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RECIP.NAME RECIPIENT AFFILIATION
RUSSELL,W.T. Region 1, Ofc of the Director

SUBJECT: Responds to 880112 ltr re repts of investigation of inattentiveness of operation shift supervisor while on duty.

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MAY 0 2 1988

Mr. William T. Russell
Regional Administrator, Region I
U.S. Nuclear Regulatory Commission
475 Allendale Road
King of Prussia, PA 19406

SUSQUEHANNA STEAM ELECTRIC STATION
REPORT OF INATTENTIVENESS OF A SHIFT SUPERVISOR
PLA-3025 FILE R41-2

Docket Nos. 50-387
and 50-388

Dear Mr. Russell:

This letter is provided in response to your letter of January 12, 1988. Your letter provided comments on our reports of investigation regarding inattentiveness of an Operations Shift Supervisor while on duty (PLA-2910 dated September 14, 1988). Attachment I to this letter contains the responses to your comments. Attachment II is a compilation of actions taken in response to this incident and their status.

We are submitting this letter in accordance with agreements reached at the management meeting held on March 2, 1988. A 30 day extension to submitting our response was granted by Mr. A. R. Blough of your staff on March 21, 1988.

Should you have additional questions, please call.

Very truly yours,

H. W. Keiser

Attachment

cc: NRC Document Control Desk (original)
NRC Region I
Mr. F. I. Young, NRC Sr. Resident Inspector
Mr. M. C. Thadani, NRC Project Manager

IE01
1/1

NRC Concerns Relative to Licensee Investigation of Inattentive Operator

1. The documentation provided does not sufficiently explain the basis for Pennsylvania Power and Light (PP&L) conclusions regarding the appropriateness of initial actions by section supervision. The PP&L conclusions and corrective actions suggest that the actions were not sufficiently conservative but could be considered reasonable based on the information available to the supervisors at the time. In order to evaluate this conclusion, it is necessary to know the extent to which supervision was aware of the problem at various times. For example, what did supervision know (1) prior to June 19, and (2) between June 19 and 23? What was their basis for concluding that the situation had improved and was acceptable after June 23? To what extent did the PP&L investigation attempt to determine whether instances of inattentiveness occurred after June 23?

PP&L's Response:

PP&L's investigation was not designed to determine the exact information requested. However, the Supervisor of Operations and the Day Shift Supervisor, as well as the Superintendent and other plant management, were aware of the individual's long standing personal problems. No actions were taken because there was no evidence of degradation in the performance of his shift and crew. In retrospect, these supervisors should have been more aggressive in evaluating the shift supervisor's personal problems, particularly their potential for negative impact on his performance and that of his crew.

The June 19 input to the operations supervisor from the security supervisor regarding statements made by a nuclear plant operator was not perceived as an indicator of a problem with the shift supervisor. In fact, the initial reaction on the part of the operations supervisor was that he may have been dealing with a matter of a disgruntled employee attempting to undercut his supervisor.

On June 23, the shift supervisor admitted to his supervisors that he was having trouble staying awake on the back shift. These supervisors concluded that they were confronted with a problem of a shift worker struggling with alertness on back shift. They further concluded that the problem was one they could handle at their level. In retrospect, the conclusion that the situation had improved and was acceptable after June 23 was influenced by expectations rather than substantiated facts. Such a conclusion was undoubtedly influenced by the admission on the part of the shift supervisor that he was having a problem with alertness, by his discussion of the problem with his subordinate unit supervisors, and by the fact that he had made progress on resolving prior problems.

PP&L's investigation was not sufficiently comprehensive to determine whether further inattentiveness occurred after June 23.

Lessons Learned

- Personal problems/behavioral issues must receive the same level of Management attention and corrective action as given to programs, material or operating issues. The inattentiveness incident itself has had a major impact on the Nuclear Department. It eliminated any false sense of security that such incidents couldn't happen at Susquehanna SES. Further, it has created a new climate of sensitivity, questioning and conservative action when dealing with behavioral problems.

- To provide programmatic support, PP&L has amended the policies on dealing with behavioral issues. Essentially, this change adds an additional psychological evaluation tool entitled "Suitability Examination". This tool is designed to satisfy management's need to know by providing direct feedback from consulting psychologists. It also is structured to preserve the confidentiality of the Employee Consultation Program. Nuclear Department Line Supervisors were provided details on the Suitability Option during company sponsored Drug and Alcohol Training given during December 1987 and January 1988.

- The Nuclear Department recognizes the value of independent investigation in certain situations and will consider the use of a trained, independent investigator on a case-by-case basis in the future.

2. The PP&L report does not directly address the safety significance of the item relative to the importance of the attitude and example which are set by shift management. Also, it does not address the event relative to compliance with procedures for shift manning and alertness.

PP&L's Response:

The shift supervisor's behavior had the potential to create improper attitudes and behavior on the part of his subordinates which could potentially have safety significance. Based on interviews with the members of the shift in question, we have concluded that the shift supervisor's inattentiveness did not degrade their attitude or sense of responsibility toward the protection of public safety. In part, they rationalized his behavior because of their confidence in their ability to safely operate the units. The shift members clearly believed the behavior to be wrong and several individuals commented on the fact that the Shift Supervisor was a poor role model.

