

# UNITED STATES OF AMERICA NUCLEAR REGULATORY COMMISSION

Title: PERIODIC BRIEFING ON OPERATING REACTORS AND  
FUEL FACILITIES

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UNITED STATES OF AMERICA  
NUCLEAR REGULATORY COMMISSION

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PERIODIC BRIEFING ON OPERATING  
REACTORS AND FUEL FACILITIES

- - - -

PUBLIC MEETING

Nuclear Regulatory Commission  
One White Flint North  
Rockville, Maryland

Thursday, January 27, 1994

The Commission met in open session,  
pursuant to notice, at 1:30 p.m., Ivan Selin,  
Chairman, presiding.

COMMISSIONERS PRESENT:

IVAN SELIN, Chairman of the Commission  
KENNETH C. ROGERS, Commissioner  
FORREST J. REMICK, Commissioner  
E. GAIL de PLANQUE, Commissioner

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STAFF SEATED AT THE COMMISSION TABLE:

JOHN HOYLE, Office of the Secretary

KAREN CYR, Office of the General Counsel

JAMES TAYLOR, Executive Director for Operations

THOMAS MURLEY, Director, NRR

ROBERT BERNERO, Director, NMSS

THOMAS MARTIN, Region I Administrator

STEWART EBNETER, Region II Administrator

JOHN MARTIN, Region III Administrator

JOE CALLAN, Region IV Administrator

KENNETH PERKINS, Region V Administrator

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P-R-O-C-E-E-D-I-N-G-S

1:30 p.m.

CHAIRMAN SELIN: Good afternoon, ladies and gentlemen.

The Commission is meeting now to receive a briefing from our staff on the status of operating reactors and fuel facilities. This is a semi-annual presentation of the results of discussions, these held at the most recent NRC senior management meeting in January 11th, 12th and 13th at our Region IV office. During these meetings, the senior NRC staff performs detailed evaluations of those licensees selected for discussion.

The observations and recommendations presented today are a result of the Agency's senior managers as a group reviewing the performance of operating reactors and fuel facilities across the country. This review includes inspection results, scores on our systematic assessment of licensee performance, events, performance indicators, enforcement history and recent changes to the plant. The evaluation serves a leveling function to assure that the standards are applied or a standardization function to assure that we apply these standards evenly across the country.

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1 In my opinion, these meetings have been  
2 very effective in determining which licensees need  
3 additional attention and where our limited resources  
4 could be most effectively used in carrying out the  
5 Agency's mission.

6 The Commission is, without exaggeration,  
7 quite eager to receive the staff's observations and  
8 recommendations.

9 Copies of the viewgraphs are available at  
10 the entrance to the room.

11 Mr. Taylor?

12 MR. TAYLOR: Good afternoon. With me at  
13 the table are Doctor Murley from NRR and Bob Bernero  
14 from NMSS and the five regional administrators. I  
15 would note that this is Mr. Callan's first appearance  
16 as a regional administrator with the Commission.

17 I would like to speak for just a moment to  
18 talk about the use of the so-called trending letters  
19 which we issue where performance is trending  
20 adversely. We believe that this particular situation  
21 needs to be communicated to the corporate president or  
22 the board of directors. I thought I'd talk about this  
23 for the benefit of all.

24 This type of letter was only initiated at  
25 the previous NRC senior management meeting in June of

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1 last year. I would also note that the practice was  
2 suggested by the Commission itself in a staff  
3 requirements memorandum issued to the staff in May of  
4 1993. The Commission idea, as I understand it, was  
5 to send an early warning, the purpose of which was to  
6 get corrective action in the highest levels of the  
7 corporation so that it would not be necessary to put  
8 a plant on the so-called problem plant list.

9 The staff supports that idea and you'll  
10 hear today about how it has successfully been applied  
11 to the Perry Station. In addition, you will hear of  
12 how it is currently being applied to three additional  
13 nuclear power stations.

14 I would emphasize to all that receiving a  
15 trending type notification is not, and I emphasize  
16 not, the same NRC action as being placed on what is  
17 called the problem plant list. Certainly failure to  
18 heed the message of a trending letter could, however,  
19 ultimately lead, if conditions were not corrected, to  
20 a plant being designated as a problem plant. But it  
21 is not the same. I thought that brief discussion was  
22 important since this is only the second meeting in  
23 which the staff has utilized this tool at the  
24 suggestion of the Commission.

25 Now I'll ask Tom Murley to continue. Tom

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1 will touch on some of the background of what we do at  
2 the senior management meeting and the elements  
3 considered. You mentioned some, Mr. Chairman. Then  
4 we'll continue on with the actual plant discussions.

5 Tom?

6 DOCTOR MURLEY: Thank you, Jim.

7 Commissioners.

8 In preparation for our January senior  
9 management meeting, we held a series of meetings in  
10 November of this year where NRR and AEOD staff met  
11 with the regional administrators and we reviewed the  
12 performance of each nuclear plant in the country.  
13 From these screening meetings then, the regional  
14 administrators and I selected for further analysis an  
15 in-depth discussion those plants that we wanted to  
16 analyze further at the senior management meeting  
17 itself.

18 This review process has become the central  
19 feature of the staff's process for evaluating  
20 operational safety in the United States. The meetings  
21 bring together the most experienced people in the  
22 staff with the purpose of being able to get their  
23 views and assess the information about operational  
24 safety. We gather together a great deal of plant  
25 performance that exists throughout the Agency in

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1 preparation for this meeting. Most important, of  
2 course, are the findings from our own inspection  
3 reports, from resident inspection reports, specialist  
4 inspections and team inspections, and the conclusions  
5 from the most recent SALP reports for that plant. But  
6 we also look at other things like the risk insights  
7 from the plants own IPE or if the NRC has a PRA for  
8 that plant. We look at the operating event history,  
9 particularly any severe accident precursor events. We  
10 look at the performance indicators, the operator  
11 requalification exam records, the status and condition  
12 of plant equipment as determined through our  
13 inspections, and the enforcement history at the site.

14 The central focus of the meetings is to  
15 determine whether the operational performance of these  
16 plants being discussed has revealed weaknesses or  
17 downward trends that warrant increased NRC regulatory  
18 attention. But we also review plants that have been  
19 found to have good safety performance over the past  
20 year or so and I'll talk about those first.

21 What the staff considers in good  
22 performance are primarily the recent SALP results for  
23 that plant. But we also weigh the plant's enforcement  
24 history and particularly the licensee's approach to  
25 self-assessment and problem resolution. Among those

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1 plants that we've discussed, we've concluded that ten  
2 have shown consistently high performance and warrant  
3 recognition and reduced inspection activity.

4 (Slide) If I could have the second slide,  
5 please. Yes.

6 These ten plants include Diablo Canyon 1  
7 and 2, Grand Gulf, St. Lucie 1 and 2 and Summer, which  
8 were all on the list last time. But there have been  
9 four new plants added which are Callaway and  
10 Monticello and Byron 1 and 2.

11 With Byron, this is the first time that a  
12 utility has had plants on the good performer list and  
13 the watch list simultaneously.

14 (Slide) Now I'll turn the watch list, if  
15 I could have slide 3.

16 COMMISSIONER REMICK: Tom, before you  
17 leave that, how far along are we on the pilot program  
18 for identifying good performers? I think that was to  
19 be a trial period, but I forget how many years and how  
20 far along. Does anybody remember?

21 DOCTOR MURLEY: Yes. I don't recall the  
22 exact time or actually what's next. We treat it as  
23 pretty much a standard effort, but we realize I think  
24 we do have to get back to the Commission.

25 COMMISSIONER REMICK: Okay.

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1 COMMISSIONER ROGERS: Yes, we're pretty  
2 close to the end of that cycle, I think. One more, I  
3 think, to go.

4 MR. TAYLOR: Yes, I think it is.

5 COMMISSIONER ROGERS: Yes.

6 MR. TAYLOR: We'll check that and get back  
7 to you. We're close. I think it was two years  
8 approximately, but we'll check that.

9 DOCTOR MURLEY: Could I have slide 3,  
10 please?

11 Turning to the watch list, category 1  
12 plants are those that have been removed from the watch  
13 list. The evaluation factors that the staff considers  
14 for removal from the watch list are the following.  
15 They're really questions that we ask. Has the  
16 licensee identified the fundamental problems and their  
17 root cause? The second question is has the licensee  
18 identified and developed a corrective action plan and  
19 begun to take steps to implement that plan? Is there  
20 evidence that the corrective actions are working and  
21 performance is improving in the plant? We use  
22 judgment in assessing the answers to those questions.  
23 And also, I should add for two unit sites the staff in  
24 the past has expected to see a period of operation of  
25 both units before removal from the watch list. The

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1 staff judges that Fitzpatrick is a category 1 plant at  
2 this time and Tim Martin will later discuss the  
3 background for that judgment.

4 (Slide) Could I have slide 4, please?

5 Category 2 plants are those that are on  
6 the watch list but they're authorized to operate but  
7 NRC staff believes they must be monitored closely.  
8 The purpose of placing plants on the watch list is to  
9 give the NRC regulatory attention and action if  
10 necessary before unsatisfactory conditions are self-  
11 revealed by a serious event or even an accident at a  
12 plant. That means that there's a fundamental safety  
13 reason for the watch list and this is not an open-  
14 ended quest to push the industry toward a vague  
15 standard of excellence, as some have suggested that  
16 the watch list is.

17 The questions that we consider in judging  
18 whether to place a plant on the watch list are the  
19 following. First is the performance on a declining  
20 trend as evidenced by operational incidents,  
21 enforcement history, plant material condition,  
22 operator regualification exam results or other  
23 indicators that I mentioned earlier.

24 The second question is does it appear that  
25 the licensee is not aware of that declining trend or

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1 does not accept the performance problems or have they  
2 been ineffective in dealing with the problems? The  
3 third question is does the staff judge that if the  
4 performance trend continues to decline, it would soon  
5 reach a level that would be unacceptable for continued  
6 operation. So, the whole intent is to prevent an  
7 accident, to not wait around until conditions get so  
8 bad that there is an event or an accident.

9 These are essentially the same questions  
10 that we have asked ourselves since starting this  
11 process in 1986. I don't believe our standard have  
12 changed over that time, although our ability to  
13 develop answers to those questions has gotten better  
14 with experience. We do more analysis now, but the  
15 questions are the same.

16 There are seven category 2 plants,  
17 Brunswick 1 and 2, Dresden 2 and 3, Indian Point 3,  
18 and South Texas 1 and 2. There were no new category  
19 plants identified this period.

20 (Slide) Slide 5, please.

21 Category 3 plants are those that are  
22 shutdown and require Commission approval to operate  
23 and which we monitor closely while they're shutdown.  
24 Browns Ferry 1 and 3 remain as category 3 plants.

25 Finally, Jim Taylor talked about the

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1 trending letters. We do believe that this promises to  
2 be an effective method that allows an early warning by  
3 the staff and it allows early action by the licensee  
4 to take steps to prevent operational safety problems  
5 that could lead to being placed on the watch list.

