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FEB 14 1994

Docket Nos. 50-245  
50-336  
50-423

Executive Vice President-Nuclear  
Northeast Nuclear Energy Company  
P.O. Box 270  
Hartford, Connecticut 06141-0270

SUBJECT: COMBINED INSPECTION REPORTS 50-245/93-10; 50-336/93-06; 50-423/93-07

Dear Mr. Opeka:

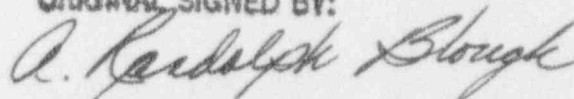
This letter refers to your June 7, 1993, correspondence, in response to our April 30, 1993, letter.

Thank you for informing us of the corrective and preventive actions documented in your letter. Notwithstanding the corrective action plans which you have implemented to address weaknesses in your self-assessment and corrective action programs, our reviews indicate that events caused by personnel error, inattention to detail, and noncompliance with procedures continue to occur. While most of these events, taken individually, have been of minor safety significance, the frequency at which they continue to occur indicates that your corrective actions have not been entirely effective. We will continue to examine these actions during future inspections of your licensed program.

Your cooperation with us is appreciated.

Sincerely,

ORIGINAL SIGNED BY:

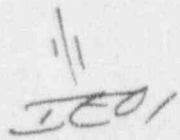


Lawrence T. Doerflein, Chief  
Projects Branch No. 4  
Division of Reactor Projects

*for*

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Mr. John F. Opeka

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cc:


S. E. Scace, Vice President, Nuclear Operations Services  
D. B. Miller, Senior Vice President, Millstone Station  
H. F. Haynes, Nuclear Unit Director  
G. H. Bouchard, Nuclear Unit Director  
F. R. Dacimo, Nuclear Unit Director  
R. M. Kacich, Director, Nuclear Planning, Licensing and Budgeting  
J. Solymossy, Director of Nuclear Quality and Assessment Services

cc w/cy of Licensee's Response Letter:

Gerald Garfield, Esquire  
Nicholas Reynolds, Esquire  
K. Abraham, PAO (2 copies)  
Public Document Room (PDR)  
Local Public Document Room (LPDR)  
Nuclear Safety Information Center (NSIC)  
State of Connecticut SLO Designee  
NRC Resident Inspector

bcc w/cy of Licensee's Response Letter:


Region I Docket Room (with concurrences)  
J. Stolz, NRR/PD I-4  
V. McCree, OEDO  
G. Vissing, PM, NRR  
V. Rooney, PM, NRR  
D. Jaffe, PM, NRR  
J. Anderson, NRR  
N. Blumberg, DRP  
L. Doerflein, DRP

  
RI:DRP  
Blumberg

12/2/93

  
RI:DRP  
Rogge

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RI:DRP  
Doerflein

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**NORTHEAST UTILITIES**



THE CONNECTICUT LIGHT AND POWER COMPANY  
WESTERN MASSACHUSETTS ELECTRIC COMPANY  
HOLYOKE WATER POWER COMPANY  
NORTHEAST UTILITIES SERVICE COMPANY  
NORTHEAST NUCLEAR ENERGY COMPANY

General Offices • Selden Street, Berlin, Connecticut

P.O. BOX 270  
HARTFORD, CONNECTICUT 06141-0270  
(203) 665-5000

June 7, 1993

Docket Nos. 50-245  
50-336  
50-423  
B14486

Re: 10CFR2.201

U.S. Nuclear Regulatory Commission  
Attention: Document Control Desk  
Washington, DC 20555

Gentlemen:

**Millstone Nuclear Power Station, Unit Nos. 1, 2, and 3**  
**Reply to Notice of Violations**  
**Combined Inspection 50-245/93-10; 50-336/93-06; 50-423/93-07**

In a letter dated April 30, 1993,<sup>(1)</sup> the NRC Staff transmitted its Notice of Violation (NOV) relating to NRC Combined Inspection Report Nos. 50-245/93-10; 50-336/93-06; and 50-423/93-07. The report discussed the results of safety inspections conducted between March 3, 1993, and April 3, 1993. Based on the results of the Staff's inspection, three violations were identified. Attachment 1 to this letter provides Northeast Nuclear Energy Company's (NNECO) response to the first violation, on behalf of Millstone Unit No. 1 pursuant to the provisions of 10CFR2.201. Attachment 2 provides NNECO's response to the second and third violations on behalf of Millstone Unit No. 2 pursuant to the provisions of 10CFR2.201. In a telephone conference with the NRC Staff on May 24, 1993, it was mutually agreed that this response would be submitted within 30 days from May 6, 1993, the date of receipt.

