

May 31, 2002

Mr. Fred Dacimo  
Vice President - Operations  
Entergy Nuclear Operations, Inc.  
Indian Point Nuclear Generating Units 1 & 2  
295 Broadway, Suite 1  
Post Office Box 249  
Buchanan, NY 10511-0249

SUBJECT: INDIAN POINT 2 NUCLEAR POWER PLANT - NRC SUPPLEMENTAL  
INSPECTION REPORT 50-247/02-09

Dear Mr. Dacimo:

On April 18, 2002, the NRC completed a supplemental inspection at your Indian Point 2 Nuclear Power Plant. During this inspection the NRC reviewed evaluations and corrective actions that your staff has completed or initiated in response to a finding of substantial safety significance (Yellow). The finding was associated with crew high failure rate during facility-administered annual licensed operator requalification examinations conducted last fall (NRC Inspection Report 50-247/01-013). The enclosed report documents the inspection findings which were discussed with you and other members of your staff during an exit meeting on April 18, 2002.

This supplemental inspection was conducted to provide assurance that the root causes and contributing causes of the Yellow finding were understood, to independently assess the extent of the condition, and to provide assurance that the corrective actions to risk significant performance issues were sufficient to address the causes, and to prevent recurrence. To accomplish these objectives, the inspectors reviewed your root cause analysis and evaluation of extent of condition, and conducted an independent assessment of the extent of condition and generic implications.

Based on our inspection, we determined you identified reasonable causes for the Yellow finding. The corrective actions described in your Training Improvement Plan (TIP) are appropriately focused on the identified causes. These actions were appropriately prioritized, and were either complete or scheduled for completion. We noted that you took immediate steps following the requalification examination failures to provide extensive retraining to each shift, and continue to provide this high intensity training. Your extent of condition reviews found, consistent with our independent assessment, that underlying problems in the operator training programs were long standing. Although many of these problems had been identified, previous corrective actions were either incomplete or had not been fully effective. Your success in fully resolving the issues that led to the crew high failure rate will rely heavily on your staff's continued rigorous implementation of the corrective actions.

Your facility remains under the Multiple/Repetitive Degraded Cornerstone column of the NRC's Action Matrix due to other inspection findings. Although your actions to date are considered

appropriate, further demonstration of improved performance is needed for us to have confidence that your corrective actions will be effective in addressing the underlying causes of this Yellow finding. Consequently, this finding will remain open until after completion of your licensed operator requalification examinations, scheduled for later this year. The NRC will continue to monitor the mitigating systems cornerstone through normal baseline inspections and oversight of your TIP.

Your letter of January 18, 2002, indicated an intent to rescind your commitment to NRC to not use for watchstanding purposes restricted operators (as defined in your letter of December 13, 2001) who had not been observed by NRC in a plant operational setting. As noted in our Final Determination Letter of February 18, 2002, we requested that you maintain this commitment until the completion of this supplemental inspection, which has just concluded. Based on NRC's previous observations of retesting of operations staff and on the results of this inspection, we have determined that it is appropriate to release you from the commitment.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosures will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records (PARS) component of NRC's document system (ADAMS). ADAMS is accessible from the NRC Web site at <http://www.nrc.gov/reading-rm/adams.html> (the Public Electronic Reading Room).

Sincerely,

**/RA/**

Wayne D. Lanning, Director  
Division of Reactor Safety

Docket No. 50-247  
License No. DPR-26

Enclosure: NRC Inspection Report No. 50-247/02-09

cc w/encl: J. Yelverton, Chief Executive Officer  
M. Kansler, Senior Vice President and CEO  
J. Herron, Senior Vice President  
R. J. Barrett, Vice President - Operations  
L. Temple, General Manager - Operations  
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Mayor, Village of Buchanan  
R. Albanese, Executive Chair, Four County Nuclear Safety Committee  
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Public Citizen's Critical Mass Energy Project  
M. Mariotte, Nuclear Information & Resources Service  
F. Zalzman, Pace Law School, Energy Project  
L. Puglisi, Supervisor, Town of Cortlandt  
Congresswoman Sue W. Kelly  
Congressman Ben Gilman  
Congresswoman Nita Lowey  
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Senator Charles Schumer  
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D. Katz, Executive Director, Citizens Awareness Network  
P. Gunter, Nuclear Information & Resource Service  
P. Leventhal, The Nuclear Control Institute  
K. Copeland, Pace Environmental Litigation Clinic

Mr. Fred Dacimo

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**Distribution w/encl: (VIA E-MAIL)**

