ENCLOSURE 1

U.S. NUCLEAR REGULATORY COMMISSION

REGION I

SYSTEMATIC ASSESSMENT OF LICENSEE PERFORMANCE (SALP)

FINAL SALP REPORT 50-443/89-99

NEW HAMPSHIRE YANKEE (NHY)

SEABROOK STATION

JULY 1, 1989 - OCTOBER 31, 1990

MANAGEMENT MEETING: JANUARY 9, 1991

TABLE OF CONTENTS

I. INTRODUCTION 1

II. SUMMARY 2
II.A Facility Performance 2
II.B Overall Facility Evaluation 2

III. PERFORMANCE ANALYSIS 3
III.A. Plant Operations 3
III.B. Radiological Controls 4
III.C. Maintenance/Surveillance 7
III.D. Emergency Preparedness 8
III.E. Security and Safeguards 10
III.F. Engineering and Technical Support 11
III.G. Safety Assessment/Quality Verification 13

A. SALP Evaluation Criteria 15
B. Background 16
C. Reactor Trips/Unplanned Shutdowns 17
D. Management Conferences 18
E. Enforcement Action 18
F. Confirmatory Action Letter 18
G. Allegation Review 18
H. Licensee Event Report Table 19
I. Table of Violations by Severity Level 19

I. INTRODUCTION

The Systematic Assessment of Licensee Performance (SALP) program is an integrated NRC staff effort to periodically collect observations/data and evaluate licensee performance. SALPs supplement the processes used to ensure compliance with NRC requirements. They are intended to be diagnostic enough to provide a rational basis for allocating NRC resources and to provide meaningful feedback to licensee management on facility performance.

An NRC SALP Board met on December 10, 1990 to assess Seabrook performance in accordance with NRC Manual Chapter 0516, "Systematic Assessment of Licensee Performance." The guidance and evaluation criteria are summarized in the Supporting Data and Summaries Section of this report.

This report assesses New Hampshire Yankee's (NHY's) safety performance at the Seabrook Station from July 1, 1989 through October 31, 1990.

The SALP Board was composed as follows.

Board Chairman

C. Hehl, Director, Division of Reactor Projects (DRP)

Board Members

M. Hodges, Director, Division of Reactor Safety (DRS)
J. Joyner, Chief, Facilities Radiological Safety and Safeguards Branch, Division of Radiation Safety & Safeguards (DRSS)
E. McCabe, Chief, Reactor Projects Section 3B, DRP
N. Dudley, Senior Resident Inspector, DRP
R. Wessman, Director, Project Directorate I-3, Office of Nuclear Reactor Regulation (NRR)
V. Nerses, Project Manager, PD I-3, NRR

Other Attendees

R. Albert, Physical Security Inspector, DRSS
G. Edison, Project Manager, NRR
R. Fuhrmeister, Resident Inspector, DRP
J. Furia, Radiation Specialist, DRSS
W. Lazarus, Chief, Emergency Preparedness Section, DRSS
W. Oliveira, Reactor Engineer, DRS
W. Pasciak, Chief, Facilities Radiation Protection Section, DRSS
P. Sena, Reactor Engineer, DRP
S. Wookey, Reactor Engineer, DRP

II. SUMMARY

II.A Facility Performance

Functional Area	9/1/87 - 6/30/89 Category/Trend	7/1/89 - 10/31/90 Category/Trend
1. Plant Operations	2	2 Improving
2. Radiological Controls	Not Rated	2
3. Maintenance/Surveillance	2	2
4. Emergency Preparedness	1	1
5. Security and Safeguards	1	1
6. Engineering and Technical Support	2	2
7. Safety Assessment/Quality Verification.	2	2 Improving

II.B Overall Facility Evaluation

This 16-month SALP encompassed preparation for full-power licensing, power ascension testing, and initial commercial operation. These activities were characterized by careful, conservative planning and safe, proficient accomplishment. Management was intimately involved and exercised positive leadership throughout. There was continued, critical self-assessment and aggressive upgrading of associated activities.

The licensee demonstrated superior performance in the Emergency Preparedness area and in the Security and Safeguards area. All other areas were rated as good. An improving trend in Plant Operations was noted: excellent power ascension test program performance and subsequent operation contrasted with the earlier collapse of a primary drain tank and the interruption of decay heat removal due to procedure adherence problems.

Maintenance/Surveillance and Radiological Controls effectively supported existing activities, but improvements appeared to be needed to properly support continued operation and outages. Licensee action to improve maintenance was evident: NHY self-assessments and NRC questions were followed by a Maintenance Department reorganization late in the SALP period. Radiation Protection strengths included the absence of unplanned exposures and excellent contamination control. However, weaknesses such as the use of overtime for routine activities, a lack of challenging ALARA goals, and weak criteria for job ALARA reviews showed that program improvements are appropriate.

III. PERFORMANCE ANALYSIS

III.A. **Plant Operations** (4535 hours, 59%)

During the previous SALP, Plant Operations was rated Category 2. The
operated safely by a well-trained staff. A significant weakness was ide
operators failed to manually trip the reactor when required during the
test.

This SALP encompasses preparations for issuance of a full power
completion of Confirmatory Action Letter (CAL) corrective ac
sion testing,
and operation for two months at up to 100% power. NRC in
an
operational readiness team inspection, a special inspection
CAL corrective
actions, and around-the-clock coverage of the power asce
n (PATP).

After corrective actions were taken on the natural cir
, improvements were
noted in staff training, pretest briefings, equipmen
st procedure quality.
Extensive involvement by senior management le
e program implementation.
There were few unanticipated transients and o
ed automatic reactor
shutdowns during the PATP. Also, about 1
P inspection by the NRC
identified no safety concerns.

Overall, the well-staffed PATP was c
, controlled and deliberate manner by
knowledgeable operations and techn
nnel. The PATP was performed in
accordance with the facility licen
Requirements Manual, the Final Safety
Analysis Report, and applicable
s. The shift test organization was an
integral part of the operating
, power ascension and technical support
personnel worked well toge
ATP pretest briefings were conducted for all
personnel before each sh
ulator, classroom and plant training was conducted
for all personnel partic
jor planned transient. Communications between the
PATP shift director
intendent were concise and generally good.

Management and
rt participated in establishing test prerequisites, precautions,
boundaries, ar
conducting tests, and post-test restorations. Management's
observation
is contributed to the positive attitude and morale of test and
operations
Self-Assessment Team review during the PATP used rigorous
evaluati
veloped self-critical recommendations. NHY Independent Review
Team
lation of a turbine pressure transmitter and the turbine trip at 100 rpm
wer
sulted in upgrading of the licensee's system readiness list.

nse to off-normal events, such as the ground on the offsite power line and
or trips, was excellent. The operators safely controlled the plant, consistently
ocedures, and provided timely briefings to management.

