

NINE MILE POINT UNIT 1 RESTART ACTION PLAN

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NIAGARA MOHAWK POWER CORPORATION

NINE MILE POINT UNIT 1

RESTART ACTION PLAN

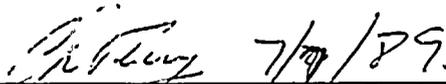
REVISION 2

JULY 1989

Approved:

 7/7/89
Executive Vice President - Nuclear Operations

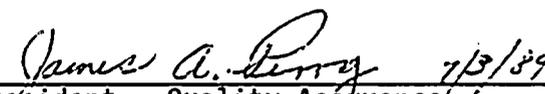
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 7/5/89
Vice President - Purchasing and Materials Management

Changes made to this plan per Revision 2 involve:

1. Addition in Part I, Section 5 and new Appendix D containing Vision and Mission Statements and Standards of Performance.
2. Change in restart corrective actions 1.1.2 and 5.1.6.
3. Changed commitment on Long-Term Strategies relating to Specific Issue #2.
4. Addition of new restart corrective actions 3.1.8A, 3.3.1A, 4.1.1A.
5. Change in corrective actions 3.E.8, 6.E.1, 6.K.1, 11.A.1, and verification actions 6.A.1.1, 6.C.1.1 and 6K.1.1.
6. Addition of Appendix E covering matrix of training required.

Revision Status

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NOTES: 1. The revised pages are identified at the top, right-hand corner by revision number, and a vertical line in the left margin will indicate the location of the change. For Revision 1, "Q" followed by a number indicates the change relates to NRC questions.

2. Pages that do not show a revision number are revision zero.

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INTRODUCTION

In December 1987, Nine Mile Point Unit 1 was manually shut down due to excessive vibration in the feedwater system. It was originally anticipated that the feedwater system would be repaired and the Unit would be restarted and operated until the planned Spring 1988 refueling and maintenance outage. However, prior to the December 1987 shutdown, both Niagara Mohawk and the Nuclear Regulatory Commission (NRC) had identified several concerns with respect to the Inservice Inspection (ISI) Program. Because of these concerns, Niagara Mohawk committed to resolve the open items associated with the ISI Program prior to Unit 1 restart. Further Niagara Mohawk evaluation of the ISI concerns indicated that the problems were potentially more extensive than originally believed. Based on this evaluation, Niagara Mohawk decided to start the refueling and maintenance outage early.

In March 1988, Niagara Mohawk identified a deficiency in a fire barrier under the Nine Mile Point Unit 1 Battery Rooms during installation of a modification. As a result of this deficiency, a program was initiated to evaluate the adequacy of all fire barriers.

In addition to the Inservice Inspection and Fire Protection programmatic issues, other technical issues were identified by Niagara Mohawk and the NRC. These issues were discussed with the NRC on June 20, 1988. Following this meeting, the NRC discussed additional commitments with Niagara Mohawk. This led to the NRC issuing Confirmatory Action Letter (CAL) 88-17 dated July 24, 1988 that contains the actions to be taken by Niagara Mohawk prior to restart of Nine Mile Point Unit 1. The specific actions contained in the letter are:

- "1. Determine and document [Niagara Mohawk's] assessment of the root cause(s) of why Niagara Mohawk line management has not been effective in recognizing and remedying problems; in particular, the problems which were the subject of CAL 88-13 (maintenance of operator licenses), Inspection Report 50-220/88-22 (licensed operators' knowledge and use of emergency operating procedures), and the issues discussed during the June 20, 1988 meeting at Region I.
2. Prepare a proposed restart action plan, and submit it to the NRC Region I Regional Administrator for review and approval. The plan will identify all actions required to be completed prior to startup and a schedule for completion of all other actions to be completed after startup that are needed to address the root cause(s) identified in Item 1. For actions proposed for completion after restart, [Niagara Mohawk] will provide justification for why completion after restart will not have an adverse impact on safe plant operation.
3. Provide a written report relative to the readiness of NMP1 for restart. Include in this report a) [the] bases for concluding that NMP1 is ready for restart, b) a self-assessment of the implementation of the restart action plan, and c) [the] conclusions as to whether Niagara Mohawk's current line management has the appropriate leadership and management skills to prevent, or detect and correct, future problems."

The Restart Action Plan describes Niagara Mohawk's restart actions in response to Confirmatory Action Letter 88-17. Specifically this document:

- Summarizes the assessment process used to identify issues and their root causes.
- Summarizes the assessment process used to identify the underlying root causes of why line management had not been effective in recognizing and remedying problems and issues.
- Identifies the specific issues, causes and the corrective actions associated with those causes required to be completed prior to plant startup, based on the identified root causes.
- Summarizes those long-term strategies that address actions that will be completed after restart. These strategies reflect enhancements that will further strengthen the effectiveness of management and the organization and, therefore, go beyond the specific actions required for restart and safe plant operation.

This Restart Action Plan represents the short-term part of Niagara Mohawk's commitment to improve performance. The Nuclear Improvement Program an internal Niagara Mohawk document, is being developed in parallel with this Plan and will include the near-term and long-term corrective actions for addressing management and organizational effectiveness and long-term corrective actions associated with specific issues.

The Restart Action Plan contains an Executive Summary, an Introduction that includes a glossary of terms and a body which is divided into Parts I and II, and Appendices. Part I provides an overview of the development and implementation of this plan. It describes the processes used to identify issues, determine root causes, and develop corrective actions. It describes how specific issues will continue to be identified and addressed, and how the Plan is being implemented.

Part II contains the corrective actions related to underlying root causes and specific issues that are being addressed in preparation for restarting Nine Mile Point Unit 1. Information provided includes actions that will be taken to verify corrective action implementation. Completion of these corrective and verification actions is a prerequisite for restart and safe operation.

Part II also contains strategies for post-restart actions where applicable. These strategies are intended to prevent recurrence of similar problems. Near-term and long-term corrective actions to implement these strategies are part of the Nuclear Improvement Program, which will be available for NRC review.

