G:\ALLEG\PANEL\20030110arb9.wpdALLEGATION REVIEW BOARD DISPOSITION RECORD

Allegation No.: RI-2003-A-0110 Site/Facility: Salem/Hope Creek

Acknowledged: Yes

Branch Chief (AOC): Meyer

ARB Date: <u>01/29/2004</u>

Confidentiality Granted: No

Issue discussed: Current Actions on Tech Issues and SCWE

Alleger contacted prior to referral to licensee? <u>Issue will not be referred to licensee until NRC has completed an interim review that adequately assesses the work environment at the station.</u>

ALLEGATION REVIEW BOARD DECISIONS

Attendees: Chair - Blough Branch Chief (AOC) - Meyer SAC - Vito

Ol Rep. - Neff, Wilson RI Counsel - Farrar Others - Barber, Holody, Wingfield, Crlenjak

	ISPOSITI	ON AC	TIONS	:
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				ne
Responsible Person: <u>Wilso</u> Closure Documentation:	on	ECD: Comple	TBDted:	_

2) DRP to modify drafted violation(s) per ARB discussion and provide to Regional Counsel, OI and SAC.

Responsible Person: <u>Barber</u>	ECD: <u>2/6/04</u>
Closure Documentation:	Completed:

3) DRP to compare depth of surveys at PSEG with those some other utilities such as Susquehanna. Provide documentation of results to SAC and OI for file.

Responsible Person: Meyer	ECD: <u>2/18/2004</u>
Closure Documentation:	Completed:

4) Perform an interim assessment of the Salem and Hope Creek interviews completed to determine whether additional NRC action is needed to address work environment concerns. Consider Issuance of a letter describing the work environment issues identified to date and request PSEG review and assessment.

Responsible Person: All	ECD: <u>1/29/04</u>
Closure Documentation: <u>Letter to Licensee</u>	Completed: 1/28/2004

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OIA	2005-194

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5)	Upon completion of these interviews dete	•
	Responsible Person: <u>Barber/Neff</u> Closure Documentation:	
6)	Upon completion of the additional interview for additional correspondence (beyond 1/2)	ews reconvene as needed to determine need 28/04 letter) or other actions.
	Responsible Person: All Closure Documentation:	
7)	DRP/DRS to continue review of interview of safety culture/SCWE and technical iss	transcripts and provide summaries in terms ues.
	Responsible Person: Blough/Lanning Closure Documentation:	ECD: <u>Ongoing</u> Completed:
8)	DRP will continue to update the summary considering information from additional in from review of transcripts of completed in TARP reports and NRB documentation a DRP/DRS to assess.	formation from interviews, and information sterviews. DRS has completed review of
	Responsible Person:Meyer Closure Documentation:	ECD: Ongoing Completed:
9)		plan in response to our 1/28/04 letter, repanel e licensee additional detailed information on
	Responsible Person:Panel	
10)	Repanel the listing of attributes/behaviors representative of a good safety culture/S outcomes of the SCWE review, and possevents/activities/inspection findings at the	CWE, to be used as a point of comparison for sibly considering how other
	Responsible Person:SACClosure Documentation:	ECD: <u>TBD</u> Completed: <u>1/29/04</u>
11)	Next periodic ARB	
	Responsible Person: _SACClosure Documentation:	ECD: <u>2/18/2004 @ 10:00</u> Completed:

SAFETY SIGNIFICANCE ASSESSMENT: SCWE Review

PRIORITY OF OI INVESTIGATION: High

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 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)

Next ARB will include a discussion of suggestions for binning inputs related to SCWE (e.g., management production vs. safety pressure, non-conservative decision making, union pressures to suppress concerns identification, etc.) And how that will feed into the overall SCWE assessment.

<u>Distribution</u>: Panel Attendees, Regional Counsel, OI, Responsible Individuals (original to SAC)



BINNING OF SALEM/HOPE CREEK SCWE ISSUES

The objective of this binning is to establish the preliminary significance of issues that have been raised from a Salem/Hope Creek allegation (fall 2003) or that were identified during interviews conducted to assess this allegation.

The categories are ranked in decreasing order of safety significance.

