

NORTHEAST UTILITIES

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WESTERN MASSACHUSETTS ELECTRIC COMPANY
HOLYOKE WATER POWER COMPANY
NORTHEAST UTILITIES SERVICE COMPANY
NOR THEAST NUCLEAR ENERGY COMPANY

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February 14, 1990

Docket No. 50-213
B13445

Re: SALP

U.S. Nuclear Regulatory Commission
Attention: Document Control Desk
Washington, DC 20555

Gentlemen:

Haddam Neck Plant
Systematic Assessment of Licensee Performance (SALP) Update

The NRC Staff forwarded the SALP Board Report for the period from April 1, 1987 through July 31, 1988 to Connecticut Yankee Atomic Power Company (CYAPCO) by letter dated October 4, 1988. ⁽¹⁾ After a meeting between members of the Staff and CYAPCO on October 27, 1988, CYAPCO submitted a response to the SALP Board recommendations for individual evaluation categories by letter dated November 23, 1988. ⁽²⁾ On December 8, 1988, the Staff transmitted the final SALP report. ⁽³⁾

The purpose of this letter is to provide an update on the implementation status of the corrective actions to the SALP Board recommendations discussed in our November 23, 1988, response. This letter also provides additional relevant information similar to our meeting on July 21, 1989, with Region I management. Attachment A provides the status of the corrective actions for the Haddam Neck Plant which were incomplete as of our November 23, 1988 response. Items which were completed as of that response are not discussed in this letter.

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- (1) W. T. Russell letter to E. J. Mrocza, "SALP Report No. 50-213/87-99," dated October 4, 1988.
 - (2) E. J. Mrocza letter to U.S. Nuclear Regulatory Commission, "Haddam Neck Plant SALP," dated November 23, 1988.
 - (3) W. T. Russell letter to E. J. Mrocza, "SALP Report No. 50-213/87-99," dated December 8, 1988.

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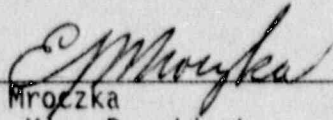
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We believe the actions presented in the attachment address the concerns of the SALP Board, illustrate that these concerns are being adequately resolved, and will be useful to the NRC in conducting subsequent SALP evaluations. Please feel free to contact us if any questions arise on these matters.

Very truly yours,

CONNECTICUT YANKEE ATOMIC POWER COMPANY



E. J. Mrozka
Senior Vice President

Attachment

cc: W. T. Russell, Region I Administrator
A. B. Wang, NRC Project Manager, Haddam Neck Plant
J. T. Shedlosky, Senior Resident Inspector, Haddam Neck Plant

Attachment A

Connecticut Yankee Atomic Power Company
Haddam Neck Plant
Status Update to SALP Report

Functional Area: PLANT OPERATIONS

Board Recommendation: Consider using Quality Services Department reviews/audits to aid in maintaining EOP quality.

Current Status:

EOP Quality

The Quality Service Department (QSD) will include a review of the Emergency Operating Procedures (EOPs) as part of the routine 10CFR50, Appendix B, Audit Program.

This review will be conducted under Audit A60274 "Emergency Operating Procedures" which is scheduled to be performed at the Haddam Neck Plant during the first quarter of 1990.

The audit will verify that EOPs:

1. meet the applicable writer's guide and NRC regulations,
2. have been verified as usable,
3. have been adequately incorporated into the operator training program, and
4. comply with the provisions of NUREG 1358.

Tagging Improvements

Generally, the ongoing emphasis on the importance of attention to detail by operations personnel has yielded very positive results. However, two events have underscored the need for constant vigilance in the areas of tagging and plant equipment operation.