The Restart Action Plan Appendices contain the Restart Task Force Charter, the Integrated Team Charter, Process for Assessment of Root Causes, Process for Prioritizing Corrective Actions, Nuclear Division Vision and Mission Statements and Standards of Performance, and a Matrix of Training Required.

The Restart Action Plan has been updated to address NRC questions and concerns. Updates (page changes) will be provided to the NRC as a controlled document until restart authorization is granted by the NRC. The Plan will not be updated with any new specific issue unless it addresses a new underlying root cause. Updates (page changes) will be controlled by appropriate identification of revisions, review and approvals.

the corrective actions and verification actions listed in the Plan are completed, documented, and signed off for an issue, a review and approval of the entire issue is made by the Site Operations Review Committee before the issue is considered to satisfy its restart requirements. Upon completion of verification actions, the NRC is notified that the specific corrective action and its verification action have been completed.

Niagara Mohawk management provides oversight of restart activities and evaluates progress at weekly and monthly review meetings. In addition, Niagara Mohawk senior management has established a structured approach to assess readiness for restart. This self-assessment involves various levels of review, including reviews by the Safety Review and Audit Board (SRAB) and a Restart Review Panel. The Restart Review Panel will be chaired by the Executive Vice President - Nuclear Operations and consists of Niagara Mohawk senior management from both within and outside the Nuclear Division, representatives from other nuclear utilities, and outside consultants. The individuals on this panel will have broad nuclear industry experience, and be independent thinkers, oriented to both details of nuclear energy generation and the future of the industry. The panel membership will include experience in the areas of nuclear operations, engineering, management, regulatory requirements, and quality assurance. In addition to the self-assessment, an INPO assist team assessment will be performed. Prior to the final decision regarding the Company's readiness for restart being made by the Chief Executive Officer, the President and Board of Directors, including its Nuclear Oversight Committee, will participate in the review of restart readiness. The Restart Action Plan involves all levels of management in a comprehensive self-assessment process.

5. CONCLUSION

Recognizing that the issue identification and the root cause analysis efforts in the past were not completely satisfactory, Niagara Mohawk developed the Restart Action Plan using a substantially more detailed and comprehensive process than used in previous self-assessments. Specifically, issues and trends from various historical findings were evaluated to determine if they were symptoms of broader, underlying problems. The assessment clearly points out that underlying the specific restart issues are broader management and organizational effectiveness issues which have also had a detrimental effect on morale and attitude. Several restart corrective actions have been initiated which illustrate the types of actions being taken prior to restart to correct causes which affected morale and attitude. For example, Niagara Mohawk has formalized and disseminated to its employees a Vision Statement, Mission Statement and Standards of Performance. These statements set forth the Nuclear Division's purpose, our long-term objectives, and the qualitative expectations and principles that are to be demonstrated by every person who is involved in our nuclear program. Appendix D contains a copy of the Vision and Mission Statements and Standards of Performance. The process that has been initiated is intended to be an iterative process. As these root causes are addressed, morale and attitude will improve at all levels of the workforce.

By addressing the broader management and organizational effectiveness issues from identification and assessment of root causes through close out of their corrective actions, Niagara Mohawk is confident that the recognition of shortcomings and the effectiveness of the actions taken to correct those shortcomings will improve its performance across the organization. The comprehensive process used to develop the Restart Action Plan has also identified the specific issues having regulatory significance that may impact the safe operation of Unit 1. With the implementation of the corrective and verification actions committed to in this Plan, Niagara Mohawk is confident that it will be ready to successfully start up and operate Nine Mile Point Unit 1.

Senior management is committed to address the underlying root causes by establishing performance measurements, clarifying ownership, and performing timely assessments. The Restart Action Plan is the initial step in the Nuclear Improvement Program. Successful completion of the corrective actions in this Plan will constitute key early points on the path toward the long-term goal of steadily improving Niagara Mohawk's overall effectiveness.

TABLE U1
UNDERLYING ROOT CAUSE 1

Management and Organizational Effectiveness Category

Underlying Root Cause:

1. The management tasks of planning and goal setting have not kept pace with the changing needs of the Nuclear Division and with changes within the nuclear industry.

Corrective Action Objective

- 1.1 Develop and communicate senior management's vision, mission, and performance expectations to address changing needs in the Nuclear Division and changing industry standards. (NOTE: Communication will be achieved through Corrective Actions 1.1.3 and 5.1.3.)

Restart Corrective Actions

Verification Actions

- | | | |
|-------|--|---------|
| 1.1.1 | Develop the Nuclear Division vision and the goals for 1989 to establish the basis for current planning. | 2, 6 |
| 1.1.2 | Modify Corporate goals, as necessary, to support attainment of 1989 Division goals. | 1, 2, 6 |
| 1.1.3 | Modify the monthly Performance Monitoring - Management Information reporting system to include senior management expectations. | 1, 2, 6 |

Long-Term Strategies

Enhance the Nuclear Division planning and goals process such that the objectives, goals, and standards of performance for 1990 and beyond will be integrated, aligned, and developed from the top down to the first line supervisor with implementing action plans developed from the bottom up. Provide a linkage between the organization goals and individual performance expectations.

Corrective Action Objective

- 1.2 Establish and implement a Nuclear Division planning and scheduling process which defines specific performance objectives, assigns responsibilities and priorities, and integrates and aligns the activities.

