January 31, 2005

Mr. M. Nazar
Senior Vice President and
Chief Nuclear Officer
Nuclear Generation Group
American Electric Power Company
500 Circle Drive
Buchanan, MI 49107

SUBJECT: D. C. COOK NUCLEAR POWER PLANT, UNITS 1 AND 2
NRC PROBLEM IDENTIFICATION AND RESOLUTION INSPECTION REPORT
05000315/2004014; 05000316/2004014

Dear Mr. Nazar:

On December 17, 2004, the U.S. Nuclear Regulatory Commission completed an inspection at your D. C. Cook Nuclear Power Plant, Units 1 and 2. The enclosed report documents the inspection findings which were discussed on December 17, 2004, 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 a selected examination of procedures and representative records, observations of activities, and interviews with personnel. Although this inspection was a scheduled biennial review, because a problem identification and resolution inspection was performed in December of 2003, this inspection reviewed the activities since the completion of that inspection.

The team concluded that in general, problems were being properly identified, evaluated, and corrected. The specific conclusions, also reflected in the feedback received from your staff, was that the identification of issues was generally satisfactory, but that problem resolution, although improved, warranted additional attention. Nonetheless, your implementation of the D.C. Cook Recovery Plan appears to have improved the effectiveness of your corrective action program as evidenced by the issues identified by the inspectors which, with one exception, were of only minor significance. The inspectors also concluded that there was no evidence that management did not foster an environment where workers felt free to raise safety concerns.

Based on the results from this inspection, one NRC-identified finding of very low safety significance (Green) which involved a violation of NRC requirements was identified. However, because the violation was of very low safety significance and because the issue was 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 contest the subject or severity of a Non-Cited Violation, you should provide a response with a basis for your denial, within 30 days of the date of this inspection report, to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555-0001, with a copy to the Regional Administrator, U.S. Nuclear Regulatory Commission - Region III, 2443 Warrenville Road, Suite 10, Lisle, IL 60532-4352; the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001; and the NRC Resident Inspector at the D.C. Cook facility.

In accordance with 10 CFR 2.390 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/reading-rm/adams.html (the Public Electronic Reading Room).

Sincerely,

/RA/

Eric R. Duncan, Chief
Branch 6
Division of Reactor Projects

Docket Nos. 50-315; 50-316
License Nos. DPR-58; DPR-74

Enclosure: Inspection Report 05000315/2004014; 05000316/2004014
w/Attachment: Supplemental Information

cc w/encl: J. Jensen, Site Vice President
M. Finissi, Plant Manager
G. White, Michigan Public Service Commission
Michigan Department of Environmental Quality
Emergency Management Division
MI Department of State Police
D. Lochbaum, Union of Concerned Scientists

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U. S. NUCLEAR REGULATORY COMMISSION

REGION III

Docket Nos:	50-315; 50-316
License Nos:	DPR-58; DPR-74
Report No:	05000315/2004014; 05000316/2004014
Licensee:	American Electric Power Company
Facility:	D. C. Cook Nuclear Power Plant, Units 1 and 2
Location:	1 Cook Place Bridgman, MI 49106
Dates:	November 29 through December 17, 2004
Inspectors:	R. Lerch, Project Engineer, DRP M. Garza, Resident Inspector, Palisades L. Haeg, Reactor Engineer, DRP I. Netzel, Resident Inspector, D.C. Cook R. Ng, Reactor Engineer, DRP R. Winter, Reactor Engineer, DRS
Approved by:	E. Duncan, Chief Branch 6 Division of Reactor Projects

Enclosure

SUMMARY OF FINDINGS

IR 05000315/2004014; 05000316/2004014; 11/29/2004-12/17/2004; D. C. Cook Nuclear Power Plant, Units 1 and 2; Problem Identification and Resolution.

The inspection was conducted by region-based inspectors and resident inspectors. One Green finding of very low safety significance with an associated Non-Cited Violation was identified. 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 may be "Green" or be assigned a severity level after NRC management review. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process," Revision 3, dated July 2000.