6 (Slide) Could I have slide 6, please?

7 In our discussions, we concluded that both  
8 Quad Cities 1 and 2 and LaSalle 1 and 2, Commonwealth  
9 Edison plants, have indications of downward trending  
10 performance. In addition, the Cooper plant  
11 performance was identified as trending downwards.  
12 Jack Martin and Joe Callan will discuss those plants  
13 in their discussion. Jack will also briefly discuss  
14 the status of the Perry plant which received a  
15 trending letter, you'll recall, last June.

16 So, in summary, there were no new plants  
17 added to the category 2 watch list and one was taken  
18 off. Five new plants received a trending letter.

19 I'll turn to the regional administrators  
20 and Tim Martin will begin for Region I.

21 COMMISSIONER ROGERS: Just before we do  
22 that, Tom, have you seen any inconsistencies in the  
23 materials that you examined for any particular plant?  
24 In other words, when you come to render a judgment as  
25 to the status of a plant, are any of the materials

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1 that you use in that -- in coming to that ever  
2 inconsistent with the general finding?

3 DOCTOR MURLEY: Yes, in the sense that --

4 COMMISSIONER ROGERS: Such as SALPs?

5 DOCTOR MURLEY: Yes. In some cases the  
6 information does not all uniformly point in the same  
7 direction. I can't think of a specific example, but  
8 I know there have been some. These are typically the  
9 plants that we spend an awful lot of time on.  
10 Sometimes we will want to make sure we take a closer  
11 look at them at our next meeting. But it's not a  
12 numerical process that we go through and it's not --  
13 as you correctly point out, it's not always clear cut  
14 that the evidence is pointing in one direction. But  
15 that just, I think, spurs us to do even more  
16 introspection.

17 COMMISSIONER ROGERS: The follow-on to  
18 that is when you find situations of that sort, in  
19 retrospect would that flag some change in our  
20 procedures or some change in what we're looking for or  
21 how we look for things?

22 DOCTOR MURLEY: I think yes, it has. I  
23 think its had an impact on the changes that we've made  
24 in SALP in the last year, for example. There have  
25 been other impacts on the SALP process as well, but I

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1 think the needs of our senior management meeting has  
2 had that impact. It clearly has caused us to look at  
3 how we treat the information from the accident  
4 precursor program. We now bring that into our  
5 discussions. So, in that sense, there has been this  
6 feedback and I think it's been good. I believe our  
7 analysis is sharper now than it was by some margin.

8 COMMISSIONER REMICK: I know that you're  
9 also bringing in results from the IPE program.

10 DOCTOR MURLEY: Yes.

11 COMMISSIONER REMICK: I found that quite  
12 of interest.

13 DOCTOR MURLEY: Yes.

14 CHAIRMAN SELIN: Actually, before we go on  
15 to the specific plants, since your presentation is  
16 really quite an important one, I would like to offer  
17 a couple of observations. I do believe based on my  
18 two and a half years of watching this process that  
19 there hasn't been a systematic toughening of standards  
20 per se, but I think there have been four significant  
21 changes in this process. The first -- and this is one  
22 that I hope in the new few weeks you'll have a chance  
23 to set down somewhat more precisely, Doctor Murley.

24 The first is the process by which plants  
25 are brought up to be discussed at the senior

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1 management meeting I think has gotten much more  
2 careful. In fact, as you know, there's a great deal  
3 of interest in what the overall process is and I think  
4 it would be useful to illuminate not so much what  
5 happens at the senior management meeting, that's  
6 relatively straightforward, but how plants get on the  
7 agenda in the first place because that's more of a  
8 staff function than it is the high-level function that  
9 the discussions lead to.

10 The second, as Commissioner Remick notes,  
11 is the use of the individual plant evaluations and the  
12 probabilistic risk assessments. The third has been  
13 much greater use just in these last two years of the  
14 licensee event reports and particularly the precursor  
15 results. I've been impressed with the role that the  
16 AEOD information which is quantitative, which does  
17 compare plants with others in the class on a whole  
18 range of pieces. Not that the numbers are added up or  
19 averaged, but that the systematic data are  
20 consistently used and referred to.

21 The fourth is that again, as you've  
22 pointed out, is the SALP process has improved. The  
23 SALP process has become a more senior level process  
24 and a more timely one so that in most cases you're  
25 dealing with SALP information that's more relevant.

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1 I think that's led into a more replicable process.

2 So, I think you and the staff are to be  
3 congratulated on a consistently self-improving  
4 process. But I think it's important to lay out at the  
5 next level of discussion some of the indicators that  
6 are used to say these are plants that we should  
7 discuss. Obviously the discussions themselves are  
8 hard to quantify since they are senior people with a  
9 great deal of experience comparing the same set of  
10 information. But I do think that it's been a marked  
11 improvement in the process and I think that's quite a  
12 worthwhile point. At some point, these trending  
13 letters will be a source of interest as well.

14 Thank you.

15 DOCTOR MURLEY: Thank you, Mr. Chairman.

16 Tim reminded me. I'd forgotten one of the  
17 most important inputs that we get for a plant and that  
18 is when we do a diagnostic evaluation team inspection.  
19 That forms the basis for that particular plant. We  
20 typically only do one of those, one or two a year, but  
21 that is important information also.

22 CHAIRMAN SELIN: Thank you.

23 DOCTOR MURLEY: Tim?

24 MR. T. MARTIN: First I'd like to talk  
25 about the Indian Point 3 plant.

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1           The New York Power Authority's Indian  
2 Point 3 Nuclear Power Plant was first discussed in the  
3 June 1992 senior management meeting. The SALP for the  
4 period June '91 through August '92 identified  
5 declining performance in five of seven functional  
6 areas. Of particular concern was performance and  
7 engineering in tech support. During 1992, NRC took  
8 escalated enforcement action against IP-3 on four  
9 occasions. Recurring elements at route to these  
10 actions included inadequate procedural adherence and  
11 attention to detail, inadequate implementation of the  
12 surveillance testing program, untimely or ineffective  
13 correction action for identified problems, inadequate  
14 or inaccurate information flow and inadequate  
15 management guidance, oversight and control.

16           In response to the SALP and a mounting  
17 list of problems, the New York Power Authority  
18 performed a self-assessment and developed a  
19 performance improvement program. On February 26th,  
20 the New York Power Authority determined that the  
21 anticipated transient without scram mitigation system  
22 actuation circuitry, better known as AMSAC, had not  
23 been maintained in compliance with NRC regulations and  
24 shut the plant down.

25           Subsequently, NYPA announced an extension

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1 of the shutdown as a plant performance improvement  
2 outage. The licensee also committed not to restart  
3 the until they were ready and the NRC had agreed.

4 Last May, the NRC completed a three week  
5 special team inspection and concluded that the root  
6 causes of the past performance deficiencies could be  
7 grouped into three categories, including weak  
8 management processes and controls, weak management  
9 skills and vigor and weak independent oversight.  
10 Specific problems were identified with the programs  
11 for corrective action, commitment tracking,  
12 surveillance testing, emergency diesel generator  
13 preventive maintenance and dissemination of the  
14 administrative policy and guidance with performance  
15 and planning and scheduling, establishing  
16 accountability, management of change and  
17 organizational communications and with oversight  
18 provided by the QA organization, corporate insight  
19 management and the on and off-site safety review  
20 committees.

21 On June 17th, 1993, the NRC issued a  
22 confirmatory action letter that outlined steps that  
23 NYPA must take prior to restarting the facility.  
24 Indian Point 3 was subsequently placed on the NRC's  
25 watch list as a category 2 facility requiring close

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1 monitoring. Since last June's senior management  
2 meeting, Indian Point 3 has established or revised a  
3 number of programs and devoted significant effort to  
4 reduce a daunting backlog of corrective action work,  
5 modification and engineering requests.

6 As a positive result of these efforts,  
7 additional significant equipment problems have been  
8 identified by the licensee for corrective action.  
9 These include pipe wall thinning on steam lines and  
10 unexpected locations due to original construction fit-  
11 up problems, multiple valve deficiencies in design,  
12 operations, maintenance and modification history, a  
13 modification which inadvertently bypassed a gas  
14 stripper and liquid rad waste process line and  
15 redundant required cooling fans for safety-related  
16 switch gear powered from the same bus.

17 However, during the same period we  
18 continued to identify problems with procedural  
19 adherence, attention to detail, work control and  
20 communications. As a result, and admittedly the most  
21 significant examples, two or three emergency diesel  
22 generators were made inoperable. The wrong rad waste  
23 monitor tank and a condensate storage tank were dumped  
24 to the Hudson River on separate occasions. One  
25 thousand gallons was inadvertently spilled from the

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1 boric acid storage tank and a fan cooler unit service  
2 water header was opened while still pressurized.

3 In November 1993, the NRC conducted a  
4 service water system operational performance  
5 inspection. The team found the service water system  
6 was generally capable of performing its safety  
7 functions, but identified several concerns. One of  
8 those concerns was the use of solenoid operated valves  
9 at pressures beyond their design limit. To address  
10 this concern, NYPA developed a plan to replace certain  
11 valves throughout the plant. Unfortunately,  
12 maintenance control problems associated with the valve  
13 work led to all three emergency diesel generators  
14 being simultaneously inoperable without the knowledge  
15 of the operating staff.

16 An enforcement conference was held on  
17 December 10th. Subsequently, NYPA provided the  
18 details of an improved plant work control process  
19 which included a station-wide work slowdown. During  
20 a public meeting on December 17th at the site, the NRC  
21 again expressed concern about the continued personnel  
22 errors and weak performance at the facility,  
23 particularly in the areas of plant configuration  
24 control, work control, procedural adherence. The NRC  
25 also expressed concern with the effectiveness of the

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1 licensee's performance improvement plan and whether it  
2 was sufficiently comprehensive to adequately address  
3 continuing performance problems that must be resolved  
4 prior to restart.

5 NYPA has formed a corporate task group to  
6 assess the current status of Indian Point 3's  
7 improvement plans and revise those plans accordingly.  
8 Despite these concerns, improvements have been noted.  
9 Problem identification and documentation at the site  
10 has improved. The new resident manager has provided  
11 stronger oversight of day to day activities and has  
12 promoted better performance tracking and  
13 accountability. A new system for reporting and  
14 tracking deficiencies has been instituted. The Indian  
15 Point 3 staff has established additional interfaces  
16 with the industry to learn from their experiences and  
17 the site is now actively seeking outside assistance to  
18 review deficiencies and help determine root causes of  
19 problems.

20 The Board of Trustees has also established  
21 a Nuclear Advisory Committee to provide expert opinion  
22 on the operation of NYPA's nuclear facilities. The  
23 committee is composed of three individuals with senior  
24 management level industry and regulatory experience.  
25 It should be noted that in less than a year nearly

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1 half of NYPA's top management positions responsible  
2 for oversight and support of activities at Indian  
3 Point 3 have experienced personnel changes. These  
4 changes include the Chairman of the Board, the  
5 President, the Indian Point 3 resident manager, two or  
6 three site general managers and many of their  
7 subordinate managers.

