October 4, 2004

Region III Enforcement/Investigations Officer
U. S. Nuclear Regulatory Commission
2443 Warrenville Road, Suite 210
Lisle, IL 60532-4352

Point Beach Nuclear Plant
Dockets 50-266 and 50-301
License Nos. DPR-24 and DPR-27

Requests For Information
RIII-04-A-0051, RIII-04-A-0052, RIII-04-A-0061, and RIII-04-A-0077

On September 15, 2004, a request for information was forwarded to Nuclear Management Company LLC (NMC). The request relates to information received by the Nuclear Regulatory Commission (NRC) regarding a lack of trust in upper station management by some individuals at Point Beach Nuclear Plant (PBNP).

NMC's response to the request for information is contained as an attachment to this letter.

Summary of Commitments

- Operations Shift Managers will attend a briefing on NMC corporate policy CP 0017, "Nuclear Safety Culture," by October 12, 2004.
- An action plan to enhance operational decision-making, increase engagement with the workforce, and improve communications will be available for NRC review by November 15, 2004.
- NMC Human Resources practices associated with mitigating adverse cultural impacts of high visibility employment actions will be reviewed with enhancements defined by November 15, 2004.

AA-7

If you have questions or require additional information regarding this response, please contact Mr. Aldo Capristo, NMC Fleet Employee Concerns Program (ECP) Manager, at 920/755-7633. Supporting records for this request for information are available for review at PBNP.

Dennis L. Koehl
Site Vice-President Point Beach Nuclear Plant
Nuclear Management Company, LLC

Attachment

Attachment

Response to NRC Requests for Information
RIII-04-A-0051, RIII-04-A-0052, RIII-04-A-0061, and RIII-04-A-0077

Background

In a letter dated September 14, 2004, the Nuclear Regulatory Commission (NRC) notified Nuclear Management Company, LLC, of four concerns that had been raised at Point Beach Nuclear Plant (PBNP). While NRC's evaluation of these concerns did not identify reluctance by employees to raise safety issues, a number of employees indicated there were varying degrees of trust in station upper management. This belief was based on strong views held by certain individuals regarding the station's handling of two events that occurred early in 2004. These events involved the Unit 2 safety injection accumulator and the resignations of four SROs related to the installation of nozzle dams for Unit 1.

The NRC letter provided four examples of concerns that prompted NRC inquiry. The NRC requested that NMC perform an evaluation that includes sufficient information for the NRC to determine: (a) if the concerns were substantiated; (b) that the organization or individual conducting the evaluation was independent; (c) that the evaluation was of sufficient depth and scope to determine that the appropriate root causes and generic implications were considered; (d) that the corrective actions, both planned and completed, were sufficient to correct the specific example(s) and generic implications to prevent recurrence; and (e) if the NMC evaluation identified any deficiencies with a license condition, the corrective actions that were taken or are planned, identifying the corrective action document that addressed the deficiencies.

In addition, the NRC letter requests that NMC discuss the actions it has taken or has planned to ensure that a sound safety culture is maintained at PBNP and to address the lack of trust and other issues identified via self-assessment report PBSA-PBNP-04-01, dated July 13, 2004. The NRC directed that the NMC review should not be limited to the Operations department, since the very visible dismissal of high profile individuals from the Operations department may affect the safety conscious work environment in all of the NMC departments either at the site or in the corporate office.

The PBNP Employee Concerns Program (ECP) Manager led the investigations into these concerns. The PBNP ECP Manager is independent of the PBNP line organization and reports to the NMC Fleet ECP Manager. The scope of the investigations included reviews of applicable corrective action program documents, interviews with personnel and a review of relevant records.

The NMC Fleet ECP Manager assessed the safety culture issues and attributes at the NMC fleet level. The NMC Fleet ECP Manager is independent of the PBNP line organization. As the current NMC Vice-President of Nuclear Assessment who would normally review and approve this letter had been temporarily assigned as acting PBNP Site Vice-President from January 26, 2004 to June 18, 2004, the period covered by

these concerns, the current PBNP Site Vice-President, Dennis L. Koehl, reviewed and approved this letter.

