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~~IE 04~~

IE45

September 10, 1997

Mr. W. T. Subalusky, Jr.
Site Vice President
LaSalle County Station
Commonwealth Edison Company
2601 North 21st Road
Marseilles, IL 61341

SUBJECT: NRC OVERSIGHT PANEL MEETING SUMMARY

Dear Mr. Subalusky:

The NRC Oversight Panel met with Commonwealth Edison and LaSalle County Station management on August 28, 1997. This management meeting was open to public observation. Enclosure 1 contains the associated meeting summary. Enclosure 2 contains the handout provided to the NRC Oversight Panel by Commonwealth Edison during the meeting.

In accordance with Section 2.790 of the NRC's "Rules of Practice," Part 2, Title 10, Code of Federal Regulations, a copy of this letter and its enclosures will be placed in the NRC's Public Document Room.

Sincerely,

/s/ Melvyn N. Leach

Melvyn N. Leach, Chief
Operator Licensing Branch
Division of Reactor Safety

Docket Nos.: 50-373; 50-374
License Nos.: NPF-11; NPF-18

Enclosures: 1. Meeting Summary
2. Meeting Handout

See Attached Distribution

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BWR Operations
Liaison Officer, NOC-BOD
D. A. Sager, Vice President,
Generation Support
D. Farrar, Nuclear Regulatory
Services Manager
I. Johnson, Licensing
Operations Manager
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Enclosure 1

Public Meeting Summary

Enclosure 1
Public Meeting Summary
NRC Oversight Panel for LaSalle County Station

August 28 Management Meeting

Summary:

The licensee presented information contained in the applicable handout in Enclosure 2. During the licensee's presentation, the licensee provided clarification in response to NRC questions and comments. The licensee provided a restart schedule, discussed recent changes to the Restart Plan, provided a brief status of several restart strategies, discussed the results of the first line supervisor evaluations, and discussed the status of the High Intensity Training Program for operators.

During the discussion, the licensee indicated the following with regards to the effectiveness of improvement actions and current plant performance:

- Operator involvement had improved with operators demanding resolution of plant problems when not satisfied with the original response.
- The level of work activity in the plant had significantly increased, which provides targets of opportunity for personnel error and observation.
- Personnel performance as indicated by the event free clock had been on an improving trend, but had leveled in the last few weeks. This was attributed to workers not paying as much attention when the management focus is reduced.
- Out-of-service errors are currently the most significant problem in operations due to the effect on personnel safety and plant configuration control. While previously the largest contributor to this problem had been component mispositioning, the largest contributor was now scheduling deficiencies with component mispositioning almost to zero.
- Some improvements have been noted in maintenance rework and engineering product quality compared to a year ago, but performance in these areas is still not where it needs to be.
- With regard to the new corrective action program, results are being achieved, but some shortfalls still exist. For example, the Corrective Action Review Board reject rate remains high.
- With regard to material condition improvement efforts, the difference between current efforts and efforts during any other plant outage is that current efforts are being driven by aspects of other Restart Plan strategies, such as operator work around...

During the discussion, the NRC staff communicated the following considerations:

- Progress made with regard to operators demanding resolution of problems could eventually be lost if the operators continue to see problems not addressed correctly the first time.

- In addition to the licensee's Restart Plan, which the licensee previously provided, the NRC staff needed to see the associated detailed action plans to assist in inspection planning and integration of inspection findings. The licensee agreed to provide these within 30 days.

- During NRC review of the licensee's Restart Plan, the staff found it difficult to associate the restart issues to the root causes of performance problems. The licensee indicated that an open corrective action record existed for this same problem, which the licensee was trying to address.

- Further dialogue is necessary between the licensee and the NRC inspection staff regarding licensee plans and schedules for resolving technical issues such as those identified in the licensee's system performance functional reviews.

- With regard to NRC observations of examinations during the licensee's High Intensity Training Program for operators, the simulator examinations were good, but the written examinations were not challenging. The licensee responded that they had already identified that many questions in their examination bank did not reflect higher order objectives and discussed current activities to address the concern.

Attendees:

NRC

G. Grant, Director, Division of Reactor Projects (DRP)
R. Capra, Director, Project Directorate III-2, Office of Nuclear Reactor Regulation (NRR)
M. Leach, Chief, Operator Licensing Branch
M. Galloway, Acting Chief, DRP Branch 2
D. Hills, Project Engineer
J. Hansen, Resident Inspector

Commonwealth Edison

J. Brons, Vice-President, Nuclear Support, ComEd
B. Subalusky, Site Vice-President, LaSalle
G. Poletto, Site Engineering Manager, LaSalle
D. Farr, Operations Manager, LaSalle
L. Guthrie, Restart Manager, LaSalle
R. Heisterman, Maintenance Manger, LaSalle
B. Riffer, Corrective Action Manager, LaSalle
G. Kaegi, Operations Training Superintendent, LaSalle
G. Schwartz, Safety Assessment Manager, ComEd
J. Gieseker, Executive Assistant, Lasalle
L. Johnson, Licensing Director, ComEd
P. Barnes, Regulatory Assurance Supervisor, LaSalle
G. Benes, Licensing Administrator, ComEd
J. Marshall, Offsite Review, ComEd
J. Reynolds, Member, NOC-BOC, ComEd
B. Rybak, Licensing Operations, ComEd
D. Sanchez, Manager Training, ComEd
G. Wald, Nuclear Communications Administrator, ComEd
P. Resler, Communications Coordinator, LaSalle
J. Kinsey, Engineering, LaSalle
G. Byson, BB Steno - Bargaining Unit, LaSalle
J. Schrage, WMD, LaSalle
T. Galyen, MMD, LaSalle
A. Bebar, Radiation Protection Technician, LaSalle
B. Burent, IMD, LaSalle
M. Ruder, EMD, LaSalle
M. Reynolds, IMD, LaSalle
J. Fiesel, PGM Staff Assistant, ComEd
R. Godley, Regulatory Assurance Manager, Zion

Other

K. Suiton, Attorney, Winston & Strawn
T. Poindexter, Attorney, Winston & Strawn
C. Mathews, Resident Engineer, Illinois Department of Nuclear Safety

Enclosure 2

Commonwealth Edison
Management Meeting Handout

LASALLE COUNTY STATION

Safe Uneventful Startup

⬇

Safe Uneventful Long Run

⬇

World Class Performance

August 28,1997

NRC Region III - Lisle, Illinois

LaSalle

NRC Public Meeting
August 28, 1997
13:00 - 16:00

• NRC Introduction	Leach/Beach
• LaSalle Introduction	Subalusky
➢ Integrated Restart Schedule	
• Key Activities Since Last Meeting	
➢ Restart Plan Revision	Guthrie
• Restart Plan Status Report	
➢ Out of Service	Farr
➢ Material Condition	Guthrie
– Unit 1 L1F35 Outage	
➢ System Functional Performance Review	Poletto
– NRC Generic Issues	
➢ Corrective Action and Self Assessment	McDonald
➢ High Intensity Training	Farr
• Closing Remarks	Subalusky
• NRC Closing Remarks	Leach/Beach

