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

July 26, 2000

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

SUBJECT: NRC INSPECTION REPORT NO. 50-382/2000-05

Dear Mr. Dugger:

This refers to the inspection conducted on May 14 through July 1, 2000, at the Waterford Steam Electric Station, Unit 3 facility. The enclosed report presents the results of this inspection. The radiation safety results of this inspection were discussed on June 9, 2000, with Mr. E. Ewing, and other members of your staff. The remainder of the results of this inspection were discussed on July 6, 2000, with you and other members of your staff.

Based on the results of this inspection, three issues of very low safety significance (Green) were identified. These issues were determined to involve violations of NRC requirements. However, the violations were not cited because of their very low safety significance and because they have been entered into your corrective action program. If you contest these noncited violations, you should provide a response within 30 days of the date of this inspection report, with the basis for your denial, to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington DC 20555-0001, with copies to the Regional Administrator, U.S. Nuclear Regulatory Commission, Region IV, 611 Ryan Plaza Drive, Suite 400, Arlington, Texas 76011, the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001; and the NRC Resident Inspector at the Waterford Steam Electric Station, Unit 3 facility.

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 /

Linda Joy Smith, Chief
Project Branch E
Division of Reactor Projects

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

Enclosures:
NRC Inspection Report No.
50-382/2000-05

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Only inspection reports to the following:
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NRR Event Tracking System **(IPAS)**
WAT Site Secretary **(AHY)**

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ENCLOSURE

U.S. NUCLEAR REGULATORY COMMISSION
REGION IV

Docket No.: 50-382

License No.: NPF-38

Report No.: 50-382/2000-005

Licensee: Entergy Operations, Inc.

Facility: Waterford Steam Electric Station, Unit 3

Location: Hwy. 18
Killona, Louisiana

Dates: May 15 through July 1, 2000

Inspectors: T. R. Farnholtz, Senior Resident Inspector
J. M. Keeton, Resident Inspector
L. T. Ricketson, Senior Health Physicist

Approved By: L. J. Smith, Chief, Project Branch E

ATTACHMENTS:

Attachment 1: Supplemental Information

Attachment 2: NRC's Revised Reactor Oversight Process

SUMMARY OF FINDINGS

Waterford Steam Electric Station, Unit 3
NRC Inspection Report 50-382/2000-005

The report covers a 7-week period of resident inspection and an announced inspection by a regional health physicist. The significance of issues is indicated by their color (green, white, yellow, or red) and was determined by the significance determination process in Inspection Manual Chapter 0609.

Cornerstone: Mitigating Systems

- Green. The inspectors identified discrepancies in the portable fire extinguisher monthly inspection process. Discrepancies included inconsistencies between the fire extinguisher list and the corresponding maps of fire extinguisher locations, expired hydrostatic test dates on fire extinguishers, and lack of training for personnel performing the monthly inspections. A total of 35 fire extinguishers with expired or unknown hydrostatic test performance dates were identified. Technical Specification 6.8.1.f, "Fire Protection Program Implementation," required that fire protection procedures shall be implemented. Procedure MM-007-010, "Fire Extinguisher Inspection and Extinguisher Replacement," described the requirements for fire extinguisher inspections. This failure to ensure that fire extinguishers were within their current hydrostatic test date was a violation of Technical Specification 6.8.1.f. This violation is being treated as a noncited violation and is in the corrective action program as Condition Reports 2000-0504 and 2000-0530.

  The inspectors assessed this issue using the reactor safety significance determination process. The inspectors found that the issue had very low risk significance because the overall condition of portable fire extinguishers was considered adequate, although degraded (Section 1R05).

- Green. The inspectors identified that the specified postmaintenance tests conducted following corrective maintenance on Charging Pump AB were not adequate to identify incorrectly performed maintenance. Specifically, inadequate maintenance resulted in oil seals installed incorrectly and low oil pressure. These conditions were not identified during postmaintenance testing and resulted in the equipment being out of service for a longer period of time than was necessary. This failure to establish adequate postmaintenance test procedures was a violation of 10 CFR Part 50, Appendix B, Criterion V. This violation is being treated as a noncited violation and is in the corrective action program as Condition Report 2000-0679.