Nuclear Safety Culture Assessment

While the events referred to above were evaluated individually from a technical perspective via the Root Cause Evaluation (RCE) process, it was self-identified that these events should also be evaluated collectively from a nuclear safety culture perspective. CAP056175, initiated on April 28, 2004, identified the need for this activity to be performed. A multi-disciplinary, management/union team led by an external consultant performed a focused self-assessment of the current PBNP nuclear safety culture. The self-assessment was performed from May 17 through June 11, 2004, and was documented in report PBSA-PBNP-04-01. The report was approved by station management on July 13, 2004.

The conclusion reached by the self-assessment team was: "There is no indication that the current Point Beach Nuclear Plant nuclear safety culture cannot support continued safe operation or carry out committed improvement plans. However, it will take strong, facilitative leadership against a backdrop of tough standards to establish vertical trust, instill structured decision making, embrace performance measurement forms of feedback, and reach out to the industry for better methods than PBNP can develop in isolation."

The report also noted that, "At no time during the self-assessment did the team find any indication that a PBNP individual would refrain from expressing a nuclear safety concern that he or she was able to recognize. While the team interviewed several individuals who expressed dissatisfaction with the handling of various issues, the team discovered no new significant conditions adverse to quality." (Emphasis was placed on this phrase in the source document.)

PBNP Management has led several actions that have already been taken in response to this report. A "Burning Platform" team-building seminar was conducted with members of the leadership team on July 14, 2004. The "Burning Platform" seminar was designed to provide the PBNP site leadership with a sense of urgency for implementing change at PBNP. Positive problem statements for each of the eight "INPO Principles for a Strong Nuclear Safety Culture (Preliminary)" were reviewed. The short-term actions identified to immediately begin addressing the problem statements were:

- Implement the INPO Operational Decision Making Issue Evaluation Model. This document was issued as administrative procedure NP 1.1.12, "Operational Decision-Making Issue Evaluation Process," on July 30, 2004. The purpose of this procedure is to establish the requirements for evaluation and documentation of technical and operational decisions.

- Improve the plant-meeting schedule to provide additional opportunities for senior members of the leadership team to engage in direct, personal contact with employees to promote communications, reinforce standards and expectations, ensure structured decision-making is accomplished via procedure NP 1.1.12 for significant emergent conditions, and ensure external operating experience is shared. The plant-meeting schedule was revised and implemented on July 29, 2004.

- Develop a communications plan (completed) to address the problem areas identified in the self-assessment.

Since the above actions were taken, a Common Factors Analysis (CFA) of seven recent root cause evaluations has also been completed. The consultant performing the CFA has recommended a number of enhancements to the Operational Decision Making Evaluation Process. The enhancements will provide a mechanism for this process to be routinely used throughout the organization. The enhancements are under evaluation. The action plan to implement these enhancements will be developed and available for discussion and/or review by NRC representatives by November 15, 2004.

Concern from Tracking Number RIII-04-A-0051

"An individual was concerned that a chilled environment exists at the station in which operators are afraid they will lose their job if they raise safety issues or take actions counter to management direction, even if the direction is thought to be wrong. The individual stated that a Shift Manager did not declare a Unit 2 Safety Injection Accumulator level transmitter inoperable because senior plant management did not want it declared inoperable. The Shift Manager did not want to take an action against senior management's instruction for fear of losing his job. The individual stated that in this case, declaring the component inoperable would have required that the plant be shutdown."

Evaluation

NMC became aware of the concern relating to the Unit 2 safety injection level transmitter operability determination during interviews of personnel and via an e-mail sent to the NMC President by a former employee on July 21, 2004. The Shift Manager who was alleged to have failed to declare the equipment inoperable had previously called the PBNP ECP Manager on April 15, 2004, to discuss his termination paperwork and did not raise any issues associated with the Unit 2 safety injection (SI) level transmitter operability determination. This former Shift Manager was given the opportunity following his resignation to identify any safety issues and failed to do so. The only issue identified during discussions were related to the wording of the documentation associated with his resignation.

The investigation and troubleshooting of 2LT-939, Unit 2 SI accumulator transmitter (CAP053829) was conducted during the timeframe of February 14, 2004, to March 30, 2004, at which time it was confirmed that the SI accumulator level was out of specification high, and the accumulator was inoperable. Required Action C.1 of Technical Specification Limiting Condition for Operation (LCO) 3.5.1 requires that the accumulator be restored to operable status within one hour. Required Action D.1 is to bring the affected unit to Mode 3 in six hours and Required Action D.2 is to reduce reactor coolant system pressure to less than or equal to 1000 psig in 12 hours.

