EDO-001

UNION OF
CONCERNED
SCIENTISTS

February 10, 2000

Dr. William Travers
Executive Director for Operations
United States Nuclear Regulatory Commission
Washington, DC 20555-0001

SUBJECT: PETITION PURSUANT TO 10 CFR 2.206: SAFETY CONSCIOUS WORK ENVIRONMENT AND CORRECTIVE ACTION PROCESS AT INDIAN POINT UNIT 3

Dear Dr. Travers:

The Union of Concerned Scientists (UCS) submits this petition pursuant to the provisions of 10 CFR 2.206. We want the NRC to order the New York Power Authority to investigate the corrective action process and the work environment at the Indian Point 3 nuclear power plant and take immediate actions to remedy any deficiencies identified.

Background

The NRC is transitioning to a monitoring program for safety at nuclear power plants that relies heavily on performance in seven cornerstone areas. This new monitoring program assumes that the plant owner effectively finds and fixes safety problems via what is called a corrective action process. In addition, the new program assumes that the plant owner provides a work place where employees feel free to raise safety concerns without fear of discrimination or reprisals. The NRC calls this a safety conscious work environment. While the reasons for having an effective corrective action process and a safety conscious work environment at a nuclear power plant are fairly obvious, the fact remains that they are mandated by federal regulations. Appendix B to Part 50 of Title 10 of the Code of Federal Regulations (cited as 10 CFR) requires plant owners to have an effective corrective action process. Section 50.7 of 10 CFR protects plant workers from harassment and intimidation for reporting safety concerns. Thus, the NRC's new monitoring program for nuclear power plant safety assumes that plant owners are complying with these important federal regulations.

Basis for Requested Action

The Union of Concerned Scientists (UCS) is a non-profit, public-interest organization with members across the United States, including New York. UCS monitors performance at nuclear power plants in the United States against safety regulations promulgated by the NRC to protect the public and plant workers. When real or potential erosion of mandated safety margins is detected, UCS engages the NRC, the US Congress, the media, and other authorities to resolve the safety concerns.

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EDO-01

Workers at nuclear plants are commonly referred to as the "eyes and ears" for the NRC. The NRC openly admits that it can only oversee a small portion of the safety issues and relies heavily on nuclear plant employees to identify potential safety issues to management and, if necessary, to the NRC.

Ms. Rebecca Green, who until recently worked in the Operations Review Group at Indian Point 3, contacted UCS and related her concerns that the corrective action process at Indian Point 3 is not effective in identifying problems and ensuring their timely resolution. In addition, Ms. Green reported that her work environment was not safety conscious – in fact, when she raised safety concerns she was treated to such sustained abuse that she ultimately transferred out of the group.

Ms. Green's contentions appear to be documented by NYPA's own internal investigation of her concerns. As indicated by the enclosed NYPA report, NYPA's investigation substantiated eleven (11) of her thirteen (13) concerns. Most of the substantiated concerns involved programmatic deficiencies and faults with the Action and Commitment Tracking System (ACTS) and Deviation Event Reports (DERs) used by NYPA in its corrective action process. The report stated that these programmatic problems with ACTS and DERs would be handled via the initiation of several ACTS items and a DER.

UCS reviewed current records in the NRC's Public Document Room in Washington, DC. Our review reinforced the information obtained from Ms. Green. NRC inspectors have repeatedly documented violations of 10 CFR 50 Appendix B and have documented at least one recent violation of 10 CFR 50.7. Some examples of what could be a very lengthy compilation:

- By letter dated August 17, 1999, the NRC informed NYPA that its Office of Investigations had identified an apparent violation of 10 CFR 50.7 involving discrimination against a Performance Supervisor at Indian Point 3 after that individual raised safety concerns.

- By letter dated August 9, 1999, the NRC informed NYPA that its inspectors concluded, "Although personnel are using the DER process to identify station deficiencies, the team identified several discrepancies related to an inconsistent understanding of management's expectations for the DER process. Specifically, personnel did not always initiate a DER to report low-level human performance deficiencies, and many did not understand the use of DER trend codes." The NRC also reported that "Discrepancies were noted involving administration of the corrective action program. Examples include: deficiency tags in the field were not removed after repair work was completed, effectiveness reviews were not always completed, and **a large backlog of DERs needed evaluation by the operations review group**." [emphasis added]

- By letter dated October 13, 1999, the NRC informed NYPA that its inspectors were "concerned that the corrective actions to identify the root cause or to prevent a significant accumulation of water in the bottom of the 32 emergency diesel generator fuel oil storage tank were not effective." The NRC also reported that its inspectors had "concluded that the licensee's [nukespeak for plant owner's] equipment failure evaluations were poor."

- By letter dated April 20, 1999, the NRC informed NYPA that its inspectors concluded that "the deviation event report (DER) initial screening [for a problem with the 33 auxiliary boiler feed water pump] was poor in that it did not identify the repeat failure nor did it raise the level of the DER causal analysis."

