MANAGEMENT CONFERENCE

Regulatory Oversight

Oak Ridge, TN

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MR. JACKSON: Let me first of all welcome you again to Oak Ridge. This is a management conference. The agenda for this conference is very simple. I intend to give us an introduction, explanation of what we're hoping to achieve at this management conference, what we plan to address and accomplish, allow USEC to make a presentation.

Following that, I recognize the Nuclear Regulatory Commission has representatives here, and I would welcome or encourage any comments that they may have during this period. And then we'll take a break. That will give us a chance to caucus. And then we can come back in and ask any additional questions of USEC that we may need for clarification from their presentation. And then we will adjourn.

As a matter of introduction, let me say what this management conference is. It's a management conference. Our program does not have specific guidelines for a management conference. It's not an enforcement conference though. It's not -- we've talked with USEC and our own staff before, so this is not intended to be an enforcement conference where we go through the

litany of issues and potential violations and violations and to discuss those from a safety significance.

We do want it to be a communication tool. We do want open communication. We can discuss feelings. We can discuss how we perceive things in this conference. It's very important that we communicate what we're doing here. And as I said, we don't want to limit our discussion to the examples we gave you. They were to be representative of concerns that we have in my letter calling for the conference. We hope you'll leave this meeting with a common understanding and recognition of the problem and clear course of action to help us get there.

From the overview standpoint, as our letter indicated, we see problems, issues, violations in areas of procedures, corrective action dispositioning, and maintenance of and adherence to the authorization basis. To reach this conclusion, we have used the DOE site safety representatives' input. We have used our inspection reports. We have looked at your own problem reports. We have looked at your own USEC self-assessments. I spent the last two nights

just refreshing myself. And it's really concerning the litany, the number, and the repetitiveness of these violations, these issues, over the last several years.

It's our expectation that we can reach a common understanding and that we can get an agreement on a plan of action, of course, today, recognizing that we've asked you in our letter that you have till the end of May to give us a formal written plan of schedule. But we hope we can get a clear understanding of it today and a recognition of who's responsi. le.

Okay. This is what I don't have. This is what this whole issue is about. I don't have the confidence I need to stand here as an effective regulator in these areas. I rely on my site safety representatives. They do not give me that confidence in these programs. I've spent a great deal of time with NRC, both of the headquarters in the region. They seem to share or reflect some of these same concerns. And I'm not speaking for them, but that's in my dealings with them.

In the next hour, you all cannot convince me -- there's not enough time -- that we do not have problems, that our violations that are

issued, inspection reports, your problem reports, the NRC observation reports, your own self-assessments are wrong. However, you can make a lot of progress in relieving for me what I call a burden with respect to ensuring safe operation of these plants.

The part of the burden I share and I have is that our program in the regulatory process was set up to instill in your organization a sense of taking management control of these things. Over this past year, I've allowed part of my focus to go towards the application, the transition and certification process. And because of the slipping of schedule, I have let myself depart from our program.

Our program says, once you have repetitive violations, once you have programmatic failures -- it's not a burden on me. It's a process that we go through to have enforcement conferences, issue level two violations, issue civil penalties as appropriate, and to get your emphasis, your attention on these areas that way. But I've allowed myself to depart from that to, you know, facilitate this process.

The burden I have is that I really feel

that we have spent a lot of time. Progress in certain areas, and I think I've been willing to recognize that progress in certain -- in many areas. I've recognized the efforts of Steve Polston and his group with respect to the Radiation Protection Program. I've recognized with respect to Dale Allen in his program some of his attention to OSR significance. So I've tried to recognize that as we go along also.

But my burden is that I feel that after three years, roughly three years, there's been millions of dollars -- I think I was at a presentation yesterday where there was roughly eight to ten million dollars spent on procedures. And, quite frankly, I can't see it. I can't feel it. I don't hear it from my site safety reps that we're there. I do not hear that we have good procedures, that we have confidence in them, that we know where we are, that we know we have fifty three percent of the safety-related procedures in place today.

I guess all I'm really saying is I want you to use this meeting and the follow-up time between now and the end of the month that you have to educate me if I'm the one that doesn't -- if

there's a lot out there that I don't know. I need to be educated. But it goes back to that one word. I need the confidence that these programs are in shape.

Tnese are basically the points that we're concerned about, the development of the new procedures, the implementation of the new procedures, control, maintenance, adherence.

Corrective actions. Repeat violations are unacceptable. They're unacceptable in nature and the number and levels of repeat violations are unacceptable.

Corrective actions, you know -- and, again, I'm going here from feelings. I don't have -- that's what this is. This is not an enforcement conference. But I think our documentation and your own seems to support this. You know, it's -- to go to a regulated controlled configuration management system is hard. And I think it is, you know, a difficult thing to change, but we're almost three years into it. So change, we feel, is required. It's hard. We understand that. But at the same time, we've been I think as patient as humanly possible.

As I've always said, the maintenance of the

authorization basis, knowing where you are, knowing and having effective controls and programs as you -- you know, the JCOs are, in their simplest form, an extension of the authorization basis putting controls on you and your imposing controls on yourself. I'm not talking about the technical issues with regard to JCOs, but the -- but the management controls that you impose on those.

Management should know where all these controls are, know where all the compensatory actions are. And I would think, as effective managers, you wouldn't want temporary conditions and compensatory actions. You'd want those to a minimum.

Overall, I guess what we're saying -- I guess what we've said in our letter and what I'm trying to express is that we don't feel management controls today are providing you with the tools you need to effectively manage this. I feel that the management in this room is committed to safe operation. I feel the management in this room wants these plants to operate safely and effectively. I feel the management in this room knows that the two have to go hand in hand. And

that's why I have confidence in that. It's the controls and it's the flow of your expectations to all levels of management and employees that we feel needs to be there. It's an issue of our confidence to do that.

So I guess here in a moment I'm going to turn it over to USEC to share this with us. But it's our expectations that we can talk this through enough that we do have a common understanding of management controls and we can hear enough of your intended plan of action. We need to see some near-term measurable schedules and accomplishments. I think that would go a long way towards giving us the confidence we need. And the third one or the final bullet is you have to -- everyone has to know who's accountable. It has to be somebody's task to make it effective.

Okay. Now I'd like to -- I'm going to request that we allow USEC to do their presentation. If there's questions of clarification, I would like our folks to feel comfortable in asking those. I would not like -- I would like this presentation -- for them to be able to go through it and then let's -- for issues that we do not feel accomplish what we in the DOE

need to hear, we're going to caucus after their presentation.

So I would like -- questions other than clarification questions are to be basically held to the end. I do want it to be a -- I do want us to understand it. And I didn't want to say that to say don't ask the questions, but I also want it to be -- us to maintain control of the meeting and allow this to process through.

Okay. Before I go on, I'm going to ask Joe Parks and Liz Teneyck if they have anything to add. And then I would like us to go -- I'm not sure everyone knows everyone in the room, so I would like us to go quickly around the room and identify yourself. So, Joe, do you --

MR. PARKS: Well, I -- I'm a person that has two missions, one is to support certification and then the privatization as an aim of the administration. I fully support that and will encourage all of our people to support that activity with all haste.

I have reviewed some of Jackson's reports and feel that -- I encouraged him to have this action and I feel that the second part is just as important as the certification. And that is the

providing a safe environment for these facilities while it's still under the Department's watch. So I do support both of those missions.

I do think, George, that -- seeing your staff here -- that the attention you're bringing to this is very encouraging to. And I think with that and our dialogue today and the follow-up actions -- I think we can address the concerns that the Department has at this time. Thanks for coming everybody.

MR. JACKSON: Liz, do you have anything to add?

MS. TENEYCK: Well, I just might say that we're really here as observers today. I think our comments have been included in the NRC observation reports, and we just feel that it's important for us to have a good understanding of the issues to aid in the transition of regulatory oversight.

MR. JACKSON: Thank you very much.

Okay. Do you want to go around the room and identify yourselves?

(Whereupon the audience introduced themselves.)

MR. JACKSON: Once again, thank all of you for being here.

MR. RIFAKES: We have a formal

presentation. But before we give it, I'd like to make a couple comments or remarks. I sincerely apologize if we haven't instilled the confidence in you that's necessary. And I think that's probably a failure to communicate on our part, and hopefully we'll start that process today.

I think we've come a long way in the area of safety and regulatory compliance at these plants. That doesn't mean that we don't have a long way to go, because we clearly do. You said that you're not convinced that there are no problems. Well, we're not here to convince you that there are no problems, because there are a lot of problems.

What we'd like to do today is at least get started on the road of convincing you that we're aware of those problems and that we are putting measures into effect that will address them. It would be naive to believe that we will ever be perfect, because nothing is. Our goal is to constantly improve rather than a goal of perfection. If we set that, we'll probably miss the target and people will get discouraged.

