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NewYork Power Authority

James Knubel
Senior Vice President and
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November 25, 1998
IPN-98-125

Mr. Charles W. Hehl, Director
Division of Reactor Projects
U. S. Nuclear Regulatory Commission, Region I
475 Allendale Road
King of Prussia, PA 19406-1415

SUBJECT: Indian Point 3 Nuclear Power Plant
Docket No. 50-286
RESPONSE TO NRC OCTOBER 23, 1998 LETTER

Reference: NRC letter, C. W. Hehl (Region I) to J. Knubel dated October 23, 1998.

Dear Mr. Hehl:

This letter responds to your October 23, 1998 request for information concerning an individual whose unescorted access to the Indian Point 3 (IP3) protected area was temporarily denied on October 9, 1998 (Reference). The following describes the incident, summarizes the Authority's investigation of the incident, and reviews the actions the Authority has taken, and those it plans to take, to assure that this matter is not having a chilling effect on the willingness of employees and contractors to raise safety and compliance concerns within the Indian Point organization.

INVESTIGATION OF INCIDENT OF OCTOBER 8TH AND 9TH

Inspector General's Summary Conclusion

An independent investigation of this incident was conducted by the Authority's newly created Office of the Inspector General (IG). The IG's investigation included interviews with the individuals involved (except for the employee, who was unwilling to meet with the IG on this issue) as well as a review of plant policies, procedures and regulatory requirements. The IG's report concludes "... the incident in question flowed almost inexorably from a series of misunderstandings, misjudgments and a failure to communicate, and not from willful wrongdoing."

Background

Events leading up to the incident, as I understand them, are outlined below.

On October 8, 1998, the employee in question attended a meeting that was also attended by the Site Executive Officer (SEO). The employee did not in any way, either before, during or after the meeting, speak to the SEO about any new potential safety issues that he identified. After returning to his office following the meeting, the SEO opened an E-mail message from the employee in which the employee described potential safety issues. The message had not been on the SEO's computer prior to his leaving his office for the meeting. The SEO telephoned the employee to obtain clarification of these issues, but learned that the employee had left the site due to sickness. The SEO thought it was unusual that the employee did not mention the safety issues at the meeting they had both just attended. He also thought it unusual that the employee left the site immediately after sending an E-mail message to the SEO raising potential safety issues.

The SEO was concerned about the potential safety issues raised in the E-mail[

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]

The SEO then directed the IP3 Security Manager to place a message on the employee's access badge requesting the employee to meet with the SEO early the next morning in the SEO's office. (At IP3, access badges are surrendered to Security whenever an individual exits the protected area, and it is a common practice to leave a message affixed to a badge so an employee will receive the message when he requests his badge at the Security access point.)

The Security Manager misinterpreted the SEO's request and revoked the employee's ability to enter the protected area unescorted. The employee was denied unescorted access when he arrived at IP3 in the morning of October 9, 1998. Upon learning of the actions taken by the Security Manager, the SEO ordered the employee's unescorted access restored. The period from denial of access to restoration lasted approximately one hour. The SEO apologized to the employee.

Inspector General's Full Conclusion

The Inspector General developed the evidence described above and concluded:

> While some inconsistencies exist in the various renditions of the events of October 8 and 9, the evidence establishes mistake, misinterpretation and a failure of communication, as opposed to wrongful intent, as the explanation for the events in question.

It seems clear from the interviews conducted that [the SEO] intended simply to have a note placed on [the employees] badge, a well-established means of conveying messages and notifications to employees. The note was to request that [the employee] report to [the SEO's] office at 7:30 the following morning.

[The SEO] informed the IG that his instructions included nothing beyond the placement of this note. Both [the General Manager of Operations and the employee's supervisor], two of the three individuals who heard [the SEO's] instruction, agreed. [The Security Manager], the third attendee at the October 8 meeting, stated that [the SEO] instructed that [the employee] be "brought" to [the SEO's] office the next morning. [The General Manager of Operations and the employee's supervisor] were both certain that this was not the case.

After the meeting concluded, [the Security Manager] became concerned

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When [the Security Manager's] interpretations of his responsibilities were confirmed by two other members of the security staff, he decided to have [the employee's] badge put aside and informed [the employee] that he could not enter the facility unescorted.

As [the Security Manager] did not discuss this decision with [the SEO] before he took this action, [the SEO] was caught by surprise when he was told of these events at approximately 7:30 on the morning of October 9. As he stated to [the General Manager of Operations, the employee's supervisor and the Security Manager] upon hearing what had happened, he simply wanted to know "how we got from Point A to Point B", from leaving a note to pulling a badge.

