New Hampshire
Yankee

Ted C. Feigenbaum
President and
Chief Executive Officer

NYN-92060

May 8, 1992

United States Nuclear Regulatory Commission
Washington, D.C. 20555

Attention: Document Control Desk

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

(b) NHY Letter NYN-92044 dated April 8, 1992, "Licensee Event Report (LER) 92-03-00: Missed Technical Specification Surveillance Requirements," T. C. Feigenbaum to USNRC.

(c) NHY Letter NYN-92036 dated March 27, 1992, "Auxiliary Operator Performance Concerns," T. C. Feigenbaum to T. T. Martin

(d) NHY Letter NYN-92045 dated April 10, 1992, "Auxiliary Operator Performance Concerns," T. C. Feigenbaum to T. T. Martin

Subject: Licensee Event Report (LER) 92-03-01: Missed Technical Specification Surveillance Requirements

Gentlemen:

Enclosed please find Licensee Event Report (LER) No. 92-03-01 for Seabrook Station. This submittal transmits a revision to LER No. 92-03-00, which was previously transmitted to the NRC in a letter dated April 8, 1992 [Reference (b)]. The revised LER describes the root causes for the Auxiliary Operator (AO) performance concerns as determined by the New Hampshire Yankee (NHY) Independent Review Team. The revised LER also describes corrective actions to be taken by NHY in response to the AO performance concerns as previously documented in an NHY letter dated April 10, 1992 [Reference (d)].

Should you require additional information regarding this matter please contact Mr. James M. Peschel, Regulatory Compliance Manager, at (603) 474-9521, extension 3772.

Very truly yours,

Ted C. Feigenbaum

Enclosure: NRC Form 366 & 366A

TCF:JES

IE28

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NRC Form 366
(9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/88

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
SEABROOK STATION	0 5 0 0 0 4 4 3	1 OF 0 4

TITLE (4)
Missed Technical Specification Surveillance Requirements

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES	DOCKET NUMBER(S)
0 3	0 9	9 2	9 2	0 0 3	0 1	0 5	0 8	9 2		0 5 0 0 0
										0 5 0 0 0

OPERATING MODE (9)	1
POWER LEVEL (10)	1 0 0

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)

	20.402(b)		20.405(c)		50.73(a)(2)(iii)		73.71(b)
	20.405(a)(1)(i)		50.36(c)(1)		50.73(a)(2)(iv)		73.71(c)
	20.405(a)(1)(ii)		50.36(c)(2)		50.73(a)(2)(vii)		OTHER (Specify in Abstract below and in Text, NRC Form 366A)
	20.405(a)(1)(iii)	X	50.73(a)(2)(i)		50.73(a)(2)(viii)(A)		
	20.405(a)(1)(iv)		50.73(a)(2)(ii)		50.73(a)(2)(viii)(B)		
	20.405(a)(1)(v)		50.73(a)(2)(iii)		50.73(a)(2)(x)		

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
J. M. Peschel - Regulatory Compliance Manager, extension 3772	AREA CODE: 6 0 3 — 4 7 4 - 9 5 2 1

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	

SUPPLEMENTAL REPORT EXPECTED (14)

		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
	YES (If yes, complete EXPECTED SUBMISSION DATE)				
X	NO				

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

During a periodic performance monitoring surveillance of on-shift personnel on March 1, 1992, it was determined that an Auxiliary Operator (AO) did not completely perform the AO watch rounds to which he was assigned. Auxiliary Operators do not require a reactor operator license. Auxiliary Operators perform routine inspection and surveillance activities in the plant under the direction of control room personnel. Subsequent extensive evaluation by the NHY Independent Review Team revealed other occasions on which AO's did not completely perform their assigned AO duties. On March 9, 1992 and during subsequent evaluation it was determined that AO performance concerns caused six Technical Specification Surveillance Requirements to be missed.