I think we've put a lot of things in place, and you'll hear about many of them this morning,

that are going to move us in that direction. It's no secret that the plants have been in a state of flux. We've had a lot of priorities, some of which may appear to be competing. We have three priorities that we've tried to keep on a par and tried to address on the par, probably not perfectly all the time. But this is what we've tried to do.

Those priorities have been safe operations, meet customer requirements, and get certified so that we can come under NRC. I'd be kidding you if I told you that achieving those has not stressed a lot of people, because it clearly has. Because the same people who are charged with one of those issues are charged with the other two. And we, like everybody else, are quite eager to get the certification behind us so we can go on to the day-to-day operations and concentrate more on the other two priorities that we've had the allotted time to do.

I say we've made a lot of progress. As you probably know, we have an outside group that oversees operations at the plants and criticizes us and advises us and rates us. They've been in business for about a year now, and at a recent

meeting they were asked, well, how are we doing; what have you seen in the past year. And they set up a series of criteria which are kind of like the INPO criteria, the criteria that INPO uses when they rate power plants, and they go to many of the issues that you're concerned with.

Their ratings were fairly frank. They said, you know, when we came in here and we looked at these things with these plants in light of these criteria, we gave you a rating of two. Today we give you a rating of five on a scale of one to ten. You don't even begin to get good until you get to an eight. And don't get sanguine about the fact that you've moved from a two to a five. It's the progress a person makes from when he's born till he learns to walk. You've got a long way to go before you're mature, and it's going to take a lot of attention and a lot of work. And we're fully aware of that.

I think the presentations that you hear this morning are designed to put the progress in some perspective. That is, where do we think we started? Where are we? Where do we need to go? And what are some of the things we're doing to get us there? And on that, I'll just turn it over to

Jim.

MR. MILLER: For those of you that I haven't met, I'm Jim Miller. I'm vice president of production with USEC. So obviously this meeting is extremely concerning to me, important to me. I'm greatly concerned that there's a -- I think a lack of confidence in our regulator. But I'd like to just cover some things briefly and try to convey to you my tone, how I look at this task ahead of us. I'd like to cover some things very briefly because we have a tremendous amount of information that the two general managers will cover today that I think will shed a lot of light on areas that we have failed to communicate.

Now, just a couple issues on some of your comments, Dale, that I think were on target. George stated it. I'll say it another way. I don't think there will ever be a meeting that I'll attend that I'll be able to stand up and say that we have no problems. I just don't see that in the equation. There will always be issues to deal with. It's continuous improvement and no different in this business than any other business.

Given that, I think we've failed to

communicate and convey, one, the progress that we have made. And I think today we'll make a strong attempt to do that but not let that be the keynote agenda here. Obviously not.

Additionally, we've failed to communicate clearly where we feel we have problems and I think, as a follow-up to that, what are we doing about those problems. So I think that's going to be a big part of the message that we deliver today.

So part of our purpose today -- I should say a big part of our purpose -- is to, as Dale said, educate, but, as well, make sure that you understand that we understand where our weaknesses are. The areas we're doing well in we don't have to worry about too much. But the areas we're doing poorly in, those are the ones we've really got to focus. So with that, let me just very quickly look at a couple issues.

Management controls. It's a big issue and I think we're going to speak to that throughout the two general managers' discussions today.

Progress during the past two years. There has been progress made during the past two years. But as well and most importantly, there are areas

that we are not making the progress we would like to and, in fact, should.

Path to the future. That's where I have to be satisfied, comfortable, as well as Dale and Joe, that we have recognized the weaknesses and we've formulated a path to take us to the future that will improve these areas of weakness.

I just throw this up because my message there is I understand you loud and clear. I don't think that when we talk about management controls -- when I think of management controls, I immediately think of process because, in any situation, what's most important I feel to achieve regulatory compliance is that USEC, in concert with our LMUS operators in the field, have process and follow that process. If the processes are correct and sensible and appropriate and we adhere to them, we're ninety percent of the way there. So that's the issue. Do we have process and what areas do we not have adequate process?

We're going to talk today about what controls are there. Are they adequate? Are they in depth enough? Where are we on the life cycle of those process development issues? What are our weaknesses? We have weaknesses. No question

about it. We're aware of those weaknesses, and we're doing everything we can to deal with those. Are we satisfied with the rate? No. We'll never be satisfied with the rate of progress. Have there been improvements? From my perspective, absolutely yes. And I think when you see some of the discussion from the GMs you'll see that there has been progress. But be aware. We've tried to de-focus our discussions on showing progress and concentrate on where we are weak.

What additional controls have been implemented? There are a number -- and I won't go into them -- but there are a number of new areas that we have gone back, reassessed, and attempted to reorganize, redefine, and in some cases, eliminate and totally relook at. And I don't want to get into them because there are three or four key ones that play I think to a lot of Dale's chief concerns.

Very briefly. Progress. I've thrown up about four areas that I submit to you we have made progress in. I'm not going to say much more about it. Problem reporting, formality of operations, self-assessments and organization and accountability. I can turn the other edge of that

sword on all four of those and point out weaknesses that we have not climbed the wall over yet.

Problem reporting is the front end of a good, solid, corrective action process. The back end of our corrective action process is clearly not where we want it to be. So Dale and Steve will speak to that in detail today.

Formality of operations. I've been in operations for many years, and I've seen a distinct change in the six months that I've been here at USEC in the formality of operations. But I am not at all satisfied where we are today. We've got a long way to go and recognize it.

Self-assessments. I think Dale's spoken to over the past few weeks and months in his assessment of our ability to look at our own actions.

And, very importantly, organization. We have made a major, major organizational change in these facilities for the positive. It's one of the best things we could have ever done.

And I just mention accountability. Accountability, we will speak to both the positive reenforcement concerning accountability and we

will also show you the negative aspect -- or, the negative reenforcement that we provide in the accountability area. Now, there has been progress. But, as well, there are a lot of areas that we, as I said, are not there.

Additionally today I'd like to speak -- or, I should say the GMs will speak to the path to the future. Because all of this history is nice and the fact that we've made some progress is good, but we have a lot of obstacles to climb. And I think to instill confidence in someone, in anyone, we collectively have to believe that USEC has a plan for the future to get us there.

Now, I'm not going to speak in detail, but I'd just say that there are some key ingredients to having a plan. And I think the first is to capture your priorities in one arena in an organized fashion, and we call that our quality of operations plan. It's a constantly living document. And, in fact, recognizing that we haven't made the progress we wanted to make, we are in a process as we speak of stepping back, looking at that plan, and reprioritizing our focus. And the GMs will speak to the details of that.

Compliance plan. I don't need to say a word about that. Dale and Joe and the NRC understand that issue. And that's a big piece of how we go forward and improve our operation.

Nuclear safety upgrades has been a tremendous program, a tremendous program. I've been very personally involved and will continue to be in the nuclear safety upgrade program, capital/major maintenance efforts, to make every effort to ensure that we're getting the most bang for the buck and that we're completing these issues in a timely fashion. But I think the path to the future can't be successful unless we have a commitment to provide the capital and major maintenance moneys as a corporation to improve the material condition of these plants, because our real success is going to be the ability to adhere to policy and procedure and to bring the material condition of these plants to the right level.

We operate in a unique -- somewhat unique in comparison to the nuclear power plants -- a unique relationship with USEC/LMUS. And so the question immediately comes up are we jointly and collectively one organization focussed on the same goals. My answer to that is generally in the past

I think the answer has been yes, but there's many questions that we've asked ourselves. And in doing that, George and I have talked to this subject at great length along with LMUS, and we've determined over the past few months that we need to refine this further.

So we are in the process as we speak in revising and refocusing the USEC/LMUS contractual relationships specifically in the arena of how do we incentivise an individual to reach the goals that we want them to reach. So I think that's very important and that will be ongoing. Every year we will relook at what is our contractual relationship; have we incentivised; have we provided the right vehicles to get everyone to move towards a common goal.

I've said a lot. I want to keep my portion of this very short, but I wanted you to understand that I do, in fact, view this as extremely serious. It's my job. It's what I do. It's what I'm here for. And I echo George's comments that certainly our recognition of our weaknesses are there. We focus on our weaknesses more than we sit and brag and gloat over our successes at whatever level they may be. But there's certainly

a commitment from USEC and from myself to be in these facilities, to be in touch, to be on board with what's going on day to day. And with that, I'll turn it over to our regulatory affairs manager from the Portsmouth plant, Ron Gaston.

MR.RIFAKES: Ron is going to address a specific issue, Dale --

MR. JACKSON: Okay.

MR. RIFAKES: -- that has to do with the authorization basis.

MR. MILLER: Yes. Ron will speak to the authorization basis.

MR. GASTON: Once again, I'm Ron Gaston, the regulatory affairs manager at Portsmouth. I'm going to talk to you about the maintenance of the authorization basis, mainly focusing on two areas, one being compliance with the authorization basis and the other one maintenance of the authorization basis.

