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 50-263/94-04. Corrective actions: revised C.1 start-up
 procedure.

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August 4, 1994

10 CFR Part 2
Section 2.201

U.S. Nuclear Regulatory Commission
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MONTICELLO NUCLEAR GENERATING PLANT
Docket No. 50-263 License No. DPR-22

Reply to Notices of Violation Contained
in NRC Inspection Report No. 50-263/94004

Pursuant to the provisions of 10 CFR Part 2, Section 2.201, our reply to the notices of violation contained in your letter of July 5, 1994 is provided as Attachment A.

In your July 5, 1994 cover letter that forwarded Inspection report 263/94004 and the associated Notices of Violation, you also requested that our response address our activities to identify the root causes behind the increase in personnel errors and the actions we were taking to reduce them. Our response to this request is provided as Attachment B.

This letter contains the following new NRC commitments:

Violation No. 1(B):

1. A comprehensive review of RHR system flow paths, system interconnections and system operating procedures, including procedural precautions, limitations, and prerequisites, will be administered to all licensed personnel by 9/15/94.
2. An evaluation of the operator initial and continuing licensing training program content and administration will be conducted to determine if enhancements are necessary. Routine operator tasks that are risk significant will be identified and evaluated and simulator training will be performed to address pre-conditioning concerns. This action will be completed by 1/20/95.

Violation No. 1(D):

1. The plant administrative work instruction regarding material control and Stores Requisition Form processing will be revised to require preparers to uniquely identify non-stock items on the

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Stores Requisition Form. This action will be completed by 9/15/94.

2. Pre-job briefing guidance will be revised to ensure key aspects of equipment modifications and alterations are addressed in the briefings. This action will be completed by 9/15/94.

Violation No. 2:

1. The methodology used for predicted critical calculations will be evaluated for changes necessary to provide more accurate predictions. This action will be completed by 10/15/94.
2. An evaluation of the role of the Reactivity Manager in control room operations will be performed to determine if this position is functioning as intended. This action will be completed by 9/15/94.
3. Operations management will meet with all operations personnel to discuss management's expectations and the site policy concerning the intent of the terms "shall", "should", and "may" as they appear in plant procedures. This action will be completed by 9/15/94.

Violation No. 3:

1. The plant administrative directive that provides guidance on preparation and review of procedures will be revised to enhance guidance on review of prerequisites. This action will be completed by 9/15/94.

Violation No. 4:

1. Permanent revisions to drawings NH-36241-1 and NH-36242 are being processed to correct the cross-referencing error. The permanent revisions will be completed by 9/15/94.
2. Plant administrative procedures governing the preparation and review of systems isolation procedures will be revised to clarify management expectations in this regard. This action will be completed by 9/15/94.
3. Plant Engineering and Technical Staff training will be performed addressing the causes of this event, lessons learned, and the changes resulting from action (2) above. This action will be

completed prior to 9/15/94.

Please contact Terry Coss, Sr Licensing Engineer, at (612) 294-1449 if you have any questions or wish further information concerning this matter.



Roger O Anderson
Director
Licensing and Management Issues

c: Regional Administrator, Region III, NRC
Senior Resident Inspector, Monticello Site, NRC
NRR Project Manager, NRC
J Silberg

Attachments: A - Reply to Notice of Violation
B - Response to Question Concerning Root Cause and Corrective
Action

Attachment A

REPLY TO NOTICE OF VIOLATION

Violation No. 1:

Note: For purposes of clarity, examples (A) through (D) of Violation No. 1 are addressed individually below.

"Technical Specification 6.5 requires, in part, that detailed written procedures, including applicable check-off lists and instructions, covering the following, shall be prepared and followed.

- A. *Specification 6.5.A.1 requires, in part, integrated and system procedures for normal startup, operation and shutdown of the reactor. Step C.3.c of Operations Manual Procedure C.1, "Startup Procedures" requires, in part, that before reaching the predicted critical band indicated on form 2159 (Predicted Critical), the source range monitor recorder and at least one intermediate range monitor recorder were to be placed in fast speed.*

Contrary to the above, neither the source range monitor recorder nor any of the intermediate range monitor recorders were placed in fast speed before reaching the predicted critical band during the startup on June 5, 1994."

