From: A. Randolph Blough / RI
To: Ernest Wilson; Glenn Meyer; Joseph Schoppy; Marc Ferdas
Date: 4/6/04 6:07PM
Subject: Re: FYI - IAT Inquiries

i likewise would tend to want to do the OI interview.
Part of what may be at play in this internal debate is the varying definitions that we each hold about 'willfulness.'
This was evident in our panel.
More facts will about what happened, and **what the key participants were thinking and saying,** won't solve the 'definition issue,' but will help us overall. Right now, we have fuzzy facts and a fuzzy understanding of the threshold.
>>> Ernest Wilson 04/06/04 03:11PM >>>
Randy,

You are correct, the ARB decision last week was to open an OI case [redacted] I suggest the re-panel after we do the initial interview(s). As I understand it, there was a conscious decision made by the control room staff(s) to not follow the procedure as written by reducing RFP speed and/or taking the pump out of service after the RFP vibration alarm initiated. A shift manager who had been interviewed on the SCWE matter has admitted there was a violation since the pump was not taken out of service and it took them almost 2 ½ weeks before they dispositioned the issue by doing a TMOD. Further, testimony from the same shift manager said this event left people with the perception that they could pick and choose the procedures they want to follow. The control room supervision was also apparently very concerned early on when the alarm sounded and the pump was not taken out of service (as directed in the procedure). Given the status of this site and the fact that the SCWE is definitely in question, I think the NRC would be remiss if OI didn't sit down with some of the involved folks and get their take on what went down. They may very well have reasonable explanations for their actions or inactions (e.g., it would be less conservative to take pump out of service and run plant on only two), but at this point we have an admission that a violation of procedure had occurred and an indication that it occurred knowingly, coupled with a not very timely resolution. Its OI's job to determine thru investigation if this adds up to willfulness. Even the site IAT has apparently recognized the potential for OI's involvement in this matter. As you know, the fact that the violation is currently "not more than minor" isn't a factor whether OI opens a case.

Ernie
>>> A. Randolph Blough 04/06/04 01:02PM >>>
i think we decided to open a case on one of these examples at the last alleg panel; if br#3 feels strongly that it is not appropriate, then please schedule a repanel. Or, we can repanel after the initial OI interview.
thanks.
randy
>>> Glenn Meyer 04/05/04 03:35PM >>>
I totally agree with Joe.

While both instances had aspects of procedures which were not followed, the root cause of the behaviors was poor operational decision-making and not wrongdoing. In each poor decision there were multiple people involved; although wrongdoing could involved multiple people, the poor organizational performance regarding planning, evaluation, and execution is the likely root cause, i.e., the poor "handling of emergent equipment issues and the associated operational decision-making" as our January 28th letter pointed out.

Glenn

>>> Joseph Schoppy 04/02/04 05:04PM >>>
Randy,

Since asked to comment, I will take a shot at it. In both cases, I was present in the control room and directly observed and engaged the involved operators.

RFO 11 outage kickoff post scram: It was a planned scram and not an EOP entry driven by an emergent condition (not that this should make a big difference). The SRO and operations team in general were more focused on getting the outage off to a clean crisp start than on the task of using their procedures to safely and methodically control the shutdown and cooldown. They put the cart before the horse in attempt to jumpstart that magical 20 day outage. However, their outage planning and organizational performance can not support this level of achievement and something had to give. In this case, the SRO was trying to orchestrate several competing outage activities during the plant shutdown instead of demonstrating command and control in the conduct of a pre-planned plant transient.

C RFP vibrations: Although the C RFP issue reared its ugly head on November 1, during my control room tours on November 18-19, I sensed a high level of reactor operator frustration with operation management's inability to provide adequate guidance (they were being kept in limbo). I wasn't present when the alarm originally came in and do not know exactly what words the SRO used to dissuade reactor operators from following their alarm response procedure as written. However, in observing the control room communications relative to the issue and in discussing the C RFP vibration condition with operators and SROs, I did not get the impression that operators were told not to follow their procedures. Instead, the reactor operators were informed that engineering was evaluating the condition and it was probably just an errant indication. When engineering's evaluation dragged on for two weeks, reactor operators demanded guidance. Engineering could not prove that it was a false indication so they developed a TMOD to raise the alarm setpoint. I immediately recognized the condition as another example of proceeding forward in the face of uncertainty and failure to follow procedures. Jim Hutton agreed fully and demanded a full accounting from his staff (SL 2 corrective action report). I also noticed that the apparent discord between reactor operators and SROs (operations management in general). This helped form some of the basis for my PI&R team's comments relative to the poor working relationship within operations (SCWE). The reactor operators should have demanded a better answer way back on November 1 and in a better work environment they may raised the issue up. But the reactor operators did not willfully violate their procedure. The SROs abdicated their responsibility to safely operate the plant to engineering and felt comfortable waiting for engineering's evaluation explaining why the condition was okay. Were the SROs guilty of less than adequate corrective action: yes! Did they willfully violate the procedure: no.