The first thing I was going to talk about is the emphasis on verbatim compliance. Over the last eighteen months, which is approximately the same time I've been at the plant, I believe we've made a step change in our enforcement on the verbatim compliance with the OSR. And that's

evidenced by the number of OSR violations that we've reported since I started keeping the performance indicators.

As you can see, in 1994 at Portsmouth we had two and in '95 we had thirty three OSR violations that we reported. I believe the violations were there. We were probably just not emphasizing the strict verbatim compliance with them. And as you can see from the numbers, to date this year through the end of March those numbers have come down. I believe we've made a lot of improvement in that area. A lot of the problems that we've identified with the OSR as we've come to you and requested OSR changes. We have a similar experience in the FSAR compliance as well, as evidenced by the JCOs and enforcement disbursing that we've had to come to you with over the past eighteen months as well.

One of the things that's really contributed to that is the OSRs themselves as far as, at Portsmouth at least, the format of the OSRs. There was a tiger team evaluation in '91 and then a corporate audit in '92 that essentially identified the fact that the OSRs needed to be revised in order to improve the compliance with

the OSRs. Some of those revisions were prepared and submitted. Some of them were approved at Portsmouth, but due to the closeness in time to the OSR to TSR transition, we chose not to implement some of the improved OSRs. So some of those will simply be resolved through the transition to the TSRs. But, overall, I believe that the compliance in the area of OSR -- both OSR and FSAR compliance has improved over the last few years.

I'm going to talk a little bit about FSAR maintenance, sort of starting with a little bit of history. I guess at the time of the ROA development, the status of the FSAR revision or the current revision of the FSAR at the time of the ROA development was an item that was known and established. One of the unknowns, though, was the degree of conformance that the plant had or the position that the plant was in as compared to the FSAR, and that was an unknown.

One of the things we also know, and that I'm sure you know as well, is that the infrastructure that we had in place for maintaining the FSAR at that time and still is deficient in a lot of areas as far as the

procedures and processes for maintaining that current.

There are some other causal factors that are also responsible for the FSAR not being up-to-date. And after reviewing the information notice 96-17, which for those of you that are not familiar with it, it was the information notice that was written on Millstone for the FSAR not being up-to-date and in compliance with the FSAR. And a lot of those causal factors involve laxity with the rigor for keeping the FSAR up-to-date. And some of those causal factors we share as well.

The other thing I want to talk about there is our review process for the NRC application where it created a special case where we identified a large number of discrepancies between the FSAR and what we submitted in the SAR. A lot of those were to update the SAR to the way the plant currently was reflected as compared to the FSAR. I believe at Portsmouth our last revision on the FSAR was in 1990. So there were a lot of differences and things that were not incorporated, changes that occurred over time that were not incorporated into the FSAR at that time.

Both plants wrote a problem report which

essentially identified the fact that there were differences that needed to be dispositioned and resolved. The formal process requires for the as-found conditions that we, one, do a screening to determine if there is a potential USQ and the other is to do an evaluation for each of those conditions.

At Portsmouth the lack of priority that was put on performing that part of it prompted DOE to issue us an order for action and complete that action in a reasonable schedule. We had informally done some screening on the problem report when we identified it, not documented those evalutions, and didn't put the right priority on getting the formal evalutions completed.

Since the issuance of that order, I can assure you that proper attention has been given to that. The safety analysis manager is reassigned, given temporary duty for and responsibility for ensuring that evalutions are completed on schedule. And those evalutions currently are on schedule for that.

I think by now you've received our response to that order in which we identified twenty potential USQs of the six hundred and sixteen

identified discrepancies that we had there. We're also performing a review. At this time we're finalizing that review to determine which of those actually constituted as-found conditions. In some cases, there was some level of detail that was changed from the FSAR to the SAR. We're going back and verifying whether or not those actually constituted as-found conditions.

In some case, surveillance requirements and the like that were in the FSAR were not carried over to the SAR. So we're going through and verifying which ones of those were actually as-found conditions currently. And all of the identified items from that prior report were going to be evaluated per the plant procedure, H-45. And we have reviewed that procedure, and there are sufficient controls in there for dealing with as-found conditions.

One of the things we did note is that the procedure in the process itself is essentially geared for the as-found conditions as you discover them. The review and the transfer to the SAR created sort of a special condition whereby comparing the two documents we identified a large number at one time. So it kind of choked the

process a little bit.

In the area of maintaining the authorization basis, the -- in the application, one of the things we did is formalize the responsibility and assignment for making changes to the TSRs and the SAR which is similar to the FSAR and OSRs currently. And that assigns basically myself and Bill Sykes with that responsibility.

We're also assigned the responsibility for ensuring that all the commitments that are contained in both of those documents are accurately flowed down into procedures and validated. And there are some other infrastructure items as far as control of design changes and how those are factored back into the FSAR that are contained in the compliance plan issue twenty three. And the procedures to ensure that all of those take place are covered by those compliance plan items at this time.

And, overall, I believe with these improvements and our current program that we have the necessary procedures either in place or planned through part of the compliance plan to ensure that the FSAR or the SAR is maintained

current and up-to-date in the future. That's all I had.

MR. POLSTON: Dale and I will talk about -- the main focus is the points you had in the letter. We have -- we've gone beyond that in some instances in talking about a total assessment he and I did in February and March where we came to the conclusion we had some weaknesses where performance had been improving but it leveled off. And so the stage we're in now is looking at revitalizing the progress and turning that slope of improvement back up.

So we have -- as Jim Miller and George has said, we have a mixture of things that have gone reasonably well, but we have some specific areas that we feel like that we need to raise the slope of progress and improvement. And we hope to begin to share that and convince you of that here today, Dale.

My part of this today is to focus on procedures, focus on the procedures program, and demonstrate to you some key management control steps we have taken since April of '94. And we will share both some of the perceived weaknesses and real weaknesses, as well as some of the

progress.

Back in '94 DOE's concern was primarily with the procedures. It had to do with the adherence of procedures and attention to detail. Now, we did a lot of follow-up analysis on that, and we determined there were two obvious conclusions about procedures. One was that the procedures were inadequate in a lot of cases. And then in a lot of cases, we simply failed to follow the procedures.

So those two -- with those two causal problems, we have taken a lot of strong steps in the way of management expectations. I just want to focus in on this process here, not looking to convey everything on that chart, but I want to tell you conceptually what we've done.

In trying to lay down a definition of a new culture, the culture required with procedures and other management controls, we have defined at Paducah, as well as Portsmouth -- we defined management's expectations starting with the general manager and our senior management team. This is in the form of ten expectations here. We then asked every supervisor and manager at the Paducah site to sign off on this. So at this

point we have their signatures. Now, I will candidly say, because someone signs it, it doesn't necessarily mean they're going to always act on it. That gap does exist. But it does say that if someone puts their signature on the line that raises the stakes and that does raise the accountability.

So we have our culture -- expected culture from a total management expectation outlined in this form with everybody's commitment in writing. For example, on the procedure front, if you look at this one, it says that we will -- our expectation is that they will never fail to follow a procedure or policy. And if they encounter something wrong with the procedure, that the reflex is to stop the job and get it fixed. And there's no penalty to stopping the job. There's a great penalty if you fail to do that. So that's our expectation. We've seen some progress in that area.

Now, we've driven this in a number of ways. Let's talk about the Paducah and Portsmouth disciplinary action. One of the ways that we've dealt with failure to deliver on those expectations is our disciplinary profile. And you

can see that at both plants in the last year that we've had well over a hundred instances where we have administered discipline to managers and workers. And a major part of this was failure to follow procedures and failure to follow policy. So this is one of the ways that we've accomplished an improvement. Our number one root cause at Paducah a year ago was lack of enforcement. We have dealt very forthrightly. We have dealt very aggressively with that. And I think I can show you some positive results of that effort.

Some of the key steps we've taken that I believe you're familiar with -- some of you are more familiar with it than others, but just let me touch on those briefly. At both plants we do what's called crew briefings. Crew briefings are a defined presentation that's directed at some particular issue or a set of problems and it's delivered by the senior managers going out into the area and meeting with the first-line managers, the first-line supervisors and their crews. So it's a small group exchange. And in that we get feedback from the workers as to what they're seeing and what the problems are that they're having in complying. So crew briefings are held

by procedure at Paducah now. We've found those -- we've institutionalized those now. We've found those to be very effective. We do those quarterly and do topics that are selected and ultimately approved by me.

The drill program we took from Portsmouth. Portsmouth started the drill program in 1993 -- '92/'93 and we got on to it a little late. We started in December of '94. The drill program is primarily going out into the areas with a design drill that checks our workers on some phaze of a procedure or policy. So today we have that across all the operating divisions, cascade, chemical, power and utilities, and we do on the average of one a week. So we get a couple hundred of these a year.

