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

August 22, 2000

Charles M. Dugger, Vice President
Operations - Waterford 3
Entergy Operations, Inc.
17265 River Road
Killona, Louisiana 70066-0751

SUBJECT: WATERFORD, UNIT 3 - NRC INSPECTION REPORT NO. 50-382/00-06

Dear Mr. Dugger:

On June 30, 2000, the NRC completed an inspection at your Waterford Steam Electric Station, Unit 3, facility. The enclosed report presents the results of that inspection. The preliminary results of the inspection were discussed on June 29, 2000, with Mr. Early Ewing, General Manager Plant Operations, and members of your staff. A telephonic exit meeting was conducted on July 12, 2000, with Mr. Ewing to inform your staff of the results of the in-office review following the team's departure from the site.

This 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 involved selected examination of procedures and representative records, observations of activities, and interviews with personnel. There were no findings identified during this inspection. On the basis of the sample selected for review, the team concluded problems were, in general, 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).

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

Sincerely,

**/RA/**

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

Docket No.: 50-382
License No.: NPF-38

Enclosure:
NRC Inspection Report No.
50-382/00-06

cc w/enclosure:
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Senior Project Engineer, DRP/E **(GAP)**
Branch Chief, DRP/TSS **(LAY)**
RITS Coordinator **(NBH)**
D. Lange **(DJL)**
NRR Event Tracking System **(IPAS)**
WAT Site Secretary **(AHY)**

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**ENCLOSURE**

U.S. NUCLEAR REGULATORY COMMISSION
REGION IV

| | |
|---|---|
| Docket No.: | 50-382 |
| License No.: | NPF-38 |
| Report No.: | 50-382/00-06 |
| Licensee: | Entergy Operations, Inc. |
| Facility: | Waterford Steam Electric Station, Unit 3 |
| Location: | Hwy. 18<br>Killona, Louisiana |
| Dates: | June 26 to 30, 2000 |
| Inspectors: | Gary W. Johnston, Senior Operations Engineer<br>Operations Branch |
| | Thomas O. McKernon, Senior Operations Engineer<br>Operations Branch |
| | Ryan E. Lantz, Operations Engineer<br>Operations Branch |
| | Jack M. Keeton, Resident Inspector<br>Project Branch E |
| Accompanying Personnel: | Richard W. Deese, Reactor Engineer<br>Engineering Maintenance Branch |
| Approved By: | John L. Pellet, Chief<br>Operations Branch<br>Division of Reactor Safety |

ATTACHMENTS:

Attachment 1: Supplemental Information

Attachment 2: Material Requested

Attachment 3: NRC's Revised Reactor Oversight Process

## Summary of Findings

IR 05000382-00-06; on 06/26-30/2000; Entergy Operations, Inc.; Waterford Steam Electric Station, Unit 3, Annual Baseline Inspection of the Identification and Resolution of Problems.

The inspection was conducted by three regional operations engineers, one resident inspector and a regional engineering inspector. The significance of issues is indicated by their color (green, white, yellow, red) and was determined by the Significance Determination Process.

Identification and Resolution of Problems

- The team concluded that the licensee was effective in the identification, resolution, and prevention of problems. However, the team observed that the licensee's monitoring of equipment deficiencies involving degraded, but operable, components and systems, did not track the corrective actions to completion until recently. Further, the condition review group had not consistently considered the need to address degraded, but operable, conditions of safety-related equipment in prioritizing actions. The licensee identified 57 open condition reports that were not identified in the condition report system as involving degraded, but operable equipment. The team reviewed 5 of these open condition reports and found prioritization of the sample was appropriate and that the licensee had determined that the due dates for completion of corrective actions were responsive. Corrective actions, when specified, were implemented in a timely manner. Licensee audits and assessments were effective in identifying areas of improvement and underlying programmatic problems. Based on the interviews conducted during this inspection, workers at the site felt free to initiate condition reports for safety issues in the licensee's identification and resolution of problems program. The team noted that site personnel clearly understood the importance of this program.

