: DPR-57, NPF-5

Report No: 50-321/01-05, 50-366/01-05, 72-36/01-02

Licensee: Southern Nuclear Operating Company, Inc. (SNC)

Facility: E. I. Hatch Nuclear Power Plant, Units 1 & 2

Location: P. O. Box 2010
Baxley, Georgia 31515

Dates: July 1, 2001 - September 29, 2001

Inspectors: J. Munday, Senior Resident Inspector
N. Garrett, Resident Inspector
R. Chou, (Section 1R02)
D. Forbes, Regional Radiation Protection Inspector,
(Section 2OS1, 2OS2, 2PS1, 2PS3, 4OA5)
A. Nielsen, Regional Radiation Protection Inspector,
(Section 2OS1, 2OS2, 2PS1, 2PS3, 4OA5)
D. Holman, Regional Physical Security Inspector,
(Section 3PP1, 3PP2, 4OA1.2 and 4OA3.3)

Approved by: Stephen J. Cahill, Chief
Reactor Projects Branch 2
Division of Reactor Projects

Enclosure

SUMMARY OF FINDINGS

IR 05000321-01-05, IR 05000366-01-05, IR 07200036/01-02 on 07/01 - 09/29/2001, Southern Nuclear Operating Company, Inc., Edwin I. Hatch Nuclear Power Plant, Units 1 & 2, Surveillance Testing.

The report covers a 13-week period of inspection conducted by resident inspectors, a regional security inspector, and regional health physics inspectors. The inspectors identified three findings of very low safety significance (Green). One finding was determined to involve a violation of NRC Requirements which is a Non-Cited Violation. The significance of most findings is indicated by their color (Green, White, Yellow, Red) using Inspection Manual Chapter 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 at <http://www.nrc.gov/NRR/OVERSIGHT/index.html>.

A. Inspector Identified Findings

Cornerstone: Mitigating Systems

- Green. A non-cited violation (NCV) of 10 CFR 50, Appendix B, criterion XVI was identified by the inspectors for the licensee's failure to identify repetitive calibration problems and prevent recurrence of a setpoint drift problem associated with 4 kv emergency bus undervoltage relays.

The finding was of very low safety significance because the setpoint drift would not result in the failure of the Emergency Diesel Generator (EDG) to provide emergency power to the bus, but would only result in a delay of the automatic start feature of the EDG. Additionally, this problem would have to occur in multiple relays simultaneously before the auto start feature of the EDG would be affected. The inspectors reviewed the past 11 years and did not identify any examples where the problem occurred in multiple relays simultaneously (Section 1R22).

Cornerstone: Public Radiation Safety

- Green. The inspectors identified a finding of very low safety significance for the licensee's failure to perform corrective maintenance or implement compensatory measures for degraded primary meteorological tower atmospheric temperature instruments that impaired the ability to assess offsite dose during a plant emergency.

The finding has very low safety significance because the secondary meteorological tower instruments were available for use and no release of radioactivity that required a prompt offsite dose assessment occurred. There was no actual public safety consequence (Section 2PS3.2).

Cornerstone: Other Activities

- Green. The inspectors identified a finding of very low safety significance for the licensee's failure to perform preventative maintenance on traveling water screen (TWS) system instruments that affected the performance of the Plant Service Water (PSW) system. As a result, the screens became clogged with debris and the intake structure water level decreased causing fluctuations in PSW flow and pressure. Operators reduced power to 85% on Unit 1 and 90% on Unit 2 in response to the problem and dispatched operators to start the TWS locally. Quick response of the operators prevented further degradation of PSW as well as any adverse impact on mitigating systems.

The finding has very low safety significance because prompt operator response and performance demonstrated that the procedures in place were satisfactory and the operators were properly trained to perform the evolution (Section 4OA3.1).

B. Licensee Identified Violations

Violations of very low significance which were identified by the licensee have been reviewed by the inspectors. Corrective actions taken or planned by the licensee appear reasonable. These violations are listed in section 4OA7 of this report.

Report Details

Summary of Plant Status

Unit 1 operated at or near full Rated Thermal Power (RTP), with the exception of planned maintenance and testing, during most of this inspection period. On July 23, reactor power was reduced to 85% when debris clogging the traveling water screens (TWS) affected performance of the PSW system. Reactor power was returned to 100% the following day.

Unit 2 operated at or near full RTP, with the exception of planned maintenance and testing, during most of this inspection period. On July 23, reactor power was reduced to 90% when debris clogging of the TWS affected performance of the PSW system. Reactor power was returned to 100% the following day. A power reduction was commenced on September 14 in preparation for a scheduled refueling outage. The unit was placed in Cold Shutdown on September 15 where it remained for the rest of the inspection period.

1. REACTOR SAFETY

Cornerstones: Initiating Events, Mitigating Systems, Barrier Integrity

1R02 Evaluations of Changes, Tests, or Experiments

a. Inspection Scope

The inspectors reviewed selected samples of safety evaluations to verify the licensee had appropriately considered the conditions under which changes to the facility or procedures may be made, and tests conducted, without prior NRC approval. The inspectors reviewed 10 safety evaluations (SEs) for changes to designs and procedures. There were two tests selected. The inspectors reviewed information, such as drawings, procedures, or other supporting documents, to verify that the licensee had appropriately concluded the changes could be accomplished without obtaining a license amendment. The inspectors compared licensee performance to the requirements in 10 CFR 50.59. The 10 safety evaluations reviewed are listed in the Attachment of this report.

The inspectors also reviewed samples of design/engineering permanent or temporary modifications and procedure changes for which the licensee had determined that evaluations were not required, to verify the licensee's conclusions to "screen out" these changes were correct and consistent with 10 CFR 50.59. The 12 "screen out" changes reviewed are listed in the Attachment of this report.

b. Findings

No findings of significance were identified.

1R04 Equipment Alignment (Quarterly)

a. Inspection Scope

The inspectors reviewed licensee procedures, system and component checklists, and plant configuration to verify systems and components were correctly aligned.

Procedures and documents reviewed are listed in the Attachment of this report. Systems verified for correct alignment included the following:

- Unit 1 Reactor Core Isolation Cooling System (RCIC)
- Unit 1 A Loop Core Spray System
- Unit 1 B Loop Core Spray System
- Unit 1 A Standby Liquid Control System
- Unit 2 A & B Loop Core Spray System
- Unit 2 B Residual Heat Removal System (RHR)

b. Findings

No findings of significance were identified.

