From: Mel Gray
To: David Vito; Glenn Meyer
Date: 2/19/04 5:45PM
Subject: Re: Recent info submitted by RI-2003-A-0110 alleger and UCS

Dave and Glenn,

Marc and I met with the SL1 author for 1.5 hours this afternoon to understand the context of the document in question. See attached file for context and our thoughts. We can talk tomorrow. I will let you decide who to send this to outside the branch.

>>> David Vito 02/18/04 08:51AM >>>
- SENSITIVE ALLEGATION INFORMATION -
- PROTECT APPROPRIATELY -

We should discuss this issue at the Update ARB tomorrow.

Please see the attached recent information submitted by the alleger. Initially we did not have the document to which she referred (an N1 review?). The document-in-question was later provided to Eileen N. by Dave Lochbaum. It appears, although I'm not absolutely sure, that the document was authored by A. Carolyn Taylor, Salem/HC's Plant Support Root Cause and Advanced Organizational and Programmatic (O&P) analysis expert. It's also not obvious why the review was done which prompted the development of the document. The document is an assessment of several Severity Level 1 Root Cause Assessments and reaches a conclusion that there is inadequate accountability at all levels of site management, and that his had been the cause of many recent problems at the facility. While I don't know everything that has happened at the site over the past few years, it appears that many, if not all, of the SL1 RCA's referred to in the document relate to issues already known by the NRC. In fact, for one issue, the author provided a previous comment made by NRC about the issue, and for another issue, the document specifically acknowledged that the issue was identified by the NRC. I ask that those with more knowledge than me about these items, review the document, and give me a read on our awareness of issues discussed therein and what our follow-up has been. It would appear to me that much of what is referred to in this document are similar issues to those which helped form the basis for our 1/28/04 letter to the licensee.

As you can see by the alleger's note, she has formed a conclusion, based on her review of this singular document, that the NRC should reconsider shutting down all the plants at Salem/HC before someone is killed or a nuclear disaster happens. She is expecting feeback on her comments, so I need to get back to her after I get some internal feedback on the N1 document. So, as before, thanks in advance for yourprompt review and comments. Please be ready to discuss at the ARB tomorrow, so that I can formulate an appropriate e-mail in response to her comments. My hope is that we can inform her that we are aware of the issues mentioned in the N1 document and that we wil incorporate this into our ongoing follow-up.

CC: Daniel Orr; George Malone; Scott Barber

B 79

This memo describes the context of the recent SL 1 document sent from Dave Lochbaum to Eileen Neff in email dated 2/17/2004. This was provided at the request of an alleger.

This document is corrective action notification #20161225. It was authored by PSEG's Caroline Taylor on October 6, 2003. Caroline Taylor works in the CAP self assessment section of Station Support function. (Her management is Steve Bernasconi, Pat Steinhaur, Larry Wagner, C. Bakkan)

Marc and I talked to Caroline this afternoon (2/19/04) about this SL1 (in the context of other SL1s she has evaluated so as not to disclose the reason for inquiring). We learned the following:

Caroline's responsibilities include trending corrective action data. In this capacity she initiated this notification in October 2003. She previously was involved with or was the primary author of a number of SL1 cause evaluations for discrete equipment problems at Salem and Hope Creek. From these prior SL1 evaluations she identified the high level common causal factor is an inadequate accountability system.

The notification was approved at both Salem and Hope Creek management meetings as an SL1 (after a number of iterations) on 10/20/2003. Larry Wagner approved a charter and team to perform the evaluation on 1/24/04. The evaluation was completed on 2/15/04 and is in management review for concurrence (Steinhaur and Wagner). It will then be presented to CARB. (Not yet scheduled). Caroline provided a draft copy of the evaluation and the proposed corrective actions. She also provided the signed charter.

The draft evaluation concludes the primary casual factor is: "The organization is not fully effective in defining clear and reasonable expectations, managing personnel (prioritizing work load) and then holding them accountable (reward good performers and motivate dissatisfactory performers to improve)." Two secondary casual factors identified are: (1) PSEG-Nuclear organization does not utilize an integrated approach. Due to this there is an inadequate lateral integration between organization to organization and program to program process and/or procedure. (2) There are constant and extensive changes to organizational structure, key management positions and programs, processes and procedures.

Consistent with the conclusions, the proposed corrective actions are at high level. Proposed owners are at the VP and CNO level. They include clarifying key processes and defining authority and interfaces, and improving inter-department dialogue.

With regard to safety, the evaluation states "There is no direct impact to SSC or to safety or reliability of plant operations, radiological safety and/or personnel safety at this time. Uncorrected, and collectively, these global and interactive organizational and programmatic casual factors have the potential to cause a further erosion of the effectiveness of the organization and overall plant performance."

Our thoughts:

Context: This notification was not initiated by upper management, but came from the "bottom up" through the CAP group (We believe it is mainly C. Taylors' initiative). The conclusions reached by the evaluation team (working level staff people) are generally management problems/failures. The proposed corrective actions would be assigned to the highest levels of

the organization if approved. It remains to be seen whether senior management agrees these are the primary casual factors and will accept the proposed corrective actions.

Conclusions: The evaluation concluded performance problems at Salem and Hope Creek involved inadequate accountability, teamwork issues and a changing management team. During the past mid-cycle (2003) and subsequent briefings with upper regional management, the branch reached conclusions regarding potential underlying causes of Artificial Island performance issues as follows: "weaknesses in work standards and reinforcement, high workload, poor questioning attitude/self critical approach, inexperienced engineers and poor work planning and control." There is overlap between the two assessments. Consistent with the SL1 safety impact assessment, we conclude that while safety margins remain acceptable, performance needs to improve. This is consistent with our mid and end of cycle assessments, letters and NRC messages in meetings with PSEG.

Background information:

The following is a summary of the previous SL1 evaluations that were aggregated to develop this common cause notification:

70027584 was a roll-up of NRC inspection results for Salem and HC in October 2002. OPEN, completion of all action scheduled for 3/31/04

70028106 was for Salem PORV misassembly w/o spacer, played out in Salem IR. OPEN, completion of all action scheduled for 4/15/04

70026521, FRVS controller issue cited in HC IR 2002-006 (11/02) CLOSED

70032416, General work control shortcomings, no specific NRC IR documentation. OPEN, completion of all action scheduled for 7/13/04

70033541, In 9/2003 HC recirc MG set recirc fan failed to start when inservice fan tripped. Downpower to 93%. Multiple maintenance related failures. However, non safety BOP SSC that did trip NRC PI. Mentioned in IR but no findings. OPEN, completion of all action scheduled for 12/15/04