



UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION IV
611 RYAN PLAZA DRIVE, SUITE 400
ARLINGTON, TEXAS 76011-4005

August 9, 2006

John S. Keenan
Senior Vice President - Generation
and Chief Nuclear Officer
Pacific Gas and Electric Company
P.O. Box 770000
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San Francisco, CA 94177-0001

SUBJECT: DIABLO CANYON POWER PLANT - NRC PROBLEM IDENTIFICATION AND
RESOLUTION INSPECTION REPORT 05000275/2006012 AND
05000323/2006012

Dear Mr. Keenan:

From June 5 through 22, 2006, the U. S. Nuclear Regulatory Commission (NRC) conducted the onsite portion of a team inspection at your Diablo Canyon Power Plant. The enclosed report documents the inspection findings, which were discussed with your staff as described in Section 4OA6 of this report.

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 the conditions of your operating license. The team reviewed approximately 280 action requests, associated non-conformance reports and apparent cause evaluations, and other supporting documents. The team reviewed cross-cutting aspects of NRC and licensee-identified findings and interviewed personnel regarding the condition of a safety conscious work environment at the Diablo Canyon Power Plant.

On the basis of the sample selected for review, the team concluded that, in general, your processes to identify, prioritize, evaluate, and correct problems were effective; thresholds for identifying issues remained appropriately low and, in most cases, corrective actions were adequate to address conditions adverse to quality. Notwithstanding the above, a relatively high number of self-revealing and NRC identified findings were noted at your site during the assessment period. Ineffective and incomplete corrective actions led to a number of repeat problems that could have been prevented, with a notable number of repeat findings of previously documented NRC-identified and self-revealing findings. Overall however performance had improved in the all areas of your corrective action program since the last problem identification and resolution inspection. The team concluded that while a safety-conscious work environment existed at your Diablo Canyon Power Plant

Based on the results of this inspection, no findings of significance were identified.

In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your response will be made available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records component of NRC's document system (ADAMS). ADAMS is accessible from the NRC web site at <http://www.nrc.gov/reading-rm/adams.html> (the Public Electronic Reading Room).

Sincerely,

DLProulx for

Linda J. Smith, Chief
Engineering Branch 2
Division of Reactor Safety

Docket: 50-275, 323
License: NPF-80, NPF-82

Enclosure:
NRC Inspection Report 05000275; 323/2006012
w/Attachment: Supplemental Information

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J. Lamb, OEDO RIV Coordinator (**JGL1**)

ROPreports

DC Site Secretary (**AWC1**)

SUNSI Review Completed: _____ ADAMS: ☒ Yes ☐ No Initials: _____
☒ Publicly Available ☐ Non-Publicly Available ☐ Sensitive ☒ Non-Sensitive

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ML

RIV:SRI/PBE	RI:PBA	RI:PBB	SOE:OB	SRI:EB2
RWDeese	RBCohen	TAMcConnell	TOMcKernon	DLProulx
T=DLProulx	T=DLProulx			/RA/
8/8/06	8/8/06	8/8/06	8/8/06	8/4/06

C:PSB	C:EB2			
WBJones	LJSmith			
/RA/	DLPfor			
8/7/06	8/8/06			

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ENCLOSURE

U.S. NUCLEAR REGULATORY COMMISSION
REGION IV

Docket.: 50-275, 323
License: NPF-80, NPF-82
Report No.: 05000275,323/2006012
Licensee: Pacific Gas and Electric Company
Facility: Diablo Canyon Power Plant
Location: 7 ½ miles NW of Avila Beach
Avila Beach, California
Dates: June 5-22, 2006
Team Leader: R. Deese, Senior Resident Inspector, Projects Branch E
Inspectors: R. Cohen, Resident Inspector, Projects Branch A
T. McConnell, Resident Inspector, Projects Branch B
T. McKernon, Senior Operations Engineer, Operations Branch
D. Proulx, Senior Reactor Inspector, Engineering Branch 2

Approved By: Linda Smith, Chief
Engineering Branch 2
Division of Reactor Safety

SUMMARY OF FINDINGS

IR 05000275, 323/2006012; 6/5-22/2006; Diablo Canyon Power Plant, Units 1 and 2; Biennial Identification and Resolution of Problems.

