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NIAGARA MOHAWK

NMP52350

NINE MILE POINT NUCLEAR STATION / P.O. BOX 32 LYCOMING, NEW YORK 13093 / TELEPHONE (315) 343-2110

June 23, 1989

United States Nuclear Regulatory Commission
Attention: Document Control Desk
Washington, DC 20555

Re: Nine Mile Point Unit 1 — Docket No. 50-220 — DPR-63
Nine Mile Point Unit 2 — Docket No. 50-410 — NPF-69
Systematic Assessment of Licensee Performance

Gentlemen:

This letter transmits Niagara Mohawk Power Corporation's response to your Systematic Assessment of Licensee Performance (SALP) Report dated May 22, 1989. These written comments incorporate the oral responses and discussions with the USNRC on June 7, 1989 during the meeting at Nine Mile Point.

In summary, we find your assessment to be fair and, agree with its overall observations, findings and recommendations. These observations and findings are consistent with the evaluations by Niagara Mohawk management. Most were identified and targeted for corrective action before the end of your most recent SALP assessment period. Indeed, many of the appropriate corrective actions have already been implemented and are addressed in the Unit 1 Restart Action Plan (RAP), or are included in Niagara Mohawk's long-term Nuclear Improvement Plan (NIP). Nevertheless, we are discussing, herein, those corrective actions pertinent to the concerns described in your SALP Report.

We note your observation that the development of the RAP, the NIP and the leadership changes in the Nuclear Division occurred late in the SALP period and agree that their full impact was not effective in the assessment period. However, we can report at this time that we are encouraged by the signs of progress. We will be continuing to assess our performance against the RAP and NIP objectives. Because of the rapidity of the changes expected during the present SALP period, and because of the usefulness of feedback from the NRC, we suggest meeting with your staff periodically to discuss our progress and findings. Perhaps an appropriate time would be midway through the current assessment period; accordingly, we suggest a meeting in September 1989 for this purpose.

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Let me reiterate that Niagara Mohawk is firmly dedicated to improvement of the overall effectiveness of our nuclear programs and becoming a leader in the Nuclear Industry.

Very truly yours,

L. Burkhardt III
Executive Vice President
Nuclear Operations

LB/mjv
(0596V)

cc: Regional Administrator, Region I
Mr. R. A. Capra, Director
Ms. M. M. Slosson, Project Manager
Mr. W. A. Cook, Senior Resident Inspector
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SPECIFIC COMMENTS AND RESPONSE TO RECOMMENDATIONS

OPERATIONS

UNIT 1

Niagara Mohawk agrees with the assessment regarding operator attitude during training (SALP Report - Page 11) and this has been a key issue with Nuclear Division and Station Management. Several corrective actions have been taken or are ongoing. The Operator Training Program Advisory Committee (OTPAC) was created. This committee, which is comprised of Station Management, Operations personnel, and Training personnel, assesses training and makes recommendations to improve training programs. OTPAC has been instrumental in the development of Systematic Approach to Training (SAT) based training programs. The oversight responsibility for the Licensed Operator Requalification Training Program has been assigned to the Operations Superintendent. An Operations Training Coordinator position has been assigned to serve as a focal point between Operators and Training, and to assure that concerns are addressed and brought to the attention of the Operations Superintendent, if required. These actions have resulted in timely resolution of training questions regarding program material development and lesson implementation.

Prompt action was taken in the case of the individual who exhibited disruptive behavior during training sessions. Each operating shift was counseled by the Executive Vice President and the Station Superintendent that disruptive behavior will not be tolerated.

All of these corrective actions have increased Operator involvement in the licensed and non-licensed Operator training programs, and improved Operator attitude toward training. This is supported by the results of the May 1989 NRC EOP evaluation. At the interim exit meeting, the NRC commented that each crew conducted itself in a professional manner. Also, the Quality Assurance Department has interviewed 46 of 49 license holders and 11 training instructors regarding the overall improvement in the relationship between the two departments, and whether the quality of training had improved. To summarize the findings of these interviews, Operators feel training is meeting their needs to safely perform their license duties, better cooperation exists between the two departments and the overall quality of training has improved.

