

ACCELERATED DOCUMENT DISTRIBUTION SYSTEM

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR:9306160021 DOC.DATE: 93/05/27 NOTARIZED: NO DOCKET #
 FACIL:50-397 WPPSS Nuclear Project, Unit 2, Washington Public Powe 05000397
 AUTH.NAME AUTHOR AFFILIATION
 COUNCIL,W.G. Washington Public Power Supply System
 RECIP.NAME RECIPIENT AFFILIATION
 FAULKENBERRY,B. Region 5 (Post 820201)

SUBJECT: Forwards response to NRC 930414 ltr transmitting SALP Rept
 50-397/93-04 for Jan 1992 through Feb 1993.Mgt attention to
 emergency preparedness effort increased by including lead
 ctr directors in resolving problems & making changes.

DISTRIBUTION CODE: IE40D COPIES RECEIVED:LTR 1 ENCL 1 SIZE: 27
 TITLE: Systematic Assessment of Licensee Performance (SALP) Report

NOTES:

	RECIPIENT ID CODE/NAME	COPIES LTTR ENCL	RECIPIENT ID CODE/NAME	COPIES LTTR ENCL
	PDV LA	1 1	PDV PD	1 1
	CLIFFORD,J	1 1		
INTERNAL:	ACRS	2 2	AEOD/DOA	1 1
	AEOD/DSP/TPAB	1 1	COMMISSION	5 5
	DEDRO	1 1	NRR/DRCH/HHFBPT	1 1
	NRR/DRCH/HOLB	1 1	NRR/DRIL/RPEB	1 1
	NRR/DRIL/RSIB	1 1	NRR/DRPW/OEAB	1 1
	NRR/DRSS/PEPB	1 1	NRR/DRSS/PRPB	1 1
	NRR/DRSS/RSGB	1 1	NRR/PMAS/ILRB	1 1
	NUDOCS-ABSTRACT	1 1	OE DIR	1 1
	OGC/HDS1	1 1	REG FILE 02	1 1
	RGN5 FILE 01	1 1		
EXTERNAL:	EG&G/BRYCE,J.H.	1 1	L ST LOBBY WARD	1 1
	NRC PDR	1 1	NSIC	1 1

NOTE TO ALL "RIDS" RECIPIENTS:

PLEASE HELP US TO REDUCE WASTE! CONTACT THE DOCUMENT CONTROL DESK,
 ROOM P1-37 (EXT. 504-2065) TO ELIMINATE YOUR NAME FROM DISTRIBUTION
 LISTS FOR DOCUMENTS YOU DON'T NEED!

TOTAL NUMBER OF COPIES REQUIRED: LTTR 31 ENCL 31



WASHINGTON PUBLIC POWER SUPPLY SYSTEM

P.O. Box 968 • 3000 George Washington Way • Richland, Washington 99352-0968 • (509) 372-5000

May 27, 1993
G02-93-125

Mr. B. H. Faulkenberry
Regional Administrator
U. S. Nuclear Regulatory Commission
Region V
1450 Maria Lane
Walnut Creek, California 94596-5368

Dear Mr. Faulkenberry:

Subject: WNP-2, OPERATING LICENSE NPF-21, RESPONSE TO THE 1993
SYSTEMATIC ASSESSMENT OF LICENSEE PERFORMANCE (SALP)

Reference: Letter dated April 14, 1993, from J. B. Martin (NRC) to
Mr. W. G. Counsil (SS), "Systematic Assessment of Licensee Performance
(SALP)"

The Supply System acknowledges the NRC Staff's Systematic Assessment of Licensee Performance (SALP) Report No. 50-397/93-04, for the period of January 1, 1992 through February 28, 1993. We concur with your finding that the performance of licensed activities at WNP-2 is acceptable and directed toward safe facility operation. We also concur with your assessment that areas of weakness exist. Your assessment will be utilized to help direct our continuing efforts to improve our performance in all aspects of plant activities.

As requested by the reference, the attachment to this letter is the Supply System response to the SALP report. The attachment describes the steps we have taken along with planned actions to improve performance at WNP-2. Measures will be established by which we can determine whether the planned steps have been effective in improving performance. As required, the attachment addresses those areas rated by the SALP Board as Category 3. In addition, we also address improvement programs for those areas rated Category 2. Our objective is to have each functional area meet a SALP Category 1 level of performance, as does our Security program, with continued improvement.

Based on my review of the SALP report and a review of its findings with my organization, I concur with the SALP Board conclusions on the need for change and improvement in WNP-2 performance in the identified areas. As discussed in detail in the attached response, and as you will observe in the future, significant improvements in these areas will be achieved.

9306160021 930527
PDR ADDCK 05000397
G PDR



IE-40

Page Two

May 27, 1993

**RESPONSE TO THE 1993 SYSTEMATIC ASSESSMENT
OF LICENSEE PERFORMANCE (SALP)**

One of the Supply System's top priorities over the past 18 months has been to add into key management and staff positions personnel experienced in successful nuclear power plant management. We have been and continue to be successful in achieving that goal. In addition to myself, we have hired experienced personnel with records of successful performance to fill the positions of: Assistant Managing Director for Operations; Quality Assurance Director; Operations Division Manager; Chemistry Manager; Maintenance Production Manager; Corporate Radiological Health Officer; and Corporate Chemist. Joining us within the next two months will be the new Engineering Director and the new Plant Manager.

The challenge ahead of this management team, and every member of the Supply System, is to accomplish the significant changes necessary for WNP-2 overall performance to reach a SALP 1 level. Under my direction, I expect this team to set a new course for the Supply System and WNP-2. Changes in personnel and organizational performance will come about because of this new leadership and the initiatives described in our response. Given the scope of organizational and structural changes needed to reach a state of excellence, I foresee an evolutionary process that will result in sustainable, monitorable performance improvements.

One of the critical needs for our future success, as pointed out by the SALP Board, is improved support of day-to-day plant operations. Our new management team has implemented organizational changes to more closely align organization strengths with plant needs. These changes also provide for more effective management and supervision. I will briefly discuss several important issues below. Greater details of our improvement plans can be found in the attachment to this letter.

The continued procedural adherence problems noted by the SALP Board and my own staff shows inadequate senior management communication and monitoring on this issue. Effective management communication to plant personnel is clearly required. Increased supervisory interaction and monitoring provided by the revised organizational structure, in conjunction with the development of formal performance expectations, will result in marked, and necessary, improvement in this area.

Improved root cause evaluation, identification of appropriate effective corrective actions to preclude recurrence, and implementation of those actions is paramount for our success. The WNP-2 root cause analysis process will be revised to place the responsibility for evaluation/resolution of problems at the line organization level. As a result, we will rapidly respond to problems, identify corrective actions that the responsible organizations believe will preclude recurrence, and carry out those corrective actions. By placing this responsibility with the line organizations, accountability for prevention of recurrence will lie with the people who develop the corrective actions. The line organizations will be held accountable for problem recurrence. This realignment will free the current root cause personnel to monitor the process through an oversight role.

