

4. Is the revised reactor oversight process faulty with its focus on a single event? - Isn't it a better indicator of the overall plant performance to include some recent past history? A "good performer" would be much less likely to have two events in a row that had significance. IP2 may be one of the worst "combination" of events ever. It wouldn't be a major effort to look back on previous trip or two at a plant involved in a potentially serious event.

The new reactor oversight process (ROP) is not focused on a single event, and does use recent plant history as an overall indication of plant performance. Through the use of an "Action Matrix," the assessment process integrates numerous inputs reflecting recent plant history to identify declining licensee performance that warrants increased NRC interaction. The inputs to the "Action Matrix" include both performance indicators (PIs) and inspection findings.

Each of the 18 PIs included in the ROP are based on at least 12 months of data to calculate the indicator, with several of the indicators based on 24 or 36 months of data. This allows recent plant events and issues to be integrated in a meaningful way, with the data applied against thresholds to indicate when additional agency action is warranted. For example both the August 1999 and February 2000 reactor trips were counted in the Unplanned Scrams PI, and resulted in this PI crossing the Green/White threshold for the 2nd quarter 2000, indicating the need for increased regulatory oversight above the baseline inspection program.

In addition, each inspection finding is evaluated through the Significance Determination Process (SDP) to characterize the risk significance of the issue. The SDP does require that concurrent performance deficiencies be assessed collectively to determine the total contribution to change in the core damage frequency (Δ CDF). This allows the collective assessment of a combination of different deficiencies that although may have been discovered at different times, occurred concurrently and impacted licensee performance. However, the SDP evaluation must be based on known existing facts and should not include hypothetical failures. For example, in evaluating the risk significance of the February 2000 steam generator tube failure (SGTF), it would be inappropriate to include the equipment failures that occurred during August 1999 loss of offsite power (LOOP) event, since these failures had been corrected and did not occur during the February 2000 event.

Logically incorrect. SDP is a Δ CDF analysis. During that year, frequency of SBO CO sequences was elevated by conditions revealed by any event. Evaluation SBO CO sequences given higher BLER for your view tube weakness is consideration.

The SDP evaluation of the August 1999 reactor trip event determined that this was a Yellow finding, with substantial safety significance. The SDP evaluation of the February 2000 SGTF determined that this was a Red finding, with high safety significance and a significant reduction in safety margin. Subsequent to the SGTF and the identification of degraded steam generator tubes, the staff re-evaluated the conditional core damage probability (CCDP) for the August 1999 event and included the potential for a steam generator tube rupture (SGTR) to have occurred during this event. The staff concluded that there was not a significant change to the CCDP for the August 1999 LOOP event when the potential for a SGTR to complicate the sequences leading to core damage were made more likely. The staff is evaluating the need for revising the SDP to account for the re-evaluation of findings when new, risk-significant deficiencies are later identified and are found to have existed concurrently with the original issue.

The assessment process uses the "Action Matrix" to integrate these PI and SDP results and

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determine the appropriate level of NRC interaction based on these indications of licensee performance. The assessment process uses a 12-month rolling window of data to allow the accumulation of risk-significant issues, which may be indicative of systemic and pervasive breakdowns in licensee performance. As described in the Indian Point 2 Assessment Follow-up letter dated October 10, 2000, the PI and inspection finding data collected over the previous year indicated that several cornerstones of safety were degraded, principally associated with the August 1999 reactor trip and the February 2000 SGTF. As directed by the "Action Matrix," this resulted in the conduct of several NRC activities above the baseline level of oversight, such as monitoring the licensee's performance improvement plan and the conduct of an independent team inspection to diagnose the breadth and depth of the safety, organizational, and programmatic issues that led to the degraded cornerstones of safety.