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January 2, 1995 *7* per Margo Bridges

MEMORANDUM TO: Chairman Jackson
Commissioner Rogers
Commissioner Dicus
Commissioner Diaz
Commissioner McGaffigan

FROM: James M. Taylor *[Signature]*
Executive Director for Operations

SUBJECT: SALEM RESTART ACTIVITIES

The purpose of this memorandum is to inform the Commission of Public Service Electric & Gas (PSE&G's) and NRC's activities related to the restart of the Salem Units. The lead unit for restart is Salem Unit 2.

Background

Salem Units 1 and 2 were first discussed during the January 1990 and January 1991 Senior Management Meeting (SMM), and then each SMM since June of 1994 due to frequent operational transients (which were initiated or complicated by equipment failures, mainly in balance of plant systems), procedural adherence problems, poor root cause determinations, and less than adequate management oversight. NRC Augmented Inspection Teams (AIT) were dispatched to Salem every year between 1991 and 1994. AITs were required in: 1991 to review the Unit 2 turbine-generator catastrophic failure; in 1992 to review loss of overhead annunciators; in 1993 to review repetitive control rod system failures; and in 1994 to review the grass intrusion and a subsequent turbine/reactor trip with complications. In March of 1995, the Executive Director for Operations, the Regional Administrator, and the Director of the Office of Nuclear Reactor Regulation took the significant regulatory action of meeting with the Board of Directors to ensure PSE&G's Board understood the NRC's concerns about Salem's equipment reliability and staff performance. In April 1995, an NRC Special Inspection Team (SIT) was sent to Salem to assess the licensee's safety perspective in the areas of work implementation and scheduling, problem identification, and management oversight.

As a result of continued performance deficiencies, weak management oversight, and ineffective communications coupled with the Technical Specification (TS) required shutdowns of both units, NRC Region I issued a Confirmatory Action Letter (CAL) on June 9, 1995. This CAL delineated licensee commitments that must be satisfied prior to the restart of either Salem unit. In February 1996, Salem Unit 1 startup was delayed because unacceptable degradations were discovered in the steam generators. The Salem Unit 1 steam generators are scheduled to be replaced in early 1997, with unit startup being projected six to twelve months after Salem Unit 2.

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public per Don Brinkman

In July 1995, the staff initiated actions to monitor the licensee's restart plans in accordance with NRC Manual Chapter 0350, "Staff Guidelines for Restart Approval." These guidelines were established to guide agency actions in situations when plants have shutdown voluntarily or involuntarily as a result of a significant event, complex hardware problem, or serious management deficiencies. These guidelines also provide a framework that helps assure adequate coordination among agency offices (i.e., Region, NRR, AEOD, etc.), other federal agencies, state and local officials, and the public. Finally, they establish a basis for a record of agency actions and decisions made in connection with plant restart. Consistent with NRC Manual Chapter 0350, the Salem Assessment Panel (SAP) was chartered and was tasked with monitoring and assessing the licensee's restart plans. The SAP consists of regional and headquarters office Division of Reactor Projects (DRP) and regional Division of Reactor Safety (DRS) management with line responsibility for Salem. The SAP also developed the NRC's plans to oversee Salem restart activities.

Licensee Restart Plan Development

The June 1995 CAL required the investigation of long-standing equipment reliability and operability issues, including corrective maintenance and operator workarounds, and the quality of management oversight that led to these conditions. To accomplish this, the licensee developed a multi-step, systematic methodology to identify and investigate previous problems and to develop its restart plan. This review concluded that 12 common cause issues were significant factors that led to the overall degradation in Salem performance. Typical causes included weak performance standards and expectations; inadequate communications; poor process controls for field work and maintenance; and an ineffective corrective action program (See Attachment 1). These 12 common causes were refined into the licensee's restart plan which included 9 sub-plans. These sub-plans were designed to ensure that the wide spectrum of process, plant equipment, and human performance issues would be satisfactorily resolved prior to restart.