::Salem:Nuclear:Equipment:Operator:(NEO)) Issues

PERCEIVED LACK OF FREEDOM TO RAISE SAFETY CONCERNS TO PSEG MANAGEMENT

- Environment believed to be intentionally cumbersome to discourage the identification and resolution of issues
 - 10/22/03, p. 20
- Management is perceived as responding negatively when issues are raised (types of 'negative' responses: inequitable distribution of work, negative performance appraisals, withholding of pay raises, etc.)
 - 10/22/03, p. 20, 23 & 47
 - 11/7/03, p. 26 31

PRODUCTION OVER SAFETY ISSUES

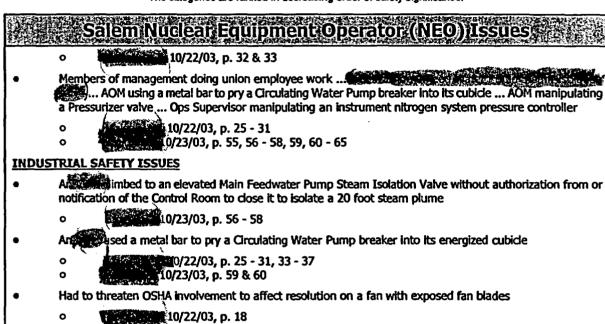
- Ar authorization from the Control Room ... This was contrary to the Operating shift's intent to take the Main turbine offline to address a 20 foot steam plume from the affected valve ... Could be considered a violation of the Conduct of Operations procedure which prohibits operation of equipment without the operating shift's knowledge/permission
 - o 0/23/03, p. 56 58 o 11/7/03, p. 14 & 15
- The 24 Steam Generator Feed Regulating Valve (FRV), 248F19, failed to respond ... The NCOs, and at least one Senior Reactor Operator (SRO), on shift believed the valve was mechanically bound ... Management didn't want to declare the valve mechanically bound and therefore inoperable because that would require a Limiting Condition for Operation (LCO) 3.0.3. shutdown ... Management elected to pursue a controls failure ... Shutdown delayed for about 36 hours
 - 0/23/03, p. 7 29 0 11/7/03, p. 16 & 17
- The operations department operates outside of established processes (i.e. cleaning condenser waterboxes) because of a 'just fix it and the unit(s) back up to full power' mentality ... An AOM used a metal bar to pry a Circulating Water Pump breaker into its cubicle in facilitation of a rapid return of the pump to support return to full power
 - o /22/03, p. 25 31, 33 37
- Overheard a member of Operations Management saying that he did not receive a raise at the end of 2003
 after numerous instances of voicing an opinion in contrast to the 'production mentality' ... its built into their
 compensation package
 - o 0/22/03, p. 23 & 47
- Made an emergent change to the plant startup procedure to remove the restriction that the steam dumps be operated in automatic ... Conducted emergent training to extra NCOs and required them to control Reactor temperature and pressure (which affects reactivity) in manual instead of fixing the system to operate in automatic as designed
 - o 10/23/03, p. 40 48
- Main Steam Isolation Valves (MSIVs) were opened late during the startup following the 'hurricane-salting' shutdown
 - o 10/23/03, p. 32 40
- They have had NEOs operating the components required to synchronize and load the Emergency Diesel

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Salem Shift Manager/Ops Superintendent (SM/OS)) Issues :::

PERCEIVED LACK OF FREEDOM TO RAISE SAFETY CONCERNS TO PSEG MANAGEMENT

 Not observed yet. All personnel interviewed that they would not hesitate to raise a safety concern to management even though management's reaction may be to shoot the messenger.

PRODUCTION OVER SAFETY ISSUES

An AOM.

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SCHEDULE PRESSURE ISSUES

During.

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LABOR - MANAGEMENT ISSUES

Union.

INDUSTRIAL SAFETY ISSUES

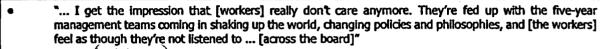
During the recent Salem Unit 2 outage, a SW valve was stroked to allow system fill prior to setting the torque
and limit switches. This was done to save time on the outage schedule. The valve destroyed itself when
stroked remotely. Could have caused serious personnel injury if someone had been in the vicinity at the time
of the failure.

12/23/03, p. 37 - 39

BINNING OF SALEM/HOPE CREEK SCWE ISSUES

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The categories are ranked in decreasing order of safety significance.



