Enclosure 3: Dominion Presentation
Meeting Summary of July 28, 2010
Public Meeting with NEI
Dated August 4, 2010

NEI 09-07 Pilot Program

North Anna Power Station

Region II

Eric Hendrixson

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Implementation

- **Modified Previous Safety Culture Binning**
  - **Started in 2008**
  - **Only looked at RCEs**
  - **Only used the Leadership Team**
  - **Informal**
  - **Biennial Safety Culture Assessment conducted with 4 SMEs**
- **Formal Program**
  - **Started in 3rd Quarter, 2009**
  - **Developed LI-NA-1002 (Rev. 2)**
  - **Expanded to the NEI 09-07 guidance**
  - **Results are reviewed by MSRC**

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Safety Culture Assessment

- **71 question electronic survey provided to 1,099 site workers (included supplemental personnel)**
- **Survey was conducted 11/18/09 – 11/30/09**
- **70.15% response rate, resulted in 55,509 data points**
- **Results used to focus the interviews**

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Safety Culture Assessment

- **Site Assessment performed 12/14/09 – 12/19/09**
- **Team consisted of 21 members (11 from North Anna), as well as several observers**
- **62 interviews conducted, and 12 observations, resulted in 1,282 data points**
- **3 strengths, 0 weaknesses, 5 positive, 3 negative, and 7 general observations were made**
- **Results loaded into the Self Assessment module of the Corrective Action Program**

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Safety Culture Monitoring Panel

- **Consists of Supervisors and Specialists**
  - **Operations**
  - **Engineering**
  - **Maintenance**
  - **RP/Chemistry**
  - **Corrective Action**
  - **Human Resources**
  - **ECP**
  - **HU Coordinator**
- **Also has attendance by OR (organizational effectiveness) Manager and NS&L Director for consistency**

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Safety Culture Leadership Team

- **Consists of Senior Management**
  - **Site Vice President**
  - **Plant Manager**
  - **NS&L Director**
  - **Engineering Director**
  - **OR Manager**
  - **Training Manager**

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Data Analysis

- **Used Guidance from NEI 09-07**
  - **Monitoring Panel meets 1-2 times per Quarter**
  - **Leadership Team meets once per Quarter**
  - **Considered larger extent than previous binning**
    - **RCEs, NRC Violations and Findings, ACEs, Oversight AFIs and PDs, CAP and HU Trend Reports, INPO AFIs and PDs, OWAs, Margin Management Issues, HR and ECP Concerns/Trends, ODEC Concerns**
  - **91 items considered in the current 4 quarters**
  - **58 Items binned, 8 “doubled counted”, 33 items not binned**
  - **Bin to both INPO Safety Culture Codes and NRC Cross Cutting Aspects**

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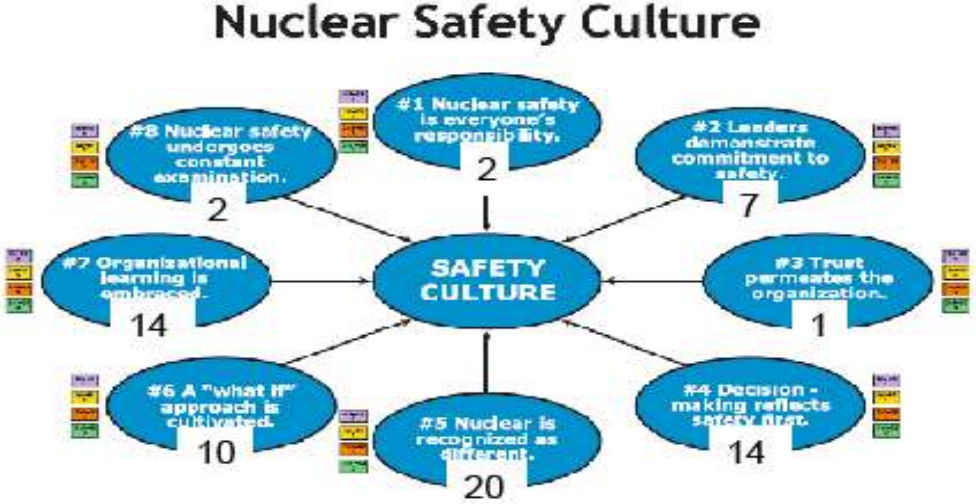
North Anna Power Station