8 Further, in early December 1993, the  
9 Executive Vice President for Nuclear Generation went  
10 on sick leave. In light of these changes, the NRC is  
11 particularly concerned with the substantial reduction  
12 in nuclear experience and continuity of leadership of  
13 the corporate management staff. NYPA must assure the  
14 pace and substance of these changes does not prevent  
15 the management team from providing appropriate and  
16 timely support and oversight of plant activities in  
17 nuclear safety.

18 In summary, overall performance at the  
19 facility has not significantly changed since the last  
20 senior management meeting. Indian Point 3 remains  
21 shutdown and the New York Power Authority has  
22 committed not to restart the unit until they are ready  
23 and we agree. However, in light of the hardware and  
24 program problems identified to date, the improvements  
25 necessary in plant management and staff performance

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1 and the need to demonstrate plant readiness for  
2 restart, the NRC staff has concluded that IP-3 should  
3 remain a category 2 facility subject to close NRC  
4 monitoring.

5 Are there any questions?

6 CHAIRMAN SELIN: I have a comment. It's  
7 clear given the improvement we've seen at Fitzpatrick  
8 that good local management can lead to significant  
9 improvement even without much corporate support. But  
10 I'm really just astounded at how weak this chain has  
11 been at Indian Point 3 from the top, the trustees, the  
12 lack of supervision by the trustees, the lack of  
13 performance at the corporate level, as well as at the  
14 staff level. I think we should just make it clear to  
15 the new management at the New York Power Authority  
16 that they really have their work cut out for them.  
17 There's just no strength up and down the line. It's  
18 not just an occasional pocket of problems here or  
19 there, there's a complete rebuilding to be done and  
20 this turnover has been from the bottom up, not from  
21 the top down, as if somebody is replaced and if that  
22 doesn't work then somebody else gets the axe and it  
23 just keeps going, as opposed to a solid piece of  
24 management comes in and says, "We've analyzed the  
25 problem from top to bottom and here's our solution to

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1 do this."

2 So, I certainly support your conclusions  
3 at the end and hope that the new management both at  
4 the trustees level and at the operations level at the  
5 Power Authority realizes just how much their work is  
6 cut out for them and this plant up and down.

7 I don't think I'm putting words in your  
8 mouth. I heard at least elements of those pieces in  
9 your observations this morning.

10 MR. T. MARTIN: Mr. Chairman, you're not  
11 putting words in my mouth. In fact, based upon my  
12 discussion with the current president and the vice  
13 president there, they are very clearly aware that this  
14 is a problem and they are concerned also and they've  
15 got a lot of work to do.

16 The next one I'd like to talk about is the  
17 Fitzpatrick facility. The New York Power Authority's  
18 James E. Fitzpatrick Nuclear Power Plant was first  
19 discussed during the June 1991 senior management  
20 meeting. We were concerned with declining performance  
21 in the functional areas of operations, radiological  
22 controls and safety assessment quality verification.  
23 The occurrence of an unmonitored radioactive release  
24 from their house heating boiler and the identification  
25 of an unsatisfactory licensed operator requalification

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1 program in the months immediately preceding the senior  
2 management meeting further supported those concerns.  
3 As a result, the EDO directed the performance of a  
4 diagnostic evaluation team assessment.

5 The licensee utilized the results of their  
6 own evaluations, along with those of the DET, to  
7 develop a long-term results improvement program which  
8 they continued to implement. The licensee shut down  
9 Fitzpatrick in November 1991 due to equipment problems  
10 and subsequently extended the shutdown in order to  
11 resolve numerous design and engineering deficiencies,  
12 most notably in the fire protection and Appendix R  
13 safe shutdown programs.

14 During the January 1992 senior management  
15 meeting we placed Fitzpatrick on the watch list as a  
16 category 2 facility. The licensee completed a  
17 significant number of major work tasks during the  
18 extended 14 month shutdown and the work was typically  
19 well controlled and performed. Further, the reduction  
20 in contaminated areas and combustible material in the  
21 plant and the improvement in plant and equipment  
22 preservation and cleanliness were notable.

23 In December 1992, the NRC agreed with the  
24 New York Power Authority's conclusion that the  
25 facility and staff are ready to safely support restart

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1 and power operations and on January 3rd the reactor  
2 was again made critical. During unit restart and  
3 power ascension, the control room was quiet and  
4 professional and the shift supervisor exhibited good  
5 command and control. Evolutions in progress were  
6 closely monitored to minimize any interference or  
7 distractions. Overall, the start-up was conducted in  
8 a deliberate and safe manner with excellent management  
9 oversight and control.

10 During the first six months of 1993, the  
11 licensee experienced five forced outages due to  
12 equipment failures or design deficiencies. In each  
13 case, operator response to the event, staff safety  
14 perspective and outage performance and management  
15 involvement and oversight were good. The unit has  
16 been operating pretty much at full power since the  
17 last senior management meeting.

18 On September 23rd, power was reduced and  
19 the turbine generator was taken off the line in order  
20 to locate a battery ground in the turbine  
21 electrohydraulic control system. However, while  
22 troubleshooting the system, a bypass valve  
23 inadvertently closed in the reactor scram due to high  
24 reactor pressure. This was the only automatic reactor  
25 trip from power since the June 1993 senior management

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1 meeting.

2 After the battery ground was repaired, the  
3 reactor was restarted and operated at full power until  
4 the plant was shutdown on October 23rd for a scheduled  
5 maintenance outage. Performance during the outage was  
6 mixed. The licensee identified an increase in human  
7 performance-related problems early in the outage and  
8 invoked a safety stand down to reemphasize the need  
9 for greater attention to detail and self-verification.

10 The unit restarted on November 20th and no  
11 additional significant human performance problems had  
12 been identified.

13 In October 1993, the NRC also conducted an  
14 operational safety team inspection to assess the  
15 quality of management programs, self-assessment  
16 programs, corrective action programs, and engineering  
17 and tech support. The team found that corporate and  
18 plant management practices were effective in assuring  
19 safe plant operations. Self-assessment programs and  
20 processes for problem identification, assessment and  
21 resolution were generally effective. Corporate  
22 engineering interfaces with plant and technical  
23 support for maintenance and operations were improved.  
24 The root cause evaluation program had mixed  
25 performance, planning and prioritization of

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1 modifications needed enhancement and there existed a  
2 significant backlog of outstanding requests and  
3 corrective actions.

4 Overall, the licensee has made significant  
5 changes to promote both short and long-term  
6 improvements in performance. Corporate management has  
7 provided substantial resources and support. Licensed  
8 operator staffing has been improved. The operator  
9 requalification program is again satisfactory and the  
10 performance and operations, maintenance surveillance,  
11 radiological controls and safety assessment quality  
12 verification have improved. In addition, the plant's  
13 material condition has been improved. Operating  
14 maintenance and surveillance procedures have been  
15 enhanced and the long needed administration building  
16 is complete and the facility management team under the  
17 new resident manager has been effective.

18 As discussed in the Indian Point 3  
19 presentation, there's been a large number of  
20 significant changes in corporate management staff,  
21 particularly those responsible for support and  
22 oversight of nuclear safety activities. The loss of  
23 nuclear experience and the continuity of leadership  
24 from these positions remains a significant NRC  
25 concern. NYPA must ensure the management attention

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1 and resources necessary to sustain continued  
2 improvement at Fitzpatrick are not diverted by current  
3 efforts to resolve their corporate staffing issues or  
4 by the significant effort needed to address continued  
5 performance and programmatic weaknesses and restart  
6 issues at the Indian Point 3 Nuclear Power Plant.

7 In summary, Fitzpatrick is currently  
8 operating at full power with no significant problems.  
9 Performance since the last senior management continues  
10 to be good and improving. Improved management  
11 oversight, increased staff accountability and a  
12 conservative safety approach toward operations have  
13 been evident. Further, despite the significant  
14 changes that have occurred in the corporate  
15 management, we have concluded that the licensee has  
16 committed or provided sufficient resources, programs,  
17 site management and oversight to carry out planned  
18 long-term performance improvements. As a result, the  
19 NRC has determined that sufficient overall improvement  
20 has been demonstrated by the licensee such that close  
21 monitoring of licensee activities is no longer  
22 warranted.

23 Are there any questions?

24 DOCTOR MURLEY: Stu?

25 MR. EBNETER: I have two plants to

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1 discuss, Brunswick and Browns Ferry. I'll discuss  
2 Brunswick first.

3 Brunswick, a two unit boiling water  
4 reactor owned by Carolina Power and Light Company,  
5 located in Southport, North Carolina. Unit 2 is  
6 presently at 100 percent power and Unit 1 is in start-  
7 up readiness operations. Brunswick was placed on the  
8 problem plant list as a category 2 plant in June of  
9 1992 as a result of weak senior management involvement  
10 and ineffective self-assessment and corrective action  
11 program and a poor work control program. These  
12 conditions resulted in poor unit performance, degraded  
13 plant material conditions, high backlogs in numerous  
14 areas and extensive enforcement actions.

15 CP&L has made extensive management changes  
16 at all levels from the President, Chief Operating  
17 Officer to Operations Shift Supervisor. These changes  
18 have been made at both corporate office and the  
19 station. The new management has been primarily  
20 recruited from sources external to CP&L and has  
21 brought experience in nuclear operations. The CP&L  
22 management has developed a recovery plan and a three  
23 year business plan for the Brunswick plant which  
24 clearly sets forth management goals and expectations  
25 based on higher standards of performance. These have

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1       been communicated effectively to the site staff via  
2       senior management meetings at the site.

3               The self-assessment has been strengthened  
4       and improved with regards to Brunswick operations has  
5       been noted.     Additional assessment and feedback  
6       channels have been instituted and they have  
7       incorporated two levels of senior type managers who  
8       provide the nuclear committee oversights.     These  
9       communities both have experienced and diverse nuclear  
10      personnel on them from industry.

11             The work control system has been revised  
12      and restructured to ensure that adverse conditions are  
13      addressed promptly and correctly and that the backlogs  
14      are controlled to appropriate targets.     The backlogs  
15      have been reduced at both units and the material  
16      condition of the station has improved significantly.

17             The effectiveness of the new management  
18      and revised program has been demonstrated by the  
19      recovery, restart and exceptional performance of unit  
20      2.     Unit 2 was restarted in April of 1993.     Start-up  
21      was essentially error free and the unit has run  
22      without any trips, forced outages or major personnel  
23      errors for approximately 250 days.

24             Unit 1 has remained shutdown since April  
25      1992 and is being refueled and upgraded.     Unit 1

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1 start-up was originally scheduled for September of  
2 1993, but this has been delayed by emergent work,  
3 primarily the cracks in the core shroud and some  
4 debris found in the reactor coolant system. The  
5 resolution of the shroud issue and the industry  
6 identified jet pump hold-down beams was characterized  
7 by very good conservative decision making to focus on  
8 safety issues and effective engineering corrective  
9 actions.

