



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

July 18, 2001

John T. Herron  
Vice President Operations  
Waterford 3  
Entergy Operations, Inc.  
17265 River Road  
Killona, Louisiana 70066-0751

SUBJECT: NRC INSPECTION REPORT 50-382/01-08

Dear Mr. Herron:

On June 22, 2001, the NRC completed a team inspection at your Waterford Steam Electric Station, Unit 3 for the period June 11-22, 2001. The enclosed report documents the inspection findings, which were discussed on June 22, 2001, with you and other members of your staff on the results of the onsite inspection.

This inspection was an examination of activities conducted under your license as they relate to the identification and resolution of problems, safety and compliance with the Commission's rules and regulations, and the conditions of your license. Within these areas, the inspection consisted of a selected examination of procedures and representative records, observations of activities, and interviews with personnel.

No findings of significance were identified.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your response will be made available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records (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/*

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

Entergy Operations, Inc.

-2-

Docket: 50-382

License: NPF-38

Enclosure:

NRC Inspection Report

50-382/01-08

cc w/enclosure:

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-3-

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**ENCLOSURE**

U.S. NUCLEAR REGULATORY COMMISSION  
REGION IV

Docket: 50-382

License: NPF-38

Report No: 50-382/01-08

Licensee: Entergy Operations, Inc.

Facility: Waterford Steam Electric Station, Unit 3

Location: Hwy. 18  
Killona, Louisiana

Dates: June 11-22, 2001

Inspectors: T. R. Farnholtz, Senior Resident Inspector, Project Branch E  
S. L. McCrory, Senior Operations Engineer, Operations Branch  
G. A. Pick, Senior Project Engineer, Project Branch E

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

Attachment: Supplemental Information

## SUMMARY OF FINDINGS

### Waterford Steam Electric Station, Unit 3 NRC Inspection Report 50-382/0108

IR05000382-01-08; on 6/11-22/2001; Entergy Operations, Inc.; Waterford Steam Electric Station; Unit 3; Identification and Resolution of Problems.

The inspection was conducted by one senior resident inspector, one senior operations engineer, and one senior project engineer. The significance of most findings is indicated by their color (Green, White, Yellow, or Red) using IMC 0609 "Significance Determination Process" (SDP). The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described at its Reactor Oversight Process website at <http://www.nrc.gov/NRR/OVERSIGHT/index.html>. Findings for which the SDP does not apply are indicated by No Color or by the severity level of the applicable violation.

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

The licensee effectively identified problems and entered them into the corrective action program. This was evidenced by the relatively few deficiencies identified by external organizations (including the NRC) that had not been previously identified by the licensee during the review period. The licensee appropriately prioritized, characterized, and evaluated issues that were significant conditions adverse to quality. However, it was noted that human performance was a significant contributor to conditions documented in the corrective action program. The licensee adequately implemented corrective actions commensurate with safety that were generally effective. The licensee acknowledged that effectiveness of corrective actions was an ongoing issue. Licensee audits and assessments critically assessed problem identification and resolution activities and identified needs for improvement, as appropriate. Based on the interviews conducted during this inspection, workers at the site felt free to input safety issues into the corrective action program.

## Report Details

### **4. OTHER ACTIVITIES (OA)**

#### 4OA2 Identification and Resolution of Problems (71152)

##### a. Effectiveness of Problem Identification

##### .1 Inspection Scope

The inspectors reviewed items selected across the seven cornerstones to determine if the licensee properly identified, characterized, and entered deficiencies into their corrective action program for evaluation and resolution. Specifically, the inspectors selected approximately 160 condition reports (which included the licensee response to 13 NRC information notices and Part 21 reports) and approximately 100 licensee self-assessments and audits, which had been issued between June 1, 2000, and May 31, 2001.

The inspectors evaluated the condition reports to determine the threshold for identifying problems and entering them into the corrective action program. The inspectors reviewed licensee self-assessments and audits and evaluated their effectiveness by comparing the results against self-revealing and NRC-identified issues. Also, the inspectors evaluated licensee efforts in establishing the scope of problems by reviewing pertinent operational logs, work orders, audit and self-assessment results, action plans, and results from surveillance tests and preventive maintenance tasks. The inspectors used condition reports and other documents listed in Attachment 1 to facilitate the review.