Restart Corrective ActionsVerification Actions

- | <u>Restart Corrective Actions</u> | <u>Verification Actions</u> |
|---|-----------------------------|
| Q7 1.2.1 Develop and implement the Nuclear Commitment Tracking System (NCTS) | 1,6,8 |
| Q7 1.2.2 Review and verify that regulatory and licensing commitments are entered onto the Nuclear Commitment Tracking System (NCTS) database tracking system.
Complete items required prior to startup. | 1,2,6 |
| Q32 1.2.3 Develop a controlled and consolidated matrix showing implementing procedures and assigned responsibilities for all Technical Specification test requirements.
Develop and implement procedures that are missing. | 1,2,6 |
| Q32 1.2.4 Define responsibilities for surveillance testing by the following: | 1,6 |
| a. Develop an administrative procedure to describe overall management responsibilities for surveillance testing. | |
| b. Establish that surveillance test implementing procedures include assigned responsibility. | |
| Q7 1.2.5 Develop controlled lists to identify specific types of equipment subject to preventive maintenance, surveillance testing or other operational requirements. | 1,2,6 |
| Q7 1.2.6 Implement an improved program for scheduling, tracking, monitoring, and trending surveillance tests at Unit 1. Consider lessons learned and the program used at Unit 2. | 1,6,8 |

Long-Term Strategies

Enhance the planning and scheduling process by implementing a Division-wide integrated planning process which incorporates a consistent prioritization method. Management will utilize the integrated plan to improve the process by which accountabilities are established, activities coordinated, performance monitored, and performance controlled. Follow-up evaluations will be performed to confirm that the integrated plan is working.

Restart Corrective ActionsVerification Actions

	2.1.7	Review lessons learned from Nine Mile Point Unit 2 that may identify issues applicable to Nine Mile Point Unit 1 that may relate to restart.	2
Q7	2.1.8	Interview personnel to determine the existing management processes and tools, identify process problems, and obtain recommended solutions.	2,6
Q7	2.1.9	Clarify and document the current problem reporting process used for restart and provide links to other reporting and corrective action systems.	1,6,8
Q7	2.1.10	Implement corrective actions 1.A.1, 1.A.2, 1.A.3, 1.A.4 and 1.A.5 listed under Specific Issue 1, Outage Management Oversight (repeated here for completeness).	1,6,8
	1.A.1	Establish and document an interim outage management organization with sufficient resources and clearly defined authority and responsibility to coordinate, integrate, and close out activities of the present outage.	
	1.A.2	Develop and implement detailed temporary procedures 88-6, 88-7 and 88-8 that identify and integrate required restart activities including detailed checklists for completion, verification, and close out of specific tasks.	
	1.A.3	Obtain Site Operations Review Committee (SORC) approval of completed prerequisite restart issues.	
	1.A.4	Obtain NMPC Restart Review Panel Chairman's approval that readiness for restart actions have been determined to be satisfied, including approval by NMPC CEO. Submit Readiness for Restart Report to NRC.	
	1.A.5	Obtain NRC Region I Administrator authorization for restart.	

Long Term Strategies

Develop a streamlined deficiency reporting system to simplify the problem identification process. Improve the capability of employees to recognize and respond to problems and concerns through training. Establish methods to actively solicit employee input with regard to problem identification and to provide feedback on actions to be taken. Finalize actions for improving the root cause and trending program. Review and upgrade, as required, the processes used to develop corrective action plans, establish accountability for implementation, assign priority, complete the actions, and assess the corrective actions against the original issue. Implement a lessons learned system throughout the Nuclear Division.

TABLE U3
UNDERLYING ROOT CAUSE 3

Management and Organizational Effectiveness Category

Underlying Root Cause:

3. Management's technical focus has created an organizational culture that diverts attention away from the needs and effective use of employees.

Corrective Action Objective

- 3.1 Strengthen and consistently apply management attention to the effective utilization and needs of employees.

Restart Corrective Actions

Verification Actions

- | | |
|--|---------|
| 3.1.1 Update the functional organization chart to define the areas of responsibility for the Nuclear Division based on the November 1988 organization chart and issue to Nuclear Division personnel. | 1, 2, 6 |
| 3.1.2 Communicate to employees the status and intended action on previous 1988 commitments made to employees during meetings. | 1, 2, 6 |
| 3.1.3 Communicate the Restart Action Plan to Nuclear Division employees and obtain feedback | 2, 6, 7 |
| 3.1.8A Determine critical training needs of Engineering personnel. | 2, 3, 6 |

Long-Term Strategies

Establish a program for employee development to include succession planning; career development; improved definition of position responsibilities, accountabilities, and authority; increased focus on training; and improving the personnel appraisal process to better recognize superior and substandard performance.

Corrective Action Objective

- 3.2 Provide training to managers and supervisors to improve their teambuilding and coaching skills in support of implementing Nuclear Division standards of performance.

Restart Corrective ActionsVerification Actions

- 3.2.1 Provide organizational development professionals to work with the Executive Vice President-Nuclear Operations and his direct reports to facilitate in-line training within their respective organizations.

5, 7

Long-Term Strategies

Interpersonal and management skills required for managers, supervisors, and employees to do their jobs more effectively will be identified, and training and development programs will include and emphasize these skills.

Corrective Action Objective

- 3.3 Improve training and recruiting practices to support implementing the Nuclear Division standards of performance.

Restart Corrective ActionsVerification Actions

- 3.3.1 Provide in-line training to managers to support implementation of the Nuclear Division standards of performance.

5, 6

- 3.3.1A Provide training to support completion of appropriate Restart Action Plan corrective actions. Appendix E describes the scope, audience, training methods and evaluation methods for this training.

2, 3, 4, 6

Long-Term Strategies

A selection process with appropriate criteria will be developed and implemented in filling positions from internal and external sources. The process will be designed to reflect the Nuclear Division's standards of performance and career development strategies. Training programs will be developed to support achievement of the desired standards and strategies.

TABLE U4
UNDERLYING ROOT CAUSE 4

Management and Organizational Effectiveness Category

Underlying Root Cause:

4. Standards of performance have not been defined or described sufficiently for effective assessment, and self-assessments have not been consistent or effective.

Corrective Action Objective

- 4.1 Define and establish standards of performance within the Nuclear Division and its support groups with emphasis on achievement of results..

