***************** -COMM. JOURNAL- ********************* DATE FEB-05-2003 ***** TIME 09:16 ********

MODE = MEMORY TRANSMISSION START=FEB-05 09:14 END=FEB-05 09:16

FILE NO.=395

| STN NO. | COMM. | ABBR NO. | STATION NAME/TEL NO. | PAGES | DURATION |
|---|---|---|---|---|---|
| 001 | OK | <12> | RI ALLEG OFFICE | 007/007 | 00:02:08 |

-USNRC RESIDENT INSPECTER -

**************************************** - - ***** - 856 935 3741- *********

# SALEM/HOPE CREEK RESIDENT OFFICE

## FAX COVER SHEET

Kathy
Put in Safe
Here's file
Called
Salem Allegation

DATE: Feb 5, 2003

TO: Allegation office

FROM: RAYMOND K. LORSON, SRI, SALEM ___

FRED L. BOWER, RI, SALEM ___

JOSEPH G. SCHOPPY, JR., SRI, HOPE CREEK ___

MARC S. FERDAS, RI, HOPE CREEK X

KATHY VENUTO, SECRETARY ___

NO. PAGES: 7 (INCLUDING COVER SHEET)

OFFICE PHONE NO. SALEM/HC (856) 935-3850; SALEM 935-5151; HC 935-5373

REMARKS:

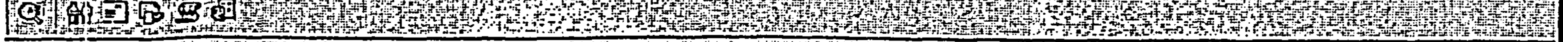
Add'l info to Salem Allegation that you received ~~yesterday~~ earlier this week.

Information in this record was deleted in accordance with the Freedom of Information Act, exemptions 7C
FOIA- 2005-0194

R-3

Display PM Notification: NOC Maint. Request

Maintenance notification  Edit  Goto  Extras  Environment  System  Help



Notification 20120207 N1 Procedural compliance concerns
Status ATCO NOCO NOPT ORAS APRD
Order 70028116

Notification | System Availability | Malfunction, Breakdown | Location data | Item | Tasks | Activities

**Areas of responsibility**

| | | |
|---|---|---|
| Planner group | 650 / NNUC | Salem Operations |
| Main WorkCtr | O-SS / NNUC | SALEM OPS SUPERINTENDENT (AOM SHIFTS) |
| Person Respons. | | |
| Reported by | [redacted] | Notif.date 11/03/2002 20:57:12 |

**User data**

Sig Level 3   Mrule code NFF

**Reference object**

| | | |
|---|---|---|
| FunctLocation | SC | SALEM COMMON |
| Equipment | | |
| Assembly | | |

**Basic dates**

| | | | |
|---|---|---|---|
| Req.start | 11/03/2002 | 20:57:12 | Priority High |
| Required end | 12/04/2002 | 20:57:12 | Breakdown |

**Item**

Object part

Damage

Prints the window's content.   P00 (1) (100)   sappa02   INS   16:58

20120207/70028116



7C

11/03/2002 21:05:27 [redacted] (NUMBM)

1. Describe the actual condition? Operations personnel who challenge their supervisors on procedural compliance and work standards arent always receiving the expected encouragement and support. Not only arent they receiving support, in some cases individuals who challenge their supervisors are perceived as "road blocks" in the work management process. Procedure adherence is not only a standard it is a management expectation. Procedures should be complied with at all times. If a procedure section/step cannot be performed as written, all personnel are responsible to contact their supervisor. If it is determined that the guidance is vague or incorrect, the condition should be corrected. Individuals shouldnt be afraid to raise concerns to their supervisors. The most recent concerns being raised at this time pertain to safety, the use of valve leverage devices, "independent" verifications, component labeling, fire retardant clothing and tagging issues. It has become evident in some instances that safety and procedural compliance is taking a back seat to schedule pressure. Please investigate and rectify the situation so that both the supervisors and workers are alignedwith standards and expectations.
2. How does this issue impact plant or personnel safety? Procedural non-compliance can impact both personnel and plant safety.
3. PSEG Nuclear or regulatory requirement not met. NC.NA-AP.ZZ-0001, NC.NA-AP.ZZ-0005 and management expectations.
4. What caused the condition? Schedule pressure, miss-communication and vague standards/procedural guidance.
5. What actions, if any, have been taken to correct the condition? Initiated this notification.
6. Recommend action/ corrective action and work center responsible for correcting condition. (Use title/position, not name) Please investigate and rectify the situation so that both the supervisors and workers are aligned with standards and expectations. /[redacted]
7. Any other relevant information (who, when, where, why, references, estimated cost, EMIS tag, etc.). Please contact [redacted] for any specifics or additional information
*=.NA. FOR SIGNIFICANCE LEVEL X NOTFS

11/04/2002 10:54:54 [redacted] (NUBLS)
CRRC Note: H-NUT1C.
11/05/2002 11:03:12 [redacted] (NUBLS)
CRRC Note: O-SS.

