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# Human Performance Strategy

## ***CULTURE TRANSFORMATION INITIATIVE***

**Kymn H. Rutigliano, Ph.D.**  
**Manager-Culture Transformation**

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May, 1999

B-191

## Public Service Electric and Gas Nuclear Business Unit Culture Transformation Initiative Project Plan

**Title:** Culture Transformation Initiative

**Sponsor:** Harry Keiser

**Owner:** Kymn Rutigliano

### Introduction

Our goal is simple: *to generate a fully engaged, high performing workforce/culture that will lead us to top quartile performance.*

This document is an overview of the transformation initiative that is being created and implemented at the NBU.

### Philosophy

*"Safety, Reliability, and Cost Effectiveness through People"* remains our business philosophy. What is paramount is how we implement that philosophy, engage everyone in our organization in aligning behind it, and bring that philosophy to all our actions. The keys to fulfilling on this and successfully transforming our business lie in four related arenas: **leadership, alignment, accountability, and esprit de corps.**

**Leadership as action, not position:** Highly effective, top quartile organizations have leaders at all levels and in all positions, not just in the executive or managerial ranks. People at all levels take the lead in generating effective action as a function of their commitment to producing breakthrough results that will benefit the organization. The heart of leadership is communication—speaking *and* listening that makes a difference, that calls people forth, that focuses on what's possible vs. what's wrong.

**Alignment:** High performing teams are masterful at alignment. Everyone's energies are focused in a common direction. Using the analogy of a rowing team, the more people are rowing in the same direction, the more effective and successful the team will be. Even one person rowing in a different direction, or not rowing at all, can have a significant impact on results. Alignment happens when people are willing to give up their singular points-of-view in favor of the whole. Teamwork, synergy, and ease are natural expressions of alignment.

**Accountability:** High performing teams and individuals focus on doing whatever it takes to produce great results *with integrity*. They, in essence, say: “The buck stops here.” Accountability is not imposed by directive; accountability is self-imposed because high performance demands it. Blame and finger-pointing are a thing of the past; what matters is learning from failed actions, sharing the glory of successes, and continually focusing on what’s next vs. the past. High performing teams and individuals honor their word with each other, peer to peer and at all levels from the crew to the President.

**Esprit de Corps:** Top quartile, high performing organizations have an energy, a spirit, a comradeship about them. People care about the organization and care about each other. Possibility is present. People are challenged by their work, give their best, and value their colleagues. What moves people from customary results to breakthrough performance is the power of relationship—everyone being *for* each other, in partnership for results, willing to move beyond likes and dislikes to authentic respect.

## Desired Future State

NBU team members are winners both at home and at work. At home, we enjoy a quality family life and may choose to be active in our community. At work, we enjoy being part of a winning team and the resultant *esprit de corps*. A common thread of excellence runs through the organization, from the shop floor to the boardroom. Being part of PSE&G and the NBU team is valued. Employees want to come to work—to work hard, to make a positive difference, and to have fun. Team members engage in extraordinary thinking and extraordinary action to generate extraordinary results for our business. Everyone at the NBU is proficient at what we do and has the knowledge, skills and abilities to be winners at many jobs. We are a “learning organization,” focusing on discovering new ways to be, to work, to accomplish. Supervisors are viewed as valued members of the team, acting as effective coaches and champions. As NBU team members see ourselves as causing extraordinary business results rather than as victims of circumstances. We relate to people not from the past but from the future they are committed to causing for the NBU. Diversity is not only appreciated but fostered. Open, candid communication flows throughout the organization and team members feel free to raise issues and concerns. People see themselves and others as valuable and valued. Each employee holds themselves accountable to the business goals and established work standards and each employee expects similar attitudes to be held by their associates. Peer to peer coaching is welcomed. We have a new-found emphasis on the power of relationship—teammates with each other, with their coaches and leaders, and with a common goal of achieving the extraordinary. The NBU is a tremendously satisfying place to work.

## The Approach

Utilizing the coaching and education services of Gap International, cadres of NBU team members—from the Senior Leadership Team through the entire workforce—will be trained in bringing “extraordinary thinking and extraordinary action” to their jobs, their accountabilities, and their work relationships. The focus will be on producing extraordinary results by *being, thinking, and acting* in new ways that lead to high performance.

A Culture Transformation Design Team has been formed to be the “architects” of this transformation initiative. The Human Performance Team, which has been engaged with Gap since October 1998 and whose members have been champions for the NBU’s future, will have a new charter and be expanded to include a total of 40 people. The team’s new charter is to become “coaches” to others in the organization who will participate in Gap’s “Breakthrough Thinking” programs and take on breakthrough projects. This represents an important step in the NBU receiving a “skills transfer” from the Gap consultants to our own employees.

At its off-site in mid-June, the Senior Executives, General Managers, Directors, and Design Team will reach alignment as to how we will proceed with this transformation initiative. What follows are proposed actions and timeframes for consideration.

**Plan Overview:**

**CULTURE TRANSFORMATION INITIATIVE PHASES  
(PROPOSED)**

<b>STEP</b>	<b>ACTIVITY</b>	<b>OWNER</b>	<b>TARGET START</b>	<b>TARGET COMPLETION</b>	<b>STATUS</b>
<b>PHASE A</b>					
<b>CHANGE LEADER PHASE</b>					
1	Selection of the Human Performance Strategy Team membership from Senior Leadership nominations	Bakken	9/15/98	10/15/98	Complete
2	Selection of a consultant to help create the Change Leader cadre and provide continuous coaching for sustaining change leadership in the field	Bakken	10/1/98	10/15/98	Complete
3	Training the initial Change Leader cadre	Bakken	10/15/99	11/3/98	Complete
4	Creation of Change Leader mini-projects to exercise the change leaders skills in the workplace.	Bakken	11/1/99	Ongoing	In Progress
5	Creation of Breakthrough Project involving Senior Leadership-NBU Season Opener	Bakken	12/20/98	1/29/99	Complete
6	Ongoing coaching to sustain change leaders as change agents	Bakken	10/15/99	Ongoing	In Progress
<b>HUMAN RESOURCES STRATEGY PHASE</b>					
1	Create sub-team from change leaders above to review and recommend change human resource policy and tools to align with future state of culture	Bakken	10/15/98	Ongoing	In Progress
2	Creation of Performance Partnership Program	Garofalo	11/15/98	03/15/99	Complete
3	Creation of Performance Partnership Incentive goal	Garofalo	1/15/99	03/15/99	Complete
4	Ongoing review of Human Resource policies and tools	Garofalo	10/15/98	Ongoing	In Progress

**PHASE 1(June – November 1999)**

**EXECUTIVE ALIGNMENT: SENIOR LEADERSHIP TEAM**

1	Train & Align Executive Leadership	Keiser	2/1/99	Ongoing	In Progress
2	Ongoing Executive Coaching	Keiser	3/1/99	Ongoing	In Progress
3	Monthly Executive Alignment Sessions	Keiser	7/1/99	Ongoing	Scheduled

**TOTAL ORGANIZATIONAL ALIGNMENT**

1	Create Design Team	Keiser	4/21/99	6/1/99	In Progress
2	Train Design Team	Rutigliano	6/16/99	6/18/99	Scheduled
3	Monthly Design Team Alignment Sessions	Rutigliano	7/1/99	Ongoing	Scheduled
4	Clarifying Messages to be delivered	Design Team	6/18/99	Ongoing	Scheduled
5	Developing Strategy & Feedback Mechanism to Monitor Project Success	Design Team	6/18/99	Ongoing	Scheduled
6	Establishment of Champions & Leverage Groups	Design Team	6/18/99	Ongoing	Scheduled

PSE&G Nuclear Business Unit Culture Transformation Initiative

STEP	ACTIVITY	OWNER	TARGET START	TARGET COMPLETION	STATUS
7	Deployment of Communication Tools with Leverage Groups	Design Team	6/18/99	Ongoing	Scheduled
8	Spirit & Alignment Training	Rutigliano	7/1/99	Ongoing	Scheduled
9	Feedback Loop Monitoring	Design Team	7/1/99	Ongoing	Scheduled

**CHANGE COACHES PHASE 1: FACILITATION TEAM**

1	Select remaining change leader population	Design Team	5/7/99	6/18/99	In Progress
2	Train change leaders as coaches	Rutigliano	5/26/99	8/1/99	Scheduled
3	Assign coaches to breakthrough projects	Rutigliano	7/1/99	8/1/99	Scheduled
4	Ongoing 2:1 Coaches Coaching	Rutigliano	8/1/99	Ongoing	Scheduled
5	Monthly Coaches Alignment Sessions	Rutigliano	7/1/99	Ongoing	Scheduled

**POTENTIAL MAJOR BUSINESS PROCESS BREAKTHROUGH: PHASE 1  
TO BE SELECTED BY DESIGN TEAM**

1	Industrial Safety Performance Breakthrough (0.1)	Tocci/Heller	7/1/99	TBD	Scheduled
2	IR13 Outage Breakthrough	Clancy/Iannucci	7/1/99	TBD	Scheduled
3	Risk Informed Change	Moeller	7/1/99	TBD	Scheduled
4	Red Tagging	Coursey	8/1/99	TBD	Scheduled
5	Corrective Action	DeFebo	8/1/99	TBD	Scheduled
6	1st Line Supervisors as Leaders	Hassler	8/1/99	TBD	Scheduled
7	Union/Management Partnership	Gary/Wagner	7/15/99	TBD	Scheduled
8	Maximize SAP benefits for business	Shea	7/15/99	TBD	Scheduled
9	Function to Process Orientation	McClain/Moaba	8/1/99	TBD	Scheduled
10	Reorganization	Garofalo/Page	7/1/99	TBD	Scheduled
11	Competitive Marketing	Stadler/Carlson	8/1/99	TBD	Scheduled
12	Effective Financial Support Organization	Clark	7/1/99	TBD	Scheduled

**TRAINING & DEVELOPMENT PHASE  
FULLY ENGAGED HIGH PERFORMING WORK FORCE**

5	Building A Breakthrough Enterprise-Select One Leader	Rutigliano	8/1/99	8/1/01	Schedule TBD
6	Entrepreneurs' Challenge Course-Select Five Leaders	Rutigliano	7/1/99	12/31/00	Schedule TBD
7	Training & Development Module: Breakthrough Thinking—Supt./Supv.	Rutigliano	9/1/99	12/31/00	Schedule TBD
8	Causing Change Module: The Work Force	Rutigliano	3/1/00	12/31/00	Schedule TBD
9	Breakthrough Thinking Training-As needed for building the cadre of Change Leaders	Rutigliano	8/1/99	12/31/00	Schedule TBD

PSE&G Nuclear Business Unit Culture Transformation Initiative

STEP	ACTIVITY	OWNER	TARGET START	TARGET COMPLETION	STATUS
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**PHASE 2(November 1999- March 2000)**

**EXECUTIVE ALIGNMENT: SENIOR LEADERSHIP TEAM**

2	Ongoing Executive Coaching	Keiser	3/1/99	Ongoing	In Progress
3	Monthly Executive Alignment Sessions	Keiser	7/1/99	Ongoing	Scheduled

**TOTAL ORGANIZATIONAL ALIGNMENT**

1	Monthly Design Team Alignment Sessions	Rutigliano	7/1/99	Ongoing	Scheduled
2	Clarifying Messages to be delivered	Design Team	6/18/99	Ongoing	Scheduled
3	Developing Strategy & Feedback Mechanism to Monitor Project Success	Design Team	6/18/99	Ongoing	Scheduled
4	Establishment of Champions & Leverage Groups	Design Team	6/18/99	Ongoing	Scheduled
5	Deployment of Communication Tools with Leverage Groups	Design Team	6/18/99	Ongoing	Scheduled
6	Spirit & Alignment Training	Rutigliano	7/1/99	Ongoing	Scheduled
7	Feedback Loop Monitoring	Design Team	7/1/99	Ongoing	Scheduled

**CHANGE COACHES PHASE 2: FACILITATION TEAM**

1	Assign coaches to breakthrough projects	Rutigliano	7/1/99	8/1/99	Scheduled
2	Ongoing 2:1 Coaches Coaching	Rutigliano	8/1/99	Ongoing	Scheduled
3	Monthly Coaches Alignment Sessions	Rutigliano	7/1/99	Ongoing	Scheduled

**PHASE 3(April 2000-September 2000)**

**EXECUTIVE ALIGNMENT: SENIOR LEADERSHIP TEAM**

1	Ongoing Executive Coaching	Keiser	3/1/99	Ongoing	In Progress
2	Monthly Executive Alignment Sessions	Keiser	7/1/99	Ongoing	Scheduled

**TOTAL ORGANIZATIONAL ALIGNMENT**

1	Monthly Design Team Alignment Sessions	Rutigliano	7/1/99	Ongoing	Scheduled
2	Clarifying Messages to be delivered	Design Team	6/18/99	Ongoing	Scheduled
3	Developing Strategy & Feedback Mechanism to Monitor Project Success	Design Team	6/18/99	Ongoing	Scheduled
4	Establishment of Champions & Leverage Groups	Design Team	6/18/99	Ongoing	Scheduled
5	Deployment of Communication Tools with Leverage Groups	Design Team	6/18/99	Ongoing	Scheduled
6	Spirit & Alignment Training	Rutigliano	7/1/99	Ongoing	Scheduled
7	Feedback Loop Monitoring	Design Team	7/1/99	Ongoing	Scheduled

**CHANGE COACHES PHASE 3: FACILITATION TEAM**

3	Assign coaches to breakthrough projects	Rutigliano	7/1/99	8/1/99	Scheduled
4	Ongoing 2:1 Coaches Coaching	Rutigliano	8/1/99	Ongoing	Scheduled
5	Monthly Coaches Alignment Sessions	Rutigliano	7/1/99	Ongoing	Scheduled

**POST IMPLEMENTATION**

1	Post Program interviews & comparison against baseline	Design Team	5/1/00	As Appropriate	Scheduled
2	Assessing culture & creating actions to deepen message & results	Design Team	5/1/00	As Appropriate	Scheduled

PSE&G Nuclear Business Unit Culture Transformation Initiative

STEP	ACTIVITY	OWNER	TARGET START	TARGET COMPLETION	STATUS
<b>PHASE 4 (October 2000-December 2000)</b>					
<b>EXECUTIVE ALIGNMENT: SENIOR LEADERSHIP TEAM</b>					
2	Ongoing Executive Coaching	Keiser	3/1/99	Ongoing	In Progress
3	Monthly Executive Alignment Sessions	Keiser	7/1/99	Ongoing	Scheduled
<b>TOTAL ORGANIZATIONAL ALIGNMENT</b>					
3	Monthly Design Team Alignment Sessions	Rutigliano	7/1/99	Ongoing	Scheduled
4	Clarifying Messages to be delivered	Design Team	6/18/99	Ongoing	Scheduled
5	Developing Strategy & Feedback Mechanism to Monitor Project Success	Design Team	6/18/99	Ongoing	Scheduled
6	Establishment of Champions & Leverage Groups	Design Team	6/18/99	Ongoing	Scheduled
7	Deployment of Communication Tools with Leverage Groups	Design Team	6/18/99	Ongoing	Scheduled
8	Spirit & Alignment Training	Rutigliano	7/1/99	Ongoing	Scheduled
9	Feedback Loop Monitoring	Design Team	7/1/99	Ongoing	Scheduled
<b>CHANGE COACHES PHASE 4: FACILITATION TEAM</b>					
3	Assign coaches to breakthrough projects	Rutigliano	7/1/99	8/1/99	Scheduled
4	Ongoing 2:1 Coaches Coaching	Rutigliano	8/1/99	Ongoing	Scheduled
5	Monthly Coaches Alignment Sessions	Rutigliano	7/1/99	Ongoing	Scheduled
<b>POST IMPLEMENTATION</b>					
1	Post Program interviews & comparison against baseline	Design Team	10/1/00	As Appropriate	Scheduled
2	Assessing culture & creating actions to deepen message & results	Design Team	10/1/00	As Appropriate	Scheduled

## Modules

### **Breakthrough Thinking: Leadership, Team and High Performance**

This 2 or 3-day program is about inventing a future for our organization that allows us to produce extraordinary results right now. It stimulates and generates “extraordinary thinking,” thinking distinct from the past, thinking that allows for breakthrough results. At the NBU we will utilize this program to break the grip of our assumptions about ourselves, our colleagues, our work, and what’s possible. People will begin to think thoughts they have never thought before, to examine “truths” that are limiting, and to explore uncharted territory. As we shift from “automatic knowing” to “extraordinary thinking” new worlds of opportunity open up.

### **Total Organization Alignment Program**

This module is designed to focus the thinking and action of the entire organization on the fulfillment of key strategic messages as articulated by senior leadership. The program is designed to move swiftly and incisively to register the messages in every corner of the NBU, fostering spirit and passion in people—two ingredients critical to top quartile performance. The Design Team is accountable for the Total Organization Alignment Program and is coached in monthly meetings by a Gap International executive.

### **Spirit and Alignment Workshops**

These full-day sessions are designed to engage the IBEW workforce in realizing their importance to the success of the NBU. Ownership, accountability and alignment are key areas of focus.

### **Change Coaches Training: Facilitation Team**

The five-day intensive training, followed by monthly group days and 2:1 coaching sessions, is designed to transfer coaching skills from Gap consultants to our own employees. This team of approximately 40 NBU “change champions” will be trained to coach and support breakthrough projects across the NBU. The Design Team will select 20 additional NBU associates to join the current Human Performance Team members and become the NBU’s cadre of coaches.

### **Potential Major Business Breakthrough Projects**

The list of 12 potential breakthrough projects includes areas where we see breakthrough thinking and action would significantly support our commitment to Safety, Reliability, and Cost Effectiveness through People. It is the job of the Design Team to decide on which breakthrough projects the organization will focus on and in what timeframes. Participants on breakthrough project teams will participate in “Breakthrough Thinking: Leadership, Team and High Performance” or the Entrepreneurial Challenge Course.

### **Building a Breakthrough Enterprise**

This year-long program, comprised of four 5-day intensive sessions, focuses on accessing and demonstrating distinct and exceptional power as leaders. With executives from other companies, our NBU participants will gain mastery in their ability to lead our organization into the 21<sup>st</sup> century. This program is practical, not theoretical, and focuses on each leader's own relationships and organizational accountabilities and commits to breakthrough results.

### **Entrepreneurs' Challenge Course**

This six month program (4 hour sessions every 3 weeks) is designed to have those who manage others generate breakthrough results over time through people. The course is comprised of middle-level managers from numerous companies, not just the NBU, who are committed to being extraordinary leaders. While being grounded in and coached in practicing breakthrough thinking, participants invent and fulfill on "impossible" projects. Coaching and support between sessions catalyzes unprecedented results and new levels of job satisfaction.

### **Causing Change Module**

This module consists of training sessions in targeted areas of the organization where "sacred cows" are inhibiting breakthrough results. People who attend these sessions will become engaged in new ways of thinking and acting which are essential to achieving significant cultural transformation and sustainable breakthrough results. These sessions are important to further aligning the workforce with our business goals.

### **Performance Measures**

It is the responsibility of the Design Team to determine the performance measures for this initiative and to monitor progress. This work will commence at the June 16-18 off-site. It is recommended that performance measures be tied to breakthrough projects as well as our business plan.

### **Periodic Reports**

- Monthly contract administration reports
- Monthly Training Status Reports
- Monthly Breakthrough Project Updates
- Quarterly full project reviews by Design Team

## Support staff can be a barometer of a company's state of mind

Receptionists and secretaries often give a first impression to visitors, and their outlook can affect the entire staff.

By Jane M. Von Bergen  
Inquirer Staff Writer

Whether a workplace's culture is toxic or tonic depends a lot on the attitude and leadership of workers whose place might be near the bottom of the corporate organizational chart.

And management experts say receptionists are among the lower-level employees with the highest potential to affect a company's culture.

"They can carry the company's culture on the nitty-gritty level," said Gary Blau, a management professor at Temple University.

"People get cultural cues from a lot of different sources in an organization - from lower levels and higher levels," Blau said.

Part of the receptionist's influence comes from her broad access within a company, said James Smither, an industrial psychologist and a management professor at Philadelphia's La Salle University.

"A receptionist interacts with more people than most people in the organization, and that's a subtle source of power and a subtle source of influence," he said. "She has more opportunity for influence than many other employees, including bosses."

Ross DeSimone, a business psychologist and partner with Delta Consultants in Wayne, said the tone of a company's culture was usually set by formal or informal leaders of an organization.

Sometimes, they are the same. But sometimes the formal leader, the chief executive officer, might be too isolated from the rank and file to have much influence on the day-to-day workings of a company.

"A receptionist can be an example of an informal leader," DeSimone said.

He said one of his clients gave the receptionist the title of "director of first impressions."

And while the title might have a kind of Dilbert-like quality, there's a ring of truth to it, since the receptionist can provide clues to both customers and potential employees about the nature of the organization, he said.

DeSimone said that, when companies hire him to analyze relationships at the workplace, he always carefully notices the attitude of the receptionist or the secretary.

"If the receptionist is sour, it's usually symptomatic of something else going on in the culture of the work group," he said. On the other hand, even a toxic corporate culture can be masked by an outstanding receptionist.

Smither said academicians and consultants like to talk about the idea of social capital, meaning the "quality of social connections."

"You have a lot of social capital if you have people connected that are not lines on organizational charts, but in other ways that are more on a personal level," he said.

"People exchange information more easily, data flows more frequently, and there is much less tendency to protect or hoard data.

"That can work bottom-up and not just top-down," he said.

A receptionist can build social capital and help to create a stronger, more pleasant company, he said. But a receptionist can also have an equally powerful negative influence.

"If you believe that moods are contagious like a common cold," then a "dispositionally cynical or mean-spirited receptionist can infect a whole office," Smither said.

"If she works with five people, and each of them is slapped with this [bad] mood by the receptionist, then everybody has their mood depressed," he said. "Everybody has been brought down a ratchet. There's a pervasive effect. To the extent that each person gets a little moodier, these things become mutually reinforcing."

That's why "it is so critical to nurture those people," said Gregory P. Smith, author of *Here Today, Here Tomorrow: Transforming your Workforce from High Turnover to High-Retention*, published in 2001.

To nurture them, companies need to provide a positive work environment; reward, recognize and appreciate their efforts; urge them to contribute their ideas; and continue to offer training to work toward improvement, Smith said.

"It's those people who create the company," he said. "The CEOs may come and go, but these people are the backbone and the bedrock."

Contact staff writer Jane M. Von Bergen at 215-854-2769 or [jvonbergen@phillynews.com](mailto:jvonbergen@phillynews.com).

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PROPOSED NUCLEAR LEADERSHIP TRAINING

*Leadership Learning Center*

**MEMO**

TO: Jim Reid

FROM: Johanna Bishop and Stormi Carlson

DATE: January 6, 2003

RE: Proposed NTC Leadership Program

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Jim: As per our conversations last Friday and this morning, these are the suggestions we have to offer for a comprehensive, in-house leadership program. As we discussed, a "sheep-dip" approach is rarely effective; we need to infuse leadership behaviors throughout the people and the organization. For this reason, we suggest the following approach:

1. Develop a Leadership Charter
2. Develop a Comprehensive Leadership Curriculum to be delivered in-house
3. Suggestions for Implementation
4. Create of a Leadership Behaviors Rubric
5. Offer leadership training for represented employees

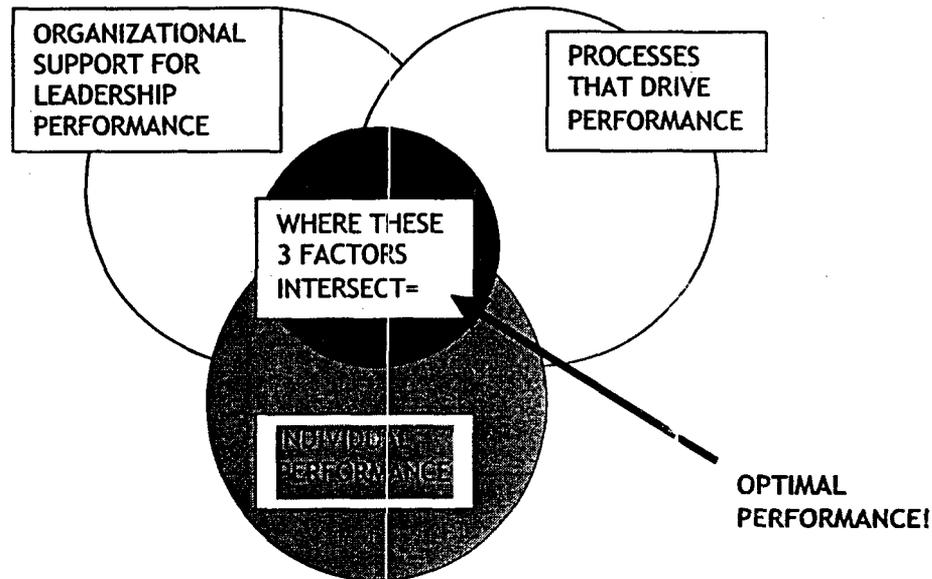
**1. Develop a Leadership Charter** (business plan) to answer the following:

- What is our leadership mission?
- What do we want our supervisors and managers to be able to do?
- How will we know whether supervisors or managers are achieving or attaining the goals specified in the leadership charter?
- How will we gather and monitor the necessary performance information?
- How will we set and measure progress toward goals?

## PROPOSED NUCLEAR LEADERSHIP TRAINING

### Leadership Learning Center

**2. Comprehensive Leadership Curriculum-** a comprehensive leadership curriculum must be available to all employees, represented as well as MAST associates, regardless of rank. This is necessary in order to infuse leadership expectations and behaviors throughout the organization. Leadership training and development needs to be supported at all levels as shown in the following diagram:



The depth and breadth of leadership development training will be determined by the business needs of the organization and its management.

**Leadership Development/ Training-** a comprehensive curriculum shall include:

- Leading and managing others: change management, understanding self and others, leading and managing the work, motivation, etc.
- Business acumen: resource allocation, organizational culture, organizational strategy, business development, business management internal/external awareness, customer relationships, human resource management.
- Managing information and knowledge: use of information technology, knowledge management, leading learning and on-going process improvement; information security, using change management.
- Personal effectiveness: cognitive skills, relating to others, personal capabilities.
- Discipline specific: broad understanding of the discipline (systems thinking), communication and advocacy, management policies, understanding enterprise strategic plan

## PROPOSED NUCLEAR LEADERSHIP TRAINING

### *Leadership Learning Center*

#### **3. Suggestions for Implementation:**

**Leadership Qual Cards-** attach leadership development to a qual card so that each person is responsible for maintaining his/her leadership development.

- 360 degree feedback assessments are conducted as an initial assessment of leadership skills development.
  - This allows for individualized leadership development.
  - Periodic 360 degree feedback is conducted to assess progress (usually once a year).
- Components of leadership development are completed by individuals within a specified time frame (i.e. three years).
  - Leadership development shall be offered through:
    - Classroom settings (formal training);
    - Workshops (less formal than training, but oriented to solving specific problems);
    - Recommended reading list (this will be an annotated reading list people will be encouraged to read and followed up with questions/ quizzes);
    - Discussion groups (these will be focused around specific issues and share insights from readings from the recommended reading list);
    - Independent study:
      - CBT based modules,
      - Reading packages, or
      - Individual development plans,
      - Mentoring programs;
    - College courses; and/or
    - Vendor training.
- When all leadership quals have been completed, participants will engage in a continuing training/ leadership development program. The intent of this program will be to keep the leadership focus fresh in their minds and instill a leadership performance behavior.

**PROPOSED NUCLEAR LEADERSHIP TRAINING**

*Leadership Learning Center*

**4. Leadership Behaviors Rubric-** create a behavior continuum of leadership behaviors ranging from developing leadership behaviors to accomplished (polished) leadership behaviors. The purpose of this rubric is to define specific leadership behaviors across a development span so that leadership behaviors are clearly defined.

Example: Suppose you want to assess how well a leader values the viewpoints of others.

Value Others' Viewpoints					
Behavior Criteria	1	2	3	4	Total Points
Listen to Other Team Members	Dominates- Is always talking-- never allows anyone else to speak.	Usually doing most of the talking-- rarely allows others to speak.	Listens, but sometimes talks too much.	Listens and speaks a fair amount.	
Cooperate with Team Members	Usually argues with other members of the team.	Sometimes argues.	Rarely argues.	Does not argue with team members.	
Make Fair Decisions	Usually wants to have things this/her way.	Often sides with favorite colleagues instead of considering all views.	Usually considers all views.	Always helps team to reach a fair decision.	

The points would simply help to indicate how weak or how strong an individual is in this area.

**5. Open Enrollment Leadership Training for Represented Employees-** a menu of training courses shall be available for all employees. These courses will include, but not be limited to:

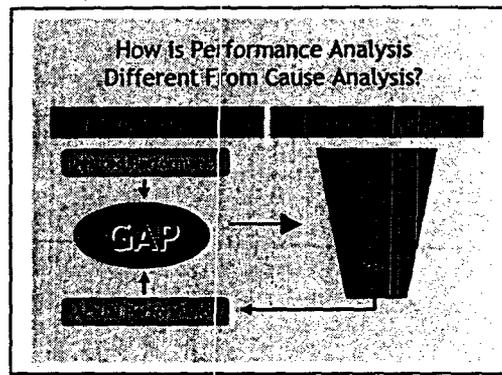
- Assessing One's Personal Communication Styles
- Leadership Lessons from Great Leaders
- Respecting Diversity
- Managing Conflict Within Organizations and groups
- Effective Communications
- Powerful Presentation Skills
- Team Building
- Influencing Others
- Group Dynamics
- Leadership Theory
- Mentoring, etc.

Developing a comprehensive curriculum and standards of leadership behavior will infuse leadership into the organization at all levels.

## Analysis Plan Leadership Development for Operations Supervisors

This analysis plan was developed to provide a systematic approach to assessing the need for leadership development within the ranks of Operations Supervisors. When carried out, the purpose of this analysis plan is to provide results that will guide future Ops Supervisors' leadership development.

The focus of the analysis will be to determine the gap between current and desired performance. After the gap has been determined, the next step will be to find out what causes the gap (a graphical representation is shown below).



In order to conduct this analysis in an efficient manner and thus avoid "analysis paralysis," the following questions are suggested as a guide in conducting this analysis:

- Are Ops Supervisors ready to meet the challenges imposed by PSEG Nuclear's business plans and goals?
- What are some indicators of inadequate performance?
- What are the competencies of exemplary performers?
- What is the relationship of the Ops Supervisor's work as defined in the job description and quality performers?
- What is the performance level of typical Ops Supervisors? How does their performance differ from the exemplary? What competencies are they missing?
- Is the performance level of the organization competitive with that of its competitors?
- How do identified performance problems hinder the organization's goals?
- What is causing performance below mastery level? How can these be eliminated?
- How can performance improvement boost the productivity of the workforce?