##### .2 Issues and Findings

The inspectors did not observe any instances in which conditions adverse to quality were being handled outside the corrective action program. The inspectors concluded that there were no findings of significance regarding the licensee performance in identification of problems.

The inspectors determined that the licensee effectively identified problems and entered them into the corrective action program. This was evidenced by the relatively few deficiencies identified by external organizations (including the NRC) that had not been previously identified by the licensee during the review period. Licensee audits and assessments were appropriately comprehensive. Licensee identified issues were similar to those that were self-revealing or raised during previous NRC inspections. The inspectors independently observed a number of corrective action performance areas that the licensee had already identified as areas for concern and required attention. These areas included effectiveness of corrective actions and the large number of human performance areas that exceeded the site goals.

b. Prioritization and Evaluation of Issues

.1 Inspection Scope

The inspectors reviewed approximately 160 condition reports and supporting documentation, including root cause evaluations, to ascertain whether the licensee identified and considered the full extent of conditions, generic implications, common causes, and previous occurrences. In addition, the inspectors reviewed licensee evaluations of selected industry experience information, including operating event reports and NRC and vendor generic notices, to assess if issues applicable to the Waterford facility were appropriately addressed. Specific items reviewed are listed in Attachment 1.

.2 Issues and Findings

Based on review of records, the inspectors concluded that the licensee effectively prioritized and evaluated issues applicable to the Waterford facility. The licensee appropriately characterized and evaluated issues that were significant conditions adverse to quality. The inspectors identified no findings related to prioritization and evaluation of issues. The inspectors concluded that a significant number of conditions documented in the corrective action program had a component of human error associated with them; however, the licensee had recognized this condition and had taken appropriate action to document, trend, and correct this situation. The human error trend data for the subsequent period indicates that the adverse trend was improving.

The inspectors noted that human performance was a significant contributor to conditions documented in the corrective action program. Approximately 400 of the 1750 condition reports generated during this inspection period had a human performance component associated with them. A selected sample of these condition reports revealed that the human errors were not limited to any specific group or department but were instead spread throughout the organization. The inspectors reviewed the trending data for the first two months of the second quarter 2001 for the human error rate per 10,000 man hours. This showed improvement when compared to the previous quarter. The inspectors noted that over this short period the adverse trend was improving but that additional attention in this area would be appropriate.

The majority of the condition reports with a human performance component documented conditions of minor risk significance. However, the operations department generated Condition Report 2001-0059 to document a rising trend in human performance-related errors within that department that were of greater significance. Specifically, this condition report documented 29 errors, which had occurred in the year 2000, including 6 errors related to the implementation of Technical Specifications; 2 errors requiring a licensee event report; and 1 error requiring a special report to the NRC. Two additional operations department errors were included in this condition report, which had occurred in 2001. The inspectors considered it appropriate to document this specific trend and place it in the corrective action program for further consideration.



The licensee carried procedure noncompliance as an adverse trend for the fourth quarter 2000 and the first quarter 2001 in their quarterly trend report. Procedure noncompliance was considered the major contributor to the identified human error conditions. Condition Report 2000-0373 documented an increase in the number of condition reports involving procedure noncompliance. In response to this condition report, the licensee performed a root cause determination that included recommended corrective actions. The team assessed these actions and considered them an adequate and appropriate response to the adverse trend in the human performance error rate.

The inspectors reviewed report, "Waterford 3 Human Performance Assessment," for the assessment performed the week of August 14, 2000. This assessment evaluated the health of the human performance program at the facility. The inspectors found this report to be comprehensive. The report included specific examples and background information along with recommendations to improve the areas identified as needing improvement. The inspectors considered this report and its findings to be adequate to identify and document specific areas requiring additional attention.

c. Effectiveness of Corrective Actions

.1 Inspection Scope

The inspectors reviewed condition reports, audits, and self-assessments to verify that the licensee implemented corrective actions relating to identified issues in a timely manner commensurate with safety, including corrective actions to address common cause or generic concerns. The inspectors also conducted walkdowns and interviewed plant personnel to independently verify and assess the effectiveness of corrective actions implemented by the licensee. The inspectors included the following specific focus areas within the scope of this review:

- Failure of the primary sampling system inside and outside containment isolation valves
- Low Temperature/Over Pressure relief valves lifted while in solid reactor coolant system condition
- Potential degradation of feedwater isolation valves because of design-basis deficiencies
- Failure to protect safeguards information
- Safeguard system vulnerability because of security software function for upgrading access
- Equipment required for safe shutdown following a fire not separated by 1-hour fire barrier
- Inadequate corrective actions for control board switch knob replacement

- Operating in a condition prohibited by Technical Specifications because of an inoperable core protection calculator channel

A listing of specific documents reviewed during the inspection is included in Attachment 1.