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\* concurrence on previous page

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U.S. NUCLEAR REGULATORY COMMISSION

REGION I

Docket No: 50-247

License No: DPR-26

Report No: 50-247/02-09

Licensee: Entergy Nuclear Generation Company

Facility: Indian Point 2 Nuclear Power Plant

Dates: April 8 - 12, 2002  
April 15 - 18, 2002

Inspectors: T. Fish, Operations Engineer, DRS, RI (Detailed - Team Leader)  
A. Blamey, Sr. Operations Engineer, DRS, RI  
J. D'Antonio, Operations Engineer, DRS, RI  
R. Pelton, Human Factors Specialist, NRR

Approved by: Richard J. Conte, Chief  
Operational Safety Branch  
Division of Reactor Safety

## SUMMARY OF FINDINGS

IR 05000247/02-09; on 4/8-18/02; Entergy Nuclear Generation Co.; Indian Point 2 Nuclear Power Plant; Supplemental inspection for one degraded cornerstone in a strategic performance area (mitigating systems).

The inspection was performed by three regional inspectors and one headquarters inspector. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process," Revision 3, dated July 2000.

Cornerstone: Mitigating Systems

### Supplemental Inspection Findings

This supplemental inspection was performed by the NRC to assess the licensee's evaluation associated with crew high failure rate (four of seven crews failed) during facility-administered annual licensed operator requalification examinations conducted last fall. The finding was previously characterized as having substantial safety significance (Yellow) in NRC Inspection Report 50-247/01-13.

The inspectors noted that the licensee's evaluation identified a fundamental underlying weakness: The station has yet to overcome cultural weaknesses that include an unwillingness to confront poor performance, an over reliance on procedures to change behavior, and compartmentalization. More specifically, the licensee identified three root causes: 1) Operations training had not focused on the basic building blocks that ensure a healthy program; 2) The station had not maintained a core of career oriented, plant knowledgeable instructors and operators; and 3) Operations department involvement with Operations Training had often been ineffective. The inspectors concluded that the methodology and level of detail of the licensee's root cause evaluation were reasonable.

The licensee implemented a number of corrective actions to address the identified causes. The corrective actions are described in the station's Training Improvement Plan. The more significant corrective actions included initiatives that aimed to 1) improve the quality of training and training materials; 2) increase the number of instructors who have Unit 2 plant experience; and 3) provide additional management support and oversight of training. The inspectors determined that the corrective actions are appropriately focused on the identified causes. These actions were appropriately prioritized, and either complete or scheduled for completion. Notably, the licensee took strong immediate corrective actions following the requalification examination failures to provide extensive retraining to each shift, and continue to provide this high intensity training.

The inspectors independently assessed the extent of the underlying conditions that led to the Yellow finding and found that performance issues had also existed in other Operations Training programs, such as initial licensed operator and non-licensed operator training programs. These problems existed for at least three years, both prior to and following the steam generator tube failure event in 2001. Although licensee audits and assessments had identified most of the performance problems prior to the crew high failure rate, they did not identify long-term operator performance as a concern. The inspectors concluded that the licensee's extent of condition review

appropriately bounded the underlying conditions that led to the Yellow finding as evidenced by the fact that the licensee had also identified the duration and extent of the problems, and the failure to recognize the long standing issues.

## Report Details

### 01 Inspection Scope (95002)

The NRC performed this supplemental inspection to assess the licensee's evaluation associated with crew high failure rate during facility-administered annual licensed operator requalification examinations. This performance issue was previously characterized as Yellow in NRC Inspection Report 50-247/01-13 and is related to the mitigating systems cornerstone in the reactor safety strategic performance area.

### 02 Evaluation of Inspection Requirements

#### 02.01 Problem Identification

##### a. Issue Identification

The issue, crew high failure rate, was self-revealing and was the final result of the facility-administered annual 2001 requalification operating examinations. During the root cause evaluation, the licensee identified numerous factors leading up to and contributing to the issue.

##### b. Duration and Prior Opportunities for Identification

Crew high failure rate existed during and after the administration of the 2001 annual exams, essentially September through October, 2001. However, the licensee's root cause evaluation showed that the genesis of the issue, including prior opportunities for identification, dated back several years. Their staff reviewed quality assurance audits, industry peer assessments, self assessments, plant events, and operator performance records dating back to 1998. Those documents, especially the facility's own quality assurance audits, previously identified many of same performance issues that were again exposed by the 2001 examinations. As discussed in section 02.04 of this report, the inspectors agreed with the licensee's evaluation that prior opportunities to identify this issue existed.

