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Inspection Report Nos. 50-387/95-05; 50-388/95-05

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Licensee: Pennsylvania Power and Light Company
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Allentown, Pennsylvania 18101

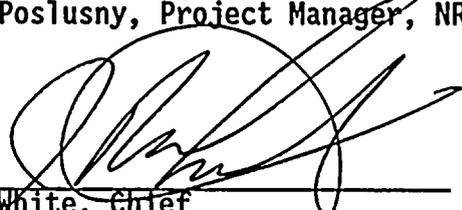
Facility Name: Susquehanna Steam Electric Station

Inspection At: Salem Township, Pennsylvania

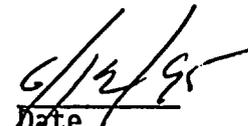
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Date

Scope: Conduct a performance-based assessment of the effectiveness of licensee controls and processes in identifying problems and implementing adequate timely corrective actions.

Results: NRC assessment is summarized in the Executive Summary. Details are provided in the full Inspection Report.

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EXECUTIVE SUMMARY
Susquehanna Inspection Reports
Report Nos. 50-387/95-80; 50-388/95-80
May 8-12, 1995

Problem Identification and Corrective Action Processes

In 1993, Pennsylvania Power & Light Company (PP&L) management conducted a broad-based review of how business was being conducted in the Nuclear Department at the SSES. Some areas for improvement were identified including: management oversight, administrative controls, corrective action program, organizational culture and human factors. In 1994, Continuous Performance Improvement Process (CPIP) Teams, including the Corrective Action and Assessment teams, began to meet and review the plant processes. An Assessment Task Force was also formed in November 1994 by the Senior Vice President-Nuclear. The principal purpose of the task force was to develop a plan to address recommendations and issues from the CPIP Teams.

The Corrective Action CPIP Team recommended that a new Condition Report (CR) process be established, which would consolidate four previous deficiency tracking systems. The Corrective Action Team (CAT) review portion of the CR process, including the 24 hour event investigation by the Operating Experience Service (OES) staff, was a strength. The daily review provided immediate management involvement and attention for all CRs generated the previous day. The CAT process ensures that management is not only made aware of the events, but actually contributes to correcting the problem early on in the process. A random sample of 20 CRs issued since the program was initiated indicated that, with few exceptions, appropriate issues were identified and that effective actions were taken as a result of the identified deficient conditions.

There was a smooth transition to the integrated CR program from old processes prior to the recent Unit 1 outage. The use of the Event Review Teams (ERT) was appropriate and provided good insights. Monitoring of the effectiveness of previously implemented corrective actions was weak, in that cause/trend information was difficult to retrieve and evaluate using the existing CR system database. The station did not currently have an effective method to conduct an integrated approach to trending performance history of various conditions. Interviews with members of the line organizations including foreman and workers, indicated that they did not have a clear understanding of the CR process. From their vantage point, the four old programs just had a new name.

Operating Experience Feedback

SSES has implemented an industry event review program (IERP) that utilizes lessons learned throughout the nuclear industry to prevent similar problems at SSES and to enhance the operation of the two units by using information obtained from other operating plants in the nation. In general, PP&L seems to successfully deal with the wealth of information that is received regarding operating experience and effectively provides it to the line organization. Further, NRC information documents are promptly dealt with. The inspector

noted that some weakness exists in obtaining timely data retrieval from the various industry data bases but the new organization should be able to implement improvements in this area.

Self-Assessment

In February, 1995, PP&L completed its task force effort on the assessment process and issued a report on this subject. The report provided the basis for the establishment of a new organization that would focus on conducting and supporting assessments and established new procedures and requirements for the staff to meet. In March of 1995, PP&L then created the NAS organization. This new organization is responsible for developing tools to support assessments; conducting audits, surveillance, and quality control activities.

Based on a review of the program and documented reports, and discussions with NAS staff, as well as members of the line organization, the inspector found that the consolidation of the assessment function under one on-site organization has been successful to date. Within NAS, there is good support across the sub-groups for the conduct of audits and assessments and the staff are working well together. Interviews with a number of site staff revealed that there is a positive attitude toward the NAS group and its functions and there is evidence that improvements have been made as a result of the assessments being performed. Having the assessment function in one organization as currently established provides obvious planning, control, and resource benefits.

Safety Committees

The review of the Susquehanna Review Committee (SRC) meeting minutes indicated that the SRC critically reviewed appropriate safety-related activities and provided oversight of the audit of nuclear plant operations. The meeting minutes were well written and included sufficient information to document all the required reviews, as well as action items assigned to the plant staff by the SRC. At a meeting of the SRC, the inspector found the discussions open and reflected a priority concern for safety. The SRC not only met its responsibilities as defined in the technical specification, but also provides added defense-in-depth to the problem identification and corrective action process.

At a Plant Operation Review Committee (PORC) meeting, the members displayed a questioning attitude and challenged the staff on the safety evaluations performed for the modifications. A weakness was identified in the area of the PORC procedure change review. A review of 59 procedure changes, lasted 10-15 minutes during a PORC meeting, was conducted with no question or comments. The inspector questioned the staff regarding the value added with that type of review. The supervisor of OES informed the inspector that this issue was being reviewed at that time and an effort was being made to reduce the burden on the PORC.



TABLE OF CONTENTS

EXECUTIVE SUMMARY	ii
1.0 40500 INSPECTION	1
2.0 BACKGROUND	1
3.0 PROBLEM IDENTIFICATION AND CORRECTIVE ACTION PROGRAM	2
3.1 Condition Report Process	2
3.2 Review of Condition Reports	5
3.3 Work Authorization System	6
3.4 Operator "Work-arounds"	7
3.5 Other Identification/Corrective Action Processes	7
3.6 Event Response Teams	8
3.7 Investigator's Guide	8
3.8 Employee Concern Program	9
3.9 Performance Trending	10
3.10 Summary of NRC Assessment	11
4.0 OPERATION EXPERIENCE FEEDBACK	11
5.0 SELF-ASSESSMENT	13
5.1 Independent Safety Evaluation Services	13
5.2 Audit Services	14
5.3 Surveillance Services	15
5.4 Quality Control Services	16
5.5 Operating Experience Services	16
5.6 Assessment Process Services	17
5.7 Summary of NRC Assessment	18
6.0 SAFETY COMMITTEES	19
6.1 Susquehanna Review Committee	19
6.2 Plant Operation Review Committee	19
7.0 INTERVIEWS	19
8.0 EXIT INTERVIEW	21

DETAILS

1.0 40500 INSPECTION

The objective of this inspection was to conduct a performance based evaluation to determine the effectiveness of the Susquehanna Steam Electric Station (SSES) controls in identifying, resolving, and preventing issues that may degrade the quality of plant operations or safety. These controls included: safety review committees, root-cause analysis programs, corrective action programs, self-assessment programs, and other processes that are provided for the incorporation of operating experience feedback.

The inspectors performed the inspection using the guidance of Inspection Procedure 40500 "Effectiveness of Licensee Controls in Identifying and Resolving Problems." The inspectors directly observed portions of activities, interviewed management and staff, reviewed and assessed past problems and associated corrective actions.