Niagara Mohawk acknowledges that implementation of the Emergency Operating Procedures (EOPs) was not complete early in the assessment period (SALP Report - Page 12). Efforts to correct this situation have been extensive. Operating shifts have received extensive training on the revised flowcharts and their technical bases. The operating shifts have been evaluated for implementation of the EOPs by Niagara Mohawk and the NRC. The NRC evaluation (May 1989) found all but one shift to be satisfactory in EOP implementation. Remedial training is being provided to the shift determined to be unsatisfactory. Further, the EOP flowcharts have been revised and revalidated. The validation effort included a human factors review to facilitate implementation.

Additionally, the verification and validation effort has been performed for all EOP actions required outside the control room. This effort involved walkthroughs of all actions. Procedures were revised as required.

Administrative controls have been implemented to assure that the EOP basis calculation input values are supported by design bases, dedicated equipment to perform EOP tasks is available, and that procedures referenced by the EOPs are not changed without assessing the effect on EOP performance.

Niagara Mohawk acknowledges that not all licensed Operators completed all required training prior to the end of the annual requalification period (SALP Report - Page 11). To address this concern, required training has been completed for licensed Operators, and Niagara Mohawk has verified that requalification training is being maintained in accordance with the approved procedure, NTP-11, "Licensed Operator Retraining and Continued Training".

Procedure NTI-5.0 was developed and issued to direct the preparation, processing, and approval of NRC Form 398 for license renewals. The training record system is being upgraded from a manual entry to a computerized system. The computerized system will have the ability to "flag" by individual Operator 10CFR55 and training commitments not completed. This will assure that future NRC Form 398 submittals are correct prior to being forwarded to the NRC.

UNIT 2

Niagara Mohawk agrees that the rate of personnel errors was unacceptably high during the period of the SALP assessment (SALP Report - Page 13). Niagara Mohawk has taken several actions to address this concern. An Operations task force has been assigned to analyze personnel errors for 1987 and 1988. Chief Shift Operator direct involvement with procedures (I&C, Maintenance, etc.) has been reduced in order for him or her to maintain a broader perspective of operations, especially during the day shift. Complex procedures have been improved to be more easily understood, especially those in the surveillance area. An Operations Department Instruction titled, "Personnel Error Reduction" will be issued. Accountability of Operators and Supervisors has been reinforced by the Station Superintendent via shift meetings. A "Site Procedure Compliance Program" was initiated in March 1989. A "Lessons Learned Program" has been incorporated in the training program, with increased emphasis on the prevention of personnel errors. Improvements have been made in planning work activities, including the assignment of more surveillances to back shifts, thereby reducing the dayshift workload and increasing Operator oversight of dayshift activities.

Several corrective actions were taken by Niagara Mohawk regarding errors made in the work release process (SALP Report - Page 13). Surveillance procedure plant impact statements have been improved. Work planning has been improved by making daily work control documents more comprehensive and accurate. The mark-up process was reviewed and reinforced with all departments under the direction of the Unit 2 Station Superintendent. In particular, the duties of the mark-up man, Controller, and Station Shift Supervisor were better defined and reinforced. Niagara Mohawk is presently working to implement computer-generated mark-up process and revise mark-up forms to be more usable.

Niagara Mohawk concurs that the number of lit annunciators has been more than desirable (SALP Report - Page 14). Operations and Engineering have been working together to identify, evaluate, and resolve the problems associated with annunciators which fall into the nuisance category (i.e., continuously illuminated or frequently activated). In March 1989, a project report was written to formalize this process. The goal is to: 1) have all nuisance annunciators identified by the end of June 1989; 2) have proposed resolutions for those identified prepared by the end of September 1989; and 3) have modifications and equipment maintenance actions completed by the end of the Spring 1990 refueling outage. Increased priority will be assigned to corrective maintenance items that cause lit annunciators. The current backlog of these corrective maintenance action items will be greatly reduced by the end of the Fall 1989 outage.

