

ATTACHMENT 10

UNITED STATES NUCLEAR REGULATORY COMMISSION  
REGION 1

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In re: PUBLIC SERVICE ELECTRIC AND GAS CO.  
SALEM GENERATING STATION

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An Enforcement Conference was held before Loretta B. Devery, Registered Professional Reporter and Notary Public, at the offices of the United States Nuclear Regulatory Commission, Region 1, 475 Allendale Road, King of Prussia, Pennsylvania, on Wednesday, February 8, 1995, commencing at 10:00 A.M.

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PRESENT:

WAYNE LANNING  
JOHN WHITE  
KARLA SMITH, ESQ.  
DANIEL HOLODY  
SCOTT BARBER  
LENNY OLSHAN  
MARK SATORIUS  
KEITH LOGAN  
KRIS MONROE

LEON ELIASON  
JOSEPH HAGAN  
FRANK THOMSON  
JEFF BENJAMIN  
JOHN SUMMERS  
BOB BURRICELLI  
DAVE DODSON  
MARK J. WETTERHAHN, ESQ.  
ARTHUR H. DOMBY, ESQ.  
LAWRENCE REITER  
WILLIAM BRIGGS, ESQ.  
VINCENT POLIZZI

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ORIGINAL

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2 MR. WHITE: Gentlemen, my name is John  
3 White, United States Nuclear Regulatory Commission.  
4 I'm the Chief of the Reactor Projects Section 2A,  
5 Division of Reactor Projects. That is the section  
6 that is responsible for the administration of  
7 special activities at Salem and Hope Creek.

8 The purpose of this enforcement  
9 today -- this is a closed enforcement conference --  
10 is to discuss the findings of our Office of  
11 Investigations report of activities related to the  
12 potential harassment and intimidation of employees  
13 of PSE&G by members of the management staff at Salem  
14 Nuclear Power Station.

15 Previously, on January 11th, PSE&G, Mr.  
16 Eliason and Mr. Reiter and Mr. Polizzi and Mr.  
17 Vondra were provided a letter from NRC inviting them  
18 to this enforcement conference and identifying the  
19 issue that were going to be discussed.

20 Specifically, the matter that is up for  
21 review today is that on December 3rd, 1992, two SRG  
22 engineers attempted to process a safety issue in  
23 accordance with your station procedures by  
24 submitting an incident report to the then general

1 manager of Salem operations, Mr. Cal Vondra, and the  
2 operations manager, Mr. Vince Polizzi. The incident  
3 report questioned the qualification of commercial  
4 grade air pressure regulators which control service  
5 water flow to containment fan cooling units.

6 In conversations with the SRG  
7 engineers, the general manager, Mr. Vondra, with the  
8 cooperation, and we believe the advice of Mr.  
9 Polizzi, told the individuals to get out of his  
10 office and threatened to have them removed from  
11 site, an action that was interpreted by the SRG  
12 engineers as harassing and intimidating.

13 Upon deliberation, Mr. Vondra wrote a  
14 memorandum to the General Manager of Quality  
15 Assurance, Mr. Lawrence Reiter, requesting him to  
16 have the engineers removed from any direct  
17 involvement with the Salem station.

18 Subsequently, further apparent  
19 discriminating action was directed against the  
20 individuals when the General Manager of Quality  
21 Assurance and Nuclear Safety Review, Mr. Reiter,  
22 deliberated and took action to in some fashion  
23 reprimand or counsel the individuals relative to  
24 their submittal of the incident report and their

1 handling of the situation.

2 In conclusion, the NRC investigation  
3 determined that information appears to support the  
4 finding that the SRG engineers were harassed and  
5 intimidated by various actions taken or directed by  
6 these former Salem senior managers.

7 As we discussed in the letter, the  
8 purpose of this enforcement conference today is, now  
9 that we have completed our investigation, is to give  
10 the licensee first, and then the individuals later  
11 on in the afternoon and Mr. Vondra later on on  
12 February 24th, an opportunity to understand the  
13 NRC's understanding of this issue and how we  
14 perceive the harassment and intimidation relative to  
15 the regulatory requirements, and to allow the  
16 licensee and those individuals an opportunity to  
17 provide the information to the NRC that explains  
18 their actions, provides any mitigation, mitigating  
19 information that might pertain, allows the licensee  
20 and his individuals an opportunity to discuss any  
21 corrective actions that may have been taken since  
22 that time, the resolution of these issues with the  
23 individuals and what the future plans are relative  
24 to the licensee relative to preventing any chilling

1 effect relative to this incident.

2 This meeting is transcribed. It is  
3 closed to public participation. We have informed  
4 Mr. Reiter and Mr. Polizzi that in the context of  
5 our meeting with you today, with the licensee, that  
6 if they are to be asked any questions and they  
7 choose to answer those questions not in this forum,  
8 that we will provide them another type of forum,  
9 another place in which they can respond without the  
10 presence of licensee representatives, if they are  
11 here today.

12 With that, I'll entertain any questions  
13 that you might have relative to protocol and  
14 comments today. Let me take an opportunity to  
15 introduce the NRC staff and then we can go around  
16 the room. Mr. Dan Holody is the Regional  
17 Representative for our Enforcement Coordinator here  
18 in Region 1. Karla Smith is Regional Counsel,  
19 Region 1. Scott Barber is Project Engineer, works  
20 in my section. Mr. Lenny Olshan is the Project  
21 Manager, Office of Nuclear Reactor Regulation. Mr.  
22 Mark Satorius is a representative with the Office of  
23 Enforcement. Mr. Wayne Lanning is my supervisor, my  
24 boss, Deputy Director, Division of Reactor Projects.

1 Also here is Kristen Monroe, who is from the Office  
2 of Investigations and was the lead O.I. investigator  
3 relative to this case. And Keith Logan, who is also  
4 a member of the Office of Investigations.

5 If you take an opportunity and just  
6 introduce yourselves so we're familiar with you, I  
7 appreciate it, please.

8 MR. DOMBY: My name is Art Dobby. I'm  
9 with the law firm of Troutman Sanders in Atlanta,  
10 Georgia, and I'm representing Mr. Reiter  
11 individually.

12 MR. REITER: Larry Reiter.

13 MR. THOMSON: Frank Thomson, Manager,  
14 Licensing and Regulations.

15 MR. ELIASON: Leon Eliason, President  
16 and Chief Nuclear Office of the Nuclear Business  
17 Unit for PSE&G.

18 MR. HAGAN: Joseph Hagan. I'm the Vice  
19 President of Nuclear Operations.

20 MR. SUMMERS: John Summers. I am the  
21 General Manager of Salem.

22 MR. BENJAMIN: I'm Jeff Benjamin, the  
23 Director of Quality Assurance and Nuclear Safety  
24 Review.

1 MR. DODSON: Dave Dodson. I work in  
2 Licensing and Regulations for Frank Thomson.

3 MR. BURRICELLI: Bob Burricelli, PSE&G.

4 MR. WETTERHAHN: Mark Wetterhahn with  
5 the law firm of Winston and Strawn.

6 MR. POLIZZI: Vince Polizzi, PSE&G.

7 MR. BRIGGS: Bill Briggs, Mr. Polizzi's  
8 attorney.

9 MR. WHITE: Gentlemen, do you have any  
10 questions on our purpose here today and the protocol  
11 and format? Our plan here today is to take as much  
12 time as necessary. The hope is that relative to our  
13 meeting with PSE&G that we will be able to do that  
14 within the next couple of hours. Following that, we  
15 will take a lunch break and then resume with  
16 individual enforcement conferences, starting with  
17 Mr. Reiter first and then Mr. Polizzi.

18 I'd like to do Mr. Reiter's conference,  
19 if we can accommodate 1:30 for that, Mr. Reiter, and  
20 I'm anticipating maybe an hour, an hour and a half  
21 of that, followed by you, Mr. Polizzi.

22 If there are no questions, then I'll  
23 turn it over to your organization, Mr. Eliason.

24 MR. ELIASON: Okay, thank you, Mr.

1 White. Joe Hagan will provide our review of the  
2 incident, the root causes, the corrective actions  
3 and those issues. Before he does that, I'd like to  
4 make a few opening comments.

5 We want to accomplish three things here  
6 today from our perspective. One is to discuss our  
7 assessment of the event and its root causes, to  
8 demonstrate that appropriate corrective actions have  
9 been taken to address the issues from the December  
10 3rd event, and to talk about our ongoing actions  
11 which we believe will continue to improve the  
12 environment for dispersing the information pursuant  
13 to safety concerns.

14 Before I turn the presentation over to  
15 Mr. Hagan, let me first make a few key points on the  
16 event of December 3rd and thereafter. Certain  
17 department managers engaged in actions that were  
18 harassment or intimidation or failed to respond. We  
19 believe the Nuclear Department management's actions  
20 to address the issues between December 3rd and  
21 January 27th were untimely and not effective. And  
22 once the implications of the event were recognized,  
23 however, the Nuclear Department did initiate an  
24 aggressive internal investigation to bring the issue

1 to closure and disclose any underlying issues that  
2 were associated with the event.

3 Ultimately, the root cause of this  
4 event was really management's failure to establish  
5 and enforce the uniform standards of performance  
6 relative to the treatment of all individuals engaged  
7 in protected activities. We have come to these  
8 basic conclusions. And this really completes my  
9 opening discussion.

10 And I'd like to now turn it over to Mr.  
11 Hagan to review the event. Joe?

12 MR. HAGAN: What I'd like to do is  
13 start with a brief summary of the synopsis of the  
14 NRC findings in your letter to us and the apparent  
15 violations. I won't take the time to read them.

16 I'd like to go through a sequence of  
17 events just for those people who may not be real  
18 familiar with what happened. And we'll do that  
19 starting on December the 3rd, which took place the  
20 initial discussion between the Operating Manager and  
21 the Safety Review Engineers, and there were two  
22 Safety Review Engineers. That dealt with the  
23 incident report, the filing of an incident report  
24 with the concern with some containment fan cooling

1 unit regulators.

2 The discussion in the Ops Manager's  
3 office really developed into a confrontation when  
4 there were some discussions about adding some  
5 additional information to the incident report in  
6 terms of what the position was, or was there a  
7 position that the Safety Review Engineers had on  
8 operability. That confrontation then spilled over  
9 to the General Manager's office when the Ops Manager  
10 directed the Safety Review Engineers to follow him  
11 to the General Manager's office where they were  
12 going to have a discussion concerning the incident  
13 report and really what it meant.

14 The discussion in the General Manager's  
15 office was held after the Ops Manager briefed the  
16 General Manager on what the concern was. And that  
17 took I believe about 10 minutes or so.

18 The Safety Review Engineers were  
19 brought into the office. There was a discussion  
20 held in the office. Again, that really developed  
21 into a confrontation and resulted with the plant  
22 manager asking the Safety Review Engineers to leave  
23 his office.

24 The Salem GM then initiated a contact

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3  
1 with the General Manager of Quality Assurance and  
2 Nuclear Safety Review to tell what had occurred and  
3 to seek his assistance in follow-up. The General  
4 Manager of QA/NSR, who I believe was in a SERT at  
5 Hope Creek, which was our Significant Event Response  
6 Team, our evaluation at Hope Creek, directed that he  
7 wanted his people to do the management of the safety  
8 review function itself on the island to due the  
9 follow-up.

10 The General Manager directed the OM to  
11 draft a letter to the GM-QA/NSR to ask him for the  
12 SRG engineers to be removed from the Salem oversight  
13 role. His purpose, as stated to me, was that he  
14 felt that the SRG engineers would not be effective  
15 in the relationship because of the confrontation  
16 that had occurred, and he was asking for a  
17 reassignment.