Since the SI accumulator could not be restored to operable status within one hour, a Unit 2 power reduction, at a rate of 12% per hour, was commenced at 1215 on March 30, 2004. The affected SI accumulator was restored to operable status within two hours of commencement of the unit load reduction, at which time the unit was stabilized at 83% power. Operation of the Unit 2 2T-34A SI accumulator with a fluid level exceeding the level specified in PBNP Technical Specification SR 3.5.1.2, 1100 cubic feet to 1136 cubic feet, constituted a condition prohibited by Technical Specifications. Accordingly, Licensee Event Report (LER) 301/2004-004-00 was submitted to the NRC on May 21, 2004, via NMC letter NRC 2004-0055.

A review of action requests initiated by Operations personnel shows that 1252 action requests were initiated during 2003. In 2004 through August, 1708 action requests have been initiated. A review of this data for 2004 shows there is an overall increasing trend in the number of action requests initiated by Operations personnel.

Conclusions

The first element of this concern, that there is a chilled environment among the operators at PBNP is **NOT SUBSTANTIATED**. The results of the Nuclear Safety Culture Self-Assessment, NRC observations as cited in the September 14, 2004, NRC request, interviews conducted with Operations personnel, and a review of action request volume within Operations support the conclusion that PBNP personnel continue to report safety concerns.

The second element of this concern, that a Shift Manager did not declare the Unit 2 SI accumulator inoperable because senior management was opposed to this action, is **NOT SUBSTANTIATED**. Several of the individuals involved in this event have left NMC and were not interviewed. However, NMC has found no evidence that the Shift Manager believed that declaring the accumulator inoperable was appropriate prior to March 30, 2004. To our knowledge, no claim was made by the Shift Manager at the time, nor since he left employment at PBNP on April 14, that he was improperly influenced against making such a declaration.

The departing employees on April 14, in accordance with NMC practice, were provided exit forms containing an opportunity to present any safety concerns they had. None were submitted with this allegation. Further, the Shift Manager called the PBNP ECP Manager to discuss his termination, and not raise any issue concerning the safety injection accumulator. Finally, NMC counsel recently participated in OI investigative interviews that did not provide any evidence demonstrating that the Shift Manager had been influenced against declaring the accumulator inoperable.

The third element of this concern, that the Shift Manager did not want to take an action against senior management's instruction for fear of losing his job, is **NOT SUBSTANTIATED** for reasons stated above.

The fourth element of the concern, namely, declaring the component inoperable would have required that the plant be shutdown is **PARTIALLY SUBSTANTIATED**. The actions specified in TS LCO 3.5.1, Required Actions, require that if an SI accumulator cannot be restored to operability within one hour, an orderly unit shutdown must commence. In this case, a Unit 2 power reduction commenced. However, when the SI accumulator was returned to service within two hours of commencing the power

reduction, the operators stabilized the unit and began returning the unit to full power operation. When the Unit 2 SI accumulator level was recognized to be outside of the Technical Specifications limit, PBNP commenced the required Technical Specification actions within permissible time limits.

Concern from Tracking Number RIII-04-A-0052

"An individual is concerned that a chilled environment exists within the Operations department. The individual stated that the chilled communication environment was caused when upper management relieved Senior Reactor Operators (SROs) from duty and the perceived forced resignation of three SROs and the former Operations Manager."

Evaluation

As noted above in the evaluation of RIII-04-A-0051, Operations department personnel continue to report safety concerns using at least one of the avenues available for raising issues such as using their chain of command, the corrective action system, the Employee Concerns Program, or directly to the NRC. Operations personnel interviewed affirmed that they feel most comfortable discussing their concerns with individuals in their chain of command up through their Shift Manager.

PBNP has determined that the working relationship between Operations management and the Operations staff requires improvement. The new Operations Manager has made direct and personal contact with members of his staff in order to introduce himself. This action was completed in June 2004. The Operations Manager also attended the NMC leadership development module focused on safety conscious work environment entitled, "Taking Action," in July 2004. A third action is to ensure that Shift Managers attend a briefing on CP 0017, "Nuclear Safety Culture," by October 12, 2004.