NSP Response:

NSP acknowledges the above violation example. The reasons for the violation, as well as corrective actions taken and actions planned to prevent recurrence, are discussed below:

Reason for the Violation:

The cause of this violation was cognitive personnel error. A contributing cause was the sequence and presentation of the steps involving this action as they appeared in the C.1 startup procedure.

The requirement to place the SRM and IRM recorders in fast speed was specified in the procedure in a manner that, although not optimum, should have been adequate to assure this action was taken. Thus, the primary cause of the error was lack of attention to detail on the part of the control room operator. If the procedure had been organized in a different manner, it is possible that the requirement may have been more evident to the operator and the error would not have occurred.

Corrective Action Taken and Results Achieved:

1. This occurrence has been discussed with the personnel involved as well as other shift operating crews, with an emphasis on the importance of attention to detail.
2. The C.1 Start-up procedure has been revised to improve the organization and presentation of the section specifying placement of the SRM and IRM recorders in fast speed before reaching the predicted critical band. It is believed this enhancement will make this requirement more apparent to the operator and help preclude future occurrences.
3. Additional corrective actions have been taken as described in Attachment B.

Corrective Action to be Taken to Avoid Further Violation

No additional corrective actions are believed to be necessary at this time. The actions described in the preceding section are considered adequate to avoid further violation.

Date When Full Compliance Will Be Achieved

Full compliance has been achieved.

"B. Specification 6.5.A.1 requires integrated and system procedures for normal startup, operation and shutdown of the reactor and all systems and components involving nuclear safety of the facility. Prerequisite 1 of Section D.3 of Operations Manual B.3.4-05, "RHR to Radwaste Mode", requires that "Shutdown cooling is not in service on the "A" loop of RHR."

Contrary to the above, on June 8, 1994, with shutdown cooling being maintained by the "A" loop, the procedure was performed with this prerequisite not met."

NSP Response:

NSP acknowledges the above violation example. The reasons for the violation, as well as corrective actions taken and actions planned to prevent recurrence, are discussed below.

Reason for the Violation:

The cause of this violation was cognitive personnel error. A contributing factor was pre-conditioning of Operations personnel due to the routine nature of the task.

The operator involved in this event obtained the proper procedure to utilize as a reference but, because this was considered a routine task, did not review and thus did not adhere to the prerequisites stated in the procedure. Also, by failing to perform self-checking by examining the RHR system mimic depicting the RHR to Radwaste inter-connection on the control panel prior to manipulating controls, the operator missed an opportunity to avert this event.

A second opportunity to avert this event was missed because the Lead Operator did not question the appropriateness of performing this action.

Corrective Action Taken and Results Achieved:

1. The company Positive Discipline (PD) Program was implemented for the operations personnel.
2. Operations Management has met with all Operations personnel to reemphasize management's expectations regarding procedural performance, procedural adherence, and the need to self-check.
3. All RHR system operating procedures have been reviewed for vulnerabilities to drain down events and the loss of forced cooling. Procedure enhancements have been implemented where necessary.

4. Additional corrective actions have been taken as described in Attachment B.

Corrective Action to be Taken to Avoid Further Violation

1. A comprehensive review of RHR system flow paths, system interconnections and system operating procedures, including procedural precautions, limitations, and prerequisites, will be administered to all licensed personnel by 9/15/94.
2. An evaluation of the operator initial and continuing licensing training program content and administration will be conducted to determine if enhancements are necessary. Routine operator tasks that are risk significant will be identified and evaluated and simulator training will be performed to address pre-conditioning concerns. This action will be completed by 1/20/95.

Date When Full Compliance Will Be Achieved

Full compliance has been achieved.

"C. Specification 6.5.C.1 requires maintenance and test procedures for routine testing of engineered safeguards and equipment as required by the facility license and the Technical Specifications. The refueling floor radiation monitors are identified in Table 3.2.4 of the Technical Specifications as required instrumentation. Step 6 of surveillance procedure #0067A, "Spent Fuel Pool Monitor Functional Test", required that the "trip check adjust" knob be turned fully counter-clockwise.

Contrary to the above, on June 20, 1994, during the performance of step 6 to procedure #0067A, the operator in lieu of adjusting the "trip check adjust" on the power supply, instead turned off the power to two monitors."

NSP Response:

NSP acknowledges the above violation example. The reasons for the violation, as well as corrective actions taken and actions planned to prevent recurrence, are discussed below. The event noted in this example was previously reported under Licensee Event Report 94-006, dated July 19, 1994.

