UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION IV
611 RYAN PLAZA DRIVE, SUITE 400
ARLINGTON, TEXAS 76011-8064

August 21, 2000

William T. Cottle, President and
Chief Executive Officer
STP Nuclear Operating Company
P.O. Box 289
Wadsworth, Texas 77483

SUBJECT: SOUTH TEXAS PROJECT - NRC INSPECTION REPORT NO. 50-498/00-08; 50-499/00-08

Dear Mr. Cottle:

On July 6, 2000, the NRC completed a team inspection at the South Texas Project Electric Generating Station, Units 1 and 2, facilities. The enclosed report presents the results of this inspection. We discussed the preliminary results of the onsite inspection on June 22, 2000, with you and members of your staff. On July 6, 2000, we conducted a telephonic exit meeting with Mr. T. Cloninger and members of your staff, to inform your staff of the results of the in-office review following the team's departure from the site.

This inspection examined 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.

We concluded that you have implemented an effective program for the identification and resolution of problems.

There was one green finding identified during this inspection associated with access control. This finding was determined to be a violation of NRC requirements. This violation is being treated as a Non-Cited Violation, consistent with Section VI.A of the NRC Enforcement Policy. If you contest this Non-Cited Violation you should provide a response within 30 days of the date of this inspection report, with the basis for your denial, to the Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington DC 20555-0001; with copies to the Regional Administrator, Region IV, 611 Ryan Plaza Drive, Suite 400, Arlington, Texas 76011; the Director, Office of Enforcement, United States Nuclear Regulatory Commission, Washington, DC 20555-0001; and the NRC Resident Inspector at the South Texas Project Electric Generating Station, Units 1 and 2, facilities.

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).

Should you have any questions concerning this inspection, we will be pleased to discuss them with you.

Sincerely,

/RA/

John L. Pellet, Chief
Operations Branch
Division of Reactor Safety

Docket Nos.: 50-498; 50-499
License Nos.: NPF-76; NPF-80

Enclosures:
NRC Inspection Report No.
50-498/00-08; 50-499/00-08

cc w/enclosures:
T. H. Cloninger, Vice President
Engineering & Technical Services
STP Nuclear Operating Company
P.O. Box 289
Wadsworth, Texas 77483

S. M. Head, Supervisor, Licensing
Quality & Licensing Department
STP Nuclear Operating Company
P.O. Box 289
Wadsworth, Texas 77483

A. Ramirez/C. M. Canady
City of Austin
Electric Utility Department
721 Barton Springs Road
Austin, Texas 78704

M. T. Hardt/W. C. Gunst
City Public Service Board
P.O. Box 1771
San Antonio, Texas 78296

D. G. Tees/R. L. Balcom
Houston Lighting & Power Company
P.O. Box 1700
Houston, Texas 77251

Jon C. Wood
Matthews & Branscomb
One Alamo Center
106 S. St. Mary's Street, Suite 700
San Antonio, Texas 78205-3692

A. H. Gutterman, Esq.
Morgan, Lewis & Bockius
1800 M. Street, N.W.
Washington, D.C. 20036-5869

G. E. Vaughn/C. A. Johnson
Central Power & Light Company
P.O. Box 289
Mail Code: N5012
Wadsworth, Texas 77483

INPO
Records Center
700 Galleria Parkway
Atlanta, Georgia 30339-5957

Bureau of Radiation Control
State of Texas
1100 West 49th Street
Austin, Texas 78756

Jim Calloway
Public Utility Commission
William B. Travis Building
P.O. Box 13326
1701 North Congress Avenue
Austin, Texas 78701-3326

John L. Howard, Director
Environmental and Natural Resources Policy
Office of the Governor
P.O. Box 12428
Austin, Texas 78711-3189

Judge, Matagorda County
Matagorda County Courthouse
1700 Seventh Street
Bay City, Texas 77414

Electronic distribution from ADAMS by RIV:
Regional Administrator **(EWM)**
DRP Director **(KEB)**
DRS Director **(ATH)**
Senior Resident Inspector **(NFO)**
Branch Chief, DRP/A **(JIT)**
Senior Project Engineer, DRP/A **(DNG)**
Branch Chief, DRP/TSS **(LAY)**
RITS Coordinator **(NBH)**
D. Lange **(DJL)**
NRR Event Tracking System **(IPAS)**
STP Site Secretary **(LAR)**

DOCUMENT NAME: R:_STP\ST00-08rp-slm.wpd

SOR:OB	SOR:OB	SOR:OB	SOR:OB	RI:PBA
SLMcCrory/lmb	HFBundy*	MEMurphy	TFStetka	GLGuerra
/RA/		**/RA/ E**	**/RA/ E**	**/RA/ JIT For**
08/09/00	/ /00	08/14/00	08/14/00	08/14/00

PS:PSB	C:OB	C:PSB	C:PBA	C:OB
DWSchaefer	JLPellet	GMGood	JITapia	JLPellet
/RA/ E	**/RA/**	**/RA/ E**	**/RA/**	**/RA/**
08/11/00	08/11/00	08/11/00	08/14/00	08/21/00

***unavailable - 8-wks of leave - will be given opportunity to cc when returns**
OFFICIAL RECORD COPY T=Telephone E=E-mail F=Fax

ENCLOSURE

U.S. NUCLEAR REGULATORY COMMISSION
REGION IV

Docket Nos.:	50-498; 50-499
License Nos.:	NPF-76; NPF-80
Report No.:	50-498/00-08; 50-499/00-08
Licensee:	STP Nuclear Operating Company
Facility:	South Texas Project Electric Generating Station, Units 1 and 2
Location:	FM 521 - 8 miles west of Wadsworth Wadsworth, Texas
Dates:	June 19 through July 6, 2000
Inspectors:	S. L. McCrory, Senior Operations Engineer, Operations Branch H. F. Bundy, Senior Operations Engineer, Operations Branch M. E. Murphy, Senior Operations Engineer, Operations Branch T. F. Stetka, Senior Operations Engineer, Operations Branch G. L. Guerra, Resident Inspector, Project Branch A D. W. Schaefer, Senior Physical Security Inspector, Plant Support Branch
Accompanying Personnel:	G. E . Werner, Operations Engineer, Operations Branch
Approved By:	John L. Pellet, Chief Operations Branch Division of Reactor Safety

ATTACHMENTS:

Attachment 1:	Supplemental Information
Attachment 2:	Initial Material Request
Attachment 3:	Information Material Request No. 2
Attachment 4:	Information Material Request No. 3
Attachment 5:	NRC's Revised Reactor Oversight Process

SUMMARY OF FINDINGS

IR 05000-498/00-08; 05000-499/00-08; on 06/19-07/06/2000; South Texas Project Electric Generating Station, Units 1 and 2; Physical Protection, Other Activities (Identification and Resolution of Problems).

The inspection was conducted by regional operations inspectors, a resident inspector, and a regional security inspector. This inspection identified one green issue, which was a Non-Cited Violation. The significance of issues is indicated by their color (no color, green, white, yellow, red) and was determined by the Significance Determination Process.

Identification and Resolution of Problems:

The team identified that the licensee was effective at identifying problems and putting them into the corrective action program. The licensee self-identified the significant deficiencies identified during the review period. The licensee effectively prioritized the extent to which individual problems would be evaluated consistent with their safety and risk significance and established schedules for implementation of corrective actions. In most instances, the licensee implemented corrective actions that were timely and effective. However, the team observed two isolated cases in which initial corrective actions were ineffective. The cases involved security access authorization and access control.