In May of 1989 with the plant at 100 percent power, electrical power to 4160 volt emergency bus 9 was momentarily lost while restoring from a normal, scheduled monthly surveillance test of the B emergency diesel generator. The event occurred when a control room operator mistakenly opened the normal supply instead of the diesel generator output breaker following shutdown of the diesel. This action isolated emergency bus 9 from the normal power supply, deenergizing bus 9 and 480 volt buses 6 and 7. Emergency diesel generator B automatically started and reenergized the bus. Immediate action was taken by control room operators to restore the normal power supply to bus 9.

A Human Performance Evaluation System (HPES) review of the event determined the root cause was personnel error on the part of the control room operator who erroneously opened the tie breaker. Specifically, the individual failed to check and verify his actions prior to operating the controls.

The operator involved in the event was counseled regarding the cause and effects of his actions. Additionally, efforts were and continue to be undertaken to increase operators' attention to detail and the self-checking of intended actions prior to carrying them out. Although determined not to be a major contributing cause, the location of the permanent plant labels on the breaker control switches was changed to ensure they are visible even when an operator's hand is on the switch.

A tagging error occurred in October 1989 when an operator failed to tag out the proper electrical breaker. Specifically, an operator erroneously tagged and racked out the "C" service water pump breaker in lieu of the "C" circulating water pump breaker, as was required by the tagging order.

The error was discovered by Maintenance Department personnel as part of their pre-job tagging verification. The error was promptly corrected. A Human Performance Evaluation System (HPES) investigation was conducted. This investigation determined the error to be the result of inattention to detail on the part of the operator. Appropriate disciplinary action was taken and additional emphasis was placed by Operations management on the necessity of attention to detail.

Procedure Adherence

As of the beginning of 1990, the station procedure rewrite and upgrade program is essentially complete. We are now working to maintain the quality of procedures and incorporate enhancements in the station procedures program, as appropriate. We consider that the upgraded station procedures have increased personnel efficiency and productivity, and have reduced the possibility of worker error and procedure noncompliance.

In addition to upgraded procedures, we have continued to emphasize the necessity of procedural adherence. A vital element to the procedure adherence ethic is to encourage feedback from procedure users as a means of identifying and correcting procedural shortcomings.

Functional Area: Radiological Controls

Board Recommendation: None.

Current Status:

The existing health physics data tracking system (HELPORE) will be replaced with a new system entitled Radiological Information Tracking System (RITS). The software for this new system will be developed by the Northeast Utilities Information Resources Group. Presently, detailed software design specifications are being prepared. Following review and approval by the site and corporate health physics personnel, actual software development will take place. It is envisioned that software preparation will begin in early 1990 to support RITS implementation by early 1991.

Other issues of importance in this area since the issuance of the last SALP report include:

Radiation Protection Manual

A project was initiated in 1988 to improve the content and quality of the station radiation protection procedures by incorporating them into a Radiation Protection Manual. This effort was performed in concert with the overall spirit of improving station procedures as a means of enhancing personnel performance. As such, the thrust of the program was directed towards increasing the "user friendliness" and accessibility of the procedures. Assurance of procedure quality was enhanced by separate technical and procedure format reviews, as well as procedural verification by the primary users. In addition, the procedures were developed using guidance from a Human Factored Procedures Writers Guide. Each procedure contains requisites for which technical bases are specified. Presently, the program is greater than 95% complete with only minor work remaining. The manual has been well received by all levels at the station.

Authorization of Radiation Work

In October of 1989 during the refueling and maintenance outage, a contract worker entered a potentially high radiation area without first signing in on an RWP or being assigned high range dosimetry. Specifically, while assigned to escorting other contract steam generator workers to the lower level of the containment, the worker failed to sign-in on the RWP controlling access to this area and also failed to obtain high range dosimetry. Upon exiting the containment, the RWP violation was discovered and an investigation was initiated. The cause of the event was personnel error on the part of the contract worker for failing to sign in on an RWP. The worker was removed from the site.