Reason for the Violation:

The cause of this violation was cognitive personnel error. The operator was following the applicable surveillance procedure but mistakenly manipulated the wrong switch. The test procedure used by the operator correctly identified the "B" Fuel Pool Radiation Monitor "Trip Check Adjust" as the switch to be manipulated.

A contributing factor is believed to be the human factors aspect of the panel design. The "Trip Check Adjust" and "Power Supply" control switches are located adjacent to one another and are similar in appearance.

Corrective Action Taken and Results Achieved

1. The NSP Positive Discipline (PD) Program was implemented for the operator involved.
2. The knob associated with the "Power Supply" control switch has been removed. This makes the switches more clearly distinguishable from one another. The "Power Supply" control switch is only operated during radiation monitor repair or replacement.
3. Additional corrective actions have been taken as described in

Attachment B.

Corrective Action to be Taken to Avoid Further Violation

No additional corrective actions are believed to be necessary at this time. The actions described in the preceding section are considered adequate to avoid further violation.

Date When Full Compliance Will Be Achieved

Full compliance has been achieved.

"D. Specification 6.5.C.3 requires maintenance and test procedures for preventive or corrective maintenance of plant equipment and systems that could have an effect on nuclear safety. Corrective maintenance work request authorization 94-04194 identified one spring button to be installed on top of the spring.

Contrary to the above, on June 2, 1994, maintenance personnel installed two spring buttons, one on top of and the other underneath the spring while performing work request authorization 94-04194."

NSP Response:

NSP acknowledges the above violation example. The reasons for the violation, as well as corrective actions taken and actions planned to prevent recurrence, are discussed below.

Reason for the Violation:

The primary cause of this violation was insufficient work planning and preparation. When preparing the package, the System Engineer did not specifically and uniquely identify the non-stock parts required on the stores requisition and Warehouse personnel did not seek clarification. As a result, additional parts were issued to the workers from the warehouse. Also, if the pre-job briefing had included a more thorough discussion of the scope and specifics of the alteration being performed, the problem would likely have been identified before the valve was reassembled.

An opportunity to avert the error was subsequently missed by the workers installing the parts. The workers had noted the discrepancy between the number of buttons issued from the warehouse and the instructions in the work package, but mistakenly assumed that the additional button was required as part of the alteration being performed. The workers should have sought clarification prior to proceeding with valve reassembly.

Corrective Action Taken and Results Achieved

1. The General Superintendent of Maintenance has discussed this event with all maintenance personnel. This discussion emphasized the importance of seeking clarification of any questions or concerns from engineering or supervision before proceeding with work.
2. Additional corrective actions have been taken as described in Attachment B.

Corrective Action to be Taken to Avoid Further Violation

1. The plant administrative work instruction regarding material control and Stores Requisition Form processing will be revised to require preparers to uniquely identify non-stock items on the Stores Requisition Form. This action will be completed by 9/15/94.
2. Pre-job briefing guidance will be revised to ensure key aspects of equipment modifications and alterations are addressed in the briefings. This action will be completed by 9/15/94.

Date When Full Compliance Will Be Achieved

Full compliance has been achieved.

Violation No. 2:

"10 CFR Part 50, Appendix B, Criterion V requires, in part, that activities affecting quality shall be prescribed by documented instructions, procedures, or drawings of a type appropriate to the circumstances and shall be accomplished in accordance with these instructions, procedures, or drawing. Section IV.A.d of Operations Manual C.1 specifies operator actions for rod withdrawals to take the reactor critical.

Contrary to the above, as of April 17, 1994, the procedure was not of a type appropriate to the circumstances in that it contained only recommendations and no requirements to ensure that during withdrawal of control rods, plant parameters were monitored to anticipate criticality.

This is a Severity Level IV violation (Supplement I)."

NSP Response:

NSP acknowledges that a violation occurred, but believes that it should have been included in Violation No. 1 as an additional example of failure to adhere to procedures rather cited separately as a procedural inadequacy. NSP believes that the applicable procedure was adequate and appropriate for the circumstances and, if it had been followed as intended, the event described in the inspection report would have been avoided. The reasons for the event, as well as corrective actions taken and actions planned to prevent recurrence, are discussed below.