18 On the 4th of December, the next day,  
19 the SRG engineers filed a quality concern, which is  
20 in accordance with our process, anybody can file a  
21 quality concern. The Salem GM signed a letter that  
22 he had asked the OM, OM being the Operations  
23 Manager, to draft, but it was not transmitted. The  
24 letter was signed, but it was not transmitted on the

3  
1 4th when it was signed. And I'll get to when it  
2 actually was transmitted.

3 On the 14th, the Salem General Manager  
4 provided a copy of the letter to the General Manager  
5 QA/NSR to the Vice President of Nuclear Operations,  
6 and he discussed the content of the letter and what  
7 his concerns were. At that point in time, the VP  
8 Nuclear Operations thought the letter had already  
9 been sent, but as I said before, it had not been  
10 transmitted.

11 On the 16th, the GM of QA/NSR met with  
12 the plant manager, the Ops Manager and other Salem  
13 managers to discuss what had happened and received  
14 some feedback on the SRGs' performance. And he  
15 really, at that time, provided his reenforcement of  
16 the independent nature of the safety review  
17 function, what the individuals were expected to do.

18 On the 18th, the Chief Nuclear Officer  
19 received a copy of the letter from the Vice  
20 President of Nuclear Operations. On the 21st of  
21 December, the CNO reads the letter and requests  
22 status from the GM of QA/NSR. The GM-QA/NSR met  
23 with the Salem Plant Manager and he also met with an  
24 HR facilitator who was assigned to the Salem plant

1 to discuss some of the options that he might have on  
2 reaching a resolution.

3 The Salem GM on the 21st, he clarified  
4 his request for reassignment of the SRG engineers to  
5 the General Manager of QA/NSR. At that time, the  
6 GM-QA/NSR told the General Manager that the request  
7 was inappropriate and would not be acted on. The  
8 individuals would not be reassigned.

9 On the 22nd, the GM-QA/NSR received a  
10 copy of the letter. He actually received a copy  
11 from the CNO and responds to a request for status.  
12 He indicates he's working with the Salem General  
13 Manager to resolve the issues.

14 Following on the 30th, the GM-QA/NSR  
15 receives the transmittal. So there's some confusion  
16 on what happened, why the letter was delayed in the  
17 mail. There's a couple reasons that we understand  
18 may be possible. I can't tell you which one really  
19 happened. But in any event, the letter was  
20 transmitted, but it did not get to the destination  
21 until the 30th of December. But we had copies of  
22 the letter that were signed. So there was informal  
23 distribution that actually occurred before the  
24 letter was transmitted.

1                   On the 6th of January, the General  
2                   Manager of QA/NSR provided response to the safety  
3                   concern to the SRG engineers. The SRG engineer was  
4                   not satisfied with the response to his quality  
5                   concern. And on the 27th of January, he escalates  
6                   his quality concern. And the way the quality  
7                   concern was handed to the Senior Vice President of  
8                   the Business Unit, who's office is in Newark, our  
9                   main headquarters.

10                   On the 28th of January, there's  
11                   conversation held and the CNO directs the General  
12                   Manager of Information Systems/External Affairs to  
13                   initiate a formal investigation. So he charters the  
14                   General Manager-Information Systems, which is  
15                   independent of the QA organization, to initiate a  
16                   formal investigation. And the CNO and the VP of  
17                   Nuclear Ops briefed the NRC Senior Resident  
18                   Inspector on what the issues are and what our plans  
19                   are.

20                   Our assessment of the December 3rd  
21                   event itself and the Nuclear Department actions to  
22                   resolve the issues between December 3rd and January  
23                   27th were not timely and not effective.

24                   Once the implications of the events

1 were recognized, the CNO initiated an aggressive  
2 internal investigation of the circumstances and  
3 underlying issues associated with the event. There  
4 was a charter drafted that was approved by the  
5 Senior Vice President and General Counsel on what  
6 the investigation was to accomplish. Independent  
7 task force operated under the General Manager of  
8 Information Systems and External Affairs,  
9 independent of Quality Assurance.

10 Altogether, there was 30 individuals  
11 interviewed to establish the facts and relevant  
12 information required to address the charter. It was  
13 conducted between January 27th and April the 2nd,  
14 the actual investigation.

15 The conclusions of the investigation  
16 were that the SRG engineers' actions were consistent  
17 with management expectations regarding the  
18 identification and resolution of safety issues or  
19 safety concerns, and that the two SRG engineers were  
20 in fact harassed and intimidated by statements and  
21 actions of the Ops Manager and the general manager  
22 on December the 3rd.

23 With respect to the actions of the  
24 Salem General Manager and the Ops Manager, the

1 actions were unprofessional and inappropriate. The  
2 Ops Manager and the GM did harass and intimidate the  
3 SRG engineers. We do not believe that these actions  
4 were deliberate. The fact that the confrontation  
5 did take place was evidence that there was the  
6 harassment or intimidation did occur.

7           However, we did not conclude that it  
8 was a deliberate intent to suppress a safety  
9 concern. In fact, there was a lot of discussion,  
10 subsequent discussion about the 50.7 issue or what  
11 50.7 meant subsequent to the investigation. And the  
12 conclusion that we drew or the opinion that the  
13 Plant Manager and the Ops Manager had was that  
14 unless the individuals were stopped or threatened to  
15 not go to the NRC with the concern, then there was  
16 no -- there would not be intimidation. That's what  
17 their interpretation was.

18           With respect to the General Manager  
19 QA/NSR, the actions to resolve the situation were  
20 not timely and not effective. And although a formal  
21 reprimand was drafted for one of the SRG engineers,  
22 it was not issued. And that was because of  
23 subsequent discussions the GM-QA/NSR had with the  
24 individuals. Although he drafted the counseling, it

4  
1 was not delivered.

2 He did have some discussion with the  
3 individual about some remarks that were made  
4 concerning one of the processes, what we call the  
5 DEF process. There were some conversations held  
6 around the inappropriateness of that statement where  
7 the individual had no confidence in the system and  
8 would not use it. Within our system, as far as the  
9 counseling or reprimand, that was not done within  
10 our system as we define counsel and reprimand.

11 The root cause of the event was -- hole

12 MR. HOLODY: Could I interrupt you  
13 before you go on to the root cause? I guess this  
14 pretty much completed the description of the fact  
15 finding. What was the -- what did you conclude was  
16 the reason for the harassment and intimidation of  
17 the engineers?

18 MR. HAGAN: Why were they --

19 MR. HOLODY: Why did they do what they  
20 did to these two individuals?

21 MR. HAGAN: The actions that were taken  
22 between -- actually it was a confrontation and an  
23 argument that occurred between the managers and the  
24 individuals was really the desire of the Ops Manager

4  
1 to have a statement or some discussion about what  
2 the opinion was of the SRG engineers concerning  
3 operability. And from that discussion, it was a  
4 technical discussion that dissolved into a  
5 confrontation between one opinion and another  
6 opinion and the Ops Manager's desire to have some  
7 statements written on the incident report or  
8 supplied on the incident report that he thought was  
9 had already been resolved.

10 And the issue about the argument,  
11 instead of just saying -- our process would have  
12 been to initiate the incident report and file it,  
13 file the incident report and let the process take  
14 its route. That would have been the expectation.  
15 The fact that there was an argument that occurred  
16 was the intimidation itself about whether there  
17 should have been anymore added. Should there have  
18 been some information that was not there, that  
19 should have been on the incident report, should not  
20 have been in the conversation, should have been  
21 filed with the shift and the incident report  
22 progressed from there.

23 MR. HOLODY: I'm trying to understand  
24 what you concluded in terms of why that argument

4  
1 took place. Was it because the individual wanted an  
2 operability determination, the General Manager and  
3 the Ops Manager, and didn't get one? Was it  
4 anything beyond that?

5 MR. HAGAN: I think what -- not -- I'm  
6 giving my opinion of what it was, and this is my  
7 opinion is that the Ops Manager, from the report  
8 itself, the Ops Manager had asked for information  
9 regarding the operability. When the SRG engineers  
10 were hesitant to provide that so and they didn't  
11 want to provide that information, they didn't think  
12 it would be appropriate, it got off that issue into  
13 an argument of well why not. The information is  
14 here, we need to have that information to discuss  
15 with the senior, the senior shift supervisor. When  
16 it got to that point, it was an argument between the  
17 two individuals.

18 MR. HOLODY: Do other individuals have,  
19 you know, in the course of work, do people routinely  
20 blow up at each other occasionally, routinely,  
21 periodically?

22 MR. HAGAN: I would have to say that  
23 there's occasion when people would have a discussion  
24 or a difference of opinion. In the case of -- I

1 won't call it an argument or a blowup.

2 MR. HOLODY: Do you ever have heated  
3 discussions in the course of your work activities?

4 MR. HAGAN: I would --

5 MR. HOLODY: I'm not asking you  
6 particularly, I'm asking any employee at the plant,  
7 any manager with a subordinate, do you have heated  
8 discussions at times?

9 MR. HAGAN: I would assume there would  
10 be cases where there would be discussion on  
11 technical issues or discussions, you know, involving  
12 personnel issues.

13 MR. HOLODY: And if you have that type  
14 of discussion, do you conclude that that's  
15 harassment and intimidation when you have these  
16 heated arguments?

17 MR. HAGAN: Depending on what the  
18 nature would be, what the nature of the argument  
19 would be.

20 MR. HOLODY: What in this particular  
21 case would make this harassment/intimidation --  
22 that's what I'm trying to understand -- in your  
23 mind, as opposed to just a heated argument?

24 MR. HAGAN: Well the fact that the

1 individuals were attempting to file an incident  
2 report, which is what the process tells them to do.  
3 The fact that they were following that process and  
4 the argument interfered with that to the point where  
5 they felt intimidated now to turn in the incident  
6 report, that in fact is the intimidation.

7 MR. HOLODY: So your conclusion is  
8 based on the fact that they were -- you accept the  
9 fact that these individuals were raising what in  
10 their minds were safety concerns, and this action,  
11 this treatment that they received was because of  
12 their raising of the safety concerns?

13 MR. HAGAN: As far as the safety -- the  
14 raising of the safety concern itself, the fact that  
15 they did not file the incident report and there was  
16 an argument that ensued from that just because they  
17 were filing the incident report, that argument  
18 itself is the intimidation, yes.

19 MR. HOLODY: Did you conclude at all  
20 that they were attempting to discourage the use of  
21 the safety report because it was required an  
22 operability determination?

23 MR. HAGAN: No.

24 MR. HOLODY: That's all.

1 MR. LANNING: Mr. Hagan, just a couple  
2 clarifications. The formal investigation that was  
3 initiated on January the 28th, that's the one that's  
4 documented April the 2nd; is that right?

5 MR. HAGAN: The answer is yes.

6 MR. LANNING: And some of the findings  
7 that you've listed here are out of this report or  
8 are they independent management findings?

9 MR. HAGAN: They're out of the report  
10 itself.

11 MR. LANNING: So is it accurate that  
12 PSE&G management has reviewed this report and accept  
13 the findings and conclusions that are put forth in  
14 this report?

15 MR. HAGAN: That's accurate.

16 MR. LANNING: None of your conclusions  
17 really addressed senior managers above the General  
18 Manager of the plant, that being the Chief Nuclear  
19 Officer and the VP for Ops, I guess which are  
20 addressed in the report.