  The inspectors assessed this issue using the reactor safety significance determination process. The finding had very low risk significance. Since Charging Pumps A and B were always available, both trains of the chemical and volume control system remained operable (Section 1R19).

Cornerstone: Public Radiation Safety

- Green. During NRC Inspection 50-382/99-19, the inspector determined that a portion of the radiological environmental monitoring program was not implemented as described in

the Offsite Dose Calculation Manual. Specifically, the broadleaf control station was not located in the least prevalent wind direction, as described. The finding was identified as an unresolved item, pending licensee review of historical information about the sample location. Since that inspection, the licensee had been unable to justify the change in the broadleaf control station location. Technical Specification 6.8.1.j requires that the Radiological Environmental Monitoring Program be implemented as described in the Offsite Dose Calculation Manual. The Offsite Dose Calculation Manual, Attachment 7.23, required that radiological environmental monitoring program be implemented as required by the Technical Requirements Manual, Table 3.12-1. The Technical Requirements Manual , Table 3.12-1 Section 4c, required that the broadleaf control sample point be located in the least prevalent wind direction. The failure to place the broadleaf control station in the least prevalent wind direction is a violation of Technical Specification 6.8.1.j. This violation is being treated as a noncited violation, consistent with Section VI.A of the NRC Enforcement Policy. This violation is in the corrective action program as Condition Report 1999-1004.

The inspectors assessed this issue using the public radiation safety significance determination process. The inspectors determined that the deficiency had very low risk significance because there was no specific event or abnormal radioactive release associated with the finding. Additionally, had there been an event, the licensee had other radiological environmental monitoring data, so the licensee had maintained the ability to assess the environmental impact (Section 2PS3).

Report Details

Summary of Plant Status: The plant was operating at full power from the beginning of this inspection period until June 8, 2000, when the plant was shut down for a planned maintenance outage. A plant startup was conducted on June 15 and full power was achieved on June 16. The plant remained at that level for the remainder of this inspection period.

1 REACTOR SAFETY

Cornerstones: Initiating Events, Mitigating Systems, Barrier Integrity (R)

1R01 Adverse Weather (71111.01)

a. Inspection Scope

The inspectors reviewed appropriate plant documents such as technical specifications and plant logs for surveillance currency of the emergency diesel generators and the ultimate heat sink to verify that continued operability of the systems during hurricanes and tornadoes had been appropriately addressed. The inspectors also reviewed Procedure OP-901-521, "Severe Weather and Flooding," Revision 3, to verify operator actions focused on maintaining readiness of essential systems.

b. Issues and Findings

There were no findings identified during this inspection.

1R04 Equipment Alignments (71111.04)

Partial Alignment

a. Inspection Scope

The inspectors reviewed the mechanical and electrical alignment of Essential Chiller AB, which was in operation at a time when Essential Chiller A was taken out of service for planned maintenance activities. The review was conducted using Procedure OP-002-004, "Chilled Water System," Revision 11.

b. Issues and Findings

There were no findings identified during this inspection.

1R05 Fire Protection (71111.05)

.1 Tour of Plant Areas

a. Inspection Scope

The inspectors toured the fire pump rooms, transformer deluge systems, and main switchgear and assessed the material condition of the active and manual fire suppression systems.

b. Observations and Findings

There were no findings identified during this inspection.

.2 Monthly Inspection of Fire Extinguishers

a. Inspection Scope

The inspectors reviewed the fire extinguisher surveillance process required by Procedure MM-007-010, "Fire Extinguisher Inspection and Extinguisher Replacement," Revision 11.

b. Issues and Findings

The inspectors identified discrepancies in the fire extinguisher monthly inspection process and found that inspections had not been conducted and documented in accordance with procedures or management expectations.

