



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

November 29, 2000

Gregory M. Rueger, Senior Vice President  
and General Manager  
Nuclear Power Generation Bus. Unit  
Pacific Gas and Electric Company  
Nuclear Power Generation, B32  
77 Beale Street, 32nd Floor  
P.O. Box 770000  
San Francisco, California 94177

**SUBJECT: DIABLO CANYON INSPECTION REPORT NO. 50-275/00-14; 50-323/00-14**

Dear Mr. Rueger:

This refers to the routine resident inspection conducted from September 24 through November 4, 2000, a radiation protection inspection conducted from October 16 through October 20, 2000, and an inservice inspection conducted from October 24 through October 27, 2000, at the Diablo Canyon Nuclear Power Plant, Units 1 and 2 facility. The enclosed report presents the results of this inspection. The results of this inspection were discussed on October 20, October 27, and November 10, 2000, with David H. Oatley and members of your staff.

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

Based on the results of this inspection, the inspectors identified one issue of "no color," which involved radiation protection personnel failure to perform a contamination survey prior to workers entering the area. This issue was determined to involve a violation of NRC requirements. Two additional violations of NRC requirements were identified by the licensee. The first violation involved personnel entry into a high radiation area without the dose rates in the area having been determined and entry personnel knowledgeable of them. The second violation involved the failure to follow procedures for the shutdown of offsite power sources and a surveillance on the reactor coolant leak detection system. Because each of these violations were determined to be of very low safety significance and they have been entered into your corrective action program, the NRC is treating the issues as noncited violations, in accordance with Section VI.A.1 of the NRC's Enforcement Policy. If you deny these noncited violations, you should provide a response with the basis for your denial, within 30 days of the date of this inspection report, to the U. S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington DC 20555-0001; with copies to the Regional Administrator, Region IV; the Director, Office of Enforcement, U. S. Nuclear Regulatory Commission, Washington, DC 20555-0001; and the NRC Resident Inspector at the Diablo Canyon Nuclear Power Plant facility.

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Sincerely,

*/RA/*

William B. Jones, Chief  
Project Branch E  
Division of Reactor Projects

Docket Nos.: 50-275  
50-323  
License Nos.: DPR-80  
DPR-82

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NRC Inspection Report No.  
50-275/00-14; 50-323/00-14

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**ENCLOSURE**

U.S. NUCLEAR REGULATORY COMMISSION  
REGION IV

Docket Nos.: 50-275  
50-323

License Nos.: DPR-80  
DPR-82

Report No.: 50-275/00-14  
50-323/00-14

Licensee: Pacific Gas and Electric Company

Facility: Diablo Canyon Nuclear Power Plant, Units 1 and 2

Location: 7 ½ miles NW of Avila Beach  
Avila Beach, California

Dates: September 24 through November 4, 2000

Inspectors: D. L. Proulx, Senior Resident Inspector  
D. G. Acker, Resident Inspector  
G. A. Pick, Senior Project Engineer, Region IV  
M. P. Shannon, Senior Health Physicist, Region IV  
C. A. Johnson, Senior Reactor Inspector, Region IV

Approved By: W. B. Jones, Chief, Project Branch E  
Division of Reactor Projects

**ATTACHMENTS:**

Attachment 1: Supplemental Information

Attachment 2: NRC's Revised Reactor Oversight Process

## SUMMARY OF FINDINGS

IR 05000-275-00-14, IR 05000-323-00-14, on 09/24-11/4/00; Pacific Gas and Electric Co.; Diablo Canyon Nuclear Power Plant Units 1 and 2. Integrated Resident & Regional Report.

This report covers a 6-week routine resident inspection, an inspection of access controls by a Region IV inspector during October 16-20, 2000, and an inspection of inservice inspection activities by a Region IV inspector during October 23-27, 2000. The inspection identified one noncited violation (NCV) with no color. The significance of most issues is indicated by their color (green, white, yellow, or red) and was determined by the Significance Determination Process in Inspection Manual Chapter 0609. Findings for which the Significance Determination Process does not apply are indicated by "no color" or by the severity level of the applicable violation.