Cornerstone: Physical Protection

- Green. The failure to revoke an individual's unescorted access when an individual was terminated and no longer required unescorted access, was a violation of Section 4.1 of the physical security plan and paragraph 8.5 of Procedure OPGP09-ZA-0001, Revision 11. This violation is being treated as a Non-Cited Violation, consistent with Section VI.A of the NRC Enforcement Policy. This violation is in the licensee's corrective action program as Condition Record 00-6209 (Section 3PP1).

  This Non-Cited Violation was characterized as a "green" finding using the physical protection significant determination process. The violation had very low risk significance (green) because there were no more than two similar findings in the last four quarters.

Report Details

Summary of Plant Status: Units 1 and 2 operated at 100 percent power throughout the inspection period.

3. Safeguards

Physical Protection

3PP1 Access Authorization

(Closed) Licensee Event Report 50-498;-499/2000-S01-00: Failure of Contract Manager and Staff to Properly Identify and Report Employment Terminations of Plant Employees

On April 5, 2000, the licensee identified that a recently terminated contract employee used her security badge to enter the protected area. The former employee's security badge should have been deactivated the previous afternoon, and unescorted access authorization terminated under favorable conditions. However, because of incorrect information, another employee's badge, with the same last name, had been mistakenly deactivated. On April 5, 2000, the former employee returned to the site for an appreciation luncheon. While pursuing visitor access, security told the former employee that her badge was valid. After the former employee gained unescorted access, a plant employee identified her as no longer having authorized access to the protected area, and escorted her to security. Subsequently, the former employee exited the protected area. The former employee's access authorization did not include vital areas and no vital area entries were made or attempted by the former employee. The licensee submitted the information to the NRC in a licensee event report dated May 4, 2000.

The licensee's investigation determined that the root causes of this event were:

- Insufficient management oversight over the badge termination process.

- Ineffective corrective action for a previous access control event on September 15, 1999. Corrective action for the previous event included revision of the plant access authorization program, to require badge action by the releasing employer for any terminated employee. However, the licensee determined that the required corrective action was not specified, and led to indecision.

The licensee's corrective actions for this event, identified in Condition Record 00-0629, were in-process at the time of the inspection.

The failure to revoke an individual's unescorted access when an individual was terminated and no longer required unescorted access, was a violation of License Condition 2.F and Technical Specification 6.8.1, as implemented via Section 4.1 of the physical security plan, and paragraph 8.5 of Procedure OPGP09-ZA-0001, Revision 11. This violation is being treated as a Non-Cited Violation, consistent with Section VI.A of the NRC Enforcement Policy. This violation is in the licensee's corrective action program as Condition Record 00-6209 (50-498;-499/08-01).

This Non-Cited Violation was characterized as a "green" finding using the physical protection significance determination process. The violation had very low risk significance (green) because there were no more than two similar findings in the last four quarters.

4. OTHER ACTIVITIES

4OA2 Identification and Resolution of Problems

a. Inspection Scope

This inspection consisted of a review of the licensee's programs that were intended to identify and resolve problems discovered at the facility. The review focused on the following attributes of Inspection Procedure 71152, "Identification and Resolution of Problems," Section 03.02.c: 1) complete and accurate identification of the problem in a timely manner commensurate with its significance and ease of discovery; 2) proper evaluation and disposition of operability and reportability issues; 3) consideration of extent of the condition (generic implications, common cause, repetitive, etc.); 4) classification and prioritization of the resolution of the problem; 5) identification of root and contributing causes; 6) identification of corrective actions; 7) completion of corrective actions in a timely manner; and 8) accurate accounting for equipment unavailability.

The team selected several issues for focused review, across the seven cornerstones, based upon their risk importance, a review of the licensee's documented system status, the requirements of NRC Inspection Procedure 71152, and past NRC inspection findings. These selected items included:

Specific Events

- Loss of offsite power to Unit 2 Trains B and C event,
- Charcoal leaks in emergency ventilation filters,
- Valve D1AFFV7526 failed to open during auxiliary feedwater pump testing,
- Engineering evaluation of the residual heat removal bypass and throttle valve,
- Failure to monitor for neutron dose,
- Radioactive material released from the radiologically controlled area, and
- Access-authorization and access-control.

Repetitive Issues with Generic Implications

- Reactivity management,
- Balance-of-plant equipment reliability,
- An adverse trend in fire protection,
- Operations procedure adherence, use, and adequacy,
- Technical specification entry/application/operability determination errors, and
- Multiple fuel handling events.

In addition, the team assessed licensee identification and resolution of problem performance against the eight attributes through a review of over 200 licensee records, including approximately 44 licensee quality assurance surveillances and audits, and self-assessment reports, related to the selected items. The team independently verified associated corrective actions that had been completed.

b. Issues and Findings

b.1. Effectiveness of Problem Identification

Based on the review of over 200 licensee records related to the issues for focused review noted in AO4a. above, the team concluded that the licensee effectively identified problems. The team identified no findings related to the applicable attributes of Inspection Procedure 71152, “Identification and Resolution of Problems,” Section 03.02.c for the area of problem identification.

b.2. Prioritization and Evaluation of Issues

Based on the review of over 200 licensee records related to the issues for focused review noted in AO4a. above, the team concluded that the licensee effectively prioritized and evaluated issues. The team observed the exceptions discussed below related to issue prioritization and evaluation.

The team reviewed Condition Record 99-11967 related to failures of the fuel handling building ventilation charcoal filter banks. The system engineer reviewed the nature of these events and determined that Condition Record 99-11967 was improperly classified in the licensee’s corrective action process. Subsequently, the system engineer initiated Condition Record 00-288 on January 5, 2000, to document and correct the misclassification. The team determined that the delay in assigning the appropriate classification to the condition did not affect timely problem evaluation and corrective action implementation.

Of the six focused review areas the team reviewed for repetitive issues, they identified only one in which the licensee had not aggregated several individual events/issues to evaluate for common cause. The team reviewed 38 condition reports that involved technical specification entry and application decisions and operability determination errors made by plant personnel. As the result of these reviews, the team observed repetitive human performance error issues involving technical specification compliance.

When these observations were discussed with the licensee, the licensee acknowledged that it had these human performance problems. As the result of the team's observations, the licensee wrote Condition Record 00-10839 to perform a self-assessment of technical specification compliance and implementation issues. This self-assessment would review all technical specification compliance issues since January 1997 and review the effectiveness of the corrective actions.

The team identified no findings related to the applicable attributes of Inspection Procedure 71152, "Identification and Resolution of Problems," Section 03.02.c for the areas of prioritization and evaluation of issues.

b.3. Effectiveness of Corrective Actions

Based on the review of over 200 licensee records related to the issues for focused review noted in AO4a. above, the team concluded that the licensee implemented effective corrective actions. The team observed the exception discussed below related to corrective action effectiveness.

The team reviewed corrective actions related to physical protection access authorization and access control and determined that the licensee had been initially ineffective in correcting performance errors in these areas. The team reviewed Condition Records 99-08275 and 99-10116, related to an access authorization event, which addressed multiple failures to review and consider derogatory background information prior to granting a contract employee unescorted plant access (dispositioned in NRC Inspection Report 50-498;-499/99-12). Subsequent to this event, the licensee identified an additional example of access authorization personnel failing to consider all derogatory information obtained during a background investigation prior to granting unescorted access. The team reviewed Condition Record 99-17363, which addressed two separate occasions, when the licensee failed to properly evaluate derogatory information discovered during a background investigation (dispositioned in NRC Inspection Report 50-498;-499/00-03).