21 MR. HAGAN: The subsequent corrective  
22 actions will.

23 MR. LANNING: I guess what I'm most  
24 concerned about is the lack of action, the omission

5  
1 of actions by most senior levels of management to  
2 deal with this issue, their inactions to interject  
3 themselves in a timely manner to insure that an  
4 atmosphere of intimidation didn't prevail at the  
5 site. And I didn't see that addressed in your  
6 findings.

7 MR. HAGAN: That will be addressed in  
8 the root cause and the corrective action section in  
9 the presentation.

10 MR. LANNING: Okay.

11 MR. HAGAN: The fact that the -- it was  
12 recognized from the CNO down the corporate action  
13 and timely action was not taken, and those  
14 individuals were in fact disciplined because of  
15 their lack of effective follow-through.

16 MR. LANNING: So would you agree that  
17 that active omission fostered a continuing situation  
18 at the site probably that would indeed result in a  
19 chilling effect?

20 MR. HAGAN: No, because of the  
21 effective and aggressive actions and investigation  
22 that we did take in the period from January,  
23 February, March into April. I feel that the actions  
24 that we took sent a very positive message to the

5  
1 organization on what was expected in terms of  
2 raising safety concerns and how the management of  
3 PSE&G and would handle the safety concerns.

4 MR. LANNING: Are you satisfied with  
5 the actions that these senior managers -- their  
6 response to the fact that these individuals were  
7 being directed offsite? Are you satisfied that they  
8 aggressively pursued the underlying reasons for that  
9 and took appropriate action?

10 MR. HAGAN: For the investigation  
11 itself, yes.

12 MR. LANNING: When they first became  
13 aware of the fact that there were two individuals  
14 being requested to be reassigned --

15 MR. HAGAN: Yes.

16 MR. LANNING: I would think that if  
17 that occurred, I would want to know the underlying  
18 reasons for such a drastic action.

19 MR. HAGAN: Yes.

20 MR. LANNING: And I'm just wondering if  
21 they pursued the underlying reasons for such an  
22 action.

23 MR. HAGAN: And that was pursued during  
24 the subsequent events -- investigation. In the

5  
1 month of December, we concluded that that was not  
2 aggressively pursued.

3 MR. LANNING: Wasn't there a period of  
4 two weeks there for which senior management had  
5 knowledge of what was occurring and did not take any  
6 positive action to resolve it?

7 MR. HAGAN: There was a period when the  
8 CNO was first aware of the issue, it was brought up.  
9 He went to the General Manager of QA/NSR and  
10 directed that that be resolved. He understood what  
11 the underlying issues were and he wanted to know  
12 what actions that were being taken.

13 MR. WHITE: When did Mr. Miltenberger  
14 first become aware of this situation? December  
15 18th?

16 MR. HAGAN: The 18th, in the copy of  
17 the letter from our investigation, the copy of the  
18 letter itself was stamped on the 18th. The  
19 investigation shows that the CNO read the letter on  
20 the 21st.

21 MR. WHITE: And his involvement at that  
22 time, to what you understand from, I would guess  
23 from your interviews with Mr. Miltenberger, what was  
24 his involvement then from the 18th on?

6  
1 MR. HAGAN: From the 18th on, he  
2 direct -- actually from the 21st on, from the 21st  
3 on, he directed the General Manager of Quality  
4 Assurance and Nuclear Safety Review to get to the  
5 underlying causes of what happened and to take the  
6 action of advising him what action would be  
7 appropriate to be taken.

8 MR. WHITE: And so they're reacting  
9 to -- how was that direction proposed at that  
10 meeting? How were they directed to do that?

11 MR. HAGAN: How was the General Manager  
12 of QA/NSR directed to do that?

13 MR. WHITE: Yes.

14 MR. HAGAN: I believe it was verbal  
15 direction.

16 MR. WHITE: And did they ever get back  
17 to Mr. Miltenberger with a report as to how this --  
18 what the situation was, what the causes and effects  
19 were and how it was going to be resolved?

20 MR. HAGAN: I do not believe it was a  
21 formal written report, because it was ongoing. But  
22 there were periodic updates provided.

23 MR. REITER: If I can add to this  
24 action on the I think it was the 21st, I received a

6 1 copy of the Vondra memorandum from Miltenberger with  
2 a handwritten note on it asking what was going on.  
3 He was out. I left him a handwritten note that said  
4 that was the first I had seen that letter, told him  
5 that I had been working with Mr. Vondra to try and  
6 resolve the issue, that I would not remove the  
7 engineers from the site, that I felt that that was  
8 inappropriate.

9 I left him a handwritten note because I  
10 was out of the office for the next week and a half  
11 and I knew he was going to be out also. And I  
12 wanted to leave him something to indicate what was  
13 happening.

14 MR. WHITE: So was -- it was either  
15 verbal or handwritten notes in the corner or  
16 attached to the memorandum there?

17 MR. REITER: It was a handwritten note  
18 from Miltenberger on the top of Vondra's note, and  
19 then a handwritten note from me back to him.

20 MR. LANNING: The other individual is  
21 the then Vice President of Nuclear Operations, when  
22 did he become aware of the issue?

23 MR. HAGAN: I believe that was on a  
24 discussion that he had with the General Manager of

1 Salem on the 14th.

2 MR. LANNING: On the 14th. And what  
3 actions did he take from the 14th until -- what  
4 actions did he take in response to knowing that  
5 information?

6 MR. HAGAN: To the best of my  
7 knowledge, he directed the Plant Manager to work  
8 with Mr. Reiter, the GM-QA/NSR to resolve the  
9 differences that were -- that were involved with the  
10 event itself as far as what would be the appropriate  
11 actions to take that had to be resolved between the  
12 General Manager of the station and the General  
13 Manager of QA/NSR. I believe that's the direction  
14 that was given.

15 MR. LANNING: You may have to help me,  
16 but it's my understanding that he in essence just  
17 passed the memorandum on to the Chief Nuclear  
18 Officer, and he took no actions in response to it.  
19 In fact, your investigation concluded that he  
20 exercised poor judgment in abstaining from any  
21 involvement with the resolution of the issues.

22 MR. HAGAN: There was not effective  
23 action taken, that's true. That's what the report  
24 concluded.

1 MR. LANNING: Well I guess the point is  
2 he had an opportunity to intervene and nip this in  
3 the bud, so to speak.

4 MR. BURRICELLI: It's my understanding  
5 that Mr. LaBruna, when he received a copy of the  
6 letter from Mr. Vondra, believed that that letter  
7 had already been issued to Mr. Reiter and the action  
8 had been taken. And he thought, you know, he could  
9 not influence that issue anymore because it was an  
10 action that had already been completed. So he  
11 passed it on to Mr. Miltenberger so that he would  
12 have knowledge of at least the letter that had been  
13 initiated and passed on the matter.

14 MR. WHITE: That's kind of important.  
15 Is it not true that the quality assurance function  
16 is separate and independent from the line function  
17 at the site?

18 MR. HAGAN: The reporting relationship  
19 is independent of the operations department, yes.

20 MR. WHITE: You indicate that Mr.  
21 LaBruna received this letter and thought that the  
22 action had already been taken.

23 MR. BURRICELLI: What Mr. LaBruna had,  
24 to my recollection, was a signed letter, a copy of

6  
7  
1 the letter that he thought had been issued to Mr.  
2 Reiter, and that that action had been consummated  
3 between Mr. Vondra and Mr. Reiter. And so he had  
4 passed that on to Mr. Miltenberger for his  
5 information.

6 MR. HAGAN: The action that you're  
7 referring to, Bob, to clarify, the action that  
8 you're referring to is the action of the transmittal  
9 of the letter.

10 MR. BURRICELLI: That's correct.

11 MR. HAGAN: Not that the individuals  
12 had been removed from their duties.

13 MR. WHITE: One more question. Is it  
14 appropriate for a line function, an operations  
15 function to request the independent quality  
16 oversight function to remove individuals from the  
17 site?

18 MR. HAGAN: No, that's not appropriate.

19 MR. WHITE: And from your review, was  
20 there a bases why Mr. Vondra would request or make  
21 such a request?

22 MR. HAGAN: No.

23 MR. LANNING: Well I guess neither Mr.  
24 LaBruna or Mr. Miltenberger recognized that it was

7  
1 inappropriate for Vondra to make such a request.

2 MR. HAGAN: I believe in the actions  
3 that were taken from the VP, the VP and the CNO for  
4 Nuclear Operations, that the request was  
5 inappropriate.

6 Again, you're asking my opinion what  
7 actions they took and what they were thinking. Our  
8 report analysis says that the action they took was  
9 ineffective in resolving the issue. The fact of  
10 whether they felt that was the right action or not,  
11 in my opinion, is they thought that was the wrong  
12 action and there was no basis for that. That's what  
13 they were asking to be resolved.

14 MR. WHITE: Prior to this event, what  
15 was the relationship between the SRG quality  
16 assurance function and the Salem line function?

17 MR. HAGAN: There was, if I can get  
18 into my root cause here, John, we can cover some of  
19 the questions you have.

20 MR. HOLODY: Before you get to that,  
21 Joe, I just want to back up to the SRG filing of the  
22 incident report. Was it appropriate for him to use  
23 that system?

24 MR. HAGAN: The incident report, yes.

7  
1 MR. HOLODY: When he filed the incident  
2 report, was it appropriate for him not to have an  
3 operability determination on there?

4 MR. HAGAN: Yes. That's not a  
5 requirement of the incident report.

6 MR. HOLODY: But is it a requirement  
7 that operations then do an operability analysis on  
8 that incident report?

9 MR. HAGAN: Yes, it is. And for  
10 whatever information they need from the organization  
11 to make that operability determination.

12 MR. HOLODY: So after this occurred  
13 when the engineers provided the report to  
14 operations, this particular report, what would you  
15 have expected to have occurred that day?

16 MR. HAGAN: What would I have expected  
17 to occur if in fact they would have turned the  
18 report in?

19 MR. HOLODY: When the report was  
20 brought over to operations and given to operations,  
21 what --

22 MR. HAGAN: The normal process would  
23 be --

24 MR. HOLODY: What should have occurred

7  
1 that day?

2 MR. HAGAN: That the senior would have  
3 asked the individual to submit an incident report  
4 for whatever further information he felt that he  
5 would need or whatever information they might have.  
6 That's normal for the senior supervisor to ask that  
7 whatever else you may have that you may want to add  
8 to the incident report for his knowledge. Then he  
9 would have called the appropriate people that he  
10 needed, if in fact he needed anybody to make an  
11 operability determination, whether that was Systems  
12 Engineering, whether it be Nuclear Engineering,  
13 whether it be in his own Ops management chain.

14 MR. HOLODY: So in this case, would you  
15 have expected an operating determination would have  
16 been made that same day by operations alone?

17 MR. HAGAN: Within a reasonable period  
18 of time, yes, within a reasonable period of time.

19 MR. HOLODY: And that would have been  
20 based on --

21 MR. HAGAN: Whatever the technical  
22 concern or the technical implications would have  
23 been on the piece of equipment.

24 MR. HOLODY: The Ops Manager had

7  
1 discussions with another individual that particular  
2 day that got -- I forget the name -- what was it,  
3 Morrioni?

4 MR. HAGAN: Mike Morrioni was the  
5 technical manager of the System Engineering/Station  
6 Engineering.

7 MR. HOLODY: Would it have been  
8 sufficient, just based on telephone discussions with  
9 that individual or verbal discussions, to then write  
10 on that incident report system is operable, okay,  
11 based on discussions with this individual? Would  
12 that have been an acceptable method of resolving  
13 that incident report to come to an operability  
14 conclusion?

15 MR. HAGAN: That information could be  
16 provided, could be provided to the Operations  
17 Supervisor, but it's the Operations Supervisor's  
18 responsibility to make the operability  
19 determination.