10 Unit 1 material condition. Upgrades have  
11 been accomplished, backlog resolutions and the targets  
12 have been met. Unit management changes and revised  
13 programs are in place. Criticality is scheduled for  
14 Brunswick Unit 1 on January 28th, 1994 and I believe  
15 that is still on schedule.

16 The recent systematic SALP assessment that  
17 we performed of Brunswick was very positive. One in  
18 operations and plant support and two in the  
19 maintenance and engineering. The SALP recognizing  
20 increased performance at the station.

21 In summary, the root causes attributed to  
22 the past cyclical performance of Brunswick have been  
23 addressed and demonstrated to be effective on Unit 2.  
24 Unit 1 recovery is complete and the unit is ready for  
25 restart. The licensee must now demonstrate dual unit

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1 operational performance. Brunswick remains on the  
2 problem plant list as a category 2 plant.

3 Any questions?

4 CHAIRMAN SELIN: It sounds as if the main  
5 thing that remains to be shown is a successful restart  
6 of Unit 1. Is that a fair assessment, that you're  
7 quite pleased with Unit 2 and you remain to be seen  
8 that Unit 1 can come up and that both units can be  
9 operated satisfactorily?

10 MR. EBNETER: Yes. There's a lot of  
11 management at Brunswick that was brought in that have  
12 not actively operated a BWR. These people will be  
13 doing the start-up of Unit 2 -- or Unit 1 start-up.  
14 Unit 2 will be coming down in an outage just at the  
15 end of the build-up or start-up of Unit 1. I think we  
16 need to see the ability of CP&L to operate both units  
17 in these conditions. Past cyclical performance of  
18 Brunswick has been troublesome for us since mid-1980s.  
19 So, I don't expect them to stumble, however. I am  
20 very confident that this present management structure  
21 is very, very good.

22 COMMISSIONER REMICK: Just a related  
23 comment. First, I want it to be clear that I am not  
24 second guessing staff judgment or differing with your  
25 judgment, but it's a comment hopefully for the future

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1 good of the process.

2 When I read the letter that was sent to  
3 Brunswick, read it very carefully. In your  
4 presentation there's a list of seven very positive  
5 statements about progress. There's one statement that  
6 says management's focus should now be directed to safe  
7 start-up of Unit 1 and demonstration of sustained good  
8 dual unit operational performance, which I view as a  
9 neutral type of recommendation, which makes good  
10 sense. But then came the conclusion that they would  
11 remain basically on the watch list. I thought  
12 somebody just reading that letter, not hearing the  
13 things you just presented to the Chairman in response  
14 to his comment, I don't think the conclusion  
15 necessarily follows. It's just purely, I think, that  
16 the letter itself does not have that transition from  
17 here are all the promising things, but an explanation  
18 of why the staff feels that they should continue on  
19 the list. I think somebody reading it coldly could  
20 understand, well, what is it then the NRC is  
21 expecting? That's just a comment.

22 COMMISSIONER ROGERS: I had exactly the  
23 same reaction. I read the letter carefully and there  
24 were nothing but positives in it. Then the next  
25 sentence says, "Based on this, the plant will remain

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1 on the watch list." I don't think that it follows  
2 that based on that, the preceding paragraph. There  
3 are other considerations for keeping it on the watch  
4 list.

5 It seemed to me that if whoever received  
6 that letter knew nothing else but what was in that  
7 letter, it didn't give them any guidance in any way.

8 MR. TAYLOR: That's a reasonable comment.  
9 We were perhaps too terse in the letter and I think  
10 we'll take that in our --

11 COMMISSIONER ROGERS: I read all the other  
12 letters just to see how this one compared and this one  
13 really stood out in that sense. The other ones listed  
14 specific problems. This one only listed positive  
15 accomplishments and then said, "Based on those, you're  
16 going to stay on the problem list."

17 MR. TAYLOR: We presumed too much  
18 knowledge perhaps on the part of the readers in terms  
19 of -- but that's a reasonable comment. We'll take  
20 that. Excuse me.

21 CHAIRMAN SELIN: But, you know, as  
22 Commissioner Remick said, I believe that based on the  
23 discussion, the judgment is correct. It's purely a  
24 question of how much goes in the letter.

25 MR. TAYLOR: We have confidence they've

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1 built up confidence. We need this extra bit of  
2 demonstration.

3 MR. EBNETER: Trust, but verify.

4 Any other questions on Brunswick?

5 Browns Ferry. We'll be discussing Browns  
6 Ferry Units 3 and 1.

7 Browns Ferry 3 Unit, BWR station owned by  
8 the Tennessee Valley Authority located in Northern  
9 Alabama. Unit 2 is at 100 percent power and has been  
10 there in excess of 200 continuous on-line days, which  
11 is very good for that unit. But Units 3 and 1 are  
12 both shutdown and defueled.

13 Browns Ferry Units 1, 2 and 3 were placed  
14 on the problem plant list as category 3 plants in 1986  
15 as a result of management issues and chronic poor  
16 performance. Unit 2 was restarted in May 1991 and  
17 after a period of sustained good operations was  
18 removed from the problem plant list in June of 1992.  
19 Units 3 and 1 remain on the problem plant list as  
20 category 3 units.

21 Recent changes at TVA are positive. Two  
22 Board of Director vacancies were filled last summer  
23 and the Board is now fully constituted. The Board has  
24 been providing adequate resources for Browns Ferry  
25 Station.

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1           A recent reorganization has placed nuclear  
2 activities in a separate organization with senior  
3 management dedicated nuclear operations. The long-  
4 vacant senior vice president position was filled by  
5 internal promotion. We think these changes are  
6 positive and will have a positive impact on the  
7 nuclear operations.

8           Unit 3 is being upgraded and modified to  
9 the standards incorporated in the Unit 2 recovery and  
10 these were agreed upon by the staff. The base  
11 engineering of these modifications is essentially  
12 complete and licensee attention is now focused on  
13 construction activities. Management changes which  
14 placed all Browns Ferry units under the site vice  
15 president approximately 15 months ago was made in  
16 response to ineffective contractor interface control  
17 and inefficiencies in the work practices. These  
18 changes apparently have been effective. We have seen  
19 progress in the engineering area and the construction  
20 areas are moving forward in the electrical systems,  
21 piping and hangers and supports.

22           Additional work performed in response to  
23 available windows of opportunity such as vessel NDE,  
24 non-destructive exam, on the shroud and the vessel.  
25 These both demonstrate good planning and a slow

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1 deliberate approach to recovery activities. Unit 3 is  
2 scheduled for fuel load in June 1995 with criticality  
3 several months later.

4 Unit 1. Work on unit 1 is basically  
5 suspended pending senior management decisions on the  
6 selection of a strategy for future utilization of this  
7 unit. This unit has very low priority and very little  
8 work is being done on the unit.

9 CHAIRMAN SELIN: I'm sorry. Is this a  
10 strategy from a business sense or from an allocation  
11 of engineering resources?

12 MR. EBNETER: Mostly from a business  
13 sense, I believe.

14 CHAIRMAN SELIN: When they need the power  
15 basically.

16 MR. EBNETER: Well, that and I think it's  
17 tied perhaps to the discussion with relicensing  
18 issues. That unit came on-line in the early '70s and  
19 has quite of bit expended on it.

20 One comment. Although no adverse  
21 conditions have been noted, the recent changes at the  
22 Browns Ferry site have the potential to adversely  
23 impact activities at the station. TVA senior  
24 management is monitoring this closely. We haven't  
25 seen any issues. Just quickly, the site vice

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1 president was promoted to the senior vice president  
2 position and he's serving in a dual capacity there and  
3 there have been some other changes below him at the  
4 site.

5 Browns Ferry Units 3 and 1 remain on the  
6 problem plant list as category 3 units and require  
7 Commission authorization to restart.

8 Any questions on Browns Ferry?

9 CHAIRMAN SELIN: Do you see any reason to  
10 believe that the Tennessee Valley Authority does not  
11 have adequate resources, either financial or personal,  
12 to manage the plan that they put forward to the  
13 Commission?

14 MR. EBNETER: I don't see any problems  
15 with that.

16 DOCTOR MURLEY: Jack Martin?

17 MR. J. MARTIN: Well, I will discuss the  
18 Commonwealth plants and then go on to Perry, starting  
19 with Dresden 2 and 3.

20 Dresden Station was placed on the NRC's  
21 watch list in June of 1987, removed in December of  
22 1988 and again placed on the watch list in January of  
23 1992. Significant contributors to Dresden being  
24 placed on the watch list a second time included  
25 weaknesses in work performance, control of work

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1 activities, plant material condition, procedure  
2 quality, adherence to procedures by personnel and  
3 engineering support.

4 Over the last two years, Commonwealth  
5 Edison has been working to address the problems at  
6 Dresden. This has included the institution of a  
7 performance improvement program, personnel changes,  
8 increased resources and engineering support, enhanced  
9 corporate oversight and a corporate upgrade program.

10 Dresden is improving, although very  
11 slowly. Some areas that have seen progress include  
12 the resolution of long-standing equipment problems and  
13 a program to upgrade procedure quality. Operator  
14 performance during requalification examinations has  
15 improved and both units have experienced relatively  
16 event-free operation over the last six months.

17 The most recent SALP presented to the  
18 licensee in October of 1993 resulted in Dresden being  
19 rated category 2 in maintenance and plant support and  
20 category 3 in engineering and operations. In the  
21 maintenance area, Dresden has made significant  
22 progress in resolving the equipment problems that have  
23 plagued the station for years. Working around or  
24 living with equipment problems seems to be no longer  
25 a way of life. More work is still needed, however, in

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1 planning and scheduling work and getting it done  
2 efficiently at a reasonable dose. I would expect  
3 continued progress in this area.

4 Radiological protection continues to be an  
5 area of concern. There have been continuing problems  
6 with contamination control dose and high source term.  
7 Engineering continues to need attention. There have  
8 been problems with the motor-operated valve program,  
9 component cooling service water and system engineer  
10 performance in the last few months. Considering the  
11 additional emphasis and resources that have been  
12 placed in this area, engineering would appear to be  
13 poised for an improvement that we'd hope to see in  
14 1994.

15 Similarly, the operations area has  
16 improved somewhat. However, there have been several  
17 operator errors in the last few months that displayed  
18 poor instincts and work habits. Of note were  
19 misalignments of breakers in the 34 KV switchyard and  
20 some valves in the emergency core cooling system.  
21 Most in need of attention is the area of self-  
22 assessment. Problems are still not being reported  
23 regularly, given a root cause review or trended and an  
24 effective performance monitoring program is still not  
25 completely in place.

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1                   There have been several management changes  
2                   in the last few months, including a new plant manager  
3                   and a radiological protection manager and a site  
4                   quality and verification director. Commonwealth  
5                   recently announced the intent to replace the plant's  
6                   technical services superintendent. The effect of  
7                   these changes is not yet entirely clear.