From my standpoint, one of the ways -- one of many ways that I communicate from a management action/management control standpoint is what I call cultural observations. Now, this is taking fresh data out of our problem reporting -- the six thousand annual problem reports -- taking current data, looking at patterns and seeing what kind of issues and trends may exist there that we need to talk to the work force about. So we write these

up. We cite real data. We cite four or five problem reports that support what I'm saying. And then we lay down my expectations in terms of improvement and turning that around.

You're familiar with the sweep teams back in -- after the enforcement conference, we implemented sweep teams to try to define what's wrong with our procedures. We had teams go out, walk down procedures to see if they're defective, to see if workers were using them, what have you, to see the problems. Once we profiled that, after a while we understood the kind of errors that were being made and the kind of flaws that were there. We discontinued the sweep teams in favor later of our problem reporting system. So one of our principal data gatherers now is that problem reporting system and our walking around and observing.

Some of the training that we've done specific to procedures is shown here. This term LES is leadership enhancement series. It's directed at our first-line managers primarily and our department heads. We have trained almost a hundred and fifty managers and supervisors specifically in the care and feeding and the use

of procedures and our expectations. And so their job then is to carry that message to the last level, which is their crews in the field.

As their operators come through the training school for the two-week annual refresher, we get -- so far we've done specifically two hundred and ten of those people in training that has to do with the absolute requirement of following procedures or stopping the job and getting the procedure fixed. We do fact sheets. These come out of the procedures organization at both plants. And they help carry the message out of the requirement and the necessity of following and correcting our procedures as we go.

The new blood that was referred to in the organization -- and this is the Paducah story. Dale has a similar story at Portsmouth -- primarily this came about in the reorganization. And I agree with Jim's comment. I think we have found that -- already found that focus that we've gotten out of that reorganization to be very positive. But, as you can see, many of these commercial nuclear people that have recent experience in the nuclear power plants we have hired and put in your top management positions.

Most of these were done this year and most of them are already on the job. We have one exception to that. This gentleman here will come to Paducah June the 1st. He's from Grand Gulf, and he has a background in conduct of operations and maintenance in that facility.

So we've gotten a good bit of leadership already from these people in our plant. We continue to use the coaches for the mid level to help us with the mid-level managers and the first-line managers. So our coaches -- we had a staff of eight coaches, and those people have been instrumental in helping us get out to the rest of the management team.

I'd like to switch gears and talk about probably the biggest effort -- single effort in our procedures world. And that is the nuclear safety upgrade that we're doing on upgrading procedures. And I know, Dale, this addresses one of your questions about where are you and all that. We'll have to do a better job starting right now of communicating on an ongoing basis with you and the site reps as to where we are in these programs.

At Paducah, back in November of '94, we

started the procedures upgrade program, the nuclear safety upgrade. So we've been at it about eighteen months now. We've identified almost fifteen hundred procedures that primarily are upgrade of old procedures, but in some cases they are new procedures that are being developed. But the great majority of them is upgrade of old procedure.

And so where are we today? Today at Paducah we have finished -- what I call finished -- seven hundred and thirty five of these. And these are in the field and they're being used. These have been implemented. So these are new procedures -- of this number here, these are new procedures that are in the field and they're working for us now. And I'll talk more about how the quality of those procedures is coming along. We've got some information, data that will show you something about the quality of those procedures. This is some other information about procedures, but principally I wanted to show you the total, wanted to show you that we have about half of those already out there trucking for us now. At Portsmouth --

MR. JACKSON: Do you -- let me just ask

you. Do you have a feel for -- you're showing you're halfway there. Is that the easy half or the hard half or do you think it's pretty representative of half?

MR. POLSTON: Well, it's -- my view is that it tends to be the hard half done. And, I mean, the experience -- I mean, certainly we're learning. For example, a year ago, four months into it I looked at the quality of the procedure upgrade program. After four months I stopped the program. Dale, in turn, stopped it at Portsmouth. And we called a halt. We retrained. We were not getting human factor considerations in, et cetera.

So I'm not saying that we have an easy path from here on. I'm sure there's some bumps in the road, but I feel like it's somewhat linear from here on.

MR. RIFAKES: Some of the requirements have been changing too as we've gone through the certification program. So procedures were written and redrafted to meet changing requirements. And that's why we're not quite as far along as we'd like. That's one of the reasons. It's not the only one. It's just a massive effort.

MR. JACKSON: Go ahead, Steve. I'm sorry.

MR. POLSTON: Now, the Portsmouth story is similar. They got kind of a late start, as you see here in November of 1996, a misprint. But they're really sprinting. They've done well since then. I apologize to Dale for that misprint. I discovered it last night on my viewgraph and didn't have an opportunity to change it.

MR. JACKSON: He didn't mess his up though.

MR. POLSTON: Thank you, Dale. Dale Allen's already pointed that out to me this morning.

But Dale has a similar number, almost sixteen hundred identified. And as of April of '96, the current status is that they have implemented seven hundred and thirty three of these procedures. And you can see some other efforts that are going there.

Now, I'd like to talk about how that's doing. I mean, the real question is not how many you've done, but how good are they. We walked down a lot of these new procedures. I mean, that's one of my areas of emphasis as general manager and one of Dale's. I've been personally active in walking down procedures. I may not be the best at it in the plant, but I raise the most

hell about it when I find something I don't like.

I mentioned we stopped the job. We stopped it almost a year ago and held it until we got it right. We're really anxious that the quality of these procedures be outstanding. What we know at this point is what I've shown here. Out of twenty six procedures we walked down in April, my assignment to our senior managers was go out and tell me -- come back and tell me -- walk these procedures down. At the end of April I want you to tell me whether or not you've got the quality that we feel is necessary. Don't come back six months or a year from now and say, well, bad procedures, terrible procedure writers and et cetera. Tell me now.

So basically all of our senior managers went out and walked down. They had some criteria to go by. They had a folder. They walked down procedures. And the message we came back with is that we found one that we would consider unacceptable out of the twenty six. And we're not happy with that. And that leads me to -- you know, that always leads you to the next level. The next level is -- this one failure had to do with flow down. It had to do with a lack of

proper flow down. So our next concern is how do we know our process for flow down of all the things that are -- that we want in our procedures is working at a high-performance level and working the way we want it to.

So our next stop with our line managers is to go back and calibrate all that flow down and see that what we want in there is all there, criticality, safety, TSR, OSR, everything. But right now, at both plants, we would say that the technical quality of the new procedures seems to be reasonably good on the whole.

What does that mean at the bottom line? The bottom line, the Paducah data -- Dale will have a comment I think on Portsmouth. But what we saw -- this chart here shows errors due to failure to follow. Somebody didn't follow the procedure. For some reason, they didn't follow the procedure. So what we saw is -- as we brought the problem reporting system up and we began to get the real picture, we saw an expected increase in the number of these instances where we had procedure errors due to failure to follow. And they got up around -- you know, real unnerving for us. For us it got up around sixty or seventy. Since that time,

we've seen some improvement.

Now, I'm going to tell you in a minute we're very dissatisfied with this flattening out and that it's still not acceptable. It's still unacceptable to us. But what we've done -- this improvement that we have seen has come about for several reasons. One is we've driven enforcement. And I think probably that's the biggest single component. The number one root cause at Paducah a year and a half ago was failure to enforce. They knew what to do, but they didn't do it for some reason. So we're seeing that improvement.

Secondly, I would say work packages has been an instrument in improving this area. Work packages are coming along. Both plants are not what we want to be. The quality's still in question on the work packages. We're doing a lot of work packages. That's positive. Now we've got to work on the quality, because we're finding that some of the work packages are incomplete.

The third factor there I believe has to do with pre-job briefings. We have stressed pre-job briefings to the hilt. And we have driven that point home, that before you start a job, you're a supervisor and you talk to the crew head-on about

what's in that work package and what they need to be doing when they're going out doing a job. Don't just send them out, you know, with skill of the craft or seat of the pants.

In this area here, this flattening out, we're still high. I think it's primarily due to now -- it's not -- it's not somebody knowing they should follow the procedure and not. There's a combination of human factors. There are some root causes we don't fully understand yet. We're working this problem. We don't have the total answer. But the yardage gets harder as you come down. I'm just here to tell you we're not satisfied. We've got more work to do on that one.

Now, this next one is -- before I put it up, I've got to tell you that it's not a declaration of victory in any form. It's a recognition that some of the more onerous things that have happened to us -- and, frankly, have been terribly embarrassing to me as general manager, gotten in the newspaper type of things, cold feeding, leaks in the feed facilities, corroded pipe, the whole litany of things -- is we've seemed to have -- to begin to turn a corner on that. And that's what I want to show you.

