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

January 29, 2001

Southern Nuclear Operating Company, Inc.
ATTN: Mr. J. B. Beasley, Jr., Vice President
P. O. Box 1295
Birmingham, AL 35201-1295

SUBJECT: VOGTLE ELECTRIC GENERATING PLANT - NRC INTEGRATED INSPECTION REPORT NOS. 50-424/00-05 AND 50-425/00-05

Dear Mr. Beasley:

On December 30, 2000, the NRC completed an inspection at your Vogtle Units 1 and 2 reactor facilities. The enclosed integrated report presents the results of that inspection which were discussed on January 12, 2001, with Mr. G. Frederick and other members of your staff.

The inspection examined activities conducted under your license as they relate to safety and compliance with the Commission's rules and regulations and with the conditions of your license. The inspectors reviewed selected procedures and records, observed activities, and interviewed personnel.

No findings of significance were identified by the NRC.

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/

Stephen J. Cahill, Chief
Reactor Projects Branch 2
Division of Reactor Projects

Docket Nos. 50-424 and 50-425
License Nos. NPF-68 and NPF-81

Enclosure: NRC Integrated Inspection Report
50-424/00-05 and 50-425/00-05

cc w/encl: (See Page 2)

cc w/encl:
J. D. Woodard
Executive Vice President
Southern Nuclear Operating Company, Inc.
Electronic Mail Distribution

J. T. Gasser
General Manager, Plant Vogtle
Southern Nuclear Operating Company, Inc.
Electronic Mail Distribution

J. A. Bailey
Manager-Licensing
Southern Nuclear Operating Company, Inc.
Electronic Mail Distribution

Director, Consumers' Utility Counsel
Division
Governor's Office of Consumer Affairs
2 M. L. King, Jr. Drive
Plaza Level East; Suite 356
Atlanta, GA 30334-4600

Office of Planning and Budget
Room 615B
270 Washington Street, SW
Atlanta, GA 30334

Office of the County Commissioner
Burke County Commission
Waynesboro, GA 30830

Director, Department of Natural Resources
205 Butler Street, SE, Suite 1252
Atlanta, GA 30334

Manager, Radioactive Materials Program
Department of Natural Resources
Electronic Mail Distribution

Attorney General
Law Department
132 Judicial Building
Atlanta, GA 30334

Resident Manager
Oglethorpe Power Corporation
Alvin W. Vogtle Nuclear Plant
Electronic Mail Distribution

Charles A. Patrizia, Esq.
Paul, Hastings, Janofsky & Walker
10th Floor
1299 Pennsylvania Avenue
Washington, D. C. 20004-9500

Arthur H. Domby, Esq.
Troutman Sanders
NationsBank Plaza
600 Peachtree Street, NE, Suite 5200
Atlanta, GA 30308-2216

Senior Engineer - Power Supply
Municipal Electric Authority
of Georgia
Electronic Mail Distribution

Distribution w/encl:
D. Jaffe, NRR
RIDSNRRDIPMLIPB
PUBLIC

PUBLIC DOCUMENT (circle one): YES NO

OFFICE	RII:DRP	RII:DRP	RII:DRP	RII:DRS			
SIGNATURE	BHolbrook	JZeiler	JZeiler for	GKuzo for			
NAME	BHolbrook	JZeiler	TMorrissey	DForbes			
DATE	1/23/2001	1/23/2001	1/23/2001	1/23/2001	2/ /2001	2/ /2001	2/ /2001
E-MAIL COPY?	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO

OFFICIAL RECORD COPY DOCUMENT NAME: C:\2000-05drp.wpd

U. S. NUCLEAR REGULATORY COMMISSION (NRC)

REGION II

Docket Nos.	50-424 and 50-425
License Nos.	NPF-68 and NPF-81
Report No:	50-424/00-05 and 50-425/00-05
Licensee:	Southern Nuclear Operating Company, Inc. (SNC)
Facility:	Vogtle Electric Generating Plant, Units 1 and 2
Location:	7821 River Road Waynesboro, GA 30830
Dates:	October 1 through December 30, 2000
Inspectors:	J. Zeiler, Senior Resident Inspector T. Morrissey, Resident Inspector D. Forbes, Radiation Protection Specialist (Sections 2OS2, 2PS2, and 4OA1) B. Holbrook, Project Engineer (Sections 1RO1, 1RO6, and 1RO7)
Approved by:	Stephen J. Cahill, Chief Reactor Projects Branch 2 Division of Reactor Projects

Enclosure

SUMMARY OF FINDINGS

IR 05000424-00-05, IR 05000425-00-05, on 10/01-12/30/2000; Southern Nuclear Operating Company; Vogtle Electric Generating Plant, Units 1 and 2; Resident Inspector Report.

This report covers a 13 week period of inspection conducted by resident inspectors, a regional project engineer, and a regional radiation specialist. The significance of issues would be indicated by their color (green, white, yellow, or red) as determined by the Significance Determination Process in NRC Inspection Manual Chapter 0609.

A. Inspector Identified Findings

There were no findings of significance.

B. Licensee Identified Violations

Three violations of very low significance which were identified by the licensee have been reviewed by the inspectors. Corrective actions taken or planned by the licensee appear reasonable. These violations are listed in section 4OA7 of this report.

Report Details

Summary of Plant Status

Unit 1 began the inspection period shut down for a scheduled refueling outage. On October 17, the unit was restarted and reached full power on October 21. The unit operated at essentially 100 % Rated Thermal Power (RTP) until December 9, when an automatic reactor trip occurred during testing. The unit was restarted on December 10 and attained full power operation on December 11. The unit operated at essentially 100% RTP for the remainder of the inspection period.

Unit 2 operated at essentially 100% RTP throughout the inspection period.

1. REACTOR SAFETY
Cornerstones: Initiating Events, Mitigating Systems, Barrier Integrity

1R01 Adverse Weather (Annual Review)

a. Inspection Scope

The inspectors reviewed the procedures listed below and conducted a walkdown of the Refueling Water Storage Tank and the Nuclear Service Cooling Water (NSCW) systems to verify they would remain functional during adverse weather. The inspectors also verified that the preventative maintenance activities associated with heat tracing and freeze protection systems were appropriate and completed as scheduled. The inspectors also reviewed the licensee's corrective action program for adverse weather related items.

- 25743-C, Thermon Solid State Heat Tracing and Freeze Protection System Calibration and Maintenance
- 11877-1/2, Cold Weather Checklist
- 11889-C, Severe Weather Checklist
- 11901-1, Heat Tracing System Alignment
- 13901-1, Heat Tracing System
- 17104-1, Annunciator Response for Heat Tracing Panel
- 50050-C, Heat Tracing Program

b. Findings

No findings of significance were identified.

1R04 Equipment Alignment

a. Inspection Scope

The inspectors conducted partial walkdowns of the following systems to evaluate the operability of selected trains or backup systems when the redundant train or system was inoperable or out of service. The walkdowns included a review of applicable system procedures, checklists, and drawings to verify the correct system alignment. The

inspectors conducted an evaluation of conditions which could affect the operability of the redundant train or backup system.

- 1A and 1B High Head Safety Injection systems
- 1A and 1B Residual Heat Removal (RHR) systems
- 2B Containment Spray (CS) system
- 2A Component Cooling Water (CCW) system
- 2A Safety Injection (SI) system

b. Findings

No findings of significance were identified.

1R05 Fire Protection

a. Inspection Scope

The inspectors conducted tours of the areas listed below and evaluated conditions related to licensee control of combustible and ignition sources; the material condition, operational status, and operational lineup of fire detection and suppression systems; and, the status of fire protection barriers used to prevent fire damage or fire propagation. The inspectors compared fire protection requirements delineated in Section 9 of the Updated Final Safety Analysis Report (UFSAR) to the licensee's implementation of the program. Additionally, the inspectors periodically reviewed the licensee's fire protection limiting condition for operation log to assess the impact of fire protection equipment impairments and to determine if corrective actions were commensurate with the safety significance of the impairment.