1R05 Fire Protection

a. Inspection Scope

The inspectors toured risk significant areas to assess the material condition of the fire protection and fire detection equipment and to verify fire protection system equipment was not obstructed. The inspectors reviewed procedure 40AC-ENG-008-OS, Fire Protection Program, Revision (Rev.) 8, Edition (Ed.) 2 and conducted area walkdowns to assess the licensee's control of transient combustibles. The inspectors also reviewed the Site Fire Hazards Analysis, and applicable Pre-fire Plan drawings to verify that the necessary fire fighting equipment, such as fire extinguishers, hose stations, ladders, and communications equipment, was in place. Procedures and documents reviewed are listed in the Attachment of this report. The fire areas inspected included the following:

- Fire Areas 2203I, 2205Q, 2205S, 2205T, 2205R, 2205U, 2205V, 2205X and 2205Y, Unit 2 Reactor Bldg. elevation (el.) 185' and 203'
- Fire Area 0024A, Cable Spreading Room
- Fire Area 1004, Unit 1A Station Service Battery Room
- Fire Area 1005, Unit 1B Station Service Battery Room
- Fire Areas 1203F & 1205F, Unit 1 Reactor Bldg. el. 130'

b. Findings

No findings of significance were identified.

1R06 Flood Protection

a. Inspection Scope

The inspectors reviewed the Updated Final Safety Analysis Report (UFSAR) and the Individual Plant Examination to determine plant areas susceptible to flooding. The inspectors performed walkdowns in the Unit 1 and Unit 2 reactor buildings in areas susceptible to internal flooding to assess facility condition, the adequacy of flood detection and mitigation systems, and identify potential sources of internal flooding not previously identified by the licensee. The preventive maintenance program for the

reactor building leakage detection systems was assessed to determine if it was adequate to ensure a flooding condition could be promptly identified. In addition, the inspectors assessed the licensee's procedures to mitigate water intrusion into the reactor buildings through underground cable ways. Procedures, drawings, and documents reviewed are listed in the Attachment of this report.

b. Findings

No findings of significance were identified.

1R11 Licensed Operator Requalification (Quarterly Review)

a. Inspection Scope

The inspectors observed licensed operator simulator training involving a simulated reactor startup with the reactor coolant system already hot. In addition, the inspectors observed the performance of two simulator scenarios; LT-SG-50314, Aircraft Crash on Diesel Generator Building/Fire/Loss of Emergency Busses, Rev. 1 and LT-SG-50332, Loss of Vital AC Buss/Loss of Stator Cooling/Small ATWS, Rev. 10. The inspectors reviewed licensee procedures 10AC-MGR-019-0S, Procedure Use and Adherence, Rev. 3 and DI-OPS-59-0896N, Operations Management Expectations, Rev. 10, to assess operator performance for the following: formality of communication; procedure usage; alarm response; control board manipulations; group dynamics; and supervisory oversight. The inspectors also reviewed licensee procedure 73-EP-EIP-001-0S, Emergency Classification and Initial Actions, Rev. 14, Ed. 1, to verify that the event action level was correctly identified and reported. In addition, the inspectors reviewed the critique results from previous training sessions to assess performance improvement. The inspectors attended the licensee's critique of operator performance to assess if the licensee identified issues were comparable to issues identified by the inspectors. The inspectors compared their observations of licensee performance to the requirements in procedure DI-TRN-24-0885N, Simulator Documentation Requirements, Rev. 3.

b. Findings

No findings of significance were identified.

1R12 Maintenance Rule (MR) Implementation

a. Inspection Scope

The inspectors reviewed the following performance-based problems associated with structures, systems, and components to assess the licensee's implementation of the MR (10 CFR 50.65) with respect to the characterization of failures and the appropriateness of the associated (a)(1) or (a)(2) classification. For the equipment problems identified below, the inspectors reviewed operator logs, associated CRs, and the licensee's procedures for implementing the MR. The review was to determine if equipment failures were being identified, properly assessed, and corrective actions established to return the equipment to a satisfactory condition. Procedures and documents reviewed are listed in the Attachment of this report.

- Unit 1 Down River Traveling Water Screen Failure, CR 2001004934
- Unit 1 Down River Traveling Water Screen Failure, CR 2001005748
- Unit 2 Turbine Building Chiller B (2 trips), CR 2001005185
- Unit 1 Control Room HVAC Trip, CR 2001003485
- Unit 2 RHR Minimum Flow Valve 2E11-F007A, CR 2001006322
- Unit 2 Turbine Building Chiller A Trip, CR 2001006704

b. Findings

No findings of significance were identified.

1R13 Maintenance Risk Assessments and Emergent Work Evaluation

a. Inspection Scope

The inspectors reviewed licensee Plan of the Day (POD) documents to verify that risk assessments were performed prior to components being removed from service. In addition, when emergent work was identified, the inspectors held discussions with licensee personnel and walked down plant systems to verify that actions were taken to minimize the probability of an initiating event and maintain the functional capability of mitigating systems. Documents reviewed to support this inspection are listed in the Attachment of this report. Work activities observed and maintenance work orders (MWOs) reviewed included the following:

- 4KV Bus 1F Alternate Supply Breaker, MWO 10103125
- POD for the weeks of June 30 - July 6, August 4-10, and September 8-14, 2001
- 1A RHR Pump inoperable due to wear particles in the oil, CR 2001005610
- Low Intake Structure water level affecting plant service water performance, CR 2001005748
- RPS Alternate Power Supply failure, CR 2001006233 and CR 2001006292
- POD following trip of 2A and 2B Tb Bldg. Chillers, CR 2001006704
- POD resulting from Operability Determination for Unit 1 RHRSW Pump 'D', CR 01007081

b. Findings

No findings of significance were identified.

1R14 Personnel Performance During Nonroutine Plant Evolutions

a. Inspection Scope

The inspectors reviewed licensee procedures, control room logs, chart data recordings, and discussed personnel performance with licensee management following an unplanned power reduction and declaration of a Notification of Unusual Event for both units on July 23. These actions were taken following a low intake structure water level which resulted in PSW system flow and pressure fluctuations. Details are included in Section 4OA3.1, Event Follow-up, of this report. The Inspectors review was to verify

operator performance was in accordance with the procedures listed in the Attachment of this report.

b. Findings

No findings of significance were identified.