20 MR. HOLODY: And he judges then what  
21 information or who he relies upon to make that  
22 determination?

23 MR. HOLODY: As part of his license,  
24 yes, it's his responsibility to make that

7  
1 determination on operability.

2 MR. HOLODY: So that would have been an  
3 acceptable approach, you're saying, for him to have  
4 called Mr. Morroni, gotten the information that he  
5 felt was sufficient and then made that determination  
6 that the system was operable?

7 MR. HAGAN: And documented that  
8 determination for the basis of the operability on  
9 the incident report. That's what normally would  
10 happen, yes, the basis for the operability  
11 determination.

12 MR. HOLODY: And if the two SRGs became  
13 aware of that and disagreed with that, what would be  
14 the next course of action?

15 MR. HAGAN: If they felt that the  
16 operability determination was the wrong  
17 determination? They would have -- they would  
18 have -- the normal process would be to follow up  
19 through their management chain and made that  
20 understanding known of that opinion that they did  
21 not agree with the operability determination.

22 MR. HOLODY: So if this had taken a  
23 different course, just speculating here, the Ops  
24 Manager had taken the report, discussed it with the

1 General Manager and they then just made a decision  
2 that the system was operable --

3 MR. HAGAN: That's not their decision  
4 to make.

5 MR. HOLODY: The Ops Manager?

6 MR. HAGAN: That's not his decision to  
7 make.

8 MR. HOLODY: Who makes that?

9 MR. HAGAN: The Senior Shift  
10 Supervisor.

11 MR. HOLODY: So if he had given that  
12 information to the Senior Shift Supervisor, and the  
13 Senior Shift Supervisor had made that decision and  
14 the Safety Review Engineers disagreed with that,  
15 then you would have expected them to immediately  
16 take that up to their management?

17 MR. HAGAN: Yes, yes.

18 MR. HOLODY: And then their management  
19 immediately discuss it with the Ops Manager's  
20 management?

21 MR. HAGAN: Within a reasonable amount  
22 of time, yes.

23 MR. HOLODY: And then you may have had  
24 the same issue you had in this particular case, but

8  
1 perhaps at a higher level?

2 MR. HAGAN: I don't know that. I mean  
3 it wouldn't have been -- you would have had a  
4 difference of opinion.

5 MR. HOLODY: Was there ever any concern  
6 here on anyone's part about not taking the plant  
7 down?

8 MR. HAGAN: Anyone's concern here about  
9 not taking the plant down?

10 MR. HOLODY: Not wanting to process  
11 that incident report because it would have required  
12 an operability determination.

13 MR. HAGAN: I believe those discussions  
14 were held in the Ops Manager's office. There was  
15 some discussion about what effect it would have on  
16 the fan cooling units and on the plant. I believe  
17 that occurred in the Ops Manager's Office.

18 MR. HOLODY: Was there any conclusion  
19 on PSE&G's part that that was a factor in the  
20 actions taken against these individuals?

21 MR. HAGAN: No. No.

22 MR. WHITE: In your investigation  
23 report, you indicated that as this argument ensued  
24 between Mr. Vondra and the SRG engineers, there was

1 one of the SRG engineers had indicated that he was  
 2 prepared to file a safety concern report, a safety  
 3 report. What is that report? What is the  
 4 consequence of such a report?

5 MR. HAGAN: The safety concerns program  
 6 itself is a program that's provided as an outlet  
 7 of -- as a means to raise any concern, whether it be  
 8 industrial safety or nuclear safety or radiological  
 9 safety, up in the management chain to quality  
 10 assurance as an independent organization. For an  
 11 answer that maybe someone didn't agree with and they  
 12 had gotten a reply or saw action taken that they  
 13 didn't agree with, that's an outlet provided to get  
 14 that information into the system.

15 MR. WHITE: So again the SRG engineers  
 16 were still within the confines of normally  
 17 established procedures, they filed an incident  
 18 report, they were not satisfied with the operability  
 19 decision.

20 MR. HAGAN: They could have filed a  
 21 safety concern, yes.

22 MR. WHITE: And they were prepared, or  
 23 at least it's indicated they were prepared to file a  
 24 safety concern report. And is there anything

1 personal about a safety concern report? Does it  
2 personally indict any particular individual or is it  
3 just raising a safety concern?

4 MR. HAGAN: It's simply raising a  
5 safety concern.

6 MR. HOLODY: Do you get many in the  
7 course of a year or a month?

8 MR. HAGAN: I couldn't give you the  
9 numbers. Jeff?

10 MR. BENJAMIN: In the last 13 months,  
11 we've had 39 total submitted. About 13 of those  
12 involved quality related, potentially safety related  
13 issues, yes.

14 MR. WHITE: I don't expect you to  
15 answer on behalf of Mr. Vondra or Mr. Polizzi, but  
16 the investigation report indicated that when the  
17 individuals brought up the safety concern that there  
18 was some feel that this was a personal attack on  
19 those individuals. From your assessment as a  
20 licensee rep, why would they feel that way? We will  
21 pursue this of course with them, but what's your  
22 assessment as to why they would feel this is a  
23 personal indictment of their performance?

24 MR. HAGAN: I think the words that were

8  
1 used in the investigation -- or the investigation  
2 itself was threatening, and the individuals said  
3 that they felt that they were threatened with the  
4 individual filing a safety concern just by the way  
5 in which it was said, I believe.

6 MR. WHITE: Is there any reason why  
7 they should feel threatened? I mean a safety  
8 concern -- if the safety concern is part of the  
9 program, the filing of a safety concern, does that  
10 threaten the manager, his team or the position of  
11 the managers?

12 MR. HAGAN: Again, I can give you my  
13 opinion, John. It's my opinion would be that the  
14 threat would be applied, being that the individual  
15 who said that, that the individual that they were  
16 talking to did not have a proper safety perspective  
17 there, being we are not taking the action we think  
18 is appropriate, I'm going to be forced to file a  
19 safety concern. That would be the only way I would  
20 say that's my opinion of why someone would feel  
21 threatened.

22 MR. WHITE: Who would resolve the  
23 safety concern? What organization would resolve a  
24 safety concern and would come to a conclusion that

8  
1 either this is or is not an operability problem?

2 MR. HAGAN: The ultimate resolution  
3 resides with Quality Assurance of Nuclear Safety.  
4 How they do that is a process within itself, how the  
5 resolution occurs. They have the ultimate  
6 responsibility for that.

7 MR. BENJAMIN: In this particular case  
8 since the quality concern involved some quality  
9 assurance individuals, the process would require  
10 that to be sent to another organization, Mr.  
11 Burricelli's organization, for an independent cut on  
12 it. He would be expected to draw in the appropriate  
13 technical resources to resolve the technical issue  
14 as well as to resolve the other issues of training  
15 and quality concern. That's today. That was not in  
16 place at the time.

17 MR. WHITE: That's today?

18 MR. BENJAMIN: That came out of this.

19 MR. WHITE: What would have been the  
20 situation back in '92?

21 MR. BENJAMIN: The General Manager of  
22 Quality Assurance/Nuclear Safety Review handled it.

23 MR. WHITE: The reason that was  
24 changed, I suppose, is because of the apparent

9  
1 conflict of interest that was --

2 MR. BENJAMIN: The potential conflict  
3 of interest. There was a recognition that that  
4 would be a more effective way to deal with this, to  
5 avoid that question.

6 MR. LANNING: In 1992, was there a  
7 written procedure for review, processing and  
8 disposition of incident reports?

9 MR. HAGAN: Yes.

10 MR. LANNING: So it was clear who had  
11 the responsibility to determine operability of how  
12 that report was to be processed?

13 MR. HAGAN: Yes. It's covered within  
14 the procedure.

15 MR. LANNING: And that existed during  
16 '92 and '93?

17 MR. HAGAN: That existed, but it's been  
18 revised a number of times. But it was in existence  
19 in 1992.

20 MR. LANNING: Okay.

21 MR. SATORIUS: I have one question too.  
22 From the time that this memo was first drafted  
23 around December 3rd or 4th until it finally  
24 disappeared apparently, some very senior people got

9  
1 a chance to look at it. Were the SRG engineers  
2 aware that this memo was penned? Were they aware  
3 that this thing was floating around hanging over  
4 their heads, so to speak?

5 MR. HAGAN: I believe our investigation  
6 says yes, they were aware of it. They may not have  
7 had copies of it, they did not see it, but they were  
8 aware of it.

9 MR. SATORIUS: Thank you.

10 MR. HAGAN: Okay, to continue now,  
11 John --

12 MS. SMITH: I have a question about the  
13 investigation conclusions before you go on. You  
14 indicated that the two engineers were harassed and  
15 intimidated by statements and actions of Salem  
16 managers. What were those specific statements and  
17 actions that you view as harassment and  
18 intimidation?

19 MR. HAGAN: I don't have the exact  
20 statements in my head right now to tell you what  
21 they were. I mean that was the evaluation  
22 conclusion was that the actions that were taking  
23 place and the way the individuals were handled  
24 between in the Ops Manager's office and the General

1 Manager's office, they were in fact continually  
2 harassed. I don't have the statement. I don't  
3 think I could pin it down to a particular statement.

4 MR. HOLODY: Do you have anybody here  
5 that worked on this investigation that would be able  
6 to shed some light on that?

7 MR. HAGAN: Bob Burricelli was in  
8 charge of the investigation, but I don't know  
9 whether Bob could shed any light on the specific  
10 statements or not.

11 MR. BURRICELLI: I would respond to  
12 your question in this way: I believe that there  
13 were certain things said and done in Mr. Polizzi's  
14 office with Mr. Craig and Mr. Williams, and then  
15 again in Mr. Vondra's office, that were harassing  
16 and intimidating.

17 MS. SMITH: Do you remember what any of  
18 those specific statements were?

19 MR. BURRICELLI: I would have to relate  
20 to you what we were told in the investigation from  
21 Mr. Williams and Mr. Craig. They felt that they  
22 were intimidated by the statement that we don't do  
23 things like that at Salem Generating Station in  
24 regard to trying to give an incident report to the

1 Operations Manager. Mr. Polizzi then at some point  
2 had discussion, so-called, downstairs and set up a  
3 meeting with Mr. Vondra. They all marched  
4 downstairs to go to Mr. Vondra's office.

5 At some point in time a comment was  
6 made to them about a smile on their face, that they  
7 better call the manager because they're in trouble,  
8 at least that's what was reported to the  
9 investigators by those two individuals. Then they  
10 sat outside Mr. Vondra's office for a period of 10  
11 or 15 minutes while there was a private meeting  
12 between Mr. Vondra and Mr. Polizzi, and certainly  
13 the statements in Mr. Vondra's office where he told  
14 them to leave his office or he's going to have  
15 security remove them.

16 MS. SMITH: Thank you.

17 MR. WHITE: I know you want to try and  
18 get along with this Joe. The H and I that the  
19 licensee -- harassment and intimidation that the  
20 licensee admits relative to actions or statements  
21 that were occurred in Mr. Vondra's office, what  
22 about the letter itself?

23 MR. HAGAN: The letter itself was  
24 deemed to be a form of harassment or intimidation.

1 The existence of the letter, which was thought to be  
2 inappropriate, and the fact that it existed was  
3 viewed to be as intimidating.

4 MR. WHITE: Was there in fact, outside  
5 of the fact that the individuals felt harassed and  
6 intimidated by the event that took place, was there  
7 any action actually initiated against them during  
8 the period of time that this was under review and  
9 investigation? Did their work environment change?  
10 Did the scope of their work change? Did their  
11 duties change? Did the climate around these  
12 individuals change in any way?

