



**CENTERIOR
ENERGY**

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U.S. Nuclear Regulatory Commission
Document Control Room
Washington, D.C. 20555

Perry Nuclear Power Plant
Docket No. 50-440
Response to Notice of Violation

Gentlemen:

Perry Nuclear Power Plant hereby responds to the Notice of Violation contained within Inspection Report 50-440/94006 dated June 17, 1994. The inspection report documented the results of the special team inspection by the NRC Perry oversight team during a special team inspection conducted March 10 through April 21, 1994.

The response to the Notice of Violation is provided in Attachment 1. As stated in the Notice of Violation, no reply to violation 4 and 5 are required. In addition, the letter transmitting the Notice of Violation requested additional information regarding specific actions taken as a result of safety tagging errors that have occurred. This information is included as Attachment 2.

If you have questions or require additional information, please contact Mr. James D. Kloosterman, Manager - Regulatory Affairs, at (216) 280-5833.

Very truly yours,

RAS:DAH:sc

Attachments

cc: NRC Project Manager
NRC Resident Inspector
NRC Region III

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Operating Companies
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Toledo Edison

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RESPONSE TO NOTICE OF VIOLATION

1. Violation 94006-06

Restatement of the Violation

10 CFR Part 50, Appendix B, Criterion XVI, as implemented by the Cleveland Electric Illuminating Company, Quality Assurance Program, Section 17.2.16, "Corrective Action," requires that measures shall be established which ensure that conditions adverse to quality, such as malfunctions, deficiencies, deviations, defective material and equipment, and nonconformances be identified promptly and corrected. Criterion XVI also requires that the cause of the condition adverse to quality be determined and corrective action be taken to preclude repetition.

Contrary to the above:

- a. Adequate corrective actions were not taken for Condition Report No. CR 92-244, closed on January 24, 1994, regarding the hardened grease issue on ABB breakers.
- b. From 1989 to April 8, 1994, conditions adverse to quality were not promptly identified and corrected to ensure that Appendix R related emergency lighting was available for safe shutdown of the plant.

Acceptance of Violation

Cleveland Electric Illuminating Company accepts the violation as written.

Reason for the Violation

The cause of the above violation is attributed to the failure to complete timely corrective actions for identified problems. In both examples, plant deficiencies had been properly identified and documented; however, appropriate priority and actions to ensure the completion of the required corrective steps were not completed.

The need to perform periodic preventative maintenance on the ABB breakers had been identified in late 1992 by Condition Report (CR) 92-0244. As a corrective action from this CR, repetitive tasks were generated to ensure the performance of the 10 year breaker maintenance required by ABB. However, no actions were taken to ensure that these repetitive tasks were planned, scheduled, and completed.

Deficiencies in the installed Appendix R related emergency lighting had been identified through previous CRs and Quality Assurance Section audits. Additionally, an Independent Safety Engineering Group (ISEG) project report was being prepared to address emergency lighting deficiencies. Although discrepancies were appropriately identified and documented, they were not corrected in a timely manner commensurate with the importance of the equipment.

Corrective Action Taken and Results Achieved

The past ineffectiveness of the Corrective Action Program at Perry Nuclear Power Plant (PNPP) has been previously identified to the NRC as detailed in the PNPP Course of Action (PCA) transmitted by letter dated November 15, 1993. Two categories of problems were identified in the PCA concerning the Corrective Action Program that correspond to these examples.

- o Completion of the corrective action process has not been confirmed
- o Limited emphasis has been placed on the importance of timely corrective actions

As detailed in the PCA, several activities have been initiated to resolve issues related to the Corrective Action Program. These include increased emphasis on the importance of timely investigations and corrective actions. Additionally, a multidisciplinary review board comprised of senior supervisory personnel has been established to review plant Condition Reports. Improvements to the program are continuing and are intended to ensure the completion of timely corrective actions for identified discrepancies.

Specific corrective actions for the examples identified in this violation are provided below.

ABB Breakers

As a result of the hardened grease issue on the ABB Breakers, extensive corrective actions have been taken. Operability of the installed ABB breakers has been evaluated. Schedules and priorities have been established to ensure that the ABB breakers are inspected and refurbished as required to ensure a high degree of reliability for the operation of the breakers.