Niagara Mohawk acknowledges that indications existed which could have implied low performance expectations (SALP Report - Page 14), due in part to Station Management's expectations and standards not having been effectively communicated and reinforced to all levels of operations. Corrective actions have been taken. Performance expectations and standards have been reviewed by the Station Superintendent with each shift. The Station Superintendent stressed in these reviews, that inattention to detail errors are inexcusable, that the chain-of-command be properly utilized, and that the Station Shift Supervisor and other shift supervision must expect error free day-to-day operation. These expectations will be continually reinforced by the Station Superintendent. Operations management will continue to assess these areas. Additional operations staff positions are planned to provide increased management oversight capability.

RADIOLOGICAL AND CHEMISTRY CONTROLS

Niagara Mohawk concurs with the summary conclusion stating the overall program has shown steady improvement over the SALP period (SALP Report - Page 16). Niagara Mohawk believes that this improvement will continue as a result of program changes noted.

Niagara Mohawk acknowledges the deficiencies noted in the report and believes that corrective actions that have been implemented will avoid similar problems in the future. Access to the locked high radiation area (SALP Report - Page 16) has been improved by installing a ladder guard. Also, radiation protection technicians have been trained to be more cognizant of deficiencies of this type. In addition, the entire restricted area was inspected to assure that no similar problems exist; none were found. The Radiation Protection Manager and Supervisor Radiological Support monitoring of radiological work as well as radiation protection management oversight in general (SALP Report - Page 16) were enhanced by a number of corrective actions. These actions will include scheduling of Radiation Protection Manager and Supervisor

Radiological Support activities to personally perform additional field monitoring, plus the assignment of six additional assistant Radiation Protection Supervisors enabling expanded supervisory monitoring of radiological work. Radiation Protection Implementing Procedure 9.2 is being developed to formalize the policy for radiation protection management personnel to periodically tour radiologically controlled areas. The Nuclear Improvement Program includes several tasks which will enhance management monitoring in the field.

The cancellation of the chemical decontamination effort scheduled for 1988 (SALP Report - Page 17) was due to the decision to not perform the task that would have derived the most benefit from the decontamination effort; i.e. replacement of the recirculation pump coolers. Niagara Mohawk plans to consider the merits of this step for the 1990 outage as the work scope for this outage is defined.

New respiratory protection equipment was placed in service in April 1988 without the associated procedures having been implemented (SALP Report - Page 17). Procedures for implementing the use of newly acquired respiratory equipment were changed to ensure procedures for using the equipment are in place prior to their use. It has been stressed to Station personnel that procedural requirements must be observed in a timely manner.

MAINTENANCE AND SURVEILLANCE

Niagara Mohawk agrees with the SALP Report assessment in the Maintenance and Surveillance area (SALP Report - Page 20). Several actions have been taken to improve overall performance in this area.

Niagara Mohawk personnel responsible for contractor supervision initiated a surveillance checklist in March 1989 similar to the one used in Maintenance. Periodic meetings are scheduled to begin in July 1989 between Niagara Mohawk maintenance management and Niagara Mohawk contractor management to exchange surveillance checklists and take any necessary corrective actions. The overall goal is to ensure compliance with performance standards which result in consistent practices in maintenance activities. Procedure compliance and adequacy have been stressed and continue to be monitored as a result of the effort in implementing Station General Order 89-03. Maintenance was re-organized to include a dedicated procedure group which has already assumed responsibility for the maintenance procedure process. The written Periodic Maintenance Program did not include all vendor recommended maintenance activities and actual periodic maintenance being performed on the equipment. This written program is being upgraded to reflect annual maintenance reviews, vendor manual recommendations, industry experience, and periodic maintenance which has been performed in the past. Training interface coordinators have been appointed between line and training staff. The program addressing continued training has been revised to be

consistent for all maintenance disciplines. Continued training and a Systematic Approach to Training will be looked at in the maintenance area. Lessons-learned training is now part of the plan-of-the-day meetings.