2.0 BACKGROUND

In 1993, Pennsylvania Power & Light Company (PP&L) management conducted a broad-based review of how business was being conducted in the Nuclear Department at the SSES. Some areas for improvement were identified including: management oversight, administrative controls, corrective action program, organizational culture and human factors. In an effort to improve performance in these areas, four Nuclear Department Improvement Initiative Teams were established to review the conduct of business and to propose improvement recommendations. In 1994, two of the four teams, know as Continuous Performance Improvement Process (CPIP) Teams, began to meet and review the plant processes. The CPIP teams included the Corrective Action and Assessment teams. An Assessment Task Force was also formed in November 1994 by the Senior Vice President-Nuclear. The principal purpose of the task force was to develop a plan to address recommendations and issues from the CPIP Teams with regard to the existing Nuclear Quality Assurance (NQA), Nuclear Safety Assessment Group (NSAG), and Nuclear Regulatory Affairs (NRA) groups.

The Corrective Action CPIP Team recommended that a new Condition Report (CR) process be established, which would consolidate four previous deficiency tracking systems. Senior management's review of the new CR process determined that effective implementation would require changes in the organization and resources of NRA and NQA. The Assessment CPIP Team made a number of recommendations in support of achieving a major increase in the effectiveness of independent and self-assessment activities at all levels. Based on these recommendations, the Assessment Task Force identified and implemented a number of changes, which are discussed in this report (section 5.0).

To facilitate the new program changes, a new organization was formed by consolidating the three existing functional units, NQA, NSAG, and NRA. The new functional group is called the Nuclear Assessment Services (NAS) organization (See Attachment 1). The principal responsibilities for NAS included support of assessment within the Nuclear Department, development of tools to support assessment including methodology and information, conduct of independent assessment, audits and surveillance, and quality controls activities. The NAS was also charged with providing centralized tracking of

all deficiency and assessment data including the nature of events that occur, causes, and action items. NAS is currently developing a comprehensive schedule for assessments, including those identified by Vice Presidents and functional unit managers, external assessments, audits and independent assessments.

3.0 PROBLEM IDENTIFICATION AND CORRECTIVE ACTION PROGRAM

The Corrective Action CPIP Team determined that the existing programs were not effective in identifying and correcting the root causes of human performance, in identifying adverse trends for repetitive events of a lesser significance, nor in the effecting of a final resolution to persistent problems. In response to these issues, the team recommended that a single system be established for the handling of deficiency from initiation through closure. The single process would consolidate the following processes: Significant Operating Occurrence Report (SOOR); Non-conformance Reports (NCR); Human Performance Enhancement System (HPES) Report; Audits and Surveillance findings; and Engineering Discrepancy Reports (EDR). This recommendation led to the development of the Condition Report process and its associated Nuclear Department Procedure (NDAP)-QA-0702, Revision 0, dated March 6, 1995. This procedure was designed so that the identifier does not have to choose which corrective action document best fits the condition, and that the condition identified will receive appropriate management attention. A condition is defined in this procedure as any operating occurrences, plant non-conformances, audit or surveillance findings, procedural or programmatic violations, engineering discrepancies, or human performance near misses that fall outside of normally accepted variance with respect to personnel performance, procedural requirements, design documents, regulatory requirements.

The inspectors selected events from the Condition Report problem identification processes being used at the site. The inspectors performed a detailed analysis for a number of events, issues and other plant performance problems. This analysis was performed to determine the effectiveness of the SSES program for initial identification of problems, the characterization of problems, elevation of problems to appropriate levels of management, and the determination of system operability, reporting, and implementation of immediate, interim and final corrective actions required to effectively resolve the problem.

3.1 Condition Report Process

The Operating Experience Service (OES) group under NAS is responsible for maintaining the Condition Report program and for maintaining the central data base that includes all CRs. Anyone can initiate a CR with or without their supervisors notification and approval. The system is also set up to accept confidential or anonymous CRs. Once the CR is written, the cognizant supervisor signs it and per NDAP-QA-0702, Condition Report, forwards it to either the Shift Supervisor/Shift Technical Advisor, when it is believed that the condition renders equipment inoperable, or to the Supervisor-OES when the impact is not known, or there is no operability impact. Both Operations and OES review the CR for operability/reportability determinations and attaches

the required forms to the CR package. Within 24 hours of the event, the OES staff performs a Significance Review that includes an assessment of the identified condition, determination of the similarity of the condition to any previous condition at SSES or in the industry, and an assessment for apparent generic implications. The following morning, the OES staff presents the prior day's CRs to members of the Corrective Actions Team (CAT) and recommends the appropriate classification (level 1 or level 2), the assigned or proposed lead functional unit manager, and what is needed to resolve the condition. The CAT consists of the Vice President-Nuclear Operations, and Functional Unit Managers (FUM) from Operations, Maintenance and Engineering. The CAT then designates a lead FUM to investigate the condition and provide an Evaluation and Action Plan, including actions to correct the condition and prevent recurrence. For CRs that require no further action, the CAT can immediately close the CR at the daily morning meeting.

All level 1 CRs (and those designated level 2 that require additional review, as determined by the CAT) require a root cause analysis and actions to prevent recurrence. Level 1 CRs also receive Plant Operating Review Committee (PORC) review. The due date for the development of an Action Plan is 20 calendar days after assigned for a level 1 CR and 30 calendar days for a level 2 CR. The required completion date for actions to prevent recurrence for a CR is six months from the Evaluation and Action Plan approval date for all actions not requiring an outage or modification to complete. Under the old deficiency tracking systems the plant staff was given 45 days to develop an Action Plan and up to an operating cycle to complete actions to prevent recurrence.

The inspectors found that the CAT review portion of the CR process, including the 24 hour event investigation by the OES staff, was a strength. The daily review provided immediate management involvement and attention for all CRs generated the previous day. The following three examples are CRs that were generated during the inspection week. The CAT provided an excellent review of these events by contributing additional information, and demonstrating a questioning attitude concerning the root cause of the problems.

- CR No. 95-202 - Standby Gas Treatment 'A' train inlet damper failed in the open position. OES recommended a level 2 classification, with no root cause analysis. CAT identified generic implications with hydromotors (used in the damper) at the station and directed OES to perform a failure trend for this type of motor. OES was also directed to compare SSES with the industry average and look at potential factors leading to failures like plant location. Electrical Maintenance was requested to perform a component failure analysis for the particular hydromotor.
- CR No. 95-203 - RFPT 1C reset without operator action after being tripped during uncoupled overspeed test. OES recommended a level 2 classification with System Engineering to revise test procedure to preclude automatic resets during the performance of the procedure. CAT identified that this event was similar enough to a previous out of position event on another system. System Engineering was directed to determine what the test director is allowed to do regarding performing steps out of order in test procedures. Operation was directed to

address communication issues between test directors and both the control room and field personnel. CAT believed this event was a human performance issue and requested System Engineering also develop training for test directors specifying their accountabilities and responsibilities.