To further define outstanding equipment issues, the licensee initiated a system readiness review process for 46 important systems which required the system manager (engineer), with a contingent of support personnel, to walk down the system and review its documented performance history, as well as related industry experience, to identify outstanding deficiencies. The identified deficiencies were documented and reviewed against pre-established screening criteria to determine which of these items had to be resolved prior to restart. After the deficiency lists for each of these 46 systems were compiled, they were sent through a three-part review process which included an initial review by the line organization, and subsequent management reviews by a system readiness review board (SRRB) and a higher tiered Management Review Committee. The staff confirmed the acceptability of these screening decisions through inspection. This same three-step review process was used for the closeout of restart items to ensure that the necessary resolution (maintenance, modifications, or process improvements) was effected. This same process was also used, in general, for reviewing the quality of restart activities. The licensee's initial restart plan addressed the underlying weaknesses with process, plant equipment, and human performance issues in a general manner. These and other concerns were discussed in management meetings with the licensee. In addition, the NRC staff reinforced the importance of the need for the licensee to independently develop a comprehensive performance improvement plan which encompassed, but was not necessarily limited, to the specific NRC regulatory concerns. PSE&G docketed its revised restart

plan in November 1995 and it was discussed in a subsequent management meeting. In a letter to the licensee dated February 13, 1996, the NRC staff concluded that the revised restart plan, if implemented effectively, was adequate.

Restart Plan Implementation

PSE&G has undertaken a large scope of work during the outage in seeking to address past equipment and human performance issues. The licensee's restart plan identified approximately 30,000 items and over 400 modifications that were scheduled to be implemented prior to restart. Some of the major modifications included: diesel modifications, comprehensive control room renovation, installation of a digital feedwater control system, and the replacement of approximately 800 Hagan instrument modules used throughout the plant in various control and protection applications.

During restart plan development, the licensee identified that eight systems caused 45 of the 54 forced outages since 1988 and developed actions to address these forced outage initiators. For example, the service water system, which was one of the eight systems, has been significantly upgraded with the replacement of all pumps and the installation of corrosion resistant piping throughout the system.

The licensee has completed an examination of selected design documents and operating/test procedures in accordance with their Salem Unit 2 Final Safety Analysis Report (FSAR) Project Plan. Notwithstanding the correction of problems identified during this effort, the licensee concluded that the licensing and design bases were correctly translated into engineering documents, and that there is reasonable assurance that Unit 2 can be operated within its licensing and design bases. PSE&G management expects to continue to examine aspects of their design and configuration control processes as requested in the October 9, 1996, 50.54(f) letter on licensing and design bases conformance. A December 1996 NRC Safety System Functional Inspection (SSFI) noted that many of the discrepancies with the component cooling water system (CCW) have been identified and corrected. However, the SSFI did identify some problems that the licensee had not found. The staff is continuing to evaluate the nature of design and licensing bases related issues in advance of startup. Attachment 2 contains additional details.

Regarding human performance, the licensee has implemented initiatives to address these issues. For example, the Salem general manager and all of the department heads (operations, maintenance, engineering, etc.) have been replaced with experienced managers from other nuclear facilities. All of the senior corporate nuclear executives were also replaced and the nuclear department was reorganized to enhance visibility and accountability. The new senior licensee management team has endeavored to inculcate high safety standards into the organization. In addition, a new corrective action program has been implemented that involves a low threshold for the identification of issues.

Approximately twenty operators from other operating nuclear facilities were hired to improve the on-shift safety ethic. All operators were challenged by a "standards of excellence" training program that emphasized top quality operation and safety conscious decision making. Finally, each operator was required to pass a systematic evaluation conducted by operations management before resuming plant duties. During the summer of 1996 following a series of

maintenance errors, the PSE&G maintenance staff was also removed from plant activities for approximately three months and entered into a "back to basics" training program that emphasized basic skills.

NRC Restart Plan Development

To assure a rigorous assessment of the licensee's restart plan, the SAP began development of the NRC's Restart Action Plan in July 1995. The plan was to provide the framework that the staff would use to evaluate and ensure adequate licensee progress toward restart. The history of events, inspections, enforcement actions, management meetings, plant performance review meetings and SALPs was reviewed in detail to identify candidate items for the plan. Prior to their inclusion, each item was reviewed against the following screening criteria to determine if resolution of the issue was required to:

- (1) ensure safe operation of the facility;
- (2) comply with technical specifications;
- (3) comply with other regulatory requirements;
- (4) meet the design/licensing basis;
- (5) ensure effective management oversight; or
- (6) ensure an effective corrective action process.

Items that met any of these criteria were included in the Restart Action Plan (RAP).