Results



2nd Quarter 2009	3rd Quarter 2009	4th Quarter 2009	1st Quarter 2010
RCE0000969 – Unit 1 Fuel Loading, #5 – Design and Operating margins not carefully guarded, special attention paid to fission product barriers. RCE0000976 – 131-25-21 Breaker Fire, #7 - Thermography not routinely used inside buckets to identify overheating energized operators RCE0000978 – "H" RSST Cable Failure, #7 - 2007 RCE did not go far enough AC0017455 – MCR Chiller CD Pumps did not meet original specs, #5 – Inadequate engineering program review of an IEE AC0017466 – I-IDA-36 found open, #7 – Latent Organizational error – Operating procedure and Operator did not recognize the importance of the task AC0017479 – Containment guard plugs found corroded – programmatic and organizational issues, #6: - Engineering did not understand the technical aspects of the Containment Liner plugs. AC0017482 – U1 Containment airborne activity reached stop work levels, #6 – Did not recognize that a shorter time to Head lift could lead to other issues. AC0017490 – Individual fell under HP Turbine, #4 – Workers perceived the path to be safe Oversight Items 09-002-N – OSCE Process not always followed, #2 – Deviations from the OSCE Process was allowed to transpire. Oversight AFI 09-015-N – FME Weaknesses, #5 – Special attention to FME not fully internalized by the staff.	AC0017454 – Worker caused lamp to fail & open breaker- #6 –Workers did not consider worst case scenario. AC0017538 – No technical guidance for 20 hole diaphragm - #5 - Equipment not maintained and reliability. AC0017518 – Main Feed Isv. Valve Surveillance Timing #5 – Design margin not adequately guarded. AC0017605 – Coolant leak on 1J EDG - #2 and #6 – Decisions must reflect safety first regardless of production or financial challenges. AC0017621 – Corrective deposit/locking 1-LO-E-III – #7 – Must be well informed of lessons learned from corrective actions areas of condition. AC0017583 - 2-PT-48.6 requires clarification - #6 – Did not question use of PCS for alternate indication. AC0017596 - Task Qual List for Crane – #5 & #7 – Task qualification process is weak and does not adequately track quals. AC0017689 - 1-HV-F-76A/B control switches found in OFF - #4 – Allowable and prudent choices for control of station equipment. AC0017773 - Negative Trend noted in Passive Design Feature Assurance - #6 & #7 – Passive Design features not questioned or adequately maintained. AC0017706 -Pulling Dye came off Odds - #7 –Compliance with vendor expertise. Oversight AFI 09-017-N – Operational Decision Making Process Improvement - #2 – Basis for operational decision not properly documented or communicated.	[illegible]	ACR17995 – Worker entered HRA under incorrect RWP - #1 - Error prevention tools were not used to their fullest extent. ACR 17999 – Incomplete manhole inspection - #4 – Ineffective communication of expectations for verbatim procedural compliance. ACR 18002 – Vendor Performed Maintenance without Maintenance Oversight - #7 - Work Control Process allowed latent weakness with formerly considered oversight of security maintenance vs. Maintenance oversight of all maintenance. ACR 18010 – 2H EDG Exhaust oil leakage causes precautionary engine shutdown – #5 and #4 - Equipment is environmentally maintained and Organization maintains a knowledgeable work force – should have known that a subset EDG crank over was required. ACR 18011 – 1-FCV-B-1A spent fuel pool cooler tube leakage - #7 – Individuals are well informed of underlying lessons learned from the industry. ACR 18033 – Received alarm for Fuel Oil Room 1 high pressure CO2 – #6 and #5 – Individuals recognize the possibility of mistakes and worst case scenarios and Equipment is meticulously maintained. ACR 18065 – Open contactor failed for 1-SW-SEB-1H1-22-D1 – #4 – Decision making reflects prudent vs. allowable choices. ACR 18076 – Four selector switches found out in correct alignment, Switchyard Transformer #3 - #5 - Plant activities are governed by high quality procedures. ACR 18080 – Failure mechanism for N2 C20 fuel assemblies 4NFO & 5WI - #5 – Design and operating margins are carefully guarded. ACR 18082 – U2 Reactor head outage and weld failure at MD-1d - #4 - Decision making reflects prudent vs. allowable choices. ACR 18101 – Radiography near miss (worker inadvertently inside RCP boundary) – #2 and #6 - Supervisors are appropriate oversight of risk significant activities and Personnel do not proceed in the face of uncertainty. WOD AFI 18-014-N – Vehicle Safety - #2 - Management places leadership in the field, and coaches to reinforce standards. Deviations from expectations are promptly corrected. WOD AFI 10-008,009,010-N – Boric Acid Deposit Analysis - #3 – The organization avoids complacency and cultivates a continuous learning environment.