The evaluation of the continued operability of the installed ABB breakers was performed based upon industry events, vendor information, EPRI studies, plant experience and testing, and inspection results of PNPP breakers refurbished by ABB. Although some as-found conditions for ABB breakers have identified early stages of hardened lubrication, the operability requirements for the circuit breakers were satisfactorily met. The evaluation concluded that the ABB breakers are operable in their installed condition.

Based upon the results of the operability evaluation, PNPP has instituted a periodic maintenance schedule to ensure the refurbishment of the ABB circuit breakers. Critical breakers have been identified that are required to cycle and operate automatically in order to perform their intended design functions in accordance with specific plant conditions. Emphasis has been placed on inspecting and refurbishing these critical breakers. Fifteen safety-related critical breakers and seven non-safety related breakers have been refurbished during the current refueling outage (RFO4).

Appendix R Emergency Lighting

As a result of this condition, the following corrective actions have been completed.

- o Responsibility for the oversight of the Appendix R related emergency lighting has been assigned to a cognizant engineer in the System Engineering Section. This engineer is responsible for the coordination of activities to ensure the continued operability of the emergency lighting. This has included oversight to ensure that the identified Appendix R related emergency lighting discrepancies were repaired and actions to ensure that appropriate programmatic changes were initiated.
- o The importance of maintaining the operability of fire protection equipment has been reemphasized to plant Management/Supervision by the Plant Manager. Management expectations of maintaining a high availability of fire protection equipment and the need to treat this equipment similar to specific Technical Specification required equipment were reiterated.
- o The identified equipment deficiencies have been corrected. Additionally, the batteries in the Appendix R related emergency lighting have been replaced with larger rated batteries to address low rating margins with the original batteries.
- o Following the repairs and battery replacements, testing of the batteries has been completed to demonstrate the adequate capabilities of the installed equipment.
- o Several program/procedure enhancements have been implemented which will enhance the reliability of the emergency lighting units and ensure proper testing.

Actions to Avoid Further Violations

Planned actions to improve the Corrective Action Program as detailed in the PCA include the following.

- o A single process system for conditions considered potentially adverse to quality will be established.
- o An improved root cause investigation process that is supplemented by training will be established.
- o A trending process to assess the program's effectiveness will be implemented.

The actions that have been completed and are planned will result in a Corrective Action Program that will more adequately provide for timely resolution of identified plant deficiencies.

Specific planned actions for the examples identified in this violation are below.

ABB Breakers

The refurbishment of the remaining ABB breakers is continuing. The remainder of critical breaker refurbishments (7) have been identified and will be completed by December 31, 1994. Refurbishment of the balance of safety-related circuit breakers (46) will be completed by the end of the next refueling outage (RFO5) as based on the developed schedule.

Additionally, the Electrical Design Section will evaluate other applicable 125 VDC circuit breakers (other than molded case breakers) to ensure that all applicable preventative maintenance and repetitive tasks have been identified and implemented. This evaluation will also include the identification of any applicable vendor refurbishment requirements. This evaluation will be completed by December 31, 1994.

Appendix R Emergency Lighting

Corrective actions which are planned to be completed include the following.

- o Additional procedure changes will be implemented to enhance the capability to ensure the operability of the Appendix R related emergency lighting. System Operating Instructions (SOI) for R10 (Unit 1 and 2) and R71, Periodic Test Instructions (PTI) R71-P003 through P0010, and Generic Electrical Instruction (GEI) 117 will be revised by December 31, 1994.
- o As part of the requalification training for licensed operators, the importance of fire protection requirements will be reemphasized.
- o Additional training on the Fire Protection Program will be developed for Operator License Classes, Requalification Training, and Shift Technical Advisor (STA) Training. This training will provide background information along with information pertaining to the implementation of the Fire Protection Program at PNPP. This training will be developed and incorporated into the appropriate training plans by June 1, 1995.

Date When Full Compliance Will Be Achieved

Actions planned for the improvements to the Corrective Action Program are detailed in the PCA and will be completed in accordance with that plan. The operability of the ABB breakers has been evaluated and a schedule for refurbishment of the remainder of the safety related critical breakers has been established. The deficiencies identified for the Appendix R related emergency lighting have been corrected and successful testing of the installed equipment has been performed.

2. Violation 94006-02

Restatement of the Violation

10 CFR Part 50, Appendix B, Criterion V, as implemented by the Cleveland Electric Illuminating Company Quality Assurance Program, Section 17.2.5, requires that activities covered under the program are prescribed by documented procedures, instructions and/or drawings and that those activities be accomplished through the implementation of these documents.