KJAN  
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## Managerial Rules of Engagement

### Fundamental Principles

1. Each and every PSEG Nuclear Employee has a moral obligation to achieving the highest standards of nuclear safety.
  - a. Procedures are rigorously adhered to, or changed if necessary.
  - b. "0" Tolerance for equipment problems that threaten the achievement of our business objective of Top Quartile Performance (Safety System Availability, Force Outage Drivers or Capacity Factor, Or Cost Objectives)
  - c. Top quartile performance in Radiological Exposure
  - d. Maintenance of NRC Cornerstones of Safety in a Green Status
  - e. Minimizing environmental consequences of our operations, both radiological & non-radiological
2. Each and every PSEG Nuclear Employee has an ethical obligation to achieving the business objectives established in the Annual Budget & Business Plan
  - a. Plan your work, work your plan
  - b. Meet your commitments, deliver on promises
  - c. Ask for help
  - d. Strict adherence to authorization & internal control policies
3. Maximize the effectiveness of the utilization of company resources
  - a. Ensure that your efforts are aligned with the organizational objectives
  - b. Nobody owns a budget; the nuclear department has stewardship over a pool of resources that are allocated to maximize the achievement of the overall business objectives. Every person who has stewardship of company resources is constantly refining and analyzing if those resources are better applied elsewhere in the organization.
4. Maximize the effectiveness & utilization of the people within the organization
  - a. Every worker understands what high standards are expected in their job performance, and how those high standards can be achieved
  - b. No person may be assigned work for which they are not fully qualified to do so
  - c. Training is viewed as a critical enabler of results. Line supervisors actively are enrolled in maximizing the effectiveness of training.
  - d. Processes that waste time & energy of people are relentlessly refined and improved

### Rules Of Engagement

In pursuit of these 15 key principles the following behaviors are expected of every employee and supervisor:

#### Inquiry

# Management Human Performance Competency

## Desired Outcomes

All leaders within the organization will demonstrate to a high level of proficiency, the following attributes:

1. Leaders Facilitate Open Communications
  - a. Communicate individual roles, responsibilities, expected behaviors, results & standards in clear, unmistakable terms.
  - b. Cultivate an atmosphere of open communications. Leaders listen to what others say, as well as how they say it. They encourage individuals to identify weaknesses with organizational processes, such as training program deficiencies, or an inadequate labeling process, that could create the conditions for error. Leaders establish high levels of trust to encourage individuals at all levels to seek assistance and share and learn from mistakes.
  - c. Challenge shared values, assumptions, and beliefs that potentially breed complacency. Leaders continually monitor organizational processes, values, and problem solving methods to detect organizational weaknesses that could affect the workplace. For instance, differing opinions and ways that break with tradition (business as usual may not be encouraged by some individuals.) Consequently, flaws in important decisions or erroneous assumptions might go undetected.
2. Leaders Promote teamwork to eliminate error likely situations and strengthen defenses.
  - a. Explore tasks to identify potential error likely situations. Leaders actively consult others about conditions causing error-likely situations or flawed defenses for specific tasks and evolutions and the organizational weaknesses that may create them.
  - b. Reinforce uniform adherence to high standards. A sense of vulnerability to error uneasiness toward the possibility of error – is vigorously advocated to promote the need for uniform adherence to high standards. Individuals who maintain strict adherence to operating limits and procedures receive positive reinforcement.
  - c. Confirm that front line workers accurately perceive the potential consequences of unsafe behaviors. This especially holds true for experienced personnel who unknowingly possess a sense of invulnerability to error. Long periods of successful performance foster complacency, potentially blinding individuals to error- likely situations and their potential consequences. Without timely warnings such as the

sharing of operating experience, people can become careless or engage in risk taking behaviors.

- d. Resolve conflicts between individuals or among work groups. Disagreements create distractions that can complicate plant activities important to nuclear safety. Leaders place a high priority on identifying personality conflicts within work teams and on taking actions to resolve conflicts promptly.
- e. Verify that individuals possess capabilities to achieve task requirements. Leaders compare mental and physical task demands and work environment factors with the capabilities and limitations of workers to identify potential mismatches. Such mismatches create error likely situations.
- f. Minimize unfamiliarity among member of a crew. A greater willingness to challenge and peer checks exists when team members are comfortable with each other.
- g. Compensate for weaknesses in supervision, training or procedures before conducting work. A supervisor should closely monitor an activity if an individual is performing a task important for nuclear safety for the first time or has not performed the task recently. The availability of supervision is reviewed before the work is conducted. Leaders should consider postponement of activities important for nuclear safety if a balance of supervision, training, and procedures cannot be established.

3. Leaders search for, and eliminate organization weaknesses that create the conditions for error.

- a. Solicit and act on feedback from workers about problems that may lead to error. Worker knowledge about the work environment is a respected source of information about jobsite conditions. Individuals are actively encouraged to identify problems through means such as post job critiques, voluntary reporting systems, and deficiency reports.
- b. Determine fundamental causes of performance problems. Leaders focus attention and energy on preventing recurrence of organizational weaknesses creating conditions that provoke error and weaken defenses.
- c. Monitor trends in plant and human performance. Leaders can determine organization weaknesses from broader trends of data derived from plant events, self-assessments, and voluntary reports. In some cases, error trends may appear cyclical.

4. Leaders reinforce desired jobsite behaviors

- a. Specify behaviors important for task success. Leaders can carefully identify results and required behaviors in work procedures for tasks important to nuclear safety. "Skill of the craft" is explicitly determined, not assumed. Leaders reinforce workers to proceed with a task only if they know exactly what is to be done.
- b. Reinforce desired individual behaviors at every opportunity, especially actions related to nuclear safety. Rewards & discipline are tied to

specific behaviors. Reactor safety is communicated as a personal and moral responsibility, and conditions that entice people to engage in unsafe behaviors are vigilantly eliminated.

- c. Monitor & coach workers through firsthand observation, active listening, and questioning. Leaders know their people and understand their strengths and weaknesses, especially as they related to assigned tasks. They interact with the workforce in the field, reinforcing expected behaviors and resolving emergent human performance problems. Leaders monitor the level of attention exhibited by individuals performing work at the job site, and if necessary, arrange for appropriate assistance to maintain focus on the task at hand.
- d. Stop Unsafe Behaviors. Leaders use specific and timely feedback methods that enable individuals to change their behaviors. Fair-minded accountability throughout the organization fosters teamwork and a spirit of continuous improvement.
- e. Participate in training program activities. Leaders monitor and provide feedback to improve training program quality as well as to coach and reinforce individuals who meet or exceed behavior expectations and standards of performance. During training activities, leaders guide workers on how actions or inactions influence reactor safety and on the potential consequences of mistakes. They give particular attention to recognizing error likely situations and flawed defenses during tasks important for nuclear safety.

5. Leaders Value The Prevention of Errors

- a. Promote nuclear safety as the overriding priority. Leaders insist on the careful consideration of protecting the reactor core in all decisions and actions. Conflicts between daily operational pressures and nuclear safety standards are consistently resolved to maintain nuclear safety as the first priority.
- b. Encourage candid acknowledgement of personal limitations. Leaders promote an environment in which individuals are comfortable revealing circumstances of a personal nature that may influence jobsite performance, especially those concerning activities important to nuclear safety. Example limitations include: lack of specific knowledge, family related concerns, or health related matters.
- c. Assign individuals to tasks using established criteria. Leaders fill positions with highly trained, fully qualified individuals who possess the knowledge, skills, and attitudes needed to perform work in a cautious, questioning manner. The qualifications should be documented and used to make independent work assignments.
- d. Incorporate defensive measures into tasks important for nuclear safety to accommodate organization wide distractions in the workforce. Changes related to downsizing, mergers, management turnover, regulatory focus, or new programs could potentially divert individual attention from the task at hand.

- e. Monitor and modify their own behaviors to be consistent with the values of the organization. A leader's values and beliefs are readily recognized by simply observing his or her actions associated with the following situations:
  - 1. What is paid attention to, measured, or controlled
  - 2. Reactions to incidents or crises
  - 3. Coaching interactions
  - 4. Criteria used for positive reinforcement and discipline
  
- 6. Management Fosters A Culture That Values The Prevention Of Events
  - a. Implement organizational process so that people do not experience undue haste. Effective planning & coordination of work activities, coupled with clearly communicated priorities ensure that production schedules can be accomplished without creating inappropriate schedule pressure.
  - b. Provide individuals with opportunities to work with positive role models.
  - c. Simplify work processes. Processes are designed and maintained simple and easy to see. Individuals cannot repeatedly overcome inefficient or illogical processes. Leaders see that individual performance is not burdened by ineffective coordination among work groups, unrealistic time demands, inaccurate procedures, or distractions They closely monitor interfaces between functional departments, such as process handoffs, to verify effectiveness and efficiency.
  - d. Eliminate "workarounds". Leaders avoid long-term reliance on manual compensatory actions. Work control processes support systematic identification and correction of "workaround" conditions.
  
- 7. Leaders strengthen the integrity of defenses to prevent or mitigate the consequences of error
  - a. Facilitate the free flow of information among work groups as well as individuals. Obstacles in communication are vigorously eliminated. Leaders promote candid communication in conjunction with other defenses to strengthen a plant's resistance to events.
  - b. Delegate authority to the lowest competent level in the organization. Multiple layers of review and approval weaken accountability and dilute ownership.
  - c. Develop procedures with a clear logical sequence of tasks that make them understandable to the user.
  - d. Communicate policies for procedure use and adherence.
  - e. Verify the integrity of defenses, especially for tasks important for nuclear safety. Leaders explicitly review defenses for a specific task (multiple safeguards equipment trains, interlocks, physical barriers, supervision, procedures, and safety consequences of errors) to verify their ability to prevent errors and events. They do not rely on an individual as the only defense against undesirable consequences. Unusual equipment or component lineups or deliberate disabling of physical defenses are avoided.

- f. Design work processes and allocate resources to facilitate supervisor's time in the field. Meetings and administrative requirements are simplified and shared or delegated so as not to overburden first line supervisors.
8. Leaders Preclude The Development Of Error Likely Situations
    - a. Train workers, supervisors, and leaders to recognize error likely situations.
    - b. Alert workers and supervisors to key task decision points.
    - c. Institute processes for retraining on infrequently performed tasks before the tasks are performed.
  9. Leaders Create A Learning Environment That Promotes Continuous Improvement
    - a. Conduct self-evaluations to measure and improve organizational performance. Use self-evaluation to compare actual performance with industry standards of excellence and management expectations to identify organizational weaknesses.
    - b. Learn from error. Regarding operating experience reports, leaders remind everyone that "it could happen here". Lessons learned and their application to specific tasks is communicated in a timely fashion. The content of training is derived, in part, by an analysis of the errors that could occur.

### Knowledge Requirements

Personality Types & How Personality Affects InterTeam Performance

Problem Solving & Decision Making

Self-Awareness -- Strengths & Weaknesses, Personality Type & Motivators

Thought Processes & Others Perceptions

Motivation

[Human Information Processing

Physiology -- Stress, Fatigue, etc.

Individual Culture Differences

Understanding Roles -- Leadership/Followership

Human Error

Defense In Depth Theory

## Individual vs. Group Behavior

## Conflict Management

## Skills

### Communications

- Transferring Messages clearly, accurately, adequately, and timely – oral & written
- Active & Passive Listening
- Assertive Behavior – (*Not aggressive, but positive, confident, respectful, empathic, persistent, clear, specific, questions, listens, understands, open honest, expresses feelings, states needs, compromises, relaxed*)
- Questions/Checking Understanding
- Aware of, and manages own body language
- Reading of body language
- Demonstrating empathy
- Giving & receiving feedback constructively
- Technical information processing

### Teamwork

- Team membership & developing teams
- Developing effective relationships
- Motivating self & others
- Developing team members
- Disclosing honest feelings & thoughts
- Coping with anger
- Supporting others without absolving responsibility
- Conflict Management
- Coaching
- Patience
- Recognizing & coping with stress, fatigue, and other performance reducing states in self & others
- Relaxation

### Task Management

- Situation Awareness
- Problem Solving
- Decision Making
- Problem Prevention
- Planning
- Time Management
- Delegating & Workload Management
- Monitoring/Vigilance – Active & Passive

**Taking Action  
Prioritizing  
Interaction With Technology & Integrating Technical Input**

**Attitudes**

**Belief that the principle interacting groups (Ops, Maintenance, Work Control, HP, Chemistry, Engineering, Business Support) should work together as effectively as possible**

**Belief that good Management Human Performance prevents incidents and accidents, improves the working environment, improves results, and is consistent with good business practices.**

**Are committed to continuous self improvement professionally**

**Are committed to ensuring self and crew perform to their maximum potential**

**Have self-respect and respect for others**

**Understand the importance of attention to detail**

**Are willing to take full responsibility for giving and receive the correct information and messages**

**Believe in being open and honest**

**Do not believe in stereotypes**

**Are willing to take responsibility for decisions and support the decisions of the team**

## Management Practices

1. Hold biweekly (minimum) staff meetings.
  - Clearly communicate reverence for nuclear & reactor safety, and how it is expected to be applied
  - Clearly communicate priorities & expectations for conduct of work, including compliance with industrial safety guidelines
  - Discuss operating experience & application for work being conducted
2. Participate in accredited training
  - At least once every cycle, attend classroom, conduct an OJT, and perform an OJE
  - Clearly communicate management expectations & standards, and application of accredited training
3. Perform self assessment to industry standards monthly
  - Include management standards & industry standards of excellence as reference criteria
4. Spend at least 50% of your time "In The Field"
  - Reinforce desirable behaviors, correct inappropriate behaviors on the spot
  - Provide supervisory feedback on inappropriate behaviors
  - Review procedure use & application
  - Review PPE use & application
  - Consciously review & discuss error likely and unsafe conditions
  - Discuss "High Standards" - What does it look like with the crew
  - Review application of error reducing techniques
    - Communicate Accurately & Frequently Using Three Way Communication With All Affected Station Groups
    - Self Checking
    - Peer Checking
    - Focus On The Task At Hand
    - Expect Success, But Anticipate Failure
    - Take Time Needed To Do The Job Right
    - Monitor Vital Parameters
    - Stop The Task When Uncertainties Arise
    - Provide Feedback Into Corrective Action Program At The End Of Each Task

*Employees* have the obligation to ask for clarification regarding uncertainty that they may have associated with task completion, uncertainty with respect to the standards of performance, or uncertainty about the results expected. Employees are expected to seek out all information that is necessary to successfully complete a task to Standards of Nuclear Excellence.

*Supervisors* will be open and forthright with discloseable information, respectful of confidential information. Supervisors will not exhibit behaviors which might "shutdown" employee inquiry. Supervisors will pursue answers to employees questions, followup, and take responsibility for being the primary contact for employee information.

#### **Advocate**

*Employees* are expected, within the constraints of their knowledge, training, and experience, to thoughtfully consider all of the relevant information and take decisive actions that are consistent with the overall organizational objectives. When substandard results are obtained, the employee has the primary accountability for a critical self assessment with regard to the decision making process. Employees are expected to stand for what they believe in.

*Supervisors* will be respectful that the employees gave due consideration. Supervisors are expected to hold employees to the highest standards of Nuclear Excellence. When substandard results are obtained, the critique will focus on the decision making process, not the person. Supervisors are expected to stand for what they believe in.

#### **Initiative**

*Employees* will take personal responsibility and accountability for achieving results, both personal and organizational. There is no place for "it can't be done". In all cases, organizational results will take precedence over personal objectives.

*Supervisors* will respect and encourage personal initiative, and not feel threatened or intimidated. Initiative taken by employees that is results oriented, and consistent with the PSEG Nuclear Fundamental Principles will be recognized and rewarded.

#### **Conflict Resolution**

*Employees* recognize that differences of opinion & perspective generate critical thought that coupled with action, renders improved results. Different views are welcomed. There is no place for "we've always done it that way" or "we don't do it that way."

*Supervisors* are responsible for creating and fostering an environment where differences are openly expressed, actively considered. Supervisors are responsible for ensuring that unhealthy conflict is uncovered and quickly resolved.

### **Critique**

*Employees* recognize the value of feedback and critical self assessment. External feedback is actively sought. Self assessments to the highest industry standards are frequently conducted. Actions are taken to close performance gaps. At the completion of EVERY task, a deliberate, critical analysis is performed with the objective of determining "How Could It Be Done Better Next Time?"

*Supervisors* are the principle provider of performance feedback. Supervisory feedback is critical, frequent, fair, and honest. The delivery of substandard results is not tolerated.

## SOER EVALUATION GUIDELINE

### Organizational Effectiveness/Learning Organization SOER 02-4, Reactor Pressure Vessel Head Degradation at Davis-Besse Nuclear Power Station

#### Recommendation 2 Evaluation Guidelines

1. Review the station's self-assessment plan(s) to ensure that the plan(s) are sufficiently broad in scope to address the minimum attributes identified in recommendation 2 (a-e) and that personnel conducting the self-assessment have the requisite experience. Consider the following:
  - Plan includes *Principles for Effective Operational Decision-Making* or *Safety Culture Performance Objectives and Criteria* as the bases for performing the assessment.
  - Leadership skills and approaches necessary to achieve and maintain the proper focus on nuclear safety are assessed.
  - Expertise of the individuals conducting the assessment is sufficiently broad to allow them to effectively evaluate leadership and worker skills and behaviors, and to assess across the technical organizations.
  - The assessment should include some participation from outside the utility company to gain industry perspective.
  
2. Review self-assessment reports/results to determine the effectiveness of the assessment. Review for the following:
  - Have the results been reviewed by senior plant and executive managers?
  - Have strengths and weaknesses been clearly identified?
  - Have the weaknesses been documented in the corrective action program and the appropriate priority assigned for resolution? Are corrective actions defined and assigned to an individual with a due date? Are corrective actions on track for completion?
  - Have the self-assessment results been clearly communicated to the station staff?
  
3. Determine if discrepancies exist between the strengths and weaknesses identified in the self-assessment report and the evaluation team's results, specifically in the following areas (recommendation 2, items a-e):
  - Employees readily identify and report degraded conditions. Review corrective action documents and performance indicators. Interview employees.
  - Station personnel pursue resolution of important and long-standing equipment and materiel problems through a review of EP&MC.
  - Management is involved in important plant activities. Interview workers and managers. Review management observation reports. Observe manager interactions in the plant and at meetings, such as corrective action and system health review meetings.

- Managers seek critical feedback from both internal and external sources.
- Events determined to be significant are recognized and aggressively addressed.  
Review corrective action program.

Consider discussing these points during a team analysis meeting.

4. Interview managers and workers to determine if the strengths and weaknesses identified by self-assessments are accurate.
5. Review the station's self-assessment guidance document and plans for future assessments to determine if ongoing self-assessments incorporate similar objectives as recommendation 2, items a-e.

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9/2/2003

## SOER EVALUATION GUIDELINE

### Organizational Effectiveness/Learning Organization

SOER 02-4, Reactor Pressure Vessel Head Degradation at Davis-Besse Nuclear Power Station

#### Recommendation 3:

Identify and document abnormal plant conditions or indications at your station that cannot be readily explained. Pay particular attention to long-term unexplained conditions. The sources for this information might include the corrective action database as well as discussions with experienced plant personnel. Include unexplained abnormal plant conditions as part of the case study discussion of Recommendation 1.

- a. Once abnormal conditions are identified, thoroughly investigate the causes to confirm there is no adverse condition that could impact safety or reliability. Evaluate the potential effects of these abnormal conditions in the aggregate as well as individually.
- b. Evaluate the abnormal conditions for worst-case outcomes, and use that information to help prioritize actions to identify and correct the causes.
- c. Establish a method to ensure that senior management is made aware of significant abnormal conditions in a timely manner.
- d. Verify that significant abnormal conditions are investigated to determine their root causes, evaluated for their actual or potential effects on plant safety and reliability, and resolved in a manner that is both timely and prevents recurrence.

#### Basis

The CRDM nozzle leak and the wastage in the RPV head went undetected for several years, although symptoms of leakage and corrosion were present. Corrective action reports were not reviewed for recurring problems or for long-standing problems that were left uncorrected. The station identified and documented boric acid accumulation on the RPV head in Refueling Outages 10 through 12 (1996 – 2000). Most of the corrective action documents that identified boric acid accumulation on the head, although initially designated for root cause analyses, were ultimately downgraded to routine reports that did not require root causes to be determined or corrective actions specified to prevent recurrence. In general, station managers did not verify that corrective actions were being completed in a timely manner or if completion dates were being extended without an evaluation of the potential consequences of not correcting the problems.

#### Scope

The station should review all uncorrected, unresolved, or unreported abnormalities identified by station personnel, and ensure that the organization is escalating and following up on identified abnormalities that are not corrected or resolved. Station management should seek out and encourage personnel who report abnormal conditions to help foster and sustain this behavior throughout the organization.

### **Intent**

The intent of this recommendation is to change the behavior of station personnel. They should develop intolerance for equipment problems and develop a questioning attitude toward unexplained or unusual indications. The entire organization, including non-technical personnel should be proactive in identifying abnormal conditions and quickly reporting their existence. Following identification, personnel should feel ownership for the timely resolution of the problem and not rely solely on processes or programs to eventually handle the issue. Personnel should be encouraged to elevate issues to senior management without fear of retribution when they believe that normal corrective action processes are not satisfactorily addressing their concerns.

### **Recommendation 3 Evaluation Guidelines**

1. Review abnormal conditions identified by the plant to ensure the conditions are evaluated and appropriate corrective actions are taken. Ensure discrepancies are documented in the station's corrective action program, have been prioritized, and evaluations assigned. Review root cause analyses to ensure the analyses are thorough and the extent of condition determined. Through interviews, verify that senior station management is aware of significant abnormal conditions identified by the staff.
2. Determine if discrepancies exist between the abnormal conditions identified by the station staff and the evaluation team's review (plant data reviews, interviews, and observations) for similar problems.

Data reviews by the team can include but are not limited to:

- event and corrective action reports
- system health reports
- predictive maintenance results
- plant performance indicators
- reactor coolant system or drywell unidentified leak rate
- chemistry data trends and anomalous indications
- equipment and system surveillances
- Inservice testing and inspection (IST/ISI) results
- Equipment leak detection and trending processes
- Boric acid leak monitoring programs
- BWRVIP and steam generator review reports

- Slightly increasing adverse changes in system parameters over time that are unexplained.

Whenever possible, abnormal conditions noted should be observed first hand, or through the use of remote cameras or video recordings.

Interview a cross-section of the plant staff to determine if they are aware of any abnormal conditions that have not been documented in the corrective action program. Review trends and performance reports with managers, system engineers, operators, chemistry and maintenance personnel.

Evaluation team observations of plant activities should identify abnormal conditions observed during routine plant operations and maintenance. Observations during outage periods affords the team the opportunity to observe equipment conditions during major repair and overhaul, as well as, observing areas inside the plant that are not normally accessible, such as the reactor vessel head and containment air coolers.

If any abnormal conditions are identified by the team that are not identified by station staff, evaluate why the staff is unaware of the problem.

3. For any abnormal conditions that have been identified and corrective actions taken, ensure that the plant conducts an effectiveness review of the corrective actions.
4. Verify that station personnel have a questioning attitude and a method to communicate abnormal conditions upward. Determine through interviews that there is effective downward communication to the originator on the status of identified abnormal conditions.
5. Determine if the station's emphasis on identifying abnormal conditions are sustainable. Key to sustainability is the perception of the workforce about management's commitment to addressing abnormal conditions, corrective actions that are not rigorous enough to resolve the abnormal condition, a low priority given to many identified abnormal conditions in the work management system, and lastly, multiple deferments of scheduled work intended to resolve abnormal conditions.

INPO WEBCAST – REVIEW OF SOER 02-4 – November 20, 2002

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Q1. *The warning flags were present at Davis-Besse but no action was taken. Are the warning flags reactive instead of predictive? Should the warning flags be revised?*

A1. The warning flags were present at Davis-Besse but the management team in place at the time took no action to address them. The warning flags are predictive but the management team must be committed to identifying their presence and taking action on them for the flags to be an effective tool. Therefore, the flags do not need revision but rather reinforcement.

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Q2. *Was there a "chilling effect" at Davis-Besse? Were the employees either directly or indirectly made to feel they could not bring forward issues that may impact the plant's output?*

A2. INPO has no indication of indirect or direct management pressure on the station employees to not report deficiencies or unusual conditions. The station culture valued teamwork to the point that personnel were not critical of each other's actions or lack of action.

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Q3. *Were the abnormalities associated with the radiation monitors and the containment filters entered into the station's corrective action program?*

A3. While we know the filter samples were sent to a lab for analysis, we need to check to see if the items were captured in the plant corrective action program.

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Q4. *Can you provide more detail on the factors at Davis-Besse that resulted in excessive emphasis on production and less emphasis on nuclear safety?*

A4. INPO does not have any additional information besides what is reported in the SOER.

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Q5. *Should stations use the warning flags in conducting the self-- assessment discussed in recommendation 2?*

A5. Yes. A reference to the warning flags will be included in the Flash version.

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Q6. *Should recommendation 2.d be split into two items?*

A6. No. Feedback from both internal and external personnel is necessary to fully understand the depth of the problem.

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Q7. *If the Davis-Besse station had completed the self assessment discussed in recommendation 2, would the event have been prevented?*

A7. We don't know for sure but it could have been if the self assessment was effective.

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Q8. *Can INPO provide any objective criteria for conducting the self- assessment discussed in recommendation 2?*

A8. The documents referenced in the recommendation-Principles for Operational Decision making, etc., and the plant evaluation Performance Objectives and Criteria.

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Q9. *Can you clarify the leadership skills lacking at Davis Besse?*

A9. The SOER describes some information on the leadership skills. INPO has no further information beyond what is described in the SOER.

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Q10. *Does INPO have a "safety culture" model that the stations can use in addressing the recommendations?*

A10. No. However, the safety culture Performance Objectives & Criteria are available

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Q11. *Were there other issues at Davis-Besse besides the head degradation that could be related to the organizational deficiencies?*

A11. INPO has no information on other issues at Davis Besse. Other events from the industry will be referenced in the Flash version.

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Q12. *Is there a plan to share the results of station self assessments with others?*

A12. INPO will look at the feasibility of developing a method to do this.

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Q13. *Should the recommendations be addressed in any particular sequence?*

A13. No, but in writing the recommendations the rationale was for Recommendation 1 to be implemented first because it could be accomplished in the short term. However, there was never any intent to require any particular sequence to be followed.

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Q14. *Does INPO have or recommend any methodology in addressing the recommendations?*

A14. No. Each station should use their own processes to address the recommendations.

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*Q15. Can INPO provide any assistance in helping the stations address the recommendations?*

**A15. Yes. The station should coordinate requests for assistance through their Senior Representative**

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## SUPERVISOR

### Interview Questions for SOER 02-4 Recommendation 2

**Objective 1: Assess the extent that all employees are encouraged to, and have demonstrated a willingness to identify degraded conditions and to escalate their concerns when the conditions are not corrected.**

- What is the threshold and preferred mechanism for reporting nuclear safety concerns?
- How do you communicate this expectation to your employees and measure the effectiveness of the communication?
- How would an employee determine the response to a raised concern?
- When and how would you expect an employee to escalate a concern if unsatisfied with the resolution?

**Objective 2: Assess the degree to which management drives the organization to correct important and long-term materiel deficiencies.**

- What processes are in place to ensure that long-term materiel deficiencies are properly prioritized and pursued in an aggressive manner?
- Are they effective? (i.e., are people held accountable for results?) Give examples.
- What leadership role do you play in correcting important and long-term deficiencies? How do you accomplish it?
- How often do you discuss correcting important material deficiencies with your manager? Do they encourage your input? Give examples.
- How often do you discuss correcting important material deficiencies with your technicians and workers? Do they frequently bring deficiencies to your attention? How?

**Objective 3: Assess the willingness of station management to sacrifice production for safety to effect repairs. *Warning flag: Important equipment problems linger, and repairs are postponed while the plant stays on line.***

- Do you feel that work important to nuclear safety is being deferred during outages or at other times in order to meet production goals? Give examples.

**Objective 4: Assess the level of which manger are engaged and involved in plant activities having the potential to affect nuclear safety.**

- At what point would you involve your manager with plant problems that fall below Tech Spec or procedurally required actions but which involves equipment important to nuclear safety?

## SUPERVISOR

### Interview Questions for SOER 02-4 Recommendation 2

- How often do you observe/have contact with your managers in the field outside of meetings? Is their involvement one of an observer or are they part of the problem resolution process? Please give an example or two.

**Objective 5: Assess the level to which management exercises accountability and follow-up regarding plant activities having the potential to affect nuclear safety.**

- No questions.
- How are you held accountable for plant activities involving nuclear safety?
- How do you hold your technicians and workers responsible for nuclear safety?

**Objective 6: Assess the level to which managers seek critical feedback from both internal and external sources.**

- Have you or any of your employees participated on a self-assessment team?
- If so, were you satisfied with the changes that resulted from the self-assessment recommendations? Give examples.
- Do you feel comfortable alerting your managers to material problems that might extend a forced or planned outage? If so, why? If not, why?

**Objective 7: Assess the level at which management actively seeks first-hand information from those personnel intimately involved with the issues.**

- Does your management routinely ask you directly for facts concerning plant problems? Please provide examples.

**Objective 8: Assess the level at which significant in house or industry events are recognized.**

- What are the criteria for requiring a root cause determination for a plant event?
- How do you obtain in-house and industry operating experience information? How do you use it to analyze equipment performance problems?

**Objective 9: Assess the level at which identified significant events are aggressively addressed to determine the root causes, and timely corrective actions are taken to prevent recurrence.**

- Do repetitive problems in your area get identified, escalated and fixed? Provide examples. How do you track rework? How do you identify when training might be required to correct knowledge or skill deficiencies?

## EMPLOYEE

### Interview Questions for SOER 02-4 Recommendation 2

**Objective 1: Assess the extent that all employees are encouraged to, and have demonstrated a willingness to identify degraded conditions and to escalate their concerns when the conditions are not corrected.**

- What mechanisms are available to you to identify concerns and which ones have you used?
- How do you receive feedback on how your concerns were resolved?
- What would you do if you were not satisfied with the resolution to your concern? Would you be comfortable taking these actions?

**Objective 2: Assess the degree to which management drives the organization to correct important and long-term materiel deficiencies.**

- Is the proper priority placed on long term materiel deficiencies in important systems and are they pursued in an aggressive manner?
- Are you as an organization effective in correcting these problems? (i.e. are people held accountable for results?) Give examples.

**Objective 3: Assess the willingness of station management to sacrifice production for safety to effect repairs. *Warning flag: Important equipment problems linger, and repairs are postponed while the plant stays on line.***

- Do you feel that work important to nuclear safety is being deferred during outages or at other times in order to meet production goals? Give examples.

**Objective 4: Assess the level of which manger are engaged and involved in plant activities having the potential to affect nuclear safety.**

- No questions.

**Objective 5: Assess the level to which management exercises accountability and follow-up regarding plant activities having the potential to affect nuclear safety.**

- No questions.

**Objective 6: Assess the level to which managers seek critical feedback from both internal and external sources.**

- Have you or your co-workers participated on a self-assessment team?
- If so, were you satisfied with the changes that resulted from the self-assessment recommendations? Give examples.

EMPLOYEE  
Interview Questions for SOER 02-4 Recommendation 2

- Is the corrective action program effective in resolving concerns and making you perform better? Why?

**Objective 7: Assess the level at which management actively seeks first-hand information from those personnel intimately involved with the issues.**

- Does your management routinely ask you directly for facts concerning plant problems?

**Objective 8: Assess the level at which significant events are recognized.**

- What level problems are entered into the corrective action program?
- What are the criteria for requiring a root cause determination for a plant event?

**Objective 9: Assess the level at which identified significant events are aggressively addressed to determine the root causes, and timely corrective actions are taken to prevent recurrence.**

- Do repetitive problems in your area get identified, escalated and fixed? Provide examples.

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## MANAGER

### Interview Questions for SOER 02-4 Recommendation 2

**Objective 1: Assess the extent that all employees are encouraged to, and have demonstrated a willingness to identify degraded conditions and to escalate their concerns when the conditions are not corrected.**

- What is your threshold and preferred mechanism for your employees to report nuclear safety concerns?
- How do you communicate this expectation to your employees and measure the effectiveness of the communication?
- How are employees and supervisors held accountable to meet reporting expectations?

**Objective 2: Assess the degree to which management drives the organization to correct important and long-term material deficiencies.**

- How do you ensure that long-term material deficiencies are pursued in an aggressive manner? How are short-term production goals balanced against correcting long-term material deficiencies?
- How do you encourage open and candid discussions about potential problems or plant conditions?

**Objective 3: Assess the willingness of station management to sacrifice production for safety to effect repairs. *Warning flag: Important equipment problems linger, and repairs are postponed while the plant stays on line.***

- How do you emphasize to employees that they have time to do a job right versus meeting short-term production goals?
- What processes do you use to make and evaluate (after the fact) decisions of production or justification for continued operation versus safety? (Give examples of recent decisions where these processes were used.)

**Objective 4: Assess the level of which manager are engaged and involved in plant activities having the potential to affect nuclear safety.**

- Do you have short-term production incentive goals that might influence your long-term safety decisions? Please give examples.
- ***As to Warning flag: Senior managers are not involved in operations and do not exercise accountability or follow-up.*** At what point do you expect to be involved with plant problems that fall below Tech Spec or procedurally required actions? How do you verify assumptions that others (supervisors) are adequately addressing problems?

## MANAGER

### Interview Questions for SOER 02-4 Recommendation 2

- What are the current plant nuclear safety concerns and what is your level of involvement?
- How do you stay informed, on a daily basis, of actual plant conditions?

