



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

August 24, 2000

Tennessee Valley Authority
ATTN: Mr. J. A. Scalice
Chief Nuclear Officer and
Executive Vice President
6A Lookout Place
1101 Market Street
Chattanooga, TN 37402-2801

SUBJECT: WATTS BAR NUCLEAR PLANT - NRC INSPECTION REPORT NO.
50-390/00-07 AND 50-391/00-07

Dear Mr. Scalice:

On July 28, 2000, the NRC completed a team inspection at your Watts Bar 1 & 2 reactor facilities. The enclosed report presents the results of that inspection. The results were discussed on July 28, and August 3, 2000, with Mr. L. Bryant and other members of your staff.

The inspection was an examination of activities conducted under your license as they relate to the identification and resolution of problems, and compliance with the Commission's rules and regulations and with the conditions of your operating license. Within these areas the inspection consisted of a selective examination of procedures and representative records, observations of activities, and interviews with personnel.

Based on the results of the inspection, no findings were identified during this inspection. The team concluded that problems were properly identified, evaluated and resolved within your corrective action program.

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 Public 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/

Paul E. Fredrickson, Chief
Reactor Projects Branch 6
Division of Reactor Projects

Docket Nos. 50-390, 50-391
License No. NPF-90 and Construction
Permit No. CPPR-92

Enclosure: NRC Inspection Report w/Attachments

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U.S. NUCLEAR REGULATORY COMMISSION

Enclosure

REGION II

Docket Nos: 50-390, 50-391
License Nos: NPF-90 and Construction Permit CPPR-92

Report No: 50-390/00-07, 50-391/00-07

Licensee: Tennessee Valley Authority (TVA)

Facility: Watts Bar Nuclear Plant, Units 1 & 2

Location: 1260 Nuclear Plant Road
Spring City TN 37381

Dates: July 10, through July 28, 2000

Inspectors: W. Smith, Senior Resident Inspector, Browns Ferry, Team Leader
D. Rich, Resident Inspector, Watts Bar
C. Smith, P.E., Senior Reactor Inspector, Engineering Branch

Approved by: P. Fredrickson, Chief
Reactor Projects Branch 6
Division of Reactor Projects

Enclosure

SUMMARY OF FINDINGS

Adams Template:

IR 05000390-00-07,05000391-00-07; on 07/10-07/28/2000; Tennessee Valley Authority (TVA); Watts Bar Units 1 and 2; Annual baseline inspection of the identification and resolution of problems. The inspection was conducted by a team consisting of a senior resident inspector from Browns Ferry, the Watts Bar resident inspector, and a regional senior reactor inspector. This inspection was accomplished in accordance with NRC Inspection Procedure 71152, Identification and Resolution of Problems, and the NRC's Reactor Oversight Process, a summary of which is included as Attachment 1. There were no findings identified.

Identification and Resolution of Problems:

No findings were identified. The licensee was effective at identifying problems and placing them into the corrective action program. The licensee's effectiveness at problem identification was evident by the relatively few deficiencies identified by external organizations, including the NRC, that had not been previously identified by the licensee. The licensee appropriately evaluated individual problems based on risk significance when establishing schedules for implementing corrective actions. Corrective actions were generally implemented in a timely manner. Licensee audits and assessments were found to be effective with an improving trend noted in the quality of problem reporting. In addition, findings and problems identified by the audits and assessments were consistent with the team's observations. The interviews of plant personnel indicated that they felt free to input safety issues and conditions adverse to quality into the corrective action program. A safety conscious work environment was evident at Watts Bar.

REPORT DETAILS

4. OTHER ACTIVITIES (OA)

4OA2 Problem Identification and Resolution

.1 Effectiveness of Problem Identification

a. Inspection Scope

The inspectors reviewed items selected across the seven cornerstones of safety to verify that problems were being properly identified, appropriately characterized, and entered into the corrective action program for evaluation and resolution. Specifically, the inspectors selected 80 problem evaluation reports (PERs) from approximately 2000 which had been issued over the past year.

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

The licensee's identification of plant equipment problems was reviewed to verify that degraded and/or non-conforming equipment were corrected in accordance with the recommendations of NRC Generic Letter 91-18, Revision 1.