1R15 Operability Evaluations

a. Inspection Scope

The inspectors reviewed operability evaluations and compared the evaluations to the system requirements identified in the Technical Specifications (TS) and the UFSAR to ensure that operability was adequately assessed and the system or component remained available to perform its intended function. Procedures and documents reviewed are listed in the Attachment of this report. Operability evaluations reviewed included the following:

- 1C Plant Service Water Pump vibration high, CR 2001005214
- 1A RHR Pump Motor with metal particles in the oil, CR 2001005610
- Unit 1 and 2 Suppression Pool Vent Expansion Joint, CR 2001005592
- Unit 2 High Pressure Coolant Injection (HPCI) Suction Pressure Transmitter, CR 2001006074
- 1B Emergency Diesel Generator (EDG) oil analysis identifying wear particles, CR 2001006507
- Unit 1 and 2 Main Steam Isolation Valve Limit Switches, CR 2001006969

b. Findings

No findings of significance were identified.

1R19 Post Maintenance Testing

a. Inspection Scope

The inspectors reviewed licensee procedures listed in the Attachment of this report and observed personnel performance during selected maintenance and testing activities to verify procedural requirements were met. The inspectors also reviewed the activities to determine if the scope of testing demonstrated that the work performed was correctly completed and that the affected equipment was functional and operable. Following the maintenance activities, the inspectors reviewed equipment status and alignment to verify the system or component was available to perform the required safety function. The work activities observed included the following:

- RHR Minimum Flow Valve, 2E11F007A, MWO 2012289
- 4KV Bus 1F Alternate Supply Breaker, MWO 10103125
- Unit 1 HPCI Turbine Control Valve, MWO 10102867
- Metal Particles in 1A RHR Pump Motor Oil, MWO 10103266
- RHR Service Water Valve 1E11-N751B, MWO 10102546

- Reactor Protection System Alternate Power Supply 2C71P003E, MWO 20102243

b. Findings

No findings of significance were identified.

1R20 Refueling and Outage Activities

a. Inspection Scope

The inspectors reviewed licensee records and witnessed maintenance and testing activities to assess the licensee's risk management of Unit 2 refueling outage activities. Specific activities are listed below and documents reviewed are listed in the Attachment of this report.

Review of Outage Planning: The inspectors reviewed the licensee's outage schedule and shutdown risk assessment to determine if the licensee had appropriately considered risk, industry experience, and previous site experience. Additionally, the inspectors assessed the licensee's mitigation strategies for limiting those times of highest risk.

Monitoring of Shutdown Activities: The inspectors witnessed portions of the reactor shutdown and reactor coolant system cooldown to verify the TS cooldown rates were followed.

Licensee Control of Outage Activities: The inspectors periodically reviewed the outage safety assessment to verify the licensee was correctly considering the equipment that was available for service. In addition, the inspectors reviewed contingency procedures and equipment relied upon to implement the various actions required to mitigate an event. This review was to verify procedures and equipment were in place and were consistent with the assumptions in the shutdown risk assessment. The inspectors reviewed reactor vessel water level instruments used during reactor vessel fill to verify they were calibrated and in service. In addition, the inspectors reviewed the Decay Heat Removal system to verify it was in service, properly aligned, and removing decay heat sufficiently. The secondary containment configuration was reviewed to verify it was intact to support the refueling functions, with the appropriate Standby Gas Treatment Units operable. Plant electrical systems were reviewed to verify proper alignment during the 2A and 2C EDG outages. The inspectors walked down a clearance to confirm the associated equipment was properly configured to support the function of the clearance.

b. Findings

No findings of significance were identified.

1R22 Surveillance Testing

a. Inspection Scope

The inspectors reviewed surveillance test procedures and either witnessed the test or reviewed test records to determine if the scope of the test adequately demonstrated that

the affected equipment was operable. The inspectors reviewed the activities to assess for preconditioning of equipment, procedure adherence, and valve alignment following completion of the surveillance. The inspectors reviewed licensee procedure AG-MGR-21-0386N, Evolution and Pre-and Post-Job Brief Guidance, Rev. 2, and attended selected briefings to determine if procedure requirements were met. Documents reviewed to support this inspection are listed in the Attachment of this report. Test procedures either reviewed or witnessed included the following:

- 34SV-E41-004-1S, HPCI Pump Operability, Rev. 24, Ed 5
- 34SV-T48-002-1S, Suppression Chamber to Drywell Vacuum Breaker Operability and Containment Purge/Vent Valve Position Check, Rev. 6, Ed 2
- 34SV-R43-003-2S, Diesel Generator 2C Monthly Test, Rev. 21, Ed 6
- 42SV-P41-001-2S, PSW Pump and Isolation Valve Auto Function Functional Test, Rev. 4, Ed 1
- 57SV-CAL-003-1S, ATTS Transmitter Calibration, Rev. 15, Ed 3
- 42SV-E11-001-2S, RHR-LPCI LSFT Testing, Rev. 7.2
- 57SV-S32-002-1S, Emergency Buses 1E, 1F, and 1G Undervoltage Relay Instrument FT&C, Rev. 10

b. Findings

One finding of very low safety significance was identified by the inspectors for the licensee's failure to prevent recurrence of a setpoint drift problem associated with 4 kv emergency bus undervoltage relays. The finding is a violation of 10 CFR 50, Appendix B, criterion XVI (Green).

While reviewing the results of surveillance test procedure 57SV-S32-002-1S, which is completed once every 18 months, the inspectors noted that two relays were discovered with setpoints outside of their allowed TS tolerance. The inspectors conducted a more detailed review of past performance of the two relays and similar undervoltage relays associated with all the EDGs and determined that numerous occurrences of setpoint drift had been identified in the past eleven five years or so for multiple relays. The inspectors discussed this observation with licensee management who then performed a more rigorous review of relay past performance and concluded that the relays did have a setpoint drift problem. The licensee concluded that out of 24 relays, 10 were acceptable, 5 needed to be replaced, 7 would be replaced if they were found out of tolerance again, and 2 had already been replaced. In addition, licensee personnel recommended that the calibration frequency be increased from once every 18 months to once each year.