## .2 Issues and Findings

The inspectors determined that the licensee adequately implemented corrective actions commensurate with safety that were generally effective. The inspectors observed the following exceptions in which the licensee identified that previous corrective actions had been ineffective:

<u>Condition Report</u>	<u>Nature of Ineffective Corrective Action</u>	<u>Date</u>
2000-0601	Procedural guidance had been developed to address the difficulty of manually controlling reactor coolant pump controlled bleed off pressure during reactor plant cooldown. However, the development process did not consider all situations that could affect manual control such that pressure limits were exceeded in a subsequent cooldown.	06/09/00
2000-0650	The licensee identified a high incidence of tailgating through security card reader doors in December 1999 (Condition Report 1999-1270). The licensee implemented no interim corrective actions while engineering evaluated the need to redesign the card reader indications. In June 2000, the licensee again identified a high incidence of tailgating through security card reader doors and identified the same root cause as the previous condition.	06/15/00
2000-0770	During replacement of failed control switch knobs on control room panels, a valve stroked improperly as a result of failure to fully seat the knob in the switch assembly. The licensee had previously identified this deficiency in Condition Report 1999-0920, which formulated a corrective action to add a verification step to the postmaintenance testing procedure to ensure that the knob seated fully.	07/11/00
2001-0243	Following the failure of Valves PSL-303 and -304 to close on demand from the control room on January 28, 2001, the licensee modified the valve actuator by replacing the actuator spring to increase closing thrust. Subsequent to the modification, the valves failed to close on demand again on February 20, during retest. Followup evaluation determined that thermal binding caused the valve failure.	02/20/01

2001-0568 In March 2001, the licensee determined that procedures for testing the reactor trip switch gear manual trip push-button contacts should be revised to check circuit continuity vice volts to ensure that the contacts closed. In May 2001, the licensee determined that the revised test procedure failed to correct the condition and the test would continue to give erroneous indication of reactor trip switch gear contact performance. 05/15/01

The inspectors reviewed the instances of ineffective corrective actions and determined that they did not involve more than minor failures to comply with agency regulations.

The inspectors also reviewed Condition Report 2000-0372 dated April 18, 2000, in which the licensee identified a number of condition reports that cited ineffective corrective actions as a cause for the condition. The licensee acknowledged that effectiveness of corrective actions was an ongoing issue. However, the licensee provided information that demonstrated that there had been a clear decline in the occurrence of ineffective corrective actions since the implementation of the corrective actions associated with Condition Report 2000-0372.

The inspectors reviewed the corrective actions specified in Condition Report 2000-0372 which included performing a root cause analysis, additional training for management and staff on the corrective action program, and cross referencing condition reports and associated maintenance action items. The licensee provided recent trending data concerning condition reports that were identified as having ineffective corrective actions. This data showed a clear decline in the occurrence of ineffective corrective actions since the implementation of the corrective actions associated with Condition Report 2000-0372.

The inspectors identified no findings of significance related to the effectiveness of corrective actions.

d. Assessment of Safety-Conscious Work Environment

.1 Inspection Scope

The inspectors interviewed approximately 15 individuals from the licensee's staff, which represented a cross-section of functional organizations and supervisory and nonsupervisory personnel. These interviews assessed whether conditions existed that would challenge the establishment of a safety-conscience work environment.

.2 Issues and Findings

Based on interviews, the inspectors identified no findings related to the safety-conscience work environment. The inspectors concluded, based on information collected from these interviews, that employees were willing to identify safety issues and enter them into a corrective action system.