On May 19, 2000, during a periodic tour of a plant area important to safety, the inspectors identified a fire extinguisher inspection tag that had not been stamped for the previous month (April) as required by procedures. The inspectors related the discrepancy to the shift manager and Condition Report 2000-0504 was written. Followup revealed that the fire extinguisher had been signed off on Attachment 12.3 to Procedure MM-007-010 as having received appropriate inspection even though the tag had not been stamped. The licensee conducted additional inspections of fire extinguishers in response to Condition Report 2000-0504 and found several other discrepancies. These were documented in Condition Report 2000-0530 initiated on May 24. The deficiencies included discrepancies between the fire extinguisher list in Attachment 12.3 and area maps showing fire extinguisher locations, expired hydrostatic test dates on fire extinguishers, and lack of training for personnel performing the monthly inspections. Based on these findings, the inspectors concluded that many aspects of the portable fire extinguisher program had not been maintained at an acceptable level.

The licensee placed the identified problems into their corrective action program. The inspectors determined that this issue did not contribute to a measurable increase in plant risk; therefore, the issue screened out of the significance determination process at Phase 2 and is green.

The National Fire Protection Association Standard 10, "Portable Fire Extinguisher," requires hydrostatic testing of portable fire extinguishers at specific time intervals based on type. Technical Specification 6.8.1.f, "Fire Protection Program Implementation," requires that procedures shall be implemented. Procedure MM-007-010, Section 8.2.5, establishes acceptance criteria for fire extinguishers as being within their current hydrostatic test date, yearly maintenance date, and 6-year maintenance date. Contrary to these requirements, the licensee identified 35 fire extinguishers that had expired or had unknown hydrostatic performance dates. This violation is being treated as a noncited violation, consistent with Section VI.A of the NRC Enforcement Policy. This

violation is in the corrective action program as Condition Report 2000-0530 (NCV 50-382/0005-01).

The inspectors assessed this issue using the reactor safety significance determination process. The inspectors found that the issue had very low risk significance because the overall condition of portable fire extinguishers was considered adequate, although degraded.

.3 Containment Building Walkdown

a. Inspection Scope

The inspectors conducted a detailed walkdown of all levels and areas of the containment building during the planned maintenance outage. Fire suppression equipment was observed and the general condition of plant equipment was inspected.

b. Issues and Findings

There were no findings identified during this inspection.

1R12 Maintenance Rule Implementation (71111.12)

a. Inspection Scope

The inspectors reviewed the maintenance rule data for the following:

- Main feedwater system as it applies to the main feedwater insolation valves. These valves have had frequent problems in meeting required stroke times. The inspectors reviewed Engineering Evaluation ER-0464, “Main Feedwater Isolation Valve (MFIV) Stroke Time Operability Criteria Input,” past functional failure determination criteria, performance criteria, and actions taken by the licensee.

- Broad range toxic gas monitor system. The inspectors reviewed the operational history; interviewed the maintenance rule coordinator; and assessed the maintenance rule functions, unavailability criteria, and reliability criteria. This system is classified as a (1) in the maintenance rule.

- Chemical and volume control system as it applies to the charging pumps. Charging Pump AB experienced a maintenance problem during this inspection period. The inspectors reviewed the maintenance history, interviewed the maintenance rule coordinator, and assessed the maintenance rule functions for this system.

b. Issues and Findings

There were no findings identified during this inspection.

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

.1 Actuator Replacement on Shutdown Cooling Suction Isolation Valve SI-405B

a. Inspection Scope

The inspectors reviewed Work Control Package MAI 414130 and verified that the appropriate risk assessments for performance of the actuator replacement on Shutdown Cooling Suction Isolation Valve SI-405B in the existing plant configuration had been considered. The inspectors also reviewed the Technical Specifications to verify that the licensee was in compliance with these requirements throughout the duration of the maintenance activity.

b. Issues and Findings

There were no findings identified during this inspection.

.2 Rigging of Containment Fan Cooler C and Removal from Containment

a. Inspection Scope

The inspectors reviewed Engineering Request ER-0339, "Rigging of FCCSMAHU0001 C Blower Out of Containment," and Work Control Package MAI 416627 for removal of the containment fan cooler assembly from the containment building. The calculations for determining the adequacy of the support structures and movement path of the fan cooler assembly were assessed to ensure that these activities minimized risk.

b. Issues and Findings

There were no findings identified during this inspection.

1R15 Operability Evaluations (71111.15)

a. Inspection Scope

The inspectors reviewed the operability evaluations associated with the following condition reports:

- 2000-0470 Potential for failure of a boric acid makeup tank gravity feed valve to open to the charging pump suction header following a main steam line break and a loss of off site power.