SEE AMENDED PAGE
REGIONAL ADMINISTRATOR

III. PERFORMANCE ANALYSIS

III.A. **Plant Operations** (4885 hours, 59%)

During the previous SALP, Plant Operations was rated Category 2. The reactor was operated safely by a well-trained staff. A significant weakness was identified when the operators failed to manually trip the reactor when required during the natural circulation test.

This SALP encompasses preparations for issuance of a full power license including completion of Confirmatory Action Letter (CAL) corrective actions, power ascension testing, and operation for two months at up to 100% power. NRC inspections included an operational readiness team inspection, a special inspection of the adequacy of CAL corrective actions, and around-the-clock coverage of the power ascension test program (PATP).

After corrective actions were taken on the natural circulation test event, improvements were noted in staff training, pretest briefings, equipment readiness, and test procedure quality. Extensive involvement by senior management led to more effective program implementation. There were few unanticipated transients and only two unscheduled automatic reactor shutdowns during the PATP. Also, about 1500 hours of PATP inspection by the NRC identified no safety concerns.

Overall, the well-staffed PATP was conducted in a safe, controlled and deliberate manner by knowledgeable operations and technical support personnel. The PATP was performed in accordance with the facility license, the Technical Requirements Manual, the Final Safety Analysis Report, and applicable Regulatory Guides. The shift test organization was an integral part of the operating staff. Operations, power ascension and technical support personnel worked well together. Thorough PATP pretest briefings were conducted for all personnel before each shift. Excellent simulator, classroom and plant training was conducted for all personnel participating in each major planned transient. Communications between the PATP shift director and the shift superintendent were concise and generally good.

Management and operations support participated in establishing test prerequisites, precautions, boundaries, and system lineups; conducting tests, and post-test restorations. Management's observation of major evolutions contributed to the positive attitude and morale of test and operations personnel. NHY Self-Assessment Team review during the PATP used rigorous evaluation methods and developed self-critical recommendations. NHY Independent Review Team reviews of the isolation of a turbine pressure transmitter and the turbine trip at 100 rpm were thorough and resulted in upgrading of the licensee's system readiness list.

Operational response to off-normal events, such as the ground on the offsite power line and unplanned reactor trips, was excellent. The operators safely controlled the plant, consistently adhered to procedures, and provided timely briefings to management.

Shift superintendents treated equipment failures conservatively. Abnormal indicati
aggressively pursued until the causes were understood and appropriate correction
Management assured appropriate involvement by engineering and support orga

The six operating crews were fully staffed. Over 75% of the licensed ope
reactor operator (SRO) licenses. Use of SRO-licensed work control sup ıate
maintenance reduced the administrative burden on the shift superinten

Operator training was good, with a pass rate of 83% on initial lic ns. Crew
performance was good during evaluation of CAL actions, emer ocedure
inspection, and NRC-administered requalification examinatior ng
requalification examinations, some weaknesses were noted s formality and
in requalification evaluation techniques.

Technical issue resolution was approached from a sa was generally well-
directed and timely. For example, the reactor was ilitate replacement of a
power supply to the rod drive control system. C onsite organizations
effectively addressed complex technical proble ater oscillations and
maintenance of secondary chemistry. Ampl ort and training staffing ensured
that concerns received prompt, accurate a ion.

The absence of operator error-caused proper response to plant transients,
and the absence of operationally sig were indicative of outstanding operator
performance. However, early in improper implementation of operational
procedures resulted in the colla rain tank and in an interruption of residual
heat removal while the plant orrective action effectiveness was indicated
by a lack of repetition of s the strict adherence to procedures observed
subsequently.

Overall, operational very good, with operations being safely performed by a
professional and h aff during a period of significant challenge. Performance
of the PATP wa agement involvement, training, and independent assessment
contributed di formance.

Performa gory 2, Improving.

III Controls (347 hours, 4%)

t rated during the last SALP because of the lack of a significant challenge.
r, noted that the radiological controls organization was staffed with well-
sonnel and that a comprehensive radiation protection program supported initial
and low power operation.

SEE AMENDED PAGE
REGIONAL ADMINISTRATOR

Shift superintendents treated equipment failures conservatively. Abnormal indications were aggressively pursued until the causes were understood and appropriate corrections were made. Management assured appropriate involvement by engineering and support organizations.

The six operating crews were fully staffed. Over 75% of the licensed operators held senior reactor operator (SRO) licenses. Use of SRO-licensed work control supervisors to coordinate maintenance reduced the administrative burden on the shift superintendent.

Operator training was good, with a pass rate of 83% on initial licensing examinations. Crew performance was good during evaluation of CAL actions, emergency operating procedure inspection, and NRC-administered requalification examinations. However, during requalification examinations, some weaknesses were noted in communications formality and in requalification evaluation techniques.

Technical issue resolution was approached from a safety standpoint and was generally well-directed and timely. For example, the reactor was shut down to facilitate replacement of a power supply to the rod drive control system. Coordination with onsite organizations effectively addressed complex technical problems such as feedwater oscillations and maintenance of secondary chemistry. Ample operational support and training staffing ensured that concerns received prompt, accurate and thorough attention.

The absence of operator error-caused reactor trips, the proper response to plant transients, and the absence of operationally significant violations were indicative of outstanding operator performance. However, early in the SALP period, improper implementation of operational procedures resulted in the collapse of a primary drain tank and in an interruption of residual heat removal while the plant was in Mode 5. Corrective action effectiveness was indicated by a lack of repetition of such events and by the strict adherence to procedures observed subsequently.

Overall, operational performance was very good, with operations being safely performed by a professional and highly motivated staff during a period of significant challenge. Performance of the PATP was excellent. Management involvement, training, and independent assessment contributed directly to good performance.

Performance Rating: Category 2, Improving.

III.B. Radiological Controls (357 hours, 4%)

This area was not rated during the last SALP because of the lack of a significant challenge. It was, however, noted that the radiological controls organization was staffed with well-qualified personnel and that a comprehensive radiation protection program supported initial criticality and low power operation.

Radiation Protection

Radiation and contamination levels and the challenge to the radiation protection program at Seabrook continued to be low. Some activities (e.g., letdown heat exchanger repair) provided a limited opportunity to evaluate the ability to support normal operation. There were no unplanned exposures. The few personnel contaminations which occurred were promptly evaluated and appropriate actions were taken to prevent recurrence. There were few contaminated areas and limited amounts of radioactive waste, due in part to the age of the plant.

