July 7, 2000

Mr. Robert J. Barrett
Site Executive Officer
New York Power Authority
Indian Point 3 Nuclear Power Plant
Post Office Box 215
Buchanan, NY 10511

SUBJECT: INDIAN POINT 3 - NRC INSPECTION REPORT NO. 05000286/2000-003

Dear Mr. Barrett:

On June 9, 2000, the NRC completed a team inspection at the Indian Point 3 Nuclear Power Plant. The enclosed report presents the results of that inspection. The results were discussed on June 9, 2000, with Mr. F. Dacimo 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 the Commission's rules and regulations, and with the conditions of your operating license. Within these areas, the inspection involved selected examination of procedures and representative records, observations of activities, and interviews with personnel.

Based on the results of the inspection, there were no findings identified. The team concluded that your implementation of the corrective action program in the past year was acceptable with some noted improvements, including good oversight by the Corrective Action Review Board. In general, problems were properly identified, evaluated and resolved using the corrective action program. However, a few minor issues were identified in the area of problem identification. For example, during the inspection, non-conforming conditions were identified by the team which previously had not been entered into the corrective action program.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosures 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 by Brian E. Holian for/

Wayne D. Lanning, Director
Division of Reactor Safety

Docket No. 05000286

License No. DPR-64

Enclosure Inspection Report No. 05000286/2000-003

cc w/encl:
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E. Zeltmann, President and Chief Operating Officer
J. Knubel, Chief Nuclear Officer and Senior Vice President
F. Dacimo, Plant Manager
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REGION I

Docket No.	05000286
License No.	DPR-64
Report No.	05000286/2000-003
Licensee:	Power Authority of the State of New York, doing business as The New York Power Authority (NYPA)
Facility:	Indian Point 3 Nuclear Power Plant
Location:	P.O. Box 215 Buchanan, New York 10511
Dates:	May 22 - June 9, 2000
Inspectors:	L. Prividy, Senior Reactor Inspector, Division of Reactor Safety (DRS), Team Leader J. England, Resident Inspector, Division of Reactor Projects (DRP) K. Kolaczyk, Reactor Inspector, DRS M. Gray, Reactor Inspector, DRS K. Young, Reactor Inspector, DRS G. Smith, Senior Security Specialist, DRS
Approved by:	Lawrence Doerflein, Chief Systems Branch Division of Reactor Safety

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SUMMARY OF FINDINGS

Indian Point 3 Nuclear Power Plant
NRC Inspection Report 05000268/2000-003

This report includes the results of a region-based team inspection of the effectiveness of problem identification and resolution at Indian Point 3. The inspection covered all seven cornerstones of safety and was accomplished in accordance with NRC Inspection Procedure 71152, "Identification and Resolution of Problems." (Refer to Attachment 1)

Identification and Resolution of Problems

- Based on the results of the inspection, there were no findings identified. The implementation of the corrective action program in the past year was acceptable with some improvements noted. The licensee was generally effective at identifying and correcting problems. However, a few minor issues were identified in the area of problem identification. During the inspection, non-conforming conditions were identified by the team which previously had not been entered into the corrective action program. The team noted that the area of problem identification had not been highlighted as an area of concern in past licensee audits of the corrective action program. Deviation & Event Reports (DERs) were being appropriately resolved. The DER evaluations were of good quality and reflected proper consideration for common cause and extent of condition. One exception was noted where service water intake bay silt level measurement techniques were not well established and not commensurate with the risk significance of the silt issue. The Corrective Action Review Board was effective in achieving consistent DER evaluations and corrective actions. In the Safety Conscious Work Environment area, there appeared to be a visible acceptance of the DER process by plant personnel who did not feel reluctant to use this and other processes that existed for raising safety issues.