### A. Inspector Identified Findings

Cornerstone: Occupational Radiation Safety

No color. On October 17, 2000, the inspector identified that radiation protection personnel failed to perform a contamination survey of the upper internal lifting rig platform prior to a worker entering the area. 10 CFR Part 20, Section 1501(a), states, in part, each licensee shall make or cause to be made, surveys that are reasonable under the circumstances to evaluate concentrations or quantities of radioactive material and the potential radiological hazards. The failure to perform a contamination survey of the above area was a violation of 10 CFR 20.1501(a). This violation is being treated as a noncited violation and is in the licensee's corrective action program as Action Request A0517252.

The significance of this violation was determined to be more than minor because there was a credible impact on a worker's radiation safety; however, it did not affect the cornerstone since there were no actual consequences and monitoring devices remained operable (Section 2OS1).

### B. Licensee Identified Violations

Violations of very low significance which were identified by the licensee have been reviewed by the inspector. 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

Diablo Canyon Unit 1 began this inspection period at 100 percent power. On October 8, 2000, operators commenced a reactor shutdown for Refueling Outage 1R10, and entered Mode 3, (Hot Standby). Operators initiated a plant cooldown and entered Mode 5 (Cold Shutdown) on October 9. Maintenance personnel detensioned the reactor head on October 13, entering Mode 6 (Refueling). On October 15, operators commenced core offload, and the reactor was defueled as of October 17. Following outage work, the core was reloaded on October 24, entering Mode 6. The reactor head was retensioned on October 27, entering Mode 5. On November 2, operators commenced reactor coolant system heatup and Unit 1 entered Mode 4 (Hot Shutdown). On November 3, Unit 1 entered Mode 3 (Hot Standby) and remained in Mode 3 until the end of the inspection period.

Diablo Canyon Unit 2 began this inspection period at 100 percent power. On October 20, 2000, operators reduced power to 50 percent to support cleaning of the main condenser. Following successful condenser cleaning, Unit 2 was returned to 100 percent power on October 21, and continued to operate at that level until the end of the inspection period.

#### 1. **REACTOR SAFETY**

##### **Cornerstones: Initiating Events, Mitigating Systems, Barrier Integrity**

#### 1R04 Equipment Alignments (71111.04Q)

##### Partial System Walkdowns

##### a. Inspection Scope

The inspectors performed partial system walkdowns of the Unit 2 offsite power system and diesel engine generators when the Unit 2 230 kV startup transformer was unavailable on October 24-25, 2000. The inspectors used Procedure I-1C, "Routine Weekly Checks," Revision 53, as guidance. The inspectors reviewed the equipment alignments to verify their configuration and that any discrepancies that could impact the function of the systems were identified. The review considered whether there were any alignment problems that could cause an initiating event or impact mitigating system unavailability.

##### b. Issues and Findings

No findings of significance were identified.

1R05 Fire Protection (71111.05)

Monthly Routine Inspection

a. Inspection Scope

The inspectors performed fire protection walkdowns to assess the material condition of plant fire detection and suppression and proper control of transient combustibles. Specific risk significant areas inspected included the intake structure, the radiologically controlled area of the auxiliary building, and the safety-related areas of the turbine building.

b. Issues and Findings

No findings of significance were identified.

1R08 Inservice Inspection Activities, Unit 1 (71111.08)

a. Inspection Scope

The inspectors reviewed the following areas: (1) nondestructive examination procedures used in the examinations witnessed, (2) training and qualification/certification records for licensee and contractor L-II and L-III nondestructive examiners certification, (3) Steam Generator 1-2 U-bend crack results, (4) component cooling water heat exchanger repair, and (4) radiographic film.

The inspectors also participated in a conference call held on October 24, 2000, with the licensee and NRC Headquarters personnel regarding the eddy current test results for the steam generator inspections.

The inspectors observed the following nondestructive examination activities: (1) VT-1 (visual) on Valve SI-1-88B, (2) VT-2 (system pressure test) for Diesel Generator 1-2 jacket water system, (3) VT-3 for Snubber 14-18SL and its structural attachments, and (4) an ultrasonic examination for Welds 94-4A and 94-4B for Steam Generator 4 feedwater supply line.

The inspectors also observed one Code and one non-Code replacement activity for the auxiliary salt water pump discharge vacuum relief check valve and component cooling water CCW 1-2 inlet and outlet protective coatings repair, respectively. Additionally, the inspectors reviewed records of two additional replacement activities that related to replacement of the suction strainer spool piece for centrifugal charging pump CCP 1-1 and 1-2, which included the review of radiographic film for both charging pumps.

