



Nebraska Public Power District

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PDR

COOPER NUCLEAR STATION
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NLS960078
May 17, 1996

Director, Office of Enforcement
U. S. Nuclear Regulatory Commission
Washington, D.C. 20555-0001

Gentlemen:

Subject: Reply to a Notice of Violation and Proposed
Imposition of a Civil Penalty;
NRC Inspection Report Nos. 50-298/96-04 and 50-298/96-08
Cooper Nuclear Station, NRC Docket 50-298, DPR-46

Reference: Letter from Mr. L. J. Callan (USNRC) to Mr. G. R. Horn (NPPD), dated April 17, 1996, "NOTICE OF VIOLATION AND PROPOSED IMPOSITION OF CIVIL PENALTY - \$50,000 (NRC Inspection Report Nos. 50-298/96-04 and 50-298/96-08)"

This letter, including Attachments 1 and 2, constitutes Nebraska Public Power District's (the District) reply to the referenced Notice of Violation (NOV) and Proposed Imposition of Civil Penalty pursuant to the provisions of 10 CFR 2.201. Attachment 2 is a certified check in the amount of \$50,000, for payment of the civil penalty.

The referenced inspection reports document the results of two NRC inspections conducted from February 5 through 22, and from February 26 through March 1, 1996, at Cooper Nuclear Station (CNS). The NRC inspection reports described three violations related to: (1) the improper modification of the main steam tunnel blowout panel sections; (2) the improper modification of the solenoid valves which control the muffler bypass valves associated with each emergency diesel generator; and (3) the inadequate isolation of the control power circuitry for Diesel Generator 2 from the potential effects of a postulated control room fire.

The District admits the Violations and has taken corrective actions to restore compliance. However, as discussed during the pre-decisional enforcement conference held on April 1, 1996, the three violations collectively underscore broad and significant engineering issues. Resolution of these issues remains an area of primary focus in the District's efforts to continue to improve CNS plant performance.

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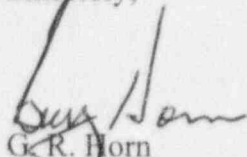
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Should you have any questions concerning this matter, please contact my office.

Sincerely,



G. R. Horn

Vice-President - Nuclear

/crm

Attachments

cc: Document Control Desk
USNRC

Regional Administrator
USNRC - Region IV

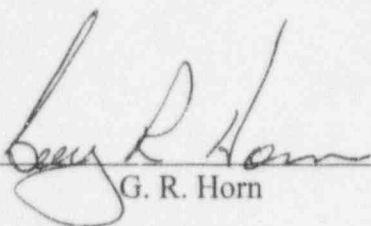
Senior Project Manager
USNRC - NRR Project Directorate IV-1

Senior Resident Inspector
USNRC - Cooper Nuclear Station

NPG Distribution

STATE OF NEBRASKA)
)
NEMAHA COUNTY)

G. R. Horn, being first duly sworn, deposes and says that he is an authorized representative of the Nebraska Public Power District, a public corporation and political subdivision of the State of Nebraska; that he is duly authorized to submit this correspondence on behalf of Nebraska Public Power District; and that the statements contained herein are true to the best of his knowledge and belief.

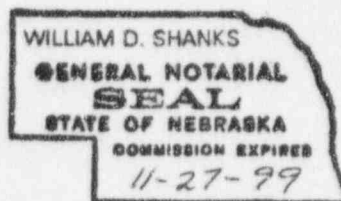


G. R. Horn

Subscribed in my presence and sworn to before me this 17 day of May, 1996.



NOTARY PUBLIC



REPLY TO APRIL 17, 1996 NOTICE OF VIOLATION AND
PROPOSED IMPOSITION OF CIVIL PENALTY - EAs 96-062, 96-094
COOPER NUCLEAR STATION
NRC DOCKET No. 50-298, LICENSE No. DPR-46

During NRC inspections conducted from February 5 through February 22, 1996, and from February 26 through March 1, 1996, violations of NRC requirements were identified. In accordance with the "General Statement of Policy and Procedures for NRC Enforcement Actions," NUREG-1600, the Nuclear Regulatory Commission proposed a civil penalty pursuant to Section 234 of the Atomic Energy Act of 1954, as amended, 42 U.S.C. 2282, and 10 CFR 2.205.