Report Details

4. OTHER ACTIVITIES (OA)

4OA2 Problem Identification and Resolution (IP 71152)

.1 Problem Identification

a. Inspection Scope

The inspectors reviewed items selected across the seven cornerstones of safety to determine if problems were being properly identified, characterized and entered into the corrective action program for evaluation and resolution. Specifically, the inspectors selected 70 Deviation & Event Reports (DERs) from approximately 3000 which had been issued between April 1999 and April 2000. Twenty additional DERs were reviewed that were issued prior to April 1999 and still open.

The inspectors evaluated these DERs to determine the licensee's threshold for identifying problems and entering them into the corrective action program. Also, the licensee's efforts in establishing the scope of problems were evaluated by reviewing pertinent control room logs, work requests, engineering modification packages, self assessment results, system health reports, action plans, and results from surveillance tests and preventive maintenance tasks. The DERs and other documents listed in Attachment 2 were used to facilitate the review.

The inspectors also conducted walkdowns and interviewed plant personnel to identify other processes that may exist where problems and issues could be identified. The inspectors reviewed work requests and attended the licensee's daily work control meeting to understand the interface between the corrective action program and the work control process.

b. Observations and Findings

There were no findings identified during this inspection.

The inspectors concluded that the licensee's threshold for problem identification was generally appropriate and consistent with implementing procedures. The problems being identified were meaningful with an appropriate scope. However, based on the following observations and the resultant DERs, the inspectors concluded that additional licensee attention regarding problem identification was warranted in selected areas:

- Cable Workmanship and Separation Issues: The inspectors identified cable run workmanship issues during a plant walkdown. Subsequently, the licensee determined that one installed configuration in the primary auxiliary building did not meet the cable separation requirements in the plant design basis and issued DER-00-01262 accordingly. The condition was reported to the NRC in accordance with 10 CFR 50.72. The subject cable was removed to comply with the cable separation requirements. At the end of the onsite inspection, the licensee was conducting walkdowns as part of an extent-of-condition review. Thirty additional DERs on improper cable routing were issued, and another

10 CFR 50.72 report was submitted to the NRC for a condition that did not meet cable separation requirements. The licensee was preparing a licensee event report to describe these cable separation problems.

- Post-Accident Containment Venting (PACV) System: During the review of DERs 98-01097 and 99-00472 regarding the status of the PACV system operating procedure, the inspectors performed a system walkdown and identified several problems. The air signal to flow integrator FI-1249A, which was shown in FSAR Figure 5.4-1, was not installed. Similarly, the integrator's flow counter was not installed. The inspectors also identified non-zero readings for other system instruments and questioned if the system instruments and pressure control valves were periodically calibrated. The licensee determined that they were not periodically calibrated. DER-00-01433 and problem identification description (PID) documents, PIDs #47872 and #47873, were issued to correct these problems.

As these problems were identified and DERs issued, the licensee appropriately reviewed them for operability. No immediate operability concerns were apparent. However, extent-of-condition reviews were continuing on most of these problems.

.2 Problem Resolution and Corrective Actions

a. Inspection Scope

The inspectors reviewed the documents listed in Attachment 2 to determine the appropriateness of the problem resolution, including the comprehensiveness of the root cause analysis, and the specified corrective actions. The review included those corrective actions taken in response to non-cited violations (NCVs) issued in the past year. The inspectors also reviewed the backlog of open DERs to determine if there were any items that individually or collectively represented an adverse effect on plant risk or an adverse trend in the implementation of the corrective action program.

b. Observations and Findings

There were no findings identified during this inspection.

The inspectors determined that DERs were being appropriately resolved. The DER evaluations reviewed were of good quality and reflected proper consideration for common cause and extent-of-condition. Based on the review of selected DERs, which included those in response to NCVs, the inspectors verified that corrective actions were appropriate. No significant problems were found. The inspectors observed one exception to these positive observations where service water (SW) intake bay silt level measurement techniques were not well established and not commensurate with the risk significance of the silt issue.