The inspection was conducted by three resident inspectors and one regional specialist inspector. One unresolved item was identified during this inspection. The significance of most findings is indicated by their color (Green, White, Yellow, Red) using Inspection Manual Chapter 0609, "Significance Determination Process." Findings for which the significance determination process does not apply may be Green or be assigned a severity level after NRC management review. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process," Revision 3, dated July 2000.

Identification and Resolution of Problems

The team reviewed approximately 280 action requests, apparent cause evaluations, and root cause analyses, as well as supporting documents to assess problem identification and resolution activities. In general, the corrective action program procedures and processes were effective, thresholds for identifying issues were low, and corrective actions were adequate to address conditions adverse to quality. Notwithstanding the above, a number of self-revealing and NRC identified findings in each of these attributes of your problem identification and resolution program were noted over the past two years. Many of these findings were related to equipment deficiencies, some of which resulted in inoperable safety-related equipment. The team noted improvement in all three areas when comparing the results of this and more recent inspections when compared to inspections two years ago.

Based on the interviews conducted, the team concluded that a positive safety conscious work environment existed at Diablo Canyon Power Plant. The team determined that employees felt free to raise safety concerns to station managers and supervisors, the employee concerns program, and the NRC. However, the team noted two isolated incidents regarding the environment that did not foster openly raising safety concerns. The licensee had already taken actions to address the concerns. All the interviewees believed that potential safety issues were being addressed.

A. Inspector-Identified and Self-Revealing Findings

None.

REPORT DETAILS

4 OTHER ACTIVITIES (OA)

4OA2 Identification and Resolution of Problems

The team based the following conclusions, in part, on all issues that were identified in the assessment period, which ranged from June 25, 2004, (the last biennial problem identification and resolution inspection) to the end of the inspection on June 22, 2006. The issues are divided into two groups. The first group (Current Issues) included problems identified during the assessment period where at least one performance deficiency occurred during the assessment period. The second group (Historical Issues) included issues that were identified during the assessment period where all the performance deficiencies occurred outside the assessment period.

a. Effectiveness of Problem Identification

(1) Inspection Scope

The team reviewed items selected across the seven cornerstones to determine if problems were being properly identified, characterized, and entered into the corrective action program for evaluation and resolution. The team performed field walkdowns of selected systems and equipment to inspect for deficiencies that should have been entered in the corrective action program. The team also observed control room operations and reviewed operator logs, plant tracking logs, and station work orders to ensure conditions adverse to quality were being entered into the corrective action program. Additionally, the team reviewed a sample of self assessments, trending reports, system health reports, and various other documents related to the corrective action program.

The team interviewed station personnel, attended action request (AR) review team and corrective action review board meetings, and evaluated corrective action documentation to determine the licensee's threshold for entering problems in their corrective action program. In addition, the team reviewed the licensee's evaluation of selected industry operating experience information, including operator event reports, NRC generic letters and information notices, and generic vendor notifications to ensure that issues applicable to Diablo Canyon Power Plant were appropriately addressed.

(2) Assessment

The team determined that, in general, problems were properly identified and entered into the corrective action program as evidenced by the relatively few findings identified during the assessment period. The team concluded that the licensee's current threshold for entering issues into the corrective action program was appropriately low. However, the licensee did fail in some instances to identify or document deficiencies which led to unnecessarily operating the units with degraded conditions affecting safety.

As listed below, four NRC-identified and self-revealing issues were documented during the period. The trend of NRC identified findings with problem identification and resolution aspects in effectiveness of problem identification has been fairly steady since 2004, with two findings in the last half of 2004, two in all of year 2005, and no additional findings identified during this inspection in the effectiveness of problem identification area. The team concluded that the licensee's performance had improved in the area of effectiveness of problem identification when compared to the previous problem identification and resolution assessment (NRC Inspection Report 05000275; 323/2004012).

Current Issues

Example 1: The licensee failed to promptly identify multiple grounds in the breaker control circuitry for Containment Spray Pump 2-2, resulting in the degraded control wires affecting the pump's circuitry for 70 days following the initial ground indication. (NRC Inspection Report 05000275,323 (IR) 2004004).