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Restart Schedule

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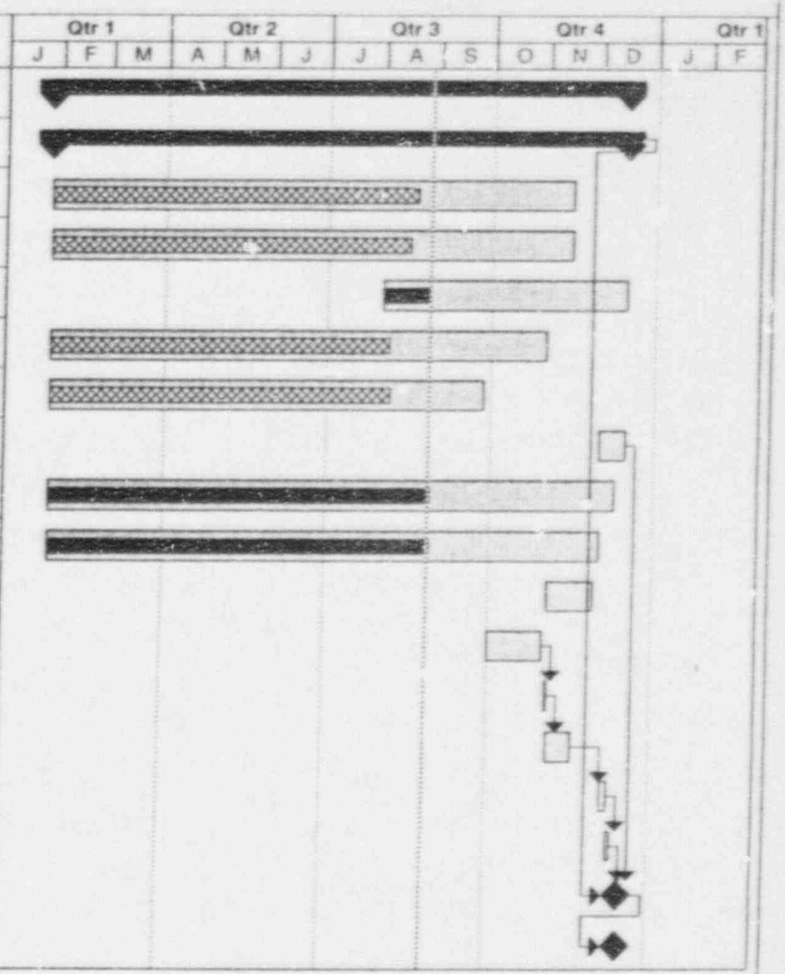
Unit 1 Integrated Summary Restart Schedule

ID	Task Name	Lead
1	**Unit 1 Integrated Restart Schedule**	**Guthrie**
2	**Unit 1 L1F35 Outage Schedule**	**Higgins**
3	Divisional Work Windows	Higgins
4	Non-Divisional Work Windows	Higgins
5	Unit 1 Restart Testing	Magnafici
6	Design Changes (DCP's)	Connell
7	Engineering Requests (ER's)	Connell
8	Operator Startup Training	Sanchez
9	Regulatory Issues	Barnes
10	Nuclear Tracking System (NTS)	Barnes / McDonald
11	System Readiness Review	Palmieri
12	Perform Site Department Self Assessment	Smith / Poletto
13	RIRC Restart Recommendation	Guthrie
14	SQV Readiness Assessment	McDonald
15	CNO Evaluation	Brons
16	NOC / BOD Approval For Restart	Keiser
17	Mode Switch to Start Up	Smith
18	On Line	Smith



Project:
Date: Wed 8/27/97

Task
Progress
Milestone
Summary
Rolled Up Task
Rolled Up Milestone
Rolled Up Progress

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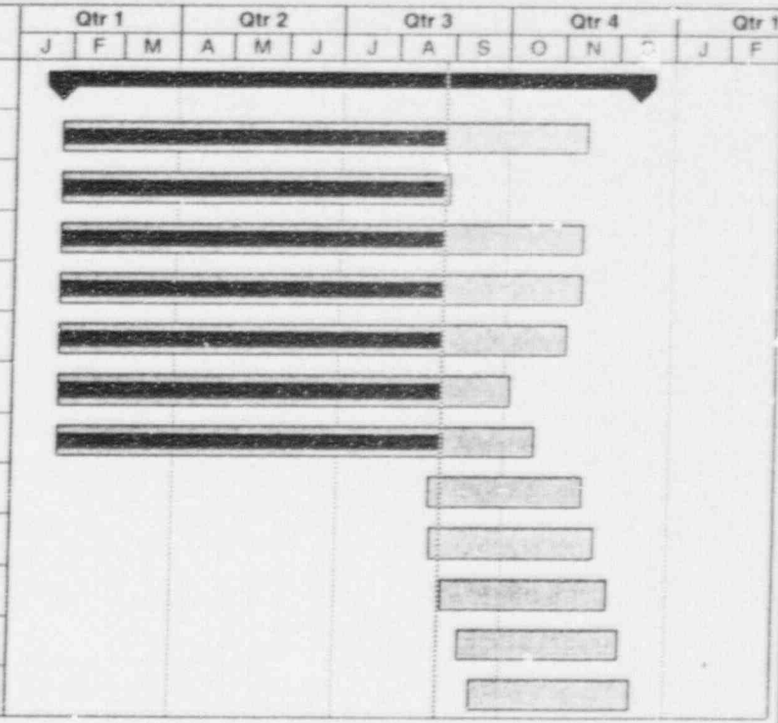
Unit 1 Integrated Summary Restart Schedule

ID	Task Name	Lead
19	**Unit 1 Restart Action Plan**	
20	Strategy 1- Safe Plant Operation	Smith
21	Strategy 2 - Human Performance	Boone
22	Strategy 3 - Plant Materiel Condition	Higgins
23	Strategy 4 - Effective Engineering Support	Poletto
24	Strategy 5- Corrective Action and Self Assessment	McDonald
25	Strategy 6 - Training	Sanchez
26	Strategy 7 - Process Improvement	Smith
27	Complete Strategy	
28	Strategy Close-out	
29	Restart Issues Committee Review	
30	SQV Review	
31	Offsite Corporate Assessment	



Project:
Date: Wed 0/27/97

Task
Progress
Milestone
Summary
Rolled Up Task
Rolled Up Milestone
Rolled Up Progress

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Restart Plan Revision

- Restart Issues Review Committee
- Closeout Process
- CAL Matrix*
- Readiness Measures

* Strategy Action Plans under Review/Revision

CAL Matrix

Action Plan Number	Item	CAL ISSUE					
		Materiel Condition	Humman Performance	Corrective Action Process	Engineering Support	Design Deficiencies	Licensed Operator Training
1	**Safe Plant Operations**						
1.1	Improve Operator Performance						
1.1A	Monitoring Critical Operations Functions						X
1.1B	Operator Work Environment	X	X				
1.1C	Restart and Power Ascension Plan	X			X	X	
1.2	Reduce Operator Challenges						
1.2A	Operator Workarounds	X	X				
1.2B	Temporary Alterations	X					
1.2C	Main Control Room Distractions	X					
1.3	Correct Processes that Challenge Safe Plant Operation						
1.3A	Plant Labeling Program	X	X				
1.3B	Out-of-Service Program		X				
1.3C	Operating Procedures Readiness		X				X
2	**Human Performance**						
2.1	Human Interaction and Performance		X				
3	**Plant Materiel Condition**						
3.1	Unit 1 Outage Management Plan	X				X	
3.2	Unit 2 Outage Management Plan	X				X	
3.3	Maintenance Backlog Review Plan	X				X	
4	**Effective Engineering Support**						
4.1	Engineering Capability		X		X	X	
4.2	Plant Operational Readiness	X			X	X	
5	**Corrective Action and Self Assessment**						
5.1	Corrective Action Program			X			
5.2	Quality Verification Effectiveness			X			
5.3	Department Self Assessment		X	X			
6	**Training**						
6.1	Operator Training		X				X
7	Process Improvement						
7.1	Procedures		X				

Readiness Measures

Area	Restart Target
(1) Safe Plant Operation	
• Improve Operator Performance	Improving Trend In OPS Event Free Clock
• Operator Work Around	≤10 And No Significant Ones
• Outstanding Temp Alts	≤10 Greater Than 1 Refuel Outage
• Control Room Distractions	≤10 And No Significant Ones
(2) Human Performance	
• Site Human Performance	Improving Trend In Station Event Free Clock
• Out of Service Errors	≤2 Per Month
• Safety System Actuations	≤2 Per Month
• Open Significant Human Performance PIF	≤4
• Open Significant Procedures Adherence PIF	≤4
(3) Plant Material Condition	
• Outage Backlog	100% As Required for Startup
(4) Engineering Effectiveness	
• Engineering Quality	Improving Trend In Engineering Score Card
• SFPR Reviews	100% As Required for Startup
• Outstanding Engineering Requests	100% As Required for Startup
• System Readiness Review	100% As Required for Startup
• Design Changes	100% As Required for Startup
(5) Corrective Action - Self Assessment	
• CARB Rejections Rate	≤40%
• Significant Repeat Events	≤2 per Month
• Significant Corrective Actions Overdue	≤ 15 per Quarter
(6) Training	HIT Training Complete
(7) Process Improvement (Procedures)	100% Required for Startup

NOTE: (1) The Restart Targets are a per Unit basis.