13 MR. HAGAN: The climate question, I  
14 don't think -- I can't answer, John, because that's  
15 going to be how they perceived it. I don't know of  
16 any special assignments that were made or not made.  
17 I'm not aware of those. I know our investigation  
18 concluded that these people felt, both the  
19 individuals felt they were being intimidated by the  
20 existence of the letter, by the threat that was  
21 imposed, that's what they felt.

22 MR. WHITE: Did they continue to do  
23 safety review group activities at Salem even after  
24 this event?

1 MR. HAGAN: Again, to the best of my  
2 knowledge, yes. I don't know of any modification to  
3 their assignment.

4 MR. WHITE: Did they identify any  
5 further issues outside of this particular matter  
6 after this initial occurrence?

7 MR. HAGAN: Other than there was -- the  
8 way the quality concern was handled, that was an  
9 issue in itself that was raised by Mr. Williams.  
10 The way -- the response to quality concerns, that's  
11 an issue. Was there anything else that either one  
12 as individuals raised? I don't know. As far as if  
13 they reviewed something, they had some comments on  
14 it, is that what you're asking?

15 MR. WHITE: Yeah.

16 MR. HAGAN: I don't know that.

17 MR. WHITE: To the best of your  
18 knowledge then, and Frank, if you have information,  
19 Mr. Thompson, if you have information on this,  
20 please volunteer it, but the assignments, the duties  
21 of the individuals, were they changed at all from  
22 this point?

23 MR. THOMSON: I think, Joe, can I just  
24 add a few? Joe was I think speaking more near terms

10  
1 about December '92. Over the past year, as far as  
2 Mr. Williams goes, in fact his assignment didn't  
3 change. As far as one of the other individuals,  
4 recently, August of '94, as part of a number of  
5 other rotational developmental moves in the SRG  
6 organization, he was moved over to the Hope Creek  
7 SRG function. And also the supervisor of the group  
8 as part of that, at his request, was reassigned, I  
9 think it was about a year ago, to the Engineering  
10 Projects Group.

11 MR. HAGAN: Are you talking near terms?

12 MR. WHITE: I was talking near terms,  
13 in the vicinity of within the next six months for  
14 point of reference. Were these individuals expected  
15 or were they performing any differently from this  
16 point on, from December 16th or 18th on, as they  
17 normally would have been performing?

18 MR. HAGAN: As far as their job duties,  
19 not that I'm aware of.

20 MR. REITER: John, if I can interject,  
21 during that period of time there was no change to  
22 their job duties, no change to their assignments.  
23 They continued to do the normal safety review  
24 functions. So there was no change at all.

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MR. WHITE: All right. Thank you.

MR. LANNING: Just one more question.

Did Messrs. Miltenberger or LaBruna receive any counseling, letters of reprimand?

MR. ELIASON: We'll hit that, that will be addressed.

MR. HAGAN: Yes. I'll cover them.

MR. LANNING: Are you going to explain why?

MR. HAGAN: In the next couple of pages.

MR. WHITE: Why don't you do it before we stop you again.

MR. HAGAN: The root causes we talked about was Public Service failed to set uniform standards for who raised safety or quality concerns. Contributing factors would be the confrontational environment existed between certain Salem managers and Safety Review Group personnel. That came from our investigation. There was a confrontational relationship that did exist.

Salem Operations Manager failed to follow the standard process for incident report evaluation and disposition, as we talked earlier.

1                    Ineffective training of management  
2 personnel on safeguards afforded protected  
3 activities.

4                    Near term corrective actions that we  
5 took was aggressive self-initiated internal  
6 investigation undertaken to bring issue to the  
7 resolution and identify the underlying issues and  
8 causes. Periodic updates to the NRC on the  
9 investigation results were provided.

10                    Additional preliminary action taken  
11 from the Nuclear Department management personnel  
12 involved -- there were disciplinary actions taken.  
13 All level management from the CNO to the line  
14 managers received a form of -- appropriate form of  
15 disciplinary action. It varied depending upon the  
16 involvement of the individuals.

17                    MR. WHITE: Are you prepared to discuss  
18 specifically what that was?

19                    MR. HAGAN: I'm prepared to discuss it  
20 in -- yeah, I'm prepared to discuss it if you have  
21 specific questions.

22                    MR. WHITE: What was the action that  
23 was assigned to Mr. Miltenberger?

24                    MR. HAGAN: Mr. Miltenberger received a

1 letter of reprimand, a disciplinary letter from the  
2 Senior Vice President of Electric, which was his  
3 boss for his inactions, being ineffective, not  
4 timely and inappropriate. Same was true for the  
5 Vice President of Nuclear Operations, and that was  
6 issued from the CNO.

7 MR. WHITE: For the same reasons, not  
8 timely and inappropriate?

9 MR. HAGAN: Yes, inappropriate actions.

10 MR. WHITE: So there was an expectation  
11 from senior executive management in the corporation  
12 that on this issue that these line managers had more  
13 responsibility?

14 MR. HAGAN: Than what they fulfilled,  
15 right.

16 MR. LANNING: Is there any significance  
17 from whom these letters came from? One came from  
18 the CEO, one came from senior VP.

19 MR. HAGAN: Their respective  
20 supervisor, the letter of disciplinary action came  
21 from the individual's respective supervisor.

22 MR. BENJAMIN: Did you say CEO or CNO?

23 MR. LANNING: I thought he said CEO.

24 MR. HAGAN: CNO.

11  
1 MR. LANNING: I'm sorry, I  
2 misunderstood you. Good clarification.

3 MR. HAGAN: Any other questions with  
4 disciplinary action? The CNO met with the SRG  
5 engineers on February 11th and on April 22nd and  
6 reassured them that their actions were appropriate.

7 CNO issued a letter to the SRG  
8 engineers reaffirming that their actions were  
9 appropriate. Letters of apology were issued from  
10 the station GM and the Ops Manager to the SRG  
11 engineers.

12 MR. WHITE: I'd like to back up one  
13 point, one more time back into contributing factors,  
14 "A confrontational environment existed between  
15 certain Salem managers and Safety Review Group  
16 personnel," was that first revealed by your  
17 investigation?

18 MR. HAGAN: Yes. Yes.

19 MR. WHITE: And I take it that  
20 management, plant management was unaware of any  
21 confrontational situation between SRG and line  
22 management function before that?

23 MR. HAGAN: As far as our investigation  
24 concluded, yeah, the station management was unaware.

1 MR. WHITE: So this was a revelation  
2 then that this confrontational attitude existed?

3 MR. HAGAN: I don't know whether I'd  
4 call it a revelation, but it was a formal disclosure  
5 that there was a confrontational relationship  
6 between certain managers and certain people in SRG.

7 MR. WHITE: Prior to the investigation  
8 report revealing this, was it the -- was there a  
9 respect for the SRG function as it applied to the  
10 Salem site and how those personnel perform their  
11 duties and the findings that they made? Were their  
12 findings considered important and relied upon by  
13 Salem management prior to this event?

14 MR. HAGAN: I think we have to go back  
15 and look at the entire track record for SRG. I  
16 would say that the individuals who were in SRG since  
17 the formation of SRG, there was a respect for SRG  
18 and what they did. Some of the individuals that  
19 were originally in the SRG were subsequently  
20 promoted and moved. I think it became a function of  
21 who in fact was in SRG at the time.

22 MR. LANNING: Well let's ask Mr.  
23 Reiter. Did you have any knowledge of any  
24 differences of opinion or confrontational atmosphere

1 between your organization and management?

2 MR. REITER: I was not aware that there  
3 was an atmosphere as this is characterized here. I  
4 did not directly supervise the Safety Review Group,  
5 but I have to go based on feedback that I received  
6 from the Plant General Manager, from Vondra, who on  
7 several occasions called me or dropped me a note  
8 indicating how pleased he was with some work that  
9 they had done. So from my perspective, I was not  
10 aware that there was any confrontational atmosphere  
11 that existed.

12 MR. WHITE: All right. Please  
13 continue.

14 MR. HAGAN: Near term corrective  
15 actions, continuing, is the presentation to the  
16 Nuclear Department Managers on April 23rd, this was  
17 done by the General Manager and the Ops Manager to  
18 all the Nuclear Department management personnel,  
19 managerial people.

20 CNO reaffirmed Public Service's  
21 commitment to maintaining a work environment which  
22 is conducive to filing safety concerns.

23 Emphasized that the action of the  
24 Safety Review engineers were in accordance with the

11  
1 management expectations.

2 And reviewed the December 3rd event,  
3 including sequence of events and management's  
4 responsibility, the lessons learned and a summary of  
5 the investigation report conclusions.

6 Salem OM and Plant Manager acknowledged  
7 their actions were inappropriate, and this  
8 presentation was given by the Ops Manager and the  
9 General Manager and was a part of the disciplinary  
10 action that was deemed to be appropriate. These  
11 individuals delivered a lessons learned and  
12 delivered the right message to their peers.

13 The presentation by the Manager of  
14 Licensing and Regulation on employee rights and  
15 responsibilities. The VP-NO reinforced expectations  
16 for incident report processing, and that was -- I  
17 was the VP-NO at that meeting.

18 Managers are required to roll-down that  
19 information from April 23rd to all their employees.  
20 That was a requirement that was documented.

12  
21 I personally conducted a one-on-one  
22 follow-up with each of the Salem managers on the  
23 roll-down of the April 23rd meeting and informing,  
24 including discussion of the elements of

1 intimidation.

2 Near term corrective actions, the  
3 letter issued by the CNO on April 26th to all  
4 Nuclear Department employees re-emphasizing  
5 employees should continue to pursue safety concerns.  
6 And in fact there was an expectation that safety  
7 concerns be pursued.

8 General Manager QA/NSR met with  
9 employees to emphasize that the actions of the SRG  
10 engineers were appropriate, and in particular that  
11 escalation to senior management fully met  
12 expectations and was consistent with safety concern  
13 resolution process. And it was emphasized there  
14 that they should not feel any hesitation about  
15 raising a concern or what level the concern needed  
16 to go.

17 General employee training was revised  
18 to include elements of employee rights and  
19 responsibilities.

20 The procedural revision in NAP-6, which  
21 was the document we talked about earlier, was  
22 revised to require the GM-IS&EA to investigate  
23 quality concerns initiated by QA/NSR personnel.

24 MR. WHITE: Before you proceed there,

1 most of these corrective actions, in fact all these  
2 corrective actions relative to citing responsibility  
3 appear to place the burden largely on the Operations  
4 Manager and General Manager. What was the  
5 licensee's review and evaluation of the General  
6 Manager of Quality Assurance and Nuclear Safety  
7 Review?

8 MR. HAGAN: The resolution of the issue  
9 itself was not handled effectively or in a timely  
10 manner. That was the conclusion.

11 MR. WHITE: Was there any conclusion  
12 that there was further harassment or intimidation by  
13 any actions of the General Manager QA and Nuclear  
14 Safety Review?

15 MR. HAGAN: We did not determine that  
16 there was any further harassment by the General  
17 Manager QA/NSR.

18 MR. WHITE: So the view of the licensee  
19 is that the H and I that took place here was largely  
20 caused by actions by Mr. Polizzi and Mr. Vondra and  
21 not Mr. Reiter, is that correct, from your  
22 assessment, the licensee's assessment?