Page Three
May 27, 1993

**RESPONSE TO THE 1993 SYSTEMATIC ASSESSMENT
OF LICENSEE PERFORMANCE (SALP)**

Based on the planned changes to the root cause analysis process, I will demand improved management performance in corrective action implementation. Failure to implement a corrective action by the scheduled date is unacceptable. Where circumstances dictate that a commitment date cannot be met, the responsible manager will revise the date per Supply System procedures. In the case of commitments to the NRC, the Supply System will discuss the commitment and schedule change with appropriate members of the Staff and, where appropriate and necessary, we will docket a schedule revision. Inadequate procedural adherence and untimely completion of corrective actions reflect a lack of personal accountability. The acceptance of personal responsibility for work performed and actions taken are critical for organizational success. The acceptance of problems and failures as organizational problems is often the acceptance of single or multiple individual failures. In those instances where management or personnel performance is clearly not up to acceptable standards, dramatic steps have been, and will continue to be, taken to reinforce the expectation of personal accountability.

Past management performance has been less than adequate in long range planning. No formal, consistent, across the board process existed to rank and perform work. This has led to a misallocation of available resources, including devoting those resources to projects that only minimally support plant operations. The Senior Management Review Group sponsored development of a formal process to prioritize work, including corrective actions, based on importance to plant safety, reliability, and regulatory performance. This process will allow us to better understand the resource impact of commitments as we make them, with the resultant reduction or elimination of missed commitments. Equally important is that this process raise the priority of issues that affect plant operation. The process will also allow us to identify misallocated resources which affect efficient resolution of plant problems. A cohesive process for long range planning and work prioritization is sorely needed.

Finally, to close the loop on the planned improvements, the Supply System will establish goals and programs to measure and evaluate performance of our efforts directed to meeting these goals. These programs for monitoring performance in each of the functional areas noted in the SALP report (with Corrective Actions treated as a separate area), will consist of three parts. The first part will be to monitor the corrective actions for specific items identified by the SALP Board as addressed in our response. The second part will be to establish milestones and schedules for implementation of the broader scope programs and commitments in the attachment to this letter. This part, as well as the first part, will be for the short-term and will be discontinued when the specific items are corrected and/or the various programs are implemented. The third part will be an ongoing performance monitoring program consisting of quantitative goals, periodic evaluation of performance in meeting those goals, and identification and implementation of permanent corrective actions if the goals are not met (or modification of the goals if they prove unreasonable).

Page Four
May 27, 1993

**RESPONSE TO THE 1993 SYSTEMATIC ASSESSMENT
OF LICENSEE PERFORMANCE (SALP)**

The attachment to this letter goes into greater detail on the actions we will take to improve performance. Each of the SALP Board recommendations is specifically addressed. Responses to the specific technical examples cited in the SALP were, in almost all cases, previously docketed and the committed corrective actions completed or planned. We will use this response to address resolution of the underlying problems that provided an environment in which the specific problems could occur.

Based on my observations during the short time I have been at the Supply System, I believe the issues discussed above pose serious challenges to our success. These challenges must be met head on. Every member of my management team will provide leadership and oversight to ensure problems are effectively resolved the first time. Equally important, each and every member of the Supply System team must assume responsibility and ownership for every action taken. Only through personal ownership will WNP-2 achieve the improvements that are crucial to our success. I accept personal responsibility for ensuring these improvements are realized.

Very Truly Yours,



W. G. Council
Managing Director

DAS
Attachment

cc: JW Clifford - NRC
TE Murley - NRC
JG Partlow - NRC
JW Roe - NRC
Document Control Desk - NRC
NRC Site Inspector - 901A

Z Pate - INPO
M Peifer - INPO
K Strahm - INPO
DL Williams - BPA/399
NS Reynolds - Winston & Strawn

ATTACHMENT

Response to the 1993 Systematic Assessment of Licensee Performance (SALP) Report

A. Functional Area: Corrective Action Program (Overall)

Board Recommendations

A prime concern stated by the SALP Board is the need for an effective corrective action program that reliably identifies and corrects problems the first time to preclude recurrence. This concern, which the Supply System shares, is applicable to several functional areas. As a result, we are breaking this concern out as a separate "area." The SALP Board recommendations regarding corrective actions are as follows.

- The Operations organization needs to assure that lingering equipment/plant problems are not tolerated.
- The Board recommends that licensee management ensure long-term corrective actions are timely, fully implemented, and effective in correcting identified problems (Radiological Controls).
- Management should ensure that prompt and thorough corrective actions are taken for known plant deficiencies (Maintenance).
- The Board recommends that the Quality Assurance (QA) organization substantially improve the prioritization, tracking, and follow-up of their findings.
- Line management needs to consistently implement and complete corrective actions for known problems and effectively respond to QA audit findings. Where this does not occur, QA needs to aggressively involve senior management.

Response

1. **Problem Identification:** The first step in an effective corrective action program is consistent identification of problems. To address adverse conditions, the Supply System has had several programs in effect simultaneously within the different departments. This resulted in confusion and a lack focus. In instances identified by both the Supply System Quality Assurance organization and the NRC, problems were not brought to the attention of the appropriate level of management. This resulted in an unacceptable delay in implementation of either corrective actions or compensatory measures.

To provide clear direction to all Supply System personnel, a single corrective action program, exclusive of the Maintenance Work Request (MWR) and the Security Incident Report processes, will be used: the Problem Evaluation Request (PER) process. Procedure PPM 1.3.12, Problem Evaluation Request, will be revised by July 31, 1993 to clearly state this requirement. In addition, a review of Supply System procedures to identify other problem resolution processes dealing with plant equipment or processes will be completed by July 31, 1993. This review has already resulted in the cancellation of one redundant process. Applicable procedures will be changed by August 31, 1993 to clearly delineate the interface with the PER process. Due to the safeguards requirements, the Security Incident Report process will remain intact.

The MWR process will remain separate from the PER process. However, significant plant problems that meet the PER requirements will continue to have a PER as well as an MWR. The MWR process at WNP-2 is being converted to an on line computer process. This process will provide immediate access to MWRs for review and update. The system will begin testing in June 1993 and will be operational by September 30, 1993. The Total Exposure module of this system, which will integrate the ALARA and maintenance planning processes, will be operational by December 31, 1993. Full implementation of the computerized MWR process, including discontinuing the parallel use of the existing paper process for new MWRs, will be accomplished by December 31, 1993.

A team of Supply System personnel visited Diablo Canyon on May 17 and 18, 1993 to review their corrective action program. The goal of this visit was to identify program strengths that could be beneficial to the Supply System. Identified strengths are being evaluated and, where appropriate, will be incorporated into the Supply System corrective action program. Schedule for implementation is dependent on the scope of changes identified. Benchmarking against other plants will continue to further validate and improve the WNP-2 corrective action process.

A status report on the PER process will be provided to the Staff by August 31, 1993. This report will include the results of evaluations, and identification of any planned process changes. A status report on the MWR process changes will be provided by October 30, 1993. This report will include a discussion of the computerized MWR process and the experience gained to date with the new system. Potential enhancements will also be addressed.

