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Allegation No.: RI-2003-A-0110
Site/Facility: Salem/Hope Creek
ARB Date: 3/9/2005

Branch Chief (AOC): Cobey
Acknowledged: Yes
Confidentiality Granted: No

Issue discussed: Review of completed OI Report [redacted]

Branch 3 review determined the draft violation, upon which the OI investigation was based, is no longer applicable due to the information obtained during the investigation. There is, however, a violation of the Technical Specification required management directive NC.NA-ME.ZZ-0015(Z) dated February 9, 2002.

The original draft violation (upon which the OI investigation was based) cited Salem Generating Station Technical Specification (TS) 6.8.1, Regulatory Guide 1.33 "Quality Assurance Program Requirements," 10 CFR 50.54 (j), and PSEG procedure NC.NA-AP.ZZ-0005(Q), "Station Operating Practices." The draft violation concluded that contrary to the guidance delineated in these documents, "... on September 21, 2002, the on duty shift manager, following identification of a steam leak on a main feedwater pump turbine steam admission valve during a planned power reduction, commenced a briefing of the operations staff to discuss plans to increase the rate or power reduction to minimize any adverse affects of the steam leak; however, about the same time, [redacted]

While there is some disagreement by personnel in the interviews about whether or not the [redacted] the OS, the CRS and the Unit 2 Operator stated that they either knew [redacted] was going to [redacted] or recall thoroughly discussing [redacted] to the extent that they could understand how [redacted] could have thought he had their approval. In addition, neither 10 CFR 50.54(j) nor NC.NA-AP.ZZ-0005(Q) use the word "authorized." Instead, CFR and the procedure require that manipulation of equipment must be done with the knowledge and consent of the on-duty licensed operator. We come to the conclusion that [redacted] contacted the CRS and OS prior to [redacted] indicated by information contained in the OI report ... "three comments listed in the ECP document indicate that [redacted] informed the on-duty licensed operators, including ... [redacted] that he was going to [redacted]. [redacted] notes of his October 2002 interview of the [OS]... told [redacted] conducting brief in CR [control room], while this going on [redacted] came to me and said going to [redacted]. [redacted] at the time of the incident] was "positive that [redacted] told him he was going to [redacted] ...[Plant Operator on Unit 1 at the time of the incident] indicated in his OI interview that "later in the shift he talked to [the OS] who initially indicated that he understood what [redacted] was doing when [redacted] left the control room" and indicated that during his ECP interview "he may have told [redacted] that [the OS] told him he knew what was going to happen" ... [Salem Unit 2 Control Room Supervisor at the time of the incident] indicated that "he and [redacted] observed the steam leak and agreed that if conditions changed it would be desirable to [redacted] ... although he did not specifically give [redacted] the direction to close the valve, based on their earlier discussion ... it is his opinion that [redacted] thought he had his go ahead/approval to [redacted] ... [the OS'] second interview indicated that he "admitted that what he told [redacted] back in October 2002 ... may have been more accurate than the information he provided to OI during his December 31, 2003 interview ... [and he then recalled that] [redacted] whispered in his ear during the control room briefing that he was either going to [redacted] or look to see if it could be closed."

As noted above, there is evidence that control room personnel to one extent or another were aware that [redacted] was going to [redacted] and at least tacitly gave their consent by not responding and not directing that the [redacted] However, it is clear as detailed in the OI report that there was confusion, a lack of complete understanding, and inadequate communications. To

8-26

minimize confusion and misunderstanding during complex evolutions and events, it is important for all personnel involved to know who is in charge and what the plan is for proceeding. The Salem Unit 2 Technical Specifications, paragraph 6.1.2 requires that a designated individual be responsible for the Control Room command function and further requires a management directive to that effect be issued annually. PSEG Management Directive NC.NA-ME.ZZ-0015(Z), *Shift Management Responsibility for Station Operation (Technical Specification 6.1.2)* dated February 9, 2002, was in effect on September 21, 2002 during the steam leak event.