Technical Specification SURVEILLANCE REQUIREMENT 4.7.1.3 requires in part, that the integrity of the concrete structure which encloses the Condensate Storage Tank (CST) be verified at least once per 12 hours. Contrary to this requirement, the integrity of the CST enclosure was not verified as required on August 25, 1990 (2 instances), December 22, 1990, May 12, 1991, and November 9, 1991.

Technical Specification SURVEILLANCE REQUIREMENT 4.7.10 requires that the temperature of areas listed in Table 3.7-3 be determined to be within its limit at least once per 12 hours. On February 21, 1992 this requirement was not met for the Fuel Storage Building Spent Fuel Pool Cooling Pump Area. This area is included in Table 3.7-3.

Immediate corrective actions include the removal of the involved AO's from watchstanding duties, briefing other Operations Department personnel on the importance of correctly completing rounds and the initiation of disciplinary action including suspension and/or termination of the involved AO's. In addition a special Independent Review Team was assigned to fully evaluate the AO performance concerns and to determine the root cause.

The root cause of this incident has been determined to be *Failure to Follow Procedures*. A secondary root cause is *Management Systems*, in that procedure compliance policy was not uniformly applied regarding documentation of routine rounds. NHY has developed corrective actions to address these concerns.

During a periodic performance monitoring surveillance of on-shift personnel on March 1, 1992, it was determined that an Auxiliary Operator (AO) did not completely perform the AO watch rounds to which he was assigned. Auxiliary Operators do not require a reactor operator license. Auxiliary Operators perform routine inspection and surveillance activities in the plant under the direction of control room personnel. Subsequent extensive investigation by the NHY Independent Review Team revealed other occasions on which AO's did not completely perform their assigned AO duties. On March 9, 1992 and during subsequent investigation it was determined that AO performance concerns caused six Technical Specification Surveillance Requirements to be missed.

Seabrook Station Technical Specification 3.7.1.3 requires the Condensate Storage Tank (CST) [TK] and the concrete CST enclosure to be OPERABLE in MODES 1, 2, and 3. OPERABLE is defined as the CST containing a minimum volume of 212,000 gallons of water and the CST enclosure being capable of retaining the 212,000 gallons of water in the event of a tank failure.

On the following dates the requirement to verify that the CST enclosure was capable of containing 212,000 gallons of water was not performed: August 25, 1990 (2 instances), December 22, 1990, May 12, 1991, and November 9, 1991. This requirement is defined in Surveillance Requirement 4.7.1.3.

Seabrook Station Technical Specification 3.7.10 specifies maximum temperatures for certain areas in the plant. Technical Specification SURVEILLANCE REQUIREMENT 4.7.10 requires that the temperature of the area be determined to be within its limit at least once per 12 hours. On February 21, 1992 this surveillance requirement was not performed for the Fuel Storage Building Spent Fuel Pool Cooling Pump Area.

The CST enclosure integrity and FSB temperature are obtained every 4 hours as part of routine log taking associated with various Auxiliary Operator (AO) watch stations. The logs for the AO watches indicated that the areas had been checked. However, a comparison of these logs with the security keycard transaction log indicated that the AO's involved had not made entry into the buildings. Therefore, verification of CST integrity and FSB temperature could not have occurred.

Background

The CST is the source of demineralized water for the Emergency Feedwater System (EFW) [BA]. The CST enclosure is a two foot thick concrete structure which surrounds the CST two inches from the tank. The enclosure provides tornado missile protection and ensures that the minimum amount of water required by Technical Specifications would be available in the unlikely event of a tank failure.

The Fuel Storage Building (FSB) [ND] is the building which encloses the following areas: new fuel storage, spent fuel pool cooling equipment [DA], HVAC equipment [VG] and spent fuel handling [DF] and storage facilities.

Root and Secondary Causes

The following are the root and secondary causes, and the contributing factors for the AO performance concerns as determined by the Independent Review Team (IRT), and as stated in the IRT Report that was transmitted to the NRC in NHY Letter NYN-92045, dated April 10, 1992. The root cause for the AO performance concerns has been determined to be *Failure to Follow*

Procedures, in that the Auxiliary Operators (AOs) in question did not use the Operations Management Manual (OPMM), which was the governing procedure for their rounds. Although several AOs had stated that they did not consider logs to be in the same category as "procedures," the IRT concluded that sufficient guidance exists in the OPMM concerning the requirements for log keeping.