- CR No. 95-204 - While performing a fill and vent procedure on the 'C' condensate demineralizer, water backed up from the floor drains contaminating a 200 square foot area on elevation 656'. OES recommended that Operations take the lead, with systems engineering assisting, to determine the appropriate actions to prevent recurrence. The root cause was already known since this event had occurred a number of times before. This event was assigned a level 2 classification with no root cause analysis; however, CAT concerned with the generic implications of the event, directed Operations to investigate why the previously identified problems with fill and vent had taken so long to be addressed. The modification group was directed to investigate the modification process to determine if it creates restrictive barriers between people and fixing problems.

In these examples the CAT, aided by the 24 hour review of the event by OES, provided the plant staff with clear direction (using all available information at that time) to resolve the issues and establish appropriate corrective actions. The CAT process ensures that management is not only made aware of the events, but actually contributes to correcting the problem early on in the process.

As a result of the change to the new CR system, deficiency items tracked under the old methodologies (SOOR's, NCR's, etc.) have plateaued and are beginning to decline. PP&L established a goal to eliminate the pre-CR backlog by the end of the next Unit 1 operating cycle; any open items at that time would be converted to a CR for resolution. The inspectors determined that causal factors for closed items tracked under the older systems will not be easily retrievable for use in future root cause determinations or for performance trending under the CR process. However, PP&L independently recognized this shortcoming and has initiated a plan to address the concern. The plans include the development of a news information system prototype, and a new methodology and an approach to trending. These initiatives are expected to be in place later this year.

The inspectors noted that performance indicators for deficiency and open items were tracked in a monthly NAS status report. As of May 4, 1995, there were 378 pre-CR deficiency items and 145 open CRs; this backlog slowly decreased over the last year even though the number of new items generated each month remained nearly constant. Overdue CR initial responses (Action Plans) were also monitored, and at the time of the inspection stood at approximately the 12% level. Though a process was available to formally request extensions for action deadlines, the inspectors determined that this process was generally not employed. Distractions from the recently completed Unit 1 outage and general lack of familiarity with the new CR system were cited as reasons for the overdue actions.

3.2 Review of Condition Reports

At the time of the inspection, the plant staff generated approximately 200 CRs since the program's inception on March 6, 1995. The inspectors reviewed a random sample of 20 CRs issued since the program was initiated and concluded that, with few exceptions, appropriate issues were identified and that effective actions were taken as a result of the identified deficient conditions. Specifically, operability, reportability, and root cause determinations, as well as, recommended and completed corrective actions were generally of good quality. The CR process was also effective in bringing issues to management attention. Proper significance levels were assigned and the appropriate evaluations were performed. The threshold levels for capturing items in the system were set sufficiently low to identify significant plant conditions. Recurrent deficiencies were usually recognized and considered before assigning action priority. Bases for decisions made with respect to CR followup actions were well documented.

As an example, CR 95-150, which documented the potential for RCIC suppression pool suction strainer clogging, clearly described the deficient condition, established the safety significance, and provided a detailed basis for determining operability and reportability. CAT team recommendations were evident. Past occurrences and generic implications were considered and documented. Actions to correct the deficient condition and prevent its recurrence were clearly established and were appropriate.

One example of an exception to the generally good quality of CRs was CR 95-075, which identified measuring and test equipment (M&TE) that was found out of calibration. The significance review portion of this CR stated that there were no generic implications as a result of this deficiency and that no other equipment was susceptible to this problem. However, in apparent contradiction to this evaluation, the inspectors determined that CR 95-024 documented a virtually identical deficient condition that occurred only two weeks before. The inspectors concluded that, even though immediate actions taken to verify work performed using the affected M&TE was scheduled to be rechecked, actions to prevent recurrence were not evident and no evaluation for potential adverse trends was conducted. Since the CAT team approved the CRs disposition as a "Level 2 with no root cause," cause/trend codes may not have been established to aid in the identification of declining performance in the M&TE area.

In fact, the inspectors determined that cause/trend information was difficult to retrieve and evaluate using the existing CR system database. No formal mechanism was in place to integrate causal information. PP&L was well aware of this programmatic weakness since it has been documented in several previous self assessments. In the sample of CRs reviewed, very few clearly established cause or trend codes, indicating that little predictive analysis was being performed to identify recurrent deficiencies. Without improved cause/trend information, the inspectors concluded that PP&L monitoring of the effectiveness of previously implemented corrective actions was weak. This issue is further described in section 3.9.

3.3 Work Authorization System

Deficiencies affecting structures, systems and components may be identified by any member of the PP&L staff by initiating a Deficiency Tag and/or Work Authorization (WA) in accordance with the station work control procedure NDAP-QA-0502. The initiator prepares a tag identifying the deficiency and attaches it to the malfunctioning component. In addition, the initiator submits a WA that gets tracked in the Plant Management Information System (PMIS). The WA is then reviewed, approved, prioritized and planned by the appropriate work group and station supervision.

Deficiencies may also be identified by using the WA process alone without using Deficiency Tags. If the significance is deemed to be high or the deficiency is a recurring one, the issue may be developed into a CR for root cause evaluation and development of corrective actions. The inspectors learned, however, that the WA (PMIS) database is not routinely analyzed to understand equipment performance trending; the information system is not well suited for this activity. In the course of equipment CR evaluations, the WA database is sometimes consulted in an attempt to understand previous performance history, but the process is cumbersome and the maintenance history information is somewhat limited. The inspectors noted that a new Nuclear Information Management System (NIMS), scheduled to be operational in two to three years, is being developed with enhanced search capability for equipment maintenance history and performance trending.

The inspectors discussed the WA process with various members of the plant staff and management. Several thousand work documents were generated in 1994; approximately 4000 currently exist as backlog. Of this backlog, approximately 580 represented corrective maintenance (CM) needed (this is a typical number for Susquehanna which has remained relatively constant over the last several years). The inspectors noted that the CM backlog was well managed, with more detailed backlog trending based on individual CM priority level. The inspectors determined that, of the existing CM backlog, the vast majority were of the lowest priority level and only 10% of the total were greater than 1 year old.

The inspectors learned that a new program, the Emergent Work Action Crew (EWAC), was scheduled to begin pilot operation in mid-May 1995. This initiative, resulting from an internal PP&L Work Process Improvement Team recommendation, was intended to support operations personnel in the timely resolution of emergent work. Station management believed that the all volunteer team, comprised of a foreman and six maintenance technicians of varying specialties, would help to minimize interruption of scheduled work, enhance equipment failure investigations, improve feedback to work planning staff, and reduce the CM backlog. PP&L intended to review the effectiveness of the EWAC program and it will be evaluated after three months to ensure that established goals were being met.

The inspectors concluded that, in general, PP&L's use of the WA process was effective in identifying and resolving deficiencies in the plant. CM backlog was well managed and performance indicators were frequently generated (and closely monitored) to ensure maintenance goals were being met. Recent

enhancements to the work control process, including the new EWAC team, were judged to be excellent initiatives. Though retrieving equipment maintenance history and performance trending from PMIS was somewhat difficult, the station's use of the system for this purpose was routine and deemed to be adequate.