#### 4OA3 Event Followup

.1 The inspectors reviewed the following licensee event reports to determine: (1) the risk significance of the issue using the Significance Determination Process; (2) whether the licensee placed the issue in the corrective action program; and (3) whether any enforcement would be necessary. The inspectors determined that the licensee had identified each of the issues, that the findings involved had very low risk/safety significance, and that any violations were minor violations from review of the Manual Chapter 0610\*, Group 1 questions.

- (Closed) Licensee Event Report 50-382/99-008-00: Failure to Perform Testing of Emergency Safety Features Filtration Units Per Technical Specifications

The inspectors confirmed that this issue had minimal risk/safety significance. The licensee performed a root cause analysis and documented this event in Condition Report 1999-0719.

- (Closed) Licensee Event Report 50-382/00-013-00: Technical Specification Violation Because of Failure to Perform Surveillance Required for Mode Change

The inspectors confirmed that this was a documentation error. The licensee performed a root cause analysis and documented this event in Condition Report 2000-1547.

- (Closed) Licensee Event Report 50-382/01-001-00: Violation of Technical Specification 3.3.1 Because a Technical Specification Channel Check Was Not Performed as Required by Technical Specification 4.3.1.1

The inspectors confirmed that this was a documentation error. The licensee performed a root cause analysis and documented this event in Condition Report 2001-0042.

.2 (Closed) Licensee Event Report 50-382/2000-08-00: Operation in a Condition Prohibited by Technical Specification 3.3.1 Because of an Inoperable Core Protection Calculator

On September 14, 2000, technicians performed a Technical Specification surveillance on Core Protection Calculator Channel B. They failed to recognize that an out-of-tolerance condition existed that affected low departure from nucleate boiling trip function. This condition delayed the trip signal such that it would not have been generated when required by the design basis (as established in the core operating limit report). The licensee returned the channel to service and declared it operable in this condition.

The inspectors reviewed Group 1 questions contained in Manual Chapter 0610\* and determined that returning a core protection calculator channel to service, which was incapable of generating a reactor trip signal at the established setpoint, as required by design, represented a credible impact on safety since it could not perform its design

basis safety function. This deficiency affected the mitigating systems cornerstone; however, the issue had very low safety significance because three other core protection calculator channels were operable and capable of generating the required low departure from nucleate boiling trip. Technical Specification 3.3.1 requires that an inoperable channel be placed in the bypassed or tripped condition within 1 hour. The failure to place Core Protection Calculator Channel B in the bypassed or tripped condition resulted in a violation of Technical Specification 3.3.1. This violation is being treated as a noncited violation, consistent with Section VI.A of the NRC Enforcement Policy. The licensee included this deficiency in their corrective action program as Condition Report 2000-1074. This is considered a licensee-identified noncited violation and is included in Section 4OA7 of this report.

.3 (Closed) Licensee Event Report 50-382/2000-12-00: Mode Change in Violation of Technical Specifications Because of a Mispositioned Control Panel Switch

On November 13, 2000, after shift change, operators found the Charging Pump B control switch in the OFF position instead of AUTO. Operators had transitioned the reactor from Mode 5 to Mode 4 approximately 8 hours earlier. Technical Specification 3.1.2.4 requires two operable charging pumps prior to entering Mode 4. Charging Pump A was running.

The inspectors reviewed the Group 1 questions contained in Manual Chapter 0610\* and determined that the control switch in the OFF position represented a credible impact on safety since Charging Pump A could have been inoperable (single failure). The inspectors concluded that this deficiency affected the mitigating systems cornerstone. The inspectors concluded that the charging pump could have been manually started if required, thus the risk significance was considered to be very low. The failure to meet the requirements of Technical Specification 3.1.2.4 prior to changing from Mode 5 to Mode 4 resulted in a violation of Technical Specification 3.0.4. This violation is being treated as a noncited violation, consistent with Section VI.A of the NRC Enforcement Policy. The licensee included this deficiency in their corrective action program as Condition Report 2000-1515. This is considered a licensee-identified noncited violation and is included in Section 4OA7 of this report.

4OA6 Meetings

Exit Meeting

The team debriefed Mr. John Herron, Vice President, Operations, and members of the licensee's staff on the preliminary inspection findings at the conclusion of the onsite inspection on June 22, 2001.

The inspectors asked the licensee's management whether any materials examined during the inspection should be considered proprietary. 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 noncited violations.