Finally, immediately upon being told of what had transpired, [the SEO] instructed [the employee's supervisor] to find [the employee], to explain that a misunderstanding had occurred and that his badge had been restored. In addition, [the SEO] offered [the employee] his personal apology when he next met with him, well prior to the receipt of the NRC's "Potential Chilling Effect" letter.

Based upon the information provided, the IG concludes that the incident in question flowed almost inexorably from a series of misunderstandings, misjudgments and a failure to communicate, and not from willful wrongdoing.

SAFETY CULTURE AT INDIAN POINT 3

Described below are specific actions and programs that the Authority has in place and those actions it plans to take to assure that the willingness of employees and contractors to raise safety and compliance concerns to our organization and to the NRC will not be adversely affected by this event.

Actions Taken as a Result of the Event

- The employee's unescorted access was promptly restored and an apology was subsequently given to the employee.
- The Authority's Office of the Inspector General conducted an independent investigation of this event.
- A Deviation Event Report (DER) has been prepared documenting the safety issues identified by the employee. The Authority is completing a review of the issues raised.
- A nuclear safety culture assessment will be conducted. This assessment will be conducted by an independent organization to evaluate the safety conscious work environment. The organization currently under consideration for this task has significant experience conducting similar assessments at other nuclear power plants, as well as at industrial facilities. The vendor will assess the willingness of employees and contractors at IP3 to identify potential nuclear safety issues and concerns. It is planned that the safety culture assessment will be completed, and a report issued by mid-1999. Results of this assessment will be shared with the Senior NRC Resident Inspector.

Existing Safety Programs

The Authority has long been committed to ensuring the safe, reliable operation of its nuclear power plants, and to ensuring the safety of its employees and contractors. Employees and contractors are actively encouraged to identify safety problems and to bring them to management's attention (such as Nuclear Administrative Policy NuAP 1.9). Programs to put this commitment into practice have long been in place at both of the Authority's nuclear power plants (such as Indian Point 3 Plant Standards PS-01.12 and PS-01.06).

To further communicate its safety commitment, the Authority has adopted a set of "Management Expectations." This list of mutual obligations let nuclear plant personnel know what is expected of them – and what they can expect from management. First and foremost on this list is "*Management wants problems identified.*" The second expectation is "*A questioning attitude is an important part of safety.*" Introduced several years ago, the Authority's commitment to these management expectations has not diminished. Rather, the commitment has become stronger than ever, as they are reflected in the every-day actions of its personnel and absorbed into the culture of the plant.

The Authority's commitment to candid and open communications is clear in our Speakout program where employees and contractors can readily and anonymously raise their safety concerns. The Speakout program is well publicized to all plant personnel and described during general employee training. Both employees and contractors are advised about the purpose of the Speakout program, as well as the protections it affords them.

Determination of No Chilling Effect

Based on the following, I have concluded that it is unlikely that this event had a chilling effect on employees and contractors at IP3.

- The incident was prompted by a legitimate concern of the SEO to address safety issues and to fulfill his obligations under 10 CFR Part 26.
- The Authority's Inspector General found that the incident flowed from a series of misunderstandings, misjudgments and a failure to communicate – not from willful wrongdoing.
- Management promptly and freely recognized its error in denying the employee unescorted access and restored the access within approximately one hour. The SEO apologized to the employee.
- A 1996 safety culture assessment indicated that the Authority made significant progress towards improving its safety culture. This assessment also concluded that the overwhelming majority of employees rated the environment for raising and pursuing nuclear safety issues as adequate to excellent.

If you have any questions, please feel free to contact me.

Very truly yours,

J. Knubel
Senior Vice President and
Chief Nuclear Officer

Attachment: Affidavit of J. Knubel.

Attachment to IPN-98-125

UNITED STATES OF AMERICA
NUCLEAR REGULATORY COMMISSION

In the Matter of	)	
	)	
Power Authority of the State of New York	)	Docket No. 50-286
	)	
(Indian Point 3)	)	

VERIFICATION

I, James Knubel, verify as follows:

I am the Chief Nuclear Officer for the Power Authority of the State of New York, owner and operator of the Indian Point 3 nuclear power plant. I have read the foregoing letter, "Response to NRC October 23, 1998 Letter," and to the best of my knowledge and belief, the statements therein are accurate. Those statements that are not based on my personal knowledge are based upon information provided by other Power Authority employees and/or consultants. I believe the information provided to me is accurate.

James Knubel
Senior Vice President and
Chief Nuclear Officer

STATE OF NEW YORK
COUNTY OF WESTCHESTER

Subscribed and Sworn to before me
this 25th day of November 1998.

Barbara A. White

Notary Public

BARBARA A. WHITE
Notary Public, State of New York
No. 0335000
Qualified in Putnam County
My Commission Expires Jan. 31, 2000