The inspectors reviewed records for rejectable Weld WIC-95 (RHR Injection to Hot Legs 1 and 2) to determine if the evaluations were appropriate.

The inspectors evaluated the effectiveness of the corrective action process to identify and correct problems related to inservice inspection activities. In this effort, the



inspectors reviewed action requests and the subsequent associated corrective actions. The action requests (ARs), which were reviewed, are listed in Attachment 1.

b. Issues and Findings

No findings of significance were identified.

1R12 Maintenance Rule Implementation (71111.12)

Routine Reviews

a. Inspection Scope

The inspectors reviewed the maintenance rule implementation for equipment performance problems, including:

- AR A0515507, Failure of Extraction Steam Bellows
- AR A0518701, Failure of Penetration 59B Containment Isolation Valve

b. Issues and Findings

No findings of significance were identified.

1R13 Maintenance Risk Assessment and Emergent Work Control (71111.13)

.1 Risk Assessments

a. Inspection Scope

Throughout the inspection period, the inspectors reviewed daily and weekly work schedules to determine when risk significant activities were scheduled. The inspectors reviewed selected activities regarding risk evaluations and overall plant configuration control. The activities reviewed were associated with a Unit 2 230 kV startup transformer outage on October 24, 2000.

b. Issues and Findings

No findings of significance were identified.

1R15 Operability Evaluations (71111.15)

a. Inspection Scope

The inspectors reviewed the following operability evaluations and supporting documents:

- AR A0515162, Check Valve CCW-1-609 degrading
- AR A0518814, Auxiliary Salt Water Pump 2-1 failed to start

b. Issues and Findings

No findings of significance were identified.

1R19 Postmaintenance Testing (71111.19)

c. Inspection Scope

The inspectors observed and evaluated the following postmaintenance test procedures to determine if the test adequately demonstrated that the equipment was capable of performing its safety functions:

- Procedure E-65.1A, "Maintenance and Overhaul of Solidstate Controls 20 KVA UPS," Revision 22, for Inverter 1-3 on October 17 after circuit card replacement.
- Procedure M-9D2, "Diesel Generator Partial Load Rejection Test," Revision 10, for Diesel Engine Generator 1-1 on October 24 after engine maintenance.
- Procedure M-16Q7, "Main Feedwater Control and Bypass Valve Time Response Determination," Revision 5, on October 27 after valve work.
- Procedure M21.02, "Diesel Generators Single Air Start Motor Test," Revision 0, for Diesel Engine Generator 1-3 on October 13 after air start motor replacement.

Issues and Findings

No findings of significance were identified.

1R20 Refueling and Outage Activities

a. Inspection Scope

The inspectors witnessed and evaluated licensee performance in the area of consideration of risk in developing outage schedules; use of risk reduction methodologies in control of plant configurations; development of mitigation strategies for losses of key safety functions; and adherence to operating licensee and Technical Specification requirements from the beginning of the outage through return to Mode 3. The remaining startup activities will be reviewed as part of the next routine resident inspection.

Specifically the inspectors:

- Reviewed the outage risk control plan prior to implementation
- Monitored cooldown rates

- Verified the licensee maintained defense-in-depth and addressed unexpected conditions
- Verified a sample of clearances for appropriate configuration and control
- Verified temporary reactor coolant system instrumentation used to maintain shutdown conditions were correctly configured
- Verified electrical power meet Technical Specification requirements and that switchyard activities were adequately controlled
- Verified decay heat parameters were adequate
- Verified adequate control of spent pool cooling
- Verified adequate inventory control and contingency plans
- Verified containment closure and containment closure capability were in accordance with Technical Specifications and outage risk plans
- Verified adequate control of reduced inventory and mid-loop conditions including observation of both occasions when the reactor coolant system was drained to mid-loop
- Verified adequate refueling control, including tracking of fuel assemblies in the core and spent fuel pool
- Observed startup activities through the end of the inspection period

b. Issues and Findings

No findings of significance were identified.