The licensee used experienced independent audit and assessment teams to evaluate the program. Assessments were performance-based; findings were tracked to resolution. The audits and assessments, including internal radiation protection department surveillances, developed good findings and reflected a good approach to quality.

NHY implemented acceptable internal and external exposure control programs for this stage in plant life. However, there were weaknesses in in-plant radiation protection. Records were complete, but difficulties with retrieveability of survey records for radiation work permits were a weakness. Posting and barricading of in-plant radiological controlled sub-areas were good, but associated weaknesses included radiation work permits that lacked adequate guidance or contained subjective guidance, and poor posting of the overall radiological controlled area boundary. In addition, there were weaknesses in the licensee's review of radiological surveys. The licensee had pre-selected anticipated radionuclides for use as instrument calibration standards, but NHY review of contamination surveys did not closely evaluate the radionuclides actually present to identify anomalies. Unanticipated radionuclides were encountered but were of less hazard than the anticipated nuclides and did not present any onsite or offsite concerns. Once identified by the NRC, these weaknesses were promptly corrected by the licensee.

NHY identified a repetitive failure to control access to a Locked High Radiation Area. The licensee initiated aggressive corrective action after being cited by the NRC because of the repetition. Nonetheless, this example and a non-cited violation for an individual entering a posted High Radiation Area without the required survey meter indicated a need for more aggressive corrective action upon initial occurrence of a problem.

Staffing of the radiation protection program effectively supported power ascension and initial full power operation. Power ascension surveys were completed as required, with good attention to plant conditions. The licensee released the contractors hired for power ascension testing, and overtime has since been needed to complete routine work (e.g., radiological surveillances). The licensee was closely monitoring overtime, however.

Training and qualification of the radiation protection staff has been effective. Identified problems were not attributable to weaknesses in training. A weakness involving lack of training of long term contractors was identified and resolved by the licensee.

A basic ALARA program was in place, but did not provide challenging ALARA goals. For example, the ALARA goal at the end of the period was about ten times the expected aggregate personnel exposure. The program was also found weak on criteria for performance of on-going job ALARA reviews and post-job ALARA evaluations. In addition, there were limited mock-ups for use in training personnel. NHY performed a self-assessment of the ALARA program, developed detailed ALARA check lists, established a steam generator task force, and initiated action to develop training programs and enhance ALARA training.

Solid Radwaste, Effluents and Radiological Environmental Monitoring Program

The licensee's programs for the solid radwaste and effluents/radiological areas were good. All audits, both in-plant and of vendors, were thorough and of high quality. Quality control programs for the Radiological Environmental Monitoring Program (REMP) were excellent.

Although staffing was ample, responsibilities for handling and shipping radioactive waste were not all clearly defined. A training program for radioactive waste and transportation was subsequently developed and implemented.

The licensee was effective at minimizing the volume of radioactive waste. For example, NHY installed a temporary filter/demineralizer to process liquid waste in lieu of using the installed, inefficient waste evaporator. Other initiatives included the development of a radwaste minimization committee to review radwaste generating activities periodically, and the frisking and sorting of waste to minimize volume.

Because the State of New Hampshire is not a party to a radwaste burial compact, the licensee cannot ship radioactive waste offsite. No long-term plan to deal with interim onsite storage of radioactive waste was established by the licensee.

In summary, the licensee implemented a sound radiological controls program for this stage of plant life. Audits and assessments indicated a high degree of management attention and involvement. Radiological controls were good but areas for improvement were noted (e.g. high radiation area access controls, posting of the radiological controlled area and adequacy of radiation work permits). There was adequate staffing and good training and qualification. ALARA and interim radiological waste storage weaknesses were evident. The licensee implemented effective programs for effluent monitoring and REMP.

Performance Rating: Category 2.

Board Comment: Better integration of ALARA into the radiation protection program and a long-term plan for interim storage of radwaste are needed.

III.C. **Maintenance/Surveillance** (490 hours, 6%)

During the previous SALP, this area was rated Category 2. Maintenance and surveillance were effective, equipment operability was high, training was adequate, procedures were well-written, and technical problems were adequately resolved.

During this SALP period, the maintenance and surveillance organizations effectively supported the PATP and plant operation, but several unplanned plant transients were attributed to maintenance. Also, the root causes of the majority of Licensee Event Reports were related to maintenance or surveillance.

During the second half of the SALP period, NHY extensively evaluated the Maintenance Department. The Power Ascension Self-Assessment Team reviewed the maintenance conducted in support of the PATP. The Independent Review Team reviewed configuration control, and an internal maintenance team inspection was conducted. These reviews provided numerous recommendations. As a result, the Maintenance Department was reorganized and efforts were initiated to enhance the program.

Since the beginning of the assessment period, a large backlog of work requests was reduced to meet established NHY goals. Improvements were made in the management of outstanding work requests, and planning was effective in scheduling and tracking maintenance and surveillance. Establishment of a deficiency tagging system reduced the number of duplicate work requests. The Maintenance Department identified a need to streamline the present work control system and improve documentation of root causes and of corrective actions performed during maintenance. These programmatic improvements have been initiated.

Maintenance effectiveness was shown by the high availability of equipment and the good material condition of the plant. Appropriate prioritization of work minimized the unavailability of equipment. The formality and consistency of post-maintenance testing requirements improved. However, attention to detail in system restorations such as bolting up electrical panels and blank flanges was noted as being weak on several occasions.

Maintenance was conducted by a trained and experienced staff who were knowledgeable of equipment repair techniques. But, some poor practices were observed including working on the wrong equipment train, personnel not being fully cognizant of equipment isolation boundaries, and failure to follow personnel safety practices.

Overall, the surveillance program was effective and well-controlled. However, some (about 4 of 1400) Technical Specification surveillances were missed, and repetitive turbine runbacks were initiated during routine surveillances. To correct this problem, NHY upgraded their surveillance tracking program.

Resolution of safety issues was generally thorough and timely. Maintenance personnel actively solicited advice and assistance from Technical Support engineers. System engineers were continually involved in resolving problems, and requests for engineering services (RESs) were routinely written for formal disposition of technical questions. However, there were repeated problems with ventilation system radiation monitors. Five of these involved

the east ventilation air intake, which repeatedly alarmed due to check sources sticking in front of the detector (3 times), moisture in the detector housing, and failure of the Geiger tube. A licensee root cause analysis was initiated after a series of spurious engineered safety feature actuations. The analysis was extensive and a design modification to the system was initiated.