**Objective 5: Assess the level to which management exercises accountability and follow-up regarding plant activities having the potential to affect nuclear safety.**

- How do you ensure that corrective actions and self-assessment actions are closed in an effective and timely manner to resolve root causes of problems (e.g., not closed to another action plan or not closed on symptoms of problems)?

**Objective 6: Assess the level to which managers seek critical feedback from both internal and external sources.**

- What processes do you have in place to provide critical feedback on you, your direct reports and processes? Include any internal and external sources such as self-assessments, benchmarking, OE, CAP and CAP trends, external agency evaluations, observations, etc.
- How often do you use personnel from outside your organization to help provide this feedback?
- How is accountability for improvement maintained within these programs?
- Give examples of process improvement resulting from feedback.

**Objective 7: Assess the level at which management actively seeks first-hand information from those personnel intimately involved with the issues.**

- How do you verify conditions reported to you within your organization?

**Objective 8: Assess the level at which significant events are recognized.**

- What are your criteria for requiring a root cause determination for a plant event?

**Objective 9: Assess the level at which identified significant events are aggressively addressed to determine the root causes, and timely corrective actions are taken to prevent recurrence.**

- How do you use/process/trend industry event information to identify and initiate corrective actions to "Prevent Events?"

*organization. The plant did not use industry experience or vendors effectively, and in many areas became isolated from the industry.”*

*“There was a lack of sensitivity to nuclear safety, and the focus was to justify existing conditions. The overall conclusion is that management ineffectively implemented processes and thus failed to detect and address plant problems as opportunities arose.”*

### **Scope**

The self-assessment should be conducted periodically (such as every cycle, biennially, etc.) as determined by the station. The *Principles for Effective Operational Decision-Making*, the *Warning Flags*, and the *Plant Evaluation Performance Objectives and Criteria* should be used as references for conducting the self-assessment. Consideration should be given to including one or more participants who are independent of the station organization to provide additional insight and objectivity to the self-assessment.

### **Intent**

The intent of the self-assessment is to determine areas where the station has weaknesses in safety culture. These weaknesses can then be addressed to improve the station's safety culture. Periodic reassessment will help the station determine if the organization's safety focus has changed.

## SOER EVALUATION GUIDELINE

### Organizational Effectiveness/Learning Organization

SOER 02-4, Reactor Pressure Vessel Head Degradation at Davis-Besse Nuclear Power Station

#### Recommendation 1:

Discuss the Davis-Besse case study outline provided with this SOER, or a similar case study, with all managers and supervisors in the nuclear organization. Continue this effort on a periodic basis and for new managers and supervisors. Include in the discussions the technical and nontechnical contributors to the event described in INPO Significant Event Report 2-02 and this SOER. The case study discussion should include, as a minimum, the following topics:

- a. Describe what caused the CRDM nozzle crack and the subsequent degradation of the reactor pressure vessel head, as well as what led to the organization's inability to identify and correct the situation.
- b. Summarize the organizational factors that influenced how decisions were made and the missed opportunities that led to the event. Contrast the organizational factors in this SOER with your organization, and identify similarities and differences.
- c. Discuss the factors at Davis-Besse that resulted in excessive emphasis on production and less emphasis on nuclear safety.
- d. Discuss the standards at your station for equipment performance and materiel condition and the expectations for aggressively following up on and correcting degraded conditions when standards are not met.
- e. Discuss how your oversight and corrective action programs analyze and aggressively resolve identified deficiencies.

#### Basis

A major contributor to this event was a shift in the focus at all levels of the organization from implementing high standards to justifying minimum standards. This reduction in standards resulted from excessive focus on meeting short-term production goals, a lack of management oversight, symptom-based problem solving, justification of plant problems, isolationism, ineffective use of operating experience, and a lack of sensitivity to nuclear safety.

Station managers were unaware of the actual condition of the RPV head or that conditions related to boric acid accumulation and corrosion had worsened over the past several years. Many managers were not cognizant of the results of RPV head and containment inspections that would have identified the degrading conditions. When

problems were identified, such as the pressurizer spray valve RC-2 leak that occurred in 1998, the management team encouraged engineering personnel to justify continued operation, rather than taking actions to correct the problems. Open and candid discussions about potential problems or plant conditions, particularly those related to boric acid corrosion, were rare and were not encouraged by management. Management normally limited its involvement in problem resolution to those problems that affected reliability.

### **Scope**

The case study training should be conducted periodically (such as every cycle, biennially, etc.) as determined by the station. The target audience is all managers and supervisors at the station. In addition, any corporate managers and supervisors that directly support the station should receive this training. This training should be provided to all newly assigned managers and supervisors, including nonstation personnel assigned to management or supervisory positions.

### **Intent**

The intent of this training is to ensure that all levels of the organization understand the underlying behaviors that led to the Davis-Besse event, as well as the technical causes. The training should reinforce site and senior management's emphasis on implementing high standards instead of justifying minimum standards. Participants should come away from this training with an understanding of how the lessons learned at Davis-Besse apply to their roles at the station.

### **Recommendation 1 Evaluation Guidelines**

1. Review the training materials used in case study discussions with managers and supervisors in the nuclear organization to determine if the minimum topics identified in recommendation 1 were addressed. Consider the following:
  - Learning points should cover topics such as the differences in organizational factors between this station and Davis-Besse, the station's standards for equipment performance and materiel condition, and the effectiveness of the station's oversight and corrective action programs.
  - A utility executive or senior manager at the plant should lead the discussion on lessons learned or learning points to reinforce the importance of these lessons learned.
  - Review station self-assessments, plant evaluation reports, and other performance reports to determine if the presenters painted an accurate picture of the station's equipment performance and materiel condition, and corrective action program effectiveness.
2. Verify that all managers and supervisors attended the case study presentation. Ensure that continuous training plans are in-place to periodically present this or similar case studies to managers and supervisors, as well as, new managers and supervisors.

From: Keiser, Harold  
Sent: Wednesday, February 05, 2003 2:57 PM  
To: Harvin, Kymn R.  
Subject: RE: Duke Energy Operations Assessment

Kymn  
It would be a good experience for you  
Harry

-----Original Message-----  
From: Harvin, Kymn R.  
Sent: Wednesday, February 05, 2003 2:47 PM  
To: Keiser, Harold  
Subject: FW: Duke Energy Operations Assessment

Harry:

I've been asked to be on the team evaluating Operations Leadership at three INPO 1 sites at Duke Energy.

Per our conversation today, this IS specifically Operations. (I got the message!)

I'd like to say "yes." Tim concurred. This is both a great benchmarking experience and broadening experience for me since I've not been to other nuclear plants. It would be well worth the investment and I'd bring back the learnings.

OK?

Kymn

-----Original Message-----  
From: Turner, Jennifer M. On Behalf Of Waldinger, Lon H.  
Sent: Wednesday, February 05, 2003 2:35 PM  
To: Harvin, Kymn R.  
Subject: FW: Duke Energy Operations Assessment

-----Original Message-----  
From: Sandra O Delonis [mailto:sodeloni@duke-energy.com]  
Sent: Wednesday, February 05, 2003 12:40 PM  
To: lon.waldinger@pseg.com  
Subject: Duke Energy Operations Assessment

One of my collateral duties in the oversight group is to augment our assessments teams with outside experts. This year's operations assessment will be led by Rick Abbott. Rick was formerly part of the Duke Engineering & Services Operations Mentor consulting team who spent several months in 2001 in the Salem and Hope Creek plants at PSEG (at Dave Garchow's request).

Rick is forming a team of Duke and industry experts to help assess, evaluate, and strengthen Operations at the three Duke nuclear sites (Oconee, McGuire, & Catawba) all of which are INPO 1. The team will focus in several areas including Management Leadership, Accountability, Direction, Expectations, Planning, Organizing, Monitoring, Assessing, Follow-up, Reinforcement, Feedback, and Responsibility for Human Performance. It is Duke's desire to assess these attributes using the insights and views of individuals with strong leadership and management skills.

When Rick was at PSEG Nuclear, he worked closely with the Hope Creek Operations Manager Kurt Krueger and found him to be a strong leader. We have talked to Kurt and he has agreed to support the Oconee portion of this assessment, pending your approval. The date for this support is April 7-10, 2003. We believe Kurt will provide Duke with valuable insights about our leadership and accountability. In exchange, one of our Operations Managers would spend a week at your site as an industry peer.

Also, Dr. Kymn Harvin expressed an earlier desire to benchmark Duke in the area of management and leadership. Rick worked with Kymn while at PSEG Nuclear and was impressed with her coaching of the Operations Leadership Team and the unique role she plays in your organization. No other nuclear plant that we know of has a Manager of Culture Transformation. Rick mentioned he personally benefited from candid and incisive conversations with her. The Duke Business Excellence Steering Team (BEST), comprised of senior leaders of our plants welcome Kymn's participation in visiting and evaluating all three of our sites.

As is customary for peer visits, expenses would be incurred by your company for Kymn's visit. Duke can offer great southern hospitality to Kymn and will do everything we can to make her visit a success towards achieving both Duke and PSEG goals.

Please let me know of PSEG Nuclear's interest. With your acceptance of this invitation, Duke will begin corresponding directly with Kurt and Kymn to solidify the team. It would be much appreciated if you could get back to me by February 5. Give me a call (work 704-382-4098 or Page 800/777-3853; 777-7177) or you may contact Rick (work 704-373-3879 or Page 800/777-3853; 778-9614) if you have any questions.

Thanks,  
Sandy Delonis

From: OHare, Kevin F.  
Sent: Saturday, March 01, 2003 11:47 AM  
To: Wagner, Lawrence M.; Waldinger, Lon H.; Schimmel, Mark

Cc: Reid, James G.; Krueger, Kurt L.; Fricker, Carl J.; Harvin, Kymn R.;  
Phillips, Duane L.; Harvey, Sam L.; Henriksen, Robert A.; Nagy, Eugene  
M.; Anderson, Todd W.; Cellmer, Terry L.; Straub, Theodore W.; Boyle,  
Daniel  
Subject: CPIG action items 022803

#### SITE MEETING AGENDA

##### PROBLEM:

"Managers are not engaged as managers, do not know the work being done each week, are not providing the thinking and defense in depth to cause the bleeding to stop and results to be different"

##### ACTION:

The following actions are being championed to arrest January and February performance:

##### SHORT TERM

- 1) Duty Managers initiative designed to create ownership of the workweek schedule and field performance.
  - a. Champions - Deppi, Nagy, Anderson
- 2) Superintendent alignment meetings to create a sense of urgency and an understanding of the current performance by the superintendent team
  - a. Champions - Phillips, Hassler
- 3) Standard Manager meeting schedule to create focus
  - a. Management engagement in field activities,
  - b. A predictable and significant field presence for the management team.
  - c. Consistent engagement by required managers in site processes
  - d. The creation of strategic and tactical approach to our efforts
  - e. A more productive set of key meetings by creating set agendas, participants, and deliverables for each meeting
- 4) Weekly manager team meetings to ensure continued focus - this will be incorporated into the weekly corrective action meeting as a subset of the CPIG
  - a. Champions - Fricker, Krueger, O'Hare

##### INTERMEDIATE TERM

- 1) Develop and implement daily "M.E.L.T" (Most Error Likely Task) focus for the management team
  - a. Champions - Deppi, Philips, O'Hare
- 2) Conduct manager observations of Operations, Maintenance and Engineering turnovers
  - a. Champions - O'Hare, Krueger, Fricker
- 3) RP personnel will become directly involved with Operations, Maintenance and Engineering corrective action and self-assessment programs to create improvements in each
  - a. Champions - Cellmer
- 4) Conduct a configuration verification of critical plant systems
  - a. Champions - Fricker, Krueger

##### LONG TERM

- 1) Conduct a common cause analysis of the January and February events to gain a detailed understanding of the events and their respective causes
    - a. Champions - Cellmer, Herriksen
- From: RobertDeppi@aol.com

Sent: Sunday, March 02, 2003 8:32 AM  
To: eugene.nagey@pseg.com; todd.anderson@pseg.com;  
lawrence.wagner@pseg.com; kymn.harvin@pseg.com  
Subject: Draft-Duty Manager Responsibilities

Draft for your perusal

From: RobertDeppi@aol.com  
Sent: Saturday, March 01, 2003 11:25 PM  
To: todd.anderson@pseg.com; jim.clancey@pseg.com; gene.nagey@pseg.com;  
kymn.harvin@pseg.com; lawrence.wagner@pseg.com; robert.deppi@pseg.com  
Subject: Draft Duty Manager responsibilities

Attached for your perusal are drafts for duty managers responsibilities.  
Subject: Next CRS meeting  
Location: Conference room 17 in the Services Building (same one as  
last time).

Start: Thu 4/17/03 5:00 PM  
End: Thu 4/17/03 7:00 PM  
Show Time As: Tentative

Recurrence: (none)

Meeting Status: Not yet responded

Required Attendees: Fricker, Carl J.; Abbott, Paul; Bashore, Timothy  
C.; Binggeli, Benson L.; Blose, Robert A.; Boos, Brian; Bricker, Jeffrey  
K.; Byykkonen, Thomas E.; Chan, Rudolph J.; Cordrey, Robert J.;  
Crampton, Alan D.; Gallagher, Edward M.; Hantho, Karl A.; Harsh, Peter  
G.; Lynch, Conor J.; Marcucci, Patrick W.; Marshall, Glenn A.; Martin,  
Paul W.; Martino, Patrick A.; Meekins, Gary; Miller, Jeffrey E.; Mog,  
Matthew D.; ODonnell, Philip P.; Osborne, John T.; Recchione,  
Christopher M.; Scanish, Jeffrey E.; Shetrone, Timothy J.; Suey, Gregory  
M.; White, William S.; Williams, Paul B.; Wolk, Michael; Wygant, Timothy  
J.; DeSanctis, Richard J.; Ford, Van L.; Garecht, John F.; Gwartz,  
Michael D.; Konovalchick, John; Olsen, Robert W.; Powell, Eric C.;  
Sauer, Stephen J.; Soens, Frank J.; Straubmuller, Michael  
Optional Attendees: Sullivan, Joseph C.; Harvin, Kymn R.

When: Thursday, April 17, 2003 5:00 PM-7:00 PM (GMT-05:00) Eastern Time  
(US & Canada).  
Where: Conference room 17 in the Services Building (same one as last  
time).

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-----Original Message-----

From: Harvin, Kymn R.  
Sent: Tuesday, March 18, 2003 2:49 PM  
To: Fricker, Carl J.; Garecht, John F.  
Subject: STRAIGHT TALK Re: Next CRS Leadership Meeting 3/20/03  
Sensitivity: Private

Carl and John,

I tried calling and paging you today after receiving this agenda from Joe Sullivan. I couldn't reach you so I am writing my thoughts to you. Please feel free to page me (866 691 0141) to discuss.

This agenda falls short.

There are some "root issues" that I believe we need to get on the table and grapple with at this next CRS meeting and elsewhere. As I have said repeatedly, dealing with root issues is critical to us moving forward. Results--in safety, human performance, flawless execution, INPO index, etc.--cannot be expected to improve without such a focus.

Here is my "read" from having talked with the crews:

1. CRSs--even the very best ones--feel like "puppets." They do not feel they have the support, latitude, empowerment or authority to execute the non-technical responsibilities they have of leading their crews. They feel "trapped" between the Union guys and you. We will not succeed in reaching our business goals and moving out of INPO 3 space unless this is dealt with head-on.

2. CRSs and the Union guys feel disconnected from anyone above the OS. A "Cold War" is underway. Carl, you are still an "unknown" to them. They don't think you are engaged. They don't think you are "with them." They don't think you care. They think you are here only to get your ticket punched and move on. They don't think you are making Salem better. They see you as indecisive, out of touch, remote, and lacking influence or real decision-making willingness (especially in non-technical arenas). John, you are viewed as caring but spread way too thin to make any real difference. You, also, are viewed as a puppet, unable to make any decisions on his on. "Loyal but impotent" summarizes the collective view.

Bottom line, gentlemen, is this: You are not viewed as leaders worth following....by the guys you are called to lead. I believe in you, others above you believe in you, but unfortunately a critical mass at Salem does not.

While these perceptions can be written off by saying "they are just being victims," I urge you not to do that. Focus instead on whatever grain of truth may be in these statements. They are "clues" for each of you. You MUST change this. You must gain support of those working in Salem Operations. IT IS POSSIBLE. Please listen. I will coach you, guide you, support you but I cannot do it for you.

Remember what Rudy Giuliani said, "I'm responsible." Tackle this issue.

Kymn

-----Original Message-----

From: Sullivan, Joseph C.  
Sent: Tuesday, March 18, 2003 1:44 PM  
To: Olsen, Robert W.; DeSanctis, Richard J.; Ford, Van L.; Sauer, Stephen J.; Straubmuller, Michael; Abbott, Paul; Bashore, Timothy C.; Birggeli, Benson L.; Blose, Robert A.; Boos, Brian; Bricker, Jeffrey K.; Byykkonen, Thomas E.; Chan, Rudolph J.; Cordrey, Robert J.; Crampton, Alan D.; Gallagher, Edward M.; Hantho, Karl A.; Harsh, Peter G.; Lynch,

Conor J.; Marcucci, Patrick W.; Marshall, Carl W.; Martin, Paul W.;  
Martino, Patrick A.; Meekins, Gary; Miller, Jeffrey E.; Mog, Matthew D.;  
ODonnell, Philip P.; Osborne, John T.; Powell, Eric C.; Recchione,  
Christopher M.; Scanish, Jeffrey E.; Shetrone, Timothy J.; Suey, Gregory  
M.; White, William S.; Williams, Paul B.; Wolk, Michael; Wygant, Timothy  
J.; Fricker, Carl J.; Garecht, John F.; Soens, Frank J.  
Cc: Shindel, Richard D.; Harvin, Kymn R.  
Subject: FW: Next CRS Leadership Meeting 3/20/03  
Importance: High

Thursday is getting closer. The meeting is on for 1700-1900 3/20/03 in  
conference room 17 in the Services Building (same one as last time).

The agenda is as follows:

1700: John Garecht opening remarks

1715-1730: Rick Shindel: Notifications and Operability tasks

1730-1820: Follow-up on action items from last meeting (~5 min. each):

\* We should temporary release returning equipment and have the field  
supervisor and the maintenance supervisor walk it down, if it is not  
right, retag it and fix the problem. (GS) - action item accepted by  
Greg Suey.

\* The NEO's are concerned that we are not fixing the equipment. We  
need to focus on fewer windows and concentrate on what is in the window.  
Have the NEO's walk down the equipment early in the T-week process to  
ensure that right work is in the window. (GS) - action item accepted by  
Matt Mog.

\* Need to assign an NEO to the WIN team SRO on day shift. (TB) -  
action item accepted by Bob Cordrey.

\* Need to empower the NEO's/NCO's to do the things that we do. Give  
them the schedule and let them do the work, i.e. lubes. Have them tell  
me what they are going to do. (TB) - action item accepted by Tim  
Bashore.

\* We need to learn to read the schedule so we can look ahead better.  
(JB) - action item accepted by Jeff Bricker.

\* Teach the NCO's and NEO's how to read the schedule, then they can  
walk down the job and look at redundant equipment ahead of time. (JB) -  
action item accepted by Jeff Bricker.

\* We need to learn SAP to see what is going to be worked when. (JB)  
- action item accepted by Pete Harsh.

\* Need to empower the CRS's to deal with the above issue, allow them  
to supervise and coach the people. (JO) - action item accepted by Jack  
Osborne and Carl Fricker.

\* Need a full time NCO at the WCC, not one that relieves the shift  
all of the time. (PM) - action item accepted by Pat Martino.

\* We need to be educated on the work week process. (PH) - action  
item accepted by Pete Harsh.

1820-1850: All: open discussion:

1850-1900: John Garecht and Carl Fricker: closing thoughts.

It would be helpful for everyone to work out turnover (late or early) to  
support maximizing meeting attendance, particularly for those who  
stepped up and took away an action from the last meeting. Let me know  
if you have any questions and I am looking forward to seeing you at the  
meeting. Thank you.

Subject: KYMN, DANA & DAVE

Location: D. BRAUN'S OFFICE

Start: Mon 3/24/03 11:00 AM

End: Mon 3/24/03 11:30 AM  
Show Time As: Tentative

Recurrence: (none)

Meeting Status: Not yet responded

Required Attendees: Harvin, Kymn R.; Bussey, Dana L.

When: Monday, March 24, 2003 11:00 AM-11:30 AM (GMT-05:00) Eastern Time  
(US & Canada).

Where: D. BRAUN'S OFFICE

Subject: Exit Interview  
Location: D. Bussey's Office

Start: Fri 3/28/03 10:00 AM  
End: Fri 3/28/03 11:00 AM  
Show Time As: Tentative

Recurrence: (none)

Meeting Status: Not yet responded

Required Attendees: Straubmuller, Deborah L.; Harvin, Kymn R.

When: Friday, March 28, 2003 10:00 AM-11:00 AM (GMT-05:00) Eastern Time  
(US & Canada).

Where: D. Bussey's Office

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From: pseg@softscape.com  
Sent: Tuesday, January 28, 2003 8:35 AM  
To: Kymn.Harvin@pseg.com  
Subject: Performance Partnership Notification

Dear Kymn

Please note the new item below in your "To Do" list. To begin your work on this item, please log on to the PSEG Online Performance Partnership System.

<http://pseg.softscape.com>

If you have any questions regarding this program, please contact the HRSC at 1-800-571-0400 (option 4).

Tasks assigned:

Task Name: (2002 Nuclear) Step 4 for Associate: Associate's Comments and Signoff for KYMN RUTIGLIANO

From: Ellis, James M.  
Sent: Tuesday, February 04, 2003 3:44 PM  
To: Harvin, Kymn R.  
Subject: DELTA Shift

Kymn - just a reminder, per our original email, your day for Delta Shift (Steve Sauer) is 2/18. I have you scheduled from 1330 to 1500.

Jim Ellis

From: Lake, Thomas D.  
To: Harvin, Kymn R.  
Sent: Wednesday, March 26, 2003 1:06 PM  
Subject: Read: Exit interview 3/28

From: Lake, Thomas D.  
To: Harvin, Kymn R.  
Sent: Wednesday, March 26, 2003 12:32 PM  
Subject: Read: Duke Energy Operations Assessment

From: Lake, Thomas D.  
To: Harvin, Kymn R.  
Sent: Wednesday, March 26, 2003 12:29 PM  
Subject: Read: Planning for Duke Operations Assessment

From: Lake, Thomas D.  
To: Harvin, Kymn R.  
Sent: Wednesday, March 26, 2003 12:28 PM  
Subject: Read: Planning for Duke Operations Assessment

From: Bussey, Dana L.  
To: Harvin, Kymn R.  
Sent: Tuesday, March 18, 2003 6:05 PM  
Subject: Read: Open positions

From: Keiser, Harold  
To: Harvin, Kymn R.  
Sent: Tuesday, March 18, 2003 12:35 PM  
Subject: Read: Open positions

From: Keiser, Harold  
To: Harvin, Kymn R.  
Sent: Monday, March 17, 2003 10:38 AM  
Subject: Read: Monday 3/17

From: Shimp, Ann L. on behalf of Keiser, Harold  
To: Harvin, Kymn R.  
Sent: Wednesday, February 05, 2003 2:50 PM  
Subject: Read: Duke Energy Operations Assessment

12.14.00 1400

Harry:

I don't know when we'll get an opportunity to talk, so I want to get this note to you right away....a RED FLAG of sorts.

I have an unreasonable request to make of you:

**Cancel this Saturday's meeting.  
Reschedule the meeting one day next week,  
4 p.m. into the evening.**

The amount of damage being done is, in my view, far outweighing the good we are committed to coming of these meetings.

Here is what people—highly credible, deeply committed people—are saying:

The meetings are valuable and necessary.

Good content, important discussions, people are learning.

The timing is causing a sense of failing here at work.

Guys who normally use Saturdays to have quality "think" time, to catch up on in-basket, emails, reports, etc. now lose the day. Sundays are their only family time, so if they don't do "thinking" and "catch up" work, they then start the week feeling already behind. The sense is one of failing before they even start the week. THIS IS PERVASIVE.

The timing is causing a sense of failing at home.

The sense of failing happens at home also. Many of the guys we count on have children at home. Their wives and kids are hating the company for what is happening. Many are telling their husbands and dads to "quit." Very committed leaders are feeling torn. They feel out of integrity with their families...and with their work. They feel they are in a "no win" situation. The sense of demoralization is high, even with our best and brightest.

The desire for a win/win is strong.

Everyone I talked with is clear about the gap, the need to bridge it, and the urgency to ACT NOW. No one I talked with *wants* to leave the business. Some feel pressured to do so because of they have no sense of winning, either at home or work. In part because we've urged people to be "real," express what's really there, not be on automatic, "sucking it up," pretending, or ignoring the pain doesn't work anymore.

I have hesitated to share this with you for fear that you will hear it only as "whining." But just in the last two days, several top guys have "spilled their guts" to me even to the point of tears, guys you would never expect to show such emotion. When our best feel like losers, we're in trouble.

My concern is that these are the guys we are counting on to get us to Top Quartile. We're losing them....if not yet in body, certainly in spirit. While there are many issues plaguing them, the Saturday meeting timeframe seems to be the hardest. *And the one most within our control.*

I urge you to consider taking the courageous action of rescheduling this Saturday's meeting and then let's look to see how we can accomplish the same end through different means. Maybe some "outside the box" thinking can help us realize win/win solutions. Right now, I'm afraid we have a lose/lose situation that, in the short-term and long term, is costing us dearly.

Please page me if you'd like to discuss. 277 2842

**POLICY STATEMENT, Dated: 1/24/1989,  
Conduct of Nuclear Power Plant Operations**

**Document: POLICY STATEMENT  
Publication Date: 1/24/1989  
Pages: 5  
Date Entered: 8/19/1994  
Title: Conduct of Nuclear Power Plant Operations**

NUCLEAR REGULATORY COMMISSION

10 CFR Parts 50 and 55

Policy Statement on the Conduct of Nuclear Power Plant Operations

AGENCY: Nuclear Regulatory Commission.

ACTION: Final policy statement. -----  
----- SUMMARY: This policy statement is being issued to make clear the Commission's expectation of utility management and licensed operators with respect to the conduct of nuclear power plant operations. The Commission believes that it is essential that utility management at each nuclear power reactor facility establish and maintain a professional working environment with a focus on safety in control rooms and throughout the plant. The Commission also believes that each individual licensed by the NRC to operate the controls of a nuclear power reactor must be keenly aware that he or she holds the special trust and confidence of the American people, conferred through the NRC license, and that his or her first responsibility is to assure that the reactor is in a safe condition at all times. This policy statement specifically describes the Commission's expectations of utility management and licensed operators in fulfilling NRC regulations and prior guidance regarding the conduct of control room operations. The policy statement further provides the Commission's endorsement of industry initiatives to enhance professionalism by both management and plant operators.

EFFECTIVE DATE: January 24, 1989.

FOR FURTHER INFORMATION CONTACT: Jack W. Roe, Office of Nuclear Reactor Regulation, U.S. Nuclear Regulatory Commission, Washington, DC 20555, Telephone: (301) 492-1004.

SUPPLEMENTARY INFORMATION:

Background

It is essential that control room operators are (1) well trained and qualified, (2) physically and mentally fit to carry out their duties, and (3) attentive to plant status relevant to their responsibilities to ensure the continued safe operation of nuclear facilities. It is also essential that management at each nuclear power reactor facility establish and maintain a professional working environment in which the

## NRC Policy Statements

licensed operator may be fully successful in discharging his or her safety responsibilities. On a number of occasions, the NRC has received reports and has found instances of operator inattentiveness and unprofessional behavior in control rooms of some operating facilities. Reported instances include: (1) Licensed operators observed to be apparently sleeping while on duty in the control room or otherwise being inattentive to their license obligations, (2) operators using entertainment devices (for example, radios, tape players, and video games) in the control room in a way that might distract their attention from required safety-related duties, and (3) unauthorized individuals being allowed to manipulate reactivity controls. Such conduct is unacceptable and inconsistent with the operators' licensed duties. The Commission has previously addressed its expectations of operator conduct in Commission regulations and regulatory guidance. Under 10 CFR 50.54(k), "An operator or senior operator licensed pursuant to Part 55 of this chapter shall be present at the controls at all times during the operation of the facility." /1/ The continuous presence of a senior operator in the control room to ensure that the operator at the controls is able to perform the actions and/or mitigate an accident is required by Sec. 50.54(m)(2)(iii). Commission regulations in 10 CFR Part 55 establish standards for licensing nuclear power plant operators.

NOTE /1/ Copies of Title 10, Code of Federal Regulations, Parts 0 to 50 and Parts 51 to 199 (revised January 1, 1988), may be purchased from the Superintendent of Documents, U.S. Government Printing Office, by calling (202) 275-2060 or by writing to the U.S. Government Printing Office, P.O. Box 37082, Washington, DC 20013-7082. Copies may also be purchased from the National Technical Information Service, 5285 Port Royal Road, Springfield, VA 22161. A copy of 10 CFR is available for inspection and/or copying for a fee in the NRC Public Document Room, 2120 L Street NW., Washington, DC.

The Commission has addressed operator training and qualifications and fitness-for-duty in policy statements./2/ The policy statement on training and qualifications endorsed the Institute of Nuclear Power Operations (INPO)- managed Training Accreditation Program. The policy statement on fitness for duty endorsed the concept that the workplace at nuclear power plants is to be drug and alcohol free. Fitness-for-duty rulemaking is under consideration by the Commission./3/

NOTE /2/ Policy Statement on Training and Qualification of Nuclear Power Plant Personnel (50 FR 11147, March 20, 1985; and amended 53 FR 46603, November 18, 1988) and Policy Statement on Fitness for Duty of Nuclear Power Plant Personnel (51 FR 27921, August 4, 1986).

NOTE /3/ Proposed Rule on 10 CFR Part 26 Fitness-for-Duty Programs (53 FR 36795, September 22, 1988).

Guidance regarding the conduct of licensed operator and control room operations has been addressed in an NRC Circular and in NRC Information Notices./4/ Specifically, IE Information Notice 79-20, Revision 1, emphasized that only licensed operators are permitted to manipulate controls (10 CFR 50.54(i)) and that a licensed operator is required to be present at the controls during facility operation (10 CFR 50.54(k)). IE Circular 81-02 provided the following guidance: (1) Knowledge of the plant's status must be ensured during shift changes by a formal watch

## NRC Policy Statements

turnover and relief, (2) licensed operators must be alert and attentive to instruments and controls, (3) potentially distracting activities in the control room must be prohibited, (4) access to the control room must be limited, and (5) eating and training activities should not compromise operator attentiveness or a professional atmosphere. Information Notice 85-53 reiterated the guidance of IE Circular 81-02.

NOTE /4/ IE Circular 81-02, dated February 9, 1981; Information Notice 79-20, Revision 1, dated September 7, 1979; Information Notice 85-53, dated July 12, 1985; Information Notice 87-21, dated May 11, 1987; and Information Notice 88-20, dated May 5, 1988 (available at the NRC Public Document Room at 2120 L Street, NW., Washington, DC).

In Information Notice 87-21, the NRC informed all nuclear power reactor facilities and licensed operators about certain licensed operators observed to be apparently sleeping while on duty. The notice reaffirmed the necessity for high standards of control room professionalism and operator attentiveness to ensure safe operation of nuclear power facilities. Further, Information Notice 88-20 reiterated the concern about unauthorized individuals manipulating controls and performing control room activities. The Commission is aware that the industry has taken action to foster the development of professional codes of conduct by operators and has worked toward establishing management principles for enhancing professionalism of nuclear personnel. The Commission believes that such an operator code of conduct developed by operators and supported by utility management can contribute to operator professionalism and commends the industry and especially the operators who contributed to these efforts. The Commission encourages and supports the prompt and effective implementation of these industry initiatives at each licensed power reactor. The Commission has decided to issue this policy statement to help foster the development and maintenance of a safety culture at every facility licensed by the NRC, and to make clear its expectations of utility management and licensed operators in fulfilling NRC regulations and prior guidance regarding the conduct of control room operations.