Personnel Exposure Trends

CYAPCO continues to take initiatives to reduce the collective exposure at the station. These measures include requiring major modifications to be submitted for ALARA preplanning reviews 90 days prior to the start of an outage; fostering ALARA awareness among first line supervision through formalized training; and performing accurate ALARA goal setting based on complete evaluation of worksopes. These, combined with on-going station management involvement and support, and worker cooperation, have resulted in reduced exposure. The goal and actual manrem figures for 1989 were:

	<u>Goal</u>	<u>Actual</u>
Yearly Total	619.6	596.5
Outage Total	569.9	546.7

These figures reflect the extension of the current refueling and maintenance outage into 1990 to complete removal of the thermal shield and fuel recastitution.

Radwaste Trends

CYAPCO continues to place emphasis on reducing the volume of radwaste generated at the station. Some actions taken to reduce this volume include strictly limiting material brought into the radiological control area (RCA), use of a sorting station to segregate reusable materials from material to be disposed, use of reusable (washable) collection bags throughout the RCS in lieu of disposable plastic bags and placing clean (noncontaminated) trash receptacles in the RCA. The goal and actual radwaste volumes for 1989 were:

Goal	7230 ft ³
Actual	5486 ft ³

Effluent Releases

Continued emphasis has been placed on minimizing liquid, gaseous and particulate effluents. This resulted in all yearly corresponding site boundary doses being within established limits. The figures for 1989 were:

		<u>Limit</u>	<u>Actual</u>
LIQUIDS	Total Body	3.0	0.36 (mrem)
	Max Organ	10.0	0.16
GASES	Gamma	10.0	4.0 (mrad)
	Beta	20.0	16.9
PARTICULATE	Thyroid	15	4.39 (mrem)
	Max Organ	15	1.52

The third quarter actual gaseous Beta dose (15.6 mrad) exceeded the quarterly limit of 10 mrad due to gas releases from the fuel during cooldown and depressurization of the RCS going into the current refueling and maintenance outage. The core had experienced cladding damage during the last cycle due, apparently, to debris in the Reactor Coolant System. All other quarterly doses were within limits. Overall, 1989 was the twelfth consecutive year that less than one curie of activity (excluding tritium and noble gases) was discharged via the liquid pathway.

Functional Area: Maintenance/Surveillance

- Board Recommendation:
- (1) Improve balance of plant maintenance in order to decrease avoidable reactor trips.
 - (2) Improve overview of contractors.

Current Status:

The Haddam Neck Plant continues to stress and foster the philosophy that balance of plant (BOP) maintenance is conducted to the same standards as safety-related tasks. This philosophy extends to the format and quality of BOP procedures, technical training standards and management expectations of workers. We continue to evaluate the case-by-case appropriateness of BOP maintenance procedures. Where appropriate, procedures are developed and implemented. In addition, emphasis continues to be placed on modifications to enhance BOP reliability and reduce the possibility of BOP initiated plant transients.

A predictive maintenance program covering selected safety-related and BOP components has been developed and is presently being implemented. The program includes procedures covering data collection as well as analysis techniques to be utilized for data evaluation. To support the program, specialized test equipment is being procured.

The plant has experienced no automatic reactor trips during the current SALP period. The last reactor trip occurred on April 30, 1988 and was the result of an improperly installed turbine stop valve cam switch. This event was discussed in the previous SALP report.

Overview of Contractors

Prior to the 1989 refueling and maintenance outage, all Maintenance Department contractors were provided site specific technical training and then tested to determine their qualifications. A qualification matrix similar to those utilized for station mechanics and electricians was developed and utilized to assure that only qualified individuals were allowed to work, unsupervised, on specific maintenance activities.

The need for effective contractor control utilized by the on-site corporate construction group continued to be emphasized and positive results have been obtained. A work order pre-job checklist for Construction Supervisors to use prior to the start of a job has been created. The checklist was designed to ensure uniformity and a programmed approach to each job by the work supervisors and to ensure all quality and administrative requirements were addressed. The checklist has been utilized for approximately one year now with extremely positive results. Most work projects are further reviewed prior to the start of the work by use of a coordinated walkdown involving applicable personnel depending upon the work location and scope. A memorandum

is then written specifying the work controls imposed. This memorandum is then included in any work package assembled to perform the specific job.