The NRC letter also involved a detailed review of the activities of groups which contributed to the overall self-assessment functions at the Millstone Station. While NNECO does not dispute the inspection findings, we have included a brief discussion relating to self-assessment activities in Attachment 3.

(1) A. R. Blough letter to J. F. Opeka, "Millstone Combined Inspection 50-245/93-10; 50-336/93-06; 50-423/93-07," dated April 30, 1993.

*9306140322 17M*

Attachment 1

Millstone Nuclear Power Station, Unit No. 1

Reply to a Notice of Violation  
Combined Inspection 50-245/93-10; 50-336/93-06; 50-423/93-07

June 1993

was completed on April 28, 1993. Note that this program did not reveal any contact abnormality sufficient to inhibit the component from performing its safety function.

3. The Corrective Steps That Will Be Taken to Avoid Further Violations (Violation A)

Since the time of the 1991 PIR, there have been numerous enhancements made to the PIR process such that the PIR Administrative Control Procedure (ACP-QA-10.01) now requires that commitments be established for all corrective actions and/or actions to prevent recurrence identified in the PIR that are incomplete at the time of PIR close-out.

The importance and significance of commitment tracking and follow-through will be reinforced to all personnel involved with PIR investigations and close-outs. This will be completed by July 30, 1993.

A periodic PM program will be established to clean and lubricate all the safety-related contacts every other refuel outage. All nonsafety-related auxiliary contacts will be cleaned and lubricated every third refuel outage. This program will be in place by December 31, 1993, to be implemented during the 1994 refuel outage.

4. The Date When Full Compliance Will Be Achieved (Violation A)

An expedited program was established to identify, inspect, clean, and lubricate the applicable safety-related auxiliary contacts. Full compliance was achieved when this program was completed on April 28, 1993.

5. Generic Implications (Violation A)

This issue will be identified to Engineering Management personnel at Millstone Unit Nos. 2 and 3 and the Haddam Neck Plant. Actions will be taken as appropriate.

Additional Information (Violation A)

The Staff expressed concern with the timeliness of corrective actions established following the 1992 auxiliary contact failure. An immediate program to clean or replace the auxiliary contacts was not considered based on the following:

# NORTHEAST UTILITIES



THE CONNECTICUT LIGHT AND POWER COMPANY  
WESTERN MASSACHUSETTS ELECTRIC COMPANY  
HOLYOKE WATER POWER COMPANY  
NORTHEAST UTILITIES SERVICE COMPANY  
NORTHEAST NUCLEAR ENERGY COMPANY

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June 7, 1993

Docket Nos. 50-245  
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Re: 10CFR2.201

U.S. Nuclear Regulatory Commission  
Attention: Document Control Desk  
Washington, DC 20555

Gentlemen:

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Reply to Notice of Violations  
Combined Inspection 50-245/93-10; 50-336/93-06; 50-423/93-07

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The NRC letter also involved a detailed review of the activities of groups which contributed to the overall self-assessment functions at the Millstone Station. While NNECO does not dispute the inspection findings, we have included a brief discussion relating to self-assessment activities in Attachment 3.

(1) A. R. Blough letter to J. F. Opeka, "Millstone Combined Inspection 50-245/93-10; 50-336/93-06; 50-423/93-07," dated April 30, 1993.

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June 7, 1993

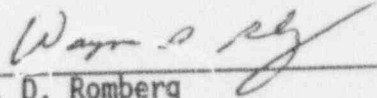
If you have any questions regarding information contained herein, please contact us.