Measurements taken in July 1999 and April 2000 indicated that the distance from the top of the silt layer in the SW intake bay to the inlet of the pump suction bell had significantly decreased from about 8 feet (7 to 9 feet) to about 3 ½ feet (3 to 4 feet). The licensee issued DER-00-00891 in April 2000 to monitor this condition with monthly

silt level measurements. During this inspection, slightly higher silt levels were observed when compared to the prior measurements. Apparently, the initial corrective actions were not fully effective since the licensee now became concerned with the repeatability and accuracy of the sonar equipment being used to measure the silt level. DER-00-01403 was issued to investigate alternate silt level measurement methods. The inspectors noted that the licensee used the same equipment to measure the SW intake bay silt levels during this inspection and in July 1999 and April 2000. While the measured silt levels did not result in SW pump operability concerns, the inspectors concluded that the licensee missed previous opportunities to identify silt level measurement equipment repeatability and accuracy problems. The silt level measurement information is critical for assessing the potential for adverse system impacts and common mode failure. Furthermore, the silt level measurement information is used in the decision making process concerning the desilting of the SW bays during refueling outages.

The inspectors determined that the corrective action review board (CARB) was effective in achieving consistent DER evaluations and corrective actions. Also, measures taken by licensee management in the past 6 months to minimize extensions of due dates for DER evaluations have been effective in improving corrective action program performance.

.3 Effectiveness of Self-assessments

a. Inspection Scope

The team reviewed two Quality Assurance (QA) audits of the corrective action program. An Instrumentation and Control department self assessment and several Independent Safety Evaluation Group and Safety Review Committee reports were also reviewed.

b. Observations and Findings

There were no findings identified during this inspection. The QA audits contained constructive comments for improving the corrective action program. The observations and findings of this inspection were consistent with the last QA audit (Audit Report A99-08I) except for the minor issues identified by the inspectors with regard to problem identification. The inspectors noted that the need for attention to problem identification in selected areas was not highlighted as an area of concern by QA.

.4 Safety Conscious Work Environment

a. Inspection Scope

The inspectors reviewed the licensee's safety conscious work environment program implementation (Employee Concerns Program known as Speakout). Interviews were conducted with plant personnel to determine if conditions existed that would challenge the establishment and maintenance of a safety conscious work environment at Indian Point 3. Forty individuals were interviewed. Additionally, the inspectors reviewed several items referenced in a licensee letter dated March 3, 2000, that responded to a

10 CFR 2.206 petition regarding the safety conscious work environment and corrective action program at Indian Point 3.

b. Observations and Findings

There were no findings identified during this inspection. There appeared to be a visible acceptance of the DER process by plant personnel who did not feel reluctant to use this and other processes that existed for raising safety issues.

4OA5 Other

.1 Accuracy of Performance Indicator Data - Security Detection Equipment

The inspectors identified a problem in the licensee's calculation of a security equipment performance indicator (PI). This brought into question the accuracy of PI data for security equipment availability. Equipment unavailability due to extreme environmental conditions is not to be counted in the PI data. NEI 99-02, Revision 0, defined extreme environmental conditions as conditions beyond the design specifications of the system including severe storms, heavy fog, and heavy snow fall. However, the inspectors determined that the licensee had not provided clear guidance to the security supervisors for determining the reasons for equipment unavailability. In many cases equipment unavailability was attributed to adverse weather when the conditions did not meet the criteria for severe weather. The inspectors made this determination based on a review of equipment unavailability logs and meteorological data for the dates the equipment was not available. This resulted in equipment unavailability not being captured in the PI data when it should have been. The licensee acknowledged the deficiency in the process and issued a DER to review the PI data submitted for the first quarter of 2000 and to clarify the guidance for security supervisors who make decisions on the reasons for equipment unavailability.

4OA6 Management Meetings

.1 Exit Meeting Summary

The team presented the inspection results to Mr. F. Dacimo, Plant Manager, and other members of licensee management during an exit meeting on June 9, 2000. The licensee acknowledged the findings presented. No information examined or reviewed during the inspection was considered to be proprietary.