Prior to finalizing the NRC's restart plan, the SAP solicited input from state officials (New Jersey and Delaware) and from the public. In December 1995, the NRC staff met with the public to solicit their concerns. Similarly, in January 1996, two meetings were held with representatives of the state of New Jersey to solicit their comments. The RAP was revised to include the public and state comments, such as New Jersey's concern relative to emergency preparedness. At the conclusion of this process, senior NRC management approved the original NRC restart plan on February 23, 1996.

The staff's restart action plan has continued to evolve to include emerging issues or concerns. For example, the restart plan was modified and significant additional inspection activity was undertaken in light of developments at Millstone, Haddam Neck, and Maine Yankee. Specifically, inspections and meetings with licensee management were conducted to determine if design and licensing bases problems similar to those at these other facilities existed at Salem. Given the significant scope of licensee maintenance and modification activities, the staff greatly expanded inspection of the licensee's integrated test program. These efforts are ongoing.

Salem Restart Inspections

The conduct of Salem restart inspections has been managed by the Salem Assessment Panel. The overall inspection effort has been comprised of the following:

- Three NRC resident inspectors conducting restart inspections on a continuing basis. These inspections overlap core inspections.
- Expanded on-site support of resident inspectors with regional (one full time, two part

time) and contract specialist inspectors (two full time). These inspectors were assigned restart inspections commensurate with their specific technical expertise.

- State officials have accompanied the NRC on several restart inspections.
- A Safety System Functional Inspection (SSFI) was initiated in December 1996 to assess a specific safety system against the design and license requirements. This multi-disciplined team of design specialists is performing a deep vertical slice of the component cooling water system. The on-site portion of the inspection has been completed. The staff is currently assessing the results of the inspection and developing the inspection report.
- A multi-disciplined team of specialist inspectors has begun assessing the adequacy of the licensee's integrated test program (ITP). This effort includes evaluating the scope of the ITP to assure that the appropriate tests are scheduled for the maintenance and modifications that were performed. The team will also directly observe a representative sample of component and system tests.
- A Restart Assessment Team Inspection (RATI) will be used to provide an independent overall assessment of the licensee's readiness for restart shortly before restart occurs. This is planned to coincide with the licensee's second plant heatup currently scheduled for early 1997.
- NRC augmented restart inspection coverage is planned for criticality and power ascension.
- The Salem Assessment Panel plans to continue oversight activities for a minimum of six months after restart.

Performance Expectations to Support Restart

The staff's restart plan established expectations that must be met before plant restart. The general expectation is that significant problems with process, plant equipment and human performance that were exhibited in previous plant operations and events be corrected. While every equipment problem in the plant will not be fixed before restart, it is expected that significant operator workarounds, along with known design and material deficiencies which threaten safety system functions, will be resolved. The NRC plan identified selected equipment problems that must be addressed. More broadly, the staff expects that substantial reductions in the backlog of equipment deficiencies must be made to significantly improve the margins of safety, reduce operator burden, and assure more consistent plant operation.

Fundamental change is required at Salem to assure past problems do not recur. Before startup, the staff expects the licensee to demonstrate that previous management weaknesses and flaws in problem identification and corrective action processes have been effectively addressed.

The staff expects that all restart items will be corrected and verified to be acceptable prior to restart; however, certain technical issues may require power operations before the effectiveness of corrective actions can be verified. For example, final testing of the new feedwater control

system will require operation of the balance of plant. The staff will scrutinize licensee improvements in these areas to assure such testing is conducted in a deliberate and controlled manner.

An additional important consideration is the solicitation of input from the states and from the public to assure that their concerns are considered and appropriately resolved prior to restart. NRC has coordinated with the states and plans to continue to solicit input from state officials and the public through specific meetings.

Observations to Date

The licensee has completed much of the work required for restart. Much remains to be done, however, before the licensee is finished with restart work. Generally, the current licensee management team has established significantly higher standards for performance. The staff has observed stronger questioning attitudes and a much lower threshold for problem identification. The station staff has been challenged by the large scope of maintenance activity and supporting plant evolutions which have occurred during the current dual unit outage. Some errors have occurred but the relative number and significance of errors has declined. While there have been some problems with first line and middle management response, senior station management has responded appropriately where personnel errors have occurred. While the station is now actively closing out restart issues, the staff has noted problems in a number of closeout packages. This matter has been raised with PSE&G management leading to some improvement, but continued close scrutiny will be necessary.

