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

October 11, 2000

Mr. C. L. Terry
TXU Electric
Senior Vice President & Principal Nuclear Officer
ATTN: Regulatory Affairs Department
P.O. Box 1002
Glen Rose, Texas 76043

SUBJECT: COMANCHE PEAK - NRC INSPECTION REPORT NO. 50-445/00-05; 50-446/00-05

Dear Mr. Terry:

On August 4, 2000, the NRC completed onsite inspection at your Comanche Peak Steam Electric Station, Units 1 and 2, facilities. The enclosed report presents the results of that inspection. The preliminary results of the inspection were discussed on August 3, 2000, with you, and members of your staff. A telephonic exit meeting was conducted on August 28, 2000, with Mr. Terry Hope, to inform your staff of the results of the in-office review following the team's departure from the site.

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

Based on the results of the inspection, we concluded that your program effectively identified and resolved conditions adverse to quality. The team did not identify any issues that resulted in the operability of safety-related or risk-significant plant equipment being questioned. Also, we concluded that your personnel communicated an acceptable level of responsibility in identifying and entering safety issues into the corrective action program.

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

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

Sincerely,

/**RA**/

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

Docket Nos.: 50-445; 50-446
License Nos.: NPF-87; NPF-89

Enclosure:
NRC Inspection Report No.
50-445/00-05; 50-446/00-05

cc w/enclosure:
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Regulatory Affairs Manager
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SOE:OB	SOE:OB	SOE:OB	PE:PBE	SRI:PBE
GWJohnston/lmb	TOMcKernon	MEMurphy	GAPick	TFarmholtz
/**RA**/	/**RA**/	/**RA**/	/**RA**/	/**RA**/
08/31/00	08/31/00	09/01/00	09/01/00	08/31/00

C:OB	C:PBA	C:OB		
JLPellet	JITapia	JLPellet		
for	/**RA**/	/**RA**/		
08/31/00	08/31/00	10/11/00		

ENCLOSURE

U.S. NUCLEAR REGULATORY COMMISSION
REGION IV

Docket Nos.:	50-445; 50-446
License Nos.:	NPF-87; NPF-89
Report No.:	50-445/00-05; 50-446/00-05
Licensee:	TXU Electric
Facility:	Comanche Peak Steam Electric Station, Units 1 and 2
Location:	FM-56 Glen Rose, Texas
Dates:	July 31 through August 4, 2000
Inspectors:	Gary W. Johnston, Senior Operations Engineer, Operations Branch Thomas O. McKernon, Senior Operations Engineer, Operations Branch Michael E. Murphy, Senior Operations Engineer, Operations Branch Greg A. Pick, Senior Project Engineer, Projects Branch E Thomas R. Farnholtz, Senior Resident Inspector, Projects Branch E
Approved By:	John L. Pellet, Chief Operations Branch Division of Reactor Safety

ATTACHMENTS:

Attachment 1: Supplemental Information

Attachment 2: Material Requested

Attachment 3: NRC's Revised Reactor Oversight Process

Summary of Findings

IR 05000445-00-05; 05000446-00-05; on 07/31-08/2000; TXU Electric; Comanche Peak Steam Electric Station, Units 1 and 2; Annual Baseline Inspection of the Identification and Resolution of Problems. No findings were identified.

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

Identification and Resolution of Problems

- The licensee was effective at identifying problems and putting them into the corrective action program. The licensee self-identified the significant deficiencies identified during the review period. The licensee effectively prioritized the extent to which individual problems would be evaluated consistent with their safety and risk significance and established schedules for implementation of corrective actions. The licensee implemented corrective actions that were timely and effective.