PARTIAL LIST OF PERSONS CONTACTED

R. Barrett	Site Executive Officer
R. Burroni	I&C Manager
F. Dacimo	Plant Manager
J. Comiotes	General Manager-Operations
J. DeRoy	Director, IP-3 Engineering
R. Deschamps	Health Physics Manager
D. Mayer	General Manager-Support Services
J. Perrotta	Quality Assurance Manager
K. Peters	Licensing Manager
P. Rubin	Assistant Operations Manager
J. Russell	General Manager-Maintenance
A. Vitale	Maintenance Manager

INSPECTION PROCEDURE USED

71152	Identification and Resolution of Problems

LIST OF ACRONYMS USED

CAP	Corrective Action Program
CARB	Corrective Action Review Board
DER	Deviation and Event Report
EDG	Emergency Diesel Generator
EP	Emergency Preparedness
GL	Generic Letter
LER	Licensee Event Report
NCV	Non cited violation
NRC	Nuclear Regulatory Commission
OE	Operating Experience
PI	Performance Indicator
QA	Quality Assurance
SDP	Significance Determination Process
SW	Service Water
TS	Technical Specifications
UFSAR	Updated Final Safety Analysis Report

ATTACHMENT 1
NRC's REVISED REACTOR OVERSIGHT PROCESS

The federal Nuclear Regulatory Commission (NRC) 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 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 with low to moderate safety significance, which may require additional NRC inspections. YELLOW findings are more serious issues with substantial safety significance and would require the NRC to take additional actions. RED findings represent issues of high safety significance with an unacceptable loss of safety margin and would result in the NRC taking significant actions that could include ordering the plant shut down.

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 incremental degradation in safety: GREEN, WHITE, YELLOW, and RED. The color for an indicator corresponds to levels of performance that may result in increased NRC oversight (WHITE), performance that results in definitive, required action by the NRC (YELLOW), and performance that is unacceptable but still provides adequate protection to public health and safety (RED). GREEN indicators represent performance at a level requiring no additional NRC oversight beyond the baseline inspections.

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. As a licensee's safety performance degrades, the NRC will take more and increasingly significant action, as described in the matrix. 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.

ATTACHMENT 2
LIST OF DOCUMENTS REVIEWED

Deviation & Event Reports (DERs)

95-01849	Set Point Control Program Corrective Actions Untimely & Ineffective
96-00493	Auxiliary Full Flow Test Acceptance Criteria
96-01776	Service Water Pressure Control Valve Stroke
97-01361	Underground Service Water Piping Corrosion (WEKO Seals)
97-01484	Blockage of 32 CCW Heat Exchanger Outlet Pressure Relief Valve Line
97-01497	Intake Structure Silt Level Measurements
97-02118	Flow Discrepancy in 31 Emergency Diesel Generator Cooler
98-00300	Auxiliary Boiler Feed Pump Developed Head Acceptance Criteria
98-00549	Failure of City Water Backup to Circulating Water Pumps
98-00550	Service Water Drawing Discrepancies
98-00660	Seismic Class of Waste Disposal System Components
98-00830	Failed Emergency Lights
98-00905	Need to Revise Operability Call DER-98-00830
98-00922	FSAR Discrepancies
98-01089	Disconnect between MRC and Corrective Action Program
98-01097	Loss of Configuration Control for Post Accident Test Alarm Response Procedure
98-01190	Root Cause Analysis did not determine When, How, and Why the condition existed
98-01912	RCS Hot Leg RTD Calibration Range not IAW Draft FSAR Section 14.1
98-02361	Discrepancy between Computer and Manual ECPs
98-02428	Post-Accident CS Pump Flow to VC
99-00320	Shims Missing on Charging Pump Recirculation Line Supports
99-00472	Licensing not Maintaining Design Basis and FSAR Commitment
99-00563	Venting of Process Transmitters
99-00560	SI-MOV-1852A Torque Switch Screws Loose
99-00626	Steam Generator Level Perturbation
99-00667	31 EDG Cooler Inlet Thermal Relief Valve Leaking
99-00754	Differential Pressure could not properly be recorded for EDG 31
99-00788	32 Boric Acid Transfer Pump Inoperable
99-00855	Potential for Untested Configuration
99-00833	Post-Accident Sampling System Integrity Test was unable to be performed as written and had to be suspended
99-00868	Weld Degraded Downstream of SWN 34-2, Line#407
99-00924	ABFP Room Fan Motor Replacement with Technical Evaluation
99-00928	Control Room Air Conditioning System Relief Valve Failure
99-01015	Seal Oil Cooler Temperature Control Valves Bypassed
99-01369	Trend DER for LCO tracking
99-01479	During the receipt of new fuel on 7/20/99 empty truck was directed to exit without a HP in the FSB
99-01494	Non-cited Violation 99-03-02
99-01805	Equipment Operability During Breaker Cell Switch Testing
99-01548	I&C Department Concerns
99-01851	SW relief valve SWN 110-1 failed to lift
99-01822	Transport vehicle left the site prior to being authorized by a NYPA representative
99-01861	Potential Inaccuracy in Setting Breaker Amptector Trips
99-01862	Weld Degraded in 24" Line#409
99-01503	Breaker A1062 Overcurrent Trip Switch (OTS) Failure
99-01568	Improper Battery Application