The inspectors concluded that the licensee had not identified this issue as a repetitive problem, had not determined the cause of the setpoint drift, had not implemented corrective action to prevent recurrence, and had not been taking appropriate steps to identify repetitive calibration problems until identified by the inspectors. The inspectors concluded that this finding was a significant condition adverse to quality and had a credible impact on safety because the problem affected the automatic start function of the EDGs. However, the relay setpoint drift would not prevent the EDG from performing its safety function and would only delay the automatic start feature of the EDG and power supplied to the emergency bus. Additionally, the relay drift problem would have

to occur in multiple relays simultaneously before the auto start feature of the EDG would be affected. The inspectors conducted a relay and system performance review for the past 11 years and did not identify any examples where the automatic start feature of the EDG had been affected. The inspectors determined this finding was of very low safety significance (Green).

10 CFR 50 Appendix B, Criterion XVI, requires that for significant conditions adverse to quality, measures shall be established to assure that the cause of the condition is determined and corrective action taken to preclude repetition. Contrary to the above, the licensee did not identify the repetitive problem, determine the cause of the setpoint drift problem associated with the 4 kv emergency bus undervoltage relays or implement corrective actions to preclude recurrence. This NRC identified violation is being treated as a NCV consistent with Section VI.A.1 of NRC Enforcement Policy and is identified as NCV 50-366/01-005-01, Failure to Prevent Recurrence of Emergency Bus Undervoltage Relay Setpoint Drift. The licensee documented this violation in CR 2001005805.

2. RADIATION SAFETY

Cornerstone: Occupational Radiation Safety (OS)

2OS1 Access Control To Radiologically Significant Areas

a. Inspection Scope

Licensee radiation protection activities for occupational radiation workers were evaluated against licensee procedures, UFSAR, TS, and 10 CFR 20 requirements. To evaluate the licensee's control of access to radiologically significant areas the inspectors reviewed radiation work permits (RWPs), radiation surveys, air sampling locations, and the licensee's controls of locked and very high radiation areas. The inspectors observed postings and control of access to radiological areas during inspections of the Radiologically Controlled Areas (RCAs). Adherence to access control procedures and RWP-specified access controls by radiation workers and Health Physics (HP) technicians providing job coverage were also observed during job site inspections. The inspectors independently measured radiation dose rates at selected locations of the reactor building, radioactive waste building, and turbine building. Licensee surveillances of high radiation key controls and locked high radiation doors were reviewed. The inspectors also reviewed licensee self-assessments, radiological incidents identified in CRs, and licensee auditor checklist for audits involving exposure significant work areas. Procedures and documents reviewed are listed in the Attachment of this report.

b. Findings

No findings of significance were identified.

2OS2 As Low As Reasonably Achievable (ALARA) Planning and Controls

a. Inspection Scope

The inspectors reviewed licensee activities against UFSAR, TSs, 10 CFR 20 requirements, and licensee procedures. The inspectors reviewed the plant collective

exposure history and current exposure dose trends. The inspectors also evaluated the licensee's performance establishing and implementing occupational radiation exposure goals and estimates for the Unit 2 RFO activities. Radiological work plans and exposure estimates for the five jobs anticipated to incur the highest exposures during the Unit 2 RFO were evaluated for consistency with previous plant performance. The inspectors reviewed and discussed ALARA Committee Meeting minutes in which the site's performance in maintaining exposures ALARA were addressed by plant management. The inspectors attended a maintenance activity planning meeting and observed plant supervisors, and health physics personnel providing ALARA input for maintenance work to be performed during an upcoming Unit 2 RHR "A" Loop System outage. During plant tours and observations of work in progress, the inspectors evaluated ALARA controls and initiatives. Licensee procedures 60AC-HPX-009-OS, ALARA Program, Rev. 14; HPX-0011, ALARA Review Package, Rev. 12; and HPX-0570, ALARA Review Guidelines For Procedures, Rev. 5 were evaluated during the inspection. The inspectors reviewed and discussed Quality Assurance Audit 00-HP-1, LR-SAER-001-0201 dated February 22, 2001, for the radiation protection program. The inspectors also reviewed licensee CRs associated with ALARA which included the following:

- CR 2001000715 dated 01/27/2001
- CR 2001001529 dated 02/28/2001
- CR 2001001530 dated 02/28/2001
- CR 2001004437 dated 06/05/2001
- CR 2001005115 dated 06/29/2001

b. Findings

No findings of significance were identified.

RADIATION SAFETY

Cornerstone: Public Radiation Safety (PS)

2PS1 Radioactive Gaseous and Liquid Effluent Monitoring Systems

.1 Effluent Release Processing

a. Inspection Scope

Hatch laboratory quality control program activities for liquid and airborne sample radionuclide analyses were evaluated. The inspectors discussed and reviewed, as applicable, current gamma spectroscopy detection equipment calibrations and daily system performance results. The inspectors reviewed the offsite effluent dose results as reported in the Annual Radiological Effluent Release Report for the year 2000 and the results were evaluated against 10 CFR 20 requirements, Appendix I to 10 CFR 50 design criteria, TS, UFSAR details, and the Offsite Dose Calculation Manual (ODCM), Rev. 13. A liquid release, permit number 10216 for a Unit 1 waste storage tank was evaluated against ODCM requirements. Appropriate alarm set points for the discharge radiation monitor were also evaluated. The inspectors reviewed licensee procedure 64CI-OCB-002-0S, Reactor Building Vents Radiation Monitoring, Rev. 1 and evaluated

the changing of particulate and iodine air sampler heads on the reactor building vent stack monitors .

b. Findings

No findings of significance were identified.

.2 Airborne Effluent Vent Flow and Air Cleaning System Surveillance

a. Inspection Scope

The inspectors evaluated current surveillance activities and reviewed calibration records for ventilation system flow meters for the main stack, recombiner building vent, Unit 1 reactor building vent, and the Unit 2 reactor building vent.

Program activities were reviewed against TS; UFSAR; American Nuclear Institute Standard N510, 1989, Testing of Nuclear Air-Cleaning Systems; and Regulatory Guide (RG) 1.52, Design, Testing and Maintenance Criteria for Post Accident Engineered Safety-Feature Atmosphere Cleanup System Air Filtration and Adsorption Units of Light Water Cooled Nuclear Power Plants, Rev. 2. The following procedures were reviewed and discussed during inspection of this program area: 64CH-RPT-006-OS, Chemistry Control Procedure, Rev. 4 and 64CH-RPT-007-OS, Gaseous Effluent Reports, Rev. 2.

b. Findings

No findings of significance were identified.