## Report Details

Summary of Plant Status: The plant operated at 100 percent power throughout the inspection period.

## 4 OTHER ACTIVITIES

### 4OA2 Identification and Resolution of Problems

a. Inspection Scope

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

The team selected several items based upon their risk importance, a review of the licensee's documented system status, the requirements of NRC Inspection Procedure 71152, and past NRC inspection findings. These selected items included: (1) personnel communication issues, (2) operating events assessments, (3) human performance issues, (4) generic communication responses, (5) self-assessments, (6) feedwater isolation valve actuator issues, and (7) component cooling water system. The team also reviewed repetitive issues related to: exceeding reactor coolant system cooldown rates; dosimetry issues involving controlled area access; emergency action level classifications; and Mode changes with inoperable equipment.

The team reviewed the selected items' associated corrective action documentation against the eight attributes to assess the licensee's program for identifying and resolving conditions adverse to quality. The selected items were also examined to determine whether there were instances of an increase in risk significance with other systems or components in the corrective action backlog.

The team interviewed 3 managers, 5 supervisors, 10 engineers, 2 operators, and 2 maintenance craft personnel with respect to safety conscious work environment.

b. Issues and Findings

All personnel interviewed indicated no concerns with identifying safety issues and were satisfied with the employee concerns program for processing safety issues. In addition, none of the interviewees noted any reluctance of other personnel to identify any safety issues.

Complete and Accurate Identification of the Problem in a Timely Manner

The team observed that problem identification for the overall sample of items reviewed was timely and accurate. The team identified one instance when an issue was apparent that a condition report was not submitted in a timely manner. For the balance of the condition reports reviewed, the team found the timeliness of the condition reports to be appropriate.

The team observed that Section 5.8.2.1 of Procedure OEEP-103, "Operating Experience Review," required that a operating experience program effectiveness review be conducted each 18 months. Licensee representatives explained that due to pending changes in the site program to adopt a corporate procedure for operating experience reviews, as well as management changes occurring in the second and third quarter of 1999, the 18-month review was not conducted. Delays in adoption of the new corporate procedure continued during the duration of the inspection. The effectiveness review was not derived from a requirement by Appendix B of 10 CFR Part 50 or the facility technical specifications, as such, the failure to implement it did not constitute a violation of NRC requirements. The licensee did not identify the condition in its identification and resolution of problems program until the issue was raised by the team during this inspection. The licensee wrote Condition Report CR-WF3-2000-0724, "Failure to Perform OE Effectiveness Review," June 29, 2000, to document this issue.

The team reviewed Condition Reports CR-WF3-2000-0282, CR-WF3-2000-0400, and CR-WF3-2000-0523 associated with repeated occasions of chlorine loop Monitors HVCIA5400A/B not being operable. The monitors failed response tests due to being out of calibration tolerance low. While not all the monitor failures were due to instrument drift, the appropriateness of the practice of testing both monitors on the same day was not considered until subsequent surveillance test failures. The failure to consider the implications of not following a staggered test schedule in doing the surveillances tests presented a vulnerability to having had both trains inoperable at the same time. This would have meant, in the case of instrument drift, that both trains experiencing similar drift characteristics could have gone inoperable at roughly the same time. As such, not considering the implications of multiple train failures did not demonstrate complete and accurate identification of a problem.

The team observed from the detailed review of 54 condition reports and a survey of operational experience reviews, root cause analyses, assessments, and other documents, the issues were reported to the condition reporting system in a timely manner. The condition reports were uniformly generated on the day of the occurrence or when the condition was determined to be reportable.

No findings were identified.

Proper Evaluation and Disposition of Operability and Reportability Issues

Overall, the team found that evaluation and disposition of reportable issues was accomplished consistently when required. Evaluation and disposition of operability issues were also accomplished consistently when required, with an exception noted below.