##### c. Risk Significance and Regulatory Compliance

Crew performance on the simulator provides a measure of how operators could be expected to perform during actual plant events. The NRC Operator Requalification Human Performance Significance Determination Process provides a guide to the perceived risk associated with crew failure rate. NRC staff considered the significance of this event to warrant a Yellow finding, based, in part, on important performance deficiencies operators exhibited both in the plant and during simulator evaluations.

The licensee's evaluation of the crew high failure rate was assigned the highest importance level (Level 1). Further, the results of personnel interviews and docketed correspondence to the NRC indicated Entergy staff recognized the substantial safety significance of the issue.

No compliance concerns were associated with the issue, because the operators that failed requalification examinations were removed from shift following the failures and



were retrained as required. In addition, NRC inspections of portions of the operator requalification program itself did not reveal violations of regulatory requirements.

## 02.02 Root Cause and Extent of Condition Evaluation

### a. Root Cause Methodology

The inspectors reviewed Entergy's condition report (CR) 200110995 and supporting analysis. The licensee utilized Events and Causal Factors Charting together with a Hazard-Barrier-Target Analysis to obtain an understanding of the training deficiencies and develop corrective actions. The worksheets detailing the methodologies used were available for inspection. The methods used by the licensee were reasonable.

### b. Level of Detail

The inspectors noted that the licensee's evaluation identified a fundamental underlying weakness: The station has yet to overcome cultural weaknesses that include an unwillingness to confront poor performance, an over reliance on procedures to change behavior, and compartmentalization. More specifically, the licensee identified three root causes: 1) Operations training had not focused on the basic building blocks that ensure a healthy, creditable program; 2) The station had not maintained a core of career oriented, plant knowledgeable instructors and operators; and 3) Operations department involvement with Operations Training often had been ineffective. The licensee performed an appropriate evaluation of the issues associated with the Yellow finding.

### c. Prior Occurrences

The analysis considered training issues, plant events, self-assessments, audits, and evaluations dating back to May 1998. Entergy staff, as well as consultants and personnel external to Indian Point 2, performed these reviews. The inspectors determined that this thorough review was evidence that the licensee considered prior occurrences and operating experience.

### d. Common Cause and Extent of Condition Reviews

The licensee's evaluation considered the potential for common cause and extent of condition associated with the Yellow finding. They expanded the scope of the evaluation beyond issues within licensed operator requalification to include a broader spectrum of programmatic issues within Operations Training. The inspectors agreed with the licensee's evaluation of common causes and extent of condition.

### 02.03 Corrective Actions

#### a. Appropriateness

The licensee's corrective actions were appropriately linked to the identified causes. Representative corrective actions for each of the root causes included initiatives to: improve the quality of training and training materials; increase the number of instructors who have Unit 2 plant experience; and provide additional management support and oversight of training. The causal factors identified in the licensee's January 18, 2002 letter to the NRC were also addressed by the corrective actions. The inspectors determined the completed and proposed corrective actions were appropriate.

#### b. Prioritization

The licensee's actions related to the root and contributing causes of the issue were appropriately prioritized. The licensee took immediate corrective actions such as improving instruction quality and providing extensive retraining to each shift. Following completion of the root cause evaluation, the licensee identified additional corrective actions and established a schedule for completion of the actions.

#### c. Implementation and Completion

The inspectors determined that the licensee had either completed, or was tracking the completion of corrective actions identified within the Training Improvement Plan (TIP). The inspectors noted each corrective action had a responsible individual assigned and an identified due date. As of the end of April, approximately 60% of the TIP was completed. The remainder of the programmatic improvements were scheduled for completion by the end of the year.

#### d. Effectiveness Measures

The licensee's evaluation includes a section for corrective action effectiveness measurement. Effectiveness reviews are scheduled for 2002 and 2003, with the specifics detailed in the TIP. The TIP also contains the process for evaluation and closure of corrective actions.

### 02.04 Independent Assessment of Extent of Condition and Generic Implications

The inspectors made their independent assessment of the extent of condition and generic implications using NRC Inspection Procedure 41500, "Training and Qualification Effectiveness" and NUREG-1220, "Training Review Criteria and Procedures". Using an interview protocol, as outlined in Attachment 1, "Interview Protocol", the inspectors interviewed personnel from the Operations Department, Training Department, and management ranks.