Reason for the Violation:

Although there were a number of factors contributing to this event, the primary cause was failure to adhere to procedures. A related factor was weaknesses in the methodology used for criticality predictions. It is also possible that fatigue may have played a role in the event. Specific examples of how the above factors were involved are as follows:

1. The Reactor Operator has ultimate responsibility for monitoring and controlling reactor power and for judging the appropriateness of any control manipulations affecting reactivity. This responsibility is in no way diminished by the fact that a Nuclear Engineer is at times present in the control room to provide advice and assistance during significant power changes or other key evolutions. In this instance, the Reactor Operator was relying too heavily on the advice of the Nuclear Engineer and was not determining, independently, that the planned reactivity insertions were appropriate based on plant conditions.

2. Both the Nuclear Engineer and the Reactor Operator were relying too heavily on the result of a computer generated prediction of when criticality would occur and, contrary to the C.1 Startup Procedure, were not paying sufficient attention to control room instrumentation.
3. Although the violation describes the C.1 procedure as providing only recommendations concerning this evolution, the intent of the procedure was that the applicable steps be performed as described unless otherwise approved by supervision. The plant has a definitive policy concerning the use of the terms "shall", "should" and "may" in procedures and this event would not have occurred if that policy had been adhered to.
4. The computer program used to predict criticality is known to be less accurate for hot, high-Xenon conditions than for cold, Xenon-free conditions, but in this instance the prediction was off even further than would normally be expected. This was caused by inaccuracies in calculating the temperature defect reactivity contribution, which is not modeled well by the current methodology.
5. Monticello adopted the practice of assigning an additional licensed reactor operator to the control room during start-ups to serve in the role of Reactivity Manager. This individual is intended to serve as a resource and act in an advisory capacity to assist the shift Reactor Operator. However, it appears that, similar to the discussion involving the Nuclear Engineer in (1.) above, the presence of this individual may have the unintended effect of diluting the perceived responsibilities of the shift Reactor Operator. In addition, the individual serving as the Reactivity Manager had in this case been called in and, due to delays in the start-up, had been awake for 21 hours when the event occurred. This was not known by management and may have been a factor.

Corrective Action Taken and Results Achieved

1. Operations Management has met with all operating crews to discuss performance expectations and to reemphasize the responsibilities of licensed reactor operators with respect to monitoring and controlling all activities affecting reactor power.
2. The discussion described above addressed the importance of maintaining continual awareness of plant conditions and the need to rely on plant instrumentation as the primary indicator of plant status. The discussion also included reemphasis of Management's expectations concerning workers adherence to plant procedures.

3. The call-in policy for personnel has been revised to avoid situations resulting in employee fatigue.
4. Operations Manual C.1 and the associated Startup Checklist have been revised to provide additional cautions, guidance and requirements concerning instrument monitoring during the approach to criticality.
5. Additional corrective actions have been taken as described in Attachment B.

Corrective Action to be Taken to Avoid Further Violation

1. The methodology used for predicted critical calculations will be evaluated for changes necessary to provide more accurate predictions. This action will be completed by 10/15/94.
2. An evaluation of the role of the Reactivity Manager in control room operations will be performed to determine if this position is functioning as intended. This action will be completed by 9/15/94.
3. Operations management will meet with all operations personnel to discuss management's expectations and the site policy concerning the intent of the terms "shall", "should", and "may " as they appear in plant procedures. This action will be completed by 9/15/94.

Date When Full Compliance Will Be Achieved

Full compliance has been achieved.

Violation No. 3:

"Technical Specification Table 4.2.1 required that the Safety/Relief Valve (SRV) Low-Low Set Logic Reactor Scram Sensing Surveillance be performed once per shutdown if not tested during the previous 3-month period.

Contrary to the above, for the shutdown on July 31, 1993, this required surveillance was not performed even though it had not been performed in the previous 3-month period. The reactor was started up on August 1, 1993, and the surveillance was not completed until March 24, 1994."

NSP Response:

NSP acknowledges the above violation. The reasons for the violation, as well as corrective actions taken and actions planned to prevent recurrence, are discussed below. The event described in this violation was previously reported to the NRC in LER 94-001.

Reason for the Violation:

The cause of the missed surveillance was cognitive personnel error resulting in an incorrect surveillance procedure prerequisite. The Technical Specification requirement for this surveillance procedure was issued on November 16, 1984. The test was first performed on January 4, 1985. In December, 1987, the prerequisite was incorrectly revised to state (underlining added for emphasis):

"Plant in shutdown or refuel mode, reactor pressure < 110 psig and temperature < 345 [degrees] F."