The particular violations and the District's responses are set forth below:

I. Violation Assessed a Civil Penalty

10 CFR 50.59(a)(1) states, in part, that a licensee may make changes in the facility as described in the safety analysis report without prior Commission approval unless the change involves a change in the technical specifications incorporated in the license or an unreviewed safety question. 10 CFR 50.59(b)(1) states in part that the licensee shall maintain records of changes in the facility, to the extent that these changes constitute changes in the facility as described in the safety analysis report, and that these records must include a written safety evaluation which provides the basis for the determination that the change did not involve an unreviewed safety question.

The Updated Safety Analysis Report (USAR) for Cooper Nuclear Station, Section 12.1, and the June 8, 1973, supplement to USAR Amendment 25 state that the steam tunnel blowout panel sections will operate to relieve pressure in the steam tunnel in the event of a main steam line break. The associated safety analysis described in the supplement to Amendment 25 indicates that the steam tunnel door and blowout panels operate to ensure steam tunnel pressure remains below the design and licensed safety analysis limit of 15 psi.

Contrary to the above, between July 1985 and November 1995, the facility was not operated as described in the USAR and a written safety evaluation of the change from the USAR had not been performed to determine whether this change involved an unreviewed safety question. Specifically, the licensee made a change to the facility when fiberglass was applied to the steam tunnel blowout panels in July 1985. In November 1995, the licensee determined that the change had significantly altered the material characteristics of the blowout panels such that, in the event of a steam line break inside the steam tunnel, the peak steam tunnel pressure would have been greater than the analyzed limit of 15 psi, and therefore that the change had resulted in an unreviewed safety question. (01013)

Admission or Denial of Violation

The District admits the Violation.

Reasons for Violation

Due to the passage of time since 1985 and personnel turnover, a definitive root cause for this Violation could not be determined. In determining the apparent cause, investigations were made into: a) the procedural guidance in place at the time, b) the onsite resources available for making design-affecting determinations, and c) the Maintenance Work Request (MWR) that performed the installation. The following conclusions were reached:

1. The procedures in place were adequate to ensure that safety evaluations were performed as long as proposed activities were recognized as design changes, rather than maintenance activities. The work control process had mechanisms that ensured that experienced and knowledgeable individuals would assess proposed work items and determine if a design change was required. However, little standardized guidance was available to help resolve the point at which a maintenance activity ended and a design change began.
2. There was little information readily available onsite that described the blowout panels, or their design basis function. Specifically, the blowout panels were not described on plant drawings and, although they were identified in the USAR, there was insufficient information to discern their construction or exact location. These were two key information sources that typically provided the means of determining when a maintenance activity could affect the design of the plant. It is significant to note that Amendment 25 to the Final Safety Analysis Report, which provided the CNS licensing basis High Energy Line Break (HELB) analysis, pictorially describes the basic vent paths for a HELB in the steam tunnel, but does not specifically discuss the blowout panels.
3. The MWR was initiated by the System Engineer responsible for Secondary Containment issues. As the System Engineer, he was considered to be the most knowledgeable individual onsite regarding the design functions of Secondary Containment penetrations. The fact that he chose to initiate an MWR rather than a design change request suggests that he did not consider the design basis HELB mitigation function of the blowout panels. The MWR itself describes the work essentially as the replacement of the existing expansion boots with new expansion boots combined with a new pressure shield. The individuals involved with this work item may have believed they were installing an equivalent configuration that enhanced the Secondary Containment leakage mitigation function.

In summary, the apparent cause of the Violation was the failure of individuals to recognize that the expansion boot replacement combined with the fiberglass installation was a design change. More fundamentally, this error was caused by an apparent failure to fully research the design basis of the steam tunnel/heater bay wall.

Corrective Steps Taken and the Results Achieved

The following corrective actions have been taken:

1. A station modification has been performed which has removed the bulk of the fiberglass from the blowout panels. This has restored the panels' ability to perform their design basis HELB function.
2. Walk downs have been performed which have confirmed the adequacy of the venting paths needed to mitigate the postulated HELBs of high energy piping in other plant compartments.
3. An evaluation was performed which assessed the safety consequences of the discrepant configuration. This effort provided an analytical basis for concluding that, while the fiberglass installation did constitute an unreviewed safety question, the safety implications were minimal and there was no significant hazard.
4. Plant drawings have been upgraded to improve the visibility of the blowout panel configurations.
5. A sample of past MWRs has been searched for examples of unauthorized modifications and unreviewed safety questions. As a result, two minor nonsafety-related modifications were found. However, no unreviewed safety questions were identified.
6. A review was performed of the barriers that are currently in place to preclude performing maintenance activities that should be evaluated against the criteria of 10CFR50.59. It was concluded that:
 - a) Improvements to the work control process have been put in place since 1985 when this condition occurred. The decision as to whether a work item is a maintenance or design change activity is vested with the Work Control Center (WCC) Supervisor, versus the Maintenance Planner/Scheduler. The WCC Supervisor is by job description an experienced individual who holds a Senior Reactor Operator license. The governing work control procedure provides a clear definition of the types of activities that can be performed as corrective maintenance. Additionally, a technical engineering review is required for all initiated MWR packages (in 1985, a System Engineering review was required, but only for MWRs that were considered safety-related).