3.4 Operator "Work-arounds"

The inspectors questioned various levels of plant staff regarding their awareness of operator "work-arounds" at the station, and whether these work arounds were being identified, managed and resolved. PP&L responded to generic industry guidance on the subject (i.e. INPO SOER 94-01) by explicitly defining what constituted a work around, then soliciting input from plant operators (and others) regarding known plant deficiencies that met the established criteria. Based on this input, a list of items was generated and reviewed by plant management, including PORC. This list, currently tracking 24 items, has been frequently updated and submitted to PORC for review on a quarterly basis.

The inspectors concluded that PP&L was very sensitive to the work around issue and established a reasonable tracking system to ensure that identified deficiencies were resolved. Because work arounds identified in the future should be captured by the CR process, the existing list should ultimately be eliminated. The inspectors noted that all of the items being tracked on the current list were issued a WA number, indicating that each was submitted to planning for ultimate resolution. The inspectors concluded that the schedule for resolution was appropriate.

3.5 Other Identification/Corrective Action Processes

Though not explicitly defined as part of the overall formal system used for the identification and resolution of deficiencies (CRs), the inspectors observed several other "sub-tier" methods and processes that the station employed to document and correct adverse conditions. Examples included the Area Contamination Report (ACR) program, the Instrumentation and Controls (I&C) component and instrument failure tracking database, and the Nuclear Systems Engineering (NSE) department's system status report program.

In the latter example above, the inspectors reviewed a high pressure coolant injection (HPCI) semiannual system status report (dated November 1994) and noted it to be of excellent quality. The report included detailed assessments of system performance, descriptions of open deficiency items, reviews of repeat deficiency occurrences, material condition, etc. The inspectors concluded that the report provided NSE and PP&L management necessary and concise information needed to maintain the system in a highly reliable state.

Of further note, the inspectors attended an NSE training session during the week of the inspection. During this monthly gathering of all NSE system engineers, short informational briefings were conducted to describe the events and lessons learned of five different significant CRs generated since the last

meeting. The inspectors judged this feedback to be timely and informative, and overall an excellent initiative to ensure that recurrence of identified deficiencies was minimized.

3.6 Event Response Teams

The inspectors reviewed the Event Review Team (ERT) process, including observation of a currently active team investigating a recent reportable event involving the Unit 1 hydrogen seal oil system (CR 95-190). The inspectors noted that 83 ERT's have been formed since the inception of the program in April 1990 (approximately 16 per year). Though PP&L has not formally established a threshold for the type of issues requiring ERT followup, interviews with plant management indicated that these reviews were reserved for investigating issues that had significant potential to identify root causes that were not previously understood or recognized; that is, management's prerogative drove the process. The inspectors noted from a review of completed ERT's that reports were generally comprehensive and provided detailed assessments of event root and contributing causes. ERT recommended corrective actions were considered appropriate to address identified causes. However, in the samples of ERT's reviewed, specific team charters were not provided and the methods used by the teams to establish their findings were not evident.

The inspectors learned that a newly created "Investigator's Guide" was being used for the first time to aid in the conduct of the hydrogen seal oil ERT. The team demonstrated effective use of formal root cause analysis tools, and indicated that the new manual was beneficial in facilitating their investigative process. The inspectors considered team composition appropriate for the event being analyzed; further, most team members had received formal root cause training. The inspectors concluded that the ERT process effectively provided station management with information needed to ensure that event causes were fully understood and corrective actions implemented would prevent recurrence.

3.7 Investigator's Guide

The Corrective Action CPIP Team identified that an upgrade in the SSES investigation techniques was required to properly correct problems. The team obtained copies of investigative programs in place at a wide variety of utilities, as well as review of the NRC's Human Performance Investigation Guidebook. The team concluded that other utilities had some very good methods for assessing human error. Several of these methods were tested using an example event and actual root cause analysis. A subteam was then established to prepare an investigator's guidebook. The inspectors reviewed the draft Investigator's Guide, Revision 0, dated April 24, 1995.

The Investigator's Guide was developed to assist personnel assigned to investigate events, problems, or malfunctions. It provides tools to help the investigator determine root causes of performance problems, identify associated causal factors, check for generic implications of an event, determine if the event is recurrent, and to recommend corrective actions.

The manual provides the tools necessary to perform an investigation. The manual was written for both the individual investigator and an Event Review Team, and includes information such as Investigative Techniques, Root Cause Analysis Techniques, Corrective Action Development Techniques, and the composition and expectations of an Event Review Team. The techniques include: event and causal factors, cause and effect, change analysis, barrier analysis and task analysis. The manual also includes a "Quick Start" Application Guide, designed to provide step by step instructions on how to investigate an event.

At the time of the inspection, the manual was being used in a pilot training course and on a trial basis during a recent ERT investigation, prior to issuing it to the staff for training and official use. The inspector concluded that the Inspector's Guide was an excellent initiative and is indicative of SSES commitment to perform quality investigations of events. While it is too early to assess effectiveness of this manual, it will function as a single reference point for root cause analysis and effective trending, with a focus on human performance errors.

3.8 Employee Concern Program

The SSES Employee Concerns Program (ECP) was established in 1989 and was reviewed by an independent contractor in 1993. Subsequently, a workshop for employees was held to identify areas for improvement. Shortly thereafter, recommendations were accepted and implemented by department management. The inspector reviewed the procedure that describes the program, NDAP-00-1510, "Nuclear Concerns of Individuals," dated December 22, 1994. According to this procedure, the ECP provides an avenue to identify and resolve employee identified concerns. Specifically, each employee is encouraged to officially raise concerns to the immediate supervisor. In the event there is a reluctance to use the normal communication avenue, a path is available outside the management chain to raise concerns by reporting them to the Nuclear Safety Concerns Program Representative who can serve as an advocacy representative for those who provide concerns directly to them. When concerns do not get resolved to the satisfaction of the identifier, a Difference of Professional Opinion can be identified and provided to the cognizant vice president for evaluation and decision making. When requested, the system can handle requests for anonymity.

The inspector interviewed several managers and line employees to determine if employees have been made aware of the ECP and understand how the program is designed to work. Based on the feedback received during the interviews it appears that there is a general understanding of the ECP at SSES and a belief that most employees are willing to bring up concerns informally with their supervisors and routinely reach acceptable resolution. There are some employees that rely upon the ECP to formally register and request resolution of issues with the ECP Representative and these items are tracked through resolution. The inspector reviewed the list of concerns being tracked by PP&L for 1994 and 1995 and it appears that the resolution time has been reasonable, and that the program staff have been responsive to identified concerns. In discussions, the inspector noted that SSES management has demonstrated immediate response to recently identified concerns. Training has

been provided to all employees concerning the current program and it is included in the general annual training program. In addition, information about the employee concerns program regarding contacts and process are posted at the entrance gates to the plant and in locked bulletin boards throughout the plant. Overall, the ECP appears to be an effective method for identifying and resolving employee concerns.

3.9 Performance Trending

The inspectors noted that there were several issues at the station that received comprehensive review and assessment over the last year; management focused on these issues in part as a result of station QA and NSAG (now Independent Safety Evaluation Services) findings, NRC inspection reports, and other outside assessments. These assessments indicated that adverse trends had developed and performance in the specific areas was declining. Status control, work control, and problem identification and resolution were dominant areas of focus. PP&L initiated several dedicated, full-time process improvement teams in 1994 to thoroughly assess and make improvement recommendations in the identified areas.