The licensee determined that the corrective actions implemented as a result of Condition Records 99-08275 and 99-10116 were ineffective. The ineffective corrective actions were related to procedure revisions to clarify requirements for processing personnel for unescorted access, to revise checklist forms used to ensure that all requirements for granting unescorted access are listed, to add requirements to perform second independent reviews of criminal history information, and to clarify the requirements and process for evaluating derogatory information.

The team reviewed an access control event in Condition Record 99-13652, which addressed the failure to prevent unescorted access of a contract employee who had resigned (dispositioned in NRC Inspection Report 50-498;-499/00-03). Subsequent to this event, the licensee identified an additional example of failure of a contract manager and staff to properly identify and report employment terminations of plant employees. The team reviewed Condition Record 00-06209, which addressed the licensee's failure to revoke an individual's unescorted access when an individual was favorably terminated

and no longer required unescorted access. This event was discussed in Section 3PP1 above.

The licensee determined that the corrective actions implemented for Condition Record 99-13652 were ineffective. Both events involved repeated failure by contract managers to provide clear direction to administrative staff, and to take specific required actions with badges of contract employees. Corrective action for the previous event included revision of the plant access authorization program, to require badge action by the releasing employer for any terminated employee. However, the licensee determined that the required corrective action was not specified, and led to indecision. Additionally, corrective action training for the previous event did not reach the target audience.

The team concluded that the licensee did not identify the appropriate corrective actions in each of the initial occurrences regarding access authorization and access control. This led to the corrective actions being ineffective in preventing each of the subsequent occurrences. This performance did not constitute a failure to comply with regulatory requirements because the access authorization and access control programs were not subject to the requirements of 10 CFR Part 50, Appendix B, Criterion XVI. Further, the team did not evaluate this performance as representative of the licensee's overall ability to identify and implement effective corrective actions.

The team identified no findings related to the applicable attributes of Inspection Procedure 71152, "Identification and Resolution of Problems," Section 03.02.c for the area of effectiveness of corrective actions.

4OA6 Meetings

a. Exit Meeting Summary

The team debriefed Mr. William Cottle, President and Chief Executive Officer, and members of licensee's management on the preliminary inspection findings at the conclusion of the onsite inspection on June 22, 2000. The licensee's management acknowledged the findings presented.

A telephonic exit meeting was held on July 6, 2000, with Mr. T. Cloninger, Vice President, and other licensee staff members, during which the team leader characterized the results of the in-office review following the team's departure from the site.

The team asked the licensee's management whether any materials examined during the inspection should be considered proprietary. No proprietary information was identified.

ATTACHMENT 1

PARTIAL LIST OF PERSONS CONTACTED

Licensee

R. Aguilera, Health Physicist
P. Arrington, Licensing
M. Berg, Manager, Maintenance
M. Berrens, Manager, Waste Control
T. Cloninger, Vice President, Generation
W. Dowdy, Manager, Operations Support
S. Head, Supervisor, Licensing
T. Jordan, Manager, Nuclear Engineering
W. Mookhoek, Licensing
J. Owen, Unit Supervisor
G. Parkey, Plant General Manager
G. Russell, Parts Coordinator
P. Serra, Manager, Plant Protection
J. Sheppard, Vice President, Engineering and Technical Support

NRC

P. Gage, Acting Chief, Operations Branch

ITEM CLOSED

Closed

50 498;-499/2000-S01-00	LER	Failure of Contract Manager and Staff to Properly Identify and Report Employment Terminations of Plant Employees

PARTIAL LIST OF DOCUMENTS REVIEWED

PROCEDURES

0P0P08-FH-0004, “RCC Change Fixture Operation,” Revision 5

0P0P08-FH-0006, “Burnable Poison Rod Assembly Handling Tool Operating Instructions,” Revision 4

0P0P08-FH-0007, “Thimble Lug Handling Tool Operating Instructions,” Revision 6

0PEP02-ZM-0005, “Internal Transfer of Fuel Assemblies,” Revision 9

0POP08-FH-0001, “Refueling Machine Operating Instruction,” Revisions 12 and 14

0POP08-FH-0003, “Fuel Transfer System,” Revision 12

0POP08-FH-0012, “Spent Fuel Pool RCCA Change Tool,” Revision 8

0PRP08-ZR-0020, “Installation and Operation of the Tri Nuclear Underwater Filtration Equipment,” Revision 8

0PGP03-ZX-0002, “Condition Reporting Process,” Revision 20

CONDITION RECORDS

97-2736 "Determine If Removal of Incore Thimble Tubes Is a Core Alteration," 2/13/97.

97-10207 "S. Kidd Discovered Limiting Condition for Operation Time Clock and OAS for Tracking the Hydrogen Analyzer CM-4105 Was Incorrect," 6/18/97.

97-14189 "Tri-Nuke Filters Discovered in the In-containment Storage Area," 9/13/97

97-17881 "Tracking CR for Recommendations in QA Audit 97-16," 11/5/97

98-7825 "System Generated Trend for Procedural Adherence/Execution Issues (Operations)," 6/5/98

98-10705 "Failure to Satisfy 10 CFR 50, Appendix R Requirements," 6/16/98

98-14202 "During a System Engineer Review of Surveillance OPSP03-AF-0007 for Auxiliary Feedwater Pump 14, it Was Discovered That the Inservice Test (ST 86000588) Was Not Performed on 7/9/98 as Scheduled," 9/15/98.

98-14552 "Investigate Cause of the Reactor Trip Caused by the Performance of BS-354091," 9/22/98.

98-14592 "During Performance of OPSP03-ZQ-0028 Operator Logs it Was Noted That Reactor Containment Fan Cooler 12a Inlet Temperature TI-9673 Had Been Logged as Having CR 98-13686 Written Against it Stating That the Indication Had Failed Low," 9/23/98.

98-19327 "Tracking CR for Findings of System Engineering 1999 Self Assessment," 12/1/98

99-2042 "Engineering to Evaluate the RHR Bypass and Throttle Valve," 2/10/99

99-2925 “480vac Load Centers has Exceeded the Acceptable Number of Functional Failures,” 8/19/99