### Policy Statement

The Commission believes that the working environment provided for the conduct of operations at nuclear power facilities has a direct relationship to safety. Management has a duty and obligation to foster the development of a "safety culture" at each facility and to provide a professional working environment, in the control room and throughout the facility, that assures safe operations. Management must provide the leadership that nurtures and perpetuates the safety culture. In this context, the term "safety culture" is defined as follows:

The phrase 'safety culture' refers to a very general matter, the personal dedication and accountability of all individuals engaged in any activity which has a bearing on the safety of nuclear power plants. The starting point for the necessary full attention to safety matters is with the senior management of all organizations concerned. Policies are established and implemented which ensure correct practices, with the recognition that their importance lies not just in the practices themselves but also in the environment of safety consciousness which they create. Clear lines of responsibility and communication are

## NRC Policy Statements

established; sound procedures are developed; strict adherence to these procedures is demanded; internal reviews are performed of safety related activities; above all, staff training and education emphasize the reasons behind the safety practices established, together with the consequences for safety of shortfalls in personal performance. These matters are especially important for operating organizations and the staff directly engaged in plant operation. For the latter, at all levels, training emphasizes the significance of their individual tasks from the standpoint of basic understanding and knowledge of the plant and the equipment at their command, with special emphasis on the reasons underlying safety limits and the safety consequences of violations. Open attitudes are required in such staff to ensure that information relevant to plant safety is freely communicated; when errors of practice are committed, their admission is particularly encouraged. By these means, an all pervading safety thinking is achieved, allowing an inherently questioning attitude, the prevention of complacency, a commitment to excellence, and the fostering of both personal accountability and corporate self-regulation in safety matters./5/

NOTE /5/ International Nuclear Safety Advisory Group (INSAG)-3, Basic Safety Principles for Nuclear Power Plants.

Nuclear power plant operators have a professional responsibility to ensure that the facility is operated safely and within the requirements of the facility's license, including its technical specifications and the regulations and orders of the NRC. Mechanical and electrical systems and components required for safety can and do fail. However, the automated safety features of the plant, together with the operator, can identify at an early stage degradation in plant systems that could affect reactor safety. The operator can take action to mitigate the situation. Therefore, nuclear power plant operators on each shift must have knowledge of those aspects of plant status relevant to their responsibilities, maintain their working environment free of distractions, and using all their senses, be alert to prevent or mitigate any operational problems. Each individual licensed by the NRC to operate the controls of a nuclear power reactor must be keenly aware that he or she holds the special trust and confidence of the American people, conferred through the NRC license, and that his or her first responsibility is to assure that the reactor is in a safe condition at all times. The following criteria reflect the Commission's expectations concerning the conduct of operations in control rooms and licensed operators at nuclear reactors consistent with 10 CFR 50.54 and guidance provided in an NRC Circular and Information Notices: -- Conduct within the control room should always be professional and proper, reflecting a safety-minded approach to routine operations. The operator "at the controls" and the immediate supervisor must never relinquish their safety responsibilities unless properly relieved, including a thorough turnover briefing, by a qualified operator. -- Activities within the control room should be performed with formality. Operator actions must be in accordance with approved procedures. Verbal communications should be clear and concise. Appropriate consideration should be given to the need for acknowledgment and verification of instructions received. --The control room of a nuclear power plant, and in particular the area "at the controls", must be secure from intrusion. Access should be strictly controlled by a designated authority; only authorized personnel should be permitted to be present

## NRC Policy Statements

in the control room; and regulatory restrictions concerning manipulation of the controls must be meticulously observed. --The operator at the controls, and the immediate supervisor, must be continuously alert to plant conditions and ongoing activities affecting plant operations, including conditions external to the plant such as grid stability, meteorological conditions, and change in support equipment status; operational occurrences should be anticipated; alarms and off-normal conditions should be promptly responded to; and problems affecting reactor operations should be corrected in a timely fashion. --Activities within the control room should be limited to those necessary for the safe operation of the plant. Management should provide the direction, facilities, and resources needed to accommodate activities not directly related to plant operations. --Activities outside the control room with the potential to affect plant operations, such as on-line maintenance and surveillance, should be fully coordinated with the control room. Effective methods for communication with or notification of the operator at the controls should be established and maintained throughout each evolution. --Written records of plant operations must be carefully prepared and maintained in accordance with requirements for such records and in sufficient detail to provide a full understanding of operationally significant matters. --The working environment in the control room should be maintained to minimize distractions to the operators. Management should act to remove distractions that would interfere with the operator's ability to monitor the plant either audibly or visually, including work activities that are not related to the operator's immediate responsibility for safe plant operation. Consideration should be given to reducing environmental distractions such as lighted alarms that are not operationally significant, or alarms that signify normal operating conditions. --Foreign objects and materials not necessary for plant operations, ongoing maintenance, or surveillance testing should be restricted from the area "at the controls" to preclude inadvertent actuation of the controls or contamination of control devices.

### Implementation of Policy

The Commission intends this Policy Statement to make clear the Commission's expectations and to provide guidance to licensees in improving and assessing the conduct of operations in the control rooms of nuclear power plants. The Commission believes that utility management should routinely monitor the conduct of operations at the plant, particularly in the control room, and review their procedures and policies on the conduct of operations, considering the guidance of this policy statement, to assure they support an environment for professional conduct. Nothing in this policy statement limits the authority of the NRC to take appropriate enforcement action for violations of Commission requirements or on matters otherwise affecting the safe operation of the plant and thus the public health and safety.

Dated at Rockville, Maryland, this 17th day of January 1989.

For the Nuclear Regulatory Commission.

Samuel J. Chilk,

Secretary of the Commission.

**NRC Policy Statements**

[FF. Doc. 89-1498 Filed 1-23-89; 8:45 am]

# LEAVING PSEG NUCLEAR: REFLECTIONS OF A CHANGE AGENT

Kymn Harvin, Ph.D.  
Manager-Culture Transformation  
PSEG Nuclear  
March 28, 2003

Today is my last day at PSEG Nuclear. And while I toyed with the idea of slipping away without a word, I couldn't do that. It just wouldn't be me.

Instead I'd like to offer a few reflections on my five years here.

I joined the team in 1998, a month after Harry came in. I knew no one, knew nothing about nuclear power, and had never before worked with almost solely men. However, I do know a lot about what it takes to make workplaces great, and that's why I came here.

Despite having a Ph.D. and a great track record in my field, I initially felt small and unimportant. I felt like a stranger in a strange land. Many of you thought I was from another planet—and you were right. I didn't know your language, your customs, your way of life.

I thought “restart” was what you do when your car stalls,  
I thought “RPM” meant revolutions per minute, and an “Outage Manager”  
was someone who dispatched the PSEG trucks during power failures.

Initially most of you didn't give me the time of day, especially when I said things like:

*Relationships determine results.*

*Leaders cause, not do.*

*Do you have a best friend at work?*

*Let's bring LOVE back into business.*

I know I intruded on your hard-charging, techonocrat world and you may have wondered why the hell I just didn't go back from where I came.

One reason: *You, and the people of this site, captured my heart.*

Your brilliance, your commitment, your dedication, your potential drew me close like a magnet and I couldn't let go.

And it hurts to do so today, five years later. But it's time.

Together we've been through a lot--the lows of a transformer fire and serious injuries to our co-workers, the highs of Best Outages and Best Years Ever. Many of you were with me during the toughest time of my life, when my father died. For your support, I will be forever grateful.

In-between, we've battled the status quo, business as usual, and, too often, each other. Sometimes I crossed the line and made you feel small—for every instance of that, I apologize.

Sometimes I was too scared or too intimidated to speak up, and for that I apologize as well.

It was always my intention to give you my best. And to demand yours.

I am proud of the changes we've made, the ground we have taken. Root issues are up on the table. The practice of 'straight talk' is growing. We are learning from our mistakes and being way more self critical. Many of you have grown by leaps and bounds—you may not see that in yourself, but I can. There is still unfinished business and a ways to go to excellence. I trust you all to take care of it. You can. You're ready. As I am learning, just do it.

I too have grown tremendously. You have taught me much—not just about nuclear power but about commitment, dedication, courage and what it really means to stand for someone, something. My goal of this place being a great place to work—*safe for the human spirit and all concerned*—is closer to

becoming reality. And because of working with you, I am a better person, a better coach, a better leader, and a better friend.

Change happens. And even for the Manager of Culture Transformation it isn't always easy....sometimes it even sucks. Job eliminations are hard to swallow...especially mine. However, change causes us to grow and that's one of my very favorite things.

I'm off on some new adventures....I'll be participating this month and next in Operations assessments at three Duke Energy INPO 1 plants. After that I will be focusing on the book I've long intended to write. It will include learnings from my almost 30 years in public and private sector leadership, including working here. In fact Devon Price inspired the title....*A Leader Worth Following*.

The book will focus on an unspoken question, one the bears all of us grappling with. It's a question that is hanging in the air about our new CNO...and I shared this on Monday when I met with Roy Anderson.

*Are you a leader worth following?*

Frankly, he looked a little askance at me—like I was from another plant. I told him that truly great people work here and they deserve a leader worth following. I told him I hope he will be. I urge you to demand that he be. Don't settle for less. Promise me that much, please. And, of course, be a leader worth following yourself.

I'm going to leave you with the words I wrote in honor of the RF09 leadership team led by Kurt Krueger, Devon Price, Harlan Hanson, Jesse Pike, Mitch Dior and Mike Mohnney:

### **Leadership Is....**

**Leadership is a stand, a declaration of being cause in the matter.**

**Leadership is place to come from, not a position to hold.**

**Leadership is a privilege, the opportunity to make a difference any time, any where, simply by being you.**

**Leadership is a willingness to risk, to intervene, to make the 'impossible' happen.**

**Leadership gives voice to the future, causing the greatness in people to be fully expressed.**

**Leadership moves the world.**

\* \* \*

Keep moving this world. Thank you very much. God bless you all.

**D**uring the past few weeks, you've received several messages about the Power Shift initiative and its cornerstone, the Power Playbook. The objective is to take a thorough look at how PSEG Power operates and develop a market-focused, "company-best" way of managing our business for long-term success.

I realize that many of you want to know how the outcomes of this initiative may affect you and the job you do. That's completely understandable. Although the teams are hard at work, it will take more time before any concrete outcomes can be shared. We will, of course, provide you with information and status updates on the work of each team as that work progresses.

For now, however, I want to focus on what we *do* know – about our industry, the marketplace and what it will take for generation companies like PSEG Power to succeed now and well into the future.

If you follow what's been happening lately, you know that the economic environment and the markets we operate in are tough – and will undoubtedly get more difficult in the short term.

Here's the situation across the industry:

- Energy-sector stock prices are heavily depressed.
- Wholesale prices are depressed and, as a result,
- Profit margins are dropping significantly.
- Investor confidence is at an all-time low, reflecting recent events within and outside our industry.

- Many regions have overbuilt capacity.
- Plants are being sold at depressed prices and projects or being stalled or even cancelled.

This dismal outlook prompted one industry analyst to recently comment, "I don't see any catalyst to turn things around in the short term."

The good news is that PSEG – reflecting in large part PSEG Power's contributions -- is expected to meet annual earnings estimates, unlike many of our peers who are making headlines recently.

However, that doesn't mean we're immune from these marketplace forces. Last week, our stock continued its downward slide. And while Moody's Investors Service reaffirmed debt ratings, the agency changed its outlook for PSEG, PSEG Energy Holdings and PSEG Power to "negative" from "stable." (Only PSE&G, the utility, kept its "stable" outlook.)

Moody's said it will monitor our business more closely for developments that may impact its ratings. Those developments include the outcome of next year's auction to supply Basic Generation Service (BGS) and the prospect of lower profit margins because of the overall outlook for the wholesale power market.

What does all this mean for us? While we can't control the market, we can take control of how we run our business to not only weather the short-term bumps in the road but gain additional market strength for the long-term.

At the moment, we're in better shape than most:

- Despite its current price, our stock is still higher than many of our competitors.
- We have strong cash flow, and are taking steps to improve it even further.
- The BGS contract provides a secure market for most of Power's generation, at least until next year.
- Our location in PJM, with its current transmission constraints, is a plus.
- We've adjusted Power's growth strategy from new construction to acquiring existing assets like Wisvest.

This market *will* turn around. This industry will recover and thrive. And when it does, we will be there.

###

But these advantages alone aren't enough to see us through the next few years while we wait for the market to turn around. Successful companies will take the opportunity to become stronger operationally. For us, that means developing best practices, driving out unnecessary costs and better aligning the way we do things across our footprint where it makes sense. It means understanding better how one part of our business affects another – and sharing that information more quickly and effectively. And it means ensuring that PSEG Power is guided by one vision, a sound strategy and a meaningful, core set of values that we adhere to relentlessly.

That's exactly what Power Shift and Power Playbook are designed to accomplish. Will there be changes in how we work? Absolutely. But I'm confident they will be the right changes for the right reasons. And most importantly, all parts and all employees of PSEG Power will play a vital and integral part in achieving excellence -- together.

I've said before that we're in this business for the long haul. And so are the outcomes we're envisioning. I can assure you that this is not a program that, given enough time, will fall by the wayside. We simply can't afford for that to happen. Power's senior leaders won't allow it to happen.

---

BUILDING A  
STRONGER WORKPLACE  
at  
*PSEG Nuclear*

Q<sup>12</sup><sup>TM</sup> Leadership Forum Presentation  
23 January 2002

# INPO Feedback on Engagement

Summer 2001

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## *Leadership Through People:*

- Management is not successfully driving the station vision through engagement of the workforce
  - Not tapped the talent of the workforce
  - Not engaged
  - Field time limited(don't block time)
  - People want to be led
  - Working and listening not well established
  - No clear plan to close the gap

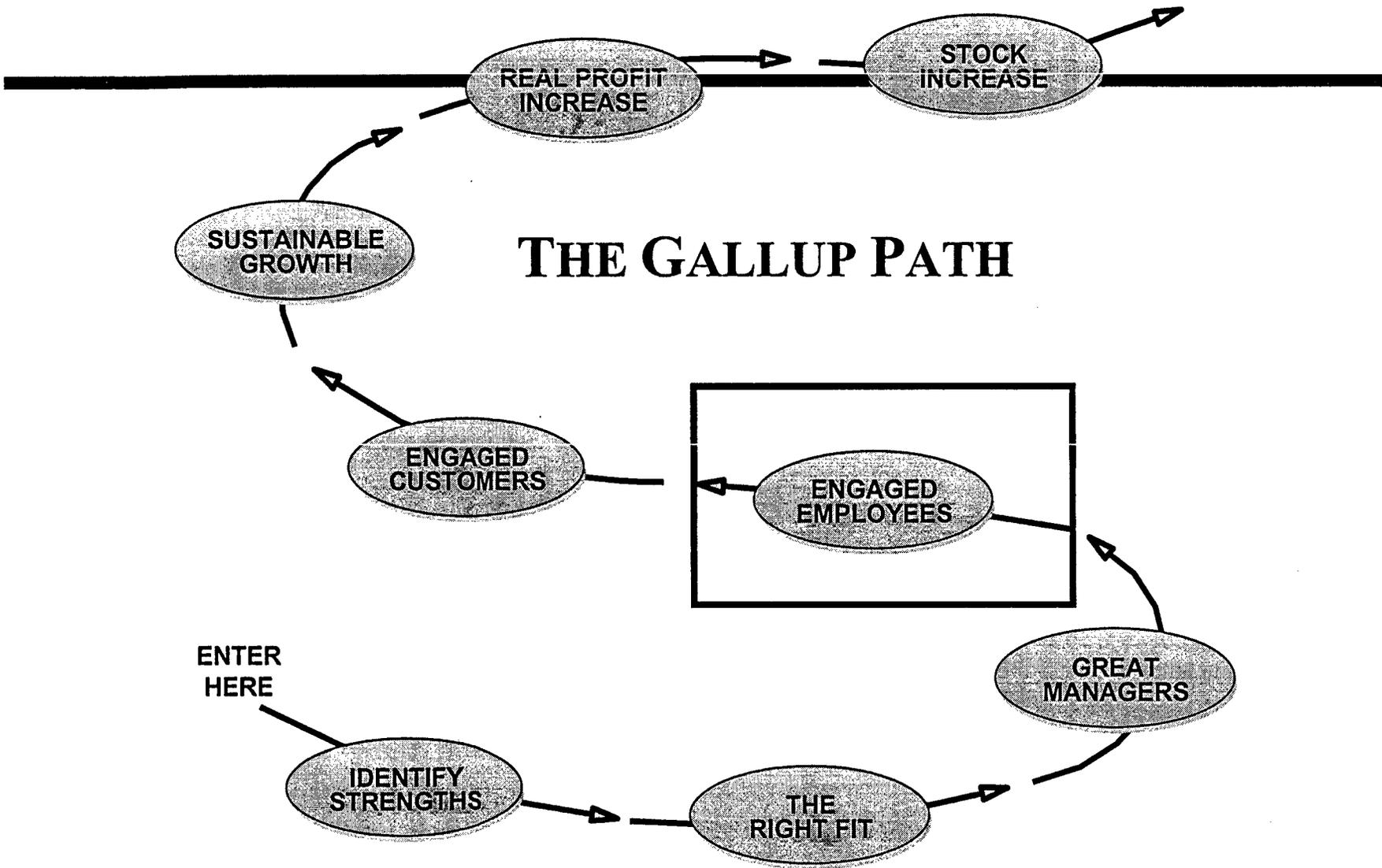
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# THE GALLUP PATH

# Q<sup>12</sup><sup>TM</sup> Review

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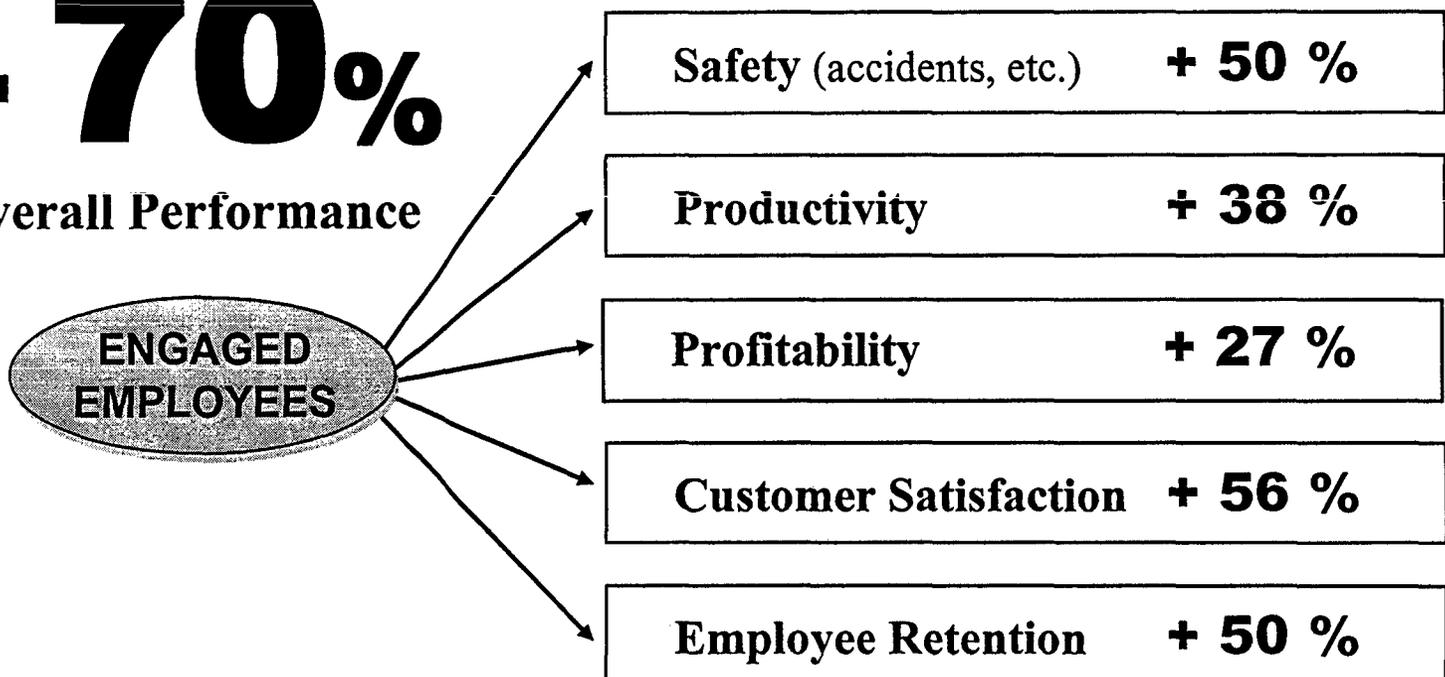
- The conditions that engage employees are very local.
  - There is no central fix to making your workplace stronger.
- The Q<sup>12</sup> items measure the *most* information, and most *important* information about a workplace.
  - The Q<sup>12</sup> items predict business outcomes, across industries and job functions.
- There is a hierarchy behind the Q<sup>12</sup> items; the first six questions form the foundation of a great place to work.

# Meta-Analysis 2000 – Business Impact

---

**+ 70%**  
Overall Performance

**ENGAGED  
EMPLOYEES**



```
graph LR; A(ENGAGED EMPLOYEES) --> B[Safety (accidents, etc.) + 50%]; A --> C[Productivity + 38%]; A --> D[Profitability + 27%]; A --> E[Customer Satisfaction + 56%]; A --> F[Employee Retention + 50%];
```

**Safety** (accidents, etc.)

**+ 50 %**

**Productivity**

**+ 38 %**

**Profitability**

**+ 27 %**

**Customer Satisfaction**

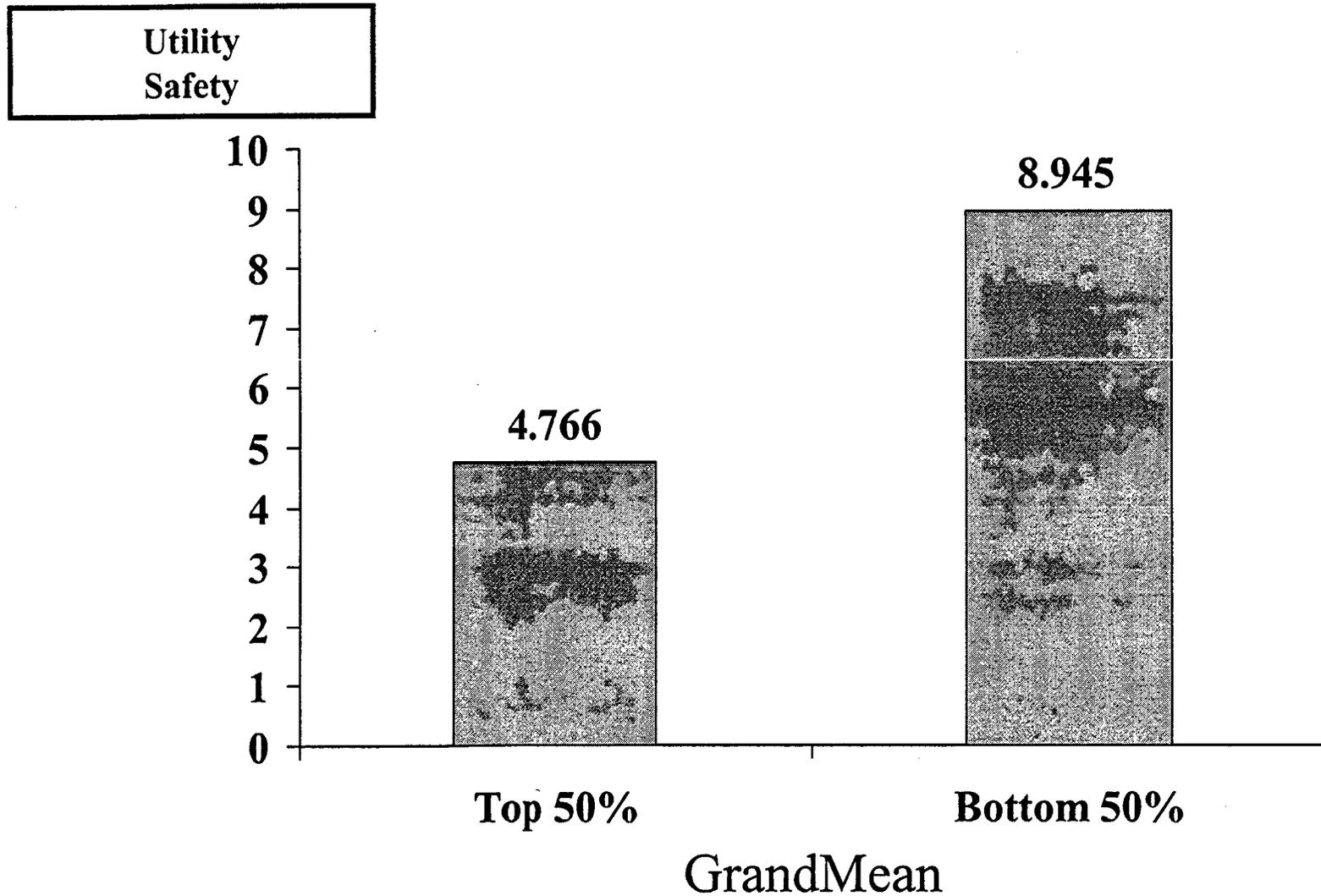
**+ 56 %**

**Employee Retention**

**+ 50 %**

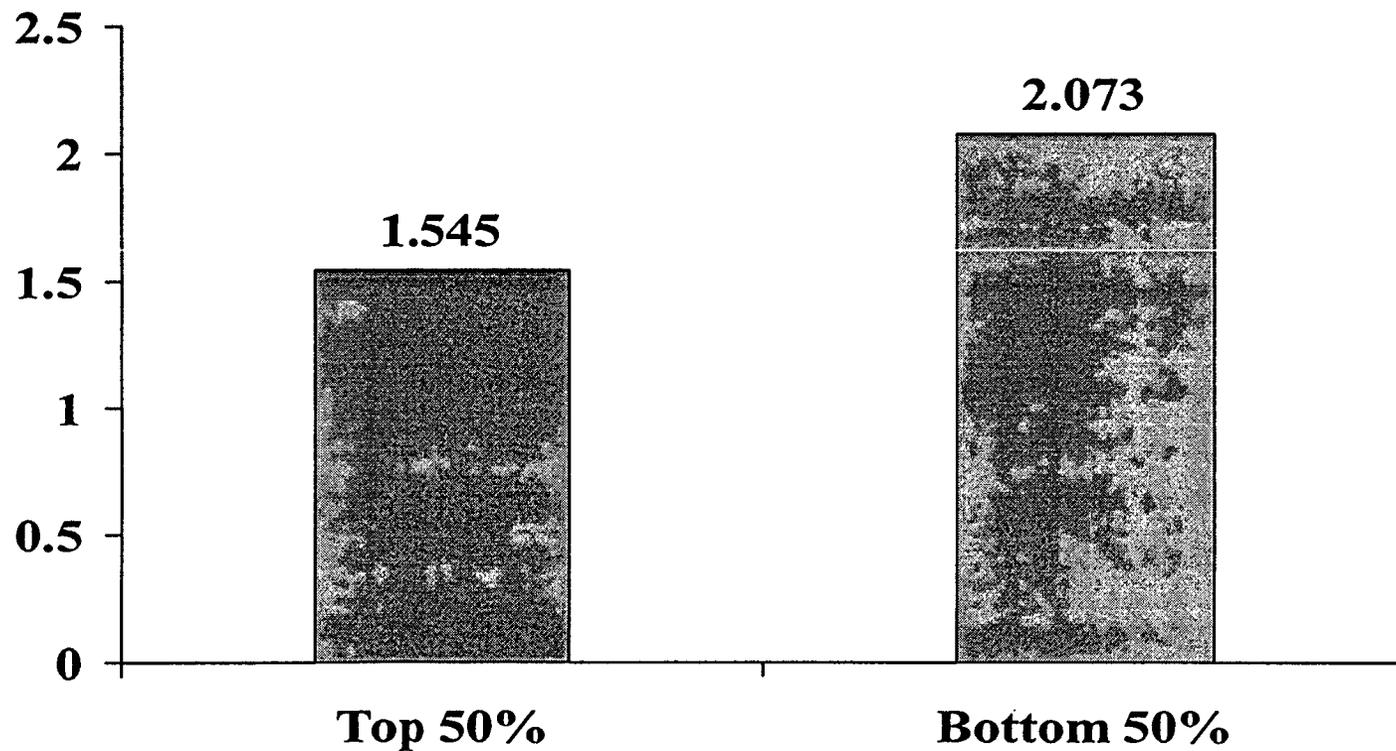
Probability  
of Success

# Number of Incidents (a)



# Lost Work Days Per Incident (a)

Utility  
Safety



GrandMean

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Employee Engagement at  
*PSEG Nuclear*

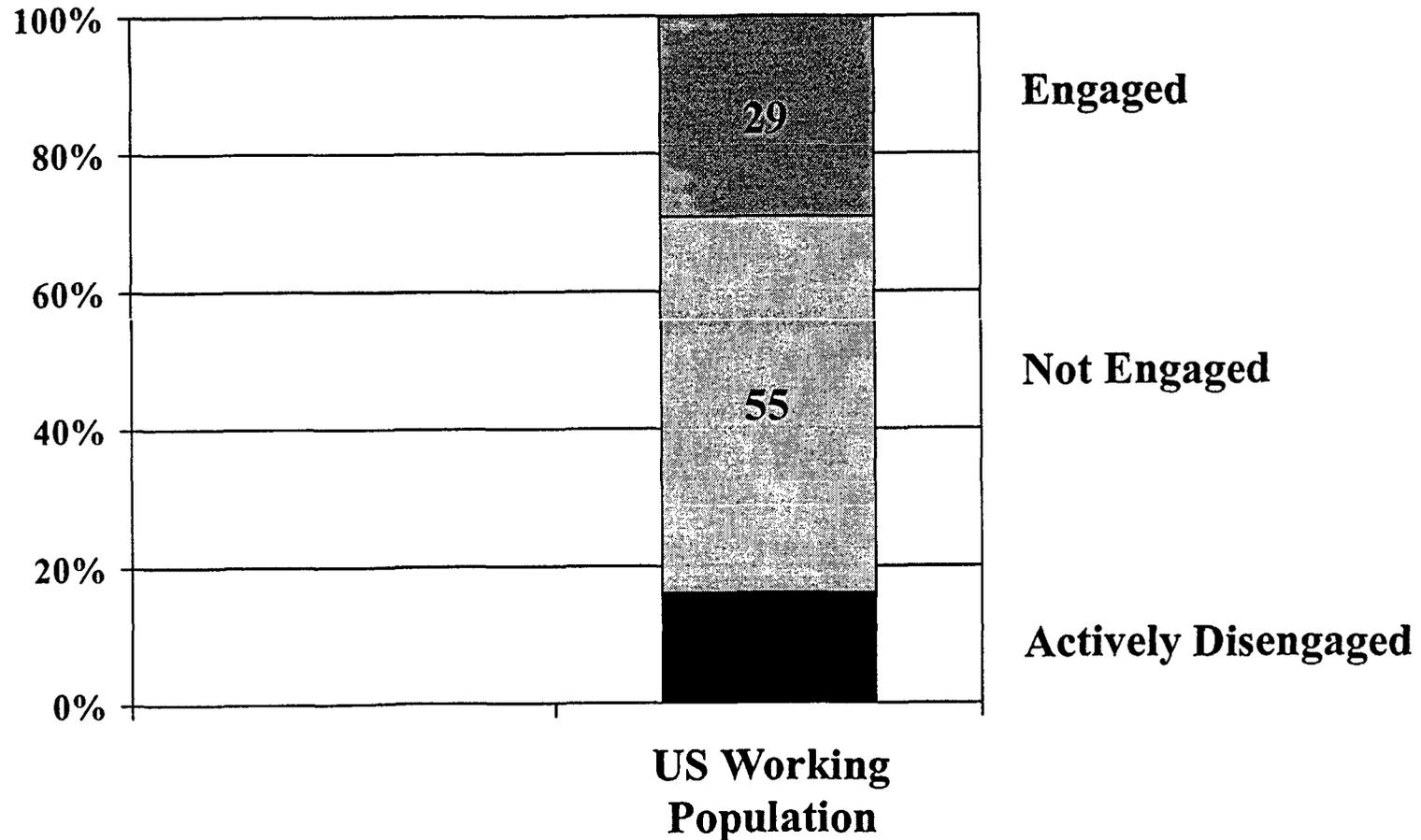
# Methodology

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- **Survey administration occurred via IVR methodology during November 26 – December 9, 2001.**
- **Survey items included Gallup's Q<sup>12</sup> items and overall satisfaction. In addition, employees were asked to indicate their length of service, length of service with current supervisor, job function, and shift worked.**
- **1,440 employees participated from PSEG Nuclear's total population of 1,821, yielding a 79.3% response rate.**
  - **PSEG Nuclear 2000: 69%.**
  - **Gallup's average rate of response: 77%.**