Results of these interviews indicated deficiencies within the operator requalification program, such as poor instructors and inaccurate lesson plans, had existed in other Operations Training programs including initial licensed operator and non-licensed operator training programs. Interviews also indicated that operators supported the

changes made as a result of the crew high failure rate. The changes most frequently stated involved those associated with the conduct of operations in the classroom, simulator, and control room. All personnel interviewed indicated there was substantial improvement in the quality of training as well as a sharp increase in management involvement in the training processes.

Audits of operations training were conducted annually by Nuclear Quality Assurance. Additionally, since 1998, assessments of operations training have been conducted following operational events. For example, an assessment of operations training was conducted following the tube rupture event in February 2000 and training areas for improvement (AFI) were identified. The AFIs identified in the assessment had the potential to improve operations training and operator knowledge.

Implementation of the AFIs was in progress, and a plan to determine effectiveness of the completed actions was in place when the technical training program was placed on probation by the Institute of Nuclear Power Operations (INPO) in the fall of 2000. This focused management attention and limited resources on the technical training programs rather than on operations training. While corrective actions were underway for improvements to the technical training programs, failures on the licensed operator biennial written examinations focused management attention on new operations training problems, further derailing actions being taken as a result of the tube failure event. Both the technical training program probation and the written examination failures were evaluated using the condition reporting process. Problems similar to those found in the technical training programs were found in operations training programs. As a result, a plan was developed and implemented to improve many aspects of operations training.

In early 2001, the corrective actions and the plan were evaluated by the NRC (Inspection Report 50-247/2001-002). The NRC determined that the plan appeared to identify appropriate causes, corrective actions appeared to appropriately address the causes of the training deficiencies, the corrective actions were being taken in a timely manner, long-term corrective actions were budgeted for completion in subsequent years, and corrective action effectiveness evaluations were scheduled starting in the summer of 2001. The crew high failure rate occurred during the annual licensed operator requalification examinations in September 2001 indicating that actions up to this point had not been fully effective.

The team determined that the performance issues associated with the crew high failure rate in fall 2001 had existed in other areas of operator training for at least three years. However, continued ineffective, and in many cases incomplete, response to the corrective actions associated with the assessments and evaluations prevented any significant improvement in operations training. Audits and self-assessments of operations training were conducted by station personnel, contractors, and industry peers at least annually since 1998. The audits and assessments were critical of all aspects and areas of operations training, including plant specific knowledge of the instructors, the lack of instructors with IP2 experience, the quality of lesson materials, and the fundamental knowledge weaknesses of the licensed operators. However, the inspectors noted that none of the audits or self-assessments identified long-term operator performance, either in the simulator or control room, as an area of concern.

The licensee's recent evaluation of the crew high failure rate identified poor performance of operators as a fundamental underlying operations training program weakness. As noted in 02.02.d above, the licensee had appropriately considered extent of condition beyond licensed operator requalification training and had substantiated it during the course of their evaluation. Consistent with the team's conclusions, the licensee's evaluation also determined that assessments of long term licensed operator performance and response to internal audits and self-assessments had not been effective.

### 03 Management Meetings

#### Exit Meeting Summary

The inspectors presented the inspection results to Mr. F. Dacimo and other licensee personnel at the conclusion of the inspection on April 18, 2002. The licensee acknowledged the observations presented.

During the meeting, the team stated that there was continued confidence in the ability of IP2 training and operations department staff to effectively and objectively evaluate licensed operator performance. This confidence is based, in part, on independent NRC assessment of crew performance; observation of high intensity training in both the simulator and classroom; interviews with operators, trainers, and managers; and the NRC evaluations of operator performance conducted since November 5, 2001. However, the team also expressed its reservation regarding the "run time" for the corrective actions. Most of the licensee's initiatives had been in place for just a few months. Consequently, the team did not make any determinations as to whether the corrective actions had effected or would effect positive, long term improvement in operator performance and behavior.

The team also discussed the licensee's letter of January 18, 2002, in which Entergy indicated their intent to rescind a commitment to NRC to not use for watchstanding purposes restricted operators (as defined in Entergy letter of December 13, 2001) who had not been observed by NRC in a plant operational setting. As noted in NRC Final Determination Letter of February 18, 2002, NRC requested the licensee maintain the commitment until the completion of this inspection. The inspection team completed its activities and found the following, which serves as the basis to release the licensee from the commitment:

- 1) To date, operators have achieved a 100% pass rate on all operational evaluations conducted by the NRC staff.
- 2) The inspection team gained additional confidence in the licensee's ability to retrain and reevaluate subsequent to the high intensity training (HIT) initiated in January 2002. NRC independent review of the HIT material and its determinations made while observing its administration also indicated that licensee staff is providing higher standards of performance in operator training.

