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

October 5, 2000

Southern Nuclear Operating Company, Inc.
ATT.: Mr. D. N. Morey
Vice President
P. O. Box 1295
Birmingham, AL 35201-1295

SUBJECT: JOSEPH M. FARLEY NUCLEAR PLANT - NRC INSPECTION REPORT NOS. 50-348/00-10 AND 50-364/00-10

Dear Mr. Morey:

On September 8, 2000, the NRC completed an inspection at the Farley Nuclear Plant. The enclosed report documents the inspection findings which were discussed on September 8, 2000, with Mr. M. Stinson 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 and compliance with both the Commission's rules and regulations and the conditions of your operating license. Within these areas, the inspection involved selected examination of procedures and representative records, observations of activities, and interviews with personnel.

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

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available records (PARS) component of NRC's document system (ADAMS). ADAMS is accessible from the NRC Web-site at *http://www.nrc.gov/NRC/ADAMS/index.html* (the Public Electronic Reading Room).

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

Docket Nos. 50-348 and 50-364
License Nos. NPF-2 and NPF-8

Enclosure: NRC Inspection Report Nos. 50-348/00-10
and 50-364/00-10

cc w/encl: (See page 2)

cc w/encl:
M. J. Ajluni, Licensing
Services Manager, B-031
Southern Nuclear Operating
Company, Inc.
Electronic Mail Distribution

L. M. Stinson
General Manager, Farley Plant
Southern Nuclear Operating
Company, Inc.
Electronic Mail Distribution

J. D. Woodard
Executive Vice President
Southern Nuclear Operating
Company, Inc.
Electronic Mail Distribution

State Health Officer
Alabama Department of Public Health
RSA Tower - Administration
Suite 1552
P. O. Box 303017
Montgomery, AL 36130-3017

M. Stanford Blanton
Balch and Bingham Law Firm
P. O. Box 306
1710 Sixth Avenue North
Birmingham, AL 35201

Rebecca V. Badham
SAER Supervisor
Southern Nuclear Operating Company
Electronic Mail Distribution

Distribution w/encl:
M. Padovan, NRR
PUBLIC

OFFICE	RII:DRP	RII:Vogtle	RII:Farley	RII:St. Lucie	NRR:IIPB		
SIGNATURE	CR	JZeiler (fax)	SJC (for)	GWarnick (fax)	SJC(for) E-mail		
NAME	CRapp:sjw	JZeiler	RCaldwell	GWarnick	JJacobsen		
DATE	10/04/2000	10/05/2000	10/05/2000	10/04/2000	10/04/2000	10/ /2000	10/ /2000
E-MAIL COPY?	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO

OFFICIAL RECORD COPY DOCUMENT NAME: C:\FNP P&IR rev 3.wpd

U. S. NUCLEAR REGULATORY COMMISSION

REGION II

Docket Nos.:	50-348 and 50-364
License Nos.:	NPF-2 and NPF-8
Report Nos.:	50-348/00-10 and 50-364/00-10
Licensee:	Southern Nuclear Operating Company, Inc.
Facility:	Farley Nuclear Plant, Units 1 and 2
Location:	7388 N. State Highway 95 Columbia, AL 36319
Dates:	August 28 to September 8, 2000
Inspectors:	J. Zeiler, Senior Resident Inspector, Vogtle Electric Generating Plant (Lead) R. Caldwell, Resident Inspector, Farley Nuclear Plant G. Warnick, Resident Inspector, St. Lucie Nuclear Plant
Approved by:	Stephen J. Cahill, Chief Reactor Projects, Branch 2 Division of Reactor Projects

Enclosure

SUMMARY OF FINDINGS

ADAMS Template:

IR 05000348-00-10, IR 05000364-00-10, on 08/28-09/08/2000, Southern Nuclear Operating Company, Joseph M. Farley Nuclear Plant, Units 1 & 2, annual baseline inspection of the identification and resolution of problems. The corrective action program was acceptable with negative observations noted.

The inspection was conducted by a team consisting of a Senior Resident Inspector from the Vogtle Electric Generating Plant, the Farley Resident Inspector, and a Resident Inspector from the St. Lucie Nuclear Plant. No significant findings were identified.

