U.S. NUCLEAR REGULATORY COMMISSION

REGION I

Report No. 50-272/82-32
50-311/82-30

Docket No. 50-272
50-311

License No. DPR-70 & DPR-75

Licensee: Public Service Electric and Gas Company

80 Park Plaza

Newark, New Jersey 07101

Facility Name: Salem Nuclear Generating Station - Units 1 and 2

Meeting At: NRC Region I, King of Prussia, Pennsylvania

Meeting Conducted: November 9, 1982

Inspectors: for L. E. Tripp 12/3/82
L. J. Norrholm, Senior Resident Inspector date signed

for L. E. Tripp 12/3/82
R. Summers, Resident Inspector date signed

Approved by: L. E. Tripp 12/3/82
L. E. Tripp, Chief, Reactor Projects date signed
Section No. 2A, Projects Branch No. 2, DPRP

Meeting Summary:

Meeting on November 9, 1982 (Combined Meeting Report Nos. 50-272/82-32, 50-311/82-30)

Scope: Enforcement conference held to discuss a tagging and valve alignment error on October 4, 1982 which resulted in degraded auxiliary feedwater capability for a period of seven hours. Areas discussed included the licensee's history of tagging and valve alignment errors, corrective actions, adherence to procedures, management controls, supervision, and field personnel responsibility in this area. The licensee discussed design and management initiatives to reduce these types of errors.

DETAILS

1. Meeting Attendees

PSE&G

J. Boettger, General Manager - Nuclear Support
L. Fry, Operations Manager
H. Midura, General Manager - Salem Operations
R. Uderitz, Vice President - Nuclear
J. Zupko, General Manager - Nuclear Services

USNRC

J. Allan, Deputy Administrator, NRC Region I
D. Caphton, Chief, Management Programs Section, DETP
C. Cowgill, Acting Chief, Reactor Projects Section 2A, DPRP
R. Keimig, Chief, Projects Branch No. 2, DPRP
L. J. Norrholm, Senior Resident Inspector
R. Starostecki, Director, Division of Project and Resident Programs
R. J. Summers, Resident Inspector

2. Background

On October 4, 1982, in preparation for maintenance on safety related equipment, a valve was closed (and tagged) mistakenly which isolated the auxiliary feedwater supply to one of the four steam generators. The tagging order correctly indicated which valves should have been closed. Independent verification of compliance with the tagging order was not performed in accordance with plant procedures and did not detect the error. The mispositioned valve was found and corrected about seven hours later. An identical event, involving the same valves, occurred on August 17, 1982. At that time, the second verification was conducted properly, detected the error, and correction was immediate.

Details of this event are provided in NRC Inspection Report 50-311/82-28.

A review of the licensee's enforcement history for the past three years identified a series of 13 system valve alignment or tagging errors. Each of these findings was a violation and, individually, was not significant. Licensee corrective actions appeared adequate in each case. These events are detailed in the following NRC Inspection Reports: 50-272/79-32, 79-28, 80-06, 80-16, 80-28, 81-01, 81-50, 81-23, 82-01, 82-05, 82-14, 50-311/80-12 and 81-19. As a result of these findings, the licensee has performed independent verification in some form since early 1980.

3. Discussion

NRC Management expressed concern that while the licensee, based on the above experience, has instituted strict procedural controls, these types of violations have not been effectively prevented. The reasons appear to stem from a failure to adequately monitor field operators and maintenance personnel. Procedure adherence is clear policy in the control room but does not seem to be enforced in the case of field personnel in the plant.

Additional concern was expressed with regard to employee attitude and responsibility for adherence to approved procedures and the extent to which first line supervisors monitor the activities of field personnel.

The licensee stated that, while the error rate was not excessive based on available industry statistics, additional steps could be taken, and were being considered, to decrease the frequency of tagging and valve alignment errors.

The following initiatives were proposed by the licensee:

-- The use of remote status indication in the control room for key valves.

-- Strengthening the employees' understanding of procedure adherence policy and philosophy.

-- More effective use of corrective discipline to emphasize the requirement for strict procedure adherence and hold individuals more positively accountable for job performance.

-- Continued use of existing operating department audits of compliance with administrative practices, to identify problem areas.

-- Stronger training emphasis on proper valve operation, including position verification and locking of valves.

Some of these items are being implemented and the remainder are under review to ensure the desired impact on station operations is achieved.

Inspection findings and details relating to the October 4, 1982 event were forwarded separately via our letter of October 26, 1982 transmitting Inspection Report 50-311/82-28. We have determined that an apparent violation of NRC requirements occurred as the result of that event. A Notice of Violation is enclosed as Appendix A to the letter transmitting this report.