Report Details

4. OTHER ACTIVITIES (OA)

4OA2 Problem Identification and Resolution

.1 Effectiveness of Problem Identification

a. Inspection Scope

The team reviewed items that pertained to the seven cornerstones of the reactor safety, radiation safety, and safeguards strategic performance areas to determine if problems were appropriately being identified, characterized, and entered into the corrective action program. The team assessed licensee identification and resolution of problem performance through a review of more than 140 licensee records, including approximately 9 licensee quality assurance surveillances and audits and self-assessment reports, related to the selected items completed in the time period from June 1999 to June 2000. The team independently verified associated corrective actions that had been completed. A listing of the specific documents reviewed during the inspection is attached to the report.

b. Issues and Findings

The team identified no findings related to the area of problem identification. Based on the review of more than 140 licensee records, the team concluded that the licensee effectively identified problems. The team's review of SmartForms and comparison to operating events and lower level problems found no instances where previously unidentified problems were not revealed. Licensee self-assessments and audits consistently identified issues. The team noted that plant incident reports were rigorous in evaluating significant events, and that the depth of the evaluations were sufficient to ensure that contributing and root cause analyses identified problems. The team noted that in interviews with plant personnel that there was no reluctance to initiate a SmartForm when an issue was in doubt. Reviews by the team of operating experience from licensee event reports, and facility event evaluations indicated issues were being identified and evaluated. This was exhibited in the team's review of Licensee Event Report 446/00-001-00 and the licensee's SmartForm 1999-3504-00, which evaluated the event that consisted of an occurrence of exceeding an 18-month surveillance interval for molded case circuit breakers. The team concurred in the licensee's conclusion that the cause of the event was because of inadequate scheduling coordination.

.2 Prioritization and Evaluation of Issues

a. Inspection Scope

The team reviewed condition reports, audits, and self-assessments to verify that identified issues were appropriately characterized, an appropriate analysis of the cause

of the problem was performed for significant conditions adverse to quality, and the risk associated with combinations of issues was appropriately considered. In addition, the team reviewed the licensee's evaluation of selected industry experience information to assess if issues applicable to Comanche Peak Steam Electric Station. Documents reviewed included operating event reports and NRC and vendor generic notices. Information that the team reviewed was selected in the time period from June 1999 to June 2000. A listing of the specific documents reviewed during the inspection is attached to the report.

b. Issues and Findings

Based on the review of more than 140 licensee records, the team concluded that the licensee effectively prioritized and evaluated issues. The team identified no findings related to prioritization and evaluation of issues. The team determined from the records reviewed, which included selected SmartForms, audits, and self-assessments, that the licensee entered identified issues in their corrective action program with the appropriate priority based on the observation by the team that none of the records reviewed exhibited inappropriate prioritization.

Examples reviewed by the team included Plant Incident Reports 2000-000059-01-00 "ESF Actuation Following XST-1 De-energizing," and 1999-001769-01-00 "Emergency Sirens Rendered Inoperable Following IT Work," where the team's assessment agreed with the licensee's prioritization and evaluation of the problems. Further, the licensee's evaluations of identified issues were observed as appropriate based on the evaluations in all of the records that were reviewed by the team. The team noted the evaluations were to the appropriate depth and scope to ensure that issues significant to quality were resolved timely. Team members attended daily meetings of the SmartForm review committee and observed that the prioritization and initial evaluation conducted during these meetings were appropriate for each of the SmartForms reviewed.

.3 Effectiveness of Corrective Actions

a. Inspection Scope

The team reviewed condition reports, audits, and self-assessments to verify that corrective actions commensurate with the issues were identified and implemented in a timely manner, including corrective actions to address common cause or generic concerns. Information that the team reviewed was selected in the time period from June 1999 to June 2000. A listing of the specific documents reviewed during the inspection is attached to the report.

b. Issues and Findings

Based on the review of more than 140 licensee records, the team concluded that the licensee implemented effective corrective actions. The team identified no findings related to effectiveness of corrective actions. The team did not identify any issues regarding the risk associated with combinations of issues. The basis for the team's conclusion was no inappropriate corrective actions were noted for each corrective action

document reviewed, and repeat occurrences were appropriately resolved and tracked to completion. This was exemplified in the team's review of SmartForm 1998-2203-00. This SmartForm identified that heaters were installed on the thermal overload relays for the hot-leg recirculation Valves 8701A/B, which was contrary to caution tags hung on the local handswitch. The heaters were to be removed prior to entering a mode where the residual heat removal system was to be placed in standby, this action was in lieu of opening the supply breakers to the valves. The licensee's determination was that a procedural error occurred in not removing the heaters, however, the licensee also determined that this was not the optimal method of ensuring the valves were open and de-energized and opted to forego removing the heaters, and subsequently changed the procedure to rely on opening the supply breakers. The team agreed that this corrective action was appropriate and was reflected in the licensee's depth of evaluation.