Example 2: The licensee failed to establish compensatory measures to ensure the prompt implementation of the Diablo Canyon Emergency Plan was met, in part due to the fact that the licensee missed opportunities to identify the emergency plan impact prior to removing seismic instrumentation from service. (IR 2004005)

Example 3: The licensee failed promptly identify a condition adverse to quality. Specifically, PG&E initially screened industry operating experience regarding the potential for containment recirculation sump valves failing to open following certain small-break loss of cooling accidents as not being applicable to Diablo Canyon Power Plant. (IR 2005004)

Example 4: Licensee operators had two opportunities to identify the mispositioning of Valve SFS-2-8765 but failed to identify the condition. The mis-positioned valve resulted in a loss of approximately 2600 gallons of water from the spent fuel pool. (IR 2005005)

Historical Issues

Example 1: The licensee failed to recognize a broken bonnet stud on the Unit 2 Atmospheric Dump Valve PCV-21 as a significant condition adverse to quality and promptly perform an operability assessment. (IR 2001007)

Example 2: The licensee failed to promptly identify and correct a nonconservative safety features setpoint by not ensuring that the Unit 2 plant response to a loss of feedwater flow to Steam Generator 2-4 was appropriate during their post trip event review process. (IR 2002007)

Example 3: The licensee failed to identify and correct a leak in Check Valve FW-2-370 and the backward installation of the disk for Check Valve FW-2-377 despite auxiliary feedwater system backflow alarms and industry experience on properly assembly of the check valves. (IR 2003006)

Example 4: The licensee failed to correct the population of Rockwell-Edwards valves in safety-related and risk-significant system that were susceptible to failure of the packing gland follower flange because they did not properly identify all of the potentially affected valves. (IR 2003008)

b. Prioritization and Evaluation of Issues

(1) Inspection Scope

The team reviewed ARs, work orders, and operability evaluations to assess the licensee's ability to evaluate the importance of adverse conditions. The inspectors reviewed a sample of ARs, apparent and root cause analyses to ascertain whether the licensee properly considered the full extent of causes and conditions, generic implications, common causes, and previous occurrences. The inspectors also attended various meetings to assess the threshold of prioritization and evaluation of issues identified.

In addition, the team reviewed licensee evaluations of selected industry operating experience reports, including licensee event reports, NRC generic letters, bulletins and information notices, and generic vendor notifications to assess whether issues applicable to Diablo Canyon Power Plant were appropriately addressed.

The team performed a historical review of ARs and notifications written over the last 5 years that addressed the emergency diesel generators, safety related switchgear ventilation, the auxiliary feedwater system, and the component cooling water system.

(2) Assessment

The team concluded that problems were generally prioritized and evaluated in accordance with the licensee's corrective action program guidance and NRC requirements. The team found that for the sample of root cause reports reviewed, the licensee was generally self-critical and thorough in evaluating the causes of significant conditions adverse to quality. Notwithstanding the above, ineffective prioritization and evaluation of issues resulted in a relatively high number of self-revealing and NRC identified findings during the period. One of these findings culminated in a plant trip. Others were related to equipment deficiencies, some of which resulted in inoperable safety-related equipment.

The team found that for the sample of root cause reports reviewed, the licensee was generally self-critical and thorough in evaluating the causes of significant conditions adverse to quality. The team noted that the quality and rigor of root causes had improved when compared to the previous problem identification and resolution assessment. Additionally, the trend of NRC identified findings with problem identification and resolution aspects in evaluation of problems has been improving since 2004, with six findings in 2004 and two in 2005, however, the inspectors identified one additional finding during this inspection in the evaluation area. The team concluded that the licensee had improved in performance in the area of prioritization and evaluation of issues when compared to the previous problem identification and resolution assessment.

Current Issues

Example 1: The licensee failed to properly evaluate the cause for Safety Injection Check Valve SI-1-8820 not seating following a forward flow test after the valve was found stuck open during a back flow leak test. (IR 2004003)

Example 2: The licensee failed to properly evaluate indications of reverse rotation of the fan motor for a containment fan cooler unit (CFCU), impacting the operability of the CFCU over the 13-year period that reverse rotation was observed. (IR 2004005)

Example 3: The licensee failed to recognize the significance of not establishing compensatory measures to ensure the prompt implementation of the Diablo Canyon Emergency Plan. (IR 2004005)