- 2000-0653 Excessive pressures in Main Feedwater Isolation Valve 1 operator accumulators.

b. Issues and Findings

There were no findings identified during this inspection.

1R19 Postmaintenance Testing (71111.19)

.1 Postmaintenance Testing on Shutdown Cooling Suction Isolation Valve SI-405B

a. Inspection Scope

The inspectors reviewed the postmaintenance testing conducted on Reactor Coolant System Loop 1 Shutdown Cooling Suction Isolation Valve SI-405B. The operator for this valve was replaced during the planned maintenance outage. The postmaintenance testing was conducted in accordance with Procedures OP-903-008, "Reactor Coolant System Isolation Leakage Test," Revision 5, and OP-903-033, "Cold Shutdown IST Valve Tests," Revision 15. These two test procedures measured the leak rate and the stroke time of the valve, respectively.

b. Issues and Findings

There were no findings identified during this inspection.

.2 Postmaintenance Testing on Charging Pump AB

a. Inspection Scope

The inspectors reviewed the postmaintenance testing conducted following maintenance on Charging Pump AB.

b. Issues and Findings

On June 9, 2000, the licensee identified that Charging Pump AB exhibited internal leakage, which resulted in a low discharge flow rate at low reactor coolant system pressures. The pump was tagged out for maintenance and Condition Report 2000-0602 was generated. The inspectors reviewed the two primary work packages, MAI 409195 and MAI 406603, to determine the extent of work performed and the adequacy of the postmaintenance testing. Major maintenance was performed including replacement of gaskets, seals, and fittings along with replacement of the pump packing and internal suction and discharge valves.

Following completion of this work, specified postmaintenance testing was conducted. Work Package MAI 409195 specified postmaintenance testing as (1) monitor pump for leakage when running and (2) perform the pump inservice test in accordance with Procedure OP-903-003, "Charging Pump Operability Check," Revision 10. The test requirements did not specify what type of leakage to monitor (i.e., water or oil) or specifically where to examine for possible leaks. The inservice test measured the discharge flow rate and the inboard and outboard pump bearing vibration levels. In addition, the equipment out-of-service retest sheet contained a note stating that mechanical maintenance technicians were to set the oil pressure regulator prior to performing the test with the pump running. The tests were completed and documented as having satisfactory results and the pump was declared operable and returned to service.

On June 20, the pump was again declared inoperable and tagged out when a knocking noise was heard from the pump during operation. The licensee determined that a crosshead adjustment was required and that oil seals were not installed properly during the previous maintenance effort. These items were corrected and the pump inservice test (Procedure OP-903-003) was again performed to verify correct pump operation. No tests for seal leakage were documented. Several hours after the completion of the test but before the pump was declared operable, a plant operator identified that the oil pressure was 23 psig. The normal oil pressure on an operating charging pump ranges from 34 to 37 psig. Condition Report 2000-0679 was generated to document this condition. The inspectors determined that this condition did not lead to any measurable change in plant risk; therefore, the issue had very low safety significance. Since Charging Pumps A and B were always available, both trains of the chemical and volume control system remained operable. The issue did not meet the initial significance determination process screening and is green.

Appendix B, Criterion V of 10 CFR Part 50 states, in part, instructions, procedures, or drawings shall include appropriate quantitative or qualitative acceptance criteria for determining that important activities have been satisfactorily accomplished. Contrary to this requirement, the inspectors considered the specified postmaintenance tests inadequate because these tests did not verify all the pump parameters affected by the maintenance performed. Specifically, inadequate maintenance resulted in oil seals installed incorrectly and low oil pressure. These conditions were not identified as a result of postmaintenance testing and resulted in the equipment being out of service for a longer period of time than was necessary. This violation is being treated as a noncited violation, consistent with Section VI.A of the NRC Enforcement Policy. This violation is in the corrective action program as Condition Report 2000-0679 (NCV 50-382/0005-02).