Identification and Resolution of Problems

The team concluded that overall, problems were being properly identified, evaluated, and corrected. The specific conclusions, also reflected in the feedback received from the licensee's staff, was that the identification of issues was generally satisfactory, but that problem resolution, although improved, warranted additional attention. Nonetheless, the implementation of the D.C. Cook Recovery Plan appeared to have improved the effectiveness of the licensee's corrective action program as evidenced by the issues identified by the inspectors which, with one exception, were of only minor significance. The inspectors also concluded that there was no evidence that management did not foster an environment where workers felt free to raise safety concerns.

Cornerstone: Occupational Radiation Safety

Green. A finding of very low safety significance was identified by the inspectors when licensee personnel failed to adequately address repetitive radiological posting errors. The issue was more than minor since it was associated with the Program and Process attribute of the Occupational Radiation Safety cornerstone and adversely affected the cornerstone objective of ensuring the adequate protection of worker health and safety from exposure to radiation.

The finding was of very low safety significance since the issue did not directly impact As Low As Reasonably Achievable (ALARA) planning or work controls, was not associated with an overexposure or a substantial potential for an overexposure, or compromise the licensee's ability to assess dose. As part of the licensee's immediate corrective actions, areas with survey maps which were outdated were immediately updated to reflect the most recent survey results. One Non-Cited Violation of Technical Specification 6.8.1 was identified. (Section 4OA2.3)

REPORT DETAILS

4. OTHER ACTIVITIES (OA)

4OA2 Problem Identification and Resolution (71152B)

.1 Effectiveness of Problem Identification

a. Inspection Scope

The inspectors reviewed documentation from over the last year including NRC inspection report findings, selected corrective action documents, Recovery Plan actions, operating experience reports, and trend assessments, to determine if problems were being entered into the corrective action program (CAP) at the proper threshold. Corrective action program implementation, metrics, and status such as corrective action generation rates and departmental performance indicators were reviewed and discussed with licensee personnel.

b. Assessment

In general, licensee personnel identified issues and entered them into the corrective action program at an appropriate level. However, when the D.C. Cook Recovery Plan was developed and actions to be taken were identified, these actions were not tracked using the corrective action program. When this was identified by the NRC, the actions were entered into the corrective action program. The inspectors had several additional observations about the program, although no significant problems were identified. For example, the green card, intended for identifying issues when a computer was not available, was difficult to understand, especially by individuals such as contractors, who would not be familiar with plant CAP input codes. The green card itself was not well defined or controlled by procedures.

Since departmental self-assessments of CAP implementation were not performed, this area was not reviewed by the inspectors. The licensee established the Performance Observation Program (POP) to conduct narrowly focused self-assessments. This program had its own procedure and documentation forms separate from the corrective action program. Although a valuable tool, the inspectors identified a vulnerability for a problem to be identified through a POP observation and not tracked to resolution. While most departments diligently reviewed POP results, not all departments ensured that each problem identified during a POP observation was captured in a condition report (CR) in the CAP. A review of a sample of POP reports by the inspectors did not identify an example where a significant issue was not adequately resolved as a direct result of the failure to identify a POP observation in a condition report. The inspectors also identified that licensee personnel had an earlier opportunity to address this vulnerability. The evaluation of CR 03363023, which identified that POP findings in the radiation protection department were inadequately reviewed because CRs were not generated, erroneously concluded that this problem was limited to the radiation protection department.

Cause codes were being used and trend thresholds were established and being used to identify trends in condition reports. Also, the handling of operating experience reports was improved with this improvement confirmed by licensee audits, the most recent of which identified only minor issues. Interviews of plant staff also indicated that problem identification was viewed as a strength.

.2 Prioritization and Evaluation of Issues

a. Inspection Scope

The inspectors reviewed procedures, inspection reports, and corrective action documents to verify that identified issues were appropriately characterized and prioritized in the CAP. Evaluations documented in CRs were reviewed to verify an appropriate depth and thoroughness of the review relative to the actual or potential significance of each issue. The inspectors attended management meetings to observe the assignment of CR categories for current issues and to observe the review of root cause, apparent cause, and common cause analyses, and corrective actions for existing CRs. The inspectors also assessed the corrective actions implemented to address Non-Cited Violations (NCVs).

b. Assessment

Although several minor performance issues with individual condition reports were identified as discussed below, evaluations in general were acceptable.

