

Master CR List

**Davis-Besse
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56	78	79	81	82	CA	CA
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43	<p>Effectiveness Review Area</p> <p>Review Standards and Expectations in the Technical Services/Nuclear Engineering Department with emphasis on lessons learned from its root cause evaluation (procedure compliance, operational/decision-making hazards analysis safety focus) Refer to CA 02-00891-46, -48, -62, -75, -83, -112.</p>	44	<p>2. Management will ensure standards of excellence are communicated and monitoring will ensure these standards are upheld at all levels. This entails management behaviors, first line supervisor behaviors and individual worker behaviors. These standards will not only focus on behaviors, but also on the expectations for manager involvement in station activities.</p>	59	<p>Develop and implement the FENOC Hierarchy of Documents for D-B to ensure consistent policies and standards for analyses of safety issues, similar to other FENOC plants. 2. Establish policy for internal OE information that will establish the connection between the information and the applicable process or program. The information should be considered for inclusion into existing station procedures, and it should also be referenced for easy retrieval for future use. 2. Improvements to the Industry OE program will be made to ensure the appropriate actions identified from other plants or sources of information are properly tracked and implemented.</p>	0891 Corrective Action #	CA

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Develop and implement a formal systematic approach for collective significance reviews.		Define and implement training on evaluation (basic and apparent cause evaluation) techniques associated with equipment problem analysis to heighten expertise in this analysis area.		Assess the number of personnel that should be qualified and utilized to perform root cause analysis (e.g. a broad number of people [infrequent application], or a small-dedicated group [frequent application], or a combination of the two). Implement the recommendation from assessment. Provide justification for why the course chosen will improve the effectiveness of root causes.	CA	0891 Corrective Action #	CA	0891 Corrective Action #	CA
						Provide specific training (such as root cause training, effectiveness reviews) for CARB members. Revise the CARB charter to require specific training for CARB members.		Strengthen and expand the procedural guidance for utilization of quarantine for station events. Training and expectations for this tool should be administered to station personnel.	

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Develop and implement apparent cause training. (Suggestion is a one or two day problem solving class.) Obtain upper management approval of curriculum. Perform training for all personnel that perform apparent cause evaluations. (Personnel that have completed root cause training should be exempted.)	101	Provide root cause evaluation teams with a formal charter of expectations.					

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Define and implement training on evaluation (basic and apparent cause evaluation) techniques associated with equipment problem analysis to heighten expertise in this analysis area.	83	4. Update processes and procedures determined to require performance of hazard analysis to reference the applicable policy/guidelines for implementation. The guideline should provide examples of issues that warrant entry into hazards analysis.					

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<p>Define and implement training on evaluation (basic and apparent cause evaluation) techniques associated with equipment problem analysis to heighten expertise in this analysis area.</p>	<p>83</p>	<p>4. Update processes and procedures determined to require performance of hazard analysis to reference the applicable policy/guidelines for implementation. The guideline should provide examples of issues that warrant entry into hazards analysis.</p>							

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Develop and implement apparent cause training. (Suggestion is a one or two day problem solving class.) Obtain upper management approval of curriculum. Perform training for all personnel that perform apparent cause evaluations. (Personnel that have completed root cause training should be exempted.)	101	Provide root cause evaluation teams with a formal charter of expectations.		

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