March 27, 2001

Mr. Guy G. Campbell
Vice President - Nuclear
FirstEnergy Nuclear Operating Company
Davis-Besse Nuclear Power Station
5501 North State Route 2
Oak Harbor, OH 43449-9760

SUBJECT: DAVIS-BESSE NUCLEAR POWER STATION
NRC INSPECTION REPORT NO. 50-346/01-05(DRP)

Dear Mr. Campbell:

On March 9, 2001, the NRC completed a team inspection at the Davis-Besse Nuclear Power Station. The enclosed report documents the inspection findings which were discussed on March 9, 2001, 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 selected examination of procedures and representative records, observations of activities, and interviews with personnel.

On the basis of the samples 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/Thomas J. Kozak

Thomas J. Kozak, Chief
Projects Branch 4
Division of Reactor Projects

Docket No. 50-346
License No. NPF-3

Enclosure: Inspection Report No. 50-346/01-05(DRP)

See Attached Distribution

cc w/encl: B. Saunders, President - FENOC
Plant Manager
Manager - Regulatory Affairs
M. O'Reilly, FirstEnergy
Ohio State Liaison Officer
R. Owen, Ohio Department of Health
A. Schriber, Chairman, Ohio Public
Utilities Commission

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/s/Thomas J. Kozak

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Division of Reactor Projects

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U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Docket No:	50-346
License No:	NPF-3
Report No:	50-346/01-05(DRP)
Licensee:	FirstEnergy Nuclear Operating Company
Facility:	Davis-Besse Nuclear Power Station
Location:	5501 N. State Route 2 Oak Harbor, OH 43449-9760
Dates:	February 26 - March 9, 2001
Inspectors:	L. L. Collins, Lead Inspector D. S. Simpkins, Resident Inspector H. A. Walker, Reactor Engineer
Approved by:	Thomas J. Kozak, Chief Reactor Projects Branch 4 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 margins.

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 a performance 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 margins and requires even more NRC oversight. And RED indicates performance that represents a significant reduction in safety margins 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 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.

SUMMARY OF FINDINGS

IR 05000346-01-05, on 02/26 - 03/09/2001; FirstEnergy Nuclear Operating Company; Davis-Besse Nuclear Power Station; identification and resolution of problems.

The inspection was conducted by two region-based inspectors and one resident inspector.

Identification and Resolution of Problems

The team concluded that the licensee effectively identified, evaluated, and corrected plant problems. Problem identification was determined to be effective based on a low condition report initiation threshold and effective Quality Assurance audits and self assessments. Trending and industry operating experience were two programs which could be used more broadly to identify issues with the potential to affect the plant. Root cause evaluations used structured techniques and were effective in identifying one or more root causes. Corrective actions specified appropriately matched the identified causes and were effective in preventing recurrence of significant conditions adverse to quality. Licensee staff indicated a willingness to identify safety issues.

Report Details

4. OTHER ACTIVITIES (OA)

4OA2 Problem Identification and Resolution

.1 Effectiveness of Problem Identification

a. Inspection Scope

The inspectors reviewed inspection reports issued over the last year, various condition reports (CR) and corrective action documents, industry operating experience documents, audits, and self-assessments in order to determine if problems were being identified at the proper threshold and entered into the corrective action process. The documents listed in Attachment 1 were used during the review.

b. Issues and Findings

No findings of significance were identified involving the effectiveness of problem identification. The team concluded that the licensee effectively identified problems and entered them into the corrective action process. The threshold for generating a CR was appropriate. Quality assurance audits and self-assessments identified problems which were processed and corrected through the CR system. The inspectors had several observations regarding trending and the use of operating experience to identify problems which are described below.

