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NRC ISSUES REPORT ON MILLSTONE ALLEGATIONS; REQUIRES  
THIRD-PARTY OVERSIGHT OF EMPLOYEE CONCERNS

An independent Nuclear Regulatory Commission review has concluded that the work environment and failures of licensee management are primary reasons for continuing employee concerns problems in the employee concerns program at the Millstone nuclear station in Connecticut.

Concurrent with issuing the NRC team's report, the NRC has issued an order that directs Northeast Utilities (NU) to devise and implement a comprehensive plan for handling safety concerns raised by Millstone employees and for assuring an environment free from retaliation and discrimination.

The NRC also ordered NU to contract for an independent third party to oversee its corrective action plan for the employee concerns program. The independent third-party must have expertise necessary to audit reviews of employee concerns, monitor corrective actions, recognize weaknesses in approaches, audit investigations into discrimination complaints, and conduct employee surveys.

Further, the members of the independent third-party organization must not have had any direct previous involvement with activities at the Millstone Station, and the team members' technical qualifications must be approved by the NRC, along with its oversight plan.

Findings and recommendations of the third-party organization will be reported in parallel to the licensee and to the NRC.

Oversight by the third-party group will continue until the licensee demonstrates, by performance, that the conditions leading to the NRC order have been corrected.

When developed, both NU's and third-party oversight plans will be available for examination at the local Public Document Rooms for Millstone: the Three Rivers Community Technical College, Thames Valley Campus, 574 New London Turnpike, Norwich, CT; the Waterford (CT) Public Library; and at the NRC's Public

Document Room, 2120 L Street, N.W., Washington, D.C. The plans will also be discussed in one or more public meetings to allow members of the public to review and comment on the plans before implementation.

The basis for today's order is that, notwithstanding the NRC regulatory actions over the past several years, the licensee has not been effective in 1) its review and disposition of safety issues raised by its employees, and 2) ensuring that employees who bring safety concerns to its management can do so without fear of retaliation.

The NRC review found that for several years dissenting views were not tolerated or welcomed at Millstone. "This poor environment has resulted in repeated instances of discrimination and ineffective handling of employee concerns, and contributed to Millstone being placed on the NRC's Watch List," the team reported. It added: "None of the findings of this team are new. Every problem identified during this review had been previously identified to NU management. . . yet the same problems were allowed to continue."

Recent licensee internal reviews have made similar findings for which corrective action has not yet been effectively implemented.

The NRC review also criticized the NRC's own process for handling allegations at Millstone. Six main problem areas were cited: inadequate sensitivity and responsiveness, inadequate discrimination follow up, unclear enforcement, ineffective inspection techniques and performance measures, cumbersome NRC/Department of Labor interactions and ineffective implementation of an allegation program.

Recommendations to improve NRC processes are being evaluated in a separate paper and will be publicly released following Commission review.

Any person adversely affected by the order to Northeast Utilities may request a hearing within 20 days of its issuance. The request should be submitted to the Director, Office of Nuclear Reactor Regulation, Nuclear Regulatory Commission, Washington, D.C. 20555.

The text of the order has been posted on the Internet at this address: <http://www.nrc.gov/OPA/reports>.

An executive summary of the NRC review group report is attached. News media may obtain a copy of the report by contacting the NRC's Office of Public Affairs.

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Attachment:

As stated

## **EXECUTIVE SUMMARY**

Since the late 1980's Millstone Nuclear Power Station (Millstone Units 1, 2, and 3) has been the source of a high volume of employee concerns and allegations related to safety of plant operations and harassment and intimidation (H&I) of employees. NRC has conducted numerous inspections and investigations which have substantiated many of the employee concerns and allegations. The licensee has been cited for violations and escalated enforcement has been taken. Notwithstanding these NRC actions, the licensee has not been effective in handling many employee concerns or in implementing effective corrective action for problems that have been identified by concerned employees.

On December 12, 1995, the NRC Executive Director for Operations (EDO) established a review group to conduct an independent evaluation of the history of the licensee's and the staff's handling of employee concerns and allegations related to licensed activities at Millstone Station. A copy of the Millstone Independent Review Group's (MIRG's) charter is attached as Appendix 9.1. The charter directed the MIRG to critically evaluate both the licensee's and NRC staff's effectiveness in addressing Millstone-related employee concerns and allegations. The MIRG was requested to identify root causes, common patterns between cases, and lessons learned and recommend both plant-specific and programmatic corrective actions.