The licensee's staff issued Condition Report CR-WF3-2000-0344, which identified that there were 57 condition reports where degraded, but operable equipment considerations were not identified by the setting of a software flag in the paperless condition reporting system. This presented a vulnerability, where a population of condition reports involving equipment or systems determined to be operable, but with degraded conditions had not been tracked to completion ensuring that corrective actions were timely. The licensee, dispositioned these condition reports by conducting reviews of each condition report to determine if changes to corrective action due dates or the classification of the condition report had to be reconsidered.

The condition review group review determined that all condition reports involving these issues did not need reclassification or changes to the corrective action due date. To validate that conclusion, the team reviewed a sample of 5 condition reports from this set and concluded all met the current regulatory guidance. The sample included the following condition reports: CR-WF3-1998-1151, CR-WF3-1996-1528, CR-WF3-1999-0204, CR-WF3-1998-0212, and CR-WF3-1997-1333. The condition review group determined that corrective actions would be completed by the next refueling outage (RF-10 in October 2000), and if not, written justification would be required for an extension of the due date of any corrective action for all 57 condition reports. That requirement was inserted into the corrective action section of the affected condition reports.

No findings were identified.

Consideration of Extent of the Condition (generic implications, etc.)

The extent of conditions and common cause areas were adequately evaluated and addressed. The team noted a licensee-identified example where generic implications and common cause circumstances were not captured in the licensee's initial attempt to resolve the problem.

The team reviewed Condition Reports CR-WF3-1999-1210, CR-WF3-1999-1211, CR-WF3-1999-1259, CR-WF3-1999-1263, and CR-WF3-1994-0983, noting that common cause and generic issues were evident. The condition reports involved deficiencies with reach rods to valves and position indicators on the pedestal of valves. The team’s review of these condition reports and supporting materials indicated that the licensee’s initial review of the extent of reach rod problems was not comprehensive and coordinated, such that all deficient valves and conditions were identified. For example, previously identified problems with Valve CS-111B, in which the reach rod failed and the valve was inoperable, were reported in Licensee Event Report 85-055-01.

Subsequently, Valve CS-117A became disabled, when a roll pin connecting a valve gallery handwheel to the valve stem backed out. The licensee's corrective actions at that time only involved Valves CS-117A and B. Consequently, other valves and the generic implications were not appropriately addressed. Additionally, subsequent to the most recent finding associated with Valve SI-417B, the licensee's walkdown efforts did not identify all affected safety-related valves. Subsequent walkdowns by plant mechanical maintenance identified that Valve SI-410B had a significant roll pin deficiency. While no significant safety findings, such as inoperable valves, were identified with the subsequent corrective actions, the team noted an inadequate coordination between different organizations (Operations, Engineering, and Maintenance) contributed to difficulties in identifying the extent of the problem and generic implications.

The team observed that a backlog of approximately 40 operating experience evaluations was awaiting disposition, and that they were being addressed on a plant priority basis. Interviews with one of the two operating experience engineers indicated that the backlog had been worked down from approximately 120 over the past year.

No findings were identified.

Classification and Prioritization of the Resolution of the Problem

The team observed from the review of 54 condition reports that the condition review group was appropriately classifying and prioritizing condition reports. When there was a change in the condition or the nature of the concern had changed, the condition review group reconsidered the classification or prioritization. One example was where the condition review group had upgraded the classification of Condition Report CR-WF3-1998-0476, involving the loss of temperature control for Essential Chiller A, when it was determined that a causal factors analysis was necessary.

No findings were identified.

Identification of Root and Contributing Causes

From the review of the root cause analyses, the team determined that root cause analysis and determinations were thorough and identified adequate corrective actions. The team did not find any analysis that did not consider the most probable cause. Contributing causes were consistently considered in the analyses. On occasion, the analysis made an indeterminate cause finding, which was appropriate, when information necessary to determine a cause was incomplete or unavailable to derive an actual cause.