(2) Significant is defined as a generic breakdown in the process.

Out of Service Events

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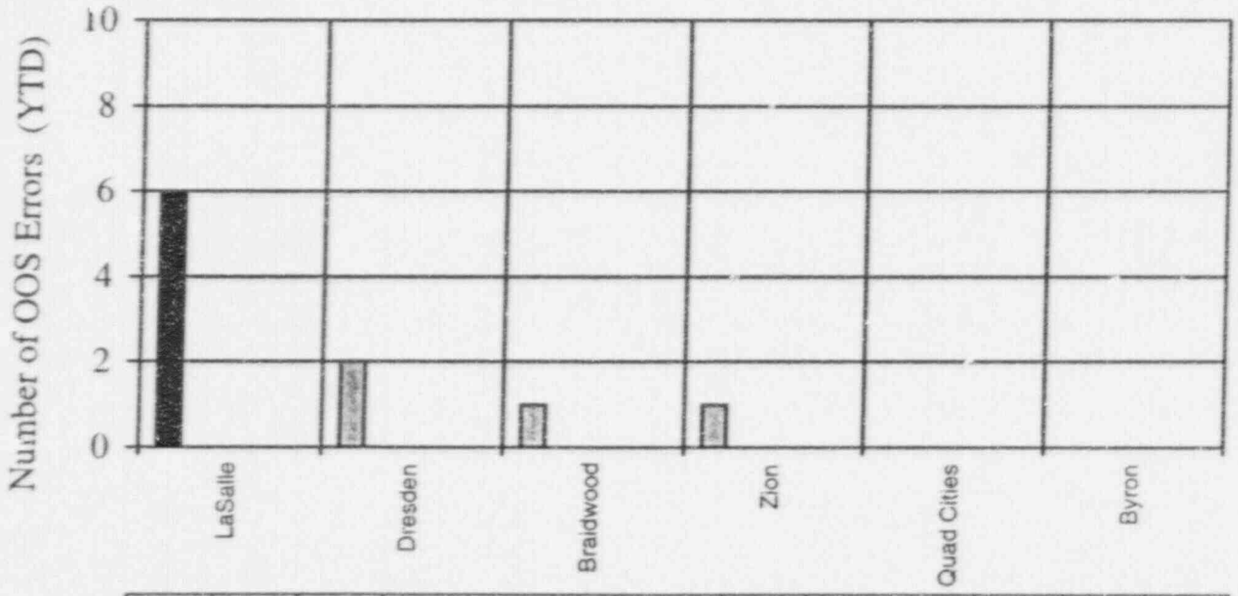
Out of Service Errors



Definition:

The total number of OOS error PIFs that are designated as significant. (Level 1, 2, 3 PIFs or SCAQ in the new CAP process.) (# for the month)

Threshold:

Greater than 5 per year

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
BWD	0	0	1	0	0	0	0					
BYR	0	0	0	0	0	0	0					
ZIN	1	0	0	0	0	0	0					
DRS	0	1	0	1	0	0	0					
LAS	2	0	1	1	0	1	1					
QDC	0	0	0	0	0	0	0					

* = No Data Available

NOTE: This is a NOD Indicator

Data Analysis

- **1996 and 1997 (January through April)**
  - Events driven by poor human performance by NLOs in the field
    - Component mispositioning
    - Wrong component
- **1997 (May - July)**
  - Events driven by poor human performance in the areas of scheduling and planning
    - OOS hang checklist development
    - OOS boundary interactions
    - OOS restoration

Corrective Actions

- **In Field Human Performance**
  - ➢ Independent Verification - *Apart in Time*
  - ➢ Strict Disciplinary Action
  - ➢ HIT Training - Use of Self Check Simulator
  - ➢ Prejob Walkdowns

Corrective Actions Appear to Have Been Effective

Additional Corrective Actions

- **To Address Planning/Scheduling Issues**
  - Corporate SQV Investigation
  - Formal Root Cause Investigation
  - Mechanical/Electrical Lineup Verification
  - Operations Outage Interface Group Established
  - Outage Schedule "Frozen" for 7-day Periods
  - Experienced Self-Assessment Coordinator Assigned to Operations
  - SCORECARD Revised to Address Human Behavior Codes
  - SCORECARD Observations Limited in Scope

Materiel Condition Improvement (L1F35 Outage Performance)

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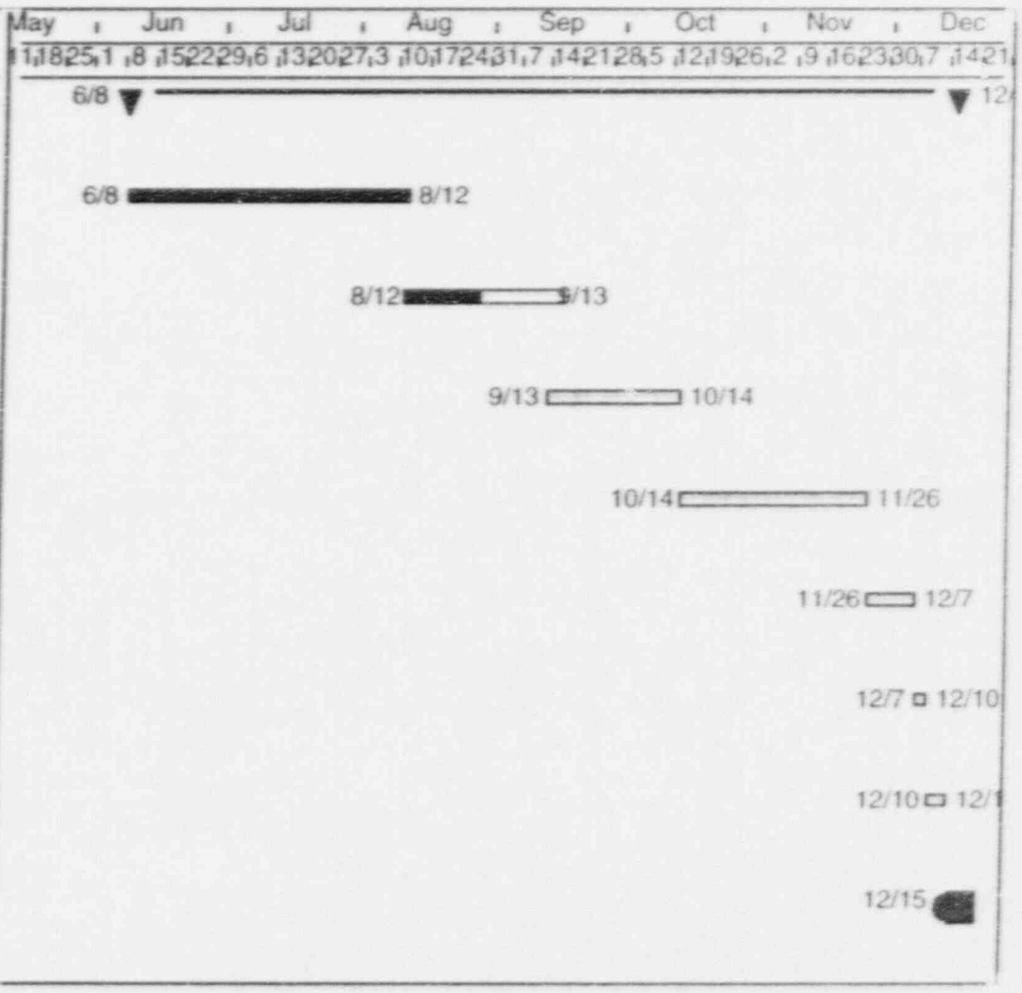
L1F35 Critical Path Overview