The inspectors reviewed corrective actions developed by the licensee in response to NRC Information Notice (IN) 00-06, Offsite Power Voltage Inadequacies, and Significant Operating Experience Report (SOER) 99-01, Loss of Grid. The corrective actions were reviewed in order to evaluate the capability of the licensee's corrective action program to address NRC and industry identified issues.

The inspectors also conducted system walkdowns and interviewed plant personnel to identify other processes that may exist where problems and issues could be identified. The inspectors attended the licensee's daily plan-of-the-day and management review committee meetings to help understand plant management's involvement in the corrective action program.

b. Issues and Findings

No findings were identified. Based on a review of the 2000 PERs, the threshold for documenting conditions adverse to quality was at an appropriate level. Management oversight was evident in all aspects of the program, and trending was extensive and informative with an appropriate focus on human performance. Particularly noteworthy was the licensee's PER Coordinator concept. Each department with any significant PER traffic had a peer representative who coordinated the processing of PERs assigned to their respective disciplines, from origination to closure. In addition the PER coordinators met biweekly to review management expectations for process

improvements, and utilized a grading process to evaluate the quality of selected PERs and provide feedback to the originators.

The licensee initiated PER 00-000154-000, Level C, in order to track and review actions to be developed for SOER 99-01. The developed corrective actions consisted of eight action items for addressing the recommendations contained in the SOER. NRC IN 00-06 was incorporated in the action items developed for SOER 99-01 because of the similar concern addressed by SOER 99-01. The inspectors concluded that implementation of the licensee's corrective action program provided for identifying and dispositioning issues through NRC generic communications and industry operating experience.

.2 Analyses of Cause(s) of Significant Conditions Adverse to Quality

a. Inspection Scope

The inspectors verified that an appropriate analysis for cause was made commensurate with risk and severity of problems, by evaluating the cause or root cause determination performed by the licensee in each of the 80 sampled PERs.

Correction of plant equipment problems was evaluated in order to verify that the cause analyses of conditions adverse to quality were adequately performed. Classification of the PERs describing the equipment problems was reviewed to ensure that the classification was appropriate to the safety significance of the issue. Problem resolution was also evaluated to ensure that priority for correcting the equipment problems was based on safety significance.

b. Issues and Findings

No findings were identified. Plant equipment problems were, for the most part, documented on Level C and D PERs. The "Apparent Cause" investigation performed for Level C and D PERs was intended to determine why the problems occurred. Sufficient information was collected to ensure that appropriate corrective actions could be developed and implemented for resolution of the equipment problems. A few examples of PERs reviewed did not have a description of the apparent cause of the equipment problems, although, corrective action plans had been developed. The inspectors determined the guidance provided in Procedure SPP-3.1, Appendix A, Condition Classification Criteria, for classifying PERs based on the safety significance of the equipment problem, was correctly applied in most instances. Additionally, equipment problems documented on Level C and D PERs were corrected in a timely manner appropriate to the safety significance of the issue. Level A and B PERs were few in number, and those reviewed by the team had received significant management attention. Root causes were determined properly, and the licensee had determined acceptable corrective actions.

.3 Effectiveness of Corrective Actions

a. Inspection Scope

The inspectors also reviewed the sampling of 80 PERs to verify that the licensee had identified and implemented corrective actions commensurate with issue safety-significance, and where possible, evaluated the effectiveness of the actions taken. The inspectors also verified that common causes and generic concerns were addressed where appropriate.

Corrective actions developed and implemented by the licensee for noncited violation (NCV) 50-390/99-07-01, Failure to Maintain Two Trains of Emergency Gas Treatment System Operable, and NCV 50-390/99-07-02, Failure to Follow Calibration Procedures, were also reviewed by the inspectors in order to verify the adequacy of developed corrective action plans.

Corrective actions developed and implemented for plant equipment problems were reviewed to ensure that design engineering requirements and the plants current licensing bases were satisfied.

b. Issues and Findings

No findings were identified. PER 99-008187-000, level B, was initiated by the licensee in response to NCV 50-390/99-07-01. The inspectors reviewed this PER and verified that corrective actions described on Licensee Event Report (LER) 1999-005-00 were developed and implemented as committed to by the licensee. Other corrective actions described in the PER that were not regulatory commitments were also completed at the time of the inspection. The licensee initiated PER 99-10093-000, level C, and PER 99-010947-000, level C, for resolution of the violation described in NCV 50-390/99-07-02. The inspectors reviewed both PERs and noted that the licensee's cause determinations were reasonable. Additionally, the developed corrective actions provided reasonable assurance for recurrence control and had been implemented. The inspectors concluded that implementation of the corrective action program for resolution of NRC-identified findings was adequate.