The team noted only one minor exception. Condition Report CR-WF3-1999-1022 did not address in the root cause analysis the potential knowledge deficiencies of the crew concerning operability of containment spray and safety injection tanks when going to

Mode 4 at 392°F and 400 psig respectively. This was addressed in NRC Inspection Report 50-382/99-23 as a noncited violation (50-382/9923-01). The crew was removed from shift for one day and developed a communication plan, but no evaluation of potential training deficiencies was documented. The inspectors considered this a minor example of incomplete corrective actions

No findings were identified.

Identification of Corrective Actions

The licensee's identification of corrective actions was effective based upon the sample of condition reports reviewed by the team. However, the team expended a substantial portion of the inspection time onsite in determining the basis for closure of condition reports. This was because of insufficient wording or lack of sufficient information in the condition reports to enable a reviewer to determine adequacy of closure of the corrective actions. In order to evaluate closure decisions, reviewers either had to retrieve the hard copy package (record), or to interview the staff who could provide working documents to establish the basis for closure.

No findings were identified.

Accurate Accounting for Equipment Unavailability

The team observed that system engineers were tracking the unavailability time for the maintenance rule, along with the functional failures. This was accomplished by each system engineer gathering unavailability time from condition reports and logs. The current system for gathering time and functional failures was observed to be systematic. Performance indicator information was also being tracked and unavailability time was independently monitored by a dedicated engineer.

No findings were identified.

## 4OA6 Meetings

a. Exit Meeting Summary

The team presented the preliminary inspection results to Mr. Charles Dugger, Vice President Operations - Waterford 3, and other members of licensee management at the conclusion of the onsite inspection on June 29, 2000. The licensee's management acknowledged the findings presented.

A telephonic exit meeting was held on July 12, 2000, with Mr. Early Ewing, General Manager Plant Operations, and other licensee staff members, during which the team leader characterized the results of the in-office review following the team's departure from the site.

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

ATTACHMENT 1

PARTIAL LIST OF PERSONS CONTACTED

Licensee

M. Brandon, Licensing Manager
C. Dugger, Vice President, Operations
E. Ewing, General Manager, Plant Operations
C. Fugate, Manager, Equipment Reliability
J. Holman, Supervisor, Events Assessments
R. Peters, Manager, Corrective Actions and Assessments
E. Perkins, Director, Nuclear Safety Assurance
O. Pipkins, Senior Licensing Engineer
R. Putnam, Engineering Supervisor
P. Gropp, Director, Engineering

NRC

T. Farnholtz, Senior Resident Inspector
J. Pellet, Chief, Operations Branch

**PARTIAL LIST OF DOCUMENTS REVIEWED**

PROCEDURES

CE-003-514, Liquid Radioactive Waste Release Permit (Computer), Revision 2, November 4, 1999

W1.106, Excellence in Human Performance, Revision 1, February 23, 1999

OEEP-103, Operating Experience Review, Revision 2,

LI-102, Corrective Action Process, Revision 0, March 23, 2000

LI-104, Assessment Process, Revision 0, May 17, 2000

NTP-202, Fire Protection Training, Revision 9

OI-0002-000, Annunciator, Control Room Instrumentation and Workarounds Status Control, Revision 1