23 MR. HAGAN: That's our assessment, yes.

24 MR. WHITE: And why do you exonerate

1 Mr. Reiter of any H and I, what is your basis?

2 MR. HAGAN: The basis is that Mr.  
3 Reiter took action to -- although we have determined  
4 it was not timely or effective, he was actively  
5 pursuing resolution. He did not take any action  
6 against the individuals, did not -- in fact did not  
7 feel that their actions were inappropriate, and did  
8 not pursue any further action against the  
9 individuals, short of the counseling or the coaching  
10 session that he had drafted up. And that was in  
11 reference to the statement made by the Quality  
12 Engineer about the process, the DEF process, which  
13 was felt to be an inappropriate statement from the  
14 Quality Assurance Engineer. Because if it's a  
15 problem with the system, you shouldn't tell people  
16 you're not going to use that system.

17 MR. WHITE: His perspective was that  
18 this took too much time, it was too lengthy?

19 MR. HAGAN: That was his opinion, it  
20 was too lengthy, it didn't work and he wasn't going  
21 to use it. That was the comment that was made.

22 MR. LANNING: Are the corrective  
23 actions you just addressed, are they the result of  
24 the recommendations in your task force report?

1 MR. HAGAN: Yes, they are. And there's  
2 additional ongoing actions.

3 MR. LANNING: Regarding the  
4 recommendations in the task force report, did  
5 management adopt all of those or some of those?

6 MR. HAGAN: I think the recommendations  
7 were adopted, parts were adopted -- a large part  
8 were adopted. There may be some variations to it,  
9 but in large part, it was acted on. And there were  
10 some other actions that were taken that are not in  
11 the recommendations.

12 MR. LANNING: You not only addressed  
13 the recommendations in the task force's report, you  
14 went beyond that and did additional things?

15 MR. HAGAN: What we felt would be  
16 appropriate. The ongoing actions to improve the  
17 environment, current actions of the Nuclear Business  
18 Unit directed at providing for continued improvement  
19 in the safety/quality concerns reporting environment  
20 at Salem and Hope Creek are focused in the following  
21 areas:

22 Improved communications and feedback  
23 and formation of the Employee Concern Group. And  
24 the improved communications feedback, I mean it's

12  
1 our expectation that the management is responsive to  
2 safety concerns, concerns from a technical nature or  
3 a personal nature, the management organization  
4 responds to those and resolves them accordingly. If  
5 that doesn't work, they're still concerned, then we  
6 have, I'll call the outlets.

7 Formation of Employee Concern Group,  
8 that's to provide a means for any individual to  
9 pursue a concern he or she may have and get what  
10 they consider a timely resolution.

11 Management/supervisory training, that's  
12 ongoing. It's been formulated, it's ongoing as far  
13 as supervisory training and how to handle the  
14 confrontations, how to handle the resolution of  
15 concerns.

16 And the assessment and measuring tools  
17 themselves, as far as the surveys that we do, asking  
18 people how do you feel, I mean are you free to bring  
19 up safety concerns, do you have any concerns that we  
20 should know about and your ability to raise that  
21 issue or resolve an issue.

22 The indications are that the  
23 environment has improved. Again, that's our  
24 assessment of how the process is used, the daily

1 re-enforcement of the expectation for incident  
2 reports, that things get into our system so we can  
3 do a timely follow-up.

4 At this time, I'd like to ask Jeff  
5 Benjamin -- Jeff is our Director of Quality  
6 Assurance/Nuclear Safety Review, to make some  
7 comments on what he's seen. Jeff, as you know, has  
8 been with us for about a month now.

9 MR. BENJAMIN: Closer to six weeks now.

10 MR. WHITE: I hate to interrupt, but  
11 since we're making a break here, I'd just like to  
12 get into a couple things. Relative to the CNO,  
13 Chief Nuclear Officer, and the Vice President of  
14 Operations and the General Manager of Quality  
15 Assurance/Nuclear Safety Review, their actions were  
16 seen as being untimely and ineffective, consequently  
17 ineffective relative to the resolution of this  
18 issue.

19 MR. HAGAN: And inappropriate.

20 MR. WHITE: What was the cause of that?  
21 Why was it untimely? What was it about this issue  
22 that didn't permit or allow the individuals to  
23 vigorously pursue resolution of this particular  
24 matter?

13  
1 MR. HAGAN: I couldn't -- I don't know  
2 what there was, if anything in particular, to this  
3 incident that would prevent them from doing that.  
4 The fact was that they didn't, they didn't take the  
5 action, the aggressive action that we felt should  
6 have been taken in this particular case.

7 MR. WHITE: Was it ineffectiveness,  
8 overall ineffectiveness?

9 MR. HAGAN: In this particular case,  
10 they did not respond the way we felt that they  
11 should have responded.

12 MR. WHITE: I take it at this point  
13 that you expect that the personnel in these  
14 positions will respond differently, more vigorously  
15 in similar situations?

16 MR. HAGAN: Yes.

17 MR. WHITE: Relative to disciplinary  
18 action, could you identify what the disciplinary  
19 action was that was applied to Mr. Polizzi and Mr.  
20 Vondra and Mr. Reiter, if that's appropriate?

21 MR. HAGAN: In terms of Mr. Polizzi,  
22 Mr. Polizzi was given a decision making leave, which  
23 is the last step of our process, where the  
24 individual is given the order to prepare a

1 performance improvement plan which is designed to  
2 convince us why they should retain their employment  
3 with PSE&G. That was given to both Mr. Vondra and  
4 Mr. Polizzi.

5 Mr. Polizzi was removed from his job as  
6 the Operations Manager. He was given the  
7 opportunity to develop the performance improvement  
8 plan. He was also given the opportunity to pursue  
9 an assignment for PSE&G with an organization outside  
10 of the Nuclear Department itself.

11 MR. WHITE: Was that non-voluntary?

12 MR. HAGAN: What he was given was the  
13 option, and I gave him the option, of pursuing that.  
14 And if that did not work, my direction was, to Mr.  
15 Polizzi, was I didn't know what his next option was.  
16 That was an option that he had to pursue.

17 MS. SMITH: So he didn't ask for that  
18 assignment?

19 MR. HAGAN: He had no -- he did not ask  
20 for that assignment. He had no choice at the time  
21 in my office. Now he had expressed an interest --  
22 he and a number of other people had expressed an  
23 interest earlier, months earlier about the  
24 possibility of such assignment.

1                   Also, Mr. Polizzi was also removed from  
 2 our plans for succession plan. They were, both the  
 3 Plant Manager and Mr. Polizzi, were required to give  
 4 the presentation to the Business Unit Managers to  
 5 explain what happened, what they did wrong in a  
 6 public meeting with their peers.

7                   As far as Mr. Vondra's overall  
 8 performance, he was told that this was not in  
 9 accordance with the expectations of a Plant Manager,  
 10 and this would be incorporated in his performance  
 11 packet or performance assessment and would probably  
 12 result in his removal as Plant Manager.

13                   MR. WHITE: He was told that?

14                   MR. HAGAN: He was told that.

15                   MR. WHITE: When was he actually  
 16 removed?

17                   MR. HAGAN: February.

18                   MR. WHITE: February '94?

19                   MR. THOMSON: February '94.

20                   MR. HAGAN: '94.

21                   MR. LANNING: Were any of these  
 22 individuals previously involved in any similar  
 23 activities?

24                   MR. HAGAN: Not that I have knowledge

13  
1 of.

2 MR. WHITE: Mr. Vondra's removal, was  
3 that largely due to this incident?

4 MR. HAGAN: I wouldn't say it was  
5 largely due to it, John. It was a major factor in  
6 the decision to remove him as Plant Manager, because  
7 we did not see the sustained improvement we felt was  
8 appropriate for that position.

9 MR. WHITE: Anything else on Vondra?

10 MR. HAGAN: No.

11 MR. WHITE: How about Mr. Reiter?

12 MR. HAGAN: Mr. Reiter, now Mr.  
13 Reiter's disciplinary action was not handled by me,  
14 so I'll give you what I know is that Mr. Reiter was  
15 actually removed from his position prior to the  
16 conclusion of this report. He was also given a  
17 disciplinary letter for ineffective and untimely or  
18 inappropriate action.

19 MR. WHITE: Was he removed from that  
20 position because of this event? Was he removed from  
21 his position as General Manager of Quality  
22 Assurance/Nuclear Safety Review because of this  
23 event?

24 MR. HAGAN: I cannot say that that's in

1 fact what happened. I was not part of that  
2 decision. I do have knowledge from conversations  
3 that I had with the CNO at the time that it played a  
4 major part. I cannot say that that's as a direct  
5 result of this event that that's what was done.

6 MR. REITER: I can tell you that when I  
7 was given a different assignment, this was not  
8 identified to me as a contributing factor.

9 MR. OLSHAN: The confrontational  
10 environment that existed at this time and before  
11 then, did that extend before this incident there?  
12 Were more people involved in the confrontational  
13 environment?

14 MR. HAGAN: Mostly it involved the  
15 NSRs.

16 MR. OLSHAN: It was those people?

17 MR. HAGAN: Yes.

18 MR. WHITE: Before I leave Mr. Reiter,  
19 I'd like to be clear on what the disciplinary action  
20 was. He was removed from the position and  
21 reassigned?

22 MR. HAGAN: When Larry made the  
23 comment, I was not involved in the decision making  
24 process. I know he was given a disciplinary letter

1 in his file for ineffective and inappropriate action  
2 in regards to this issue.

3 MS. SMITH: Do you know who was  
4 involved in his disciplinary action? You said you  
5 weren't. But do you know who was?

6 MR. HAGAN: Mr. Miltenberger.

7 MR. WHITE: Mr. Reiter was subsequently  
8 terminated from employment from PSE&G, and did that  
9 have anything to do with this event?

10 MR. HAGAN: That would be again an  
11 inference on my part. I did not participate in that  
12 decision, so I can't tell you.

13 MR. LANNING: Any other managers below  
14 Mr. Reiter receive any kind of personnel action?

15 MR. HAGAN: Within the QA/NSR  
16 organization, yes, the individual who was the  
17 Manager of Nuclear Safety Review was also issued a  
18 disciplinary letter for ineffective and  
19 inappropriate handling of the issue. His name would  
20 be Liden.

21 MR. LANNING: How about the Manager of  
22 the SRG?

23 MS. SMITH: Did you say what kind of  
24 action was taken against Liden?

14  
1 MR. HAGAN: A disciplinary letter was  
2 issued to Mr. Liden. Below Mr. Liden, I do not have  
3 any knowledge of any disciplinary action was taken  
4 against anybody below Mr. Liden.

5 MR. BURRICELLI: The SRG reported to  
6 Mr. Liden.

7 MR. HOLODY: I had a question on the  
8 last discussion before the disciplinary discussion,  
9 the ongoing actions to improve the environment. You  
10 may have mentioned this and I missed it. When was  
11 the Employee Concern Group formed?

12 MR. BENJAMIN: I'll handle that one.  
13 Just yesterday I named a manager for that group.  
14 And it's part of our organizational effectiveness  
15 review, which is ongoing. That is being added as a  
16 separate function and a dedicated group to handle  
17 these types of issues. So the answer is it's  
18 ongoing and the manager was named yesterday.

19 MR. HOLODY: So it's not in place yet?

20 MR. BENJAMIN: Correct. We haven't  
21 made all of the changes to totally effect that into  
22 our organization. He starts on Monday.

23 MR. HOLODY: And you're going to talk  
24 about what you have envisioned for this program and

14  
1 how it's going to run?

2 MR. BENJAMIN: Yes. We can do that now  
3 or --

4 MR. HOLODY: Sure.

5 MR. LANNING: Before you get to that,  
6 I'd like to pursue the conclusion that the  
7 environment has improved. Can you give me specific  
8 indicators?