- 1A and 1B centrifugal charging pump rooms
- 1B CS pump room
- 2A and 2B CS pump rooms
- 1A and 1B Piping Penetration Area Filtration and Exhaust system rooms
- 2A CCW pump room
- 2A and 2B SI pump rooms
- 1A and 1B Emergency Diesel Generator (EDG) rooms

b. Findings

No findings of significance were identified.

1R06 Flood Protection Measures (Annual Review)

a. Inspection Scope

The internal flooding analysis, plant design features described in the UFSAR and plant procedures listed below were used as criteria for this inspection. The inspectors conducted a walkdown of plant areas to verify that selected risk significant and safety related plant equipment would be protected from internal flooding. These plant areas included the CCW heat exchanger rooms, auxiliary component cooling water (ACCW)

heat exchanger rooms, selected switchgear rooms, SI pump rooms, the EDG and Auxiliary Feedwater (AFW) Pump Buildings. The inspectors also inspected selected Auxiliary Building watertight doors and penetrations, building drain systems, flood retaining rooms, alarms and drains, and selected leak protection system components. Additionally, the inspectors reviewed the licensee's corrective action program for flood protection related items.

- UFSAR Chapter 1, Introduction and General Description of Plant
- UFSAR Chapter 2, Site Characteristics
- UFSAR Chapter 3, Water Level (Flood) Design
- UFSAR Chapter 15, Accident Analysis
- 85032-C, Penetration Seal Inspection
- 85038-C, General Checkout of Watertight Door Seals
- 11219-1, Auxiliary and Containment Buildings and Miscellaneous Drain Alignment
- Design Control Document (DC)-1003, Flooding - Interdiscipline
- Abnormal Operating Procedures 18008-C, Secondary Coolant Leakage; 18020-C, Loss of CCW; and 18022-C, Loss of ACCW
- Emergency Operating Procedure 19112-C, ECA-1.2- LOCA Outside Containment

b. Findings

No findings of significance were identified.

1R07 Heat Sink Performance (Annual Review)

a. Inspection Scope

The inspectors selected the following risk significant heat exchangers (HX's) for evaluation: Unit 1 CCW and ACCW HX's and the EDG jacket water HX's. The inspectors also reviewed selected safety related pump motor and oil coolers and penetration coolers. The inspectors verified selected heat exchanger test and inspection methodology was consistent with accepted industry practices, or equivalent; test conditions were appropriately considered; test criteria were appropriate; test results appropriately considered differences between testing conditions and design conditions; test frequency was appropriate; and, test results considered test instrument inaccuracies and differences. The inspectors reviewed performance data from tests and inspections completed in 1994, 1996, and 2000. The inspectors reviewed the following procedures related to heat exchanger testing and verified procedure requirements were met:

- 83305-C, Heat Exchanger Testing/Maintenance Program
- 83306-C, CCW and ACCW Heat Exchanger Testing
- 83308-C, Testing of Safety-Related NSCW System Coolers
- 83309-C, Safety-Related Heat Exchanger Inspection
- 83310-C, Emergency Diesel Generator Jacket Water Heat Exchanger Testing

The inspectors reviewed the licensee's corrective action program for heat sink related items.

b. Findings

No findings of significance were identified.

1R11 Licensed Operator Requalification

Resident Quarterly Review

a. Inspection Scope

The inspectors observed portions of licensed operator simulator training for two separate scenarios involving a faulted steam generator and a small break loss of coolant accident. The inspectors assessed the following items: 1) correct use and implementation of Emergency Operating, Annunciator Response, and Emergency Classification Procedures, 2) control board manipulations, including high-risk operator actions, 3) crew command and control, 4) communications, and 5) effectiveness of the post training critique.

b. Findings

No findings of significance were identified.