- During the CR screening process, plant management assessed the significance of each CR and the appropriate evaluation. The inspectors identified two examples where these reviews prescribed inadequate corrective actions. The inspectors determined that during the review of CR 0448040, the concern was mis-interpreted in a non-conservative manner. Also, in CR 04330018, immediate corrective actions to post up-to-date radiation surveys clearly indicated that some surveys were not updated; but screening reviewers did not identify that the immediate corrective actions were inadequate (Section 4OA2.3). The licensee entered these issues into the corrective action program as CRs 04351051 and 04351038, respectively.

- The inspectors identified that the review of an audit finding lacked an appropriate extent of condition review. A finding in Audit PA 04-08 identified that a specified equipment performance criteria had not been measured. Although the specific issue, documented on CR 04043039, was of only minor significance, since the criteria was subsequently deleted, the licensee's evaluation failed to address whether other criteria in the document might not have been tested appropriately. The licensee generated CR 04350007 to enter this issue into the corrective action program.

- The inspectors identified one example of improper closure of a condition report (CR 0400604) where corrective actions were not complete. This was due to a revision in the planned corrective actions that was not documented in the CR. Throughout the assessment period, licensee personnel also identified CRs that were not properly closed and issued followup CRs to identify those instances. In the examples reviewed by the inspectors, there were no issues which were of more than minor significance.

.3 Effectiveness of Corrective Actions

a. Inspection Scope

The inspectors reviewed corrective action documents including root cause reports and apparent cause evaluations and verified that corrective actions were identified and implemented in a timely manner, commensurate with the safety significance of the issues, and were effective. The inspectors also reviewed the licensee's corrective actions for NCVs documented in NRC inspection reports in the past year.

b. Assessment

In general, the licensee's corrective actions for the samples reviewed were appropriate. The inspectors identified one finding of very low safety significance (Green) and an associated Non-Cited Violation of Technical Specification 6.8.1, "Procedures and Programs," when licensee personnel failed to adequately address repetitive radiological posting errors. The inspectors identified some additional issues that were repetitive in nature, however the significance of those issues was minor.

b.1 Failure to Promptly Correct Outdated Radiological Survey Maps

Introduction

The inspectors identified a Green finding and an associated Non-Cited Violation of Technical Specification 6.8.1, "Procedures and Programs," when licensee personnel failed to adequately address repetitive radiological posting errors.

Description

In January 2004, Performance Assurance Audit PA-04-07 identified that Radiological Area Status Sheets (Radiation Protection (RP) Survey Maps) posted in the access control hallway had not been updated as required by 12-THP-6010-RPP-401, "Performance of Radiation and Contamination Surveys." Condition Report (CR) 04016049 was generated on January 16, 2004 to document the issue. The condition report also stated that this problem had been previously identified following a Performance Assurance (PA) field observation on February 9, 2002.

CR 040019014 was generated on January 19, 2004 by the radiation protection (RP) department personnel to document recurring deficiencies identified by the PA organization, including outdated surveys.

On February 16, 2004, radiation protection personnel performed a Performance Observation Program (POP) observation to verify that radiological survey maps posted at the turbine building side restricted access control area had been properly updated. Licensee personnel discovered that 20 routine radiological surveys were not properly posted and CR 04047061 was generated to document the issue.

Due to the recurring instances of outdated survey maps in the access control area, an apparent cause evaluation (ACE) was performed to review this issue. Licensee

personnel determined that the apparent cause for the issue was the failure of radiation protection personnel to ensure that the radiological surveys they performed were posted as prescribed by radiation protection procedures and in accordance with management expectations. Procedures and processes for conducting radiological surveys were evaluated and the need to revise the process to enhance the ownership and provide a second verification was identified. As a result, radiation protection management issued a letter dated April 15, 2004, to all radiation protection technicians which outlined the process change and accountability requirements for conducting and posting surveys.

On November 25, 2004, another POP observation was performed and again identified numerous deficiencies in the posting of survey maps. CR 04330018 was generated to identify this problem. As part of the licensee's immediate corrective actions, all missing or outdated survey maps were properly posted. An ACE was scheduled to be performed by December 22, 2004 to evaluate this issue, however no additional corrective actions were planned in the interim.