A secondary cause has been identified as *Management Systems*, in that the procedure compliance policy was not uniformly applied with regard to documentation of routine rounds. The IRT concluded that this is due largely to an unnecessarily large burden of procedures, policies, and programs on company personnel.

Contributing Factors

Several contributing factors have been judged to have had a bearing on the AO performance concerns. Contributing factors are not ranked or listed by any priority.

A contributing factor has been identified in the area of *Training*. Since several AOs believed that logs were not considered procedures, the On-the-Job Training (OJT) specifically associated with AO round taking was judged to be ineffective in clearly establishing management expectations for this task.

A contributing factor has been identified in the area of *Management Systems*. There is an inadequate policy concerning explicit descriptions of management expectations for routine tasks.

The final contributing factor has also been identified in the area of *Management Systems*. Specifically, there was inadequate supervision of AO rounds keeping practices.

Corrective Actions

Immediate corrective actions included the removal of the involved AO's from watchstanding duties, briefing other Operations Department personnel on the importance of correctly completing rounds and the initiation of disciplinary action including suspension or termination of the involved AO's. In addition the NHY Independent Review Team was assigned to fully evaluate the AO performance concerns and to determine the root cause.

The IRT identified twenty-one recommendations to respond to the AO performance concerns. Upon review of the IRT Report, NHY Management added four additional recommendations. All of the recommendations are described in the attached "Summary Report by the Executive Director Nuclear Production Regarding AO Performance Concerns." This summary report has previously been transmitted to the NRC as Enclosure 1 to NHY Letter NYN-92045, dated April 10, 1992. Additionally, as stated in NHY Letter NYN-92045, NHY will implement the above stated recommendations and will keep the NRC informed of their completion status.

Safety Significance

There was no significant safety impact as a result of the missed CST integrity and FSB area temperature surveillance.

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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
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TEXT (If more space is required, use additional NRC Form 366A's) (17)

The integrity of the CST enclosure was verified prior to, and subsequent to the missed surveillances, therefore it existed during the time the surveillances were missed.

The temperature of the FSB SFP Cooling Pump Area was verified to be within its limit prior to, and subsequent to the missed surveillance. It is highly unlikely that the area temperature rose above the specified limit for the short period of time that the surveillance was missed and then returned to normal. The temperature for this area has historically been steady and was verified by surveillance to be in its normal band prior to and following the missed surveillance.

At the time of the discovery the plant was in MODE 1.

This is the first event of this type at Seabrook Station.

SUMMARY REPORT BY THE
EXECUTIVE DIRECTOR NUCLEAR PRODUCTION
REGARDING AO PERFORMANCE CONCERNS

B.L. Drawbridge
Executive Director Nuclear Production

Date: April 10, 1992

Enclosure 1

SUMMARY REPORT BY THE
EXE IVE DIRECTOR NUCLEAR PRODUCTION
RE RDING AO PERFORMANCE CONCERN.

Two reports have been provided to me and are enclosed. One report has been provided by the Independent Review Team (IRT) and is an assessment of the Auxiliary Operator performance concerns; the second report has been provided by the Station Manager and it summarizes Station Management activities with regard to the Auxiliary Operator performance concerns. The purpose of this report is to provide an Executive Summary of the two reports and to provide a perspective on the Auxiliary Operator watchstander (AO) performance concerns.

There were certain AO watchstanders who did not perform their jobs correctly. Management cannot always prevent an individual from performing poorly if he is predisposed to performing in an unacceptable manner. However, Management must take responsibility for the overall impact on the organization of the AO performance concerns. These concerns have prompted Management to carefully reflect on how the organization performs activities, how Management interacts with all levels of the organization and how Management communicates expectations to the organization. In the final analysis, Management is responsible for all activities at Seabrook Station. As Executive Director Nuclear Production, I take ultimate responsibility for these performance concerns.