CONDITION REPORTS

| | | |
|---|---|---|
| CR-WF3-1996-1528 | MOV Fastener Applications | October 1, 1996 |
| CR-WF3-1996-1857 | Noncompliance with TS 3.3.3.6 for Containment Isolation Valve Position Indication | November 24, 1996 |
| CR-WF3-1997-1333 | Transfer Tube Gate Valve | May 27, 1997 |
| CR-WF3-1998-0212 | Diaphragm Valve Diaphragm Replacement Interval | February 11, 1998 |
| CR-WF3-1998-0337 | Feedwater Isolation Valve Closure Time Calculation Discrepancies | March 6, 1998 |
| CR-WF3-1998-0476 | Essential Chiller a Loss of Temperature Control | April 2,1998 |
| CR-WF3-1998-1151 | CC-620 Opened When it Should Have Remained Closed | August 1, 1998 |
| CR-WF3-1999-0155 | RCA Entry Without a TLD | February 16, 1999 |
| CR-WF3-1999-0202 | CAA Entry Without a TLD | February 25, 1999 |
| CR-WF3-1999-0204 | Inconel Nozzle Fitting Leakage | February 25, 1999 |
| CR-WF3-1999-0399 | Diesel Generator B Exhaust Fan Not Seismically Restrained During Replacement | March 19,1999 |
| CR-WF3-1999-0542 | Inadequate Sprinkler System Flow and Pressure | April 29, 1999 |
| CR-WF3-1999-0728 | Misplaced Dosimetry Problems | July 1, 1999 |
| CR-WF3-1999-0763 | PDP Cover Installation Causing Breaker Trips, | July 15, 1999 |
| CR-WF3-1999-0789 | Inadequate Pumping Capacity in the Dry Cooling Tower Areas | July 26,1999 |
| CR-WF3-1999-0790 | Appendix R Separation Criteria Noncompliance | July 27, 1999 |
| CR-WF3-1999-0828 | Cooldown Exceeded Maximum Allowed Rate | August 7, 1999 |
| CR-WF3-1999-0830 | Ph Sampling Time for Release | August 8, 1999 |
| CR-WF3-1999-0844 | Failure to Perform Technical Specification Surveillance Tests on a Penetration Overcurrent Protection Device | August 11, 1999 |
| CR-WF3-1999-0847 | Hot Spot Documentation Discrepancies | August 12, 1999 |
| CR-WF3-1999-0907 | Fire Brigade Qualification Verification | September 2, 1999 |
| CR-WF3-1999-0920 | Main Control Board Switch Knob Failures | September 8, 1999 |

| | | |
|---|---|---|
| CR-WF3-1999-0931 | TS 3.4.8.1 Cooldown Rate Exceeded During SDC | September 13, 1999 |
| CR-WF3-1999-0949 | Fire Hose Impairment of Dct2 Float Switch | September 15, 1999 |
| CR-WF3-1999-0963 | TS 3.4.8.1 Cooldown Rate Exceeded During RCS Fill and Vent | September 17, 1999 |
| CR-WF3-1999-0994 | TS 3.4.8.1 Cooldown Rate Exceeded During Startup | September 21, 1999 |
| CR-WF3-1999-1022 | Mode Change with Containment Spray Inoperable | September 27, 1999 |
| CR-WF3-1999-1022 | Technical Specification Non-compliance While Raising Reactor Coolant System Pressure | September 27,1999 |
| CR-WF3-1999-1030 | Undocumented Missed Training for Fire Brigade Personnel | September 29, 1999 |
| CR-WF3-1999-1055 | Failure to Meet Licensing Basis for Four Sprinkler Systems | October 6, 1999 |
| CR-WF3-1999-1074 | Sprinkler System Fpm 16 Unable to Supply the Required Design Basis Density | October 12, 1999 |
| CR-WF3-1999-1087 | Unusual Event Not Declared IAW Exercise Package | October 14, 2009 |
| CR-WF3-1999-1210 | Diversion of RCS Inventory When Placing Shutdown Cooling in Service | November 27, 1999 |
| CR-WF3-1999-1230 | Alert Declaration Evaluation | November 30, 1999 |
| CR-WF3-1999-1235 | Exceeding Alert Classification Time | December 2, 1999 |
| CR-WF3-1999-1254 | Late Freeze Protection Shelter Inspections | December 8, 1999 |
| CR-WF3-2000-0082 | Essential Chiller a Trip on High Compressor Motor Temperature | January 29, 2000 |
| CR-WF3-2000-0083 | Essential Chiller a Trip on High Compressor Motor Temperature | January 30, 2000 |
| CR-WF3-2000-0191 | Steam Generator Snubber Calculations | March 3, 2000 |
| CR-WF3-2000-0192 | Inoperable Steam Generator Snubbers | March 3, 2000 |
| CR-WF3-2000-0199 | Cracked Weld Which Renders the Charging System Inoperable | March 6, 2000 |
| CR-WF3-2000-0227 | Dry Cooling Tower Sump Pumps Disabled | March 16, 2000 |