This is sort of a macro look at things I call big events with a name, things that are serious, that are a potential -- are or will be a potential safety problem. And they embarrass us. We've had -- we've collected about two a year down through time of these, and I think you're probably as painfully aware of that as we are. For example, in '93 and '94, we had the 37 building -- we lost the entire building because we had a leaking roof in a pump house and we didn't attend to our business. We allowed a leak to persist and it finally bit us. These things all self-reveal.

The 37 building shutdown I mentioned. The thrown line shaft -- a thrown line shaft on the 37 4.3 compressor, a case where we didn't torque the bolts properly bit us. It became an expensive, unsafe problem and it was a big embarrassment for us. The UF6 leak, I mentioned the corroded pipe. We lifted a cylinder without disconnecting the pigtail, and that's not the way we want it to be done there. And that one made the national scene, that news. And then the cold feeding.

But in the last eighteen months I think we have seen -- because of the improvement in the procedures, because of the management

expectations, management control, I think we have begun to turn the corner on some of these things that were just, you know, basically scandalous events that self-revealed and things we didn't catch. I'm not saying -- we still have serious problems. We're a ways away from perfection yet, but we're driving in that direction. And that's our intent. But I think this represents some progress. I hope I didn't belabor that too much, but I wanted to put it in perspective.

Now, Dale and I will come back to this chart, and I'm just going to flash it up to let you know we'll jointly come back after he finishes and we'll talk about what we believe are the highest priority weaknesses that we have remaining. I'd like to introduce him in this fashion. Dale's going to talk about the corrective action process this morning. And I've got a little bit of a Paducah version. It also is an introductory statement to Dale.

This is the way we view the corrective action dilemma that we have at Paducah. It's one of mixed -- it's a mixed story. Some cases we have progress that is promising and other cases we've got significant weaknesses.

In terms of the senior management, overall commitment I think is good. I think that commitment is good. I think we need to drive that out into the mid level and front line more than what it is now. The discovery part of corrective action is coming along in both plants. I think we've had in the neighborhood of six thousand problem reports last year and we're on that pace again this year. So I think that part of it is promising.

We're coming along. We're certainly not where we want to be, but we're coming along on are these things closed; are you staying on schedule with them. It's one thing -- I mean, initially we had this huge backlog -- and it's sort of like Ron Gaston was saying in his area -- huge backlog and all of the sudden you're looking at the big mountain and you're way behind on closure.

We're beginning to make some significant improvements there, and we've come from about sixty percent on schedule with those problem reports and their disposition to a little better than ninety percent. And then the problem -- it gets a little more unhappy from there on. I think our root cause determinations in a gross sense

about a year ago were valuable initially. For example, we identified the lack of enforcement. We picked the easy fruit there. But now we've hit a stage where that needs refining. It certainly needs refining. And Dale will talk more about that and what our plans are to improve that. But that's a mixed story, and we're not in a strong position with our root cause.

Corrective action is -- I mean, I can't say any more than I feel that we're ineffective and immature at this point. In the actual selection of a fix for the problem and targeting those action steps to fix it once, we consider it a long way to go. We've got work to do there as well as the verification.

With that, I'd like to introduce Dale Allen.

MR. CRUM: Steve, June 3rd, what is that? Is that a workshop?

MR. ALLEN: I'm going to be talking about that.

MR. POLSTON: It is. It's a two-day workshop.

MR. JACKSON: I know several of you all are -- we're pretty packed in here. I don't really

want to take a recess, but would a five-minute stand-up break and a rest-room break be welcome? I see an enough head shakes. Dale, if you don't mind, let's take a very short break.

(A break was taken.)

MR. JACKSON: Dale, I apologize for the interruption.

MR. ALLEN: I want to go back to the 1994 management conference as kind of a base line, because in that conference, in addition to the procedure and attention to detail kinds of things that Steve has just talked about, there was an expressed concern with the lack of timely characterization and reporting of events.

There was a notation that we've had several events that led to personnel exposures that exceeded the plant allowable limits. There was discussion in that enforcement conference about the lack of commitment to corrective actions and unacceptable implementation of corrective actions. And I'm going to sort of move forward from that conference on a base line and address some of the things that we have done, our current activities, and then Steve and I will wrap up with a quick summary of the assessment that he alluded to

earlier of our needed focus for change.

The problem reporting piece, which is that sort of second step in the corrective action piece, has had some pretty strong management support. Two kinds of things. The general managers, Steve and I, drove the implementation of the problem reporting system starting in March of '94, and then we had a strong support from the quality assurance side of the house which eventually led to the creation of an SS&Q organization which reports directly to the executive vice president and helps us maintain the focus on the reporting -- both the identification and the reporting process.

These numbers simply indicate that up to the time we initiated the problem reporting system both sites were running with fairly small numbers of problem identifications and then, from March on, much larger identification of problems. The current rate in '96, as Steve points out, will put us both at six thousand or above problems identified, which is an indication that self-assessment activities, identification and the surfacing of those problems has improved significantly.

We're going to address this issue. We set up a criteria for screening problem reports and determining significant conditions adverse to quality. And you see a difference in the two sites. And I think that's an area that we've been working on and we'll talk a little bit more to it. We recognize that difference and that is a part of this mixed results in the development of corrective action plans as Steve alluded to.

Following the 1994 conference, we did do some specific kinds of things. Root cause determination was loosely done by half a dozen different methods or not at all. And we established the use of a comprehensive process. It's called tap root. It's a licensed process. It's licensed at both plants now. We've taught a number of people in that root cause determination method. We did improve the development of some of our actions through our proficiency with tap root. We use it for the significant conditions adverse to quality determination of course. We trained selected individuals. We used some people to help assist in the investigation of incidents and problem reports. And we saw some improvement there.

In the area of corrective actions, certainly over the last couple of months since our reorganization, we've refocussed the corrective action planning process itself. And I mentioned we used the tap root to help us look at the root cause determination. But one of the kind of sacred cows, if you will, that existed certainly in our plant to even greater extent than in Paducah, although we had similar issues there, is that we had a system that quality organization was responsible for the -- for the quality of the corrective action plan, for the development of the corrective action plan. The line management was in a support kind of role. And we've shifted now to where the line managers are responsible for the -- not only the problem report screening but the corrective action development and implementation process.

For the last couple of months at the Portsmouth facility, we've adapted from lessens learned at Paducah a process where our senior managers -- line managers meet at seven o'clock in the morning and review the problem reports and then immediately go into a corrective action review board where the responsible line managers

bring those things that have been selected in to look at the corrective action plan. However, even with those actions, with the things we've taken, we've had mixed results. And Steve and I will both talk to the efforts that we think need to be done in that area.

I mentioned already that the reorganization of both plants along traditional functional lines to increase accountability for actions was accomplished in the December '95, January time frame. We sort of finished that up in the latter part of February I guess at both plants.

And at Portsmouth, as at Paducah, we have made significant numbers of changes in personnel. We've changed out fourteen key technical senior and middle management persons with people with commercial nuclear or Navy nuclear background. And you see this in critical technical support areas, maintenance, engineering, operations and some of the support organizations. So there's been a specific move to change the way we do business, the formality of the way we do business, with the change of personnel.

In some selected areas, we've made some -- some notable progress. In other areas, we're not

satisfied with our progress and our corrective actions. If I go look at the autoclaves, the thirteen autoclaves in the three feed and transfer buildings, we've had a series of problems. And you're aware, Dale, of the things we've done to focus on the problem reports and looking at the problems there and developing changes to improve.

We've just completed this month a reliability study of the data from the period of May '95 through April of '96. And, as a result, we've looked at our autoclave material condition improvement as one of the focus areas for us. We've incorporated the strategies of pulling back, moving faster with the NSU upgrades program. We've developed specific corrective actions to fix some of the safety-related problem reports. We're working to do an even more in-depth inspection. And we've been pursuing PM standards to improve the reliability on none-safety-related kinds of things on the autoclave. And that's an area I think that we've made some amount of progress in.

As Ron mentioned earlier, if you look at the OSR violation trend at Portsmouth, this was about the period I guess I talked to you about verbatim compliance. And we started implementing

the verbatim compliance and we did hit a high level of OSR violations. And as time progressed, we came -- we tended to trend down. But this is unacceptable from my standpoint because there just simply has to be OSR compliance on the part of our operations because some of the areas that we see here are out of the human performance arena.

This is an area that I mentioned to you all earlier, the personnel error and failure to follow procedure in Portsmouth. This indicates a renewed emphasis in the January time frame on our part to try to get below the surface, to collect data and do in-depth screening using the tap root methodology of procedural errors. And I mentioned to you at the last reg affairs conference, the reason that's of concern, if you look at our problem reports, this indeed indicated an intent to drive the problem reporting even deeper. But if you look at our total scheme, you see that human performance problems represents the bulk of our problem report areas.