The Independent Review Team provided a comprehensive report with regard to the Auxiliary Operator performance concerns. I feel

however, that there are certain additional actions that go beyond the recommendations provided by the IRT that we, as a Company, should pursue. Those additional actions are detailed later in this report.

During the course of their investigation, the IRT performed numerous tasks. The IRT performed data reduction of AO roundkeeping documentation and Security Department keycard transaction logs. They also interviewed numerous Auxiliary Operators, some of whom had just received disciplinary action. The IRT was not a participant in any of the disciplinary process data gathering interviews or disciplinary action meetings. In order to preserve independence, Station Management and Executive Management were not participants in the confidential interviews that were held between members of the IRT and members of the Auxiliary Operator Staff, Operations Staff, other members of the plant, and Management. Therefore, the primary purpose of this report is to provide a total perspective of company actions in response to the AO performance concerns.

As a result of these concerns, thirteen individuals have received disciplinary action. Of the thirteen individuals four individuals have separated from the Company, and the remainder have been suspended for a period of time without pay. In the case of three individuals who held NRC licenses, these licenses have been withdrawn.

The suspended individuals have been disqualified as AO watchstanders and will not be requalified until they have completed

a remedial training program, the scope of which is now defined. They have been placed on probation for a minimum of six months, during which time their performance will be closely monitored. If any individuals cannot be remediated within the probationary period, further disciplinary action will be initiated by Management. None of the suspended individuals will be reinstated to AO watchstanding duties without prior approval of the President.

Management adopted the philosophy from the outset that it is essential to deal with the AO performance concerns aggressively in order to ensure that its seriousness is well understood by all Company employees. It is essential that all NHY employees understand Management's expectations and their personal responsibilities and accountability. In addition to the removal from duty of those individuals involved and the immediate initiation of an IRT assessment, the following additional short-term corrective actions have been or are being taken.

- The Shift Superintendent that made the initial identification of the discrepancy, discussed the incident with the oncoming Shift Superintendent at shift turnover that same night. Each Shift Superintendent has counseled his crew on watchstanding practice and Management expectations regarding AO rounds.
- A comparison of the computerized card key entry logs with the AO's required Rover rounds and log entries are being performed on a daily basis until further notice.
- Operations Management issued a night order on March 3 to the operating crews regarding complacency.

- On March 6, Operations Management issued a second night order that addressed shift records requirements, log sheets, attention to detail, and work ethics.
- Operations Management briefed all of the operating crews on the disciplinary action taken to date. Additional briefings will be provided as required.
- Operations Management has required each Shift Superintendent to perform a set of rounds with each AO and to review the watchstation and all other duties expected of the AO.
- On March 9, the Executive Director Nuclea Production began a series of briefings for all Operations Department personnel. He discussed the investigation, requirements for rounds, and Management expectations.
- The Station Manager has begun a series of briefings to Station departments on this occurrence and on Management's expectations on work performance in order to increase the sensitivity of Station employees in other areas.
- The suspended individuals are being required to complete a comprehensive remedial training program. The training program will address, as a minimum, Management expectations of their performance, their specific job responsibilities, Technical Specification and Technical Requirements and on-the-job refresher training with special emphasis on the proper performance of rounds and filling out logsheets. Each AO will be required to stand each watchstation with a trainer/evaluator. In addition, Station and Production

Management will complete interviews with each individual in order to ascertain their understanding of their duties and responsibilities and Management's expectations of them.

- The NHY President issued a letter to all employees summarizing the AO performance concerns and stressing employee responsibility regarding accuracy and accountability. The NHY President has met with the Management and supervisory staff and has issued a memorandum reminding all employees of the NRC's regulations related to deliberate misconduct.