8                   In summary, there's been progress at  
9                   Dresden, but very slowly and much still needs to be  
10                  done. Accordingly, the senior managers decided to  
11                  maintain Dresden on the watch list as a category 2  
12                  plant.

13                  CHAIRMAN SELIN: Why don't you go through  
14                  all the Commonwealth plants because there are certain  
15                  patterns.

16                  MR. J. MARTIN: Right. Next we make the  
17                  jump to the trending plants which, as Tom pointed out,  
18                  are not the same as problem plants. But I'll talk  
19                  about Quad Cities first and then LaSalle.

20                  Quad Cities was first discussed at the  
21                  June 1992 senior management meeting and then again in  
22                  June of 1993. A decline in overall performance  
23                  precipitated these discussions. Inadequate procedure  
24                  adherence, poor procedure quality, substandard  
25                  equipment reliability and ineffective engineering and

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1       licensing support have all contributed to problems in  
2       Quad Cities. In early June 1993, a high pressure core  
3       injection system rupture disk failed during  
4       surveillance testing, resulting in extensive damage  
5       and personnel injuries. In response to these concerns  
6       raised at the June 1993 senior management meeting, a  
7       diagnostic inspection team was sent to the site in  
8       September of 1993. The material condition of Quad  
9       Cities and their problems in maintaining the  
10      operability of safety-related systems, in particular  
11      the high pressure coolant injection and the reactor  
12      core isolation cooling systems, is the most  
13      significant aspect of the decline in performance.

14               As of mid-1993, most managers at Quad  
15      Cities were unaware that their safety system failure  
16      rate was significantly greater than average. The  
17      diagnostic inspection found that management was  
18      willing to accept equipment problems without pursuing  
19      corrective actions, the work control processes were  
20      ineffectual and that engineering evaluations of  
21      degraded equipment were not rigorous. Additionally,  
22      the licensee's self-assessment program was considered  
23      to be ineffective, root cause analyses were weak and  
24      the oversight provided by system engineering program  
25      was weak.

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1           The licensee conducted an assessment of  
2           equipment vulnerabilities patterned after that done at  
3           Dresden late in 1992. This was a licensee effort. It  
4           was called the vulnerability assessment. The  
5           vulnerability assessment identified many plant issues  
6           of plant equipment, but was not followed up. After  
7           the NRC expressed concerns over the lack of management  
8           oversight, a Commonwealth Edison task force was formed  
9           to establish a corrective action plan. The licensee  
10          also conducted short maintenance outages on each unit  
11          as a start to improving the material condition. This  
12          was done just recently.

13               Several recent management changes have  
14          been affected. We've yet to see a significant  
15          positive impact, but it's hoped that these changes  
16          will help ameliorate the leadership deficiencies at  
17          Quad. Although the operators were considered to be a  
18          relatively strong performing group by the diagnostic  
19          inspection, performance in routine plant operations  
20          has been mixed. Personnel errors have been involved  
21          in incidents resulting in short cycling the shutdown  
22          cooling flow and flooding the turbine building  
23          basement through open manways in the condenser.

24               Because of the issues found by the  
25          diagnostic and the declining material condition in

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1 performance at Quad Cities, the senior managers  
2 decided that a letter to the company citing these  
3 negative trends would be appropriate.

4 I'll go on now to LaSalle. LaSalle's  
5 performance has declined. The licensee has  
6 demonstrated deficiencies in their ability to conduct  
7 engineering evaluations of recurring equipment  
8 problems and in the conduct of their preventive  
9 maintenance program. Lack of a clear management  
10 focus, poor self-assessment capabilities and an  
11 inability to identify root causes all contribute to  
12 LaSalle's declining performance.

13 There have been recurring problems in the  
14 radiological controls area at LaSalle. This is due to  
15 a number of reasons, foremost being a lack of  
16 management and supervisory oversight. In looking into  
17 the poor radiological work practices and a major spill  
18 in July of 1993, I found that the radiation protection  
19 manager hadn't been in the controlled area of the  
20 plant yet that year.

21 Subsequent to this, several significant  
22 radiological incidents have occurred at LaSalle,  
23 including a major personnel contamination involving 22  
24 people and an administrative over exposure due to a  
25 worker ignoring his alarming dosimeter. More

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1 recently, there were two occurrences of radiation  
2 workers personal clothing being intentionally  
3 contaminated by others.

4 Plant material conditions are degrading  
5 due to an ineffective maintenance program. A recent  
6 loss of off-site power event was complicated by a  
7 cascade of equipment failures. There have bene  
8 problems, repeat problems, with several key pieces of  
9 equipment and balance of plant equipment failures are  
10 becoming more prevalent.

11 The situation at LaSalle has been  
12 complicated also by management instability. The site  
13 vice president was hired about a year ago from outside  
14 the company, but has only spent part-time on site,  
15 maybe a little over half-time. A new plant manager  
16 from Haddam Neck reported this month. However, there  
17 was no plant manager at all for the last six months of  
18 1993. The previous plant manager was reassigned to  
19 Dresden in June of 1993 only after a few months on-  
20 site.

21 Due to the events at LaSalle this year and  
22 using the Quad Cities evaluations as a guide,  
23 Commonwealth Edison did an extensive analysis of  
24 LaSalle in late November 1993. The Commonwealth  
25 assessment found many of the same types of issues as

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1 were found by our DET at Quad Cities. In addition,  
2 the new LaSalle quality verification director has  
3 raised vigorous issues with the LaSalle corrective  
4 action program. These self-analyses are very positive  
5 developments. It's too early to tell whether the  
6 issues raised are complete or will be dealt with.

7 Because of events, equipment and personnel  
8 issues at LaSalle, the senior managers also considered  
9 that a trending letter similar to Quad Cities would be  
10 appropriate.

11 Now, to complete the picture, at the  
12 opposite end of the spectrum or continuing in that  
13 direction is the Byron plant which is considered an  
14 excellent performer by any measure and was considered  
15 by the senior managers appropriate to recognize as  
16 such. Now, because of this picture at Commonwealth  
17 involving the spectrum of performance in the letter  
18 that we sent, we considered it wise to also request a  
19 meeting with their board of directors to discuss this  
20 situation in some detail.

21 That completes our --

22 CHAIRMAN SELIN: Well, I have some  
23 comments. First of all, the one thing, Mr. Martin,  
24 that you didn't raise particularly but is there is  
25 that the radiological performance of LaSalle is not

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1 unique within the system, that all -- although LaSalle  
2 is probably the worst, that all three of the boiling  
3 water reactors within the Commonwealth system have  
4 much poorer than industry performance as measured  
5 either in incidents or in the cumulative exposure.  
6 That's a clear sign of mangement inattention. There's  
7 absolutely no reason in the world that a reactor  
8 should have such -- any reactor should have such poor  
9 radiological performance other than toleration of poor  
10 performance.

11 In fact, the picture that you paint of one  
12 site, two reactors on the problem list, one site, two  
13 reactors on the good performance list and two sites on  
14 the downward trending list, if it's necessary, should  
15 be quite a wakeup call to overall management. There's  
16 just something wrong, whether it's in terms of overall  
17 resources or how they're allocated or the continued  
18 attention. That's just too poor an overall  
19 performance picture to be at random. If anything, I  
20 read the putting of Byron on the good performers' list  
21 as a great credit to the people at Byron, but yet  
22 another indication that the corporate management  
23 really isn't delivering the added value that they  
24 should be delivering. If such a wide range of  
25 performance can exist, there's clearly lessons to be

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1 learned from the better performers from outside the  
2 system that have to be implemented.

3 I did want to ask you one question. Is it  
4 plausible that either or both of the plants that got  
5 the trending letters could be back in a stable  
6 situation within six months or do you see the problems  
7 as requiring more than that time to turn around?

8 MR. J. MARTIN: Well, I think we're still  
9 a little bit developmental here in the use of the  
10 trending. I think what we have tried to use so far  
11 was has the situation been arrested, not has it been  
12 corrected.

13 CHAIRMAN SELIN: Right.

14 MR. J. MARTIN: The Perry thing was so  
15 clear cut that there really wasn't even any close call  
16 discussion on it.

17 CHAIRMAN SELIN: Where there were  
18 corrections, not merely --

19 MR. J. MARTIN: Well, not only arrested  
20 but very vigorously so. So, that would be our hope,  
21 that it would be arrested.

22 COMMISSIONER ROGERS: Can you trace any of  
23 this to resource problems? Commonwealth has had  
24 severe resource problems, I take it, from overall  
25 corporate position. They've told us that it doesn't

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1 affect their nuclear, but do you disagree with that?

2 MR. J. MARTIN: Well, it depends on who  
3 you talk to. Certainly at the working level at the  
4 plants, it's not infrequent to find people in a state  
5 of mind that a lot of this results from resource  
6 limitations. But we did not discuss this explicitly  
7 among the managers, but my sense is that's not a real  
8 contributor here. It may have been the far distance  
9 past, but the issues we're dealing with certainly at  
10 the trending plants and Dresden's rather slow  
11 improvement I don't sense are primarily resource  
12 driven. But again, we didn't really thrash that out  
13 completely. I'm not sure whether that's a fair  
14 representation.

15 CHAIRMAN SELIN: Resources in the sense of  
16 the dollars and the number of bodies.

17 MR. J. MARTIN: Yes, or numbers of people.

18 CHAIRMAN SELIN: But you have painted a  
19 picture of trying to get by with maybe too thin a set  
20 of management where they're trying to be both  
21 corporate managers and --

22 MR. J. MARTIN: Both, too thin and  
23 quality.

24 COMMISSIONER de PLANQUE: You're talking  
25 about the amount of change, significant changes in the

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1 management?

2 MR. J. MARTIN: Well, here again, we  
3 didn't -- I think there has been significant change.  
4 Some of the traditional patterns have been broken.  
5 They are bringing in people from the outside to some  
6 degree. I think it would be fair to say that one of  
7 the major complicating factors here with the company  
8 is continual change. One of the major issues we had  
9 at Quad Cities, for example, is failure to implement  
10 the last get well program and there is a degree of  
11 skepticism that these things come up every couple of  
12 years and that's something that people have to be  
13 convinced that it's different today than it was in the  
14 past. But change is, to a degree, part of the problem  
15 here.

16 COMMISSIONER de PLANQUE: Yes.

17 DOCTOR MURLEY: I believe you were going  
18 to discuss the Perry.

19 MR. J. MARTIN: Right. Going on to Perry,  
20 it was discussed at the senior management meeting  
21 several times in the past inadequate corrective  
22 actions for cleanliness problems that caused the ECCS  
23 suction strainer fouling. It led to a discussion of  
24 Perry status at the June 1993 senior management  
25 meeting. Other issues included poor material

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1 condition of balance of plant equipment, problems with  
2 failed fuel, personnel errors and problems with the  
3 licensee's engineering evaluation.