70028116



see long text
This issue has been discussed at a recent Operations
Superintendent meeting, with the [redacted] rolling out
clear expectation that all Operations personnel follow standards
and comply with procedures.
This message is being rolled out to all of the shifts by the
[redacted] via the rollout of the Department Vision
rollout

20119301/70027871  Safety Not #1 PRIORITY To ALL

10/29/2002 09:25:24 [redacted] (NUMBM)

7C

1. Describe the actual condition? (SC) Safety does not appear to #1 priority to all. A safety, equipment and FME concern was identified to several management personnel for over a week now starting on 10/20/02. To date I have been unsuccessful in getting timely resolution on this issue. The 12 FHB exhaust fan (1VHE21) outlet expansion joint has an extremely large tear (25% missing) making the fan blades accessible. The tear in the expansion joint and the rotation of the fan in the reverse direction hasalready been identified under notification 20117669. However, the SAFETY and FME aspects have not been address. A screen of some sort should immediately be installed over the opening to prevent personnel injury and for FME control. Please take immediate action to resolve this SAFETY CONCERN.
2. How does this issue impact plant or personnel safety? Accessible opening on rotating equipment is a personnel safety concern.
3. PSEG Nuclear or regulatory requirement not met. Failure to timely rectify a safety concern does not meet management expectations of SAFETY BEING THE #1 PRIORITY.
4. What caused the condition? Schedule pressure causing management personnel to not promptly address safety issue.
5. What actions, if any, have been taken to correct the condition? Notified numerous management personnel (evolution team OS, OCC, safety personnel) and have been unable to get issue corrected so this notification was initiated.
6. Recommend action/ corrective action and work center responsible for correcting condition. (Use title/position, not name) A screen of some sort should immediately be installed over the opening to prevent personnel injury and for FME control. Please take immediate action to resolve this SAFETY CONCERN. VP Operations
7. Any other relevant information (who, when, where, why, references, estimated cost, EMIS tag, etc.). Please contact [redacted] for any additional information.
*=.NA. FOR SIGNIFICANCE LEVEL X NOTFS

10/30/2002 06:23:08 [redacted] (NUM3C)
Notification 20116679 closed by Outage Control Center indicating that the issue had been corrected.

10/30/2002 12:24:16 [redacted] (NUMAT)
CRRC NOTE: DOWNGRADED TO SL-3 AT THE SM MEETING ON 10/30/02.
10/31/2002 10:55:27 [redacted] (NUM3C)
WIN TO VALIDATE IMMEDIATE SAFETY CONCERNS RESOLVED PER WMSC MEETING

11/04/2002 06:19:04 [redacted] (NUTOB)
Validated
11/04/2002 10:38:49 [redacted] (NUBLS)
CRRC Note: H-NUT1C.
11/05/2002 10:38:24 [redacted] (NUBLS)
CRRC Note: O-SS.

see long text
(1) Initiator failed to identify that the notification 20117669 that was noted in this order was closed to trend 2 days after it was written. This was 5 days prior to this notification being written for the safety concern. Of interest is also the fact that the (2) previously closed notification did not identify a safety concern, but rather identified that the fan could rotate in reverse and cause the breaker to trip when starting the fan.

(3) This notification leads one to believe that this safety issue was intentionally disregarded, my determination is that this is not the case and in fact the initiator of this notification did not properly investigate his concern prior to writing htis notification. Had the proper investigation been performed, the initiator would have discovered that the notification that he referenced as being ignored for many days, was in fact closed after the condition was believed to be corrected after only 1 day. If the initiator had written a notification identifying that the ductwork had reopen (ripped) and that this was a safety issue the condition would have been resolved sooner.

(1) The initiator only referenced that the tear + reverse rotation was previously identified under notification 20117669.

(2) I don't know why notification did not identify a safety concern

(3) - The safety issue was not addressed properly and was disregarded or not handled with the sense of urgency that it should have been

- The initiator did properly investigate his concern

- The initiator never stated that the notification he referenced was ignored. Only that safety + FME aspects have not been adequately addressed after bringing it to the attention of several management personnel.

- I didn't realize it required a notification to address a safety/FME concern.

(*) The 1st notification was closed to trend after band-aiding the duct expansion joint with [illegible]

**PSE&G**

# Notification Overview



*Notification* 20117669
*Notification type* N1
*Description* 12 FHB Exh Fan rotating backward /OOS
Nuc. Maint. Request
*Reporter* [redacted] 04:48:28
*Notification date* 10/21/2002
*Start date* 10/21/2002 *End date* 11/21/2002
*Start time* 04:48:28 *End time* 04:48:28
*Priority* 4 Other *Sig. Level* 3 *Main WorkCtr.* M-OS101
*Funct. location* S1FHV-1VHE21
12 FUEL HDLG BLDG VENT FUEL HANDLING ARE
*Equipment*
*Assembly*
*Order*
*PM planner grp*

7C

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10/21/2002 04:49:35 [redacted] (NUF3S)
Description of condition:
S1FHV-1VHE21 12 Fuel Handling Building Exhaust was observed rotating backwards at approximately 2200 hrs 10/20/2002, when this fan was not in service. 11 FHB Exhaust fan was in service at the time. This is most likely a direct result of combined effect of conditions identified, but not repaired in the plant: 1) tear in fan outlet expansion joint (which now appears significantly larger) and 2) T-mod 02-025, which gags open the inlet guide vanes because they were not controlling properly to maintain FHB D/P.

Impact on plant or personnel safety:
Possible damage to S1FHV-1VHE2-MTRX, drive belts, or the fan if the fan is started while rotating backward.

PSEG Nuclear or Regulatory requirement not met:
Unknown.

What caused the condition:
Identified equipment deficiencies not repaired, but T-MODed and duct taped (literally) away.

Corrective actions taken:
Initiated this notification.

Recommended corrective action:
Fix the previously identified equipment deficiencies.

Recommended responsible group:
Maintenance / Work Management / OCC

Other relevant information:
See 20116336, 20117195, 20116999

Initiator:
Frank Szanyi, R-PRW09, x3488
10/22/2002 14:08:21 [redacted] (NUAPS)
PER [redacted] THIS ISSUE WAS CORRECTED, CLOSE TO TREND.