The team reviewed SmartForm SMF-1999-001744-00 to determine the adequacy of the licensee's response to NRC Inspection Report 50-445;446/99-14, which described this condition as Non-Cited Violation 50-445;446/9914-04. The subject of the SmartForm was the failure to consider any potential heat of adsorption generated in the control room emergency pressurization unit charcoal filters from post-accident deposition of radioactive material in the design calculation. The team observed that the licensee's resolution of SmartForm SMF-1999-001744-00 concluded that the design of the control room emergency ventilation system would preclude any failure of the charcoal filter in the control room emergency pressurization unit from affecting control room habitability. The licensee administratively determined from this review that no revision to the design basis was necessitated. The team agreed with the licensee's determination that there was no effect on control room habitability, but noted that the calculation had not been updated following the closure of SmartForm SMF-1999-001744-00. The licensee subsequently performed the design calculation, taking into consideration the heat of adsorption, and found the impact to be negligible.

.4 Effectiveness of Licensee Audits and Assessments

a. Inspection Scope:

The team reviewed licensee audits and self-assessments performed since June 1999. This included four self-assessments of the implementation of the corrective action program conducted between September 13, 1999. In addition, the team interviewed licensee personnel regarding the audit and self-assessment programs. The specific documents reviewed during the inspection are attached to the report.

b. Issues and Findings:

The team identified no findings related to the areas of licensee audits and self-assessments. The team determined this conclusion from the review of 9 assessments and audits conducted from July 30, 1999, through June 30, 2000. The team observed that each of the assessments or audits developed extensive conclusions and, when an issue warranted corrective action, the appropriate corrective action documentation was generated to address the identified issues. The team reviewed NOE EVAL-2000-026 "Nuclear Oversight Biannual Corrective Action Evalaution," which exemplified the basis

for the team's conclusion. The evaluation generated SmartForm 2000-001366 to followup on identifed problems associated with SmartForms. Licensee staff made the observation that approximately half of the SmartForms generated in 1999 had their completion due dates extended at least one time. The licensee's analysis determined that the due date extensions were largely because of the use of default due dates being assigned prior to establishing the scope of effort needed to resolve the problem. The team concurred with the determination in providing licensee management with useful observations on performance. The team observed that the other assessments and audits included significant events, program performance, and examination of organizational trend information.

.5 Assessment of Safety Conscious Work Environment

a. Inspection Scope:

The team interviewed 4 managers, 8 supervisors, 2 regulatory compliance specialists, 11 systems engineers, and 2 licensed operators, regarding the licensee corrective action program, including the employees concerns program. These interviews assessed whether conditions existed that would challenge the establishment of a safety conscious work environment.

b. Issues and Findings:

The team identified no findings for the area of safety conscious work environment. The team based this conclusion on information collected from interviews with 27 licensee personnel. From these interviews, the team concluded that licensee personnel communicated and accepted responsibility to proactively identify and enter safety issues into the corrective action program. The personnel interviewed demonstrated a working knowledge of the corrective action program, uniformly indicated a willingness to utilize the program, and indicated that the program effectively resolved issues.

4OA6 Meetings

Exit Meeting Summary

The team presented the preliminary inspection results to Mr. C. L. Terry, and other members of licensee management at the conclusion of the onsite inspection on August 3, 2000. The licensee's management acknowledged the findings presented.

A telephonic exit meeting was held on August 28, 2000, with Mr. T. A. Hope, and other licensee staff members, during which the team leader characterized the results of the in-office review following the team's departure from the site.