| | | |
|---|---|---|
| CR-WF3-2000-0249 | Feedwater Isolation Valve Actuator Closure Times Too Fast | March 21, 2000 |
| CR-WF3-2000-0344 | Generic Letter 91-18 Implementation | April 12, 2000 |
| CR-WF3-2000-0372 | CRS with Ineffective Corrective Actions | April 18, 2000 |
| CR-WF3-2000-0373 | Adverse Trend Human Performance Errors | April 18, 2000 |
| CR-WF3-2000-0380 | Component Outage Delays | April 19, 2000 |
| CR-WF3-2000-0418 | Cw Evacuation Pump Strainer Missing | May 5, 2000 |
| CR-WF3-2000-0483 | Piping Fittings on EFW-224b | May 16, 2000 |
| CR-WF3-2000-0567 | EDG B1 Receiver Drain Valve Open out of Position | June 4, 2000 |
| CR-WF3-2000-0579 | CC-620 Opened When it Should Have Remained Closed | June 7, 2000 |
| CR-WF3-2000-0724 | Failure to Perform OE Effectiveness Review | June 29, 2000 |

Operational Experience Reviews

ITR 99-013: Part 21 - Inappropriate Low Signal Application of Agastat E7000 Series Timing Relay

ITR 99-005: Part 21 - Notification Related to Minimum Critical Power Ratio

ITR 99-011: Part 21 - Potential Manufacturing Deviation in Fuel Assembly Guide Tube Wear Sleeves

ITR 99-021: Part 21 - Potential Defect in Enterprise Diesel Generator System

ITR 99-06: Part 21 - Potential Stress Corrosion Cracking in Service Water Pumps

ITR 99-53: Part 21- Eaton Cutler-hammer Circuit Breakers

ITR 99-032: Part 21 - Defective Oscillation Power Range Monitors

ITR 99-031: Part 21 - Abb 4kv Circuit Breakers

ITR 99-02: Part 21 - Rosemount Model-1153b Alphaline Nuclear Pressure Transmitter

NRC Information Notice 99-13: Insights from NRC Inspections of Low and Medium Voltage Circuit Breaker Maintenance Programs

NRC Information Notice 99-004: Unplanned Radiation Exposures to Radiographers, Resulting from Failures to Follow Proper Radiation Safety Procedures

NRC Information Notice 99-011: Incidents Involving the Use of Radioactive Iodine

Licensee Event Reports

97-019: “Noncompliance with TS 3.3.3.6 for Containment Isolation Valve Position Indication”

99-009: “An Appendix R Non-compliance Condition Involving Inadequate Separation of Safe Shutdown Cables”

99-016: “An Appendix R Non-compliance Outside Design Basis Condition Involving an Inoperable Sprinkler System”

99-017: “Failure to Perform Technical Specification Surveillance Tests on a Penetration Overcurrent Protection Device”

00-002: “Technical Specification Violations Due to Plant Mode Changes with Inoperable Steam Generator Snubbers”

00-003: “Shutdown per TS LCO 3.0.3 Due to Cracked Weld Which Rendered the Charging System Inoperable”

Engineering Requests

| | | |
|---|---|---|
| Er-w3-99-0623-00-00 | Revision to Fire Sprinkler System Specifications | June 25, 1999 |
| Er-w3-99-0815-00-00 | Fire Area Rab 30, Appendix R Compliance | August 18, 1999 |
| Er-w3-99-0999-00-00 | Sprinkler System Fpm4b and Fpm16 Pipe Changes | October 14, 1999 |

