From: Scott Barber
To: David Vito; Robert Fretz
Date: 1/8/04 9:43AM
Subject: Routine update for Salem/HC SCWE)(RI-2003-A-0110)

Appended is some useful reference material for today's discussion (10:00a.m.). I will bring hard copies to the meeting.

Please treat this as predecisional information. It should not be shared with personnel outside NRC.

MCI Conference Number
1-877-917-2512
Code [redacted]

Problems.....call 1-877-855-4797 and refer to confirmation [redacted]

CC: A. Randolph Blough; Brian Holian; Daniel Holody; Daniel Orr; Eileen Neff; Ernest Wilson; Glenn Meyer; Karl Farrar; Leanne Harrison; Sharon Johnson; Theodore Wingfield

SALEM/HC SCWE

HIGH LEVEL SUMMARY

Unsafe Operations

To date, there has been no contemporary information that has been conveyed through interviews or through inspection that would rise to the level of unsafe acts on the part of licensee management or operations that would warrant prompt and immediate action by the NRC. This aspect is evaluated in an ongoing and continuous manner.

There have been issues where production over safety pressures have been evident. In one case, an Salem [redacted] was alleged to have taken an action to [redacted] on the steam supply to a main feedwater without approval of the operating shift. This was done to avoid taking the unit off line to effect repairs. A December 31, 2003 interview with the responsible Salem Shift Manager confirmed that the [redacted] did not have permission to operate the valve. Thus, this is an apparent violation of the PSEG Conduct of Operations procedure. DRP recommends that [redacted] 7C 7C 7C

In a recent HC interview, a HC reactor operator related a situation where he wanted to take a conservative action because he had lost reactor power indication (from a computerized calorimetric calculation) and wanted to lower power to a known state (approximately a 1% power reduction) and was prohibited from doing so by the operating supervisor (OS). More interviews are needed to review this matter.

The PSEG Work Environment

To date there has been no information conveyed through interviews or through inspection that indicates that personnel would not raise safety issues to management. Thus, PSEG meets minimum standards for implementing a **Safety Conscious Work Environment** at Salem/HC.

Although the Salem interviewees to date have all indicated that interviewees would not hesitate to raise safety issues to management, they have indicated that senior management's response is often one to directly challenge the issue as being a safety issue or to recharacterize it as minor or to take action to minimize the importance of the concern. In a HC case, there appeared to be a desire to maximize generation in the face of uncertain reactor power conditions. Some Salem Shift Managers (SMs) indicated that there had been a paradigm shift under the [redacted] in which they were being asked why they couldn't take an action to improve production rather than being asked if it was a proposed action was safe or not. These SMs provided examples of situation in which they were asked to either delay a shutdown or to proceed with startup or power ascension even when they were reluctant to do so. According to the SMs, none of these examples constituted a violation of the license or technical specifications, but management's approach was diametrically opposed to past practice in these instances. Cost pressures appeared to have been a contributor to the paradigm shift. 7C

PSEG Industrial Safety Issues

Many Nuclear Equipment Operators (NEOs) interviewed raised a number of industrial safety issues that have not been adequately addressed. They indicated that they had wrote notifications but that they either were never addressed or addressed in an inadequate manner. In some instances, they indicated that management did not want to hear about there problems and considered it "whining" on their part.

PSEG Labor-Management Issues

One interviewee [redacted] During the interview, he stated that he had been on days off and had traveled to the site on his own time to resolve other labor management issues. He was requested to take a [redacted] even though he was off which he discussed with operations management at that time. The [redacted] told him to go home and to not worry about it which he did. He subsequently got a call from a [redacted] was told to come in for the test which he subsequently did. Later, he was told he was being fired for FFD rule violations. When asked why this occurred during the interview, he indicated that [redacted] had told another manager that "We're going to make an example out of [redacted] and we're going to show the union that management is running the station and not the union." 7c 7c

There were other examples where union members indicated that management was generally unresponsive to industrial safety issues rased by the union. One union member [redacted] indicated that he and others had to protect the plant from management's "good ideas." By anecdote, he also commented that "PSEG has the right management team in place for the sixth time". identity #6 7c

PSEG's Corrective Action Process(CAP)

Some interviewees indicated that the CAP provides a shield or a convenient excuse for why action has not been taken to address equipment problems or personnel safety issues. On occasion, NEOs have been told to reenter thier concerns in the system. When they have done so nothing changes.