On December 15, 2004, the inspectors performed a walkdown of the turbine building side restricted access control area to verify that posted survey maps reflected the most recent survey information. The inspectors discovered that the licensee's corrective actions in response to the November 15, 2004, event were not effective and that 10 survey maps posted at the access control area were still outdated. Upon questioning by the inspectors, the licensee updated these survey maps and generated CR 04351038 to identify this issue.

Analysis

The inspectors determined that the failure to update survey postings to reflect the most recent survey information was a performance deficiency warranting a significance evaluation. The inspectors concluded that the issue was more than minor in accordance with Inspection Manual Chapter (IMC) 0612, "Power Reactor Inspection Reports," Appendix B, "Issue Disposition Screening," since the finding was associated with the Program and Process attribute of the Occupational Radiation Safety cornerstone and adversely affected the cornerstone objective of ensuring the adequate protection of the worker health and safety from exposure to radiation. Specially, the failure to post survey data using the most recent survey information could result in an unintended exposure of workers to radiation in the event that radiological conditions had changed and workers were not aware of those conditions.

Using IMC 0609, Appendix C, "Occupational Radiation Safety Significance Determination Process," the inspectors determined that because the radiological survey maps posted at the entrance to restricted areas were for informational use and workers were required to contact radiation protection technicians before they enter the radiological restricted area, the issue did not directly impact As Low As Reasonably Achievable (ALARA) planning or work controls, was not associated with an overexposure or a substantial potential for an overexposure, or compromise the licensee's ability to assess dose. Consequently, the finding screened as Green and was considered to be of very low safety significance.

Enforcement:

Technical Specification 6.8.1 requires, in part, that procedures shall be established implemented and maintained for the applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2. Appendix A, Section 7.e, "Radiation Protection Procedures," of Regulatory Guide 1.33 specifies procedures for radiation surveys and contamination control. Radiation protection procedure 12-THP-6010-RPP-401, "Performance of Radiation and Contamination Surveys," required that up-to-date survey maps be posted in the access control hallway. Contrary to the above, licensee personnel failed to post up-to-date survey maps in the access control hallway as required by radiation protection procedure 12-THP-6010-RPP-401. In particular, licensee personnel failed to recognize that only those missing or outdated maps that originals could be located for were updated when this condition were identified on November 25, 2004. As a result, 10 radiological survey maps were still outdated when the inspectors inspected the postings on December 15, 2004.

However, because this violation was associated with a finding of very low safety significance and because the finding was entered into the licensee's corrective action program, this violation is being treated as a Non-Cited Violation, consistent with Section VI.A.1 of the NRC Enforcement Policy (NCV 05000315/2004014-01; 050000316/2004014-01). This issue was entered into the licensee's corrective action program as CAP059216. As part of the licensee's immediate corrective actions, areas with survey maps which were outdated were immediately updated to reflect the most recent survey results.

b.2 Observations on the Effectiveness of Corrective Actions

The inspectors had several observations regarding corrective actions that were not sufficiently effective in correcting the identified issue or to prevent recurrence. The examples identified were of only minor significance and are described below.

Foreign Material Exclusion

On August 5, 2004, a vacuum hose was inadvertently dropped into the screen house forebay and could not be located for retrieval. Although no adverse impact on plant equipment occurred as a result of this event, the event revealed a potential vulnerability in the licensee's Foreign Material Exclusion (FME) program. A root cause evaluation was performed for CR 04218086. Subsequently, other failures of FME controls occurred and on October 26, 2004 the Performance Assurance organization generated CR 0429044 to document an FME programmatic concern. The inspectors noted that even before the August 5, 2004 event, FME program implementation had been a repetitive and long-term issue, and corrective actions were not sufficiently effective. At the end of this inspection, a root cause evaluation for CRs 04296044 and 4298002 was in progress.

Procedural Adherence

The inspectors identified through a review of CRs that failures by licensee personnel to adhere to procedures was a persistent and repetitive issue. Although the examples

were of only minor significance, these issues demonstrated the potential for a significant issue to occur. Some examples included the following:

- CR 04313006 identified that workers were signed out of a work clearance regarding a primary relief tank maintenance activity before they had exited the area which was not permitted by procedures.

- CR 04337070 identified that workers verified that a nonsafety-related cavity sump was inspected for debris, although inspectors identified foreign material in the sump shortly afterward.