The inspectors reviewed CRs that documented testing problems, including 3 CRs initiated in the past year that were written after the NRC had identified post-maintenance or post-modification testing deficiencies. For each of these CRs, the licensee took timely and appropriate corrective action. However, the licensee did not evaluate the issues collectively as a potential trend and did not look broadly at the post-maintenance testing program to identify any program weaknesses. After the inspectors identified the potential adverse trend, the licensee initiated a CR to collectively review the significance of the post-maintenance testing problems. Although, the trending program did not identify this trend, the inspectors noted that the trending program did identify some trends which were evaluated under the corrective action process. The licensee had recently made changes in the trending process and planned to continue improvements in this area.

The inspectors reviewed several CRs which described plant equipment problems experienced during the electrical circuit breaker refurbishment program. The inspectors determined that the licensee did not use industry operating experience information before beginning the circuit breaker refurbishment program which potentially could have prevented some of the equipment problems. Prior to the refurbishment program, circuit breakers were maintained in designated cubicles and removed only for maintenance activities such as repair or troubleshooting. The refurbishment program allowed circuit breakers to be interchangeable between cubicles. Although technically feasible, this

practice had previously resulted in breaker-cubicle interface problems in the industry. Several breaker-cubicle interface problems occurred during the refurbishment program, two of which resulted in unplanned unavailability of risk significant equipment which may have been avoided if the industry operating experience had been used to anticipate the interface problems. This issue is discussed further in NRC Inspection Report 50-346/01-03. The inspectors also reviewed other operating experience documents and found that the licensee's process for the less significant industry issues was informal. However, the inspectors did not identify any other instances in which the use of industry operating experience could have prevented plant equipment problems.

.2 Prioritization and Evaluation of Issues

a. Inspection Scope

The inspectors conducted an independent assessment of the prioritization and evaluation of a selected sample of CRs. The assessment included a review of the category assigned, operability and reportability determinations, extent of condition evaluations, cause investigations, and the appropriateness of the assigned corrective actions. The documents listed in Attachment 1 were used during the review.

The inspectors attended daily management meetings to observe the assignment of CR categories for current issues and the review of root cause analyses and corrective actions.

b. Issues and Findings

No significant findings were identified in the area of prioritization and evaluation of issues. The inspectors concluded that the significance of issues was properly assigned and that root cause evaluations were performed as required by the corrective action program. Root cause evaluations were thorough, used structured techniques, and identified one or more root causes. Operability and reportability determinations reviewed were properly supported with technical justification. Corrective actions assigned matched the causes specified. The team had several observations involving documentation deficiencies with the evaluation or the corrective action tracking system. In all cases, the inspectors were able to determine that the issue had been properly evaluated but could not always draw that conclusion based solely on the corrective action documents. As an example, the flash point on a shipment of diesel fuel tested far below the acceptable limit. This issue was documented on CR 2000-1552 but the evaluation was very brief. The inspectors discussed the issue with licensee personnel who described additional actions that were taken but not documented in the CR. The team also noted that the more recent CRs reviewed were, in general, more clearly documented.

.3 Effectiveness of Corrective Action

a. Inspection Scope

The inspectors reviewed selected CRs and associated corrective actions to evaluate the effectiveness of corrective actions. The documents listed in Attachment 1 were used during the review.

b. Issues and Findings

No significant findings were identified in the area of corrective action effectiveness. Root cause evaluations clearly specified the corrective actions which were intended to prevent recurrence of the problem. In all cases reviewed, these actions matched the identified causes and were completed by the required due dates. The inspectors did not identify any significant repetitive problems which would indicate that corrective actions to prevent recurrence had been ineffective.

.4 Assessment of Safety-Conscious Work Environment

a. Inspection Scope

The inspectors conducted interviews with plant staff to assess whether there were impediments to the establishment of a safety conscious work environment. During these interviews, the inspectors used Appendix 1 to Inspection Procedure 71152, "Suggested Questions for Use in Discussions with Licensee Individuals Concerning PI&R Issues," as a guide to gather information and develop insights. The inspectors also discussed the implementation of the Employee Concerns Program conducted per procedure with the plant's Ombudsman

b. Issues and Findings

No significant findings were identified during the assessment of safety-conscious work environment. Plant staff interviewed indicated a willingness to identify safety issues. The low threshold for initiating CRs, the increasing number of CRs, and management support for using the CR process observed during the daily management meeting also supported a safety conscious work environment.