- o 11/13/03, p. 5
- Threats and intimidation used against an individual for responding to a request by a shift manager
 - o 11/13/03, p. 10 14
- Indication of the disorganization within management An individual had, simultaneously, 2 supervisors, 3 other people who give him direction ... Another person (whom he had never received any direction from) gave him his annual performance review (the written evaluation of which written by the person being evaluated)
 - o 11/13/03, p. 30 & 31

INDUSTRIAL SAFETY ISSUES

- Restart pressure exerted to fix a valve by flashlight vs. correcting the lighting deficiency ... the situation was eventually resolved by using temporary lighting
 - o 10/21/03, p. 53 60, 64 65
- During the recent Salem Unit 2 outage, a SW valve was stroked to allow system fill prior to setting the torque
 and limit switches. This was done to save time on the outage schedule. The valve destroyed itself when
 stroked remotely. Could have caused serious personnel injury if someone had been in the vicinity at the time
 of the failure.
 - o 11/13/03, p. 42

Salem/Hope Creek Allegation Background/Chronology

Issue/Event Date	Description
Jan. 28th, 2004	Issued a "significant letter" to PSEG providing them with interim results of our ongoing SCWE review (they have until February 27th to respond with an action plan).
Jan. 28th, 2004	Interviews conducted Jan. 7th and Jan. 28th
Dec. 31 st , 2003	Interviews conducted Dec. 2 nd and Dec. 31 st
Nov. 13th, 2003	5th ARB
Nov. 12th, 2003	Interviews conducted Nov. 12th and Nov. 13th
Nov. 7th coop	
Nov. 7th, 2003	4 th ARB
Nov. 4 th , 2003	Interviews conducted Nov. 4th through Nov. 7th
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Oct. 28th, 2003	3 rd ARB
Oct. 24 th , 2003	Interviews conducted Oct. 24th through Oct. 29th
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Oct. 23 rd , 2003	Interviews conducted on Oct. 23rd
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Description Issue/Event Date March 17th, 2003 1. Hope Creek Reactivity Event - Manipulation of Electro Hydraulic Control (EHC) system caused an unanticipated rise in reactor power 6 1/2 % to 13 % ... not discovered until Wednesday (3/19/03). 2. Entering a planned shutdown to repair 3 technical/mechanical failures (late Sunday / early Monday morning). 3. Monday morning (0800) Turbine Bypass Valve (TBV) stuck open (47%). TBV closed fully during subsequent testing. The concern here was between about whether or not a shut down was required. The concern here was between about whether or not a shut down was required. heads. He apparently "harassed" (from interviews with 4 hours on why a shutdown to repair the TBV was necessary when all of the department heads believed that shutting down was a "no brainer". Although non-conservative decision making is a possible root cause, there was no TS violation. 4. Heated discussions about the duration of the forced outage. Mar. 28th, 2003 Alleger's last day on site (employment officially terminated this date). Alleger told (by Mar. 26th, 2003 wanted the alleger "out by Friday" (March 28th, 2003). Mar. 25th, 2003 Alleger submitted letter to CEO reiterating work environment concerns and describing the alleged retaliatory actions. Alleger met with the later of purportedly discuss [the] bonus. But, after discussing concerns Feb. 26th, 2003 about the work environment at Artificial Island, the alleger was informed of future termination (originally planned for April 16th). It was also alleged that the the control of the directed that the termination be "accelerated." Nov. 2002 Higher Tritium sample concentration in Spring 2003 - "a serious issue that had to be handled with kid gloves to keep us [PSEG] out of trouble* Manager Value and Manager Valu to NA a startup checklist step. Fall 2002 tried to have fired but was unsuccessful. Information received indicates this alleged activity may have actually occurred when "NA" a surveillance step for the Reactor Vessel Vent valves when a single valve indicated dual Indication during this routine stroking evolution. 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 the SU procedure as a actually done by himself and 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. Sept. 24th, 2002 Based on the size and location of a significant steam leak (20' to 40' plume from the bonnet of a Feed Water Pump steam admission valve), the agreed with the shift operators that the plant should be shut down to affect repairs. left to speak with "upper management" and, upon his return, subsequently which isolated the steam leak avoiding a shut down. confidential report substantiates allegation, Third Step Grievance

without regard to his own personal safety, without a Nuclear Equipment Operator (NEO),

and without the permission/knowledge of control room personnel).