99-01969	SI-MOV-842 Motor Current High and Upward Trend
99-01475	The distance to the nearest residence may be closer than listed in the Off-site Dose Calculation Manual
99-02077	31 FCU relief valve SWN 42-1 failed testing
99-02119	SI-MOV-889A As-Found Data Overthrusting
99-02179	One element of the Access Authorization Screening Process was inadvertently omitted
99-02204	SW relief valve SWN 110-2 failed to lift
99-02235	Failure of SW relief valves SWN 42-2 and 42-4
99-02359	FT-435 Flow Transmitter Failure
99-02574	EBR-38-PAB AC Fuse Blown
99-02580	Defective Batteries
99-02537	Appendix R Emergency Light EBR-53-GT Failed Testing
99-02538	33 Service Water Pump Differential Pressure Trending Down
99-02541	Corroded Batteries
99-02776	Package survey by HP Tech obtained dose values on shipping container higher than expected
99-02807	Sealand container loaded for shipment surveyed and found dose values Greater than DOT limits
99-02904	36 Service Water Pump Differential Pressure Trending Down
99-03537	SI-MOV-842 motor has high current
00-00018	QA audits 98-021 and 98-020 identified inconsistencies in Security Program Plans, Procedures, and Instructions
00-00064	A Security System was found to be in noncompliance with the current Security Plan
00-00086	Plant Configuration Potentially Unknown
00-00108	Improvement Initiatives from the Security Cultural Survey have not been implemented
00-00112	31 Service Water Pump Differential Pressure Trending Down
00-00144	An existing Security Power System is not in accordance with the Security Plan
00-00168	Security Denied Access for the Failure to Provide Information Regarding Previous Denial at Another Licensee
00-00189	34 Battery Room Temperature Low Out of Specification
00-00205	33 EDG Inoperable Due to Inoperable Louvers
00-00206	Resolution of Actions Concerning FCU Service Water Flow Indicators
00-00218	NRC Noted Weakness with Regard to Service Water
00-00455	35 Service Water Pump Differential Pressure Trending Down
00-00478	The MRO determined that the HHS did not conduct the required Confirmatory Test for a positive FFD test
00-00567	Review of EP issues resulting from the ConED Alert
00-00573	Review of Indian Point 2 Steam Generator Tube Rupture
00-00618	Instrument Performance
00-00652	Deficient Auxiliary Switches in MCC311
00-00703	Nonconservatisms in Iodine Spiking Calculation - Potential Part 21
00-00773	Pin for the Vehicle Barrier Was Not Properly Engaged
00-00811	Steam Generator Level Controller Failure
00-00816	Steam Generator Level Controller Failure
00-00829	35 Service Water Pump Inoperable
00-00832	34 Service Water Zurn Strainer Failure
00-00891	Intake Structure Service Water Bay Silt Measurements
00-01091	Two Broken Welds on Hanger
00-01117	Failure of R-62 MSL Activity Monitor
00-01221	Emergency Light Test