This is not a valid prerequisite for this surveillance. The prerequisite was included in this surveillance procedure with the addition of other Low-Low Set surveillances to this procedure. This was a cognitive error during the procedure revision.

During the August 1993 shutdown, the plant did not go below 110 psig and 345 degrees F and the surveillance was not done because the prerequisites were not met.

This problem was self-identified by NSP through the Design Basis Documentation effort. While investigating the problem, it was determined that opportunities to correct the problem had been missed on two prior occasions. The surveillance procedure had been temporarily changed to eliminate the incorrect prerequisites twice before, once in 1988 and again in 1992, but the change had not been permanently incorporated. Administrative controls on temporary changes have been

revised since that time and it is unlikely that a similar repeat error will occur. This aspect of the violation is discussed in further detail in LER 94-001.

Corrective Action Taken and Results Achieved

1. The Reactor Scram sensing surveillance of the SRV Low-Low Set Logic was successfully completed on March 23 and 24, 1994.
2. The Reactor Scram sensing surveillance procedure was revised to remove the incorrect prerequisite.
3. A review of other Technical Specification required surveillance tests was conducted. All surveillance procedures not routinely scheduled were reviewed for the last ten years. No other problems were identified in this review.
4. Training on the procedure review and temporary change processes was provided to the engineering staff during quarterly Engineering and Technical Staff Training.
5. Additional corrective actions have been taken as described in Attachment B.

Corrective Action to be Taken to Avoid Further Violation

1. The plant administrative directive that provides guidance on preparation and review of procedures will be revised to enhance guidance on review of prerequisites. This action will be completed by 9/15/94.

Date When Full Compliance Will Be Achieved

Full compliance has been achieved.

Violation No 4:

"10 CFR Part 50, Appendix B, Criterion III requires, in part, that measures shall be established to assure that applicable regulatory requirements and the design basis are correctly translated into drawings.

Contrary to the above, in July, 1987, the design of the reactor pressure instrumentation system, which included physical separation of divisional components as described in Monticello Updated Safety Analysis Report, section 7.4, was not correctly translated into drawings NH-36241-1 and NH-36242 in that the drawings incorrectly showed components in locations where physical divisional separation would not exist.

This is a Severity Level IV violation (Supplement I)."

NSP Response:

NSP acknowledges the above violation. The reasons for the violation, as well as corrective actions taken and actions planned to prevent recurrence, are discussed below.

Reason for the Violation:

This violation was the result of personnel error that occurred in 1987 during the addition of drawing NH-36241-1 and the revision of NH-36242 involving the mutual cross-referencing of coordinates for continuations between the two drawings. Other related information on the drawings concerning instrument numbers and rack locations was correct.

An opportunity to uncover this error was missed during the preparation of the work procedure for testing the newly installed backfill modification. If the instrument numbers and locations had been confirmed during the procedure preparation and review process by performing a more thorough walkdown, the error would likely have been detected earlier. This is considered a cognitive personnel error in that this verification method is described in the administrative work instruction concerning work procedure preparation, review and approval, but was not performed in the desired manner.

Corrective Action Taken and Results Achieved

1. The Construction File for Drawings NH-36241-1 and NH-36242 has been updated to correct the error.
2. A review of the remaining portions of drawings NH-36241-1 and NH-36242 was performed to validate all instrument cross references.

3. The original drawing error occurred in 1987, thus it is not practical to reconstruct the specific circumstances that might have caused the individuals involved to make the error. However, a number of improvements in our drawing update process, including more stringent review requirements, have been implemented since that time that would make the occurrence of such an error today unlikely.
4. The individuals responsible for the preparation and review of the backfill modification test procedure have been counseled on the importance of conducting thorough reviews in accordance with applicable administrative directives.
5. Additional corrective actions have been taken as described in Attachment B.

Corrective Action to be Taken to Avoid Further Violation

1. Permanent revisions to drawings NH-36241-1 and NH-36242 are being processed to correct the cross-referencing error. The permanent revisions will be completed by 9/15/94.
2. Plant administrative procedures governing the preparation and review of systems isolation procedures will be revised to clarify management expectations in this regard. This action will be completed by 9/15/94.
3. Plant Engineering and Technical Staff training will be performed addressing the causes of this event, lessons learned, and the changes resulting from action (2) above. This action will be completed prior to 9/15/94.