2PS3 Radiological Environmental Monitoring and Radioactive Material Control Program

.1 Unrestricted Release of Material from the RCA

a. Inspection Scope

Licensee guidance and program implementation for monitoring potentially contaminated material for unrestricted release from the RCA were reviewed and evaluated. The evaluation included current direct monitoring activities and recent licensee initiatives to evaluate hard-to-detect radionuclides. Availability and accuracy of survey instruments used for release, e.g., friskers, proportional counters, small article monitor (SAM)-9 at RCA control points were evaluated. The inspectors observed the calibration of a SAM-9 and a SAM-11 using licensee procedure 62HI-OCB-090-OS, NE Technology SAM-9 Bag Waste Monitor and SAM-11 Small Articles Monitor Operation and Calibration, Rev. 4. The inspectors also observed and evaluated routine release survey activities that implemented licensee procedure 62RP-RAD-017-OS, Release Surveys, Rev. 10.

Licensee activities were evaluated against 10 CFR 20 requirements and UFSAR details. Established detection limits were reviewed against guidance provided in NRC Circular 81-07 and Information Notice 85-92.

b. Findings

No findings of significance were identified.

.2 Meteorological Monitoring Instrumentation

a. Inspection Scope

The inspectors evaluated meteorological data collection for the primary and secondary towers and reviewed related records. This included comparing data readouts at the tower with those displayed in the Emergency Operations Facility (EOF) and Main Control Room (MCR). The inspectors examined the calibration records for the meteorological instruments on the primary tower and reviewed the year 2000 annual meteorological data report. The inspectors compared the current meteorological data collection configuration with the requirements in the UFSAR. The inspectors reviewed the following data collection and analysis procedures: 64CH-ENV-001-0N, Meteorological Station, Rev. 5; 73EP-EIP-018-0S Prompt Offsite Dose Assessment, Rev. 5; and 57IT-Y33-001-0S, Climatronics Instruments, Rev. 3 and discussed applicable sections with cognizant chemistry and emergency preparedness personnel. Corrective actions in the area of meteorological monitoring were reviewed. CRs reviewed included: CR 2000004263, CR 2001001685, CR 2000010348, CR 2001005421, and CR 2001000938.

b. Findings

The inspectors identified a very low safety significant finding (Green) for the licensee's failure to perform corrective maintenance or implement compensatory measures for degraded primary meteorological tower atmospheric temperature instruments that impaired the ability to assess offsite dose during a plant emergency.

On January 14, 2000, plant technicians conducted repair work on the primary meteorological tower. They discovered that the winch motor which raises and lowers the temperature instruments would not raise the instruments to their original elevated positions. As a consequence, the instruments were stuck approximately two-thirds of the way up the tower and CR 2000000366 was written to document the problem. The instruments were still functioning and sending data to the EOF and the MCR. The primary tower was in this condition for a three month period until repairs were effected on April 11, 2000.

The inspectors determined that the impact of CR 2000000366 on the ability to assess offsite dose during an emergency was not fully recognized by the CR author or reviewers. In the event of an accident that resulted in an offsite release of radioactive material, MCR operators implement procedure 73EP-EIP-018-0S, Prompt Offsite Dose Assessment, Rev. 5, to provide dose assessment information to the Emergency Director. This procedure requires a determination of atmospheric stability class based on vertical temperature differences using the 100m, 60m and 10m temperature sensors from the primary meteorological tower (as described in Section 2.3 of the HNP-2 UFSAR and Regulatory Guide 1.97). However, the 100m sensor was at approximately 66m, the 60m sensor was at about 26m, and the 10m sensor was on the ground. As a

result, the ability to determine the correct stability class using the primary meteorological tower was degraded. MCR operators could use backup meteorological tower data to determine the correct stability class. However, the inspectors determined that the MCR staff was not aware that the primary tower was in a degraded condition and did not declare the meteorological tower inoperable or degraded or initiate compensatory measures during this three month period.

The inspectors assessed this finding using the Public Radiation Safety Significance Determination Process and determined the finding is more than minor and has a credible impact on safety because the dose to the public during an actual event could have been incorrectly estimated during the three month period. The finding has very low safety significance and is categorized as GREEN because no release of radioactivity that required a prompt offsite dose assessment occurred and there was no actual public safety consequence. It did not constitute a violation of regulatory requirements.

3. SAFEGUARDS **Cornerstone: Physical Protection**

3PP1 Access Authorization)

.1 Licensee Interviews

a. Inspection Scope

The inspector evaluated licensee Fitness For Duty (FFD) program and FFD performance data of Jan - June 2001. Additionally, the inspector interviewed five representatives of licensee management and five escort personnel concerning their understanding of the behavior observation portion of the personnel screening and FFD program. In interviewing these personnel, the inspector evaluated the effectiveness of their training and abilities to recognize aberrant behavioral traits, physiological indications of narcotic and alcohol use, and work call-out reporting procedures. Licensee compliance was evaluated against requirements in the Edwin I. Hatch Nuclear Plant Units 1 and 2 Physical Security Plan and associated procedures, and 10 CFR Part 26, Fitness For Duty Programs.

b. Findings

No findings of significance were identified.

3PP2 Access Control

.1 Entry Point Observations

a. Inspection Scope

The inspector observed access control activities and search/access control equipment testing on September 5, 2001. In observing the access control activities, the inspector

assessed whether officers could detect contraband prior to it being introduced into the protected area. The protective barriers for the Final Access Control facility were inspected to ensure compliance with protection standards in the Physical Security Plan. Additionally, the inspector assessed whether the officers were conducting access control equipment testing in accordance with regulatory requirements through observation, review of procedures and log entries. Lock, combination, and key control procedures were evaluated by reviewing Security Department Daily Key Inventory Logs, as well as interviewing key custodians. Licensee compliance was evaluated against requirements in the Edwin I. Hatch Nuclear Plant Units 1 and 2 Physical Security Plan and associated procedures, and 10 CFR Part 73.55, Requirements for Physical Protection of Licensed Activities in Nuclear Power Reactors Against Radiological Sabotage, and Part 73.56, Personnel Access Authorization Requirements for Nuclear Power Plants.

b. Findings

No findings of significance were identified.