1R22 Surveillance Testing (71111.22)

Routine Observations

a. Inspection Scope

The inspectors observed all or part of the following surveillance and inservice test procedures:

- Procedure M-81J, "Test of Diesel Fuel Oil Day Tank Level Instruments," Revision 7 for Diesel Engine Generator 1-2 on October 18.
- Procedure M-15, "Integrated Test of Engineered Safeguards and Diesel Generators," Revision 34 for Diesel Engine Generator 1-2 on October 30.

- Procedure M-16Q5, "Functional Testing of Reactor Coolant Pump Seal Return Containment Isolation Valves 8100 and 8112," Revision 10 on October 26.

b. Issues and Findings

No findings of significance were identified.

**2. Radiation Safety**  
**Cornerstone: Occupational Radiation Safety**

2OS1 Access Controls to Radiologically Significant Areas (7112101)

a. Inspection Scope

Radiation workers and radiation protection personnel were interviewed concerning their radiation protection work requirements. A number of tours of the radiologically controlled area were conducted. The following items were reviewed to ensure that the physical and administrative controls for airborne areas, radiation areas, high radiation areas, high-high radiation areas, very high radiation areas, and worker adherence to these controls were accomplished in accordance with regulatory requirements:

- Nuclear Quality Services Audit EDMS-003680435
- Access controls and surveys of the following three significant high dose work areas in the radiologically controlled area: Unit 1 primary side steam generator work, Residual Heat Removal Pump 1-2, and removal/replacement of the Unit 1 reactor head
- The following two job-in-progress reviews were performed: Unit 1 primary side steam generator work and Residual Heat Removal Pump 1-2
- Radiation work permits and specified electronic dosimeter set points
- Placement of personnel dosimetry
- Job coverage by radiation protection personnel
- Associated program procedures
- Thirty-four radiological operational action reports written between October 1, 1999, and October 16, 2000

b. Findings

During a tour of the Unit 1 containment building on October 17, 2000, the inspectors observed a radiation worker disconnect the upper internal lifting rig from the upper internals. When questioned by the inspectors, a radiation protection technician providing general area radiological job coverage could not find a radiological survey of

the work area. The inspectors were informed by the radiation protection technician who started the job that the radiation levels on the upper internals lift rig platform were 50 to 150 millirems per hour and contamination levels were less than 10,000 disintegrations per minute per 100 centimeters squared. However, this survey information was based on the technician's memory of past refueling radiological conditions and not from a recent radiological survey.

The licensee investigation determined that on October 15, a radiation protection technician performed a radiation dose rate survey but did not document it until October 18. However, from a review of the radiological survey performed on October 15, the inspectors determined that a contamination survey was not performed prior to the worker entering the area.

10 CFR Part 20, Section 1501(a), states, in part, each licensee shall make or cause to be made surveys that are reasonable under the circumstances to evaluate concentrations or quantities of radioactive material and the potential radiological hazards. The failure to perform a contamination survey was a violation of 10 CFR 20.1501(a). This violation is being treated as a noncited violation consistent with Section VI.A.1 of the NRC Enforcement Policy. This violation is in the licensee's corrective action program as Action Request A0517252 (50-275/00014-01).

The significance of this violation was determined to be more than minor because there was a credible impact on a worker's radiation safety; however, it did not affect the cornerstone since there were no actual consequences and monitoring devices remained operable.

#### **4. OTHER ACTIVITIES**

##### **40A1 Performance Indicator Verification (71151)**

###### **a. Inspection Scope**

The inspectors reviewed corrective action program records for high-high radiation areas, very high radiation areas, and unplanned exposure occurrences for the past 12 months to confirm that these occurrences were properly recorded as performance indicators. Licensee procedures define a high-high radiation area as an area with dose rates greater than 1000 millirems per hour but less than or equal to 500 rads per hour at 1 meter from a radiation source. Radiologically controlled area exit transactions with exposures greater than 100 millirems for the past 12 months were reviewed and selected examples were investigated to determine whether they were within the dose projections of the governing radiation work permits.

Additionally, radiological effluent release program corrective action records, licensee event reports, and annual effluent release reports documented during the past four quarters were reviewed to determine if any events exceeded the performance indicator thresholds.

b. Findings

No findings of significance were identified.

40A6 Management Meetings

Exit Meeting Summary

The inspectors presented the inspection results to Mr. D. Oatley, Vice President, and other members of licensee management at the conclusion of the inspections on October 20, October 27, and November 10, 2000. The licensee acknowledged the findings presented.