# Gallup Q<sup>12</sup><sup>TM</sup> Engagement Index

THE GALLUP POLL

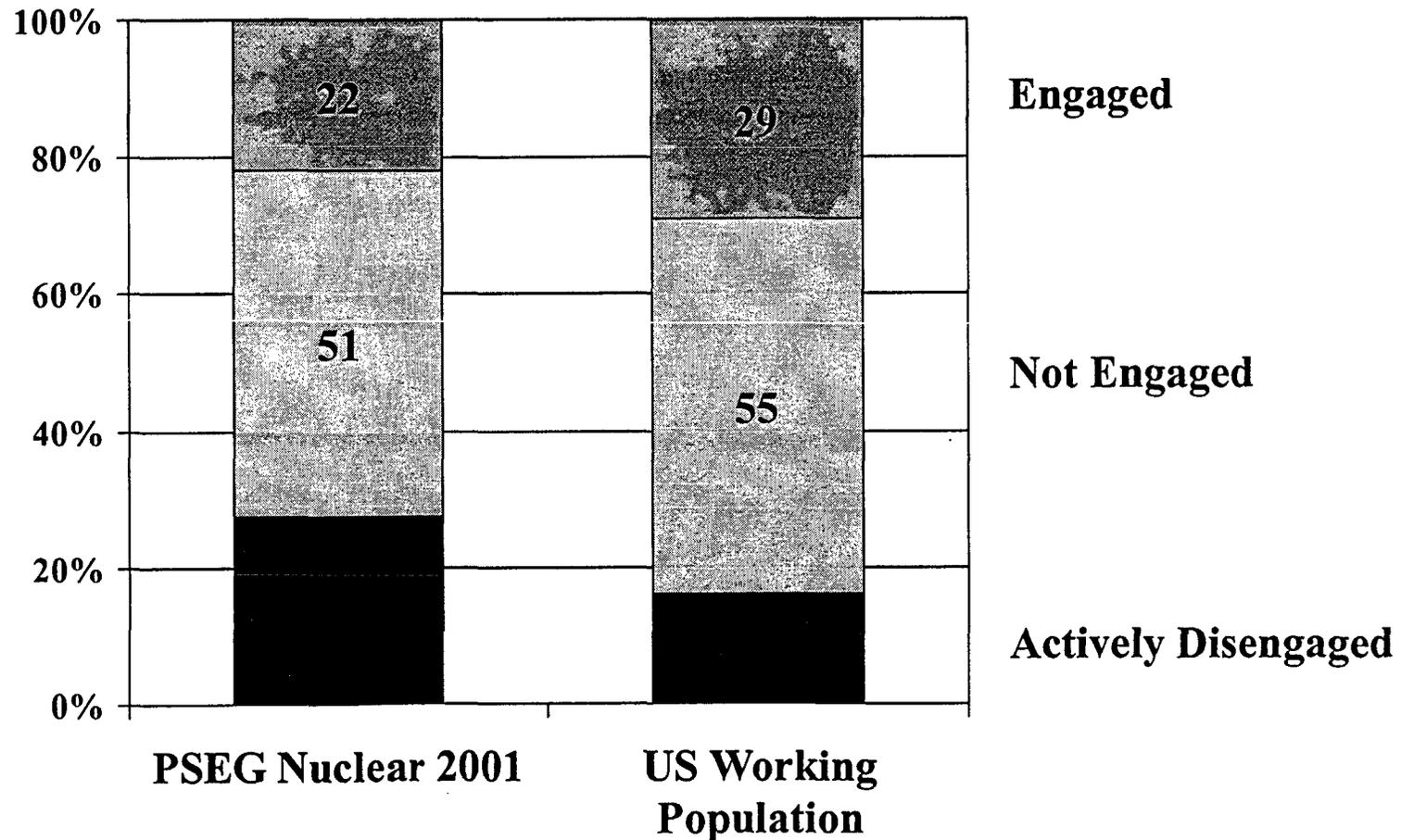


Source: Gallup Poll data of U.S. working population 18 years and older, accumulated over October 2000, February 2001, and May 2001

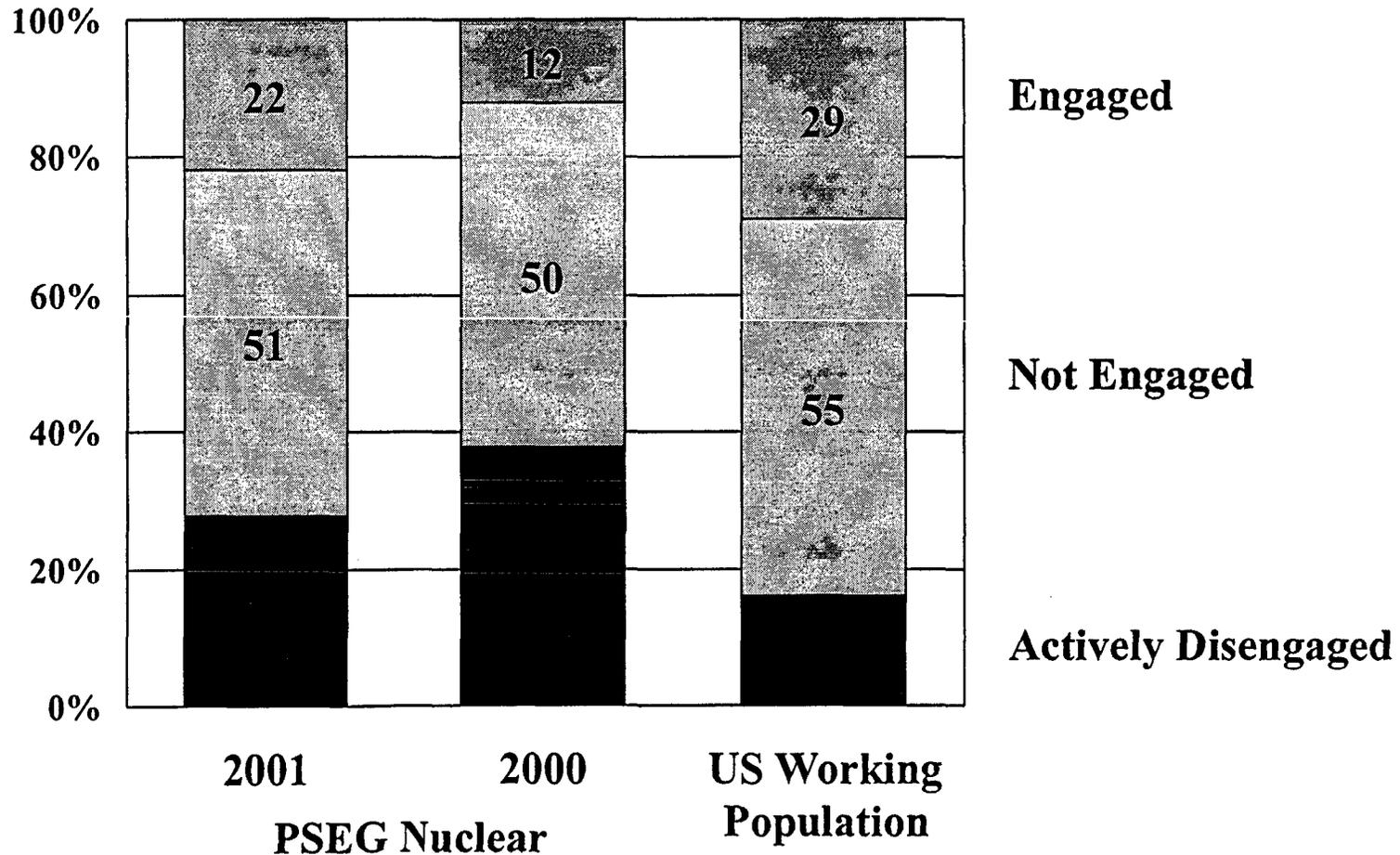
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# Gallup Q12™ Engagement Index

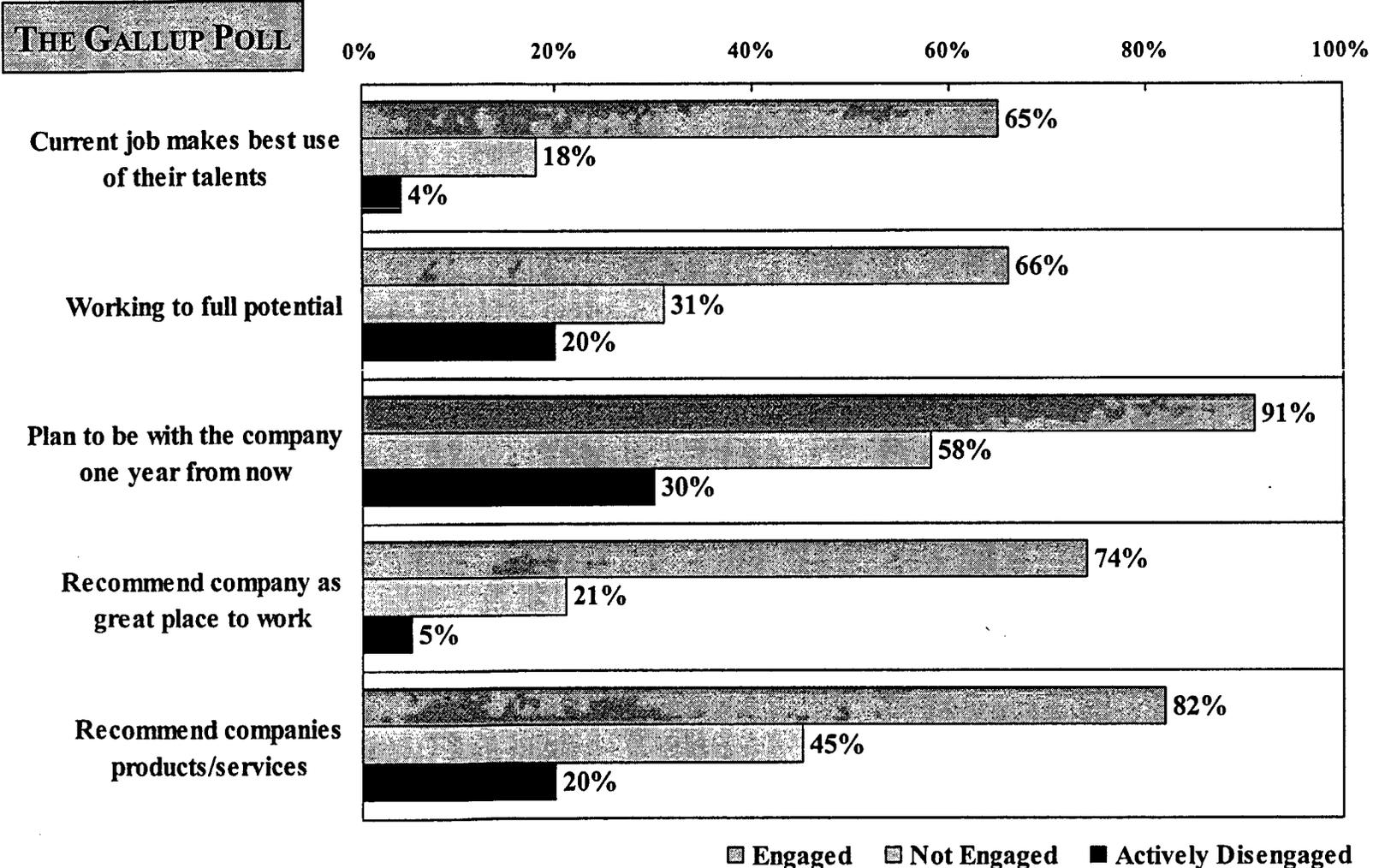


# Gallup Q12™ Engagement Index



# Gallup Q12™ Engagement Index

## Business Impact



© 2001 Gallup Poll data of US working population 18 years and older

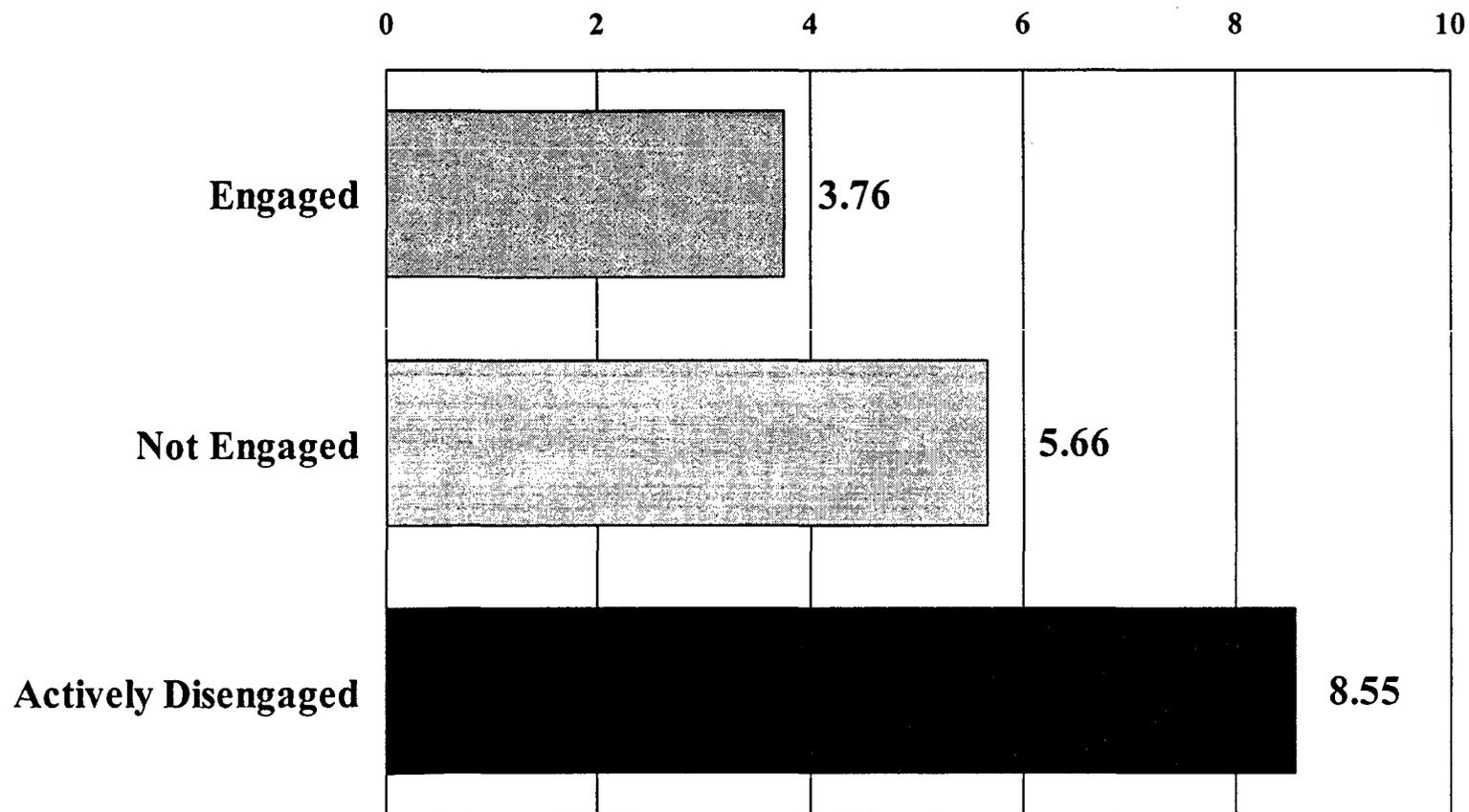
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# Gallup Q12™ Engagement Index

## Days missed from work in last year

THE GALLUP POLL



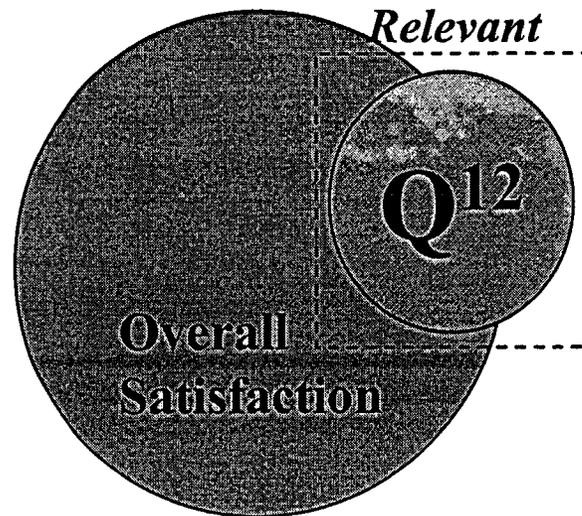
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# Overall Satisfaction with PSEG Nuclear

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- PSEG Nuclear 2001 = **17 %**
- PSEG Nuclear 2000 = **7 %**
- *Gallup dB 50th Percentile* = **17 %**



# Highest Rated Q<sup>12</sup><sup>TM</sup> Items Overall (2001)

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	Mean	% 5s
My associates or fellow employees are committed to doing quality work. <b>71<sup>st</sup> Percentile</b>	3.92	31
I know what is expected of me at work. <b>20<sup>th</sup> Percentile</b>	3.82	31
My supervisor, or someone at work seems to care about me as a person. <b>39<sup>th</sup> Percentile</b>	3.60	32
The mission or purpose of my company makes me feel my job is important. <b>44<sup>th</sup> Percentile</b>	3.55	22
This last year, I have had opportunities at work to learn and grow. <b>34<sup>th</sup> Percentile</b>	3.48	28
I have the materials & equipment to do my work right. <b>28<sup>th</sup> Percentile</b>	3.41	18

# Lowest Rated Q<sup>12</sup><sup>TM</sup> Items Overall (2001)

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	Mean	% 5s
In the last 7 days, I have received recognition or praise for doing good work. <b>47<sup>th</sup> Percentile</b>	3.04	23
In the last 6 months, someone at work has talked to me about my progress. <b>31<sup>st</sup> Percentile</b>	3.13	24
There is someone at work who encourages my development. <b>30<sup>th</sup> Percentile</b>	3.14	18
I have a best friend at work. <b>39<sup>th</sup> Percentile</b>	3.19	21
At work, my opinions seem to count. <b>39<sup>th</sup> Percentile</b>	3.26	18
At work, I have the opportunity to do what I do best every day. <b>31<sup>th</sup> Percentile</b>	3.40	19

# PSEG Nuclear 2001 vs 2000

**34<sup>th</sup> Percentile**

**GrandMean:**

**PSEG Nuclear 2001**

**3.41**

(n=1,440)

**% 5s**

**Opportunities to learn and grow  
Progress in last six months**

**28  
24**

**Best friend  
Coworkers committed to quality  
Mission/Purpose of company  
My opinions count**

**21  
31  
22  
18**

**Encourages development  
Supervisor/Someone at work cares  
Recognition last seven days  
Do what I do best every day**

**18  
32  
23  
19**

**Materials and equipment  
I know what is expected of me at work**

**18  
31**

# PSEG Nuclear 2001 vs. 2000

	34 <sup>th</sup> Percentile		15 <sup>th</sup> Percentile	
	PSEG Nuclear 2001		PSEG Nuclear 2000	
<b>GrandMean:</b>	3.41		3.12	
	(n=1,440)		(n=1,315)	
	% 5s		% 5s	
<b>Opportunities to learn and grow Progress in last six months</b>	28	+ 6	22	
	24	- 3	27	
<b>Best friend Coworkers committed to quality Mission/Purpose of company My opinions count</b>	21	+ 4	17	
	31	+ 4	27	
	22	+ 11	11	
	18	+ 8	10	
<b>Encourages development Supervisor/Someone at work cares Recognition last seven days Do what I do best every day</b>	18	+ 5	13	
	32	+ 10	22	
	23	+ 6	17	
	19	+ 8	11	
<b>Materials and equipment I know what is expected of me at work</b>	18	+ 6	12	
	31	+ 10	21	

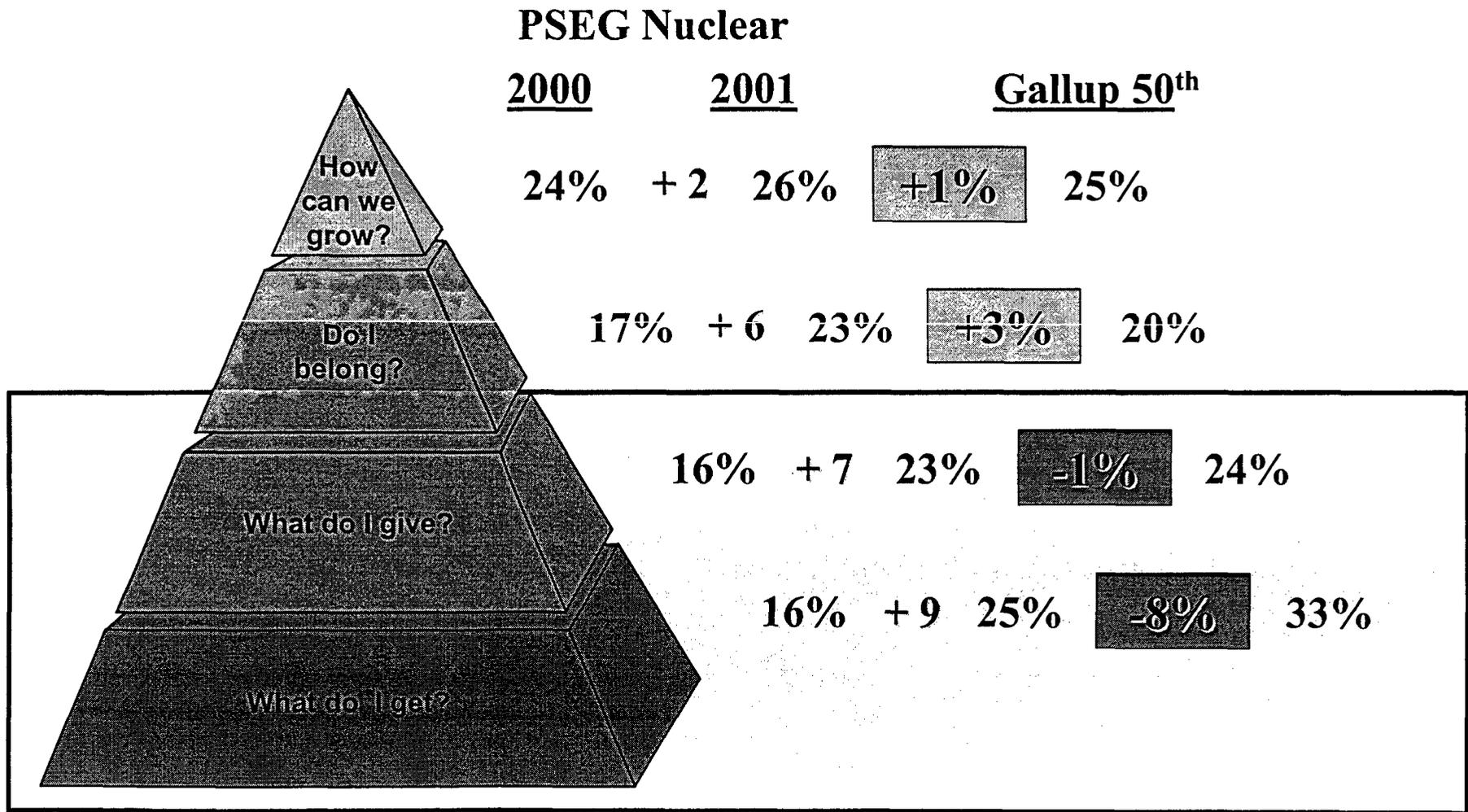
Based on 2000 Database, GrandMeans fall in the 32<sup>nd</sup> (2001) and 13<sup>th</sup> (2000) percentiles.

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# PSEG Nuclear 2001 vs. Gallup Database

GrandMean:	PSEG Nuclear 2001	Gallup 50 <sup>th</sup> Percentile
		3.41 (n=1,440)
	% 5s	% 5s
Opportunities to learn and grow Progress in last six months	28 24	29 22
Best friend Coworkers committed to quality Mission/Purpose of company My opinions count	21 ⇒ 31 22 18	22 ⇒ 21 20 17
Encourages development Supervisor/Someone at work cares Recognition last seven days Do what I do best every day	18 32 23 19	20 32 20 22
Materials and equipment I know what is expected of me at work	⇒ 18 ⇒ 31	⇒ 23 ⇒ 42

# PSEG Nuclear Engagement Hierarchy



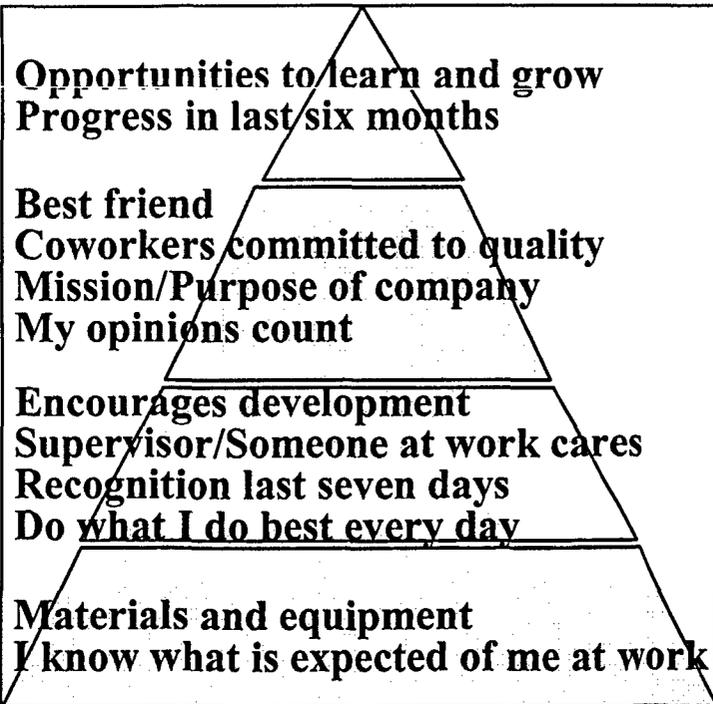
# PSEG Nuclear vs. Gallup Manufacturing

	PSEG Nuclear 2001	Manufacturing 50 <sup>th</sup> Pcntl
<b>GrandMean:</b>	3.41	3.51
	(n=1,440)	
	% 5s	% 5s
<b>Opportunities to learn and grow</b>	⇒ 28	⇒ 23
<b>Progress in last six months</b>	⇒ 24	⇒ 17
<b>Best friend</b>	⇒ 21	⇒ 20
<b>Coworkers committed to quality</b>	⇒ 31	⇒ 20
<b>Mission/Purpose of company</b>	22	19
<b>My opinions count</b>	18	14
<b>Encourages development</b>	⇒ 18	⇒ 17
<b>Supervisor/Someone at work cares</b>	⇒ 32	⇒ 25
<b>Recognition last seven days</b>	⇒ 23	⇒ 14
<b>Do what I do best every day</b>	19	20
<b>Materials and equipment</b>	⇒ 18	⇒ 20
<b>I know what is expected of me at work</b>	⇒ 31	⇒ 36

# PSEG Nuclear Top Quartile (2001)

GrandMean:

	PSEG Nuclear Overall 2001	PSEG Nuclear 75 <sup>th</sup> Pcntl 2001	Gallup 75 <sup>th</sup> Percentile
	3.41	4.11	3.86
	(n=1,440)		
	% 5s	% 5s	% 5s
Opportunities to learn and grow	28	⇒ 55	⇒ 43
	24	⇒ 48	⇒ 40
Best friend Coworkers committed to quality Mission/Purpose of company My opinions count	21	38	36
	31	⇒ 45	⇒ 37
	22	⇒ 41	⇒ 33
	18	⇒ 37	⇒ 29
Encourages development Supervisor/Someone at work cares Recognition last seven days Do what I do best every day	18	38	36
	32	⇒ 60	⇒ 48
	23	⇒ 43	⇒ 33
	19	38	38
Materials and equipment I know what is expected of me at work	18	36	40
	31	⇒ 50	⇒ 60



# PSEG Nuclear Top Quartile (2001 vs. 2000)

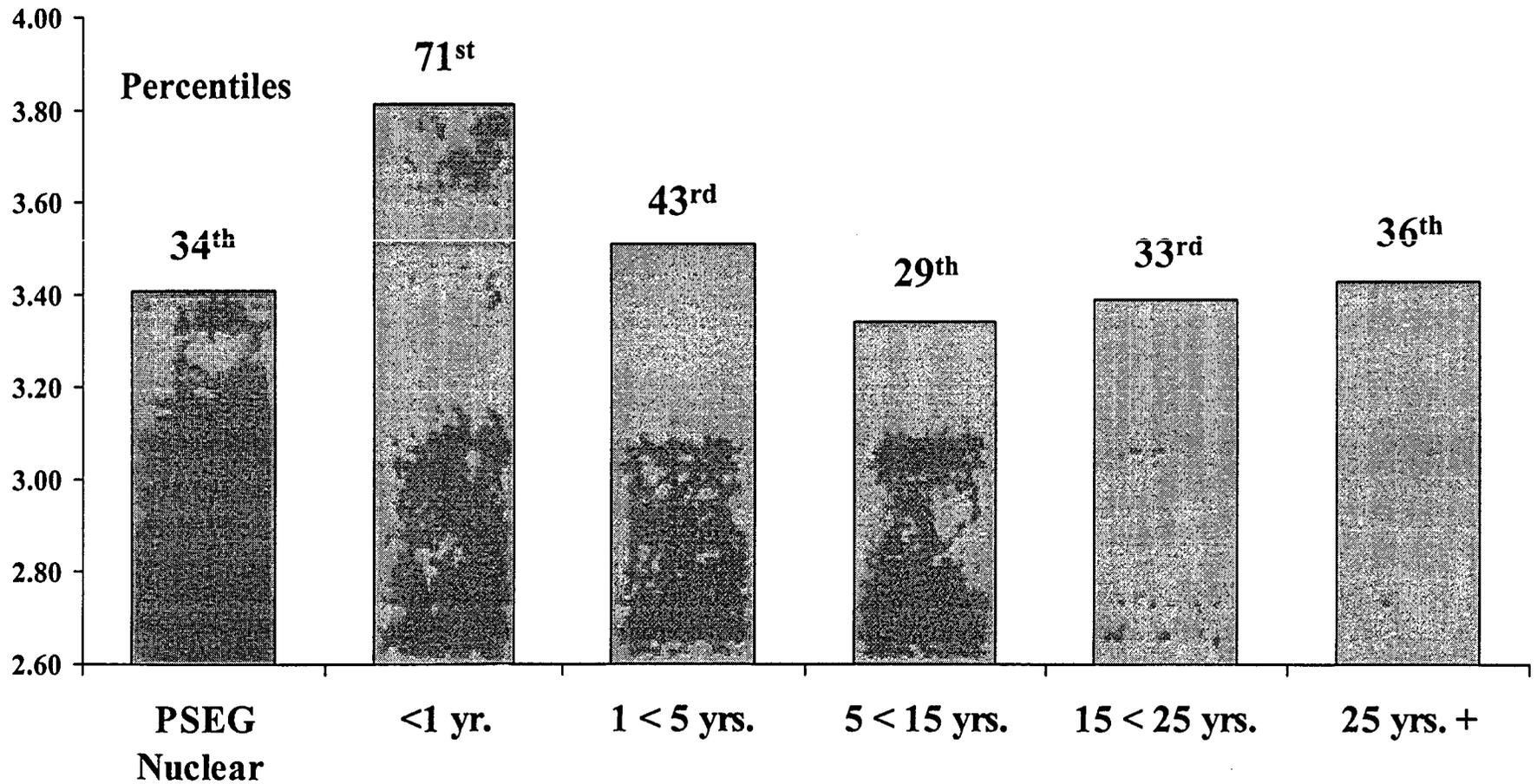
GrandMean:	PSEG Nuclear Overall 2001	PSEG Nuclear 75 <sup>th</sup> Pcntl 2001	PSEG Nuclear 75 <sup>th</sup> Pcntl 2000
	3.41	4.11	3.75
	(n=1,440)		
	% 5s	% 5s	% 5s
Opportunities to learn and grow Progress in last six months	28	55 + 16	39
	24	48 + 4	44
Best friend Coworkers committed to quality Mission/Purpose of company My opinions count	21	38 + 16	22
	31	45 + 15	30
	22	41 + 22	19
	18	37 + 17	20
Encourages development Supervisor/Someone at work cares Recognition last seven days Do what I do best every day	18	38 + 14	24
	32	60 + 21	39
	23	43 + 12	31
	19	38 + 18	20
Materials and equipment I know what is expected of me at work	18	36 + 14	22
	31	50 + 15	35