00-01253 CCR Door Blocked Open without LCO Entry
00-01262 Spare Cable in Cable Tray
00-01403 Intake Structure Service Water Bay Silt Measurements
00-01433 NRC Question Regarding Operational Capability of Post-Accident Venting
00-01439 Use of Work Request Instead of an Engineering Test
00-02716 High Number of “Out of Position Events”

Action Commitment Tracking System Items

98-32499-12 Auxiliary Boiler Recirculation Valves
98-32499-32 Auxiliary Feedwater Runout Analysis
98-33127-4 Emergency Diesel Generator Trouble Alarm
98-33127-6 Emergency Diesel Generator Starting Signal
98-38030 Emergency Diesel Generator Storage Tank Tornado Protection
98-32745-27 Residual Heat Removal System Configuration
98-35564-4 Control Room Air Conditioning Ventilation FSAR Discrepancies
98-35564-7 Control Room Air Conditioning Ventilation Testing
98-35564-8 Control Room Air Conditioning Ventilation Flow Balance Criteria
98-33619-3 Refueling Water Boron Concentration
98-33554-18 Residual heat Removal System Configuration
98-33011-40 Component Cooling Water Surge Tank Isolation
99-45875 Swagelok Company Part 21 Report Regarding Possible Defect
00-49207 Recommend RHR Warmup Operations with Adverse Containment
00-49208 Determine OPS Operability without a Containment Entry
00-49209 Store Blocking Device for use during Technical Specification required Cooldowns
00-49210 Evaluate Testing Requirements for PORV Testing and RHR Valve Testing during EOP and Technical Specification required shutdowns
00-49211 Evaluate Drill Scenarios for Less Than Design Basis Accidents and Include Transitions to Cold Shutdown
00-49212 Coordinate with Chemistry to identify Release Paths
00-49214 Have CTO/PTO Required for Cool Down Staged
00-49215 Update ODCM with Release Paths
00-47887 Perform Analysis to Determine New Minimum Temperature for 34 Battery Room

Non-Cited Violations

99-01-01 Mispositioned Valves
99-01-02 Containment Vent Design Deficiency
99-01-03 Missing Shims in CVCS Supports
99-02-01 BATP Trip
99-03-01 Inadequate Tag Out for Atmospheric Relief
99-03-02 Inadequate Testing of Breakers
99-05-01 Inadequate Test Control and Tagout during the Modification of the IVSW System
99-05-02 RHR Flow Indicator Deficiencies
99-06-01 Design Control - Temporary Modification, RWST OD, SI Pump Leakage OD, ONOP/EOP Issue
99-06-02 Ineffective Corrective Actions - PID Removal and RWST Level Indicator
99-07-01 EDG Fuel Oil System Water Intrusion
99-07-02 SW Flow Balance
99-08-01 RCS Draindown
99-08-02 Primary Safety Relief Inoperable Due to Poor Communication
99-08-03 Commercial Dedication RCS Flow Meter
99-10-02 Plant Configuration Control Problems

99-10-03 EDG Louvers
99-11-01 SW Flow Balance Problems, SW Flow Indicator Problems, RHR Flow Meter
99-11-02 RHR Work Not Performed “At Risk”

Licensee Event Reports (LER)

LER 50-286/99-005 - A Condition Prohibited by Technical Specifications, Incomplete Testing of Emergency Power Supply Tie-breaker Interlocks due to Personnel Error.