- By letter dated September 30, 1999, the NRC provided NYPA with a long list of problems identified by its inspectors from January 1, 1999, through September 15, 1999. Some of these problems were:

  - Inadequate tagout corrective actions
  - Weak corrective actions
  - Problem identification tags on risk significant systems were not being corrected in a timely manner
  - The plant owner's critique of control room ventilation maintenance problems did not capture the material and communication problems that occurred
  - The plant owner's development and implementation of a test connection modification to the isolation valve seal water system was poor in that it did not address significant issues with plant and personnel safety
  - Timely and effective actions had not been implemented for a degraded refueling water storage tank level indicating switch problem

The information provided by Ms. Green and the information contained in these recent NRC documents strongly suggests to us that NYPA may not have an effective corrective action process at Indian Point 3 and may not be providing a safety conscious work environment. Because federal regulations require NYPA to do so and because the NRC's new safety monitoring program explicitly assumes that NYPA is doing so, it is imperative that any apparent improprieties in these areas be addressed promptly. Such safety warnings must be taken seriously.

Requested Actions

UCS petitions the NRC to order NYPA to do the following:

1. Perform a comprehensive assessment of the corrective action process at Indian Point 3. This assessment must include surveys of the workers' training and awareness of the ACTS and DER processes. From the available data, it appears that workers, either broadly or within certain departments, do not have a common understanding of the threshold level for initiating ACTS and DER items.

2. Perform a comprehensive assessment of the work environment at Indian Point 3. This assessment must include surveys of worker perceptions of their freedom to report safety problems and of management's openness in receiving such reports. Workers in all departments at the site must be covered by this assessment.

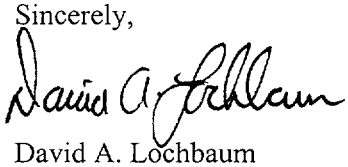
3. Implement timely remedial actions as appropriate based on the results from the two assessments.

The NRC should monitor NYPA's progress in conducting the two assessments and should independently verify that all remedial actions have been completed by NYPA before closing out the order.

We understand that NYPA is engaged in negotiations with a potential buyer of Indian Point 3. We request the NRC to close out the order to NYPA before ownership of the facility is transferred.

UCS believes that the requested actions are necessary to provide reasonable assurance that the corrective action program at Indian Point 3 is effective and that a safety conscious work environment exists at the plant. Absent these requested actions, the NRC will lack the confidence in these areas that the agency needs before implementing its new safety monitoring program at this site.

Sincerely,



David A. Lochbaum
Nuclear Safety Engineer
Union of Concerned Scientists

Enclosure: NYPA Letter NSS-IP3-99-0170 dated November 9, 1999

Cc: Ms. Rebecca Green
Mr. Robert W. Heagney, Gilman & Marks
Mr. Hubert J. Miller, Regional Administrator, NRC
Congressman Edward Markey
Congressman Dennis Kucinich
Entergy Nuclear

Indian Point 3
Nuclear Power Plant
P.O. Box 215
Buchanan, New York 10511
914 736.8000

NewYorkPower Authority

November 9, 1999
NSS-IP3-99-0170

Dear Concernee No. NSS-IP3-99-0170:

Nuclear Safety SPEAKOUT has concluded the investigation into your concerns. We thank you for bringing your concerns to our attention for investigation.

On January 5, 1999, you filed a formal SPEAKOUT concern. The concern was separated into two issues: 1) hostile work environment which was assigned to Corporate Human Resources for investigation in a letter dated January 7, 1999, and 2) thirteen specific issues alleging poor quality and questionable ethics regarding the manner in which the Operational Review Group (ORG) processed DERs and ACTS which were assigned to them for evaluation and action in a letter dated January 7, 1999. Initially, the IP3 QA Manager was given the technical issues for investigation in a letter dated January 7, 1999. Subsequently, the IP3 Facility Manager of Employee Relations was designated as the responsible person to investigate the hostile work environment concern. The Independent Safety Evaluation Group (ISEG) was tasked with investigating the technical concerns. Concurrently, QA was reviewing these technical issues during their QA Corrective Action Program Audit A99-01-I, conducted from February 6 - 20, 1999.

1. INVESTIGATION AND EVALUATION OF HOSTILE WORK ENVIRONMENT

This investigation was conducted by the IP3 Facility Manager of Employee Relations. As stated in his report, its conclusions are based on interviews conducted with sixteen NYPA employees, including each member of the ORG, the former ORG Manager and the former General Manager Support Services (GMSS), the individual to whom ORG reports. Throughout the investigation there were numerous interviews and follow-up contacts with you (1/11, 2/8, 2/9, 4/16, 4/20, 5/12, 5/17, 8/3, 9/29). This does not include other contacts, in person or by telephone, which occurred, but were not documented. In addition, a comprehensive review was conducted of documentation (i.e., daily logs, emails, technical forms) submitted to SPEAKOUT and Human Resources.

