

August 31, 2001

Mr. Charles H. Cruse
Vice President
Constellation Nuclear
Calvert Cliffs Nuclear Power Plant, Inc.
1650 Calvert Cliffs Parkway
Lusby, MD 20657-4702

SUBJECT: CALVERT CLIFFS NUCLEAR POWER PLANT - NRC INSPECTION REPORT 50-317/01-06, 50-318/01-06

Dear Mr. Cruse:

On August 11, 2001, the NRC completed an inspection at your Calvert Cliffs Nuclear Power Plant Units 1 & 2. The enclosed report documents the inspection findings which were discussed on August 22, 2001, with Mr. Katz and other members of your staff.

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.

Based on the results of this inspection, the inspectors identified one issue of very low safety significance (Green). This issue 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 inspection report, to the Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington DC 20555-0001; with copies to the Regional Administrator, Region I; the Director, Office of Enforcement; and the NRC Resident Inspector at the Calvert Cliffs facility.

Charles H. Cruse

2

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Sincerely,

/RA/

Michele G. Evans, Chief
Projects Branch 1
Division of Reactor Projects

Docket Nos. 05000317
05000318
License Nos. DPR-53
DPR-69

Enclosures: Inspection Report 50-317/01-06 and 50-318/01-06

Attachment 1 - Supplemental Information

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U.S. NUCLEAR REGULATORY COMMISSION

REGION I

Docket Nos: 50-317, 50-318

License Nos.: DPR-53, DPR-69

Report No: 50-317/01-06;
50-318/01-06

Licensee: Calvert Cliffs Nuclear Power Plant, Inc.

Facility: Calvert Cliffs Nuclear Power Plant, Units 1 and 2

Location: 1650 Calvert Cliffs Parkway
Lusby, MD 20657-4702

Dates: July 1, 2001 - August 11, 2001

Inspectors: David Beaulieu, Senior Resident Inspector
Fred Bower, Resident Inspector
Leonard Cline, Resident Inspector
Gordon Hunegs, Senior Resident Inspector, Nine Mile Point
Ronald Nimitz, Senior Health Physicist

Approved by: Michele G. Evans, Chief, Projects Branch 1
Division of Reactor Projects

SUMMARY OF FINDINGS

IR 05000317-01-06, IR 05000318-01-06, on 08/01-09/11/2001, Calvert Cliffs Nuclear Plant, Inc.; Calvert Cliffs Nuclear Power Plant, Units 1 & 2. Access Control to Radiologically Significant Areas.

The inspection was conducted by resident inspectors and a regional senior health physicist. One Green finding was identified which involved a Non-Cited Violation. 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 at <http://www.nrc.gov/NRR/OVERSIGHT/index.html>.

A. Inspector Identified Findings

Cornerstone: Occupational Radiation Safety

(GREEN) A Non-Cited Violation of Technical Specification 5.4 was identified for failure to implement a maintenance work order for repair of the 22 Chemical Volume and Control System (CVCS) ion exchanger (IX) gasket on July 23, 2001. The licensee did not install and use the high efficiency particulate air (HEPA) filtering system, that was specified in the work order, and which was necessary to control the spread of radioactive contamination and reduce the potential airborne radioactivity concentrations during the work.

This finding was greater than minor because the failure to use the HEPA filtering system that was specified for this work contributed to the unnecessary personnel exposure to airborne radioactivity. However, this issue did not constitute an As Low As Reasonably Achievable (ALARA) finding, did not result in a substantial potential for an overexposure, and did not affect the licensee's ability to assess dose to workers. Accordingly, this finding is considered as having very low safety significance. The Non-Cited Violation was entered into the licensee's corrective action program under Issue Report No. IR3-045-473. (Section 2OS1)

B. Licensee Identified Findings

A violation of very low significance, which was identified by the licensee, has been reviewed by the inspector. Corrective actions taken or planned by the licensee appear reasonable. This violation is listed in Section 4OA7 of this report.