4 At the June 1993 meeting, it was decided  
5 that a letter should be sent to Perry senior  
6 management citing adverse trends and requesting a  
7 meeting to discuss the issues. In response to that,  
8 the licensee has instituted a major reorganization  
9 which resulted in the replacement of a large  
10 percentage of the senior management down to and  
11 including the department head level. This included  
12 the transfer of a number of managers of demonstrated  
13 effectiveness from Davis-Besse to Perry. The company  
14 was also somewhat reorganized and a senior vice  
15 president nuclear appointed and he set up his office  
16 on-site at Perry and has been involved in monitoring  
17 daily plant activities.

18 Strenuous efforts are also underway to  
19 improve the plant material condition and develop a new  
20 work attitude. They took a recent maintenance outage  
21 to focus on balance of plant equipment problems. The  
22 Perry corrective action plan seems complete and  
23 aggressive and it's expected to correct the problems  
24 if implemented as planned. There's already been some  
25 noticeable improvement in many portions of the plant.

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1           As a footnote, after the senior management  
2 meeting, at their request, I met with the entire board  
3 of directors for Centerior the day before yesterday to  
4 discuss the situation with them. I thought that was  
5 significant that they would ask for that. I came away  
6 with the conclusion that each and every one of them  
7 understands what they're up against. We went around  
8 the table and each and every one was committed to  
9 doing what needs to be done to implement this plan.  
10 So, there's no ambiguity or misunderstandings from the  
11 top to the bottom at this point.

12           So, because of all the near-term actions  
13 that could reasonably have been taken, have been taken  
14 by the utility and most importantly because the  
15 declining trend has been stopped, the senior managers  
16 decided to remove Perry from the trending status. We  
17 recognize it will be some time for Perry to fully  
18 achieve its desired results.

19           CHAIRMAN SELIN: Have you seen any  
20 offsetting deterioration at Davis-Besse as the  
21 resources have shifted?

22           MR. J. MARTIN: What I told the directors  
23 is that -- I'm not sure who's responsible for this,  
24 but there was an enormous depth built into the Davis-  
25 Besse plant, down two to three levels in each

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1 position. It was sort of a prototype of a succession  
2 planning so that when the crisis came there were  
3 people to fill it.

4 Now, what we discussed is that it's  
5 probably necessary now to go back and rebuild that so  
6 that you restore the situation. But I am nervous  
7 about that, but haven't seen anything yet.

8 DOCTOR MURLEY: But there has not been a  
9 deterioration that we've seen.

10 MR. J. MARTIN: No, no, not yet.  
11 Hopefully there won't be, but it's something we need  
12 to be careful about.

13 CHAIRMAN SELIN: Very good. Thank you.

14 DOCTOR MURLEY: Okay. We'll go on to  
15 Region IV then, Joe Callan.

16 MR. CALLAN: Thank you, Tom.

17 I have one category 2 watch list plant to  
18 discuss. That's South Texas project and then I'll go  
19 on to our single trending facility, Cooper Station.

20 The South Texas project was identified as  
21 a category 2 watch list plant during the June 1993  
22 senior management meeting. This categorization  
23 resulted from declining performance characterized by  
24 longstanding equipment problems, ineffective and  
25 inefficient work control processes, inadequate problem

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1 identification and corrective active programs, a  
2 general lack of effective management direction and  
3 support, and ineffective use of self-assessment and  
4 quality oversight functions.

5 In August 1993, Houston Lighting and Power  
6 provided the EDO with their initial response to the  
7 NRC diagnostic evaluation team inspection report.  
8 This response emphasized those actions necessary to  
9 support resumption of power operations. A more  
10 comprehensive response that addressed longer range  
11 actions was provided to the EDO in October 1993.

12 An NRC restart panel composed of managers  
13 from Region IV and NRR was formed to assure consistent  
14 agency approach to the issues identified, to track  
15 progress on completion of plant restart issues  
16 addressed in the region's confirmatory action letters  
17 to Houston Lighting and Power and to assure proper  
18 coordination of significant meetings and inspections.  
19 The panel meets biweekly and meets with Houston  
20 Lighting and Power representatives monthly with public  
21 observation.

22 The NRC's principal efforts at South Texas  
23 project since October 1993 have consisted of reviewing  
24 items associated with the identified restart issues.  
25 Recent inspections have noted continuing improvement

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1 in management initiatives and program development, but  
2 have identified examples of implementation  
3 shortcomings. Despite these inspection findings, the  
4 general performance trend of South Texas project has  
5 been slowly improving. For example, in the operations  
6 area there have been staffing enhancements such as the  
7 addition of a sixth shift and the control room  
8 operators have had their non-watch standing duties  
9 reduced.

10 In the maintenance area, there is evidence  
11 of successful work prioritization and an effective  
12 maintenance planning and coordination. Training  
13 improvements and more effective management oversight  
14 also have been evident in the maintenance area.

15 The NRC operational readiness assessment  
16 team inspection that completed its on-site activities  
17 last week identified continuing concerns in some  
18 areas, however. Examples include corrective action  
19 programs, configuration management and plant  
20 procedures. The team also identified various  
21 strengths, such as a control room operator  
22 professionalism and qualifications, staff morale and  
23 their willingness to raise concerns to management and  
24 the independent assessment function. The team did not  
25 consider any of its findings to be serious enough in

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1 themselves to prohibit plant restart.

2 The conclusions of the operational  
3 readiness assessment team are an important step in the  
4 staff decision for permitting restart of Unit 1.  
5 Another important step will be a restart meeting with  
6 Houston Lighting and Power in which the readiness of  
7 Unit 1 for restart will be reviewed in some detail.  
8 This meeting will be open to the public.

9 CHAIRMAN SELIN: When is that meeting?

10 MR. CALLAN: Mr. Chairman, as of this  
11 morning, it's penciled in for February 8th, but we  
12 haven't received formal confirmation of that.

13 Intensive NRC inspection activities are  
14 planned in the event that the staff decides to permit  
15 plant restart. Particular attention will be paid to  
16 the considerable post-maintenance testing that can be  
17 performed only when the unit is heated up, including  
18 the testing of the turbine-driven auxiliary feedwater  
19 pumps whose failure in February 1993 led to the  
20 shutdown of both units.

21 Continued close NRC monitoring of South  
22 Texas project performance will be necessary if the  
23 decision is made to permit plant restart in order to  
24 assure that improvements underway can be sustained.  
25 This is especially important due to the extensive

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1 management and organizational changes that have  
2 occurred over the past nine months. These changes  
3 appeared to be promising, but the test of their  
4 effectiveness will occur only as operational  
5 challenges are faced.

6 This concludes my discussion of South  
7 Texas project.

8 CHAIRMAN SELIN: Mr. Callan, I was  
9 particularly interested in your remark about high  
10 staff morale and a willingness to raise concerns to  
11 management because, as we all know, this has been a  
12 plant that's been notorious for its number of  
13 allegations in the poor labor-management relations.  
14 Can you talk a little bit more about that, and  
15 particularly the basis for the remark?

16 MR. CALLAN: They base their remark on  
17 their interactions with plant staff. Shortly before  
18 the operational readiness assessment team, whose  
19 remarks I discussed, there was a region-based review  
20 of their employee concerns program, what used to be  
21 called the speak-out program. It's since been  
22 changed. The picture from that inspection isn't quite  
23 as rosy. There's still a significant minority of  
24 plant personnel who are suspicious of the program and  
25 who still remain concerned about retaliation. That

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1 inspection led to a management meeting and subsequent  
2 commitments by the licensee and we'll be following  
3 that very closely. But it appears that there are  
4 enough short-term corrective actions in place to give  
5 us the confidence that they have a workable program in  
6 place today.

7 CHAIRMAN SELIN: I hope a lot of attention  
8 will be paid to that in the restart decision because  
9 that's -- you know, although it's true that one or two  
10 people with a determined effort could make the  
11 problems seem worse, then it might objectively be.  
12 Nevertheless, that seems to be a pretty good indicator  
13 of labor-management relations and you need to have the  
14 people running the plant in-line with the program if  
15 the plant is to operate safely. So, I hope we will  
16 look at that in some depth and assure ourselves that  
17 we're comfortable that such an attitude does exist,  
18 namely a willingness to come forward with safety  
19 concerns. We depend very much on that and the  
20 operation of the plant.

21 I forgot to welcome you to our meeting,  
22 Mr. Callan.

23 MR. CALLAN: Thank you.

24 CHAIRMAN SELIN: Congratulations. I hope  
25 you find standards higher than when you were in the

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1 southern part of the former Soviet Union. Thank you.

2 DOCTOR MURLEY: He has one more plant to  
3 discuss.

4 MR. CALLAN: As I said, that was the  
5 single category 2 watch list facility in Region IV.  
6 The next facility I'm going to discuss is in the  
7 trending category and that's Cooper Nuclear Station.

8 Nebraska Public Power District's Cooper  
9 Nuclear Station is a single unit BWR-4 located in the  
10 southeast corner of Nebraska. It began commercial  
11 operation in 1974. Over the past year, the NRC has  
12 identified problems at Cooper Nuclear Station that  
13 have warranted increased regional attention and NRC  
14 corrective action inspection performed in the spring  
15 of 1993 identified several issues for which escalated  
16 enforcement action was subsequently taken.

17 These issues mainly concern hardware  
18 problems that had existed for some time without  
19 corrective action being taken. For example, this  
20 inspection identified the potential for existing  
21 leakage of reactor coolant past two containment  
22 isolation valves to over pressurize adjoining low  
23 pressure piping and thereby bypass containment. This  
24 potential had gone unrecognized and unreported by  
25 Cooper Station.

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1           In July 1993, a public meeting was held  
2           with Nebraska Public Power District to discuss the  
3           most recent SALP report. At this meeting we noted  
4           that performance had declined in several functional  
5           areas and that a large number of equipment problems  
6           had occurred during the latter part of the SALP period  
7           that were caused in part by the failure of Cooper  
8           Station employees to aggressively pursue the root  
9           cause of potential significant equipment problems.  
10          Plant personnel often appeared willing to live with  
11          problems rather than thoroughly evaluating degraded or  
12          potentially degraded equipment issues.

13                Many of the examples were longstanding and  
14          were viewed as reflective of fundamental weaknesses in  
15          the oversight and self-assessment functions. These  
16          concerns were most evident in the areas of maintenance  
17          surveillance and safety assessment and quality  
18          verification, both of which were rated as a category  
19          3.

20                Another important recent resource of  
21          information about Cooper Nuclear Station performance  
22          was the operational safety team inspection, the OSTI,  
23          which was conducted in November 1993. The team  
24          concluded that there was a general lack of management  
25          direction and control of routine and complex

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1 operations and that certain procedures and training  
2 were weak. Of particular concern to us was that  
3 several of the team findings were similar to previous  
4 NRC and plant self-identified findings, suggesting  
5 continuing weaknesses in the station's corrective  
6 action process.