1R12 Maintenance Rule Implementation

a. Inspection Scope

The inspectors reviewed equipment issues described in the following Condition Reports (CRs) and assessed the effectiveness of licensee maintenance efforts related to the requirements of the Maintenance Rule (10 CFR 50.65) and licensee procedure 50028-C, Engineering Maintenance Rule Implementation. The inspectors reviewed the licensee's implementation of the Maintenance Rule regarding characterization of failures, performance criteria or a(1) performance goals, and corrective actions.

- CR 2000001529, auxiliary feedwater pump 1A failed to start during slave relay testing
- CR 2000001933, containment radiation monitor 2RE2565A setpoints incorrect
- CR 2000001945, containment isolation valve 1HV0781 had excessive leak rate
- CR 2000002001, power operated relief valve 1PV0456A failed stroke time test
- CR 2000002273, atmospheric relief valve 1PV3010 failed stroke time test

b. Findings

No findings of significance were identified.

1R13 Maintenance Risk Assessment and Emergent Work Evaluation

a. Inspection Scope

For the maintenance activities listed below, the inspectors evaluated: 1) work control activities; 2) the effectiveness of the risk assessments performed before the

maintenance activities were conducted; and 3) implementation of risk management controls, such as, establishing compensatory actions, minimizing the duration of the activity, obtaining appropriate management approval, and informing appropriate plant staff.

- Steam Generator Loop 4 Feedwater Isolation Valve 1HV5230 problem during stroke test
- System outage activities on 2A CS system equipment
- Unit 2 Steam Jet Air Ejector #2 troubleshooting repair activity
- System outage activities on 2B Piping Penetration Area Filtration and Exhaust system
- System outage activities on 2A SI system equipment
- System outage activities on 2B CS system equipment
- System outage activities on 1A Reserve Auxiliary Transformer
- Forced outage activities following Unit 1 reactor trip
- Unit 2 letdown heat exchanger liner leakage repairs

b. Findings

No findings of significance were identified.

1R15 Operability Evaluations

a. Inspection Scope

The inspectors reviewed the following licensee evaluations of degraded equipment or non-conforming conditions. The inspectors evaluated the technical adequacy of the evaluations, the adequacy of compensatory measures, and the impact on continued plant operation.

- CR 2000001703, Fuel assemblies with fractured top nozzle hold-down spring screws
- CR 2000001965, Use of non-approved grease on 4.16 kilo-volt switchgear 1AA02
- CR 2000002016, Unit 1 turbine driven auxiliary feedwater pump governor valve sticking
- CR 2000002236, Unit 2 reactor trip breakers tripped using incorrect pushbutton
- CR 2000001567, 1B RHR miniflow valve, 1FV-0611, did not autoclose
- CR 2000002288, NSCW pump #3 discharge valve stroke time outside limits
- CR 2000002049, Unit 1 refueling water storage tank boron concentration out of specification low

b. Findings

No findings of significance were identified.

1R16 Operator Workarounds

a. Inspection Scope

The inspectors reviewed the control room logs, operator turnover logs, clearance and tagging logs, caution tag logs, out of normal position log, maintenance work orders, and

CRs to identify any potential operator workarounds. Any identified workarounds were evaluated for affect on either the functional capability of the related system or human reliability in responding to an initiating event.

b. Findings

No findings of significance were identified.

1R19 Post Maintenance Testing

a. Inspection Scope

The inspectors reviewed or witnessed the following post maintenance test activities to determine whether the scope of testing adequately verified that the work performed was correctly completed and demonstrated that the affected equipment was operable.

- Retest of steam generator loop #1 sample isolation valve following repairs
- 1B Piping Penetration Area Filtration and Exhaust system post maintenance testing following system outage
- Retest of Unit 2 Steam Jet Air Ejector #2 following maintenance
- 2B CS pump and pump discharge valve 1HV9001B post maintenance testing following system outage
- Retest of Unit 1 Normal Charging Pump following repairs
- Inservice testing of 2A Boric Acid Transfer Pump following pump replacement

b. Findings

No findings of significance were identified.