Restart Corrective Actions

Verification Actions

- | | | |
|--------|--|------|
| 4.1.1 | Develop and communicate the initial set of Nuclear Division standards of performance. | 1, 6 |
| 4.1.1A | Using the chain of command, have supervisors and managers take timely action, such as frequent tours to observe work in progress and to discuss policies and important procedures with employees, to assure that policies and procedures are disseminated to, understood by, and are being implemented by their employees. | 1, 6 |
| 4.1.2 | Develop and disseminate a policy to more accurately define specific responsibilities pertaining to contractor oversight. | 1, 6 |

Long-Term Strategies

Develop and communicate more specific standards of performance at the department level and lower. These standards will be used in assessments and self-assessments as the performance targets that each level of the organization will be measured against.

Corrective Action Objective

- 4.2 Establish and implement a process by which the Nuclear Division and its support groups are routinely assessed against standards of performance with emphasis on results achieved.

Restart Corrective ActionsVerification Actions

Q7 | 4.2.1 Develop and implement a comprehensive self-assessment program to determine readiness for restart.

1,2,5,6

Long-Term Strategies

Use the program developed during restart as a model for establishing a process to assess the implementation of standards, policies, and procedures as part of normal Nuclear Division business practices.

TABLE U5
UNDERLYING ROOT CAUSE 5

Management and Organizational Effectiveness Category

Underlying Root Cause:

5. Lack of effective teamwork within the Nuclear Division and with support organizations is evidenced by lack of coordination, cooperation, and communication in carrying out responsibilities.

Corrective Action Objective

- 5.1 Develop and maintain an organizational environment which promotes team building.

Restart Corrective Actions

Verification Actions

- | | | |
|-------|--|---------|
| 5.1.1 | Convene meetings with senior management, managers, and supervisors to promote Teamwork including identifying and resolving management and organization issues. | 1, 2, 7 |
| 5.1.2 | Convene "town hall" meetings with employees to share information and obtain feedback on issues, problems, concerns, and direction Nuclear Division is going. | 6, 7 |
| 5.1.3 | Communicate the Nuclear Division vision and goals for 1989. | 1, 2, 6 |
| 5.1.4 | Establish a Restart Task Force that carries out tasks per charter contained in Appendix A of the Restart Action Plan. | 1, 2, 7 |
| 5.1.5 | Establish an integrated team of selected Nuclear Division, support organizations, and Restart Task Force representatives to meet on a regular basis to provide input to the restart effort and to resolve issues encountered in the development, implementation, and self-assessment of the restart actions. | 2, 6, 7 |
| 5.1.6 | Communicate to the organization the importance of timely identification and resolution of deficiencies including clarification of reportability requirements. (Use specific issues 4, 6, and 17 as examples of the need to resolve potential system operability issues in a more timely manner.) | 2 |

TABLE 1
SPECIFIC ISSUE 1. OUTAGE MANAGEMENT OVERSIGHT

SUB-ELEMENT	ROOT CAUSE	CORRECTIVE ACTION	VERIFICATION ACTION
		<u>1.A.4</u> Obtain NMPC Restart Review Panel Chairman's approval that readiness for restart actions have been determined to be satisfied including approval by NMPC CEO. Submit Readiness for Restart Report to NRC.	<u>1.A.4.1</u> Verify submission of Readiness for Restart Report to NRC.
		<u>1.A.5</u> Obtain NRC Region 1 Administrator authorization for restart.	<u>1.A.5.1</u> Confirm required authorization has been received.

SPECIFIC ISSUE 2. MAINTENANCE OF OPERATOR LICENSES

A. ISSUE DESCRIPTION

Operator licenses were not maintained in accordance with 10CFR55 in that:

1. Some personnel did not attend some of the scheduled requalification training during the prescribed training cycle.
2. Records of requalification training attendance were not complete for some of the licensed operators.
3. Some license applications, Form NRC-398, Personal Qualifications Statement, were incorrectly submitted in that missed training was not listed on the form as required.
4. Training directives were incomplete in that they did not reflect some of the requirements of the NRC-approved licensed operator requalification regulations.

B. REFER TO TABLE 2 FOR CORRELATION OF ISSUE SUB-ELEMENTS, ROOT CAUSES, CORRECTIVE ACTION, AND VERIFICATION ACTION.

Corrective actions and verification actions identified in Table 2 will be completed by restart.

C. LONG-TERM STRATEGIES

To upgrade the requalification program, a job and task analysis for requalification of RO's/SRO's is in progress and training material based on this analysis will be developed by July 31, 1989.

To enhance the effectiveness of operator training, a plan for rotating experienced licensed operators to assignments in the training department will be developed. The goal is to have licensed individuals participating as trainers by June 30, 1990.

TABLE 3

SPECIFIC ISSUE 3. EMERGENCY OPERATING PROCEDURES

SUB-ELEMENT	ROOT CAUSE	CORRECTIVE ACTION	VERIFICATION ACTION
		<u>3.E.7</u> Review ongoing EOP evaluation program and add controls to ensure quality EOPs are maintained and modified as necessary from plant operational experience and use, training, Control Room walk-throughs, and plant modifications (Open Item 88-22-04).	<u>3.E.7.1</u> Review documentation to verify completion.
		<u>3.E.8</u> Ensure the EOP input values are consistent with existing design basis information as part of 3.E.3 and 3.E.7.	<u>3.E.8.1</u> Review documentation to verify completion.
	<u>3.F</u> Lack of management oversight of records of instructors to assure compliance with procedural requirements.	<u>3.F.1</u> Assemble required records related to instructors to fully satisfy existing procedural requirements.	<u>3.F.1.1</u> Verify that records satisfy procedural requirements.
		<u>3.F.2</u> Perform a human performance evaluation to determine why operators were unable to implement the EOPs despite the training they received and why Operations management was unaware of this condition. The evaluation will also be used to determine what other deficiencies with licensed operator training may exist as a basis for further corrective action (Open Item 88-22-03).	<u>3.F.2.1</u> Verify the existence of a report containing the results of the human performance evaluation.
			<u>3.F.2.2</u> Conduct interviews as appropriate.