Example 4: The licensee failed to maintain approximately 70 safety related solenoid operated valves in an environmentally qualified condition because they did not promptly evaluate the extent of condition of a previous valve failure. This failure delayed the identification of elastomer qualification issues for approximately 1 year and ultimately caused a loss of Steam Generator feed event and a Unit 2 manual plant trip. (IR 2004005)

Example 5: The licensee failed to properly prioritize an issue regarding the re-submission of required documents for individual criminal history record information and subsequently missed the opportunity to have their security department correct the issue. (IR 2004007)

Example 6: The licensee did not fully evaluate the extent of a problem regarding generally-licensed devices and did not ascertain that the radiation sources and generally-licensed devices were properly controlled in accordance with NRC regulations and/or vendor instructions. (IR 2004009)

Example 7: The licensee failed to adequately evaluate and therefore provide for timely corrective actions regarding emergency core cooling system check valve back-leakage and its potential to cause gas-binding of emergency core cooling system pumps and/or water hammer of emergency core cooling system piping. (IR 2005005)

Example 8: The licensee improperly evaluated operating experience related to the minimum flow settings for the auxiliary feedwater pumps, in that they did not properly verify the minimum flow settings with the pump manufacturer. (IR 2005006)

Historical Issue

Example: The licensee failed to appropriately prioritize and evaluate battery charger failures between January 1999 and May 2003 because they consistently assigned low significance, did not assign any cause investigation, and did not recognize a trend of charger failures existed, even when multiple failures were identified in a short period of time. (IR 2003010)

c. Effectiveness of Corrective Actions

(1) Inspection Scope

The team reviewed plant records, primarily ARs, to verify that corrective actions related to identified problems were developed and implemented, including corrective actions to address common cause or generic concerns. The team sampled specific technical issues to evaluate the adequacy of the licensee's operability assessments.

Additionally, the team reviewed a sample of ARs that addressed past NRC identified violations, for each affected cornerstone, to ensure that the corrective actions adequately addressed the issues as described in the inspection reports. The team also reviewed a sample of corrective actions closed to other ARs, work orders, or tracking programs to ensure that corrective actions were still appropriate and timely.

(2) Assessment

The effectiveness of identified corrective actions to address adverse conditions was generally adequate. The NRC identified numerous instances over the assessment period where historical corrective actions were not effective but, overall, the licensee demonstrated acceptable performance in this area. Of note, the inspectors observed that the licensee had allowed recurrence of four previously documented NRC-identified or self-revealing findings. These repeat findings, listed below as Examples 4, 5, 9, and 10, represented a significant portion of the examples from the report period.

The trend of NRC identified findings with problem identification and resolution aspects in effectiveness of corrective actions has been improving since 2004, with four findings in the last half of 2004, seven in all of 2005, and no additional findings identified during this inspection or other inspections completed in 2006 before the exit date of this inspection. The team concluded that the licensee had improved in performance in the area of effectiveness of corrective actions when compared to the previous problem identification and resolution assessment.

Current Issues

Example 1: The licensee failed to assess the extent of condition regarding a failed pressurizer heater connection and thereby missed an opportunity to identify a corrosive agent that degraded all heater electrical connections for the Unit 1 pressurizer, causing at least one connection to fail. (IR 2004004)

Example 2: The licensee failed take adequate corrective actions to prevent the emergency core cooling system (ECCS) void space from exceeding the volume allowed by plant procedures, causing operators to declare the ECCS inoperable and enter Technical Specification 3.0.3 twice. (IR 2004005)

Example 3: The licensee failed to maintain design control of the emergency diesel generator fuel oil transfer system requirements after original corrective actions after the licensee originally identified the issue did not correct the problem. (IR 2004006)

Example 4: The licensee failed to prevent recurrence of a failure to perform surveys of a high radiation area in the Unit 2 Gas Decay Tank Room during evolutions due to ineffective corrective actions. (IR 2004006)

Example 5: The licensee failed to adequately resolve a condition adverse to their fire protection program. Specifically, operations department responders were not required to participate in fire drills for initial qualification or to maintain their qualification, which was noted to be a previously identified qualification deficiency. (IR 2005002)

Example 6: The licensee failed to promptly correct a cracked lube oil instrument sensing line on Emergency Diesel Generator 2-3, thereby increasing the potential for the diesel generator to trip on low lube oil level. (IR 2005002)