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

ATTACHMENT 1

PARTIAL LIST OF PERSONS CONTACTED

Licensee

O. Bhatty, Senior Engineer
R. Calder, Executive Assistant
T. Evans, Engineering Supervisor
C. Feist, Design Basis Engineer
R. Flores, System Engineering Manager
T. Hope, Regulatory Compliance Manager
J. Kelly, Vice President, Nuclear Engineering and Support
G. Krishnan, System Engineer
D. Riemer, Technical Support Manager
D. Snow, Senior Regulatory Compliance Specialist
C. Terry, Senior Vice President and Principal Nuclear Officer
R. Walker, Regulatory Affairs Manager

NRC

T. Gody, Senior Resident Inspector
J. Pellet, Chief, Operations Branch, DRS
J. Tapia, Chief, Project Branch A

PARTIAL LIST OF DOCUMENTS REVIEWED

PROCEDURES

STA-421, "Initiation and Processing of SmartForms," Revision 8
STA-422, "Disposition of SmartForms Identifying Potential Adverse Conditions, " Revision 15
STA-515, "Root Cause Analysis," Revision 6

SmartForms (Licensee's condition reporting documents)

NUMBER	DESCRIPTION	DATE
1998-2232-00	Replace drag valve with metering valves because of system flow changes	November 18, 1998
1999-0371-00	Qualifications of QC personnel	February 25, 1999
1999-0487-00	(ONE 98-0909) Hydrogen purge system license basis - PIR	March 9, 1999
1999-0698-00	Access authorization for protected and vital areas - PIR	March 25, 1999
1999-0800-00	Valve 2SI-8983 failed its as found set pressure - PIR	April 1, 1999
1999-0808-00	Evaluate continuous air monitoring practices	April 1, 1999

NUMBER	DESCRIPTION	DATE
1999-0813-00	Evaluate temporary shielding	April 2, 1999
1999-0884-00	Seven compressed gas bottles inadequately tied off	April 5, 1999
1999-0951-00	Operations surveillance tests not tracked to a LCOAR	April 8, 1999
1999-0992-00	Insufficient flow through SI hot leg injection lines	April 11, 1999
1999-1103-00	Check valve packing bar	April 20, 1999
1999-1103-00	Auxiliary feedwater check valves installed in system with shipping bars installed.	April 20, 1999
1999-1233-00	Level decreasing slowly in SI Accumulator 2-04	May 2, 1999
1999-1289-00	Missed testing on PORV actuation circuit - PIR	May 10, 1999
1999-1302-00	CCW DBD has incorrect setpoint for level	May 11, 1999
1999-1303-00	Inleakage into accumulator from RCS	May 11, 1999
1999-1321-00	SSEI TM and testing requirements for RMUWST	May 13, 1999
1999-1322-00	Calculation 16345 IC(B)-156 missing from vault	May 13, 1999
1999-1326-00	Disposition of IN 97-90	May 14, 1999
1999-1334-00	Calculation ME(B)-255 has non-conservative assumptions	May 17, 1999
1999-1339-00	Missed Surveillance IAW TS 4.7.1.4	May 18, 1999
1999-1353-00	Missed battery surveillance	May 19, 1999
1999-1376-00	BT1ED1 test current calculation	May 24, 1999
1999-1377-00	SW loop flow calculations did not include inaccuracy of flow elements	May 24, 1999
1999-1386-00	Limit switch for 1-HV-4573 setpoint development	May 25, 1999
1999-1396-00	Flow distribution during “P” signal not effectively determined	May 26, 1999
1999-1445-00	SIS accumulator is experiencing out leakage	June 7, 1999
1999-1645-00	Unit 2 reduction in power due to high sodium levels in steam generators	June 28, 1999
1999-1744-00	Inadequate design change for control room emergency pressurization unit	July 15, 1999