1R20 Refueling and Outage Activities

a. Inspection Scope

The inspectors reviewed the following activities accomplished during the scheduled Unit 1 refueling outage (1R9). These activities were inspected for conformance with applicable plant procedures and Technical Specifications (TS). Selected aspects of each of these activities were also witnessed by the inspectors.

- refueling operations
- reduced reactor cooling system inventory and midloop operations
- equipment clearances
- containment isolation valve leak rate testing
- mode changes
- startup and low power physics testing

b. Findings

No findings of significance were identified.

1R22 Surveillance Testing

a. Inspection Scope

The inspectors reviewed the following surveillance test procedures and either witnessed the testing and/or reviewed completed records to verify that testing was conducted in accordance with the procedures and that the testing adequately demonstrated that the affected equipment was operable.

- 14812-1, B RHR Pump and Check Valve IST
- 14666-1, Train A Diesel Generator and ESFAS Test, Section 5.2
- 88006-C, Control Rod Drop Testing (Mode 3 portions)
- 14980-1, Diesel Generator Operability Test (for 1A EDG)
- 14905-1, RCS Leakage Calculation (Inventory Balance)
- 14410-1, Control Rod Operability Test
- 14421-1, Solid State Protection System and Reactor Trip Breaker Train B Operability Test

b. Findings

No findings of significance were identified.

1R23 Temporary Plant Modifications

a. Inspection Scope

The inspectors reviewed temporary modification (TM) package TM 2000-V1T055, Unit 1 Feedwater Heater Drain Pump Gasket Repair, to determine if system operability/availability was affected, configuration control was maintained, and that the associated safety evaluation adequately justified implementation.

b. Findings

No findings of significance were identified.

Cornerstone: Emergency Preparedness

1EP6 Drill Evaluation

a. Inspection Scope

On October 31, the inspectors observed a facility activation drill. The inspectors observed licensee activities in the main control room (simulator) and Technical Support Center to assess whether event classification, notification, and protective action recommendations were conducted in accordance with applicable emergency plan implementing procedures. Additionally, the inspectors evaluated the adequacy of the post drill critique.

b. Findings

No findings of significance were identified.

2. RADIATION SAFETY
Cornerstone: Occupational Radiation Safety

2OS2 As Low As Reasonably Achievable (ALARA) Planning and Controls

a. Inspection Scope

The inspectors reviewed radiation work permits, internal dose assessments, the plant collective exposure history from the recent refueling outage (1R9), current exposure dose trends, attended the ALARA briefing, and observed the loading of irradiated hardware into a shipping cask liner to determine if the licensee was implementing ALARA practices as required by 10 CFR 20.1101(b) and licensee procedure 00910-C, VEGP ALARA Program, Revision 11. During plant tours, the inspectors also discussed ALARA practices being implemented during ongoing daily work activities with cognizant health physics personnel.

b. Findings

No findings of significance were identified.

2PS2 Radioactive Material Processing and Transportation

a. Inspection Scope

The inspectors evaluated the licensee's transportation of radioactive materials programs for implementing NRC and Department of Transportation regulations. The inspectors observed the preparation of reviewed procedures and assessed whether the procedures adequately addressed the shipping requirements. Licensee procedures for handling and shipping radioactive material, 10 CFR Part 61 licensee waste stream analysis, and records of six shipments of radioactive material performed since the last inspection of this area were reviewed to determine if the shipping papers contained the required information.

b. Findings

No findings of significance were identified.