2. Root Cause Identification: The second step for an effective corrective action program is accurate problem cause identification. During most of the SALP period, the Management Review Committee (MRC) had responsibility to disposition (assess probable cause and assign corrective action) PERs. Significant conditions adverse to quality were identified by the MRC and sent to the Operational Experience Assessment and Resolution (OEAR) group for a Root Cause Analysis (RCA). Formal RCA was performed for approximately 10% of the PER population. These 10% were significant conditions adverse to quality or other PERs for which management requested a RCA be performed. For the 90% of the PERs that were not significant

conditions adverse to quality, a probable cause was assessed by MRC. Some of these assessments were made with incomplete information. For this 90%, line organization resources were typically focused on completing the MRC assigned corrective actions rather than on investigation. This was due, in part, to a lack of ownership of the identified problem. This process did not always lead to effective corrective actions to preclude recurrence. For formal root causes, OEAR was also chartered with developing and reaching consensus with line management on corrective actions to preclude recurrence. This consensus approach sometimes resulted in a lack of problem/corrective action ownership.

The PER process was revised in January 1993 to assign to the line organizations responsibility for assessment of probable cause and identification of corrective action. This better assures that ownership of problems is understood. Work Control assigns the PER to a responsible organization for disposition. When the dispositioner determines that the PER represents a significant condition adverse to quality, however, OEAR performs the RCA and develops the corrective actions to preclude recurrence.

The current process may dilute ownership of significant problems through use of the dedicated OEAR group. In addition, the personnel who specify corrective actions for the 90% of the PERs that are not significant conditions adverse to quality are, in most instances, not trained in RCA techniques. The identified corrective actions do not always address the underlying cause.

Planned changes will transfer responsibility for RCA and corrective action identification to the line organization for problems, including significant conditions adverse to quality. Line organization performance of the RCA will put the responsibility with the people who understand the processes that have failed. This change will improve the ability of the line organizations to be self-critical. Corrective action program responsibility will lie with the people who will be held accountable for problem recurrence.

Implementation of this process change requires RCA trained personnel within the line organizations. Sufficient personnel within each line organization will be trained by October 30, 1993 to assume the responsibility for RCA. Additional personnel will be trained after October to increase the body of RCA knowledge.

Selected major plant problems and events, such as reactor scrams with safety system actuations, will be handled in a different manner. A multi-discipline team will be convened to investigate major plant events with the team headed by the line organization. A dedicated group trained in advanced RCA techniques will assist in analysis of complex problems, train personnel in RCA techniques, and assess the quality of RCA efforts. The Incident Review Board approach will continue to be used to gather data in a timely manner if a plant event occurs.

Beginning in July 1993 for six months, as part of the transfer of RCA responsibilities, two levels of supervisor/manager review and approval will be required for PER problem disposition and associated corrective actions. This second level review, in conjunction with the oversight role to be performed by the dedicated RCA group, will provide added assurance that the corrective actions identified will preclude recurrence.

3. Implementation: The third step of an effective corrective action program is effective implementation of identified corrective actions. As evidenced by the current backlog of work, performance in this area needs improvement. To emphasize the importance of corrective actions, the personnel Performance Plans for the Operations, Engineering, and Quality Assurance Directorates supervisory personnel are being modified to include specific goals for quality and timeliness of corrective actions. These Performance Plan changes will be completed by June 30, 1993 and will provide clear expectations for management and supervision regarding implementation of the corrective action program.

To provide a consistent approach for implementation of corrective actions and improvement initiatives, the Supply System is developing a prioritization methodology. This methodology will set priorities based on factors such as nuclear/public safety, industrial/radiological safety, plant reliability/availability, regulatory performance, and economic performance. It will thus be easier to identify, at the time work is being proposed, when resources will be available to support completion.

The Supply System Business Plan identifies the overall business objectives, strategies, performance targets and management initiatives for fiscal years 1993-1995. Many of these initiatives are directly related to the concerns expressed by the Board. The prioritization process and criteria developed by a Supply System action team, along with the insights gained to date, will be proceduralized by July 31, 1993. Prioritization of Business Plan initiatives and other plant work will allocate resources to better support plant operations.

In the past, to satisfy commitments, resources have been devoted to activities that do not directly support plant operations. Using the prioritization methodology, resource conflicts can be identified before a commitment is made, and schedules for completion can be adjusted accordingly. This will provide management with a valuable tool to help satisfy commitments on schedule. The new methodology will be fully implemented no later than December 31, 1993.

4. Management Oversight: The fourth step in an effective corrective action program is strong oversight of the program by management. Performance improvement is warranted as evidenced by overdue corrective actions and repeat plant problems. Several planned improvements are identified below.

In addition to corrective action program implementation expectations in management Performance Plans, the need for continuation of the six-month second level manager review of PER dispositions will be evaluated by January 31, 1994. These second level reviews will provide additional experience for managers and employees to better understand expectations regarding adequate corrective actions.

The Plant Operations Committee (POC) will review selected root causes and corrective actions to assess their ability to preclude recurrence for significant conditions adverse to quality. These reviews will provide plant management with additional knowledge of the effectiveness of the new RCA effort. Management will thus be in a position to require enhancements of the PER and RCA processes, based on the quality of results, when necessary. This POC review will be proceduralized by September 30, 1993.

QA will continue to perform sample reviews of PERs for process adequacy and quality of dispositions. Trending program results will also be reviewed to determine the effectiveness of PER program implementation. The results of these reviews will be used by senior management as performance indicators.

The final step for an effective corrective action program is QA oversight. This activity is discussed in Section G of this attachment, Safety Assessment/Quality Verification.

B. Functional Area: Plant Operations

Board Recommendations and Concerns

The SALP Board assigned a Category 2 rating to the plant Operations area and noted improvement in overall performance. In addition to the Board recommendations several areas of concern were noted. The Supply System concurs with the Board's assessment in this area.

The Board noted several strengths in this functional area:

Generally, performance in the plant Operations functional area improved from the previous assessment period. Licensed operator performance in the requalification program appeared to improve significantly, and operator response to events was generally good. With a few exceptions, operators also performed well during normal startups and shutdowns.

The Board recommendations in this area were:

- The Operations organization more aggressively assert its ownership and leadership role in activities affecting operation of the plant, including work control.

- The Operations organization needs to assure that lingering equipment/plant problems are not tolerated.
- Licensee management should also ensure that high expectations for the performance of licensed and non-licensed operators are established and attained.

Other concerns noted by the Board were:

- insufficient understanding or evaluation of technical issues;
- inadequate adherence to procedures;
- weakness in operator knowledge of some industry events;
- a decline in non-licensed equipment operator (EO) performance as a result of ineffective supervision; and
- Operations personnel did not perform their duties with a sufficient degree of questioning, conservatism, or formality.

Response

1. **Leadership and Ownership:** The Board's first and second recommendations are for Operations to take ownership and leadership of activities affecting operations of the plant, and not tolerate lingering equipment/plants problems. Actions outlined below will result in improved ownership of plant activities by Operations.

Several changes were made within the Operations organization over the SALP period, and other changes are scheduled for near term implementation. These changes will more effectively focus the Operations organization's resources and will support a more active role in problem resolution.