NUMBER	DESCRIPTION	DATE
1999-1832-00	First aid and rescue team training	July 28, 1999
1999-1902-00	Control rod urgent failure alarm received during downpower	July 31, 1999
1999-1903-00	Testing of EHC speed sensing circuit card causes 140 MWe load swing. MFP1-B control valve jammed in open position	July 31, 1999
1999-1914-00	During testing I&C technician tripped 3 loops	August 2, 1999
1999-1928-00	SGBD resin sluicing and transfer problems	August 2, 1999
1999-1929-00	Chlorine pump repetitive maintenance problem	August 3, 1999
1999-2063-00	Gaitronics system plant announcement during EP drill	August 17, 1999
1999-2079-00	Storage cart not restrained properly and the wheels were not locked as required.	August 18, 1999
1999-2090-00	Paint fumes in control room	August 19, 1999
1999-2096-00	Fire preplans may not consider impact on alternate trains	August 20, 1999
1999-2097-00	ESF exhaust fans did not respond as expected	August 20, 1999
1999-2098-00	NRC1999 82701 Inspection Items	August 20, 1999
1999-2108-00	Radiation monitor spiking into alarm	August 21, 1999
1999-2118-00	Eight violations of non-plant equipment storage and use procedure	August 24, 1999
1999-2128-00	Corrective actions for EP inspection items	August 25, 1999
1999-2140-00	Activation and operation of the EOF	August 26, 1999
1999-2227-00	Valves 1SI-8816A, B, C, & D have questionable stake marks in the outlet nozzle	September 7, 1999
1999-2262-00	Valve FCV-0121 packing problems	September 13, 1999
1999-2421-00	Valve 1PS-0268 failed in service	September 25, 1999
1999-2493-00	Found excessive amount of grease in the bearing housings of Rx coolant pipe penetration ventilation fans	September 29, 1999
1999-2502-00	Contractor using tobacco in RCA	September 28, 1999

NUMBER	DESCRIPTION	DATE
1999-2528-00	Valve bodies eroded	September 30, 1999
1999-2530-00	Rubber gloves not in use in RCA	September 26, 1999
1999-2578-00	At least 20 compressed gas bottles inadequately tied off	October 3, 1999
1999-2590-00	Plastic plug found in oil line on drain side of Safety Injection Pump 1-02	October 3, 1999
1999-2635-00	TSC plant computer terminal not working	September 21, 1999
1999-2637-00	Power supply failure	October 5, 1999
1999-2642-00	Valve 1HV-4514 o-ring is too big	October 6, 1999
1999-2650-00	Chain failure on RCP motor lift - PIR	October 6, 1999
1999-2679-00	PC glove liners and RCA tool found outside RCA	October 7, 1999
1999-2684-00	Existing T-rings installed in butterfly valves had become separated at manufacturer bond	October 7, 1999
1999-2717-00	Thimble plug set in wrong location	October 8, 1999
1999-2747-00	Vacuum breaker failed surveillance test	October 10, 1999
1999-2848-00	Starter in breaker for DG-1B jacket heater	October 15, 1999
1999-2859-00	Valve 1-8804B exceeded stroke time acceptance criteria	October 15, 1999
1999-2875-00	RMUW to CVCS header relief valve	October 17, 1999
1999-2905-00	Fuel assemblies loaded in wrong core locations - PIR	October 19, 1999
1999-2945-00	Failure codes not documented on work order	October 20, 1999
1999-3000-00	Valve 1-LCV-0459 failed stroke time	October 24, 1999
1999-3130-00	Generic Letter 96-06 resolutions	November 5, 1999
1999-3147-00	Recording error found on OPT-406-19 performed on 8-16-1999	November 8, 1999
1999-3201-00	Tracking of self assessment items on temp mods	November 15, 1999
1999-3216-00	1-RE-5100 transferred to co-current waste post comm. failure	November 17, 1999
1999-3260-00	Refusal to initiate a SmartForm for industrial safety concern	November 22, 1999