1R20 Refueling and Outage (71111.20)

a. Inspection Scope

The inspectors reviewed the outage plan and the outage risk management team activities that were performed in preparation for a planned maintenance outage. The inspectors verified that shutdown and cooldown activities were in accordance with the Technical Specifications and Procedure OP-010-005, “Plant Shutdown,” Revision 0, requirements; an equipment tagout was in accordance with Procedure UNT-005-003, “Clearance Request, Approval, and Release,” Revision 16; shutdown cooling had been appropriately established and monitored; and the reactor startup was performed in accordance with Procedure OP-010-003, “Plant Startup,” Revision 0.

b. Issues and Findings

There were no findings identified during this inspection.

1R22 Surveillance Testing (71111.22)

.1 Containment Personnel Hatch Seal Test

a. Inspection Scope

The inspectors observed the performance of the containment personnel door seal test for both the inner and outer doors. The test was performed in accordance with Procedure STA-001-001, "Containment Air Lock Door Seal Leakage Test," Revision 3.

b. Observations and Findings

There were no findings identified during this inspection.

.2 Emergency Diesel Generator B Test

a. Inspection Scope

The inspectors observed portions of the Emergency Diesel Generator B surveillance test on June 26, 2000. The test was conducted in accordance with Procedure OP-903-068, "Emergency Diesel Generator and Subgroup Relay Operability Verification," Revision 12.

b. Issues and Findings

There were no findings identified during this inspection.

.3 High-Pressure Safety Injection Pump AB Test

a. Inspection Scope

The inspectors observed a scheduled surveillance test of High-Pressure Safety Injection Pump AB. The test was conducted using Procedures OP-903-011, "High Pressure Safety Injection Pump Preservice Check," Revision 8, and OP-903-030, "Safety Injection Pump Operability Verification," Revision 13.

b. Issues and Findings

There were no findings identified during this inspection.

1R23 Temporary Plant Modifications (71111.23)

a. Inspection Scope

The inspectors reviewed Engineering Request ER-W3-00-0042-02-00, "Installation of Temporary Cover for Hatch in Reactor Auxiliary Building +21 Floor." This temporary cover allowed installation of required piping to be used for steam generator chemical cleaning during Refueling Outage 10 scheduled for Fall, 2000. The temporary alteration

was performed in accordance with Procedure UNT-005-004, “Temporary Alteration Control,” Revision 14.

b. Issues and Findings

There were no findings identified during this inspection.

2 RADIATION SAFETY

Cornerstones: Occupational Radiation Safety (OS), Public Radiation Safety (PS)

2OS2 ALARA Planning and Controls (71121.02)

a. Inspection Scope

Independent radiation surveys of selected work areas within the controlled access area were performed. The following items were reviewed:

- ALARA program procedures
- Processes used to estimate and track exposures
- Plant collective exposure history for the past 3 years, current exposure trends, and 3-year rolling average dose information
- Twelve radiation work permit packages from the outage/online work activities, which resulted in the highest personnel collective exposures during the inspection period
- Available data for trends in collective exposures and source term measurements
- Hot spot tracking and reduction program
- Plant related source term data, including source term control strategy
- Radiological work planning
- Selected corrective action documentation [involving higher than planned exposures and radiation worker practice deficiencies since the last inspection in this area]
- Declared pregnant worker dose monitoring controls

b. Findings

The inspectors identified no findings during this inspection.

2PS3 Radiological Environmental Monitoring Program (71122.03)

(Closed) Unresolved Item (URI) 50-382/9919-01: Broadleaf Control Station Placement

The inspectors found that the broadleaf control station was not located in the least prevalent wind direction. This appeared to be a violation of Technical Specification 6.8.1.j, which required that the sampling station be located as described in the Offsite Dose Calculation Manual. However, because the finding was identified late in the inspection, it was treated as an unresolved item until the licensee had sufficient time to review the matter and determine the reason for the sample relocation.

Licensee representatives reviewed the matter but were unable to justify the sample location change. Therefore, the inspectors identified the placement of the broadleaf control station in a location other than the least prevalent wind direction as a violation of Technical Specification 6.8.1.j. This violation is being treated as a noncited violation, consistent with Section VI.A of the NRC Enforcement Policy. This violation is in the corrective action program as Condition Report 1999-1004.