The position of Operations Division Manager was created and filled from outside the Supply System to provide new management direction. This addition allows the Operations Manager to focus on staff performance, to provide the necessary Operations interface with other organizations, and to provide leadership for emerging plant problems and issues. This change in focus for the Operations Manager assists in raising to the appropriate level of management plant problems not being expeditiously resolved.

In addition to the new position of Operations Division Manager, one of the Shift Managers has been moved to full time day shift. This position will address emerging and long standing issues to effect resolution. The individual in this position will thus provide an interface with other organizations for problems that are not immediately impacting to plant operation.

In partnership with the Systems Engineering, Design Engineering, and Maintenance organizations, Operations personnel will perform walkdowns and periodic reviews for targeted plant systems under the System Management concept. Through these walkdowns and reviews, Operations concerns and needs will be brought to light. Operations will assign a "system expert" for each of the targeted systems. These individuals will be responsible for ensuring the Systems Engineering and Design Engineering personnel are aware of concerns or changes in performance of the targeted systems. Additional details on this effort can be found in Section F of this attachment, Engineering/Technical Support.

In order to learn from outstanding performers in the industry in the operations area, benchmarking tours of a minimum of three plants will be performed by December 31, 1993. These benchmarking teams will visit outstanding plants and will review operations activities at all levels from EOs to Shift Manager. In addition, peer Shift Managers and Operations Supervisors from other plants are assisting WNP-2 in reinforcing and evaluating the Operations department performance with respect to management expectations. Finally, Operations personnel will continue to participate as INPO Peer Evaluators at other plants.

Operations recently implemented a five-year staffing plan scheduled for completion in 1997. As noted in the SALP report, WNP-2 will exit the current refueling outage with an additional operating crew to raise the total number to six. This additional crew will provide added support during heavy workload periods, and reduce the amount of overtime required. The expected workload reduction for each crew will allow for greater management skills training for supervisory personnel, and increased industry events review for licensed and non-licensed crew members.

A second goal of the five-year staffing plan is to license a sufficient number of Senior Reactor Operators (SRO) so that SROs can take temporary assignments within other departments. This will provide an Operations oriented perspective to these other departments such as Training, Maintenance, Systems Engineering, QA, and Emergency Preparedness. This will also provide the SROs with a better understanding of resources available to support plant operations.

The Operations Training Development organization will be reorganized along two lines, classroom instruction, and lesson plan development/industry tracking. The lesson plan development group will take ownership of the lesson materials and testing methods. The group will be responsible for including industry events in the lesson plans and tests. Semi-annual reviews will be conducted by Operations Training to ensure the desired focus on industry events is achieved, and to assure Operations personnel understand industry experience.

At the conclusion of refueling outage eight a new position, Shift Engineer, will be added to the Operations crew. The Shift Engineer will provide valuable engineering expertise to the crew for the evaluation of technical issues. This expertise will aid in the effective evaluation of emerging plant problems. The Shift Engineer, not responsible for ongoing operation of the plant, can provide interface with appropriate plant personnel to ensure operational problems are

resolved. The Shift Engineer will also function as the Shift Technical Advisor (STA). Making the STA a member of the Operations crew, instead of using qualified members of the Technical Support staff, enforces the management expectation for Operations ownership of the Plant.

As discussed in detail in Section D, Maintenance/Surveillance, lingering equipment deficiencies will be reduced. Plans are in place to systematically reduce the number of non-outage work requests and control room deficiencies prior to the next refueling outage.

Operations ownership of work control was enhanced during the SALP period by the transfer of this function to the Operations Division from the Maintenance Division. This change will ensure an operations focus in Work Control. The Operations department representative to the Work Control department is now matrixed to Work Control, but remains a member of the Operations department. Previously, the Operations member was transferred to Work Control. Management has also expressed the expectation that control room personnel maintain a questioning attitude. Control room staff have recently questioned Work Control about requested work authorization for activities that do not show up on the schedule.

2. **Performance Expectations:** The third Board recommendation is for Operations Management to establish high expectations for the licensed and non-licensed operators, and to ensure these expectations are met. Actions are being taken to improve the communications process and clearly communicate expectations. Each member of the Operations Division will have formal Performance Plans by June 30, 1993. These Plans will clearly define expectations for ownership of the plant and resolution of plant problems. The Plans will also include expectations for supervision of personnel including, where applicable, review of EO work in the field to ensure expectations are being met. These personnel Performance Plans will be reviewed with them by their management on a quarterly basis.

C. Functional Area: Radiological Controls

Board Concerns and Recommendations

The SALP Board assigned a Category 2 rating to the Radiological Controls area and noted generally good performance, particularly during outage periods. Several areas of concern, in addition to the Board recommendations, were noted. The Supply System concurs with the Board's assessment in this area.

As noted by the Board:

Management involvement and planning were evident in reducing exposures during a challenging R-7 outage. During the outage, the licensee successfully implemented a chemical decontamination of selected outage work areas, which saved an estimated 200 person-rem during the outage. In addition, the licensee initiated a long-term radiation source-reduction program in January 1993. Just prior to starting the R-7 outage, management had to allocate additional resources

to support ALARA planning. Management allocated resources well in advance of the R-8 outage to better support ALARA planning. The ALARA planning group actively established, analyzed, and revised goals throughout the R-7 outage. During 1991 the licensee expended 387 person-rem, and during 1992 the licensee expended 612 person-rem. The increase was largely due to the increased work scope of the R-7 outage. The licensee projected that the R-7 outage would expend 587 person-rem, but the actual R-7 accumulated occupational exposure was 470 person-rem.

The Board recommendations in this area were:

- The Board recommends that licensee management ensure long-term corrective actions are timely, fully implemented, and effective in correcting identified problems.
- The Board also encourages additional management attention to routine radiological control activities.
- In addition, the Board recommends that licensee management take action to improve the staff's performance regarding radwaste management and shipment activities.

In addition to the Board recommendations, several concerns were also noted:

- continued procedural adherence problems and failure to implement good radiological control practices, and
- weaknesses in the effluent control program led to unplanned liquid releases to the storm drain pond and contamination in the auxiliary boiler which resulted in an unmonitored gaseous release pathway.

Response

1. **Corrective Actions:** The first Board recommendation deals with the implementation of the corrective action program. The Supply System will implement the corrective action program upgrades detailed in Section A of this attachment. In addition, Radiation Protection will conduct a self assessment of previous corrective actions based on Notice of Violation responses, and Licensee Event Reports, submitted since January 1990. This assessment will determine if the corrective actions, in hindsight, are adequate and effective to preclude recurrence. This assessment will be completed by October 31, 1993.

2. **Management Attention:** The second Board recommendation was for additional management attention to routine radiological control activities. This recommendation encompasses the procedural adherence problems noted. Several initiatives are planned or have been implemented to incorporate appropriate radiation protection practices into routine plant activities. These initiatives include: 1) quarterly health physics meetings with plant radiation

area workers to discuss events, concerns, and expectations; 2) discussion of procedural compliance, including radiation protection procedures, during individual quarterly performance reviews; 3) a documented program to encourage plant personnel to focus on sound radiation protection practices and provide clearly identified disciplinary actions for repeated failures; 4) a review of health physics status at the plant status morning meeting; and 5) an overview tour process to assign formal tour responsibility to selected managers. One responsibility of assigned managers is to observe and document radiological performance.