The management directive states in the first paragraph that the OS is responsible for ensuring proper command and control during all planned evolution and upset conditions. Contrary to this requirement, the on-duty OS on September 21, 2002, did not ensure proper command and control during the Salem Unit [redacted] as evidenced by the confusion, lack of understanding, and inadequate communications that occurred during the event. Confusion, lack of understanding, and inadequate communications are inconsistent with proper command and control. The OS provided conflicting statements concerning whether or not he knew that [redacted] was going to [redacted] During his last interview with OI, the OS maintained that it was unclear to him whether [redacted] was going to [redacted] or further assess the situation. As the individual with the control room command function, the OS must ensure that the plan for proceeding is clear to him and the other personnel involved.

[redacted] contributed to the OS' failure to ensure proper command and control. At a management level above the OS, [redacted] made a decision that the [redacted] That decision should normally be provided to the OS as the person in charge (per the Technical Specifications and NC.NA-ME.ZZ-0015(Z)) to determine if that is the correct and safe decision. The OS would then direct personnel to carry out the decision. However, [redacted] also decided that he was the best person to carry out the action. In such a situation, to ensure proper command and control is exercised as required, clear communications with all involved must take place. The management directive states in the third paragraph that all personnel should have a clear understanding of the chain of command. Contrary to this, [redacted] did not exhibit a clear understanding of the chain of command when he made a decision that [redacted] performed inadequate communications with several levels of personnel in the command structure, and then performed the action of [redacted]

The above are two examples of a violation of the Technical Specification required management directive, NC.NA-ME.ZZ-0015(Z). The violation is minor because it was not willful (as determined by OI), had no impact on safety equipment, and caused no safety consequences. The [redacted] was in compliance with S2.OP-AB.STM-0001(Q), *Excessive Steam Flow,* which was being implemented in response to the steam leak.

ALLEGATION REVIEW BOARD DECISIONS

Attendees: Chair - Uhle Branch Chief (AOC) - Cobey SAC - Vito, Harrison
OI Rep. - Teator RI Counsel - Farrar
Others - Wiebe, Arrighi, S Lewis, Jackson, Quichocho, J White, Urban, Holody

DISPOSITION ACTIONS:

1) Prepare letters to licensee and alleger providing NRC conclusion of the OI investigation and that a minor violation of a Technical Specification required management directive was determined to have occurred. (This issue will be addressed in the letters previously drafted to the licensee and the individual concerning the individual's discrimination complaint) Before issuance of the letters, they will be sent to OE to obtain HQ concurrence (in lieu of the 3 week e-mail process) given the sensitivity of these issues. Obtain all regional

concurrences and send to HQ.

Responsible Person: Urban ECD: 3/16/05 (to concur by 3/11/05)
Closure Documentation: _____ Completed:_____

2) Issue after HQ concurs, OE briefs the EDO, DEDO, Commissioners Assistants and Commissioner Merrifield. DRP to carry out comm plan.

Responsible Person: Cobey ECD: 3/30/05
Closure Documentation: _____ Completed:_____

SAFETY SIGNIFICANCE ASSESSMENT:

PRIORITY OF OI INVESTIGATION:

If potential discrimination or wrongdoing and OI is not opening a case, provide rationale here (e.g., no prima facie, lack of specific indication of wrongdoing):

Rationale used to defer OI discrimination case (DOL case in progress):

ENFORCEMENT STATUTE OF LIMITATIONS CONSIDERATION (only applies to wrongdoing matters (including discrimination issues) that are under investigation by OI, DOL, or DOJ):
What is the potential violation and regulatory requirement?_____
When did the potential violation occur?_____
(Assign action to determine date, if unknown)
Once date of potential violation is established, SAC will assign AMS action to have another ARB at four (4) years from that date, to discuss enforcement statute of limitations issues.

NOTES: (Include other pertinent comments. Also include considerations related to licensee referral, if appropriate. Identify any potential generic issues)_____

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Distribution: Panel Attendees, Regional Counsel, OI, Responsible Individuals (original to SAC)

ARB MINUTES ARE REVIEWED AND APPROVED AT THE ARB