- b) The actual work being performed via an MWR is controlled either by: i) Station procedures or Special Instructions that have been evaluated against 10CFR50.59 criteria and approved by the Station Operations Review Committee, or ii) Work Instructions when specific criteria are met as defined in the SORC-approved Work Control procedure.
 - c) The Replacement Component Evaluation (RCE) process governs the installation of parts that are not like-for-like replacements of the original. An RCE establishes equivalency on the basis of identical form, fit, and function. The proposed expansion boot replacement combined with the fiberglass reinforcement of the blowout panels would not have met this criteria and would therefore not have been allowed as a maintenance activity.
 - d) As part of the CNS Engineering reorganization that occurred in 1995, the Design Engineering Department (DED) has been moved to the site. As conservator of the CNS design basis, DED's direct onsite involvement has improved the Station's ability to understand when a planned configurational change affects the design of the plant. Recent DED initiatives included: i) site-wide communication defining what a plant modification is and what types of routine activities could constitute unintended design changes, and ii) specific presentations to the Maintenance Department discussing the challenge of preventing unauthorized modifications. Additionally, the Licensing Department was also relocated to the site. This proximity affords an enhanced capability to research and resolve issues concerning the effect of proposed activities on the CNS Current Licensing Basis.
 - e) Since the 1994 extended outage, the CNS safety culture and communication of management's expectations in this regard have improved. This has fostered a more conservative decision-making environment.
7. Since the Enforcement Conference of April 1, 1996, a Quality Assurance special audit was performed in the area of "Unauthorized Modifications." The findings underscored a continued need for Management attention to process improvements and staff sensitization to this issue. Accordingly, the District is dispositioning the findings of this audit and taking additional corrective actions, as needed, to resolve the concerns raised in this audit.

Corrective Steps That Will be Taken to Avoid Future Violations

The following corrective actions will be taken:

1. A further sampling of candidate MWRs will be conducted according to a pre-established sampling plan to detect other examples where modifications were performed without performance of safety evaluations. The sample size will initially consist of ten percent of a selected population of MWRs from 1974 to the present. As part of this effort, walk

downs of certain historical MWRs will be performed according to a defined screening criteria. This effort will be completed by June 1996 for accessible MWRs and by restart from the RE17 refueling outage for those not accessible due to plant conditions.

2. HELB and Secondary Containment Design Criteria Documents will be developed by October 1996.
3. Changes will be made to the USAR to make the licensing basis functions of the blowout panels more visible, and these changes will be incorporated as part of the next USAR update submittal.

Date When Full Compliance Will Be Achieved

The District is in full compliance with the requirements of 10 CFR 50.59 with respect to the identified violation.

II.A. Violation Not Assessed a Civil Penalty

Title 10 of CFR 50, Appendix R, Section III.G.1., requires that fire protection features be provided for structures, systems, and components important to safe shutdown. These features shall be capable of limiting fire damage so that one train of systems necessary to achieve and maintain hot shutdown conditions from either the control room or emergency control station is free of fire damage.

Contrary to the above, from approximately January 3 to November 25, 1995, fire protection features capable of limiting fire damage so that one train of the systems necessary to achieve and maintain hot shutdown conditions from either the control room or emergency control station would be free of fire damage, were not provided. Specifically, control power circuitry for Diesel Generator 2 (the protected safe shutdown train power supply) was not protected from the effects of a postulated control room fire. A fire in the control room could have rendered the diesel generator unable to perform its safe shutdown function and hot shutdown conditions could not have been maintained. (02013)

Admission or Denial to Violation

The District admits the Violation.