NUMBER	DESCRIPTION	DATE
1999-3276-00	MFIV 1-03 hydraulic pump was running continuously without increasing pressure - PIR	November 24, 1999
1999-3312-00	Radio communications consistently inadequate w/ ineffective CA	November 30, 1999
1999-3322-00	Blackstart radio would be lost on LOOP	November 22, 1999
1999-3341-00	Issues from NOD 1RF07 TS Eval. 1999-049	December 3, 1999
1999-3376-00	Radio communication problems In-Field	December 8, 1999
1999-3440-00	As found values for CCW flow to 2-01 RHR and 2-01 CS heat exchangers out of allowable band	December 16, 1999
1999-3468-00	MFIV hydraulic pump running longer than normally expected	December 20, 1999
1999-3504-00	Unit 2 breaker surveillance interval exceeded in the past	December 29, 1999
2000-0061-00	All three trains of AFW made inoperable during response to a Unit 2 blackout	January 8, 2000
2000-0094-00	Functional failures not documented on SmartForm	January 13, 2000
2000-0108-00	Broken flex conduit on security door	January 14, 2000
2000-0120-00	Software not evaluated for Y2K compliance	January 18, 2000
2000-0130-00	Resolution statement improperly documented	January 18, 2000
2000-0131-00	Corrective action statements improperly documented	January 18, 2000
2000-0132-00	Smart form closed without lessons learned being distributed	January 18, 2000
2000-0134-00	Smart form failed to properly document corrective actions taken	January 18, 2000
2000-0142-00	Compliance to RG 1.81 Rev 1 (dc systems in multi-unit nuclear power plants should not be shared	January 19, 2000
2000-0168-00	NRC security inspection finding	January 20, 2000
2000-0171-00	Failure to properly document engineering justification	January 20, 2000
2000-0178-00	ERO paging group page did not work on drill	January 20, 2000
2000-0180-00	During replacement of hydraulic pump for MFIV several parts were missing	January 21, 2000

NUMBER	DESCRIPTION	DATE
2000-0244-00	Valve 1-8047 exceeded alert limit for closed stroke time	January 29, 2000
2000-0246-00	DG 1-01 audible alarm horn failures	January 29, 2000
2000-0361-00	SPDS and ERDS inoperable in EOF	February 9, 2000
2000-0442-00	Safety valve leakage	February 17, 2000
2000-0542-00	NI power rancge drawers for flux mapping test connections	February 23, 2000
2000-0554-00	SW bearing cooler outlet flow switch	February 24, 2000
2000-0562-00	MFIV hydraulic pump running longer than normally expected	February 25, 2000
2000-0594-00	Maintenance rule review of functional failure on CCW (SMF-1999-3381-00) found not to be functional failure	March 1, 2000
2000-0723-01	MEL database information missing	May 31, 2000
2000-0998-00	2-FCV-0121 exceeds unavailability performance criteria	March 31, 2000
2000-1014-00	Siren CPX-EAS353-56 failed monthly sound test	April 3, 2000
2000-1033-00	Instrument air exceeding performance criteria	April 5, 2000
2000-1055-00	Exercise findings associated with fire drill.	April 7, 2000
2000-1204-00	VAU performance criteria exceeded	April 26, 2000
2000-1232-00	Calculations non-conservative	April 27, 2000
2000-1247-00	Use of toolpouch work type failure coding	May 1, 2000
2000-1343-00	Valve 2-2456 stroke time appeared to exceed alert limit	May 11, 2000
2000-1366-00	NOD Corrective Action Evaluation 2000-26 concerns	May 12, 2000
2000-1412-00	Corrective action for SMF-1999-0671 were not adequate	May 18, 2000
2000-1536-00	1-FCV-0121 exceeds unavailability performance criteria	June 1, 2000
2000-1655-00	Operations area for improvement identified by INPO	June 19, 2000
2000-1661-00	Refueling cavity skimmer pump failures	June 19, 2000

NUMBER	DESCRIPTION	DATE
2000-1768-00	Blown fuse and capacitors on charger	July 3, 2000
2000-1768-00	No failure code on work order	July 6, 2000
2000-1858-00	EP Baseline Inspection Items	July 24, 2000
2000-1890-00	JUMA audit recommendations	July 27, 2000