Improved senior management focus on the radiological controls effort will be achieved by having the Radiation Protection organization report to the Corporate Radiological Health Officer who reports directly to the Assistant Managing Director for Operations. This direct senior management access will be used to address recurring performance issues and to resolve long standing radiological control problems.

3. Radwaste Management and Shipment: The third Board recommendation is for improvement in the radwaste management and shipment area. In order to improve compliance in this area, the former Radwaste Supervisor at Trojan was hired by the Corporate Health Physics support organization as a Principal Health Physicist. For the remainder of 1993, this individual will perform independent reviews of radwaste shipments to assure compliance.

A multi-step procedure review and upgrade program will be implemented in the radwaste shipping area. These steps are:

- a. The new Principal Health Physicist will perform a detailed review for compliance issues.
- b. An assessment of the radwaste program for regulatory compliance by an external evaluator.
- c. An outside consultant with expertise in waste classification and scaling factor determination is assisting with a revision of the Supply System radwaste shipping methodology. His recommendations are being validated to the current set of 10 C.F.R. Part 61 offsite sample analysis results. Upon completion of validation this new methodology will be incorporated into the applicable procedures. The results of the offsite analysis of samples are expected by June 30, 1993. Validation and verification of the new methodology will be complete within two weeks of receipt of these results. The procedure upgrades identified will be complete by August 30, 1993.
- d. In order to learn from outstanding performers in the industry in the radwaste management and shipping area, two utilities will be visited to benchmark the WNP-2 radwaste program and to identify improvement opportunities. Identified changes and improvements will be incorporated into the program and procedures. The first visit will be made by June 30, 1993. A second visit will be made in 1993.

The radwaste training and qualification program is being reviewed by Corporate Health Physics to ensure this program trains personnel to meet radwaste shipping regulatory requirements. Any deficiencies identified will be resolved with appropriate training enhancements, including additional materials and supplemental training. This review will be completed by May 31, 1993. Radwaste personnel will be provided with required training by October 30, 1993 as part of the ongoing department training program.

Procedural compliance will be enhanced through more supervisory and management emphasis, including implementation of the previously-mentioned plans to improve management communication of expectations, both during procedure revision familiarization training and during field performance of the work. Radwaste personnel have been given self-checking training and are expected to be self-critical and questioning in all activities to ensure regulatory commitments are met and procedural requirements adhered to. These expectations have been included in the personnel Performance Plans.

4. **Effluent Program:** The concerns regarding the effluent program have been addressed in several ways. The Turbine Building floor drains have been rerouted to radwaste. Procedure NOS-38, Radiation Protection Program, has been revised to require clean liquids to be monitored to environmental levels prior to release. Training on the Radiological Control Area clean liquid release requirements has been provided to responsible personnel. Procedures are now in place to allow batch releases of Turbine Building drain water to the storm drain ponds after sampling and verification of status. Periodic sampling of the auxiliary boiler and Turbine Building drain sumps is being performed. A 10 C.F.R. § 50.59 review of the auxiliary boiler release path was performed and the Final Safety Analysis Report (FSAR) will be revised in the 1993 update to identify this path. A revision to the Offsite Dose Calculation Manual (ODCM), identifying this potential release path, will be submitted to the Staff with the 1993 Annual Radioactive Effluent Release Report.

D. Functional Area: Maintenance/Surveillance

Board Concerns and Recommendations

The SALP Board assigned a Category 2 rating to the Maintenance/Surveillance area and noted a decline in overall performance. Several areas of concern, in addition to the Board recommendations, were noted. The Supply System concurs with the Board's assessment in this area.

The Board noted several strengths in this functional area:

Management was thoroughly involved in planning and executing the 1992 refueling outage. As a result, the outage was completed on schedule and radiation exposure goals for the outage were met. The integration of outage work was well thought out. Many first-time, high-risk jobs, such as chemical decontamination

of reactor recirculation piping, were completed on time with few problems. Maintenance Department support of other outage tasks, including replacement of the three low pressure turbine rotors, inspection and cleaning of heat exchangers, and numerous other maintenance efforts was good. Effective performance of plant maintenance activities contributed to a period of sustained plant operation. The surveillance scheduling program was usually effective, and a licensee-initiated assessment of the program provided for the identification and correction of numerous weaknesses.

The SALP Board recommendations in this area were:

- Management and supervision provide consistent, effective in-plant oversight of maintenance and surveillance activities.
- Management is strongly encouraged to demand improvement in procedure quality and adherence and in individual care for plant equipment.
- Management should ensure that prompt and thorough corrective actions are taken for known plant deficiencies.
- Efforts to improve forced outage planning and work control are clearly warranted.

Other concerns noted by the Board were:

- Management involvement and oversight of the forced outages that occurred between January 21 and February 12, 1993 were less critical and intrusive, resulting in challenges to safety systems (e.g., excessive discharge of the HPCS battery).
- equipment problems recurred because previous corrective actions had not been sufficiently thorough (e.g., feedwater pump governor failure, low recirculation pump motor oil level, and continuing leakage of safety/relief valves). The outages which occurred in January and February 1993 also indicated significant weaknesses in the licensee's program for the planning and control of forced outages.
- Management did not place consistent reliance on self-assessment resources to ensure quality in Maintenance/Surveillance activities.

Response

1. **Supervisory Oversight:** The first Board recommendation deals with inadequate supervisory oversight of maintenance activities. In order to better support maintenance activities, the Maintenance organization recently reorganized along functional lines, Production, Maintenance Engineering and Planning, and Support including procedures. By aligning management and supervision along functional lines increased in-plant oversight will be achieved.

Personnel Performance Plans will be written for each maintenance supervisor no later than June 30, 1993. The Plans for the Production organization supervisors will provide specific expectations relative to observing field work and providing appropriate feedback to personnel. Quarterly reviews of these expectations by management with the supervisors will be conducted to ensure the expectations are met.

In addition to the personnel Performance Plans, a Maintenance Observation program will be implemented. This program will provide weekly observations of in-progress work by key managers and supervisors. The goal of this program is to improve management involvement and oversight of day-to-day maintenance activities. This program will be in place by June 30, 1993.

2. **Procedure Quality and Compliance:** The second Board recommendation is for improvement in procedure quality and adherence, and in individual care for plant equipment. Procedural quality is being addressed through two separate programs. An upgrade of maintenance procedures is a major initiative at the Supply System. This five-year effort includes verification and validation for each maintenance procedure used to perform work in the plant. It covers approximately 1250 procedures and will complete in December 1996. The maintenance portion of the Technical Specification surveillance test procedure upgrade effort will be complete by March 30, 1994.

The Technical Specification Surveillance Improvement Project is currently underway within the Technical Support division. This effort will review each surveillance procedure to ensure that it is technically correct and satisfies the Technical Specification surveillance requirements.