A comprehensive housekeeping plan has been completed. The schedule to complete this three-year improvement program is currently being evaluated for implementation. Some housekeeping improvements have been commenced and, to continue this effort, Site Maintenance has been re-organized and a Building and Grounds Superintendent position established. This individual will be responsible for the overall improvement in housekeeping.

A new item has been added to the Nuclear Improvement Program (NIP) to ensure continued management attention in the area of housekeeping (SALP Report - Page 21).

Short term resolution of problems identified in the 1987 Maintenance Self Assessment are being addressed in new Administrative Procedures for conduct of maintenance. Several long term resolutions are noted in the Nuclear Improvement Program (NIP).

Actions have been taken to improve the timely performance of surveillances and to enhance management oversight of the surveillance program (SALP Report - Page 22). These actions include: implementation of a surveillance monitoring program by the newly established Nuclear Regulatory Compliance Group and issuance of a Station General Order (89-01) providing guidance and direction for the surveillance scheduling and performance. Actions scheduled to be completed in the Restart Action Plan in this area include; generation of an improved Site Surveillance Program procedure, review of certain Unit 1 surveillance tests for technical content, and generation of a surveillance test scheduling matrix for Unit 1. Direction and training on Station General Order (SGO) 89-03, "Procedural Adequacy and Compliance", has been given to promote strict procedural adherence.

A number of actions regarding fire protection enhancements (SALP Report - Page 23) have been completed or are scheduled for accomplishment. A walkdown of pertinent Technical Specification areas has been completed. New surveillance requirements address the entire barrier as well as individual penetrations, with the exception of conduit penetrations. Additional training of personnel in procedural compliance has been completed in conjunction with issuance of Station General Order 89-03. The Fire Department will enhance the program by staffing each unit with a Unit Supervisor, Assistant Unit Supervisor, and a Planning Coordinator to improve the day-to-day operation of the department. The Fire Department will identify, discuss and incorporate the applicable commitments, documents, department responsibilities and activities into a comprehensive plan, which together with existing procedures, will form the Nine Mile Point Fire Protection Program. The plan is scheduled to be approved in August 1989.

Niagara Mohawk acknowledges that past In-Service Inspection (ISI) and In-Service Testing (IST) problems were attributable in part, to past management ineffectiveness and appreciates NRC's recent recognition of the effectiveness of our efforts in the In Service Inspection program (SALP Report - Page 22).

This program involved several departments, working as a team, to define roles and responsibilities and establish and implement transition plans. Substantial interaction was required among Nuclear Engineering, Quality Assurance, and Nuclear Generation. In particular, corrective actions were taken to improve the In-Service Inspection and In-Service Testing programs. A root cause evaluation was performed to address In-Service Inspection/In-Service Testing problems. A re-definition of the functional responsibility between Nuclear Engineering and Licensing (Design, Nuclear Technology, and Site Engineering), Nuclear Generation, and Quality Assurance was made. Programs and procedures were developed to control and document In-Service Inspection and In-Service Testing activities. Staffing levels in Quality Assurance and the Site Engineering Group are increasing to support In-Service Inspection/In-Service Testing program implementation. These actions were in place to support the Niagara Mohawk Unit 2 mid-cycle outage. Niagara Mohawk's self assessment of the outcome of the In-Service Inspection and In-Service Testing activities during the outage has concluded that the corrective actions taken were adequate to ensure proper program implementation. An organizational structure similar to that used for Unit 2, is being used to implement the Unit 1 In-Service Testing Program. Also, detailed reviews conducted as part of the In-Service Inspection program at Unit 1 is enabling Niagara Mohawk to effectively implement the In-Service Testing program. With regard to the Stop Work Order by QA against the In-Service Inspection contractor, Niagara Mohawk recognizes that the NRC does not regard this as a substitute for oversight by the Engineering Department. Niagara Mohawk agrees with the need for Engineering to increase its oversight of contractors, in general (corrective actions are discussed in the Engineering and Technical Support section).

