December 9, 1998

Mr. J. E. Cross President Generation Group Duquesne Light Company (DLC) Post Office Box 4 Shippingport, Pennsylvania 15077

SUBJECT: Mid-Year Inspection Resource Planning Meeting - BEAVER VALLEY POWER STATION

Dear Mr. Cross:

On November 10, 1998, the NRC staff held an inspection resource planning meeting (IRPM). The IRPM provided a coordinated mechanism for Region I to adjust inspection schedules, as needed, prior to the conclusion of the Plant Performance Review cycle in May 1999.

Enclosure 1 contains a historical listing of plant issues, referred to as the Plant Issues Matrix (PIM), that were considered during this IRPM process to arrive at an integrated view of licensee performance trends. The PIM includes only items from inspection reports or other docketed correspondence between the NRC and DLC. The IRPM may also have considered some predecisional and draft material that does not appear in the attached PIM, including observations from events and inspections that had occurred since the last NRC inspection report was issued, but had not yet received full review and consideration. This material will be placed in the Public Document Room as part of the normal issuance of NRC inspection reports and other correspondence.

This letter advises you of our planned inspection effort resulting from the Beaver Valley Power Station IRPM review. It is provided to minimize the resource impact on your staff and to allow for scheduling conflicts and personnel availability to be resolved in advance of inspector arrival onsite. Enclosure 2 details our inspection plan for the next 6 months. Resident inspections are not listed due to their ongoing and continuous nature.

We will inform you of any changes to the inspection plan. If you have any questions, please contact me at (610) 337-5234.

Add RES/DET

Sincerely,

Original Signed By:

Peter W. Eselgroth, Chief Reactor Projects Branch 7 Division of Reactor Projects



Docket Nos. 50-334, 50-412

Enclosures: 1) Plant Issues Matrix 2) Inspection Plan

16:01

Mr. J. E. Cross

cc w/encl:

Sushil C. Jain, Senior Vice President, Nuclear Services Group

K. Ostrowski, Vice President, Nuclear Operations Group and Plant Manager

R. Brandt, Vice President, Operations Support Group

B. Tuite, General Manager, Nuclear Operations Unit

W. Kline, Manager, Nuclear Engineering Department

M. Pergar, Acting Manager, Quality Services Unit

M. Ackerman, Manager, Safety & Licensing Department

J. Macdonald, Manager, System and Performance Engineering

J. A. Hultz, Manager, Projects and Support Services, FirstEnergy

M. Clancy, Mayor, Shippingport, PA

Commonwealth of Pennsylvania

State of Ohio

State of West Virginia

Mr. J. E. Cross

Distribution w/encl: Region I Docket Room (with concurrences) Nuclear Safety Information Center (NSIC) PUBLIC NRC Resident Inspector H. Miller, RA/W. Axelson, DRA P. Eselgroth, DRP N. Perry, DRP C. O'Daniell, DRP M. Oprendek, DRP DRS Director, Region I DRS Deputy Director, Region I

Distribution w/encl (VIA E-MAIL): B. McCabe, OEDO R. Capra, PD1-2, NRR D. Collins, PDI-2, NRR V. Nerses, PDI-2, NRR R. Correia, NRR DOCDESK Inspection Program Branch, NRR (IPAS)

DOCUMENT NAME: G:\BRANCH7\PPR\STD-IRPM.BV

To receive a copy of this document, indicate in the box: "C" = Copy without attachment/enclosure "E" = Copy with attachment/enclosure "N" = No copy