Identification and Resolution of Problems:

The inspectors determined that the licensee was effective at identifying problems and entering them into the corrective action program. Generally, problems entered into the corrective action program were adequately evaluated and appropriate corrective actions were identified. Formal root cause evaluations and corrective actions for significant issues were thorough and detailed. Corrective actions were implemented in a timely manner commensurate with their safety significance. Licensee audits and self-assessments adequately identified deficiencies in the corrective action program and audit findings were consistent with the NRC's observations. Based on interviews conducted during this inspection, plant employees were not reluctant to report nuclear safety issues. However, some negative observations were identified for failing to enter some issues into the corrective action system and for issues that did not receive adequate investigation and development of corrective actions or that were not assigned the appropriate severity level classification. These negative observations involved issues that were of very low safety significance.

Report Details

4. OTHER ACTIVITIES (OA)

4OA2 Problem Identification and Resolution

.1 Effectiveness of Problem Identification

a. Inspection Scope

The inspectors reviewed Unit 1 and Unit 2 operating logs from June through July 2000 and ten maintenance work orders (WOs) associated with components in selected risk significant systems to determine if deficiencies were being entered into the corrective action program. The WOs reviewed are listed in Attachment 2. The inspectors also toured portions of the service water (SW), component cooling water (CCW), high head safety injection (HHSI), containment spray, and residual heat removal (RHR) systems to determine if deficiencies existed that had not been entered into the corrective action program.

The inspectors reviewed items from the licensee's corrective action database associated with high risk significant systems identified in the plant specific probabilistic risk assessment. The specific high risk systems selected for review included the electrical distribution system and emergency diesel generators (EDGs), SW system, CCW system, HHSI system, and RHR system. In addition, the inspectors reviewed items involving the operations, maintenance, engineering, chemistry, emergency preparedness, and security departments. Specifically, the inspectors selected 63 Condition Reports (CRs) from approximately 3000 CRs issued since August 1998. The inspectors evaluated the CRs to determine the licensee's threshold for identifying problems and entering them into the corrective action program. The CRs reviewed are listed in Attachment 2.

The inspectors attended a Plant Operation Review Committee (PORC) meeting and several of the licensee's daily morning status meetings to determine if plant issues were being properly reviewed and if appropriate management attention was applied to significant plant issues. The inspectors also reviewed Human Performance Board meeting results to verify that they were providing an independent review of significant plant issues resulting from human performance errors.

The inspectors reviewed the nineteen licensee operating experience (OE) items identified in Attachment 2 to determine if they were appropriately evaluated for applicability and if problems identified through these reviews were entered into the corrective action program.

The inspectors reviewed four Safety Audit and Engineering Review (SAER) audits and four self-assessments (focusing on problem identification and resolution) to determine if they were consistent with NRC findings, if they were performed in accordance with licensee commitments, and if audit and self-assessment findings were entered into the licensee's corrective action program. These audits and self-assessments are identified in Attachment 2.

b. Issues and Findings

No findings were identified.

The inspectors determined that the licensee was generally effective at identifying problems and entering them into the corrective action system. However, the inspectors identified several issues that should have been but were not entered into their CR program. These included an improperly torqued RHR valve bonnet fastener identified by the licensee during the performance of WO 98008567, an incorrect fuse that was installed in the control circuit for a charging pump discharge header isolation valve identified by the licensee during the performance of WO 20002114, and an unexpected entry into a Technical Specification Limiting Condition for Operation for the 1A Post Accident Hydrogen Analyzer. Based on review of the licensee's CR database, the inspectors did not identify any negative trends related to improper torque of valve fasteners or improper fuse installation; therefore, these items were determined to be minor and isolated cases. Also, the inspectors determined that licensee controls existed for these activities further reducing the possibility of more generic problems. Based on the above considerations and prompt correction of the degraded conditions, the inspectors determined that these issues were of very low risk significance. The licensee initiated CR 2000005364 to address these items.

The inspectors determined that the licensee's OE program was effective in evaluating the applicability of internal and external issues. Problems identified by personnel performing OE reviews were properly entered into the licensee's corrective action program.

The licensee's audits were adequate in identifying deficiencies in the corrective action program. Audit findings were similar to observations made by the inspectors. The inspectors noted that the last semi-annual audit was performed before recent corrective action program changes that occurred in late March and June so the licensee had not yet evaluated the effectiveness of these program changes. However, the next audit is scheduled for September 2000. Self-assessment activities were actively pursued and findings were entered into the CR program.