4. OTHER ACTIVITIES

4OA1 Performance Indicator (PI) Verification

.1 Reactor Coolant System (RCS) Leak Rate (Initiating Event Cornerstone) Occupational and Public Radiation Safety (Occupational and Public Radiation Safety Cornerstones)

a. Inspection Scope

The inspectors performed a review of the RCS leakage PI for Units 1 and 2. Specifically, the inspectors reviewed the data submitted to the NRC for the first through third quarters of 2000 to verify its accuracy and completeness. The inspectors reviewed the corresponding leakage calculation results obtained from procedures 14905-1,2, RCS Leakage Calculation (Inventory Balance), as well as the monthly PI Summary reports for the first three quarters of 2000.

The inspectors reviewed condition reports issued between January 1, 2000 and November 16, 2000, that documented problems in the cornerstone areas of occupational and public radiation safety. The inspectors also reviewed audits and self assessments of these cornerstones to evaluate the effectiveness of comparing the audits and self assessments against self revealing or other identified issues.

b. Findings

No findings of significance were identified.

.2 Safety System Unavailability - AFW (Mitigating System Cornerstone)

a. Inspection Scope

The inspectors performed a review of the Units 1 and 2 AFW system unavailability PI data submitted to the NRC for the first through third quarters of 2000 to determine its accuracy and completeness. Documentation reviewed included operator logs, licensee maintenance rule database, licensee monthly PI Summary reports, and several monthly and quarterly AFW system surveillance procedure results. In addition, the inspectors held discussions with the licensee Maintenance Rule Coordinator, PI Coordinator, the AFW system engineer and several reactor operators.

b. Findings

The inspectors found minor discrepancies with the AFW PI data submitted to the NRC. The inspectors determined that the licensee did not correctly utilize the dedicated operator provision as delineated in NEI 99-02, “Regulatory Assessment Performance Indicator Guideline,” Revision 0. NEI 99-02, under certain conditions, allows the use of dedicated operators so that the time the system is undergoing testing is not counted as unavailability time. The inspectors determined, through discussions with operators, that the operators did not consider themselves dedicated. For example, if the unit had a

transient that would require the use of emergency operating procedures (EOPs), the operators stated that they would take the immediate actions dictated by the EOP. The EOP would ensure adequate AFW flow is available but would not necessarily place the train undergoing testing in the required configuration as the first action. The licensee reviewed this information and CR 2000002334 was written to place this issue in the corrective action program. Guidance was promulgated to the system engineers responsible for the four systems associated with the NRC safety system unavailability PI's to not use the dedicated operator provision of NEI 99-02 until further review and guidance was provided. Since implementing this guidance, approximately one additional hour/train/month of planned AFW surveillance unavailability time will be included by the licensee in the PI calculation. In addition, due to solid state protection system surveillance testing, approximately two to three hours/train/quarter is expected to be included in the PI calculation. This is considered a minor discrepancy since the additional time added to the AFW PI calculation would not have resulted in the PI reaching a threshold. The licensee is evaluating the need to correct the PI information previously submitted to the NRC and whether to submit a Frequently Asked Question (FAQ) on this matter.

4OA3 Event Follow-up

.1 Unit 1 Automatic Reactor Trip During Surveillance Testing

a. Inspection Scope

The inspectors observed and reviewed equipment and operator response to a Unit 1 automatic reactor trip that occurred on December 9, 2000, during reactor protection system surveillance testing. The inspectors reviewed the sequence of events and plant trip data and verified the proper performance of mitigating systems. The inspectors observed operator use of emergency and abnormal operating procedures in response to the trip and reviewed operator actions to stabilize the unit in Mode 3. The inspectors verified that the licensee reported the event to the NRC in accordance with regulatory and licensee requirements. The inspectors also reviewed operator actions during the unit restart on December 10 and verified procedures and mode change prerequisites were followed.

b. Findings

The cause of the reactor trip was an inadequate procedure. This item is dispositioned in Section 4OA7 of this report. No findings of significance were identified by the inspectors.

.2 (Closed) Licensee Event Report (LER) 50-425/98-007-01, Loss of Feedwater Flow Leads to Reactor Trip

This revision of the LER involved the licensee's decision to replace other Westinghouse 7300 process control and protection system power supplies that were similar to the ones that failed and resulted in the reactor trip. No other new information or violations of regulatory requirements were identified in the LER.

