Public Service
Electric and Gas
Company

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DEC 01 1995
LR-N95202

United States Nuclear Regulatory Commission
Document Control Desk
Washington, DC 20555

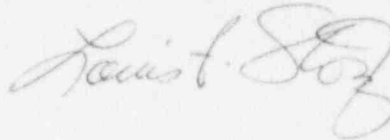
Gentlemen:

REPLY TO A NOTICE OF VIOLATION
OFFICE OF INVESTIGATIONS REPORT 1-94-048
HOPE CREEK GENERATING STATION
FACILITY OPERATING LICENSE NPF-57
DOCKET NO. 50-354

Pursuant to the provisions of 10CFR2.201, this letter submits the response of Public Service Electric and Gas Company to the notice of violation issued to the Hope Creek Generating Station in a letter dated September 19, 1995. In addition, the response to Violation B also supersedes letter LR-N95034, which was transmitted on April 3, 1995.

Should you have any questions or comments on this transmittal, do not hesitate to contact us.

Sincerely,



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ATTACHMENT

REPLY TO NOTICE OF VIOLATION
OFFICE OF INVESTIGATIONS REPORT 1-94-048
HOPE CREEK GENERATING STATION
DOCKET NO. 50-354 LR-N95202

I. INTRODUCTION

The NRC Office of Investigation conducted an investigation concerning findings set forth in a PSE&G internal investigation report issued on October 11, 1994, and in a Licensee Event Report (LER), dated October 14, 1994. As a result of this investigation, the NRC issued a notice of violation citing two violations of NRC requirements in a letter dated September 19, 1995.

In accordance with the provisions of 10CFR2.201, Public Service Electric and Gas Company hereby submits a written response to the notice of violation which includes for each violation: (1) the reason for 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.

A. Violation A

1. Description of the Notice of Violation

"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.

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

2. <u>Response to Notice of Violation</u>

PSE&G does not dispute the violation.

i. <u>Description of Event</u>

On June 3, 1992, at 1338 hours, the Nuclear Shift Supervisor (NSS) who had assumed the command and control role left the control room. The Senior Nuclear Shift Supervisor (SNSS) had previously turned over to the NSS to attend a department staff meeting. Some time after the SNSS had left the control room, a problem was brought to the attention of the NSS regarding control room chillers. The NSS decided to go to the chillers, and contacted the Shift Technical Advisor (STA - SRO licensed) to discuss the problem and to be relieved. Following this discussion, the NSS walked into the rear of the control room area to get his hard hat and safety gear while the STA returned to the work control office. Both individuals believed the other was to remain in the control room; the NSS believed he had turned over command and control while the STA believed the turnover was yet to occur. The two individuals left from different doors that are not visible from each other. The on duty Nuclear Control Operator and a Quality Assurance engineer who were in the control room realized that no SRO was present and paged the STA. The STA returned to the control room within three minutes of the time he exited.

ii. <u>Reason for Violation</u>

This event was attributed to personnel error on the part of the NSS who left the control room after assuming command and control.

iii. <u>Corrective Steps That Have Been Taken and Results Achieved</u>

Command and control turnover process expectations have been reinforced with the SRO's involved in the event as well as with the other SRO's.

A mechanical restraint on the SRO's identification photo badge is being utilized as an additional barrier to prevent inadvertent recurrence.

The individuals involved in this incident have been disciplined.

iv. Corrective Steps that will be Taken to Avoid Further Violations

All Corrective Actions are stated in LER 354/94-013 and are complete.

v. Date When Full Compliance Will Be Achieved

Based on the completion of the corrective steps listed above and in LER 354/94-013, full compliance has been achieved.

B. **Violation B**

1. **Description of the Notice of Violation**

"10CFR50.73(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 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.

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

2. Response to Notice of Violation

PSE&G does not dispute the violation.

i. Description of Event

Subsequent to the event discussed in Violation A, the SNSS, NSS, and STA discussed the fact that for a period of approximately three minutes (2 minutes, 56 seconds) no SRO was in the control room and recognized that a noncompliance with the administrative section of Technical Specifications had occurred. The SNSS discussed the matter with a QA Engineer and inappropriately decided not to file an incident report. The SNSS has explained that when the incident occurred, he did not give it proper consideration. He has also explained that, at the time, he incorrectly minimized the safety significance of the event and allowed that to influence his decision not to report the incident. As a result, he failed to fulfill his obligation as the on-duty SNSS to report the event, which then led to PSE&G's failure to file the required LER in a timely manner.

ii. Reason for Violation

Personnel error on the part of the SNSS, NSS, STA, and QA Engineer resulted in a missed LER. PSE&G has previously investigated the issue of whether the SNSS knew at the time of the event that an incident report was required to be filed. These investigations into the SNSS's knowledge in 1992 yielded inconsistent conclusions. The Company's initial investigation suggested that the SNSS was aware of the reporting requirement. The report of this initial investigation was provided to and discussed with the NRC in October, 1994.

The report's conclusion was later determined by PSE&G to have an insufficient basis. In the Company's April 3, 1995 report (letter LR-N95034) to the NRC concerning this matter, PSE&G indicated that due to the absence of conclusive evidence, it had not found that the SNSS was aware at the time of the event that an incident report was required to be prepared.

A recent review and assessment of the Company's earlier investigations identified weaknesses in the approach that was utilized to formulate the final conclusion communicated in the April 3, 1995 report. The recent review and assessment also concluded that these weaknesses led to subjective conclusions in the Company's follow-up investigation, which was further hampered by the passage of time since the occurrence. As a result, this violation response, which contains the Company's final position on the issue, supersedes letter LR-N95034, which was transmitted on April 3, 1995.