OFFICE	RI/DRP	N	RI/DRP	E	/		
NAME	NPerry		PERMITTOH				
DATE	12/08/98		12/8/98		12/ /98	12/ /98	12/ /98

OFFICIAL RECORD COPY

Date	Туре	Source	íD	SFA	Code	Item Description
9/15/98 387	Positive	IR 98-04	Ν	1-OPS	5A 5C	The licensee developed and implemented a Unit 1 Restart Action Plan (RAP) to provide assurance that known conditions adverse to quality were corrected and that personnel, processes, and equipment were ready for unit restart. Corrective actions to address weaknesses in Technical Specification compliance were comprehensive. The RAP and its implementation were appropriate to address the root causes for the extended forced unit outage.
9/15/98 386	Positive	IR 98-04	L	1-OPS	5A 5C	The post trip critique and event response team report identified several important causes and corrective actions for the trip. The inspectors identified several information gathering/assessment deficiencies, including the lack of recommended actions to improve steam generator level control during subsequent feedwater regulating valve transfer evolutions. Plant management took appropriate actions to address these concerns prior to authorizing plant restart. Operating crew seminars, conducted prior to unit restart, effectively focussed on crew awareness and communications.
9/15/98 385	Negative	IR 98-04	S	1-OPS	3A 3B	On August 11, Unit 1 tripped from 24% reactor power due to a steam generator (SG) level transient experienced while transferring feedwater flow control from the bypass feedwater regulating valve (FRV) to the main FRV. Prior to the trip, operators did not fully discuss and recognize the effects of placing a failed steam flow instrument in trip, which enabled the reactor to trip at a higher SG water level. Operators responded properly to the reactor trip.
9/15/98 384	Positive	IR 98-04	N	1-OPS	1A 3A	Command and control prior to and during the August 11, Unit 1 reactor startup were good. The prestartup containment walkdown as well as the preevolution briefing for startup were comprehensive. Maintenance personnel responded promptly and effectively coordinated with operations personnel to resolve concerns regarding instrument indications.
8/5/98 370.6	LER	IR 98-03 LER 1-97-23	L	1-OPS	2A	TS 3.0.3 Entry Due to Two Analog Rod Position Indicator (ARPI) Channels Inoperable.
8/5/98 370.3	LER	IR 98-03 LER 1-97-22	L	1-CPS	3B	Engineered Safety Feature Actuation of the P-12 Interlock Due to Decreasing Water Temperature.

Date	Туре	Source	ID	SFA	Code	Item Description
8/5/98 370	NCV Positive LER	IR 98-03 NCV 98-03- 03 LER 1-97- 12-01, 02	L	1-OPS	5C	During review of a previous event, the licensee identified three instances during which TS required shutdown margin determinations were not performed. The identification of this issue and subsequent corrective actions were good. Corrective actions for a previous violation associated with configuration control for a Unit 1 pressurizer power operated relief valve (PORV) were properly implemented to preclude recurrence of a similar event. (Noncited Violation of TS 4.1.1.1.1.a; Enforcement Discretion per VII.B.1 of the Enforcement Policy)
8/5/98 369	Negative	IR 98-03	N	1-OPS	1C	Implementation of several TS amendments, and communication of approved changes to the UFSAR for use by the station's staff were poor.
8/5/98 368	NCV Negative	IR 98-03 NCV 98-03- 02	L	1-OPS	3A 5C	On April 7, 1998, a Unit 2 quench spray (QS) pump experienced a significant water hammer event. Several process barriers failed including the corrective actions for similar previous events, system restoration procedures, planning, and scheduling. The final barrier failed when operations personnel did not fully resolve valid safety concerns prior to performing a surveillance test during which the water hammer occurred. Although the QS system was not damaged, this condition represented a failure of the licensee corrective action program. The event critique and Multi-discipline Analysis Team (MDAT) assessments were excellent. The MDAT recommended comprehensive corrective actions to address this event. (Noncited Violation of 10 CFR 50, Appendix B, Criterion XVI; Enforcement Discretion per VII.B.1 of the Enforcement Policy)
8/5/98 367	Positive	IR 98-03	Ν	1-OPS	1C	The controls instituted for the TS 3.0.6 amendment, including procedure changes and training, were sufficient and in place prior to implementation.
8/5/98 366	Positive	IR 98-03	N	1-OPS	1C 5C	The licensee review of alarm response procedures generally identified all Technical Specification (TS) related issues and improved operator awareness of TS 3.0.3 entry conditions. The alarm response procedures were adequate for proper operator response.
8/5/98 365	VIO Negative	IR 98-03 VIO 98-03- 01	Ν	1-OPS	3A 5C	The licensee experienced an increase in the number of personnel performance problems. The partial stop work order issued by the plant manager was important to focus workers on proper attention to detail. Although some improvement was noted, human performance errors continued after the stop work order was lifted. The errors resulted in additional out-of-service time for safety related equipment, and failure of operations personnel to be aware of plant conditions including inoperability of safety related equipment. (Violation of TS 6.8.1a)