The inspectors did not specifically evaluate the processes used by each of the noted teams or the specific findings of each, but rather observed the effectiveness of a sample of recommended actions for improvement. For example, as a direct result of initiatives implemented just weeks before the recent Unit 1 refueling outage, Susquehanna realized a significant reduction in status control errors that far exceeded expectations. Further, efficiency of work control improved at the station by relocating the work control center to an area more convenient for workers. A completely restructured quality assurance/nuclear safety review organization was created that enhanced the station's self assessment capability and ability to identify and correct deficient conditions. The inspectors concluded that PP&L's process improvement teams provided station management with excellent insights into recurrent plant problems and methods to resolve them.

However, the station's capability to recognize and develop actions to improve less "global" problems was not as evident. This was primarily due to the fact that the station did not currently have an effective method to conduct an integrated approach to trending performance history of various conditions. Even the new CR process, which forces cause and trend codes to be assigned to identified deficiencies, was not particularly effective due in part to the cumbersome nature of the computer system in which the CR database resides. The inspectors observed some "localized" trending at the station, and noted that individual station departments often kept their own records of performance history. Specifically, Operations has independently developed a new self-assessment process, based on the use of a one page checklist, that collects and feeds information to a data base for tracking and trending of human performance in the conduct of operations tasks. I&C staff perform some trending related to equipment performance. Surveillance Services trends the results of its inspections, and Quality Control Services trends "In-Process Corrected Errors." In addition, Operating Experience Services trends the results of NAS assessments and audits.

The inspector observed that each of these trending activities provides valuable information to the parent and other organizations and often leads to improvements in the conduct of routine work activities. However, during interviews, PP&L staff stated that improvements in trending need to be made through system enhancements and centralization of the trending function in NAS. This issue was also recognized by the PP&L staff prior to the inspection.

Though some declining performance trends were easily detected based on the nature of the equipment affected or the volume/frequency of CRs generated in a particular area (e.g. recent focus on Rod Drive Control System failures), the inspectors concluded that less obvious conditions might not be discovered or addressed by plant management until the problem resulted in an unexpected plant event.

3.10 Summary of NRC Assessment

The inspectors concluded that the new CR process was an effective program overall, as evidenced by good overall plant performance and a successful Unit 1 outage. Deficiencies are being captured and tracked by available systems (CR, WA, etc). The CAT review portion of the CR process, including the 24 hour event investigation by the OES staff, was assessed as a strength in the program. This process allows prompt management review of identified deficient conditions. The inspectors noted there was a smooth transition to the integrated CR program from old processes prior to the recent Unit 1 outage. It was well managed and monitored by plant management. Semi-annual system engineering status reports were noted to be of excellent quality and provided PP&L management with information needed to maintain system reliability. The use of the ERTs was appropriate and provided good insights; however, in the sample of ERTs reviewed, specific team charters were not provided. Monitoring of the effectiveness of previously implemented corrective actions was weak, in that cause/trend information was difficult to retrieve and evaluate using the existing CR system database. The station did not currently have an effective method to conduct an integrated approach to trending performance history of various conditions.

Overall, the CPIP Teams' recommendations have given the plant staff the tools to effectively identify and resolve problems or issues that affect plant safety and/or are conditions adverse to quality. PP&L management has taken strong measures and applied significant resources to improve performance in specific problem areas, as well as improve the effectiveness of the corrective action process. While the inspectors could not fully assess the long term affects of the new management structure and program changes, some improvements have already been realized in the short time the programs have been in place.

4.0 OPERATION EXPERIENCE FEEDBACK

SSES has implemented an industry event review program (IERP) that is addressed in Nuclear Department Procedure NDAP-QA-0725, dated February 6, 1995. (The inspector reviewed this document and noted that this procedure needs to be updated to reflect the recent reorganization that established the Nuclear

Assessment Services organization). The procedure is based on INPO Guideline 89.005, "Guidelines for the Use of Operating Experience" and Final Safety Analysis Report Section 18.1.12, "Feedback of Operating Experience."

The purpose of the IERP is to utilize lessons learned throughout the nuclear industry to prevent similar problems at SSES and to enhance the operation of the two units by using information obtained from other operating plants in the industry. The inputs to the system include: INPO Significant Event Evaluations and Information Network items, INPO "Good Practice" Documents, applicable GE Service Information Letters, Technical Information Letters, Service Advice Letters, NRC Information Notices, Bulletins, Generic Letters, selected NUREGs, applicable vendor information, and 10 CFR Part 21 notices. All items are screened and reviewed by an IERP evaluator. Items that are input for action have a 45 day turnaround and if operability determinations or reportability actions are required then they must be completed within 2 weeks of receipt of the item. Items are assigned Priority I if they affect nuclear or industrial safety or if they reflect NRC commitments, or are assigned Priority II if they affect power generation, are considered enhancement items, or would be discretionary modifications to the plant. The inspector noted from his experience in processing SSES responses to NRC bulletins and generic letters, that PP&L has routinely provided timely and quality responses to these items over the past year.

The inspector discussed the program with the IERP coordinator and learned that each day a large amount of experience information received from the nuclear network or from other sources in hard copy is screened for direct or indirect applicability to SSES staff. About 200 IERP items and 500 information items are generated and transmitted to the SSES staff each year. In addition to these items an internal electronic newsletter is prepared with wide distribution that includes information on industry events.

The inspector discussed aspects of the use of operating experience related to the followup of the issue with Rosemount transmitters and loss of fill oil and the issue on suction strainer clogging with instrumentation and control, and systems management. It was found that even before the NRC issued generic guidance or requirements to PP&L, that its staff had received information from the nuclear network, had talked directly with staff at other affected plants or with owners group representatives. The process for information flow seemed to ensure that the plant staff were prepared to address regulatory requirements well in advance of the request date. It was observed that there was significant benefits gained by informal contacts with counterparts at other utilities in the exchange of operational information. The inspector found that there was a good understanding about the role of the IERP coordinator and the procedure that is being followed.

Under the new NAS organization, the responsibility for activity in the operating experience area falls in the Operating Experience Services group. It was indicated that the IERP coordination function, currently held by the Nuclear Engineering Organization at PP&L headquarters, would be transferring to this group in the near future.

In general, PP&L seems to successfully deal with the wealth of information that is received regarding operating experience and effectively provides it to the line organization. Further, NRC information documents are promptly dealt with. The inspector noted that some weakness exists in obtaining timely data retrieval from the various industry data bases but the new organization is planning to implement system improvements in this area.

5.0 SELF-ASSESSMENT

In February, 1995, PP&L completed its task force effort on the assessment process and issued a report on this subject. The report provided the basis for the establishment of a new organization that would focus on conducting and supporting assessments and established new procedures and requirements for the staff to meet. In March of 1995, PP&L then created the NAS organization. This included the previous organizations of Nuclear Quality Assurance, Nuclear Safety Assessment, and a portion of the Nuclear Regulatory Affairs group. This new organization is responsible for developing tools to support assessments; conducting audits, surveillance, quality control activities, and operating experience review. The NAS is composed of the following organizations: Independent Safety Evaluation Services (ISES), Audit Services (AS), Surveillance Services (SS), Quality Control Services (QCS), Operating Experience Services (OES), and Assessment Process Services (APS) (See Attachment 1). All but one of these groups is responsible for conducting self-assessments or audits. Discussions of the NAS groups below also reflect activities of each group under the previous organization.