Calculations

ER-M00-006, "Closure Time Analysis for Main Feedwater Isolation Valves FW-184 A & B," Revision A

Root Cause Analyses

Root Cause Analysis Report for Essential Chiller a Loss of Temperature Control, August 4, 1998

Root Cause Determination for Inadequate Pumping Capacity in the Dry Cooling Tower Areas, August 25, 1999

Failure Analysis of Microswitch Knob, by H.S. Silvus, Jr., Manager, Component-analysis Laboratory for Entergy Operations, Inc., Waterford 3, Killona, La, December 9, 1999

Root Cause Analysis Report for Technical Specification Non-compliance While Raising Reactor Coolant System Pressure, October 7, 1999

Root Cause Analysis Report for Diversion of RCS Inventory When Placing Shutdown Cooling in Service, December 13, 1999

Assessments and Audits

1999 Biennial Exercise Participant Critique Notes, October 18, 1999

SA-99-004.1 Quality Assurance Audit Report Corrective Action/nonconformance, May 25, 1999

Assessment Activities Plan for 2000, January 17, 2000

Repetitive Task Self Assessment, Revision 2, May 9, 2000

Miscellaneous

Workarounds - Outage Related, June 6, 2000

Memorandum to File, NRC Generic Letter 98-02 Response, November 19, 1998

Generic Letter Response, Generic Letter 99-02, November 23, 1999

ATTACHMENT 2

Material Requested for the 71152 Inspection

- All procedures governing or applying to the corrective action program, including the processing of information regarding generic communications and industry operating experiences.

- Procedures and descriptions of any informal systems, especially used by operations, for issues below the threshold of the formal corrective action program.

- Index of all corrective action documents (e.g., condition reports) from June 1999 to June 2000.

- All major corrective action documents (i.e., those that subsume or roll-up one or more smaller issues) since June 1999.

- All corrective action documents associated with non-escalated no response required or noncited violations since June 1999.

- All corrective action program reports or metrics (since June 1999) used for tracking effectiveness of the corrective action program.

- All risk analysis performed for currently open significant conditions adverse to quality (including open design modifications).

- All corrective action documents associated with:

  (1) Repetitive problems or issues
  (2) Human performance issues
  (3) Operator workarounds
  (4) Occupational exposure
  (5) Emergency preparedness

- All corrective action documents associated with green findings of NRC inspection reports since June 1999.

- All corrective action documents related to the following industry operating experience generic communications:

| Part 21 Reports: | NRC Generic Letters | NRC Information Notices: |
|---|---|---|
| 99-02 | | |
| 99-05 | 98-002 | |
| 99-06 | 98-004 | 99-004 |
| 99-07 | 99-002 | 99-010 |
| 99-12 | | 99-011 |
| 99-22 | | 99-013 |
| 99-23 | | 99-014 |
| 99-33 | | 99-021 |
| 99-34 | | 00-003 |
| 99-51 | | 00-006 |