Date	Туре	Source	ID	SFA	Code	Item Description
4/25/98 359	Positive	IR 98-02	N	1-OPS	1C 3A 5C	Corrective actions to previously identified configuration control deficiencies were effective. The number of component misposition events was dramatically reduced. Operator adherence to procedures and identification of procedure deficiencies improved.
4/25/98 358	Positive	IR 98-02	N	1-OPS	5C	The licensee developed a comprehensive Restart Action Plan by which the organization could implement corrective actions for known material, process, and performance deficiencies which had led to the current forced outages on both units. Appropriate independent oversight was established and senior management maintained both units in a safe condition pending plant readiness for transition to the four established plant restart milestones.
4/25/98 357	Positive	IR 98-02	N	1-OPS	1C 3B	A two day training course was conducted for over 400 station personnel to improve knowledge and understanding of technical specification compliance. The training plan was excellent and provided a wide range of examples which were specifically selected to enhance training effectiveness across the varied background of the attendees. A major strength of the training was the broad scope of people trained. Training effectiveness was evaluated through highly challenging written examinations.
4/25/98 356.5	Positive	IR 98-02	Ν	1-OPS	1C 5A	Operations personnel performed a thorough and conscientious review of operations procedures and the procedure change backlog for technical specification (TS) implications. Over thirty procedure deficiencies which had the potential to place the units in a condition not permitted by TS were identified and appropriate corrective action initiated. Noteworthy strengths were the broad scope of procedures reviewed, individual training conducted prior to the reviews, and the involvement of the various station departments.
9/15/98 391	Positive	IR 98-04	N	2- MAINT	ЗA	Maintenance on safety related check valves to correct a motion binding issue was properly performed and supervised.
9/15/98 389	VIO Negative	IR 98-04 VIO 98-04- 01	N	2- MAINT	ЗA	Human performance errors continued to impact plant operations. Maintenance personnel failed to adhere to procedures for configuration control and work control when attempting to resolve excessive packing leakage on the Unit 1 turbine driven auxiliary feedwater pump. These actions delayed pump restoration by twenty-two hours. (Violation of TS 6.8.1a)

Date	Туре	Source	ID	SFA	Code	Item Description
9/15/98 388	Positive	IR 98-04	N	2- MAINT	3B 4A 5A 5C	A design change to modify the Unit 1 480 Volt emergency bus under voltage relay scheme was implemented correctly. The maintenance personnel performing the work were knowledgeable and appropriately briefed. Missing motor control center panel fasteners were identified by the maintenance crew and properly dispositioned by the site staff. The infrequently performed test or evolution briefing was professional, notwithstanding two minor deficiencies.
8/5/98 374	NCV Positive LER	IR 98-03 NCV 98-03- 04 LER 1-98-12	L	2- MAINT	5A 5B 5C	Maintenance and engineering personnel identified that high energy line break actuation system capacitor replacements, performed five years ago, resulted in the system being non-seismically qualified. Identification of this issue demonstrated a good questioning attitude and corrective actions were properly implemented in a timely manner. (Noncited Violation of 10 CFR 50, Appendix B, Criterion III; Enforcement Discretion per VII.B.1 of the Enforcement Policy)
8/5/98 373	Negative	IR 98-03	Ν	2- MAINT	3A 4C	Evaluation, scheduling, and management oversight of Unit 2 periodic inservice test (IST) program requirements from February through May was poor.
8/5/98 372	Negative	IR 98-03	Ν	2- MAINT	2B 5A	Posting and control of equipment deficiency tags continued to be poor.
8/5/98 371	Negative	IR 98-03	N	2- MAINT	3A 3C	Surveillances were generally conducted safely. In some cases marginal procedure quality challenged operators and equipment. One example of operator inconsistent use of available indications resulted in a violation of procedure.
4/25/98 363	NCV Negative	IR 98-02 NCV 98-02- 02	Ν	2- MAINT	5A 5C	Licensee identification and corrective actions to address a degraded floor penetration flood seal which caused the auxiliary feedwater (AFW) system to be outside its design basis were slow. Subsequent corrective actions including required reports to the NRC were good. However, while the licensee event report was detailed, it did not properly address the issue of AFW system operability. (Noncited Violation of 10 CFR 50, Appendix B, Criterion XVI; Enforcement Discretion per VII.B.1 of the Enforcement Policy)
4/25/98 362	Negative	IR 98-02	N	2- MAINT	1C 5A	The Quality Services Unit provided thorcugh and objective evaluations of maintenance performance; however, maintenance self-assessment was weak. A program for periodic maintenance self-assessment was not established, and maintenance self-assessments tended to be reactive to self-evident issues. No program for periodic trending of Condition Reports was established.