.2 Prioritization and Evaluation of Issues

a. Inspection Scope

The inspectors reviewed selected CRs to determine the appropriateness of the resolution, including the depth and scope of the cause and root cause analysis, and the specified corrective actions. The review was conducted on the same sample of CRs selected in 4OA2.1 above. This sample included three CRs that had formal root cause evaluations.

The licensee classified CRs based on safety significance ranging from Severity Level (SL) 1 (high safety significance) through SL 5 (little or no safety significance). A greater depth-of-review was required with increasing safety significance. FNP Administrative Procedure FNP-0-AP-30 provides guidance for implementing this program. Each of the

63 sampled CRs were reviewed to ensure that the severity level classification was appropriate to the safety significance of the issue and in accordance with FNP-0-AP-30.

b. Issues and Findings

No findings were identified.

Generally, the licensee's cause evaluations were adequate and appropriate corrective actions were identified. Formal root cause evaluations for significant issues were especially thorough and detailed. However, the inspectors identified a negative observation related to the cause investigation and development of corrective actions for several CRs involving lower safety significance (i.e., SL 4 and SL 5) issues. Although there was no violation of regulatory requirements, these lower safety significance items were not thoroughly investigated and the corrective actions were not comprehensive. These examples are described as follows:

1) CR 98325: Corrective actions added a requirement for an independent Senior Reactor Operator review of Minor Departures but this requirement was not communicated to the applicable personnel either by administrative controls or procedural changes.

2) CR 98441: The cause analysis and corrective actions did not address why a breaker failure troubleshooting guide was not implemented in a timely manner prior to this particular failure.

3) CR 200038: The cause analysis and corrective actions only addressed one of the two valves that became hydraulically pressure locked due the configuration error.

4) CR 200084: The personal statements indicated that there was a lack of operator understanding on the use of the oil manual which was further complicated by infrequent on-shift operator performance of equipment lubrication activities. The cause analysis and corrective actions did not address these operator knowledge, training, and experience deficiencies.

5) CR 2000107: Statements by the individuals recording the data indicated there were procedural weaknesses in how the data was to be recorded. However, the cause analysis did not address the need for procedural changes. A similar problem occurred in 1999 involving a charging pump inservice test (CR 99154) and no corrective actions were identified to evaluate the need for procedural changes.

The inspectors also identified a negative observation regarding the failure to properly classify the severity levels of CRs. Specifically, the inspectors identified six CRs classified as SL 5 that should have been classified as SL 4. An important distinction between the licensee's CR severity levels was that SL 5 issues did not require a root cause investigation or any further corrective actions. The inspectors determined that

even though these CRs were mis-classified as SL 5, appropriate root cause investigations and corrective actions were conducted for each, minimizing the impact of these mis-classifications. The inspectors determined that the most probable cause for these mis-classifications was an error in the classification definitions contained in Attachment A (CR submittal form) of procedure FNP-0-AP-30, Rev. 27, dated March 31, 2000. When the licensee issued revision 28 on June 28, 2000 to implement new program requirements, the error was inadvertently corrected. However, the licensee was not aware of the error until identified by the inspectors. The licensee stated that all CR classifications during the period March 31 through June 28 would be reviewed and corrected as needed. Also, the licensee stated that additional training would be provided to plant employees to ensure there was a clear understanding of the CR classification definitions.

.3 Effectiveness of Corrective Actions

a. Inspection Scope

The inspectors reviewed selected CRs to determine if appropriate corrective actions were prescribed and implemented by the licensee. The review was conducted on the same sample of CRs selected in 4OA2.1 above. This sample included three CRs that had formal root cause evaluations performed, as well as three Licensee Event Reports (LERs) that are described in Attachment 2 of this report.

b. Issues and Findings

No findings were identified.

The prescribed corrective actions for these CRs, with the exceptions discussed in section 4OA2.2 above, were appropriately focused to correct the problems. Corrective actions for problems were implemented in a timely manner commensurate with the safety significance of the issue. The backlog of corrective actions was being adequately managed and corrective action extensions required management approvals.

.4 Assessment of Safety Conscious Work Environment

a. Inspection Scope

The inspectors interviewed over 28 licensee employees, including employees from most departments that perform regulated activities, to determine if employees were reluctant to raise safety concerns.

b. Issues and Findings

No findings were identified.

Employees were familiar with the corrective action and employee concerns programs and did not feel reluctant to raise nuclear safety issues. Employees said the corrective action program was successful in resolving issues and had noted that plant management emphasized a decreased threshold for reporting deficiencies.