Reasons for Violation

This Violation was caused by weaknesses in the Drawing Change Process. As further detailed below, all drawings affected by Design Change (DC) 94-263, "Fuse Modification For Diesel Generator (DG) Engine Control Panels," were not immediately flagged as having pending changes. DC 94-263 was implemented to correct an Appendix R noncompliance discovered on

August 4, 1994, and reported in LER 94-016. The data in the Drawing Control Program Database (a computerized database providing information such as the current revision number and pending changes) corresponding to the changes implemented under DC 94-263 was not immediately updated. Consequently, a subsequent design change was developed and implemented using drawings that did not reflect the actual plant configuration. As a result, a portion of the DG 2 control logic was rendered susceptible to an Appendix R fault.

On October 7, 1994, a design flaw was discovered that could have caused both DGs to be rendered inoperable during a fire in the Turbine Building or a design basis earthquake. During either of these events the High Pressure Carbon Dioxide Extinguishing System could have erroneously isolated the HVAC to both DG Rooms, thereby threatening DG operability. This condition, reported in LER 94-021, was corrected by DC 94-302, "HV-FCU-(HV-DG-1C) and HV-FCU-(HV-DG-1D) Circuit Modification."

At the time that DC 94-263 and DC 94-302 were developed, the Drawing Change Process provided two mechanisms for the tracking of pending drawing changes. Following the approval of the modification:

1. The aperture cards for all affected drawings listed in the modification were stamped to indicate that a change was pending.
2. The Drawing Control Program Database was updated to reflect pending changes to drawings maintained in the Control Room; non-Control Room drawings were not updated in the database until submittal of the Drawing Change Notices (DCNs). Per the Design Change Process, this would occur (for non-Control Room drawings) as part of the modification completion report following installation. As it applies to this Violation, the post-installation DCNs for DC 94-263 were not submitted until after the design work and independent design review for DC 94-302 had been completed.

Therefore, the Drawing Control Program Database did not reflect the fact that non-Control Room drawings subsequently used in the development of DC 94-302 were pending revision as a result of DC 94-263. Because of this weakness in the Drawing Change Process, the preparer and independent reviewer (although having consulted the Drawing Control Program Database to confirm the current status of drawings used) were unaware that drawings used to develop DC 94-302 no longer reflected the configuration of the plant and, hence, the need to coordinate the two modifications.

Corrective Steps Taken and the Results Achieved

The wiring discrepancy was corrected as part of Amendment 1 to DC 93-024, "DG Governor Replacement and Electric Overspeed Modification," thus eliminating the susceptibility to an Appendix R fault.

An analysis of installed wiring was performed to determine past DG 2 operability for non-Appendix R events. As documented in Engineering Judgement (EJ) 95-137, the worst case in-

rush current resulting from the incorrectly connected relays and indicators would not have exceeded the current time rating for the misconfigured fuse. Therefore, DG 2 remained operable for all non-Appendix R events.

A hand-over-hand walkdown of the loads connected to the applicable Appendix R fuses were performed to ensure that no other discrepancies existed. None were found.

To further assess the generic concerns associated with this Violation, a review was conducted to determine which drawings were most likely to have a similar error. As a result, the drawings associated with 25 Control Room and Auxiliary Relay Room panels (i.e., those panels that control a significant portion of the Emergency Core Cooling Systems) were identified. This population size was based on the following:

1. The connection diagrams for these panels contain a high concentration of daisy-chains.
2. These panels have had a large concentration of modifications.

Of the 25 panels, five were selected for an immediate detailed evaluation. The connection diagrams for each selected panel were identified and, for each diagram, a table was developed showing the revision history. From the revision history table, a time line was constructed to identify potential modification interactions. (A potential modification interaction was assumed to exist if a pending revision to a connection diagram existed at the time an independent design review was completed for a modification.) Any potential interaction identified by this process was examined further to ensure the suspect termination points and applicable circuitry were not adversely affected. No discrepancies were identified in the five selected panels.

Corrective Steps That Will Be Taken to Avoid Further Violations

A project plan for evaluating the remaining 20 panels has been developed using the lessons learned from the completed 5 panel review. Evaluation of the 20 remaining panels will be completed by June 30, 1996.

As a result of process improvements unrelated to this Violation which were implemented in June 1995, all drawings pending revision are currently being flagged in the Drawing Control Program Database.

