



UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
REGION II  
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July 27, 2000

Carolina Power & Light Company  
ATTN: Mr. James Scarola  
Vice President - Harris Plant  
Shearon Harris Nuclear Power Plant  
P. O. Box 165, Mail Code: Zone 1  
New Hill, NC 27562-0165

SUBJECT: HARRIS - NRC INSPECTION REPORT 50-400/00-08

Dear Mr. Scarola:

On June 30, 2000, the Nuclear Regulatory Commission (NRC) completed an inspection at your Shearon Harris reactor facility. The enclosed report presents the results of that inspection which were discussed on June 30, 2000, with Ms. D. Alexander 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 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 the problem identification and resolution programs.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records (PARS) component of NRC's document system (ADAMS). ADAMS is accessible from the NRC Web site at <http://www.nrc.gov/NRC/ADAMS/index.html> (the Public Electronic Reading Room).

Sincerely,  
**/RA/**

Brian Bonser, Chief  
Reactor Projects Branch 4  
Division of Reactor Projects

Docket No.: 50-400  
License No.: NPF-63

Enclosure: (See page 2)

## Enclosure: Inspection Report

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U. S. NUCLEAR REGULATORY COMMISSION

REGION II

Docket No: 50-400  
License No: NPF-63

Report No: 50-400/2000-08

Licensee: Carolina Power & Light (CP&L)

Facility: Shearon Harris Nuclear Power Plant, Unit 1

Location: 5413 Shearon Harris Road  
New Hill, NC 27562

Dates: June 12- 30, 2000

Inspectors: R. Musser, Senior Resident Inspector, Surry (Lead)  
R. Hagar, Resident Inspector, Harris  
J. Lenahan, Senior Reactor Inspector

Approved by: B. Bonser, Chief  
Reactor Projects Branch 4  
Division of Reactor Projects

Enclosure

## SUMMARY OF FINDINGS

Shearon Harris Nuclear Power Plant, Unit 1  
NRC Inspection Report 50-400/00-08

### Adams Template

IR 05000400-00-08; on 06/12-06/30/2000; Shearon Harris Nuclear Power Plant; Annual baseline inspection of the Identification and Resolution of Problems. Corrective action program was acceptable with negative observations noted.

The inspection was conducted by resident inspectors and a regional reactor inspector. There were no findings identified. The significance of issues is indicated by their color (green, white, yellow, red) as determined by the Significance Determination Process (See Attachment).

### **Identification and Resolution of Problems:**

- Based on the results of the inspection, there were no findings identified. The implementation of the corrective action program was acceptable with negative observations noted. The licensee was effective at identifying problems and placing them into the corrective action program as evidenced by the inspectors review of external operating experience, Corrective Action Program Trend Reports, and items from system health reports. When conditions adverse to quality were identified, the licensee generally identified the appropriate causes and developed and implemented effective corrective actions. Based on several negative observations, additional attention and emphasis was needed on investigating conditions adverse to quality; developing effective corrective actions; documenting the investigation, the corrective actions, and the ongoing status of those actions; and completing and documenting effectiveness reviews. The inspectors determined that the licensee properly classified discrepant conditions, but did not use risk when classifying/assigning prioritization of these items. The licensee's self-assessments and audits were effective in identifying deficiencies in the corrective action program, and were similar to the problems identified by the inspectors during review of the program. Based on discussions conducted with plant employees from various departments, the inspectors determined that a reluctance to report safety concerns did not exist.

## Report Details

### 4. OTHER ACTIVITIES

#### 4OA2 Identification and Resolution of Problems

##### .1 Effectiveness of Problem Identification

###### a. Inspection Scope

The inspectors reviewed the NRC inspection reports for the past two years and discussed the licensee's performance of problem identification with the resident inspectors who independently observe problem identification and resolution on a routine basis.