Supplemental Material Requested for the 71152 Inspection

Condition Reports

| | | |
|---|---|---|
| CR-WF3-1999-0794 | CR-WF3-2000-0192 | CR-WF3-1999-1030 |
| CR-WF3-1999-1030 | CR-WF3-1999-0810 | CR-WF3-1999-1107 |
| CR-WF3-1999-1077 | CR-WF3-1999-0830 | CR-WF3-1999-1183 |
| CR-WF3-1999-1243 | CR-WF3-1999-0857 | CR-WF3-1999-1204 |
| CR-WF3-1999-0674 | CR-WF3-1999-0896 | CR-WF3-2000-0027 |
| CR-WF3-1999-1087 | CR-WF3-1999-0903 | CR-WF3-2000-0038 |
| CR-WF3-1999-1230 | CR-WF3-1999-0907 | CR-WF3-2000-0059 |
| CR-WF3-1999-1235 | CR-WF3-1999-0870 | CR-WF3-2000-0061 |
| CR-WF3-1999-0722 | CR-WF3-1999-1022 | CR-WF3-2000-0191 |
| CR-WF3-1999-0789 | CR-WF3-2000-0338 | CR-WF3-2000-0257 |
| CR-WF3-1999-0828 | CR-WF3-2000-0418 | CR-WF3-2000-0262 |
| CR-WF3-1999-1022 | CR-WF3-2000-0567 | CR-WF3-2000-0286 |
| CR-WF3-1999-0907 | CR-WF3-2000-0373 | CR-WF3-2000-0293 |
| CR-WF3-1999-1210 | CR-WF3-2000-0372 | CR-WF3-2000-0227 |
| CR-WF3-1999-1254 | CR-WF3-2000-0329 | CR-WF3-2000-0236 |
| CR-WF3-1999-0747 | CR-WF3-2000-0236 | CR-WF3-2000-0319 |
| CR-WF3-1999-0763 | CR-WF3-2000-0562 | |

ATTACHMENT 3

## NRC's REVISED REACTOR OVERSIGHT PROCESS

The federal Nuclear Regulatory Commission (NRC) recently revamped its inspection, assessment, and enforcement programs for commercial nuclear power plants. The new process takes into account improvements in the performance of the nuclear industry over the past 25 years and improved approaches of inspecting and assessing safety performance at NRC licensed plants.

The new process monitors licensee performance in three broad areas (called strategic performance areas): reactor safety (avoiding accidents and reducing the consequences of accidents if they occur), radiation safety (protecting plant employees and the public during routine operations), and safeguards (protecting the plant against sabotage or other security threats). The process focuses on licensee performance within each of seven cornerstones of safety in the three areas:

| Reactor Safety | Radiation Safety | Safeguards |
|---|---|---|
| ● Initiating Events | ● Occupational | ● Physical Protection |
| ● Mitigating Systems | ● Public | |
| ● Barrier Integrity | | |
| ● Emergency Preparedness | | |

To monitor these seven cornerstones of safety, the NRC uses two processes that generate information about the safety significance of plant operations: inspections and performance indicators. Inspection Findings will be evaluated according to their potential significance for safety, using the Significance Determination Process, and assigned colors of GREEN, WHITE, YELLOW or RED. GREEN Findings are indicative of issues that, while they may not be desirable, represent very low safety significance. WHITE Findings indicate issues that are of low to moderate safety significance. YELLOW Findings are issues that are of substantial safety significance. RED Findings represent issues that are of high safety significance with a significant reduction in safety margin.

Performance indicator data will be compared to established criteria for measuring licensee performance in terms of potential safety. Based on prescribed thresholds, the indicators will be classified by color representing varying levels of performance and incremental degradation in safety: GREEN, WHITE, YELLOW, and RED. GREEN indicators represent performance at a level requiring no additional NRC oversight beyond the baseline inspections. WHITE corresponds to performance that may result in increased NRC oversight. YELLOW represents performance that minimally reduces safety margin and requires even more NRC oversight. And RED indicates performance that represents a significant reduction in safety margin, but still provides adequate protection to public health and safety.

The assessment process integrates performance indicators and inspection so the agency can reach objective conclusions regarding overall plant performance. The agency will use an Action Matrix to determine in a systematic, predictable manner, which regulatory actions should be taken based on a licensee's performance. The NRC's actions in response to the significance (as represented by the color) of issues will be the same for performance indicators as for inspection findings. As a licensee's safety performance degrades, the NRC will take more and increasingly significant action, which can include shutting down a plant, as described in the Action Matrix.

More information can be found at: http://www.nrc.gov/NRR/OVERSIGHT/index.html.