Corrective actions developed and implemented for plant equipment problems were effective in correcting the equipment deficiencies. The apparent cause determination was generally correct in identifying why the equipment problems occurred. Additionally, plant modifications packages prepared as part of the developed corrective actions were determined to be technically adequate and provided reasonable assurance for equipment problem recurrence control.

The inspectors found that the scope and depth of corrective actions assigned by the licensee were generally appropriate to the severity and risk significance of the problem identified. The licensee was thorough in completing corrective actions. The licensee identified appropriate PERs for consideration as a generic concern and evaluation of common causes.

.4 Effects of Problems on Availability of Safety-Related Equipment

a. Inspection Scope

An additional aspect of the 80-PER sample review was to verify that the licensee was appropriately identifying and capturing issues that could affect the availability of equipment tracked by the performance indicators and/or the maintenance rule.

b. Issues and Findings

No findings were identified. The inspectors did not identify any problems that affected the availability of safety related equipment, equipment tracked by the performance indicators, and equipment tracked by the maintenance rule, that had not been previously identified by the licensee. In general, the licensee had few long-term problems which affected the availability of equipment important to safety. Corrective action plans were being implemented and were appropriately prioritized for identified problems.

.5 Effectiveness of Licensee Audits and Assessments

a. Inspection Scope

The inspectors reviewed audits and assessments relating to problem identification and resolution. The specific documents reviewed are listed in Attachment 2. The inspectors compared the findings and problems identified by the audits and assessments with the findings and observations of the inspectors. Corrective actions resulting from the audits and assessments were evaluated for appropriateness to the circumstances.

b. Issues and Findings

No findings were identified. PER 99-010057-000, level C, described a condition where the corrective action program was not being consistently used for correcting design errors involving the preparation of post-issuance changes (PICs). The specific concern involved the failure of engineering personnel to initiate PERs for design errors identified after the issuance of the design change notices (DCNs). The corrective actions developed and implemented for this issue were to prepare a lessons-learned memorandum for distribution to engineering personnel. This memorandum specified three criteria to be used for determining when a PER should be written for PICs. The licensee also performed an assessment of the design change process for fiscal year 1999 in order to determine the scope of the problem. The assessment included a one hundred percent review of plant modifications implemented for the Unit 1, cycle 2 refueling outage. Based on the results of this assessment the licensee concluded that the corrective action program was generally being applied appropriately, and the number of PICs and field design change notices (F-DCNs) that should have resulted in PERs, but did not, was minimal. The licensee also concluded that the corrective actions implemented for PER 99-010057-000 were sufficient to address the identified deficiency. Based on a limited review of design change notices developed as corrective actions for identified deficiencies the team concurred with the licensee's conclusion.

The inspectors found that the licensee's self-assessments and audits were generally thorough with areas for improvement identified in addition to documented findings and deficiencies. Corrective actions were appropriate to the circumstances. Based on the

results of this corrective action program inspection, the inspectors concluded that the licensee's assessments identified issues similar to those identified by the inspectors. The inspectors noted, however, that the number and significance of issues diminished with time, thus indicating effective corrective actions were being taken.

.6 Assessment of Safety Conscious Work Environment

a. Inspection Scope

The inspectors interviewed plant personnel and developed a general view of the safety culture at Watts Bar in terms of willingness to report problems, and attitudes toward doing the right thing to maintain safety margins and defense in depth.

b. Issues and Findings

No findings were identified. The inspectors found that the licensee generally fostered a safety-conscious work environment by emphasizing safe operations and encouraging problem reporting. Employees felt free to identify safety concerns to either supervision or the employee concerns program. Based on the team's observation that there were a small number of employee concerns on file for this year, coupled with the decreasing trend, the team concluded that supervision and/or the PER was the preferred method.

4OA6 Management Meetings

The inspectors presented the inspection results to Mr. L. Bryant and other members of licensee management at the conclusion of the inspection on July 28, 2000 and at a teleconference on August 3, 2000. The licensee acknowledged the findings presented.

The inspectors asked the licensee whether any of the material examined during the inspection should be considered proprietary. No proprietary information was identified.