SPECIFIC ISSUE 4. INSERVICE INSPECTION

A. ISSUE DESCRIPTION

The Nine Mile Point Unit 1 first 10 year Inservice Inspection (ISI) interval ended in June 1986, concurrent with completion of the 1986 outage. Two months later a concern about a through wall leak on the reactor building closed loop cooling heat exchanger was identified to management. The investigation of this concern led to the discovery of an incorrect disposition of a defect reported during ISI hydrostatic testing. In July 1987 Quality Assurance conducted an audit of ISI deficiency procedures. This audit identified several deficiencies in the Deficiency Corrective Action (DCA) process. However, not all of the DCA records were reviewed during this audit. During a separate review of ISI records from the 1986 outage, a nonconformance report was initiated for five DCAs because the dispositions originally recommended by Engineering were not implemented. The five DCAs were redispositioned and closed, and the remaining open DCAs were reviewed and dispositioned. Engineering, Quality Assurance, and the ISI group did not recognize that undispositioned DCAs affected component operability and failed to report these conditions to operations management. As a result of these deficiencies and an NRC inspection of ISI, Niagara Mohawk initiated a more comprehensive investigation.

This investigation disclosed that a number of components listed in the ISI program plan were either not examined or were missing records for the exams by the end of the interval. This problem was reported in LER 88-01. The scope of the investigation was expanded, and it was determined that other examinations required by the ASME Code were not included in the program plan. Subsequent Niagara Mohawk reviews identified several omissions/errors in the first and second interval program plans. These were documented in Corrective Action Reports 2025 and 2026.

B. REFER TO TABLE 4 FOR CORRELATION OF ISSUE SUB-ELEMENTS, ROOT CAUSES, CORRECTIVE ACTION, AND VERIFICATION ACTION.

Corrective actions and verification actions identified in Table 4 will be completed by restart.

Q83

C. LONG-TERM STRATEGIES

Quality Assurance oversight of the Fire Department surveillance tests will provide added assurance of the adequacy of the fire barriers.

The design bases documents for fire barriers will be updated to reflect the as-installed condition. In the future, Nuclear Engineering will be responsible for assuring that the design data base is kept current.

These are ongoing actions aimed at preventing recurrence. As noted in our October 21, 1988 letter, the surveillance procedure and posting of changes to design basis documents will be complete prior to restart.

D. REFERENCES

1. NMPC letter to NRC (LER 88-09) dated April 25, 1988
2. NRC letter to NMPC Inspection Report 50-220/88-15 dated June 7, 1988.
3. NRC letter to NMPC Meeting Summary dated July 19, 1988
4. NRC letter to NMPC Meeting Summary of Enforcement Conference dated July 21, 1988
5. NRC letter to NMPC Notice of Violation dated September 19, 1988
6. NMPC letter to NRC Response to Notice of Violation dated October 21, 1988

TABLE 6

SPECIFIC ISSUE 6. FIRE BARRIER PENETRATIONS

<u>SUB-ELEMENT</u>	<u>ROOT CAUSE</u>	<u>CORRECTIVE ACTION</u>	<u>VERIFICATION ACTION</u>
<u>6.1</u> Fire barrier penetrations were inadequate. (Root Causes 6B, 6D, 6E and 6J)	<u>6.A</u> Design and station personnel lacked proper understanding of what constitutes degradation of a fire barrier.	<u>6.A.1</u> Develop and issue walkdown specifications/instruction; integrate Fire Department and design personnel on present walkdown teams to promote teamwork and identification of penetrations; and instruct Fire Department and design personnel.	<u>6.A.1.1</u> Verify that walkdown Specifications/Instructions have been generated, data sheets prepared, PRs have been generated, NCRs have been generated, and work package folders have been established. Perform independent walkdowns to verify that discrepancies have been reported. Conduct interviews as appropriate.
<u>6.2</u> Niagara Mohawk failed to detect the inadequacies in a timely manner. (Root Causes 6A, 6B, 6C, 6E, 6F, 6G, 6H, 6I, 6J, and 6K)		<u>6.A.2</u> Review the adequacy of the past and present penetration sealing details and revise their associated instructions.	<u>6.A.2.1</u> Verify that past penetration sealing detail problem report has been dispositioned and revised penetration sealing details generated.
		<u>6.A.3</u> Revise or issue new Walkdown Specifications/Instructions if new configurations which threaten the fire barrier's rating are discovered. Review fire barriers looking for the new configurations.	<u>6.A.3.1</u> Verify that revised or new Specifications/Instructions were issued and new NCRs were generated.
		<u>6.A.4</u> Revise the Breach Permit Procedure to include Nuclear Engineering and Licensing review.	<u>6.A.4.1</u> Verify that the Breach Permit Procedure has been revised to include NEL review.
	<u>6.B</u> Present and past penetration sealing detail drawings did not provide adequate instructions.	<u>6.B.1</u> Revise drawing control procedures to ensure clear instructions are provided. Train personnel regarding updating drawings related to fire penetrations (As-Built vs. Construction).	<u>6.B.1.1</u> Verify that the procedures have been issued and training has been completed. Conduct interviews as appropriate.
		<u>6.B.2</u> Update the penetration design data base defined as the penetration location drawings, penetration sealing detail drawings, and penetration computerized schedule to match the plant restart configuration.	<u>6.B.2.1</u> Verify that the penetration design data base has been updated.