NRC Considerations

During interviews, we listen very carefully to issues that may be safety significant and try to develop questions that sufficently probe the issue so that it's significance is fully understood. WE use this approach as part of our ongoing litmus test to determine if any unsafe acts have been idnetified.

Recent interviews have applauded the [redacted] regime as being effective at addressing emerging concerns (both safety and otherwise) from all levels of the organization. The retirement of [redacted] and the removal of [redacted] from positions of power has been viewed as bringing relief to the previously unhealthy work environment. However, one potential contributor [redacted] to this environment still wields significant management influence power on-site. We plan to continue to understand both his positive and negative contribution to the SCWE at Salem/HC. 7c

NRC ASSESSMENT OF SIGNIFICANT SALEM/HC ALLEGATION

	Discrete Issue / Event (Derived directly from 2003-0110)	NRC Assessment (Including interview results)	Technical Violation?	Wrong doing?
1	**March 17, 2003 at Hope Creek -** [redacted] and [redacted] confide that [redacted] and [redacted] **pressured for restart** without forced outage - bypass valve incident; Forced outage & turbine bypass valve (TBV) repair occurred.	STATUS: ACTIVE INVESTIGATION INTERVIEWS: Interviews to date have suggested that the concern here was between [redacted] and his department heads. He apparently "harassed" (From interviews with [redacted] and [redacted] them for four hours on why a shutdown to repair a TBV was necessary when all of the department heads believe the decision to shutdown was a "no brainer". Although non-conservative decision making is a possible root cause, there was no TS violation.	No	N/A
2	**March 17, 2003 at Hope Creek -** [redacted] told alleger he **did not have the authority to stop** the evolution (**reactivity excursion** during the bypass valve shutdown?) **even though he knew it was ill-conceived.**	STATUS: ACTIVE INVESTIGATION INTERVIEWS: Not yet developed - More to follow	No	N/A
3	**June 17, 2003 at Hope Creek** - EDG leakage exceeds LCO time; **pressure to avoid shutdown;** [redacted] directed operator [redacted] to not shutdown; shutdown commenced within acceptable time frame and met regulations.	STATUS: ACTIVE INVESTIGATION INTERVIEWS: Interviews to date have suggested that there was time pressure to delay the shutdown as long as possible to allow engineering time to come up with an adequate operability justification. Although non-conservative decision making was a possible root cause, there was no TS violation. The HC RIs were fully engaged with the issue as it unfolded.	No	N/A
4	**September 24, 2002 at Salem -** [redacted] ECP confidential report substantiates allegation, Third Step Grievance.	STATUS: ACTIVE INVESTIGATION INTERVIEWS: Interviews to date have suggested that this issue may have been substantiated. Many NEOs noted that the [redacted] went and the field and [redacted] without: an NEO to operate the valve, wearing the necessary personal safety gear, and without following the work control process. Non-conservative decision making was viewed as a possible root cause for this action. After coordination with OE and comparison to another recent issue (Mgr operating Ginna SW valves) , this will be considered as a violation of PSEG's Conduct of Operations procedure because the [redacted] did not have approval from shift personnel to operate the valve. The technical staff is recommending tha [redacted]	Yes	TBD

