ENCLOSURE 1

NOTICE OF VIOLATION

Mr. Lawrence M. Wagner

Docket No. 55-61135
License No. SOP-10807-1
IA 95-036

As a result of a review of the findings of an NRC investigation conducted by the NRC Office of Investigations in 1994 and 1995, a violation of your Senior Reactor Operator license was identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions" (NUREG-1600; 60 FR 34381, June 30, 1995), the violation is set forth below:

Senior Reactor Operator License No. SOP-10807-1 requires, in part, that when manipulating, or directing manipulation of, the controls of the Hope Creek Generating Station, you shall observe the operating procedures and other conditions specified in the facility license which authorizes operation of the facility.

Hope Creek Technical Specification 6.8.1.a requires that written procedures be established, implemented, and maintained covering the activities referenced in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978. Section 1 of Appendix A of Regulatory Guide 1.33, Revision 2, February 1978, specifies the need for administrative procedures.

Nuclear Administrative Procedure NC.NA-AP.EZ-0006 (Q), Revision 3, written to satisfy the requirements in Appendix A of Regulatory Guide 1.33, requires, in Section 5.1, that anyone discovering an off-normal event shall report it to their supervisor, department manager, or Senior Nuclear Shift Supervisor (SNSS). After receiving the report of an off-normal event, the supervisor or department manager will initiate an incident report (IR) and notify the SNSS. After being notified of an off-normal event by a supervisor or department manager, the SNSS will process the IR, or if an individual has reported an off-normal event directly to the SNSS, the SNSS will initiate and process an IR. Attachment 2, Item 2, of Nuclear Administrative Procedure NC.NA-AP.EZ-0006 (Q), Revision 3, provides, in part, as an example of an off-normal event, events requiring notification in accordance with the Code of Federal Regulations.

10 CFR 50.73(a)(2)(i)(B) requires that the licensee submit a Licensee Event Report (LER) within 30 days after discovery of any event involving any operation or condition prohibited by the Technical Specifications.

Technical Specification 6.2.2.b requires that a Senior Reactor Operator be in the control room during Operational Conditions 1, 2, or 3.

Contrary to the above, on June 3, 1992, an off-normal event occurred at the facility (namely, a violation of Technical Specification 6.2.2.b in that there was no Senior Reactor Operator in the control room from 1:38 pm through 1:41 pm), and you as the SNSS on-duty at the time, although notified of the event shortly thereafter, did not initiate an IR as required by the administrative procedure. (01013)

This is a Severity Level III Violation (Supplement VII).

Pursuant to the provisions of 10 CFR 2.201, you are hereby required to submit a written statement or explanation to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, D.C. 20555 with a copy to the Regional Administrator, Region I, and a copy to the NRC Resident Inspector at the facility that is the subject of this Notice, within 30 days of the date of the letter transmitting this Notice of Violation (Notice). This reply should be clearly marked as a "Reply to a Notice of Violation" and should include for each violation: (1) the reason for the violation, or, if contested, the basis for disputing the violation, (2) the corrective steps that have been taken and the results achieved, (3) the corrective steps that will be taken to avoid further violations, and (4) the date when full compliance will be achieved. If an adequate reply is not received within the time specified in this Notice, an order or a Demand for Information may be issued as to why your license should not be modified, suspended, or revoked, or why such other action as may be proper should not be taken. Where good cause is shown, consideration will be given to extending the response time.

Under the authority of Section 182 of the Act, 42 U.S.C. 2232, this response shall be submitted under oath or affirmation.

Because your response will be placed in the NRC Public Document Room (PDR), to the extent possible, it should not include any personal privacy, proprietary, or safeguards information so that it can be placed in the PDR without redaction. However, if you find it necessary to include such information, you should clearly indicate the specific information that you desire not to be placed in the PDR, and provide the legal basis to support your request for withholding the information from the public.

Dated at King of Prussia, Pennsylvania
this 19th day of September 1995

ENCLOSURE 2

UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION I
475 ALLENDALE ROAD
KING OF PRUSSIA, PENNSYLVANIA 19406-1415

September 19, 1995

EA 95-160

Mr. Leon R. Eliason
Chief Nuclear Officer and President
Nuclear Business Unit
Public Service Electric and Gas Company
Post Office Box 236
Hancocks Bridge, New Jersey 08038

SUBJECT: NOTICE OF VIOLATION FOR HOPE CREEK
(OFFICE OF INVESTIGATIONS REPORT 1-94-048)

Dear Mr. Eliason:

This letter refers to the investigation conducted by the NRC Office of Investigations (OI) concerning findings set forth in your internal investigation report issued on October 11, 1994, and in your Licensee Event Report (LER), dated October 14, 1994. The LER and your investigation dealt with the failure of your Senior Nuclear Shift Supervisor (SNSS) to disclose a known violation of a Technical Specification at Hope Creek by failing to prepare an incident report (as required by your procedures) after determining that there was not a Senior Reactor Operator (SRO) in the control room for approximately three minutes on June 3, 1992, when the reactor was operational. Your technical specifications require that a person holding an SRO license for the nuclear power plant be in the control room at all times when your unit is in Operational Condition 1. In addition, this event was not reported to the NRC in an LER within 30 days, as required, which constitutes another violation of NRC requirements. Both violations are described in the enclosed Notice.

With respect to the first violation, on June 3, 1992, the on-duty SNSS left the control room to attend a staff meeting in the office of the Operations Manager and turned the "command and control" function over to the on-duty Nuclear Shift Supervisor (NSS) (also an SRO). The on-duty NSS subsequently wanted to check the status of maintenance being done outside of the control room. Since the SNSS was still absent from the control room at the time, the on-duty NSS requested another NSS (also an SRO) to relieve him. While the on-duty NSS was out of the control room, the other NSS also left the control room for approximately three minutes, thereby leaving no SRO in the control room during that period due to a breakdown in communications among the involved individuals.

When the SNSS was apprised later of what had occurred by the individuals involved, he did not develop an incident report relative to this matter, and he did not record or report the occurrence in accordance with applicable station procedures. As a result of his failure to complete the incident report, Public Service Electric and Gas (PSE&G) management was not apprised of the event, and an LER was not issued to the NRC until more than two years later.

Based on the information developed from the NRC and licensee investigations, the NRC has determined that violations of NRC requirements occurred. Given the short period of time that the condition existed, and the fact that all three SROs were nearby with quick access to the control room, if needed, the two violations are each classified at Severity Level IV in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions" (Enforcement Policy), (NUREG-1600; 60 FR 34381, June 30, 1995). Nonetheless, the NRC is concerned that the SNSS, when he became aware of the incident, did not complete an incident report as required by your procedures. Since the SNSS was aware that the incident constituted an off-normal event, and since the SNSS was aware that off-normal events required completion of an incident report, his failure to do so constitutes a violation of his SRO license which requires him to comply with all of your procedures. A separate Notice of Violation is being issued on this date to the SNSS relative to his conduct of operations, which led to your failure to issue an LER concerning this incident promptly. While the NRC believes the other two SROs involved in the incident also should have taken action to report the incident, we are taking specific enforcement action against the SNSS only, based on his overall responsibility in the incident.

The NRC recognizes that these violations were identified during your internal investigation and promptly reported to the NRC once identified by PSE&G management. The NRC also recognizes that you took prompt action to initiate an investigation after receiving indications that the event occurred; and you took significant corrective actions. The corrective actions included development of remediation plans by the SNSS, and other involved personnel; disciplinary actions regarding the individuals; reinforcement of the command and control turnover process expectations; communication of management's expectations regarding the initiation of incident reports; and placing a mechanical restraint on all SRO identification photo badges as an additional barrier to prevent recurrence of the control room staffing incident. The incident demonstrates the importance of proper communications among the SROs at the facility, as well as prompt completion of incident reports when incidents occur.

You are required to respond to this letter and should follow the instructions specified in the enclosed Notice when preparing your response. In your response, you should document the specific actions taken and any additional actions you plan to prevent recurrence. In your response, you may reference, as appropriate, prior submittals to the NRC regarding this matter. After reviewing your response to this Notice, including your proposed corrective actions and the results of future inspections, the NRC will determine whether further NRC enforcement action is necessary to ensure compliance with NRC regulatory requirements.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your response will be placed in the NRC Public Document Room (PDR). To the extent possible, your response should not include any personal privacy, proprietary, or safeguards information so that it can be placed in the PDR without redaction.

The responses directed by this letter and the enclosed Notice are not subject to the clearance procedures of the Office of Management and Budget as required by the Paperwork Reduction Act of 1980, Pub. L. No. 96.511.