Example 7: The licensee failed to effectively implement interim corrective actions for Emergency Diesel Generator 1-1, which led to unplanned unavailability of the diesel generator to remove carbonized lube oil from the lube oil system. (IR 2005003)

Example 8: The licensee failed to identify the root cause and propose any corrective actions to prevent recurrence of the Unit 2 pressurizer safety valve lift setpoints being significantly out of tolerance, despite a history of pressurizer safety valve lift setpoints being out of tolerance. (IR 2005003)

Example 9: The licensee failed to prevent a repeat of a similar performance deficiency when they failed to conduct a circuit isolation plan when maintenance personnel were performing work on Startup Transformer 1-1, which was which was a risk management action required by plant procedure. The circuit isolation plan would have provided an opportunity to identify the potential of disrupting startup power to Unit 2, which occurred as a result of the maintenance activities. (IR 2005005)

Example 10: The licensee failed to prevent a repeat of a similar performance deficiency when they failed to post an area within Vault 26 as a radiation area. (IR 2005005)

Example 11: The licensee failed to take adequate corrective action to address an on-going problem with emergency core cooling system gas voiding in the common suction crossover line. The licensee had a sustained history of gas voiding in emergency core cooling system piping, which had the potential to lead to failure of the centrifugal charging pumps or safety injection pumps during the switchover from cold-leg recirculation to hot-leg recirculation during a loss-of-coolant accident. (IR 2005-06)

Historical Issues

Example 1: The licensee failed to take action to docket a justification and schedule to correct a nonconservative Technical Specification dealing with dose equivalent iodine activity in the reactor coolant system. (IR 2001006)

Example 2: The licensee failed to prevent recurrence of a previous event because of ineffective corrective action in placement of ventilation louvers on the 12 kilovolt grounding transformer fuse boxes. (IR 2003005)

Example 3: The licensee failed to promptly identify and correct lube oil carbonization in the emergency diesel generator lube oil systems, resulting in diesel generator unavailability to clean the lube oil lines. (IR 2003007)

Example 4: The licensee failed to promptly identify and correct a degraded mechanical governor on emergency diesel generator 2-2, causing the degraded governor to remain in service for over six months and requiring increasing difficulty by operators to maintain the required load on the diesel generator. (IR 2003007)

Example 5: The licensee failed to correct a safety-related battery charger design deficiency between January 1999 and May 2003 after multiple battery charger failures. (IR 2003010)

d. Assessment of Safety Conscious Work Environment

(1) Inspection Scope

The team interviewed approximately 27 individuals from different departments representing a cross section of functional organizations and supervisory and non-supervisory personnel. These interviews assessed whether conditions existed that would challenge the establishment of a safety conscience work environment.

(2) Assessment

The team concluded that a safety conscious work environment existed at the Diablo Canyon Power Plant. Employees felt free to enter issues into the corrective action program, as well as raise safety concerns to their supervision, the employee concerns program, and the NRC. However, two isolated concerns were discovered by the team concerning the environment for raising concerns specific regarding two different organizations. The team noted that due to recent organizational changes, the licensee had addressed the concerns the individuals raised. The team concluded, based on interviews, that the conditions raised by the concerned individuals were no longer present and never prevented individuals from raising their concerns. All of the interviewees believed that potential safety issues were being addressed and there were no instances identified where these individuals had experienced negative consequences for bringing safety issues to the NRC.

e. Specific Issues Identified During This Inspection

(1) Inspection Scope

During the reviews described in Sections 4OA2 a.(1), 4OA2 b.(1), and 4OA2 c.(1), above, the inspectors identified the following unresolved item.

(2) Findings and Observations

(I) Oil Found in the Vicinity of Residual Heat Removal Pumps

During a walkdown of the residual heat removal pumps during the weeks of June 5 and June 19, 2006, inspectors noted oil in the vicinity of the drain plugs for the motors for Residual Heat Removal Pumps 1-1, 2-1, and 2-2. The team questioned the licensee as to the source of the oil, specifically questioning whether the motors were leaking from the motor oil drain plugs during operation. Additionally, the inspectors discovered that the licensee was not performing the 72 hour cure time for the drain plug sealant recommended by the vendor which would ensure proper sealing characteristics. The team noted that any small leakage combined with the required lengthy mission time for the pumps could result in a situation where a loss of adequate inventory of motor oil could occur and challenge long term operation of the pumps.