Very truly yours,

NORTHEAST NUCLEAR ENERGY COMPANY

FOR: J. F. Opeka  
Executive Vice President

BY:

  
\_\_\_\_\_  
W. D. Romberg  
Vice President

cc: T. T. Martin, Region I Administrator  
D. H. Jaffe, NRC Project Manager, Millstone Station  
J. W. Andersen, NRC Project Manager, Millstone Unit No. 1  
G. S. Vissing, NRC Project Manager, Millstone Unit No. 2  
V. L. Rooney, NRC Project Manager, Millstone Unit No. 3  
P. D. Swetland, Senior Resident Inspector, Millstone Unit Nos. 1, 2,  
and 3

Attachment 1

Millstone Nuclear Power Station, Unit No. 1

Reply to a Notice of Violation  
Combined Inspection 50-245/93-10; 50-336/93-06; 50-423/93-07

June 1993



Millstone Nuclear Power Station, Unit No. 1

Reply to a Notice of Violation  
Combined Inspection 50-245/93-10; 50-336/93-06; 50-423/93-07

Restatement of Violation

During an NRC inspection conducted on March 3, 1993, through April 3, 1993, violations of NRC requirements were identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," 10CFR Part 2, Appendix C, the violation is listed below:

- A. 10CFR Part 50, Appendix B, Criterion XVI (Corrective Actions) requires, in part, that measures shall be established to assure that conditions adverse to quality, such as failures, deficiencies, and deviations be promptly identified and corrected. The measures shall assure that the cause of the condition is determined and corrective action is taken to preclude recurrence.

Contrary to the above, since 1985, fourteen safety-related auxiliary electrical contacts have failed to operate on demand, rendering Unit 1 equipment inoperable. The cause of the failures was attributed to dried grease/cleaner residue, a maintenance-related condition applicable to many similar safety-related contacts. The licensee did not develop effective corrective actions to preclude recurrence of the subsequent failures.

This is a Severity Level IV Violation. (Supplement I)

1. Reason for Violation (Violation A)

Plant Incident Report (PIR) investigations, relating to auxiliary contact failures, identified the need to perform Preventative Maintenance (PM) of the auxiliary contacts in order to improve component reliability. This action was not completed at the time of PIR close-out and no tracking commitment was established to ensure the completion of the PM activity, which resulted in subsequent failures.

Although it would have been expected that this action would have been completed, the PIR Administrative Control Procedure did not specifically require action item tracking prior to close-out.

2. Corrective Steps That Have Been Taken and the Results Achieved (Violation A)

An expedited program was established to identify, inspect, clean, and lubricate the applicable safety related auxiliary contacts. This program

was completed on April 28, 1993. Note that this program did not reveal any contact abnormality sufficient to inhibit the component from performing its safety function.

3. The Corrective Steps That Will Be Taken to Avoid Further Violations (Violation A)

Since the time of the 1991 PIR, there have been numerous enhancements made to the PIR process such that the PIR Administrative Control Procedure (ACP-QA-10.01) now requires that commitments be established for all corrective actions and/or actions to prevent recurrence identified in the PIR that are incomplete at the time of PIR close-out.

The importance and significance of commitment tracking and follow-through will be reinforced to all personnel involved with PIR investigations and close-outs. This will be completed by July 30, 1993.

A periodic PM program will be established to clean and lubricate all the safety-related contacts every other refuel outage. All nonsafety-related auxiliary contacts will be cleaned and lubricated every third refuel outage. This program will be in place by December 31, 1993, to be implemented during the 1994 refuel outage.

4. The Date When Full Compliance Will Be Achieved (Violation A)

An expedited program was established to identify, inspect, clean, and lubricate the applicable safety-related auxiliary contacts. Full compliance was achieved when this program was completed on April 28, 1993.

5. Generic Implications (Violation A)

This issue will be identified to Engineering Management personnel at Millstone Unit Nos. 2 and 3 and the Haddam Neck Plant. Actions will be taken as appropriate.

Additional Information (Violation A)

The Staff expressed concern with the timeliness of corrective actions established following the 1992 auxiliary contact failure. An immediate program to clean or replace the auxiliary contacts was not considered based on the following:

- NNECO was awaiting a response to a verbal request made to GE for recommendations to improve the reliability of the auxiliary contacts.
- Based on the number of auxiliary contacts utilized, a failure rate of two safety-related contacts per year was not deemed excessive.
- Performance of Technical Specification surveillance would detect contact failures.
- Absent explicit technical vendor information, Millstone Unit No. 1 personnel elected not to implement actions which had the potential to increase the failure rate.