Contrary to the above, activities covered by the program were not accomplished through adequate implementation of documented procedures and instructions, as evidenced by the following examples:

- a. Technical Specification functional test procedure SVI-C11-T0245-A, contained a note requiring a 5-minute warmup time prior to taking data on the Rosemount readout assembly.

During the performance of this test, the warmup time was not met.

- b. Plant Administrative procedure PAP 1201, "Control of Measuring and Test Equipment" requires that the individual receiving M&TE verify that Traveler information is correct. PAP 1202, "Calibration of Measuring and Test Equipment" requires that the person completing the test equipment calibration complete and place a calibrated sticker on the test equipment. PAP 1201 also requires that under no circumstances is M&TE to be left unattended.

The above requirements of these procedures were not met as identified by the inspector and other licensee personnel as documented in Condition Reports 94-239, 94-282, and 94-322.

- c. Perry Administrative Procedure PAP-1912, "Burn Permits For Ignition Sources," Revision 4, requires that combustible material be removed or be covered with flame retardant material within a 35 foot radius of a work area.

On April 5, 1994, brazing activities were conducted in the turbine building without having all combustibles removed or covered within 35 feet of these activities.

Acceptance of Violation

Cleveland Electric Illuminating Company accepts the violation as written.

Introduction

After the occurrence of these events but prior to the receipt of the notice of violation, PNPP responded to Violation 50-440/94004-01 by letter dated June 3, 1994. In that response, specific corrective actions were detailed to

improve overall performance in the areas of procedural adherence and procedural deficiencies. The status of these corrective actions are listed below.

The Vice-President, Nuclear has issued a policy statement that clarifies and reinforces the requirement for procedural adherence.

Meetings have been held between the Vice-President, Nuclear and site employees and between department directors and employees which included discussions emphasizing management expectations regarding adherence to procedures.

A procedure review checklist has been implemented to improve the quality of procedures.

A study of the process which governs procedure development, review, approval and revision has been completed. The recommendations from this study include activities which can improve the quality of the process and the resultant procedures. A task force will be formed to assess and develop an implementation strategy based on the recommendations.

These corrective actions in addition to the specific corrective actions delineated in the response to each example below, will improve the overall performance in the areas of procedural adherence and procedural deficiencies. Specific responses for each of the examples for this violation follows.

94006-02A - 5 minute warmup time

Reason for the Violation

The root cause of this event was personnel error, inattention to detail. The technicians performing the surveillance instruction (SVI) did not utilize positive means to verify the 5-minute warmup time, but assumed that the 5-minute time would elapse while other SVI steps were being performed.

Corrective Action Taken and Results Achieved

The technicians involved in this event have been coached and counseled concerning this event. Additionally, the results of the SVI were reviewed by an I&C engineer and the manufacturer was consulted concerning the affects of warmup time. The SVI data was determined to be satisfactory and did not require reperformance.

Actions to Avoid Further Violations

No additional actions are required for this event.

Date When Full Compliance Will Be Achieved

Full compliance has been met.

92006-02B - Control of M&TE

Reason for the Violation

Several instances were identified during the current refueling outage where Measuring and Test Equipment (M&TE) was left unmarked and unattended (e.g., CR 94-0322). These instances were evaluated collectively and root cause and corrective actions were determined based on this evaluation. The root cause of these events was attributed to inadequate procedural controls regarding the control and use of M&TE commensurate to the level of training and supervision provided to contract maintenance workers.

Incorrect calibration/limited use stickers for issued M&TE (CR 94-0239 and CR 94-0282) was determined to be caused by personnel error by the Metrology personnel. In each case, the incorrect labeling should have been detected by issue point personnel and/or the M&TE user prior to use. The M&TE identified in CR 94-0239 was not used outside its actual calibration period and an evaluation on the use of the torque wrench identified in CR 94-0282 determined that it was highly improbable that it was used on the wrong scale.

Corrective Action Taken and Results Achieved

For the instances involving the unattended M&TE, the following corrective actions were taken.

The M&TE that was identified as unattended was collected and delivered to the Metrology Lab.

A M&TE User's Guide was developed. A memorandum emphasizing the requirements for the control of M&TE and a copy of the M&TE User's Guide was issued to all site contract organizations.