The licensee performed a prompt operability assessment to provide reasonable assurance of operability of the pumps based on the observed conditions. Additionally the licensee made plans to measure leakage from the pumps during the next pump runs. Because the inspectors could not ascertain the source and the rate of the oil leakage until the pumps are run and could not determine the effect of a shortened sealant cure time, the team treated this issue as an unresolved item: URI 05000275,323/2006012-01, Oil Found in the Vicinity of Residual Heat Removal Pumps.

4OA6 Exit Meeting

On June 22, 2006, at the end of the onsite portion of the inspection, the inspection findings were discussed with Mr. J. Keenan and other members of the licensee's staff. The licensee acknowledged the findings.

The team asked the licensee whether any materials examined during the inspection should be considered proprietary. The licensee did not identify any proprietary information that may have been reviewed by the team.

Attachment: Supplemental Information

Supplemental Information

Partial List of Persons Contacted

Licensee

J. Becker, Vice President - Diablo Canyon Operations and Station Director
K. Peters, Director, Engineering Services
J. Welsch, Manager, Operations
M. Meko, Director, Site Services
R. Hite, Manager, Radiation Protection
D. Jacobs, Vice President - Nuclear Services
P. Roller, Director, Performance Improvement
B. Waltos, Manager, Emergency Preparedness
J. Purkis, Director, Maintenance Services
P. Roller, Director, Operations Services
D. Taggart, Manager, Quality Verification

LIST OF ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

05000275,323/2006012-01 URI Oil Found in the Vicinity of Residual Heat
Removal Pumps (Section 4OA2.e(2)(i))

Documents Reviewed

In addition to the documents called out in the inspection report, the following documents were selected and reviewed by the inspectors to accomplish the objectives and scope of the inspection and to support any findings:

Section 4OA2: Identification and Resolution of Problems

Action Requests

A0111266	A0537891	A0577808	A0589499	A0600842	A0608942
A0162000	A0548704	A0580131	A0589740	A0601862	A0609107
A0302183	A0553420	A0580778	A0589959	A0601877	A0609150
A0334222	A0557532	A0581860	A0590358	A0602129	A0609937
A0425218	A0558389	A0581890	A0590574	A0602745	A0611033
A0427658	A0562738	A0583472	A0592778	A0603995	A0611346
A0459989	A0562741	A0584386	A0592779	A0605066	A0611505
A0491470	A0562742	A0585459	A0592782	A0605096	A0611638
A0499791	A0566266	A0586913	A0594018	A0605203	A0611784
A0513762	A0571554	A0586915	A0597931	A0607200	A0612144
A0528837	A0571556	A0587031	A0598237	A0607398	A0612248
A0530124	A0573112	A0587032	A0598825	A0608163	A0613109
A0535731	A0577295	A0587150	A0598883	A0608433	A0613505
A0535871	A0577690	A0587494	A0599961	A0608483	A0614983

A0615425	A0634736	A0646838	A0659971	A0664021	A0670344
A0616852	A0634915	A0648502	A0660081	A0664053	A0670432
A0617647	A0635851	A0648550	A0661082	A0664134	A0670555
A0617988	A0635980	A0649123	A0661405	A0664825	A0670572
A0618799	A0636501	A0649373	A0661677	A0664885	A0670586
A0618992	A0636815	A0649461	A0661818	A0664920	A0670655
A0619215	A0636903	A0649887	A0661988	A0665039	A0670658
A0619650	A0638978	A0649932	A0661990	A0665166	A0670706
A0621027	A0639044	A0652157	A0662045	A0665588	A0670727
A0622185	A0640437	A0652663	A0662138	A0665755	A0670734
A0622355	A0640943	A0652667	A0662331	A0666116	A0670790
A0622599	A0640963	A0652726	A0662502	A0666132	A0670820
A0623479	A0641228	A0652914	A0663128	A0666319	A0670857
A0624472	A0642000	A0653033	A0663281	A0666828	A0670868
A0624585	A0642041	A0653445	A0663526	A0666867	A0670868
A0625005	A0642114	A0656436	A0663561	A0667282	A0670920
A0625548	A0642617	A0656452	A0663626	A0667383	A0671047
A0626353	A0642979	A0657228	A0663634	A0667541	A0671215
A0628329	A0642982	A0657247	A0663646	A0667549	A0671425
A0628375	A0643434	A0657248	A0663731	A0667755	A0671529
A0629528	A0644041	A0657515	A0663823	A0667995	A0671556
A0629995	A0644920	A0657517	A0663838	A0668040	A0671557
A0630154	A0644933	A0658443	A0663853	A0668297	A0671722
A0630229	A0644941	A0658540	A0663854	A0668929	A0671723
A0633325	A0644949	A0658670	A0663858	A0669488	A0671724
A0633568	A0644951	A0658794	A0663941	A0669488	A0671771
A0633772	A0645232	A0658795	A0663949	A0669488	
A0634066	A0645298	A0659274	A0663985	A0669871	
A0634214	A0646729	A0659858			