Bottom line: as inspectors, we must constantly remain vigilant and keep our antenna up for possible instances of wrongdoing. If there is an inkling of potential wrongdoing, we are driven to notify OI immediately. In both circumstances above, in my opinion, there was not a glimmer of wrongdoing - just the typical non-conservative PSEG approach to problems encountered (The Practical Guide to Operating a Nuclear Power Plant). Senior reactor operators have been conditioned to work around problems, leave the thinking to others, shy away from plant ownership, and trust engineering to come up with a reason why it's okay to continue to run with degraded equipment. [The last point is supported by their thick book of active operability determinations, presently numbering near 20.] I believe willful involves knowing the right thing to do and deliberately (and consciously) not taking this action. Operators allowed the outage plan and their misguided reliance on engineering analysis, respectively, to cloud their vision with respect to knowing and recognizing the right thing to do, especially when it was clearly defined by procedures. In most cases, the perpetrator has something to gain by the willful noncompliance. In the circumstances above, operators would have had to restore water level above 12 inches and reduce power to 95 percent to remove the C RFP, respectively. Neither case presented ample motivation for a willful violation.

I am not defending operators' actions in these circumstances (that's why I took them to task in both cases, to the limit of our program anyway). Did they take the appropriate action in accordance with plant procedures when faced with an abnormal condition: no. Did they willfully violate these procedures: no.

I hope this helps.

Joe

>>> A. Randolph Blough 04/02/04 12:34PM >>>
good answer to the IAT, we should still remain independent of them.

but now I'm curious - - did we consider whether the 4/15 finding could be a willful violation of procedures, and how did we conclude it was more likely nonwillful?
Maybe Glenn or Joe can answer - - this case seems very similar to the one we just referred to OI yesterday involving failure to follow alarm procedures for feedpump high vibration.

>>> Marc Ferdas 04/02/04 10:15AM >>>
Randy,
Recently I have received 2 phone calls (one just minutes ago) from members of the IAT asking questions on what the NRC is doing or has done w/ respect to issues/events at HC. In particular I was asked about the following:

1. HC RHR Vibration (Call received early wk of 3/29)
I was asked if we have heard of anything suspicious (ie work environment issues) in regards to the above event, and what we were doing. I informed the IAT member that the residents and the region were interested in the issue in terms of its technical merits (ie, operability and restart issue)

2. Reactor Level Control Post Scram Going Into RF11 (April 15, 2003). - Call received today
See below for brief description from inspection report 2003004 Section 1R20. Also I attached the report to this email.

PSEG did not properly implement procedural guidance associated with post-scram reactor water level control on April 15. While implementing EOPs following the reactor scram to begin the refueling outage, reactor water level was controlled in a manner which conflicted with EOPs. The water level control addressed planned outage activities but for which no pre-approved basis existed. The inspectors determined that this performance deficiency was of very low safety significance (Green) and a non-cited violation of TS 6.8.1.

The IAT asked if OI was investigating this issue and if this was being treated as wrongdoing. I informed them that I cannot comment on inquiries on that subject. I believe the basis for the question stems from their review of the inspection record (as they stated they would do in their letter).

Any further inquiries from the IAT on specific issues I am going to refer them to the region. I have no problems discussing items that developed from the review I lead, but I think the IAT is using me as a point of contact for all their questions.

I think if we get another question, we should discuss with them that the inspection record speaks for itself and contains all necessary information w/ a risk significance. Additionally, if they believe concerns exist then they need to investigate and not depend on us to develop the issue.

If you have any questions please let me know.

CC: Daniel Holody; Daniel Orr; David Vito; Eileen Neff; Jeffrey Teator; Karl Farrar; Mel Gray; Scott Barber