<u>NCV Tracking Number</u>	<u>Requirement Licensee Failed to Meet</u>
(1) 50-382/01-08-01	Technical Specification 3.3.1 requires that an inoperable core protection calculator channel be placed in the bypassed or tripped condition within 1 hour. On September 14, 2000, the licensee returned a core protection calculator channel to service, which was found out-of-tolerance and incapable of generating a low departure from nucleate boiling reactor trip signal as required. This deficiency was included in the corrective action program as Condition Report 2000-1074 and described in Licensee Event Report 00-008 (refer to Section 4OA3(2)).
(2) NCV 382/01-08-02	Technical Specification 3.1.2.4 requires two operable charging pumps prior to entering Mode 4. Technical Specification 3.0.4 specifies that entry into an operational mode shall not be made when the conditions for a limiting condition for operation are not met. On November 13, 2000, with the plant in Mode 5, operators transitioned to Mode 4 with the Charging Pump B handswitch in the OFF position. This deficiency is documented in the corrective action program as Condition Report 2000-1515 and described in Licensee Event Report 00-012 refer to Section 4OA3(3)).

## ATTACHMENT 1

### PARTIAL LIST OF PERSONS CONTACTED

#### Licensee

A. Bergeron, Chemistry Superintendent  
D. Boan, Employee Concerns Program Coordinator  
M. Brandon, Manager, Licensing  
D. Dale, Engineer, Programs and Components Engineering  
R. Douet, Manager, Operations  
E. Ewing, General Manager, Plant Operations  
R. Fili, Manger, Quality Assurance  
K. Fitzsimmons, System Engineer  
R. Fron, Security  
C. Fugate, Manager, Technical Support  
P. Gropp, Manager, Design Engineering  
A. Harris, Director, Nuclear Safety Assurance  
J. Herron, Vice President, Operations  
J. Houghtailing, Senior Project Manager  
S. Hymel, Specialist, Corrective Action and Assessment Department  
J. Johnston, Senior Nuclear Support Coordinator, Operating Experience  
M. Langan, Specialist, Corrective Action and Assessment Department  
C. Lindsey, Human Performance Coordinator  
D. Madere, Licensing Engineer  
D. Marpe, Manager, Programs and Components Engineering  
B. Matthew, Manager, Engineering Support  
D. Miller, Senior Health Physics Specialist, ALARA Coordinator  
D. Ortego, Assistant Operations Manager  
R. Osborne, Manager, System Engineering  
R. Perry, Senior Emergency Planner  
R. Peters, Manager, Corrective Action and Assessment  
C. Pickering, Licensing Engineer  
J. Ridgel, Manager, Maintenance  
J. Signorelli, Operations  
D. Stevens, Senior Health Physics Specialist  
D. Vines, Corporate Assessment

#### NRC

J. Keeton, Resident Inspector, Project Branch E

### ITEMS OPENED AND CLOSED

#### Opened and Closed

50-382/0108-01	NCV	Failure to place an inoperable core protection calculator channel in the bypassed or tripped condition as required by Technical Specification 3.3.1 (Section 4OA7)
50-382/0108-02	NCV	Failure to have two charging pumps operable prior to entering Mode 4 as required by Technical Specification 3.0.4 (Section 4OA7)

#### Closed

50-382/99-008-00	LER	Failure to perform testing of emergency safety features filtration units per Technical Specifications (Section 4OA3)
50-382/00-013-00	LER	Technical Specification violation because of failure to perform surveillance required for mode change (Section 4OA3)
50-382/01-001-00	LER	Violation of Technical Specification 3.3.1 because a technical specification channel check was not performed as required by Technical Specification 4.3.1.1 (Section 4OA3)

### PARTIAL LIST OF DOCUMENTS REVIEWED

The following documents were selected and reviewed by the inspectors to accomplish the objectives and scope of the inspection and to support any findings:

#### Procedures

LI-102, "Corrective Action Process," Revision 0  
LI-104, "Assessment Process," Revision 1  
OE-100, "Operating Experience Program," Revision 0  
HP-001-152, "Radioactive Material Control," Revision 15, Change 1  
MD-001-040, "Maintenance Action Item Performance and Documentation," Revision 1  
W4.104, "Engineering Request Process," Revision 4