Procedures

<u>NUMBER</u>	<u>TITLE</u>	<u>REVISION</u>
	Standard Plant Priority Assignment Scheme	5
3.4.15	RCS Leakage Detection Instrumentation	Amendment 169
AD7.ID2	Standard Plant Priority Assignment Scheme	7
AR PK-18-06	Diesel 13 Lube Oil System	8
EOP E-2	Faulted Steam Generator Isolation	15
MP E-3.1	Auxiliary Feedwater Pump Motor Overhaul	10
MP E-10.1	RHR Pump Motor Overhaul	17A
MP E-14.1	Component Cooling Water Pump Overhaul	8

MP E-17.1	Westinghouse Auxiliary Saltwater Pump Motor Overhaul	14
MP E-53.2	Split End Bell, 4000-Volt Motor Overhaul	16
MP E-57.2B	Equipment Wiring and Terminations	37
OM4.ID15	Corrective Action Review Board (CARB)	3
OM4.ID16	Plant Health Committee	1
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Drawings

<u>NUMBER</u>	<u>ITEM</u>	<u>REVISION</u>
	Diesel Engine Generator 1-3	48
106712	Unit 1 Containment Spray	34
106710	Unit 1 Residual Heat Removal System	36

System Health Reports

<u>SYSTEM</u>	<u>TITLE</u>	<u>DATE</u>
12	Containment Spray	January 2006
10	Residual Heat Removal System	January 2006
39	Radiation Monitors	January 2006
21A	Diesel Generator System	January 2006

Work Orders

WO C0196475 WO R0259278 WO R0259280 WO R0264116 WO R0264775

Information Notices

2004-01	2004-10	2005-11	2005-24	2006-03
2004-07	2004-11	2005-16	2005-26	2006-04
2004-09	2005-08	2005-21		

NCV's

04-03-03 04-03-04 04-04-05 04-04-07

Nonconformance Reports

N001722
N002178
N002195
N002189
N002194

Drawing

<u>NUMBER</u>	<u>ITEM</u>	<u>REVISION</u>
663030	Motor AC Frame Vertical Lower Bearing Assembly	1

Operator Logs

Diablo Canyon Power Plant Operations Shift Log, Unit 2, May 19, 2006, Dayshift
Diablo Canyon Power Plant Operations Shift Log, Unit 2, November 3, 2006, Dayshift
Diablo Canyon Power Plant Operations Shift Log, Unit 1, April 19, 2006, Dayshift
Diablo Canyon Power Plant Operations Shift Log, Unit 1, September 22, 2005, Nightshift
Diablo Canyon Power Plant Operations Shift Log, Unit 1, June 6, 2006, Nightshift

Calculation

<u>NUMBER</u>	<u>ITEM</u>	<u>REVISION</u>
M-928	10 CFR Part 50, Appendix R Safe, Shutdown Analysis	1

Miscellaneous

Vendor Manual for Model 3600 V-5A Indicating Gauges
Inservice Testing Program Revision 9/6, PG&E Letter DCL-94-057, dated March 21, 1994

Testing of Diesel Generator Air Start and Fuel Oil Transfer Systems, PG&E letter DCL-92-236, dated October 26, 1992

Preventive Maintenance Optimization Diablo Canyon, Dated April 16, 2006, Integrated Equipment Reliability Strategy Background Information Document Switchyard, Revision 0

Instrumentation Obsolescence Management, I & C Long Term Strategy, Dated November 14, 2005