5.1 Independent Safety Evaluation Services

Independent Safety Evaluation Services (ISES) provides independent verification of correct performance of SSES activities with minimum human errors. This group replaced the existing Nuclear Safety Assessment Group (NSAG), retaining its responsibilities. During interviews the inspector learned that this group conducted ten evaluations during 1994 and three in 1995 to date. Periodic assessments include the annual summary assessment, outage reviews, and operations and maintenance surveillances. In addition, significant events and areas of interest are evaluated based on safety significance. Over the years, it was indicated in discussions that these assessments have resulted in marked improvements in operations, maintenance effectiveness, and overall safety of the plant. Areas of success have relied on effective communications during and after evaluations and line participation in planning and focusing of the scope of evaluations. Recent indications include a reduction in the number of ESF actuations, more effective shift turnovers, improved control room communications, an improvement in the maintenance organization, and improvements in startups. The inspector observed that there is no formal requirement on how soon after assessment completion that a report is due for issuance.

The inspector reviewed two assessment reports and focused on the implementation of selected findings. The first one, Project Report 6-94, "Investigation of Control Rod Drive System Events," dated July 14, 1994 addressed two events that occurred in 1993 where a number of control rods travelled beyond the 00 position after scram and where a control rod moved

from an indicated full in position to 04 position with no operator action. Following the events, several Event Review Teams conducted reviews and subsequently the ISES (the Nuclear Safety Assessment Group at the time) conducted an independent investigation into the safety aspects of the events. Based on the contents of the report the inspector noted that the team conducted a thorough review of the events and the reviews and corrective actions that occurred after the event. Conclusions included that actions should be taken to limit the amount of crud reaching the control rod drive mechanisms such as improving water quality and vacuuming the debris from the CRD guide tubes. It was also noted that the maintenance of the directional control valves should be improved. The inspector determined for these items, no response had been provided back to ISES and they remained open. Another conclusion in the report was that surveillances to ensure that all rods are properly latched should be extended to cover Operating Conditions 4 and 5. The inspector found that the appropriate procedure had been modified and this item had been closed out in November 1994.

The second report reviewed was Project Report 9-94, Source Range Monitor Event of 5/7/94 During Unit 2 6th Refueling Outage, dated October 17, 1994. This report addressed an event of May 7, 1994, when the 13th and 14th fuel bundles were reloaded with the channel C source range monitor inoperable. The organization and details in the report reflect an extremely comprehensive technical evaluation of the event focusing on the different staff involved with the refueling evolution, the hardware performance history, internal and industry experience, root cause, and corrective actions. Conclusions included that a neutron monitor replacement policy was needed and that trouble shooting needed to include vendor guidance in procedures and work plans. For these two items, the ISES had not received a response, however during discussions the inspector was told that these items had been discussed during recent pre-outage management review meetings. In those discussions it was indicated that the I&C group was still working on a potential replacement policy and that an agreement had been made to consider procedure changes to include vendor guidance. Thus these items remain open. The report indicated that the Reactor Engineering organization needed to be responsible for neutron monitoring systems during refueling. The inspector noted that the line organization disagreed with this finding in its response to the report. Subsequently, ISES met with line management, reached agreement with the line staff and revised its finding for the record. Another item in the report indicated that an error exists in TS Section 4.9.2.c in that it does not reflect the guidance provided by GE (signal-to-noise ratio is in error). A request for TS change had been developed and sent to licensing and this item was closed.

The inspector noted that although the findings of ISES assessments are being tracked by OES, there is no requirement to ensure that all open items are resolved within a prescribed time period.

5.2 Audit Services

Audit Services (AS) conducts a wide variety of audits in accordance with 10 CFR 50 Appendix B. During interviews the inspector learned that in 1994, 28 audits were conducted, and this year nine have been conducted so far. Audits

conducted included those required by the Technical Specifications and additional ones identified by management. Audits generally last about 2 weeks and a report is provided within 30 days of completion of the audit. Organizations being evaluated are provided findings prior to report issuance so that corrective actions can be considered and identified. Cooperation with line groups is enhanced by scope discussions prior to the conduct of the evaluation effort. The inspector observed that this had enhanced mutual understanding of the scope and purpose of audits and had produced a more useful product.

Two audit reports were reviewed by the inspector. The first, NAS Audit 95-036, PLI-80051, "Program for Identifying, Resolving, and Preventing Problems," focused on programs being implemented within the Nuclear Department for the identification, resolution, and prevention of problems that degrade the quality of SSES operations or safety. In the area of self-assessment, a need to improve responsiveness to the assessment process and a need to formally define, via procedure, the assessment process and expectations were identified by PP&L staff. The inspector recognizes that although the potential for lack of responsiveness on lower level assessment findings existed, the use of the new CR system in recording significant findings ensured that priority items are given the proper attention and are closed out. Information included in the recently circulated Assessment Initiative Summary discussed below provided comprehensive guidance on the scope and process of assessment.

The second report reviewed by the inspector, Audit 94-053, PLI-78707, "Audit of SSES Fire Protection Program," focused on the requirements and administrative controls of the program and was required by the Technical Specifications. Seven findings were identified, one was closed during the audit and the remaining were adequately responded to by the line organization. Audit scope, conduct, and findings were clearly documented.

5.3 Surveillance Services

The Surveillance Services (SS) group conducts audit support, oversees surveillance and reviews procedures. During 1994, 98 surveillances were conducted and 44 were performed in 1995 to date. Planning is performed with an 18-month horizon with a goal of addressing all disciplines at least once during the planning period. Reports were provided on a timely basis but there is no requirement to issue the report by a certain time period following the evaluation. Feedback is routinely provided informally to the lowest level of management in the organization being evaluated. SS findings were documented in a CR, and observations or recommendations were passed on to the evaluated organization with signature of receipt, and noted items were those items that were immediately corrected during a surveillance. The SS group also provided summaries of surveillance results to the OES group for tracking and trending.

The inspector reviewed two reports prepared by the SS group. Report 94-089, dated December 6, 1994, "Implementation of TP-264-021, Reactor Recirculation Hydraulic Response Evaluation," summarized a surveillance of the testing of the recirculation system at higher flow rates. The report included a finding

of the exceedance of a vibration level criteria for the suppression pool hatch covers and noted that the finding had been addressed by the line organization and resulted in a modification of the acceptance criteria.

Report 94-071, dated October 20, 1994, "Evaluation of Response to a 1993 INPO Finding," addressed a finding concerning a lack of compliance with the PP&L Chemical Control Program in the area of container labeling at work group storage locations. The surveillance determined that most of the INPO findings had not been corrected at the site, at the time of the surveillance. The responses to the surveillance report from the line organization; however, reflected immediate or near term implementation of corrective actions, and established dates for the completion of all corrective actions.