.3 (Closed) LER 50-424/00-003-00, Safety Injection System Rendered Inoperable with Unit 1 in Hot Standby

This LER described a personnel error which resulted in both trains of SI being rendered inoperable while Unit 1 was in Mode 3. The safety significance was determined to be very low. This LER was entered in the licensee's corrective action program as CR 2000001563. No findings of significance were identified by the inspectors. This item is dispositioned in Section 4OA7 of this report.

4OA5 Management Meetings

Exit Meeting Summary

The inspectors presented the inspection results to members of licensee management at the conclusion of the inspection on January 12, 2001. An interim exit was held on November 17, 2000, to discuss the results of a region-based radiation protection inspection and the results of an inspection of adverse weather, flood protection measures, and heat sink performance. The licensee acknowledged the findings presented. No proprietary information was identified.

4OA7 Licensee Identified Violations

The following findings of very low significance were identified by the licensee and are violations of NRC requirements which meet the criteria of Section VI of the NRC Enforcement Policy, NUREG-1600 for being dispositioned as Non-Cited Violations (NCV).

Tracking Number	Regulatory Requirement Violated
NCV 50-424/00-05-01	Unit 1 TS 5.4.1.a requires that written procedures shall be established, implemented and maintained covering the activities listed in Regulatory Guide 1.33, Revision 2, Appendix A, February 1978. The failure to have an adequate TS surveillance procedure for conducting reactor protection system testing on December 9, 2000, was a violation of TS 5.4.1.a and resulted in a reactor trip. This violation was entered in the licensee's corrective action program as CR 2000002309. (Section 4OA3.1)
NCV 50-424/00-05-02	10 CFR 50, Appendix B, Criterion V, requires that activities affecting quality shall be prescribed by documented instructions or procedures of a type appropriate to the circumstances. On September 17, 2000, the licensee failed to perform testing of valve 1HV8802A with instructions appropriate to the circumstances, resulting in the failure to adequately control the system configuration and the inadvertent entry into TS 3.0.3 due to rendering both trains of SI inoperable. This violation was entered in

	the licensee's corrective action program as CR 2000001563. (Section 4OA3.3)
NCV 50-424,425/00-05-03	10 CFR 20.1501 requires that licensees perform surveys that are reasonable under the circumstances to evaluate the radiological hazards. The licensee failed to perform adequate surveys resulting in a package containing radioactive material being released offsite on November 9, 2000. This violation was entered in the licensee's corrective action program as CR 2000002181.

PARTIAL LIST OF PERSONS CONTACTED

Licensee

W. Bargeron, Manager Operations
R. Brown, Manager Training and Emergency Preparedness
W. Burmeister, Manager Engineering Support
G. Frederick, Plant Operations Assistant General Manager
J. Gasser, Nuclear Plant General Manager
K. Holmes, Manager Maintenance
P. Rushton, Plant Support Assistant General Manager

NRC

S. Cahill, Chief, Region II Reactor Projects Branch 2

ITEMS CLOSED

Closed

50-424/00-05-01	NCV	Inadequate TS Surveillance Procedure Results in Reactor Trip (Section 4OA7)
50-425/98-007-01	LER	Loss of Feedwater Flow Leads to Reactor Trip (Section 4OA3.2)
50-424/00-003-00	LER	Safety Injection System Rendered Inoperable with Unit 1 in Hot Standby (Section 4OA3.3)
50-424/00-05-02	NCV	Failure to Test Safety Injection Valve with Instructions Appropriate to the Circumstances Results in Inoperability of SI System (Section 4OA7)
50-424,425/00-05-03	NCV	Failure to Adequately Survey Radioactive Material as Required by 10 CFR 20.1501 (Section 4OA7)

Attachment: NRC's Revised Reactor Oversight Process Summary

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. 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*.

Attachment