Date When Full Compliance Will Be Achieved

Full compliance has been achieved.

Attachment B

REPLY REQUEST FOR ADDITIONAL INFORMATION

In your July 5, 1994 cover letter that forwarded Inspection report 263/94004 and the associated Notices of Violation, you requested that our response address our activities to identify the root causes behind the increase in personnel errors and the actions we were taking to reduce them. Our response to this request is as follows:

Activities to Identify root Causes:

NSP Management recognizes that the number of personnel errors and procedural adherence problems noted in Inspection Report 263/94004 is not characteristic of the usual high level of performance associated with the Monticello plant and its staff. In order to determine the underlying causes of these problems, several actions were taken in addition to the specific actions described in the individual Attachment A violation responses:

1. NSP Corporate and Site senior management staff met with line management and other key members of the plant staff to discuss and critique recent events. This round table discussion, which was conducted in a manner conducive to frank and open discussion of staff performance and concerns, was intended to flush out any underlying issues related to employee or management performance that might have eluded the more focused assessments associated with each individual event.
2. The Monticello plant Human Performance Task Force, which is comprised of an employee peer group of individuals from various plant organizations, has conducted a review of recent events to provide their assessment of causes and possible solutions.
3. The results of an NSP business practices survey, performed by an independent consultant in early 1994, recently became available. These results were reviewed by management and discussed with the site staff. A large portion of the survey was devoted to questions regarding the employee-management interface, such as communications, employee job satisfaction, management support, career development, compensation, etc.

When the results of the above efforts were reviewed in aggregate, several insights emerged that warrant management attention. These insights can be summarized as follows:

1. There is a need to increase employee accountability for task performance. There has been a tendency to "blame the process" rather than the individual when errors occur, and although that is appropriate in many instances, there are other times when attention to detail and a questioning attitude would have (and should have) prevented a problem from occurring.
2. There is a need to enhance employees' sense of process ownership by getting line organizations more involved in the identification and solution of problems. The added benefit of this is that the solution

developed will be closer to optimum and will be more readily accepted.

3. NSP, along with many other companies, has been faced with many challenging issues in recent years which has resulted in a period of rapid change within the company. Many of these changes, particularly those that are perceived by employees to affect job stability or benefits, create stress in the work force and have the undesirable side effect of diverting employee and management attention away from the performance of day to day tasks. Management needs to improve change management, especially in terms of how the changes are communicated to employees and then implemented.

In order to address the above concerns, the following actions have been identified:

1. Management expectations concerning individual employee performance have been clearly communicated to all site personnel. This included the topics of procedure adherence, maintaining a questioning attitude, and implementing the STOP program. As a matter of policy, plant personnel will be held more accountable for proper performance of their tasks, including application of the company's Positive Discipline program when appropriate.
2. The Human Performance Task Force issued a special newsletter to all members of the site staff emphasizing the need for each employee to accept responsibility for proper performance of the unit and for proper performance of their assigned tasks. The need for good work practices and the importance of self checking was discussed. In the same newsletter, managers and supervisors were reminded of their obligation to stay involved in work planning and preparation as well as the need to monitor job performance to ensure that employee work practices are consistent with the goals of the organization.
3. Training of Site supervisory personnel on employee coaching and performance feedback is in progress. One of the objectives of this course is to teach line supervisors effective methods to reward good employee performance and correct poor performance through positive interaction with their employees.
4. Training on the "seven work habits of highly effective people" has been offered to the plant supervisory staff. One of the goals of this training is to teach supervisors methods to better prioritize their time to ensure that individual employee performance monitoring and improvement is given the proper emphasis in relation to other supervisory tasks.
5. Additional training on "change management" is being arranged for site supervisory personnel. One of the goals of this training is to teach

supervisors methods to improve employee understanding and acceptance of changes in company policies, jobs, and organizational structure.

6. Recent enhancements have been made to the site self-assessment process to improve the timeliness of performance feedback and increase the involvement of line organizations. We are continuing to seek improvements to this process to optimize its effectiveness.

We believe that the actions described above will be successful in restoring the focus of all Monticello site employees to proper performance of their tasks and will thus ensure a continued high level of performance of the plant staff as a whole. The effectiveness of these actions will be reviewed through our enhanced self-assessment process and additional actions or changes will be implemented as deemed necessary.