The inspectors also reviewed the maintenance rule functional failure list, and the Technical Specification Limiting Condition for Operation entry list, to determine if deficiencies were being entered into the corrective action program. The inspectors also toured the plant with operators to determine if deficiencies existed that had not been entered into the corrective action program.

The inspectors reviewed the following sample of operating experience items to determine if they had been appropriately evaluated for applicability, and whether problems identified through these reviews were entered into the corrective action program:

<u>Number*</u>	<u>Title</u>
01495	Information Notice 98-28, "Development of Systematic Sample Plan for Operator Licensing Examinations"
03678	Nuclear Network Operating Experience 9598, "Loss of Essential Service Water Freeze Seal"
10011	Nuclear Network Operating Experience 10490, "Agastat Relay Internal Wiring Wrong"
10015	Westinghouse Nuclear Safety Advisory Letter 99-11, "Potential Wire Damage Barton Transmitters"
14766	Nuclear Network Operating Experience 10530, "Westinghouse Vacuum Circuit Breaker Problems"
15076/ 15116	Information Notice 99-34, "Potential Fire Hazard Testing of Filters"
15356	Significant Operating Experience Report 99-1, "Loss of Grid"

15977	Nuclear Network Operating Experience 10527, "Limitorque [Motor Operated Valve] Limit Switch Contact Tension Insufficient".
17662	Nuclear Network Operating Experience 10752, "Potential for Shutdown Plan to Violate Technical Specifications"
17921	Westinghouse Infogram on [Reactor Coolant System] Vacuum Fill
18483	Nuclear Network Operating Experience 10876, "Motor Insulation Degradation"
20108	Nuclear Network Operating Experience 11020, "Feedwater Heater Degradation due to Flow-Accelerated Corrosion"
none	Nuclear Network Operating Experience 10989, "Truck Operated Cell Switch Operator Failures in General Electric 4kv Switchgear"
none	USNRC Power Reactor Event Number 36992, "The Licensee Identified a Degraded Fire Barrier Between the 4160 C and D Vaults"
none	Westinghouse Nuclear Safety Advisory Letter 00-05, "[American Society of Mechanical Engineers] Code Compliance of Auxiliary Pump Motor Coolers"
none	USNRC Power Reactor Event Number 36744, "Reactor Manually Scrammed due to a Loss of 3 of 5 Recirculation Pumps"
none	World Operating Experience Number 00038, "Defective Swivel Eye Bolts"
none	Nuclear Network Operating Experience 10312, "Electric Chainfall Failure While Lifting a [Reactor Coolant Pump] Motor"
none	Power Reactor Event Number 37002, "Outboard Main Steam Isolation (MSIV) Valve Found Closed"
99-382	Westinghouse Technical Bulletin 99-05, "DB-50 Breaker Minimum Trip Force and seismic Enhancements"
99-225	Nuclear Network Operating Experience 9877, "Inadequate Implementation of the Troubleshooting Program"
99-001	Nuclear Network Operating Experience 9502, "Inadequate Test Methodology on Containment Isolation Valves"
99-082	Condition Report 99-00026, "Failure of WE-1728 to Permit Flow"
99-085	Condition Report 99-00207, "Oil Flinger Ring for the [Component Cooling Water] Pump Inboard Motor Bearing Installed Incorrectly Resulting in Bearing Failure"

99-179	Nuclear Network Operating Experience 9732, "Inadequate Vent Path Leads to Erroneous Level Indication During Pressurizer Draindown"
99-189	10CFR21 Notification, "Enterprise DSRV-4 Emergency Diesel Generator Connecting Rod Prestressed Fasteners"
99-206	Nuclear Network Operating Experience 9865, "Failure to Evaluate Reportability in a Timely Manner"
99-254	Condition Report 99-00888, "Post Maintenance Testing Requirements for Planned Maintenance Activities Modified Without Proper Authorization or Review by [Inservice Inspection] Program Coordinator"
99-319	Westinghouse Technical Bulletin 99-03, "Reactor Coolant Pump Thermal Barrier Cracking"

\* - The numbers in this column are the index numbers assigned to the items in the licensee's operating experience database. Where no number is listed, the item was not entered into that database, because the licensee determined that the item was not applicable to the plant.