The following additional corrective actions have been or are being taken to prevent recurrence:

1. Procedure 3.4.3, "Design Change," and Procedure 3.4.5, "Minor Modifications," will be revised by June 24, 1996, to require:
 - a. The acquisition of pre-assigned DCNs as soon as possible during modification development; and

- b. in addition to verification of drawing revision, documentation of the review of pending drawing changes for impact to the modification.
2. Procedure 3.4.8, "Design Verification," will be revised by June 24, 1996, to verify during the independent design review that:
 - a. Pre-assigned DCN numbers have been obtained for affected drawings; and
 - b. Pending changes to reference drawings are identified and taken into consideration.
3. A revision to Procedure 3.7, "Drawing Change Notice," has been implemented to allow pre-assigning DCN numbers to facilitate the tracking of drawings which have pending changes. (Previously, drawings were flagged as pending revision but DCN numbers were not pre-assigned for tracking purposes.)

Training on the revised Procedure 3.7 has been completed. Training on the changes to Procedures 3.4.3, 3.4.5, and 3.4.8 will be provided to the appropriate design personnel by July 15, 1996.

Modification packages for the 1997 refueling outage will be developed using the enhanced procedures described above.

Date When Full Compliance Will Be Achieved

The District is in full compliance with the requirements of Title 10 of CFR 50, Appendix R, Section III.G.1 with respect to the identified violation II.A.

II.B. Violation Not Assessed a Civil Penalty

10 CFR Part 50, Appendix B, Criterion III, requires, in part, that measures shall be established to assure that applicable regulatory requirements and the design basis as defined in 10 CFR 50.2 are correctly translated into specifications, drawings, procedures, and instructions. In addition, design changes shall be subject to design control measures commensurate with those applied to the original design.

The diesel generator system is required by the Updated Safety Analysis Report (USAR), Section VIII-5.1, to provide alternating current power to shut down the reactor following abnormal operational transients and postulated accidents. USAR Sections I-5.1.5 and 5.1.6 require that the design of the system must include allowances for environmental phenomena, such as tornados and seismic events. The diesel generator muffler bypass subsystem design provides the analyzed exhaust path under seismic and tornado conditions, since the muffler and associated piping are not analyzed for these conditions.

Contrary to the above, as discussed in NRC Inspection Report 50-298/96-04, during the November 1995 refueling outage, design control measures were inadequate in that an unauthorized modification was made to the Diesel Generators 1 and 2 muffler bypass systems, resulting in the muffler bypass system for Diesel Generator 2 being inoperable from December 27, 1995 to January 15, 1996. (03014)

Admission or Denial to Violation

The District admits the Violation.

Reason for Violation

This violation resulted from a failure of management to effectively communicate the expectations for installation of modifications. Craft labor and field engineers failed to recognize that installation of the exhaust tubing was an unauthorized modification. Contributing causes of this event included a weakness in field supervision and inadequate training for craft labor and field engineering in that responsibilities and expectations for them had not been clearly defined.

Design Change (DC) 93-024 modified the operation of the DG muffler bypass valves from air-to-open/air-to-close to spring-to-open/air-to-close. To facilitate this change, the existing four-way solenoid pilot operated valve (SPV) for each muffler bypass valve was replaced with a three-way SPV. As part of the DC, detailed instructions for installing the tubing and three-way SPVs were provided in sketches. Neither these sketches nor the written instructions included in the DC package directed the installation of tubing or fittings on the exhaust port of the valves. Therefore, installation of J tubes on the exhaust ports of the SPVs was an unauthorized modification.

While the involved contracted craft personnel who installed the J tube on the DG 1 SPV are no longer on site for interview, it is assumed that there were foreign material exclusion (FME) concerns associated with the as-installed orientation of the three-way muffler bypass SPV on DG 1. Specifically, foreign material could enter the upward directed exhaust ports and cause the valves to fail.

Although working to sketch SKE-DG-207 for the tubing modification on DG 2, craft personnel were directed by the contract field engineer responsible for DC implementation to duplicate DG 1 if any questions arose on DG2 modifications since DG1 had successfully passed all of the acceptance testing criteria.

The contract field engineer was contacted concerning his knowledge of the unauthorized modification. While he was aware of the J tube, he did not authorize or give direction to craft personnel for its installation. However, he believed it to be a good practice to avoid FME concerns, even though not specified in the design change package, and did not question the installation. The contract field engineer and District personnel did not recognize the J tube as an unauthorized modification.

The condition was subsequently identified during routine surveillance testing. Once a cause and effect relationship identified the unauthorized modification, the J tube was removed thus minimizing the duration of inoperability for DG 2. DG 1 remained operable as confirmed through the performance of five surveillance tests from December 30, 1995, through just prior to removing the J tube on January 18, 1996.