In the area of procedural adherence, numerous steps were taken over the past 18 months to improve performance. Management expectations for procedure use and adherence were communicated to WNP-2 personnel. Specifically, Supply System management requires full compliance with procedures. Training was provided to maintenance personnel on these expectations. In addition, the personnel Performance Plans for the maintenance craft will include specific expectations on procedural compliance. Each craftsman will have a Performance Plan by June 30, 1993. These Plans will be reviewed individually with the craft on a quarterly basis. The Maintenance Observation program as discussed above will provide on-the-job monitoring of procedural compliance. Each of the steps outlined, along with the necessary attention to detail by Supply System employees, provide a sound basis for expectation of full adherence to procedures.

Inadequate procedural adherence and inattention to detail remain significant concerns at WNP-2. Recent trends, such as the number of deviations being written to correct procedure deficiencies, indicate some improvement. These deviations show a decreasing tolerance on the part of plant staff to "work around" or ignore procedural deficiencies. This also results in improved procedure quality. Continued improvement is clearly needed, however. It is expected that continued regular reinforcement of the 100% adherence policy will provide this improvement. The previously discussed plans to improve management communication of expectations will also improve adherence.

In the area of individual care of plant equipment, events over the SALP period point out a need for improvement. The System Management concept addressed in both the Operations and Engineering/Technical Support areas will lead to a higher sense of ownership of plant equipment. This will involve the Operations, Maintenance, Design Engineering, and System Engineering staffs.

The pre-job briefing for unusual or potentially high risk tasks will be improved to ensure potential impact on plant equipment/operations is thoroughly understood by Maintenance personnel performing work. This practice is currently being used and will be formalized by September 15, 1993. Supervisory effectiveness will be observed as part of the Maintenance Observation program.

3. Corrective Action: The third Board recommendation is for management to ensure that prompt and thorough corrective actions are taken for known plant deficiencies. The current corrective maintenance backlog is indicative of too high a tolerance in this area. Initiatives have been put in place to drive these numbers down. Some of these initiatives have been discussed previously in Section A of this attachment, Corrective Action Program.

The first backlog reduction effort was the recently implemented monthly chronic problem list. This list, updated and reviewed monthly by line management, identifies chronic problems with a goal of resolving them during the month. The chronic problem list has been effective in resolving several long-standing problems. During the month of April, significant inter-departmental cooperation resulted in the non-outage recordable control room deficiencies being reduced to less than five. For May, the chronic problems identified for resolution were: 1) Main Steam Relief Valve leakage; 2) Containment Supply and Exhaust Purge valve leakage; 3) installation of Scram Discharge Volume flushing taps to reduce radiation levels; 4) rebuild of the Reactor Feedwater 10A/B level control valves; and 5) coating of the 500KV insulators to prevent flashover.

The second backlog reduction effort is more broad based. A goal of less than 265 non-outage corrective maintenance items has been set for April 30, 1994. In addition, a goal of less than 10 recordable Control Room instrumentation non-outage deficiencies has been set. A plan to achieve these goals has been developed. The Maintenance Division Manager will monitor progress on a monthly basis.

As discussed in Section A of this attachment, Corrective Action Program, the responsibility for root cause determinations is being placed with the line organizations. Line management and the QA Directorate will provide oversight to assure adequate corrective actions are identified.

4. Forced Outage Planning: The final Board recommendation in the Maintenance/Surveillance area was the need to improve forced outage planning and work control. As stated in the SALP report, strong management involvement in the planning and execution of the 1992 refueling outage resulted in completion of the outage on schedule with radiation exposure goals met. It is clear that this same focus is needed for the planning and execution of forced outages.

Forced outage procedures will be revised to include the same type of management control used during refueling outages. This will provide the necessary level of management attention and involvement to ensure control of scope is maintained. These procedure changes will be in place by July 1, 1993. The 36-hour, 72-hour, and 7-day forced outage schedules will be in place within 14 days after returning to power from the current refueling outage. In addition, future outage critique meetings will be held by line management upon the return to power from a forced outage. This will ensure that problems encountered, along with potential actions to preclude recurrence, are discussed while the outage events are fresh.

E. Functional Area: Emergency Preparedness

Board Concerns and Recommendations

The SALP Board assigned a Category 2 rating to the Emergency Preparedness area with improvement noted in some areas. Several areas of concern, in addition to the Board recommendations, were noted. The Supply System concurs with the Board's assessment in this area.

The Board noted several strengths in this functional area:

Licensee management was usually involved in EP activities. Management responded to NRC findings indicating a need for corrective action. For example, in response to an NRC concern regarding insufficient knowledge by Operations Support Center (OSC) leadership designees of OSC functions, a Quality Action Team (QAT) was established to study the OSC in full and recommend appropriate improvements. QAT recommendations were implemented prior to the 1992 annual emergency exercise resulting in significant OSC improvements being noted during the 1992 and 1993 annual exercises.

The licensee worked closely and frequently with states, local county governments, and FEMA in resolving offsite preparedness planning issues.

The Board recommendations in this area were:

- Increased management attention to improve performance during exercises.
- Licensee management should also seek to improve the EP training program to insure that ERO personnel are requalified before training expiration dates.

In addition to the recommendations the Board also noted several concerns:

- Root cause analysis and corrective actions continue to need improvement.

- The technical adequacy and review of scenarios needs to be improved.
- A Control Room (Simulator) crew failed to properly identify and classify a General Emergency during an emergency exercise.
- During an exercise, potassium iodide was not authorized prior to emergency personnel entry into an area with suspected high iodine concentrations.
- Concerns regarding Technical Support Center readiness were raised twice during the assessment period for recurring conditions.

Response

1. **Management Attention:** The first Board recommendation is for increased management attention to improve performance during exercises. Management attention to the emergency preparedness effort has been increased by:

Testing the ability to notify on-call members of the emergency response organization. Results of each test are reported to center directors and appropriate members of management. Supervisors of individuals having difficulty receiving or acknowledging the notification tests are requested to correct this problem.

For overdue training, a letter is sent to the supervisor of the overdue individual. Additionally, a list of personnel, past due on their emergency training, is included in the monthly Emergency Preparedness report to senior management.

Lead center directors are involved in resolving problems and making changes to their respective centers. Lead center directors will continue to have responsibility and authority for their centers.

Procedural adherence expectations have been communicated to WNP-2 personnel by senior management. Non-compliance led to concerns during past drills and exercises. These expectations will be included in personnel Performance Plans.

A functional assessment of the Emergency Preparedness program is conducted quarterly by the Assistant Managing Director for Operations (AMDO) with Emergency Preparedness management. This assessment provides an opportunity to discuss progress and areas of concern.

2. **Training:** The second Board recommendation was to ensure timely training for the Emergency Response Organization Staff. The Assistant Managing Director for Operations will provide a formal policy on expectations for personnel maintaining their qualification status. This policy will be issued by July 31, 1993 and will be distributed to ERO personnel. The Emergency Preparedness Department will provide quarterly monitoring with feedback to line management regarding qualification status of personnel. Finally, administrative controls have been established to remove personnel with severely lapsed qualifications from the ERO.