The inspectors assessed this issue using the public radiation safety significance determination process. The inspectors determined that the deficiency had very low risk significance because the violation did not result in a failure to assess the environmental impact. Additionally, had there been an event, the licensee had other radiological environmental monitoring data, so the licensee maintained the ability to assess the environmental impact (NCV 50-382/0005-03).

4 OTHER ACTIVITIES (OA)

4OA1 Performance Indicator Verification (71151)

a. Inspection Scope

The inspectors reviewed the performance indicator data for the following:

- Unplanned scrams per 7,000 critical hours
- Unplanned power changes per 7,000 critical hours

Both these performance indicators are included in the initiating events cornerstone.

b. Issues and Findings

There were no findings identified during this inspection.

4OA5 Meetings

Exit Meeting Summaries

.1 The regional based health physics inspector presented the inspection results to Mr. E. Ewing, General Manager, and other members of licensee management at the conclusion of the inspection on June 9, 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

.2 The resident inspectors presented the inspection results to Mr. C. Dugger, Site Vice President, and other members of licensee management at the conclusion of the inspection on July 6, 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.

ATTACHMENT 1

PARTIAL LIST OF PERSONS CONTACTED

Licensee

J. R. Douet, Manager, Operations
C. M. Dugger, Vice-President, Operations
E. C. Ewing, General Manager, Plant Operations
R. M. Fili, Manager, Quality Assurance
C. Fugate, Manager, Technical Support
P. A. Gropp, Acting Director, Engineering
J. D. Hunsaker, Manager, Site Support
T. P. Lett, Superintendent, Radiation Protection
D. Miller, ALARA Specialist, Radiation Protection
J. M. O'Hern, Manager, Training and Emergency Planning
E. P. Perkins, Jr., Director, Nuclear Safety Assurance
C. Pickering, Engineer, Licensing
J. A. Ridgel, Manager, Plant Maintenance
L. N. Rushing, Manager, System Engineering
B. E. Thigpen, Manager, Planning and Scheduling

ITEMS OPENED AND CLOSED

Opened

50-382/0005-01	NCV	Problems Implementing Program for Monthly Inspection of Fire Extinguishers (Section 1R05)
50-382/0005-02	NCV	Review of Postmaintenance Testing on Charging Pump AB (Section 1R19)
50-382/0005-03	NCV	Broadleaf Control Station Placement (Section 2PS3)

Closed

50-382/0005-01	NCV	Problems Implementing Program for Monthly Inspection of Fire Extinguishers (Section 1R05)
50-382/0005-02	NCV	Review of Postmaintenance Testing on Charging Pump AB (Section 1R19)
50-382/9919-01	URI	Broadleaf Control Station Placement (Section 2PS3)
50-382/0005-03	NCV	Broadleaf Control Station Placement (Section 2PS3)

LIST OF ACRONYMS USED

CFR	Code of Federal Regulations
NCV	noncited violation
NRC	Nuclear Regulatory Commission
URI	unresolved item

DOCUMENTS REVIEWED

Procedures

HP-001-101	ALARA Program Implementation, Revision 12
HP-001-102	Respiratory Protection, Revision 7
HP-001-109	Dosimetry Administration, Revision 18
HP-001-110	Radiation Work Permits, Revision 17
HP-001-160	Control of Airborne Exposure (DAC-Hours) and Use of Respiratory Protection Equipment, Revision 15
W4.104	Engineering Request Process, Revision 3

Engineering Request ER-W3-00-0071-02-00

ALARA Committee Meeting Minutes

99-1 (February 9, 1999)
99-2S (March 15, 1999)
99-3 (June 17, 1999)
99-4 (September 9, 1999)
99-5 (December 9, 1999)
00-1 (March 9, 2000)

Radiation Work Permits

1999-3007
1999-3022
1999-3023
1999-5016
1999-7006
2000-0303
2000-0304
2000-0305
2000-0307
2000-0309
2000-0310
2000-0311

ATTACHMENT 2

NRC'S REVISED REACTOR OVERSIGHT PROCESS

The federal Nuclear Regulatory Commission (NRC) 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 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 used 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. 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 plan, as described in the Action Matrix.

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