In addition to the above actions, continued and ongoing actions to be taken by Operations management are contained in an action plan on file with the PBNP ECP Manager. The PBNP ECP Manager will conduct a routine follow-up assessment of the effectiveness of the actions taken via interviews with Operations personnel prior to the end of 2004. Finally, an independent Comprehensive Culture Assessment (CCA) survey will be conducted by the end of 2004.

Conclusions

The concern that a chilled environment exists with the Operations department is **NOT SUBSTANTIATED.** While interviews with Operations personnel revealed there are varying degrees of trust between the station senior leadership team and the Operations

staff, Operations personnel continue to demonstrate their willingness to utilize available avenues of problem reporting.

The concern that a chilled communication environment was caused when upper management relieved Senior Reactor Operators (SROs) from duty and the perceived forced resignation of these three SROs and the former Operations Manager is **NOT SUBSTANTIATED**. While these actions strained the working relationship in the Operations department, it was self-identified that the new Operations Manager needed to promote and improve trust within the department. This area for improvement was identified in the ECP investigation into related concerns of individuals in Operations.

NMC Human Resources will review the existing practices associated with mitigating adverse cultural impacts of high visibility employment actions for enhancement by the November 15, 2004. These corrective actions are captured in action request COM000864.

Concern from Tracking Number RIII-04-A-0061

"An individual is concerned about being fired for talking to the NRC, but came to the NRC because of a concern for a safe work environment. The individual stated that s/he was afraid to go to management and the Employee Concern Program (ECP) coordinator because s/he believed that people who raise concerns are marked for termination. The individual stated that one of the individuals who was fired because of the hot leg vent incident had previously been marked for dismissal after raising dry cask storage concerns."

Evaluation

This concern, associated with an employee who resigned because of the hot leg vent incident, was previously brought to the attention of the NMC Fleet ECP Manager. On May 21, 2004, ECP file 04-07 was opened to investigate the issue. The PBNP ECP Manager evaluated this concern with assistance provided by the Palisades Nuclear Plant (PNP) ECP and PBNP Dry Fuel Storage Manager, and the NMC Dry Fuel Storage Manager.

The employee who resigned had previously commented during a meeting at PNP on or about March 17, 2004, on the use of plasma arc welding during the unloading of dry fuel casks. The use of plasma arc welding was previously reviewed by the NRC and is documented as acceptable in NRC Inspection Reports 07200032/2003-001 (DNMS) and 0720032-2003-002 (DNMS) dated July 10, 2003, for the Duane Arnold Energy Center.

The NMC DFS Manager was interviewed and indicated she had been aware of the meeting and viewed it only as a continuum of the many meetings and discussions NMC sites were having concerning the DFS projects. She did not inform senior management at PNP of the employee's comments, as the dialog during the meeting was routine and not indicative of a significant safety concern. No corrective action documents were generated by the employee or by PNP personnel.

The employee's personnel file maintained by the Human Resources Department was reviewed. The file contained no remarks or notes associated with the DFS plasma arc welding comments.

The concern element stated an individual was concerned about being fired for talking with the NRC but came to the NRC because of a concern for a safe work environment. With respect to that assertion, the right of an employee to discuss safety concerns with the NRC is clearly delineated in NMC corporate policy CP0021, "Employee Concerns Program." This right is routinely reinforced during presentations by the NMC Fleet ECP Manager and PBNP ECP Manager and by recurring articles in "NMC Today," the NMC newsletter, and other informational materials. Further, employees are informed about means for contacting the NRC or ECP anonymously, as the alleger apparently chose to do.

Conclusions

The concern elements that (1) an individual is concerned about being fired for talking to the NRC, but came to the NRC because of a concern for a safe work environment and (2) an individual was afraid to go to management and the ECP coordinator because people who raise concerns are marked for termination are **INDETERMINATE.** The identity of this employee is unknown to NMC and therefore, is not verifiable. Employees interviewed by NMC as part of the recent Nuclear Safety Culture Self-Assessment indicated that they would raise recognized safety concerns. Employees are encouraged to raise safety concerns via the many routes available, including their supervisor, manager, corrective action program, or by communicating directly with the NRC. Further, no employee has ever been terminated at NMC because of utilizing the employee concern program.

The concern element that one of the individuals who were fired because of the hot leg vent incident had previously been marked for dismissal after raising dry cask storage concerns is **NOT SUBSTANTIATED.**

Concern from Tracking Number RIII-04-A-0077

"An individual is concerned that there is a lack of a safety conscious work environment and that because of previous ECP contacts and differences with Operations

Department there was a heightened awareness being applied to him. The individual stated that s/he was fearful of raising issues that were of lower significance and would think twice about bringing issues forward."