Since technician turnover has been low, craftsmen have extensive on-the-job training. The structure and format of maintenance training programs were formalized and accredited. Approximately 40% of training lesson plans require development. Evaluation of previous experience and identification of necessary training for individual workers is still in progress. Development of the maintenance program lesson plans was in progress.

In summary, maintenance by experienced craftsmen resulted in high equipment availability, but deficiencies in maintenance and surveillance resulted in several performance problems. The backlog of open items was significantly reduced. Program enhancements identified by extensive self-assessments were developed but not fully implemented. Continued management attention and effective implementation of program improvements is needed.

Performance Rating: Category 2.

III.D. **Emergency Preparedness** (242 hours, 3%)

Emergency Preparedness was previously rated Category 1. Performance during the 1987 and 1988 annual exercises was strong. The Vehicular Alert and Notification System (VANS) and the Offsite Response Organization (ORO), including the Seabrook Plan for Massachusetts Communities, were developed.

During this SALP period, the Emergency Preparedness Program (EPP) continued to be the responsibility of the Office of Emergency Preparedness and Community Relations. The emergency preparedness staff was ample and well-qualified. A radiation technical specialist, who reports to the Director of Emergency Response and Implementation, was added. The staff provided continuous and close oversight of both onsite and offsite activities. NHY continued to convert consultant positions to full time NHY positions.

Training included 35 exercises and drills in one or more of the seven response areas. Emergency Response Facilities (ERFs), including the Remote Assembly Area and the Radiological Emergency Area of the licensee's support hospital in Exeter, N.H., were found to be well-maintained and ready. Licensee responses to NRC questions on proposed revisions to the Emergency Action Levels were technically sound and, as a result, the revisions were acceptable. All changes made to the Emergency Plan and Emergency Plan Implementing Procedures were appropriately reviewed, approved and distributed. Items identified during drills or exercises or as a result of the licensee Quality Assurance Audit of the EPP were identified and tracked to resolution. A review of the resolutions indicated correct prioritization and that corrective actions taken were technically adequate, thorough, and timely. Management, both onsite and corporate, were frequently and effectively involved,

followed the resolution of these items, and were periodically briefed on the status of the EPP. The VANS was also observed by the NRC; this compensatory measure taken for the Massachusetts portion of the emergency population zone (EPZ) demonstrated initiative and a sound technical solution to a complex offsite problem.

During observation and evaluation of the 1989 partial-participation annual exercise, no weaknesses were identified. In the Control Room simulator, operators were alert and responded appropriately to alarms and indications. Frequent and independent critical safety function checks of the plant were conducted. There was excellent communication among shift personnel, correct recognition and adherence to Technical Specification action statements, rapid classifications of events, and timely notification. At the Technical Support Center (TSC), appropriate engineering solutions were correctly pursued to mitigate casualties to equipment, good use was made of corporate technical assistance, and the TSC effectively coordinated Operation Support Center (OSC) personnel to determine plant conditions and effect repairs. Information gained from the OSC teams was rapidly provided to decision makers at the TSC and the EOF. Excellent in-plant radiation protection precautions were instituted and maintained throughout the exercise. There was excellent command and control and communications at all ERFs. Field monitoring teams were promptly and effectively prepared for dispatch. Field teams promptly set up counting equipment, effectively demonstrated control and analysis of samples, and effectively established personnel monitoring decontamination. At the Media Center, information provided to the public was obtained through authorized officials, appropriately coordinated, and was clear, concise and understandable. Rumor control was assessed as effective, and responses to simulated media questions were detailed and understandable.

The pole-mounted sirens in the New Hampshire portion of the EPZ were successfully tested. This test was observed by the NRC; the announcements were easy to understand and readily audible at selected locations. The test of 94-pole mounted and 16 truck mounted sirens in the EPZ identified two-pole mounted sirens which did not activate. NHY promptly identified the root cause as radio interference and upgraded the receiver antennae for these sirens.

The medical exercise with the Exeter Hospital was well-planned by NHY and the licensee's performance was considered excellent by the NRC. (The NRC did not evaluate the hospital's performance.) The post-exercise critique was well run and identified several areas for improvement. Self-critical NHY review also identified several program improvements.

In summary, the EPP was effectively implemented. Facilities were maintained in excellent readiness. The staff was ample and well qualified. Persons staffing the EPP demonstrated understanding and expertise such that only minor corrections were needed. Numerous emergency exercises and tests demonstrated a continued management commitment to public safety and assured a comprehensive program.

Performance Rating: Category 1.

III.E. **Security and Safeguards** (242 hours, 3%)

This area was previously rated as Category 1. The Security Program was effective and performance-oriented. Significant enhancements indicated management involvement. Efforts to upgrade the operation and reliability of systems and equipment demonstrated the licensee's commitment to maintaining an effective and high quality program.

During this SALP period, NHY continued to implement a highly effective program. The NRC attributed this to strong management involvement and support. The security program was well-planned and implemented by well-trained personnel and an excellent security support staff. Upgrades of security systems and equipment were completed, and interfaces and rapport between security and the plant staff were very good.

The plant and corporate staff were actively involved in site security. They routinely conducted program reviews and surveillance of the security force contractor and security force members. Security management also remained active in industry organizations engaged in nuclear plant matters. This demonstrated strong program support by upper management.

The licensee's training program was administered by the security force contractor with one supervisor, five instructors and a full-time administrative clerk. Training facilities were professionally equipped and maintained. The training program was well-structured, current and effective as evidenced by minimal personnel errors and a good enforcement history. NHY provided additional resources for special, off-site training courses for members of the security organization (e.g., special computer schools, law enforcement leadership training, a weapons maintenance course, and supervisory and management schools). Contingency drills were conducted for training, and the operations organization participated when the postulated event could affect plant operations. Staffing of the contract security force was consistent with program needs, as evidenced by the minimal use of overtime.

Members of the contract security force exhibited a professional demeanor and had a very good working relationship with other plant employees. The overall commitment of resources and support for the security force and its training program was evidence of management's desire to implement an effective program.

Security audits by the NHY Quality Assurance Group were comprehensive and thorough. Audit and surveillance findings were reported to appropriate levels of management to ensure proper support. Corrective actions were prompt and effective. For example, new personnel access search equipment and central and secondary alarm stations assessment monitors were installed. In addition, internal audits, reports, studies and analyses were effectively used by management to improve the program. For example, computerized monthly analyses of certain aspects of the security program were implemented.