The inspectors reviewed the following trend reports and compared the results against the corrective action program titles to determine if corrective action trends were being appropriately identified.

<u>DATE</u>	<u>TITLE</u>
5/1/00	Harris Nuclear Plant (HNP) CAP 1 <sup>st</sup> Quarter Trend Report
2/25/00	HNP CAP 4 <sup>th</sup> Quarter Trend Report
11/30/99	HNP CAP Quarterly Trend Report
6/11/99	HNP CAP Quarterly Trend Report

The inspectors reviewed quarterly System Health Reports for the 1<sup>st</sup> quarter 2000 and discussed their contents with system engineers to determine if problems identified in the health reports were entered into the corrective action program.

b. Issues and Findings

There were no findings identified.

External operating experience had been appropriately evaluated for applicability, and both external and internal operating experience had been effectively distributed to the plant staff. Problems identified through the review of external operating experience, CAP Trend Reports, and items from system health reports had been entered into the corrective action program.



.2 Prioritization and Effectiveness of Corrective Actions

a. Inspection Scope

The inspectors reviewed the following sample of corrective action documents to determine if the licensee found the appropriate causes, and, if appropriate, identified corrective action to prevent recurrence (including common cause and generic concerns). The corrective action documents selected were primarily associated with plant systems which have the highest risk significance, as determined by the plant-specific probabilistic risk assessment. These systems included high head safety injection/charging, residual heat removal, emergency diesel generator, emergency service water, electrical distribution, auxiliary feedwater, and normal feedwater systems. The inspectors also reviewed the corrective action documents to determine if they were being properly classified based on the licensee's definition of significance levels in procedure CAP-NGGC-0200, Rev 1, "Corrective Action Program." In addition, the inspectors reviewed these corrective action documents to determine whether the licensee considered risk significance for assigning prioritization of correction actions.

<u>Condition Report (CR)/Action Request (AR)</u>	<u>Description/Title</u>
02046	OWP Impact on Unavailability
03087	[Procedure] OWP-SW-002 Inconsistency 9901485
03330	[Procedure] EOP-PATH-2 Step 21
03385	Maintenance Rule - Timeliness
03472	[Main Control Board Manual/Auto Station] Controller Failure
10088	Reactor Manually Tripped due to Loss of Condensate Pump
10176	Plant Response to 12/14/99 Loss of Feed
18249	Insufficient Information in Safety Evaluation
19714	Unexpected Flow May Indicate Void in High Head Safety Injection Piping
9700631	[Turbine Driven Auxiliary Feedwater Flow Control Valve Cold Shutdown] Testing
9701588	[Procedure] OMP-3 [Auxiliary Feedwater] Requirements
9702588	Canopy Weld on [Feedwater] Check Valves
9703437	System 2060 High-Head Safety Injection Support - Train B [Performance Monitoring Group] Should be Moved to a(1) Status

9705010	[Solid State Protection System] Memories Test Anomaly
9803132	[Turbine-Driven Auxiliary Feedwater Pump] High Vibration
9803211	1CC-176 Failed [Surveillance Test] OST-1045
001220	Failure of BIT Outlet Valves - Training Scenario
001255	EOP Clarification - Overloading of EDG
001256	EOP Clarification - EDG Cooling
001340	EDG Differing Sump Oil Level Indication
001351	AFW Pump Discharge Pressure
001532	ESW Piping - Through Wall Leak
002506	ESW Breaker E-88 B Failure
003415	Penetration Protection Calculation
003520	ECCS Flow Balance Procedures
003719	Error in CCW Calculation CC-0020
003791	Inadequate Corrective Action
003867	Short Circuit Calculation Discrepancy
004170	Lack of Spare 480 Volt Breakers
008886	ESW Valve 1 SW-20 Exceeded Stroke Time
014914	C CSIP ESW Alignment
018677	Void in RHR Suction Piping When Placed in Service
019144	Discrepancy in 6.9 KV Emergency Bus Circuitry
019677	RHR Header Flow and RCP Operation
013972	NRC Identified Corrective Action Violations
013117	Incorrect Vendor Calibration
004103	EDBS Software Problems
8767/17950	EDG A & B Fuel Oil Day Tank Suspended Particulate Matter (High)
1207	EDG Day Tank Level
99-00532	Starting Air-Dew Point Concerns
9971	B EDG Functional Failure