- CR 04335009 identified that operations staff had met power escalation prerequisites, but they were not signed off before performing the procedure.

- CR 04243140 identified that reactor coolant sample valves were left open by chemists on two occasions, contrary to procedures.

The licensee was addressing this area of performance through the D.C. Cook Recovery Plan and was tracking and trending procedure performance issues.

.4 Assessment of Safety-Conscious Work Environment

a. Inspection Scope

The inspectors conducted more than 100 interviews of licensee personnel to assess whether there were impediments to the establishment of a safety conscious wok environment and whether workers felt free to raise safety concerns. During these interviews, the inspectors utilized Appendix 1,"Suggested Questions for Use in Discussions with Licensee Individuals Concerning PI&R Issues," to Inspection Procedure 71152, as a guide to gather information and develop insights. The team also discussed the implementation of the Employee Concerns Program (ECP) with the licensee's ECP Coordinator.

b. Assessment

In general, licensee personnel did not express any safety conscious work environment concerns. A few individuals expressed some hesitation to raise a concern, but they did not have any specific safety or regulatory issue to report. Licensee personnel were aware of and generally familiar with the corrective action program and other problem-reporting programs, including the ECP, through which concerns could be raised. A review of the issues entered in the ECP indicated that site personnel were appropriately using the corrective action program and the ECP to address their concerns. The ECP Coordinators were appropriately reviewing individual concerns and appropriately using the ECP and CAP programs to resolve issues. Plant communications in newsletters and posters informing workers of the CAP and ECP programs and how to access them were widely available.

The inspectors made the following observations:

- The inspectors identified that security force personnel was not well trained at generating CRs for issues they identified although these issues were entered into the corrective action program by their supervisors.

- The corrective action program provided a notification and feedback form for CR initiators to review the resolution of CRs they had written. Some initiators were frustrated by the time required to correct relatively minor issues and the number of CRs that were closed to the trending process without a corrective action to address the specific concern.

- The inspectors noted that the corrective action program did not require that the initiator be contacted during the CR evaluation process.

4OA6 Management Meetings

Exit Meeting Summary

The inspectors presented the inspection results to Mr. M. Nazar and other members of licensee management at the conclusion of the inspection on December 17, 2004. The licensee acknowledged the findings presented. The inspectors asked the licensee whether any materials examined during the inspection should be considered proprietary. The licensee indicated that no proprietary information was provided to the inspectors.

ATTACHMENT: SUPPLEMENTAL INFORMATION

SUPPLEMENTAL INFORMATION

KEY POINTS OF CONTACT

Licensee

M. Finissi, Plant Manager
J. Jensen, Senior Vice President
J. Labis, Employee Concerns Manager
M. Nazar, Chief Nuclear Officer
A. Rodriguez, Security Manager
S. Simpson, Manager, Learning Organization Department
R. Serocke, Radiation Protection Manager
L. Weber, Performance Assurance Director
T. Wood, Manager, Regulatory Assurance
J. Zwolinski, Safety Assurance Director

Nuclear Regulatory Commission

E. Duncan, Chief, Branch 6, Division of Reactor Projects
B. Kemker, Senior Resident Inspector

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

05000315/2004014-01; 050000316/2004014-01	NCV	Failure to Promptly Correct Radiological Survey Maps

Closed

05000315/2004014-01; 050000316/2004014-01	NCV	Failure to Promptly Correct Radiological Survey Maps

Discussed

None

LIST OF DOCUMENTS REVIEWED

The following is a list of licensee documents reviewed during the inspection. Inclusion of a document on this list does not imply that NRC inspectors reviewed the entire document, 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 Initiated as a Result of this Inspection

(The CR number is formatted for initiation date: The first two numbers give the year, the next three numbers are the Julian day of the year e.g. 001 = January 1, 336 = December 1. The last three digits are the sequential number of the CR for that day.)