4OA6 Meetings

.1 Exit Meeting

The inspectors presented the inspection results to Mr. G. Campbell and other members of licensee management in an exit meeting on March 9, 2001. Licensee management acknowledged the findings presented and indicated that no proprietary information was provided to the inspectors.

PARTIAL LIST OF PERSONS CONTACTED

Licensee

H. Bergendahl, Plant Manager
G. Campbell, Vice President - Nuclear
D. Eshelman, Manager, Plant Engineering
M. Haskins, Supervisor - Quality Assurance, Regulatory Affairs
B. Hennessy, Senior Nuclear Quality Evaluator, Regulatory Affairs
D. Lockwood, Manager, Regulatory Affairs
D. Miller, Supervisor - Compliance, Regulatory Affairs
R. Pell, Manager, Plant Operations
L. Worley, Director, Support Services

ATTACHMENT 1

LIST OF DOCUMENTS REVIEWED

The following is a list of licensee documents reviewed during the inspection, including documents prepared by others for the licensee. Inclusion of a document on this list does not imply that NRC inspectors reviewed the entire documents, 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.

Potential Conditions Adverse to Quality

1993-0480 Failure of Breaker BE111 Due to Racking Mechanism
1994-0641 Inaccuracies in Tagout for K-bus and #2 Startup Transformer
1994-1304 Incorrect Breaker was Tagged
1995-0722 Incorrect Fuse Removal for Service Water Pump #2 Outage
1995-0869 Breakers BE306, BE406 and BE407 Failed Due to Hardened Grease
1996-0480 Breaker BE213 Failed Due to Hardened Grease
1996-0500 Failure of Breaker BE111 Due to Racking Mechanism Second Occurrence
1996-0524 Incorrect Component Identified on Tagout for SFAS Solenoid Valves
1996-0928 Incorrect Component Tagging for CTMU Pump #2 Local Control Switch
1996-1163 Tagging Deficiencies for ICS 38D
1997-0269 Tagging Inadequacies for HPI Oil Pumps
1997-0406 Breaker AC107 Failure
1997-0985 Breaker AC1CE11 Failure
1997-1508 Adverse Trends in Safety Tagging
1997-1524 Failure of BF303 Due to Hardened Grease
1998-0027 Air Operated Valve Closing Times Not Performed
1998-1292 ABDC1 Failed to Close
1998-1429 Leak Tests Not Performed on Air Operated Valves

Condition Reports

1999-0051 Breaker Y205 (EDG #2 AC Control Power) was inadvertently tagged open instead of YF205 (CV 5010E Power Supply)
1999-0436 Breaker ABDC1 Could Not Be Racked In
1999-1002 Provide Training to Craft on 480V K-Line Breakers
1999-1142 Inadequate corrective action on CR 1999-0086.
1999-1195 Inconsistencies in Post-Maintenance Testing on MWO's.
1999-1250 Failure of Breaker BEF153 (CAC #2) to Close
1999-1259 Work orders were being issued without a quality classification.
1999-1648 Number 2 CCW pump tripped on instantaneous overcurrent and instantaneous ground.
1999-1314 Safety related service water pump motor MP3-2 was sent to a non-Q vendor for refurbishment.