The IRT, in my opinion, stated correctly that there were three groups of AO performance activities. Group I consists of those individuals who knowingly omitted portions of their rounds without any reasonable justification. Group II individuals understood the importance of and requirements of AO rounds, but had rationalized why certain areas or pieces of equipment did not have to be inspected on every round. Those individuals appeared to believe that they were doing the right thing or potentially doing a better job by devoting more of their time to what they felt were more important items. Group III individuals consist of those who clearly understood the importance of and the requirements of the AO rounds and rigorously completed those rounds. There were also instances of Group II AOs who clearly understood the requirements of their rounds, but missed certain areas on rare occasions. These areas were missed due to honest mistakes or due to distraction by other work activities. Their missed portions of rounds were

extremely rare and did not represent a pattern of behavior.

I believe that it is the rationale of the IRT, that an individual who willingly does not perform his activities cannot be prevented from doing so strictly by Management action. I agree that if an individual is predisposed to not performing his job correctly, there are no reasonable preventative measures that Management can put in place to preclude that situation. However, Management has the responsibility to review the process for hiring that individual in order to ensure that there were no potential indications which could have been identified in the preemployment screening process. In addition, Management has the responsibility to review the Company's processes for development of the affected individuals in order to identify further opportunities to reinforce Management expectations and work ethic.

The IRT, in their transmittal letter for their assessment, noted that the task force found considerable evidence that supports an effective technical task management style and safety culture within the organization. The organization is composed of extremely capable, technically oriented individuals who are very much tasked-oriented in nature. As a result, the organization as a whole, puts less emphasis on people-oriented skills. Therefore NHY should review how we train our managers and supervisors to assure that we improve the manner in which we treat and interact with all individuals within NHY. Special emphasis should be place on assuring that Management's expectations, basic work ethics, and professional interactions at all levels of the organization are

understood and properly implemented. In the case of the AOs in particular, we need to assure that NHY expectations are communicated to our First-Line Operations Management. This includes the expectation that the AOs must be fully integrated into the shift team, and then reinforce this philosophy on all shifts. There must be a "buy-in" by First-Line Supervisors that they are members of Management, and that they have ownership for the oversight and development of the AOs. The AOs must recognize that although they work in remote areas of the Station, they are an integrated portion of the NHY team. The AOs must realize that their job is important, even in the performance of routine and repetitive activities.

I recommend the following initiatives in addition to the recommendations of the Independent Review Team.

Recommendation #1

New Hampshire Yankee should acquire the services of an expert consultant to work with Management in order to enhance communications and team building. The consultant should be selected by May 15, 1992.

Management Responsibility: President & Chief Executive Officer / Executive Director Nuclear Production

Action Due Date: May 15, 1992

Recommendation #2

Management should review its hiring and orientation practices at in order to assure that they consider all appropriate attributes for hiring and developing employees. This review will be initiated by the Executive Director Nuclear Production, the Station Manager, and the Employee Relations Manager.

Management Responsibility: Employee Relations Manager

Action Due Date: June 15, 1992

Recommendation #3

Management should redouble its efforts in its support and communication with the on-shift crews. The Station Manager, Operations Manager, and the Shift Superintendents will develop a plan to foster better communications.

Management Responsibility: Station Manager

Action Due Date: June 1, 1992

Recommendation #4

Management should review industry experience with regard to these types of concerns and implement the lessons learned.

Management Responsibility: Regulatory Compliance Manager

Action Due Date: December 1, 1992

The following are recommendations recently received from the

IRT. I have performed a preliminary review of the IRT Report and I am in general agreement with its recommendations. Based on the initial review, I have made initial assignments to develop action plans in order to implement the recommendations. It should be noted that the assigned Responsible Management will have to carefully review the IRT recommendations and discuss the recommendations with the IRT Manager and Executive Management to gain a full perspective of the issues involved. This will assure that the resultant corrective action plans will be both meaningful and comprehensive. I have requested that the Regulatory Compliance Manager provide periodic status reports of their implementation, which I intend to make available to the NRC Senior Resident Inspector. I have also requested that the IRT assess the corrective actions taken prior to closure of the associated recommendations.