Date	Туре	Source	ID	SFA	Code	Item Description
4/25/98 361	NCV Negative	IR 98-02 NCV 98-02- 01	L	2- MAINT	1A 3A	Inadequate procedural instructions resulted in a Unit 2 reactor trip signal during reactor trip breaker surveillance testing. In addition, technicians demonstrated poor communications when they failed to inform the control room operators that one of the test acceptance criteria was not met. (Noncited Violation of TS 6.8.1.a; Enforcement Discretion per VII.B.1 of the Enforcement Policy)
4/25/98 360	Weaknes s	IR 98-02	N	2- MAINT	2B	Various planning and scheduling weaknesses were identified. Three separate tracking mechanisms, which did not fully agree with one another, were used to schedule surveillances due to lack of confidence in their individual accurac ₃ . Emergency diesel generator 2-1 restoration was delayed because the post-maintenance testing requirements were not established Emergency Response Facility maintenance was canceled because procedures for equipment clearance were not available. A new work control center was established and six work week manager positions were created to help improve the planning and scheduling process.
9/15/98 393	Positive	IR 98-04	Ν	3-ENG	4B 4C	System and Performance Engineering Department personnel developed a systematic and comprehensive process to evaluate system status and readiness. System engineers were knowledgeable and consistent in their implementation of the required system health reviews, providing appropriate recommendations to station management regarding readiness for Unit 1 restart. Insights gained during the system health reviews were shared with appropriate departments for implementation.
9/15/98 392	NCV Positive LER	IR 98-04 NCV 98-04- 02 LER 1-98- 22-00, -01	Ν	3-ENG	5A 5B 5C	The licensee identified binding issues associated with thirty Unit 2 check valves. Causal analysis for this issue during the last refueling outage was incomplete, which contributed to several additional failures occurring during this outage. Although the valves affected multiple safety systems, the safety significance was low due to redundant, diverse isolation valves for each of the check valves affected. Licensee investigation, root cause analysis, quality contributed to CFR 50, Appendix B, Criterion XVI: Enforcement Discretion per VII B 1 of the Enforcement Policy.

Date	Туре	Source	ID	SFA	Code	Item Description
8/5/98 379	NCV Positive LER	EA 98-359 IR 98-03 NCV 98-03- 07 LERs 1-96- 04-00, 01, 02, 03, 04; 1-97-01-00, 01, 02, 03, 04, 05; 1-97- 03-00, 01; 1- 97-31	L	3-ENG	5A 5C	The licensee conducted a comprehensive review of testing of safety related logic circuits for Unit 1, in response to NRC Generic Letter 96-01. Identified deficiencies were tested successfully, procedures were revised to include the testing, and the conditions were properly reported. (Noncited Violation of several TS surveillance requirements; Enforcement Discretion per VII.B.3 of the Enforcement Policy)
8/5/98 378	VIO Negative	IR 98-03 VIO 98-03- 06	N	3-ENG	2B 4C	The normal practice of venting the high head safety injection pumps prior to surveillance testing without the assurance that adverse conditions will be detected and corrected was a violation. Previous corrective actions to address this issue were comprehensive. (Violation of 10 CFR 50, Appendix B, Criterion XI)
8/5/98 376	Positive	IR 98-03	Ν	3-ENG	1C 4C	The licensee's staff exhibited an appropriate questioning attitude resulting in the identification of many questions regarding interpretation of TS requirements and the adequacy of plant procedures to meet them. Risk insights were generally integrated into the backlog prioritization process as evidenced by about 80 percent of the identified top risk significant backlog items being less than two years old. However, risk insights were not fully utilized for design change requests and pending design change packages. These items constituted the majority of the risk significant backlog items greater than two years old.