ID	Task Name
1	Unit 1- L1F35 Outage S chedule
2	CD-10 Window
3	Division I Window
4	Division 2 Window
5	CD-10 Window
6	Sys Perf Testing, Pri Cnt & RPV Press Test, CRD SCHAM time
7	Final Prep For ModeSwitch To Startup
8	Unit Startup & Testing
9	Turbine Sync ToGrid



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CD-10 Results

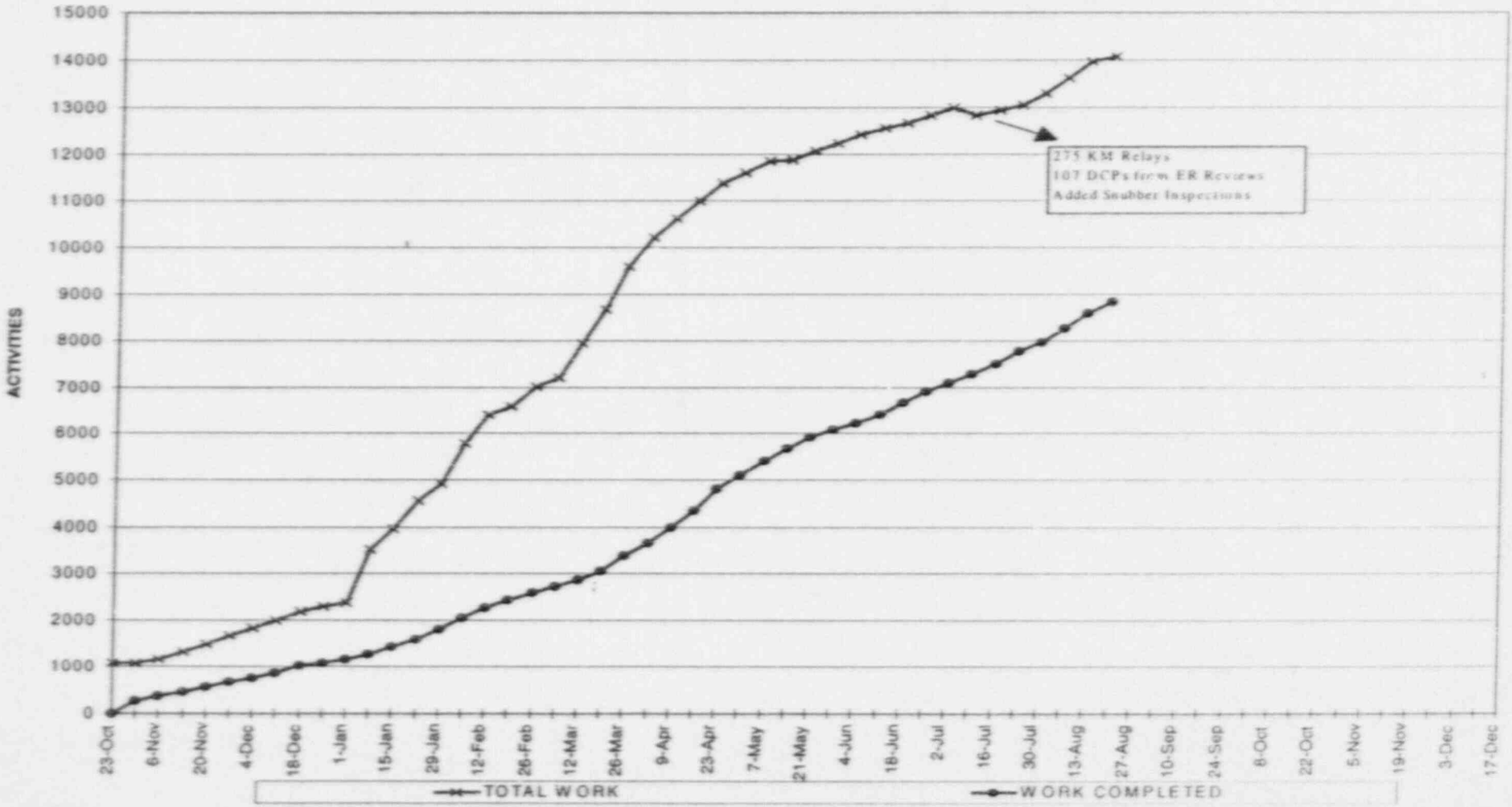
- **Summary of All Work Completed during CD - 10 Window (Includes L1F35, L2R07, and Daily Work)**

➢ Total NWR Tasks Completed	1490
➢ Total PMs and Surveillances Completed	676
➢ DCPs Completed	32
➢ Temp Alts Completed (i.e. Installed and Removed)	27
➢ Corrective Maintenance (and other Misc. Outage Work)	755

CD-10 Results

- **Summary of Major Equipment Improvements Completed:**
  - MDRFP New Seal Design
  - MSIV Solenoid Valve Upgrade
  - FW MOV Torque Switch Replacement
  - Re-Sized1B & 1D Condensate Pump Impeller Replacement
  - Outboard MSIV Room Airlock
  - "O" D/G VAR Meter Changeout

L1F35 Work (Divisional/Non-Divisional) Completed vs Total Work



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SYSTEM FUNCTIONAL PERFORMANCE REVIEWS

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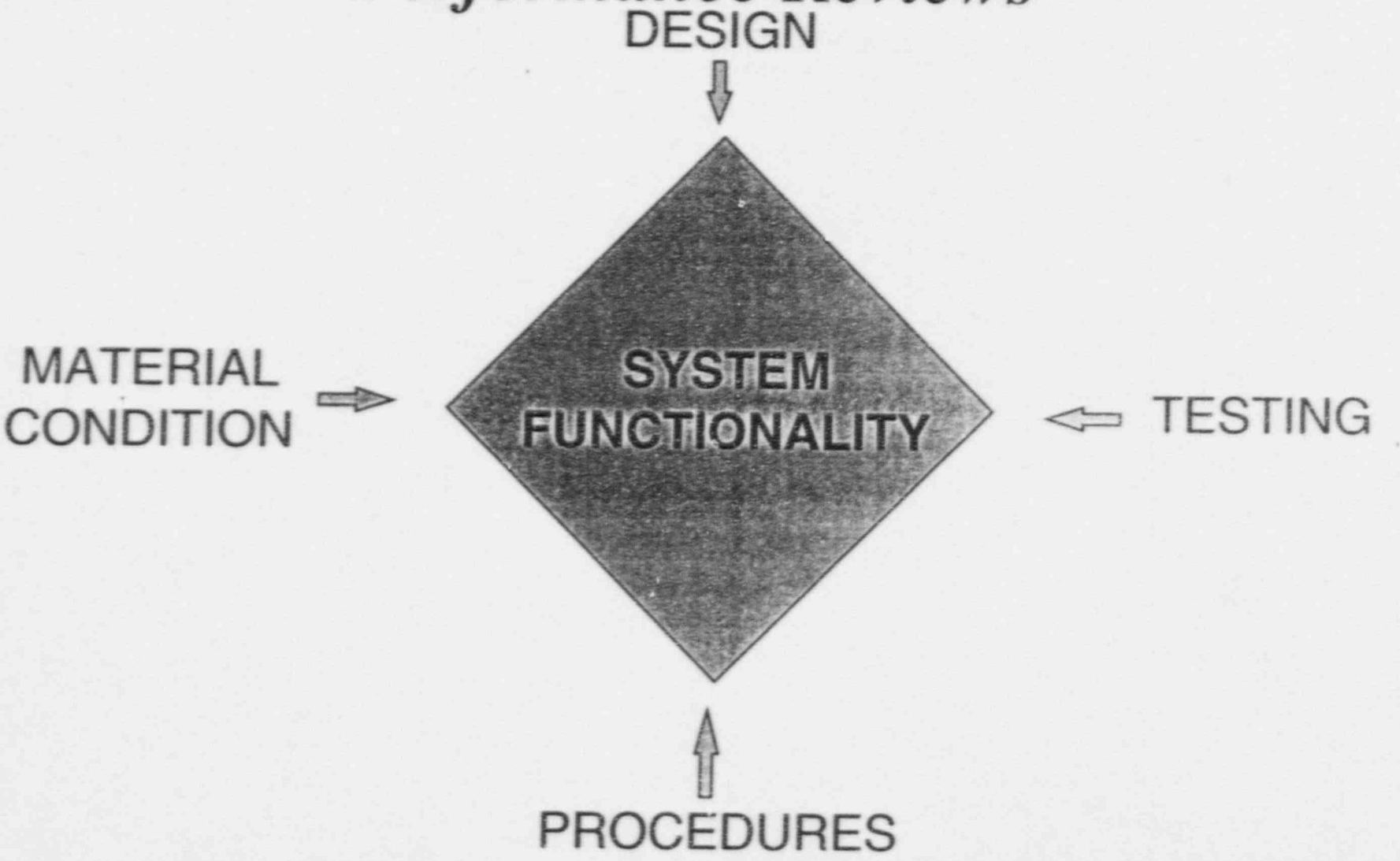
SFPR Program Elements