The security program was actively supported by other groups. Effective communications among security (both licensee and contractor) and other plant groups were indicated by a lack of interface problems. For example, prompt and effective maintenance support for security systems and equipment resulted in limited use of compensatory measures. In addition, the licensee's response to potential weaknesses in protected and vital area barriers addressed all security and operational issues with well engineered and well-planned resolutions. These examples demonstrated a clear understanding of security performance objectives and of the elements of an effective security program.

Event reporting procedures were consistent with NRC requirements. Two event reports were submitted. One involved equipment failure and the other involved a plant employee who had a weapon in his jacket when he attempted to enter the plant. Both events were properly responded to, and compensatory measures were implemented as needed. Responses to public demonstrations were also appropriate, and were well coordinated with State and local law enforcement agencies. Reports and notifications of security events to the NRC were proper and timely. Improvements were made in identifying and correcting the root causes of events: there were no recurring reportable events and few minor events (loggable) that were not effectively corrected the first time they occurred.

The licensee submitted two Security Plan revisions under 10 CFR 50.54(p). These revisions were technically sound, reflected well-developed policies and procedures, and generally demonstrated a thorough knowledge and understanding of NRC requirements and objectives.

In summary, the licensee maintained a very effective and performance-oriented security program. Resolution of technical security issues was excellent and prompt. Management attention to and support for the program were clearly evident in all aspects of program implementation. Licensee efforts to maintain and upgrade the program were commendable and demonstrated the licensee's continued emphasis on a high quality, effective program.

Performance Rating: Category 1.

III.F. **Engineering and Technical Support** (539 hours, 6%)

This area was previously rated Category 2. The knowledgeable engineering staff showed increased sensitivity to safety issues. Resolutions of start-up issues were generally sound. Occasional problems were noted with the comprehensiveness of corrective actions.

Engineering, which includes offsite design engineering and onsite support groups, continued its transition to support plant operations. Changes made to support the PATP (e.g., engineers were temporarily assigned as shift test directors) were readily accommodated. Early in the SALP period, a new Executive Director for Engineering and Licensing was appointed. This management change was accomplished with no apparent problems.

Good engineering performance was demonstrated during the PATP. For example, engineering participated in the multi-group review of all PATP procedures and contributed positively to improving these procedures prior to testing. Engineering management was

involved in ensuring the technical adequacy and performance of selected PATP tes
PATP manager personally conducted pre-test simulator training sessions for oper
personnel. Good engineering resolutions during the PATP ranged from small
relocating the turbine electro-hydraulic control system pressure switches to r
as coordinating the Low Pressure Turbine "C" rotor work to correct probl
during turbine torsional tests.

Aside from the PATP, design changes were well-engineered and pr the
offsite engineering organization, and were coordinated smoothly v ATWS
modification documentation required to comply with 10CFR 50
comprehensive.

Management established a 1990 goal to halve the backlo gineering items
(design change requests for engineering services, forc ures, etc.). That
effort was kept on track and the backlog dropped to end of the period.
Also, turnover of design documents from the Arch ngineering proceeded
satisfactorily.

The offsite design engineering group perfor erm engineering projects. The
NRC environmental qualification (EQ) ins ded in the previous SALP found
only minor deficiencies were noted. Er el exhibited a good understanding of
EQ issues and had good EQ files. F ns were made during fire protection,
ISI program, and Regulatory Guide Also, new projects were initiated such
as the development of a reliabilit iance program under which engineering
work for the emergency diesel ergency feedwater systems was completed.

The onsite technical suppo cludes the system engineers, had a very
knowledgeable staff. Th erations, was responsible for executing the PATP
tests, which were well , the technical support group properly resolved
problems. For exam aft vibration for Reactor Coolant Pump 1A was quickly
evaluated and corr coordination among technical support, manufacturer,
operations, and nnel.

Modificatio was well-controlled. For example, stem engineers effectively
implemen nation Report 87-136, "Mid-Loop Operations Instrumentation
Enhanc .C noted that several temporary modifications were performed
withe valuations. NHY promptly corrected this program weaknesses by
reo and permanent modifications to be reviewed under the same system.

ses that prompted station management involvement were effective; that was
for lesser problems addressed at lower levels (e.g., system engineer). For
root cause analysis for the EHC pressure switch vibration that resulted in a
was comprehensive and resulted in timely and effective action. Also, analysis of
ature failure of a residual heat removal pump thrust bearing resulted in instrumented

SEE AMENDED PAGE
REGIONAL ADMINISTRATOR

involved in ensuring the technical adequacy and performance of selected PATP tests. The PATP manager personally conducted pre-test simulator training sessions for operations personnel. Good engineering resolutions during the PATP ranged from small tasks such as relocating the turbine electro-hydraulic control system pressure switches to major tasks such as coordinating the Low Pressure Turbine "C" rotor work to correct problems identified during turbine torsional tests.

Aside from the PATP, design changes were well-engineered and properly planned by the offsite engineering organization, and were coordinated smoothly with other groups. ATWS modification documentation required to comply with 10CFR 50.62 was clear and comprehensive.

Management established a 1990 goal to halve the backlog of 2400 open engineering items (design changes, requests for engineering services, foreign prints, procedures, etc.). That effort was kept on track and the backlog dropped to 1400 items by the end of the period. Also, turnover of design documents from the Architect-Engineer to Engineering proceeded satisfactorily.

The offsite design engineering group performed well on long-term engineering projects. The NRC environmental qualification (EQ) inspection recommended in the previous SALP found only minor deficiencies. Engineering personnel exhibited a good understanding of EQ issues and had good EQ files. Favorable observations were made during fire protection, ISI program, and Regulatory Guide 1.97 inspections. Also, new projects were initiated such as the development of a reliability centered maintenance program under which engineering work for the emergency diesel generator and emergency feedwater systems was completed.

The onsite technical support group, which includes the system engineers, had a very knowledgeable staff. This group, with Operations, was responsible for executing the PATP tests, which were well conducted. Also, the technical support group properly resolved problems. For example, increased shaft vibration for Reactor Coolant Pump 1A was quickly evaluated and corrected, with good coordination among technical support, manufacturer, operations, and maintenance personnel.

Modification implementation was well-controlled. For example, system engineers effectively implemented Design Coordination Report 87-136, "Mid-Loop Operations Instrumentation Enhancements." The NRC noted that several temporary modifications were performed without formal NSARC safety evaluations. NHY promptly corrected this program weaknesses by requiring temporary and permanent modifications to be reviewed under the same system.