3) Finally, NRC independent observation of control room conduct indicated that operator performance was consistent, for the most part, with the higher standards introduced in the classroom and simulator environment.

## KEY POINTS OF CONTACT

Licensee

F. Dacimo - Vice President, Operations, IP2  
L. Temple - General Manager, Plant Operation  
J. Comiotes - Director Nuclear Safety Assurance  
J. McCann - Manager, Nuclear Safety and Licensing  
D. Morris - Problem Identification & Resolution Program  
J. Goebel - Acting General Manager Quality Assurance  
J. Wheeler - Site Training Manager  
W. Durr - Assistant Operations Manager, IP2  
G. Dean - Training Supervisor, IP2  
R. Allen - Manager, Regulatory Affairs  
B. Woomer - Non-Licensed Operator (NLO) Supervisor  
H. Howe - Lead Training Auditor  
S. Davis - Supervisor, IP2 Licensed Operator Requalification Training  
L. Cortopassi - IP3 Training Manager  
F. Wilson (via telephone) - Manager of Operations Training.

NRC

P. Habighorst, Senior Resident Inspector  
T. Fish, Team Leader  
J. D'Antonio, Operations Engineer  
A. Blamey, Sr. Operations Engineer  
R. Pelton, Human Factors Specialist, NRR  
R. Conte, Chief, Operational Safety Branch, DRS

## LIST OF ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

None

Closed

None

Discussed

None

## DOCUMENTS REVIEWED

Training Procedures

Training Administrative Directive (TRAD) 501, Licensed Operator Requalification Examinations  
 TRAD 104, Implementation  
 Training Program Description 406, Continuing Training for Licensed Personnel

Other Licensee Procedures

Operations Administrative Directive (OAD) 15, "Policy For Conduct of Operations"

Miscellaneous Documents

Level 1 Analysis of Condition Report, CR200110995  
 Events & Causal Factors Chart  
 Hazard-Barrier-Target Analysis  
 November 5, 2001, Entergy letter documenting October 29, 2001, telephone conference between Entergy Nuclear Operations, Inc., and NRC  
 December 5, 2001, NRC inspection report, 50-247/01-013, documenting Preliminary Yellow Finding  
 January 18, 2002, Entergy letter documenting response to significance determination related to a Yellow finding for annual requalification exam failures  
 February 28, 2002, NRC report EA-01-294, documenting final significance determination for a Yellow finding at Indian Point 2  
 Lesson Plan DIAGN-022, Problem Diagnosis, Situation Appraisal and Correcting Plant Problems for LOR Cycle 2002-2 Enhanced Training.  
 Unit 2 Operations Training Improvement Plan, Rev. 8, April 8, 2002.  
 Lesson Plan 624, Operations Standards and Expectations  
 Lesson Plan TAA022001, Transient and Accident Analysis Introduction  
 Lesson Plan, SYS-C-30, Chemical Volume Control System  
 Lesson Plan SYS-C-161 Rod Control System  
 2000 Licensed Operator Annual JPM summary  
 2001 Licensed Operator Annual JPM summary  
 Failure writeups for the 2001 simulator exams, performance improvement plans, retake scenarios for the critical task failures  
 High Intensity Training schedule  
 Human performance evaluation worksheets.  
 Training self assessments  
 Training Administrative Directives, Desktop Guides  
 FSAR accident analysis section  
 IPE risk significant actions