4OA6 Management Meetings

Exit Meeting Summary

The inspectors presented the inspection results to Mr. M. Stinson, Plant General Manager, and other members of licensee management at the conclusion of the inspection on September 8, 2000, and at a teleconference on October 5, 2000. The licensee acknowledged the findings presented.

PARTIAL LIST OF PERSONS CONTACTED

Licensee

R. V. Badham, Safety Audit Engineering Review Supervisor
C. L. Buck, Technical Manager
R. M. Coleman, Outage and Modification Manager
C. D. Collins, Operations Manager
K. C. Dyar, Security Manager
S. Fulmer, Plant Training and Emergency Preparedness Manager
J. S. Gates, Administration Manager
D. E. Grissette, Assistant General Manager - Operations
J. G. Horn, Outage Planning Supervisor
J. R. Johnson, Maintenance Manager
R. R. Martin, Engineering Support Manager
C. D. Nesbitt, Assistant General Manager - Plant Support
L. M. Stinson, Plant General Manager - FNP
R. J. Vanderbye, Emergency Preparedness Coordinator

NRC

T. Johnson, Senior Resident Inspector, Farley
V. McCree, Deputy Director, Division of Reactor Projects

NRC's REVISED REACTOR OVERSIGHT PROCESS

The federal Nuclear Regulatory Commission (NRC) recently revamped its inspection, assessment, and enforcement programs for commercial nuclear power plants. The new process takes into account improvements in the performance of the nuclear industry over the past 25 years and improved approaches of inspecting and assessing safety performance at NRC licensed plants.

The new process monitors licensee performance in three broad areas (called strategic performance areas): reactor safety (avoiding accidents and reducing the consequences of accidents if they occur), radiation safety (protecting plant employees and the public during routine operations), and safeguards (protecting the plant against sabotage or other security threats). The process focuses on licensee performance within each of seven cornerstones of safety in the three areas:

Reactor Safety	Radiation Safety	Safeguards
● Initiating Events	● Occupational	● Physical Protection
● Mitigating Systems	● Public	
● Barrier Integrity		
● Emergency Preparedness		

To monitor these seven cornerstones of safety, the NRC uses two processes that generate information about the safety significance of plant operations: inspections and performance indicators. Inspection findings will be evaluated according to their potential significance for safety, using the Significance Determination Process, and assigned colors of GREEN, WHITE, YELLOW or RED. GREEN findings are indicative of issues that, while they may not be desirable, represent very low safety significance. WHITE findings indicate issues that are of low to moderate safety significance. YELLOW findings are issues that are of substantial safety significance. RED findings represent issues that are of high safety significance with a significant reduction in safety margin.

Performance indicator data will be compared to established criteria for measuring licensee performance in terms of potential safety. Based on prescribed thresholds, the indicators will be classified by color representing varying levels of performance and incremental degradation in safety: GREEN, WHITE, YELLOW, and RED. GREEN indicators represent performance at a level requiring no additional NRC oversight beyond the baseline inspections. WHITE corresponds to performance that may result in increased NRC oversight. YELLOW represents performance that minimally reduces safety margin and requires even more NRC oversight. RED indicates performance that represents a significant reduction in safety margin but still provides adequate protection to public health and safety.

The assessment process integrates performance indicators and inspection so the agency can reach objective conclusions regarding overall plant performance. The agency will use an Action Matrix to determine in a systematic, predictable manner which regulatory actions should be taken based on a licensee's performance. The NRC's actions in response to the significance (as represented by the color) of issues will be the same for performance indicators as for inspection findings. As a licensee's safety performance degrades, the NRC will take more and increasingly significant action, which can include shutting down a plant, as described in the Action Matrix.

More information can be found at *http://www.nrc.gov/NRR/OVERSIGHT/index.html*.