#### Condition Reports

OPX-2000-0010	1999-0348	2000-0167	2000-0400	2000-0601
OPX-2000-0020	1999-0433	2000-0249	2000-0504	2000-0631
OPX-2000-0033	1999-0828	2000-0272	2000-0523	2000-0637
OPX-2001-0005	1999-0927	2000-0282	2000-0524	2000-0642
OPX-2001-0023	1999-1004	2000-0372	2000-0530	2000-0650
OPX-2001-0038	1999-1150	2000-0373	2000-0578	2000-0653
1997-0240	1999-1207	2000-0394	2000-0595	2000-0678



2000-0679	2000-1095	2000-1417	2000-1657	2001-0225
2000-0696	2000-1117	2000-1419	2001-0009	2001-0243
2000-0748	2000-1141	2000-1459	2001-0028	2001-0244
2000-0765	2000-1147	2000-1472	2001-0029	2001-0255
2000-0770	2000-1153	2000-1482	2001-0042	2001-0275
2000-0778	2000-1169	2000-1486	2001-0045	2001-0279
2000-0783	2000-1223	2000-1501	2001-0055	2001-0293
2000-0809	2000-1225	2000-1503	2001-0060	2001-0294
2000-0822	2000-1230	2000-1515	2001-0064	2001-0303
2000-0829	2000-1244	2000-1516	2001-0076	2001-0306
2000-0834	2000-1247	2000-1522	2001-0083	2001-0307
2000-0878	2000-1250	2000-1547	2001-0095	2001-0339
2000-0889	2000-1265	2000-1554	2001-0102	2001-0346
2000-0905	2000-1308	2000-1562	2001-0108	2001-0363
2000-0918	2000-1309	2000-1565	2001-0112	2001-0370
2000-0946	2000-1310	2000-1569	2001-0118	2001-0392
2000-0954	2000-1322	2000-1570	2001-0130	2001-0396
2000-0988	2000-1324	2000-1571	2001-0158	2001-0411
2000-1003	2000-1340	2000-1590	2001-0171	2001-0490
2000-1015	2000-1351	2000-1592	2001-0172	2001-0508
2000-1026	2000-1353	2000-1634	2001-0175	2001-0509
2000-1036	2000-1364	2000-1636	2001-0191	2001-0546
2000-1053	2000-1370	2000-1643	2001-0197	2001-0569
2000-1066	2000-1397	2000-1654	2001-0202	2001-0605
2000-1088	2000-1416	2000-1655	2001-0215	

Self-Assessments and Audits

Waterford 3 Human Performance Assessment, October 12, 2000

OE Effectiveness Review Project - Work Planning and Training, January 31, 2001

Corporate Assist Visit on Operating Experience Program, May 8, 2001

Entergy OE Tool Effectiveness Review, January 31, 2001

Emergency Response Facility Maintenance Assessment - 4<sup>TH</sup> Quarter 2000

Drill/Exercise Critique Assessment, September 29, 2000

Radioactive Material Control - Tool Assessment, June 28, 2000

Respirator Protection Policy Followup Assessment, November 14, 2000

Self-Assessment of Fire Protection Configuration Management, March 27, 2000

Refueling Outage 10 - Assessment of Radiation Protection Practices

EP-2000-01-WF3, Repetitive Task Self-Assessment

ES-2000-02-WF3, INPO Assist Visit - Equipment Reliability

ES-2000-04-WF3, INPO Assist Visit - Steam Generator Follow-Up Visit

ES-2000-08-WF3, Engineering & Equipment Performance Corporate

ES-2000-09-WF3, Effectiveness of the Software Control Process - PMC & Site Security Computer System

ES-2001-08-WF3, Performance Monitoring & Program Effectiveness

MA-2000-02-WF3, Work Management Process

MA-2000-03-WF3, Corporate Assessment - Maintenance/Work Management

MA-2001-02-WF3, Risk Management

MA-2001-06-WF3, Post Maintenance Testing

MA-2001-08-WF3, Self-Improvement Culture in Maintenance Assessment

MA-2001-09-WF3, M&TE Control Assessment

MA-2001-13-WF3, Paperless to the Shop / Feedback

MA-2001-18-WF3, Work management Benchmark Trip - Sequoyah / Watts Bar

OA-2000-01-WF3, Corrective Action Program Self-Assessment

OA-2001-05-WF3, SOER Assessment

OP-2001-01-WF3, Corporate Assessment - Operations

OP-2001-02-WF3, Operator Understanding & Implementation of Safety Rules Assessment