CYAPCO has also performed more extensive pre-job briefings and additional interim job briefings, i.e., increased amount of communication taking place between supervision and craft. In general, the level of consciousness regarding contractor control issues has increased and CYAPCO has become more responsive to any identified problems.

The increased confidence in the level of control enabled a significant quantity of preoutage work to be performed on major modifications such as the Appendix R switchgear project and the Reactor Protection System replacement, prior to the start of the current outage. Much of this involved working in sensitive areas, such as the control room. This work was completed without jeopardizing safe plant operation.

Containment Leakage

CYAPCO continues to actively pursue reductions in the as-found containment leakage. During the 1987/1988 refueling and maintenance outage, nine containment penetrations were modified to reduce leakage and/or increase compliance with Appendix J.

During the current SALP period, the following initiatives were taken:

- o The technique of local leak rate testing (LLRT) called the pressure decay method has been replaced in most cases by the more accurate volumetric flow measurement method. The new method measures actual penetration leakage; whereas, the former method relied on a calculated penetration leakage figure based on pressure decay.
- o Containment penetrations P-74 through P-77 have been modified during the current refueling and maintenance outage. The modification installed a valve station in each of the seal water supply lines to the reactor coolant pump (RCP) seals. The valve stations consist of two isolation valves, a check valve, a vent and a drain. This will permit the performance of the LLRT for these valves using air rather than water. This change in test methodology will bring the LLRTs performed on P-74 through P-77 into compliance with Appendix J.
- o Penetration P-63, providing component cooling water to the neutron shield tank, has been cut and capped during the current refueling outage. This will eliminate a potential leakage path.

Also during this SALP period the following steps have been taken to clarify containment isolation boundaries and their locations:

- o A new method of colored tagging for Containment Isolation Valves (CIVs) has been instituted. This will help to draw attention to the fact that

CIVs, their actuators, and other associated components are safety-related containment isolation components.

- o Containment isolation boundary drawings will be updated to reflect present configurations and those configurations that will exist at the end of the current outage.
- o CIVs have been clearly and concisely identified in Final Safety Analysis Report (FSAR) Table 7.3-1. This new table, showing valve number, penetration number, valve location (relative to the containment liner), actuation signal (if any), closure time (if any), and status of Appendix J compliance, represents the most complete description of CY's containment boundaries prepared to date.
- o CYAPCO submitted new Revised Technical Specifications (RTS), governing the containment function, for NRC approval on June 2, 1989. These new Technical Specifications, in the Westinghouse Standard Technical Specifications format, provide clearer, more concise action statements for maintaining containment integrity. The new Technical Specifications also delete the previous listing of containment isolation valves (Technical Specification Table 3.11-1) in deference to FSAR Table 7.3-1. We anticipate issuance of these revised specifications shortly.

Surveillances

There have been three adverse events relative to the station surveillance program that have occurred since the issuance of the last SALP report. The first involved a failure to satisfy all surveillance requirements of a Technical Specification due to a procedural deficiency; the other two involved missed surveillances.

In May of 1989, an internal review by the Instrumentation and Controls (I&C) Department disclosed that a quarterly Technical Specification surveillance requirement to functionally test the Refueling Water Storage Tank (RWST) level indication was not being met due to a procedural deficiency. Specifically, the functional test of the RWST channel alarms had not been included in the surveillance procedure and therefore was not being tested quarterly as required by Technical Specifications. The specific surveillance procedure was revised to include testing of the alarms. Root cause of the event was inadequate surveillance procedure preparation and review. As a result of this event, a 100 percent review of I&C Department surveillance procedures was conducted, no additional adverse findings were made. In order to prevent recurrence of this event, greater emphasis has been placed on the annual Technical Specification surveillance procedure review conducted by station departments under the provisions of station procedure ACP 1.0-59.