Training on the M&TE User's Guide was required to be completed for contract personnel prior to receiving M&TE from issue points.

For the example involving the incorrect calibration/limited use stickers, the following corrective actions were taken.

The incorrect stickers were replaced.

M&TE available for issue was verified not to have any past due calibration stickers.

Metrology personnel involved in these events were counseled and all Metrology personnel were notified of the event.

Actions to Avoid Further Violations

PAP-1201 will be revised to improve the control of M&TE at PNPP by contract personnel and to require the issue point attendant and the M&TE User to confirm the calibration sticker and calibration due date on the M&TE Traveler prior to issuance/use. This revision will be completed by September 30, 1994.

Date When Full Compliance Will Be Achieved

Full compliance has been met by the corrective actions taken to date.

94006-02C - 35 foot exclusion zone

Reason for the Violation

The cause of this event was personnel error, inattention to detail. PAP-1912, "Burn Permits for Ignition Sources," requires that the responsible work supervisor ensure combustibles have been removed or covered within a 35 foot radius of the work area. In addition, the fire watch person is required to perform a work area inspection prior to the hot work.

In this event, the combustible material within the 35 foot radius consisted of a plastic pail containing water, small spare part boxes, and plastic bags located approximately 8 feet from the ignition source on a scaffold table. Also, a step off pad with 2 clothing stations were located approximately 14 feet from the brazing activity.

Corrective Action Taken and Results Achieved

As a result of this event, the following corrective actions have been taken:

When the combustible material was identified, prompt actions were taken in accordance with PAP-1912 to either remove the material from the 35 foot zone or to cover the material with flame retardant material.

An additional firewatch was also posted in the turbine area to ensure clear view coverage of brazing activities.

On April 5 and 6, 1994, all active Burn Permits were inspected and verified to meet shielding requirements.

A meeting was held with the work group and their contract administrator to discuss this event and the importance of combustible control during hot work activities.

Lessons learned from this event have been incorporated into the Firewatch Training Program to emphasize the importance of the duties of a firewatch.

PAP-1912 has been revised in order to further clarify the shielding requirements in relation to the 35 foot exclusion zone including the use of fire resistant guards or curtains to shield the hot work activity.

A review of the control of ignition sources was conducted to determine the depth of compliance with the 35 foot radius and/or shield requirements. This review identified good compliance with the requirements of PAP-1912.

A review of all fire reports since 1992 was conducted to determine if any fires were caused by noncompliance with PAP-1912 concerning combustible materials during hot work activities. None were identified.

Actions to Avoid Further Violations

No further actions are required for this event.

Date When Full Compliance Will Be Achieved

Full compliance was met at the time of the event by removing or covering the combustible material within the 35 foot zone.

3. Violation 94006-01

Restatement of the Violation

10 CFR Part 50, Appendix E (IV.F.5), requires that exercise weaknesses that are identified be corrected, and further requires that all training, including exercises, shall provide for formal critiques in order to identify weak or deficient areas that need correction.

- a. As of the time of this inspection, an exercise weakness concerning respiratory protection identified by Inspection Report No. 50-440/93013 (DRSS) was not corrected.
- b. At the time of this inspection, formal critiques were not always provided after annual regualification emergency preparedness training was conducted by the emergency preparedness trainer to identify any potential weak or deficient areas that would need correction.

Acceptance of Violation

Cleveland Electric Illuminating Company accepts the violation as written.

Introduction

This violation concerns two examples involving compliance with 10CFR50 Appendix E, "Emergency Planning and Preparedness for Production and Utilization Facilities." In the first example, a NRC identified weakness was not corrected and in the second example, formal critiques were not always

performed. Although both examples concerned requirements of the emergency preparedness program, the root cause and corrective actions are not related. Therefore, the response to this violation will be separate for each example.

94006-01A - Exercise weakness

Reason for the Violation

The cause of this event was a program deficiency. The weakness from NRC Inspection Report 93013 was not entered into any tracking system to ensure actions were taken to correct the weakness.

NRC inspection report items requiring a response are tracked by Perry Regulatory Information Management System (PRIMS); however, inspection items which do not require a response, such as weaknesses, have not been consistently tracked via PRIMS. PAP-0610, "Commitment Tracking Program," does not address extraction of commitments from incoming regulatory correspondence such as inspection reports.