4. OTHER ACTIVITIES

4OA1 Performance Indicator (PI) Verification

.1 Mitigating Systems Cornerstone

a. Inspection Scope

The inspectors reviewed the licensee's procedures and methods for compiling and reporting PIs for safety system unavailability. The systems monitored were EDGs, RHR, RHRSW, RCIC, and HPCI. The inspectors reviewed raw PI data collected since October, 2000 for each of the indicators and compared graphical representations from the most recent PI report to the raw data to verify the data was included in the report. The inspectors also examined a sampling of operations logs and procedures to verify the PI data was appropriately captured for inclusion into the PI report, and the individual PIs were calculated correctly. The inspectors compared their observations with licensee's Administrative Control Procedure, 00AC-REG-005-0S, Preparation And Reporting Of NRC PI Data, Rev. 2, and NEI 99-02, Regulatory Assessment Performance Indicator Guideline, Rev. 1, to verify procedure and reporting requirements were met.

b. Findings

No findings of significance were identified.

.2 Physical Protection Cornerstone

a. Inspection Scope

The inspector evaluated Edwin I. Hatch Nuclear Plant programs for gathering and submitting data for the Fitness-for-Duty, Personnel Screening, and Protected Area

Security Equipment Performance Indicators. The evaluation included Edwin I. Hatch's tracking and trending reports and security event reports for the Performance Indicator data submitted for the last four reported quarters, 2001- 2000. Licensee performance was evaluated against requirements in NEI 99-02, Rev. 1, Regulatory Assessment Performance Indicator Guideline.

b. Findings

No findings of significance were identified.

40A3 Event Follow-up

- .1 The inspectors identified a very low safety significance finding (Green) for the licensee's failure to perform preventative maintenance on traveling water screen (TWS) system instruments that affected the performance of PSW.

On July 23, a thunderstorm washed a large amount of debris into the Altamaha River, which serves as the cooling water supply for the plant. One of two traveling water screens was out of service for modifications and the other failed to automatically start when the differential pressure (d/p) across the screens increased. As a result, the screens became clogged with debris and the intake structure water level decreased to about 60.1 feet. Fluctuations in PSW flow and pressure occurred, due to vortexing, and operators reduced power to 85% on Unit 1 and 90% on Unit 2. The fluctuations stopped when the TWS was manually started locally and the intake structure water level returned to normal. The event lasted approximately 30 minutes. Operators declared a Notification Of Unusual Event in accordance with procedure, 73EP-EIP-001-0S, Emergency Classification And Initial Actions, Rev. 14, Ed. 1, based on the intake structure water level being below 60.7 feet and was then terminated.

Following the event, the licensee cleaned various strainers and filters associated with PSW. In addition, equipment temperatures were trended to evaluate if component clogging might have occurred. The inspectors reviewed licensee performance and actions to assess if the licensee had adequately considered all appropriate systems. No abnormal readings were observed.

The licensee's Event Review Team determined that the TWS failed to start because the instrument air line to the d/p switch, which automatically starts the screen, was clogged. They also determined that the preventive maintenance procedure for periodically inspecting the non-safety related d/p instrument sensing lines did not check the air line to the instrument. This oversight was corrected.

The inspectors determined that although the TWS system was not safety-related, the failure to perform preventive maintenance on the d/p instrument had an actual impact on safety because the loss of the TWS system affected performance of the PSW system. However, quick response of the operators prevented further degradation of PSW. Loss of PSW would have resulted in a manual scram of both units as well as adversely impacting mitigating systems. Because the event was the result of clogging a traveling water screen due to an auto start failure, credit was given for operator recovery of the failed traveling water screen by manually starting the system. This event demonstrated

that the procedures in place were satisfactory and the operators were properly trained to perform the evolution. The inspectors evaluated the finding using NRC's Significant Determination Process (SDP) involving a potential impact on both the initiating event frequency and mitigating systems. The SDP estimated the impact of the event to be less than the impact of a doubling of the initiating event frequency for Loss of PSW. The evaluation resulted in a less than 1E-6 increase in Core Damage Frequency, making the finding GREEN.

The inspectors verified that the licensee had assessed the failure as a maintenance preventable functional failure in accordance with procedure 40AC-ENG-020-0S, Maintenance Rule (10 CFR 50.65) Implementation And Compliance, Rev. 3, and implemented preventive maintenance activities to prevent recurrence. The licensee documented the finding in CR 2001005748. The finding did not constitute a violation of regulatory requirements.

.2 (Closed) Licensee Event Report (LER) 50-321/2001-003, Error in Generic Analysis Results in Potentially Nonconservative Oscillating Power Range Monitor Setpoint

This LER was issued when the oscillating power range monitors, for both units, were declared inoperable when it was determined that the core reload licensing analysis, provided by a contractor, was potentially not adequate to prevent violation of the Minimum Critical Power Ratio. The vendor issued a 10 CFR 21 notification describing this error. Upon discovery, the licensee declared the systems inoperable, implemented compensatory measures, completed TS required actions, and entered this problem into their corrective action program as CR 2001004976. The inspectors did not identify any condition that would have initiated power oscillations on either unit. No findings of significance were identified.

.3 (Closed) LER 2001-S01-00, Inappropriately Authorized Person Enters Protected and Vital Areas.

This LER was reviewed and there were no inspector-identified findings of significance.

4OA5 Other

.1 Operation of an Independent Spent Fuel Storage Installation (ISFSI)

a. Inspection Scope

The inspectors reviewed selected elements of the licensee's radiological control program for the ISFSI to assess whether the requirements of 10 CFR 72.106 were being properly implemented. The inspectors reviewed the most recent quarterly radiation monitoring surveillances. The inspectors also reviewed and observed licensee radiological surveys and documentation performed by licensee health physics personnel during storage cask fuel loading and movement operations. The inspectors performed independent radiation surveys of the ISFSI facility to verify licensee survey results.

b. Findings

No findings of significance were identified.

4OA6 Management MeetingsExit Meeting Summary

The inspectors presented the inspection results to Mr. Pete Wells, General Manager - Nuclear Plant and other members of licensee management at the conclusion of the inspection on October 10, 2001. No proprietary information was identified.