Report Details

1. **REACTOR SAFETY**

Cornerstones: Initiating Events, Mitigating Systems and Barrier Integrity

1R04 Equipment Alignment

.1 Partial Walkdown

a. Inspection Scope

The inspectors conducted an equipment alignment partial walkdown to evaluate the operability of a selected redundant train or backup system, while the affected train or system was inoperable or out of service. The walkdown included a review of system operating instructions to determine correct system lineup and verification of critical components to identify any discrepancies which could affect operability of the redundant train or backup system. The inspectors performed partial system walkdowns on the following systems:

- Nos. 21, 22 and 23 High Pressure Safety Injection Pumps were inspected following surveillance testing.
- No. 12 Turbine Driven Auxiliary Feedwater (TDAFW) pump was inspected on August 8, 2001, while the No. 11 TDAFW pump was out of service for surveillance testing.

The inspectors reviewed the following Calvert Cliffs Nuclear Power Plant documentation:

- Operating Instruction OI-3A-1, "Safety Injection and Containment Spray."
- Operating Instruction OI-32A-1, "Auxiliary Feedwater System."
- STP O-062-1, "Monthly Valve Position Verification - Unit 1."
- STP O-05A-1, "Auxiliary Feedwater System Quarterly Surveillance Test."

b. Findings

No findings of significance were identified.

.2 Complete Walkdown

a. Inspection Scope

The inspector conducted a complete 120 Volt Vital AC system equipment alignment walkdown of both units to verify equipment alignment and to identify any discrepancies that may impact the function of the system. The inspector also reviewed the licensee's actions to identify and resolve system equipment discrepancies which may cause an initiating event or impact the mitigation capability of an associated system. The walkdown included reviews of system operating instructions, electrical diagrams and portions of surveillance test procedure (STP) O-090-1, "AC Sources and On Site Power Distribution Systems 7-Day Operability Verification," Revision 21, to determine correct

system/breaker lineups. The inspectors reviewed the following station documentation:

- 120 Volt Instrument and Vital AC System Description Nos. 17 and 18.
- Procedure AOP-7J, "Loss of 120 Volt Vital AC or 125 Volt Vital DC Power," Revision 14.
- Technical Specification 3.8, "Electrical Power Systems."

b. Findings

No findings of significance were identified.

1R05 Fire Protection - Fire Area Tours

a. Inspection Scope

The inspectors conducted tours of areas important to reactor safety to evaluate conditions related to: (1) licensee control of transient combustibles and ignition sources; (2) the material condition, operational status, and operational lineup of fire protection systems, equipment and features; and (3) the fire barriers used to prevent fire damage or fire propagation. The inspectors used administrative procedure SA-1-100, Fire Prevention, during the conduct of this inspection.

The areas inspected included:

- No. 21 Emergency Core Cooling System Pump Room.
- No. 22 Emergency Core Cooling System Pump Room.
- Unit 2 Auxiliary Feedwater Pump Room.

b. Findings

No findings of significance were identified.

1R11 Licensed Operator Requalification

a. Inspection Scope

On July 17, 2001, the inspector observed licensed operator simulator training to assess operator performance for a scenario involving a reactor coolant system leak, a spurious steam generator isolation signal and a failed open steam generator safety valve. In particular, the inspector observed operators performing Emergency Operating Procedures (EOP)-0 and EOP-8. Following the simulator exercise, the inspector observed the training instructor debrief with the shift manager and the shift manager alternate.

b. Findings

No findings of significance were identified.

1R12 Maintenance Rule Implementation

a. Inspection Scope

The inspectors reviewed performance-based problems involving selected in-scope structures, systems, or components (SSCs) to assess the effectiveness of the maintenance program. Reviews focused on: (1) proper maintenance rule scoping, in accordance with 10 CFR 50.65; (2) characterization of failed SSCs; (3) safety significance classifications; (4) 10 CFR 50.65 (a)(1) and (a)(2) classifications; and (5) the appropriateness of performance criteria for SSCs classified as (a)(2), and goals and corrective actions for SSCs classified as (a)(1). The inspectors reviewed the most recent system health reports and system functional failures of the last two years. The following SSCs were reviewed:

- 500 kV Switchyard - The licensee has classified this system as Maintenance Rule (a)(1) because the 500 kV red bus exceeded its unavailability criteria (less than 32 hours unavailability/bus/two years). It was taken out of service during the Unit 2 2001 refueling outage for preventative maintenance on the 13 kV transformer, No. P-13000-2. The licensee's evaluation determined that the unavailability criteria was exceeded because the time required to perform the preventative maintenance was greater than the unavailability criteria for this system. The inspector evaluated the acceptability of the licensee's corrective action plan as documented in Issue Report (IR) No. IR3-073-227. Per this IR, the licensee plans to establish a new unavailability criteria for the 500kV busses that will more accurately reflect the outage time required to perform electric plant preventative maintenance and be consistent with the plant's probabilistic risk assessment.
- Compressed Air - The licensee classified the system as Maintenance Rule (a)(1) due to repetitive functional failures as a result of seat leakage through check valve Nos. 1-IA-729, -730, -732, and 2-IA-300, -301, and -315A. These valves are located in close proximity to the auxiliary feedwater system air amplifier. The cyclic action of the air amplifier resulted in check valve wear. The inspector evaluated the acceptability of the licensee's corrective action plan as documented in Issue Report No. IR3-017-760. The corrective actions included replacing the affected check valves with a model better suited to the application.
- Operators noted that pressurizer pressure transmitter 2PT105A was cycling between 2248 psia and 2218 psia with the pressure indicating lower with each cycle. The issue was appropriately documented in IR No. IR3-081-941. The inspector verified this pressure transmitter failure was characterized as a Maintenance Rule functional failure and reviewed the established system performance criteria.

The inspectors also reviewed the following Calvert Cliffs Nuclear Power Plant documentation:

- Station Procedure MN-1-112, Managing System Performance.
- Maintenance Rule Scoping Document, Revision 17.
- Maintenance Rule Indicator Report, June 2001.

b. Findings

No findings of significance were identified.

1R13 Maintenance Risk Assessments and Emergent Work Evaluation

a. Inspection Scope

For the selected maintenance orders (MO) listed below, the inspectors verified: (1) risk assessments were performed in accordance with Calvert Cliffs procedure NO-1-117, "Integrated Risk Management;" (2) risk of scheduled work was managed through the use of compensatory actions; and (3) applicable contingency plans were properly identified in the integrated work schedule.

- MO2200100721, Clean Plenum and Inspect/Clean Strainer for No. 22A Service Water Heat Exchanger.
- MO2200003669, Remove Unit 2 Spare Trip Circuit Breaker (TCB) and Install TCB-5.
- MO0200100424, Reserve Battery Charger and Feeder Breaker Inspection.

b. Findings

No findings of significance were identified.

1R15 Operability Evaluations

a. Inspection Scope

The inspectors reviewed selected operability evaluations affecting risk significant mitigating systems to assess: (1) technical adequacy of the evaluations; (2) whether continued system operability was warranted; (3) whether other existing degraded conditions were appropriately addressed with respect to their collective impact on continued safe plant operation; and (4) where compensatory measures were involved, whether the measures were in place, would work as intended, and were appropriately controlled. The following evaluations were reviewed:

- Operability Determination No. 01-012, Elevated Levels of Metal Wear Particles in the No. 23 Auxiliary Feedwater Pump Outboard Bearing Lube Oil.
- ES199701913-000, Engineering Evaluation Concerning Air Trapped in the Low Pressure Safety Injection Discharge Piping following Maintenance.

b. Findings

No findings of significance were identified.

1R19 Post-Maintenance Testing

a. Inspection Scope

The inspectors reviewed post-maintenance test procedures and associated testing activities for selected risk significant mitigating systems to assess whether: (1) the effect of testing on the plant had been adequately addressed by control room and engineering personnel; (2) testing was adequate for the maintenance performed; (3) acceptance criteria were clear and adequately demonstrated operational readiness, consistent with design and licensing basis documents; (4) test instrumentation had current calibrations, range, and accuracy for the application; (5) tests were performed, as written, with applicable prerequisites satisfied; and (6) that equipment was returned to the status required to perform its safety function. The following MO activities were reviewed:

- MO1200102158, No. 11 Main Steam Isolation Valve Nitrogen Accumulator Pressure Digital Indicator.
- MO1200103193, Disassemble, Clean, and Reassemble No. 11A Service Water Heat Exchanger.
- MO2200003400, Lubricate No. 23 Component Cooling Water Pump Motor.

b. Findings

No findings of significance were identified.