3. **Corrective Action:** As stated in Section A of this attachment, Corrective Action Program, the responsibility for root cause analyses is being transferred to the line organizations. Along with this responsibility line organization personnel will be trained in RCA. This increased level of skill in root cause analysis, along with an increased focus on timely completion of corrective action, will resolve this concern. A member of the Emergency Preparedness staff will be trained in RCA by August 31, 1993.

4. **Scenario Development:** In the area of scenario development, a scenario scoping and review team will be formed to provide initial direction to the scenario developers. The team will also provide a technical review of the scenarios to ensure technical challenges are adequately modeled. This team will be activated by July 15, 1993 and will work on a part time basis to support the Emergency Preparedness staff. In addition, scenario development schedules now provide sufficient time for simulator validation prior to submittal deadlines.

5. **Simulator Exercise Failure:** In the case of a simulator control room crew misclassifying a General Emergency during an exercise, the crew was retrained and the emergency classification procedure was revised. Emergency classification requirements were emphasized in the next cycle of Operator Requalification Training. The ability to properly classify accidents was validated during our last annual exercise. The Supply System will implement the NUMARC methodology for emergency classification and the implementing document will be submitted for NRC review by January 1994.

6. **Potassium Iodide Use:** The Corporate Radiological Health Officer will provide procedural clarification on the use of potassium iodide by June 30, 1993. Emergency Preparedness will provide training on the revised procedure to Radiation Protection Managers and Radiological Emergency Managers by July 31, 1993.

7. **Technical Support Center Readiness:** Concerns regarding the Technical Support Center readiness were caused by errors in the emergency pager system and procedural inadequacies. Upgrades to the pager transmitter system are scheduled to be complete by October 31, 1993, pending FCC approval. More frequent notification testing has been instituted to ensure ERO personnel are familiar with the response process and the required actions. Finally, procedural guidance has been provided to the center directors for instances where less than full staffing has been achieved.

In addition, a task team will review the TSC material condition and will recommend improvements to management. This review will be completed by September 30, 1993.

F. Functional Area: Engineering/Technical Support

Board Concerns and Recommendations

The SALP Board assigned a Category 3 rating to the Engineering/Technical Support area and noted that the support for plant design and Operation was of variable quality. Several areas of concern, in addition to the Board recommendations, were noted. The Supply System agrees with the Board's assessment in this area.

The Board noted several strengths in this functional area:

Engineering strengths were noted in the licensee's comprehensive "Piping Design Guide," up-to-date maintenance of important drawings, and an improved drawing tracking system.

Strengths included self-identification of design problems, service water system design review and performance monitoring, resolution of switchyard problems, a comprehensive erosion/corrosion program, snubber design calculations, full implementation of system engineering walkdowns, engineering rigor in preparation of design changes, and a comprehensive setpoint program. System engineer walkdowns of automatic depressurization and containment atmospheric control systems identified problems for which corrections resulted in improved plant safety.

The Board recommendations in the Engineering/Technical Support area were:

- The engineering and technical support organizations set their priority on improving plant performance and safety by supporting plant operations.
- That emerging technical issues receive a more thorough evaluation.
- The licensee is encouraged to continue with improvement initiatives which have been undertaken in the engineering area.
- To implement an Engineering organization that is more supportive of plant operations, the Board recommends that the Engineering Director position be expeditiously filled, that the Supply System's expectations in this area be clearly established with the new Engineering Director, and that senior management assure the expectations are met.

Numerous other concerns were noted by the Board, particularly in relation to the findings from the Electrical Distribution System Functional Inspection (EDSFI), the Augmented Inspection Team (AIT) associated with the core power oscillation event of September 1992, and the multiple plant shutdowns in the January-February 1993 time period. Responses to these inspections and events were previously docketed. However, these findings, as emphasized in

the Board's recommendations, are indicative of a need to refocus the Supply System's resources in this area to better support plant operations and to effectively resolve problems. Supply System actions to achieve these goals are discussed below.

Response

1. Improve Support of Plant Operations: The first Board recommendation is to improve support of plant operations. A System Management concept is being developed consisting of enhanced system engineer involvement with inter-organizational counterparts (primarily Design Engineering, Operations, and Maintenance) to develop a team ownership concept. The initial walkdown of targeted systems will be completed prior to, and as part of, startup from the current refueling outage (R8). In support of this effort, the plant Systems Engineering organization is conducting a survey of Operations and Maintenance to determine support requirements. This will form the basis for establishing clear, unambiguous agreements on functional responsibilities. These agreements will be established by August 15, 1993.

A prioritization system to effectively integrate work activities is being developed. This system will set policies and processes for the evaluation and approval of work. These processes will be in place no later than July 31, 1993. This system will assist management and supervision, prior to accepting new work, in better understanding the impact this work will have on completion of scheduled work. The prioritization process will be fully implemented by December 31, 1993.

2. Evaluating Emerging Technical Issues: The Board's second recommendation is to assure that emerging technical issues receive a more thorough evaluation. As discussed above, a work prioritization process is under development. Through this prioritization process, work, including emerging technical issues, will be prioritized to assure it is performed commensurate with its importance to safe and reliable operation of the plant.

Personnel Performance Plans are being developed for each member of the Engineering/Technical Support staffs. The supervisor/manager Plans will include specific goals for quality and timeliness of work performed. The Plans for individual contributors will provide expectations on technical performance.

Review of industry information has been enhanced since the reactor instability event in August 1992. Boiling Water Owners Group letters or reports, NUMARC letters, and INPO letters that contain nuclear safety or plant reliability guidance or recommendations for plant operations, equipment, maintenance, or engineering are now formally reviewed through the External Operational Experience Review process.

Periodic meetings of the Assistant Managing Director for Operations, Engineering Director, QA Director, and the Plant Manager are held to discuss critical or significant issues. This forum is used to communicate emerging issues so that other organizations are informed of potential impacts.

Finally, as discussed in Section A, Corrective Action Program, the corrective action process is being simplified to use a single process. The revised Corrective Action Program will assure that problems, including emerging technical issues, are quickly brought to the attention of management and assigned the appropriate priority.

3. **Engineering Improvement Initiatives:** The third Board recommendation is to continue with improvement initiatives that have been undertaken in the engineering area. These improvement initiatives, such as the Individual Plant Examination for External Events (IPEEE), Design Requirement Documents (DRDs), Setpoint Verification program, and Technical Specification Surveillance Improvement Project (TSSIP), are continuing. It may be necessary for limited periods of time, however, to refocus resources to better support plant operational needs.

4. **Fill the Engineering Director Position:** The fourth Board recommendation is that the Engineering Director position be expeditiously filled and for senior management expectations to be clearly communicated. The new Engineering Director has been selected and is scheduled to report on July 6, 1993. The new Director has been made aware of the significant challenges and of senior managements' expectations. In order to prepare for this challenge, the new Engineering Director met with his direct reports, and plans two other trips to WNP-2 prior to his July start, to ensure there is a rapid transition.