RP-2000-01-WF3, Radioactive Material Control Self-Assessment

RP-2000-02-WF3, Radioactive Source Control

RP-2001-01-WF3, Radioactive Waste Processing & Transportation

RP-2001-03-WF3, High Radiation Area Control Assessment

RP-2001-04-WF3, Corporate Assessment - Radiation Protection

SC-2000-01-WF3, Security Organization Review

SC-2001-01-WF3, Weapons & Contingency Training

SC-2001-04-WF3, Security Operations Readiness Benchmarking Trip - Hatch

SA-00-006, "Effluent and Environmental Monitoring" with Attachment , "Environmental Audit Report"

SA-00-008, "Engineering Programs"

Quality Assurance Audits/Surveillance

QA-04-2000-W3-1, "Design Control"

QA-07-2000-W3-1, "Emergency Planning"

QA-09-2000-W3-1, "Fire Protection"

QA-12-2000-W3-1, "Operations"

QA-14-2000-W3-1, "Radiation Protection"

QA-15-2000-W3-1, "Radwaste"

QA-16-2000-W3-1, "Security"

QA-03-2001-W3-1, "Corrective Action Program"

QA-07-2001-W3-1, "Emergency Planning"

QA-09-2001-W3-1, "Fire Protection"

QS-2000-W3-007, "Adequacy of Fire Watch Patrols"

QS-2000-W3-009, "Security Self-assessment: Table Tops and Force-on-Force Drills"

QS-2000-W3-010, "Primary Access Point Activities"

QS-2000-W3-011, "Primary Access Point Activities"

QS-2000-W3-013, "Primary Access Point Activities"

QS-2000-W3-014, "Fire Protection Inspection of Fire Areas 15, 31, and 7"

QS-2000-W3-023, "Primary Access Point Activities"

QS-2000-W3-025, "Security Force-on-Force Drills"

QS-2000-W3-027, "Security Force-on-Force Drills"

QS-2000-W3-030, "Primary Access Point Activities"

QS-2000-W3-034, "Security Force-on-Force Drills"

QS-2000-W3-038, "Primary Access Point Activities"

QS-2000-W3-039, "Security Force-on-Force Drills"

QS-2000-W3-040, "Tabletop Exercises and Force-on-Force Drills"

QS-2000-W3-041, "Maintenance on Breakers for Containment Cooling Fans A&C"

QS-2000-W3-043, "Security Force-on-Force Drills and Firing Range Activities"

QS-2000-W3-045, "Evaluated Security Exercises, Drills, and Range Activities"

QS-2000-W3-050, "Effluent and Environmental Monitoring"

QS-2000-W3-059, "Unannounced Fire Drill"

QS-2000-W3-076, "Repair of Fire Wrap on Conduit 31065R-SAB"

QS-2000-W3-078, "Operator Aids"

QS-2000-W3-079, "Tagging"

QS-2000-W3-086, "Announced Fire Drill"

QS-2000-W3-088, "Primary Access Point Activities"

QS-2000-W3-093, "Update of Corrective Actions for Root Cause Analysis Report Inconsistencies in the Safeguards Contingency Plan"

QS-2000-W3-099, "Maintenance Personnel Moving Security Barrier from Train Bay Door 68"

QS-2000-W3-102, "Primary Access Point Activities"

QS-2000-W3-104, "Primary Access Point Activities"

QS-2000-W3-109, "Activities Associated with a High Integrity Container Shipment"

QS-2000-W3-111, "Safeguards Walkdown and Vehicle Trap Observations"

QS-2000-W3-112, "Physical Protection System Testing/Maintenance"

QS-2000-W3-113, "Vehicle Trap Activities"

QS-2000-W3-114, "Steam Generator Chemical Cleaning"

QS-2000-W3-115, "Security Force-on-Force Drills"

QS-2000-W3-123, "Confirmatory Order/Security Improvement Plan"

QS-2000-W3-124, "Security Force-on-Force Drills"