1R22 Surveillance Testing

a. Inspection Scope

The inspectors witnessed performance of surveillance test procedures and reviewed test data of selected risk-significant systems, structures, and components (SSCs) to assess whether the SSCs satisfied Technical Specifications, Updated Final Safety Analysis Report, Technical Requirements Manual, and licensee procedure requirements. The inspectors assessed whether the testing appropriately demonstrated that the SSCs were operationally ready and capable of performing their intended safety functions. The following tests were witnessed:

- STP M-573-2, "System Leakage Testing."
- STP M-200-1, "Reactor Trip Breaker Functional Test."
- STP O-073I-2, "Unit 2 High Pressure Safety Injection Pump and Valve Quarterly Operability Test."

b. Findings

No findings of significance were identified.

1R23 Temporary Plant Modifications

a. Inspection Scope

The inspectors reviewed a risk significant temporary modification to assess: (1) the adequacy of the 10 CFR 50.59 evaluation; (2) that the installations were consistent with the modification documentation; (3) that drawings and procedures were updated as applicable; and, (4) the adequacy of the post installation testing. The inspectors reviewed Temporary Alteration No. 2-01-0022, "Unit 2 Reactor Cavity Temperature Alarm Setpoint."

b. Findings

No findings of significance were identified.

1EP6 Drill Evaluation

a. Inspection Scope

On July 17, 2001, the inspectors observed an evaluated simulator scenario during licensed operator training to assess operator performance regarding emergency classification declarations. The scenario provided two opportunities to make an emergency classification declaration. Operators missed the Alert declaration, but properly made the Site Area Emergency declaration. However, because only the Site Area Emergency declaration was considered a critical task for licensed operator requalification training, they planned to report only this success to the Emergency Planning staff for calculation of the drill and exercise performance (DEP) performance indicator. The inspector discussed this issue with the supervisor of licensed operator requalification training and the Emergency Planning Director who agreed they should have been counting all the declaration opportunities, not just declarations that were considered critical tasks. The licensee stated that although they have taken measures to count all declaration opportunities during future requalification training, the notes and records of past simulator training were not sufficient to allow them to correct past performance indicator information. The licensee initiated IR No. IR3-051-237 to place this issue in the corrective action program. Also reference Section 4OA1 of this report.

b. Findings

No findings of significance were identified.

2. RADIATION SAFETY

Cornerstones: Occupational Radiation Safety (OS) and Public Radiation Safety (PS)

2OS1 Access Control to Radiologically Significant Areas

a. Inspection Scope

The inspector reviewed the circumstances and licensee evaluations associated with a licensee identified airborne radioactivity event that occurred on July 13, 2001. The event was associated with gasket repair work conducted on the No. 22 chemical and volume control system (CVCS) ion exchanger (IX). The following matters were reviewed:

- job planning and control.
- conduct of ALARA controls.
- use and adequacy of Special Work Permits.
- radiological surveys.
- actual and potential personnel exposures.
- implementation of the corrective action process.

The review was against applicable criteria contained in station procedures, Technical Specifications, and 10 CFR 20.

b. Findings

On July 13, 2001, the licensee improperly conducted radiological work activities on the No. 22 CVCS IX, located in a pit accessed from the 45' elevation of the Auxiliary Building. Specifically, step 40 of maintenance order (MO) No. 220010954 directed workers to coordinate with radiation protection personnel to ensure the job site had been properly setup for work. The MO specified that a high efficiency particulate air (HEPA) filtering system was to be used for the work activity on the No. 22 CVCS IX. The inspector determined that no HEPA filtering system was installed or used in support of this work activity. This is contrary to maintenance procedure MN-1-101, Rev. 25, Section 5.8 D.5, which requires maintenance activities be performed in accordance with the established MO. Accordingly, this is a violation of Technical Specification 5.4 and Regulatory Guide (RG) 1.33, 1978, (Appendix A, Section 9) that require that procedures for performing maintenance be established and implemented.