G. Functional Area: Safety Assessment/Quality Verification

Board Concerns and Recommendations

The SALP Board assigned a Category 3 rating to the Safety Assessment/Quality Verification area with improvement noted in some areas. Several areas of concern, in addition to the Board recommendations, were noted. The Supply System concurs with the Board's assessment in this area.

The Board noted several strengths in this functional area:

Generally, the quality and depth of the QA organization's audits, surveillances and technical assessments improved during this SALP period. Consequently, the QA organization's general effectiveness in identifying programmatic weaknesses and significant performance issues remained good.

The Board recommendations in the Safety Assessment/Quality Verification area were:

- The QA organization substantially improve the prioritization, tracking, and follow-up of their findings.

- Line management needs to consistently implement and complete corrective actions for known problems and effectively respond to QA audit findings. Where this does not occur, QA needs to aggressively involve senior management. Senior licensee management needs to provide effective oversight of the QA organization and line management in these areas.
- The Corporate Nuclear Safety Review Board (CNSRB), the Plant Operating Committee (POC), and the Management Review Committee (MRC) need to become more effective and involved in the resolution of safety concerns.

In addition to the recommendations the following concern, unrelated to the corrective action program, was also noted in this functional area:

- Licensing submittals generally provided arguments to support only the positive side of the proposed change, rather than a full discussion of the positive and negative consequences with the final proposal based on the balance of safety concerns. LER quality was inconsistent.

Response

1. **Corrective Action:** Recommendations one and two, along with several Board concerns in this functional area, relate to corrective action program implementation. A corrective action program requires effective implementation by numerous organizations at the Supply System; therefore, it was addressed separately in Section A of this attachment. The Board's third recommendation and other concerns in this functional area are addressed below.

2. **Quality Assurance Oversight:** An important part of the WNP-2 corrective action program, described in Section A of this attachment, is the oversight provided by the QA organization. QA audits and surveillances are used to monitor the timeliness and effectiveness of corrective action implementation. Recently identified weaknesses in QA tracking and follow-up of identified issues highlight the opportunity for improvement in these areas.

A reorganization of the Supply System QA Directorate will place assessment personnel under a single manager. This manager will be responsible for QA assessment activities, including the evaluation and verification of corrective actions on QA identified adverse findings. This reorganization requires an amendment to the WNP-2 Technical Specifications. The reorganization will be executed within thirty days of NRC approval of the Technical Specification Amendment request submitted on May 10, 1993.

QA management, in conjunction with senior management, has developed expectations for escalation of unresolved findings. Additionally, QA management is developing expectations for follow-up on findings versus performance of new assessments. These expectations will be formally provided to assessment personnel by June 30, 1993.

Expectations for tracking and resolving adverse findings from QA assessments will be incorporated in procedures by June 30, 1993. This effort will be facilitated by a single QA Directorate procedure describing tracking, acceptance, and verification of responses for QA identified problems. This procedure will also describe the criteria for escalating unresolved issues as developed with senior management.

Performance expectations for QA assessment personnel will be refined by QA management and documented in individual Performance Plans for managers and engineers. These expectations will provide a balance between performance of assessments and follow-up on previous adverse findings. The Performance Plans will be completed by June 30, 1993. Management will evaluate performance against these plans on a quarterly basis.

The QA assessment personnel training program will be modified to incorporate expectations for follow-up of adverse findings. Current assessment personnel will be required to attend this training. New assessment personnel will complete this training prior to independent performance of assessment work. Training program development will be completed by August 30, 1993, with training completed by September 30, 1993.

3. Safety Review Effectiveness: Recommendation three deals with the effectiveness of reviews performed by the MRC, POC, and CNSRB. The Plant Manager will develop performance expectations for members of POC. The Plant Manager will then provide quarterly feedback to members and the members' management on how well these expectations are being met. The Management Review Committee is being disbanded.

In an effort to improve CNSRB effectiveness, internal and external membership of the CNSRB will be re-evaluated. The CNSRB chairman will meet with senior management to clearly define the expectations and methods for carrying them out. These expectations will then be transmitted to the members. Finally, a review of offsite review groups at other plants will be performed. Comments and ideas will be solicited from CNSRB members who are also members of other plant offsite review boards. The reviews discussed above, and development of an action plan and schedule for implementation of changes, will be completed by September 1, 1993.

4. Quality of Licensing Submittals: The Board stated a concern that Licensing submittals, including LERs, were of variable quality. Several actions will be taken to improve consistency in this area. As noted in the SALP report, several LERs were revised to update the root cause section. This was primarily due to unfinished root cause analyses (RCA) at the time of original LER submittal. A major change in the RCA process, as described in Section A of this attachment, will assist in providing timely completion of RCAs.

In order to improve the overall quality of LERs, the Supply System has initiated a benchmarking of this program against other plants' programs. This benchmarking is intended to identify areas of strength that can be emulated for WNP-2 LER development. This benchmarking effort will be completed by August 30, 1993.

In an effort to improve the level of quality of Technical Specification amendment requests, these requests are being reviewed, on an interim basis, by an independent consultant. The comments from these reviews are valuable input for the WNP-2 Licensing personnel, and will increase the quality of future submittals.

H. Performance Evaluation

To achieve the level of performance desired by implementation of the changes discussed above in each of the functional areas (including Corrective Actions), the Supply System will institute a performance evaluation program. This program will evaluate performance on a short-term and an ongoing basis.

One short-term performance evaluation will consist of monitoring the Supply System's performance in resolving the specific items noted by the SALP Board in the various functional areas as addressed in this response. When these items are resolved, this short-term program will be considered complete.

A second short-term performance evaluation will be monitoring our implementation progress for the long-term corrective actions proposed above in response to the SALP Board's recommendations and concerns. The proposed corrective actions include, for example, writing procedures, improving management communications, and organizational changes. To monitor progress, milestones and schedules will be documented, and progress toward completing implementation will be evaluated against the schedule. When each program is fully implemented, evaluation of the progress toward implementation of that program will be considered completed. In other words, this program monitors the Supply System's progress in putting these corrective action programs in place. Once the programs are in place, this form of evaluation will no longer be needed.

The ongoing evaluation program will monitor the effectiveness of the long term-corrective actions proposed above for each functional area. This program will consist of establishing 1) quantitative performance goals to be met, 2) means for evaluating performance in achieving those goals, and 3) means for identifying and correcting the root cause of failures to meet those goals. This final step could include changing the corrective action if it is not effective, or modifying the goal if it is found to be unrealistic.

Instead of instituting new programs, we will utilize existing programs to provide both the short and long term monitoring necessary to achieve success. These existing programs include the use of audits and surveillances by the QA organization, management observations, personnel Performance Plans, trending of PERs, MWRs, rework, backlogs, etc. The ongoing evaluation programs of the long-term corrective actions contained in this response will be developed to help individual managers identify weaknesses, and generic causes of weaknesses, in their particular areas. Not only will this help managers take charge of their areas, but it will direct upper management's attention to areas where assistance is most needed. Short-term evaluation actions will be established by July 15, 1993. The definition of the ongoing monitoring program will be in place by July 30, 1993. These plans will be available at WNP-2 for your review.