IRT Recommendation #1:

Executive Management should review and evaluate the procedure compliance policy scope with regard to the applicability of verbatim compliance.

Responsible Management: President & Chief Executive Officer

Action Plan Due Date: May 15,1992

IRT Recommendation #2:

Conduct refresher training on a periodic basis in the following:

· Procedure Compliance Policy.

- Need for integrity/accuracy/completeness when documenting work activities. Emphasizing that all documentation may be needed to reconstruct work act ities.
- NRC regulation on willful misconduct by licensed and/or unlicensed employees.

Responsible Management: Training Manager

Action Plan Due Date: May 15, 1992

IRT Recommendation #3:

Streamline Company operations by consolidating and eliminating (as possible) programs, policies, manuals and procedures. Emphasis should be placed on eliminating redundancy and excessive administrative requirements and documentation (e.g., canceling Nuclear Production Manual, quarterly surveillance for Shift Superintendents to review Work Request priorities, procedure for bulletin boards). Consider using outside expertise.

Responsible Management: Executive Director Nuclear Production

Action Plan Due Date: June 15,1992

IRT Recommendation #4:

Determine where operations administrative burdens for compliance with Technical Specifications and NRC commitments can be reduced by design enhancements. Examples:

- EFW back leakage temperature monitoring

· Spent Fuel Pool cooling pumps area temperature

Responsible Management: Station Manager

Action Plan Due Date: July 15, 1992

IRT Recommendation #5:

Review and revise the AO logs to eliminate checks determined to be excessive (e.g., Cooling Tower and CST every four hours).

Responsible Management: Operations Manager

Action Plan Due Date: July 1, 1992

IRT Recommendation #6:

Consider providing Auxiliary Operators with updated tools for recording rounds data to provide consistent documentation and enhanced capability for equipment monitoring. Consider systems such as used by Virginia Power (Nuclear Plant Journal, Jan-Feb, 1992).

Responsible Management: Operations Manager

Action Plan Due Date: June 1, 1992

IRT Recommendation #7:

Revise the AO Initial Training Program so that at the start and the end of the program, the Executive Director Nuclear Production, Station Manager, Operations Manager, and Training Manager address the Company's expectations and standards that the AO must meet, and convey the consequences of failing to

meet these expectations and standards. This should be emphasized annually during AO Continuing Training.

Responsible Management: Training Manager

Action Plan Due Date: July 1, 1992

IRT Recommendation #8:

Revise the AO Initial Training Program so that upon AO's arrival at training, the Shift Superintendent (SS) delivers Operations Department expectations to the new AO (orientation). In addition, an AO currently on the shift meeting these expectations will be assigned as a mentor to train this new AO on job requirements during the OJT process. This will include signing of all qual guide related material. The Shift Superintendent will be responsible for monitoring the progress of assigned AOs throughout the training program to make sure the department's expectations are being met.

Responsible Management: Training Manager

Action Plan Due Date: July 1, 1992

IRT Recommendation #9:

Revise the AO OJT Program to incorporate the Operations Good Practice on AO logs and round taking.

Responsible Management: Training Manager

Action Plan Due Date: May 15, 1992

IRT Recommendation #10:

Add signature blocks on the OJT qual guide to include:

- AO mentor, stating that the AO trainee is ready for qualification approval.
- AO trainee, stating he accepts all responsibility of information found in qual guide.
- Shift Superintendent, stating his expectations have been met.
- Operations Manager, stating that the department expectations have been met.

Responsible Management: Training Manager

Action Plan Due Date: May 15, 1992

IRT Recommendation #11:

Review applicable OJT lesson plans and Job Performance Measures (i.e., rounds, logs keeping, CST integrity checks) to ensure that AO administrative requirements have been included in these lesson plans.

Responsible Management: Training Manager

Action Plan Due Date: May 15, 1992

IRT Recommendation #12:

Operations and Training should re-evaluate the priority placed on the AO Continuing Training Program. Training should ensure

adequate instructor resources are available to conduct the program. Training should consider placing an instructor on-shift in the plant to conduct training.