In July of 1989, an internal review by the Instrument and Control Department disclosed that a monthly surveillance procedure covering functional testing of automatic auxiliary feedwater initiation steam generator level instrumentation

channels and associated logic circuits had not been performed within the prescribed surveillance interval. Investigation revealed the root cause of the event to be personnel error compounded by a deficiency in the methods used to track surveillances within the I&C Department. Department supervision has taken remedial action to underscore the importance of attention to detail specifically with regard to surveillance procedure scheduling and performance. Additionally, the departmental surveillance tracking system has been modified to increase its usability and effectiveness.

Also in July of 1989, a Fire Protection Audit determined that surveillances dealing with weighing of carbon dioxide (CO₂) bottles, to assure sufficient extinguishing agent is present in the bottles, for the primary auxiliary building (PAB) ventilation charcoal filter fire protection system and the cable vault fire protection system had not been performed within the prescribed surveillance intervals. These surveillances are required to be performed at a six-month interval. Contrary to the requirements, the surveillance of the PAB ventilation system bottles was performed late twice and the surveillance of the cable vault bottle was performed late once. Investigation revealed several contributing factors to these missed surveillances. Primarily, the events were a failure to maintain sufficient attention to detail by Maintenance Department personnel responsible for managing the Maintenance Department surveillances program. Contributing factors were a weakness in the methods used to track surveillances within the Maintenance Department and administrative difficulties within the surveillance procedures that cover the weighing of bottles. Specifically, prior to this event, the weighing of the bottles, which is a semi-annual requirement, was part of a procedure that also had requirements for 18-month surveillances. Corrective action has included increased Maintenance Department management attention and oversight of the departmental surveillance program. The appropriate fire protection surveillance procedures have been revised to provide separate procedures for the semiannual and 18-month surveillance requirements.

Station management considers the three events discussed above indicative of a situation requiring additional attention and emphasis. This action is being taken. Revisions to the methods used to track and schedule Technical Specification surveillances are under consideration.

In preparation for conversion to Revised Technical Specifications (RTS), a detailed review and verification of all RTS surveillance requirements against revised station surveillance procedures was conducted. Appropriate corrective action was taken to assure compliance.

Functional Area: Emergency Preparedness

Board Recommendation: Continue efforts to improve Control Room Simulation.

Current Status:

A formal study on the feasibility of utilizing the site specific simulator for drills and partial participation exercises has been completed. The study included evaluation of the viability and expense associated with modifying the operational software and developing new software to support simulating emergency scenarios required for drills and exercises. Based on the information provided by the study, a decision has been made to proceed with a trial use of the simulator for the 1991 Emergency Plan exercise at the Haddam Neck Plant. Following that exercise an evaluation will be performed to determine whether to continue and/or expand to Millstone Nuclear Power Station Unit Nos. 1, 2, and 3.

1989 Partial Participation Exercise

On April 22, 1989 a partial participation exercise was conducted at the Haddam Neck Plant. Participants included site and corporate groups, the State of Connecticut, and 15 of 18 of the towns located in the Emergency Planning Zone. Overall assessment of the exercise was very favorable with open items consisting mainly of action to further refine emergency organization performance and interaction. All appropriate corrective actions are being implemented, with a majority of these actions to be accomplished through the annual specialized training/retraining given to emergency organization members.

Functional Area: Security

Board Recommendation: None.

Current Status:

Design work on the security computer replacement project is ongoing with design packages covering conduit and cable installation due to be issued in early 1990. Software development is currently underway by the Northeast Utilities Information Resources Group. The replacement project is scheduled for completion in early 1991.

