From:

Joel Wiebe (C)

To:

R1Allegation

Date:

3/9/05 10:58AM

Subject:

Talking Points for ARB RI-2003-A-0110 Discussion

Place:

R1Allegation

Since the ARB form is lengthy and doesn't lend itself to be read from the projector display, I have made up a one page talking points document to facilitate the discussion.

CC:

Daniel Holody; Eugene Cobey; Leigh Trocine; Russell Arrighi

Information in this record was deleted in accordance with the Freedom of Information

Act, exemptions 20

2005-194

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Talking Points for ARB RI-2003-A-0110 Discussion

Summary

Draft violation is no longer sustainable because of information obtained during the OI investigation. However, there is a violation of the Technical Specification required management directive NC.NA-ME.ZZ-0015(Z), dated February 9, 2002.

Details

There is some disagreement by personnel that were interviewed about whether or not the

However, the OI investigation revealed that the Unit 2 Reactor Operator (RO), the Unit 2 Control Room Supervisor(CRS), and the Operations Superintendent (OS) each had some knowledge and some with extensive discussion about the In addition, they agreed that was in compliance with the procedure and was the preferred action if it would isolate the steam leak.

The requirements in 10 CFR 50.54 (j) and PSEG procedure NC.NA-AP.ZZ-0005(Q) state that equipment, affecting reactivity or power level of the reactor, shall be manipulated only with the consent of a licensed operator or senjor licensed operator.

The extensive discussions and varying knowledge about the leads to the conclusion that at least tacit consent was given the The consent of the Unit 2 Reactor Operator (who states that he is positive that the told him he was going to the least tacit consent was given to least tacit consent was given the least tacit consent was given to least tacit consent was given the least tacit consent was given the least tacit consent was given to least taci

The OI investigation indicates there was confusion, a lack of understanding, and inadequate communications. We agree with this analysis.

 Confusion, lack of understanding, and inadequate communications are inconsistent with proper command and control.

• 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 2 steam leak event, as evidenced by the confusion, lack of understanding, and inadequate communications that occurred during the event.

The contributed to the OS' failure to ensure proper command and control. The management directive states in the third paragraph that all personnel should have a clear understanding of the chain of command. Contrary to this, the did not exhibit a clear understanding of the chain of command when he, at a management level above the OS, made a decision that the performed inadequate communications with several levels of personnel in the command structure, and then performed the action of

 The violation is minor because it was not willful, had no impact on safety equipment, and caused no safety consequences. 10

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