Evaluation

The PBNP ECP Manager previously investigated and substantiated a related concern that a member of the Operations group received negative feedback from Operations management after initiating a corrective action document in the Corrective Action Program (CAP). The results of the investigation of the related concern revealed that Operations management did not intend to provide negative feedback. However, miscommunications by Operations management led to the perception by the member of the Operations group that negative feedback was provided. The results of this investigation are documented in PBNP ECP file 04-06 and are available for review if additional details are required.

Approximately two months later, the KNPP ECP Manager and the PBNP ECP Manager investigated and did not substantiate a related concern raised by the same person. The concern was that the individual was being retaliated against by management for raising issues in the Corrective Action Program (CAP). This person felt targeted by management and explained that other persons in Operations made statements that management appears to be "gunning for you." The concern went on to state that this belief by members of the Operations group could lead to an environment where others would not raise issues for fear of future retaliation.

During the investigations, the person who raised the related concern affirmed that s/he would continue to raise issues to his/her Shift Manager. This investigation also included interviews of a random sampling of 18 Operations personnel. The purpose of these interviews was to evaluate the working environment. All individuals interviewed indicated that they would utilize at least one of the avenues available to raise safety concerns or similar issues. Operations personnel affirmed they were most comfortable in discussions with supervisors up to the Shift Manager level, as well as documenting issues in the Corrective Action Program (CAP).

The investigation did not substantiate a link between the non-disciplinary coaching received by the individual who raised the issues described above and use of CAP. The individual did state that s/he was uncomfortable using the corrective action program but that s/he would continue to raise issues to the Shift Manager.

Results of this investigation are documented in PBNP ECP file 04-12 and are available for review if additional details are required.

Conclusions

The first element of the concern, an individual is concerned that there is a lack of a safety conscious work environment and that because of previous ECP contacts and differences with Operations Department there was a heightened awareness being applied to the individual, is **NOT SUBSTANTIATED.** Based on the interviews conducted, which included the person who initially raised a related concern to ECP, personnel are comfortable raising issues to management.

The second element of the concern, the interviewed individual stated that s/he was fearful of raising issues that were of lower significance and would think twice about bringing issues forward, is **INDETERMINATE** because the identity of this individual is unknown to NMC.

Generic Implications

NMC considers the establishment and maintenance of a safety conscious working environment at all of our facilities and within every department to be a cornerstone principle of safe operations.

It is clear that the efforts to communicate the bases for recent employment and operational decision-making was less than adequate to maintain acceptable levels of trust of senior management within the site organization. NMC recognizes the opportunity to enhance effective communication with our staff in future situations.

In response to the steam generator nozzle dam incident, NMC acted on the unacceptable performance of several senior site personnel. NMC recognizes some opportunities to mitigate the adverse impact on the working environment in such situations but reaffirms the necessity to act upon the unacceptable performance of those individuals. In addition, company policies protecting personal privacy limit NMC's ability to address directly the reasons for the decisions.

The ability to improve individual performance by the use of human performance tools is considered essential to improving overall site performance. It is clear that the effective use of human performance tools will cause many individuals to reflect on their strengths and weaknesses in a manner that may be considered personally uncomfortable. NMC recognizes the opportunity to enhance understanding of the purpose of these tools, but reaffirms the necessity for improving individual performance.

In summary, PBNP continues to raise standards of performance while minimizing any adverse impact on the general working environment. NMC recognized the events at PBNP could transcend the PBNP Operations department and the PBNP site, and could

have impacts across the NMC operating fleet. Utilizing established communication methods such as regularly scheduled employee forums with NMC executive management, NMC monitors employee feedback and provides responses to all concerns raised. This communications tool is enhanced by the fleet Employee Concerns Program and routine departmental communications.

In reviewing the information available from recent employee forums and the intake of the fleet Employee Concerns Program, NMC is confident that the previously discussed PBNP events have not caused a reluctance to raise safety-related issues at the corporate office or at other fleet locations. As a final measure of assurance, NMC will conduct a regularly scheduled bi-annual comprehensive independent cultural assessment at all fleet locations later this year. NMC will act on weaknesses in safety culture that the survey may reveal.