Plant Incident Reports

1999-002840-01-00	HD pipe support/evaluation team	October 18, 1999
1999-002598-01-00	SG went into Category C-3f due to greater than 1% of tubes tested being defective	October 4, 1999
2000-000059-01-00	ESF actuation following XST1 de-energizing	January 10, 2000
1999-001914-01-00	Instrument loops tripped accidentally	August 4, 1999
1999-001769-01-00	Emergency sirens rendered inoperable Following IT work	July 29, 1999
2000-001354-01-00	Surveillance inadvertently left off schedule	May 15, 2000
1999-001848-01-00	Design inconsistencies regarding grating clips	July 29, 1999
2000-001751-01-00	Safety near miss fuel building crane	July 3, 2000
1999-001902-01-00	Rod control urgent alarm due to multiplexing error	July 31, 1999
1999-003399-01-00	Unit PAL outer door equalizer valve open	December 7, 1999
2000-000879-01-00	Both instrument air compressors tripped	March 12, 2000

Licensee Event Reports

LER 445/99-002	Missed TS surveillance for steam generator gross activity comp. sampling
LER 446/00-001-00	18 month surveillance testing for the molded case circuit breakers was exceeded due to less than adequate scheduling coordination dtd. 1/27/00

Assessments and Audits

Nuclear Overview Department, Evaluation Report Eval-2000-016, Followup on ONE QAD-95-000599, March 7, 2000

Nuclear Overview Department, Evaluation Report Eval-2000-034, Review of Significant Events, April 26, 2000

Nuclear Overview Department, Evaluation Report Eval-2000-026, Corrective Action, April 24, 2000

Nuclear Overview Department, Evaluation Report Eval-2000-030, Performance of Failure Analysis, July 10, 2000

Nuclear Overview Department, Evaluation Report Eval-1999-032, Correlation of Performance Enhancement Data and SmartForm Initiation Threshold, September, 13, 1999

Nuclear Overview Department, Evaluation Report Eval-2000-033, Review of Programmatic SmartForms, May 26, 2000

Nuclear Overview Department, Evaluation Report Eval-2000-011, Nuclear Overview Evalaution and Results Engineering Predictive Maintenance Program Self Assessment, March 24, 2000

Nuclear Overview Department, Evaluation Report Eval-1999-015, Steam Generator Integrity Program, July 30, 1999

Control Room Habitability Self-Assessment Report, March 6 to 9, 2000

Miscellaneous

Trend Analysis of Shift Operations & Operations Support Dpt. SmartForms, April 19, 2000

Plant Performance Report June 2000

Managment Plant Performance Indicators Package June 2000

ATTACHMENT 2

Material Requested for the 71152 Inspection

- All procedures governing or applying to the corrective action program, including the processing of information regarding generic communications and industry operating experiences.
- Procedures and descriptions of any informal systems, especially used by operations, for issues below the threshold of the formal corrective action program.
- Index of all corrective action documents (e.g., condition reports) from July 1999 to June 2000.
- Index of corrective action documents broken down by organization from July 1999 to June 2000.
- All major corrective action documents (i.e., those that subsume or roll-up one or more smaller issues) since July 1999.
- All corrective action documents associated with non-escalated no response required or noncited violations since July 1999.
- All corrective action program reports or metrics (since July 1999) used for tracking effectiveness of the corrective action program.
- All risk analysis performed for currently open significant conditions adverse to quality (including open design modifications).
- All corrective action documents associated with:

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

- All corrective action documents associated with green findings of NRC inspection reports since July 1999.
- All corrective action documents related to the following industry operating experience generic communications:

Part 21 Reports:	NRC Generic Letters	NRC Information Notices
99-02	98-002	99-004
99-03	98-004	99-010
99-05	99-002	99-011
99-10		99-013
99-12		99-014
99-19		99-021
99-23		00-003
99-25		00-006
99-29		
99-35		

ATTACHMENT 3

NRC's REVISED REACTOR OVERSIGHT PROCESS

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

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

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

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

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

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

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