PARTIAL LIST OF PERSONS CONTACTED

Licensee

R. Beecken, Maintenance and Modifications Manager
 M. Brickey, Electrical/Design Manager
 D. Boone, Radiological Control Manager
 L. Bryant, Plant Manager
 J. Bushnell, Site Licensing Representative
 S. Casteel, Radiological and Chemistry Control Manager
 R. Greer, Performance Analyst
 L. Hartley, Maintenance Rule Coordinator
 D. Helms, System Engineering Manager
 J. Kammeyer, Design Engineering Manager
 D. Kulisek, Operations Manager
 W. Lagergren, Site Vice President
 D. Nelson, Business and Work Performance Manager

P. Pace, Licensing and Industry Affairs Manager
L. Parscale, Performance Analysis Manager
R. Purcell, Site Vice President
J. Roden, Operations Superintendent
L. Thomas, Human Performance (Self-Assessments)
J. West, Site Nuclear Assurance Manager

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 |
|---|---|---|
| <ul style="list-style-type: none">• Initiating Events• Mitigating Systems• Barrier Integrity• Emergency Preparedness | <ul style="list-style-type: none">• Occupational• Public | <ul style="list-style-type: none">• Physical Protection |

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>.

LIST OF DOCUMENTS REVIEWED

Problem Evaluation Reports

97-000106-000 B Failures of shutdown boardroom chiller A
97-000723-000 B Failures of shutdown boardroom chiller A
98-000175-000 A Failures of electrical boardroom chiller B
98-000333-000 A Repeated failures of shutdown boardroom chillers
99-000969-000 C MDAFW pump A outboard bearing oiler
99-001084-000 C Westinghouse Nuclear Safety Advisory Letter (NSAL-00-001)
99-002730-000 C Deficiencies in ice condenser foreign material exclusion
99-002732-000 B Ice condenser inlet doors exceed allowable opening force
99-004880-000 C Damage found on ice condenser baskets
99-008065-000 C Radiation monitor inlet and outlet lines reversed
99-008444-000 C Centrifugal charging pump motor horsepower
99-009463-000 C EDG fuel tank cleaning instructions
99-009599-000 C Self-assessment SA-PAG-99-002 results
99-010057-000 C Corrective action program not used consistently
99-010077-000 C Contamination migration to HEPA plenum room
99-010551-000 C ERCW pump E-B TDH acceptance criteria
99-010693-000 C Operational events involving human error
99-010951-000 C TDAFW trip and throttle valve
99-011257-000 C LOCBART computer code error
99-011861-000 C Deficiencies in PER package quality
99-012582-000 C Pressurizer PORVs position indication circuitry
99-012844-000 C EDG starting air tank drain valve
99-013312-000 C SG blowdown flow control valve
99-013514-000 D 2 persons sent on missions during REP drill
99-013549-000 C MCR chiller A inoperable due to oil temperature low
99-013551-000 B Steam generator level control setpoint
99-013658-000 C Monitoring of SIS accumulator #2 problems
99-013731-000 C 2A-A EDG starting air quarterly check valve test
99-013781-000 C Limitorque tripper mechanism defective
99-014330-000 D Radioactive material control deficiency
99-014590-000 C Primary containment penetrations configuration control
99-015285-000 D TDAFW governor oil particles
99-015749-000 C Technical bases for accuracy of TS compliance instruments
99-017487-000 C Section XI testing not included as required retest
99-017489-000 C Open work orders in a PMT status not scheduled
99-018025-000 C System 26 train A scheduled to work during a train B week
99-018036-000 D Electrical connection improperly crimped
99-018126-000 C Leak bypass of ECCS pump compartment level switches
99-018363-000 C Exhaust shielding on diesel generator
99-018558-000 C Defective type KTN-R-6 fuses
00-000138-000 B Clearance related deficiencies
00-000149-000 C Insufficient ERCW flow to SI Pump 1A-A room cooling unit
00-000177-000 C Communication problem during graded REP drill
00-000975-000 C Found contaminated filter media in green bag trash area
00-001059-000 C MCR HVAC system abnormal alarm
00-001218-000 C Security zone failure impacted performance indicators
00-001753-000 C Wrong change process applied to QA records
00-002571-000 C Maintenance shift group staffing
00-002871-000 C Missed exposure estimate due to mislocated work area
00-002957-000 C Unable to achieve required flow on containment spray pump 1A-A