It should be noted that when NNECO did receive accurate information from the vendor, the issue was addressed aggressively and resolved.

The Staff also expressed concern for NNECO's lack of consideration for the potential of common mode failure. This historical failure rate, as reviewed by Probabilistic Risk Assessment, is consistent with their expectations, which are established based on industry contact failure data. However, the Staff's point regarding sensitivity to common mode failures is well taken. In this regard, NNECO will provide to Engineering and Plant Operations Review Committee members by July 30, 1993, information regarding the potential for common mode failures.

Additionally since 1991, the Engineering Department is assigned the responsibility for investigation of the majority of PIRs, allowing trends and common mode failures to be more readily recognized.

Based upon NNECO's difficulty in determining appropriate PM requirements for auxiliary contacts from the component vendor, a Nuclear Network Notification (OE 5909) was transmitted on April 6, 1993, to inform other plants of the vendor recommendation to clean and lubricate the auxiliary contacts on a three-to-five year basis.

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Attachment 2

Millstone Nuclear Power Station, Unit No. 2

Reply to Notice of Violations

Combined Inspection 50-245/93-10; 50-336/93-06; 50-423/93-07

June 1993

Millstone Nuclear Power Station, Unit No. 2

Reply to Notice of Violations  
Combined Inspection 50-245/93-10; 50-336/93-06; 50-423/93-07

Restatement of Violations

During an NRC inspection conducted on March 3, 1993, through April 3, 1993, violations of NRC requirements were identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," 10CFR Part 2, Appendix C, the violations are listed below:

- II
- B. Millstone Unit 2 Technical Specification 6.8.1.a. requires that procedures be established, implemented, and maintained as recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978. Regulatory Guide 1.33, Revision 2, February 1978. Regulatory Guide 1.33 recommends procedures for administrative control of surveillance testing. Surveillance Procedure SP-2401C, "RPS Turbine Loss of Load Test," step 6.2.1 requires that certain reactor protection system (RPS) trip bistables be bypassed prior to testing the turbine trip bistable. Step 6.2.6 requires alarms on the nuclear instrumentation linear power range channel drawer and the RPS trip bistables to be reset prior to removing the bypass keys installed in step 6.2.1.
- Violations 3

Contrary to the above, on February 22, 1993, on one occasion, step 6.2.6 of SP-2401C was not performed prior to removing the bypass keys; and, on two occasions, step 6.2.1 of SP-2401C was not performed prior to testing the turbine trip bistables.

This is a Severity Level IV Violation. (Supplement I)

- III
- C. Millstone Unit 2 Technical Specification 6.8.1.e requires that procedures be established, implemented, and maintained for emergency plan implementation. Emergency Plan Implementing Procedure 4701-4, "Event Classification," requires prompt NRC notification of any event or condition that results in an unplanned automatic actuation of any engineered safety feature, including the reactor protection system (RPS).

Contrary to the above, on February 22, 1993, an unplanned automatic actuation of the RPS system occurred due to excessive feeding of the steam generators; the licensee did not report the event to the NRC until March 11, 1993.

This is a Severity Level IV Violation. (Supplement I)

1. The Reason For the Violation (Violation B)

The reason for the violation results from a failure to specifically identify to the user which items were required to be reset prior to removing the bypass keys. The importance of this step had not specifically been clearly stated previously.

2. The Corrective Steps Taken and The Results Achieved (Violation B)

*Violation B*  
In response to the conditions which resulted in the Notice of Violation, change #2 to Revision 6 of SP-2401C was written and approved. This change added a precaution which identifies the results of the failure to reset the high voltage bistable as the initiator of a power trip test interlock (PTTI). The actuation of the PTTI results in tripping the affected channel.

The second portion of the change calls for resetting the high voltage bistable and Level 1 bistable, rather than the general reference to resetting alarms and bistables. No previous problems with this surveillance are known to have been experienced. With this change, no future recurrence is anticipated.

3. The Corrective Steps That Will Be Taken to Avoid Further Violations (Violation B)

The Instrument and Controls (I&C) Department Manager will discuss this event, the Notice of Violation, and the lessons learned with I&C department personnel. This discussion is expected to occur before June 30, 1993.