9 MR. BENJAMIN: I was prepared to talk a  
10 little bit about that. I obviously was not here  
11 when this happened; however, after reading the  
12 report, at least two questions came to my mind  
13 relative to those events and how they may have --  
14 how they may impact today's environment.

15 One question I had was whether or not  
16 these events had, the term I used, dampened the  
17 enthusiasm of my organizations in performing their  
18 job to the best of their capabilities.

19 Another question I had was whether or not  
20 those events had some residual impact on the  
21 relationship between my organizations and the line  
22 organizations.

23 In order to answer that, I interviewed  
24 the individuals within the NSR organizations,

14  
1 including their supervisors, over the past week and  
2 a half. I structured some questions basically to  
3 engage in dialogue to try to get a flavor for their  
4 feeling for what the environment is today.

5 Generally speaking, the environment is  
6 good. I should rephrase that a little bit. The  
7 interface between the current SRG group and Salem is  
8 generally good and greatly improved over the past.  
9 That was a very consistent theme in my interviews.  
10 I consistently was hearing that this event was  
11 viewed as a watershed event, if you want to call it  
12 that, and that great improvements have occurred  
13 since then in terms of the interface, a lot of that  
14 involving the receptiveness of the line  
15 organizations for the issues that would be brought  
16 forward.

17 In addition, the enthusiasm of the NSR  
18 groups, including the SRG groups, appears to be  
19 generally good in that there is an appropriate level  
20 of enthusiasm to identify and pursue concerns.

21 In the case of those individuals who  
22 expressed that they may still have some dampened  
23 enthusiasm, I have now undertaken actions to work  
24 with them to restore their confidence through new

15  
1 actions on the QA management teams, partly to try to  
2 give them that level of confidence that they will be  
3 supported and that they will in fact be a valuable  
4 contributing part of our team.

5 I wrap each discussion up with a  
6 discussion of expectations for identifying and  
7 pursuing concerns. And I included in that our  
8 organization's responsibility for packaging and  
9 communicating concerns in an effective way. And I  
10 don't want that to be lost in any of these  
11 discussions. We do have an obligation to package  
12 and communicate these concerns in an effective way  
13 so that line management can take the appropriate  
14 actions. That is a summary of my interviews with  
15 the NSR folks.

16 MR. WHITE: Are there any people that  
17 were involved in SRG back in '92 when this event was  
18 occurring still in the SRG today?

19 MR. BENJAMIN: Yes. Yes.

20 Relative to this Employee Concerns  
21 Group, there are three major challenges that I see  
22 right out of the gates. One is to establish the  
23 proper level of confidence within the Nuclear  
24 Business Unit that this was a viable and a

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responsive and effective program.

The second is this group will be responsible for clarifying or in other cases re-emphasizing what our expectations are for proper issue resolution, and that includes the appropriate role of supervision and management to address the issue. And in the case where that is not effective or where the individuals involved don't feel that's working well, to layout what the alternatives are, including the Quality Concerns Program.

The final piece will be additional and ongoing training relative to 50.7 protections and other training relative to again the handling and pursuit of concerns. The final piece of course will be to generate some effective performance indicators to ensure that we have some feel for how well this program is working. Those will be the initial challenges for this group as we get on with it. And I will have a dedicated manager with resources assigned to him to do that. I think that's consistent with what you'll find at other utilities.

Right now the way it's structured is you get a concern in and existing managers with other duties will be responsible for investigating

1 and pursuing the concern. I felt it's more  
2 effective to have that dedicated resource to do  
3 that.

4 MR. HOLODY: You say currently or prior  
5 to the adoption of this program, existing managers  
6 would deal with the issues as they arose?

7 MR. BENJAMIN: For example, the concern  
8 would come in to the GM-QA/NSR. He has collateral  
9 duties. It would also be his responsibility, or  
10 other managers who had their own responsibilities,  
11 to perform these investigations. That's being  
12 fixed.

13 MR. HAGAN: The other thing I want to  
14 do is give an opportunity for John Summers, the  
15 present General Manager of Salem, to give his  
16 perspective.

17 MR. LANNING: Before we do that, let me  
18 just understand a couple things. In your interviews  
19 with individuals, did you pursue the question of  
20 whether or not there was some form of hostility  
21 between the SRG and the Salem plant management?

22 MR. BENJAMIN: In the past or in the  
23 present?

24 MR. LANNING: In the past.

15  
1 MR. BENJAMIN: I did not try to dredge  
2 up all the past history.

3 MR. LANNING: So you really didn't  
4 assess what the environment was previously?

5 MR. BENJAMIN: That was not my intent.  
6 My intent was to establish where we are today.

7 MR. LANNING: How do you conclude that  
8 the environment has improved?

9 MR. BENJAMIN: Part of my conclusion is  
10 that consistently in the discussions there was a  
11 trending that was expressed to me by the individuals  
12 when they were to characterize to me where the  
13 environment was today as compared to the past.

14 MR. LANNING: There seems to me to be a  
15 difference in what you're concluding and what was  
16 found in the task force findings. The task force  
17 finding essentially implicated this hostile and  
18 confrontational relationship exists at the Salem  
19 facility between Salem station management and the  
20 SRG. Your conclusion is that it only existed  
21 between certain management and personnel of the SRG.  
22 I view those two things differently, unless the two  
23 individuals is all that comprised the SRG.

24 MR. BENJAMIN: Can I clarify that?

15 1 MR. LANNING: Yeah. Let me understand  
2 that.

3 MR. BENJAMIN: The letter from Mr.  
4 Doherty to Mr. Martin, dated June 18th, 1993, if you  
16 5 have the letter, it states that Mr. Martin's letter  
6 incorrectly states that the investigation equated  
7 that a confrontational and hostile environment  
8 existed between the involved Salem site managers.  
9 It goes on to say that the conclusion at the end of  
10 the report was intended to refer to several  
11 individuals collectively, and primarily one  
12 individual who to varying degrees were responsible  
13 for creating this adverse environment as more  
14 specifically discussed in the body of the report.

15 This conclusion did not include the  
16 Salem station manager. That's basically the gist of  
17 that.

18 MR. WHITE: What individuals do you  
19 think that are being focused on there?

20 MR. BENJAMIN: I'll have to let  
21 somebody else focus on that. I just recall that  
22 point being addressed.

23 MR. HAGAN: I'm sorry, I didn't hear  
24 your question.

1 MR. WHITE: What specific individuals  
2 are referred to there?

3 MR. HAGAN: The Ops Manager. Any other  
4 questions, or is it okay if John gives his  
5 perspective?

6 MR. SUMMERS: Several weeks ago I met  
7 with my managers and asked them what do they  
8 perceive the environment is related to safety  
9 concerns. And as discussed with the managers, it's  
10 well-known what has occurred, and opportunities  
11 today exist for surfacing safety concerns. So from  
12 that, and that was just a short discussion, I went  
13 and interviewed the Operations Manager independent  
14 of that meeting. We talked about the environment  
15 open to station personnel and independents for  
16 surfacing safety concerns today, and I asked why.

17 One of the reasons is the knowledge of  
18 what occurred increased awareness of that  
19 occurrence, and the fact that it was wrong. And  
20 also with the training that occurred then and the  
21 additional enhancements to improve the knowledge of  
22 the people who worked at the stations related to  
23 this.

24 I also interviewed the Onsite Safety

1 Engineer. Similar questions to ask him, his opinion  
2 of the environment at the Salem station today. He  
3 took me back in time and he said if you went for the  
4 overall environment over the past several years,  
5 it's improved. In fact, he perceived that several  
6 years ago if he were the Onsite Safety Engineer, he  
7 wasn't sure he could succeed. Today he perceives as  
8 he works as the Onsite Safety Engineer, he can  
9 succeed at Salem station.

10 He said several years ago you may find  
11 people who would say, or they were asked why are you  
12 bringing this up. He didn't see that as the way  
13 we're doing business today. Although he did note we  
14 still have opportunities to improve the function.

15 I guess the last thing I'll talk about  
16 is I'm talking to all the station personnel. I'm  
17 addressing things such as communications related to  
18 my expectations. One of the things I've  
19 established, and I've probably talked to about 25  
20 percent at least of the personnel, most of the Ops  
21 Manager's crews, I only have one crew left to talk  
22 to. Several of the station groups I already have  
23 discussed with them my expectations. And one  
24 specifically related to communications is the fact

1 that I have an open door policy. From 7 to 7:45,  
2 that's an approximate time every morning where I'll  
3 open my door. Actually they don't have to pass by  
4 the secretary. And I firmly believe in the chain of  
5 command, firmly believe it in. But sometimes people  
6 don't believe the chain of command works for them.  
7 So they have the opportunity to come down to my  
8 doorway shoulder to shoulder with me against their  
9 chain of command if it's not working and describe to  
10 me what needs to be fixed. That's not just safety  
11 concerns, but safety concerns is certainly one of  
12 those things.

13 I personally believe that line  
14 management has a responsibility for surfacing up our  
15 safety concerns. That's a line function. And we  
16 also have to resolve that too. Then I also believe  
17 that in our barrier defense, if you optimize the  
18 safety defense in depth, we've got to rely on the  
19 ones we don't catch, that the independent groups  
20 have to catch those and back us up. And they also  
21 must be heard to again optimize our defense again in  
22 depth. And I think there has to be a true liaison  
23 between Jeff's groups and the operations to insure  
24 that again we optimize our defense in depth.

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1 MR. HAGAN: If I can go to the summary,  
2 the self-initiated internal investigation of the  
3 event was conducted by independent task force with  
4 strong management support.

5 Public Service was proactive in  
6 communicating issues to NRC, including periodic  
7 updates on results of Public Service's  
8 investigation.

9 While harassment and intimidation did  
10 occur, our investigation concluded that the three  
11 PSE&G managers did not engage in deliberate  
12 misconduct. As I talked about earlier, we discussed  
13 with them what their interpretation was, what did  
14 they feel did occur and did not occur. If they felt  
15 that they essentially prevented people from going to  
16 the NRC, that in fact would be a discriminatory  
17 action. And they did not do that. They did not  
18 deliberately violate any regulation.

19 The SRG engineers' actions were in  
20 accordance with management expectations for pursuing  
21 resolution of safety concerns. And that's been  
22 positively enforced throughout the organization.

17  
23 The adverse action, there was no  
24 adverse action taken against the SRG engineers,

17

1           although we recognize the existence of the letter  
 2           itself, the fact that this all occurred, the  
 3           individuals may feel, probably do that the actions  
 4           that were taken -- there were actions taken against  
 5           them. Within our system there was no action taken  
 6           other than the reenforcement of the positive nature  
 7           of their behavior.

8                       Disciplinary action was taken to  
 9           address inappropriate management actions on and  
 10          subsequent to December 3rd.

11                      Comprehensive corrective actions were  
 12          taken to address the specific issues resulting from  
 13          this event, and including again the reassurance of  
 14          the SRG position and the SRG engineers and their  
 15          behavior.

16                      Nuclear Business Unit management is  
 17          committed to improvement to ensure an environment  
 18          exists where employees are free to raise safety  
 19          concerns. And that's an ongoing effort, as Jeff and  
 20          John both said. We don't think we're there yet, we  
 21          don't see a finish line yet. We're constantly  
 22          trying to make that improvement and we're constantly  
 23          staying attentive so that people feel they have not  
 24          only the right but the responsibility, and that's

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1 what's expected of them. That concludes my  
2 presentation.

3 MR. SATORIUS: I just had one question,  
4 and that was in your look back through your task  
5 force. Were there any precursors that you  
6 discovered that might have indicated a precursor, I  
7 mean safety concerns filed, performance appraisals  
8 that would have indicated that the managers that  
9 were involved in this incident were previously  
10 involved with SRG engineers and others in a  
11 confrontational manner?