Historically, emergency preparedness exercise weaknesses have been tracked by the Emergency Preparedness Exercise Report (EPER) and its associated tracking list. For this weakness, the 1993 EPER contained a statement that indicated that it would be tracked by the PRIMS; however, this weakness was not entered into PRIMS.

Corrective Action Taken and Results Achieved

As a result of this event, several actions have been completed. The weakness from NRC Inspection Report 93013 was entered into PRIMS and corrective actions have been taken to address the weakness.

Actions to Avoid Further Violations

In order to ensure future weaknesses from NRC Inspection Reports are captured, PAP-0610 will be revised by September 1, 1994 to require that commitments are entered into PRIMS from incoming correspondence. Additionally, NRC inspection reports received from January 1993 to July 1994 will be reviewed to verify that commitments have been entered into PRIMS. This review will be completed by September 30, 1994.

Date When Full Compliance Will Be Achieved

Full compliance has been achieved by addressing the exercise weakness.

94006-01B - Formal critiques

Reason for the Violation

The cause of this violation was personnel error, failure to follow procedures. On occasion, informal nondocumented critiques were used instead of the formal critiques required by the training manual (TMA-4117).

Corrective Action Taken and Results Achieved

The steps taken by PNPP to address site problems with procedural adherence was addressed above in the response to violation 94006-02. In this event, TMP-2302, "Emergency Plan Training Program," was revised to include the requirement for conducting course critiques in accordance with TMA-4117. Additionally, a memorandum was distributed to the appropriate training instructors reminding them of the requirement to submit formal critiques for Emergency Plan training in accordance with TMA-4117.

Actions to Avoid Further Violations

No further actions are required.

Date When Full Compliance Will Be Achieved

Full compliance has been achieved.

4. Violation 94006-10

As stated in the Notice of Violation, no reply is required.

5. Violation 94006-09

As stated in the Notice of Violation, no reply is required.

6. Violation 94006-08

Restatement of the Violation

Technical Specification 6.11.1 in part, requires that procedures for personnel radiation protection be adhered to for all operations involving personnel radiation exposure. This requirement was not adequately implemented, as evidenced by the following examples:

- a. PAP-0123, "Control of Locked High Radiation Areas," Section 6.3.4.3 states that the requester of a key for a locked high radiation area maintain possession of the key and not transfer it to another individual.

Contrary to the above, on March 19, 1994, a shift operator who was the key requester for the key to the inclined fuel transfer system (IFTS) valve room, a locked high radiation area, failed to maintain possession of the key by transferring the key to a health physics technician.

- b. PAP-0123, "Control of Locked High Radiation Areas," Section 6.3.2.1.a states, in part, that the on-duty Health Physics Supervisor verify that the entry requirements of step 6.4.1 have been satisfied before issuing any keys to locked high radiation areas. Step 6.4.1.1 states, in part, that all members of the work party be authorized to perform work in accordance with an appropriate Radiation Work Permit (RWP).

Contrary to the above, on March 30, 1994, the on-duty Health Physics Supervisor did not verify that all members of a work party to perform surveys of the IFTS valve room were authorized to perform work in accordance with an appropriate RWP before issuing keys to the IFTS valve room which was controlled as a locked high radiation area.

- c. PAP-0512, "Radiation Work Permits, " Section 6.4.3.2 states, in part, that radiation workers are required to signify their understanding and intent to comply with RWP requirements by performing the steps to log into the automated access control system.

Contrary to the above, on March 24, 1994, a contract foreman did not signify his understanding and intent to comply with the RWP requirements for entry into the RHR "A" Pump Room, a high radiation area, before entering the room.

Acceptance of Violation

Cleveland Electric Illuminating Company accepts the violation as written.

Reason for the Violation

The root cause for each of these incidents was personnel error, failure to follow procedures and perform self checking.

Corrective Action Taken and Results Achieved

Corrective actions detailed to improve overall performance in the areas of procedural adherence and procedural deficiencies was discussed in the response to violation 94006-02 above. Specific actions taken for this violation follows.

Coaching/counseling and appropriate disciplinary actions were provided to the individuals involved in the examples cited.

A Radiation Protection Section Standing Order was issued on March 31, 1994 which suspended access to Very High Radiation Areas (VHRA), until Health Physics (HP) personnel and selected Operations personnel had been retrained on the requirements for access to VHRAs. This restriction was lifted on May 19, 1994 after training was completed.