4. The Date When Full Compliance Will Be Achieved (Violation B)

SP-2401C was changed and approved on April 13, 1993, therefore, full compliance has been achieved.

5. Generic Implications (Violation B)

This event will be discussed with I&C Department personnel at Millstone Unit Nos. 1 and 3 and the Haddam Neck Plant. Actions will be taken as appropriate.

1. The Reason For The Violation (Violation C)

In reviewing the personnel actions associated with this event, it appears that during performance of the event recovery actions, there was a less-than-sufficient level of review. More attention was given to the reasons for the cooldown event than to the results of the cooldown event. The operating shift members, knowing the reactor was tripped based upon events which had occurred earlier in the morning, focused their attention on the causes of the cooldown and the appropriate actions necessary to respond to the changing plant conditions. Once the cause of the cooldown was determined, their review refocused to the level of attention which was required to prevent recurrence. The actions required to specifically identify the occurrence, or cause, of an automatic actuation of the reactor protection system (RPS) appear not to have been taken. Rather, it appears that the actions were based on the belief that the event was understood and all parameters had been addressed. Thus, the RPS actuation was unreported for 18 days.

Personnel involved in, or present during, these actuations were interviewed, with the results of these interviews accurately represented in Section 2.4 of the April 30, 1993, Combined Inspection Report.<sup>(2)</sup>

2. The Corrective Steps That Have Been Taken And The Results Achieved (Violation C)

A review of the events which occurred during February 22 and February 23, 1993, was performed upon our discovery of the cited failure to report an automatic actuation of the RPS. As a result of this review, an additional two RPS actuations were identified. NNECO has determined that neither of these two actuations is reportable pursuant to 10CFR50.72 or 10CFR50.73.

*C. Response*

The NRC reporting requirements for the automatic actuation of the RPS have been discussed extensively with members of the unit staff responsible for the reporting of these events. Additionally, the individual who was filling the role of On-Site Director of Station Emergency Operations (ODSEO) has been counseled on his judgment during this series of events. Discussions pertaining to these events have been extensive within the unit and have focused on the requirement to review the control room journal as a necessary input for determining the reportability of a specific event.

(2) A. R. Blough to J. F. Opeka, "Millstone Combined Inspection 50-245/93-10; 50-336/93-06; 50-423/93-07, dated April 30, 1993.

3. The Corrective Actions That Will Be Taken To Avoid Further Violations (Violation C)

The unit management will prepare and distribute a memorandum to Millstone Unit No. 2 personnel which will further define expectations for performance in the lower operational modes and the operability requirements of the RPS while in Mode 3. This discussion will not be limited to the Operations personnel, but will also define the expectations for personnel performing surveillance testing. Discussions under this memorandum or an additional memorandum will be distributed to the Unit Senior Operator Licensed personnel, as well as those personnel who fulfill the role of ODSEO and Duty Officer, to highlight expectations concerning the importance of timely event assessment and classification in accordance with existing Administrative Controls Procedures.

The caution statement, contained with EOP 2526, "Reactor Trip Recovery," will be reviewed to determine if it would be more appropriate as an Action step. The most appropriate location for this guidance, as either a Caution or as an Action step, will be determined.

4. The Date When Full Compliance Will Be Achieved (Violation C)

The corrective actions, stated in section 3 will be completed by July 31, 1993, with the exception of any revision to EOP 2526 which, if required, will be completed by December 31, 1993.

5. Generic Implications (Violation C)

This issue will be discussed with Engineering Department Management personnel at Millstone Unit Nos. 2 and 3, and the Haddam Neck Plant. Actions will be taken as appropriate.