The investigation report states that your allegation of hostile work environment within ORG is based largely upon encounters with two colleagues involving work issues. The HR conclusions are based on information obtained from many employees who have worked with and supervised you and your two colleagues for many years. Assessments of capabilities, character, and reputation were

obtained as a means to learn more about the principals of the concern. Witnesses to actual events and individuals who may have been made aware of the events were approached to validate the various accounts and give their opinions.

This investigation report did not substantiate the allegation of hostile work environment within ORG, although it did identify the existence of an unprofessional work environment within ORG. While it was determined that no unlawful harassment nor any violation of Power Authority policy took place, it does conclude that one of your colleagues acted in an inappropriate manner in expressing himself on various occasions and that there was no justification for his emotional responses. Although you perceived this behavior as threatening, at no time was there an actual or implied threat by this co-worker. His behavior may be characterized as unprofessional, reactionary and discourteous. However, it cannot be said to have created or promoted an atmosphere of hositility within ORG. This employee has been appropriately disciplined and counseled and will continue to be monitored.

The incident involving a second co-worker appears to have been an isolated event where two co-workers responsible for a common task failed to communicate well. It escalated to a conflict, which was addressed professionally and ultimately resolved.

This investigation report concludes that, "it is clear that ORG is a dysfunctional work group. It does not interact well as a team, and certain members have demonstrated an inability to work well with employees within the group and in other departments." The majority of the group believes it lacks sufficient leadership. It is HR's recommendation that these and other issues identified in the December 10, 1998, Team Fitness Report prepared by Corporate Management and Organizational Development, be addressed with their assistance and IP3 Site management in the form of appropriate training, development and reorganization.

The details of this investigation, and its conclusions, were formally reported to you at a meeting on September 29, 1999, by the Facility Manager of Employee Relations. The SPEAKOUT Representative was present at your request, and C. Hehl, Consultant, was present with your consent.

2. INVESTIGATION AND EVALUATION OF ORG TECHNICAL ISSUES

This investigation was conducted by the Director of ISEG and the IP3 ISEG Senior Assessment Engineer. Their review included DERs, ACTS, and procedures. As

part of the investigation, ISEG elected to use some of the data gathered by QA during the performance of their Correction Action Audit.

Most of the thirteen issues identified related to the timeliness of processing and addressing ACTS and DERs that were within the responsibilities of ORG, as well as the accuracy of data entries used in processing DERs. ISEG substantiated eleven of the thirteen issues. This means there were examples found that supported an allegation, but does not necessarily mean the problem was pervasive.

A summary of the thirteen issues submitted and the results of the ISEG investigation are outlined below:

1. Accuracy of DER coding – Substantiated
2. Accuracy of DER keywords – Not Substantiated
3. Poor dissemination if IP2/JAF DERs – Substantiated
4. Accuracy of system/component numbers – Substantiated (component and system information is not always provided)
5. Untimely responses to DERs assigned to ORG – Substantiated via two examples
6. Untimely processing of ACTS extension requests – Not Substantiated
7. Keeping ACTS items in EVAL for extended periods – Substantiated
8. ACTS items assigned to ORG are not being processed in a timely manner – Substantiated
9. Failure to revise appropriate procedures in a timely manner to address the implementation of the New ACTS program – Substantiated
10. Untimely implementation of recommendations from the Sea State report – Substantiated
11. Untimely corrective actions for compliance with ORD-AD-006 – Substantiated
12. Untimely response to an SRC concern regarding the effectiveness of the RCA process – Substantiated
13. Failure to comply with the requirements of PS-1.07 and ORG-AD-008 – Substantiated for ORG-AD-008.

The issues are grouped into four categories:

A. Entering information on the DER forms
B. Timely processing of Information
C. Procedure/Administrative Issues
D. Processing of IP2/JAF Operating Experiences

The following DERs and ACTS items were written as a result of this investigation.
DER 99-0621/Clsd 4/29/99 – (ACTS-99-41119/Clsd.)

ACTS 41158/Clsd 9/10/99

ACTS 41159/Eval

ACTS 41160/Clsd. 0/10/99

ACTS 41162/Open (due 3/31/00)

ACTS 41211/Open (due 3/15/00)

IP3 Management discussed the results of the ISEG investigation with you on September 10, 1999. During that discussion, you expressed dissatisfaction with the results of the investigation and reiterated concerns regarding the handling of DER and ACT items assigned to ORG, specifically that the unethical handling of these items raised questions regarding the integrity of the ORG Manager.

On September 12, 1999, NYPA contracted with a consulting firm to conduct an independent investigation into the validity of the alleged unethical handling of DERs by the ORG Manager. In a written report dated October 22, 1999, the consultant concluded "that the alleged inappropriate handling of DERs by the ORG Manager is not substantiated". This conclusion was based on his review of the DERs alleged to have been handled inappropriately, interviews with management and staff who may have had insights into these issues, and review of a confirmatory sample of additional actions assigned to ORG.

We hope this letter answers your concerns. Should you have any questions regarding this response, please contact me in the SPEAKOUT Office on extension 4949 or 2968.

Sincerely,

Alice Hughes

Alice Hughes
Nuclear Safety SPEAKOUT Program Administrator