Event Free Clock Resets

System Engineering
1/17/00 Engineer Did Not Get Back to Assistant Operations Manager as Agreed
3/24/00 Service Water Pump Degradation Not Communicated in a Timely Manner
5/24/00 System Engineer Late for Scheduled Training

Procedures

MCC-00 - ELC, Westinghouse 480 Volt MCC Inspection, Revision 16
IC-PC-I-P-1190, Service Water Pump Header Discharge Pressure Conventional Pressure, Revision 1
IC-PC-I-P-1191, Service Water Pump Header Discharge Pressure Nuclear Pressure, Revision 2
ARP-012, Alarm Response, Revision 30
IC-AD-4, Periodic Calibration Program, Revision 14
IC-AD-34, Drift Monitoring Program, Revision 5
BKR-017-ELC, Current Sensor and/or Trip Unit Replacement Setting and Testing, Revision 2
3PT-W1, Emergency Diesel Support Systems Inspection, Revision 33
IC-PC-I-F-1176,Service Water to Diesel Generator Cooler Flow, Revision 6
BKR-016-CUB, Westinghouse 480V Switchgear Cubicle Inspection and Cleaning, Revision 3
PS-01.19 - Event Free Clock Human Performance Indicator Guideline, Revision 0
PS-01.11 - Action Plans, Revision 2
PFM-105 - Surveillance Test and Engineering Test Preparation and Review, Revision 6
PRF-SD-02 - Engineering Tests, Revision 2
AP-8 - Deviation & Event Report Initiation, Revision 38
AP-8.2 - Deviation & Event Report Analysis, Revision 9
AP-8.3 - DER Operability & Reportability Review by Operations, Revision 1
AP-8.4 - Determining Operability of Systems, Structures & Components, Revision 1
ORG-AD-003 - Deviation & Event Report Analysis Report Processing by ORG, Revision 6
AP-8.5 - Screening & Assignment of DERs, Revision 1
AP-8.6 - Corrective Action Review Board, (CARB) Revision 0
IP3 Root Cause Analysis Manual, Revision 0
SPO-SD-01, “Work Control Process,” Revision 8
PMP-020-CVCS, Inspection/Replacement of Charging Pump Stuffing Box Seals
PMP-006-CVCS, Replacement of Charging Pump Fluid Cylinder Valves
3PT-W1, Revision 33, Emergency Diesel Generator Support Systems Inspection
Service Water System Quarterly Report for First Quarter 2000

Calculations

88-130134-SWS, Setting of SW System Header High and Low Pressure Switches, Nov. 12, 1992
6604.219-8-SW-017, Service Water System Header Pressure Alarms, Revision 1A

6604.266-8-SW-025, Service Water System Header Pressure Evaluation, Revision 0
IP3-CALC-RCS-02902, Maximum T-Hot to Ensure OTDT Operability, Revision 0 and 1

Nuclear Safety Evaluations

NSE 98-3-154-RCS, Effect of T-Hot on Overtemperature Delta-T Protection

Technical Evaluations

95-006379, Revision 1 (Westinghouse Electric Corporation, J11, Auxiliary Contact)

Action Plans

IP3-DEE-98-131, Revision 1, Set Point Control Program Action Plan
IDSE-APL-99-001, Revision 0, EBR and EBL Reliability Improvement and Cost Reduction Plan
IDSE-APL-99-015, Revision 0, Exide EBR Operability Restoration
IDSE-APL-99-024, Revision 0, FCU Locked in Alarm
IDSE-APL-98-010, Revision 0, Resolution of CVCS Vibration Issues
IDEM-APL-00-002, SWS Flow Balance Testing Closeout Action Plan

Drawings

500B971, Elementary Wiring Diagram Motor Operated Valves, Sheet 129, Revision 8
9321-F-27223, Flow Diagram Service Water System Nuclear Steam Supply Plant, Revision 36
9321-F-20333, Flow Diagram Service Water System, Revision 46 (Sheet 1), Revision 21 (Sheet 2)

Quality Assurance Audits

A99-01-I, Corrective Action Program
A99-08I, Corrective Action Program

Self Assessments

IP-GMS-00-036, I&C Self Assessment

Work Packages

97-00456-02 Test to Check VC Temperature Versus Service Water Flow

Safety Review Committee Minutes

Meetings 03-99, 04-99, and 01-00

ISEG Quarterly Reports

First, Second, Third, and Fourth Quarters of 1999