Niagara Mohawk agrees with the need to improve the collection of surveillance testing data, including review of the results and acceptance criteria in order to adequately support system operability decisions (SALP Report - Page 22). Nuclear Generation is adding System Engineers to support the ongoing review of system performance on a day-to-day basis. Also, the improved In-Service Testing (IST) program has more clearly defined responsibility for collection, evaluation, and disposition of surveillance testing results. Further, the enhanced Site Engineering Group function provides the capability for prompt resolution of questions. System Engineers, who will be added to the design organization, will ensure consistent direction and definition of design requirements on a system basis.

EMERGENCY PREPAREDNESS

As was noted in the SALP Report, Niagara Mohawk has addressed each of the Emergency Response Facility Appraisal (ERFA) (SALP Report - Pages 25-27) items and has committed to resolving each item prior to the end of the next unit specific refueling outage.

There is one minor inaccuracy on Page 26, the last paragraph: This paragraph notes that, through quarterly sessions with the State of New York and membership on the Oswego County Planning Committee, Niagara Mohawk is currently assisting the State and local authorities in the development of procedures for meteorological forecasting. Actually, these interactions are intended to help assure that various forecasting methods are understood and inputs into the dose assessment models will be similar.

SECURITY AND SAFEGUARDS

Niagara Mohawk concurs with the SALP assessment in this area.

ENGINEERING AND TECHNICAL SUPPORT

Niagara Mohawk agrees with the need to improve control of contractors (SALP Report - Page 30), and the overall need to strengthen accountability and teamwork. Two specific actions are included in the Nuclear Improvement Program: the first involves developing and disseminating a policy to more accurately define specific responsibilities pertaining to contractor oversight, and the second requires establishment of a coordinator for contractor services.

Niagara Mohawk agrees with the need to improve engineering work quality to a uniformly high level (SALP Report - Pages 30-31). However, comments are appropriate to two of the specific examples: A problem cited in the SALP Report relating to improperly sealed penetrations which might become conduits for internal flooding at Unit 2, was a deficiency missed during construction, but diligent follow through by Nuclear Engineering and Nuclear Generation personnel resulted in the problem being thoroughly investigated and resolved. Regarding Regulatory Guide 1.97, the issue resulted primarily from insufficient communications between Niagara Mohawk and the NRC regarding specific requirements and expectations. This caused misunderstanding during initial meetings. However, subsequent meetings and correspondence have been more productive and determination of specific requirements appears close at hand.

There is a need to upgrade the design bases for the core spray and HPCI systems, as well as others, on Unit 1 (SALP Report - Page 31). Niagara Mohawk will schedule a meeting with the NRC to present the long-range plans for this area. In followup to commitments made with the NRC in December 1988, a number of actions have been taken to follow through on the deficiencies identified in core spray and HPCI systems, and to implement those improvements on other systems as appropriate.

Niagara Mohawk agrees with the concerns identified relating to Engineering training (SALP Report - Page 31). Actions have been taken to ensure that the training program is properly implemented. First, Nuclear Engineering and Licensing has identified thirteen elements which are critical (Critical Needs Training) for Nuclear Engineering and Licensing personnel. Senior level management has been assigned to sponsor and monitor training. Additionally,

the Nuclear Training Department has been authorized to expand its technical training staff by four instructors to support the training needs of Nuclear Engineering and Licensing. It is anticipated that the enhanced training will commence during the Fall 1989. Senior level management sponsors will assure that the training matrix for each level of personnel is correct, and that scheduled training is attended and properly evaluated.

The need to improve the direct support to the Station by the Nuclear Engineering and Licensing Department (SALP Report - Page 30) is acknowledged. Actions have been taken to improve the day-to-day support through establishment of a Site Engineering Group. It supports In-Service Inspection (ISI), Materials Engineering, Design and Technical Evaluation, and the Independent Safety Engineering Group. Positive results of our efforts have been noted in the areas of In-Service Inspection and Materials Engineering, where these functions are fully implemented. However, staff levels in Site Engineering were not sufficient to be effective in all areas during the assessment period. At this time 67 of the 87 positions have been filled and Niagara Mohawk is actively recruiting qualified individuals to fill those positions still open.