This finding was greater than minor because the failure to use the HEPA ventilation system that was specified for this work, contributed to unnecessary personnel exposure to airborne radioactivity. However, because the matter did not constitute an ALARA finding, result in a substantial potential for an overexposure, or affect the licensee's ability to assess dose to workers, the finding is considered as having very low safety significance. (GREEN)

This violation of Technical Specification 5.4 is being treated as a Non-Cited Violation (NCV), consistent with Section VI.A of the Enforcement Policy, issued May 1, 2000 (65 FR

25368). (NCV 50-317&318/01-06-01) This issue was placed in the corrective action system as IR No. IR3-045-473.

2PS2 Radioactive Material Processing and Transportation

.1 System Walkdown

a. Inspection Scope

The inspector walked down portions of the station's radioactive solid waste storage locations to verify that the current configuration and operation agreed with the descriptions contained in the Updated Final Safety Analysis Report (UFSAR) and Process Control Program (PCP), as appropriate. The inspector also discussed the status of solid waste processing systems. The inspector reviewed the following matters:

- Status of non-operational or abandoned in-place radioactive waste process equipment, and administrative and physical controls for the systems.
- Changes made to radioactive waste processing systems and potential radiological impact.
- Physical controls to ensure non-operational or abandoned systems would not contribute to an unmonitored release path and/or affect operating systems or be a source of unnecessary personnel exposure.
- Current processes for transferring radioactive waste resin and sludge to shipping containers and mixing and sampling of the waste.
- Radioactive waste and material storage and handling practices.
- Sources of radioactive waste at the station, processing (as appropriate), and handling of the waste.
- General condition of facilities and equipment.

The review was against criteria contained in the station's UFSAR, 10 CFR Part 20, 10 CFR 61, the PCP, and applicable station procedures. The inspector performed selected radiation surveys at radioactive material and waste storage areas to evaluate the adequacy of radiological controls and interviewed personnel involved with various waste handling and processing activities to evaluate the understanding of specific program requirements.

b. Findings

No findings of significance were identified.

.2 Waste Characterization and Classification

a. Inspection Scope

The inspector reviewed the following matters:

- Radio-chemical sample analysis results for radioactive waste streams relative to 10 CFR Part 61.
- Development of scaling factors for difficult to detect and measure radionuclides.
- Methods and practices to detect changes in waste streams.
- Implementation of applicable NRC Branch Technical Positions on waste classification, concentration averaging, waste stream determination, and sampling frequency.
- Current waste streams and their processing relative to descriptions contained in the UFSAR and the station's approved PCP.
- Revisions of the PCP and the UFSAR to reflect changes (as appropriate).

The review was against criteria contained in 10 CFR 20, 10 CFR 61, 10 CFR 71, the UFSAR, the PCP, applicable NRC Branch Technical Positions, and station program procedures.

b. Findings

No findings of significance were identified.

.3 Shipment Preparation and Records

a. Inspection Scope

The inspector selected and reviewed records associated with five shipments (four of which were classified as greater than Limited Quantity shipments) of radioactive material. The shipments were Nos. 01-025, 01-023, 01-057, 01-120, and 01-074. The following matters were reviewed:

- Placarding of the transport vehicle, as appropriate.
- Conduct of vehicle checks.
- Provision of driver emergency instructions.
- Completion of shipping paper/disposal manifest.
- Evaluation of strong tight containers.
- Conformance with procedure for cask loading, closure, and use requirements (including consistency with cask vendor approved procedures).
- Implementation of applicable shipping requirements including completion of waste manifests.
- Implementation of the Certificates of Compliance (C of C) for NRC approved shipping casks including limiting package contents consistent with C of C requirements.
- Implementation of recent NRC and Department of Transportation shipping requirements rule changes.
- Conduct of shipment preparation by appropriately trained personnel.

The review was against criteria contained in 10 CFR 61 and 71, 49 CFR 100-189, the applicable disposal facility licenses, applicable C of C for various shipping casks, and NRC

Quality Assurance Program Approval for Radioactive Materials Packages, dated January 23, 2001.

The inspector also reviewed audits, assessments, and surveillances of the radioactive waste handling, processing, storage, and shipping programs, as well as, audits of the PCP. The inspector reviewed licensee actions on self-identified issues. The following documents were reviewed:

- Issue Reports 045-458, 45-454, 45-455, 82-585, 59-438, and 59-490.
- Latest Joint Utility Audit.
- July 2001 Radwaste Assessment (preliminary results).