In addition to the security computer replacement, the following initiatives have been taken in the Security area:

- o A new primary access point for the protected area has been placed in service. This access point has increased the personnel processing capability and updated the personnel and parcel screening equipment to state of the art units.
- o A vehicle search area was put into service in May 1989. This area permits vehicles to be searched in a controlled, isolated area.
- o Actions have been taken and are still ongoing to enhance the integrity of the protected area barriers and to upgrade the intrusion detection system (IDS) to current technology.
- o A program is underway to enhance the integrity of vital area barriers including doors and barrier penetrations.
- o Actions have been taken to enhance the professionalism of the contract guard force as well as increase retention of experienced personnel.
- o Monthly drills are being conducted involving the active participation of Operations and Emergency Planning personnel.

Functional Area: Engineering/Technical Support

Board Recommendation: None.

Current Status:

Turbine Runback on Negative Rate

During the design of the replacement Nuclear Instrumentation System (NIS), the turbine runback on negative rate feature was removed. As discussed below, the replacement NIS has been installed and is undergoing preoperational testing. The jumpers installed prior to the start of Cycle 15 to eliminate the turbine runback feature were removed as part of the NIS replacement.

Nuclear Instrumentation System

All physical work on the NIS replacement is complete and the system is undergoing preoperational testing. The majority of remaining testing encompasses interface testing with the replacement Reactor Protection System (RPS) and NIS testing that is dependent on neutron flux.

Equipment Qualification

In an effort to correct the weaknesses noted in the SALP report regarding corporate EQ group staffing levels and the completeness of qualification documents, three permanent engineering positions have been added to the corporate EQ group and a program to improve the EQ files has been initiated.

The first of three new engineers started in July of 1989 and has been assigned to work on the Haddam Neck Plant qualification issues. This individual has been temporarily assigned to the site Engineering Department during the current refueling and maintenance outage as a means of increasing his familiarity with the plant-related EQ issues. The second engineer started in August 1989 and has been assigned to work on Millstone Unit No. 1. The third engineer started in October 1989 and he has also been assigned to work at the Haddam Neck Plant.

The EQ files are being revised with the assistance of four full-time contract engineers. This effort is scheduled to continue until mid April 1990. Two additional contract engineers have been brought on board to support the Millstone Unit 3 and Haddam Neck Plant refueling outages.

In addition to the staff augmentation, an effort is underway at the site to exert greater administrative control over the EQ Master list and the Component Replacement Schedule (CRS). Specifically, these documents will be reviewed by the Plant Operations Review Committee (PORC) and become controlled station documents. This effort is being taken to increase site awareness of changes to these documents. Additionally, this approach will assist the site in controlling changes to the documents. The Master list was reviewed by PORC in

September 1989. The CRS is presently being prepared for PORC review and will be reviewed by mid 1990.

Reactor Protection System

The first phase of the Reactor Protection System (RPS) replacement project was the replacement of system sensors, transmitters, and Main Control Board mounted equipment. This work was completed during the 1987/1988 refueling and maintenance outage. The second phase of the project encompassed the replacement of the reactor trip relay logic system with a solid state system. All physical work on the second phase is complete and RPS is currently undergoing preoperational testing. Following completion of system level preoperational testing on RPS and NIS, the modified systems will undergo integrated testing as part of the Outage Test Program which is discussed below.

Outage Test Program

During the current refueling and maintenance outage, extensive testing will be conducted on the various major modifications installed during this outage. The RPS Integrated Test will test each modified channel of the new RPS from the sensor to input to the logic cabinets. The NIS Integrated Test involves testing each channel of the new NIS from sensor to drawer output. The new switchgear system compliance test involves simulation of three different fire scenarios and provides a means to verify appropriate action can be taken in response to these fires. The fire scenarios considered will be fire in the Control Room, fire in the old switchgear room, and fire in the new switchgear room.