QS-2000-W3-124, "Security Drills for November 22, 2000"

QS-2000-W3-125, "10CFR50.65(a)(4) Maintenance Rule"

QS-2000-W3-126, "Security Drills for November 29, 2000"

QS-2000-W3-128, "Security Force-on-Force Drills"

QS-2000-W3-138, "Fire Field Refresher Training"

QS-2001-W3-001, "Security Improvement Plan"

QS-2001-W3-004, "Implementation of 10CFR50.65(a)(4) Maintenance Rule"

QS-2001-W3-006, "Security Force-on-Force Drills"

QS-2001-W3-008, "Security Firing Range Observations"

QS-2001-W3-021, "Observation of Security Force on Force Drill"

QS-2001-W3-023, "Security Force-on-Force Drills and Weapons Training"

QS-2001-W3-024, "Security Protected Area Patrol"

QS-2001-W3-041, "PSL 303 Repair (PreJob Briefing)"

QS-2001-W3-043, "Collection and Preparation of Milk Samples"

QS-2001-W3-058, "Security Activities: PAP and CAS"

QS-2001-W3-061, "Steam Generator Feedwater Valve Operator FW 111B Bracket Weld Repair"

Licensee Event Reports

50-382/1999-008	"Failure to Perform Testing of Emergency Safety Features Filtration Units Per Technical Specifications"
50-382/2000-006	"Both Channels of Chlorine Detectors Found Outside Technical Specification (2 ppm) Limits"
50-382/2000-008	"Operation in a Condition Prohibited by Technical Specification 3.3.1 Because of an Inoperable Core Protection Calculator"

50-382/2000-009	"Potential for Loss of Safe Shutdown Equipment by a Fire in Either of Two Separate Fire Areas"
50-382/2000-010	"Nonconservative Essential Chiller Technical Specification Surveillance"
50-382/2000-011	"Reactor Coolant System Pressure Boundary Leakage Because of Primary Water Stress Corrosion Cracking and Leaking Mechanical Nozzle Seal Assembly Clamps"
50-382/2000-012	"Mode Change in Violation of Technical Specifications Because of a Mispositioned Control Panel Switch"
50-382/2000-013	"Technical Specification Violation Because of Failure to Perform Surveillance Required for Mode Change"
50-382/2001-001	"Violation of Technical Specification 3.3.1 Because a Technical Specification Channel Check Was Not Performed, as Required by Technical Specification 4.3.1.1"

Other Documents

TEAR-2001-0135, Develop training for control room operators regarding emergency response requirements for radioactive shipments, 1/16/01

Engineering Request 00-0782, "GL 86-10 Evaluation for Seals IIIA0204 and IIIA0251"

Engineering Request 98-0950, "Safety Significance for RCA 98-0476," without Attachments

November 2000, Operating Experience Status Report, 11/30/2000

December 2000, Operating Experience Status Report, 1/3/2001

January 2001, Operating Experience Status Report, 1/25/2001

February 2001, Operating Experience Status Report, 2/22/2001

March 2001, Operating Experience Status Report, 3/22/2001

April 2001, Operating Experience Status Report, 4/19/2001

May 2001, Operating Experience Status Report, 5/17/2001

**MATERIAL REQUESTED**

- 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 (i.e., condition reports) from June 2000, to May 2001.
- All major corrective action documents (i.e., those that roll-up one or more smaller issues) since June 2000.
- All corrective action documents associated with nonescalated no response required or noncited violations since June 2000.
- All corrective action program reports or metrics (since June 2000) 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 (condition reports since June 2000) 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 2000.
- All corrective action documents related to the following industry operating experience generic communications:

Part 21 Reports:

00-21-0

00-21-1

01-08-0

CR-2000-0778 (ASCO General Controls Pump Assemblies in NH Hydramotors)

CR-2001-0158 (Rosemount Nuclear Instruments Model 353C and 353C1 Equipment Seals)

CR-2001-0546 (Flowserve Model 70-18-9 and 70-19-9 Valves)

NRC Information Notices:

95-003	00-013	00-018	01-001
00-009	00-014	00-019	01-002
00-010	00-015	00-020	01-003
00-011	00-016	00-021	01-004
00-012	00-017	00-022	01-005