The review was against criteria contained in 10 CFR 20 and 10 CFR 71.

b. Findings

No findings of significance were identified.

4 OTHER ACTIVITIES

40A1 Performance Indicator Verification

a. Inspection Scope

The inspectors reviewed performance indicator (PI) data for the below listed cornerstones to verify individual PI accuracy and completeness. This inspection examined data and plant records from the second quarter of 2000 to the second quarter 2001, including review of PI Data Summary Reports, and operator narrative logs.

- Unplanned Scrams per 7000 Critical Hours
- Unplanned Scrams with a Loss of Normal Heat Removal
- Unplanned Transients per 7000 Critical Hours
- Drill and Exercise Performance

b. Findings

As discussed in Section 1EP6, Drill Evaluation, the inspector found that during operator requalification training, the licensee had been inappropriately counting only the declaration opportunities considered to be critical tasks rather than counting all declaration opportunities. Notwithstanding, PI thresholds have not been identified as having been adversely impacted by this oversight.

4OA6 Management Meetings

.1 Exit Meeting Summary

The inspectors presented the inspection results to members of licensee management at the conclusion of the inspection on August 22, 2001. The licensee acknowledged the findings presented.

The inspectors asked the licensee whether any of the material examined during the inspection should be considered proprietary. No proprietary information was identified.

4OA7 Licensee Identified Violation

The below listed finding of very low significance was identified by the licensee and is a violation of NRC requirements which meets the criteria of Section VI of the NRC Enforcement Policy, NUREG-1600, for being dispositioned as an NCV.

NCV Tracking Number

Requirement Licensee Failed to Meet

NCV 50-317&318/01-06-02

On July 13, 2001, the licensee did not implement the requirements of Technical Specification 5.4, and RG 1.33, Rev.2, February 1978 (Appendix A, Section 7e) during planning and repair of a gasket on the No. 22 CVCS IX. As a result, the leaking gasket caused elevated contamination levels that were not identified and evaluated prior to the conduct of the work activity. The issues involving this event were addressed by various corrective action IRs (Nos. 072-016 and 045-460, 461, 462, 463, 464, 465, 466, 467, 468, 469, and 470). This issue is being treated as a Non-Cited Violation.

ATTACHMENT 1

a. Key Points of Contact

C. Cruse, Vice President
 D. Holm, Superintendent, Nuclear Operations
 P. Katz, Plant General Manager
 M. Korsnick, Superintendent, Work Management
 M. Navin, Superintendent, Technical Support
 K. Nietmann, Manager, Nuclear Performance Assessment Department
 T. Pritchett, Manager, Nuclear Engineering Department
 J. Spina, Superintendent, Nuclear Maintenance
 R. Szoeh, General Supervisor, Plant Engineering
 L. Weckbaugh, Manager, Nuclear Support Services

b. List of Items Opened, Closed, or DiscussedOpened and Closed

50-317&318/01-06-01	NCV	Licensee did not follow maintenance work order (Section 2OS1)
50-317&318/01-06-02	NCV	Licensee did not implement Technical Specification 5.4, and RG 1.33 during planning and repair of gasket for 22 CVCS IX (Section 4AO7)

c. List of Acronyms

AC	Alternating Current
ALARA	As Low As Reasonably Achievable
CFR	Code of Federal Regulations
C of C	Certificates of Compliance
CVCS	Chemical and Volume Control System
DEP	Drill and Exercise Performance
EOP	Emergency Operating Procedure
HEPA	High Efficiency Particulate Air
IR	Issue Report
IX	Ion Exchanger
kV	kilo volt
MO	Maintenance Order
NCV	Non-cited Violation
NRC	Nuclear Regulatory Commission
PARS	Publicly Available Records
PCP	Process Control Program
PI	Performance Indicator
SDP	Significance Determination Process

SSC	Structure, System and Component
STP	Surveillance Test Procedure
TCB	Trip Circuit Breaker
TDAFW	Turbine Driven Auxiliary Feedwater
TS	Technical Specification
UFSAR	Updated Final Safety Analysis Report