The MIRG determined that in general, an unhealthy work environment, which did not tolerate dissenting views, and did not welcome or promote a questioning attitude, has existed at Millstone for at least several years. This poor environment has resulted in repeated instances of discrimination and ineffective handling of employee concerns. The vast majority of employee concerns and allegations that were submitted at Millstone represented little safety significance; however, many involved potentially important procedural, tagging, or quality assurance (QA) problems, and a few were ultimately determined to have safety significance. The unhealthy work environment combined with the significance of substantiated allegations contributed to Millstone being placed on the NRC's watch list in January 1996.

Many of the cultural issues that lie at the root of the company's problems had been recognized by NU management as early as August 12, 1991. An NU Allegations Root Cause Task Group issued a report on that date which highlighted the lack of respect and trust between employees and their management, and indicated insufficient management sensitivity to routine employee

concerns. Subsequently, an Independent Third Party Evaluation contracted by NU, issued a report on May 1, 1995.

The report revealed that the old culture of the 1980's had not been completely replaced by a culture encouraging the identification of problems and a questioning attitude, and attitudes impeding effective problem identification and resolution persisted. Most recently NU's Millstone Employees Concerns Assessment Report dated January 29, 1996 reiterated many of the same problems. The report highlighted an "arrogant" management style which had further eroded Millstone employee trust and confidence and which had contributed to NU's repeated failure to correct clearly identified problems.

The MIRG identified seven principal root causes for continued employee concern problems at Millstone. Specific root causes included: ineffective problem resolution and performance measures, insensitivity to employee needs, reluctance to admit mistakes, inappropriate management style and support for concerned employees, poor communications and teamwork, lack of accountability, and ineffective NSCP implementation.

The team concluded that these root causes underscored a common theme of top management failure to provide the dynamic and visible leadership needed to bring about required, basic attitude changes. None of the findings of this team are new. Every problem identified during this review had been previously identified to NU management, often by its own self-assessments, yet the same problems continue. This single failure is viewed as being at the core of Millstone's continuing employee concerns.

The team noted an increased management awareness of the need for improvement in some of these areas, and was impressed with the level of employee commitment to making significant positive changes in the Millstone work environment, as evidenced by many of the individuals interviewed.

The MIRG also identified six principal problem areas associated with NRC processes for the past handling of allegations at Millstone. Specific process problem areas included inadequate sensitivity and responsiveness, inadequate discrimination follow-up, unclear enforcement, ineffective inspection techniques and performance measures, cumbersome NRC - Department of Labor (DOL) interface, and ineffective allegation program implementation. Each of these problems appeared to involve one or more of the following elements: an inappropriate attitude that allegations were a necessary burden which detracted from more important responsibilities, an under-reaction to discrimination claims, ineffective methods for assessing licensee environments for raising safety concerns, and insufficient

appreciation of the potential for a chilling effect at Millstone. The MIRG concluded that the process problem areas identified with the past handling of allegations at Millstone have the potential to apply agency-wide.

The team noted that many initiatives had been taken by NRC to improve the process for handling allegations. Examples included policy changes, improvements in enforcement guidance, and other initiatives by OI and the Agency Allegation Advisor.

The team's preliminary findings were discussed in a private meeting with representatives from the alleger community on the morning of August 7, 1996. Following this meeting the team's findings were discussed in a public exit meeting at the Millstone site with NU officials in the afternoon of August 7, 1996, and duplicated in an evening session held at the Hilton Inn in Mystic, Connecticut on August 8, 1996 to accommodate individuals who could not or did not attend the afternoon session. These meetings solicited comments and were transcribed to facilitate consideration of comments before completing the report.

The MIRG will send its recommendations for corrective action to the EDO by separate correspondence for both NU root causes and the potential agency-wide NRC process problems. It is the team's understanding that the staff will consider this material in evaluating the adequacy of NU recovery activities and future improvements in the NRC process.

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