7 On the other hand, the various NRC  
8 inspection efforts continue to highlight areas that  
9 have been historical strengths at Cooper Nuclear  
10 Station, such as the housekeeping and material  
11 condition of the plant and the plant's operating  
12 history. However, because of the problems that have  
13 been identified at Cooper Nuclear Station, especially  
14 the demonstrated weaknesses in their self-assessment  
15 and corrective action activities, the senior managers  
16 have determined that performance improvements are  
17 warranted in order to avoid having the existing  
18 adverse trend result in more significant problems in  
19 the future. In order to provide early notice so that  
20 Nebraska Public Power District has the opportunity to  
21 take appropriate remedial action, a letter was sent to  
22 the President and Chief Executive Office of Nebraska  
23 Public Power District informing him of our concerns  
24 and of my intention to meet with him on this matter.

25 This concludes my discussion of Cooper

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1 Nuclear Station.

2 CHAIRMAN SELIN: I had a question.  
3 Between the two points, the one is the continuing  
4 identification of the same problems without resolving  
5 them, and the second is finally finding some of the  
6 engineering problems that apparently have been in  
7 place a long time. Is Cooper really deteriorating or  
8 has it been at this level and we're just sort of  
9 coming to realize that?

10 MR. CALLAN: Mr. Chairman, that's always  
11 a question that we have to ask when we encounter  
12 findings of this nature. As in the past, similar  
13 facilities, there's probably a mix of both new issues  
14 and the fact that there have been some events and some  
15 innovative inspection techniques that have allowed us  
16 to unravel some of these problems.

17 CHAIRMAN SELIN: Was that a yes or a no?

18 MR. TAYLOR: Maybe.

19 DOCTOR MURLEY: Mr. Chairman, if I could,  
20 it's frequently the case, not just in Cooper but  
21 frequently the case that what we perceive as a  
22 downward trend is a mix of actual downward trend but  
23 just our perception of it. We've, amongst ourselves,  
24 kicked this around, but the net result is, we  
25 conclude, that either way we feel we have to take the

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1 kind of actions that we take.

2 CHAIRMAN SELIN: I don't have any problem  
3 with the action. It's the diagnosis that I'm  
4 interested in.

5 DOCTOR MURLEY: Frequently we send in a  
6 team inspection. They find some things and we ask,  
7 "My gosh, how could we have missed that for so long?"  
8 because some of it obviously did not just happen. So,  
9 partly it's our perception that it gets better and  
10 partly there are real trends.

11 CHAIRMAN SELIN: Well, actually, you  
12 raised the question. I'd like to ask you -- another  
13 point that's been clear during these discussions is  
14 the truly pivotal role that -- not in the case of  
15 Cooper, but several of the other cases, that the  
16 diagnostic evaluation teams played. Could you tell us  
17 a little bit about either, Mr. Taylor or Doctor  
18 Murley, the conditions under which we decide to send  
19 in a DET? Clearly this is a very big decision. It  
20 has real impact. You know they're going to find  
21 things and that's a major decision.

22 MR. TAYLOR: Well, the diagnostic is  
23 approved by me. It is a subject we take up at the  
24 senior management meeting as to which stations may  
25 require this type of review. It's usually a mixed

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1 performance situation where we really don't feel we  
2 have enough information to make a good decision and  
3 really it's reasonably continuing decent trends maybe,  
4 but definitely some downward trends for the various  
5 things that Tom has mentioned. It causes us to feel  
6 this type of effort has been -- try to put the pieces  
7 together.

8 As Tom mentioned, we can only perform --  
9 we can perform no more than two of these a year. So,  
10 it's not something we can use in every case. In a  
11 way, some of these trending plants have not had  
12 diagnostics.

13 CHAIRMAN SELIN: Is the assumption with  
14 DET that there is a problem, but we don't really  
15 understand what the problem is and we have to --

16 MR. TAYLOR: The depth of --

17 CHAIRMAN SELIN: Yes. It's not just to  
18 determine whether there's a problem, but we can't put  
19 our fingers without that on the depth or the --

20 MR. TAYLOR: The depth of the problem.

21 MR. CALLAN: I was just going to say, Mr.  
22 Chairman, that in the case of the two plants I  
23 briefed, in the case of South Texas, they had an  
24 operational readiness assessment team which was an NRR  
25 run totally independent team inspection from Region

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1 IV. Not to the scale of a diagnostic evaluation, but  
2 it was very useful. In the case of Cooper we had the  
3 OSTI, operational safety team inspection. Again, it  
4 was NRR run with some minimum Region IV participation,  
5 but also giving us that independent third party  
6 assessment that we used, similar to a debt.

7 MR. TAYLOR: Mr. Chairman, before staff  
8 concludes, I should recognize Ken Perkins, who  
9 succeeded to the job as Region V Administrator upon  
10 the retirement of Bobby Faulkenberry. Ken was a very  
11 active participant in all these deliberations. But I  
12 should have recognized him at the beginning.

13 I believe that concludes the staff  
14 presentation.

15 CHAIRMAN SELIN: Is there any discussion  
16 on the material side?

17 MR. TAYLOR: Mr. Bernero?

18 MR. BERNERO: No, sir. We don't have any  
19 material facilities to discuss here. The focus of  
20 this whole senior management activity is on  
21 operational safety of major facilities. So, in the  
22 materials area, we confine plant concerns to large  
23 facilities and their operational safety. It's  
24 basically the fuel cycle and there are none now.

25 CHAIRMAN SELIN: Commissioner Rogers?

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1 COMMISSIONER ROGERS: Yes. I'm sure that  
2 you ask yourself this question each time you have one  
3 of these meetings, but do you see any industry trends,  
4 any sign of any broad industry trends one way or the  
5 other at this time?

6 DOCTOR MURLEY: Well, we looked very  
7 carefully backwards at the precursor history, going  
8 all the way back to 1969. In that sense, there are  
9 some trends since Three Mile Island and even since the  
10 Davis-Besse event, since 1985. The frequency and  
11 severity of severe accident precursors is down  
12 substantially. That leads us to believe that our  
13 focus on operational safety as opposed to hardware and  
14 more and more hardware, that our focus is the right  
15 focus, that the industry is improving. We think INPO  
16 is doing a very good job focusing as well. So, in the  
17 long-term trend.

18 Now, with regard to do we see trends from  
19 year to year, it's more difficult. A lot of the  
20 problems that we talked about at this senior  
21 management meeting were ones that we've talked about  
22 three, four years ago. My sense is that the job of  
23 preventing complacency at nuclear plants is going to  
24 be with us forever. This kind of a system I feel  
25 comfortable with, is a good system that forces us,

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1 almost forces us to look at that and prevent  
2 complacency.

3 COMMISSIONER ROGERS: I wonder if you  
4 could say a word or two about how you weigh corporate  
5 performance as against plant performance. I know that  
6 there was a consideration, at least in one case or so,  
7 that corporate performance did not -- stood in the way  
8 of a plant being named on the better performer list,  
9 I believe. I wonder if you could just give us what  
10 your thinking is on how you weigh those together.

11 DOCTOR MURLEY: That's a very good  
12 question because in one case we see New York Power  
13 Authority where we -- in spite of what are some clear  
14 weaknesses in problems in the corporate structure, we  
15 decided that the Fitzpatrick plant could come off the  
16 watch list. With regard to Commonwealth Edison, we  
17 clearly thought that Byron was a good performer that  
18 we should recognize. The reason for these is we've  
19 watched very carefully. We've been reluctant.  
20 There's no question we've been reluctant to  
21 acknowledge that a plant, a site can be a good  
22 performer when there's the potential for transferring  
23 one or two key people that could change all that  
24 within a matter of months. That's been our  
25 reluctance, quite frankly, at Byron. But we've talked

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1 about the plant now and observed it for several  
2 meetings, I would say, and our conclusion now is that  
3 the depth of management there at the site is solid and  
4 deep and that it's not likely -- you could almost say  
5 in spite of some weaknesses in the corporate  
6 structure. But we're confident that this performance  
7 will remain.

8 In that sense then, that's, I guess I  
9 should have mentioned, one of the things that we look  
10 at also when we look at good performance.

11 COMMISSIONER ROGERS: I think that's very  
12 reasonable to look beyond just the first cut at it, in  
13 a sense, to look to see what might lead to a  
14 diminution in that rating, yes. It may be a little  
15 bit hard in a sense on the plant, personnel where the  
16 plant is doing quite well and might conceivably  
17 qualify for outstanding performer, but the questions  
18 about whether it's sustainable or not in light of  
19 difficulties elsewhere in the system is a reasonable  
20 caution, I suspect.

21 DOCTOR MURLEY: Yes. Ultimately we have  
22 to also be -- I mean there's a matter of fairness and  
23 consistency too and we were very keenly aware of that.  
24 If the whole world recognizes that this is a good  
25 plant, but yet we don't, for some reason it's not

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1 clear, we're concerned about that. I think that was  
2 a factor also in recognizing Byron in this case.

3 COMMISSIONER ROGERS: I noticed that in  
4 the letters or perhaps just in some of the background  
5 material that there were a variety of terms or phrases  
6 that were used when poor ineffective management  
7 practices were being referred to. For example, poor  
8 supervision and control of work, inadequate management  
9 control of work, inadequate management controls, core  
10 organizational performance. These are from Dresden,  
11 Indian Point 3 and South Texas. And the question I  
12 have is is there really a clear definition that  
13 distinguishes between those three characterizations?  
14 Are they really something quite different in each of  
15 those cases or are these more or less fungible terms  
16 that could be applied in any of those cases? Is this  
17 just -- I'm really just questioning of how consistent  
18 is the language that we use to describe a concern that  
19 we have when we notify someone of a difficulty. Is  
20 there a difference between poor supervision and  
21 control of work and inadequate management controls,  
22 for example?

23 DOCTOR MURLEY: I'll ask Jack to elaborate  
24 on this. They are -- in my mind, those phrases are  
25 not congruent. They're different manifestations of

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1 management control of activities at the plant.

2 MR. J. MARTIN: Yes, I would think so. I  
3 mean the poor supervision and control of work is -- of  
4 work going on out in the field as opposed to  
5 management controls which are more of a consistent  
6 self-appraisal system and attitude, I view those as  
7 two completely different things. I think they were  
8 considered different in the context of the discussion  
9 as well.

10 COMMISSIONER ROGERS: Is there any virtue  
11 in trying to establish these terminologies on a  
12 consistent basis, what these phrases generally mean?  
13 Would that be worth trying to do?

14 MR. TAYLOR: Let us take a look at that.  
15 There is a variance that comes in of terms that  
16 sometimes certainly -- since we deal in the depth of  
17 the discussion of the problems during the meeting, you  
18 can't reflect all that in a brief letter obviously.

19 COMMISSIONER ROGERS: Right.

20 MR. TAYLOR: But let us take a look at it.  
21 Consistency in terms is reasonable. Let us take a  
22 look at it.

23 COMMISSIONER ROGERS: Well, it's really  
24 from the point of view of being helpful to the  
25 licensee --

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1 MR. TAYLOR: I understand.