5.4 Quality Control Services

Quality Control Services (QCS) conducts a broad variety of inspections of physical work in progress. During 1994 about 2200 inspections were conducted and this year about 957 were conducted (not including welding and snubber inspections that do not require separate QCS reports). In addition to regular reports, this group documents "In Process Corrected Errors" (ICEs) after they are completed, which are potential deficiencies that are identified and corrected during the inspection process. These items are documented on a form, entered into a tracking system and trended. Feedback is provided to the unit managers when a threshold of repetition is reached to correct conditions or contributors to problem areas or actions. The descriptions were found by the inspector to be clearly and concisely written so that the reader could understand what was not done properly. In 1994, 468 of these reports were generated, and in 1995, 340 have been generated to date. The inspector noted that the system is being implemented in a positive manner to identify weaknesses in programs without creating a climate of intimidation when items are identified. The data is used to facilitate productive discussions with unit managers and generate improvements.

The inspector reviewed about five routine inspection records and quality control check lists and an internal memorandum that provided ICE trending results to the Operations Manager. The documents were found to provide a useful overview of in process corrections with numbers compared to previous time periods. Examples of routine feedback to the radwaste and fire protection organization were also reviewed and found to be useful and focused on areas for improvement.

5.5 Operating Experience Services

This group is responsible for maintaining and supporting the condition reporting system for the site as discussed in Section 3.1 above. In addition, the Operating Experience Services (OES) staff provides ad-hoc support to assessments conducted by other groups and conducts less formal assessment information inputs to the on-site review committee and to management as requested. Tracking and trending of the results of ISES, AS, and SS group recommendations are performed by this group as well. It was stated in discussions with the inspector that trending activities are routinely conducted by Nuclear Operations, Electrical/I&C, ICES, and SS groups in

addition to that conducted by OES, and that in the past there was an instance where conflicting information was provided by the different trending efforts. The inspector noted that there is an effort in progress to consolidate tracking under OES. Operating experience information is provided upon request from the line organizations as discussed in Section 4.0 above.

5.6 Assessment Process Services

The Assessment Process Services (APS) is responsible for integrating all department independent assessments and performing a number of quality evaluations and studies. The assessment function is conducted on an "as-requested" basis and is performed as a service for plant management. About 12-14 assessments are conducted each year. Pre-planning discussions with the organization is conducted before each assessment and agreements are made on what will be done with findings and recommendations. No formal tracking is done by APS on the resolution of findings and recommendations and the inspector noted that there was no process to ensure that significant findings get elevated or tracked as appropriate for action. Plant improvements based on the results of assessments included the quality of engineering calculations and cross references; the establishment of the new condition reporting system; and the responsiveness to NRC inspection findings.

New requirements are being established for each functional organization manager to conduct self-assessments, to be planned at least a year in advance. During the inspection, a document was sent to the functional unit managers by NAS, which provided a comprehensive definition of the overall SSES assessment process and a preliminary integrated assessment schedule for all internal and external assessments through June of 1996. This document, the Assessment Initiative Summary, was found to be a good source of guidance for understanding the evaluation process and a model that is to be followed by those performing the efforts. Additional value from the schedule should be realized from a resource and planning perspective.

In addition to self-assessments being planned by each of the unit managers, the vice presidents also can elect to identify additional areas for assessment as need be. Support for planning and conducting these assessments will be provided by NAS as needed.

The minimum requirements for independent assessments include an annual review of performance of each department, and periodic review of corrective action and assessment items to identify areas for improvement. The objective is to have all important facets of each organization assessed at least once over a reasonable period of time. In addition, a single department wide program for capturing and tracking assessment-identified deficiencies and recommendations has been established.

The inspector reviewed two assessments. The first, PLI-78864, "Assessment of Fire Protection Program," was an independent review of the FP program's conformance with regulatory commitments, and the effectiveness of the program's implementation at the site. The report documented several recommendations and included a letter in response to the assessment report prepared by the manager of the organization being assessed. Recommendations

included: develop a procedure for site fire protection engineer to conduct weekly plant walkdowns and include a description of how the walkdowns are done. The line organization response to the assessment report indicated that a procedure change would be made to include the frequency of the walkdowns, but the response did not mention adding a description of how a walkdown should be conducted. The inspector learned in an interview that there was no procedure in place, in which the description of the walkdown will properly fit; however, it was indicated that an in-house check list was developed which is used during the performance of walkdowns. In addition, a memorandum was sent to the appropriate PP&L staff describing the requirements for the walkdown.

The second assessment reviewed, PLI-79698, "Susquehanna Steam Electric Station Setpoint Change Process Assessment Report" dated March 14, 1995, focused on the implementation and closure phase of the Setpoint Change Process, including the process of identification, tracking, and issuance of changes to all procedures affected by the setpoint change. Recommendations included: improve the identification of procedures affected by the setpoint change package (SCP), improve the timeliness of procedural changes, and provide management the opportunity to review the status of SCPs issued for implementation but not completed. In discussions with the operations manager, he indicated that this assessment resulted in significant improvements in procedures and the modification process.

5.7 Summary of NRC Assessment

Based on a review of the program and documented reports, and discussions with NAS staff, as well as members of the line organization, the inspector found that the consolidation of the assessment function under one on-site organization has been successful to date. There is a good understanding by the line organization of where to obtain support for self-assessments, operating experience, and in the future, trending information. Within NAS, there is good support across the sub-groups for the conduct of audits and assessments and the staff are working well together. Interviews with a number of site staff revealed that there is a positive attitude toward the NAS group and its functions and there is evidence that improvements have been made as a result of the assessments being performed. Recent indications of positive contributions by the ISES group include a reduction in the number of ESF actuations, more effective shift turnovers, improved control room communications, an improvement in the maintenance organization, and improvements in startups.

The inspector observed that there is a good level of support across the NAS groups for the conduct of audits and assessment and often a given assessment may have staff from two groups. This coordination of resources augments planning and provides a good mix of expertise for the required assignment areas. In addition, outside contractor help can be provided to augment in-house staff to complete the workload. Having the assessment function in one organization as currently established provides obvious planning, control, and resource benefits.

6.0 SAFETY COMMITTEES

6.1 Susquehanna Review Committee

The inspector reviewed meeting minutes from 1994 and the first quarter of 1995, and attended a Susquehanna Review Committee (SRC) meeting on May 10, 1995. The review of the SRC meeting minutes indicated that the SRC critically reviewed appropriate safety-related activities and provided oversight of the audit of nuclear plant operations. The meeting minutes were well written and included sufficient information to document all the required reviews, as well as action items assigned to the plant staff by the SRC. The inspector verified that the SRC adequately reviewed those items required by the technical specifications, at the May 10 meeting, and that the composition and quorum requirements were met. In general, the inspector found the discussions open and reflected a priority concern for safety. In particular, the inspector observed excellent discussions regarding recent plant events, and there was a very good presentation on the Unit 1 core shroud evaluation. The committee was very concerned with the impact of poor plant chemistry on shroud crack growth and asked for a followup presentation on that issue at the next meeting. Additionally, the SRC asked for a presentation on the current state of the preventive maintenance (PM) program for electrical substations, including the SSES switchyard. This request was the result of recent industry events, including the dual unit scram at the Limerick Generating Station. The inspectors concluded that the SRC not only meets its responsibilities as defined in the technical specification, but also provides added defense-in-depth to the problem identification and corrective action process.