Also, procedure implementation and use continue to warrant further management attention since operators have tended to fall back on their knowledge and experience rather than use procedures when circumstances deviated from those that were expected. Improvement is necessary in this area.

Review by the licensee and independent inspection by the staff have revealed some design and licensing bases conformance problems; individual issues are being resolved as they are identified. The extent of problems in this area is under review to determine what, if any, additional actions are necessary in advance of startup.

Summary

In providing oversight of Salem activities, the staff has been implementing the controls described in NRC Manual Chapter 0350. The development of the NRC's Restart Action Plan included input from both internal and external sources. Expectations have been established relative to performance improvement necessary for plant restart. The Salem Assessment Panel has modified its inspection plan as new issues surface. Significant inspection effort remains in a number of special NRC focus areas, including design and licensing bases conformance, integrated test program, and corrective action program. Attachment 2 contains additional details. The staff will inform the Commission of the final results of its assessment prior to restart of Salem Unit 2.

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Salem Performance Decline

Common Causes

To develop its initial restart plan, Public Service Electric & Gas (PSE&G's), the licensee, performed a detailed root cause analysis and concluded that the 12 common cause issues listed below were significant factors that led to the overall degradation in Salem performance.

- Roles, responsibilities and accountability require better definition across the NBU.
- Standards of performance and work expectations must be enhanced.
- Performance expectations must be more effectively monitored and enforced by managers and supervisors.
- Communications and coordination must be improved across functional lines and vertically within departments.
- Staffing adjustments must be made to ensure that all personnel have sufficient time to carry out core responsibilities.
- Implementation of training and qualification to meet accreditation standards must be improved.
- Higher standards for equipment performance and maintenance must be built into the operations culture.
- Conservative decision making and safety perspective must be enhanced.
- The Nuclear Business Unit (NBU) must become more operations focused.
- The ability to determine root causes for problems and establish lasting corrective actions must be improved.
- The work control process must be redesigned to improve availability of resources and hardware to resolve equipment deficiencies.
- Self assessment processes must be enhanced to ensure better identification and resolution of process/program problems.

NRC Focus Areas

The regional staff and the SAP have identified a number of issues for special focus and oversight. These include:

- **Design and Licensing Bases Conformance**

The regional staff conducted a limited (3-person) team inspection at Salem Unit 2 in May 1996 to evaluate the status of the licensing basis in the context of recent problems observed at Millstone. The team identified some licensing and design bases concerns with the operation of the Fuel Handling Ventilation system which were promptly resolved prior to resumption of fuel handling activities in June 1996.

As a result of the team's findings, NRC regional management prompted the licensee to undertake a comprehensive evaluation of the Salem licensing basis; thus, shifting the burden to PSE&G to provide the reasonable assurance that their operation of Unit 2 would be in conformance with its licensing basis. Public meetings were held on June 11th and July 2nd to discuss the framework of the project, and the NRC developed a series of 17 questions which served to "focus" the licensee's effort, subsequently termed, the FSAR Project Plan. The response to those questions, essentially describing how the FSAR Project would be conducted, was docketed in a letter dated August 23, 1996. NRC Region I provided regulatory oversight of the FSAR Project under the auspices of Inspection Procedure 40501, "Licensee Self-Assessments Related to Safety Issues Inspections." The inspection oversight concentrated upon the licensee's process, including disposition and integration of findings, expansion of scope, and independent (third-party) oversight.

The Salem FSAR Project spanned three months, involved 50 engineers (many of whom were experienced contractors), and cost 1.2 million dollars. The Project examined the Unit 2 UFSAR for both internal and external inconsistencies against selected design information/documents and the Unit 2 operating/test procedures. The Project reviewed many NRC SER's associated with license amendments (as well as all previous regulatory commitments), existing operability determinations, and the FSAR Chapter 15 accident analyses. It also screened a large sample of previously identified engineering deficiencies. The Project accomplished a line-by-line review of the UFSAR, and verified selected samples of the principal attributes and design features for 47 plant systems. Detailed reviews of seven important systems were conducted, each utilizing 4-person teams for three weeks.