Quick Hit Self Assessment – Operability Determination Program, Dated June 1-30, 2005

PG&E 2006 Performance Improvement Program Audit, Dated June 21, 2006

Surveillance Procedure STP V-5C, “ECCS Hot Leg Check Valve Leak Test”

White Paper - Evaluate Possible Minor Water Hammer During p-CSP-A11,” A0607398 dated June 20, 2006

FSAR, Chapter 17, Revisions 15 and 16

Information Request 1
April 17, 2006
Diablo Canyon Problem Identification and Resolution Inspection
(IP 71152; Inspection Report 05000275/06-12; 05000323/06-12)

The inspection will cover the period of June 1, 2004 to May 31, 2006. All requested information should be limited to this period unless otherwise specified. The information may be provided in either electronic or paper media or a combination of these. Information provided in electronic media may be in the form of e-mail attachment(s), CDs, thumb drives, or 3 ½ inch floppy disks. The agency's text editing software is Corel WordPerfect 8, Presentations, and Quattro Pro; however, we have document viewing capability for MS Word, Excel, Power Point, and Adobe Acrobat (.pdf) text files.

Please provide the following information to Rick Deese by May 3, 2006:

Note: On summary lists please include a description of problem, status, initiating date, and owner organization.

1. Summary list of all action requests of significant conditions adverse to quality opened or closed during the period
2. Summary list of all action requests which were generated during the period
3. A list of all corrective action documents that subsume or "roll-up" one or more smaller issues for the period
4. Summary list of all action requests which were down-graded or up-graded in significance during the period
5. List of all root cause analyses completed during the period
6. List of root cause analyses planned, but not complete at end of the period
7. List of all apparent cause analyses completed during the period
8. List of plant safety issues raised or addressed by the employee concerns program during the period
9. List of action items generated or addressed by the plant safety review committees during the period
10. All quality assurance audits and surveillances of corrective action activities completed during the period
11. A list of all quality assurance audits and surveillances scheduled for completion during the period, but which were not completed

12. All corrective action activity reports, functional area self-assessments, and non-NRC third party assessments completed during the period
13. Corrective action performance trending/tracking information generated during the period and broken down by functional organization
14. Current revisions of corrective action program procedures
15. A listing of all external events evaluated for applicability at Diablo Canyon during the period
16. Action requests or other actions generated for each of the items below:
 - (1) Part 21 Reports:
 2004-02, -08, -10, -14, -15, -17, -21, -22, -24, -27
 2005-01, -05, -07, -12, -13, -16, -17, -20, -22, -26, -30, -33, -37, -38, -41
 2006-01, -03, -04, -05
 - (2) NRC Information Notices:
 2004-01, -05, -07, -08, -09, -10, -11, -12, -16, -19, -21
 2005-01, -02, -03, -04, -06, -08, -09, -11, -14, -16, -19, -20, -21, -23, -24, -25,
 -26, -29, -30, -31, -32
 2006-02, -03, -04, -05, -08
 - (3) All LERs issued by Diablo Canyon during the period
 - (4) NCVs and Violations issued to Diablo Canyon during the period (including licensee identified violations)
- (17) Safeguards event logs for the period
- (18) Radiation protection event logs
- (19) Current system health reports or similar information
- (20) Current predictive performance summary reports or similar information
- (21) Corrective action effectiveness review reports generated during the period
- (22) List of risk significant components and systems
- (23) List of actions done and/or in the Human Performance Improvement Plan referenced in the last PIR inspection

Information Request 2
May 18, 2006
Diablo Canyon Problem Identification and Resolution Inspection
(IP 71152; Inspection Report 05000275/06-12; 05000323/06-12)

Please provide the following Action Requests to Rick Deese by May 30, 2006:

A0528027	A0562776	A0573563	A0577113	A0601877	A0648182
A0540712	A0562778	A0573913	A0577117	A0620471	A0658028
A0557259	A0562785	A0573920	A0578216	A0620857	A0658496
A0560825	A0562791	A0573922	A0578228	A0629704	A0659407
A0562763	A0562793	A0573923	A0578447	A0631420	A0660739
A0562767	A0562794	A0574552	A0580008	A0633646	A0663705
A0562773	A0569355	A0576825	A0584097	A0634065	
A0562775	A0569841	A0576844	A0589785	A0637904	