Niagara Mohawk is also increasing overall staffing levels in Nuclear Engineering and Licensing. In May 1988, there were 288 authorized positions in Nuclear Engineering and Licensing. There are approximately 440 positions planned by the end of 1989 and about 370 of these positions have been filled. Included within these planned positions are fifteen System Engineers to control design bases for both Unit 1 and Unit 2. The filling of these positions later in 1989, will enhance configuration control and the consistency of engineering direction provided on both units.

At Unit 1, Niagara Mohawk is developing an Engineering Program Integration Plan. This will be a comprehensive plan to upgrade the design bases for that unit, and integrate other programs such as configuration management and Unit 1 as-building efforts. On Unit 2, technology transfer programs are planned to ensure complete transfer of design ownership from the Architect-Engineer to Niagara Mohawk. These programs involve training in Architect-Engineer systems, processes, and transfer of design documentation and computer programs.

The Safety System Functional Inspection (SSFI) identified two unresolved items (50-220/88-201-02 and -09) regarding the Appendix K Reload Analysis (SALP Report - Page 31). The detailed response to these issues will be summarized in a separate followup report to the original SSFI response.

SAFETY ASSESSMENT/QUALITY VERIFICATION

Niagara Mohawk agrees with the assessment. Intensive efforts have been underway to assure proper implementation of corrective actions, including clear identifications of root causes and defined responsibilities and accountabilities (SALP Report - Page 33).

During the report, period Niagara Mohawk developed a Restart Action Plan to address the root causes of problems and to determine necessary corrective actions. The Restart Action Plan includes a summation of a critical analysis of the underlying causes of problems previously identified. These are reflected in the five underlying root cause statements, their corresponding corrective action objectives, and related corrective actions. Those corrective actions which are prerequisites for the restart are included in the Restart Action Plan. Subsequent corrective actions to be carried out after restart are identified in the Nuclear Improvement Program. Niagara Mohawk acknowledges that an improvement in root cause analysis is needed. To this end, Niagara Mohawk is modifying problem identification procedures to require use of consistent problem analysis/root cause methodology. Many of the procedure changes are expected to be implemented before restart of Unit 1. Niagara Mohawk is developing a common deficiency reporting and root cause methodology. A task force representing a cross section of groups within the Nuclear Division is carrying this out. This will result in an integrated deficiency reporting system, as is contained in the NIP. Specific responsibilities and accountabilities have been assigned for performance of root cause assessments. Standards of Performance have been issued to employees to reinforce individual accountability in meeting commitments. Niagara Mohawk is developing a number of programs as a part of the NIP to improve identification of roles and responsibilities, clarify accountability, and implement more effective ongoing self-assessments.

In order to strengthen the technical quality of QA audits (SALP Report - Page 34), Niagara Mohawk has implemented various corrective actions.

The audit staff has been strengthened by adding three people with technical backgrounds, including one individual trained as a Senior Reactor Operator (SRO). Auditors receive system training to improve technical knowledge of plant. Niagara Mohawk has increased the use of technical specialists on audit teams from an average of 26% in 1987, to 57% in 1988, and to 87% so far in 1989. In the Fall of 1988, auditors changed from compliance-based to more performance-based audits. Starting in January 1989, Niagara Mohawk expanded the technical content of audit reports to emphasize audit process and safety significance aspects, and included both strengths and weaknesses. Emphasis is now being placed on work in process, system walkdowns, and on followup of previous discrepancies to see if corrective actions taken are effective.

Niagara Mohawk has enhanced the reporting of significant QA identified deficiencies and adverse trends to senior management (SALP Report - Page 34). The Vice President of QA routinely reports QA concerns to the Executive Vice President and his staff to assure that significant findings are escalated so prompt action can be taken.

QA is in the process of modifying categorization of Corrective Action Requests (CARs) to identify relative significance of reported problems, and a team effort is underway to develop a single deficiency report system.