99-3235 "Unaccounted Tri-Nuke Filters in Spent Fuel Pool," 3/3/99

99-3690 “Loss of Offsite Power on “B” and “C” Trains, Unit 2,” 3/12/99

99-3713 "Procedure Revision Request for OPOP04-AE-0001," Addendum 5, 3/13/99

99-4632	"Technical Specification 3.3.2.10.C Action 27 Was Not Satisfied," 3/30/99.
99-5488	“Technical basis for Technical Specification 3.8.1 on Page 3/4 8-3 Where Fast Transfer Capability Is Discussed Is Not Consistent with STP Design Basis as Described in UFSAR, Chapter 8," 4/8/99.
99-5531	"During Fuel Movement in the Unit 1 Spent Fuel Pool, the Workers Snagged and Removed a Boroflex Panel and Lead in Guide," 4/8/99
99-5563	"Revise Offsite Power Technical Specification 3.8.1.1 to Better Define Offsite Power Sources and Components That Are Required," 4/9/99.
99-6302	"Fuel Assembly D16 Is Leaning in the Reactor Core," 4/19/99
98-6010	"No Storage Permit Issued for the Transient Fire Load," 4/14/98
99-7285	"Recent Nuclear Material Safety and Safeguards Decision on Bundling Exempt Quantities (GL 99-01)," 5/5/99
99-7364	"Elevated Levels of Noble Gas in the Unit 1 Reactor Coolant System Indicate the Probability of Failed Fuel," 5/5/99
99-7742	"Valve D1AFFV7526 Failed to Open During AFW Pump Testing," 5/13/99
99-7743	"Investigate Failure of MOV-7526 to Open as Required During Surveillance Testing," 5/13/99
99-8203	"Perform an Effectiveness Review of the Corrective Actions Generated on SCAQ CR 99-7742," 5/26/99
99-8515	"Adverse Trend Identified in Implementation of Corrective Actions Program by the Fire Protection Group," 6/2/99
99-8910	"Problems Associated with Post-Fire Safe-Shutdown Circuit Analyses (IN 99-17)," 6/10/99
99-8977	"Procedural Error During Vacuum Fill and Vent of RHR Train C," 6/10/99
99-9063	"Track Recommendations Developed During the Fire Protection," 6/15/99 Audit 99-12
99-9064	"Provide Feedback Items for Procedure 0PGP03-ZF-0001, Fire Protection Program," 6/15/99
99-9065	"Provide Feedback Items for Procedure 0PGP03-ZF-0014, Fire Prevention Surveys," 6/15/99

99-9066	"Provide Feedback Items for Procedure 0PGP03-ZF-0018, Fire Protection System Operability Requirements," 6/15/99
99-9068	"Provide Feedback Items for Procedure 0PGP03-ZF-0019, Control of Transient Fire Loads and use of Combustible and Flammable Liquids and Gases," 6/15/99
99-9070	"Provide Feedback Items for Procedure 0PGP03-ZT-0131, Fire Protection Training and Qualification Program," 6/15/99
99-9071	"Provide Feedback Items for Procedure 0PGP03-ZF-0011, STPEGS Fire Brigade," 6/15/99
99-9488	"Laboratory Testing of Nuclear-Grade Activated Charcoal (GL 99-02)," 6/24/99
99-9595	“Level Oscillations in Flash Tank 22 and Feedwater Heater 25B Caused Trip of Low Pressure Heater Drain Pump 22 and Isolation and Bypass of Low Pressure Feedwater Heaters 25B and 26B,” 6/2/8/99
99-9596	"System Generated Trend for Procedural Adherence/execution Issues (Operations)," 6/28/99
99-9620	"During 1RE08 the Incore Thimbles May Have Been Inserted into the Reactor Core Without Core Alteration Requirements Being Satisfied," 6/29/99.
99-9627	"Rupture of the Shell Side of a Feedwater Heater at the Point Beach Nuclear Plant (IN 99-19)," 6/24/99
99-10162	"Track Effectiveness Reviews for 1998/1999 SCAQ Condition Reports," 7/13/99.
99-10207	"Recent Plant Events Caused by Human Performance Errors (IN 99-21)," 7/8/99
99-10645	"Inadvertently Moved Wrong Fuel Assembly in the Spent Fuel Pool," 8/5/99
99-11271	"Inspect Fuel Assembly (ID P54) Bottom Nozzle Plate Area for Damage," 8/5/99
99-11574	"Request Reportability Review Concerning Performing OPSP03-EA-0002 During Performance of OPSP03-DG-0001," 8/12/99.
99-11776	"Tracking CR for Corrective Actions for Operations Self-Assessment," 8/17/99
99-11967	"There Is Charcoal on the Floor of the Charcoal Filter Cubicle in the FHB HVAC Exhaust Filtration Unit 12B Charcoal Filter," 8/19/99.
99-12130	"Request Reportability Review to Determine If Having ED-MOV-0064 or FV-7800 Closed Makes the Containment Flow Monitoring System Inoperable," 8/25/99.
99-12426	"Channel 2 Steam Generator 2D LO-LO Level Bistable Flashing," 9/1/99.

99-12762 "Nuclear Instrument 41 Appears to Have Failed Low. Investigate," 9/12/99.

99-12861 "Power Range Channel NI-0041 Failed a Channel Check," 9/13/99.

99-13106 "Discovered Inappropriate Clearance Order Boundary for EDG 22 Tagout," 9/20/99

99-13163 “Tracking BOP Task Force Actions,” 9/20/99

99-13201 “Follow Recommendations from Instrument Power Supply Self-Assessment,” 9/21/99

99-13709 "System generated trend for procedural adherence/execution issues (Operations)," 10/3/99

99-13890 "After Maintenance on 480 V Tie Breaker LC EIA on 10/05/99, a Fast Bus Transfer Was Performed to Check Breaker Continuity and TS 3.8.3.1 Was Not Entered," 10/6/99.

99-14080 “MS-MOV-0084 Limit Switch Failed Preventing Valve Operation,” 10/10/99

99-14081 “ 22B RHDT Normal Level Control Valve Failed Closed,” 10/10/99

99-14083 “HD-MOV-0365 did not Reposition Correctly,” 10/10/99

99-14085 “Main Turbine was in Avoidance Zone for 47 Minutes, Engineering Evaluation Required,” 10/10/99

99-14089 “MSR Controller Power Supply Failure Light is very Dim,” 10/10/99

99-14092 “MS-MOV-0087 had to be Manually Opened,” 10/10/99

99-14224 "Recall of Star Brand Fire Protection Sprinkler Heads (IN 99-28)," 10/11/99

99-14640 "Condition Record 99-9620 Identified a Condition During 1RE08 Where Incore Thimbles May Have Been Inserted into the Reactor Core Without Core Alteration Requirements Being Set," 10/19/99.

99-14791 "Submit a Technical Specification Change to Clarify the Definition of Core Alteration,” 10/21/99.

99-15906 "Unit 2 Auxiliary Feedwater Storage Tank Was below Minimum Technical Specification Required Level of 485,000 Gallons for 4 Hours and 37 Minutes," 11/7/99.

99-16020 "While Reducing Power in Unit 2, Pressurizer Pressure Dropped below 2219 psig (DNB parameter)," 11/8/99.

99-16173 "Effectiveness Review for CR 99-14640 Insertion of Incore Flux Thimbles During 1RE08 When Core Alteration Requirements Were Not Satisfied," 11/10/99.

99-16960 "Authorized Contents of Spent Fuel Casks (IN 99-29)," 11/29/00

99-16406 "Potential Non-Operability of the Cutler-Hammer DS and DSL Circuit Breaker Due to Zinc Chromate Plating of Hardened Parts (Part 21 99-50)," 11/16/99

99-16727 "Tracking CR for Recommendations in E/I&C '99 Self Assessment," 11/24/99

99-17110 "Filter Housing Has Loose Charcoal on Floor. Approximately One Gallon," 12/3/99.

99-17218 "Incorrect Operability Impact Determinations Made During Supervisory Reviews of CR99-11967 and CR99-17110," 12/6/99.

99-17296 "While Placing Feedwater Heater 25C on the High Level Dump Valve, Both Feedwater Strings 25/26A and 25/26B Isolated, Resulting in a Required Downpower," 12/8/99

99-17307 "During Load Rejection Event, MOV-0014 (FWH 25/26C Outlet MOV) Failed to Open," 12/8/99

99-17308 "During Load Rejection Event, MOV-0043 (FWH 25/26B Inlet MOV) Failed to Open," 12/8/99

99-17464 "Five Shift Supervisors That Attended the Tuesday Morning Shift Supervisor Meeting and than Reported for Work That Same Tuesday Night Worked 26 Hours in a 48 Hour Period," 12/13/99.

