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 [redacted] It was authored by PSEG's [redacted] on October 6, 2003. [redacted] works in the CAP self assessment section of [redacted] management is [redacted]

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

[redacted] responsibilities include trending corrective action data. In this capacity [redacted] initiated this notification in October 2003. [redacted] 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 [redacted] 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. [redacted] 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 [redacted] It will then be presented to CARB. (Not yet scheduled). [redacted] provided a draft copy of the evaluation and the proposed corrective actions. [redacted] 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 [redacted] 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