The bottom one is the failure to follow procedures. This is a whole series of things. And we use the -- again, using the methodology I mentioned earlier to examine that. And you dig a

little deeper into that, you see the human performance, personnel error kinds of trend codes, inattention to detail, improper work practices, inadequate communication in terms of pre-job briefs, shift turnovers and scheduling and failure to follow procedures. That's the four big contributors to the things that we find in the problem reports system. We recently had a session with middle and line managers because our analysis is that this is middle and front line manager work, the enforcement of those kinds of things.

If you dig into the failure to follow procedures a little deeper, do the root cause analysis on just the failure to follow procedures, this is the kind of picture that you see. The biggest contributor over the first three months of the year is enforcements less than adequate. The next biggest contributor is that management's not strict enough in the enforcement of the standards. The next biggest contributor is management's accountability is less than adequate. And that's -- that comes out of looking at those individual problem reports and racking them up. So it says that we've got some significant problems. The OSR violation that we had April the 26th here just a

few days ago is a stark example of that pattern. I'm going to talk about that a little bit later.

Here's just sort of a graphical summary of Portsmouth. All this says is that we continue to take about twelve thousand urine samples a year. So we're still, of course, looking at the -- at the process. This is samples requiring action. This blip here in '92 is as a result of heavy HEU suspension work and it's an anomaly. This is probably a more honest pattern -- or, a more practical tract because this is an unusual circumstance.

But in '95 you see that the number of actions -- in '94 we had twenty six urinalysis samples that required some kind of a follow-up action. There was some anomaly. You had to go look at it. In '95 there were only six. So a big drop in the performance of the program.

And in terms of people being restricted, in '94 there was only one restriction. That was an anomalous issue. The person had a one-time sample that wasn't attributable. It may have been a bad sample. And in '95 we've had -- and in '96 so far -- we've had no restrictions. So we think at both plants we've been successful in that particular

area.

Of course, you're aware that both plants continue to focus on the personnel injury business. The lost workday cases in '95 for Paducah were 1.1. At Portsmouth they were 1.6. The recordable illness and injury rate at Paducah was 4.5. At Portsmouth it was 3.5. Both plants continued to show a trend and that's the trend in recordable illnesses and injuries at -- this particular one is Portsmouth. The Paducah chart looks the same. RIIs continue to come down. Lost workday cases continue to come down. So we believe we're continuing to maintain the emphasis on people working safe from an industrial safe standpoint.

The big issue really comes out of this chart that Steve talked about in the corrective action process. At Portsmouth we're a little behind Paducah in problem/issue tracking. And we're a little behind them in the root cause determination and I think a little bit behind in the enforcement arena. We're in total agreement that from here on up in the corrective action process, the back end of the process if you will, that we need a lot of work.

We have developed an action plan of what to do. I mentioned that we have our senior managers reviewing the corrective actions themselves and are responsible for the implementation and the verification of completion with checks by external folks. But we believe that there's a deeper sort of learning and effort that's got to be done. We have worked out between Paducah and Portsmouth a process. On June the 3rd we're going to have a two-day workshop run by professionals with Steve and some of his line managers and me and some of my line managers together to look at root cause determination to see if we can't strengthen how we decide what it is we're going to do, also to work on our philosophies and sorting of the significant conditions adverse to quality so that we can have focus on the right kinds of things.

We've committed in an action plan that's in our business planning system and in our QOP to review the organization, to review the corrective action -- to change the corrective action procedures, to do an additional round of tap root training with selected line folks, to do a corrective action audit and an operational evaluation program audit -- the lessens learned

program -- in October of this year and, in fact, to relook at the entire corrective action process to continue to break down what probably is endemic in our culteral organization to continue to improve that. By working through the process that I just stated, I think it will not only give us a joint commonality of philosophy and process, but it will take advantage of the lessens that have been learned between the two plants and allow us to move a little faster.

As you said, change is hard, and there are some additional kinds of things that have to happen. Steve mentioned some of the things that are already in progress, but we think there are some additional focus areas. Specifically -- I'll use an example -- at Portsmouth adherence to policy and procedures is paramount. It's a cycle of you have to get the procedures right and you have to enforce the use of those procedures and you have to enforce people attending to the rules.

The recent OSR violation at Portsmouth led to severe disciplinary action for a middle manager, a front line manager, a systems engineer, and an operator. In fact, we took that particular issue and we called our middle managers together

and went through the particular event. And our middle managers, specifically those targeted at those nuclear areas, were asked basically to commit to enforcement, adherence of TSR and OSR requirements, and to enforce the expectation to adherence to procedures and requirements and their responsibility for immediate notification and that they would convey those expectations to the front line managers who work for them. But the conveyance here was for them to say back to me that I do understand that people make honest mistakes, including myself and my subordinants, and that the goal is identification and reporting and fixing, not disciplinary action. The goal is to ensure that you're increasing the margin of nuclear safety. These milled managers were asked to commit or to resign. And the folks that are in the nuclear business in that area have all committed.

MR. JACKSON: Dale, why did you specifically focus on the middle managers and below and not include everybody?

MR. ALLEN: We had -- we have done a similar kind of thing in the upper management ranks already. And if you go back and look at

this issue of enforcement, strictness and accountability, we were looking at the particular people that are able to effect that adherence to that policy.

We also ran this in our Open Line -- this story in our Open Line on Tuesday of this week, a front-page article, to try to bring to the attention of the people the real details of the incident. This article talks about the fact that an operator failed to make OSR required log entries. He made the -- logged missed entries at the next reading time in the presence of a front-line manager and a systems engineer without noting the entries as late. Neither the senior management nor the PSS office was notified as required by the problem reporting procedure. It explains why the middle manager was removed from management, why the front-line manager resigned on the -- he resigned on the spot as we began to talk about the issue. The systems engineer received a written reminder for failure to follow the requirements of the problem reporting procedure. The bargaining unit operator received unpaid crisis suspension and decision making leave for failure to make required log entries and for his

failure to voluntarily disclose that he had not made the required log entries.

Now, two good things came out of this. The good thing was that the system engineer volunteered to teach the problem reporting system and this incident to the systems engineering and technical people by the end of this month and is in the process of doing that. The other thing that came out of this that could not have come out of it two or three months ago is that -- of course, we have a labor contract at Portsmouth now as I think everybody's aware. And when this particular issue was levied, we had to look at the operator in question and his experience. He's a person who has filed problem reports in the past, which we appreciate and recognize, and that was kind of a mitigating circumstances.

The other mitigating circumstance is that the union official and this operator are out in the plant on shift telling this story and teaching a prescribed set of log keeping things to the people that have to keep the logs. The union officials I believe started yesterday. And this gentleman that received this disciplinary action starts tonight. And that was an agreed upon this

is what we will teach in terms of log keeping. And that has more impact on the peers on the floor than probably anything else. But it certainly is a step that's required.

The next step that's required has two things to do with. One is the quality of procedure and where we are in the procedures program. And the second is adherence to procedure. And its in the OSR to TSR transition phase. Once you come out of the TSR transition, once you implement the procedures that are required for the implementation of the TSRs, now you truly are through the hard part I guess you would say of the procedures within the safety umbrella. The next piece is you want to make sure that you adhere to those procedures through that process because you are trying to make sure that you are bringing a capstone to any kind of culteral change you're trying to do.

This is the OSR to TSR transition at Portsmouth. That's similar at Paducah. Just the names are different. Our plan is to change in three -- in three phrases and seven-oh-five, three-forty complex cascade withdrawal and then maintenance and support. Sometimes a procedure

carries across facilities, so we broke those out separate. Sometimes they're specific to the facility and sometimes they carry across the facilities.

This is an indicator of the number of procedures that are involved. There are two hundred and ninety nine procedures in that TSR implementation on the floor that are involved. And there's the number of people that are involved, roughly five hundred people. And there's an implementation steering team for the OSR to TSR transition at both of those sites, Ron Gaston at our site and Jerome Mansfield at the Paducah site. They've been meeting and underway for several weeks. Training on some of those procedures is already under way.

There's going to be an oversight team used at the two plants there on the floor with people when they're implementing the procedures with people that are experienced with the TSR requirements to make sure that people on the floor get immediate feedback. The best performance indicator to the guy on the floor is immediate feedback so that you don't have to collect performance indicators over three or four months.

We're also committed to doing performance indicators so that we can transfer this learning to the other processes and feed back and forth between the two plants.

The change process will have to continue and will have to be nurtured in a number of areas for assurance that we continue to see improvement in management controls and that we continue to engender a thought process, a mind set if you will, all through the organization for an increase in the margin of nuclear safety.

Work control's been mentioned already. We believe that in December of '95 when we reorganized the plant along functional lines we captured work control at both sites in a major organization role so that we can not only integrate and utilize our resources correctly, but we think it helps bring -- with the proper emphasis on continuing to improve planning to getting all of the things lined up before you do the jobs. Now, we've got a lot of problems in that area. We've got a heck of a long way to go, but I think that's the right step.