- DISCOVERY - Complete
- RESOLUTION - In Progress
- TESTING - In Progress

System Functional Performance Reviews



Restart Scope Criteria

- **Restore System Operability**
- **Restore Items That Are Outside the System Design Basis**
- **Address Plant Challenges or Reliability Issues That Affect Maintenance Rule Functions That Can Only Be Done Off-Line**
- **Resolve Immediate Personnel Safety Issues**

Restart issues will be closed out before plant restart

Short Term Issue Considerations

- Issues Do Not Compromise Safe, Reliable Operation
- Minor UFSAR Inconsistencies
- Material Condition Issues Not Affecting System Function
- Procedure and Documentation Enhancements

Long Term Issue Considerations

- Upgrade of Obsolete Hardware
- Minor UFSAR Improvement Suggestions
- Minor Procedure Corrections, Improvements

Examples of Issues

- 125 VDC
- Reactor Water Cleanup
- Control Room Ventilation
- Electrohydraulic Control (EHC)
- Reactor Core Isolation Cooling

125 VDC System

- **Restart Issue Examples**
  - Battery Load Capacity Testing
  - Cross-tie Operation

125 VDC System

- **Short Term Issue Examples**
  - Battery Charger Reliability
  - Testing Procedure Improvements
  - Design Calculation Upgrades

Reactor Water Cleanup (RT) System

- **Restart Issue Examples**
  - Replace Pumps and Pipe, Restore to Original Hot Suction Configuration
  - Replace 40 of 73 Filter/Demin Ball Valves
  - Install Pump Room Leak Detection

Reactor Water Cleanup (RT) System

- **Short Term Issue Examples**
  - Replace Filter/Demin Hold Pumps
  - Complete Replacement of Remaining 33 of 73 Ball Valves

Control Room Ventilation (VC/VE) System

- **Restart Issue Examples**
  - Control Room Radiation Monitoring
  - Control Room Pressure Control and Ventilation
  - Testing to Demonstrate Technical Specification Compliance

Control Room Ventilation (VC/VE) System

- **Short Term Issue Examples**
  - Air Supply and Makeup Charcoal Filter High Temperature Alarm
  - UFSAR Requirements For Smoke
  - System Annunciator Testing

Reactor Core Isolation Cooling (RCIC) System

- **Restart Issue Examples**
  - Turbine Governor Valve Stem
  - Turbine Exhaust Line Rupture Disk
  - Steam Supply Line Drain Trap
  - Turbine Oil System Thread Sealant

Reactor Core Isolation Cooling (RCIC) System

- **Short Term Issue Examples**
  - Turbine Governor Static Inverter
  - RCIC Suppression Chamber Suction Valve
  - Oil Piping Configuration and Drawings

Electrohydraulic Control (EHC) System

- **Restart Issue Examples**
  - EHC Fluid High Temperature
  - EHC System Calibration and Tuning
  - EHC System Leaks
  - Testing of Turbine (CIV)

Electrohydraulic Control (EHC) System

- **Short Term Issue Examples**
  - EHC Pump Reliability
  - Plant Drawings and Vendor Manual Update
  - EHC Piping Replacement

SFPR Issues Resolution Category

	Restart	Short Term	Long Term
DCP/Modifications	132	46	21
Work Request	426	302	126
Procedure Revision	187	259	202
Engineering Request	370	475	231
UFSAR Revision	24	111	10
License Amendment	3	0	0
TOTALS	**1142**	**1193**	**690**

(Note: The above values are approximate)

SFPR Resolution and System Testing

- **Process Continues with the Testing Program**
- **More Discovery Possible**
- **Focus is on Safe, Reliable System Operation for Restart**

NRC GENERIC ISSUES

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NRC Generic Issues

- **OPRM (Oscillating Power Range Monitoring)**
  - NRC Generic Letter 94-02, "Long Term Solutions and Upgrade of Interim Operating Recommendations For Thermal-Hydraulic Instabilities In Boiling Water Reactors"
  - **ECCS Suction Strainers**
  - NRC Bulletin 96-03, " Potential Plugging Of Emergency Core Cooling Suction Strainers By Debris In Boiling Water Reactors"
- **Drywell Equipment**
  - NRC Generic Letter 96-06, "Assurance of Equipment Operability and Containment Integrity During Design Basis Accident Conditions"

CORRECTIVE ACTION AND SELF ASSESSMENT STRATEGY

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Corrective Action Program

- **Issue:**
  - Implementation of the Corrective Action Program is Not Effective
- **Resolution Methodology:**
  - Overdue Corrective Actions <15 per Quarter
  - Repeat SCAQ Events < 3 per Month
  - Based on PIF Data, Demonstrate that Station Personnel Are Effectively Identifying Problems Before Events Occur
  - > 60% CARB Acceptance Rate of Original Root Cause(In Process Indicator)

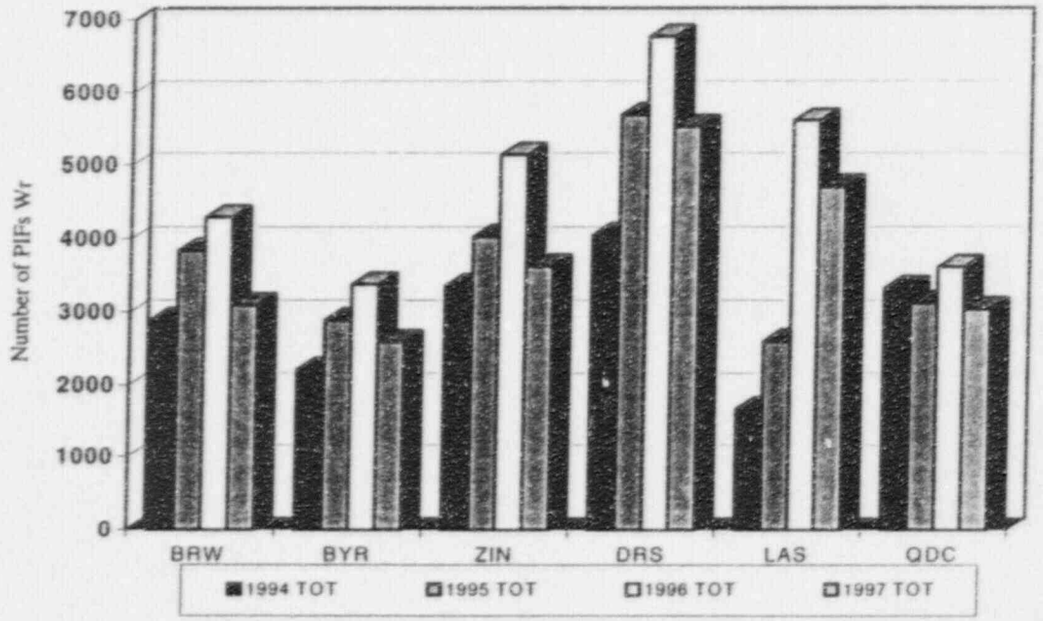
Actions

- Performed Training of CARB, Management, Root Cause Investigators, Management Personnel on New CAP Process
- Established Process and Line Ownership
- Implemented Formal Action Tracking Procedure
- Performing Weekly/Monthly Performance Indicator Review
- Implemented Formal CARB Procedure
- Established Dedicated Root Cause Team
- Assigned Effectiveness Reviews for Past Significant Events

Number of Problem Identification Forms (PIFs) Written

Definition: The number of PIFs written by the site.