A verification of the adequacy of barricaded and non-locked High Radiation Areas (HRA) was completed to ensure personnel would be alerted to HRA conditions prior to entering the area.

Additional training was provided to Health Physics personnel on the following topics:

- Access requirements to VHRAs
- Adherence to Radiation Work Permit (RWP) requirements
- Handling of VHRA keys
- Review of procedures when performing infrequent evolutions

Additional training was provided to Operations personnel authorized to issue VHRA keys on the following topics:

- Responsibilities of the Shift or Unit Supervisor when issuing VHRA keys
- Review of procedural requirements for the control of VHRA keys

Radiation Awareness Bulletins were issued to alert site personnel of the issues relative to these incidents and management expectations to prevent recurrence.

Actions to Avoid Further Violations

Additionally, the following actions are planned.

The Quality Assurance Section will perform an independent assessment of the effectiveness of HRA controls and corrective actions taken to date. This assessment will be completed by August 1, 1994.

The Radiation Protection Technical Unit is currently reviewing and evaluating current industry practices to enhance the PNPP policy for controlling access to barricaded (but unlocked) HRAs. This evaluation will be completed by August 1, 1994.

Procedure PAP-0123, "Control of Locked High Radiation Areas" will be revised to provide additional guidance on the requirements for the issuance of keys to VHRA areas. PAP-0123 will be revised by October 31, 1994.

Date When Full Compliance Will Be Achieved

Full compliance was achieved by the immediate corrective actions taken for each event.

SAFETY TAGGING

As stated in the cover letter to the Notice of Violation, a concern involving safety tagging was identified. As requested, this attachment includes the specific actions that have been or will be taken to address the safety tagging problems.

Restatement of the Concern

Additionally, management attention is required to improve industrial safety practices, particularly in light of serious safety tagging errors that occurred after the end of this inspection period. We believe that safety tagging problems discussed with you during and at the conclusion of this inspection report period should have caused you to implement effective corrective actions and prevented the most recent safety tagging problems.

Response

The need to take aggressive corrective action to address the problems with the Tagging Program at PNPP has been recognized and actions were already under way to resolve these issues. The following is a list of actions taken and planned pertaining to the Tagging Program.

1. A training lesson plan has been prepared and presented to site personnel involved with performance of work at PNPP, the implementation of the Tagging Program, or working under the protection provided by this program in order to heighten the awareness of the magnitude and severity of the tagging program problems experienced since July 1993. The intent of this training was to elevate the concern and attention given to the implementation and compliance with the Tagging Program in accordance with PAP-1401 and to emphasize management expectations for compliance with the program.
2. A training lesson plan has been prepared and presented to personnel involved with the implementation and use of the Tagging Program to reinforce their responsibilities (both specifically noted in PAP-1401 and implied by the nature of the program).
3. A Safety Tagging Policy has been issued by the Plant Manager to emphasize management expectations for compliance with the Tagging Program. Also as part of this policy, all errors associated with the administration and/or use of the Tagging Program will be jointly reviewed by the Managers of Operations, Maintenance, and I&C. This will allow review of the facts and determination of appropriate corrective actions.
4. Selected audits have been performed of existing tagouts. These included tagouts for containment integrity, tagouts located in outside areas (exposed to weather), a sample of tagouts that were protecting workers from significant personnel hazards, and several tagouts supporting work orders with multiple scope revisions. No discrepancies were identified.

5. The number of individuals authorized to sign on a tagout, tagout rider, or temporary lift as the "Person-In-Charge" has been reduced.
6. Members of the INPO Work Management assist visit team also reviewed the Tagging Program and its implementation as part of their scope.
7. The Quality Assurance Section has performed an independent assessment of the Tagging Program and its implementation including a review of the Tagging Program by industry peers. Recommendations from this assessment have been transmitted for evaluation by the Safety Tagging Improvement Team (see below).
8. A Safety Tagging Improvement Team will be established to review concerns, findings, recommendations involving the Tagging Program. This team will be established by July 31, 1994.
9. Based on the evaluation by the Safety Tagging Improvement Team, the Tagging Program will be revised to incorporate those changes needed to improve the Tagging Program. The changes to the Tagging Program will be implemented by January 31, 1995.

The corrective actions taken up to this time are considered to be adequate to minimize the possibility of additional safety tagging problems until the reviews and program changes to the Tagging Program can be implemented.