We've learned some hard lessens at Portsmouth from the view of management control and

accountability. And they're lessens that I'm not particularly proud of. I'm like Steve with my incidents with a name, and they don't seem to go away. We shut the seven-oh-five facility down in November of 1994. The trigger cause was the lack -- an operator improperly using logs, in this case not doing required calculations before the thing was -- before he ran a particular operation and a supervisor letting him.

But when we went into seven-oh-five, there were a massive number of difficulties. The criticality safety procedures were inadequate. The operating procedures were inadequate. There were even hardware changes that we had to make. We had that facility down for months before we were able to get that facility operational again.

The PEH compressor -- I sometimes call it the PEH compressor incident in June of '95 where we didn't do proper prior planning and we simply accepted the way we'd always done things and then operated from an emergency standpoint. And that was a long and arduous process in terms of looking at our management control things.

This OSR violation that we've just had is another example of the need to increase rigor and

discipline. And we've done that in some of our processes. In work control we're beginning to increase the discipline. In production support when we reorganized we pulled health physics, the quality control and the laboratory support kinds of functions together so that you could bring focus to those. The technical integration and engineering of the safety disciplines that you need to get the technical design basis, make sure that you are integrating those kinds of efforts, we've improved those processes.

The plant operational review committee is the safety committee that looks at the things that are coming out of staff to make sure that we're staying within the licensing basis, that we're looking at safety things. We have a management analysis and assessment team and a corrective action review board that works for them that's looking at the corrective action system.

We recently implemented a mid managers morning meeting. At eight fifteen all the nuclear middle managers get together and look at the work control input, the problem reports, and the things that they have to do so that that is coordinated.

In the communication arena, the floor level

sessions that Steve mentioned of us communicating with people, problem reporting is the flow up. Commitment letters from people at least indicate that they are willing to accept it. But even with that rigor and discipline, we have a long, long way to go. And Steve and I, as he mentioned -- Steve, you might want to help me go through this. In February and March, we looked at -- we did an assessment of our quality of operations plan. And when we assessed the activities, we went out and looked at the as-found condition against the plan. Although we were meeting milestones, we didn't see the results in some of the areas that we felt like we needed. And do you want to address the plan?

MR. POLSTON: Yeah. One of the things that --

MR. RIFAKES: You might tell them what the symbols are.

MR. ALLEN: Oh. Red's bad. Yellow is not too good. And green means we're satisfied with it.

MR. RIFAKES: And the triangles?

MR. ALLEN: And the triangle is some indication of whether we think it's getting better or worse.

MR. POLSTON: We looked at probably the same thing in the as-found on the floor. So we replicated Portsmouth on that. But we also looked at both plants at whether we were on schedule with the quality of operations plan milestones, and generally plants were. So that said it wasn't a matter of not doing those things. It was either a matter of we picked the wrong things -- and, generally, we picked our action step -- or corrective action was not tuned precisely to the problem. And so that led us back to where we are now.

For example, here on the upgrading the corrective action program, we found that the action plans themselves is not green. The action plan that we had relative to the corrective action program was weak. We also found naturally then that our results on the floor were not there, partly because the plan itself was faulty and partly because it was lagging behind -- even lagging behind the plan. So what Dale has described as the major effort that we're undertaking now to revitalize our corrective action, a piece of that is the June 3rd and 4th get together of the two plants to work the issue.

I want to go back to reexamine our root cause. I want to reexamine the root cause process, and we already know there's some fine tuning that needs to take place in that. So that's going to be an important time for us because, obviously, you can't have a weak root cause. I mean, you can take all kinds of actions, but they're not tuned and they're not focussed. They're not on the target. So we're going to come away from that period, at the second, third, and fourth meeting with a new refined approach to corrective action. We're bringing in some outside people to help us. We've got people from both plants. Portsmouth's coming to Paducah. So that will be a very key time for us.

MR. ALLEN: We've been in the process of revamping the plans. Steve and I met in the first of March to take a look at the two plants and our different problems and that is a joint list. There's one different at Paducah, the --

MR. RIFAKES: Do you want to quickly run down what those are?

MR. ALLEN: Sure.

MR. RIFAKES: I don't think everybody can read them.

MR. ALLEN: But it's a joint list. We agreed upon this between the two plants. Improve procedure quality and compliance; implement upgraded, technically self-sufficient NCS program; prepare GDP organizations to operate effectively within NRC regulatory environment; effective self-assessment; corrective action program; evaluate and improve UF6 cylinder handling at the GDPs; improve conduct of ops and maintenance; implement upgraded technically self-sufficient safety analysis and review programs; backlogs of material condition deficiencies; improve the maintenance work control process; develop teamwork with the GDPs; and the OSR to TSR transition. That's what we viewed as our top items for success. We started with a large number of items --

MR. POLSTON: About a hundred.

MR. ALLEN: -- about a hundred and focussed down on these so that we could direct our activities on those things that we thought were critical to our success in an attempt to focus our resources and efforts on that particular piece. Our staffs have been working on these plans now since March --

MR. POLSTON: Early March, yeah.

MR. ALLEN: -- early March, February/March time frame, and the meeting that Steve mentioned is where we're coming together to take a look at those to give them a sanity check to see if we believe we have created a better action plan in view of the assessments that we have made.

MR. PARKS: Dale, you might as well mention the scheduling and execution of floor level communications that will be kicked off in the coming weeks.

MR. ALLEN: Oh, I'm sorry. Yes. We've been -- at Portsmouth and Paducah, we have been working on a presentation that will be -- at both plants will include Jim Miller and at Paducah is led by Steve, at Portsmouth myself, with a message that we're going to take to these five hundred people at Portsmouth and similar -- I think there are a slightly fewer number at Paducah -- that we are going to deliver in small group sessions, twenty to twenty five people, the importance of the process in the OSR to TSR transition and the implementation. And we've set up scheduling and that sort of thing to correspond to this transitional phase.

MR. POLSTON: A significant time there, too, for us in that we will sit with small groups, I will, and I'll talk to them about not only what -- not so much what and how we're going to do OSR to TSR but why. We've failed in the past to really make people appreciate why the OSRs are so important. We want to take this opportunity -- we think it's a great window of opportunity to get people tuned in on the relevance and why it's a pivotal point for them and the plant to be in total compliance with the TSRs as time goes on. So that will take about thirty meetings to get all those in. So it will be a lot of small group meetings and we're using it as a big opportunity.

MR. RIFAKES: I guess I'll wrap up. One question you asked was a question of who's in charge of all this stuff. I guess, if I talk to my bosses, in the final analysis it's me -- but that's not the answer you're looking for -- then move down to Jim. Reorganization was intended in great extent to start identifying people who are in charge.

The prior organization, I'm sure, had a purpose and it met its purpose and outlived its usefulness. What it did do that I found

troublesome was it tended to get us into matrices to organize and run things, because we had responsibility for functional areas disbursed across the plant. What we've tried to do is reorganize on a line basis where the line has authority and the responsibility to do things. And we're starting to identify accountable people. And you've heard a little bit about that on who is accountable.

We have not fully eliminated committees. I don't think it's a good thing to fully eliminate committees. In some areas they're appropriate. But line management functions belong to individuals. And that's where the responsibility is going to be. And if you look at the organization chart, some of the areas responsible and the people responsible for the things we've been talking about fall out relatively easily.

We started that in December. I'm not satisfied that we have fully implemented everything. We've implemented as far as we had intended. We plan to review it again and see whether we should take it even further into the organization. That's something that's on the agenda for sometime later this year.

You've heard us talk a lot about our concerns with our corrective action process. That's clearly high in our scheme of things to do. It's not only our concern. It's your concern. The PPRC, that's all they're talking about these days is the effectiveness of corrective actions. And they're giving us suggestions on what to do about it.

Along with improving the process what we're still lacking I think is a good measurement process to measure the effectiveness of corrective actions. I mean, you can go back and look and we can do it kind of on an ad hoc basis, but we really need to set up some measures to quickly tell us where we're going and give us trends so that we can early identify problems.

On the PPRCs, I trust you're all familiar with the group that we have that's principally outsiders with -- outsiders with operating and regulatory experience advising us, bringing lessens learned from other areas into the process. We are adding another former regulator to that committee in an attempt to even further emphasize some of the processes that we have to identify and add.

And we're also refocusing the committee. The committee for one year spent its time just kind of taking a general look at the plants and becoming familiar with the operations, because they are unique and not many people had the experience with what we're doing. They've done that now, and we are going to focus them on specific areas. For example, corrective action will be one of the areas. Procedure adherence will be another area. The safety cultures is something that we need to get ingrained into people. It's something we talked about that still isn't there.

A question was asked why the agreement to adhere to procedures and to follow all these rules was not signed by upper management at the plant. I've been fairly well convinced for some time that the senior level managers understand the mission and are committed to it. I've also been convinced that that word, although there's been a lot of talk about it, has not filtered down into the lower levels.