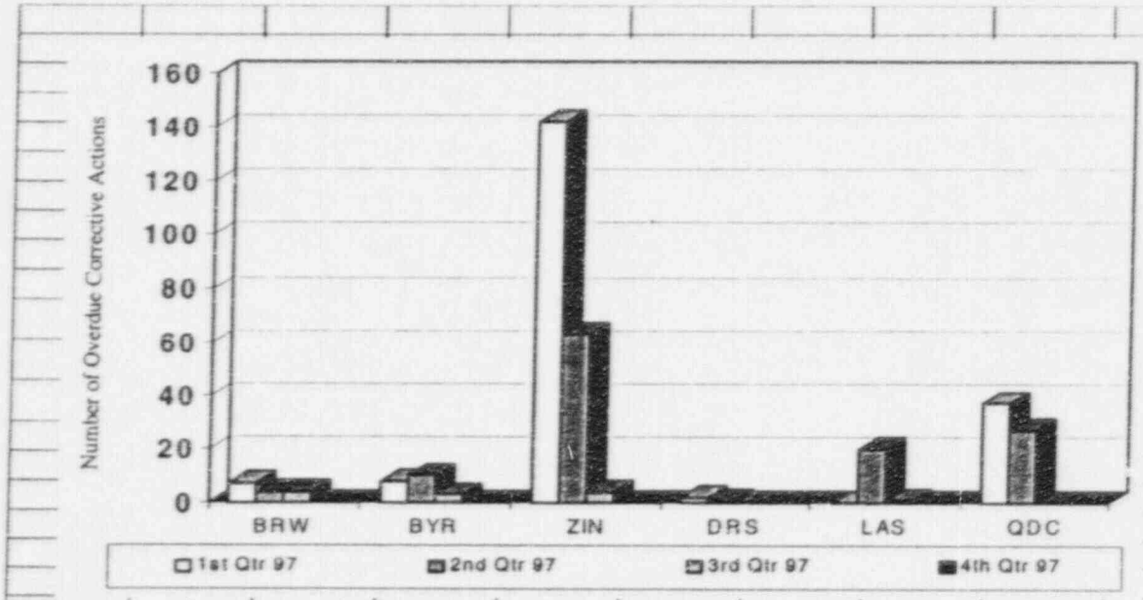
Threshold: Trend for 6 months to establish baseline prior to selecting criterion.



	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
BRW	354	331	487	550	449	382	542					
BYR	283	475	453	359	315	336	370					
ZIN	546	568	480	552	501	487	495					
DRS	746	858	892	1183	730	597	518					
LAS	653	904	929	514	435	696	573					
QDC	283	289	672	842	434	249	275					

Graph displays total number of PIFs written for the year. Table displays monthly PIF generation rate.

Overdue Corrective Actions



Definition: The number of corrective action items resulting from NOVs, PIFs, LERs and CARs that went overdue during the month. This includes NTS items with a Doc Type = 800, 180, 181, 200, 230, and 335. (Total# during the month)

Threshold: Greater than or equal to 15 per quarter.

		JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
BRW	During	1	1	5	3	1	0	4					
	End	*	*	2	2	0	0	1					
BYR	During	5	1	2	1	0	9	3					
	End	0	0	0	0	0	0	0					
ZIN	During	53	48	41	37	24	2	4					
	End	12	9	12	4	0	1	1					
DRS	During	2	0	0	1	0	0	0					
	End	0	0	0	1	0	0	0					
LAS	During	*	*	*	5	7	8	1					
	End	*	79	113	3	3	1	1					
QDC	During	14	9	14	21	6	0	0					
	End	0	0	1	3	3	0	0					

* = No Data Available. Graph is total number of overdue corrective actions. Table displays overdue during the month and number still overdue at end of month.

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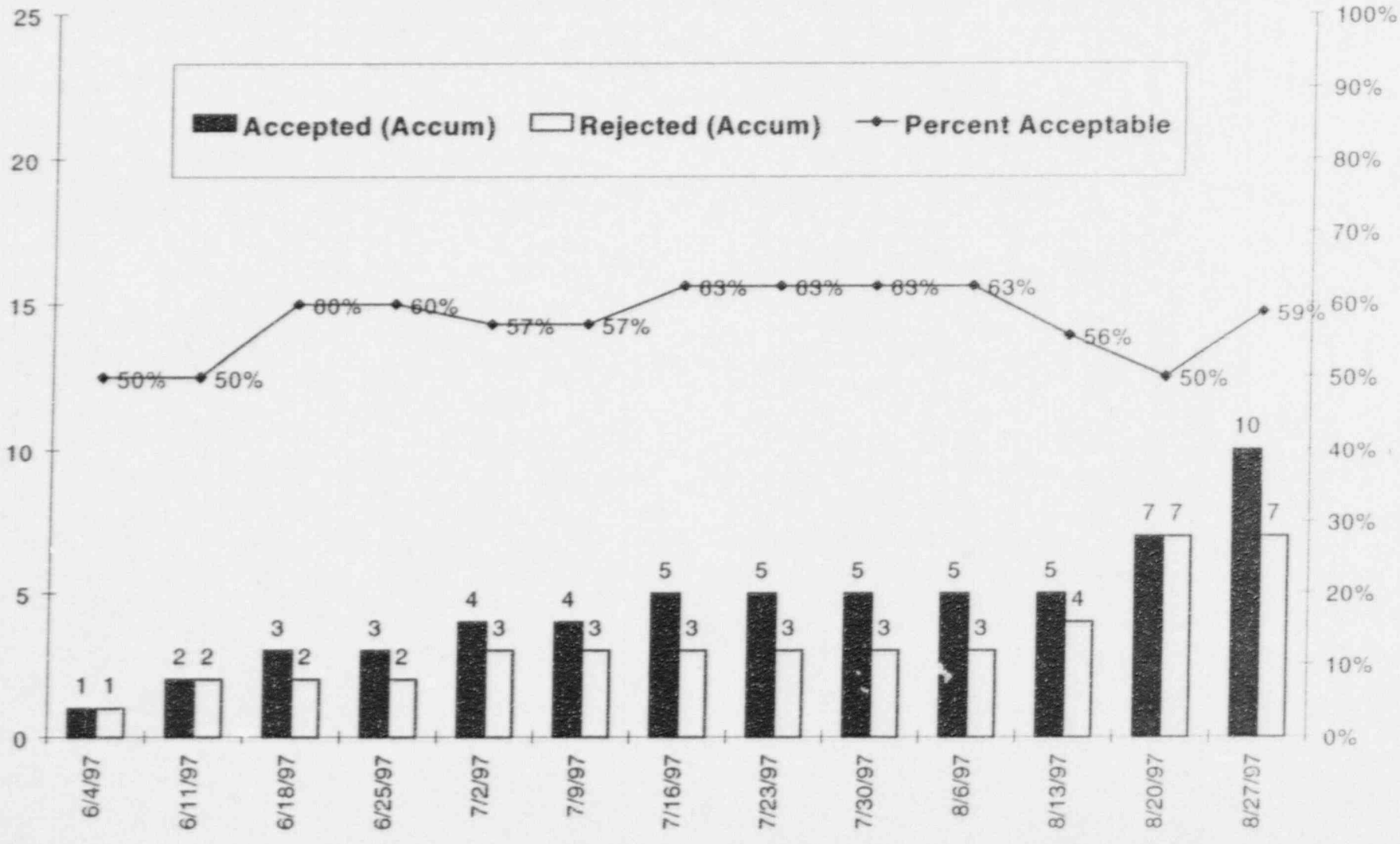
CARB Acceptance Rate