99-17643 "Unanticipated Entry into Technical Specification 3.5.1.D Due to Low Pressure in SI Accumulator 2C Occurred 12/15/1999 at 1:40 am," 12/15/99.

99-17672 "Tracking CR for Recommendations in QA Audit 99-19," 12/14/99

99-17726 "During Walkdown of Fuel Handling Building Heating, Ventilation and Air Conditioning Carbon Filters Discovered Carbon Filter Media in 21A Filter Assembly and Fines in Several Others," 12/18/99.

99-17980 "Tracking CR for Actions from Plant Aux CAP Self Assessment," 12/31/99

00-126 "Hydrogen Leakage in Vicinity of Main Generator Lead Box Bushing Area," 1/3/00

00-288 "While Performing Review of Condition Record 99-11967, it Was Noted That this Report Is Incorrectly Identified as a CNAQ Level Condition," 1/5/00.

00-302	“Minor Hydrogen Leak in Vicinity of A-Phase Neutral Bushing Water Drain Flanged Connection,” 1/5/00
00-344	"Trip Roller-HK Circuit Breakers, ABB Part Number 180097A00 (Part 21 00-02)," 1/6/00
00-762	"During Walkdown of Fuel Handling Building Heating, Ventilation and Air Conditioning Carbon Filters Discovered Carbon Filter Media (<1/2 Cup) in 23B Filter Assembly," 1/5/00.
00-955	"Engineering Has Been Requested to Evaluate/initiate Caulking of Perforated Plate Edges as a Proactive Repair for the Fuel Handling Building Exhaust Charcoal Filters," 1/19/00.
00-959	"Engineering Has Been Requested to Evaluate/initiate Caulking of Perforated Plate Edges as a Proactive Repair for the Fuel Handling Building Exhaust Charcoal Filters," 1/19/00.
00-1196	“Increase in Hydrogen Concentration in Vicinity of A or B Phase Neutral Bus,” 1/24/00
00-1891	"Shortly after Starting Essential Chiller 12C, the Chiller Tripped on High Condenser Pressure," 2/2/00.
00-1973	“Chipping/Cracking of A and C Phase Bushing Porcelain on Hydrogen Side of Neutral Bushing,” 2/6/00
00-2645	"Received Protection Cabinet 3 Power Supply/Card Failure N1-SP-UY-763K, Investigate and Correct as Necessary," 2/18/00.
00-2859	“Evaluate and Develop Mitigating Actions for High Unit 2 TG Vibrations,” 2/23/00
00-3147	"1999 Enforcement Sanctions for Deliberate Violations of NRC Employee Protection Requirements (IN 00-04)," 2/29/00
00-3341	"Determine Reportability Impact of Letter ST-HL-AE-4959 on Plant Operation. Further, Review Positive Reactivity Manipulations Performed on 3/2/2000," 3/2/00.
00-3952	“B Train Electrical Bus Was Not Declared Inoperable During Installation of Temporary Modification 99-15344-19 for Temporary Power to Spent Fuel Cooling Pump 1A," 3/8/00.
00-5354	“Documents Findings and Recommendations of Phase 1 of BOP Task Force,” 3/24/00
00-5568	"Offsite Power Voltage Inadequacies (IN 00-06)," 3/27/00

00-5570 "High Bearing Temperatures Cause Inoperability of Both Decay Heat Removal/Low Pressure Injection Pumps (IN 00-08)," 3/27/00

00-5778 "Perform a Self-assessment of the License Amendment Process"

00-6334 "Tracking CR for Nuclear Engineering Self Assessment," 4/7/00

00-6462 "System Generated Trend for Procedural Adherence/execution Issues (Maintenance)," 4/10/00

00-6799 "Special Precautions for Using Certain Self-Contained Breathing Apparatus (IN 00-07)," 4/10/00

00-10200 “Rework Various Hangers and Insulation Damaged due to a Hydraulic Transient Associated with the RHDTs and FWHTRs 21A and 21B,” 6/9/00

00-10201 “N2HDLC7241 did not Control with a High Level and did not Receive a Hi Level Alarm with High Level in Heater,” 6//9/00

00-10319 "Operations Department Self-Assessment Activities Not Documented in CRs," 6/13/00

00-10354 "Safety Related DB-25 Westinghouse Circuit Breaker did not Pass Degradation Checks (Part 21 99-44)," 6/13/00

00-10839 "Perform a Focused Self-assessment on Technical Specification Compliance and Implementation Issues in the Fourth Quarter of 2000," 6/22/00.

QUALITY AUDITS/SURVEILLANCES AND SELF-ASSESSMENTS

Quality Audit Report 99-12(FP), Fire Protection , 7/12/99

Quality Audit Report 97-15, Plant Operations, 12/18/97

Quality Audit Report 99-19, Plant Operations 1/13/00

Quality Audit Report 99-09, Licensed Operator and Non-Licensed Operator Requalification, and Initial Licensed Operator Training, 8/5/99

Quality Surveillance Report 99-030, Non-Licensed Operator Watch-Station Realignment, 8/4/99

Quality Surveillance Report 99-033, Conduct of Operations Training, 10/12/99

Quality Surveillance Report 98-006, Unit 1 Train A, B, and C Standby Diesel Generator 11, 12, and 13 Extended Allowed Outage Time

Quality Surveillance Report 98-012, Fire Brigade Training, 4/7/98

Quality Surveillance Report 98-013, Licensed Operator License Maintenance, 4/8/98

Quality Surveillance Report 98-033, Plant Operations Shift Turnover, 6/29/98

Quality Surveillance Report 98-041, Unit 2 Train C Engineered Safety Features Diesel Generator 23 Extended Allowed Outage Time, 9/17/98

Quality Surveillance Report 98-055, Non-Licensed Operator Trainee Training Program, 11/12/98

Operations Monthly Report for January, February, March, and April 2000

Effectiveness Review of SCAQ CR 97-14190, 8/16/99

Effectiveness Review of SCAQ CR 97-14188, 9/13/99

Effectiveness Review of SCAQ CR 98-7885, 9/8/99

Effectiveness Review of SCAQ CR 97-10207, 9/1/99

Effectiveness Review of SCAQ CR 96-15818, 8/11/99

Operations Assessment of Effectiveness of Corrective Actions of CR 96-14780, 12/9/98

Operations Assessment of Effectiveness of Corrective Actions of SCAQ CRs 96-14780 and 97-12966, 1/20/99

Operations Assessment of Effectiveness of Corrective Actions of CRs 98-307, 98-5091, and 98-5552, 5/3/99

Operations Assessment of Effectiveness of Corrective Actions of CR 97-13469, 11/14/99

Operations Assessment of Effectiveness of Corrective Actions of CR 99-11776, 11/29/99

Operations Self-Assessment, 9/98

Operations Department Self Assessment, Conduct of Operations, 1/98

Operations Department Self Assessment, Reactivity Management, 9/98

Operations Assessment of Human Performance Trend (10/2/98 to 10/13/98)

Plant Operations Self-Assessment Report, 3/9/99

Plant Operations Self-Assessment Report, 10/7/99

Chemistry Self-Assessment Report 99-02, Radioactive Effluents, 12/9/99

Maintenance Self Assessment 99003, Follow-Up to the 1998 Comprehensive Cultural Assessment