You hear talk about glass ceilings and how people can progress so far up and they see the sky but they can't get to it. I think in these plants

we have a glass floor where we talk down there and they kind of hear the noise, but nothing happens beyond the talk. So the focus, both in terms of communication, the things that Jim and the plant managers are going to do, is now getting down to that working level.

The focus on strict adherence and requiring people to adhere to the rules is being pushed down. Putting something in the plant communication that says somebody violated procedures and here are the consequences is a message that we have to get out. We have to get serious about this stuff. We have to get people to realize that we're serious. So that's why the push has gone now from upper management, which is something that we worked on and talked about for the last year or year and a half, down to the floor where the action is.

I personally think that we've made progress. And I think it's relatively significant. There's a lot to do. A lot of the commitments that you're looking for, Dale, I think are already in the compliance plan. When are we going to finish the procedures upgrade? When is the proper training going to be in place? Those

are things to do. They're ongoing things and they're yet to do. So I'm not sure quite what you're looking for in some of these areas. But our commitment is -- and I think the presence of the people here and hopefully these presentations -- is to keep improving this process.

MR. JACKSON: Thank you, George. Our plan at this time was to --

MR. PARKS: Can I ask George a question?

MR. JACKSON: Sure.

MR. PARKS: He and I have touched on this conversation from time to time. You know, the whole organization -- I guess all organizations involved that you operate have been under a lot of pressure to produce a lot of paper, produce a lot of changes, your organization to produce a product that you can competitively market. Are we beginning to see some burnout?

MR. RIFAKES: Yes. I mean, I'd be lying to you if I said no. I mean, not only on our side, but on everybody's side. This has been a very rigorous exercise. It's been compressed. And there are people that are burned out. There are some people that have asked to be relieved of some of their duties because of this burnout. And we

are -- you know, within the resources, we are trying to staff this thing. We've brought in outside help to the extent that it's useful.

I'm concerned that it isn't over. I mean, take the certification, the day we get certified, there's a whole knew series of knew work that's -- actions that we're going to have to take on. I'm concerned that we have several thousand people that are transitioning from OSRs to TSRs, from one set of objectives to a different set of objectives. I'm concerned, you know, that isn't going to happen easily. There are going to be mistakes. There are going to be people burned out. There are going to be people replaced. It's just the process that -- but it's there and we're there. We have to live with it. There's no getting away from it.

MR. PARKS: You all don't feel that that's in any way affecting the overall safety of the facilities?

MR.RIFAKES: We do not.

MR. PARKS: That always concerns me.

MR. RIFAKES: You know, burnout comes from a lot of reasons. Expectations that aren't always met is part of the burnout. I mean, there are

people that had hoped we'd be farther along on all these things we've talked about. And people have their highs and their lows. And a guy who feels burned out today gets a job completed and he's re-energized. We've seen some of that.

But as far as the plant operations are concerned, I mean, I think what they've been telling you is that we're increasing the emphasis on the safety. We're not going backwards. And, you know, I regret there's a lack of confidence on Dale's part on that because I don't think it has a basis in fact to be honest with you.

MR. PARKS: I think we're just reading our instruments.

MR. RIFAKES: Well, there are so damn many instruments out there though, Joe, you can't be reading all of them. And that's what we're trying to tell you. I mean, we have people here that are committed to run these things safely and to improve them. And it would be nice if we could have taken a snapshot of these plants over the last several years to see whether they're going up or down. I'd be willing to bet my last bottom dollar that the trend is upwards, not down and not flat.

MR. PARKS: I concur with that.

MR. RIFAKES: Well, that's -- you know, the proof of the pudding is in the eating. And it's going to take time.

MR. PARKS: Okay. Are you going to take your break now?

MR. JACKSON: Okay. What I'd like to do is we'll leave this room available for the USEC personnel. My staff -- and others feel welcome -- are going to adjourn to this next conference room for a few minutes to ask -- or, what we'll be looking for are any specific questions that we need USEC to further address or focus on and then we'll adjourn and I'll close.

(A break was taken.)

MR. JACKSON: Okay. I guess basically where we are is we feel there was a management commitment here to make some things happen. There was a management commitment to relook at your programs, your QOOP, to hold a June 3rd meeting to relook at some things, to look at your accuracy of corrective actions, et cetera. Those are positive.

I think what we see in the negative is these things are still here. These things are

still with us. The shipments of stuff off site happen and at a number that is unacceptable to us. It's -- we're -- you know, one analogy that I used in there is, yes, I can tell my daughter that D is passing, but I'm not -- it's better than an F. It's safe. It's passing. But it's not good enough, not what we expect. It's not what you want for your system. And the department, NRC, all regulators want to raise our standards as we go along too. As we understand things better and we make things safer, our threshold goes up. Someday D isn't good enough. And that's part of what we're dealing with here.

George and the rest of your organization -- one thing we did ask for here, I think you acknowledged part way through, is the difficulty in getting measurable actions. These are difficult, intangible things. Some of your charts that showed a downward trend, you know, we can -- we can reassess and analyze and reflect on them different ways in different issues. But we still need and we will look for your response at the end of the month to focus on giving us detailed descriptions of actions and schedules and things you need to undertake.

I still heard a -- in my staff and others questions in our caucus in here is the concern for your -- do you have resources to meet the things you're committing to? We seem to hear, see, slippage in schedules to corrective actions committed that we had very little to do with telling you this needs to be done by April 15th. We allowed you in your responses to say we can get this done by April 15th, and then we look at it and say that will be acceptable. So we give you generally the first option to pick your date. And when those slips continue to slip, it does look like a resource item or a lack of commitment item. You put us in the guessing or evaluation game as to, well, why are we not getting this done; why is this taking so long, especially for items that we've allowed you to make the commitment to.

We would look for -- I think you gave up your chart that showed your top ten or top twelve items, I think three of which are green now. What is your plan or goal to get them all green? I mean, you should have that. I mean, what is your -- you know, you should have some idea in your -- you know, in your mind or in your plan today. Are you expecting to have seven of them green by the

-- by September? All of them green by December? Or are you satisfied with the yellows and the reds? I don't think you are. So what we're saying here is we still want to see more in the area of management control.

I think you've -- I'm hearing the commitment. We're all hearing the commitment. And we want you to go back and continue to self-evaluate, continue to do some of these things and give us something -- I think you need the tools first. You need the measurable tools first. And then let us see, you know, your measurement tools to further instill this confidence.

And that's really I think all I want to say. I want to -- Joe, do you or Liz or George want to add to or say anything to that?

MR. RIFAKES: We'll respond to you by the 31st, Dale. You didn't say anything that surprised us here in closing.

MR. JACKSON: Okay.

MR. RIFAKES: I believe we can respond adequately.

MR. JACKSON: Okay. Listen, I do appreciate all of you coming. I appreciate those of you in the crowded conditions that you've

beared with us. It's -- I don't know, it's sort of like -- sometimes it's almost like we're in a war. It's good to come and look at what you have done, look at what you've progressed on, and take some pride in progress in these steps. But, remember, we're still all being shot at once we go back into our tasks. But I do have a lot of passion for my job, for trying to uphold what I'm supposed to be doing, and to demonstrate that we do have knowledge and we do have a confidence in your adequate safety preservations. Perhaps the wrong choice of words, but --

MR. RIFAKES: I'd like to say one thing.

MR. JACKSON: Yes, George?

MR. RIFAKES: We appreciate this process. I think this is a lot more constructive than waiting until there's real trouble and then we have to have enforcement conferences and NOVs. I would ask -- these next few months are going to be difficult for everybody. If you see a need or if you have a concern or a lack of confidence or however you want to describe it, before the trouble really gets there, I would ask that you'd call another one of these --

MR. JACKSON: Okay.

MR. RIFAKES: -- so we can hash these things out in a more constructive manner than just being responsive to a series of violations.

MR. JACKSON: I really feel trouble has every opportunity to be lurking in the next several months. It's going to be -- it's going to take every bit of your efforts to ensure the regulatory process, which I'm going to consider more important than the application, than the other parts.

As Bob Cantrell said, when we were talking about this, if the management control is the brain, management control needs to determine do I need to breathe or does my heart need to beat. If the heart is the safety protection and the lungs are the equivalent of your application, your operations, good management controls is probably going to say you need to do both. And the management control should allow the process for both of them to happen. You've got to protect the heart in safety and you've got to go on with your other missions.

It's going to be difficult and it's my job to ensure that you've -- and monitor and provide oversight that you do it correctly. So I

appreciate it. Thank you all for coming.

(Thereupon the meeting was adjourned.)

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C E R T I F I C A T E

I, Bonnie L. Smith, do hereby certify that the foregoing 88 pages is a true and accurate transcript of the proceedings taken by me on the day of May 9, 1996.

This 20th day of May, 1996.

Bonnie L. Smith

Notary Public

My Commission Expires:

October 28, 1997.

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