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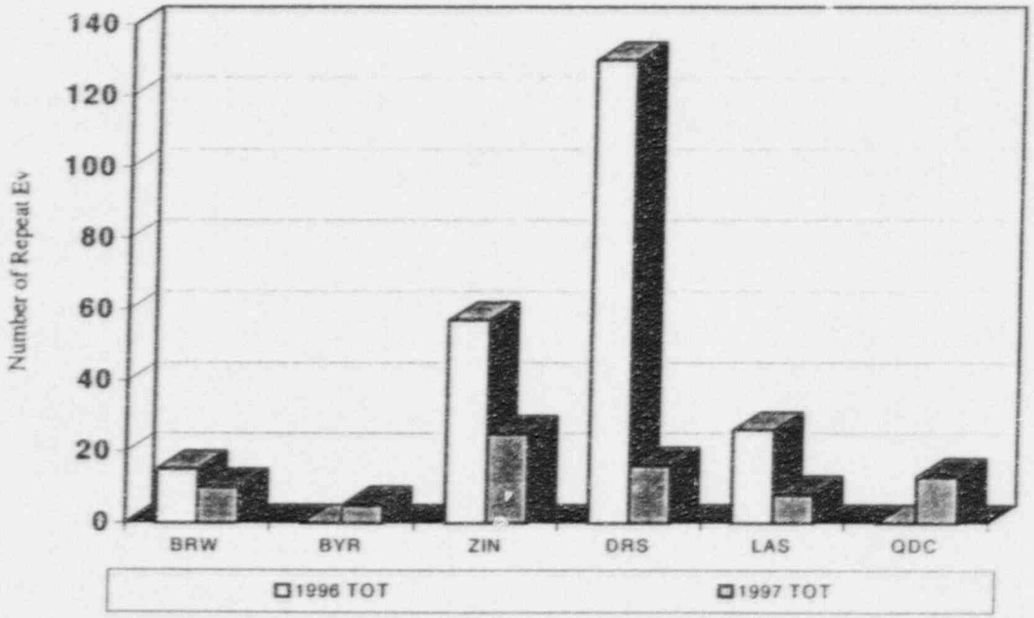
Repeat Events

Definition: The number of events that occurred in the past month with completed root cause investigation reports, which are reasonably similar in nature to events that occurred in the past 24 months that have one or more of the same root causes. (# of repeat events per month)

Threshold: Greater than 2 per month



	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
BRW	1	1	3	3	0	1	1					
BYR	1	0	2	1	0	0	1					
ZIN	3	4	4	3	10	1	0					
DRS	2	6	7	1	0	0	0					
LAS	1	1	1	3	0	1	1					
QDC	6	3	1	1	1	1	0					

Graph displays total number of repeat events. Table displays number of repeat events per month.

Self Assessment

- **Issue:**
  - Departments Not Identifying Potential Problems Prior to Event

- **Resolution Methodology:**
  - Consistent Self Identification of Substantive Issues by Line Organization

Actions

- Issued Self Assessment Procedure
- Performing Self Assessments
- Review of Assessment Results by Senior Management
- Formally Tracking Self Assessment Findings
- Development and Use of Departmental Performance Indicators

Recent Examples of Self Identified Issues

- OOS Errors
- HIT Training
- Supervisor Performance
- Overdue Corrective Actions
- System Engineering Accountability
- CD 10 Work Performance Issues
- Work Package Quality
- Maintenance Work Practice Issues
- Worker/Management Interface Issues

SQV Effectiveness

- **Issue:**
  - Improve SQV's Ability to Diagnose Nuclear Safety and Quality Concerns and Effectively Communicate Those Issues to Line Management for Resolution Prior to External Identification or Self-Revealing Events

- **Resolution Methodology:**
  - Consistent Identification of Substantive Issues
  - CAR Average Days Open - Improving Trend

Actions

- Hired Experienced Personnel
- Re-Allocated Resources for Emerging Issues
- Established Written Standards
- Assigned Functional Area Responsibility
- Established Written Self Assessment Process
- On-Going Communication with Senior Management

Recent Quality Identified Issues

- RHR Pump Testing
- Corrective Action Program Issues
- Generic Letter 82-12 Compliance
- Corrective Action Closeout
- Station Procedural Adherence
- Non-SFPR System Surveillance Testing
- Restart Plan Issues

Corrective Actions/Self Assessment Summary

- Qualitative Evidence of Results
- Performance Indicators Generally Meeting Targets
- Continuous Improvement Process In Use
- Problems Are Being Identified By Station
- Programmatic Elements In Place
- Effectiveness Review of Past Significant Events
- Remaining Problems Screened for Restart and Formally Tracked

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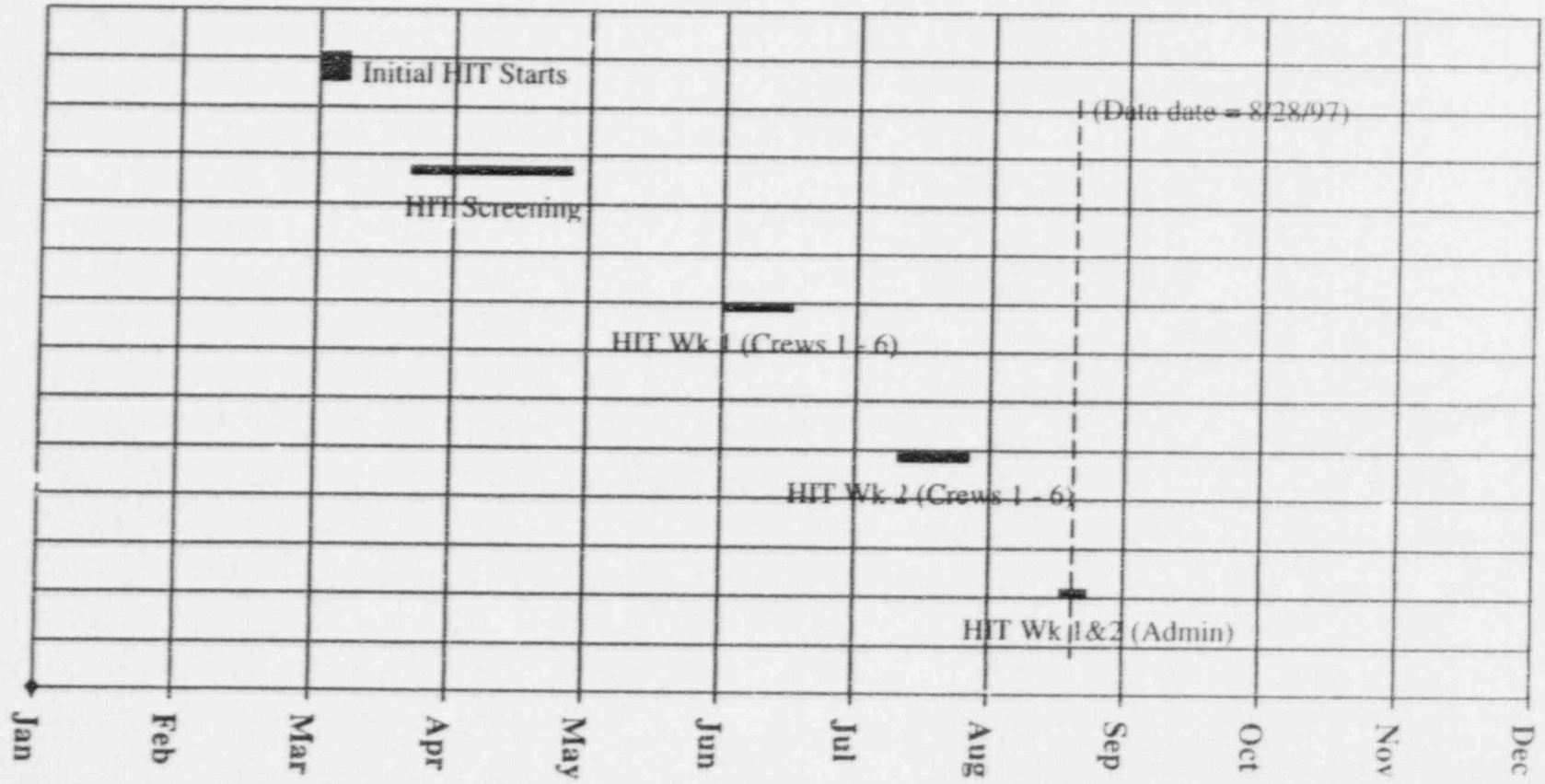
HIT Module Timeline