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

40A7 Licensee Identified Non-Compliance

The following findings of very low significance were identified by the licensee and are in violation of NRC requirements that meet the criteria of Section VI of the NRC Enforcement Policy, NUREG-1600 for being dispositioned as noncited violations.

NCV Tracking Number                      Requirement Licensee Failed to Meet

NCV 275/00014-02	Technical Specification 5.7.1.e requires that entry into a high radiation area be made only after dose rates in the area have been determined and entry personnel are knowledgeable of them. On October 10, 2000, four workers in two work groups entered a high radiation area without obtaining the dose rate information, as described in the corrective action program, reference ARs A0516173 and A0516174.
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NCV 275; 323/00014-03	Technical Specification 5.4.1.a requires that procedures be implemented for those procedures recommended in Regulatory Guide 1.33, Revision 2, Appendix A, February 1978. Regulatory Guide 1.33, Appendix A recommends procedures for shutdown of offsite power sources and surveillance procedures. Procedures OP J-2:III (Unit 1), "Startup Bank-Shutdown and Clearing," Revision 10A, and STP I-19-L62 (Unit 1), "Reactor Cavity Sump Level Channel LT-62 Calibration," Revision 2, partially implemented this requirement. Procedure OP J-2:III, step 6.1.2 required the user to open Unit 1 Switch 211-1, however, on October 23, 2000, the operator opened Switch 211-2, which inadvertently resulted in the loss of the startup transformer for Unit 2. Procedure STP I-19-L62, Step 8.4.1 required lifting the lead at Unit 1 Panel POCV1, TB-35, but on October 22, the technician lifted a
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lead in Unit 2 Panel POCV2, causing an inadvertent loss of the reactor coolant system leakage detection system in Unit 2. These examples of violation are described in the corrective action program as ARs A0517849 and A0517720.

ATTACHMENT 1

PARTIAL LIST OF PERSONS CONTACTED

Licensee

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R. Gray, Engineer, Radiation Protection  
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D. H. Oatley, Vice President and Plant Manager  
J. W. Tompkins, Manager, Nuclear Quality Analysis and Licensing  
R. A. Waltos, Manager, Maintenance Services

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

None

Opened and Closed During this Inspection

50-275/00014-01	NCV	Failure to survey
50-275/00014-02	NCV	Failure to inform workers of dose rate information
50-275; 323/00014-03	NCV	Examples of failure to follow procedures related to wrong unit work

Previous Items Closed

None

Previous Items Discussed

None

LIST OF ACRONYMS USED

AR	Action Request
CFR	Code of Federal Regulations
LER	Licensee Event Report
NCV	Noncited Violation
NRC	Nuclear Regulatory Commission



## DOCUMENTATION REVIEWED

### Procedures

Number	Title	Revision
ISI VT 2-1	Visual Examination During Section XI System Pressure Test	3
ISI VT 3-1	Visual Examination Of Component And Piping Supports	0
MP M-56.22	Protective Coatings For The Component Cooling Water Heat Exchanger	4
N-RT-1	Radiographic Examination Procedure For Welds	6

### Action Requests

A0430829	A0501133	A0516418	A0517956
A0500495	A0516357	A0516437	
A0501132	A0516358	A0517493	

### Work Orders

Number	Description
C0165632	Install New CCP 1-1 Suction Spool Piping
C0165633	Install New CCP 1-2 Suction Spool Piping
R0193411 01	Repair Inlet Heat Exchanger Coatings

### Miscellaneous

Inservice Inspection Evaluation Analysis of Flaw Indication for Weld WIC-95, dated May 7, 1997  
Engineering Evaluation for bolting degradation

## ATTACHMENT 2

### **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:

<b>Reactor Safety</b>	<b>Radiation Safety</b>	<b>Safeguards</b>
<ul style="list-style-type: none"><li>• Initiating Events</li><li>• Mitigating Systems</li><li>• Barrier Integrity</li><li>• Emergency Preparedness</li></ul>	<ul style="list-style-type: none"><li>• Occupational</li><li>• Public</li></ul>	<ul style="list-style-type: none"><li>• Physical Protection</li></ul>

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, or 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>.