04288038; NRC 2004 PI&R Inspection Team Tracking CR
04335044; Information Requested by NRC Problem Identification and Resolution (PI & R) team was not supplied promptly, because ECP personnel could not be reached, and PI & R team did not know Safety and Assurance Staff Assistant had access.
04335047; Failure to follow Regulatory Affairs Guidance, RAG-01
04335048; Grounded upper bearing on RCP motor
04337038; Evaluate the user friendliness, ease and possible anonymity of the Cook Plant Action Request Card (green card).
04337022; Evaluate the use of 'close-to-trend' for externally driven conditions or issues.
04338021; A question arose during the PI&R inspection regarding sustainability of Corrective Actions to Prevent Recurrence (CATPR) after CARB concurrence and effectiveness review.
04338041; Evaluate rigor and guidance for responding to CAT AT CRs. Initiated via PI&R Inspection.
04338048; Evaluate the best method for providing positive recognition via the CAP process. This issue was identified during the PI&R Inspection.
04338052; PI&R Inspection interviews suggest that Security personnel knowledge of procedural guidance for CR initiation may need to be improved.
04338057; Re-present CR 03176031 to CARB to remove CATPR designation for Action 3 and Action 4. This issue was identified during the PI&R Inspection.
04350007; I&M's Performance Assurance Department during Audit PA 04-08 identified a potential security plan compliance concern. This concern was documented in CR 04043039
04350063; PI & R review determined that DTG-7030-CAP-007 (Closing out Condition Request Actions to Work Request Desk Top Guide) was not followed properly when Engineering closed out Condition report 04006004-03 action to work request 04176026.
04351033; In the course of PI&R inspection 2004014, the question was raised whether or not the POP program has sufficient barriers in place to preclude CAP by-pass.
04351038; There was a missed opportunity to ensure a short turn around time with immediate corrective actions within CR 04330018. This was identified during the 2004 PI&R Inspection
04351051; Operability determination for Condition Report 04348040 incorrectly stated the condition in support of component operability

CONDITION REPORTS

01282046; During the NRC SSDI on the Essential Service Water System the Question was raised on How GL90-13 As Found Inspections Are Conducted In Reference to Functionality During the Previous Operating Period; October 9, 2001
02041007; PA observed Radiological Area Status Sheets posted in the Auxiliary Building that did not depict accurate information; February 9, 2002.
02203001; Unit 2 Reactor Automatically Tripped from 100 percent Power While Flushing Main Turbine Condenser Waterboxes; July 22, 2002
02270028; Recent NRC Inspections at other Utilities have Identified Weaknesses in Simulator Training and Documentation of Reactivity Manipulations; September 27, 2002
02309007; Westinghouse Nuclear Safety Advisory Letter NSAL-02-14 Steam Line Break during Mode 3; November 5, 2002
03025002; While at Full Load (3500 kW) GG2CD Experienced 150 kW Load Swings; January 25, 2003
03031020; 10CFR Part 21 Notification Dated 01/15/2003, Potential non Conforming Issue for Environmental Qualification of Rockbestos Cables; January 31, 2003
03065014; SER 5-01 4kV Breaker Failure Resulting in a Switchgear Fire and Damage to the Main Turbine Generator; March 6, 2003
03083036; During the 2003 Ultimate Heat Sink Inspection, the NRC Questioned CNP's Approach for Assessing the As-Found Condition of the GL89-13 Heat Exchangers; March 24, 2003
03093026; Tracking CR for Quick Hit Self-Assessment SA-2003-CAP-001; April 3, 2003
03118081; Tracking CR for Quick Hit Self-Assessment SA-2003–CAP-006; April 28, 2003
03161056; NRC Bulletin 2003-02, Potential Impact of Debris Blockage on Emerging Sump Recirculation at Pressurized Water Reactors, June 10, 2003
03176031; Within the Past Year There Have Been Two Events Where Workers Received Unanticipated Dose; June 25, 2003
03188008; OE16455 - Discharge of Station Batteries During Bus Outage Occurred at another Facility; June 7, 2003
03196045; The PI&R Team Identified Inconsistencies With Programmatic Implementation of PMP-7034-SAP, Conduct of Self Assessments" Relative to the Required
Condition Report 04149081, SA-2004-SPS-008, Site Protective Services Self Assessment; May 28, 2004
03219023; PMP 7030-OE-001 and PMP 2300-RAP-001 do not Provide Adequate Guidance on Processing NRC Generic Letters; August 7, 2003
03230010; Tracking CR for Quick Hit Self-Assessment SA-2003–CAP-014; August 18, 2003
03232016; High contact resistance in auxiliary switch for 2-52-BYB causes failure of STP-180; August 20, 2004
03234018; NRC Bulletin 2003-02, leakage from Reactor Pressure Vessel Lower Head Penetrations; August 22, 2003
03235018; 2AB EDG Could not Replace Governor Hydraulic Actuator due to Configuration Differences and Lack of Configuration Documentation; August 23, 2003
03281023; NRC Information Notice 2003-19, Unanalyzed Condition of Reactor Coolant Pump Seal Leakoff Line during Postulated Firs Scenarios or Station Blackout; October 8, 2003
03295057; The Cal Block for Performing the Reactor Vessel to Flange Appears to be Nonconforming; October 21, 2003
03341015; Removed Unit 2 AB Emergency Diesel from Service by Tripping the HEA due to a