4OA7 Licensee Identified Violations

The following findings of very low significance were identified by the licensee and are a violation of NRC requirements which meet the criteria of Section VI of the NRC Enforcement Policy, NUREG-1600 for being dispositioned as a Non-Cited Violation (NCV).

| <u>NCV Tracking Number</u> | <u>Requirement Licensee Failed to Meet</u> |
|----------------------------|--|
| 50-321,366/01-05-02 | 10 CFR 50.65(a)(4) requires, in part, that before maintenance is performed on systems shown to be risk significant, the licensee shall assess and manage the increase in risk that may result from the proposed maintenance activity. On September 13, 2001, the increase in risk associated with maintenance on the upstream traveling water screen was not assessed, as described in the licensee corrective action program Reference CR 2001007635. (Green) |
| 50-366/01-05-03 | Technical Specification Surveillance SR 3.3.1.1.16 requires the relays which actuate the "B" trip system of the reactor protection system upon sensing a turbine stop valve closure be tested for time response every 18 months. On September 9, 2001, two relays were identified that had not been tested for time response since 1995, as described in the licensee corrective action program Reference CR 2001007192 and CR 2001007276. (Green) |
| 50-321,366/01-05-04 | Technical Specification Surveillance SR 3.3.1.1.13 requires that a channel calibration of MSIV limit switches be conducted every 18 months. Procedure 52SV-B21-001-0S, MSIV Limit Switch Inspection, Rev. 4 Ed. 3, implements this requirement, in part, by recording the as found |

MSIV limit switch settings. It was determined on August 31, 2001, that the as found MSIV limit switch settings were not being recorded as described in the licensee corrective action program Reference CR 2001006969. (Green)

Supplementary Information

PARTIAL LIST OF PERSONS CONTACTED

Licensee

Betsill, J., Assistant General Manager - Plant Support
Burkett, E., Operations Support Superintendent
Curtis, S., Unit Superintendent
Cowan S. Radiation Protection Manager
Davis, D., Plant Administration Manager
Dedrickson, R., Operations Manager
Googe, M., Performance Team Manager
Hammonds, J., Engineering Support Manager
Johnson, G., Safety Audit and Engineering Review Supervisor
Kirkley, W., Health Physics and Chemistry Manager
Lewis, J., Training and Emergency Preparedness Manager
Madison, D., Assistant General Manager - Plant Operations
Reddick, R., Site Emergency Preparedness Coordinator
Roberts, P., Outage and Planning Manager
Smith D., Chemistry Manager
Thompson, J., Nuclear Security Manager
Tipps, S., Nuclear Safety and Compliance Manager
Varnadore, R., Unit Superintendent
Wells, P., General Manager - Nuclear Plant

Other licensee employees contacted included office, operations, engineering, maintenance, chemistry/radiation, and corporate personnel.

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

| | | |
|---------------------|-----|--|
| 50-321,366/01-05-01 | NCV | Failure to Prevent Recurrence of Emergency Bus Undervoltage Relay Setpoint Drift (Section 1R22) |
| 50-321,366/01-05-02 | NCV | Failure to Perform Risk Assessment Required by 10 CFR 50.65(a)(4) for Removal of Traveling Water Screen (Section 4OA7) |
| 50-366/01-05-03 | NCV | Failure to Perform Time Response Test on Turbine Stop Valve RPS Relays (Section 4OA7) |
| 50-321,366/01-05-04 | NCV | Failure to Perform Parts of the Technical Specification Required Channel Calibration Surveillance Procedure for As-Found MSIV Limit Switch Settings (Section 4OA7) |

Closed

| | | |
|---------------------|-----|--|
| 50-321,366/01-05-01 | NCV | Failure to Prevent Recurrence of Emergency Bus Undervoltage Relay Setpoint Drift (Section 1R22) |
| 50-321,366/01-05-02 | NCV | Failure to Perform Risk Assessment Required by 10 CFR 50.65(a)(4) for Removal of Traveling Water Screen (Section 4OA7) |
| 50-366/01-05-03 | NCV | Failure to Perform Time Response Test on Turbine Stop Valve RPS Relays (Section 4OA7) |
| 50-321,366/01-05-04 | NCV | Failure to Perform Parts of the Technical Specification Required Channel Calibration Surveillance Procedure for As-Found MSIV Limit Switch Settings (Section 4OA7) |
| 2001-S01-00 | LER | Inappropriately Authorized Person Enters Protected and Vital Areas (Section 4OA3) |

INSPECTION DOCUMENTS REVIEWED**Section 1RO2**

Safety Evaluations

LDCR 1-99-033, Revising Unit 1 FSAR to delete the reference
 DCR 1-97-039, Modifying MOVs for the requirements of NRC GL 89-10
 DCR 2-97-024, Replacing gate valves with ASME Section III Class 2 valves
 DCR 97-058, Adding and deleting snubbers in the RHR discharging line
 DCR 2-00-006, Modifying the 2E11 system to eliminate vent valve 2E11-FV003
 MDC 1-98-5014, Removing PAW system 6-inch check valves 1P41F552A & C
 MDC 2-00-5001, Removing air release valves 2P14-F332A-D and associated piping
 DCR 99-014T, Removing Unit Auxiliary Transformer from service for maintenance/repair
 Procedure 42SP-051100-PR-1-1S, A new Special Testing Procedure for High Pressure Coolant Injection system
 Procedure 42SP-082100-OR-1-2S, A new test procedure for RHR/CS Leakage Determination

Evaluations Screened Out

DCR 2-97-032, Building a permanent platform to operate valve 2N38-F012A
 DCR 1-98-042, Replacing Turbine control valve fast closure pressure switch
 DCR 2-00-003, Replacing HPCI pump discharge flow transmitter 2E41-N008
 TM 1-01-09, Replacing recorder 1B21-R606
 TM 2-00-17, Changing setpoints for high vibration alarm
 Procedure 52CM-MME-044-0S, Limitorque valve operator SMB/SB-4 mechanical maintenance
 Procedure 52CP-TOL-002-0S, Torque tester TTC-2000 and indicator TTD-610 calibration
 Procedure 52PM-R43-005-0S, Diesel generator starting air compressor maintenance

Procedure 34SP-011100-BA-1-2S, Increased power testing for TER 99-003
 Procedure 34GO-OPS-087-2S, Suppression chamber fill
 Procedure 34SV-E11-001-1S, Residual heat removal pump operability
 Procedure AG-MGR-69-0600N, Instruction request/development form

Section 1R04

34SO-C41-003-1S, Rev. 10 Ed 6
 34SO-E11-010-2S, RHR System, Rev. 29
 34SO-E21-001-1S, Core Spray System, Rev. 19, Ed 1
 34SO-E21-001-2S, Core Spray System, Rev. 17
 34SO-E51-001-1S, Reactor Core Isolation Cooling System, Rev. 24, Ed 2
 Plant Drawings - H-16061, Rev. 19; H-16331, Rev. 25; H16334, Rev. 38; H-16335, Rev. 25