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Evaluation Results (L.O.)

HIT Screening Phase

# Oper. Evals	Sim. Failures (Crew)	Sim. Failures (Individual)	# Written Exam (Individual)	Exam Failures (Individual)
60	9	33	N/A	N/A

HIT Week 1

# Oper. Evals	Sim. Failures (Crew)	Sim. Failures (Individual)	# Written Exam (Individual)	Exam Failures (Individual)
60	1	10	60	7

HIT Week 2

# Oper. Evals	Sim. Failures (Crew)	Sim. Failures (Individual)	# Written Exam (Individual)	Exam Failures (Individual)
54	2	13	54	2

Evaluation Results (N.L.O.)

HIT Week 1

# JPM Evals	JPM Failures (Individual)	# Written Exams (Individual)	Exam Failures (Individual)
N/A	N/A	52	4

HIT Week 2

# JPM Evals	JPM Failures (Individual)	# Written Exams (Individual)	Exam Failures (Individual)
51	1	51	1

Licensed Remediation Status

Short	Intermediate	Long	License Terminated
37	9	4	6

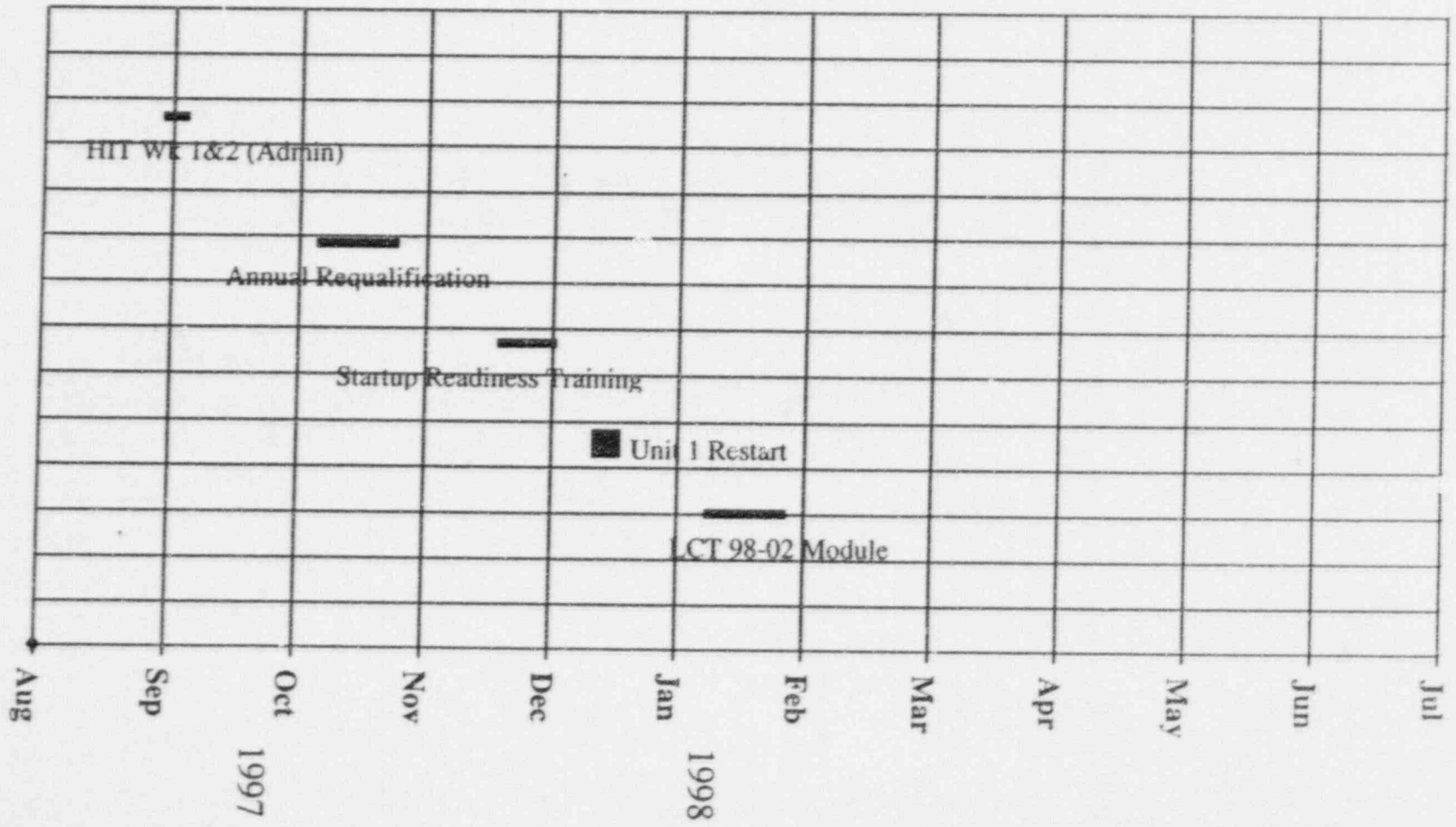
HIT Observations

- **NLO Weaknesses**
  - Rad practices
  - Use of self check
  - Communication
  - Ownership of issues and resolution
- **NSO Weaknesses**
  - Procedure knowledge
  - Diagnostics
  - Control Panel Awareness
  - Logkeeping
  - Self Check/Peer Check
- **SRO Weaknesses**
  - GSEP (Emergency Plan) Classification
  - Command and Control
  - Diagnostics
  - Procedure knowledge

HIT Learnings - Why?

- **Standards and Expectations have not been internalized and were not routinely practiced on shift**
  - Line Management has not reinforced adherence to these standards
- **Self Assessments have been ineffective.**
  - Have not taken a systematic approach to identifying/addressing weaknesses (in both the training and in-plant environments)
- **Simulator Training topics and focus not proper**
  - Risk = (probability of occurrence) X (Consequence of event)
  - Increase focus on *high probability, low consequence events*
- **Evaluation Techniques changed**
  - Normal/abnormal scenarios vs. EOP Drills
  - In the past, evaluations have been done at the *CREW* level vs *INDIVIDUAL* level.
    - » People didn't feel the need to change their behavior and performance. (No individual accountability)

After HIT



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HIT Improvements

- Improved Adherence to Standards and Expectations
- Greater Proficiency with Abnormal Procedures
- Greater Understanding of the "GSEP" Weaknesses
- Baseline Operator Knowledge in Theory
- Improved Line Management Ownership of Training
- Shift Managers Taking Charge of Crew Performance
- Improvements in Instructors Fulfilling Their Role