TABLE 6

SPECIFIC ISSUE 6. FIRE BARRIER PENETRATIONS

SUB-ELEMENT	ROOT CAUSE	CORRECTIVE ACTION	VERIFICATION ACTION
		<p><u>6.B.3</u> Perform visual examination on 100% of the penetrations through a required fire barrier on a per fire barrier basis and document results.</p>	<p><u>6.B.3.1</u> Verify that data sheets were prepared and work package folders have been established. Perform visual field verification of Technical Specification barriers/penetrations using revised Fire Department Surveillance Procedures.</p>
		<p><u>6.B.4</u> Perform destructive examination and rework on those penetrations which drawing research indicates may not conform with current penetration sealing detail drawings.</p>	<p><u>6.B.4.1</u> See 6.B.3.1 above.</p>
		<p><u>6.B.5</u> Perform a destructive examination on a sample of the remaining penetrations and rework penetrations to establish a confidence level for the remaining penetrations. Document results and supporting justification for acceptance.</p>	<p><u>6.B.5.1</u> Verify examination results were documented and that the basis for acceptance has been justified.</p>
	<p><u>6.C</u> Penetration design data base was not maintained.</p>	<p><u>6.C.1</u> Document on a Nonconformance Report (NCR) penetration configurations which are in nonconformance with the current penetration sealing detail drawings. Document on a Problem Report (PR) penetration configurations which may pose a threat to the fire barrier's rating. Complete required action to resolve these discrepancies. See also corrective actions 6.A.1, 6.A.2, 6.A.3, 6.B.1 and 6.B.2.</p>	<p><u>6.C.1.1</u> Verify that NCRs/PRs have been dispositioned. Verify by visual field verification that required rework and repairs were completed via a modification work request or a work request and the NCR/PRs required for restart are closed out.</p>
	<p><u>6.D</u> Management failed to recognize the scope, impact and implementation requirements of the commitment.</p>	<p><u>(6.D.1)</u> See corrective actions 6.A.1, 6.A.2, 6.A.3, 6.B.1 and 6.B.2.</p>	
	<p><u>6.E</u> There was no integrated program plan and definition of responsibilities.</p>	<p><u>6.E.1</u> Develop and issue a Nuclear Engineering and Licensing procedure to define Engineering responsibilities as they relate to Fire Protection. Revise Site Administrative Procedures as required to define the onsite Fire Protection responsibilities.</p>	<p><u>6.E.1.1</u> Verify that a Nuclear Engineering and Licensing Procedure has been generated. Verify that Site Administrative Procedures have been revised as required.</p>

TABLE 6

SPECIFIC ISSUE 6. FIRE BARRIER PENETRATIONS

<u>SUB-ELEMENT</u>	<u>ROOT CAUSE</u>	<u>CORRECTIVE ACTION</u>	<u>VERIFICATION ACTION</u>
		See corrective actions 6.A.1 and 6.A.3 for interim solutions used during this outage.	
	<u>6.F</u> It was incorrectly assumed the UL test program/Engineering evaluations encompassed existing penetration configurations.	<u>(6.F.1)</u> See corrective actions 6.A.1, 6.A.2, 6.A.3, 6.B.2, 6.B.3, 6.B.4 and 6.B.5.	
	<u>6.G</u> Drawing research was incomplete.	<u>(6.G.1)</u> See corrective actions 6.A.1, 6.A.2, 6.A.3, 6.B.2 and 6.B.4.	
	<u>6.H</u> Previous walkdown teams lacked an indoctrination with the Unit 1 design data base.	<u>(6.H.1)</u> See corrective actions 6.A.1 and 6.A.3.	
	<u>6.I</u> The Fire Department Surveillance Procedures only required inspection by penetration detail.	<u>6.I.1</u> Revise surveillance procedures for NRC required fire "barriers" to inspect "barriers" as well as individual penetrations.	<u>6.I.1.1</u> Verify that the revised surveillance procedures have been issued and have been properly used, as appropriate.
	<u>6.J</u> Adequate instructions were not provided by Engineering to investigate potential deviations during the 1985-1986 time frame.	<u>(6.J.1)</u> See corrective actions 6.A.1, 6.A.2, 6.A.3, 6.B.1, 6.B.3 and 6.B.5.	
	<u>6.K</u> There was no follow-up to the initial identification of a wood plug (June 1981) and there was no follow-up to the Gage-Babcock audit (1984-1986).	<u>6.K.1</u> Complete required action to resolve open items from Gage Babcock audit.	<u>6.K.1.1</u> Verify that NCRs/PRs have been dispositioned; that the required rework and repairs were completed via a modification work request or a work request and the NCRs/PRs required for restart are closed out.

TABLE 11

SPECIFIC ISSUE 11. EROSION/CORROSION PROGRAM

<u>SUB-ELEMENT</u>	<u>ROOT CAUSE</u>	<u>CORRECTIVE ACTION</u>	<u>VERIFICATION ACTION</u>
<u>11.1</u> The Nine Mile Point Unit 1 general procedures established for data identification and repeatability were difficult to comprehend and not fully understood by reviewers of the program. (Root Causes 11.A, 11.B and 11.C)	<u>11.A</u> The general Nine Mile Point Unit 1 gridding procedures were difficult to comprehend.	<u>11.A.1</u> Revise CB&C Procedures SI-1 to address consistent marking of piping and components to assure repeatability of measurement location.	<u>11.A.1.1</u> Verify that revised procedure adequately describes the requirements for a grid marking system.
	<u>11.B</u> The contractor's instructions were weak. Loss of repeatability of data could occur if the instructions were not implemented correctly.	<u>11.B.1</u> Require contractor to instruct personnel on proper grid marking in accordance with the revised procedure.	<u>11.B.1.1</u> Verify data sheets adequately address grid marking compliance with procedure. Perform overview sample re-examination to confirm data repeatability.
	<u>11.C</u> Niagara Mohawk Site oversight and coordination of the two site contractors was weak.	<u>11.C.1</u> Conduct surveillance of contractors' Erosion/Corrosion grid marking activities during the current outage to assure procedure implementation in accordance with Niagara Mohawk's approved Erosion/Corrosion Program.	<u>11.C.1.1</u> Verify surveillance was performed and documented to confirm adequacy of procedure implementation.

SPECIFIC ISSUE 12. MOTOR GENERATOR SET BATTERY CHARGERS

A. ISSUE DESCRIPTION

In preparation for a 10CFR50.59 review, Engineering, Operations, and Licensing began a complete review and verification of the 125V DC Electrical System Design Basis. During this review, it was discovered that the current safety classification of the motor generator set battery chargers did not properly reflect their intended post-accident function. In 1983, the motor generator set battery chargers were reclassified to non-safety related. Consequently, for approximately five years, work had been periodically performed without requiring the application of 10CFR50 Appendix B.