Maintenance Self Assessment 99006, Maintenance Training, 10/11/99

Work Control Self Assessment 99011, Work Package Quality, 2/1/00

STP Corrective Action Self Assessment Report, 12/99

Electrical/I&C Division Corrective Action Program Self Assessment, 12/1/99

Nuclear Engineering Department Self Assessment, 9/99

Health Physics Peer Self-Assesment, July 1999

Reactor Containment Fan Coolers Contamination Control Radiological Assessment

Contamination Control Assessment for 1RE08

External Dosimetry (TLD) Program, May 1999

Assessment of General Employee Training, February 1999

Assessment of General Employee Training Part 2, June 1999

Health Physics CAP Assessment, Third Quarter 1999

Health Physics CAP Assessment, Fourth Quarter 1999

Health Physics CAP Assessment, First Quarter 2000

DESIGN CHANGE PACKAGE

00-2859-6 "Repair of Unit 2 Generator Neutral Bushings," 2/20/00

ENGINEERING EVALUATIONS

99-9595-01 "Operated for 1 Hour and 45 Minutes at 100 Percent Power with Heater String Isolated"

00-2859-6 "Structural Evaluations of Bushing Cracks," 3/24/00

00-2859-17 "Unit 2 Vibration Issue - Develop Recommendations That Will Enhance or Monitor Unit 2 Plant Reliability Through the Peak Operating Period of 2000," 3/23/00

00-2859-18 “Obtain Services of a Vibration Specials, Complete On-Site Vibration Data Collection, and Provide Report on Findings and Recommendations,” 4/28/00

00-2859-19 “Analyze Historical and Present TG Data and Changes,” 4/5/00 “Unit 2 Generator Vibration,” 6/14/00

00-2859-20 “Provide Recommendations for Correcting and/or Mitigating Vibrations in Unit 2 TGB/TGP,” 4/5/00

MT-7893 “Evaluation of Cracked STP-2 Generator Neutral Bushing and Cracked Elastomeric Seals(3),” 5/11/00

LICENSEE EVENT REPORTS

99-003 "Engineered Safety Feature Actuation and Entry into Technical Specification 3.0.3 Following a Partial Loss of Offsite Power, and Failure to Verify ESF Power Availability per Technical Specification Requirements,” 4/9/99

99-005 "Auxiliary Feedwater Train D Inoperable for Greater than 72-hour Technical Specification Limit," 6/17/99

WORK ORDERS

169288 “Investigate MSR Power Supply Failure,” 10/10/99

169564 “Replace 120 vdc Breaker Which Supplied Primary 13vdc Power Supply for MSR Controller,” 10/30/99

163336 “Replace Defective Actuator on MOV-0084 with New Model and Test,” 10/29/99

169414 “Reworked and Tested Valve RHDT NLCV LV-7223, Which Stuck Closed During Event,” 10/31/99

169407 Trouble Shoot and Rework Valves MOV-0365 and -0364 Which Did Not Reposition to Feed Water Heater Position on Recovery after MSR Failure,” 10/28/99

169411 “Adjust Limit Switches for Valve MS-MOV-0087 and Test,” 10/9/99

169605 “Troubleshoot Reheat Temperature Control Cabinet to Determine Why the Electronics does not Respond to a Loss of Primary +13vdc Power Supply as Expected,” 10/22/99

175298 “Replacement of Phase B Bushing and Epoxy Coating all Neutral Phase Bushings,” 2/5/00

MISCELLANEOUS DOCUMENTS

“Potential 10CFR Part 21: W-2 Cell Switch Failure,” letter Westinghouse Electric Corporation to NRC, 10/16/87

“Balance of Plant Task Force Phase I Report,” 6/21/00

SER 90-004 “Unplanned Exposure From Disintegrating Materials Stored in Spent Fuel Pool,” 1/12/90

ATTACHMENT 2

Initial Material Requested for the 71152 Inspection
South Texas Project Units 1 and 2 June 19-23 2000

For each of the inspection findings and Condition Reports listed below please provide the following:

- Full text of the condition report (please indicate any findings that did not result in a condition report or corrective actions)
- Any "Roll-up" or "Aggregating" Conditions Reports related to the specific findings or condition report.
- Root Cause analysis report (if applicable)
- Risk significance assessments
- Probable Cause evaluation (if applicable)
- Approved corrective actions
- Basis for extending originally approved due dates
- Evidence of corrective action completion (work packages design change documentation temporary modifications training lesson plans/material training attendance records procedure revisions etc.)

NRC Inspection Report No. 50-498/00-03; 50-499/00-03

- A violation of Paragraph 4.1.2 of the physical security plan and Paragraph 4.1 of the licensee Procedure OHRP01-ZA-0001 was identified for failure to consider all derogatory information obtained during a background investigation. As a result an individual who would not have been granted unescorted access was improperly granted unescorted access (or allowed to retain unescorted access) on two separate occasions. A similar violation was identified in NRC Inspection Report 50-498;-499/99-12 dated September 14 1999. This Severity Level IV violation is being treated as a Non-Cited Violation consistent with Section VII.B.1.a of the NRC Enforcement Policy (EA 00-066). This violation was entered into the licensee's corrective action program as Condition Records 99-1763 and 00-4066 and Significant Condition Adverse to Quality Record 99-17363 (Section S1.1).

NRC Inspection Report No. 50-498/00-01; 50-499/00-01

- A violation of Technical Specification 6.8.1.a was identified for failure to survey and control radioactive material released from the radiologically controlled area. This Severity Level IV violation is being treated as a Non-Cited Violation consistent with Section VII.B.1.a of the NRC Enforcement Policy. Condition Report 99-16737 was written to document this issue (Section R1.2).

NRC Inspection Report No. 50-498/00-05; 50-499/00-05

- During the Unit 1 shutdown for refueling operators were observed to hesitate to depart from the power reduction plan not to borate when the observations of core behavior did not match core predictions. However on-call reactor engineers were not contacted to resolve the discrepancy. The resulting delay in the power reduction was observed to create a sense of urgency to regain the schedule among the shift supervision. As a result a recommendation by the reactor operator to reduce the power reduction rate in

order to better control primary plant temperature was denied even though temperature was briefly outside the control band (Section O1.2).

- Operators failed to recognize the full Technical Specification impact of removing the Train A battery from service. Without its associated battery as a backup power supply the licensee was required to either declare two nuclear instruments inoperable or suspend positive reactivity additions. Neither was done and rods were withdrawn 18 steps for rapid refueling operations. Failure to recognize and comply with the requirements of Technical Specifications 3.8.2.2 and 3.8.3.2 was a violation which will not be cited consistent with Section VII.B.1 of the NRC Enforcement Policy (Section O1.3).

- On February 18 2000 a misdiagnosis of a solid state protection system problem resulted in the failure to take appropriate actions within the Technical Specification allowed outage time (Licensee Event Report 498/00001-00). This violation of Technical Specification 3.3.2 is being treated as a Non-Cited Violation consistent with Section VII.B.1 of the NRC Enforcement Policy. This violation is in the licensee's corrective action program as Condition Report 00-2645 (Section O8.5).