Root cause analyses that prompted station management involvement were effective; that was not as apparent for lesser problems addressed at lower levels (e.g., system engineer). For example, the root cause analysis for the EHC pressure switch vibration that resulted in a reactor trip was comprehensive and resulted in timely and effective action. Also, analysis of the premature failure of a residual heat removal pump thrust bearing resulted in instrumented

test runs to determine the cause and in consultation with the vendor to ensure proper correction. However, the root cause analysis for a through-wall, pinhole leak in the start-up feed pump lube oil cooler piping was not fully understood until the second failure. A subsequent engineering evaluation and two design changes were needed to correct this problem.

Feedback from the self and independent assessments was used effectively. For example, a prior independent review of the emergency feedwater (EFW) system helped in achieving acceptable governor response during the EFW turbine driven pump start-up test. Also, NHY audit of four major modifications included extensive field walkdowns and yielded good results.

In summary, engineering effectiveness improved. Constructive self and independent assessments were apparent. A stable and knowledgeable engineering staff performed well during the PATP, with good management involvement. Offsite design engineering developed well-engineered design changes and long-term engineering projects. Modifications were well controlled. The lack of formal safety evaluations for temporary modifications was promptly corrected. Onsite technical support executed its PATP responsibilities well. Root cause analyses were effective for significant problems but weak for some lesser issues.

Performance Rating: Category 2.

III.G. Safety Assessment/Quality Verification (1590 hours, 19%)

This area was previously rated Category 2. The licensee was strong in resolution of licensing issues and in the qualifications and level of technical staffing. However, weaknesses in the effectiveness of the quality assurance program were noted.

After the June 1989 failure to manually trip the reactor during the Natural Circulation Test, NHY took extensive corrective action and provided comprehensive oversight. In addition, NHY established a meaningful Values for Excellence Program which promoted an awareness of goals for excellence at all levels of the organization.

NHY's Self-Assessment Team (SAT), assembled in 1988 to evaluate the PATP, was well-staffed with experienced personnel who provided extensive PATP coverage. SAT findings were self-critical and consistent with NRC observations. Their findings and recommendations were well-supported and resulted in program improvements. The SAT also reviewed, in-depth, areas such as post-maintenance testing, procedural compliance, effectiveness of the Nuclear Quality Group (NQG), reactor trips, a turbine trip, and the isolation of the turbine first stage pressure gauge. Management effectiveness in implementing SAT recommendations was shown by improvements in procedural compliance. However, needed improvements in maintenance/surveillance, radiological controls, engineering/technical support and plant operations (as noted in those sections of this SALP report) have yet to be completed.

Feedback from the self-assessments was used to improve the engineering organization. In addition to SAT audit of major modifications, an independent review of the Emergency Feedwater Systems resulted in enhancement of the system design.

NQG audit effectiveness improved. Audits and surveillances were performance-based, of good quality and conducted as required by responsible, knowledgeable personnel. During the PATP, the NQG's daily meetings were thorough and informative, and the review of ongoing activities was comprehensive. Improvements were made in PATP implementation through management attention and support of the NQG. Continuous coverage by Level II NQG inspectors was observed during the PATP. QA/QC personnel received PATP, simulator, and crew specific training. NQG inspectors also participated effectively in Station Operations Review Committee (SORC) reviews of test and test program changes.

The SORC was composed of department managers and effectively reviewed design changes, station incident reports, reportable events, and procedures. The NRC identified minor weaknesses with SORC review of two Technical Specification clarifications and failure to report some safety reviews on annual reports. The Nuclear Safety Audit Review committee (NSARC) was composed of senior managers and independently reviewed and audited safety evaluations, potential unreviewed safety questions, violations and SORC activities. An SRO-qualified reviewer assisted the NSARC.

NHY's Employee Allegation Resolution program thoroughly followed-up numerous late-filed allegations and other concerns. The Bethesda Licensing Office interfaced effectively with the NRC to expedite and clarify licensing-related issues.

The inservice inspection (ISI) staff had good understanding and knowledge of regulations and code requirements. The ISI program submittal was well-written and contained a minimum of requests for relief. NRC requests for information were answered promptly.

NHY conservatively replaced Raychem splices even though engineering analysis indicated that the existing splices could be qualified.

Licensing issues included emergency planning and preparedness, full power Technical Specifications, TMI action items, NRC bulletins and generic letters, decommissioning funding, merger plans, the first 10-year inservice inspection plan, and initial test program changes. NHY provided technically sound, thorough inputs on these issues. Of particular note was NHY's clear understanding of off-site emergency planning issues. They provided the FEMA and NRC staffs with a well documented, timely revision of the Seabrook Plan for Massachusetts Communities to resolve issues from litigation of the emergency plan.

In summary, licensing, self-assessment, and quality assurance activities were effectively performed. Management of the PATP was excellent. The information provided for licensing was detailed and complete. Improvements in the NQG resulted in more effective surveillance and audits. However, needed improvements in maintenance/surveillance, radiological controls, engineering/technical support and plant operations have yet to be completed.

Performance Rating: Category 2, Improving.

SUPPORTING DATA AND SUMMARIES

A. SALP Evaluation Criteria

The following evaluation criteria were used, as applicable, to assess each functional area:

1. Assurance of quality, including management involvement and control.

2. Approach to the resolution of technical issues from a safety standpoint.

3. Enforcement history.

4. Operational and construction events (including response to, analyses of, reporting of, and corrective actions for).

5. Staffing (including management).

6. Effectiveness of training and qualification programs.

Each functional area was rated as one of the following three performance categories.

Category 1. Licensee management attention and involvement in nuclear safety or safeguards activities resulted in superior performance. The NRC will consider reduced levels of discretionary inspection.

Category 2. Licensee management attention and involvement in nuclear safety or safeguards activities resulted in good performance. The NRC will consider maintaining normal levels of discretionary inspection.

Category 3. Licensee management attention or involvement in nuclear safety or safeguards activities resulted in acceptable performance. Performance at this level is of concern to the NRC because a decrease in performance will approach or reach an unacceptable level. The NRC will consider increased levels of discretionary inspection. (If the NRC were to conclude that there was not an adequate level of safety performance, prompt and appropriate action would be taken separately from, and on a more urgent schedule than, the SALP process.)

The SALP Board may assess a performance trend, if appropriate. The trends are:

Improving: Licensee performance was determined to be improving during the assessment period.

Declining: Licensee performance was determined to be declining during the assessment period and the licensee had not taken meaningful steps to address this pattern.

B. Background

Licensee Activities

At the beginning of the SALP period, the plant was in Mode 5, conducting major modifications on the residual heat removal system, the control building air supply system, the primary component cooling system, and the steam driven emergency feedwater pump. NHY was also completing the Corrective Action Plan and making preparations for full-power license issuance.