3931	Repetitive Calibration Failures - Flow Switch HVAC EDG Building
2678	ESR/FSAR Mismatch involving DG FO Storage Tank
1386	Configuration Control Discrepancy w/EDG Air Dryer Skid Drawing

The inspectors reviewed the following corrective action documents associated with NCVs issued during the past two years to determine if the licensee had implemented appropriate corrective action.

<u>CR/AR Number</u>	<u>Description/Title</u>
1385	[Technical Specification Interpretation] 89-003 (98-01014)
1677	Spent Fuel Pool Water Level Not Maintained >23 feet above Stored Fuel Assemblies (99-00050)
2322	Failure to Calibrate CCW Inservice Testing Instrumentation 99-00716
2329	Failure to Comply with TS 3.3.2 (99-000735)
2631	Inadequate [Post-Maintenance Test Requirement] (99-00976)
2914	1CC-176 Failure During [Preventive Maintenance]
3065	Containment Spray Pump Start Failure Due to Failure to Follow Surveillance Procedure (99-01442)
3093	[Technical Specification] Violation 1CC-202 [Post-Maintenance Test Requirement]
3115	Inadequate Investigation (99-01440)
8315	Failure to Recognize That an (a)(1) Goal was Exceeded
18388	Inadequate Corrective Actions for Activities Rendering both Trains of CREFS Inoperable

b. Issues and Findings

There were no findings identified during this inspection. However, the inspectors compiled several negative observations related to the investigation and/or development of corrective actions for several ARs.

Although none of these observations indicated that violations of regulatory requirements occurred, taken together they indicated a need for the licensee to place additional attention and emphasis on investigating conditions adverse to quality; developing

effective corrective actions; documenting the investigation, the corrective actions, and the ongoing status of those actions; and completing and documenting effectiveness reviews.

When conditions adverse to quality were identified, the licensee entered those conditions into the corrective action program and generally identified the appropriate causes and developed and implemented effective corrective actions. The inspectors determined that the licensee properly classified discrepant conditions, but did not use risk when classifying/assigning prioritization of these items.

These ARs and the related observations are described below:

(1) AR Number: 3385

Conditions Adverse to Quality Identified in AR: (1) After Maintenance-Rule-related corrective actions were scheduled for a refueling outage, management removed those actions from the outage scope.  
(2) Maintenance Rule Expert Panel review of some failures was not timely.

Observation: No corrective actions addressed the management decision to remove Maintenance-Rule-related corrective actions from the refueling outage.

(2) AR Number: 18249

Conditions Adverse to Quality Identified in AR: Safety Evaluation 00-0354 was inadequate in that:  
(1) It did not adequately describe the activity being evaluated, and  
(2) It did not adequately explain how the subject activity was bounded by a referenced Safety Evaluation.

Observations: (1) The corrective action to describe the activity in more detail was not effective, and  
(2) No corrective actions were taken to explain how the subject activity was bounded by a referenced Safety Evaluation

(3) AR Number: 2914

Conditions Adverse to Quality Identified in AR: While completing an Operations surveillance procedure, the responsible individual noted indications that a containment-isolation valve had failed to close, but misinterpreted those indications and did not initiate appropriate corrective actions.

Observations: (1) The investigation did not address the individual's actions.  
(2) The AR package did not describe any corrective actions related to either the individual's misinterpretation or his decision to not initiate corrective actions.