NRC Inspection Report No. 50-498/99-06; 50-499/99-06

- When a switchyard breaker failed Unit 2 experienced a loss of offsite power to Trains B and C equipment. The output breaker for Standby Diesel Generator 22 failed to close automatically because an essential chiller breaker cell switch failed to provide a necessary permissive input. Operators had failed to recognize that the diesel had been inoperable for 2 weeks because they did not perform the procedurally required checks. This was a violation of Technical Specification 6.8.1. This Severity Level IV violation is being treated as a Non-Cited Violation consistent with Appendix C of the NRC Enforcement Policy. This Non-Cited Violation is in the licensee's corrective action program as Condition Report 99-3690 (Section O1.2).

- During the loss of offsite power to Unit 2 Trains B and C operators quickly recognized that the diesel breaker failed to shut automatically and manually shut it to restore power to Train B equipment. While this action was appropriate it was in conflict with the loss of bus procedure. This loss of bus procedure was generic to all buses and as a result was very long cumbersome to use and did not place a priority on restoring offsite power to the engineered safety feature buses. This was a violation of 10 CFR Part 50 Appendix B Criterion V for failure to follow procedures. This Severity Level IV violation is being treated as a Non-Cited Violation consistent with Appendix C of the NRC Enforcement Policy. This Non-Cited Violation is in the licensee's corrective action program as Condition Report 99-3713 (Section O1.2).

- Operators did not understand the Technical Specification requirements for supplying offsite power to the engineered safety feature buses. As a result they failed to enter Technical Specification 3.0.3 and take the required 1 hour action to prepare to shut the plant down when offsite power was lost to Trains B and C while Standby Diesel Generator 22 was inoperable. When the Technical Specification 3.0.3 entry was recognized operators incorrectly concluded that offsite power requirements were being

met. However compliance was not restored for another hour and a half when offsite power was connected to Trains B and C. The inspectors noted that reconstruction of the event particularly decision making was significantly hampered because operators did not make log book entries or record adequate notes during the event. This was a violation of Technical Specification 3.0.3. This Severity Level IV violation is being treated as a Non-Cited Violation consistent with Appendix C of the NRC Enforcement Policy. This Non-Cited Violation is in the licensee's corrective action program as Condition Report 99-3690 (Section O1.2).

- New fuel receipt inspections in Unit 1 were well conducted utilizing proper supervision and procedural controls. However fuel movements within the spent fuel pool in Unit 2 were not controlled as well. A fuel bundle was placed in a storage location that contained used fuel pool filters. The fuel bundle was undamaged but the filters were compressed making them difficult to remove. The licensee had not documented the storage locations of the filters and had not coordinated storage of the filters with fuel storage. No violations of NRC requirements were identified (Section M1.2).

NRC Inspection Report No. 50-498/99-14; 50-499/99-14

- After securing a low pressure feedwater heater drip pump for planned maintenance the heater level control system behaved erratically and led to the isolation of one low pressure heater string. Operators evaluated the situation and decided to disregard procedural guidance to reduce power to 90 percent with management concurrence. The heater string was restored in a reasonable time and the procedure was clarified. This was an example of poorly performing balance of plant equipment challenging operators (Section O1.1).

- Operators moving fuel within the spent fuel pool became distracted while conducting informal training and failed to properly verify the correct cell location before moving a bundle. As a result they moved the wrong bundle and lowered it onto another bundle. This event was caused by inattention and improper verifications. Fuel handling movements were not stopped as required by procedure after the incident. This event was the fourth fuel handling event onsite recently indicating a weakness in attention to detail while moving fuel. Continuing examples of fuel handling events indicated that the corrective actions program was not adequately dealing with the declining trend. Failure to follow Procedure 0PEP02-ZM-0005 was a violation of Technical Specification 6.8.1. This Severity Level IV violation is being treated as a Non-Cited Violation consistent with Appendix C of the NRC Enforcement Policy. This violation is in the licensee's corrective action program as Condition Report 99-10645 (Section M1.3).

NRC Inspection Report No. 50-498/99-13; 50-499/99-13

- Operators failed to follow the plant startup procedure and caused a steam generator overpressure condition that was mitigated when a steam generator power-operated relief valve lifted. Operators made several reactivity manipulations without properly determining the expected plant response or properly monitoring all affected plant parameters. The inspectors concluded that the licensee's reactivity control program did not provide specific guidance or limits on reactivity manipulations using the chemical

control system. Operators focused on power changes and failed to recognize that temperature was out of limits. A Non-Cited Violation was identified for failure to follow the plant startup procedure while controlling coolant temperature which was entered in the licensee's corrective action program under Condition Report 99-3690 (Section O4.1).

NRC Inspection Report No. 50-498/99-12; 50-499/99-12

- A violation was identified for failure to review and consider all background investigation information prior to granting unescorted plant access as required by Paragraph 4.1.2 of the physical security plan and Paragraph 4.1 of Licensee Procedure OHRP01-ZA-0001 Revision 3. On three occasions the licensee improperly granted unescorted access to an individual who would not have been granted unescorted access if a complete review had been conducted. On two additional occasions the licensee's reevaluation resulted in continuation of individuals' unescorted access. This Severity Level IV violation is being treated as a Non-Cited Violation consistent with Appendix C of the NRC Enforcement Policy. This violation is in the licensee's corrective action program as Condition Reports 99-8275 99-6371 and 99-7237 (Section S1.1).

NRC Inspection Report No. 50-498/99-11; 50-499/99-11

- Fuel handling was adequately performed. However lack of attention to detail contributed to minor problems. These included: improperly inserting a fuel bundle in the core such that it caused another bundle to lean; inadvertently removing a poison panel from the spent fuel pool storage rack while removing a fuel bundle; and forgetting to remove a positioning handcrank before moving the refueling bridge electrically throwing the handcrank free. Additionally the licensee was unable to identify the source of a minor fuel leak during fuel inspection activities. Analysis of the isotopes present in water samples demonstrated that the leak was very small and the licensee believed that it was located in a bundle that was to be discharged from the core. However indications of a continued fuel leak were identified in the reconfigured core after the return to power (Section M4.1).

NRC Inspection Report No. 50-498/99-16; 50-499/99-16

- Inspectors identified two examples where operators did not determine the operability of safety-related equipment in a timely manner. Operators identified that charcoal was leaking out of the fuel handling building emergency ventilation exhaust filter bed but did not properly communicate the magnitude of the spilled charcoal to the weekend duty engineering staff. As a result a performance test to determine the impact of the spill on operability was not conducted until Monday. The filter was found to have been operable. Similarly operators did not properly communicate the symptoms of a failed power range nuclear instrument following a Unit 1 trip and as a result misdirected troubleshooting to find the problem. Specifically operators did not indicate that all outputs from the instrument were affected. The instrument was declared operable after troubleshooting failed to identify a problem. During the subsequent startup the instrument failed a channel check. Operators complied with the Technical

Specifications entered the applicable limiting condition for operation and repaired the instrument (Section O1.1 and O4.1).

- Unit 1 experienced a plant trip due to a material deficiency in the turbine protection system. While the licensee was unable to reproduce the problem available indications led the licensee to the conclusion that the test switch caused a brief trip signal in Channel 2 at the same time operators were testing Channel 1. The switch was found to have been covered in dust and lint. The licensee's investigation of the trip was prompt and thorough (Section O2.3).

NRC Inspection Report No. 50-498/99-20; 50-499/99-20

- Reactor reactivity manipulations were not properly balanced between borations and rod insertion and as a result the rod insertion limit was closely approached. Operators chose to override automatic control rod insertion in order to preserve shutdown margin. In doing so the reactor coolant system temperature and pressure transient was made more severe and Technical Specification action statements for exceeding the minimum temperature for criticality and departure from nucleate boiling minimum pressure were entered for brief periods (Section O1.2).