Corrective Steps Taken and the Results Achieved

The tubing and fittings on the SPV exhaust ports were removed. A walk down of accessible safety-related SPV applications for similar concerns and a review of inaccessible safety-related SPVs was performed with no operability concerns found. A walk down was also performed on selected 1995 installed modifications to inspect for unauthorized modifications with none found.

CNS management has increased the focus on the identification and prevention of unauthorized modifications. Engineering support personnel were briefed on this event in continuing training. The Design Engineering Manager has briefed appropriate site work groups on this issue to increase their awareness of the issue. Written communications were provided to station personnel that: 1) provided better definition of a station modification, 2) discussed what types of routine activities could constitute unintended design changes, and 3) solicited input from the site as to other potential unauthorized modifications that may exist in the plant. The sensitivity of station personnel to unauthorized modifications has improved as evidenced by their identification of other potential examples. These examples were evaluated with no unreviewed safety questions or safety significant issues identified.

Corrective Steps That Will Be Taken to Avoid Further Violations

The Design Engineering Manager has clearly communicated his expectations regarding post modification walk downs to appropriate Design Engineering personnel. Additionally, a total process revision is underway which will include the following long term enhancements:

1. Procedure 3.4.11, "Status Report," will be revised by June 24, 1996, to strengthen guidance on post-modification walk down criteria and documentation.
2. A field engineering functional qualification guide will be developed by June 6, 1996, to ensure consistent understanding of the Field Engineer's responsibilities for station modification implementation.
3. Construction craft training will be revised by November 11, 1996, to clearly define management expectations regarding craft responsibilities during implementation of work instructions.

The above implementation schedule will ensure these upgrades will be in place to support modifications to be performed during the 1997 refueling outage.

Date When Full Compliance Will Be Achieved

The District is in full compliance with the requirements of 10 CFR Part 50, Appendix B, Criterion III with respect to the identified violation II.B.

Correspondence No: NLS960078

The following table identifies those actions committed to by the District in this document. Any other actions discussed in the submittal represent intended or planned actions by the District. They are described to the NRC for the NRC's information and are not regulatory commitments. Please notify the Licensing Manager at Cooper Nuclear Station of any questions regarding this document or any associated regulatory commitments.

COMMITMENT	COMMITTED DATE OR OUTAGE
A further sampling of candidate MWRs will be conducted according to a pre-established sampling plan to detect other examples where modifications were performed without performance of safety evaluations. The sample size will initially consist of ten percent of a selected population of MWRs from 1974 to the present. As part of this effort, walk downs of certain historical (accessible) MWRs will be performed according to a defined screening criteria.	June 30, 1996
Walkdowns for MWRs not accessible during plant operating conditions will be completed prior to restart from the RE17 refueling outage.	Restart from RE17
HELB and Secondary Containment Design Criteria Documents will be developed.	October 31, 1996
Changes will be made to the USAR to make the licensing basis functions of the blowout panels more visible, and these changes will be incorporated as part of the next USAR update submittal.	July 22, 1996
Evaluate the 20 remaining Control Room and Auxiliary Relay Room panels.	June 30, 1996
Procedure 3.4.3, "Design Change," and Procedure 3.4.5, "Minor Modifications," are being revised to require: 1) The acquisition of pre-assigned DCNs as soon as possible during modification development; and 2) In addition to verification of drawing revision, documentation of the review of pending drawing changes for impact to the modification.	June 24, 1996
Procedure 3.4.8, "Design Verification," is being revised to verify during the independent design review that: 1) Pre-assigned DCN numbers have been obtained for affected drawings; and 2) Pending changes to reference drawings are identified and taken into consideration.	June 24, 1996
Training on changes to Procedures 3.4.3, 3.4.5, and 3.4.8, will be provided to the appropriate design personnel.	July 15, 1996
Procedure 3.4.11, "Status Report," will be revised to strengthen guidance on post-modification walk down criteria and documentation.	June 24, 1996
A field engineering functional qualification guide will be developed to ensure consistent understanding of the Field Engineer's responsibilities for station modification implementation.	June 6, 1996
Construction craft training will be revised to clearly define management expectations regarding craft responsibilities during implementation of work instructions.	November 11, 1996
Modification packages for the 1997 refueling outage will be developed using the enhanced procedures.	1997 Refueling Outage