# Distribution of PSEG Nuclear Q<sup>12</sup><sup>TM</sup> Scores

	Percent of Responses on the Agreement Scale				
	% 1s	% 2s	% 3s	% 4s	% 5s
Opportunities to learn and grow Progress in last six months	12	12	20	28	28
	21	13	20	22	24
Best friend Coworkers committed to quality Mission/Purpose of company My opinions count	16	15	24	23	21
	3	6	19	41	31
	7	11	24	35	22
	14	13	24	31	18
Encourages development Supervisor/Someone at work cares Recognition last seven days Do what I do best every day	15	17	23	26	18
	11	11	18	28	32
	24	16	16	22	23
	9	12	28	31	19
Materials and equipment I know what is expected of me at work	7	14	27	33	18
	4	9	20	37	31

# PSEG Nuclear Engagement by Tenure with Company

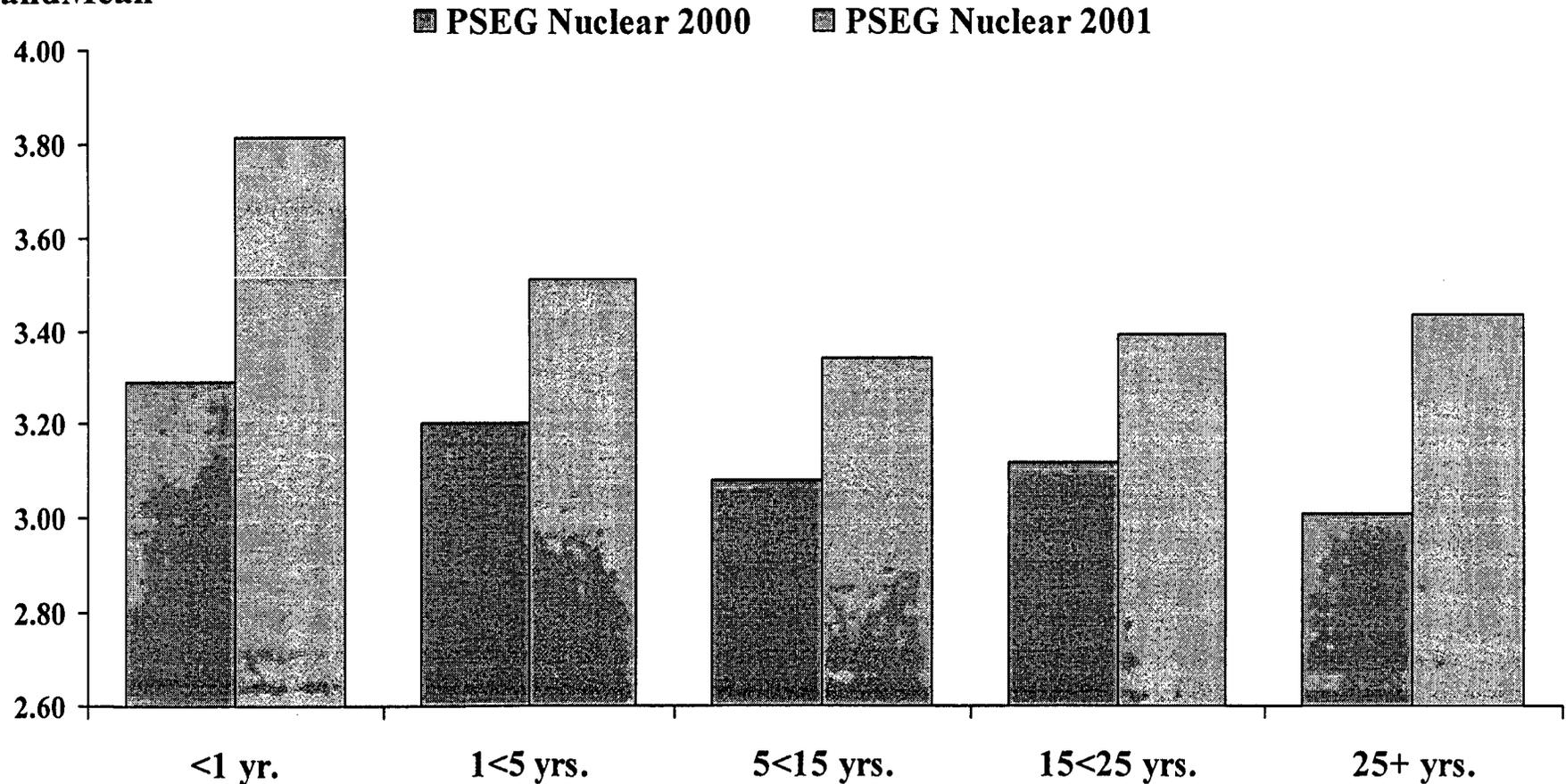
GrandMean



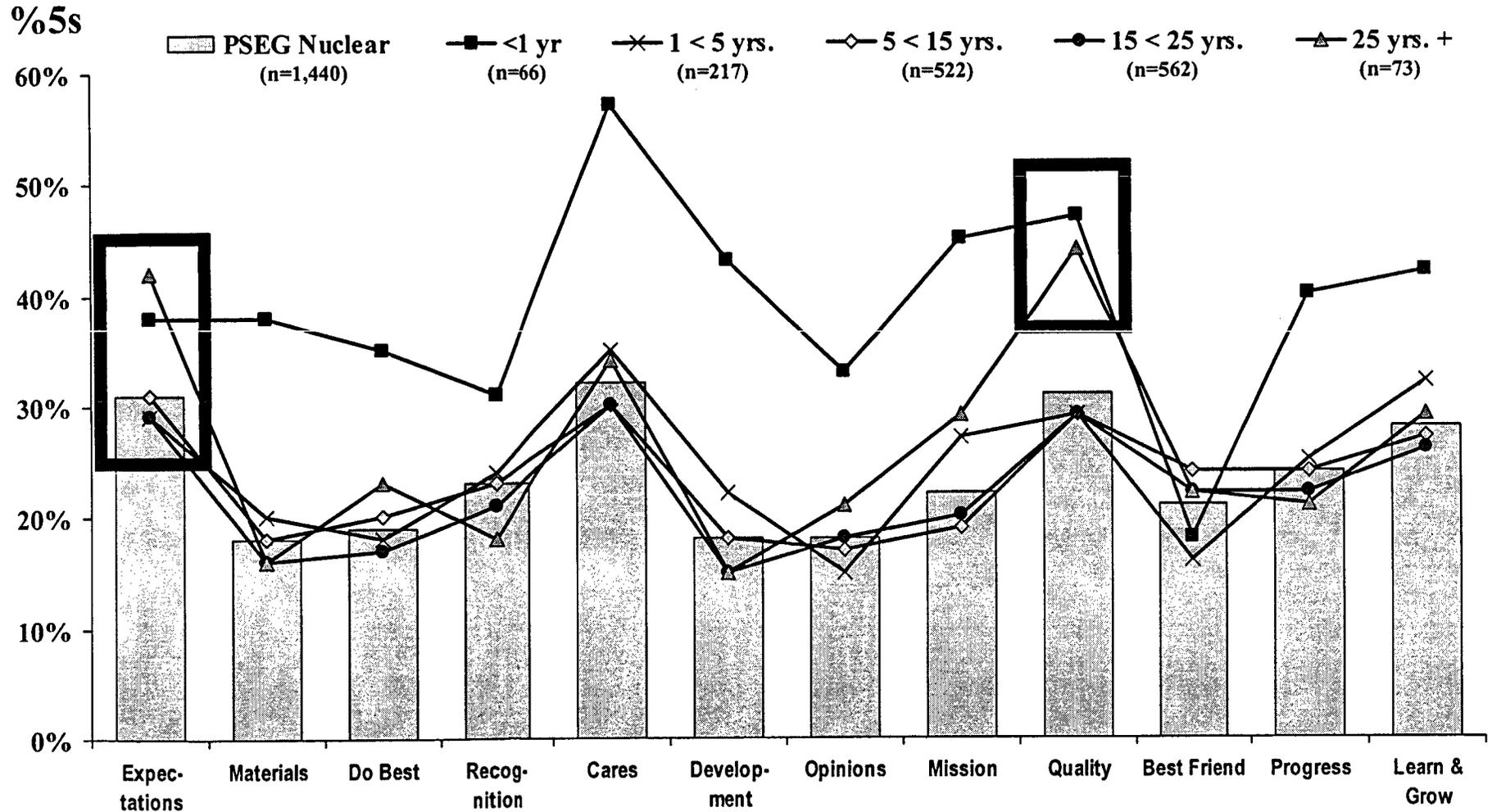
# PSEG Nuclear Engagement by Tenure with Company

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GrandMean

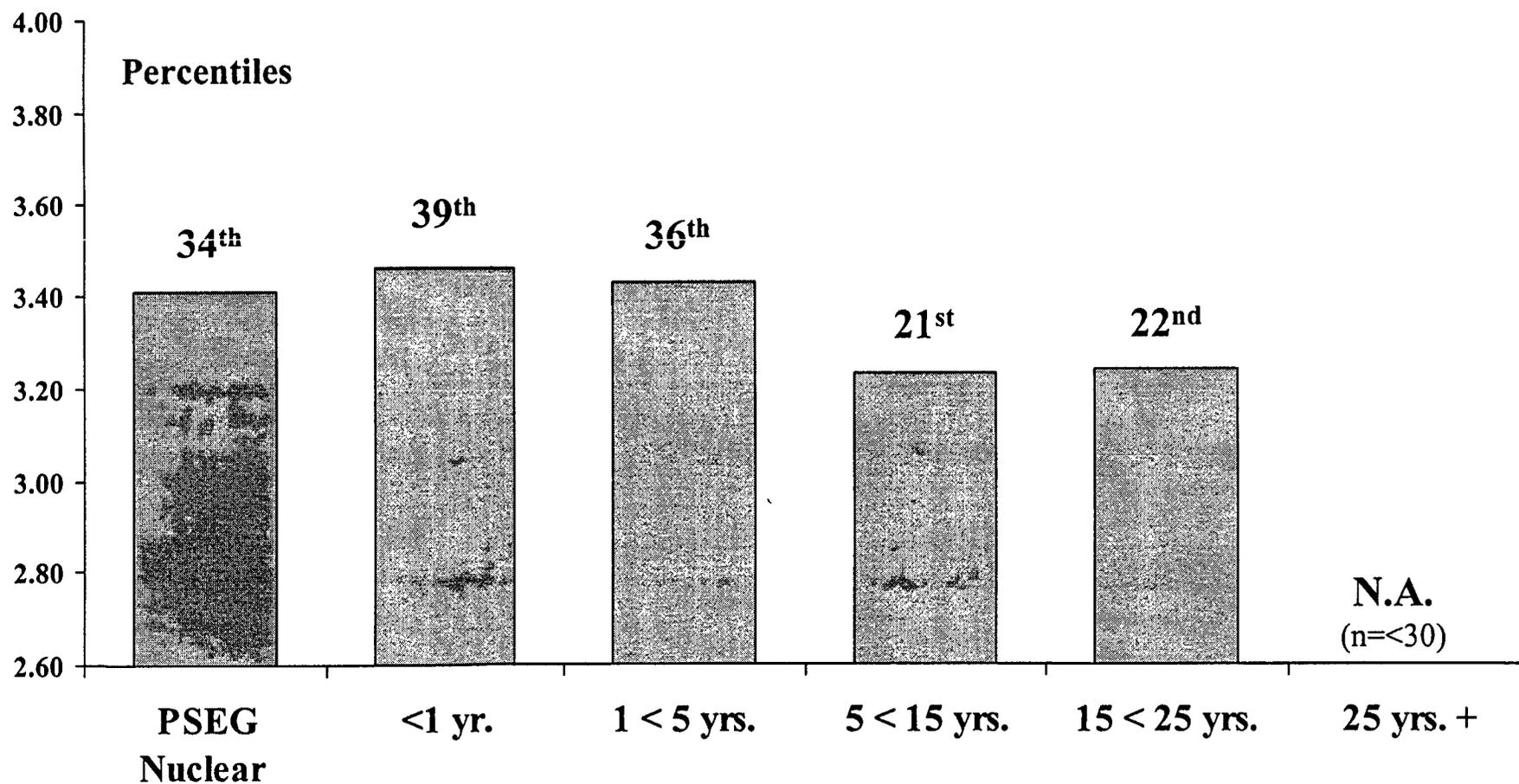


# PSEG Nuclear Q<sup>12</sup>™ Scores by Tenure with Company

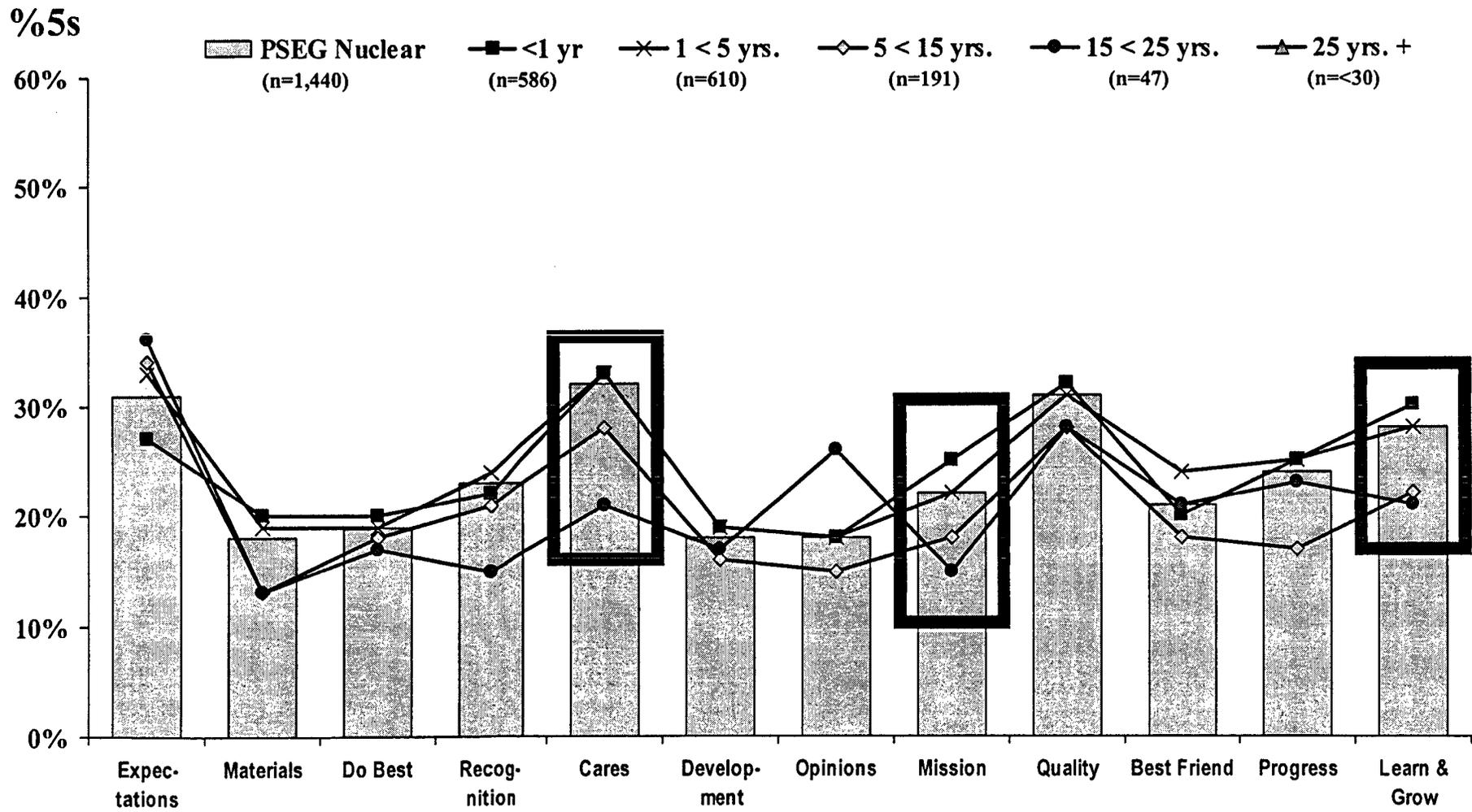


# PSEG Nuclear Engagement by Tenure with Manager

GrandMean

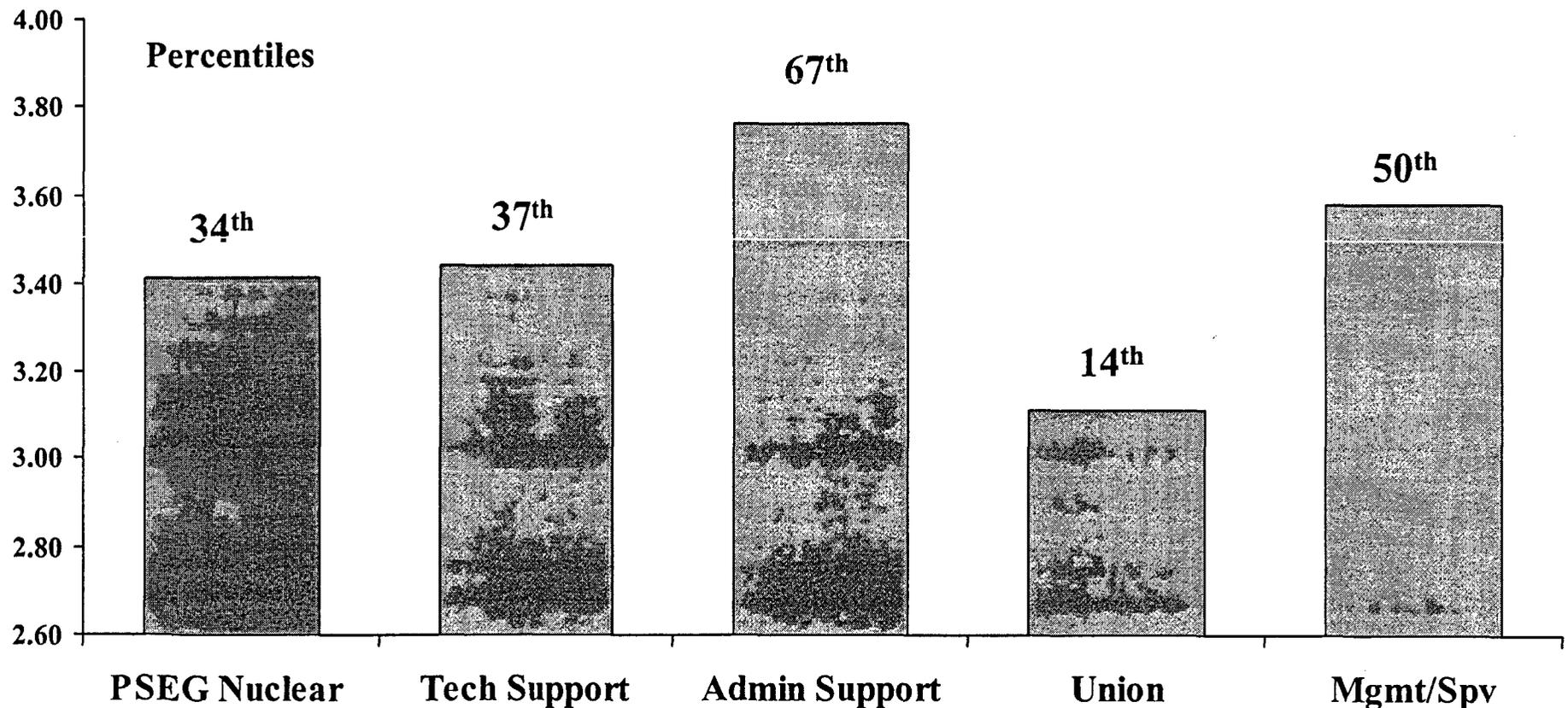


# PSEG Nuclear Q<sup>12</sup>™ Scores by Tenure with Manager

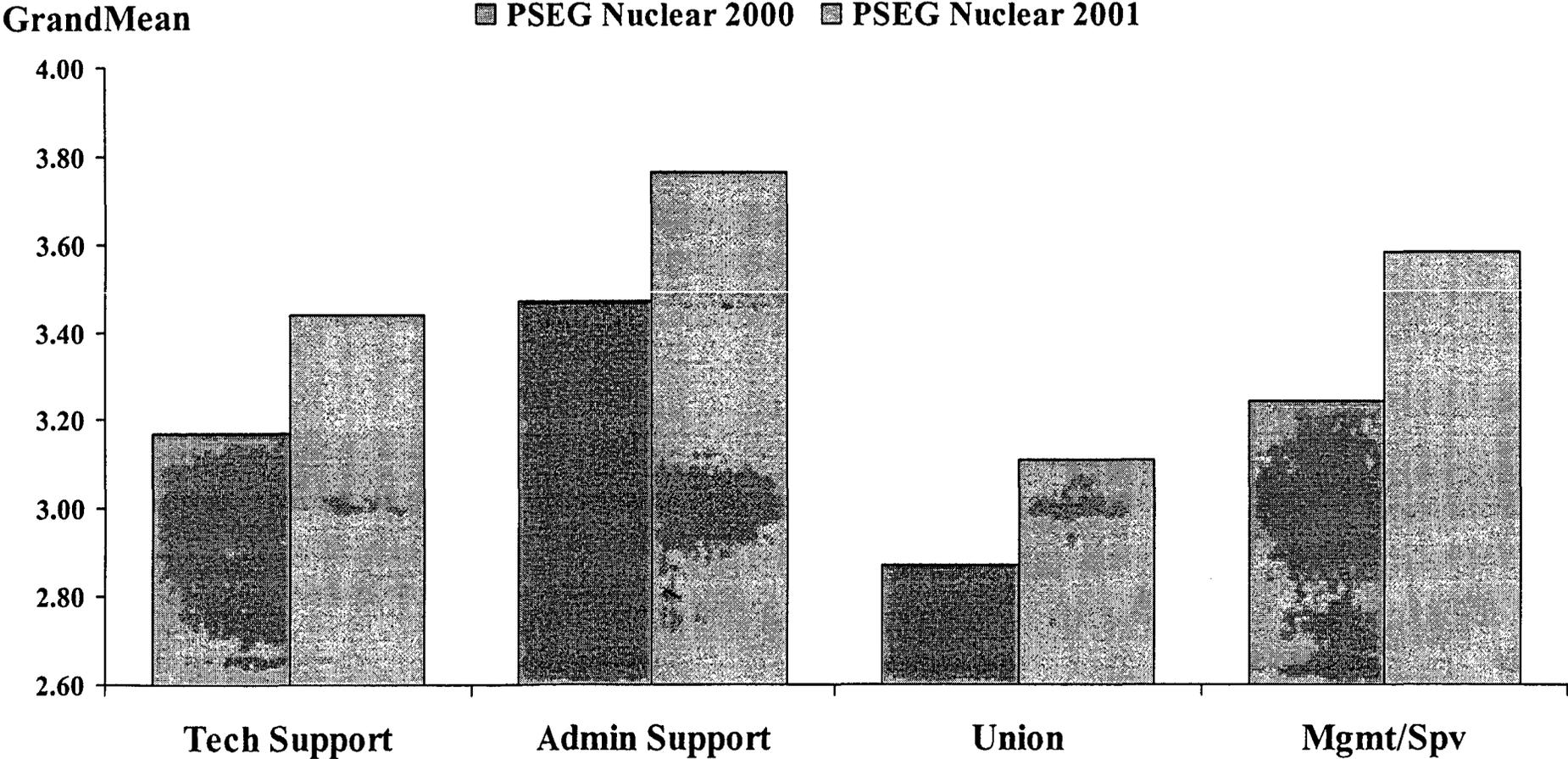


# PSEG Nuclear Engagement by Job Function

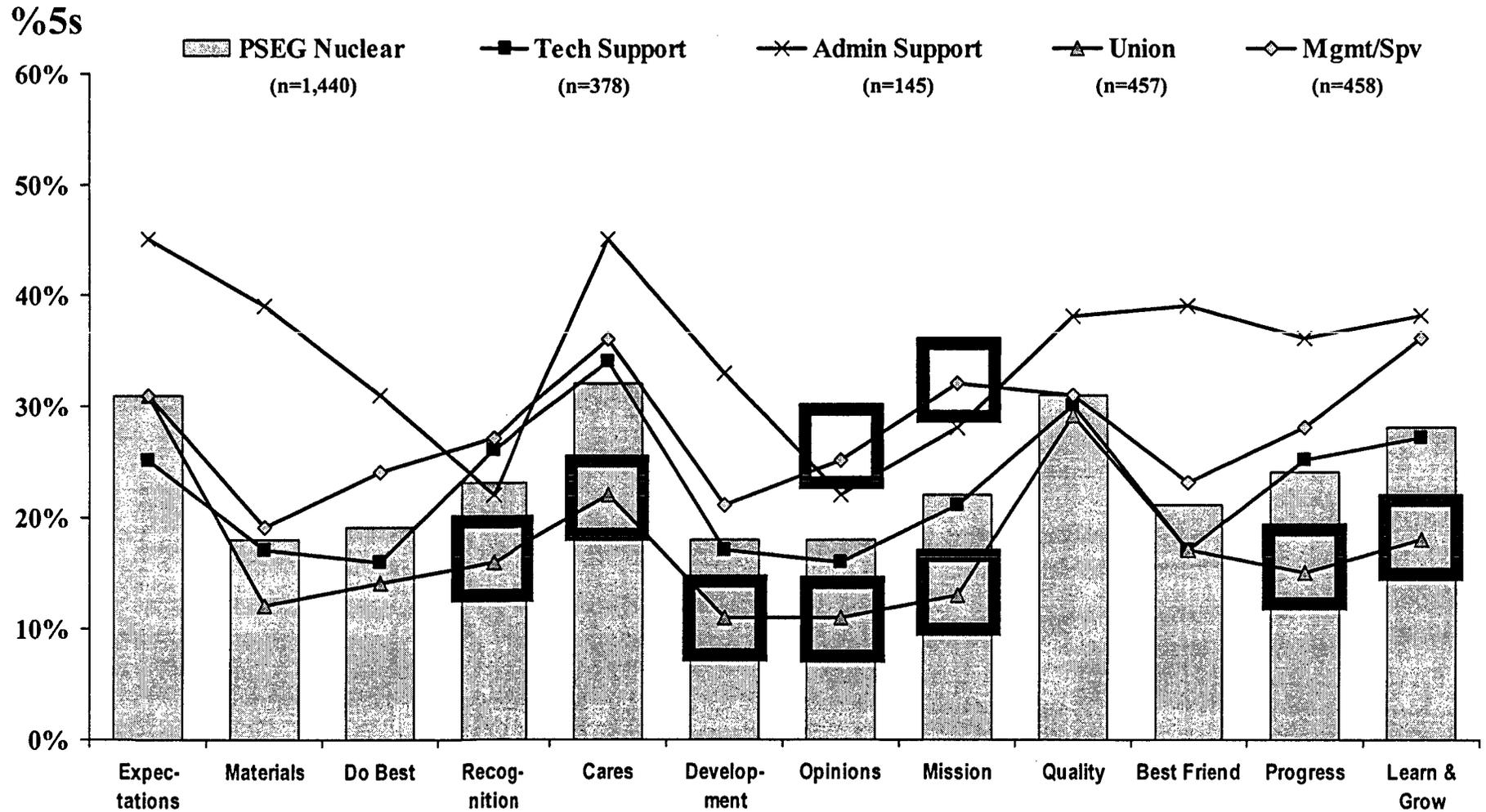
GrandMean



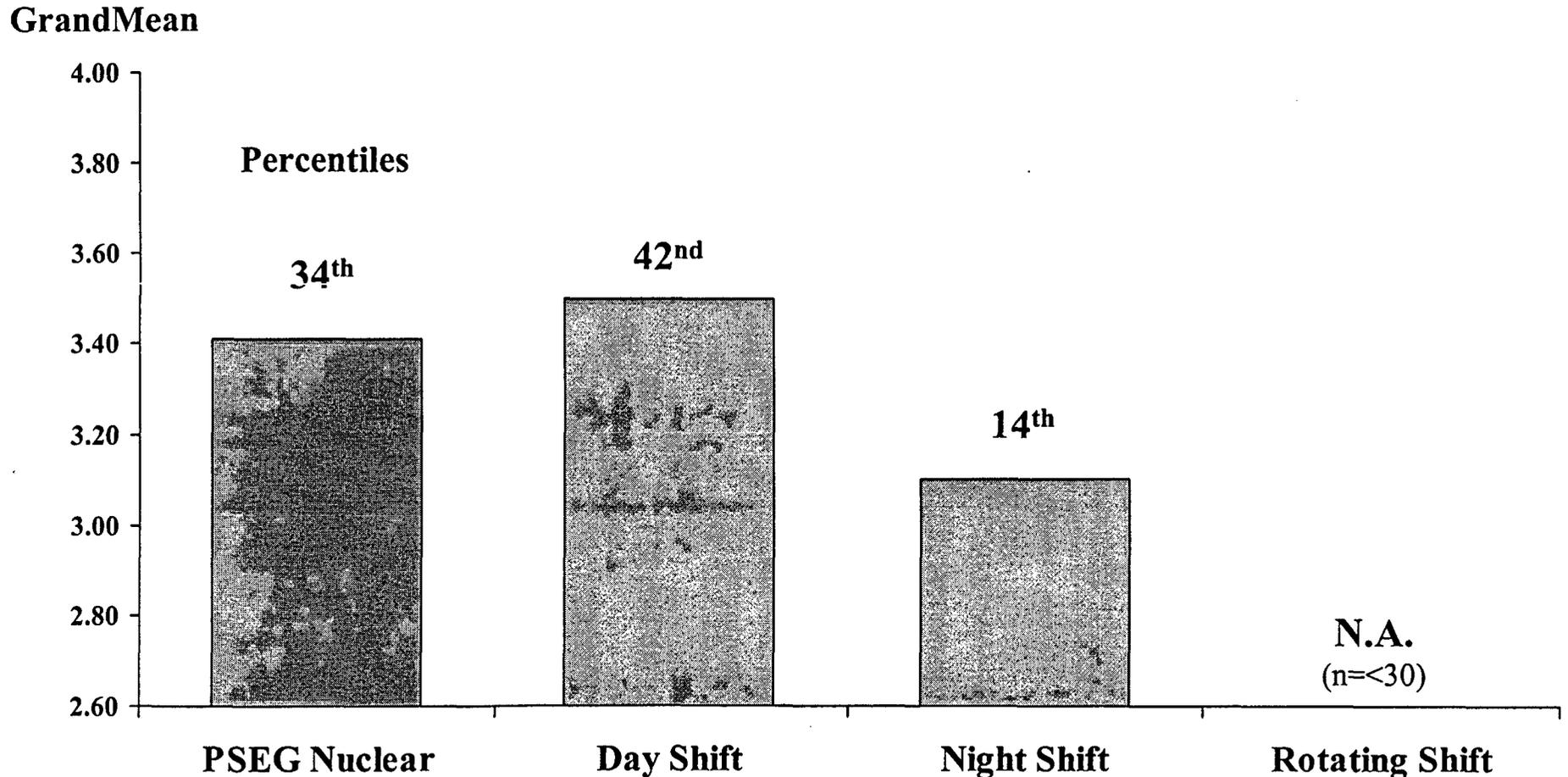
# PSEG Nuclear Engagement by Job Function