- Corrective actions for a previous uncontrolled power increase caused by improper operation without a procedure of a reheater drain tank level control system were too narrowly focused. Procedural guidance was only created for the reheater drain tank even though the same guidance was needed for all feedwater heaters. The inadequate corrective actions were a violation of 10 CFR Part 50 Appendix B Criterion XVI. This issue was entered in the licensee's corrective action program as Condition Report 99-17296. This Severity Level IV violation is being treated as a Non-Cited Violation consistent with Section VII.B.1.a of the NRC Enforcement Policy (Section O1.2).

- An inadvertent dilution of the reactor coolant system boron concentration caused a small increase in reactor power. The dilution resulted from an improper valve lineup while refilling the boron concentration monitor tank without a procedure. Operators quickly recognized the power increase and borated to restore power below 100 percent. The significance of the overpower transient was small due to the brief duration and small magnitude. The failure to utilize and follow the procedure for refilling the tank was a violation of 10 CFR Part 50 Appendix B Criterion V. This issue was entered in the licensee's corrective action program as Condition Report 99-17762. This Severity Level IV violation is being treated as a Non-Cited Violation consistent with Section VII.B.1.a of the NRC Enforcement Policy (Section O1.3).

- Unit 2 operators identified a charcoal leak in the Train B fuel handling building emergency ventilation filter on December 3 1999. It was erroneously considered to have no impact on system operability based on incomplete knowledge. Three and a half days later the system engineer determined that the leak rendered the system inoperable. On August 19 1999 a similar leak in Unit 1 was not recognized as rendering the system inoperable until evaluated by the system engineer on August 23. In both cases no Technical Specification Limiting Condition for Operation was exceeded

because the leaks were quickly repaired. The licensee addressed the poor initial operability determinations in Condition Report 99-17218 (Section O4.1).

- The inspectors determined that the licensee's initial assessment of the dose received while refilling a shield tank around a neutron source utilized electronic dosimetry which did not register neutron dose. A technician had refilled a shield tank around a 3.88 Curie neutron source in response to a low level alarm. Although some loss of shielding resulted from the low level the licensee subsequently performed a conservative estimate and determined that the dose received was small (Section R1.1).

NRC Inspection Report No. 50-498/99-18; 50-499/99-18

- Inspectors identified that Unit 1 operators crosstied safety Motor Control Centers E1A1 and E1A2 but failed to understand the requirements of and enter Technical Specification 3.8.3.1 Action a. The condition existed briefly during postmaintenance testing of the crosstie breaker so the action statement was not violated (Section O1.1).

- A controller power supply for both moisture separator reheaters failed. This caused the loss of reheat steam because the redundant power supply although set per vendor instructions was set too low to function properly. Operators performed a rapid power reduction to protect the main turbine blades from moisture damage. The operators' response was complicated by five steam plant motor operated valves which were mechanically bound or had limit switch problems that required manual action. Material condition deficiencies of balance of plant equipment both initiated and complicated this event (Section 01.3).

- The inspectors identified one instance where the licensee inserted bottom mounted instrument thimbles into the core a core alteration per the licensee's existing Technical Specifications without having containment integrity communications with the control room established or containment ventilation isolation operable. The licensee had used MERITS (a version of Improved Technical Specifications) to procedurally define what constituted a core alteration in conflict with their own Technical Specifications. The safety significance of this was low because Improved Technical Specifications permit this action. Failure to satisfy Technical Specification requirements for core alterations was a violation. As a result of the inspectors' findings the licensee wrote Condition Report 99-14640 to address the violation and made the required report to the NRC. This nonrepetitive violation will not be cited in accordance with Section VII.B.1.a of the Enforcement Policy (Section O4.1)

- The licensee identified a steam leak in a balance of plant instrument line that caused the instruments to sense less than actual steam line pressure. While planning a repair the leak degraded to the point where the affected instruments opened turbine drains. Despite prompt operator action to limit the magnitude of the transient this material deficiency in non-safety equipment caused an uncontrolled reactor power increase from 99 percent to 100.15 percent (Section M1.2).

NRC Inspection Report No. 50-498/99-21; 50-499/99-21

- Two forced outages on Unit 2 were required to repair vibration-induced damage. Hydrogen leaks from different locations on the main generator were repaired during both outages. A broken electrical connection that was affecting the voltage regulator was also repaired. Vibration of turbine generator auxiliaries have historically been a problem in the unit. During the first outage the licensee did not aggressively inspect for other vibration-induced problems which led to the subsequent outage a month later. Some turbine balancing was performed and a plan for more comprehensive action in a future outage was being developed (Section M2.1).

Condition Reports

99-2042	99-10645	99-17296	00-2645
99-3690	99-13652	99-17363	00-3341
99-3713	99-14640	99-17762	00-3952
99-7742	99-16737	99-17903	00-6209
99-8515	99-17218	00-985	

Other

Operations Self-assessment Report of September 13 1999
All Self and Independent audits and assessments of corrective action programs and processes
Procedures related to:
- Condition Reporting
- Root Cause Analysis
- Corrective Action Program

ATTACHMENT 3

Information Material Request no. 2 for the 71152 Inspection
South Texas Project Units 1 and 2 June 19-23 2000

For each of the Generic Communications (applicable to STP) and the Condition Report listed below please provide the following:

- Full text of the condition report (please indicate any findings that did not result in a condition report or corrective actions)
- Any "Roll-up" or "Aggregating" Conditions Reports related to the generic communication or condition report.
- Root Cause analysis report (if applicable)
- Risk significance assessments
- Probable Cause evaluation (if applicable)
- Approved corrective actions
- Basis for extending originally approved due dates
- Evidence of corrective action completion (work packages design change documentation temporary modifications training lesson plans/material training attendance records procedure revisions etc.)

Generic Communications

Part 21 Reports:

99-03	99-29	99-42	99-50
99-21	99-31	99-44	00-02
99-07	99-35	99-45	00-03
99-27	99-39	99-47	

NRC Generic Letters

99-001
99-002

NRC Information Notices:

99-017	99-028	00-006	00-008
99-019	99-029	00-007	
99-021	00-004		

Condition Report

99-8977

ATTACHMENT 4

Information Material Request no. 3 for the 71152 Inspection
South Texas Project Units 1 and 2 June 19-23 2000

Condition Reports

For each of the Condition Reports listed below please provide the following:

- Full text of the condition report (please indicate any findings that did not result in a condition report or corrective actions)
- Root Cause analysis report (if applicable)
- Risk significance assessments
- Probable Cause evaluation (if applicable)
- Approved corrective actions
- Basis for extending originally approved due dates
- Evidence of corrective action completion (work packages design change documentation temporary modifications training lesson plans/material training attendance records procedure revisions etc.)

97-14189	99-5531	99-11271
99-2925	99-6302	99-9596

For the following Condition Reports please provide the full condition report only (investigative reports related CRs and evidence of corrective actions are not required).

99-1666	99-8291	00-10319	00-10332
99-2166	99-12505	00-10325	00-10333
99-6591	99-11936	00-10326	00-10340
99-8278	99-17601	00-10328	

Please provide summary information for all CRs generated since 6/1/99 and related to respiratory certifications.

Other

Response to SER 90-004

ATTACHMENT 5

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. And 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.