6.2 Plant Operation Review Committee

The inspector attended a Plant Operation Review Committee (PORC) meeting on May 11, 1995. The agenda for the meeting included a review of design change packages, condition reports and procedure changes. The members displayed a questioning attitude and challenged the staff on the safety evaluations performed for the modifications. The inspectors identified a weakness in the area of the procedure change review. The agenda listed 59 procedure changes to be reviewed at the PORC meeting. After all the other PORC reviews were completed, the committee member conducted a "self study" to review the procedure changes. The "self study" lasted 10-15 minutes with no question or comments and the meeting was ended. The inspector questioned the staff regarding the value added with that type of review. (Does it meet the intent of the technical specification or just satisfy it?) The supervisor of OES informed the inspector that this issue was being reviewed at that time and an effort was being made to reduce the burden on the PORC. The inspector had no further questions.

7.0 INTERVIEWS

The inspectors conducted interviews with the Functional Unit Managers from Operation, Maintenance, System Engineering, Plant Services, and Outages. They were extremely familiar with the new CR process, in particular in their capacity as CAT members. All individuals were enthusiastic about the new process and saw it as a significant change to the way the corrective action

process had worked in the past. For the most part, they considered management's involvement in the front end of the process to be a great improvement, and should go along way toward resolving the problems with human performance errors.

The inspectors also conducted interviews with members of the line organizations including foreman and workers. The inspectors determined that the definition of a "condition" under the new CR process was not known by the line and plant workers interviewed. They knew it had replaced the four older processes but could not specifically define what a "condition" was. In addition, the workers did not have a clear understanding of the CR process. However, they all knew where to go when a problem was identified, just as if they were under the old systems. From their vantage point, the four old programs just had a new name. They also stated that the investigations of events were getting away from "placing the blame" and more at getting to the root cause of the problem. This observation was encouraging to plant management, since this was the primary focus of the new process. Initial training was conducted with Operations staff and system engineers prior to the implementation of the new process.

Interviews were conducted to gather information on the SSES self-assessment process and function. Managers interviewed included the Manager of NAS, the group leaders of Independent Safety Evaluation Services, Surveillance Services, Quality Control Services, Operating Experience Services, Assessment Process Services, and a project engineer in the Audit Services group. The Nuclear Operations and Maintenance managers were also interviewed to obtain feedback on the quality and timeliness of services provided by the NAS. These discussions provided a basis for the inspectors to conclude that benefits have been gained from the reorganization and consolidation of the assessment function under NAS. Further, a smooth working relationship has been established between the groups under NAS. The NAS "customers" reflected a belief that there is significant value added by the assessment process at the site.

To obtain information about the Employee Concerns Program (ECP) at SSES, the inspector interviewed the on-site ECP representative, the Nuclear Operations and Maintenance managers, a Mechanical Maintenance foreman, an Electrical Maintenance foreman, and a station mechanic and an electrical mechanic. Information obtained indicated that there is a good working understanding of the ECP supported by regular training and postings. In addition, there is a belief that most employees are willing to bring up concerns in an informal manner with their direct supervisor and find that items are addressed in a timely and responsible manner.

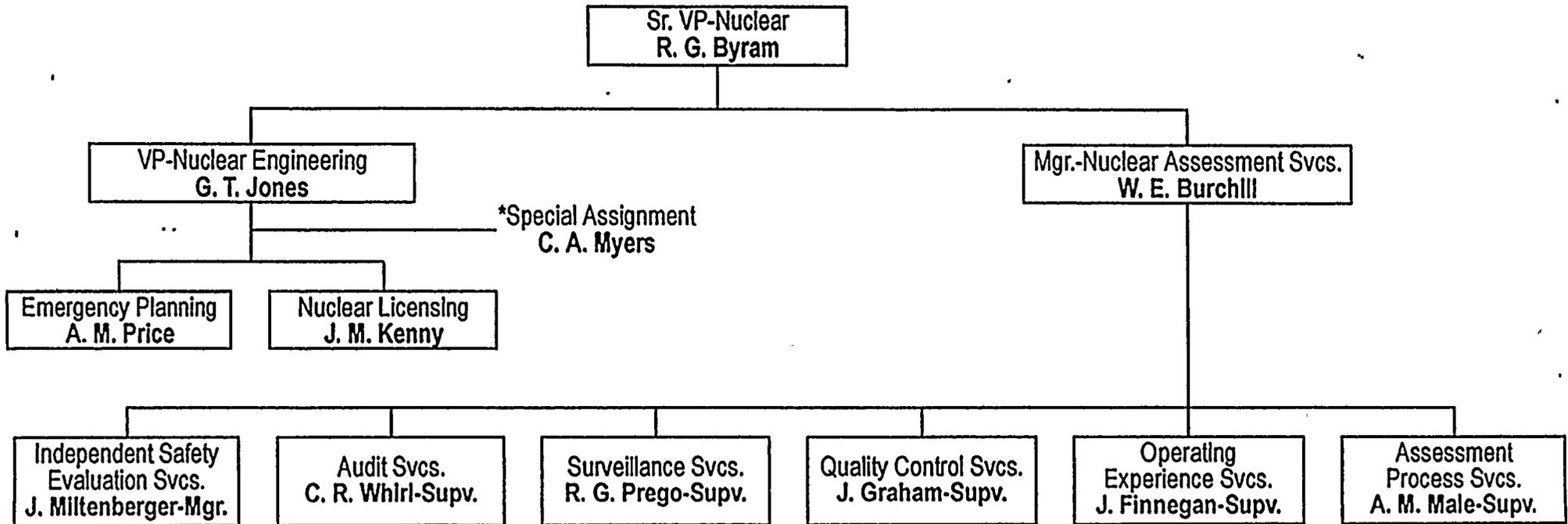
The operating experience area was discussed in interviews with the Operating Experience Services leader, the Industry Event Review Program Coordinator, the I&C Engineering Supervisor, the NSSS Supervisor and the Containment Group Leader. The program was also discussed during interviews with the Nuclear Operations and Maintenance Managers. As discussed in Section 4.0 above, the IERP provides a very useful service in screening a large amount of incoming experience information and communicating an applicable amount of information to site staff. In addition timely responses to NRC bulletins and generic

letters are supported by the function. Some weakness in the data retrieval and trending functions were identified but programs for improvement were noted as being under development.

8.0 EXIT INTERVIEW

The inspectors discussed the issues in this report with Pennsylvania Power and Light Company representatives throughout the inspection period, and summarized the findings at an exit meeting with the Vice President - Nuclear Operations, Mr. H. G. Stanley, on May 12, 1995. PP&L personnel did not express any disagreement with the inspection findings. No written inspection material was provided to licensee representatives during the inspection period.

Realignment of Nuclear Assessment Function



*Special assignment to VP-Nuclear Engineering responsible for Emergency Planning with specific responsibility as project manager to relocate the EOF and complete the Ingestion Pathway Exercise.