Loss of Load and Rapid Load Oscillations of Approximately 200-300 kW; December 7, 2003
03343008; Clearance 2033831 was hung without contacting fire brigade as required by the special instructions for the clearance. The clearance removed Fire Hose Station 2-FHC-20 and 1-FHC-23 from service which is required by ATR 2-FP-4 and 1-FP-4; December 9, 2003
03349032; Self-Assessment SA-2003-DEC-001-QH on NTS Corrective Actions; December 15, 2003
04006051; General warning received unexpectedly during routine surveillance; January 6, 2004
04016049; Six Radiological Area Status Sheets (RP Survey maps) posted in the Access Control Hallway were not current and had not been updated as required by 12THP-6010-RPP-601, Performance of Radiation and Contamination Surveys, Revision 12, section 4.8.11; January 16, 2004.
04019014; Recurring instances of PA identified deficiencies; January 19, 2004.
04022018; NRC Information Notice 2004-01, Auxiliary Feedwater Pump Recirculation Line Orifice Fouling; January 22, 2004
04047061; The most current copies of twenty routine radiological surveys were not posted at the Turbine Building side access to the Restricted Area; February 16, 2004.
04051036; Identified components have been confirmed to be obsolete. Bailey Pneumatic Controller Model AD51002 is obsolete with no direct replacement; February 20, 2004
04089033; ESAT written to generate WR's to support troubleshooting and repair activities on the reactor trip bypass breaker in Unit 2. This is to support recovery from Unit 2 reactor trip on 3/29 @ 14:04 hrs; March 29, 2004
04089034; An automatic reactor trip of Unit 2 occurred during testing in accordance with 2-IHP-4030-STP-511; March 29, 2004
0410009; Unit 2 Reactor Automatically Tripped Due to at Turbine Trip Caused by a High-High Level in #4 Steam Generator Following a Feedwater Transient; April 8, 2004
04117067; While performing procedure 12-OHP-4021-066-001, attachment 1, line-up sheet 2, South Fire Protection Tank was inadvertently transferred to the North Fire Protection Tank; April 26, 2004
04120022; Identified Components have been Confirmed to be Obsolete. ABB Kent Taylor Pneumatic Transmitter Model 303TD0021 is Obsolete; April 29, 2004
04124103; Unacceptable Human Performance Behaviors Exhibited by Operations Personnel Have Continued to Cause Significant Plant Events; May 3, 2004
04133037; Striped tag clearance hung when red tag clearance required; May 12, 2004
04133046; Recovery Plan LO 0006: Operating Experience; May 12, 2004
04141075; Installed Components are Obsolete. These are Bailey Type PG Multi Pointer Gage Pneumatic Control Room Indicators; May 20, 2004
04173040; Part 21 - 2004-0012-00; Instantaneous Trip Unit on Type CO and COM Relays; June 21, 2004
04175032; Reactor Trip bypass breaker B closed then immediately unexpectedly reopened while performing 1-IHP-4030-STP-411; June 23, 2004
04177058; Five peer inspections performed for JOA Nos. R0084531-01 and 03039015-01 did not meet the requirements of step 4.1.1 of PMI-7090; June 25, 2004
04177059; Peer inspection results are not being tracked and trended in accordance with PMI-7090; June 25, 2004
04203018; Inadequate clearance approved for placement; July 21, 2004
04205001; Request procedure enhancement (revision) for 12-THP-6010-RPP-401, "Performance of Radiation and Contamination Surveys."
04225010; NRC Inspection Report 05000315/2004006, 05000316/2004006, Routine Resident Inspection Report - 2Q2004; August 12, 2004