Operating experience is now being analyzed in a timely and effective manner (SALP Report - Page 35). In July 1987, two contract personnel were hired to reduce backlog and improve the quality of the analyses, and in June 1988, a staff member (qualified as a Senior Reactor Operator) was assigned overall control of the Operations Experience Assessment (OEA) program. Primary concerns were timeliness and adequacy of responses. In November 1988, Niagara Mohawk formed a group dedicated to administer the Operations Experience Assessment (OEA) program and resolve outstanding problems. In November 1988, approximately 20 additional contractors were brought on board to reduce Operations Experience Assessment (OEA) backlog.

Niagara Mohawk believes SORC has effectively overviewed Station operations. However, this may not have been done in the most efficient manner (SALP Report - Page 34). Several changes have been made to improve SORC efficiency. A Technical Review Committee has been formed to review items prior to presentation to SORC. An agenda is now published for scheduled SORC meetings, with allotted times for presentations. A qualified presenter is assigned for each item on the SORC agenda.

Niagara Mohawk agrees that the security vital area study (SALP Report - Page 34) could have been performed and provided for review more rapidly. It is now in the final stages of review and will be submitted to the NRC by June 30, 1989.

The level of ISEG reporting has been raised (SALP Report - Page 34). This group now reports directly to the Manager of Site Engineering, who reports to the Vice President - Nuclear Engineering and Licensing. Also, a Nuclear Division policy has been drafted which provides endorsement of the ISEG function by the Executive Vice President - Nuclear Operations. This policy allows for direct escalation of any problem identified by ISEG to the Executive Vice Present - Nuclear Operations if it cannot be promptly resolved at a lower level. These actions should enhance significantly the ISEG function.

To increase the ISEG members' involvement in day-to-day Station activities (SALP Report - Page 34), a number of specific actions have been taken. An ISEG Engineer now attends the daily plant activity planning meeting. Significant problems identified in the meeting are assigned to an engineer for evaluation. All ISEG engineers are required to read shift operating logs daily. ISEG engineers perform a formal plant tour once a week. A written report of the observations is provided to the ISEG Program Manager. Results of the tour will be entered in a data base for trending. Significant findings are transmitted to the responsible department and tracked by ISEG for closure. Formal root cause evaluation and post scram investigations performed by ISEG involve direct in-plant observations and interviews with Operators and technicians.

Actions were taken by Niagara Mohawk during the assessment period to improve the effectiveness of the SRAB (SALP Report - Page 34). The reporting level of the SRAB was raised such that it now reports directly to the Executive Vice President - Nuclear Operations. Also, the Vice President - Nuclear Engineering and Licensing was assigned as Chairman of SRAB. Additional outside consultants were added to the SRAB to improve its overall awareness of industry activities/perspectives as well as added expertise. Further improvements are being evaluated to reduce the level of detail in which the SRAB is involved. For example, the Independent Safety Engineering Group Manager is now assigned as technical coordinator for the SRAB. He is currently reviewing specific actions that can be taken by ISEG to reduce the level of detail the Board needs to review and will present results to the SRAB. This will reduce the amount of documentation SRAB members must review, and help assure that more systematic reviews are conducted.

Niagara Mohawk agrees that certain observations noted during the SALP assessment may have given the impression that some technical issues were not resolved on a timely manner due to "apparent licensee willingness to accept a high number of events" (SALP Report - Page 34). Such observations may have been due, at least in part, to management not having fully communicated its expectations to all levels within the Division; and, also to insufficient resources being applied to resolve problems sooner. Both of these underlying conditions have been vigorously addressed.

Niagara Mohawk agrees with the recommendation to ensure that Unit 2 does not suffer from the efforts on Unit 1 (SALP Report - Page 35). As part of management's staffing plans, additions are being made to both Unit 1 and Unit 2 levels and sufficient support is emphasized in all areas. A significant portion of the NIP is the continuing improvement in teamwork, and assuring that the right manager is notified quickly if either unit is not receiving appropriate support. Management recognizes that its efforts must be tuned to both units and will focus its attention accordingly.