(4) AR Number: 3093

Conditions Adverse to Quality Identified in AR: Following preventive maintenance on a containment isolation valve, the post-maintenance test that was being used to satisfy a Technical Specification (TS) surveillance requirement did not verify valve stroke times as required by the TS.

Observations: (1) Descriptions of the corrective actions were not detailed, but were only generally stated. Similarly, documentation of completed corrective actions did not specify the changes that were made. As a result, completion of effective corrective actions could not be readily verified.  
(2) The effectiveness review for this AR was waived based on the effectiveness review for CR 98-01014, but the referenced effectiveness review did not bound several of the corrective actions associated with the subject AR.

(5) AR Number: 3115

Conditions Adverse to Quality Identified in AR: The investigation documented in CR 98-03211 was inadequate.

Observations: (1) The AR package did not describe several of the important inadequacies in the referenced CR.  
(2) The adverse condition addressed in the investigation ("why previous investigations and supervisory reviews failed to fully probe the issues associated with [containment isolation valve] 1CC-176") was different from the adverse condition documented in the AR.  
(3) No specific corrective actions were identified; instead, the AR package describes CAP programmatic improvements being made or planned.  
(4) The referenced CAP changes do not adequately address the inadequacies in the subject investigation.

(6) AR Number: 8767 / 17950

Conditions Adverse to Quality Identified in AR: Particulate matter was discovered downstream of the Emergency Diesel Generator fuel-oil filters

Observation: One of the planned corrective actions (change the frequency of preventive-maintenance on the filter from conditional to every 18 months) was inconsistent with previous practice, in that the frequency of preventive maintenance had been at 18 months when the condition was discovered.

(7) AR Number: 1256

Conditions Adverse to Quality Identified in AR: In certain accident scenarios, the Emergency Diesel Generator (EDG) could become overheated.

Observations: The licensee determined that an appropriate corrective action to address this condition was to add a precaution to the appropriate Emergency Operating Procedure, to ensure that Emergency Service Water (ESW) is aligned to the EDG prior to starting the EDG. The licensee identified this condition in 10/97, and has not yet completed any related corrective action. The licensee's delay in addressing this issue is based in part on an understanding that the EDG could be run unloaded for an indefinite period without ESW being aligned. However, the basis for that understanding is not documented.

In addition, the inspectors found that for two ARs (10176 and 19714), the licensee had developed and implemented corrective actions, but had not updated the corrective action program database to describe the nature and status of those actions. In another case (AR 2914), the database includes a recommended corrective action that the licensee decided not to implement, but the licensee did not update the database to explain why completing that action was not necessary. The inspectors also found that for most ARs, AR-related records include no indications that effectiveness reviews had been conducted.

### .3 Effectiveness of Licensee Audits and Self Assessments

#### a. Inspection Scope

The inspectors reviewed the following licensee audits and self assessments (focusing on problem identification and resolution) to determine whether they were consistent with NRC findings, whether the assessments were performed in accordance with the licensee's commitments to NRC, to determine if assessment findings were entered into the licensee's corrective action program, and to determine if corrective actions were completed to resolve identified program deficiencies.

<u>Date</u>	<u>Title</u>
8/27/99	CAP-99-001, CAP Trending
9/30/99	CHEM-99-003, Self Assessment and Corrective Action
3/29/99	DOC-99-001, POM Procedure 2 year Review
9/30/99	DOC-99-003, Document Control Program
4/14/99	ENG-99-008, EGR-NGGC-0011 Review
4/09/99	ENG-R-99-001, Maintenance Rule (a)(3) Periodic Review
6/07/99	CHEM-99-001, Radioactive Effluent Control
11/30/99	NAS-99-002, Effectiveness of Corrective Actions
11/30/99	QC-99-04, QC Monthly Trending Report
11/30/99	SEC-99-013, CAP Program
7/14/99	TRN-O-99-007, 1999 ASER Corrective Action Status
4/15/00	OPS-00-001, Corrective Action
6/20/00	REG-00-007, Passport Use in the HNP Corrective Action Program
9/9/99	H-CA-99-01, NAS Report, HNP Corrective Action Program
11/16/99	99-SW-H, Performance Evaluation Support Assessment Report

b. Issues and Findings

There were no findings identified.