	Discreet Issue / Event (Derived directly from 2003-0110)	NRC Assessment (Including interview results)	Technical Violation?	Wrong doing?
5	Fall (?) 2002 at Salem - Manager [redacted] directed SRO [redacted] to NA a startup checklist step. [redacted] tried to have [redacted] fired but was unsuccessful.	STATUS: ACTIVE INVESTIGATION INTERVIEWS: New information received on November 6, indicates this alleged activity may have actually occurred when [redacted] directed [redacted] to "NA" a surveillance step for the Reactor Vessel Vent valves when a single valve indicated dual indication during this routine stroking evolution. [redacted] was allegedly told by the Operation Crew that they would not "NA" the step. Earlier information from interviews suggested that the concern involved "NA-ing" a second verification containment walkdown to be done by a VP-OPS level person step. This step was added to the SU procedure as a lessons learned from the Davis-Besse issue. According to [redacted] this walkdown was actually done by himself and [redacted] and startup was delayed by a day because of leaks that they found from some SG wet layup level indication valves. So, the step was actually completed contrary to the alleger's assertion.	No	N/A
6	Spring 2002 - Salem grassing approach (i.e., heroic efforts) deviated from expected approach / lessons learned from 1994 grassing ... non-conservative decision-making [redacted]	STATUS: COMPLETE (Licensee actions appropriate) INTERVIEWS: COMPLETE [redacted] stated that he was the duty manager during grassing season and would not have supported any efforts to station additional operators in the intake to clean the screens during heavy grassing periods. His approach would have been to take the unit offline. He indicated that he may have told the alleger that he was concerned that some of the outage staff would have chose to augment screen cleaning with operators vice shutting down the unit.	No	N/A
7	November 2002 - Higher Tritium sample concentration characterized as a serious issue that had to be "handled with kid gloves to keep us [PSEG] out of trouble" [redacted]	STATUS: COMPLETE (Licensee actions appropriate) INTERVIEWS: COMPLETE [redacted] indicated during the interview that he was not in a role in RP at the time this issue was being developed but he did recall having conversations with PSEG communications people on how to handle the issue. He said he may have discussed this with the alleger. The NRC has a great deal of information on this issue that has been derived from inspection activities including numerous face-to-face interactions between inspectors and PSEG managers and staff.	None from this allegation	N/A
8	Excessive use of temporary logs	STATUS: ACTIVE INVESTIGATION INTERVIEWS: Not yet developed - More to follow	TBD	TBD

	Discreet Issue // Event (Derived directly from 2003-0110)	NRC Assessment (including interview results)	Technical Violation?	Wrong-doing?
9	Salem 2 ISI relief request re: piping UT (coverup?)	STATUS: ACTIVE INVESTIGATION INTERVIEWS: Not yet developed - More to follow	TBD	TBD
10	HC offgas issue after [redacted] took over. **Rad safety concerns expressed but not resolved**	STATUS: ACTIVE INVESTIGATION INTERVIEWS: [redacted] indicated some knowledge of this issue since he believe it pertained to elevated HC offgas flow rates due to excessive air in-leakage into the condenser. He indicated that [redacted] wrote a somewhat inflammatory notification because the NEOs had to try to identify the location of the leak in higher than normal radiation fields. The location of the leak eventually was discovered and the offgas leakage reverted to its pre-in-leakage levels.	No	N/A
11	**HC employee allegedly asked to modify a Notification re: "in-leakage"**	STATUS: ACTIVE INVESTIGATION INTERVIEWS: [redacted] indicated some knowledge of this issue since he believe it pertained to elevated HC offgas flow rates due to excessive air in-leakage into the condenser. He indicated that [redacted] wrote a somewhat inflammatory notification because the NEOs had to try to identify the location of the leak in higher than normal radiation fields. The location of the leak eventually was discovered and the offgas leakage reverted to its pre-in-leakage levels.	No	N/A

	Discreet Issue / Event (Derived from Interviews)	NRC Assessment (Including Interview results)	Technical Violation?	Wrong-doing?
1	PSEG non-conservative decision making relative to #14 Steam Generator (SG) Feed Regulating Valve (FRV) believed to be stuck at 74% open	STATUS: ACTIVE INVESTIGATION INTERVIEWS: Interviews to date have suggested that this concern related primarily to the timing of a decision to enter TS 3.0.3. An NEO and RO have asserted that it should not have taken 12 hours to enter 3.0.3. However, once the licensee's troubleshooting plan showed that FRV was stuck they immediately entered the LCO and followed the SD requirements. Although non-conservative decision making was a possible root cause, there was no TS violation.		
2	In the Spring 2001 outage, a Salem Unit 1 reactor trip was caused by a main generator current transformer failure. The [redacted] told operations that they needed to get the reactor started up by particular date or their NRC performance indicator was going to "go white." [redacted] allegedly harassed operations daily by asking day "when are you going to start the plant". Operations then told [redacted] they would start up when they thought they were within a day of putting steam into the main turbine. Although [redacted] insisted that operations should start up the reactor with the MSIVs shut, operations refused to do so because it was contrary to their safety analysis.	STATUS: ACTIVE INVESTIGATION INTERVIEWS: Not yet developed - More to follow		

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