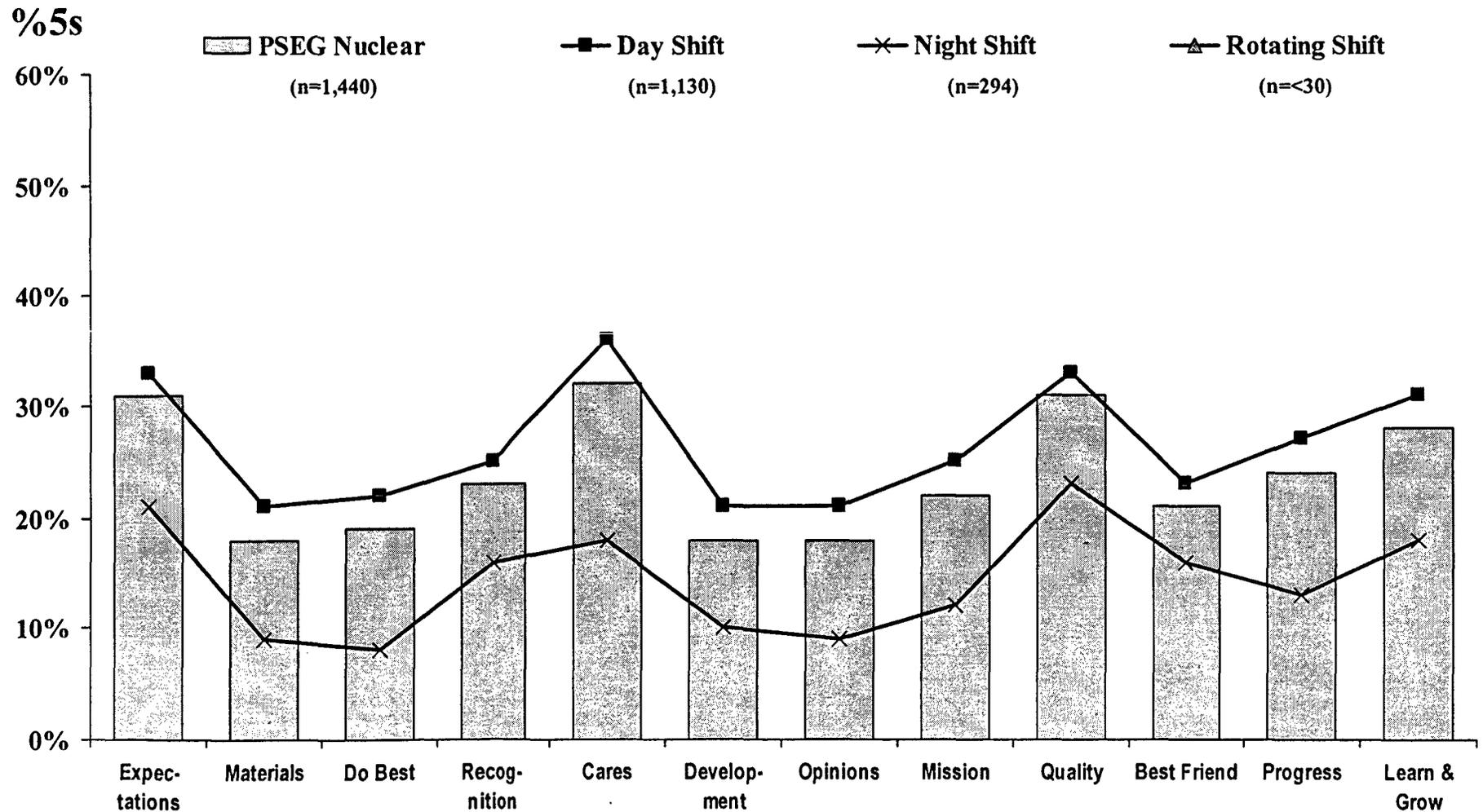
# PSEG Nuclear Q12™ Scores by Job Function



# PSEG Nuclear Engagement by Shift



# PSEG Nuclear Q12<sup>TM</sup> Scores by Shift



# PSEG Nuclear's Least & Most Engaged Work Groups

Grand Mean:	1 <sup>st</sup> Percentile	99 <sup>th</sup> Percentile
	PSEG Least Engaged	PSEG Most Engaged
	2.11	4.72
	(1 work group)	(1 work group)
	% 5s	% 5s
Opportunities to learn and grow Progress in last six months	4 8	83 100
Best friend Coworkers committed to quality Mission/Purpose of company My opinions count	0 4 4 4	67 33 67 83
Encourages development Supervisor/Someone at work cares Recognition last seven days Do what I do best every day	4 8 0 4	100 100 83 33
Materials and equipment I know what is expected of me at work	4 12	67 83

Note: Scores of top/bottom work group of 5 or more employees

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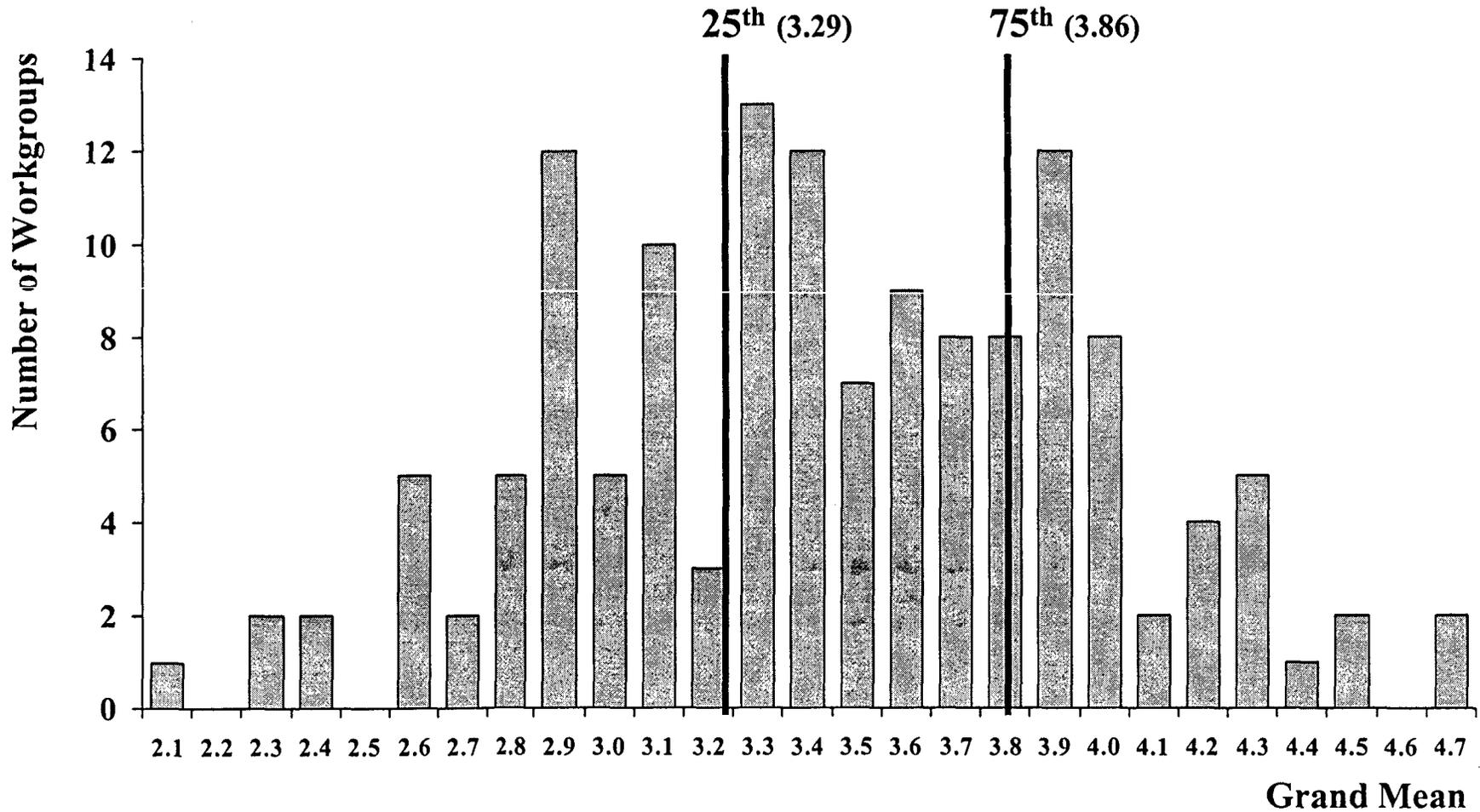
# PSEG Nuclear's Bottom 10% & Top 10% Work Groups

	Grand Mean:	
	1 <sup>st</sup> Percentile	97 <sup>th</sup> Percentile
	PSEG Bottom 10%	PSEG Top 10%
	2.56	4.36
	(16 workgroups)	(14 workgroups)
	% 5s	% 5s
Opportunities to learn and grow	10	66
Progress in last six months	9	57
Best friend	12	48
Coworkers committed to quality	21	54
Mission/Purpose of company	10	54
My opinions count	5	52
Encourages development	9	47
Supervisor/Someone at work cares	14	74
Recognition last seven days	6	52
Do what I do best every day	8	45
Materials and equipment	8	45
I know what is expected of me at work	11	65

Note: Average of top/bottom 10% work groups of 5 or more employees

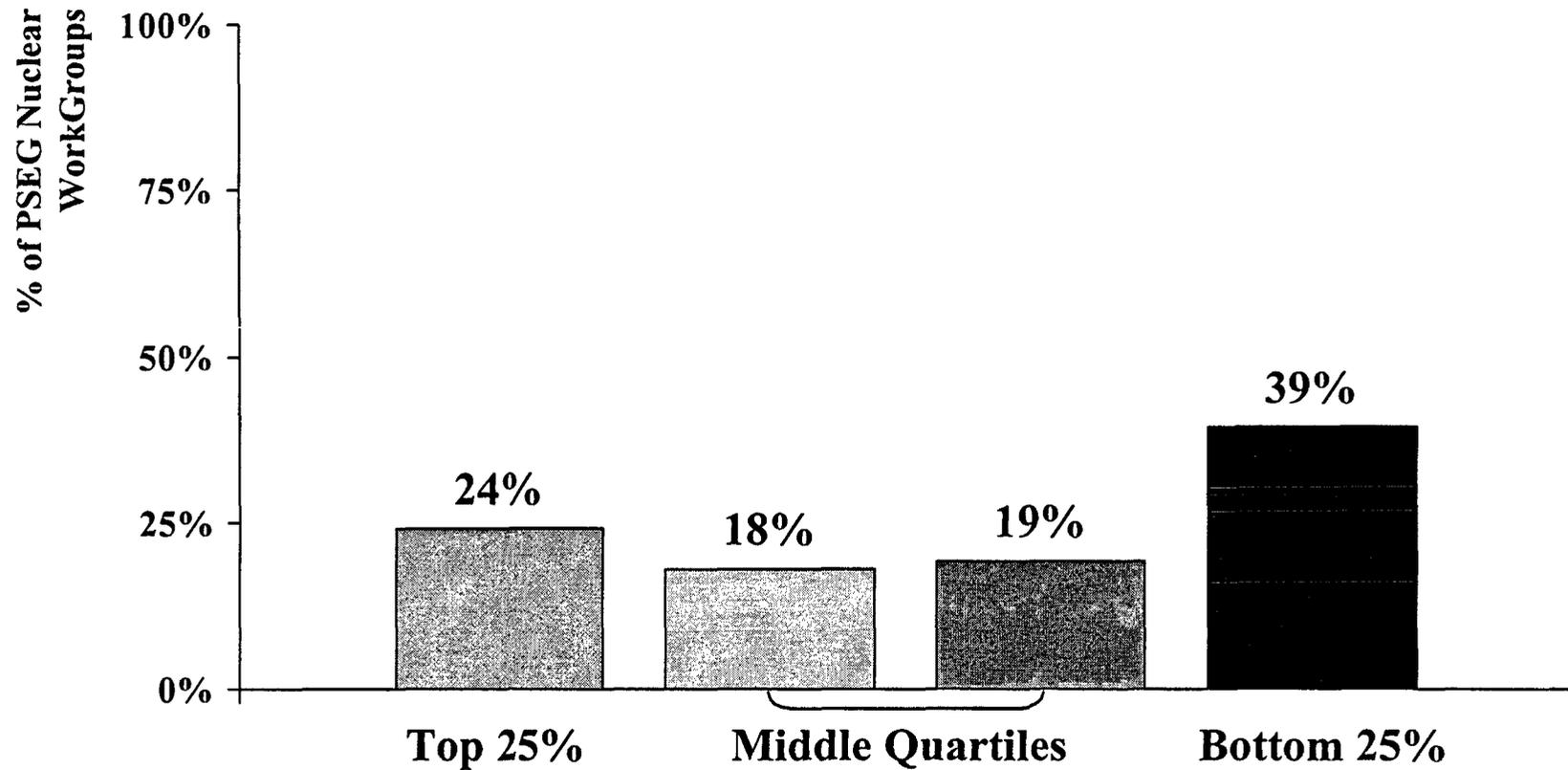
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# Range of Performance at PSEG Nuclear



# Quartile Performance on Q<sup>12</sup><sup>TM</sup>

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Quartile Designation Based on Gallup's GrandMean Database

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*Summary and  
Recommendations*

# Summary

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- **PSEG Nuclear's overall performance in employee engagement in 2001 falls into the 34<sup>th</sup> percentile.**
- **Progress has been made quite consistently across the board, moving up from the 15<sup>th</sup> percentile in 1-1/2 years.**
- **Most progress has been made:**
  - **Across the first two stages of the engagement hierarchy (Q1-6);**
  - **In setting people's expectations;**
  - **In making every employee feel cared about;**
  - **In relating the mission/purpose to each person's role;**
  - **By PSEG Nuclear's best managers/supervisors.**

# Summary

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- There is a significant range in performance, however.
  - Part of this range may be explained by function (union), shift (night), and even tenure with the manager (> 5 yrs).
  - High and low levels of engagement are found across the organization, however. The individual manager is key.
- The largest gap with a strong workplace remains in its foundation (Q1-6).

# Recommendations

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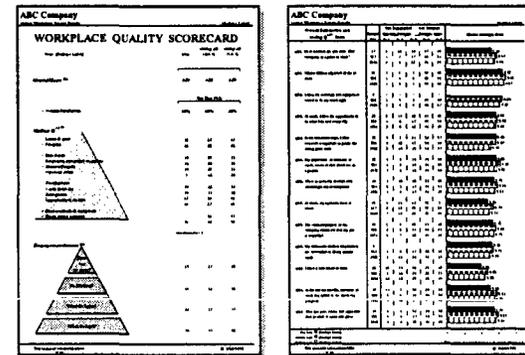
- **Increase quality by reducing your range.**
- **Reduce range through:**
  1. **Holding every manager accountable for the local culture they create;**
  2. **Involving all employees in making their workplace stronger;**
  3. **Focusing on laying the foundation of a great workplace;**
  4. **Leveraging the practices of your own best managers;**
  5. **Helping every manager achieve the outcomes in their own unique way - leverage their individual strengths;**
  6. **Having every manager *support* the managers reporting to them.**

# Next Steps – Each Manager

## Q12 Manager Orientation

- “Why did we do this?”
- “How did I do?”
- “Which items are the most important?”
- “What can I do to improve?”

## Workplace Quality Scorecard



## Workbook

*“Building a Stronger Workplace”* video



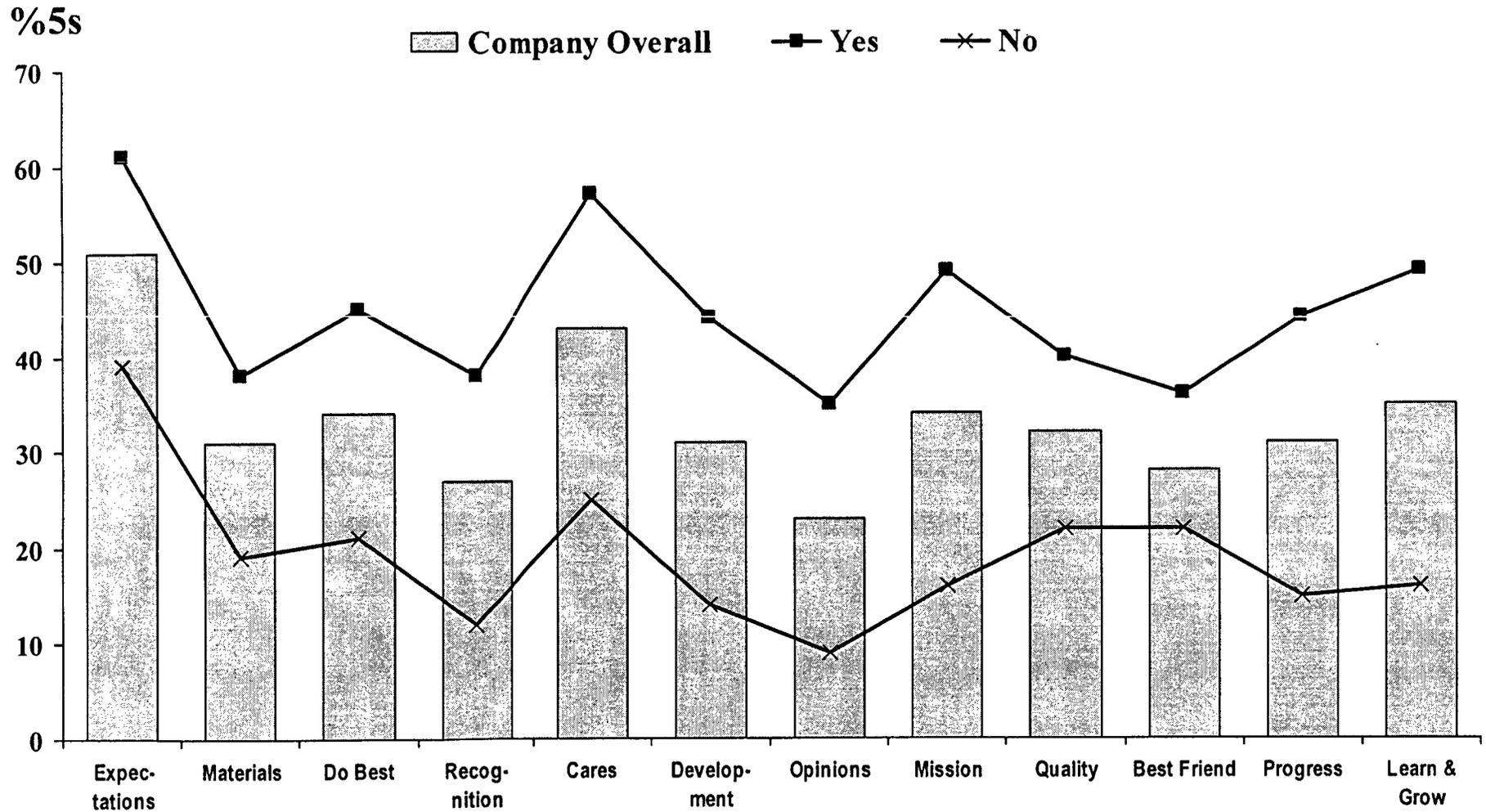
*“First, Break All The Rules”*

IMPACT Plan			
Question:			
Action	Who is accountable?	How often?	By when?
Survey Goal:			

## Team IMPACT Session

Non-PSEG data

# Were action plans developed?



# Action Plans

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- Complete Supervisor/Manager Training & Data Rollout
- Supervisors/Managers Complete Local Workgroup Action Planning Sessions by End of February 2002
- Action Plans and Data Shared Back Upward
  - Specific/Measurable/Clear Owners with Workgroups
  - Performance Partnerships Used for Accountability
- Outcomes-Notable improvements in Engagement by Next Survey

# Your Role As A Leader

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## 1. Alignment

- Ensuring consistency between your practices and alignment towards your goals

## 2. Communication

- Keeping people connected and moving in the right direction through ongoing dialogue

## 3. Accountability

- Creating a performance-based environment that sustains and replicates its successes

# INPO Feedback on Engagement

Summer 2002

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## *Everyone's Engaged!*

- Management is very successful in driving the station vision through full engagement of the workforce
  - Fully tapped the talent of the workforce
  - Fully engaged
  - Lots of Field time for supervisors( time is blocked)
  - People want to be led and are being led
  - Working and listening well established
  - Our plan to close the gap was very successful

# INPO Feedback on Engagement

Summer 2002

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## *Everyone's Engaged!*

- We seize each day as an opportunity to do our best.
- We give 100% everyday.
- We celebrate our successes.
- We strive for continuous improvement.
- We are self-critical.

# INPO Feedback on Engagement

Summer 2002

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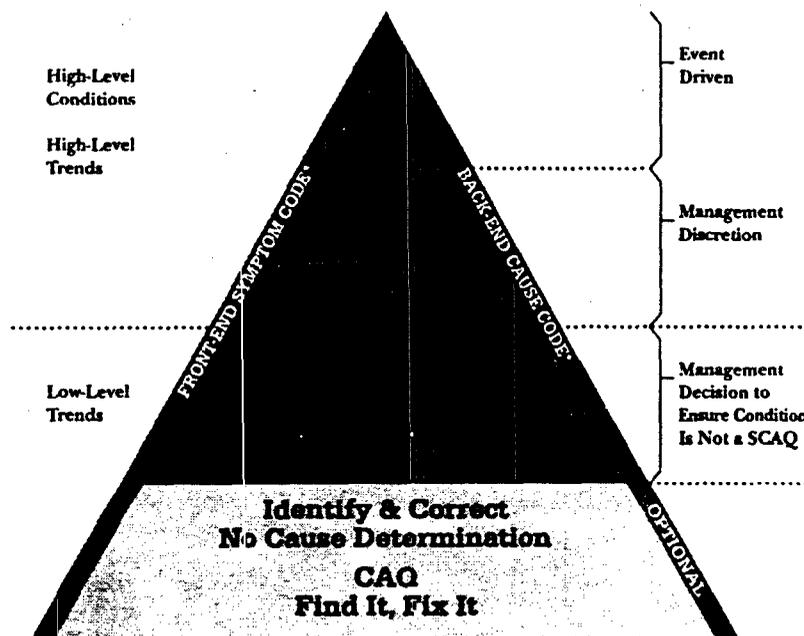
## *Everyone's Engaged!*

- We rigorously apply human performance fundamentals and aggressively utilize the corrective action program.
- Those closest to the work are involved in creating solutions to problems and driving them to resolution.
- We work together.
- Listening, supporting each other, and providing constructive feedback are common practices.
- We truly are getting better every day!

# Common Cause Analysis Operations Breakthrough Events 1996-1998

Analysis performed December 1998  
Report Issued February 23, 1999

PSE&G Internal Use Only



### Executive Summary

The common cause analysis performed by the corrective action group found the following most common committed errors in breakthrough events:

1. Component Manipulations Errors
2. Plant / Component Status Errors
3. Review / STAR validation errors

The Corrective Action Group recommends the following:

1. Perform a Work Control Assessment: The assessment should include enough personnel to observe field activities, critique procedures, procedure use, and verification techniques. Turnover and system status information and communication should also be assessed.
2. Station self-assessments should review a sample of procedures, keying off of change requests written by the users. The change requests may be indicative of a procedure that can be followed, but has potential human factor issues that can result in errors. Management may want to consider using other methodology available that can quantitatively rate procedures.

These recommendations should be worked into the station's normal self-assessment schedule. Based on the type of data and amount of data analyzed, there is no need to prioritize this above other activities.

### **A Background**

The corrective action group performed a common cause analysis of breakthrough events from 1996 through 1998. The common cause team reviewed completed root cause and apparent cause documentation and trend codes for common themes. Because of the limited number of issues associated with these events, near misses were also included in the review. The primary objective of this analysis was to identify the two or three prominent, recurring issues specifically relating to the Salem and Hope Creek operations departments. Both Salem and Hope Creek management agreed to provide resources to review the results. The secondary objective of this report was to develop a common cause process that will be incorporated into the corrective action program. Working with a consultant from Performance Improvement International (PII), corrective action personnel reviewed 148 breakthrough and near-miss issues in the database, then analyzed them for human performance, organizational and programmatic similarities. Original coding in many records was not consistent with PII technology, and many evaluations failed to

substantiate coding in the documents. The team recoded issues to provide consistency for the analysis.

## **B Discussion**

- 1) Component Manipulation Errors** The team found the largest group of errors under component manipulations. These errors tend to be more organizational driven than process driven. A review of causal factors shows that these errors are more the result of knowledgeable and trained people not performing well; rather than untrained people making poor choices.

### **a) Analysis:**

Based on the analysis of the trend codes the following possible root causes for the skilled-based errors in component manipulation are:

Poor self checking skill (STAR technique),  
Poor accountability, and  
Work environment problems such as work stress, distraction, and time pressure.

**(Note: Additional validation of these root cause factors should be conducted prior to initiating any action requests.)**

Evaluations entered into condition reports (CRs) in the corrective action database often cite "failure to STAR" as a causal factor. Unfortunately, the evaluations fail to assess the next more basic causal factor – why aren't proper self-checking techniques used. STAR technique is very effective in skill based error prevention (reduces skill based errors by a factor of two to three). STAR works by focusing attention to the task. STAR only works well when consistently applied on a task by task basis.

A second cause could be meeting accountability standards. Accountability means intrinsic responsibility to meet expectations. When people are highly accountable, people pay close attention to tasks (less skill based errors), people follow guidance closely and validate and verify inconsistencies (less rule based errors), and people are more conservative in decisions and more prone to seek help (less knowledge based errors). Accountability could be a possible root cause because of the number of skill-based errors in operations and the high incidence of rule compliance failure modes.

**Common Cause Analysis: Operations Breakthrough Events**  
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**February 23, 1999**

Although less probable, work environment problems could be the cause for the increasing operation personnel error rate, resulting in an increased error rate in component manipulation. Work environment issues include attempting to multi-task too many activities (greater than five), or work area distractions and interruptions.

Work Stress is a chronic error cause that has been known to double or triple human error rate. The four main causes of stress related incidents are non-humanistic leadership style, high workload, distractive work environment, and uncertainty of employment. Of the four, time pressure and distractions causes are less likely failure modes because of the low number of coded incidents in the database.

- 2) **Plant Status Errors** The next highest group of errors are found in a lack of / or inaccurate plant status information. Plant status appeared to be difficult to obtain, for both work control activities and tagging operations. Knowledgeable personnel not paying attention caused these errors, the same conclusion drawn for component manipulations. Errors in plant status information occurred when too much reliance was placed on oral communications, for both equipment and work document status.
  
- 3) **Review Errors** These errors occur in conjunction with plant status errors. These errors occur when a second check or verification failed to prevent the BTE or near-miss, whether it was in the review of a tagging request, an independent verification of a red tag, or for tracking the status of safety equipment. Unfortunately, coded issues rarely address the review errors committed, instead corrective action evaluations concentrate on the first barrier that failed.

**a) Analysis**

Possible root causes for plant status errors are:

Inadequate communication practices,  
Lack of independence of the review personnel, and  
Inadequate review work practices

**(Note: Additional validation of these root cause factors should be conducted prior to initiating any action requests.)**

**Common Cause Analysis: Operations Breakthrough Events**  
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**February 23, 1999**

Communication errors occur when personnel fail to use effective communication practices, such as repeatbacks, clarifying questions, and quality verification and validation checks. Other errors occur when personnel attempt to memorize or track information, and either forget the communication or incorrectly remember the information.

An example of inadequate communications of plant status was observed during the QA sponsored self-assessment training in January. An Emergency Core Cooling jockey pump was kept out of service for a period of time longer than necessary because the first line supervisor did not understand the limiting condition for operation (LCO) plan that was in effect.

An example of a document communication error was a phone call from a technician to the SRO stating the surveillance (ST) he was working on was completed, prior to maintenance supervisory review of the document. It was later found the ST had unsatisfactory acceptance criteria, after the SRO declared the component operable.

The team found corrective action evaluations generally failed to identify the review process as a contributor to breakthrough and near-miss events. Review processes can be independent verifications of components or procedure steps, or a second person review of documentation. Operations personnel may have become desensitized to the importance of the review process in preventing conditions adverse to quality.

The second possible root cause is the lack of independence when initiating a review process. For example, when an independent verification is required for tagging equipment, it would be inappropriate for the first verifier to tell the independent verifier where to find the valves. During the QA sponsored self-assessment training in January, a self-assessor in the Salem control room observed an operator positioning two switches on the board. The operator then handed the procedure to another operator, pointed to the switches and asked him to verify the positions.

- 4) Procedure Detail -The team also identified low procedure detail as a recurrent issue in coded evaluations. These issues occurred when**

personnel had enough leeway in the procedure step that allowed the wrong decision to be made by the performer. Personnel who rely on informal knowledge to successfully complete procedure tasks can unintentionally hide procedure detail issues.

**a) Analysis**

Possible root causes for low procedure detail errors are:

Writers are unfamiliar with user needs,  
Inadequate verification mechanisms for procedure review, and  
Lack of feedback from field users

**(Note: Additional validation of these root cause factors should be conducted prior to initiating any action requests.)**

The possible root causes for procedure detail errors are closely related, and are programmatic in nature. Procedure deficiencies in the corrective action database were attributed as secondary causal failures. The team only found one evaluation that touched on these possible root causes. Examples in this area generally attribute the root cause to human error, inadequate attention to detail, and then add statements concerning the procedures as having human factor deficiencies. Only one CR found the root cause in the operations procedure process. The evaluation for CR 980715244 described a potential over-pressurization condition setup by an inadequate procedure. This CR addressed inadequate verification mechanisms, in the form of the review of the safety evaluation for the component configuration, as the failure mode.

**C Recommendations**

**1) Component Manipulation, Plant Status, and Review Errors**

Station self-assessments should be geared towards two to three day (and night) observations of work management processes. The assessment should include enough personnel to observe field activities that are assigned, and a critique of procedures, procedure use, and verification techniques. Turnover and system status information and communication should also be assessed. Because of the number and type of issues

## **Common Cause Analysis: Operations Breakthrough Events**

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**February 23, 1999**

identified during the QA sponsored self-assessment training, it may be beneficial to use personnel from other departments as the assessors. Action Requests need to be generated from the observations and management should ensure the corrective actions are implemented. A review of the corrective action database indicates issues identified during the QA sponsored self-assessment were not initiated.

### **2) Procedure Detail**

Station self-assessments should review a sample of procedures, keying off of change requests written by the users. The change requests may be indicative of a procedure that can be followed, but has potential human factor issues that can result in errors. Management may want to consider using PII methodology available that can quantitatively rate procedures.

## **D Data Analysis**

### **1) Organizations**

The team reviewed the organizational breakdown of BTE and near-miss issues for 1996 through 1998 in the following table:

Operations (HOP, SOD)	79%
Maintenance (SMD, HMD, MMPS, etc.)	14%
Eng	7%

The results of this table are as expected, since this analysis concentrated on the operations department. Since operations personnel perform the highest number of activities that can lead to a breakthrough event, they will always have the highest percentage in this table. Most operational organizational errors were internal, generally revolving around communication errors, STAR, and QV&V issues, as well as poor decision-making and work practices. Less than 7% of the issues were between organization to organization. A previous common cause analysis performed in 1996 found engineering to be the organization associated with operation department errors. This analysis now found maintenance as the organization usually contributing to the errors. This is also understandable since the stations shifted from an outage/high design change mode to a mode of performing maintenance on equipment online.

### **2) Work Processes**

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The top five work processes that had the highest issues in this analysis compared to the total population were:

Station Operating Practices	25%
Safety Tagging	25%
Technical Specification Surveillance	12%
Work Control Process	10%
LCO Management	07%

This category reflects the work process individuals were involved with when events and near misses occurred. It is important to understand that the percentages do not reflect that processes are the causal failure modes. The first three processes are ranked almost the same as identified in the 1996 common cause analysis. Work control and LCO management have replaced corrective action and another category no longer in use. Based on this analysis of the operations department, these types of issues are expected to be centered in these processes.

### **3) Human Error Types**

Human error types are categorized as:

- Rule Based                      wrong decision, failure to follow existing rule
- Skill Based                      unintentional lapse or slip
- Knowledge Based              wrong decision, rule does not exist

The breakdown of errors committed by operations parallel industry averages. These categories are subject to changes from outside influences, such as increased management attention supporting verbatim compliance. This would reflect in less rule based errors, and increases in the other two categories.