LIST OF DOCUMENTS REVIEWED

Procedures:

FNP-0-AP-2	Plant Operations Review Committee, Rev. 20
FNP-0-AP-7	Corrective Action Reporting, Rev. 17
FNP-0-AP-30	Preparation and Processing of Condition Reports, Plant Event Reports, and Licensee Event Reports, Revs. 26, 27, and 28
FNP-0-AP-52	Equipment Status Control and Maintenance Authorization, Rev. 29
FNP-0-AP-55	Self-Assessment Program, Rev. 0
FNP-0-AP-62	Evaluation of Defects and Noncompliances Potentially Reportable Under 10CFR21, Rev. 5
FNP-0-AP-65	FNP Operating Experience Evaluation Program, Rev. 10
FNP-0-ACP-9.0	Root Cause Program, Revs. 3,4, and 5
FNP-0-ACP-9.1	Root Cause Investigation, Rev. 7
FNP-0-ACP-9.3	Focused Self-Assessments, Rev. 4
FNP-0-ACP-30	Condition Reporting Software Instructions, Rev. 0
FNP-0-ACP-52.1	Guidelines for Scheduling of On-Line Maintenance, Rev. 13
FNP-0-ACP-52.2	Work Order Development and Approval, Rev. 11
FNP-0-ACP-60	Excellence in Human Performance, Rev. 3
FNP-0-M-028	See-In Procedures Manual, Rev. 11
FNP-0-M-89	Maintenance Rule Site Implementation Manual, Rev. 6
FNP-0-SYP-10	FNP Event Trending, Rev. 4
FSAR-AP-10	SAER - Administrative Procedures Reviews and Evaluations, Rev. 29

Operating Experience:

2918	IN 98-01, Supplement 1, Limitorque Technical Update 98-01: Actuator output torque calculation, SMB/SB/SBD Actuators / 3 phase motors
2925	Westinghouse Nuclear Safety Advisory Letter 98-007, Analysis Modeling of Pressurizer Heaters
2927	Significant Operating Experience Report 98-01, Safety System Status Control
2944	Westinghouse Technical Bulletin 98-03, Eddy Current Analysis of Steam Generator Tubing in the Vicinity of the Edge of a Sleeved Intersection
2949	SER 4-98, Unplanned Personnel Radiation Dose
2958	Significant Event Notification Report 190, Pressurizer Spray Valve Bonnet Nuts Dissolved by Boric Acid Leak
2963	Notification under 10 CFR Part 21 for Rosemount Model 1153B Alphaline Nuclear Pressure Transmitter
2968	Significant Event Notification Report 185, Recurring Event, Inappropriate Continuous Control Rod Withdrawal From Sub-critical Conditions
2973	SER 3-98, Recurring Event, Flooding of Emergency Core Cooling System Rooms Caused by Fire Protection System Water Hammer
2974	Significant Event Notification Report 195, Unplanned Entry into Reduced Inventory Conditions During Refueling Cavity Draindown
2981	Westinghouse Technical Bulletin 99-03, Reactor Coolant Pump Thermal Barrier Cracking
2983	Westinghouse Nuclear Safety Advisory Letter 99-007, AR/ARD Relay Seismic Qualifications
2995	Significant Event Notification Report 204, Water Chemistry Induced Fuel Leaks
2999	Westinghouse Technical Bulletin 99-04, Loose Impeller on Reactor Coolant Pumps
3018	Operational Experience, Potential for the Malfunction for the Eaton Cutler-Hammer Circuit Breakers

3020	Significant Operating Experience Report 99-01, Loss of Grid
Unnumbered	Information Notice 98-28, Development of Systematic Sample Plan for Operator Licensing Examinations
Unnumbered	Information Notice 98-40, Design Deficiencies Can Lead to Reduced Emergency Core Cooling System Pump Net Positive Suction Head During Design Basis Accident
Unnumbered	Information Notice 88-23-S1 through S5, Potential for Gas Binding of High Head Safety Injection Pumps During Loss of Coolant Accident

Licensee Event Reports:

LER 99-001-01	Reactor Trip Due to Loss of Condenser Vacuum on Steam Dump Drain Line Failures
LER 99-002-00	Reactor Trip Following Loss of 1A Steam Generator Feedwater Pump
LER 00-001-00	Technical Specification 3.0.5 Entered Due to Service Water Lubrication and Cooling Pumps Inoperable

Condition Reports:

98248	Work performed without being properly released for work
98255	Emergency Core Cooling System (ECCS) inoperable in Mode 3
98282	Mode 3 entered without an operable ECCS flow path
98310	Containment sump wide range LT-3594B failed
98325	1B train charging pumps inoperable
98319	2B charging pump has high vibration
98331	Containment sump wide range LT-3594B
98341	Engineered Safety Features actuation - control room ventilation
98416	Charging pump to regenerative heat exchanger valve failed to stroke
98441	Breaker DF11 failed to close
98464	Reactor coolant system leak on high head safety injection cold legs
98473	1A charging pump failure
99089	Charging pump hold down bolts over torqued
99154	2A charging pump in alert range
99360	Inadequate procedure
99733	VT3 not performed on valve V0021A
99756	Acceptance criteria not met for STP-628.0
991064	Procedural violation of FNP-20STP-818
2000038	Valve Q1P17HV3184 closed and would not open upon demand
2000048	2A residual heat removal pump declared inoperable
2000077	2A emergency diesel generator out of service while B train service water booster pump previously removed
2000084	Wrong oil added to Unit 2 turbine driven auxiliary feedwater pump
2000107	2C service water pump in alert range not identified
2000125	Service water cooling and lube water booster pumps not in Inservice test program
2000127	Transient fire load analysis procedure table contained non-conservative values
2000131	All transient fire loads are not tracked
2000184	Valve Q1E11V016A failed to meet acceptance criteria
2000247	B train control room pressure fan to atmosphere damper PDC2768B failure
2000279	A and C containment cooler condensate level monitoring system inoperable

2000400	1A step-up transformer tripped
2000439	Delta-P for 1C charging pump was out of specification low
2000447	Valve LCV-115D failed to stroke
2000462	In-situ combustibles not considered when performance of fire load analysis
2000472	Breaker DH03 tripped
2000501	Valve Q1E11HCV0603A failed during RHR operations
2000523	Cotter pin found in bottom of motor driven auxiliary feedwater pump breaker cubicle
2000556	Pinhole leak in 8" service water miniflow line
2000567	Component cooling water to spent fuel pool heat exchanger isolated
2000584	Valve Q2E11HCV603A not going full closed
2000591	Reported failures of seal water pump regulators
2000616	Service water booster pump testing
2000619	Solid system protection system testing not performed when due
2000642	Spent fuel pool cooling lineup error
2000646	Inappropriate valves installed in the Unit 1 and Unit 2 turbine electro-hydraulic control systems
20001026	Contractor employees entered radiation control area with electronic dosimetry off
20001061	Unexpected contamination discovered in steam generator storage facility
20001089	Flange removed from cavity drain line without health physics personnel present
20002022	Tracking security group self-assessment
20002054	Uncompensated guard post
2000005001	Multi-discipline planning control problems
2000005002	H2 gas found during refueling water storage tank to charging pump suction venting
2000005011	Near miss in scheduling removal of service water cyclone separator and booster pump out of service on the same day
2000005014	Air monitoring station work took longer than expected without Chemistry knowledge
2000005028	4160 voltmeter for Bus 2H failed due to blown fuses, repeat events
2000005071	Broken lug on breaker cubicle for 1B containment spray pump room cooler fan
2000005087	Breaker DE04 tripped causing loss of all odd cooling tower fans
2000005130	Lost dosimeter
2000005174	1B emergency diesel generator air start system leaks
2000005237	Maintenance rework of 1C emergency diesel generator
2000005244	Dosimeter malfunction while working in the radiation control area
2000005267	Additional actions identified to adequately address OR 1-2000-523
2000005333	Chemistry procedure step not signed off correctly
2000005050	Unit 2 sample radiation monitor R-9 power supply failure

Maintenance Work Orders:

98002607	Letdown orifice isolation will not stroke
98002660A	Boric acid transfer pump vibrations continues in the alert range
98007700	Containment isolation valve failed local leak rate test
98008496	Valve leaking by badly
98008567	Health physics discovered loose bonnet bolt on valve during containment clean-up
99008554	FCV-122 controls erratically in automatic
20000678	RHR/LHSI pump 2B supply breaker seismic modification problem

20002114	Charging pump discharge header isolation valve failure
20003743	Emergency diesel generator 2B air start compressor system leaks
20005799	1B containment spray pump room cooler fan breaker failure

Licensee Audits:

SAER Audit No. 98-CAR/19-2	Corrective Action Program
SAER Audit No. 99-CAR/19-1	Corrective Action Program
SAER Audit No. 99-CAR/19-2	Corrective Action Program
SAER Audit No. 00-CAR/19-1	Corrective Action Program

Self-Assessments:

OR 99-140	Breakers Maintenance (R15, R16, R17) Self-Assessment
CR 20002022	Tracking Security Group Self-Assessment
CR 20003062	Chemistry Benchmark of Vogtle Self-Assessment Action Plan
CR 2000005054	Operating Experience Annual Effectiveness Review