UNITED STATES
NUCLEAR REGULATORY COMMISSION
WASHINGTON, D.C. 20555-0001

October 24, 1996

Mr. Bruce D. Kenyon
President and
Chief Executive Officer
Northeast Nuclear Energy Company
P.O. Box 128
Waterford, CT 06385-0128

SUBJECT: ORDER REQUIRING INDEPENDENT THIRD-PARTY OVERSIGHT OF NORTHEAST NUCLEAR ENERGY COMPANY'S IMPLEMENTATION OF RESOLUTION OF THE MILLSTONE STATION EMPLOYEES' SAFETY CONCERNS ISSUES

Dear Mr. Kenyon:

Over the past several years, Northeast Nuclear Energy Company (licensee) has failed to assure compliance with regulatory requirements at the Millstone Station. The NRC's Order of August 14, 1996 establishes independent, third-party oversight of corrective actions for design and plant operation deficiencies. That Order establishing an Independent Corrective Action Verification Program (ICAVP) for Millstone facilities summarizes the licensee's failure to meet Criterion XVI of Appendix B to 10 CFR Part 50 and other NRC requirements.

As discussed below, the NRC is also concerned about the failure of past licensee management processes and procedures to effectively handle safety issues raised by its employees and the manner in which the licensee treated employees who brought safety and other concerns to the attention of management. As evidenced by the large number of safety issues recently being identified at all three Millstone plants, it appears that some employees were reluctant to identify safety issues to the licensee. Failure to identify safety concerns is of significant concern to the NRC.

Over the past several years, numerous licensee assessments, audits, and internal task group studies have been conducted to assess employee safety concerns programs at the Millstone Station.

In a January 29, 1996 study, the licensee completed its review of the effectiveness of its Nuclear Safety Concerns Program (NSCP). The licensee concluded that the NSCP had been, and continued to be, ineffective. The findings of the January 1996 report were similar to those of previous licensee assessments and studies performed since 1991.

In its July 12, 1996 report, "Report of the Fundamental Cause Assessment Team," the licensee concluded that its top-level management did not consistently exercise effective leadership or articulate and implement

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appropriate vision and direction. Its nuclear organization did not establish and maintain high standards and expectations. Also, its nuclear organization's leadership, management, and interpersonal skills were found to be weak.

In its September 1996 report, "Millstone Independent Review Group Regarding Millstone Station and NRC Handling of Employee Concerns and Allegations," the NRC staff determined that in general an unhealthy work environment, which did not tolerate dissenting views, and did not welcome or promote a questioning attitude, has existed at Millstone plants for the past several years. This poor environment has resulted in repeated instances of discrimination and ineffective handling of employee concerns and contributed to the Millstone plants being placed on the NRC's "watch list" as facilities having significant weaknesses.

Also, in its past studies, the NRC staff have noted similar problems. As a result, the NRC has conducted numerous inspections and investigations that have substantiated many of the employee concerns and allegations for which the licensee's corrective actions have proven ineffective. The NRC has cited the licensee for violations and taken escalated enforcement actions. Notwithstanding these actions, the licensee's handling of employee safety concerns and implementation of corrective actions for problems identified by employees remain ineffective.

Therefore, the NRC is issuing the enclosed Order (Enclosure 1) directing that prior to restart of any Millstone units, the licensee is to develop and submit to the NRC a comprehensive plan for reviewing and dispositioning safety issues raised by its employees and ensuring that employees who raise safety concerns can do so without fear of retaliation. The comprehensive plan shall address the past performance failures including those identified in the enclosed Millstone Independent Review Group report (Enclosure 2). The Order also directs the licensee to retain an independent third-party to oversee implementation of its comprehensive plan.

The NRC anticipates that it will take some period of time to show sufficient improvement; therefore, the NRC will consider your performance with regard to safety issue resolution and employee treatment as well as the continuing need for the third party oversight within 12 to 24 months following implementation of the plan.

Sincerely,

Frank J. Miraglia

Frank J. Miraglia, Acting Director
Office of Nuclear Reactor Regulation

Docket Nos. 50-245, 336, and 423

Enclosure: Order
cc w/encl: See next page

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ENCLOSURE 1