Date	Туре	Source	ID	SFA	Code	Item Description
8/5/98 375	NCV Positive	IR 98-03 IR 98-04 EEI 98-03-05 NCV 98-04- 03	L	3-ENG	4C 5A 5B 5C	In response to an NRC violation, the licensee identified over twenty additional instances where the station TS were not sufficient to ensure the station would operate within the existing UFSAR accident analysis. These discrepancies affected the reactor protection system, engineered safety features, and various safety related system requirements. Licensee actions from approximately 1990 to 1997 were inadequate, in that station design was not properly maintained, conditions adverse to quality were not corrected, and TS were not properly maintained. In response to an NRC violation, the licensee performed an extent of condition review which identified numerous design issues for which the TSs were non-conservative. Appropriate corrective actions including interim administrative controls, development of TS amendment requests, and process revisions to ensure the facility is operated within its design basis were established. Interdepartmental coordination and the quality of engineering work to resolve the issues were excellent. The safety significance of the design issues was low and the licensee correctly determined that Unit 1 could restart prior receiving TS amendment approval from the NRC for the subject issues. (Noncited Violation of 10 CFR 50, Appendix B, Criterion III and Criterion XVI; Enforcement Discretion per VII.B.1 of the Enforcement Policy)
4/25/98 364	NCV Positive	IR 98-02 NCV 98-02- 03	L	3-ENG	4B 4C	Operators demonstrated a good questioning attitude upon noting air blowing though a shakespace seal membrane. Engineers provided good support to operations in evaluating and correcting a missing shakespace flood/fire seal which placed the auxiliary feedwater system outside of its design basis. This was the third degraded flood seal issue identified in the past fifteen months and highlighted the need for a station-wide flood barrier inspection program. Corrective actions were appropriate. (Noncited Violation of 10 CFR 50, Appendix B, Criterion III; Enforcement Discretion per VII.B.1 of the Enforcement Policy)
9/15/98 402	Positive	IR 98-04	N	4-PS	3A	Audits of the security program were comprehensive in scope and depth, audit findings were reported to the appropriate level of management, and the program was properly administered. In addition, a review of the documentation applicable to the self-assessment program indicated that the program was effectively implemented to identify and resolve potential weaknesses.
9/15/98 401	Positive	IR 98-04	N	4-PS	3C	Management support was adequate to ensure effective implementation of the security program, and was evidenced by adequate staffing levels and the allocations of resources to support programmatic needs.

Date	Туре	Source	ID	SFA	Code	Item Description
9/15/98 399	Positive	IR 98-04	N	4-PS	2A	Security facilities and equipment in the areas of protected area assessment aids, protected area detection aids, personnel search equipment, and illumination and surveillance hardware were well maintained and reliable.
9/15/98 398	Positive	IR 98-04	N	4-PS	ЗA	Security and safeguards activities were conducted in a manner that protected public health and safety in the areas of access authorization, alarm stations, communications, and protected area access control of personnel and packages.
9/15/98 396	Positive	IR 98-04	N	4-PS	3C	The program for identifying and tracking hot spots, and shielding to reduce occupational exposures was effectively implemented. The Unit 1 refueling outage in 1997 (1R12) was completed with the lowest total dose in unit history.
9/15/98 395	Positive	IR 98-04	N	4-PS	2B	The program for the control of contaminated materials and equipment was effective. The licensee appropriately identified and maintained records of spills and other occurrences as required under 10 CFR 50.75(g)(1).
8/5/98 381	Positive	IR 98-03	N	4-PS	3A 3C	Radiological controls in the containment were effectively established, implemented, and maintained; and radiological work involving the Unit 1 PORV was effectively monitored and controlled.
8/5/98 380	Positive	IR 98-03	Ν	4-PS	2C 3B	The licensee established and implemented effective radiological protection programs with respect to (1) maintenance and calibration of radiological survey instruments; (2) control and leak testing of instrument calibration sources and inventory maintenance; and, (3) training of radiation protection technicians.

ABBREVIATIONS USED IN PIM TABLE

AFW	Auxiliary Feedwater
ALARA	As Low As Reasonably Achievable
ARPI	Analog Rod Position Indication
BCO	Basis for Continued Operation
EVPS	Beaver Valley Power Station
CIV	Containment Isolation Valve
CR	Condition Report
CREBAPS	Control Room Emergency Breathing Air Pressurization System
DLC	Duquesne Light Company
EDG	Emergency Diesel Generator
EOF	Emergency Operations Facility
EP	Emergency Preparedness
ESF	Engineered Safety Features
ESFAS	Engineered Safeguard Features Actuation Signal
GL	Generic Letter
HHSI	High Head Safety Injection
ICCM	Inadequate Core Cooling Monitor
ISEG	Independent Safety Evaluation Group
NRC	Nuclear Regulatory Commission
PORV	Power Operated Relief Valve
QSU	Quality Services Unit
R12	Refueling Outage 12
RCCA	Rod Cluster Control Assembly
RFO	Refueling Outage
RHR	Residual Heat Removal
RMS	Radiation Monitoring System
RWST	Refueling Water Storage Tank
TS	Technical Specification
UFSAR	Updated Final Safety Analysis Report
URI	Unresolved Item