Sincerely,

Thomas T. Martin
Regional Administrator

Docket No. 50-354
License No. NPF-57

Enclosures:
1. Notice of Violation
2. OI Synopsis

cc w/encls:
L. Storz, Senior Vice President - Nuclear Operations
E. Simpson, Senior Vice President - Nuclear Engineering
J. Hagan, Vice President - Business Support
C. Schaefer, External Operations - Nuclear, Delmarva Power & Light Co.
P. MacFarland Goelz, Manager, Joint Generation Atlantic Electric
R. Burricelli, Director - External Affairs
M. Reddemann, General Manager - Hope Creek Operations
J. Benjamin, Director - Quality Assurance & Nuclear Safety Review
F. Thomson, Manager - Licensing and Regulation
R. Karkus, Joint Owner Affairs
A. Tapert, Program Administrator
R. Fryling, Jr., Esquire
M. Wetterhahn, Esquire
Consumer Advocate, Office of Consumer Advocate
W. Conklin, Public Safety Consultant, Lower Alloways Creek Township
State of New Jersey
State of Delaware

ENCLOSURE 1

NOTICE OF VIOLATION

Public Service Electric and Gas Company
Hope Creek Nuclear Generating Station

Docket No. 50-354
License No. NPF-57
EA 95-160

During an NRC investigation conducted in 1994 and 1995 by the NRC Office of Investigations, violations of NRC requirements were identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," (NUREG-1600; 60 FR 34381, June 30, 1995), the violations are listed below:

A. Technical Specification 6.2.2.b requires that a Senior Reactor Operator (SRO) be in the control room during Operational Conditions 1, 2, or 3.

Contrary to the above, on June 3, 1992, from 1:38 pm until 1:41 pm, while the reactor was in Operational Condition 1, there was no SRO in the control room. (01014)

This is a Severity Level IV violation (Supplement 1).

B. 10 CFR 50.73(a)(2)(i)(B) requires that the licensee submit a Licensee Event Report (LER) within 30 days after discovery of any event involving any operation or condition prohibited by the Technical Specifications.

Technical Specification 6.2.2.b requires that a Senior Reactor Operator be in the control room during Operational Conditions 1, 2, or 3.

Contrary to the above, on June 3, 1992, from 1:38 pm until 1:41 pm, while the reactor was in Operational Condition 1, there was no SRO in the control room, a condition contrary to the technical specifications, which was discovered by the on-duty Senior Nuclear Shift Supervisor on June 3, 1992, and this event was not reported to the NRC in an LER until October 14 1994. (02014)

This is a Severity Level IV violation (Supplement 1).

Pursuant to the provisions of 10 CFR 2.201, Public Service Electric & Gas (PSE&G) is hereby required to submit a written statement or explanation to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, D.C. 20555 with a copy to the Regional Administrator, Region I, and a copy to the NRC Resident Inspector at the facility that is the subject of this Notice, within 30 days of the date of the letter transmitting this Notice of Violation (Notice). This reply should be clearly marked as a "Reply to a Notice of Violation" and should include for each violation: (1) the reason for the violation, or, if contested, the basis for disputing the violation, (2) the corrective steps that have been taken and the results achieved, (3) the corrective steps that will be taken to avoid further violations, and (4) the date when full compliance will be achieved. Your response may reference or include previous docketed correspondence, if the correspondence adequately addresses the required response. If an adequate reply is not received within the time specified in this Notice, an Order or a Demand for Information may be issued as to why the license should not be modified, suspended, or revoked, or why such other action as may be proper should not be taken. Where good cause is shown, consideration will be given to extending the response time.

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Dated at King of Prussia, Pennsylvania
this 19th day of September 1995

SYNOPSIS

On October 17, 1994, the Office of Investigations (OI) initiated an investigation into the circumstances surrounding the failure of the Hope Creek Generating Station (HCGS) to report a violation of plant Technical Specifications in a timely manner. The HCGS is operated by the Public Service Electric & Gas Company (PSE&G).

On June 3, 1992, the HCGS was operated without a Senior Reactor Operator (SRO) present in the control room for approximately 2 minutes and 56 seconds while the unit was in Operational Condition 1 (Op-Con 1). NRC regulations, and HCGS technical specifications, require the licensee to have a person holding an SRO license for the nuclear power unit in the control room at all times when the unit is in Op-Con 1. NRC regulations further require such a violation of station technical specifications to be reported to the NRC within 30 days of discovery, via a Licensee Event Report (LER). The June 3, 1992, event was not reported to the NRC until October 14, 1994, via HCGS LER 94-013-00.

The OI investigation did not substantiate that HCGS operations personnel deliberately subverted NRC reporting requirements. However, the investigation did substantiate that the on duty HCGS Senior Nuclear Shift Supervisor deliberately failed to document the event in accordance with internal procedures, and his failure led to the delinquent licensee LER.

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