1999-1381	Numerous errors were found in controlled copies of the Technical Specification Interpretation Manuals.
1999-1382	Numerous errors were found in controlled copies of the Technical Specification Interpretation Manuals.
1999-1460	Failed to meet the scheduled completion date for a maintenance (a) (1) system as specified in the action plan.
1999-1567	When instrument uncertainties were included in the calculations, some test results of #2 CCW heat exchanger were below the specified minimum acceptance criteria.
1999-1702	Multi-Amp Breaker Test Set Calibration Issue
1999-1713	TS 3.3.3.6 Exited Before Equipment Operability Verified
1999-1726	Failed Reverse Flow Test for AF68
1999-1824	On 10/27/99, while attempting to fast start the #2 DA31 air start side per DB-SC-03077, the unit's 86-2 relay actuated on the failure to reach rated speed.
1999-1975	During Audit AR-99-TSTCA-01 it was identified that some M&TE was not meeting the requirements of procedure DB-M1-00003 as identified.
2000-0104	Section 3.9.12 of the Technical Specification should have been entered when emergency ventilation system train 2 was rendered inoperable for planned maintenance on fan supply breaker BF 1203.
2000-0165	No formal guidance for identifying the need for Compensatory Measure Assessment for an out-of-service safe shutdown component
2000-0210	Insufficient Detail in FE ARMS for Multiple Tech Spec Operability Checklists
2000-0731	While draining the CFT, Approximately 300 Gallons were transferred to the RCS
2000-0744	Clearance for the CFT #2 could have isolated the running DH pump.
2000-0754	#2 DHP suction pressure gauge was found isolated
2000-0784	Improper clearance could have resulted in inadvertent RCS drain
2000-0807	Service water was introduced to AFP#1
2000-0819	Negative Trend of Operations Section Defense Barrier Challenges
2000-0872	Work Order inadvertently closed without completing post-maintenance testing
2000-0906	MS 145 and MS 146 Reverse Flow Test Failure
2000-1078	EDG2 Winding Degradation
2000-1001	A number of the internal parts of RC2, pressurizer spray valve, were not per the vendor drawing.
2000-1059	Left over grouting material began to cure and gave off smoke and vapors.
2000-1124	Lockout on Startup Transformer 01
2000-1177	Drawing M-218Q Discrepancies
2000-1191	Poor implementation of the corrective action program.
2000-1297	Excessive drift of valve FW-SP07A during the performance of test DB-SS-04072 when instrument air was removed.
2000-1552	Diesel fuel flash point tested far below acceptable requirements.
2000-1685	P&ID and OS Drawings show valves CC1471 and CC1474 as normally closed when they are operated as normally open.
2000-1697	The System Description (SD-016) for Component Cooling Water appears to be incorrect.
2000-1725	Some areas of weaknesses are indicated by the Design Basis Validation checklists.
2000-1951	High particulate levels on the CCW pump #1 inboard bearing oil samples.
2000-1970	Implementation of #2 BAAT Monitoring

2000-2288 Breaker BBF2 Would Not Open
2000-2406 During the restoration after DB-ME-04001 Battery Discharge test an electric arc was seen while reconnecting the battery leads.
2000-2418 Potentially restricted flow of water through the auxiliary feedwater system when service water is used as a water source.
2000-2478 Service water relief valve SW 3962 appeared to lift prematurely.
2000-2483 Outdated methods were used to adjust the torque settings of the EDG governors.
2000-2729 Unanalyzed Decay Heat Removal System Flow Transients
2000-3077 Particles Found in CCW#2 Pump Outboard Bearing
2000-4038 ACD3 Failure to Close
2000-4041 Inadequate Containment Entry Planning
2000-4081 Re-open SER 3-99 and SOER 97-1 to Address Additional Items
2000-4096 Non-Q Refurbishment of AQ Breaker AD213
2000-4100 Emergency Diesel Generator #2 Jacket Water Out of Specification
2000-4113 ACD2 Would Not Close When Placing #3 CCW in Service as 1
2000-4114 Near Miss ACD2 Racking
2000-4116 ACD3 Breaker Closed When the Springs Discharged While Racking Out
2000-4119 Several Personal Red Tags Were Found on Energized Equipment in L5001
2001-0043 Maint. Rule (a)(1) Corrective Action Plan For Breakers May Need Re-evaluation
2001-0049 SAC1 Would Not Start or Stop Properly
2001-0052 PMT Not Performed on BE309
2001-0177 Maintenance Rule Program Enhancement
2001-0214 BE309 Failure to Operate
2001-0234 Station Switchgear Cubicles in Need of Refurbishment
2001-0366 AFW pump 1-2 Suction Pressure Switch Work Canceled
2001-0519 Condition Report/CREST Implementation Deficiencies
2001-0525 Quality Assessment Surveillance SR-01-CORAC-01 Recommendations
2001-0526 Condition Report Operability Reviews Not Completed in a Timely Manner
2001-0540 Dose Calculations for PASS Samples Outside of USAR
2001-0578 480V Breaker Issues Found by G.E.
2001-0618 CATS Follow-up Item of CR 2000-2418 was closed without the required corrective action from the CR evaluation being completed as required.
2001-0639 Independent Analysis of Breaker Failures Recommends PM Changes/Fault Tree
2001-0640 Evaluate Swapping Breakers for Future PM's
2001-0641 Determine and Document Availability Status of Refurbished Breakers