PSE&G management realizes that all of the facts relative to the June 3, 1992, Hope Creek Control Room Staffing incident cannot be completely reconstructed because of the elapsed time and the varied investigations. Therefore, due to the fact that the SNSS has not disputed the NRC's conclusion that he was aware an incident report was required, combined with the weaknesses in the approach to the previous investigations, the following represents PSE&G's final position:

> The SRO's discussed whether an incident report was required and concluded not to file an incident report in violation of station procedures.
>
> Statements in the Report by Winston and Strawn, dated October 11, 1994, that individuals knew, in 1992, that an incident report was required were conclusions reached indirectly through the interview process. Nevertheless, such statements are believed to be true.
>
> While the administrative procedure was not explicit for requiring an incident report for noncompliance with the administrative section of Technical Specifications, the SRO's and the QA Engineer exhibited poor judgment in determining that this event should not be raised to management's attention. The administrative procedure has been revised to assure the required clarity, and site-wide training and communication of management expectations for initiating corrective action documents has been completed.

The QA Engineer compromised independent QA oversight by failing to assure that the absence of an SRO in the Hope Creek Control Room was reported, and by failing to adequately inform his supervisor of the incident.

Due to the number of investigations performed to date, with varied results, no further discipline has been initiated for the four individuals involved in the manning incident. However, each individual will receive formal feedback regarding the Company's final position on the event.

iii. Corrective Steps That Have Been Taken and Results Achieved

An LER was promptly issued to the NRC when management became aware of the issue.

Additional training has been provided to appropriate personnel on the reporting requirements of 10CFR50.73 and NUREG-1022.

As stated in the letter transmitted on April 3, 1995, the individuals involved in this incident have been disciplined and remediated and have completed the following Remediation Plan:

They each submitted a written response to the investigation report that focused on their role in the incident. Preparing these responses helped the individuals to gain a better understanding of the issues surrounding this incident.

They met with the Station Operations Review Committee, the Licensing Manager, the General Manager - Hope Creek Operations, the Hope Creek Operations Manager, the Manager - Station Quality Assurance - Hope Creek, and the Nuclear Safety Review Manager. The purpose of these meetings was for the individuals to gain a broader perspective and deeper level of understanding of their actions and the impact they had. The individuals documented the key lessons learned in a Remediation Plan document.

Corrective action recommendations that generally focused on the command and control process, training enhancements, and the root causes of this incident were included as part of the Remediation Plan.

The individuals interviewed with senior management to ensure that they were ready to return to work. The remediation was determined to be successful.

The individuals have complied with the Remediation Plan and were returned to their normal duties.

Management's expectations for initiating incident reports were clarified and communicated both to the personnel involved in this incident and other applicable Nuclear Business Unit (NBU) personnel.

The NBU has developed and implemented a new Corrective Action Program (CAP) to ensure timely problem identification and resolution. As part of the development of the CAP, the NBU benchmarked several other utility's programs that have been successfully consolidated.

The CAP has consolidated and improved previously existing programs within the NBU. The program includes a low threshold for reporting problems, provides for aggressive problem assessment and root cause determination, and establishes management controls on completion schedules for specified corrective actions. The CAP includes a graded approach to root cause determination based on significance level. The CAP also requires timely completion of cause determination.

Accountability for CAP implementation rests with station line management. As such, station managers are responsible to ensure cause determinations are appropriately thorough, including the designation of corrective actions to address root and contributing causes. The Director - Quality Assurance/Nuclear Safety Review has oversight responsibility for the CAP and has established dedicated resources under the Manager - Corrective Action and Quality Services, to fulfill that responsibility. Measures have also been established to monitor the performance of the corrective action process. These include performance indicators and monthly reports to senior management.

The Company has undertaken a review of its investigation process and has made changes that have improved its quality and effectiveness, including the formation of an Employee Concerns Group that has been given the responsibility to conduct this type of investigation. Significant investigations that are conducted by the Employee Concerns Group require a charter that is approved by a member of Senior Management. The charter includes an identification of the issue to be resolved, a proposed approach, and a timetable. Interviews are conducted in a structured manner, and include a way of recording the interview. For these significant investigations, the interviewees review the record of the interview and are given an opportunity to provide corrections and additional information. This record is used to formulate the conclusions of the investigation. This structured approach minimizes the possibility of introducing uncertainty regarding "what was said" following the completion of the investigation.

iv. Corrective Steps that will be Taken to Avoid Further Violations

As stated in part (iii) above, the Company implemented an aggressive corrective action and Remediation Plan, including appropriate discipline of the SNSS, NSS, STA, and QA Engineer. These actions have been successfully completed and are considered to be sufficient to avoid further violations.

The recently completed assessment of the Company's earlier investigations has been reviewed to determine additional corrective actions. Corrective actions include counseling or discipline for the individuals involved in the conduct of the Company's follow-up investigation; feedback to the individuals involved in the original manning incident regarding the Company's final position on the event; and a review of lessons learned to identify any additional improvements in the investigation process.

v. Date When Full Compliance Will Be Achieved

All actions that are required to achieve full compliance are stated in LER 354/94-013 and are complete. Based on the completion of the Remediation Plans and the return of the individuals to their normal duties, full compliance has been achieved.

The actions identified as a result of the recently completed assessment of the Company's earlier investigations, identified in part (iv) above are in the process of being completed.