In February 1990, the plant was heated to Mode 3 and conditions were established for power ascension. On March 15, 1990, a full power operating license was issued. The reactor was taken critical on March 20 and the power ascension test program (PATP) began.

On April 28, the plant was shut down to Mode 5 to stiffen the Low Pressure Turbine "C" rotor. The plant entered Mode 1 on May 26 and the PATP was resumed.

The station began commercial operation on August 19 after a 250-hour warranty run. On October 27, the reactor was shut down to repair a main steam isolation valve actuator. During plant start-up on October 29, a ground was identified in the main generator exciter and the plant remained below 10% power until repairs were performed. The SALP period ended during this shutdown.

NRC Review and Inspection Activities

During the 16-month assessment period, the Nuclear Regulatory Commission (NRC) expended 8,345 hours of inspection resources at Seabrook Station. A breakdown of the inspection hours by SALP functional area is included in each area write-up. To assist in responding to Congressional staff questions, allegations and review of the licensing decision, the two operations resident inspectors were augmented by a senior construction resident inspector for eight months. Team inspections were conducted to assess the readiness of NHY to operate the plant at full power, the Post-Accident Sampling System, Environmental Qualification, Power Ascension Testing, and late-filed allegations.

In November 1989, the NRC conducted an Operation Readiness Assessment Team Inspection to evaluate NHY's readiness to conduct power operations at Seabrook. Between January 9 and February 3, 1990, the NRC staff reviewed the safety significance of taped main control room communications. Between January 11 and February 3, 1990, the NRC staff reviewed multiple allegations forwarded by several U.S. Congressmen. Continuous NRC inspection of startup testing activities was conducted between March 16 and August 31, 1990.

C. Reactor Trips/Unplanned Shutdowns

	Date	Power Level	Root Cause	Functional Area
1.	3/22/90	1%	Equipment Failure	Maintenance/Surveillance

Description: Controlled Shutdown to replace failed power supply in rod drive control cabinets.

2.	3/29/90	8%	Equipment Failure	Engineering/Technical Support

Description: Controlled Shutdown to reposition main turbine rotor position detector.

3.	4/8/90	2%	Equipment Failure	Maintenance/Surveillance

Description: Controlled Shutdown to repair a hydraulic leak on the actuator for main steam isolation valve "D".

4.	4/28/90	10%	Equipment Failure	Engineering/Technical Support

Description: Controlled Shutdown to strengthen low pressure turbine rotor blades to shift the turbine's natural torsional frequency.

5.	6/20/90	30%	Ground Relay Actuation	Engineering/Technical Support

Description: Reactor Trip due to an incorrect setpoint on a 180 Hz ground protection relay on the main turbine-generator. Relay activated due to erroneous setpoint.

6.	7/5/90	75%	Equipment Failure	Engineering/Technical Support

Description: Reactor Trip due to a turbine electro-hydraulic control system low oil pressure signal caused by vibration of pressure switches mounted on the turbine stop valves.

7.	8/22/90	100%	Equipment Failure	Maintenance/Surveillance

Description: Reactor Trip due to turbine trip caused by troubleshooting of the electro-hydraulic control (EHC) circuit.

8.	10/27/90	100%	Equipment Failure	Maintenance/Surveillance

Description: Controlled shutdown to repair main steam isolation valve hydraulic actuator and heater drain pumps.

D. Management Conferences

On September 6, 1989, a public meeting was held at the University of New Hampshire in Durham, New Hampshire to discuss the results of the NRC Augmented Inspection Team's (AIT) findings concerning the June 22, 1989, Natural Circulation Event.

On October 11, 1989, a public meeting was held at New Hampshire Yankee corporate offices to discuss the Systematic Assessment of Licensee Performance (SALP) evaluation.

On January 12, 1990, a public meeting was held at the site to discuss Emergency Planning preparations. This meeting was followed by an inspection tour of facilities in the Massachusetts EPZ.

During the Power Ascension Test Program (PATP), two meetings were held at NRC Region I offices in King of Prussia, Pennsylvania to discuss New Hampshire Yankee's self-assessment after the 50% and 100% power plateaus of the PATP. The meetings were held on June 19, 1990 and September 18, 1990.

E. Enforcement Action

On September 7, 1989 the NRC issued a Notice of Violation and proposed the imposition of a civil penalty of $45,000 for violation of NRC requirements identified during the NRC AIT conducted on June 28-30, 1989. The licensee accepted the Notice of Violation, paid the civil penalty, and implemented corrective actions.

F. Confirmatory Action Letter

On June 23, 1989, the NRC issued Confirmatory Action Letter (CAL) 89-11 to confirm the corrective actions to be taken on the June 22, 1989 Nature Circulation Event. After extensive review of the corrective actions, the NRC rescinded the CAL on January 9, 1990.

G. Allegation Review

During this SALP period, 16 allegations (one with 255 subparts and others with multiple subparts) were received by the NRC. Prior to the NRC staff recommendation of a full power license, all late filed allegations were reviewed and found to be unsubstantiated, or of no safety significance, and/or not material to issuance of a full power license. An NRC independent review team (IRT) also investigated allegations related to the adequacy of construction welds and issued NUREG-1425, "Welding and Nondestructive Examination Issues at Seabrook Nuclear Station." The IRT identified no safety concerns.

H. Licensee Event Report Table (89-007 to 89-015, 90-001 to 90-023)

Area	CAUSE CODE* A	B	C	D	E	X	TOTAL
1. Plant Operations	7			2			9
2. Radiological Controls	3						3
3. Maintenance/Surveillance	7	10					17
4. Emergency Preparedness							0
5. Security and Safeguards							0
6. Engineering and Technical Support		3					3
7. Safety Assessment/Quality Verification							0
TOTALS:	17	13	0	2	0	0	32

*Cause Codes:
A - Personnel Error
B - Design, Manufacturing, Construction, or Installation Error
C - External Cause
D - Defective Procedure
E - Component Failure
X - Other

I. Table of Violations by Severity Level

FUNCTIONAL AREA	V	IV	III	II	I	TOTAL
Plant Operations	2	1	(2)*			3
Radiological Controls		1				1
Maintenance/Surveillance		1				1
Emergency Preparedness						
Security						
Engineering/Technical Support		1				1
Safety Assessment/Quality Verification						
TOTAL	2	4				6

*For event during previous SALP period. Not included in total.