<u>Trending Reports</u>

1999-1171 Appears to be a trend of failing to document the parts installed under work orders.
1999-1636 Repetitive work problems identified with work orders and/or work planning.
1999-1720 Acceptance of CCW//SW components having a history of known problems have been accepted as a norm.
2000-0819 A trend was noted where the last barrier for Operations to avoid a significant problem was challenged before issues were identified.
2000-1190 Poor radiological work practices by maintenance

2000-1591	Inadequate corrective actions to correct poor radiological work practices by maintenance
2000-1794	RE 4686 should be evaluated for collective significance of required maintenance. Has been inoperable for six times this year for causes other than testing.

NCVs

2000-003-01	Failure to follow procedures during 13.8 kV bus transfer test
2000-007-02 a	Inadequate post modification testing for a change to the component cooling water system pump control logic. CR # 2000-1852 was used to track this violation and was reviewed.
2000-007-02 b	Lack of basis for the leakage acceptance criteria specified in the component cooling water system test. CR # 2000-1843 was used to track this violation and was reviewed.
2000-007-03	There was no monitoring or testing that provided reasonable assurance that theat the service water make-up flow to the component cooling water system could be provided. CR # 2000-1779 was used to track this violation and was reviewed.
2000-007-06	Inadequate corrective actions were taken to prevent recurrence of tripping problems when electro-mechanical relays were replaced with solid state relays.
2000-009-01	Loss of Auxiliary Feedwater Pump Turbine Main Steam Supply Train Separation Due to Check Valve Failure
2000-010-01	Failure to scope Makeup Pump Room Air Conditioner into the Maintenance Rule

Operability Justifications (applicable condition reports referenced)

OJ 2000-0013	As documented on CR 2000-2418 -- Potentially restricted flow of water through the auxiliary feedwater system when service water is used as an intake water source.
OJ 2000-0014	As documented on CR 2000-2478 -- Service water relief valve SW 3962aappeared to lift prematurely.
OJ 2000-0015	As documented on CR-2000-2483 -- Outdated methods were used to adjust the torque settings of the EDG governors.
OJ 2001-000	As documented on CR 2001-0013 -- Operability justification for ECCS Room Cooler #1

Test Failures

WO 1999-3442	
WO 1999-3705-000	Calibration Failure of SVSP07A and SYSP07A Steam Generator 1-2 Startup Feedwater Control valves
CR 2000-1297	Excessive drift of valve FW SP07A on the loss of instrument air pressure.

Self Assessments

1999-0165	Self Assessment of the Root Cause Evaluation Program
2000-0024	Self Assessment of the Radiation Work Permit Process and Procedure
2000-0043	Self Assessment of the GL89-10 MOV Program
2000-0061	Self Assessment of the Check Valve Monitoring Program
2000-0092	Effectiveness of DB Operating Experience Program
2000-0084	DB Comparison to INPO Principles for Corrective Action
2000-0116	Motor Operated Valve Self Assessment Program
2000-0153	Davis-Besse Safety Culture and Organizational Effectiveness