Section 1R05

42SV-FPX-007-0S, Cable Tray Surveillance - Kaowool Material, Rev. 2, Ed 1
 Plant Drawings - A-43965 Sheet 44B, Rev. 2; H-19636 Sheet 1, Rev. 8; Sheet 2, Rev. 2; H-23282,

Section 1R06

CR 2000006318
 34AB-T22-001-1S, Primary Coolant Break Reactor Building, Rev. 0 Ed 1
 34AB-T22-001-2S, Primary Coolant Break Reactor Building, Rev. 0 Ed 1
 34AB-T22-003-1S, Secondary Containment Control, Rev. 5, Ed 3
 34AB-T22-003-1S, Secondary Containment Control, Rev. 3, Ed 2
 34IT-T45-001-1S, Reactor Building Instrument Sumps Isolation Exercise, Rev. 0, Ed 4
 34IT-T45-001-2S, Reactor Building Instrument Sumps Isolation Exercise, Rev. 0, Ed 2
 52PM-Y46-001-0N, Inground Pullbox and Cable Duct Inspection for Water, Rev. 6
 57CP-T45-002-1S, GEMS LS 800 Level Switch Calibration Check, Rev. 3
 57CP-CAL-256-2N, Gems Level Switch Calibration, Rev. 2 Ed 2
 57IT-T45-002-2S, Sump Isolation Valve Actuation Test, Rev. 0
 A-17361, Edwin I. Hatch Nuclear Plant No. 1 Electrical Separation and Criteria and Raceway and Cable Numbering System, Rev. 9
 H-16039, Edwin I. Hatch Nuclear Plant No. 1 Leakage Detection System Instrument & Drainage Sumps P&ID, Rev. 7
 H-16176, Edwin I. Hatch Nuclear Plant No. 1 Radwaste System P&ID, Rev. 29
 H-17080, Edwin I. Hatch Nuclear Plant No. 1 Leakage Detection System Instrument & Drainage Sumps T45 Elemental Diagram, Rev. 13
 H-26060, Edwin I. Hatch Nuclear Plant No. 2 Radwaste System P&ID, Rev. 29
 H-26076, Edwin I. Hatch Nuclear Plant No. 2 Leakage Detection System Instrument & Drainage Sumps P&ID, Rev. 7
 H-27766, Edwin I. Hatch Nuclear Plant No. 2 Leakage Detection System Instrument & Drainage Sumps 2T45 Elemental Diagram, Rev. 11

Section 1R12

40AC-ENG-020-0S, Maintenance Rule (10 CFR 50.65) Implementation and Compliance, Rev. 3
 Maintenance Rule Monthly Report for June, 2001
 Plant Hatch 10 CFR 50.65 Scoping Manual, Rev. 4
 CR 2001005362
 CR 2001007117
 CR 2001005785

Section 1R13

90AC-OAM-002-0S, Scheduling Maintenance, Rev. 0
 MWO 2012243
 CR 2001005310

Section 1R14

34AB-P41-001-1S, Loss Of Plant Service Water, Rev. 7, Ed 2
 34AB-P41-001-2S, Loss Of Plant Service Water, Rev. 7, Ed 1
 34AR-650-229-2S, Annunciator Response Procedure for Control Panel 2H11-P650 Alarm Panel 2, Rev. 3
 34AR-650-147-2S, Annunciator Response Procedure for Control Panel 2H11-P650 Alarm Panel 1, Rev. 4, Ed 1
 34AR-650-303-1S, Annunciator Response Procedure for Control Panel 2H11-P650 Alarm Panel 3, Rev. 3, Ed 2
 73EP-EIP-001-0S, Emergency Classification And Initial Actions, Rev. 14, Ed 1
 Updated Final Safety Analysis Report, PSW system
 Operator Logs and applicable strip chart and data recordings

Section 1R15

Unit 1 and Unit 2 Technical Specifications and Bases
 Unit 1 Inservice Testing Program Plan
 34SV-P41-001-1S, Plant Service Water Pump Operability, Rev. 10, Ed 4
 Operability Evaluation - Unit 1A RHR Pump Motor - LR-REG-009-0701
 52SV-B21-001-0S, MSIV Limit Switch Inspection, Rev. 4 Ed 3
 52PM-B21-005-2S, Main Steam Isolation Valve Preventive Maintenance, Rev. 14
 34SV-B21-001-1S, MSIV Exercise and Closure Instrument Functional Test, Rev. 7 Ed 7

Section 1R19

34SV-E11-001-2S, Residual Heat Removal Pump Operability, Rev. 16, Ed 1,
 CR - 2001005310
 Plant Drawing - H-19949, Sheet 3, Rev. 2
 S - 19823, HPCI Turbine Instruction Manual , Rev. 1C
 S - 50632, Solatron Line Voltage Regulator, Operating and Service Manual, Rev. 0

Section 1R20

2001 Unit 2 Sixteenth Refueling Outage Overview of Outage Schedule, Rev. 0, 8/30/2001
34SO-G71-001-0S, Decay Heat Removal, Rev. 8 Ed 3
34GO-OPS-013-2S, Normal Plant Shutdown, Rev. 26.3
Shutdown Risk Assessment - Unit 2 Fall 2001, 9/14/2001
DI-OPS-57-0393N, Rev. 14, Outage Safety Assessment
Clearance Number 20120141

Section 1R22

51GM-CAL-003-0S, Calibration Program for LCO/BOP instrumentation, Rev. 4, Ed 1
CRs -1999007358, 2000003985, 2000004040, 2000004054, 2000007374, 2000010779,
2000011524, 2001005349, 2001005378, 2001005684, 20015804, 20015805,
Operability Evaluation - Vacuum Breaker 1T48 - F323F, November 28, 2000
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Section 2OS1

60AC-HPX-002-OS, Personnel Dosimetry Program, Rev. 11
60AC-HPX-004-OS, Radiation and Contamination Control, Rev. 16
62RP-RAD-008-OS, Radiation and Contamination Surveys, Rev. 10
62RP-RAD-016-OS, Very High Radiation Area Access Control, Rev. 17
RWP 001-2500
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Audit No. 01-HPC-1, LR-SAER-001-0901
CR 2001006161
CR 2001006785
CR 2001007441
CR 2001007527