00-003556-000 C Discrepancies in CCS calculations
 00-003837-000 C Wrong oil added to diesel engine
 00-004459-000 B Response time test not performed
 00-004485-000 C Failure of electrical boardroom chiller A
 00-004661-000 D Shutdown board breaker racked down without C-clamps
 00-004871-000 D Potential trip of chilled water pump when connecting M&TE
 00-005478-000 C CCP 1A-A pump room cooler fan had cracks
 00-005711-000 C Diesel generator air start valve testing
 00-005859-000 C MCR HVAC system A & B abnormal alarm status
 00-005865-000 D Conflicts between the REP and Procedure EPIP-1
 00-006088-000 D ERC supply header 2B temperature
 00-006428-000 D LCO exit time for EGTS train A
 00-006482-000 C High thrust during MOVATS testing of 1-MVOP-074-12-A
 00-006505-000 C Vehicle backed into fire protection valve
 00-006717-000 C Security officer failed to perform duties
 00-006897-000 D O-P/TR-70-162P002 resistor value
 00-006928-000 C Security officer failed to respond
 00-006932-000 C Inadequate flow to SI pump room coolers
 00-006964-000 D M&TE not used during shaft alignment
 00-007091-000 C Equipment door A-56 not secure
 00-007092-000 C Four security human errors
 00-007115-000 C Deficiencies in PER package quality improvement actions
 00-007198-000 C Incorrect basis for SI accumulator high pressure alarm setpoint
 00-007612-000 D 6.9Kv circuit breaker minimum trip voltage
 00-007782-000 D Breaker on D CSST defective
 00-007819-000 C Failure of safety related auxiliary control air piping
 00-008080-000 D Raw cooling water for glycol chillers
 00-008235-000 D Generic review of SQN PER 00-04-022-00
 00-008250-000 C Partial blockage of supply piping to TDAFW pump

Audits and Assessments

WBN - Analysis of Operations Performance for June 2000, Dated July 13, 2000
 WBN - Monthly Quality Assurance Oversight Reports:
 NA-WB-99-020 August 23 through September 19, 1999
 NA-WB-99-024 October 18 through November 21, 1999
 NA-WB-00-005 January 24 through February 20, 2000
 NA-WB-00-007 March 20 through April 23, 2000
 NA-WB-00-008 April 24 through May 21, 2000
 NA-WB-00-009 May 21 through June 20, 2000
 Self Assessment Report SA-PAG-99-001, Corrective Action Program, Dated
 December 18, 1998
 Self Assessment Report SA-PAG-00-001, Corrective Action Program, Dated
 May 5, 2000
 Self Assessment Report SA-ENG-99-02, Engineering

Operating Experience Issue Documents

WAT-D-10723 - Diaphragm Valve Seat Leakage, Dated February 29, 2000
 INPO Significant Event Report (SER) 00-04
 INPO Significant Operating Event Report (SOER) 99-01

Procedures

RCI-103 Radioactive Material Control, Revision 16
 SPP-3.1 Corrective Action Program, Revision 1
 SPP-4.2 Material Receipt and Inspections, Revision 4
 MMDP-1 Maintenance Management System, Revision 2
 NADP-3 Managing the Operating Experience Program, Revision 2
 SMMMD-023 Site Maintenance and Modifications Management Directive, Maintenance Shift Group, Revision 0

Other Documents

WB Level 1 Trend Analysis Report, Second Quarter FY2000, May 17, 2000
 WB Monthly Corrective Action Program and Trends Analysis Report, June 28, 2000
 NRC Special Inspection Report 50-390,391/99-06, June 3, 1999
 NRC Maintenance Rule Inspection Report 50-390/98-05, July 6, 1998
 Performance Improvement Plan for Main Control Room and Electric Board Room Chillers
 Performance Improvement Plan for Shutdown Board Room Chillers
 Radiological Emergency Plan, Revision 56
 Operations Department Standing Night Order 00-02

Previously Identified NRC Findings

50-390/99-01 NCV Failure to maintain two gas trains of Emergency Gas Treatment System operable.
 50-390/99-02 NCV Failure to follow calibration procedure.

NRC Information Notice

NRC Information Notice No. 2000-06, Offsite Power Voltage Inadequacies