The licensee's self assessments and audits were effective in identifying deficiencies in the corrective action program. Deficiencies in implementation of the corrective action program were noted in the following areas: documentation, employee training, quality of investigations, and assessment of the effectiveness of corrective actions. These were similar to the problems identified by the inspectors during review of the ARs/CRs discussed in paragraph .2 above.

.4 Assessment of Safety Conscious Work Environment

a. Inspection Scope

The inspectors queried licensee employees to determine whether any conditions exist that would cause employees to be reluctant to raise safety concerns. The inspectors also reviewed the licensee's employee concerns program which provides an alternate method to the corrective action program for employees to raise safety concerns and remain anonymous. The inspectors reviewed Employee Concern Resolution Reports to determine if concerns were being properly reviewed and identified deficiencies were being resolved in accordance with the licensee's corrective action program.

b. Issues and Findings

There were no findings identified.

Licensee management emphasizes the need for all employees to identify and report nonconforming conditions using the appropriate methods established within their administrative programs. Methods available include deficiency log entries, work requests, condition reports, and the employee concerns program. These methods are readily accessible to all employees. Since August, 1999, approximately 65 percent of the site employees have reported a nonconforming condition by generating at least one condition report. Based on discussions conducted with plant employees from various departments, the inspectors determined that a reluctance to report safety concerns did not exist.

4OA6 Management Meetings

.1 Exit Meeting Summary

The inspectors presented the inspection results to Ms. Donna Alexander, Regulatory Affairs Manager, and other members of licensee management at the conclusion of the inspection on June 30. 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

D. Alexander, Regulatory Affairs Manager  
B. Altman, Major Projects Manager  
C. Burton, Site Operations Director  
R. Duncan, Harris Plant General Manager  
R. Field, Nuclear Assessment Manager  
T. Hobbs, Operations Manager  
J. Holt, Outage and Scheduling Manager  
G. Kline, Harris Engineering Support Services Manager  
T. Natale, Training Manager  
K. Neushaeffer, Plant Support Services Manager  
J. Scarola, Harris Plant Vice President  
T. Tonkinson, Self Evaluation Unit Supervisor  
B. Waldrep, Maintenance Manager  
E. Wills, Environmental & Radiation Control Manager

NRC

J. Brady, Senior Resident Inspector, Harris  
B. Bonser, Chief, Reactor Projects Branch 4  
V. McCree, Deputy Director, Division of Reactor Projects

**ITEMS OPENED, CLOSED AND DISCUSSED**

None.

**LIST OF ACRONYMS USED**

AFW	Auxiliary Feedwater
AR	Action Request
CAP	Corrective Action Program
CCW	Component Cooling Water
CFR	Code of Federal Regulations
CR	Condition Report
CREFS	Control Room Emergency Filtration System
CSIP	Charging/Safety Injection Pump
DG	Diesel Generator
ECCS	Emergency Core Cooling System
EDBS	Equipment Data Base System
EDG	Emergency Diesel Generator
EOP	Emergency Operating Procedure
ESR	Engineering Service Request
ESW	Emergency Service Water
FSAR	Final Safety Analysis Report
HNP	Harris Nuclear Plant
NRC	Nuclear Regulatory Commission
OMP	Outage Management Procedure
OWP	Operations Work Procedure
OST	Operations Surveillance Test
RHR	Residual Heat Removal
SDP	Significance Determination Process
TS	Technical Specifications

## 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

- Initiating Events
- Mitigating Systems
- Barrier Integrity
- Emergency Preparedness

### Radiation Safety

- Occupational
- Public

### Safeguards

- 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>.