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Attachment 3

Millstone Nuclear Power Station, Unit Nos. 1, 2, and 3

Reply to Notice of Violation

Combined Inspection 50-245/93-10; 50-336/93-00; 50-423/93-07

June 1993

Millstone Nuclear Power Station, Unit Nos. 1, 2 and 3  
Reply to Notice of Violations  
Combined Inspection 50-245/93-10; 50-336/93-06; 50-423/93-07

Self Assessment Group Activities (Section 5.4)

Background

The combined inspection report<sup>(3)</sup> (Section 5.4) included a detailed review of the activities of groups that contributed to the overall self-assessment function at the Millstone Station. Several different types of assessment activities were inspected and discussed. The inspection report concluded that the effectiveness of the self-assessment groups at Millstone Station varied. The NRC Staff found that, although the Quality Services Department (QSD) critically assessed plant and corporate performance and clearly communicated findings to management, chronic weaknesses in corrective action programs and compliance with administrative procedures existed. The NRC Staff indicated that this area of the report warranted NNECO's close attention. Further, the report invited our response if we either had questions or disputed the findings. This attachment provides a discussion of NNECO's self-assessment activities at Millstone Unit Nos. 1, 2, and 3.

Immediate Action

NNECO has taken and will continue to take actions to improve performance in this area. The inspection report discussed the Corrective Action Request (CAR) 93-01, which QSD issued to NNECO management on March 3, 1993, to elicit action. In response, the Millstone Station Vice President issued two separate memoranda, dated April 30, 1993.

**Millstone Station Vice President Memorandum to NNECO Department Heads:**

The first Millstone Station Vice President memorandum was sent to NNECO Department Heads and discussed causes and actions to prevent recurrence. Three general causes of ongoing procedure noncompliance were identified. These were ambiguous or conflicting procedure content, insufficient familiarity with procedural requirements, and personnel error. The cause associated with an individual QSD Surveillance finding typically fell within one or more of these categories. The recurring nature of deficiencies identified by the QSD Surveillances indicated that the identification of causal factors was not sufficiently accurate to allow the appropriate corrective actions to be implemented. If the causal factors were not well understood, then actions to prevent recurrence could not be successful. The

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(3) A. R. Blough to J. F. Opeka, "Millstone Combined Inspection 50-245/93-10; 50-336/93-06; 50-423/93-07, dated April 30, 1993.

underlying cause of recurring procedure noncompliance was inadequate determination of the causal factors for QSD surveillance items.

One of the factors mentioned above as contributing to certain procedure noncompliance occurrences was the existence of ambiguities or errors in some procedures, especially Administrative Control Procedures (ACPs). In an attempt to minimize the impact of this factor, a review was performed of selected ACPs to identify problems that should be corrected immediately. These procedure changes are being expedited, and will make procedure compliance less difficult. It is recognized, however, that procedure inadequacy is still a potential causal factor for procedure noncompliances identified by QSD Surveillances and other processes. The existing ACP rewrite effort will continue to implement long-term corrective measures.

To address the underlying cause of recurring deficiencies identified by QSD Surveillances, station personnel were instructed to improve their determination of the causal factors for these deficiencies. This would be done in two ways: by processing and responding to each individual QSD Surveillance finding in a more rigorous manner (described below), and by evaluating trends in procedure noncompliance and work performance by analyzing QSD Surveillance findings, Work Observation Program observations, and Plant Incident Report (PIR) data. Following the identification of causal factors and corrective/preventive measures, follow-through is required to assure timely and effective completion of corrective/preventive actions.

#### Processing of QSD Surveillance Findings:

Beginning May 10, 1993, all deficiencies identified by QSD Surveillances were required to be responded to in writing by the cognizant department. These responses would address the following: cause of the deficiencies, the generic implications of the deficiency, immediate and/or long-term actions to correct the deficient condition, and actions to prevent recurrence, including interim measures, if appropriate. Five working days before the response due date, each response is required to be forwarded to the cognizant Unit Director for review. Responses not meeting the above requirements will be rejected and returned, with comments, to the submitting unit department head. The Station Vice President will be copied on each response to QSD, and will review quality and timeliness. Following a brief period for everyone to understand the process, the adequacy of these responses will be tracked and trended, for consideration in the annual performance appraisal of all personnel in the response preparation and approval chain.

#### Millstone Station Work Observation Program

The Work Observation Program was initiated in September 1992. It was identified as a strength by the Institute of Nuclear Power Operations (INPO) during a recent Millstone Station evaluation. It functions as a management and worker tool that: 1) Reinforces work practice expectations; 2) Evaluates work practices; 3) Directs supervisory involvement; 4) Provides a process to

promptly correct deficiencies; 5) Provides management information to monitor corrective action effectiveness. Observations are conducted by department heads and first line supervisors.