Requirements for shift manning are stated in the Technical Specification and these requirements were satisfied. No specific procedures requiring alertness exist because we believe this to be a fundamental duty of our employees. PP&L's standard for employee conduct is that they will remain alert and able to perform their assigned tasks at all times. This is necessary so that our operators have the aggressive, questioning, proactive attitude that we desire.

3. The event indicates that there was reluctance on the part of many to raise to management their concerns regarding a shift supervisor's attentiveness. PP&L should be prepared to discuss the adequacy of their corrective actions regarding the general issue of worker reluctance to elevate concerns to assure resolution.

PP&L's Response:

The actions management takes when an issue is raised is what delivers the real message. Our handling of the shift supervisor in question was well received by the organization. We believe that such actions on management's part go a long way toward establishing a climate where reporting of concerns will be perceived to have positive results for all involved.

4. The NSAG report investigated cases where one engineer signed for all attendees at Installation Kickoff Meetings. The report does not supply the basis for its conclusion that the event was an error, as opposed to a willful noncompliance. Also, the report does not indicate if the affected documents constituted NRC-required records.

PP&L's Response:

The specific questions of willful noncompliance and NRC required records were not addressed in the NSAG review and consequently were not covered in PP&L's previous response to the NRC. They are discussed below.

a) Willful Noncompliance

The NSAG Investigation Record dated 8/28/87 contains the following statement:

> A. admits that he erred when he initialed off for B. on the meeting minutes. He said that in the past, he has initialed off for everyone at every kickoff meeting that he has held. No one had ever voiced opposition to this practice. He said that he has now reread the procedure for holding kickoff meetings (TI-PE-028) and understands that he was wrong in doing initialing for everyone. He said that from now on, he will always have the meeting attendees initial for themselves.

Clearly, the individual erred. The statement implies that he did not understand the process. NSAG took him at his word. The question of willful noncompliance was not pursued.

A rigorous answer is that PP&L does not know that the person was not guilty of willful noncompliance. The man stated that he did not understand the process. A check showed that he had acted consistently on the other kickoff meetings that he had chaired. (He had initialed for the attendees at all of them.) There was no evidence that he had acted maliciously.

The basis for the conclusion that the event was an error is the man's statement and the impression of the NSAG investigator who conducted the interview.

b) NRC Required Records

PP&L's definition of NRC required records is found in Operational Policy Statement (OPS) Eight, which deals with Quality Assurance records. OPS-8 states:

> This policy is applicable to all documents recording activities within the scope of OPS-1 Operational Quality Assurance Program, including operating logs, results of AUDITS, TESTING, INSPECTIONS, work performance and personnel CERTIFICATION. For this policy a document is not considered to become a record until it is complete.

The Assistant Manager-NQA told the Manager-NSAG, who was researching this response, that PP&L's interpretation of OPS-8 is that NRC required records are those that govern work activities and testing. Administrative aids are not required records.

Actual installation and testing are done in accordance with formally approved work documents and test procedures. The work documents and test procedures constitute the NRC required records.

The installation kickoff meeting minutes are an administrative aid. They are used by PP&L to facilitate and coordinate the modification process.

Subsequent design and safety reviews are conducted on all modifications.

Based upon the above, PP&L concluded that installation kickoff meeting records are not NRC required records.

ATTACHMENT II

COMPREHENSIVE LIST OF CORRECTIVE ACTIONS

	ACTIONS	STATUS
1.	Relieve the shift supervisor of this shift responsibilities.	Completed
2.	Initiate two investigations: one performed by the Assistant to the the Senior Vice President-Nuclear to address the allegations in the anonymous letter to NSAG received on August 7, 1987; the second performed by NSAG to identify other concerns of operating personnel and to determine the extent to which there may be a reluctance on the part of operators to report concerns to management and the possible cause thereof.	Completed
3.	Brief station personnel of the incident stressing that inattentiveness is unacceptable behavior while on duty.	Completed
4.	Expand back shift inspections by senior plant management.	Completed
5.	Referral of the shift supervisor under PP&L's Continual Behavior Observation Program.	Completed
6.	Include an article by the Senior Vice President-Nuclear in the Nuclear Department's news weekly reiterating PP&L's policy on the importance of reporting incidents of this nature. The article also stressed that no one will ever be penalized for the reporting of concerns.	Completed
7.	Conduct follow-up briefings addressing lessons learned and standard reinforcement.	Completed
8.	Develop improved guidance to respond to situations involving personal problems with respect to conflicts between the Company's Continual Behavior Observation Program and the Company's Employee Counseling Service.	Completed
9.	Resolve six shift rotation scheduling.	Open
10.	Review operation management's handling of operator's concerns.	Completed
11.	Establish a performance evaluation team to evaluate telephone annoyance concerns in the control room and recommend improvements.	Completed
12.	Evaluate ISI program with respect to the integrity of the operation data.	Completed
13.	Meet with GPU Nuclear to discuss their experience with the use of an independent investigator.	Completed