Rule Based	52%	60% * Industry average*
Skill Based	36%	25% * based on PII research*
Knowledge Based	12%	15%

Skill based errors can be reduced with continued emphasis on STAR techniques, but personnel must go farther and preplan and think-through their jobs.

### **4) Human Error or Inappropriate Actions**

**Common Cause Analysis: Operations Breakthrough Events**  
**PSE&G Internal Use Only**  
**February 23, 1999**

The five most common human errors or inappropriate actions in operations are as follows:

Shortcuts Evoked	19%
Not Familiar with Task	12%
Unawareness	12%
Lack of Information	9%
Wrong Assumptions	9%

The first two categories indicate a significant change from the 1996 common cause analysis, and warrant further attention. Shortcuts are used to accelerate the job completion, usually due to perceived pressure to complete the task. Industry practice has shown, as described in INPO SOER 98-01, that this failure mode has resulted in some significant events in the industry, particularly during and coming out of outages. SOER 98-01 was evaluated by the NBU under SL1. An action in CR 980826176, and an action was ~~was~~ initiated to ensure NBU personnel were aware of management's expectations in this area.

Another significant change from 1996 was the failure mode of unfamiliarity with the task, associated with personnel performing the task for the first time, or infrequent performance of a complex task. With a three-outage year coming up, and a large number of newly licensed operators, attention should be placed on the experience of personnel performing critical, infrequently performed tasks.

The last three failure modes, which fall under the general heading of misjudgment, are close to their ranking in the 1996 common cause analysis. These modes are usually found in rule based errors, and are found in situations where there is inadequate verbal communications and lack of QV&V.

## **5) Organizational and Programmatic Deficiencies**

The top five organizational and programmatic deficiencies evaluated in this analysis are:

Inadequate Job Skills, Work Practices, Decision Making	49%
Insufficient Details, Procedures or Program Vague	13%
Inadequate Communications Within the Organization	11%
Inadequate Scope, Functions missing	8%
Inadequate Interface Between Organizations	7%

**Common Cause Analysis: Operations Breakthrough Events**  
**PSE&G Internal Use Only**  
**February 23, 1999**

There are some similarities in this table with the 1996 common cause analysis. Inadequate job skills, work practices, and decision making, was the highest category in the 1996 report, but it is higher in this table because of the report theme, breakthrough and near-miss issues. Individual human errors are coded in this category, and one reason it is higher is the failure of the second checker/independent verifier/reviewer. Causes in this area can be associated with inadequate communications, inadequate staff or training, conflicting or unreasonable goals, and punitive management style or inadequate supervision.

The next highest category, insufficient procedure/program details, is also closely associated with inadequate procedure/program scope. This would bring the combined category to 21% for this report. Validation of this potential issue requires an analysis of procedures. Consultants are available to quantify the adequacy of our procedures, and this may be warranted to ensure corrective action resources are applied where necessary.

Inadequate communications within the organization are usually associated with an inadequate communication path within one organization, or even within one crew. Eventually this can lead to low morale of a staff and a breakdown of teamwork.

Organization to organization issues were discussed under organizations at the beginning of this section.

## **6) Key Activities**

A new category for coding what key activity associated with a process (when the issue occurred) has been added to this corrective action coding database. This key activity index was an essential portion of the PII methodology for performing trending and assessments, but had not been incorporated into the NBU trend program until now. The following information was derived from analysis of the condition report evaluations and issue descriptions of the events:

<b>Process</b>	<b>Key Activity</b>	
Station Operating Practices	component manipulations	7%
LCO Management Process	LCO administration	6%
Safety Tagging Process	component manipulations	6%
Work Control Process	work authorization	4%
Technical Specification Surveillances	component manipulations	4%

As the table indicates, component manipulations in various processes accounted for 17% of the breakthrough and near-miss events. The other two key activities involved the administration of the LCO process (logging the entry, exit, equipment, and associated work orders) and work authorization. The corrective action department developed the key activity matrix during this report and verified the activities with a PII consultant. These groupings should enable management to see where errors are being made by their personnel and assign resources to evaluate the conditions.

## **E Significant Event Rate**

- 1) Safety performance is essentially event rate driven. If no events occur or the events occur at a very low rate, the facility is a good safety performer. To measure absolute safety performance, significant event rates relative to industry standard are analyzed. A Common Cause Analysis is then used to diagnose "where" and "why" the events are occurring.**

Three (3) models of significant event rate were analyzed:

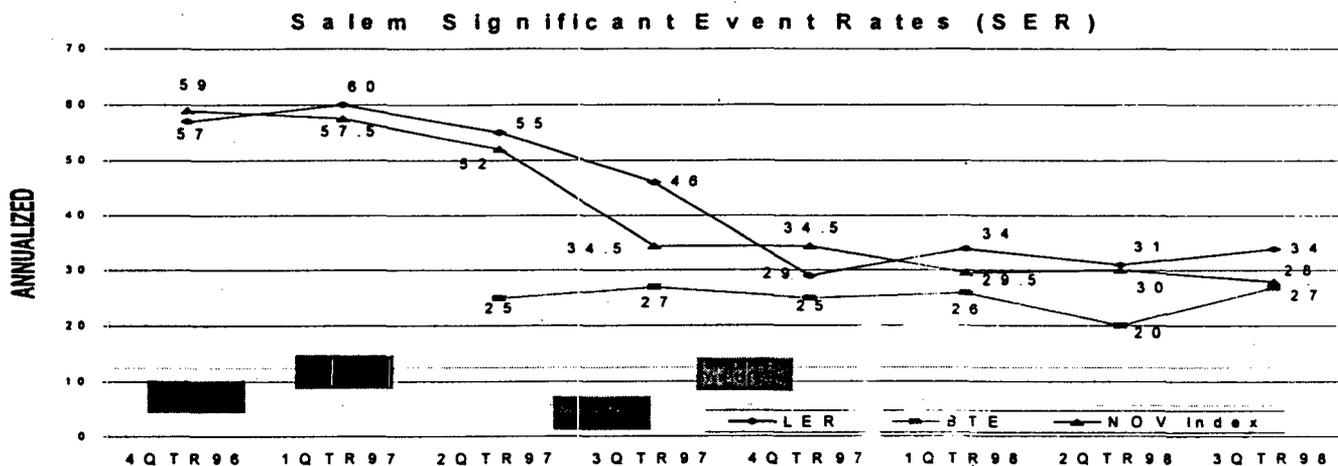
Licensee Event Report (LER) Rate  
Notice of Violation (NOV) Index  
Breakthrough Event (BTE) Rate

Each model has a particular advantage (and disadvantage). LER Rate is best for comparing US nuclear plants because of the uniform reporting threshold (NUREG 1022). However, LER Rate is not always a good measure of significant event rate because not all reportable conditions meet the industry defining of "significant", and reporting is not always consistent between licensees. NOV Index is also a good measure for comparison since the reporting is independent of licensee. However, the NOV Index is often affected by the number of inspection hours by the US NRC (more inspection hours yield more NOVs). The Breakthrough Event (BTE) Rate is a site-specific model. Comparison with other plants is difficult because the reporting threshold is not uniform.

Overall, safety performance (and human performance) appears to be improved over the last two-year period and remained constant over the last one-year

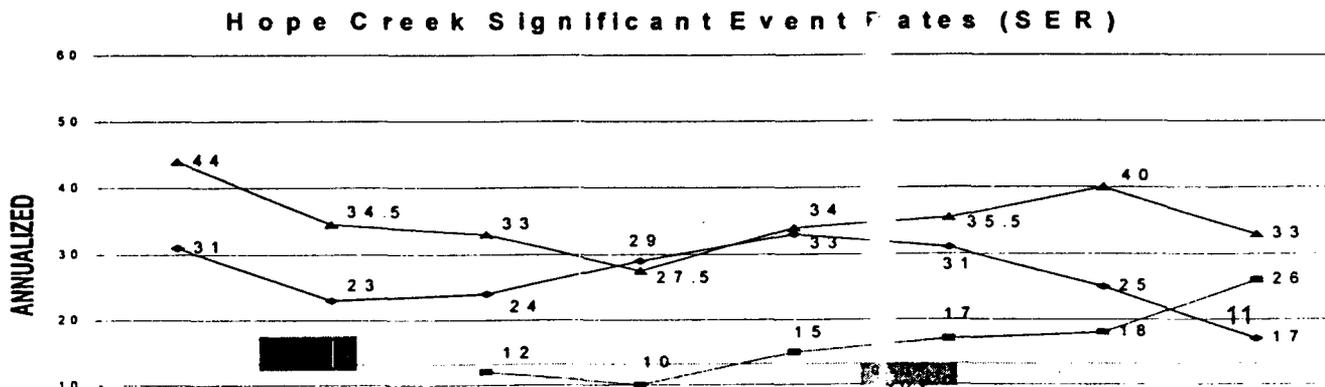
**Common Cause Analysis: Operations Breakthrough Events**  
**PSE&G Internal Use Only**  
**February 23, 1999**

period. However, since there is no acceptable significant event rate or human error rate, the BTE causal factor data can still be used to diagnose areas for continued improvement.



Review of the Salem significant event rate models (LER, NOV, and BTE) shows that over a two year period the event rates are decreasing, indicating an improvement in safety performance (and a corresponding improvement in human performance). Over the last one-year period, significant event rates have reached a plateau.

Review of the Hope Creek significant event rate model (LER and NOV) shows that over a two-year period the event rates are also decreasing, indicating an improvement in safety performance (and a corresponding improvement in human performance). The Hope Creek BTE Rate shows an increasing trend (indicative of a decline in safety performance and human performance) in the last one-year period. Therefore, the BTE Rate appears to be more indicative of a lower threshold for what is considered a significant human performance error than an increase in human error rate.



Director's Hld Court

# JANUARY Flawless Execution

→ Connection Action Page  
Incl. text  
→ Knowledge + Skills Define  
work item  
→ Business Process Wk  
mgmt

Plant   Events

- S/HC • Winterization – Cold Weather Preparations
- HC • Hope Creek/Salem Downpowers
- S • Circ Water System Maintenance
- S • RHR Ht Exchanger Bolt Replacements
- HC • A/B Control Room Chillers
- S • 26 SW Pump – Red PRA Window
- S • CO<sub>2</sub> Tank Fill
- S • 22 MG Set
- S • Rad Monitor DCP Configuration
- S • Hydrazine Spill/Over Fill
- HC • B Diesel Generator Exhaust Leak
- HC • Control Room Duct Door LCO 3.0.3
- S • B Vital Bus Loss
- 1 Slip OSHA Recordable

Issues

- Mgmt Standards
- Ops Procedures
- Maint Oversight & Procedures
- Engg Standards
- Ops/Engg Training
- Ops Standards
- Ops Procedures
- Maint Oversight
- Ops Configuration Management
- Ops Procedures
- Maint Standards
- Ops Configuration
- Ops Configuration

① Time Credit

What is mgmt going to do Different?  
Behavior  
What mgmt should do better -

# FEBRUARY

## Flawless Execution

<u>Plant</u>	<u>Events</u>	<u>Issues</u>
S	• 11 Stator Wtr Cooling Pump	Maint Work Practices
HC	• FRVS Recirc/Vent Fans	Tech Troubleshooting
HC	• B & D Diesels Out at Same Time	Ops Configuration
HC	• B Diesel Safety/Configuration	Maint Standards
HC	• A Diesel LCO Restoration	Maint Work Practices
S	• Service Air Loss/Protection	Ops Configuration/Pre-Planning
HC	• Tagging Breakthrough	Procedures
S	• 1 A Diesel 11SW39 Operability	Ops Configuration/Mgmt Standards
S	• Unit 1 Sulfate Levels 1.09	Procedures/Work Practices
HC	• Crossflow Indication Loss	Work Practices/Std
HC	• Compressor 10K 107 Leaks	Maint Practices
	• Missed Tech Spec Surveillances	Procedures
S/HC	• 2 OSHA Recordable Injuries	Standards

# THINKING/THEMES

1. What has been really killed dead since 1/1/03?  
Little has been solved – Why?
2. What or How is the Corrective Action Program causing the direction to change? February is no better than January so I would say it isn't.
3. All of the events look preventable.  
All suggest pre-planning of work and the Depth and Breadth by you is missing
4. This Management doesn't recognize the seriousness of plant operations impacts.  
There must be an educational gap with you.
5. Management/Workers are falling short in fundamentals of their jobs
  - Basic electrical print reading for operators
  - Gaskets, seals, and joints for Maintenance
  - Use of procedures, practices, processes for Defense in Depth
  - Rinsing and water sampling
  - Technical problem solving
    - o Temperature to seal life
    - o Technical issues process and troubleshooting Control Loops
6. We don't know how to authorize work for success
7. We don't know how to practice or apply safety to our work.

# DEFENSE in DEPTH STRATEGY

**WORKER EXP.** STAR – PEER CHECKS – SELF CHECK – INDEPENDENT CHECKS

**SUPERVISOR OVERSIGHT**

**COMMUNICATION**

(LOGS, TURNOVERS, PACKAGE DOCS.,  
NOTIFICATIONS & SCHEDULES)

**PRE-JOB BRIEFS**

**JOB STANDARDS**

**TRAINING**

**Procedures** Administrative Controls

**Performance at the  
Point of Contact**

**Procedures** Administrative Control

**TRAINING**

**JOB STANDARDS**

**PRE-JOB BRIEFS**

**COMMUNICATION**

(LOGS, TURNOVERS, PACKAGE DOCS.,  
NOTIFICATIONS & SCHEDULES)

**SUPERVISOR OVERSIGHT**

**WORKER EXP.** STAR – PEER CHECKS – SELF CHECK – INDEPENDENT CHECKS

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RISKY BEHAVIORS + RISKY SITUATIONS = EVENTS

# DEFENSE in DEPTH STRATEGY

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**WORKER EXP. STAR – PEER CHECKS – SELF CHECK – INDEPENDENT CHECKS**

**SUPERVISOR OVERSIGHT**

**COMMUNICATION** (LOGS, TURNOVERS, PACKAGE DOCS., NOTIFICATIONS & SCHEDULES)

**PRE-JOB BRIEFS**

**JOB STANDARDS**

**TRAINING**

**Procedures** Administrative Controls

**Performance at the  
Point of Contact**

**Procedures** Administrative Control

**TRAINING**

**JOB STANDARDS**

**PRE-JOB BRIEFS**

**COMMUNICATION** (LOGS, TURNOVERS, PACKAGE DOCS., NOTIFICATIONS & SCHEDULES)

**SUPERVISOR OVERSIGHT**

**WORKER EXP. STAR – PEER CHECKS – SELF CHECK – INDEPENDENT CHECKS**

RISKY BEHAVIORS + RISKY SITUATIONS = EVENTS

# DEFENSE in DEPTH STRATEGY

**WORKER EXP.** STAR – PEER CHECKS – SELF CHECK – INDEPENDENT CHECKS

**SUPERVISOR OVERSIGHT**

**COMMUNICATION** (LOGS, TURNOVERS, PACKAGE DOCS., NOTIFICATIONS & SCHEDULES)

**PRE-JOB BRIEFS**

**JOB STANDARDS**

**TRAINING**

**Procedures** Administrative Controls

Performance at the  
Point of Contact

**Procedures** Administrative Control

**TRAINING**

**JOB STANDARDS**

**PRE-JOB BRIEFS**

**COMMUNICATION** (LOGS, TURNOVERS, PACKAGE DOCS., NOTIFICATIONS & SCHEDULES)

**SUPERVISOR OVERSIGHT**

**WORKER EXP.** STAR – PEER CHECKS – SELF CHECK – INDEPENDENT CHECKS

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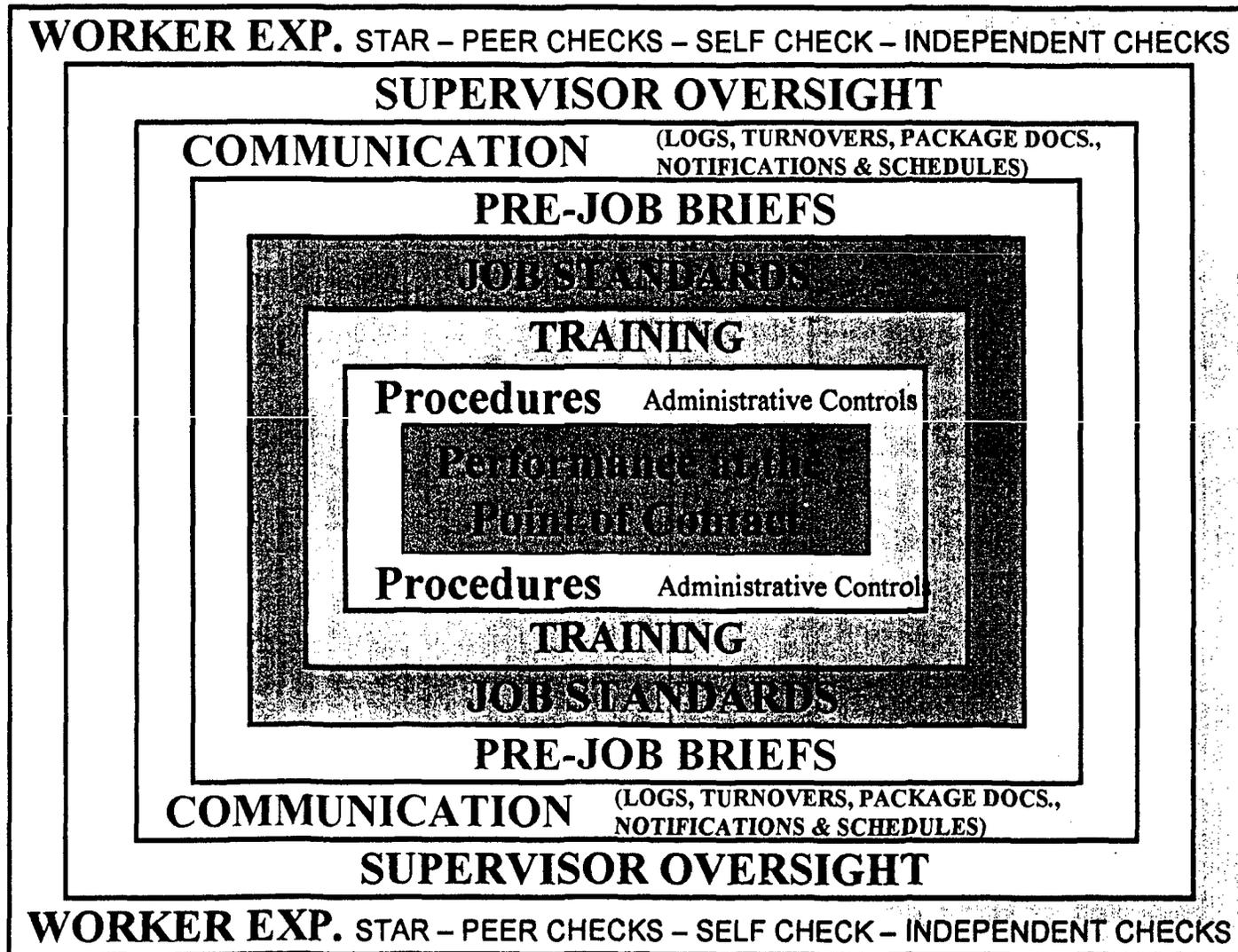
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RISKY BEHAVIORS + RISKY SITUATIONS = EVENTS

# DEFENSE in DEPTH STRATEGY

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RISKY BEHAVIORS + RISKY SITUATIONS = EVENTS

# DEFENSE in DEPTH STRATEGY

**WORKER EXP. STAR – PEER CHECKS – SELF CHECK – INDEPENDENT CHECKS**

**SUPERVISOR OVERSIGHT**

**COMMUNICATION** (LOGS, TURNOVERS, PACKAGE DOCS., NOTIFICATIONS & SCHEDULES)

**PRE-JOB BRIEFS**

**JOB STANDARDS**

**TRAINING**

**Procedures** Administrative Controls

Performance at the  
Point of Contact

**Procedures** Administrative Control

**TRAINING**

**JOB STANDARDS**

**PRE-JOB BRIEFS**

**COMMUNICATION** (LOGS, TURNOVERS, PACKAGE DOCS., NOTIFICATIONS & SCHEDULES)

**SUPERVISOR OVERSIGHT**

**WORKER EXP. STAR – PEER CHECKS – SELF CHECK – INDEPENDENT CHECKS**

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RISKY BEHAVIORS + RISKY SITUATIONS = EVENTS

# DEFENSE in DEPTH STRATEGY

Post Maintenance Testing

**WORKER EXP.** STAR - PEER CHECKS - SELF CHECK - INDEPENDENT CHECKS

**SUPERVISOR OVERSIGHT**

**COMMUNICATION** (LOGS, TURNOVERS, PACKAGE DOCS., NOTIFICATIONS & SCHEDULES)

**PRE-JOB BRIEFS**

**JOB STANDARDS**

**TRAINING**

**Procedures** Administrative Controls

**Performance at the Point of Contact**

**Procedures** Administrative Control

**TRAINING**

**JOB STANDARDS**

**PRE-JOB BRIEFS**

**COMMUNICATION** (LOGS, TURNOVERS, PACKAGE DOCS., NOTIFICATIONS & SCHEDULES)

**SUPERVISOR OVERSIGHT** *Involvement*

**WORKER EXP.** STAR - PEER CHECKS - SELF CHECK - INDEPENDENT CHECKS

Post Maintenance Testing

E  
V  
E  
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T

E  
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E  
N  
T

RISKY BEHAVIORS + RISKY SITUATIONS = EVENTS

- ① is this so urgent it needs action now?
- ② do I build a case in the coming
- ③ week for Roy?

④ Prior to mtg w/ Neil,  
is this something I missed or

→ he felt pressured - Corporate & people → By-pass Valve  
Christiana Hilton →

Mendenhall Inn

Tom Laker

Challenged to be sure I am  
making the right decisions coming  
from safety

↳ Wagner is a volatile guy.

~~NP~~

NP is too important to  
me to be haphazard.  
I'd be out of here if

I do it  
no

mgmt org is in chaos to my  
total embarrassment. Not reflected  
in the CO, we control NP plant.

MARK, LAWRENCE, LOW, Kenda

Routines

HARLAN

KZ

Task Ready Mtg.

What am I doing for Tim?

Where am I spending my time?

What am I causing?

Being + Doing  $\Rightarrow$  Actions

List all that I have  
been involved in

- examples
- contributions / results

Ops L. Mtg  
OS to ~~Q~~ SIM

Results focus Group

Creating A in LW  
100 day plan

Grp

Read CAP  
MEMTJ

Slides

A  
L

Rev + L elements

Wk Mtg →  
11:00 index  
fix night thing  
9:00 work night

the  
CA - Obsolete?  
A  
Shiny Day

Strength

figure it out  
capture it  
teach others

urgency = fear

- Confirm Wed 9/24  
7-8 people  
Dave + OI  
Tech Staff Project Side  
(people Resident Inspectors)  
Low dose record outage U1EOC-20
  - DOL - remind me as 3/20  
180 days would expire 9/17
    - Monitor EDs
    - Effectively plan and execute
    - Maintain awareness of work area dose rates
    - Utilize technology
    - Improve process by using operating experience
- clock could start.  
"pushing you out the door - more or less"

- ①
- ② independent  
narratives
- ③ come

real final adverse  
action in March  
knows people have  
C~~o~~ option could be  
accepted

• All of the  
individual  
technical issues  
wgt's approach  
to things

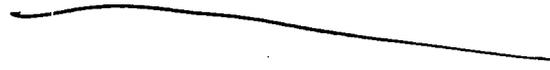
peo who are  
going to check  
technical aspects

- want as much  
specific info

Low dose  
record outage  
UIEOC-20

- Monitor EDs
- Effectively plan and execute
- Maintain awareness of work area dose rates
- Utilize technology
- Improve process by using operating experience

rice apt complex



10



back +  
around bldg  
in middle is  
Entrance | to  
Reception

We've had an issue  
w/ this place for  
awhile now. This  
fits into the puzzle  
pretty well now. Get  
this discussion  
through.

=  
Snapshot in  
time.

- Low down
- record outage
- UIEQ 20
- Monitor EDs
- Effectively plan and execute
- Maintain awareness of work area
- Update technology
- Improve process
- Improve operating performance



RAM Tuesday  
≡

DAVE  
Jeff Teeter from 01  
and/or

Ray Larson

Dan Orr  
(Resident)

Hub

- Low dose record outage U1EOC-20
- Monitor EDs
- Effectively plan and execute
- Maintain awareness of work area dose rates
- Utilize technology
- Improve process by using operating experience

left onto Allendale Rd.



Over top past church  
2nd light at Keebles  
make left behind to NRC

Blue Route 202

right onto 202 - couple of lights

476  
76 W

toward VF

DD at

Gulph Mills Rd.

long ramp.

left the right  
right S. Gulf Rd.  
by bus station →

merge head N.

- Low dose record outage U1EOC-20
- Monitor EDs
- Effectively plan and execute
- Maintain awareness of work area dose rates
- Utilize technology
- Improve process by using operating experience

# EXPLANATION

Bert Simpson  
Fran Sullivan  
Jack Carey  
John Halstead  
George Reed  
Joe Lario  
Lisa Clark (re. Templet)  
Larry Curran  
Jesse Pike

Don LeGrand - HK staff meeting

Gary Brenner  
Chris Bakken  
MAB  
Russ Gumbert  
Don Carpenter  
Bill Leeds  
Mike Friedlander

Culture is the result of leadership.  
Kiss up / Kick down fear-based culture.

XXXXXXXXXX

Are we on sch vs are we safe?  
Are we doing what we told IPO we were?

Concerns: Manning

Bill Buisch  
Andy Kaplinger going to H12  
Ed Deppe  
John Starcewicz

Tom Smith  
forced out Fossil VP

CPIG minutes -  
Ann Lloyd

[www.nrc.gov/reading-rm/doc-collections/cfr/part050/  
part050-0007](http://www.nrc.gov/reading-rm/doc-collections/cfr/part050/part050-0007)

61's in 5



all i need to know  
is just the way  
you are.

1  
im going to go  
goodnight. to bed

everyone wants to  
be noticed for  
something +  
once noticed  
rewarded.

4-5 drive away  
human

① fame

② fortune

③ wife +

④ power

⑤

being noticed  
" respected  
gaining fortune  
from my value  
is what most  
people are after.

fame = most  
respected  
leader

fortune -

---

love

famous peo  
infl others  
l " "  
at the st  
causes of action  
= =  
w/ fame comes  
fortune

why  
celebrity trouble  
in their  
lives —

don't let f & f  
rules

Am in first  
year

to see still ~~also~~  
replicated in others  
make a diff

what motivates  
a leader to lead?  
a parent to coach  
an 8 yr old  
baseball team?

measured how?

be clear on why i  
want to write this  
book —  
fame + fortune

How come I  
think I have to  
prove something to  
you? Because you do.

I led you down a  
path that was a  
dead end. Interests  
or motivations -

i hate PTIs  
because someone who  
is in touch can  
tell if peo persons  
or group is  
engaged enough to  
make it happen.

Engagement

You don't have to.

Do I have what it  
takes? Will I  
stay the  
course?

Do I have the will?

Proving is a  
deliberate action  
to convince  
someone of something.

We monitor  
metrics +  
create PTIs  
to compensate  
for being out of  
touch.

How you run  
any team —  
if stuck in the  
world of proving  
you're engaged  
or delivering  
you're not  
either.

Proving is a doing.

Convincing is a  
doing.

Proof — an investigative  
action.

## Blindspots.

Why does someone  
think they have to  
prove something?

(They don't trust  
→ Stories come  
from thinking  
you have to prove  
something.)

How will you know?

By my resolve.

If I can see/hear  
you pursuing it  
but you're not  
going out of your  
way to pretend  
or prove.

This  
explains  
everything.

~~the~~  
the hearts  
What's the definition  
of right?

Presumably differentiated  
who is actually  
del  
engaged  
A

nothing to prove

---

lets look like a  
proving ground

What brings  
you up +  
What brings you  
down?

How we come to  
focus on behaviors  
vs

behave like those  
who deliver.

+ pretend to be,  
delivering when you're  
not - story  
tellers.

Resolve to be  
emo healthy  
Stubbornness +  
Resolve

much better  
handle on my  
life than  
yours.

You want to know  
nothing + me  
everything.

Impact  
NOT sure  
empty inside  
genetic  
fun smart  
talented

The white  
water  
All trouble man fighting  
deep cold hot  
white snow

ignored safety  
issue of  
temples

visa claim

inhibit

4/1/46  
100

HK  
Paul Davis



Amend statement re. 10/10  
strength

Crunch, Boyk comments

Reservations:

lton.com or 1-800-HILTONS

Nobody is behind anybody,

We have given up on each  
other.

We deserve to be fired.



Sneaking out back door  
isn't

Defiance

Wagner

in  
on way to  
denied  
Stiles

Why was  
I treated  
differently?

Not public

Procedure not followed

HR not supported

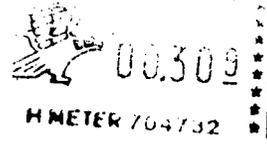
Can not HR dinner

PO Box 17006  
Wilmington DE 19850-7006

Address Service Requested



REGISTERED MAIL



13

3/1  
Sat mtd  
at NTC

~~CRASH~~

Are you a leader worth following?

An Open Letter to the Nuclear Industry

How do you write + it not be libelous?

They have more \$\$\$ than you have will.

Industrial safety work practices

net

tues 2/11

Schimmel L

Hawwin re.

Idea for site

AL + focus

Sat 1/26 AF1 mtg

NRB 1/15

Dir Union Train:

2:20 1pm

When I originally called for this "Cleanness Committee," I did so with the desire to choose wisely about the next phase of my life, beyond PSEG Nuclear. In the three weeks since I received my lay-off notice, much has transpired.

The good news is that I have become clear that I want to devote myself to writing a book entitled "*A Leader Worth Following*." It will focus on the attributes of worthy leadership and include the stories of real-life leaders who model them. It will include lessons I have learned in my nearly 30 years in public and private sector leadership, including my own failings and dilemmas. I will do my best to create a path worthy of following by those who read this book. Since gaining this clarity, a variety of publishing possibilities, resources, and support have come my way. I feel myself "called" to write this and am quite excited about undertaking this journey. I know it will be rich and rewarding.

The tough news is that, in the past few weeks, the level of chaos, anxiety, and fear at the nuclear plant has heightened. A new president is coming in April 1 and people especially at upper levels are concerned about what that means for them. We have had many plant issues caused by management and Union workers alike. A number of highly respected and knowledgeable people have come to me expressing their concerns about nuclear safety, how we are making decisions, and the increasing levels of perceived site mismanagement. I went to the current president last week to again express my concerns. He said, and I quote, "That's a bunch of bullshit." I left that meeting quite disturbed.

I sought guidance from a number of people I trust and planned to find another avenue to have these concerns investigated. Before doing so, I was told by the Human Resources lead that the current president wants me to leave work this week, instead of working through until April 16 as planned. Strongly feeling that his action is retribution for me speaking up about nuclear safety and leadership concerns, I today contacted his boss, the Chairman of the Board. I have requested a full and independent investigation of safety, management, and leadership issues at the nuclear power plant. I have engaged legal counsel to advise me further.

I feel a great sense of loss over leaving people I care about deeply. I feel in some ways that I have not done everything I could have to gain attention to these issues sooner. I am grateful we have not had a fatality or nuclear event. However, I believe that is more grace than anything. I realize that the circumstances of my leaving could actually be a catalyst for fulfilling the mission here that I undertook five years ago: *to have this be a great place to work, safe for the human spirit and all concerned.*

I feel an enormous responsibility to be a *leader worth following* through all this. I have many important decisions to make. I have already disappointed some people I greatly respect. I suspect I will be 'blackballed' and maligned by others. I am sad. I hurt. I am also quite strong and willing to go the distance.

The questions before me, before us are this: *How do I best navigate the turbulent waters that are ahead? My top priority is to insure a thorough and full investigation and actions to resolve any safety issues found. How do I accomplish that? What is my true responsibility and when does it end? What is the higher purpose to all this?*

I appreciate your ongoing support and ask for Guidance with gratitude.

When was mtg w/  
Union in Star Wars  
w/ Brown, Bussey  
Ops who else?

George Sees

Steve Speese

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Brazon → transfer  
why not tell Kymn

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Discuss Kim Weigel  
position