Trending of Work Observation Program Observations and Deficiencies Identified by QSD Surveillances:

The results of QSD Surveillances, the Work Observation Program, and PIRs will be categorized and trended on a monthly basis. This process is designed to identify trends in occurrences of similar deficiencies. A team composed of QSD, Nuclear Licensing, Unit representatives, and Program Services evaluate the results and provide analysis and trend plots to Department Heads, Directors, and the Station Vice President. The conclusions will be discussed by Directors at the third department head meeting of each month. Action items will be assigned as necessary, and controlled routings (CRs) issued for tracking.

**Millstone Station Vice President Memorandum to All Station Personnel:**

The second Millstone Station Vice President memorandum was sent to all Millstone Station personnel to emphasize the Station Vice President's expectations for procedure compliance at Millstone Station. A previous Notice of Violation and the recent CAR indicated that some station personnel were not performing to expectations regarding compliance with station AC's. The Station Vice President's expectations are stated below.

- All personnel performing work at Millstone Station are expected to use and comply with applicable procedures. When questions relating to the adequacy or interpretation of procedures arise, the work must stop until the question is resolved by first-line supervision.
- First-line supervisors are expected to assure that personnel working under their direction have sufficient knowledge and understanding of the procedures applicable to their work assignments. They are also expected to assure that personnel adhere to the provisions of these procedures. Training, project briefings, and field observations should be used to assure this expectation is understood and is being achieved.
- Department heads and Directors are expected to assure that the above expectations are met by direct observation by monitoring the Work Observation Program and QSD Surveillances, and by other appropriate measures.

The memorandum expressed that everyone should understand that the issue is performance of personnel to standards and expectations. All personnel must understand what is expected of them, examine their own performance, and recognize the need for improvement. It was emphasized that the above expectations must be met. Each individual is accountable for his/her own

performance, and supervisors are also accountable for the performance of their subordinates.

In addition to these two Station Vice President memoranda, additional short-term and long-term actions have been initiated.

#### Short-Term Actions

A task force review of approximately 30 ACPs was conducted to identify compliance problems related to the ACPs. As a result of the task force review, six procedures were identified as requiring a change. The proposed procedure changes were based on: (1) procedure clarity; (2) procedures with which personnel have compliance difficulty; (3) work observation—or QSD surveillance—identified problems. Procedure changes are currently in progress.

In addition, two global issues were identified. Specifically, ACP training is essentially a repeat of the procedure steps rather than focusing on process training; i.e., train personnel on what the process is and how they fit into that process, and how the ACPs support that process. The second global issue is a lack of a matrix that ties the procedure requirements to a position.

#### Long-Term Actions

A new work process improvement effort is currently in progress. It is expected to result in: 1) Integrated work teams; 2) Improved work scope change process; 3) Fewer interface points; 4) Improved communications; and 5) Streamlined documentation.

The Stop Think Act Review (STAR) Program is a Self-Check Program. The program will be applied to all working groups at Millstone Station. Booklets have been printed and are ready for distribution. NNECO management is treating the Self-Check Program as a philosophy, i.e., the program itself may require only brief initial training, while its concepts will be incorporated into training presented by the training department in formal training. This would include new employee training, annual general employee training, technical staff management training, technical training, and operator training. Currently, the training department has incorporated the process into certain sessions including Millstone Unit No. 1 Operator Training. Department heads and supervisors will reinforce self-checking expectations in department meetings and tailboard sessions.

By using the weekly station meeting, newsletters from the Station Vice President, Millstone Target Vision, and posters and booklet distribution, NNECO management plans to introduce the program to all Millstone workers, including contractors. The depth of training for initial presentation of the program is currently being determined.

Conclusion

NNECO management recognizes the need to improve self-assessment corrective action programs and compliance with administrative procedures. We have taken immediate action in the form of the two station Vice President memoranda to explicitly communicate expectations. Additional short-term and long-term actions are expected to reinforce these expectations. QSD and line management have recently seen improvement. The surveillance information and deficiencies have become more clear and well focused, allowing corrective actions to be more appropriately determined. We are optimistic that the sum of these actions will continue to be instrumental in strengthening this identified weakness.