12 MR. HAGAN: I believe the investigation  
13 itself, our investigation has, in the report, that  
14 from the results of that intensive investigation we  
15 did, there was at least one occasion where an  
16 engineer report was mishandled by one of the  
17 involved people.

18 MR. SATORIUS: Thank you.

19 MR. OLSHAN: When I asked earlier about  
20 the confrontational environment, you said it was  
21 limited to the individuals who partook in this event  
22 at December 3rd, and yet you talk about an overall  
23 improvement. So I guess the environment at that  
24 time, maybe it wasn't confrontational, but it wasn't

17  
1 exactly the best. How would you characterize it?

2 MR. HAGAN: If the fact that this even  
3 occurred is evidence to me that it is not where it  
4 needed to be. And that's what our efforts were  
5 directed at is to get that environment where it  
6 needs to be in terms of people feeling absolutely  
7 free to raise safety concerns. Not only free, but  
8 it's their responsibility to do so. That it's  
9 management's responsibility to insure their handling  
10 of this in the normal line function, as John puts  
11 it.

12 MR. OLSHAN: So the environment with  
13 regard to other people wasn't confrontational, but  
14 yet it was stiffling to raising safety concern.

15 MR. HAGAN: I wouldn't call it  
16 stiffling, but we want to make sure the environment  
17 is such that we actually encourage and reinforce  
18 behavior when the concerns are brought up.

19 MR. BENJAMIN: Just to clarify, I  
20 didn't get a real sense from the people I talked to  
21 that they would have characterized it as stiffling.  
22 They do again characterize it as greatly improved.  
23 I didn't try to nail down exactly how bad it was. I  
24 felt we did an investigation that covered that.

17  
1 MR. LANNING: When Mr. Summers  
2 indicated in his discussions with staff that in  
3 years past they would have been questioned if they  
4 brought back concerns, is that essentially what you  
5 indicated?

6 MR. SUMMERS: Yes, sir. That's one  
7 individual, but that's a true statement.

8 MR. LANNING: Have you given any  
9 thought to getting an independent organization to  
10 come in and asses your atmosphere?

11 MR. ELIASON: Wayne, let me address it  
12 a little bit. When I came in here in October, this  
13 is one of the issues that came to my attention  
14 because this stuff was going on. And I've done  
15 three things from my own perspective that I thought  
16 were necessary. One is I sat down and wrote a  
17 letter fairly early to everybody in the Business  
18 Unit, addressed individually to everybody in the  
19 Business Unit, basically encouraged them or  
20 encouraging them to raise safety concerns and  
21 committing to them that any concerns that were  
22 raised would be dealt with straightforward and that  
23 we would respect any issues that came up. That  
24 letter came out from me to everybody in the

17  
1 organization.

2 The second thing that I did was I also  
3 wrote a letter to the organization and everybody in  
4 the organization defining the roles of what I call  
5 self-assessment by the organization. I don't know  
6 whether you got a copy of that or not. But I was  
7 very clear in that letter on how I expected the  
8 organization to raise the issues and assess itself.

9 John talked about the line response,  
10 but I also put in that letter that I expect that the  
11 oversight groups would not only give us assessment  
12 from compliance, but I expected them to look at our  
13 performance also. As part of that I also raised the  
14 issue again, saying that the individuals, every  
18 15 individual in the organization is -- had a basic  
16 responsibility to raise these issues and not to hold  
17 them back.

18 Another thing that I did was in order  
19 to give what I call the organization a chance to  
20 vent, is I opened, you know, a communication where I  
21 ask the CNO -- I don't know whether you heard about  
22 that -- but anybody onsite can write me a note,  
23 either sign it or not sign it. And I've committed  
24 to them that I'll address whatever issue it is. And

1 it can be anonymous or not anonymous. So they have  
2 direct access to me now if they have a safety  
3 concern, an industrial concern, whatever issue that  
4 is. And I will guarantee that I will respond to  
5 that. If they write it anonymously, I'll respond to  
6 it to through the newsletter.

7 I think that we had no leadership in  
8 the Quality Assurance organization. I was frankly  
9 appalled when I saw that. And I directed  
10 immediately we go out and we make sure that we  
11 filled that organization. That's Jeff Benjamin. I  
12 said I wanted to get somebody in that organization  
13 that I believe has the technical clout and the  
14 willpower to give us better self-assessment.

15 One of the first things I talked to  
16 Jeff about was making sure we began this Employee  
17 Concerns Program. I want to give the organization a  
18 chance to use these processes that I've put in  
19 place. And we will assess ourselves so that we do  
20 believe we're getting the information. I felt we  
21 needed to give them a chance first.

22 I've made it very clear to the line  
23 management and the QA organization how I expect the  
24 organizations to function together and that I will

1 not tolerate these kinds of things. I've also  
2 voiced several times that I expect people to raise  
3 the issues to my level if they can't be addressed at  
4 a lower level. So that's kind of where we're at  
5 right now.

6 MR. LANNING: Can you share with us  
7 what your assessment is today? Have you had people  
8 respond to it.

9 MR. ELIASON: In fact I asked yesterday  
10 as to how many in the last two weeks. I think I've  
11 had 43 different issues have come to me, and not one  
12 has been raised as a safety issue. A lot of them  
13 have been more administrative issues, why are we  
14 doing this or why are we doing that. But that's --  
15 we keep a record of that so you can easily see what  
16 we're seeing. But there's been no safety issues  
17 raised to me through that process.

18 MR. SUMMERS: Can I make one comment  
19 also? In the end of February, first two weeks of  
20 March, we will have 28 people at the station  
21 independently evaluate us on how we do business.  
22 One of the things that we have the right to do with  
23 that team is to ask for specific focus, to look in  
24 given areas, what we think that we may not have the

18  
1 best picture on, we have that right to ask that, and  
2 I have that right to ask that. And it's one of the  
3 things that I'll be looking at to consider from  
4 their team manager what can they look at to benefit  
5 the station.

6 MR. WHITE: Do you have any other  
7 closing remarks?

8 MR. ELIASON: No. I think that pretty  
9 much sums up.

10 MR. LANNING: Just a comment. I  
11 appreciate your candidness and frankness. This is a  
12 difficult meeting. I think we made some progress.

13 MR. HOLODY: Wayne, I'd suggest before  
14 we conclude that we take about five minutes.

15 MR. LANNING: Amor; ourselves?

16 MR. HOLODY: If they want to use the  
17 restrooms or something, just about five minutes.

18 MR. LANNING: Okay.

19 (Brief recess.)

20 MR. WHITE: We're back on the record  
21 again. And I think we just have a couple of  
22 follow-up questions from Ms. Smith.

23 MS. SMITH: Does the company admit or  
24 deny that it violated 50.7, 10 CFR 50.7?

18  
1 MR. HAGAN: The company admits that the  
2 individuals were harassed and intimidated by the  
3 actions that were taken by members of management.

4 MS. SMITH: Are you claiming that they  
5 were harassed and intimidated because they raised  
6 safety concerns?

7 MR. HAGAN: Because they raised safety  
8 concerns? The individuals were harassed and  
9 intimidated by the way in which they were not  
10 allowed to pursue the filing of the incident report.  
11 I mean the incident report itself could have been  
12 other than a safety concern. If the same actions by  
13 management would have been applied, it still would  
14 have been intimidating and harassing.

15 MR. HOLODY: Are you describing how  
16 they were harassed and intimidated? I guess the  
17 question is were they harassed and intimidated for  
18 raising safety concerns. Did they violate 50.7?  
19 Does the company admit or deny that they violated  
20 the regulations of 50.7? I think that's your  
21 question.

22 MS. SMITH: That was the question.

23 MR. HAGAN: I think the individuals --  
24 the company position is that the individuals were

1 harassed and intimidated. In this particular case,  
2 it was raising a safety concern. So if you look at  
3 the instant case, you say in this particular case,  
4 yeah, they were raising a safety concern.

5 MS. SMITH: Through the incident report  
6 that they tried to file?

7 MR. HAGAN: Right. And what I'm saying  
8 from our review is if any other incident had been --  
9 any other case has been raised, whether it was a  
10 safety concern or not, it still would have been  
11 harassment and intimidation.

12 MS. SMITH: But in this case, they were  
13 trying to raise a safety concern and they did raise  
14 a safety concern: is that correct?

15 MR. HAGAN: Yes, they did. That's  
16 correct.

17 MS. SMITH: So then is your conclusion  
18 that the company did violate 50.7?

19 MR. HAGAN: It is our conclusion that  
20 with the way 50.7 is written that we violated 50.7.  
21 The way it is written, the way this was handled in  
22 this particular case, that was our conclusion.

23 MS. SMITH: Thank you.

24 MR. WHITE: Any other questions? Dan,

19  
1 can you just take a few minutes and address the  
2 protocol for enforcement?

3 MR. HOLODY: Sure. We have these  
4 meetings whenever we have violations that rise --  
5 potentially could rise to a severity level 1, 2 or  
6 3. And our fundamental concern is that the issue  
7 gets appropriately aired, you get an opportunity to  
8 provide your views. And probably the most important  
9 thing is that we hear from you, you understand why  
10 this happened and you've addressed, put mechanisms  
11 in place for insuring it doesn't occur again and  
12 appropriate corrective actions are taken.

13 What we will do is take into  
14 consideration what you told us today. We'll also be  
15 having conferences with three of the individuals,  
16 individual conferences, subsequent to this. And  
17 we'll look at the findings in our investigation  
18 report as well as the findings in your own  
19 investigation and come up with a decision on what we  
20 feel is the appropriate enforcement action that  
21 needs to be taken in this case.

22 We basically have three options with  
23 respect to the company. We can issue a notice of  
24 violation for the apparent violation, we can issue a

1 civil penalty, or we can issue some type of an order  
2 that somehow could be restrictive.

3           Whatever action we do take, we normally  
4 get back to you within about a month. These kinds  
5 of issues that involve investigative matters  
6 sometimes take longer, so I'm not going to guarantee  
7 that we will be getting back to you in a month,  
8 although it's feasible.

9           If we happen to issue a civil penalty  
10 or an order, there will be a press release  
11 associated with that. If we issue simply a notice  
12 of violation or were to take no action at all, there  
13 would not be a press release associated with that.  
14 You have an opportunity to respond in writing, as  
15 you well know, put down in writing what your  
16 position is. Any questions on the process?

17           MR. WHITE: Gentlemen, we appreciate  
18 you participating in this meeting with us today.  
19 It's been very helpful to us as the regulatory  
20 authority in this matter.

21           Relative to protocol for the rest of  
22 the day, our plan is to meet with Mr. Reiter at 1:30  
23 in this office. And Mr. Polizzi, I think we'd be  
24 ready for you about 3:00, if you can accommodate

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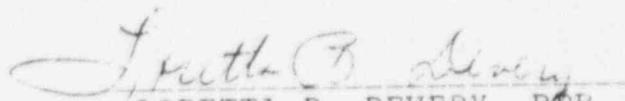
that, please. With that, the meeting is adjourned.  
Thank you very much.

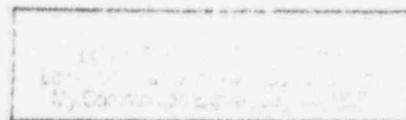
(Proceedings closed.)

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CERTIFICATION

I, Loretta B. Devery, do hereby certify that the testimony and proceedings in the foregoing matter, taken on February 8, 1995, are contained fully and accurately in the stenographic notes taken by me and that it is a true and correct transcript of the same.

  
LORETTA B. DEVERY, RPR



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