**ATTACHMENT 1**

**INTERVIEW PROTOCOL**

	<b>REFERENCE</b>	<b>QUESTION</b>	<b>M</b>	<b>T</b>	<b>O</b>
		<b>Management Questions</b>			
1	Page 4	What is the underlying root cause of the problems encountered in Ops Training?	X	X	
2	Root cause #1	What is being done about the lack of management oversight and involvement in Ops training?	X	X	
3	Root Cause #2	What is being done about the lack of management support?	X		
4	Root Cause #3	What is being done about the lack of understanding of what "ownership" means, for both Ops training and Technical training. What is being done about the lack of management oversight and involvement in Ops training?	X		
5	Overall	What is being done relative to accountability and Conduct of Operations? What is being done relative to accountability and procedural compliance?	X	X	X
6	Overall	How does accountability factor into the corrective actions?	X		
7	Page 14, items 3, 4, 5	Where does the Training Department fit into the current organization? How does this compare to other Entergy facilities.	X		
8	Page 16, items 4 and 5	\$250,000 was allocated for "simulator scenario guides." The instructor responsible for developing the guides did not have contractor assistance. Where happened to the money that was allocated for training improvements?	X	X	
9	Page 16, item 7a and 7b	How is the money split between Technical Training and Operations Training? Is this money for Unit 2 or is Unit 3 included in this number?	X	X	
10	Page 18, item 17	The Business Plan proposed a training attendance performance indicator. How is training attendance determined? Is this indicator for Ops training or all of training?	X	X	
11	Page 30, Corrective Action 1-3	What aspects of training performance will you use as an element when measuring operations crew performance?	X	X	
12	Page 18, item 18	Regardless of where the two items in question were ranked, did their placement make sense?	X	X	
13	Page 21, item 46	Following the appropriate TRAD, how often are instructor observations to be conducted? Are the appropriate number of observations being conducted?	X	X	
14	Page 27, Extent of Condition	What did the Training Improvement Plan discover regarding the relationship between Operations and Operations Training? How are any relationship problems being handled?	X	X	
15	Page 31, root cause #3, statement #1	How will continued management support and involvement be maintained after implementation of the Training Improvement Plan?	X	X	
		<b>Training improvement/change questions</b>			
16		What improvements have you seen in training? How have they helped to improve you life?	X	X	X



	REFERENCE	QUESTION	M	T	O
17		What is done if you exhibit performance, either in the simulator or the control room, that is NOT up to management expectations?		X	X
18		What is done if you (or an operator) have to be remediated?		X	X
19		What has changed in training that is having a negative impact on you?		X	X
20		What needs to be done to improve training?	X	X	X
21		What type of feedback do you provide to training? What is done with the feedback after submission? How do you find out the status of your feedback?			X
22		Why is it so difficult to retain people in Training?	X	X	
23		What is Indian Point 2's training get well plan and how do you fit into the plan?	X	X	X
24		How do you know that the licensed operators remain proficient at performing risk significant tasks?	X	X	
		<b>Level 1 Analysis of Condition Report</b>			
25	Problem statement	Does the level 1 (L1) analysis cover the actions to be taken for the staff crews or just the Ops crews?	X		
26	Page 12, item 15	What type of follow up is conducted after the Curriculum Review Committee makes a request of Training?	X		
27	Page 12, item 16	What actions were taken as result of Operations request? How was the frequency modified? Who condoned/requested these actions?	X	X	
28	Page 12, item 23	If still held, who attends the Operations Manager morning meetings?	X		
29	Page 13, item 26	What is the policy for procedural compliance relative to TRADs?	X	X	
30	Page 13, item 26	If licensed operators are required to follow procedures or modify them as appropriate, why is the training department allowed to not follow procedural requirements?	X		
31		What is the perception of operators regarding verbatim compliance versus "doing the right thing?" What are the personal consequences of not following procedures?		X	X
32	Page 25, item 11	What does the TRAD require when preparing remediation plans?	X	X	
33	Section V, page 2	The Ops crews and one staff crew are mentioned in the SL-1 report. What type of remediation, if any, did the other staff crew receive?	X	X	
34	Page 34	What is the status of the Corrective Action Effectiveness Measurement and how will these actions improve the effectiveness of the training corrective action program? Is the training corrective action program the same as the Training Action Request system?	X	X	
		<b>Condition Reporting System</b>			
35	Page 6, items 7 and 8	Why is the Training Action Request system still separate from the Condition Report system?	X		
36	Page 21 - 22, items 49 - 53	What is the status of the findings, for Operations training, from the October 2001 sitewide self-assessment?	X	X	

	REFERENCE	QUESTION	M	T	O
37	Page 26 - 27, items 16, 17, 18, 21, 22, 24, 25, 26, 27, 28	What is being done for all of these statements?	X	X	
38	Page 28 - 29 Condition Reports	What is the status of these condition reports? For those corrective actions that have been completed, how will the effectiveness of the actions be determined?	X	X	
39	Page 30	What is the status of the corrective actions for the Level 1 Analysis?	X		
40	Page 30, Corrective Action 1-1	What will you use as a template for an organization that supports excellent training? How will you establish this organization?	X		
41		How was the material to be included in the high intensity training identified and prioritized?	X	X	

M = Managers including Plant managers, training managers, Operations managers, Shift Managers

T = Training Department personnel including lead instructors and instructors

O = Operators