An overall plant integrated test includes verification of proper plant response to various accident scenarios, thereby serving to verify that the ECCS initiation logic is correct. This integrated test contains the following accident scenarios:

- o High Containment Pressure (HCP) and Safety Injection Actuation Signal (SIAS) Train 'A' with 'B' Train disabled.
- o HCP and SIAS Train 'B' with 'A' Train disabled.
- o SIAS and HCP Train 'A' with Partial loss of AC.
- o SIAS and HCP Train 'B' with Partial loss of AC.
- o Loss of Normal Power (LNP) 'A' and 'B' Train.
- o HCP and SIAS and LNP 'A' and 'B' Train.

During the development of the Plant Integrated Test procedure, the various test scenarios were run on the plant specific simulator as a means of validating the test procedure prior to performance at the plant.

In addition to the testing discussed above, the Appendix R Service Water Performance Test will demonstrate the ability of D Service Water Pump to supply adequate cooling to the B RHR heat exchanger, the A and B Diesels, component cooling water heat exchangers, No. 3 and 4 CAR fan coolers and RHR pump B seal cooler.

The scheduling of these tests has been impacted by the protracted outage. As of mid January 1990, the RPS Integrated Testing has begun. Additionally, the final preparations are being made for the performance of the Appendix R Service Water Performance Test.

Functional Area: Safety Assessment/Quality Verification

Board Recommendation: None.

Current Status:

Root Cause Training

During 1989, formal Root Cause training was provided to plant engineers and other selected individuals. This training was provided as a means of strengthening the ability of the station's staff to perform an in-depth assessment of events as a means of assuring accurate causal factor determinations are performed and appropriate corrective actions are taken. Additionally, we have increased our use of the Human Performance Evaluation System (HPES) as a means of enhancing evaluation of the effect of the human element in adverse plant events.

Self Assessment

Site and corporate management continue to emphasize the importance of self assessment as a key to self improvement. Toward this end, an in-house Safety System Functional Inspection (SSFI) was begun at the Haddam Neck Plant in January of 1990. This inspection, which will last for about 2 months, will be an in depth evaluation of the station's service water system. We anticipate sharing the results of our efforts in a fashion similar to our interactions following the SSFI's performed at Millstone Unit Nos. 1 and 2.

Technical Specifications

On August 4, 1989, CYAPCO submitted the last in a series of submittals forwarding amendment requests which will ultimately comprise an improved set of Technical Specifications for the Haddam Neck Plant. The Revised Technical Specifications (RTS) utilize the Westinghouse Standard Technical Specifications (WSTS) format. The Revised Technical Specifications:

- o Provide Technical Specifications with concise action statements and a complete set of surveillance requirements that complement the limiting conditions for operation.
- o Utilize a standard industry format.
- o Reduce the number of future amendment requests by making a one-time improvement of Technical Specifications.
- o Implement all docketed commitments regarding the plant's Technical Specifications.

The Revised Technical Specifications have been a major project for all parties involved. Numerous procedures have required extensive review and revision

based on the RTS. In order to adequately review the RTS and ensure associated procedures provide for the safe and efficient operation of the Haddam Neck Plant, approval of the RTS by the NRC Staff would have to occur in the very near future. CYAPCO expects to implement the RTS upon startup from the current refueling outage if NRC approval is obtained soon.

**Integrated Safety Assessment Program (ISAP)/
Integrated Implementation Schedule (IIS)**

The Integrated Safety Assessment Program (ISAP) evaluates, ranks and schedules projects based on multiple factors; e.g., public safety, personnel safety, personnel productivity, economic performance and cost. The final phase of the process, the Integrated Implementation Schedule (IIS), places the ranked projects in a particular implementation time frame (refuel outage) dependent on their relative rankings.

CYAPCO has taken an aggressive approach to maximize the closure of open IIS commitments. The most recent ISAP report, dated March 2, 1989, contained information for the closure of 54 ISAP topics. ISAP has afforded CYAPCO the opportunity to thoroughly evaluate 119 proposed plant modifications. The upcoming ISAP submittal provides closure documentation for 14 topics. We expect submittal of this information during the first quarter of 1990. Reviews and/or modifications are pending for the remaining 47 active ISAP topics.