ENCLOSURE 2

New Hampshire
Yankee

Ted C. Feigenbaum
President and
Chief Executive Officer

NYN-91012

January 25, 1991

United States Nuclear Regulatory Commission
Region I
475 Allendale Road
King of Prussia, PA 19406

Attention: Mr. Thomas T. Martin

References: (a) Facility Operating License No. NPF-86, Docket No. 50-443

(b) USNRC Letter dated December 20, 1990, "Systematic Assessment of Licensee Performance (SALP) Report for the period from July 1, 1989 to October 31, 1990 (50-443/89-99)", T. T. Martin to T. C. Feigenbaum

Subject: Systematic Assessment of Licensee Performance (SALP) Report No. 50-443/89-99

Dear Mr. Martin:

New Hampshire Yankee (NHY) has reviewed the SALP Report [Reference (b)] and the comments made by NRC Region I personnel during the January 9, 1991 SALP meeting. New Hampshire Yankee generally agrees with your conclusions. The following comments are provided to address areas where NHY will devote additional attention in the future. These areas for additional attention were discussed during the January 9, 1991 SALP meeting.

With the completion of the Power Ascension Test Program (PATP) we have completed some initiatives and are pursuing other initiatives, to provide enhanced support for the operation of the Station. We performed a self assessment of our Maintenance Program during the PATP and the results are being utilized to improve the total program. The Maintenance Group was reorganized to better facilitate the control of work. We are consolidating and streamlining the Maintenance Program while incorporating self assessment recommendations to provide program enhancements to support Station operation and the first refueling outage. Additionally, we are reviewing the Radiation Protection Program to provide enhanced procedural controls and to better integrate ALARA considerations. The ALARA man-rem goals for 1991 have been established to address a typical first cycle of operation with a refueling and subsequent startup. We believe these goals are typical of the industry and will provide a challenge to our personnel.

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The issue of a long-term plan for interim storage of low level radioactive waste is being addressed. A special task force evaluated the available on-site storage options and will be formally presenting their recommendations to management in the near future. In addition, New Hampshire Yankee has taken steps to minimize generation of low level radioactive waste during plant operations and will continue to refine this program in 1991. Also, we will continue to work cooperatively with the State of New Hampshire and support their effort to obtain long term access to permanent disposal facilities for low level waste from Seabrook Station.

Although we are pleased with the accomplishments of a successful Power Ascension Test Program, and plant Operations to date, we recognize the challenges ahead in performing our first refueling outage and the challenges of normal plant operations. Our goal is to achieve the same levels of success in these new challenges as we achieved in the past. We recognize that this will require continued management involvement and continued effort by everyone. We are confident that the New Hampshire Yankee organization is up to the challenge.

Should you desire additional information regarding NHY's actions in response to the SALP report, please contact Mr. James M. Peschel, Regulatory Compliance Manager, at (603) 474-9521, extension 3772.

Very truly yours,

Ted C. Feigenbaum

TCF:JMP/ssl

cc: United States Nuclear Regulatory Commission
Document Control Desk
Washington, DC 20555

Mr. Gordon E. Edison, Sr. Project Manager
Project Directorate I-3
United States Nuclear Regulatory Commission
Division of Reactor Projects
Washington, DC 20555

Mr. Noel F. Dudley
NRC Senior Resident Inspector
P.O. Box 1149
Seabrook, NH 03874

ENCLOSURE 3

SEABROOK SALP MANAGEMENT MEETING ATTENDEES

JANUARY 9, 1991

1. New Hampshire Yankee (NHY)

R. M. Cooney, Maintenance Manager
R. J. DeLoach, Executive Director of Engineering and Licensing
B. L. Drawbridge, Executive Director of Nuclear Production
T. C. Feigenbaum, President and Chief Executive Officer
G. R. Gram, Executive Director of Engineering and Licensing
J. M. Grillo, Operations Manager
D. M. Moody, Station Manager
N. A. Pillsbury, Director of Quality Programs

2. U. S. Nuclear Regulatory Commission (NRC)

N. F. Dudley, Senior Resident Inspector, RI
R. L. Fuhrmeister, Resident Inspector, RI
C. W. Hehl, Director Division of Reactor Projects, RI
J. R. Johnson, Chief, Projects Branch No.3, RI
D. Kern, Reactor Engineer, RI
V. Nerses, Project Manager, NRR
D. Wessman, Director, Project Directorate I-3, NRR

3. Members of the public, press, and other licensee staff personnel attended but did not participate in the meeting.

ENCLOSURE 4

UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION I
475 ALLENDALE ROAD
KING OF PRUSSIA, PENNSYLVANIA 19406

Docket No. 50-443

DEC 2 0 1990

Public Service Company of New Hampshire
ATTN: Mr. Ted C. Feigenbaum, President
and Chief Executive Officer
New Hampshire Yankee Division
Post Office Box 300
Seabrook, New Hampshire 03874

Gentlemen:

Subject: **Systematic Assessment of Licensee Performance (SALP) Report for Seabrook for the period from July 1, 1989 to October 31, 1990 (50-443/89-99)**

On December 10, 1990, An NRC SALP Board evaluated the safety performance of Seabrook Station. The results are documented in the enclosed report. We plan to meet with you onsite on January 9, 1990 to discuss this SALP. At that meeting, please be prepared to discuss our assessment and any plans you have to improve performance.

Overall, this SALP found careful, conservative planning and safe, proficient accomplishment of activities.

Please provide your written comments on the SALP, if any, within 20 days of our SALP discussion meeting with you.

The enclosed report and your response will be placed in the Public Document Room.

Thank you for your cooperation.

Sincerely,

Thomas T. Martin
Regional Administrator

Enclosure: NRC SALP Report 50-443/89-99

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cc w/encl:
L. E. Maglathlin, Jr., President and Chief Executive Officer, Public Service Corporation of New Hampshire (PSNH)
J. M. Peschel, Regulatory Compliance Manager, New Hampshire Yankee (NHY)
D. E. Moody, Station Manager, NHY
T. Harpster, Director of Licensing Services, NHY
R. M. Kacich, Manager of Generation Facilities Licensing, Northeast Utilities Service Corporation (NUSCO)
J. F. Opeka, Executive Vice President, Northeast Utilities (NU)
G. Garfield, Esquire
R. Hallisey, Director, Dept. of Public Health, Commonwealth of Massachusetts
S. Woodhouse, Legislative Assistant
K. Abraham, PAO, Region I (33 Copies)
Chairman Carr
Commissioner Rogers
Commissioner Curtiss
Commissioner Remick
Public Document Room (PDR)
Local Public Document Room (LPDR)
Nuclear Safety Information Center (NSIC)
NRC Resident Inspector
State of New Hampshire, SLO
Commonwealth of Massachusetts, SLO Designee
Seabrook Hearing Service List