



**New York Power
Authority**

**PROBLEM
IDENTIFICATION/
RESOLUTION**

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CORRECTIVE ACTION PROGRAM

- **Goal:** To identify, document, evaluate, and correct problems in a manner that enhances plant safety.



PROBLEM IDENTIFICATION

- ▶ **DER/PID Administrative Procedures**
- ▶ **Other Processes Track Corrective Actions (ie. DCR's, PCR's, ECN's, ACT's, etc.)**
- ▶ **Low Threshold (ie. many DER's)**

PROBLEM IDENTIFICATION

- ▶ Clear Problem Statement
- ▶ Numerous Self-Assessments
- ▶ Emphasis on Self-Critical
- ▶ Aggressive “Problem Identification Culture”



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PROBLEM IDENTIFICATION

OVERALL CONCLUSION: Station problems are being reported at a low threshold and with good level of detail.



DOCUMENTATION

- ▶ Easy to “Initiate” DER/PID Electronically
- ▶ Emphasis on “Communication” of Problem with “Owners”

DOCUMENTATION

- ▶ Emphasis on Positive Reinforcement for Documenting “Human Performance” DER’s (ie. larger no. DER’s can be viewed positively)
- ▶ Continued Review to Capture Equipment Problems with PID’s and DER’s



DOCUMENTATION

OVERALL CONCLUSION: Some examples where DER's were not initiated timely, but overall good documentation of problems.

EVALUATION

- ▶ **Screening Process Based on Risk/Significance
(ie. most DER's are "D" level)**
- ▶ **Graded Response Approach (ie. Level "D"
apparent causes, response/critiques, equipment
failure evaluations, RCA's)**

EVALUATION

- ▶ Trending Improvements (ie. roll-up assessments, etc.)
- ▶ Improved Root Cause Skills (ie. KT Training, O&P Training, etc.)

EVALUATION

OVERALL CONCLUSION: Recurring equipment challenges demonstrate a need for improvement in this area. While human performance events have not been risk significant, the need to prevent repeat occurrences has also demonstrated a need for improvement. In summary, performance is improving; however, previous events, while not risk significant, were occurring too often.

CORRECTIVE ACTIONS

- ▶ “Too Many”
- ▶ Emphasis on “One Cause/One Fix”
- ▶ Good Use of K-T
- ▶ Emphasis on “Timeliness”

CORRECTIVE ACTIONS

- ▶ Department Managers Accountable (ie. changed screening, changed ACT's process)
- ▶ Good Use of OE (Internal and External)
- ▶ System Monitoring Improvements/Ownership Needed

CORRECTIVE ACTIONS

OVERALL CONCLUSION: The volume of identified corrective actions has hindered timely/quality closure in some cases. Examples such as recent HPCI problems, RCIC problems, and ESW degradation have demonstrated the need for improved performance.



CORRECTIVE ACTION PROGRAM HEALTH

Aggressive problem identification culture with generally effective corrective actions for risk significant issues. Implementation aspects of the program are being improved to achieve excellent performance.