As a result of this effort, over 200 findings were entered into the Salem corrective action program. The findings mostly reflected minor inconsistencies in the current licensing basis, and were indicative of older (prior to 1994) information not thoroughly updated in the UFSAR. There were also some substantive findings that included: four reportable events (LER's), generic issues associated with ventilation systems (specifically charcoal

filter testing), and incomplete calculations or missing source documentation. Several safety system functionality issues were identified, such as problems with the containment fan coolers and the aforementioned ventilation systems. Notwithstanding these problems, the licensee concluded that the licensing and design bases were correctly translated into engineering documents, and that there is reasonable assurance that Unit 2 can be operated within its licensing and design bases. PSE&G management expects to continue to examine aspects of their design and configuration control processes as requested in the 50.54(f) letter on licensing basis conformance.

In order to independently test the depth and effectiveness of PSE&G's FSAR Project Plan, the NRC staff conducted a Safety System Functional Inspection (SSFI) of the component cooling water (CCW) system. This system has been evaluated, with particular emphasis upon design, configuration control and testing adequacy. It was selected because of its risk significance, its many interfaces (with other safety support systems), and because it had not been previously "sliced" by the licensee. The SSFI Team was composed of several highly experienced engineers familiar with design control and the conduct of this type of inspection. The SSFI noted that the licensee's effort was primarily focused at assuring that inconsistencies in licensing information were resolved and noted that it did not validate or verify all basic design assumptions. Based on the preliminary findings of the Team, the staff noted that the licensee had identified and corrected many of the licensing basis discrepancies associated with the system. However, the Team found some additional discrepancies as well as some design issues that may affect CCW pump capability.

The staff is still assessing the adequacy and effectiveness of PSE&G's effort; the SSFI is a key element of that assessment. The staff also notes that Salem, like all other plants, will be addressing the 50.54(f) letter and the staff will be carefully assessing the nature of design and licensing bases related issues to determine what special, additional actions will be needed, if any, in advance of startup. The SSFI has preliminarily concluded that the CCW system description contained in the FSAR was reasonably consistent with selected design information/documents and operating/test procedures.

- **Integrated Test Program**

Because of the number of systems opened, maintained, and modified, PSE&G has implemented a very detailed test program to assure, with a high confidence level, reliable operation. This test program utilizes a phased approach by testing at the component, system, train and integrated plant level. To assure adequate oversight, the NRC staff revised the RAP to include a programmatic item for the integrated test program (ITP). A multi-disciplined team of specialist inspectors has begun assessing the adequacy of the licensee's integrated test program (ITP). This effort is currently evaluating the scope of the ITP to assure that the appropriate tests are scheduled for the maintenance and modifications that were performed. The team will also directly observe a representative sample of component and system tests. A detailed inspection plan has been developed and inspections are ongoing.

- **Corrective Action Program**

Because of significant process and implementation weaknesses with the previous corrective action program, the licensee implemented a new, integrated corrective action program that has become the cornerstone for all of their safety related activities. It uses an accessible computer based system (supplemented by a paper system) to enter, approve, and correct identified discrepancies. Station personnel have received training on the system and are familiar with its use. The threshold for entry is very low and the system allows multiple users to enter information while providing appropriate safeguards. While the system is sound, its implementation has been mixed. Prioritization plays a key role in assuring appropriate follow up. Occasionally, deficiencies have been mischaracterized which leads to weak corrective actions. Additionally, because of user friendliness, there is a constant large influx of deficiencies (300-500 monthly) requiring evaluation and corrective action. This influx provides a tremendous burden on plant staff and management. The RAP contains a programmatic item for corrective action. Additionally, insights in this area are captured on a routine basis in ongoing resident and restart inspections.

- **Plant Material Condition**

During the extended outages of both Salem Units, the licensee has identified and corrected a large number of material discrepancies. This effort resulted from a large number of corrective maintenance and modification activities, as well as a general lowering of the threshold for identifying and correcting problems. The primary source of problems with safety related equipment appeared to stem from weak configuration control and configuration management. For example, Hagan instrument modules, an instrumentation and controls (I&C) device used in a significant number of safety and non-safety related applications, were frequently rebuilt without appropriate traceability measures. Thus, the expected response of a given Hagan instrument module to a given set of dynamic inputs was unclear. The controls for the atmospheric steam dump valves (ADV) had to be frequently shifted into manual to discharge a saturated capacitor within the ADV controller. This saturation phenomenon resulted in an effective raising of the ADV setpoint to a value close to the main steam safety valve setpoint. To compensate, operators would periodically shift the controllers to manual to discharge an internal capacitor and relieve the saturation condition. This condition complicated the plant's response to the April 7, 1994 grass intrusion event. In the current extended outages on both units, the Hagan instrument modules have either been rebuilt or replaced with NUS modules that incorporate an improved design with better traceability.