B. REFER TO TABLE 12 FOR CORRELATION OF ISSUE SUB-ELEMENTS, ROOT CAUSES, CORRECTIVE ACTION, AND VERIFICATION ACTION.

Corrective actions and verification actions identified in Table 12 will be completed by restart.

C. LONG-TERM STRATEGY

As part of design base improvement program, implement improvements in the detail and control of design bases documentation for plant systems (Refer to Specific Issue 14).

D. REFERENCES:

1. LER 88-013-00
2. NRC letter dated July 19, 1988

APPENDIX D

NUCLEAR DIVISION VISION AND MISSION STATEMENTS
AND STANDARDS OF PERFORMANCE



APPENDIX D

NUCLEAR DIVISION VISION AND MISSION STATEMENTS
AND STANDARDS OF PERFORMANCEVISION STATEMENT

It is our vision that Niagara Mohawk Power Corporation be a leader in the nuclear power industry and be recognized and respected as one of the best nuclear utilities.

MISSION STATEMENT

The mission of the Nuclear Division is to operate, maintain and support the Units at Nine Mile Point in a safe, reliable and economical manner by a team of involved and motivated employees dedicated to achieving the highest standards of performance in order to generate electricity at the lowest practical cost.

STANDARDS OF PERFORMANCENuclear Safety

Nuclear safety is the principal consideration in all activities related to the operation and maintenance of Nine Mile Point Units 1 and 2.

Industrial Safety

Injuries can be prevented. All employees have an obligation to work safely and to promptly report unsafe conditions to their supervisors.

Policies and Procedures

Policies and procedures are followed to safely and efficiently maintain and operate the units. When a policy or procedure is incorrect, ineffective or unclear, it is not violated or deviated from, but is reported for review, clarification and possible revision. In the case of a defective procedure, the plant is placed in a safe condition and action is suspended while the procedure is corrected. Individuals understand those policies and procedures that impact them and work with their supervisors to clarify performance expectations. All policies and procedures are fully adhered to and enforced in a consistent manner regardless of the person's position or level within the organization.

Accountability/Responsibility

All personnel, regardless of level or function within the organization, are held accountable for the performance of their assigned responsibilities and the results of their actions.

Communication

Communication is carried out with openness, honesty and integrity. The chain of command is our main channel for communication and action. Information is shared horizontally and vertically in a timely manner.

Quality

Quality is achieved through proper planning, specific direction, cooperative execution and prompt feedback. People know what they must do, by when and they do it correctly the first time, in the safest, most efficient and cost effective manner. Personnel are trained, knowledgeable and competent to perform their tasks.

Problem Identification and Resolution

Problems and potential problems are identified and reported to supervision immediately. The resolution process includes assigning responsibility for problem resolution, involving the people impacted, gathering facts, identifying solutions, taking timely corrective action and assessing results to ensure effectiveness.

Teamwork

Teamwork and cooperation are used to attain our goals. Supervisors involve their team members in decisions that affect them. People are appreciated and respected as contributing members of the team. Human differences, such as race, gender and physical condition are respected in all work-related interactions.

Cooperation, mutual respect and support among and between the Nuclear Division departments and support groups, suppliers, contractors and regulatory groups are essential and expected of everyone.

Timeliness

Work is properly prioritized. The scheduling of work considers the quality of life needs of people. Decisions are made promptly, realistic completion dates are established, tasks are assigned and resources are committed so that results are achieved on schedule and within the budget.

Management/Supervision

Management/Supervision regularly observes work in progress, monitors work methods and assesses work performance. The selection, assignment, training and professional development of all personnel is carefully planned and consistently carried out. Work is managed to minimize the use of overtime and undue reliance on resources outside of Niagara Mohawk Power Corporation. All personnel are treated courteously, fairly and with mutual trust and respect.

Goal Setting

Work tasks and assignments have a direct correlation with Nuclear Division goals and objectives. Personal daily work activities contribute to department and Division goal attainment.

APPENDIX E

Matrix of Training Required Related to:

- Underlying Root Cause - Corrective Actions
- Specific Issues - Corrective Actions

where training is not already identified
in the corrective action statements.



MATRIX OF TRAINING REQUIRED FOR UNDERLYING ROOT CAUSE CORRECTIVE ACTIONS

RAP CORRECTIVE ACTION NUMBER	RESPONSIBLE INDIVIDUAL	TRAINING DESCRIPTION	AUDIENCE	WHO DEVELOPS	WHO GIVES	DELIVERY METHOD	VERIFICATION ACTION
1.2.1, 1.2.2	Presently divided between M. Colomb, M. Brause, and G. Brownell	Train users on methods and items to be tracked on NCTS. Train on NCTS Procedures.	NCTS coordinators and selected mgrs.	Brownell	Brownell, Dooley	Group Sessions	RAP Verification Process
1.2.3	Sanford	Train managers and schedulers on matrix.	Generation Managers and Supervisors	Sanford with Training help	Sanford	Group Sessions	RAP Verification Process
1.2.4	Sanford	Train on S-WRCP-5	Procedure users and their Supervisors	Sanford with Training Assistance	Sanford	Group Sessions	RAP Verification Process
1.2.5	Colomb	Explain significance and use of controlled lists to affected department personnel developed in 1.2.5.	Manager and User Departments	Colomb with Training support	Department Supervisors	Department Meetings	RAP Verification Process
1.2.6	Tessier	Train schedulers and managers on surveillance tracking.	Managers/Schedulers	Tessier with Training support	Tessier	Group Sessions	Quiz
1.3.1	NIP Coordinator Aldrich Finnerty	Train responsible Managers on NIP Action Plan Process.	Responsible Managers	NIP Coordinators	NIP Coordinators	Individual instruction	Integrated Team review of Action Plans
2.1.9	Sweet	This Action Plan describes training on all issues under CAO 2.1. It includes training on all current problem reporting and corrective action systems now in-use.	All Nuclear Division and Support Groups	Fueller with SME support	Fueller with SME support	Group Sessions	Quiz