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North Anna Power Station

Results

Area	Components	Aspects	4th Qtr 2008	1st Qtr 2009	2nd Qtr 2009	3rd Qtr 2009	4th Qtr 2009	1st Qtr 2010	Running 4 Quarter Total
Human Performance	1. Decision Making	a. Safety/Risk Significant Decisions	1		1	1	1	1	4
		b. Conservative Assumptions & Safe Actions		1	1	1	5	1	8
		c. Communications of Decisions				1			1
	2. Resources	a. Proper Maintenance Programs				1	1	2	4
		b. Personnel Training & Qualifications				1			1
		c. Complete Documentation & Labeling	1		1	1	2	1	5
		d. Proper Facilities & Equipment							
	3. Work Control	a. Proper Work Planning	1				2		2
		b. Work Activity Coordination		1			1	1	2
	4. Work Practices	a. Human Performance & Error Prevention		1		1	3	1	5
		b. Procedural Compliance		2	1	1	3	3	8
		c. Supervisory & Management Oversight	1	1	1	1		1	3
PI & R	1. Corrective Actions Program (CAP)	a. Proper Issue Identification							
		b. Trend Performance Using CAP					1		1
		c. Thorough Evaluation of Identified Problems			1	2	1		4
		d. Appropriate Timely Corrective Actions (CA)		1				2	2
		e. Appropriate Timely Alternative CAP Process							
	2. Operating Experience	a. Utilizing Operating Experiences					1		1
		b. Implementing Operating Experience		1	1		1	2	4
	3. Self & Independent Assessment	a. Appropriate Self-Assessment					1		1
		b. Track and Trend Safety Indicators							
		c. Coordinates & Communicates Results							
SCWE	1. Environment for Raising Concerns	a. Free Flow of Information							
		b. Alternative Free Flow							
	2. Preventing, Detecting, and Mitigating Perceptions of Retaliation	a. Personnel Are Free to Raise Safety Concerns							
		b. Discrimination Claims Investigated & CA Taken							
		c. Appropriate Disciplinary Actions Taken							
OTHER	1. Accountability	Defined lines of authority and responsibility		3	2		1	1	4
	2. Continuous Learning Environment	Licensee ensures that a learning environment exists		3	2		1		3
	3. Organizational Change Management	Systematic Process for change is used					2		2
	4. Safety Policies	a. Policies reinforce the right to raise concerns							
		b. Personnel are effectively trained on safety policies							
		c. Actions are consistent with safety policies		1				1	1
		d. policies are periodically communicated							

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North Anna Power Station

Results

- **Provided Training, and other actions;**
  - **Results tracked by PIIs or CAP**
  - **Davis-Besse and Strategic and Action Planning leadership training**
  - **Managing Risk and Proceeding in the Face of Uncertainty leadership training**
  - **QVV (Question, Validate, Verify) leadership training**
  - **Change Management (Who, What, When) leadership training**
  - **Importance of adhering to nuclear standards and personal accountability leadership training**
  - **Collective significance review of items binned under INPO principle #7, (Organizational Learning is Embraced)**
  - **Passive Design Features training for the entire staff**

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North Anna Power Station

Learnings

- **Only half of the items cleanly "bin" into either the INPO Principles or the Cross Cuttings Aspects**
- **The other half are very subjective, and can easily fit into multiple categories based perspective**
- **Leadership Team tends to be more critical than the Monitoring Panel**
- **Most actions are training directed at behaviors, not changes to processes or procedures (CAP already addresses these)**
- **Biennial Safety Culture Assessment results are different than and complement the results of the binning**
- **About 20-30 "bins" appear to be manageable and meaningful, 8 is too few, 71 is too many for the quarterly binning**

Questions?