Another area that suffered from weak configuration management was the maintenance of adequate diesel generator (DG) load margins. The addition of safety related loads to safety busses fed by DGs over many years led to the slow erosion of the minimal pre-existing margins. The licensee has implemented plans to recover these lost margins and the RAP contains a technical restart item to ensure that this issue is satisfactorily resolved. Current licensee controls in the overall area of configuration control and configuration management

are improved: however, some concerns remain and will be addressed by the staff's ongoing oversight activities.

- **Operator Performance and Workarounds**

The SAP and restart inspectors have been monitoring and assessing operator performance on a continuing basis because it played a major role in the performance decline at Salem. Questioning attitudes were almost non-existent and workarounds were prevalent. Currently, operator response to routine and abnormal circumstances continues to be good. During requalification training, operators communicated and coordinated well when responding to events. However, during actual plant operation, occasional lapses continued in the operator's questioning attitude during circumstances when unusual indications were present. Procedure implementation and use continues to warrant further management attention since operators tended to fall back on their knowledge and experience rather than use procedures when circumstances deviated from those that were expected. More improvement is necessary in this area. The NRC staff has a programmatic item that addresses operator performance.

- **Employee Concerns**

In the past, Salem has had a large number of employee concerns that implicate the previous station management's ability to address safety issues. On December 3, 1992, an altercation occurred between two Safety Review Group (SRG) engineers and the previous General Manager (GM) and Operations Manager (OM). The Office of Investigations substantiated harassment and intimidation (H&I) in this case and subsequent escalated enforcement action was taken. This incident appeared to stem from the previous management's confrontational attitude with Quality Assurance & Nuclear Safety Review (QA & NSR) personnel. Currently, the staff issued an enforcement action that involved this same confrontational attitude from the 1993 time frame. The case is historically similar and involves QA&NSR personnel. Since all of the managers involved with both these cases have been replaced, this confrontational attitude appears to have dissipated.

The current management team has been receptive to and has worked to resolve employee concerns on a timely basis. Their latest briefing to the NRC included a discussion of actions to improve their organizational culture as well as their environment for raising safety concerns. Recent initiatives have included supervisory training on handling employee concerns, program self-assessments, corrective action program improvements, and communications initiatives. Salem established an Employee Concerns Program (ECP) in 1995, and benchmarked the program against other utilities. The licensee reported that its ECP program has substantiated approximately 51 percent of the 223 concerns received to date, has emphasized timely issue resolution, and uses the expertise of contractors in reviewing and resolving employee concerns. The licensee also conducted a survey of its employees that indicated significant improvements from 1995 to 1996 in employee awareness of the ECP (to >95 percent), and confidence in the processes to resolve concerns (to >80 percent). The staff will continue to evaluate performance in this area.

- **Steam Generators**

In response to Salem Unit 1 steam generator indications discovered in February 1996, the licensee shifted the lead unit for restart from Unit 1 to Unit 2. The licensee began a detailed program to characterize the indications and to evaluate their options to repair or replace the steam generators. They concluded that replacement was the appropriate option. The NRC staff conducted frequent meetings with PSE&G to better understand the licensee's assessment of the Unit 2 steam generator tube inspections and destructive examinations since no special controls were proposed for Unit 2. The licensee presented a summary of their assessment that concluded no observed damage mechanism is expected to challenge the structural and leakage integrity of the Salem Unit 2 steam generator tubes over the next cycle of operation. Based on the information presented in these meetings, the NRC staff stated that the licensee's preliminary conclusions appeared justified. On August 12, 1996, PSE&G submitted a document entitled, "Reg. Guide 1.121 Assessment of Indications at Salem Unit 2." The focus of the document was to evaluate the structural and leakage integrity of the Unit 2 steam generator tubing over the next cycle of operation. The NRC staff found that a full cycle of operation for Salem Unit 2 steam generators was justified and supported by the licensee's analysis.

Regarding the replacement of the Unit 1 steam generators, the NRC regional staff has a single, dedicated resource to oversee PSE&G's steam generator replacement project. Additional resources will be added from time to time, as the need dictates. A dedicated PSE&G organization is in place that conducts daily meetings with the contractor.