GENERAL DESCRIPTION OF PIM TABLE COLUMNS

Date	The actual date of an event or significant issue for those items that have a clear date of occurrence (mainly LERs), the date the source of the information was issued (such as for EALs), or the last date of the inspection period (for IRs).
Туре	The categorization of the item or finding - see the Type / Findings Type Code table, below.
Source	The document that describes the findings: LER for Licensee Event Reports, EAL for Enforcement Action Letters, or IR for NRC Inspection Reports.
ID	Identification of who discovered issue: N for NRC; L for Licensee; or S for Self Identifying (events).
SFA	SALP Functional Area Codes: OPS for Operations; MAINT for Maintenance; ENG for Engineering; and PS for Plant Support.
Code	Template Code - see table below.
Item Description	Details of NRC findings on LERs that have safety significance (as stated in IRs), findings described in IR Executive Summaries, and amplifying information contained in EALs.

TYPE / FINDINGS CODES

ED	Enforcement Discretion - No Civil Penalty
Strength	Overall Strong Licensee Performance
Weakness	Overall Weak Licensee Performance
EEI *	Escalated Enforcement Item - Waiting Final NRC Action
VIO	Violation Level I, II, III, or IV
NCV	Non-Cited Violation
DEV	Deviation from Licensee Commitment to NRC
Positive	Individual Good Inspection Finding
Negative	Individual Poor Inspection Finding
LER	Licensee Event Report to the NRC
URI **	Unresolved Item from Inspection Report
Licensing	Licensing Issue from NRR
MISC	Miscellaneous - Emergency Preparedness Finding (EP), Declared Emergency, Nonconformance Issue, etc. The type of all MISC findings are to be put in the Item Description column.

TEMPLATE CODES

1	Operational Performance: A - Normal Operations; B - Operations During Transients; and C - Programs and Processes		
2	Material Condition: A - Equipment Condition or B - Programs and Processes		
3	Human Performance: A - Work Performance; B - Knowledge, Skills, and Abilities / Training; C - Work Environment		
4	Engineering/Design: A - Design; B - Engineering Support; C - Programs and Processe		
5	Problem Identification and Resolution: A - Identification; B - Analysis; and C - Resolution		

NOTES:

- EEIs are apparent violations of NRC requirements that are being considered for escalated enforcement action in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Action" (Enforcement Policy), NUREG-1600. However, the NRC has not reached its final enforcement decision on the issues identified by the EEIs and the PIM entries may be modified when the final decisions are made. Before the NRC makes its enforcement decision, the licensee will be provided with an opportunity to either (1) respond to the apparent violation or (2) request a predecisional enforcement conference.
- ** URIs are unresolved items about which more information is required to determine whether the issue in question is an acceptable item, a deviation, a nonconformance, or a violation. However, the NRC has not reached its final conclusions on the issues, and the PIM entries may be modified when the final conclusions are made.

Enclosure 2 BEAVER VALLEY INSPECTION PLAN FOR DECEMBER 1998 THROUGH MAY 1999

Inspection No.	Program Area/Title	Planned Dates	No. Inspectors	Туре
IP 64704	Fire Protection Program	12/14/1998	1	Core
IP 73753	Inservice Inspection	3/15/1999	1	Core
IP 83750	Occupational Radiation Exposure	3/22/1999	1	Core
IP 84750	Radioactive Waste Treatment, and Effluent and Environmental Monitoring - Effluents	4/19/1999	1	Core

Legend:

IP	-	Inspection Procedure Number
TI	-	Temporary Instruction Program / Sequence Number
Core	-	Minimum NRC Inspection Program (mandatory at all plants
OA	-	Other Incontion Activity
RI	-	Additional II spection Effort Planned by Region I
SI	-	Safety Initiative Inspection