Responsible Management: Operations Manager/Training Manager
Action Plan Due Date: May 15, 1992

IRT Recommendation #13:

Re-evaluate the AO training commitments to see if any requirements can be reduced or eliminate. Recommend that some of the requirements deemed necessary be fulfilled on shift.

Responsible Management: Operations Manager/Training Manager
Action Plan Due Date: May 15, 1992

IRT Recommendation #14:

Provide consistent administration of exams, written or walkthrough, to document students have comprehension of the material.

Responsible Management: Training Manager/Operations Manager
Action Plan Due Date: May 15, 1992

IRT Recommendation #15:

Examine the training feedback disposition process to ensure that actions are properly addressed and implemented.

Responsible Management: Operations Manager

Action Plan Due Date: July 15, 1992

IRT Recommendation #16:

Develop a standard orientation program for new employees to convey clear and concise Management expectations and develop a means to reinforce these expectations on a requalification basis. (See Recommendation #7 and #8 for example.)

Responsible Management: Training Manager/Employee Relations Manager

Action Plan Due Date: May 15, 1992

IRT Recommendation #17:

Develop team building opportunities with all on-shift Operations personnel. Consider periodic gatherings, other than shift turnover, which would encourage team interplay.

Responsible Management: Operations Manager

Action Plan Due Date: May 1, 1992

IRT Recommendation #18:

Develop Operations Department good practices to incorporate Operations standards, management expectations and good practices pertaining to AO logs and watchstanding.

Responsible Management: Operations Manager

Action Plan Due Date: May 15, 1992

IRT Recommendation #19:

Develop Operations Department Qualification Program and include this program in the NYQM.

Responsible Management: Operations Manager

Action Plan Due Date: May 15, 1992

IRT Recommendation #20:

Review and evaluate the processes utilized to manage technical and administrative tasks to streamline and consolidate the Management function. Encourage the decisionmaking processs to be made at the appropriate levels in the organization. Allow managers more time to manage people and to develop strategies in order to facilitate improved interpersonal communications. Consider using consultants to complete this review and provide specific recommendations.

Responsible Management: Executive Director Nuclear Production

Action Plan Due Date: July 15, 1992

IRT Recommendation #21:

Operations Management should ensure that the intent of OA1.14 #8, "Plant Performance Monitoring" is met.

Responsible Management: Operations Manager

Action Plan Due Date: May 15, 1992

On some occasions the AOs did not truly understand why they had to perform their rounds; especially in regards to standby equipment that remained idle. This shows a lack of understanding in the organization regarding Management's expectations and the basis for those expectations. We, as an organization, tend to focus on high priority tasks. In that regard, we have the potential to unintentionally minimize the importance of routine activities. Management expectations should be reinforced in training; however, training cannot be used as the exclusive method for communicating expectations to the organization. Training is an extension of Management, however, training cannot be used in lieu of proper Management communications. I recommend that NHY concentrate on assuring that the management in each department clearly communicates and reinforces by example, basic expectations related to day-to-day job activities.

In concluding this report, I am heartened by two facts which I believe are important to note. First, we identified these AO performance concerns by means of our internal review programs. Second, in all of the interviews conducted with the AOs, it became clear that the AOs recognized that if their supervision had been aware of the AOs missing portions of their rounds, such action would have been considered unacceptable and the AOs believe that they would have been directed by their supervision to complete the missing portions of their rounds. Notwithstanding these facts, we must now aggressively implement the recommended actions to prevent these unacceptable practices from recurring. I have and will

continue to monitor the effectiveness of our short term corrective actions. I am confident, based on all of our actions to-date, that Seabrook Station continues to be operated safely and in accordance with all our operating license requirements. I believe that with the completion of the IRT and Management assessments, we have a good understanding of the root causes of the AO performance concerns. I also believe that with the short term corrective actions we have put in place and with the implementation of the recommendations contained herein, we can be confident that our activities are being conducted properly.

Bruce L. Drawbridge

Executive Director Nuclear Production

Enclosure