MATRIX OF TRAINING REQUIRED FOR UNDERLYING ROOT CAUSE CORRECTIVE ACTIONS

RAP CORRECTIVE ACTION NUMBER	RESPONSIBLE INDIVIDUAL	TRAINING DESCRIPTION	AUDIENCE	WHO DEVELOPS	WHO GIVES	DELIVERY METHOD	VERIFICATION ACTION
2.1.10		See specific issue #1, (RAP #1.A.2), on pg. E-3.					
4.1.2	R. Cohen	Policy for contractor oversight.	Nuclear Division Managers and Support Groups	R. Cohen with trainer help	Cohen	Burkhardt Expanded Staff Meeting	RAP Verification Process

MATRIX OF TRAINING REQUIRED FOR SPECIFIC ISSUES CORRECTIVE ACTIONS

RAP CORRECTIVE ACTION NUMBER	RESPONSIBLE INDIVIDUAL	TRAINING DESCRIPTION	AUDIENCE	WHO DEVELOPS	WHO GIVES	DELIVERY METHOD	VERIFICATION ACTION
1.A.2	R.L. Tessier	Implement detailed Temporary Procedures 88-6, 88-7 and 88-8 & Train Responsible Managers.	RAP Responsible Managers	Tessier	Tessier	Group Sessions	RAP Verification Process
4.A.1	W.R. Yaeger	Revise QAP 14.20 and 15.01 to initiate Occurrence Report when an MCR is issued and personnel retrained.	QA/QC personnel	Kraemer	Kraemer	Group Sessions	RAP Verification Process
4.A.3	W.R. Yaeger	Revise AP-8.3 to explicitly identify notification requirements and define interfaces. Train on revised procedure.	Procedure Users	Beijen-Lukens/ Contractor, Lundeen	Training and appropriate other dept. personnel	Group Sessions	RAP Verification Process
6.A.1	P.J. Finnerty	Train Fire Dept. and Design personnel on issued walkdown specifications/instructions.	Fire Dept. and Design Personnel	Finnerty Anderson	Finnerty Simonetta Sullivan	Task Force Meetings	RAP Verification Process
6.A.4	P.J. Finnerty	Revise the Breach Permit Procedure to include Nuclear Engineering and Licensing review. Train Engineers on review process.	Site Engineers,	Candela	Candela	One-on-One Sessions	RAP Verification Process
6.E.1	P.J. Finnerty	Develop and issue a Nuclear Engineering & Licensing Procedure to define Engineering responsibilities as they relate to Fire Protection. Revise Site Administrative Procedures as required to define onsite responsibilities. Train on procedures.	Engineers and Designers Procedure Users M. Balduzzi, A. Anderson, T. Perkins	Procedure writer with Training Support	Procedure writer	Group Sessions	Quiz
6.I.1	P.J. Finnerty	Revise Surveillance Procedures for MRC required Fire Barriers. Train on procedures.	Fire Department	Nicholson with Training support, Anderson	Nicholson, Langdon	One-on-One Sessions	RAP Verification Process

MATRIX OF TRAINING REQUIRED FOR SPECIFIC ISSUES CORRECTIVE ACTIONS

RAP CORRECTIVE ACTION NUMBER	RESPONSIBLE INDIVIDUAL	TRAINING DESCRIPTION	AUDIENCE	WHO DEVELOPS	WHO GIVES	DELIVERY METHOD	VERIFICATION ACTION
14.A.7	L.A. Klosowski	Revise Operating Procedures to provide appropriate response to alarm.	Operators	Ops. Trainers	Ops. Trainers	Initial and Continuing Training	Evaluation of Operator Trng. Program
14.A.8	L.A. Klosowski	Train on core spray high D/P alarm.	Operators	Ops. Trainers	Ops. Trainers	Initial and Continuing Training	Evaluation of Operator Trng. Program
14.A.9	L.A. Klosowski	Evaluate the alarm setpoint, revise it, and associated procedures if necessary. Train on revised alarm.	Operators	Ops. Trainers	Ops. Trainers	Initial and Continuing Training	Evaluation of Operator Trng. Program
14.A.10	Bandla	Revise Procedures for filling Torus. Train on procedures.	Operators	Ops. Trainers	Ops. Trainers	Initial and Continuing Training	Evaluation of Operator Trng. Program
14.A.11	Kronenbiter	Relabel the Emergency Operating Procedures graphs to clarify applicability. Train on revision.	Licensed Operators	Ops. Trainers	Ops. Trainers	Initial and Continuing Training	Evaluation of Operator Trng. Program
14.A.12	Kronenbiter	Revise the EOP to clarify water level indication limitations. Train on procedures.	Licensed Operators	Ops. Trainers	Ops. Trainers	Initial and Continuing Training	Evaluation of Operator Trng. Program
14.A.21	Bandla	Correct or revise Operating Procedures as required. Train on procedures.	Operators	Ops. Trainers	Ops. Trainers	Initial and Continuing Training	Evaluation of Operator Trng. Program

MATRIX OF TRAINING REQUIRED FOR SPECIFIC ISSUES CORRECTIVE ACTIONS

RAP CORRECTIVE ACTION NUMBER	RESPONSIBLE INDIVIDUAL	TRAINING DESCRIPTION	AUDIENCE	WHO DEVELOPS	WHO GIVES	DELIVERY METHOD	VERIFICATION ACTION
14.B.1	L.A. Klosowski	Modify appropriate Procedures with vendor recommendations after evaluation. Train on revised procedures.	Operators	Ops. Trainers	Ops. Trainers	Initial and Continuing Training	Evaluation of Operator Trng. Program
16.A.1	W.R. Yaeger	Revise Procedures and reexamine the feedwater nozzle to ensure full volume inspection. Train on procedures.	NES, NDE personnel	NES, QA	NES, QA	Group Sessions	QA Data Sheet Review