2 COMMISSIONER ROGERS: -- to know what it  
3 is they really have to pay attention to.

4 MR. TAYLOR: Yes. Behind the letters, of  
5 course, is a very extensive engagement with licensees  
6 of what the issues and problems are which can barely  
7 be captured in what is a two paged letter.

8 COMMISSIONER ROGERS: Right. Right.

9 MR. TAYLOR: Quite a record of the  
10 elements and discussion by the staff with the  
11 licensees. But there is some variance in terms of  
12 what we should look at.

13 COMMISSIONER ROGERS: Okay. Thanks very  
14 much. Very interesting briefing.

15 CHAIRMAN SELIN: Commissioner Remick?

16 COMMISSIONER REMICK: I don't have any  
17 questions, but I would agree with the comments made  
18 earlier that I think I certainly also have seen what  
19 I say a tremendous improvement in the process over  
20 time. I think that's a tribute to the group of senior  
21 managers that spend a lot of time considering these  
22 matters. I must admit in the past I had some  
23 questions about what's the difference between the SALP  
24 process and the senior managers, but I think I'm  
25 beginning to realize more and more it's kind of a

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1 supplement to the SALP process. I think it offers  
2 greater consistency on the Agency's part because we  
3 have a limited number of senior people considering all  
4 the cases. So, I think there's a greater chance of  
5 consistency in this process over what still exists in  
6 the SALP process.

7 I would ask you to look at when the pilot  
8 program is due for reconsideration and look forward to  
9 your recommendations. I look back a couple of years  
10 ago when we started this and I kind of perceived an  
11 agency that as a regulatory body is kind of willing to  
12 kick people in the pants when they think they're bad  
13 but hesitate to pat them on the head when they think  
14 they're doing a good job. I think the reason for that  
15 is some people fear if we pat somebody on the head,  
16 why two weeks later they're going to do something that  
17 we're going to be embarrassed that we pointed them out  
18 as good performers. But I think we're long over that  
19 and I think by pointing out who we think are doing a  
20 good job is a way of letting people know when we think  
21 they're doing enough to satisfy us. Otherwise, they  
22 never quite know what it is that we're really aiming  
23 for because these things are very subjective.

24 But all in all, I think it's a very good  
25 process. I know it takes a lot of your work. I see

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1 it as improving and I greatly appreciate your effort.

2 CHAIRMAN SELIN: Commissioner de Planque?

3 COMMISSIONER de PLANQUE: I have one very  
4 general question and you may not be prepared to  
5 comment on it today and, if so, at least at some point  
6 I'd like to hear your reaction. But it's become clear  
7 that there's been a great deal of movement among  
8 senior management in the utility industry, especially  
9 in the last year. Probably an unprecedented amount of  
10 movement. Certainly there's benefit to be derived  
11 from that and that's the expected benefit when someone  
12 hires a manager away from someone else. But change  
13 per se can carry some negatives and what becomes a  
14 benefit in one place can leave behind negatives in the  
15 other.

16 Given the incredible amount of movement  
17 within the industry, I'd be interested in your views  
18 as to whether you see net benefits, whether you see  
19 any potential problems resulting in the near future  
20 because of that. If so, are you paying any particular  
21 attention to that?

22 MR. TAYLOR: Well, we have certainly seen  
23 cases where strong management having achieved and  
24 turned plants around going to other plants. It has  
25 started the whole turnaround or completed the

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1 turnaround process. No question --

2 COMMISSIONER de PLANQUE: Right.

3 MR. TAYLOR: -- that that has occurred.

4 It's more difficult to assess the second part of your  
5 question. I think we -- unless you all care to  
6 comment on that, I think I'd like to take a stronger  
7 look at it. But we have certainly seen the effects of  
8 management change where it has occurred, where we  
9 already demonstrated strong management has come in to  
10 turn stations around.

11 Do you want to add to that, Tom?

12 DOCTOR MURLEY: No. Something that  
13 Commissioner Rogers had asked earlier triggered the  
14 same thought, are we seeing some trends. One of the  
15 trends along these lines is that I wonder whether the  
16 industry is developing a cadre of very good people who  
17 can move into these positions, or if they'd not see it  
18 as a dying industry or something. I think this is  
19 something that the Commission might want to ask at  
20 some stage the industry about, NUMARC or someone,  
21 because we do see frequently having to go outside of  
22 the company to get people and then they in turn have  
23 to go around and it is a game of musical chairs and I  
24 think it is a safety issue. We and the staff try to -  
25 - you know, we don't really get involved in those

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1 things, but it's an observation that I think gets a  
2 very good question.

3 COMMISSIONER de PLANQUE: We've clearly  
4 seen it within a particular utility where attention  
5 gets changed from one plant to another and sometimes  
6 you see the good performer go down. And now I think  
7 we're seeing this trend industry-wide and you have to  
8 wonder does this raise a flag that deserves some  
9 watching.

10 DOCTOR MURLEY: Yes. Now, I should amend  
11 my -- we do often encourage a utility to look outside  
12 for different points of view and that sort of thing.  
13 But that's only because they really haven't developed  
14 somebody and done some rotations to get a broader  
15 view. I just don't know the reason for that.

16 MR. TAYLOR: We've certainly seen previous  
17 problem plants turned around and stay turned around.  
18 Plants that we have had difficulties with since this  
19 process started have turned into reasonably good  
20 performing plants with high capacity and certainly  
21 performance for the utility and performance that we  
22 find to be good. So, I guess we'll reserve further  
23 comment.

24 COMMISSIONER de PLANQUE: Okay. That's  
25 all I have. Thank you.

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1                   CHAIRMAN SELIN:       I'd like to say  
2 something.       We have much more often told top  
3 management they better go outside and get some fresh  
4 blood and we have told them that you're making your  
5 guys too insecure by hiring people from outside. I  
6 think a legitimate question is not so much whether we  
7 would encourage or discourage more motion. That's  
8 clearly not our business, but whether we see a  
9 systematic lack of development of middle managers and  
10 it's something to be looked at.

11                   On the other hand, performance is  
12 improving. We have the demonstrable work at least up  
13 to the last couple of years from the precursors to see  
14 consistent improvement in performance. So, personnel  
15 development clearly is a key issue.

16                   I'd like to follow-up on something  
17 Commissioner Rogers said, but from a slightly  
18 different point of view. Not so much the question of  
19 how do you take corporate performance into account  
20 when you assess the good plant or bad plant, but I'd  
21 really like to commend you for when you have a  
22 problem, when you see a problem, to dig deeper than  
23 just stopping at the site vice president or the  
24 material condition of the plant to see what the impact  
25 is of corporate management on the problems at a plant.

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1 And more precisely, what is it going to take to fix  
2 these problems. We have really the scary -- that's  
3 slightly too strong, but the really discouraging image  
4 of the New York Power Authority management who sort of  
5 vacuum from top to bottom, concerns at Commonwealth  
6 Edison where clearly something is lacking. It's just  
7 been too long that we've had one or two problem plants  
8 on the list or trending plants. Probably some  
9 encouraging results from TVA where they've sort of cut  
10 down their workload to something they can manage and  
11 are taking steps to manage it.

12 So, it's absolutely clear that corporate  
13 performance -- no, corporate management does  
14 contribute to safety as reflected at the plants and I  
15 do think that bearing in mind all the limitations and  
16 the caveats that when we see problems or when we see  
17 improvements the possible contribution of corporate  
18 performance as opposed to the more engineering-  
19 oriented pieces is important not just in the sense of  
20 providing resources, but in terms of encouraging or  
21 discouraging the allegations program, people coming  
22 foreword, et cetera. In fact, I think you're to be  
23 commended on the broader scale for keeping up the very  
24 high level of competence and attention to the  
25 engineering questions, but looking at the other

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1 questions, the operational questions in the broader  
2 sense.

3 I like the trends that I see in the  
4 management of this process. It's inevitable that our  
5 eyes get sharper and that's okay.

6 I would, Mr. Taylor and Doctor Murley,  
7 again recommend that you try to explain to the general  
8 public a little more broadly, including the roles of  
9 these various DETs and OSTIs, et cetera, just how this  
10 process works since it's -- this process has become  
11 very important in our overall management and therefore  
12 that it be not reduced to a cookbook formula, but made  
13 more transparent, I think is an important task on the  
14 shoulders of the Agency.

15 Thank you very much for an excellent job.

16 (Whereupon, at 3:12 p.m., the above-  
17 entitled matter was concluded.)  
18  
19  
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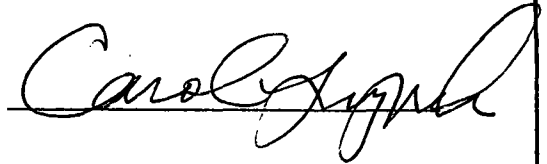
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FUEL FACILITIES

PLACE OF MEETING: ROCKVILLE, MARYLAND

DATE OF MEETING: JANUARY 27, 1994

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# **PERIODIC BRIEFING ON OPERATING REACTORS AND MATERIAL FACILITIES**

**January 27, 1994**

**J. Taylor**

**T. Murley**

**R. Bernero**

**Regional Administrators**

# **PLANTS WITH SUSTAINED HIGH LEVEL OF SAFETY PERFORMANCE**

**BYRON 1 & 2**

**CALLAWAY**

**DIABLO CANYON 1 & 2**

**GRAND GULF**

**MONTICELLO**

**ST. LUCIE 1 & 2**

**SUMMER**

# **CATEGORY 1**

## **PLANTS REMOVED FROM THE LIST OF PROBLEM FACILITIES**

**Plants in this category have taken effective action to correct identified problems and to implement programs for improved performance. No further NRC special attention is necessary beyond the regional office's current level of monitoring to ensure improvement continues.**

**FITZPATRICK**

# **CATEGORY 2**

## **PLANTS AUTHORIZED TO OPERATE THAT THE NRC WILL MONITOR CLOSELY**

**Plants in this category are having or have had weaknesses that warrant increased NRC attention from both headquarters and the regional office. A plant will remain in this category until the licensee demonstrates a period of improved performance.**

**BRUNSWICK 1 & 2**

**DRESDEN 2 & 3**

**INDIAN POINT 3**

**SOUTH TEXAS 1 & 2**

# **CATEGORY 3**

## **SHUTDOWN PLANTS REQUIRING NRC AUTHORIZATION TO OPERATE AND WHICH THE NRC WILL MONITOR CLOSELY**

**Plants in this category are having or have had significant weaknesses that warrant maintaining the plant in a shutdown condition until the licensee can demonstrate to the NRC that adequate programs have both been established and implemented to ensure substantial improvement.**

**BROWNS FERRY 1 & 3**

# **SAFETY PERFORMANCE TRENDING DOWNWARD**

**COOPER  
LASALLE  
QUAD CITIES**



# **PRIORITY MATERIAL FACILITIES**

**NONE**