QA Audits

AR-99-JUMAA-01	First Energy Quality Assessment Audit AR-99-JUMAA-01.
AR-99-TSTCA-01	Quality Assessment Testing & Calibration Audit (AR-99-TSTCA-01)
AR-00-ENGRG-01	Davis Besse Quality Assessment Audit AR-00-ENGRG-01.
AR-99-OPSNF-01	Quality Assessment Audit of Plant Operations
AR-99-CORAC-01	Quality Assessment Audit of the Corrective Action Program
AR-99-CORAC-02	Quality Assessment Audit of the Corrective Action Program
AR-00-CORAC-01	Quality Assessment Audit of the Corrective Action Program
AR-00-WKMGT-01	Quality Assessment Audit of the Work Management Organization

Procedures

DB Technical Policy 3	Corrective Actions
DB Technical Policy 26	Root Cause Analysis
DB-OP-00000	Conduct of Operations
DB-OP-00015	Safety Tagging
DB-OP-01000	Operation of Station Breakers
DB-OP-06012	Decay Heat and Low Pressure Injection System Operating Procedure
DB-OP-06903	Plant Shutdown and Cooldown
DB-ME-09104	13.8KV and 4.16KV Westinghouse DHP Breakers
DB-ME-09107	Westinghouse DHP Breaker Refurbishment
NG-DB-00018	Operability Determinations
NG-NA-00305	Operating Experience Assessment Program
NG-NA-00711	Quality Trending
NOP-LP-2001	Condition Report Process
NOP-LP-2003	Employee Concerns/Ombudsman Program
NOP-LP-3001	Safety and Health Programs
NOP-OP-1002	Conduct of Operations
NG-DB-00116	Outage Nuclear Safety Control
RA-EP-04000	Emergency Facilities Communication Monthly Test

License Amendment Requests

97-0007	Revise Technical Specification 3/4.5.2, Emergency Core Cooling Systems ECCS SubsystemsTAVG≥280°F, to Increase the Surveillance Interval for Surveillance Requirement 4.5.2.f.1
00-0003	Revisions to TS Surveillance Requirement 4.0.5, Applicability, TS Bases 4.0.5, and TS Bases 3/4.4.2 and 3/4.4.3, Reactor Coolant System Safety Valves, Regarding Inservice Testing Requirements
01-0002	Proposed New Technical Specification Administrative Controls Section 6.17, Technical Specifications Bases Control Program

Safety Evaluations

00-0039	Use of the Crane Main Hook to Carry Heavy Loads Over the Spent Fuel Pool
96-0003, Rev 3	Abandoning the Primary Water Storage Tank Mod 95-0050, FPR 95-0050-002, FPR 95-0050-008, UCN 97-063 and UCN 97-121

Maintenance Work Orders

99-002943-000	Plant ComputerCAC2 Stator Temperature is Failing Low
99-003255-000	Plant ComputerMod-Comp Computer Point Out of Tolerance Low
00-001697-000	MS 145 AFPT Main Steam Min Flow Line Check Valve Replacement
00-001697-003	MS 145 AFPT Main Steam Min Flow Line Check Valve Spring Replacement
00-001698-000	MS 146 AFPT Main Steam Min Flow Line Check Valve Replacement
00-001698-003	MS 146 AFPT Main Steam Min Flow Line Check Valve Spring Replacement
00-004299-000	480V Circuit Breaker BBF2 Stuck Closed

Miscellaneous

Intra-Company Memorandum DSO-01-00008 - Effectiveness Review CR 1999-0436
Intra-Company Memorandum PCAQR 96-0928 Remedial Action, Tagging Clearance Approved with Incorrect Nomenclature
Standing Order 99-009, Rev. 1 - Operation of Station Breakers
Standing Order 99-009, Rev. 2 - Operation of Station Breakers
Framatome Technologies FTI CR #6005776

Licensee Event Reports

2000-003	Loss of Auxiliary Feedwater Pump Turbine Main Steam Supply Train Separation Due to Check Valve Failure

Calculations

C-NSA-016.04-008	CC Surge Tank Overpressurization
C-ME-016.04-30	Calculation of maximum allowable pressure on the CCW Surge Tank