0428017; OE19208-2B Emergency Diesel Abnormal Start Indication; October 8, 2004
04296045; The PI&R Team Identified Inconsistencies with Programmatic Implementation of PMP-7034-SAP-001, Conduct of Self-Assessments; October 22, 2004
04311043; Identified by NRC containment walkdown. Reactor cavity sump had debris behind grating which was removed during a containment walkdown; November 6, 2004
04329010; OE13203 Motor Driven Auxiliary Feedwater Pump Air-Binding; November 24, 2004
04330018; POP 34016 noted several deficiencies in the posting of RP survey maps; November 25, 2004.
04337037; Topical Report 4-42, Review of Air-Operated Valve Events; December 2, 2004
04348032; While performing 01-IHP-4030-STP-410, the "A" reactor trip bypass breaker could not be racked to disconnect; December 13, 2004

PROCEDURES

PMI-7030; Corrective Action Program; Revision 31
PMI-7030-CAP-001; Corrective Action Program Process Flow; Revision 17
PMI-7090; Plant Quality Control Inspection Program; Revision 8a; effective March 24, 2004
PMP-5070-ISI-002; Inservice Inspection Program Implementation; April 19, 2004
PMP-7030-OE-001; Operating Experience Program; Revision 7
PMP-7034-SAP-001, "Conduct of Self Assessments," Revision 6
DTG-7030-OE-001; Operating Experience Evaluations; Revision 1
12-OHP-2110-CPS-001; Clearance Permit System; Revision 10; effective October 9, 2004
12-IHP-5021-EMP-010; Reactor Trip/Bypass DB-50 Circuit Breaker Maintenance; Revision 7; effective October 29, 2004
12-THP-6010-RPP-418; Radiological Posting; Revision 11.
12-THP-6010-RPP-601; Performance of Radiation and Contamination Surveys; Revision 14

MISCELLANEOUS DOCUMENTS

CNP Prevention Review Board Charter; Revision 1
Corrective Action Review Board Score Sheets; Revision 2
Effectiveness Review Presentation, Condition Report 03235018, August 2003 2AB EDG Hydraulic Actuator Replacement; December 8, 2004
Effectiveness Review Presentation, Condition Report 03025002, January 2003 EDG Hydraulic Load Oscillations; December 8, 2004
Corrective Action Review Board; CARB #292; 11/11/04
PM Task 13-2 U2 PM Tasks for Main Turbine and Associated Equipment; 05/03/2001
JORO101404 2-HE-9C Perform Inspection Per PM Task 32 Step 3.2; 12/19/2002
JO03142054 2-HE-9C Repair Cracked Weld on Air Removal Piping; 09/18/2003
DTG-7034-SAP-001, "Self Assessment Program Desktop Guide," Revision 5
Annual Assessment of the Department's Performance In the Corrective Action Area," October 22, 2004
Performance Assurance Audit PA-04-07; Radiation Protection; February 13, 2004.
Performance Assurance Field Observation FO-02-B-044; Radiological Area Status Sheet Observation; February 10, 2002.
SA-2003-OPS-004-QH; Operations Department Assessment

LIST OF ACRONYMS USED

ADAMS	Agency-wide Documents and Management System
ALARA	As Low As Reasonably Achievable
AR	Action Request
CAP	Corrective Action Program
CAQ	Condition Adverse to Quality
CFR	Code of Federal Regulations
CR	Condition Report
DC	Direct Current
DRP	Division of Reactor Projects
DRS	Division of Reactor Safety
ECP	Employee Concerns Program
EDG	Emergency Diesel Generator
INPO	Institute for Nuclear Plant Operations
IR	Inspection Report
LER	Licensee Event Report
NCV	Non-Cited Violation
NRC	U. S. Nuclear Regulatory Commission
OA	Other Activities
PA	Performance Assurance
PARS	Publicly Available Records
PI&R	Problem Identification and Resolution
SCAQ	Significant Condition Adverse to Quality
SOER	Significant Operating Experience Report